

Board Meeting in common
 Euston Room, 5th floor
 Royal College of General Practitioners
 30 Euston Square, London NW1 2FB

28 January 2026
 14.00-15.45

Agenda

Chair

Mike Bell

Apologies

/

Item	Lead	Purpose	Paper	Time	
1	Opening items				
1.1	Welcome and apologies	Mike Bell	To note	/	14.00
1.2	Declarations of interest (<i>not otherwise stated</i>) (NCL ICB and NWL ICB)	Mike Bell	To note	/	
1.3	Minutes of the previous meeting in common 04 December 2025	Mike Bell	To approve	1.3	
1.4	Matters arising and action log	Mike Bell	To note	1.4	
2	Strategy and Business				
2.1	Transition update	Ian Porter	To note	2.1	14.10
2.2	Strategy Development: update	Richard Dale	To discuss	2.2	14.25
2.3	NHS West and North London Integrated Care Board ('WNL ICB') Constitution	Sarah Morgan	To endorse	2.3	14.40
3	Overview Reports				
3.1	Performance report	Stephen Bloomer		<i>To follow</i>	14.50
3.2	Chief Executive's Report	Frances O'Callaghan	To note	3.2	15.05
4	Closing items				
4.1	Any other business	Mike Bell	/	Verbal	15.20
4.2	Date of next meeting: 24 March 2026	Mike Bell	To note	Verbal	
Questions from members of the public					
	<i>Please send your questions to one of the following by 10.00am Monday 26 January 2026:</i>	Mike Bell	To discuss		15.30



North Central London
Integrated Care Board

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Euston Room, 5th floor
Royal College of General Practitioners
30 Euston Square, London NW1 2FB



North West London

28 January 2026
14.00-15.45

NW London: nhsnw1.communications.nwl@nhs.net				
NC London: nclcb.meetingsquestions@nhs.net				

Presenters

- Mike Bell, Chair
- Stephen Bloomer, Chief Finance Officer and Deputy Chief Executive Officer
- Richard Dale, Chief Strategy Officer
- Sarah Morgan, Chief People Officer
- Frances O'Callaghan, Chief Executive Officer
- Ian Porter, Executive Director of Transition



North Central London
Integrated Care Board



North West London

Draft Minutes

**NHS North Central London ICB and NHS North West London ICB
Board Meeting in Common**

**4 December 2025 between 2.30pm and 3.30pm
Greenwood Centre, 37 Greenwood Place, London NW5 1LB**

NHS North Central London ICB Board	
Present:	
Mike Bell	Chair, NCL and NWL Integrated Care Boards
Frances O'Callaghan	Chief Executive Officer, NCL and NWL Integrated Care Boards
Stephen Bloomer	Chief Finance Officer, NCL and NWL Integrated Care Boards
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Chief Strategy Officer, NCL and NWL Integrated Care Boards
Iain Eaves	Chief Strategy and Neighbourhood Officer, North London NHS Foundation Trust
Mark Lam*	Chair, Royal Free London NHS Foundation Trust
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah McDonnell-Davies*	Chief Transformation Officer, NCL and NWL Integrated Care Boards
Sarah Morgan*	Chief People Officer, NCL and NWL Integrated Care Boards
Dr Alpesh Patel*	Co-Chair, NCL GP Provider Alliance
Simon Perry	Non-Executive Member, NCL and NWL Integrated Care Boards
Ian Porter*	Executive Director of Transition, NCL and NWL Integrated Care Boards
Jennifer Roye	Chief Nurse Officer, NCL and NWL Integrated Care Boards
Dr Jo Sauvage	Chief Medical Officer, NCL and NWL Integrated Care Boards
Liz Sayce	Non-Executive Member, NCL Integrated Care Board
Apologies:	
Cllr Peray Ahmet	Leader, Haringey Council
Anita Charlesworth	Non-Executive Member, NCL and NWL Integrated Care Boards
Jinjer Kandola	Chief Executive Officer, North London NHS Foundation Trust
Victoria Lawson*	Chief Executive, Islington Council
Julia Neuberger	Chair, UCLH and Whittington Health
Dr William Zermansky*	Co-Chair, GP Provider Alliance
Minutes:	
Steve Beeho	Senior Board Secretary, NCL Integrated Care Board
NHS North West London ICB Board	
Present:	
Mike Bell	Chair, NCL and NWL Integrated Care Boards
Frances O'Callaghan	Chief Executive Officer, NCL and NWL Integrated Care Boards
Stephen Bloomer	Chief Finance Officer, NCL and NWL Integrated Care Boards
Richard Dale*	Chief Strategy Officer, NCL and NWL Integrated Care Boards
Caroline Farrar*	Hammersmith and Fulham Borough Based Partnership
Fiona Hill*	Managing Director, 3ST NW London
Sarah McDonnell-Davies*	Chief Transformation Officer, NCL and NWL Integrated Care Boards
Sarah Morgan*	Chief People Officer, NCL and NWL Integrated Care Boards

* Standing Participant

Claire Murdoch	Chief Executive Officer, Central & North West London NHS Foundation Trust
Kunal Patel	Non-Executive Member, NWL Integrated Care Board
Simon Perry	Non-Executive Member, NCL and NWL Integrated Care Boards
Ian Porter*	Executive Director of Transition, NCL and NWL Integrated Care Boards
Akta Raja	Non-Executive Member, NWL Integrated Care Board
Jennifer Roye	Chief Nurse Officer, NCL and NWL Integrated Care Boards
Dr Jo Sauvage	Chief Medical Officer, NCL and NWL Integrated Care Boards
Tom Shakespeare*	Brent Borough Based Partnership
Dr Genevieve Small	Medical Director, Primary Care, NWL Integrated Care Board
Rita Thakaria*	Bi-Borough Partnership
Mark Thursz*	Director, Imperial College Academic Health Science Centre
Neha Unadkat*	Ealing Borough Based Partnership
Lesley Watts	Chief Executive, Chelsea & Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust
In Attendance:	
Martyn Schofield	Company Secretary, NWL Integrated Care Board
Apologies:	
Dr Dominique Allwood*	Chief Executive Officer, Imperial College Health Partners
James Benson*	Chief Executive Officer, Central London Community Healthcare NHS Trust
Anita Charlesworth	Non-Executive Member, NCL and NWL Integrated Care Boards
Rory Hegarty*	Director of Communications and Engagement, NWL Integrated Care Board
Cllr Neil Nerva	Brent Council
Cllr Jane Palmer	Hillingdon Council
Minutes:	
Steve Beeho	Senior Board Secretary, NCL Integrated Care Board

1.	INTRODUCTION
1.1	Welcome & Apologies
1.1.1	<p>Mike Bell welcomed attendees to the first meeting in common of the NHS North Central London (NCL) ICB and NHS North West London (NWL) ICB Boards.</p> <p>Apologies had been received from Cllr Peray Ahmet, Dr Dominique Allwood, James Benosn, Anita Charlesworth, Rory Hegarty, Jinjer Kandola, Victoria Lawson, Cllr Neil Nerva, Julia Neuberger, Cllr Jane Palmer and William Zermansky.</p> <p>Mike Bell noted the recent announcement that Frances O’Callaghan will be leaving the two ICBs to take up a new role as Chief Executive of NHS Blood and Transplant from 1 February 2026. He congratulated Frances and confirmed that NHS NCL ICB and NHS NWL will be looking at interim arrangements before the appointment of a new Chief Executive. Any appointment will ultimately need to be approved by NHS England. The substantive appointment will involve a full and open process, including stakeholder engagement across NCL and NWL. Precise timelines will be confirmed in due course.</p>
1.2	Declarations of Interest relating to the items on the Agenda
1.2.1	Mike Bell invited Members to declare any interests relating to items on the agenda. There were no additional declarations.
1.3	Minutes of the NHS NCL ICB Board Meetings on 22 July and 30 September 2025
1.3.1	The NHS NCL ICB Board APPROVED the minutes as an accurate record, subject to Simon Perry being added to the list of members present on 30 September 2025.

1.4	Minutes of the NHS NWL Board Meetings on 29 October 2025
1.4.1	The NHS NWL Board APPROVED the minutes as an accurate record.
1.5	Minutes of the NCL ICB Annual General Meeting on 30 September 2025
1.5.1	The NHS NCL ICB Board APPROVED the minutes as an accurate record.
1.6	Actions and Matters Arising
1.6.1	The NHS NCL ICB Board NOTED the Action Log.
2.	OVERVIEW REPORTS
2.1	Transition Update
2.1.1	<p>Ian Porter introduced the report which provided an overview of the transition programme. This is a complex programme which is being worked through at pace. The report highlighted the robust governance arrangements in place, including weekly meetings of the executive team. NCL and NWL ICBs are on track with the due diligence arrangements required by NHS England as part of the merger.</p> <p>Key programmes include IT systems and assets; reviewing over 200 policies across the ICBs; moving towards having a single financial ledger in place for April 2026 and establishing Ferguson House at Marylebone Road as the future ICB headquarters. As part of this, the two NCL ICB headquarters in Islington and Camden will be exited, which will generate substantial financial savings in respect of non-pay costs.</p> <p>Recruitment to the new Board of Members will begin in early 2026, including Non-Executive and Partner Members. There will also be a discussion of the future corporate governance landscape at the next meeting of the Transition Committee.</p> <p>The staff consultation for the new ICB structure will be launched on 8 December 2025. Approval has now been received from NHS England to simultaneously launch a Voluntary Redundancy scheme.</p> <p>It will be important to embed a new positive organisational culture as part of this programme and operating from a single headquarters will provide a strong platform to do this.</p> <p>There are now 80 working days until the merger comes into effect, so there will be a significant programme of work to deliver in the last quarter of the financial year. The executive team is mindful of the fact that there are various key areas that will need to be worked through alongside the more technical deliverables, such as partnership working and strategic planning.</p> <p>The Board will be asked to endorse the new Constitution at its next meeting in January, prior to it being submitted to NHS England for approval.</p> <p>Ian ended by thanking colleagues across the ICBs for embracing this important work, despite its complexity and the challenging circumstances.</p>
2.1.2	<p>The Boards of both ICBs discussed the report, making the following comments:</p> <ul style="list-style-type: none"> • Concern was expressed about whether the ICBs are progressing to a consultation driven by the need to meet a financial target without it being clear what the future ICB is being expected to do and what teams will be required to deliver this, and there is therefore a risk of the new ICB meeting its target but not having the right people to deliver what is required. • Assurance was given in respect of the future strategy and vision that the two Boards had previously discussed, with NCL and NWL ICBs recognising as strategic commissioners that there is work to be done in the Boroughs, with both local authorities and providers and the proposed structure will facilitate this. One of the tests

	<p>for all ICBs will be the ability to recruit a flexible workforce and respond to changing contexts. It is imperative to remain focused on this as this is an area which is continuing to evolve, including the expectations from NHSE.</p> <ul style="list-style-type: none"> • Partner members were encouraged to consider the key risks articulated in the paper. • It was noted in response that there was a strong push to ensure that there was a clear implementation plan and the current position is as good as it could be at this point in the merger implementation, as it was always acknowledged that the timetable is extremely challenging. Staff are understandably most concerned about the future organisational structure element of the consultation but they are still doing a phenomenal job of keeping the show on the road. There is inevitably still more to be done but the strategy which needs to underpin the enormity of what the ICBs are trying to enact should be coming to the Boards in the new year. • Assurance was given that the consultation will include the target operating model, which sets out what the ICB is here to do and the rationale for the operational design. A redacted version of the consultation will also be sent to partner members and stakeholder groups. The ICBs are in a comparatively good position at this stage, thanks in no small part to the preparation carried out by the executive team. • Despite the two ICBs being set an exacting process and a challenging timeline, both sets of staff have come together in a collaborative and collegiate way to get the job done in order to reach the end point, which is to deliver better services for local people through strategic commissioning.
2.1.3	<p>Mike Bell thanked Ian Porter for the update and noted that he had also provided a helpful briefing to Non Executive Members. Mike reaffirmed the importance of getting the culture right for the new organisation, bringing together teams from differently-run organisations. This will be a key part of the recruitment criteria for both the interim and the substantive Chief Executive appointment.</p>
2.1.4	<p>The NHS NCL ICB and NHS NWL ICB Boards NOTED the progress made and next steps for the transition programme.</p>
2.2	Performance Report
2.2.1	<p>Steve Bloomer introduced the report, noting that teams from both ICBs had worked together to produce a joint overview of performance in NCL and NWL. At this stage the report still consisted of separate sections to avoid losing the thread mid-year with respect to the two statutory bodies but the content will be brought increasingly closer together before April. He highlighted the following points:</p> <ul style="list-style-type: none"> • NWL has an ‘amber’ rating with regards to system flow as a result of ongoing challenges, including ED attendances and pressures around beds, as well as increases around the Patient Tracking List (PTL) and discharge pressures. Winter plans are now being implemented and are beginning to balance this to a degree. However, the operating environment is still more challenging than the previous quarter. • NWL is rated ‘green’ overall in terms of its planned delivery – it is on track with finance and staffing areas, as well as some of the main performance targets. • NCL is also rated ‘amber’ for system flow, with similar pressure around PTL, referrals and 12 hour waits in Urgent and Emergency Care, as well as smaller pressures around finances. Plans are in place to address these areas and good progress is being made. NCL is also seeing particularly strong performance in primary care.
2.2.2	<p>The Boards of both ICBs discussed the report, making the following comments:</p> <ul style="list-style-type: none"> • Although the trajectories in the reports were welcomed, it was acknowledged that acute Trusts are dealing with challenging backlogs. • It was noted that the ICBs will be losing their system co-ordination roles as part of the changes coming into effect in April and it will be important not to lose sight of this responsibility over the next few months. • It was queried whether something can be done at London level around advocacy to encourage vaccination take-up as the rates for patients and staff are significantly lower

	<p>than usual. It was confirmed in response that this point would be fed back to NHS England (London).</p> <ul style="list-style-type: none"> • It was noted that the weekly GOLD meetings have been stood up in NWL and NCL to look at being more directive about what is being done to optimise the management of winter flow. There are particular Boroughs where there are delayed discharges are more frequently manifest. Bespoke conversations will be ongoing throughout the winter months to expedite flow. • It was suggested that it would be helpful if future versions of the report could include like-for-like comparisons between NCL and NWL, rather than presenting information separately.
2.2.3	The NHS NCL ICB and NHS NWL Boards NOTED the performance against the key indicators outlined in the report.
2.2.4	Action: Jo Sauvage to discuss with the ICB Prevention and Vaccination Team what additional action can be taken to encourage staff to have the flu vaccine.
2.3	Quality Report
2.3.1	<p>Jennifer Roye provided an overview of the joint Report, highlighting the following points:</p> <ul style="list-style-type: none"> • NMUH is continuing to work through its action plan following a CQC inspection almost 12 months ago. The Trust was rated as “requires improvement” and is making good progress. This will continue to be monitored through the Local Maternity and Neonatal System (LMNS). • Following the liquidation earlier in the year of Nottingham Rehab Ltd, trading as NRS Healthcare, which provided Community Equipment to 23 London Boroughs, a large amount of work has taken place across the system to ensure that patients receive the right equipment. • The action plan of North London NHS Foundation Trust continues to be monitored following a CQC inspection of its mental health wards for adults of working age and Psychiatric Intensive Care Units rated its services as “requires improvement” overall. • As part of the Kingdon review into Paediatric Audiology services in England, Ealing Community Services were rated ‘red’. NWL ICB has been working closely with NHS England on the response to this. Various improvements have been made but a number of children may need to be recalled and the ICB is working with the teams on this. <p>Jennifer also updated the Boards on the case of a nurse at a Camden nursery who had recently pleaded guilty to charges of sexual abuse against young children. The NCL Safeguarding team is working closely with the local authority, the local community, the police and the NSPCC, as there is still an ongoing police investigation. Support is being offered to families across the system.</p> <p>It was also confirmed that the commitment to Maternity Investment Standards remains in place.</p>
2.3.2	The NHS NCL ICB and NHS NWL Boards NOTED the report.
2.4	Board Assurance Framework (BAF)
2.4.1	<p>Sarah Morgan provided an overview of the paper, noting that although this was a joint report, the BAFs were being presented separately for the two statutory organisations. She highlighted the following points:</p> <ul style="list-style-type: none"> • There are currently four risks on the NCL BAF, three system risks and one ICB-only risk concerning the merger which had been discussed earlier in the meeting. • The risk pertaining to insufficient ICS capital allocation had been closed since the last NCL ICB Board meeting because it had now been resolved. • The score for the risk regarding increased and undifferentiated demand and variation in general practice access models had also been reduced thanks to the work which had been done to mitigate this. • Although they are below the NCL BAF threshold, the report drew the Board’s attention to the risks around failing to provide adequate Child and Adolescent Mental Health

	<p>Services (CAMHS) and failing to deliver compliance with national operational standards across elective, urgent, and mental health care pathways.</p> <ul style="list-style-type: none"> • There are nine risks on the NWL BAF, three system risks and six ICB-only risks. A risk relating to the merger is currently being developed. • NCL and NWL colleagues have begun work on developing the approach to risk appetite and risk tolerance for the new organisation. • Merger and organisational design and CAMHS are being closely tracked as strategic risks. NWL ICB is working up a three-year strategy around Children and Young People (CYP), mental health services, learning disability and autism. NCL ICB has already been doing a lot of work in this area.
2.4.2	<p>Simon Perry confirmed in his capacity as Chair of the NCL and NWL ICB Audit Committees that work is taking place to develop a more aligned approach to risk for the merged organisation, building on the positive aspects of both ICBs' approach to risk management.</p>
2.4.3	<p>The Boards of both ICBs then discussed the report. It was suggested that further consideration should be given to whether the paediatrics and IHO issue should be considered as a risk or an opportunity. It was also suggested, further to the letter that Frances O'Callaghan wrote to NHS England (London) about the Royal Brompton Hospital and the Guy's and St Thomas's NHS Foundation Trust and the respiratory services, thought needs to be given to a central risk for NWL, and possibly NCL as well.</p>
2.4.4	<p>The NHS NCL ICB and NHS NWL Boards NOTED the Report.</p>
2.5	<p>Report from the Chief Executive Officer</p>
2.5.1	<p>Frances O'Callaghan provided an overview of the paper, highlighting the following points:</p> <ul style="list-style-type: none"> • The two ICBs are entering a volatile period of change but they will nevertheless come out the other side and establish the merged ICB as the strategic commissioner in accordance with the expectations of NHS England. It is crucial to remain focused on the wider picture while going through this challenging process as robustly and sensitively as possible. • The work of the Trusts to mitigate the impact of the recent industrial action was acknowledged. This is placing huge pressure on systems and planning is currently underway for a further five days of strikes in the run-up to Christmas to ensure that patients are looked after as well as possible during a period of unprecedented pressure. • The launch of Health Data for London represents a major milestone in the scale-up of the London Secure Data Environment (SDE) across the capital. NCL and NWL ICBs have been extremely active in this work, particularly Richard Dale and Kavitha Saravanakumar. This will have a significant impact on patient care, the availability of information, research and the longitudinal arrangement to commission for population health. The commitment secured from the general public to understand the benefits of the SDE was welcomed. • NWL ICB has been confirmed as fully compliant with all NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) following its formal annual assurance review. NCL ICB is undergoing the same annual assurance process and anticipating a similar positive outcome. • The hard work of staff who had been recognised in two recent national awards was commended.
2.5.2	<p>The Boards of both ICBs then discussed the report, making the following comments:</p> <ul style="list-style-type: none"> • It was queried whether it is possible to quantify the impact of the industrial action, as it appears to be heterogeneous. • It was acknowledged in response that the number of resident doctors going on strike appeared to be lower than in previous industrial action. All Trusts reported a 95% activity balance during the last industrial action in terms of what was expected but it is hard to predict these things.

	<ul style="list-style-type: none"> It was further noted that paradoxically there can be productivity gains due to teaching and other activity not taking place but this takes a toll on colleagues and is not sustainable in the long term. It is also important to recognise that this has a huge financial impact on providers which is unfunded.
2.5.3	The NHS NCL ICB and NHS NWL Boards NOTED the Report.
3.	ITEMS FOR INFORMATION AND ASSURANCE
3.1	Minutes of the NCL ICB Audit Committee Meetings on 10 June and 16 September 2025
3.1.1	The NHS NCL ICB Board NOTED the minutes of the Audit Committee.
3.2	Minutes of the NCL ICB Finance Committee Meetings on 1 April and 29 July 2025
3.2.1	The NHS NCL ICB Board NOTED the minutes of the Finance Committee.
3.3	Minutes of the NCL ICB Integrated Medicines Optimisation Committee Meeting on 6 May 2025
3.3.1	The NHS NCL ICB Board NOTED the minutes of the Integrated Medicines Optimisation Committee.
3.4	Minutes of the NCL ICB People Board Meeting on 28 April 2025
3.4.1	The NHS NCL ICB Board NOTED the minutes of the People Board.
3.5	Minutes of the NCL ICB Procurement Oversight Group Meeting on 7 May 2025
3.5.1	The NHS NCL ICB Board NOTED the minutes of the Procurement Oversight Group.
3.6	Minutes of the NCL ICB Quality and Safety Committee Meeting on 1 July 2025
3.6.1	The NHS NCL ICB Board NOTED the minutes of the Quality and Safety Committee.
3.7	Minutes of the NCL ICB Strategy and Development Committee Meeting on 18 June 2025
3.7.1	The NHS NCL ICB Board NOTED the minutes of the Strategy and Development Committee.
5.	ANY OTHER BUSINESS
5.1	<p>Mike Bell noted that he had received a question from Ben Coleman, MP for Chelsea and Fulham, who had asked for the issue of the very low proportion of children and young people across west London who are accessing the MMR vaccine to be discussed at Board level. Mike asked Jo Sauvage to consider when this would be appropriate and to also respond to Ben Coleman outside the meeting in the meantime.</p> <p>There was no other business.</p>
5.2	ACTION: Jo Sauvage to consider when the NCL and NWL Boards could discuss MMR uptake.
5.3	ACTION: Jo Sauvage to provide a written update to Ben Coleman MP on MMR uptake and what is being done to address this.
6.	DATES OF NEXT MEETINGS
6.1	28 January and 24 March 2026.

Action log for: **Corporate Governance**

As at: **21 January 2026**

Last updated:

Action delayed or critical issue identified

Action underway and progressing

Action closed



Ref	Date Raised	Currently with	Agenda item	Action	Owner	Date Due	Current RAG	Comments/progress
Integrated Care Board 2025-10	04/12/2025	ICB Board meeting in public	5	To provide a written update to Ben Coleman MP on MMR uptake and what is being done to address this (MMR vaccination uptake in children)	Dr Jo Sauvage	28/01/2026	CLOSED	16/01/2026: letter sent to Mr Coleman (JS)

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
4 December 2025	33	<p>Performance Report Paragraph 2.2.4</p> <p>To discuss with the ICB Prevention and Vaccination Teams what additional action can be taken to encourage staff to have the flu vaccine.</p>	Jo Sauvage	January 2026	<p>Vaccination 'Big Week' took place in late November with the aim of increasing vaccination uptake amongst staff and patients through a series of initiatives such as increased call/recall, outreach clinics and at-scale delivery in primary care.</p> <p>This week formed part of the wider winter campaign across West and North Central London which aims to increase flu vaccination as well as educating residents on local services.</p> <p>Flu vaccination uptake has increased by nearly 2.5% in comparison to 2024/25. Within West and North Central London, staff flu vaccination uptake has risen from approximately 32% (2024) to over 39% (2025).</p> <p>The vaccination team will continue to work with all system partners, patient groups and staff to promote flu vaccinations until the end of the season on 31 March 2026.</p>
4 December 2025	34	<p>Any Other Business Paragraph 5.2</p>	Jo Sauvage	March 2026	<p>A discussion is planned for the joint NHS NCL ICB and NHS NWL Board Seminar on 4 March 2026.</p>

**NHS NWL London and North Central London
ICB
Board of Members Meeting
Action Log**



North West London



**North Central London
Integrated Care Board**

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

		To consider when the NCL and NWL Boards could discuss MMR uptake.			
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North Central London
Integrated Care Board



North West London

**North Central London ICB and North West London ICB
Board of Members Meeting in Common
28th January 2026**

Report Title	Transition Update	Date of report	16 th January 2026	Agenda Item	2.1
Lead Director / Manager	Ian Porter, Executive Director of Transition	Email / Tel		ian.porter3@nhs.net	
Board Member Sponsor	Frances O'Callaghan, Chief Executive				
Report Author	Ian Porter	Email / Tel		ian.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 1st 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	Following the update to the North Central London (NCL) ICB and North West London (NWL) ICB Board of Members in-common in December 2025, this paper provides the Boards with a further update on the transition programme and the merger of NCL and NWL ICBs on 1st April 2026. The paper includes updates on the organisational design / staff consultation process, merger assurance process, and other updates from key workstreams.				
Recommendation	The 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: <ul style="list-style-type: none"> 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. 				

	<ul style="list-style-type: none"> • 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	<p>Significant financial, HR, Communications & Engagement, senior leadership and wider staffing resources are being utilised to deliver all aspects of the transition programme.</p> <p>Property resources are also impacted with a planned rationalisation of corporate office estates across the two ICBs.</p>
Engagement	Extensive engagement with staff, trade unions, and stakeholders through briefings, FAQs, and joint intranet content.
Equality Impact Analysis	A further equality impact assessment will be undertaken as part of the outcome of the current staff consultation on future organisational design.
Report History and Key Decisions	<ul style="list-style-type: none"> • July 2025: Boards agreed to merge. • September / October 2025: update to Boards • November 2025: National approval for voluntary redundancy scheme. • December 2025: update report to NCL and NWL Boards in-common
Next Steps	<p>A significant amount of work lies ahead – with key milestones including:</p> <ul style="list-style-type: none"> • End of staff consultation and production / publication of outcomes document – February 2026 • Due diligence checkpoint 3 – 20th February 2026 • Ongoing programme delivery through quarter 4 • Confirmation of Transfer Order in March 2026 • Merger go-live on 1st April 2026.
Appendices	Not applicable.

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

1. Introduction and Overview

Further to the update report to the North Central London (NCL) and North West London (NWL) Boards in-common on 4th December 2025 regarding the transition to the West and North London ICB, this report provides a further update on the progress over the last six weeks.

Work has continued with pace and momentum through December and January to prepare for the merger of the NCL and NWL ICBs and to meet the requirement to reduce the ICBs' running costs by 50% - both with effect from 1st April 2026.

Working with the Executive Director of Transition, a fully functioning Programme Management Office (PMO) Team is now in place – providing dedicated leadership, support, oversight, co-ordination and risk-assessment of the merger programme.

Components of the critical path to successfully delivering the merger for 1st April have been identified and mapped – and include arrangements for:

- Financial ledger and budget setting
- Payroll
- Contracts novation
- Audit, counter-fraud and insurance
- Banking and cashflow
- IT Systems
- Data Sharing Agreements
- Policies
- Organisational design and the associated change programme
- Office accommodation
- Branding
- NHSE Assurance

2. Merger Assurance

The ICBs' remain in a positive position with regards to delivering the merger programme. A key milestone in December was the completion of the 'checkpoint 2' assurance submission to NHS England. The submission included a comprehensive assessment across all of the key areas that are aligned to the ICBs' workstreams in place to deliver the merger programme:

- People
- Corporate, Governance & Accommodation
- Finance and Contracting
- Information Technology and Information Governance
- Communications and Engagement
- Transfers of Functions

Whilst a significant programme of work remains ahead through quarter 4, the assurance submission has not identified any significant current concerns across each of the

workstreams. Work continues with NHSE regional colleagues to progress all of the assurance requirements – and further checkpoint and data submissions will be required in February and March.

3. Organisational Redesign and Staff Consultation

As part of the change programme, the formal staff consultation on proposed changes to establish a new operating model for WNL ICB commenced on 8th December 2025 and is due to conclude on 25th January 2026.

During the consultation process, regular engagement continues with staff, trade unions and other key stakeholders on the proposals, responding to staff questions and providing as much supporting information as possible – including through a shared intranet space providing easy and consistent access for all staff in both ICBs. The ICBs' Joint Transition Committee was provided with an update at its meeting on 12th January 2026.

Once the consultation period has closed, all feedback will be considered and a summary of the key themes, how they have been considered, and any resulting changes to the proposals will be presented to staff in the consultation outcome document. It is expected that staff will be provided with the consultation outcome in February. An updated Equalities Impact Assessment (EQIA) will also be produced, and Individual Impact Assessments will be refreshed.

Thereafter the consultation outcome and filling posts in the new structure will be managed in accordance with the ICBs' Change Management Policy.

A key part of the merger due diligence process will require the ICBs to provide a full staffing schedule to NHS England 28 days prior to the transfer.

4. West and North London ICB – Constitution

As part of the governance workstream, the work to draft a Constitution for the new ICB has been completed. The work started from a position of strength, with both NCL and NWL ICBs having robust and aligned Constitutions and in accordance with statutory requirements.

The draft was presented to the ICBs' Joint Transition Committee in January and also to the respective ICBs' Audit Committees. The Constitution will be presented for endorsement to the ICBs' Boards in-common on 28th January 2026, prior to its submission to NHS England London for formal approval. Dialogue has taken place with regional colleagues through the drafting process – and there are no areas of concern.

The formal committee structure will also play an important part in the corporate governance arrangements for the new ICB. A top-level committee structure has been developed – with the objective of ensuring a robust governance framework that reflects the new purpose and operating landscape for ICBs. The proposed committee structure was discussed at the ICBs' Joint Transition Committee in January – with support for the four committees reporting to the Board:

- Strategic Commissioning
- Performance
- Audit
- Remuneration

As part of these arrangements, it is proposed that:

- A Primary Care & Medicines Optimisation sub-committee will report into the Strategic Commissioning Committee
- The Performance Committee will incorporate all oversight and monitoring arrangements regarding performance, finance and quality.

Detailed work will continue through February and March to develop the full corporate governance arrangements, sub-structures and interfaces. The new Board of Members, at its meeting on 1st April 2026, will be asked to approve the Terms of Reference of the committees that are directly accountable to the Board.

5. West and North London ICB – Board of Members

Another key element of the corporate governance arrangements for the West and North London ICB is the appointment of its Board of Members. It is proposed that the Board will comprise 20 voting members: the Chair, Non-Executive Members, Partner Members (local authority, Trusts/Foundation Trusts and Primary Care) and ICB Executives. Role profiles have been developed for Non-Executive and Partner Members – and the recruitment (including, where required, the mandated nominations process) will take place in February and early March.

6. Finance & Contracting

The Finance & Contracting workstream has continued to progress both:

- merger due diligence checklist activities including critical path activities and policy development; and
- (Integrated Single Finance Environment) ISFE2 post go-live activities.

Preparing for the ledger merger, the inaugural monthly SBS project board meeting took place during January. Updates to the due diligence checklist and further engagement with programme leads on templates are ongoing. The team is endeavouring to ensure readiness for the finance function at merger go-live, with close attention to compliance with NHS England requirements and dependencies such as payroll (ESR) integration. In addition to delayed and outstanding matters requiring guidance from NHSE, decisions on Standing Financial Instructions (as part of the Policies work at section 8 below) and non-pay budget allocations are pending. Overall, technical and operational preparations remain broadly on track, with problem-solving and risk management processes actively underway.

Regarding ISFE2 post go-live, the mapping of direct reports to the new Executive Directors has largely been finalised. While significant progress has been made on cost centre mapping to enable dashboard views, the team may need to defer full completion until 1st April, depending on ongoing assessments.

In addition, weekly procurement meetings are in place to manage audit contracts and a draft paper outlining procurement options is being developed.

7. Information Technology & Information Governance

The digital and IT leadership team across the two ICBs has established a joint ICT merger delivery group with responsibility to deliver the related transition plan. The workstream links into the corporate merger planning arrangements to help ensure overall readiness for 1st April.

There are four key objectives for this work – and positive progress has been made through December and January:

- **Collaborate** – To share files and folders seamlessly, work collaboratively on projects, and to be attached to a single email domain. Work has progressed in priority areas including HR and Comms - and IT colleagues are working to enable seamless access across other directorates.
- **Connect** – To enable all staff 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** – To have a single point of access for support and aligned processes (for e.g. starters, movers and leavers). The service desk teams across NWL and NCL ICB are working more closely than ever with a view to having a single front-door for all users from 1st April. A request was successfully submitted to NHSE to establish an organisation code for the new ICB and this has now been received. Preparations continue to move the ICB over to this new arrangement from 1st April.
- **Align** – To run future IT procurement strategically, with a view to standardising contracts as and when the existing contracts expire. Scoping has been completed of related policies, systems and contracts for alignment, taking into account contract end dates, notice periods etc.

To support our preparations in the context of data security, both ICBs are undertaking an early annual Data Security Protection Toolkit process during quarter 4, with independent support from respective internal auditors.

8. Policies

Policy alignment is another key area of the transition programme – of both internally and externally facing policies.

A comprehensive analysis has been undertaken across the transition workstreams to identify those policies that are critical for aligning in time for 1st April. Work is now being undertaken to plan the alignment of these critical policies with the aim of the respective ICBs' governance approving the alignments in quarter 4 – enabling single policies to be carried forward into the new ICB on 1st April and ratified by the new Board of Members accordingly.

This work also includes developing clear plans for aligning all other policies in the period beyond 1st April.

9. Transfer of Functions

NHS England has recently released an updated document setting out expectations for ongoing accountabilities and responsibilities for a range of ICB functions previously identified for potential transfer-out, as set out in the initial 'Model ICB Blueprint' guidance published in May 2025.

In the context of these ongoing ICB responsibilities, the proposed structures for WNL ICB (as set out in the current staff consultation document) are broadly in line with the revised narrative on ICB functional responsibilities.

The key gap is in relation to the System Co-ordination Centre (SCC). The publication references that ICBs should "provide or commission" this service – and the ICB will need to consider next steps in this regard. In the meantime, the NCL and NWL ICBs' SCC capacity remains in place to support the respective systems through the winter flow challenges.

In line with the ICBs' discussions and agreements in December 2025, the work on the future delivery of Complex Care responsibilities continues and is unaffected by the national changes to ICBs' roles for 2026/27, as referenced immediately above. A clear plan is in place and is progressing well. Once final details are worked through, the ICBs will be in a position to provide a further update including next steps, in advance of the Boards in-common discussion and decision in March.

10. Communications and Branding

Delivery of a range of communications and engagement activity regarding transition continues, including with our staff in relation to the organisational design / consultation process. The work has also included a comprehensiveness analysis of all partnership meetings involving North Central and / or North West London ICBs – ensuring suitable representation remains in place through this key phase of transition.

As part of our preparations to stand up the new organisation, work has taken place to develop a brand architecture and visual identity for West and North London ICB. While this work has been delivered at pace, it has followed a structured process of research, sector analysis and engagement across residents and colleagues.

Our key objective is to develop a clear, trusted and coherent brand that reflects the vision of the new West and North London ICB, enabling residents and partners to understand it and staff to feel part of something positive and new. We want the new brand to feel modern, confident, innovative and accessible, but rooted in the communities we serve and reflective of the values and principles of the over-arching NHS brand.

Following feedback from a three-stage engagement process involving residents, qualitative interviews and two staff workshops, we have worked with a local design agency to develop a new look and feel, alongside detailed brand guidelines and templates.

This brand positions the NHS as the parent brand, supported by a new design device that will be used across local platforms and materials. This device is deliberately bright, bold and flexible. At full size, the ribbon includes the letters W and N to reflect our locality, alongside

13 different colours to reflect our local boroughs. It can be used at full scale, or zoomed in, creating flexibility in the way it is used in different settings.

The core brand is supported by a secondary logo for West and North London ICS, to be used in settings where the system has worked together on a project or programme and needs to reflect partnerships beyond the NHS.

We will move to this new branding on 1st April 2026 – with examples as follows:



11. Corporate Office Accommodation

Work continues at pace to move to a single office headquarters for the West and North London ICB at Ferguson House on Marylebone Road, the current headquarters of NWL ICB.

This transition will provide a single platform to build a strong, positive culture for everyone working in the new organisation and a positive and professional working environment.

New branding, as above, will be introduced throughout each of the ICB's floors. Our work includes ensuring an optimum balance of meeting spaces and workstations throughout the building and ensuring good use of the best supporting equipment currently available across both ICBs.

A clear plan is in place to ensure a timely exit from the current NCL office locations at Laycock Street and Euston Road – and we have agreed minimal exit costs.

We have briefed all staff of the forthcoming changes and will continue to support everyone through this element of the transition programme, recognising the sensitivity of the timing.

12. Next Steps

While good progress has been made through December and January to deliver what is an extensive, complex and time-pressured transition, we are mindful that a significant programme of work remains ahead up to and beyond the point of merger on 1st April 2026.

We recognise and are grateful for all of staffs', Board Members' and partner colleagues' support for all aspects of the transition – and at a time when there is uncertainty for many and during a challenging winter period across the North Central and North West London footprints.

The Transition Committee will be provided with a further progress update at its next meeting in early March.



NHS NC Central London and NHS NW London

Board Meeting in Common

28 January 2026

Report Title	Strategy Development: update and discussion	Date of report	January 2026	Agenda Item	2.2
Lead Director / Manager	Richard Dale, Chief Strategy Officer	Email / Tel		Richard.dale@nhs.net	
Board Member Sponsor	Not applicable.				
ICB	The paper sets out the work the develop the future strategy of the newly merged West and North London ICB				
Report Author	Richard Dale, Chief Strategy Officer	Email / Tel		Richard.dale@nhs.net	
Name of Authorising Finance Lead	Not applicable.	Summary of Financial Implications The draft strategy is based on a multi-year set of planning assumptions being finalised as part of the NHS planning round.			
Recommendation	<p>The board is asked to:</p> <ul style="list-style-type: none"> • NOTE the progress to date, the future work to develop the full five year strategy and • DISCUSS the strategic themes and shape the next phase of work. 				
Report summary	<p>As part of continuing to develop the five year strategy for the newly forming West and North London ICB as a strategic commissioner, this paper sets out the work underway to develop a five year strategy, the strategic themes and high level feedback from partners and committees.</p> <p>Extensive work is now underway with system groups and partners to test/refine and develop the next version of this strategy. As an example, integrator colleagues are supporting shaping the next level of detail with regards to the development of neighbourhood teams.</p> <p>To support oversight of the development of the strategy and discussion on next steps, this paper provides an update to the board on the following:</p> <ul style="list-style-type: none"> - The overarching narrative and priorities - The guiding set of strategic insights and analysis - Assurance for the board in terms process and requirements - The work underway in response to the comments from the strategic commissioning committee. - Key questions to steer the next phase of work <p>The current draft strategic narrative is included as an appendix – noting that this is a work in progress.</p>				



Identified risks and risk management actions	Not applicable to this report directly. Following discussion, the new ICB risk register will be updated in line with the aims of the organisational strategy.
Conflicts of interest	Not applicable.
Resource implications	Not applicable to this report directly. Following discussion at the board work will progress on delivery planning in line with the new strategy and financial trajectory.
Engagement	The board paper has been the result of review and enhancements of NWL and NCL population health strategies which had extensive engagement. Following the board discussion the next stages will involve a planned programme of engagement with partners and residents to shape the plans.
Equality impact analysis	Not applicable to this report directly. The board paper has been the result of review and enhancements of NWL and NCL population health strategies which had EQIA screenings. As part of the development of the full plan a further EQIA will be undertaken.
Report history and key decisions	This draft strategic narrative and set of priorities reflect: <ul style="list-style-type: none"> • Discussions at the Board Away Day (10 November) • A review of strategies and plans across NWL and NCL • Population health needs assessments • Health economic analysis of current utilisation and future risk • National guidance on strategic commissioning and medium-term planning • Discussions at the Strategy and Commissioning Committee 12 January 2026
Next steps	Next steps are set out on slide X in terms of the development of the full strategy
Appendices	Appendix 1. The proposed approach to strategy development and review across the new organisation Appendix 2. DRAFT - STRATEGIC NARRATIVE AND AREAS FOR CHANGE

Strategy Development: Update and Discussion

West and North London ICB

January 2026

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Overview of strategy development

Developing the five-year strategy

Work continues to develop the West and North London five-year strategy, working with system partners and professional groups to test and refine the analysis and principles underpinning the strategy, while beginning to build the detail of plans to take this forward.

The work is informed by detailed population needs assessments across our communities and supplemented by local qualitative insights on what residents have told us.

The Board has given a strong steer to base the strategy on a multi-year shift of spend from acute and crisis care towards proactive, preventative care in the community.

The work is closely aligned with the operational planning approach, and the principles set out in relation to financial strategy, capacity planning and new models of care are reflected in this work.

Economic analysis and constitutional standards

The next stage of analysis will focus on two critical aspects:

- First, an overall economic assessment of the full £12bn system spend, including analysis of the scale and composition of structural costs and spend that could be repurposed and shifted over time. This will support the Board in maximising the pace of change and inform wider

conversations about how the system and NHS providers operate.

- The second will support a clearer understanding of the link between health equity, value and delivery of the NHS constitutional standards (see slide 9 for further detail), to embed a health equity approach in all decision making.

Equity, Outcomes and Value

All new models within the strategy have at their core a focus on defined population segments, a better understanding of current and future risk, and proactive, person-centred interventions to improve outcomes and value. While the scale of the shift is important, improvements in technology and data mean equal weight must be given to the accuracy of segmentation and risk prediction, to ensure interventions deliver positive impact and value.

Strategic investment and benefits case

All work within the strategy builds on good practice across the two ICBs and accelerates delivery at scale. In parallel, extensive work is underway to develop a clear strategic investment and benefits case for neighbourhood and planned care shifts, which will be brought through ICB and system governance during February.

Guiding insights and analysis (1 of 2)

Equity and outcomes

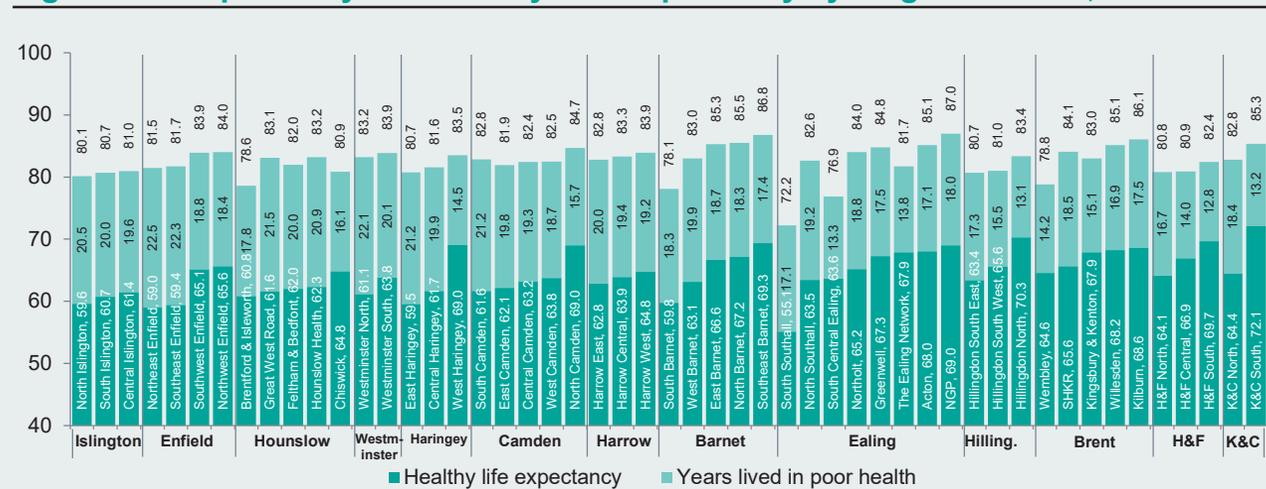
The current configuration of health and care across North and West London is unsustainable and is **failing to deliver equitable outcomes**. There is a **17-year gap in healthy life expectancy** between neighbourhoods across the new ICB footprint. These inequalities are deep-rooted and complex.

At the same time, national and local analysis highlights that we allocate a **disproportionate share of resources to high-cost acute and crisis care**, while underinvesting in prevention, primary care, community services, and planned care. Significant future population health risk – identified through improved modelling and analytics – therefore remains unaddressed.

Our analysis and data show that **certain communities experience poorer outcomes and higher use of emergency care**, for example deprived communities and adults with severe mental illness (SMI). Across West and North London, the excess under-75 (all-cause) mortality rate in adults with SMI is 379% higher than in adults without SMI, with significant variation at borough level, ranging from 291% in Camden to 496% in Hillingdon (Source: ONS, MHSDS, Fingertips).

In these communities, **lower investment in proactive and planned care in high-need areas results in higher-cost reactive care later**. As the chart to the right shows, a far greater proportion of spending in our most deprived populations is on reactive care compared with our least deprived populations.

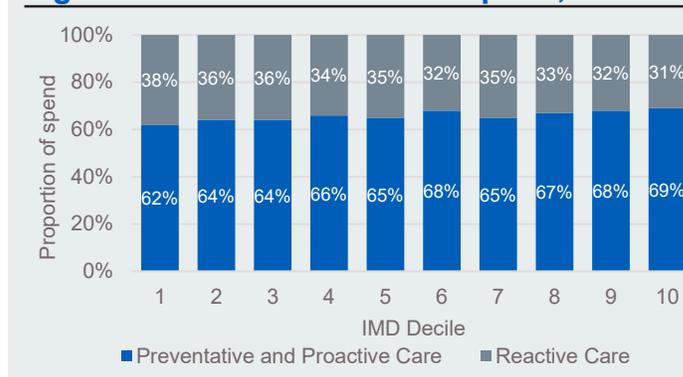
Fig. a: Life Expectancy and Healthy Life Expectancy by neighbourhood, 2022



At a neighbourhood level, the healthy life expectancy gap increases to **17 years of ill health**, with the greatest disparity seen between South Southall (55.1) and K&C South (72.1).

The chart to the right demonstrates how residents in deprived neighbourhoods such as South Southall may have **lower levels of access to proactive care**.

Fig. b: Proactive vs. reactive spend, 2024/25



Sources - HLE / LE Source: ONS data using ONS methodology; Spend: WSIC

Guiding insights and analysis (2 of 2)

A focus on multi-morbidity, building trust and patient activation

- True equity cannot be achieved without addressing multi-morbidity. Our data shows **clear gaps in the number and severity of LTCs between different deprivation levels and ethnic groups**, with people in our most deprived neighbourhoods and from ethnic minority communities developing poor health earlier in life.
- People with **multiple LTCs continue to experience fragmented, poorly coordinated pathways, typically interacting with eight or more services each year, yet very few have a shared care plan**. A review of frailty services in one borough identified 40 different services that a frail person might need to interact with.
- **Low levels of trust**, partly due to poor experiences of and access to care in our more deprived neighbourhoods and ethnic minority communities, lead to conditions being diagnosed later and poorly managed, with preventable complications, for example amputations in diabetes.

A shift to proactive, community-based, integrated care enabled by technology

- **Over-medicalisation, variation, and fragmentation in planned care pathways** lead to low-value interventions. This drives poorer outcomes and higher costs across groups, especially those with multiple LTCs and older adults.
- **The current system trajectory is financially unsustainable and operationally fragile** at a time when expectations of delivery are high. An **ageing population** (a 12.7% increase in over 65s - equivalent to 60,000 people) across will give rise to even greater levels of multi-morbidity, service demand, and financial instability. Therefore, no change is not an option.
- Our underlying assumption is that by **shifting the proportion of spend** from acute and crisis care into community-based, proactive, primary, and planned care, aligned to need and building trust – we can **achieve better outcomes and reduce the higher healthcare costs** that arise later when patients deteriorate in acute care pathways. Crisis pathways need standardising and work to reduce fragmentation, but should not be the focus for additional recurrent net investment during this period.

Fig. c: Multi-morbidity by deprivation and ethnicity

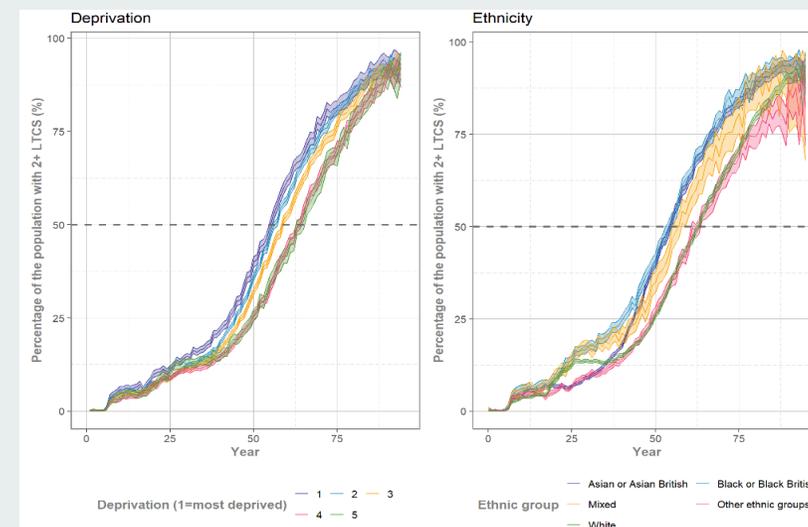


Fig. d: Population projections across WNL



Sources: WSIC, ONS, GLA

Our strategic mission and approach

Our mission: Reduce variation in healthy life expectancy – supporting everyone to have a good start in life, more years lived in good health, and a dignified death.

Problem statement: The problem statement for the ICB and system is therefore, within these constraints, how do we strategically commission for population health, deliver integrated neighbourhood care models and ensure financial sustainability while:

Meeting constitutional NHS standards across commissioned services

Reducing the variation in health life expectancy across our communities, from 17 years to 12 years

Increasing the number of years lived in good health for our most deprived quintile, from 55-59 years to 65-69 years

Reducing the number of cancers diagnosed in A&E to zero

Investing in a way that not only accounts for but reduces future population healthcare need

Our strategic approach: As commissioners, we will focus on where transformation delivers the greatest value. This means directing attention and investment towards areas with high utilisation, poor access, experience, or outcomes, and ensuring redesign translates into measurable improvements in these areas.

Reducing inequalities is our number one priority. Recognising that wider determinants of health drive these inequalities, we will work in partnership across the NHS, local authorities, and other local partners, including the VCSE. This requires a bolder, more innovative, and more trusting approach to delivery. We will reshape how we work around population cohorts and outcomes, using capitated budgets and the neighbourhood health model to rewire service delivery around our population. We will use longitudinal data and analysis to better understand and mitigate risk, suppress future costs, and improve outcomes, and implement new contractual approaches to align incentives and support providers to develop new care models that improve value for population cohorts.

In line with the new operating model we will work closely with providers, who will lead detailed pathway optimisation, reduction of unwarranted variation, and productivity improvement.

1: We will understand rising risk within communities and take a proactive, preventative approach to supporting people to stay well, identify conditions early, and self-manage LTCs. Over time, this will reduce the flow of people into high-utilisation, poor-outcome cohorts. Services will be co-designed with communities in ways that build trust.

2: We will prioritise population cohorts with high utilisation but poor outcomes or low value. These patients often interact with multiple parts of the system due to fragmented or inefficient pathways. By understanding their needs and the drivers of avoidable activity, we will work with them to redesign care so it is proactive, coordinated, and delivers better outcomes at lower cost.

3: We will drive a step-change in planned care pathways using 'should-cost' analysis. This means moving away from historic delivery patterns and modelling what pathways should cost if designed around best practice, efficient staffing, digital triage, and optimised flows. This creates a shared benchmark for improvement and a clear basis for investment and reinvestment decisions.

A multi-year financial trajectory to drive improved outcomes and value

The financial challenge and case for change

Both legacy ICBs **delivered balanced financial positions between 2022/23 and 2024/25**, supported by **non-recurrent measures**. This masks **structural challenges**, including the rising burden of chronic disease and a continued drift towards acute activity.

Acute expenditure has increased from **50% of total spend in 2019/20 to 54% in 2024/25**. In order to improve the value of healthcare we need to **change the profile of this spend** back to improve access, better coordinate care and intervene earlier to manage risk and deliver higher healthcare utility for the money we spend.

The **NHS Medium-Term Planning Framework** requires systems to adopt multi-year planning horizons, reduce reliance on non-recurrent funding, and rebalance investment into preventative and community-based care.

Principles guiding our financial strategy

Our financial strategy will set out a multi-year trajectory that will follow the following principles:

- A plan for a **sustainable financial position** and balanced plan in each year
- We will **target investments** that ensure ICB resources are invested against the **highest need**, noting that neighbourhoods are the ICB unit of delivery.
- All investment decisions will be based on the **analysis of data to estimate need** and be subject to a business case/value proposition process to evaluate positive impact.
- We will look to develop **capitated budgets and commission by outcomes** – to reduce inequalities in these outcomes through connecting and delivering services that span traditional healthcare boundaries, aligned to need in our communities.
- We will **invest in activities that reduce** emergency demand in secondary care, reduce unnecessary clinical variation, reduce follow-up outpatient appointments, reduce health inequalities, and we will **disinvest in activities that are not delivering** the intended value or outcomes.
- We will **reduce unearned income** by commissioning higher levels of activity (elective) to **reduce waiting lists inside and outside of hospital**.
- We will **target capital investment at transformation and neighbourhood development**.

Overview of priority areas

Note: more detail is available in the accompanying strategic narrative document (appendix 3)

Strengthening Relationships and Building Trust with Communities

Low activation is associated with **18% more GP contacts** and **38% more emergency admissions**, and disproportionately affects deprived and ethnic minority communities.

Patient activation must become core to care delivery, to shift care from reactive to proactive.

Neighbourhood Health as a Core Delivery Model

Health life expectancy varies by >17 years between neighbourhoods in West and North London. Rising multi-morbidity and an ageing population require local, coordinated, preventative care.

Neighbourhoods will become the core unit of delivery through integrated teams.

Planned Care Transformation Through Digital and Community-First Pathways

Planned care referrals are **growing by 8% annually** and are driving longer waits and unsustainable pressure. Pathways are complex and hospital-centric, delaying access.

Redesigning major pathways using self-referral, digital triage and community-first models will ensure patients are seen in the right place, first time.

Integrated Care for Children and Young People

An estimated **107k** children and young people have complex health needs across West and North London – around **2.1k** per neighbourhood. Fragmented services delay diagnosis, particularly for boys and disadvantaged groups.

An integrated health offer and consistent neighbourhood model will reduce duplication and improve outcomes for children and families.

Improving Outcomes for Adults with Serious Mental Illness

Adults with SMI have an under-75 mortality rate **379% higher** than those without SMI, and despite using healthcare services **over seven times more**, outcomes remain poor.

Strengthening community, acute and crisis pathways will reduce unwarranted variation and improve physical health outcomes. Through neighbourhood teams we will target investment where inequalities are greatest.

Deploying Genomics and Precision Medicine

Genomic medicine can reduce diagnostic delays from **four years to three months** for some rare diseases and cancers, and polygenic risk scores can identify individuals with higher lifetime risk for certain long term conditions.

We will deploy genomics where evidence shows clear value, and genomic insights will be embedded into real-time clinical decision-making.

Supporting a Dignified Death

Each year, **10k-11k** patients are admitted to hospital in their last year of life, with around **1.2k** experiencing three or more admissions in their final 90 days. **53%** of deaths occur in hospital compared with **45%** nationally, contrary to patient preferences.

We will redesign end-of-life pathways and strengthen community and palliative care to reduce avoidable admissions and enable more people to die in their preferred place.

Developing Robust Digital Infrastructure

Fragmented systems and poor interoperability limit information sharing and integrated working, restrict proactive care and contribute to variation in outcomes.

To support our ambitions for neighbourhood health, patient activation and data-driven decision-making at scale, we will invest in interoperable systems, real-time analytics and population health capability, aligned to the London SDE.

Next stage analysis is now underway

Work package 1: Financial analysis

How the 1% shift in spend is a catalyst for driving better value for our overall £12bn budget

A profile of the **full £12bn West and North London spend** and the extent to which we understand the pace and quantum of spend that can be changed over the next five years to achieve financial sustainability and improved outcomes.

This will include **high-level mapping of system spend**, structural costs, and the extent to which productivity improvements and re-provision into higher-value models can support the pace of change required over a multi-year trajectory within a fixed financial envelope.

Further details are provided in a proposed storyboard over the next two pages.

Work package 2:

Accomplishing our equity mission and hitting constitutional standards

A set of analyses to better understand the **link between delivery of constitutional standards and equity**, and the alignment between the two. This will be based on the following:

1. We know **deprived communities consume more reactive care**, as shown in the graph on slide 4.
2. We know these communities are **overrepresented in the longest waiting patients**, as demonstrated in both the NW London and NC London annual reviews of healthcare inequalities [NB: NWL analysis is [here](#), and NCL analysis is [here](#)]
3. We know that these **communities are also diagnosed with serious illness**, such as cancer, at a **later stage** and this results in poorer health outcomes [NB: same reference point as point 2]
4. We know **black mothers are more likely to suffer complications in childbirth** than other women as demonstrated in both the NW London and NC London annual reviews of healthcare inequalities and in a range of national reports [for example, see [here](#)]

Failure to meet constitutional standards drives inequality and vice versa i.e. delayed care, increasing crisis use, worsening outcomes, and entrenching higher costs in deprived communities. Therefore, **focusing on equity** improves performance against constitutional standards because it targets the populations and pathways that are often experiencing long waits, high acuity, and avoidable demand.

Financial analysis: proposed high-level storyboard

How the 1% shift in spend is a catalyst for driving better value for our overall £12bn budget

#	Slide title	Key message
1	What is driving our cost pressures?	“Cost growth is structurally driven by reactive care, fragmented pathways, and misaligned capacity — not a single factor and not short-term inefficiency.”
2	The ‘do nothing’ financial challenge	“If current care models continue, the system faces a widening five-year financial gap that will need to be closed through £xm allocative efficiencies and £xm technical efficiencies.”
3	Building the allocative and technical efficiency opportunity	“A structured, end-to-end analysis shows there is a significant, quantifiable opportunity of £xm to reallocate spend through prevention, productivity and pathway redesign.”
4	The 1% shift to neighbourhoods as a delivery mechanism	“A disciplined 1% annual shift of the total system budget is the ‘engine’ that funds transformation and suppresses future demand growth.”
5	Strategic transformation: what changes on the ground?	“Sustainability is achieved by redesigning pathways to prevent escalation, activate patients, reduce duplication and improve productivity at every stage of care.”
6	Performance impact: unlocking system flow	“Performance against constitutional standards improves when capacity is freed from low-value activity and redirected to pressure points in care pathways.”
7	Leadership, governance, and the ‘feedback loop’	“Closing the gap requires sustained leadership, protected transformation funding and multi-year governance focused on convergence over time, not annual ‘quick-fixes’.”

Slide 3 detail:

A. What is the £ opportunity for allocative efficiency?

- **Baseline and growth analysis:** analysis of total spend and activity by: pathway; setting; population identify where growth is structural vs episodic (separating unavoidable trauma/emergency care from "preventable" exacerbations of LTCs).
- **Demand and utilisation:** analysis of reactive vs. proactive care (by neighbourhood); analysis of the cost of inequalities; preventable escalation; over-medicalisation and low-value activity; the cost of fragmentation and duplication across settings.
- **Redesign:** including prevention; primary prevention (risk reduction, behaviours); secondary prevention (earlier diagnosis, proactive management); patient activation and self-management; right-size capacity at each pathway stage.

B. What is the £ opportunity for technical efficiency?

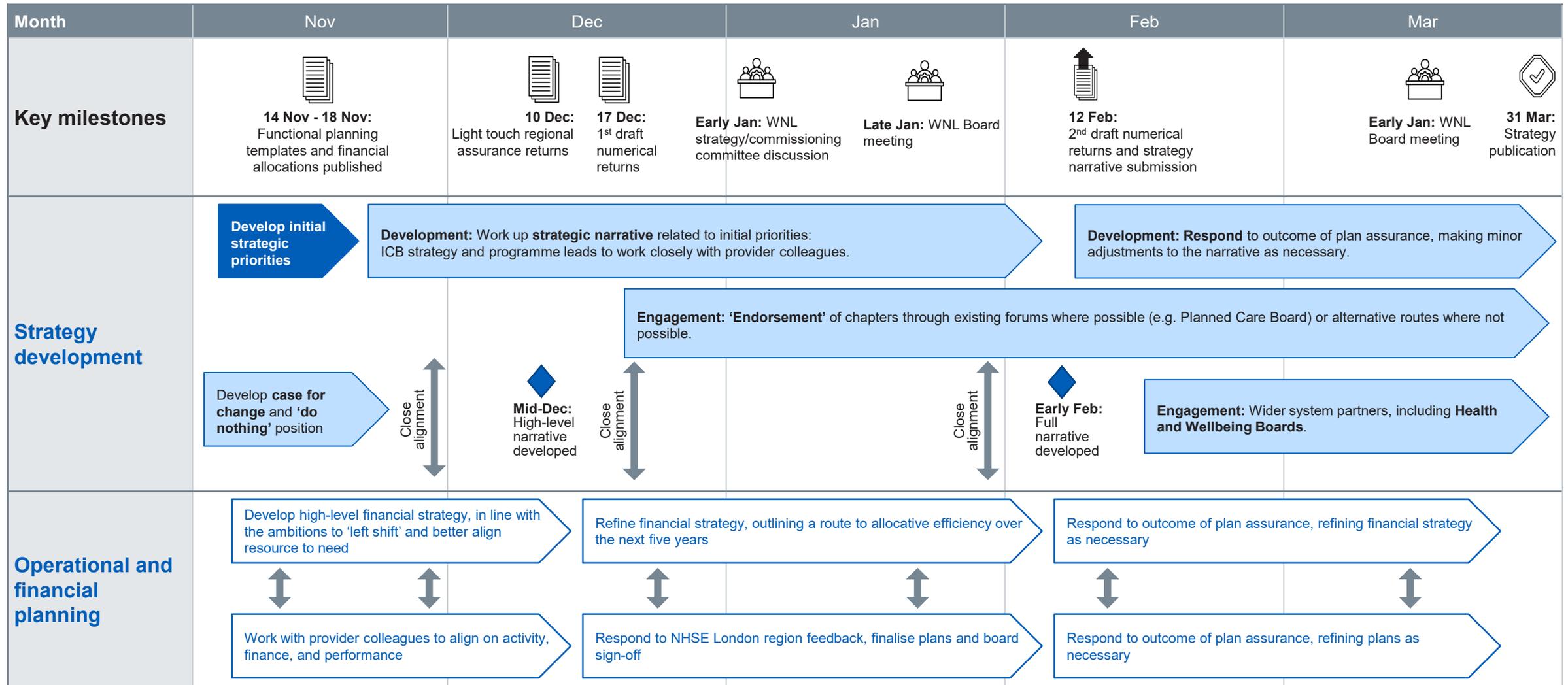
- **Productivity opportunities:** (e.g. unit cost; length of stay; digital substitution; workforce configuration, etc.)

C. What is the required financial trajectory?

- **Phasing analysis:** model realistic ramp-down and ramp-up of interventions; avoid assuming immediate acute capacity release.

Output: a single, aggregated estimate of: total efficiency opportunity; what is shiftable outright vs what requires productivity; phased delivery over five years, including likely position by sector.

Timeline to completion and wider system engagement



Key feedback themes and reflections for further work

Through a period of continued NHS and wider public sector change, how do we:

- Ensure strong partnership working through a period of change for Local Authority colleagues, including the Fairer Funding Review?
- Best work with provider alliances and influence provider business plans through the next phase of work, to support aligned provider transformation?
- Support and develop VCSE and other non-statutory delivery models via developments at place?
- Ensure the right focus on children through a multi-agency approach?

How do we make the most of the assets and specific capabilities of organisations and communities across West and North London to:

- Work with communities to support engagement with critical proactive, preventative services, such as screening and vaccine uptake?
- Maximise the impact of the work and health agenda for local communities?
- Work with the life sciences, research and innovation agenda on an international footprint?

Appendix 1.

West and North London strategy development

Purpose and role of Integrated Care Boards (ICBs)

ICBs exist to lead population health improvement and steward NHS resources for long-term value.

Our purpose
(why we are here):

“To strategically commission healthcare services that improve the health and lives of West and North London residents, both now and in the future”

**What does a
‘Model ICB’¹ look
like?**

- ICBs exist to **improve their population’s health** and ensure access to consistently high-quality services.
- They hold the **accountability** for ensuring the best use of their **population’s health budget** to improve health and healthcare, both now and in the future.
- ICBs provide **system leadership for population health**, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources.
- This involves **investing in, purchasing and evaluating the range of services and pathways** required to ensure access to high quality care, and to improve outcomes and reduce inequalities within their footprint.
- ICBs not only commission services but also **align funding and resources strategically** with long-term population health outcomes, and manage clinical and financial risks.

**What does this
mean in
practice?**

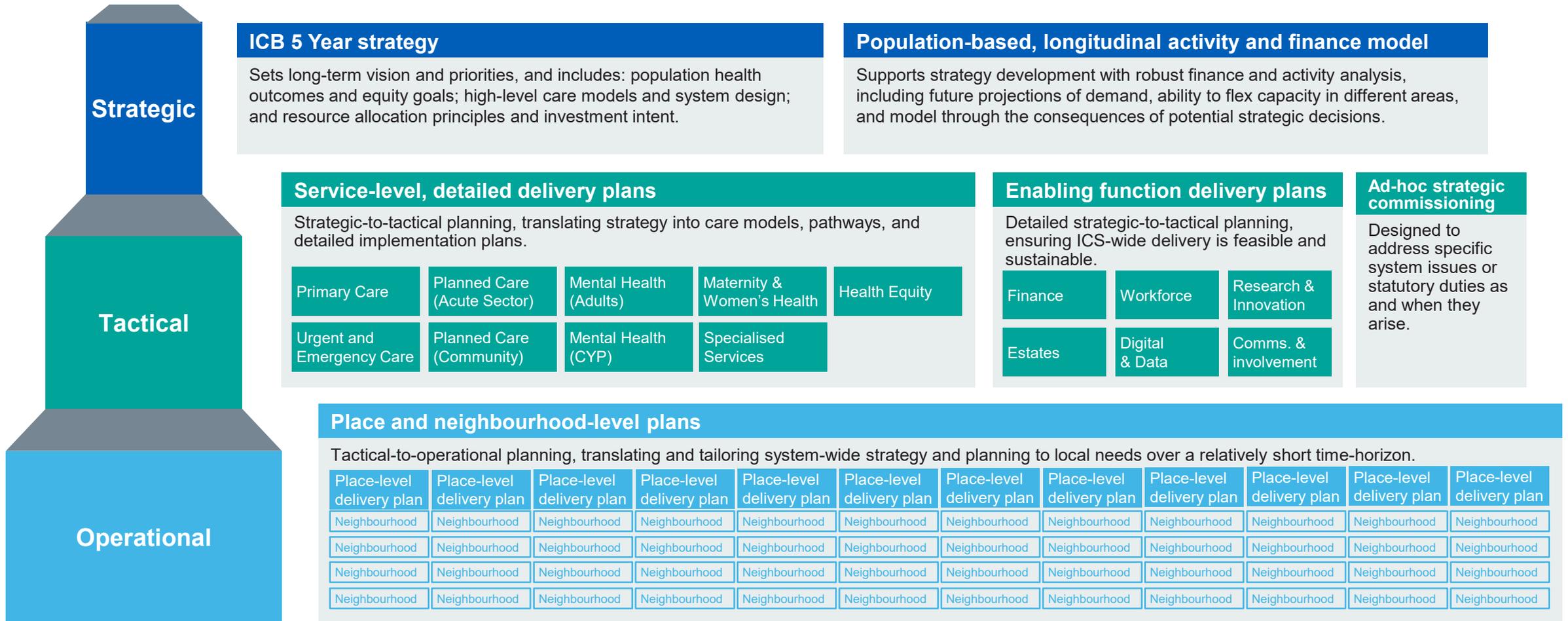
Going forward, ICBs need to refine their role and focus on being a **strategic commissioner**. This is an opportunity to take another step towards the model of Place and Neighbourhood-based leadership that our partners have been working towards – a **lighter touch commissioner** with delivery-focused, provider-led partnerships that best understand the local context and the needs of communities. This means we will:

- **Commission local and delegated healthcare services** for our population.
- **Convene the system** to ensure aligned strategic direction and an integrated plan.
- **Shape the provider market.**
- Ensure providers **deliver high-quality services** in with their contracts.
- Work with partners to **address the wider determinants of health** and to **secure innovation.**

Source: 1. Model ICB Blueprint, May 2025, NHS England

Strategy hierarchy

Different strategies serve different purposes – a clear hierarchy avoids duplication, clarifies ownership, and enables a manageable annual planning cycle and delivery.



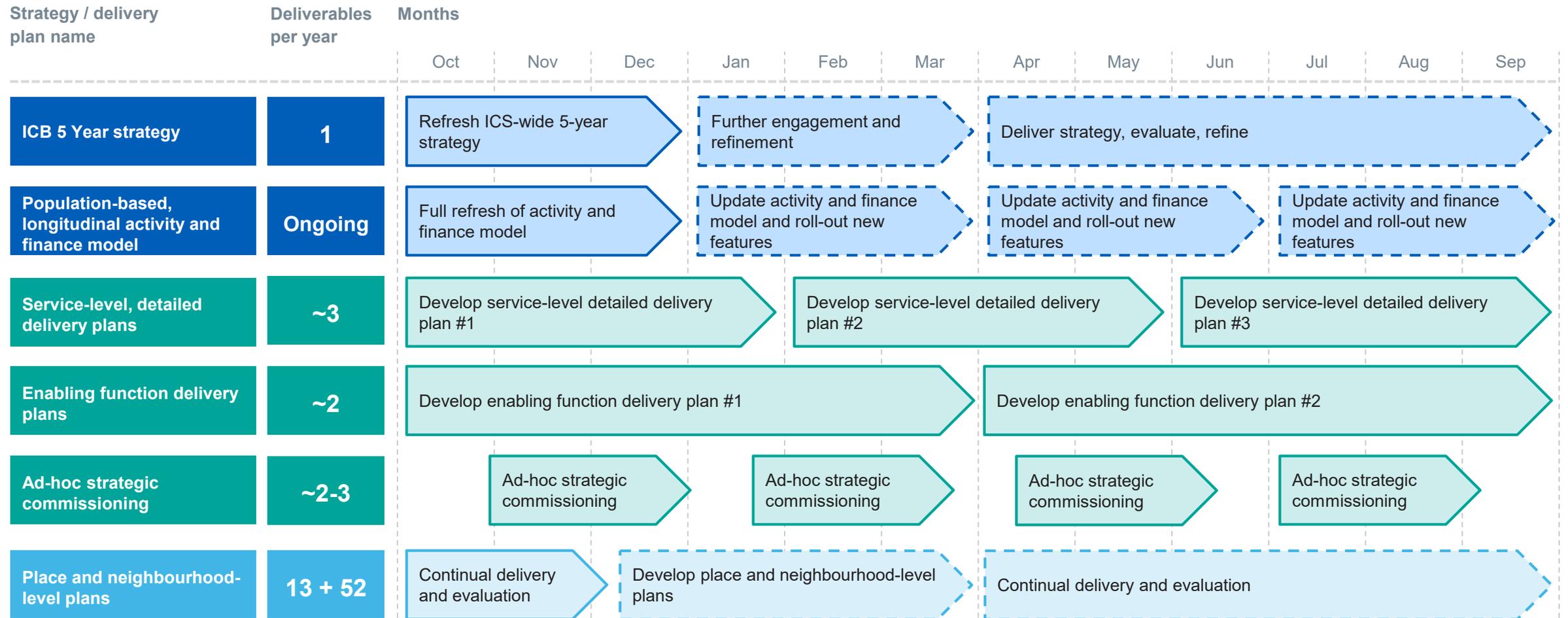
Strategy types, scope and ownership

A single system strategy, translated through aligned delivery plans and operational plans with clear ownership and accountabilities.

Strategy / delivery plan name	Type	Description	Accountable lead / support	Time horizon	Cadence
ICB 5 Year strategy	Strategic	Sets long-term vision and priorities.	Strategy team, with support from other ICB teams and system partners.	3-5 years	Refreshed annually as part of annual planning cycle.
Population-based, longitudinal activity and finance model	Strategic	Supports strategy development with robust finance and activity analysis.	Wider Strategy directorate, with support from other ICB teams (e.g. finance) and system partners.	3-5 years	Refreshed constantly as part of ongoing strategy development, delivery planning and data refreshes.
Service-level, detailed delivery plans	Strategic-to-tactical	Translating strategy into care models and pathways.	Joint ownership between Strategy team and appropriate ICB team (e.g. Transformation, Medical, etc.), with input from enabling functions as appropriate.	3-5 years	Refreshed every ~3 years.
Enabling function delivery plans	Strategic-to-tactical	Detailed strategic-to-tactical planning, ensuring ICS-wide delivery is feasible and sustainable.	Led by appropriate ICB team (e.g. Finance, Estates, etc.) with input from Strategy team and other ICB teams.	3-5 years	Refreshed every ~3 years.
Ad-hoc strategic commissioning	Tactical	Addresses specific system issues or statutory duties as and when they arise.	Led by Transformation team with input from the Strategy team and enabling functions as appropriate.	1-3 years	Refreshed as and when required.
Place and neighbourhood-level plans	Tactical-to-operational	Tactical-to-operational planning, translating and tailoring system-wide strategy and planning to local needs over a relatively short time-horizon.	Led by Place-based Partnerships, Integrators, and Neighbourhood teams.	1-3 years	Refreshed annually

Strategy as a continuous annual cycle

Strategy development is iterative, evidence-led and aligned to NHS planning timelines.



PART A. STRATEGIC NARRATIVE AND AREAS FOR CHANGE

1. Purpose of Paper

As we establish the new West and North London Integrated Care Board (ICB) and develop our role as a strategic commissioner and intelligent payor, it is essential that we clearly set out how we will better use public resources to improve outcomes and deliver better value for our population.

It is important to note that this strategy is being developed at a time of significant public sector reform both within and outside the NHS. In addition to NHS operating model changes, Local government partners are entering a period of substantial financial challenge, including the impact of the Fair Funding Review, which will reshape resource distribution across boroughs and place intense pressure on wider public services. These changes reinforce the need for us to work differently as an integrated system, focusing our collective resources where need is greatest and enabling prevention, earlier intervention and population-level change.

Nationally, the NHS Strategic Commissioning Framework and the NHS Medium-Term Planning Framework set a clear expectation that ICBs must take a longer-term, population-focused, value-driven approach. This includes strategic commissioning based on outcomes, reducing disparities in access, experience and outcomes, and shifting investment from reactive to proactive care. The direction set out in this paper is fully aligned with the national direction of travel.

This draft strategic narrative and set of priorities reflect:

- Discussions at the Board Away Day (10 November)
- A review of strategies and plans across NWL and NCL
- Population health needs assessments
- Health economic analysis of current utilisation and future risk
- National guidance on strategic commissioning and medium-term planning

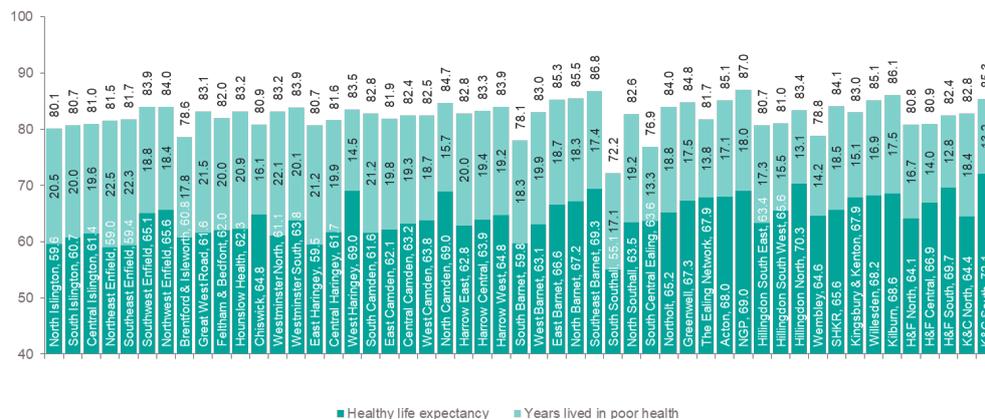
It is presented for discussion at the 4 December Board meeting. The strategy will be further refined through the Joint Strategy & Commissioning Committee on 12 January, with a final draft to the Board in late January ahead of formal adoption in February.

2. Strategic Narrative

2.1 Case for Change

The current configuration of health and care across North and West London is unsustainable and is failing to deliver equitable outcomes. There is a **17-year gap in healthy life expectancy** between neighbourhoods across the new ICB footprint. These inequalities are deep-rooted and complex in nature.

Fig. a: Healthy life expectancy and life expectancy by neighbourhood:



Healthy life expectancy (HLE) gap:
At a neighbourhood level, the healthy life expectancy increases to **17 years** of ill health, with the greatest disparity seen between **South Southall (55.1)** and **Kensington & Chelsea South (72.1)**.

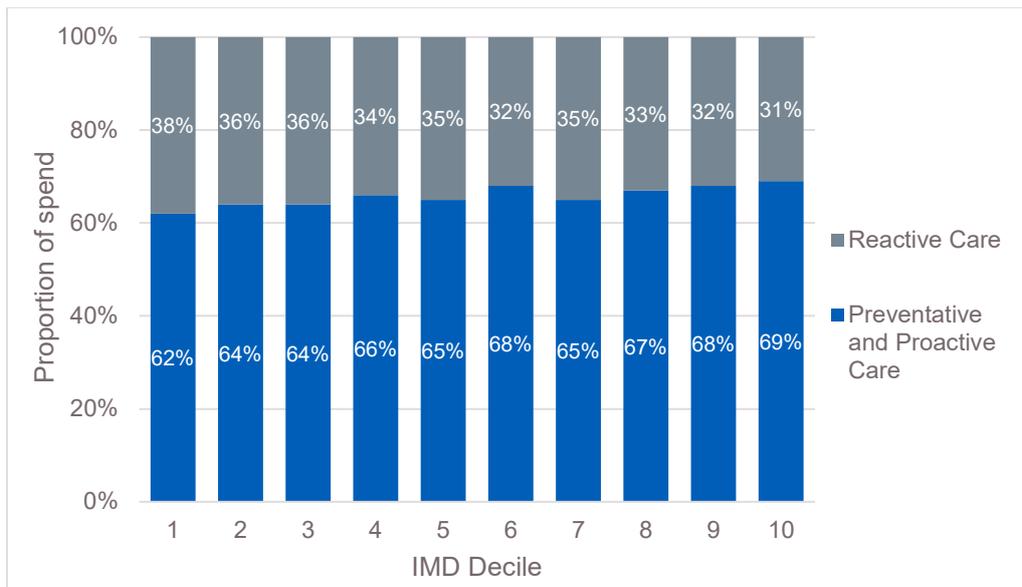
HLE / LE Source: ONS data using ONS methodology for healthy life expectancy (survey-based), age-standardised. All values relate to life expectancy at birth. Values derived from 2013 MSOA-level estimates provided by the ONS and uplifted to 2022 using borough-level, validated figures. HLE and LE values mapped from MSOA to neighbourhoods through weighted averages using Oct. 2025 registered population figures.

At the same time, national and local analyses highlight that we allocate a disproportionate share of resource to **high-cost acute and crisis care**, while underinvesting in prevention, primary care, community services, and planned care. Significant future population health risk – identified through our improved modelling and analytics – remains unaddressed.

Our analysis and data shows that:

- **Certain communities are experiencing poorer outcomes and have greater emergency care use** e.g. deprived communities and adults with SMI. Across West and North London the excess under 75 (all cause) mortality rate in adults with SMI is 379% greater than for adults without SMI – with significant variation at borough level - ranging from 291% in Camden to 496% in Hillingdon (Source: ONS, MHSDS, Fingertips).
- **In these communities, lower investment in proactive and planned care in high-need areas results in higher-cost reactive care later.** As the chart below shows, a far greater proportion of spending in our most deprived population goes on reactive care, compared with our least deprived population.

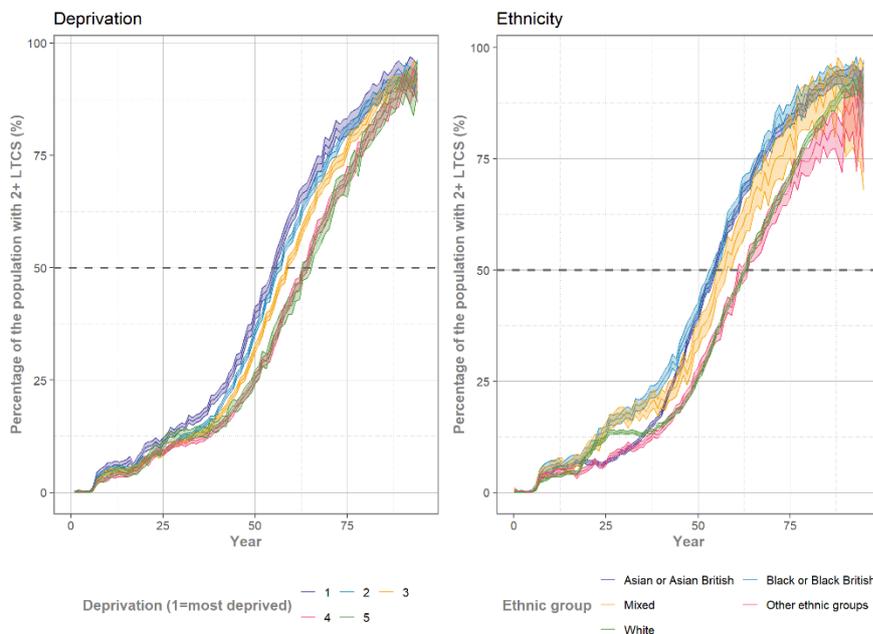
Fig. b: Proportion of spend split by type of care



Source: Optum, Total Cost of Care Data Pack, NWL. Note: further work required to accurately categorise care into these categories

- **True equity cannot be achieved without addressing multi-morbidity** – our data shows clear gaps in the number and severity of long-term conditions between different deprivation levels and ethnic groups, with people in our most deprived neighbourhoods and from ethnic minority communities developing poor health earlier in life.

Fig. c: Percentage of the population in ill-health by age



Source: WSIC, NWL Integrated Needs Assessment

- **People with multiple long-term conditions continue to experience fragmented, poorly coordinated pathways** – typically interacting with eight

or more services each year, yet very few have a shared care plan. A review of frailty services in one borough identified 40 different services that a frail person might need to interact with.

- **Low levels of trust, partly due to poor experiences and access to care within our more deprived neighbourhoods and ethnic minority communities**, leads to conditions being diagnosed later and being poorly managed
- **Over-medicalisation and excessive variation lead to low-value interventions.**
- **The current system trajectory is financially unsustainable and operationally fragile at a time when expectations of delivery are high.**

Therefore, our underlying assumption is that by shifting the proportion of spend from acute and crisis care into community-based proactive, primary and planned care, in a way that is aligned to need and builds trust we can start to achieve better outcomes and reduce higher healthcare costs consumed later when patients deteriorate in an acute care pathway.

2.2 Our strategic mission

In response to this challenging context, the ICB is setting its mission as:

Reduce the variation in health life expectancy, supporting everyone to have a good start in life, increasing the number of years lived in good health and support healthy aging

The problem statement for the ICB and system is therefore, within these constraints, how do we strategically commission for population health, deliver integrated neighbourhood care models and ensure financial sustainability while:

1. Reducing the variation in health life expectancy across our communities, from 17 years to 12 years
2. Increasing the number of years lived in good health for our most deprived quintile, from 55-59 years to 65-69 years
3. Reducing the number of cancers diagnosed in A&E to zero
4. Investing in a way that not only accounts for but reduces future population healthcare need.

2.3 Our strategic approach

As commissioners we will focus on where transformation delivers the greatest value. This means directing attention and investment toward areas with high utilisation, poor access, experience or outcomes, and ensuring that redesign efforts translate

into measurable improvements in equity, access, quality, experience and cost-effectiveness.

Given that reducing inequalities is our number one priority, and we know that the wider determinants of health and health behaviours drive these inequalities, we will work in partnership across the NHS, Local Authorities and other local partners including the VCSE to take a bolder, more innovative and more trusting approach to delivery. This means fundamentally reshaping the way we work around population cohorts and outcomes, using capitated budgets that span traditional healthcare barriers and using the neighbourhood health model to rewire how services are delivered, with our population at the heart. We will use longitudinal data assets and analysis to better understand and mitigate risks to suppress future costs and improve outcomes. As well look to implement new contractual forms to align incentives for providers to develop new and novel care models to improve value and outcomes for population cohorts.

We will also work closely with our providers who will lead on detailed pathway optimisation, reduction of unwarranted variation and productivity – they hold the clinical insight, operational levers, and day-to-day accountability.

In terms of our approach we have three critical steps to take, these need to happen in parallel:

1. We will work to understand rising risk within our communities and take a proactive, preventative approach to designing services to support people to stay healthy and well, identify conditions early and support people to self-manage conditions. This will reduce the flow of people moving into the high utilisation, poor outcome cohort. These services will be designed in collaboration with communities in a way that builds trust.
2. We will prioritise population cohorts with high utilisation but poor outcomes or poor value. These are the patients who repeatedly touch multiple parts of the system because pathways are fragmented or inefficient. By understanding their needs and the drivers of avoidable activity, and working with these patients to redesign care so that it is proactive, coordinated, and genuinely improves outcomes at lower cost.
3. We will drive a step-change in planned care pathways by using 'should-cost' analysis. This means moving away from historic patterns of delivery and instead modelling what each pathway 'should-cost' if it were designed around best practice, efficient staffing models, digital triage, and optimised flows. That creates a shared benchmark for improvement and a clear basis for investment and reinvestment decisions.

Underpinning these changes shifts are two critical enablers:

- Digital infrastructure, which enables better access and consistent triage, risk stratification and personalisation and seamless information-sharing between providers; and
- Patient activation and support, to enable people to engage in their health, be confident to self-manage where appropriate, choose the right service at the right time, and engage effectively with a fundamentally transformed NHS.

This model enables the ICB to focus on the highest-value priorities and ensure consistent delivery, while providers lead the operational transformation.

3. A Multi-Year Financial Trajectory to Drive Value

Both legacy ICBs delivered balanced financial positions between 2022/23 and 2024/25, supported by non-recurrent measures. This masks structural challenges, including the rising burden of chronic disease and a continued drift towards acute activity. Acute expenditure has increased from **50% of total spend in 2019/20 to 54% in 2024/25**. In order to improve the value of healthcare we need to change the profile of this spend back to improve access, better coordinate care and intervene earlier to manage risk and deliver higher healthcare utility for the money we spend.

The NHS Medium-Term Planning Framework requires systems to adopt multi-year planning horizons, reduce reliance on non-recurrent funding, and rebalance investment into preventative and community-based care. Our financial strategy will set out a multi-year trajectory that will follow the following principles:

- A plan for a sustainable financial position and balanced plan in each year
- We will target investments that ensure ICB resources are invested against the highest need, noting that neighbourhoods are the ICB unit of delivery.
- All investment decisions will be based on the analysis of data to estimate need and be subject to a business case/value proposition process to evaluate positive impact.
- We will develop capitated budgets and commission by outcomes, to reduce inequalities in these outcomes through connecting and delivering services that span traditional healthcare boundaries, aligned to need in our communities.
- We will invest in activities that reduce emergency demand in secondary care, reduce unnecessary clinical variation, reduce follow-up outpatients, reduce health inequality and we will disinvest in activities that are not delivering the intend value or outcomes.
- We will reduce unearned income by commissioning higher levels of activity (elective) to reduce waiting lists inside and outside of hospital.

- We will target capital investment at transformation and neighbourhood development.

4. Population based cases for change

Health economic modelling identifies population cohorts across West & North London that experience the poorest outcomes and account for disproportionately high system costs. Added to this there are areas of planned care that require radical transformation based on the need to rapidly improve access and deliver step change in costs enabled by technology.

These insights have informed eight proposed priority areas for change. Each aims to shift spend from reactive to proactive care, improve equity and deliver better value.

The following section sets out the proposed areas, an overview of the scope and links to existing work underway across the current ICBs.

Each priority will be developed into a detailed value proposition for further Board review, supported by SMEs and system partners.

4.1 Strengthening Relationships and Building Trust with Communities Experiencing poor outcomes (Including resident activation)

Patient activation – people’s knowledge, skills, and confidence to manage their health – is not a nice to have. There is a strong evidence base to support the fact healthcare costs are better and outcomes improved when patients are engaged in their health. Other industries take this very seriously, and we now need to do this within healthcare. Patient activation must become a core element of our model of care, not an optional add-on.

Activation varies significantly across West and North London. Data from North West London shows that 21% of people are ‘disengaged or overwhelmed’ when it comes to their health (i.e. least activated), 27% of people are ‘becoming aware’ of their health, 33% are taking action, and only 19% of people are ‘maintaining healthy behaviours’ (i.e. most activated). The evidence shows that people with the highest levels of activation have lower usage of GP and A&E services than people with the lowest levels of activation (18% fewer GP contacts and 38% fewer emergency admissions).

We must do more to improve activation across our communities. We will:

- Use the NHS App and digital tools to support self-management
- Deploy localised health coaching, navigation and behavioural interventions, and invest in peer support
- Use population health analytics and risk stratification to identify residents most likely to benefit

- Tailor interventions to levels of activation and specific groups experiencing the greatest inequities
- Increase levels of health literacy and focus on clear communication and shared decision making

Patient activation and trust in services are mutually reinforcing. Our communities have told us that in order to build trust they value compassionate care, community involvement and voice in service design, effective communication, equitable access and holistic care.

We must do more to increase levels of trust. We will:

- Work directly with communities to build trust and empowerment through greater participation and co-production
- Continue to build the VCSE infrastructure across the system to help deepen relationships with communities
- Invest in community in-reach models that meet people where they are and take an asset-based approach, as a core part of neighbourhood health
- Invest in workforce development, including cultural competency and active listening skills, to improve people's experiences of interacting with health services

This work will build on existing community partnerships and our equity programmes.

4.2 Neighbourhood Health as a Core Delivery Model

Neighbourhoods will be the foundation of our future model and unit of delivery. We will develop **integrated neighbourhood teams** delivering a consistent core offer across primary care, community services, mental health, local authorities and the voluntary sector.

As shown in section 2, healthy life expectancy varies by more 17 years between West and North London neighbourhoods just a few miles apart, with a 14 year gap even within the same borough. This demonstrates that the variation is local, immediate, and most actionable through neighbourhood-based care models.

We also know that the nature of the care our population requires is changing: from acute and episodic to chronic and continuous – driven by an ongoing rise in multi-morbidity that occurs earlier in our more deprived and ethnic minority communities (as demonstrated again in section 2). Care must increasingly be generalist, lower-intensity, and long-term in nature, rather than specialist and short-term. According to projections by the Greater London Authority (GLA), The over 65 population in West and North London is expected to increase 36% by 2040, compared to a 3% increase in working age population and an 8% reduction in 0-17 year olds. This demographic

change indicates significantly increased need for health and care that is best served through neighbourhood-based care models.

The neighbourhood model will:

- Fundamentally rewire local service delivery to be population centred, with contracts and incentives designed around outcomes for population cohorts and population segmentation and risk stratification driving decision making
- Be the core vehicle for delivering priority 1 above – bringing together local services to support people to stay well, investing in proactive, preventative approaches that address the wider determinants of health including employment and social welfare legal advice, co-locating services wherever possible
- Reduce variation in access, experience and outcomes, targeting resources on our most deprived communities and enabling personalised, multidisciplinary care planning
- Help set the foundation for a new type of NHS focussed on a deep understanding of and connection with residents and thriving communities.

4.3 Planned Care Transformation Through Digital and Community-First Pathways

Across the system, we have seen 8% annual growth in referrals for planned care, translating to a 5% annual growth in first outpatient appointments. This level of growth is unsustainable and leads to longer waiting times for our population. A radically different approach to planned care is needed to improve access and successfully deliver the government's commitment to achieving the 92% target for referral-to-treatment times under 18 weeks.

We will redesign major pathways to make planned care access simpler and better coordinated, reducing avoidable demand on acute outpatient services. This will support the recovery of elective performance with more patients seen in the right place first time without adding pressure onto primary care. This includes:

- Self-referral, digital triage and NHS App-enabled journeys
- Community-first pathways
- Standardised referral support and communication
- Integration with neighbourhood teams for ongoing support

Specialties we will target first will be:

- Dermatology (digital pathways)
- CYP mental health and ADHD assessment (digital pathways)

- ENT (community first)
- Gynaecology (community first)
- MSK (community first)

This builds on NWL's planned care strategy and NCL's elective recovery programme.

4.4 Integrated Care for Children and Young People

Initial estimates show that we have 107,000 children and young people across West and North London with complex physical and/or mental health needs – this is equivalent to approximately 2,100 patients per neighbourhood – all likely requiring multi-agency support. We also know that there is a significant gap in diagnosis – particularly in mental health. According to our data, we also know 4% of our children and young people have a recorded mental health condition, but we also know from recent surveys that the real prevalence is likely closer to 20, having increased significantly over the last few years (Source: Mental Health of CYP Survey, NHSE, 2023). We also know that support for low level mental health conditions in our communities has higher access and success rates for girls than boys, and see boys developing higher rates of severe mental illness.

We will strengthen support for children and young people through integrated models that bring together physical and mental health, acute and community services, as well as wider partners such as schools and social care. Bringing all these services together around children makes it easier to spot problems early, coordinate help, and avoid families having to navigate a fragmented system – where they can often face delays, repeated assessments, and inconsistent advice.

Developing an integrated model for children will help lead to better outcomes and more efficient use of resources across the system.

We will:

- Work to develop a unified Integrated Health Offer (IHO) for CYP through strong links with schools, local authorities and VCSE partners
- Define a consistent neighbourhood offer across the ICB

This will build on Child Health Hubs and the NWL CYP Mental Health Strategy.

4.5 Improving Outcomes for Adults with Serious Mental Illness

Adults with serious mental illness experience significant inequalities in life expectancy, access and outcomes.

As described in section 2, the excess under 75 (all cause) mortality rate in adults with SMI is 379% greater than for adults without SMI – with significant variation at borough level – ranging from 291% in Camden to 496% in Hillingdon (Source: ONS,

MHSDS, Fingertips). People with SMI use healthcare services at more than seven times the rate of people without SMI (Source: WSIC, NWL Integrated Needs Assessment), yet their health outcomes remain significantly worse – evidenced most starkly by these markedly higher mortality rates. This imbalance highlights both unmet need and systemic gaps in how care is organised for this group.

Our strategy will:

- Improve community, acute and crisis pathways
- Reduce unwarranted variation in care and physical health outcomes
- Expand personalised, preventative and recovery-focused support
- Strengthen earlier intervention through neighbourhood teams, targeting resources on groups that need greater investment in earlier intervention

This aligns with the NWL Adult Mental Health Strategy and equity work on SMI.

4.6 Deploying Genomics and precision medicine to Deliver High-Value Personalised Care

Advances in genomic medicine offer significant opportunities for earlier diagnosis, targeted treatment and improved population-level prevention. According to the 10 Year Health Plan, genomics can reduce the time it takes to get a definitive diagnosis from 4 years to 3 months for some rare diseases and certain cancers. Genomics have also proven to better support risk stratification – according to some studies, polygenic risk scores for conditions such as coronary artery disease, diabetes and some cancers can identify individuals at 3-5× higher lifetime risk even when conventional risk factors appear normal (Source: UK Biobank)

To support this ambition, we will:

- Deploy genomics where evidence shows clear value
- Focus on communities with the worst outcomes
- Embed new tools into real-time clinical decision-making
- Invest in tailored interventions that support people to understand their diagnosis and support a healthy lifestyle

This work will be led with genomics network partners.

4.7 Supporting a Dignified Death

Data across West and North London shows that every year, approximately 10–11,000 patients are admitted to hospital in their last year of life, and approximately 11% of these patients (c. 1,200) have three or more admissions in their last 90 days of life. As a result, more of our patients are dying in hospital which is not what the

majority of patients and families want. Of all deaths in West and North London, 53% tend to take place in hospital, compared to 45% in England overall.

This misalignment between people's preferences – with most wishing to die at home or in non-hospital settings – is wider in our deprived and ethnic minority communities. The reality of high acute-care use in the final months of life highlights the need to redesign our end-of-life pathways to support care closer to home, reduce avoidable admissions, and honour what matters most to patients and families.

We will redesign end-of-life pathways to ensure that people experience:

- Earlier conversations and advance planning
- Clearer, smoother transitions between services
- Personalised and culturally tailored support across acute, community and mental health
- More choice and dignity in place of death

This builds on the NWL Specialist Palliative Care model and NCL's end-of-life transformation work.

4.8 Developing Robust Digital Infrastructure

A digitally enabled system is essential to delivering our strategy. We will:

- Improve interoperability and real-time information sharing
- Strengthen analytics and population health capability, increasing the integration of wider data sources to better understand our population and levels of risk
- Invest in analytics skills for non-analysts, to enable data driven decision making at all levels of the system
- Optimise the NHS App for patient journeys and activation
- Enable staff to work flexibly and in integrated teams, supporting the development of Neighbourhood Health teams

This aligns with the London SDE, NWL digital strategy and relevant NCL programmes.



North Central London
Integrated Care Board



North West London

NHS NC London and NHS NW London

Board Meeting in Common

28th January 2026

Report Title	NHS West and North London Integrated Care Board ('WNL ICB') Constitution	Date of report	19 th January 2026	Agenda Item	2.3
Lead Director / Manager	Sarah Morgan, Chief People Officer Ian Porter, Executive Director of Transition	Email / Tel		sarahlouise.morgan@nhs.net ian.porter3@nhs.net	
Board Member Sponsor	Michael Bell, Chair of NHS North Central London Integrated Care Board ('NCL ICB') and NHS North West London Integrated Care Board ('NWL ICB')				
ICB	Both.				
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 The Constitution sets out the governing principles and rules for how the ICB's operates and makes decisions			
Recommendation	The Boards of Members are asked to: <ul style="list-style-type: none"> • NOTE the report; • ENDORSE the proposed NHS West and North London Integrated Care Board Constitution prior to submission to NHS England for approval 				
Report summary	This paper sets out the draft Constitution for the new West and North London Integrated Care Board. Key highlights: <ul style="list-style-type: none"> • It follows the national ICB Model Constitution; • Whilst the role of ICBs is changing nationally the legislation and statutory responsibilities remain the same until the Government passes new legislation. Therefore, once new legislation is in place the Constitution will need to be updated to reflect this and any corresponding changes; • It takes a 'best of both' approach drawing on best practice from NCL and NWL ICBs; • It has been reviewed by the ICBs' Chair, Chief Executive, Audit Committee Chair, Joint Transition Executive, Joint Transition Committee and Governance and Risk Teams. Their views have been reflected in a 				



	<p>small number of strategic choices in the Constitution such as a Board membership, quorum and the need to hold Annual General Meetings;</p> <ul style="list-style-type: none"> • It has been reviewed by the NWL ICB Audit Committee and is being reviewed by the NCL ICB Audit Committee on 27th January 2026; • Voting membership of the Board is set out in section 8 as follows: <ul style="list-style-type: none"> ○ Chair and 5 NEMs; ○ 5 Executive Directors- Chief Executive, CFO, Chief Medical Officer, Chief Nursing Officer and Chief People Officer; ○ Four Partner Members- NHS Trusts and Foundation Trusts. Two from Acute providers, one from a Community Services provider and one from a Mental Health provider; Two Partner Members- Providers of Primary Medical Services; ○ Three Partner Members- Local Authorities; • The other Executive Management Team members are listed to attend Board meetings as Standing Participants. This is set out in section 9.1 of the draft Constitution; • This proposed Board membership was shared with NHS England in December 2025 as scheduled and informal feedback indicates that they are supportive; • All roles mandated by NHS England are included; • All ICB Constitutions are approved by NHS England after being endorsed by the respective ICB Boards
Identified risks and risk management actions	The draft Constitution ensures that the new ICB operates within a robust but flexible governance framework which allows the ICB to adapt to an evolving landscape.
Conflicts of interest	The draft Constitution sets out in section 33 the key principles by which the ICB will manage its conflicts of interest. This is in accordance with the provisions of the ICB Model Constitution and NHS England guidance on the management of conflicts of interest.
Resource implications	The draft Constitution sets out the governance framework through which resources will be utilised.
Engagement	The ICBs' Chair, Chief Executive, Audit Committee Chair, Joint Transition Executive, Joint Transition Committee and Governance and Risk Teams have been engaged in the draft Constitution. The draft Constitution was also considered by the NWL ICB Audit Committee on 13 th January 2026 and is being considered by the NCL ICB Audit Committee on 27 th January 2026.
Equality impact analysis	This report and the Constitution have been written in accordance with the provisions of the Equality Act 2010. The draft Constitution positively supports the ICB in addressing inequalities.
Report history and key decisions	The draft Constitution was presented to the Joint Transition Executive meeting on 7 th January 2026 and the Joint Transition Committee meeting on 12 th January 2026. It was also presented to the NWL ICB Audit Committee on 13 th January



North Central London
Integrated Care Board



North West London

	2026 and will be presented to the NCL ICB Audit Committee on 27 th January 2026.
Next steps	If the Boards in common endorse the proposed WNL ICB Constitution it will be submitted to NHS England for approval at the end of January 2026. The timing of the submission to NHS England is in accordance with the national due diligence process for merger.
Appendices	Appendix 1: Draft NHS West and North London ICB Constitution.



West and North London
Integrated Care Board

[DRAFT]

NHS West and North London Integrated Care Board

Constitution

Version Control:

Version	Author	Amendments	Effective Date
0.1 (DRAFT)	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services- NHS North Central London Integrated Care Board	Creation of the Constitution.	1 st April 2026

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CONSTITUTION

1. NAME AND BACKGROUND

- 1.1 The name of this Integrated Care Board is NHS West and Central London Integrated Care Board ('ICB').
- 1.2 NHS England has set out the following as the four core purposes of an Integrated Care System:
 - a) Improve outcomes in population health and healthcare;
 - b) Tackle inequalities in outcomes, experiences and access;
 - c) Enhance productivity and value for money;
 - d) Help the NHS support broader social and economic development.
- 1.3 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges which include:
 - a) Improving the health of children and young people;
 - b) Supporting people to stay well and independent;
 - c) Acting sooner to help those with preventable conditions;
 - d) Supporting those with long-term conditions or mental health issues;
 - e) Caring for those with multiple needs as populations age;
 - f) Getting the best from collective resources so people get care as quickly as possible.

2. AREA COVERED BY THE INTEGRATED CARE BOARD

- 2.1 The area covered by the ICB is the geographical boundaries of the London Boroughs of Barnet, Brent, Camden, Ealing, Enfield, Hammersmith & Fulham, Haringey, Harrow, Hillingdon, Hounslow, Islington, Kensington & Chelsea and Westminster.

3. STATUTORY FRAMEWORK

- 3.1 The ICB is established by order made by NHS England under powers in the 2006 Act.
- 3.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.
- 3.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).
- 3.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published on the ICB's website: **[Insert new website address]**
- 3.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

- a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
- b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
- c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
- d) Adult safeguarding and carers (the Care Act 2014);
- e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
- f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000);
- g) Provisions of the Civil Contingencies Act 2004.

3.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

3.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

- a) Section 14Z34 (improvement in quality of services);
- b) Section 14Z35 (reducing inequalities);
- c) Section 14Z38 (obtaining appropriate advice);
- d) Section 14Z40 (duty in respect of research)
- e) Section 14Z43 (duty to have regard to effect of decisions);
- f) Section 14Z45 (public involvement and consultation);
- g) Sections 223GB to 223N (financial duties); and
- h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

3.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

4. STATUS OF THIS CONSTITUTION

4.1 The ICB was established on 1 April 2026 by The Integrated Care Boards (Establishment) Order [**insert date**], which made provision for its Constitution by reference to this document.

4.2 This document is the constitution of the ICB ('Constitution').

4.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

5. VARIATION OF THIS CONSTITUTION

5.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

- a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
- b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).

5.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

- a) Anyone may propose a variation or amendment to the Constitution;
- b) Proposed variations or amendments to this Constitution must be submitted to the ICB's Governance and Risk Team for consideration;
- c) The Executive Director with responsibility for corporate governance, in consultation with the ICB's corporate governance team, may accept or reject any proposed variation or amendment to the Constitution at this Executive Director's absolute discretion and without creating any precedents for any further or future decisions;
- d) The Executive Director referenced at 5.2(c) above shall consult with the corporate governance team, Chair and Chief Executive of the ICB Board and the Audit Committee Chair prior to any amendments or variations to the Constitution being submitted to the ICB Board for approval;
- e) Prior to making an application to NHS England in accordance with section 5.1(a) above any proposed variations or amendments to the Constitution must be approved by the ICB Board. Any motion will be passed by a simple majority of those Board members voting;
- f) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

6. RELATED DOCUMENTS

- 6.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.
- 6.2 The following are appended to the Constitution and form part of it for the purpose of section 5 and the ICB's legal duty to have a constitution:
 - a) **Standing Orders**– which set out the arrangements and procedures to be used for meetings and the selection and appointment processes for the ICB Committees.
- 6.3 The following do not form part of the Constitution but are required to be published:
 - a) **The Scheme of Reservation and Delegation ('SORD')**– This sets out those decisions that are reserved to the ICB Board and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SORD identifies where, or to whom, functions and decisions have been delegated;
 - b) **Functions and Decision Map**- This is a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England);
 - c) **Standing Financial Instructions** – Which set out the arrangements for managing the ICB's financial affairs;
 - d) **The ICB Governance Handbook**– This brings together all of the ICB's corporate governance documents so it is easy for interested people to navigate. It includes:
 - The above documents a) – c);
 - Terms of reference for all Committees and Sub-Committees of the Board that exercise ICB functions;
 - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another Integrated Care Board, NHS England, an NHS trust, NHS foundation trust, local authority,

combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act;

- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or of a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act;
- Corporate Governance and Risk Management policies including those set out at e) below;
- The up to date list of eligible providers of primary medical services under clause 15.1 below.

e) **Key policy documents-** including:

- Standards of Business Conduct Policy;
- Conflicts of interest policy and procedures;
- Speaking Up (Whistleblowing) Policy;
- Policy for public involvement and engagement.

7. MEMBERSHIP OF THE INTEGRATED CARE BOARD

7.1 This section 7 of the Constitution describes the membership of the ICB. Further information about the criteria for the roles and how they are appointed is in sections 12 to 20 below.

7.2 Further information about the individuals who fulfil these roles can be found on the ICB's website: **[Insert new website address]**

7.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act the membership of the ICB consists of:

- a) A Chair;
- b) A Chief Executive;
- c) At least three Ordinary members.

7.4 The Ordinary Members must include at least three members who will bring knowledge and a perspective from their sectors. These members (known as 'Partner Members') are nominated by the following, and appointed in accordance with the procedures set out in sections 10, 11, 14, 15 and 16 below:

- a) NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;
- b) The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;
- c) The local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

7.5 While the Partner Members will bring knowledge and experience from their sectors and will contribute the perspective of their sectors to the decisions of the Board, they are not to act as delegates of those sectors.

7.6 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

- a) Three executive members as follows:
 - Director of Finance;
 - Medical Director;
 - Director of Nursing;
- b) At least two Non-Executive Members.

7.7 The ICB has discretion to include additional members above the minimum requirements set out in sections 7.3, 7.4 and 7.6 above. These additional members are set out in section 8.3, and 12 to 20 below.

8. BOARD OF MEMBERS

8.1 The membership of the ICB shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions. This Board of Members is referred to in this Constitution as the 'Board'. The Board is comprised solely of members of the ICB. Membership, eligibility, disqualification and removal from office as per sections 7, 8, 10, 11, and 22 of the Main Body of the Constitution and any terms of appointment refer to both membership of the ICB and membership of the Board.

8.2 The ICB has 9 Partner Members:

- a) Four Partner Members- NHS Trusts and Foundation Trusts;
- b) Two Partner Members- Providers of Primary Medical Services;
- c) Three Partner Members- Local Authorities.

8.3 The ICB Board is composed of the following 20 members:

- a) Chair;
- b) Chief Executive;
- c) Four Partner Members- NHS Trusts and Foundation Trusts;
- d) Two Partner Members- Providers of Primary Medical Services;
- e) Three Partner Member- Local Authorities;
- f) Five Non-Executive Members;
- g) Director of Finance;
- h) Medical Director;
- i) Director of Nursing;
- j) Chief People Officer.

8.4 The executive members referred to in clauses 7.3, 7.7 and 8.3 above describe the required statutory and/or policy prescribed roles rather than the specific job titles of officers holding those roles. For example, the ICB may call the Director of Finance the Chief Finance Officer. The Chief Finance Officer role would incorporate the mandated Director of Finance role. In addition, the roles listed at 8.3(j) above and 9.1 below describes the substantive roles and includes any equivalent successor roles and not the individual job titles.

8.5 The Board will keep under review the skills, knowledge and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcomings.

8.6 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one Ordinary Member will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness. This Ordinary Member shall be one of the Partner Members - NHS Trusts and Foundation Trusts and shall be a Chief Executive or an Executive Director of one or more of the NHS Trusts or Foundation Trusts within the ICB's area set out in clause 14.1.

8.7 A Deputy Chair and a Senior Non-Executive Member shall be appointed from the Five Non-Executive Members listed at section 8.3(f) above and in accordance with sections 28 and 33 of the Standing Orders.

9. PARTICIPANTS AND OBSERVERS AT BOARD MEETINGS

- 9.1 The Board shall invite the Chief Strategy Officer and the Chief Transformation Officer from the ICB's executive management team to attend meetings as standing participants. The Board may also invite additional people to attend all or part of its meetings at its absolute discretion as standing participants.
- 9.2 The standing participants referred to in section 9.1 above are non-voting. Standing participants may present at Board meetings and contribute to relevant discussions.
- 9.3 The Board may invite or allow additional people to attend Board meetings, or part of meetings, as participants in order to assist it in its decision-making and in its discharge of its functions as it sees fit. Participants may present at Board meetings and contribute to relevant discussions but are not allowed to participate in any formal vote.
- 9.4 The Board may invite or allow people to attend meetings as observers. Observers may not present at Board meetings, contribute to any discussion or participate in any formal vote. Observers may ask questions and/or participate in one or more discussions at the invitation of the Chair.
- 9.5 The Board may call additional experts to attend meetings on a case by case basis to inform discussions.

10. ELIGIBILITY CRITERIA FOR BOARD MEMBERSHIP

- 10.1 Each member of the ICB must:
 - a) Comply with the criteria of the "fit and proper person test";
 - b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles);
 - c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

11. DISQUALIFICATION CRITERIA FOR BOARD MEMBERSHIP

- 11.1 The following individuals are automatically disqualified from being a member of the ICB Board:
 - a) A Member of Parliament;
 - b) A person whose appointment as a Board member ('Candidate') is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the Candidate's involvement with the private healthcare sector or otherwise;
 - c) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
 - in the United Kingdom of any offence, or
 - outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;
 - d) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the

Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings);

- e) A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body;
- f) A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:
- That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office; and/or
 - That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings; and/or
 - That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; and/or
 - of misbehaviour, misconduct or failure to carry out the person's duties;
- g) A Health Care Professional (meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—
- The person's suspension from a register held by the regulatory body, where that suspension has not been terminated; and/or
 - The person's erasure from such a register, where the person has not been restored to the register; and/or
 - A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; and/or
 - A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.
- h) A person who is subject to—
- A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; and/or
 - An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual);
- i) A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated;
- j) A person who has at any time been removed, or is suspended, from the management or control of any body under—

- Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); and/or
- Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

12. CHAIR

- 12.1 The Chair of the ICB is to be appointed by NHS England, with the approval of the Secretary of State.
- 12.2 In addition to criteria specified at clause 10.1 above, this member must fulfil the following additional eligibility criteria:
- a) The Chair will be independent.
- 12.3 Individuals will not be eligible if:
- a) They hold a role in another health and care organisation within the ICB area;
 - b) Any of the disqualification criteria set out in section 11 above apply.
- 12.4 The term of office of the Chair will be a maximum of three years and the total number of terms a Chair may serve is two terms, subject to the provisions of the Standing Orders.

13. CHIEF EXECUTIVE

- 13.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.
- 13.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.
- 13.3 The Chief Executive must fulfil the following additional eligibility criteria:
- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
- 13.4 Individuals will not be eligible if:
- a) Any of the disqualification criteria set out in section 11 above apply;
 - b) Subject to clause 13.3(a), they hold any other employment or executive role other than Chief Executive of another Integrated Care Board.

14. FOUR PARTNER MEMBERS- NHS TRUSTS AND FOUNDATION TRUSTS

- 14.1 These Partner Members are jointly nominated by the NHS trusts and/or Foundation Trusts that provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition. The partners which may nominate these Partner Members are:
- a) Central and North West London NHS Foundation Trust;
 - b) Central London Community Healthcare NHS Trust;
 - c) Chelsea & Westminster Hospital NHS Foundation Trust;
 - d) Great Ormond St Hospital for Children NHS Foundation Trust;
 - e) Imperial College Healthcare NHS Trust;
 - f) London Ambulance Service NHS Trust;
 - g) London North West University Healthcare NHS Trust;
 - h) Moorfields Eye Hospital NHS Foundation Trust;

- i) North London Foundation Trust;
- j) Royal National Orthopaedic Hospital NHS Trust;
- k) Tavistock and Portman NHS Foundation Trust;
- l) The Hillingdon Hospitals NHS Foundation Trust;
- m) The Royal Free London NHS Foundation Trust;
- n) University College London Hospitals NHS Foundation Trust;
- o) West London NHS Trust;
- p) Whittington Health NHS Trust.

14.2 These members must fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

- a) Be a Chair, Chief Executive or another executive director of one or more of the NHS trusts or foundation trusts within the ICB's area, save as set out in 14.2(d) below;
- b) Two of the Partner Members must be from an Acute Services provider;
- c) One of the Partner Members must be from a Community Services provider;
- d) One of the Partner Members must be a Chief Executive or another executive director from a mental health provider and have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

14.3 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in section 11 above apply.

14.4 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Where the number of eligible candidates that have been jointly nominated, in accordance with clause 14.5 below, is no greater than the number of vacancies in the established roles the appointments panel may consist solely of the Chair and Chief Executive at their absolute discretion and without setting any precedents for the future membership of any appointments panel.

14.5 The appointment process will be as follows:

- a) The ICB or one of the NHS Trusts or Foundation Trusts set out in clause 14.1 above acting as the ICB's agent shall write to all of the NHS Trusts and Foundation Trusts referred to in clause 14.1 above inviting nominations. For the purposes of this clause 14.5 the ICB and/or the NHS Trust or Foundation Trust acting as the ICB's agent are referred to as 'Agent';
- b) Any of the NHS Trusts and Foundation Trusts listed in clause 14.1 above may nominate candidates who meet the requirements of the role based on a role specification produced by the ICB;
- c) Each eligible organisation wishing to nominate a candidate shall send their nomination(s) to the Agent;
- d) The Agent shall review the nomination(s) and confirm whether or not each nomination meets the minimum eligibility requirements of the role based on the role specification. Where potential candidates do not meet the minimum eligibility requirements the Agent shall discuss this with the nominating organisation. The nominating organisation may put forward representations as to why it believes the potential candidate(s) meet the minimum eligibility requirements of the role specification or it may withdraw the nomination. If the Agent and the nominating organisation are unable to agree on whether the potential candidate(s) meet the minimum eligibility requirements the decision shall be: a) referred to the ICB for determination where the Agent is one of the NHS Trusts or Foundation Trusts; or b) taken by the ICB where the ICB is the Agent. Any decisions shall not set any precedents for further or future decisions;
- e) The Agent shall compile a list ('List') of candidates which meet the minimum eligibility requirements of the role specification. The List shall also contain in a separate section a list of candidates who were put forward for nomination but do not meet the minimum eligibility requirements of the role specification. The List shall not contain the names

of those candidates who do not meet the minimum eligibility requirements of the role specification where their nomination has been withdrawn;

- f) The Agent shall send the List to all NHS Trusts and Foundation Trusts referred to in clause 14.1 above. These NHS Trusts and Foundation Trusts will be requested to confirm, by simple majority, whether they jointly agree to nominate the whole list of candidates who meet the minimum eligibility requirements of the role specification. Any failure to confirm within seven working days or any such other reasonable time specified by the Agent will be deemed to constitute agreement. If they agree the list will be put forward to the next stage of the nominations and appointment process set out in clause 14.5g) below. If they do not agree the nominations process will be re-run until joint agreement is reached on the nominations put forward following the process set out in this clause 14.5a) – f);
- g) The ICB appointments panel referred to in clause 14.4 above shall consider the confirmed list of jointly nominated candidates. It shall undertake a shortlisting process and interview any shortlisted candidates;
- h) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the NHS Trusts and Foundation Trusts are suitable the nominated candidates shall be rejected and the nominations process will restart;
- i) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at his or her absolute discretion and without creating a precedent for any further or future decisions;
- j) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

14.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

15. TWO PARTNER MEMBERS - PROVIDERS OF PRIMARY MEDICAL SERVICES

15.1 These Partner Members are jointly nominated by providers of primary medical services for the purposes of the health service within the Integrated Care Board's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

15.2 The list of relevant providers of primary medical services for the purpose of clause 15.1 above is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

15.3 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in section 11 above apply.

15.4 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Where the number of eligible candidates that have been jointly nominated, in accordance with clause 15.5 below, is no greater than the number of vacancies in the established roles the appointments panel may consist solely of the Chair and Chief Executive at their absolute discretion and without setting any precedents for the future membership of any appointments panel.

15.5 The appointment process will be as follows:

- a) The ICB or another organisation ('Organisation') acting as the ICB's agent shall write to all of the providers of primary medical services referred to in clauses 15.1 and 15.2 above inviting nominations. For the purposes of this clause 15.5 the ICB and/or the Organisation acting as the ICB's agent are referred to as 'Agent';
- b) Any of the providers of primary medical services listed in clauses 15.1 and 15.2 above may nominate candidates who meet the requirements of the role based on a role specification produced by the ICB;
- c) Each eligible organisation wishing to nominate a candidate shall send their nomination(s) to the Agent;
- d) The Agent shall review the nomination(s) and confirm whether or not each nomination meets the minimum eligibility requirements of the role based on the role specification. Where potential candidates do not meet the minimum eligibility requirements the Agent shall discuss this with the nominating organisation. The nominating organisation may put forward representations as to why it believes the potential candidate(s) meets the minimum eligibility requirements of the role specification or it may withdraw the nomination. If the Agent and the nominating organisation are unable to agree on whether the potential candidate(s) meet the minimum eligibility criteria requirements the decision shall be: a) referred to the ICB for determination where the Agent is the Organisation; or b) taken by the ICB where the ICB is the Agent. Any decisions shall not set any precedents for further or future decisions;
- e) The Agent shall compile a list ('List') of candidates which meet the minimum eligibility requirements of the role specification. The List shall also contain in a separate section a list of candidates who were put forward for nomination but do not meet the minimum eligibility requirements of the role specification. The List shall not contain the names of those candidates who do not meet the minimum eligibility requirements of the role specification where their nomination has been withdrawn;
- f) The Agent shall send the List to all providers of primary medical services referred to in clauses 15.1 and 15.2 above. These providers of primary medical services will be requested to confirm, by simple majority, whether they jointly agree to nominate the whole list of candidates who meet the requirements of the role specification. Any failure to confirm within seven working days or any such other reasonable time specified by the Agent will be deemed to constitute agreement. If they agree the list will be put forward to the next stage of the nominations and appointment process set out in clause 15.5g) below. If they do not agree the nominations process will be re-run until joint agreement is reached on the nominations put forward following the process set out in this clause 15.5a) – f);
- g) The ICB appointments panel referred to in clause 15.4 above shall consider the confirmed list of jointly nominated candidates. It shall undertake a shortlisting process and interview any shortlisted candidates;
- h) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the providers of primary medical services are suitable the nominated candidates shall be rejected and the nominations process will restart;
- i) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate to appoint. The Chair of the ICB shall approve or not approve the recommendation at the Chair's absolute discretion and without creating a precedent for any further or future decisions;
- j) If the Chair of the ICB approves the recommendation the recommended candidate shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate to the Chair of the ICB or if there are no

suitable candidates the candidates shall be rejected and the nominations process will restart.

15.9 The terms of office for these Partner Members will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

16. THREE PARTNER MEMBERS- LOCAL AUTHORITIES

16.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the Integrated Care Board's area. Those local authorities are:

- a) Barnet London Borough Council;
- b) Brent London Borough Council;
- c) Camden London Borough Council;
- d) Ealing London Borough Council;
- e) Enfield London Borough Council;
- f) Hammersmith & Fulham London Borough Council;
- g) Haringey London Borough Council;
- h) Harrow London Borough Council;
- i) Hillingdon London Borough Council;
- j) Hounslow London Borough Council;
- k) Islington London Borough Council;
- l) Kensington & Chelsea London Borough Council;
- m) Westminster London Borough Council.

16.2 These members will fulfil the eligibility criteria set out at 10.1 above. This member shall be an elected Councillor, Chief Executive or hold a relevant executive level role in one of the local authorities listed in clause 16.1 above.

16.3 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in section 11 above apply.

16.4 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. Where the number of eligible candidates that have been jointly nominated, in accordance with clause 16.5 below, is no greater than the number of vacancies in the established roles the appointments panel may consist solely of the Chair and Chief Executive at their absolute discretion and without setting any precedents for the future membership of any appointments panel.

16.5 The appointment process will be as follows:

- a) Any of the local authorities listed in clause 16.1 above may nominate candidates who meet the requirements of the role based on a role specification produced by the ICB. Those candidates that meet the minimum eligibility criteria shall be placed on a list. The local authorities shall jointly agree, by simple majority, the entire list of candidates that meet the minimum eligibility criteria;
- b) If the local authorities are unable to agree on whether a potential candidate meets the minimum eligibility criteria the decision shall be referred to the ICB for determination. Any decisions shall not set any precedents for further or future decisions;
- c) Once the list is jointly agreed these local authorities will jointly sign a letter addressed to the Chair of the ICB containing their list of nominated candidates and a statement confirming that the nominated candidates meet the requirements of the role. The letter will be sent to the Chair and Chief Executive of the ICB;
- d) The ICB appointments panel referred to in clause 16.4 above shall consider the list. It shall undertake a shortlisting process and interview any shortlisted candidates;

- e) If the ICB appointments panel considers at either the shortlisting or interview stage that none of the candidates nominated by the local authorities are suitable the nominated candidates shall be rejected and the nominations process will restart;
- f) If the ICB appointments panel considers that at least one of the candidates has the skills, knowledge, experience and attributes required to fulfil the role and is therefore suitable it shall make a recommendation to the Chair of the ICB as to which candidate(s) to appoint. The Chair of the ICB shall approve or not approve the recommendation at the Chair's absolute discretion and without creating a precedent for any further or future decisions;
- g) If the Chair of the ICB approves the recommendation the recommended candidate(s) shall be appointed. If the Chair of the ICB does not approve the recommendation the ICB appointments panel shall reconsider its recommendation and shall either recommend another suitable candidate(s) to the Chair of the ICB or if there are no suitable candidates the candidates shall be rejected and the nominations process will restart.

16.6 The term of office for this Partner Member will be three years and the total number of terms they may serve is two terms, subject to the provisions of the Standing Orders.

17. MEDICAL DIRECTOR

17.1 This member will fulfil the eligibility criteria set out at 10.1 and also the following additional eligibility criteria:

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- b) Be a registered Medical Practitioner.

17.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in section 11 above apply.

17.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

18. DIRECTOR OF NURSING

18.1 This member will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;
- b) Be a registered Nurse.

18.2 Individuals will not be eligible if:

- a) Any of the disqualification criteria set out in section 11 above apply.

18.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

19. DIRECTOR OF FINANCE

19.1 This member will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:

- a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

- 19.2 Individuals will not be eligible if:
- a) Any of the disqualification criteria set out in section 11 above apply.
- 19.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

20. CHIEF PEOPLE OFFICER

- 20.1 This member will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:
- b) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
- 20.2 Individuals will not be eligible if:
- b) Any of the disqualification criteria set out in section 11 above apply.
- 20.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

21. FIVE NON-EXECUTIVE MEMBERS

- 21.1 The ICB will appoint five Non-Executive Members.
- 21.2 These members will be appointed by an ICB appointments panel subject to the approval of the Chair. The appointments panel shall include, as a minimum, at least three people as follows:
- a) The Chair of the Board;
 - b) Two representatives from ICB partner organisations.
- 21.3 These members will fulfil the eligibility criteria set out at 10.1 above and also the following additional eligibility criteria:
- a) Not be an employee of the ICB or a person seconded to the ICB;
 - b) Not hold a role in another health and care organisation in the ICS area;
 - c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;
 - d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
- 21.4 Individuals will not be eligible if:
- a) Any of the disqualification criteria set out in section 11 above apply;
 - b) They hold a role in another health and care organisation within the ICB area.
- 21.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is two terms after which they will no longer be eligible for re-appointment, subject to the provisions of the Standing Orders.
- 21.6 Initial appointments may be for a shorter period at the ICB Chair's absolute discretion and without setting any precedents for any future decision in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.
- 21.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-Executive Member for additional terms of office up to the maximum number of years permitted for their role as set out in clause 21.5 above.

22. BOARD MEMBERS: REMOVAL FROM OFFICE

- 22.1 Arrangements for the removal from office of Board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.
- 22.2 With the exception of the Chair and Executive Directors (which for the avoidance of doubt includes the Chief Executive), ICB Board members shall be removed from office, after following a fair process, if any of the following occurs:
- a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
 - b) If they fail to attend three ICB Board meetings in a row without the permission of the Chair;
 - c) A motion of no confidence is passed by a simple majority of ICB Board members. The simple majority must include the Chair of the Board or the Deputy Chair if the Chair is unable to participate in any vote due to a conflict of interest;
 - d) If their behaviour, conduct and/or professionalism:
 - Falls below the standard required for the role;
 - Brings the ICB and/or the ICB Board into disrepute;
 - Is dishonest, an abuse of position, professional misconduct or grossly negligent;
 - e) If for some other substantial reason their position has become untenable.
- 22.3 The Executive Director members of the ICB Board shall be removed from office if any of the following occurs:
- a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;
 - b) If their employment with the ICB is terminated.
- 22.4 For Executive Director Members of the ICB Board they shall only be removed upon the outcome of the ICB's HR disciplinary process where appropriate. Grounds for triggering the ICB's disciplinary process may include:
- a) If they fail to attend three ICB Board meetings in a row without the permission of the Chair;
 - b) In the event of performance concerns a motion of no confidence is passed by a simple majority of ICB Board members. The simple majority must include the Chair of the Board or the Deputy Chair if the Chair is unable to participate in any vote due to a conflict of interest;
 - c) If their behaviour, conduct and/or professionalism:
 - Falls below the standard required for the role;
 - Brings the ICB and/or the ICB Board into disrepute;
 - Is dishonest, an abuse of position, professional misconduct or grossly negligent;
 - d) If for some other substantial reason their position has become untenable.
- 22.5 Members may be suspended pending the outcome of an investigation into whether any of the matters in 22.2, 22.3 and/or 22.4 above apply.
- 22.6 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.
- 22.7 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

- 22.8 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:
- a) Terminate the appointment of the ICB's Chief Executive; and
 - b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

23. TERMS OF APPOINTMENT OF BOARD MEMBERS

23.1 With the exception of the Chair of the ICB arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy, any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body. It is a principle that no one shall decide their own pay and therefore the Remuneration Committee will be constituted accordingly.

23.2 Remuneration for the Chair of the ICB will be set by NHS England.

23.3 Other terms of appointment for Board members will be determined by the Remuneration Committee.

23.4 Terms of appointment of the Chair of the ICB will be determined by NHS England.

24. GOOD GOVERNANCE

24.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

24.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the Board and its Committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

25. GENERAL

25.1 The ICB will:

- a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
- b) Comply with directions issued by the Secretary of State for Health and Social Care;
- c) Comply with directions issued by NHS England;
- d) Have regard to statutory guidance including that issued by NHS England;
- e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England;
- f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

25.2 The ICB will develop and implement the necessary systems and processes to comply with 25.1(a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and/or other relevant policies and procedures as appropriate.

26. AUTHORITY TO ACT

26.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

- a) Any of its members or employees;
- b) A Committee or Sub-Committee of the ICB.

- 26.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.
- 26.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SORD.

27. SCHEME OF RESERVATION AND DELEGATION

- 27.1 The ICB has agreed a Scheme of Reservation and Delegation ('SORD') which is published in full on the ICB's website.
- 27.2 Only the Board may agree the SORD and amendments to the SORD may only be approved by the Board.
- 27.3 The SORD sets out:
- a) Those functions that are reserved to the Board;
 - b) Those functions that have been delegated to an individual or to Committees and sub committees;
 - c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.
- 27.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

28. FUNCTIONS AND DECISIONS MAP

- 28.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SORD.
- 28.2 The Functions and Decision Map is published on the ICB's website.
- 28.3 The Functions and Decisions Map includes:
- a) Key functions reserved to the Board of the ICB;
 - b) Commissioning functions delegated to Committees and individuals;
 - c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
 - d) Functions delegated to the ICB (for example, from NHS England).

29. COMMITTEES AND SUB-COMMITTEES

- 29.1 The ICB may appoint Committees and arrange for its functions to be exercised by such Committees. Each Committee may appoint Sub-Committees and arrange for the functions exercisable by the Committee to be exercised by those Sub-Committees at the Board's absolute discretion.

- 29.2 All Committees and Sub-Committees are listed in the SORD.
- 29.3 Each Committee and Sub-Committee established by the ICB operates under Terms of Reference agreed by the Board. All Terms of Reference are published in the Governance Handbook.
- 29.4 The Board remains accountable for all functions, including those that it has delegated to Committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in Terms of Reference. All Committees and Sub-Committees that fulfil delegated functions of the ICB, will be required to:
- a) Discharge their functions effectively and from within their delegated authorities;
 - b) Provide reports to the Board as required.
- 29.5 Any Committee or Sub-Committee established in accordance with this section 29 may consist of, or include, persons who are not ICB Members or employees.
- 29.6 All members of Committees and Sub-Committees that exercise the ICB's commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a Committee or Sub-Committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.
- 29.7 All members of Committees and Sub-Committees are required to act in accordance with this Constitution, including the Standing Orders as well as the SFIs and any other relevant ICB policy.
- 29.8 The following Committees will be maintained:
- a) **Audit Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-Executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.
 - b) **Remuneration Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) and terms of service for a) Board members (other than the Chair of the ICB), b) ICB officers, c) clinical leads and d) employees at the Very Senior Manager level. It also sets the employee pay policy for employees below the Very Senior Manager level.

The Remuneration Committee will be chaired by a Non-Executive Member other than the Chair or the Chair of Audit Committee.
- 29.9 The terms of reference for each of the above Committees are published in the Governance Handbook.
- 29.10 The Board has also established a number of other Committees to assist it with the discharge of its functions. These Committees are set out in the SORD and further information about these Committees, including terms of reference, are published in the Governance Handbook.

30. DELEGATIONS MADE UNDER SECTION 65Z5 OF THE 2006 ACT

- 30.1 As per 26.2 above the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).
- 30.2 All delegations made under these arrangements are set out in the ICB SORD and included in the Functions and Decision Map.
- 30.3 Each delegation made under section 65Z5 of the 2006 Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.
- 30.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.
- 30.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

31. STANDING ORDERS

- 31.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:
- a) Conducting the business of the ICB;
 - b) The procedures to be followed during meetings; and
 - c) The process to delegate functions.
- 31.2 The Standing Orders apply to all Committees and Sub-Committees of the ICB unless specified otherwise in Standing Orders or in terms of reference which have been agreed by the Board.
- 31.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

32. STANDING FINANCIAL INSTRUCTIONS

- 32.1 The ICB has agreed a set of Standing Financial Instructions ('SFIs') which include the delegated limits of financial authority set out in the SORD.
- 32.2 A copy of the SFIs is published in the Governance Handbook on the ICB's website.

33. CONFLICTS OF INTEREST

- 33.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.
- 33.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB's website.
- 33.3 All Board, Committee and Sub-Committee members, officers and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or

employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

33.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

33.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

33.6 The ICB has appointed the Audit Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

- a) Act as a conduit for members of the public, healthcare professionals and wider Integrated Care System partners who have any concerns with regards to conflicts of interest;
- b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
- c) Support the rigorous application of conflict of interest principles and policies;
- d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- e) Provide advice on minimising the risks of conflicts of interest.

34. PRINCIPLES FOR CONFLICT OF INTEREST MANAGEMENT

34.1 In discharging its functions the ICB will abide by the following principles:

- a) Decision making will be geared towards meeting the statutory duties of the ICB at all times including the triple aim;
- b) Any individual involved in decisions relating to ICB functions must be acting clearly in the interests of the ICB and of the public, rather than furthering any direct or indirect financial, personal, professional or organisational interests;
- c) ICBs have been created to give statutory NHS providers, local authorities and general practice providers of primary medical service nominees a role in decision making. These individuals will be expected to act in accordance with principles a) and b) above. Whilst it should not automatically be assumed that they are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations the possibility of actual and perceived conflicts of interest arising will remain. For all decisions ICBs will need to carefully consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not that outweighs the value of the knowledge they bring to the decision making process;
- d) The personal and professional interests of all ICB Board Members, ICB committee members and ICB staff who are involved in decision making need to be declared, recorded and managed appropriately;
- e) Declarations of Interest must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest and about the nature of any conflict that may arise regarding a particular decision and/or item under consideration;

- f) All Declarations of Interest will be recorded. If an interest is declared but there is no risk of a conflict arising then no further action need be taken. However, if a material interest is declared it should be considered to what extent this material interest affects the balance of the discussion and decision-making process. In doing so the ICB should ensure actual and potential conflicts of interest do not, and do not appear, to affect the integrity of the ICB's decision making processes;
- g) The ICB shall consider the composition of its decision-making forums and will clearly distinguish between those individuals who will a) be involved in formal decision making and b) those whose input informs decisions. The ICB shall consider the perspective individuals bring and the value they add to both items under discussion and decision making. This includes the ability to shape the ICB's understanding of how best to meet patients' needs and deliver care for the ICB's population;
- h) Actions to mitigate any conflicts of interest shall be proportionate and will seek to preserve the spirit of collective decision making wherever possible. Any mitigating actions shall take into account a range of factors which may include but is not limited to:
 - The perception of any conflicts of interest;
 - How a decision may be received if an individual with an actual or a perceived conflict of interest is involved in making the decision;
 - The risks and benefits of having a particular individual involved in making the decision;
- i) Options in relation to mitigation may include, but is not limited to:
 - Including a conflicted person in the discussion but not in decision making;
 - Excluding a conflicted person from both the discussion and the decision making;
 - Including a conflicted person in the discussion and decision making where there is a clear benefit to them being included in both. Including a conflicted person in the actual decision making shall be done after careful consideration of the risks and with proper mitigations in place. The rationale for inclusion shall also be properly documented and included in minutes;
 - Excluding a conflicted individual and securing technical or local expertise from an alternative, unconflicted source;
- j) The way conflicts of interest are declared and managed shall contribute to a culture of transparency about how decisions are made. The minutes or record of meetings shall include declarations of any actual or perceived conflicts of interest, how the conflict of interest shall be mitigated together with the rationale and how the conflict of interest was managed;
- k) Conflicts of interest shall be managed in accordance with NHS England guidance including for the provider selection regime and for joint working and delegation arrangements. For the provider selection regime this includes the situation where decisions are being taken as part of a formal competitive procurement of services with any individual who is associated with an organisation that has a vested interest in the procurement recusing themselves from the process.

35. DECLARING AND REGISTERING INTERESTS

35.1 The ICB maintains registers of the interests of:

- a) Members of the ICB;
- b) Members of the Board's Committees and Sub-Committees;
- c) Officers of the ICB including Clinical Leads;
- d) Its employees.

35.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB's website.

- 35.3 All relevant persons as per 33.3 and 33.5 above must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.
- 35.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.
- 35.5 All relevant declarations will be entered in the registers as per 35.1 above.
- 35.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.
- 35.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.
- 35.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

36. STANDARDS OF BUSINESS CONDUCT

- 36.1 Board members, employees, Committee and Sub-Committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
- a) Act in good faith and in the interests of the ICB;
 - b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
 - c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.
- 36.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

37. ACCOUNTABILITY AND TRANSPARENCY

- 37.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

38. MEETINGS AND PUBLICATIONS

- 38.1 ICB Board meetings and Committees or Sub-Committees composed entirely of Board members or which include all Board members will be held in public except:
- a) Where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest in accordance with section 17 of the Standing Orders;
 - b) The Audit Committee and the Remuneration Committee shall not be held in public.

- 38.2 Papers and minutes of all meetings held in public will be published.
- 38.3 Annual accounts will be externally audited and published.
- 38.4 A clear complaints process will be published.
- 38.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.
- 38.6 Information will be provided to NHS England as required.
- 38.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:
- a) Conflicts of interest policy and procedures;
 - b) Registers of interests;
 - c) Key policies.
- 38.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (this is the Joint Forward Plan). The plan will in particular:
- a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions;
 - b) explain how the ICB proposes to discharge its duties under:
 - Section 14Z34 to 14Z45 (general duties of integrated care boards);
 - Sections 223GB and 223N (financial duties);
 - c) Set out any steps that the ICB proposes to take to implement the joint health and wellbeing strategy;
 - d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25;
 - e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether children or adults).

39. SCRUTINY AND DECISION MAKING

- 39.1 At least six Non-Executive members will be appointed to the Board including the Chair. All of the Board and Committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.
- 39.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.
- 39.3 The ICB will comply with the requirements of the NHS Provider Selection Regime.
- 39.4 The ICB will comply with local authority health overview and scrutiny requirements.

40. ANNUAL REPORT

- 40.1 The ICB will publish an annual report in accordance with any guidance published by NHS England which shall:
- a) Set out how the ICB has discharged its functions and fulfilled its duties in the previous financial year and in particular explain how it has discharged its duties under sections 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards);

- b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under sections:
 - 14Z52 (forward plan); and
 - 14Z56 (capital resource use plan);
- c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and;
- d) Review any steps the Board has taken to implement any joint health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

41. ARRANGEMENTS FOR DETERMINING THE TERMS AND CONDITIONS OF EMPLOYEES

- 41.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.
- 41.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.
- 41.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee but the Board ensures that the Remuneration Committee has access to appropriate advice by:
- a) Authorising the Remuneration Committee to obtain at the ICB's expense outside legal or other professional advice on any matter within the Remuneration Committee's Terms of Reference;
 - b) Members of the Governance and/or HR teams attending Remuneration Committee meetings to advise as appropriate.
- 41.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.
- 41.5 The main purpose of the Remuneration Committee is to:
- a) Approve the remuneration and terms of service for ICB Board members except for the Chair;
 - b) Approve the remuneration and terms of service for ICB officers, clinical leads and employees at the Very Senior Manager level;
 - c) Set the pay policy for employees below the Very Senior Manager level. For the avoidance of doubt the Remuneration Committee does not approve employee pay below the Very Senior Manager level or the ICB's staffing structures. These are delegated to the ICB's Chief Executive.
- 41.6 The duties of the Remuneration Committee are set out in its Terms of Reference. The Terms of Reference agreed by the Board are published in the Governance Handbook on the ICB's website.
- 41.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

42. ARRANGEMENTS FOR PUBLIC INVOLVEMENT

- 42.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

- a) The planning of the commissioning arrangements by the Integrated Care Board;
- b) The development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them; and
- c) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

42.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

- a) The development of communication and engagement strategies and plans as appropriate;
- b) The establishment of appropriate forums and channels of communication to effectively engage with the ICB's population;
- c) The establishment of a Communications and Engagement Team;
- d) The development of local principles to support the national principles developed by NHS England for working with people and communities;
- e) The development of a transparent and open approach which considers and appropriately utilises feedback to shape our plan.

42.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

- a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;
- b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
- c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
- d) Build relationships with excluded groups – especially those affected by inequalities;
- e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
- f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
- g) Use community development approaches that empower people and communities, making connections to social action;
- h) Use co-production, insight and engagement to achieve accountable health and care services;
- i) Co-produce and redesign services and tackle system priorities in partnership with people and communities;
- j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

42.4 In addition the ICB will develop a strategy for working with our communities which will include local engagement principles. These local engagement principles will build upon the ten principles set out in clause 42.3 above.

42.5 The principles set out in clauses 42.3 and 42.4 above will be used when developing and maintaining arrangements for engaging with people and communities.

42.6 These arrangements, include:

- a) Establishing a partnership forum which oversees resident engagement and involvement in the Integrated Care System;
- b) Ensuring that the patient and resident voice is heard at a strategic level and that engagement insight is used to inform decision making and improve services;

- c) Ensuring there is appropriate representation from key partners in engagement forums;
- d) Establishing policies which supports the ICB's approach to community engagement, co-production, community power and placing local communities and their voices at the heart of the ICB's plans.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Board	The Board of Members comprising solely of members of the ICB as set out in sections 7 and 8 of the Main Body of the Constitution.
Area	The geographical area that the ICB has responsibility for, as defined in section 2 of this Constitution
Committee	A committee created and appointed by the ICB Board.
Executive Director	A member of the ICB's Executive Management Team.
Sub-Committee	A committee created and appointed by and reporting to a Committee.
Forward Plan Condition	The Forward Plan Condition as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The Level of Services Provided Condition as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Partner Member	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are appointed in accordance with the procedures set out in sections 14, 15 and 16 respectively of the Main Body of the Constitution having been nominated by the following: <ul style="list-style-type: none"> • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description; • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description; • The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social

	enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Main Body of the Constitution	The Constitution excluding all Appendices.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the ICB, excluding the Chair and Chief Executive, are referred to as Ordinary Members.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

APPENDIX 2 STANDING ORDERS

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1. INTRODUCTION

- 1.1 These Standing Orders ('Standing Orders') regulate the proceedings of the NHS North Central London Integrated Care Board ('ICB') so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution and should be read in conjunction with the Constitution.

2. AMENDMENT AND REVIEW

- 2.1 The Standing Orders are effective from 1st April 2026.
- 2.2 The Standing Orders will be reviewed every three years or sooner if required.
- 2.3 The Standing Orders form part of the ICB's Constitution and therefore any changes or amendments to the Standing Orders must be approved by both the ICB Board and NHS England prior to implementation.
- 2.4 Any changes or amendments to the Standing Orders will be made as per section 5 of the Constitution.

3. INTERPRETATION, APPLICATION AND COMPLIANCE

- 3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1 of the Constitution.
- 3.2 These Standing Orders apply to the Board of the ICB. The Terms of Reference for Committees and Sub-Committees shall set out how the proceedings of these Committees and Sub-Committees are regulated.
- 3.3 All members of the ICB Board, members of Committees and Sub-Committees, office holders and all employees should be aware of the Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions and comply with them. Failure to comply may be regarded as a disciplinary matter.
- 3.4 In the case of conflicting interpretation of the Standing Orders and/or the Scheme of Reservation and Delegation and/or the Standing Financial Instructions, the Chair supported by advice from the corporate governance team, will provide a settled view which shall be final.
- 3.5 All members of the ICB Board, its Committees, Sub-Committees, office holders and all employees have a duty to disclose and report any non-compliance with the Standing Orders, Scheme of Reservation and Delegation and/or the Standing Financial Instructions to the Governance and Risk Team as soon as possible.
- 3.6 If, for any reason, the Standing Orders and/or the Scheme of Reservation and Delegation and/or the Standing Financial Instructions are not complied with, full details of the non-compliance, any justification for non-compliance, the circumstances around the non-compliance and steps taken to ensure future compliance shall be reported to the next formal meeting of the Audit Committee and, where required, to the ICB Board for action and/or ratification.
- 3.7 Conflicts of interest shall be dealt with in accordance with sections 33 to 36 of the Main Body of the Constitution and sections 19 and 20 of the Standing Orders. Fraud and bribery shall be dealt with in accordance with the anti-fraud and bribery policy. The anti-fraud and bribery policy is available on the ICB's website in the Governance Handbook and on the staff intranet.

4. FREQUENCY OF ICB BOARD MEETINGS

- 4.1 Meetings of the ICB Board shall be held at regular intervals at such times and places as the ICB may determine.
- 4.2 In normal circumstances each member of the ICB Board will be given not less than 10 calendar days' notice in writing of any meeting to be held. However:
 - a) The Chair may call a meeting at any time by giving not less than 7 days' notice in writing;
 - b) Not less than five members of the ICB Board, which must include at least one Non-Executive Member, may request the Chair to convene a meeting by notice in writing. The notice must specify the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within 7 calendar days of such a request being presented the ICB Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the ICB Board specifying the matters to be considered at the meeting;
 - c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
- 4.3 The meeting notice shall contain the date, time and location of the meeting.
- 4.4 Where ICB Board meetings are to be held in public the date, times and location of the meetings will be published on the ICB's website and be posted at the ICB's office at least 3 clear days before the meeting is due to take place or, if the meeting is convened at shorter notice, then as soon as is reasonably practicable.

5. ICB BOARD MEETING AGENDAS AND PAPERS

- 5.1 Before each ICB Board meeting an agenda setting out the business of the meeting will be sent to every ICB Board member no less than 7 calendar days in advance of the meeting.
- 5.2 If an ICB Board member or any other person wishes to include an item on the agenda they must notify the Chair via the Secretariat no later than 9 calendar days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the ICB Board Chair but any request to add an item to the agenda must not be unreasonably refused.
- 5.3 Before each ICB Board meeting the papers of the meeting will be sent to every ICB Board member no less than 7 calendar days in advance of the meeting. Any papers received after this date will only be accepted by exception at the ICB Board Chair's absolute discretion. If the ICB Board Chair agrees that these late papers may be distributed they will be either:
 - a) Sent to ICB Board members electronically before or at the meeting to which the papers relate; and/or
 - b) Be provided with a physical copy of the papers before or at the meeting to which the papers relate.
- 5.4 ICB Board meeting papers will be published on the ICB's website and be available for inspection at the ICB's office at least 3 clear days in advance of the meeting to which they relate or, if the meeting is convened at shorter notice, then at the time it is convened. The agenda and/or papers may exclude, if thought fit, any item that is to be addressed in any meeting and/or part of a meeting that is not likely to be open to the public.

6 LACK OF SERVICE

- 6.1 Lack of service by the ICB of any of the following documents and/or lack of service within the required time limits shall not affect the validity of an ICB Board meeting as long as the ICB has acted in good faith:
- a) Notice of ICB Board meetings under section 4 above;
 - b) Agendas under section 5 above;
 - c) Papers under section 5 above.

7. CHAIR OF A MEETING

- 7.1 The Chair of the ICB shall preside over meetings of the ICB Board.
- 7.2 If the Chair is absent, or is disqualified from participating due to a conflict of interest, the Deputy Chair shall chair the meeting.
- 7.3 If both the Chair and the Deputy Chair are unable to participate in a meeting or part of a meeting due to absence or a conflict of interest a Non-Executive Member shall chair the meeting.
- 7.4 The ICB Board shall appoint a Chair to all Committee and Sub-Committees that it has established. The appointed Committee or Sub-Committee Chair will preside over the relevant meetings. Terms of Reference for Committees and Sub-Committees will specify arrangements for occasions when the appointed Chair is absent.

8. MEMBERS OF THE ICB BOARD

- 8.1 Membership of the ICB Board is set out in sections 7 and 8 of the Main Body of the Constitution as follows:
- a) Chair;
 - b) Chief Executive;
 - c) Five Non-Executive Members;
 - d) Four Partner Members- NHS Trusts and Foundation Trusts;
 - e) Two Partner Members- Providers of Primary Medical Services;
 - f) Three Partner Members- Local Authorities;
 - g) Medical Director;
 - h) Finance Director;
 - i) Director of Nursing;
 - j) Chief People Officer.
- 8.2 Each of the officer members of the ICB Board listed at 8.1 b), g), h), i) and j) above may nominate a deputy to represent them in their absence and make decisions on their behalf. The Chair and the corporate governance team must be informed of any such deputisation.
- 8.3 Each of the other Ordinary Members of the ICB Board listed at 8.1 a), c), d), e) and f) above may nominate a deputy to represent them in their absence and make decisions on their behalf. The Chair and the corporate governance team must be informed of any such deputisation. The deputy must:
- a) Be a fit and proper person; and
 - b) Have sufficient knowledge, skills and expertise to properly carry out the role; and
 - c) Meet the eligibility requirements for membership of the ICB set out in sections 10 and 11 of the Main Body of the Constitution.
- 8.4 ICB Board members who are unable to attend an ICB Board meeting howsoever caused may vote on decisions by proxy by completing a proxy voting form. The proxy voting form must be

received by the ICB Board Chair prior to the ICB Board meeting to which it relates. The corporate governance team shall establish and maintain the proxy voting form.

9. PARTICIPANTS AND OBSERVERS

- 9.1 As per section 9 of the Main Body of the Constitution the ICB Board may call additional experts to attend meetings on a case by case basis to inform discussions.
- 9.2 The ICB Board may invite or allow additional people to attend ICB Board meetings as participants. Participants may present at ICB Board meetings and contribute to relevant discussions but are not allowed to participate in any formal vote.
- 9.3 The ICB Board may invite or allow people to attend meetings as observers. Observers may not present at ICB Board meetings, contribute to any discussion or participate in any formal vote. Observers may ask questions and/or participate in one or more discussions at the invitation of the Chair.

10. QUORUM

- 10.1 The quorum for ICB Board meetings is 6 members which must include:
- a) The Chair or Deputy Chair if the Chair is not present or unable to participate due to a conflict of interest;
 - b) The Chief Executive or the Director of Finance;
 - c) The Medical Director or the Director of Nursing;
 - d) At least one Non-Executive Member;
 - e) At least one Partner Member.
- 10.2 For the sake of clarity:
- a) No person can act in more than one capacity when determining the quorum with the exception of a Non-Executive Member if they are acting in the capacity of Deputy Chair and the Chair is not present;
 - b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum;
 - c) A nominated deputy permitted in accordance with the Constitution and these Standing Orders will count towards the quorum for meetings of the Board.
- 10.3 If an ICB Board meeting is not quorate the ICB Board members present may discuss items of business but no decisions may be taken until such a time that the meeting is quorate.
- 10.4 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements. If a meeting is not quorate the Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary. However, for all Partner Members and Non-Executive Members the person temporarily appointed or co-opted to satisfy the quorum requirements must a) be a person who satisfies the requirements of section 8.3 above, and b) the Chair must give approval for the person to be temporarily appointed or co-opted.
- 10.5 In the circumstances where a quorum cannot be obtained in accordance with clauses 10.1 or 10.4 above due to the management of conflicts of interest the quorum shall be five non-conflicted ICB Board members.

10.6 In addition to the provisions contained in clauses 10.1, 10.4 and 10.5 above where it would be more appropriate and/or to better manage conflicts of interest the ICB Board may at its absolute discretion require one of its Committees or Sub-Committees to consider an item or items of business and make decisions on its behalf.

11. MINUTES

11.1 The minutes of the proceedings of a meeting shall be prepared and submitted for agreement at the next meeting. Once the minutes have been approved they shall be signed by the person presiding at the meeting.

11.2 The minutes as a minimum shall state all ICB members and participants present at the meeting, a summary of discussions held and/or decisions taken for each agenda item and how conflicts of interest were managed in accordance with the provisions of the conflicts of interest policy.

11.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

11.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

12. BOARD DECISION MAKING

12.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working through difficult issues where appropriate.

12.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

- a) All members of the Board who are present at the meeting will be eligible to cast one vote each;
- b) Absent members may vote by proxy in accordance with clause 8.4 above. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so;
- c) For the sake of clarity, any participants and/or observers (as detailed within section 9 of the Main Body of the Constitution) will not have voting rights;
- d) A resolution will be passed if more votes are cast for the resolution than against it;
- e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote;
- f) Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.

12.3 Notwithstanding the provisions of clause 12.2 above if all five Executive Members of the ICB Board, or 100% of the non-conflicted Executive Members if any are unable to vote on a resolution due to any conflicts of interest, vote against a resolution it shall not pass. The matter shall be remitted back to the ICB Board for further consideration as appropriate.

12.4 Where helpful the ICB Board may draw on third party support to assist them in resolving any disputes such as peer review or support from NHS England.

13. ICB BOARD URGENT DECISIONS UNDER CHAIR'S ACTION

- 13.1 For urgent decisions and extraordinary circumstances it is generally expected that the ICB Board will meet virtually. However, where this is not possible the decision-making powers reserved to the ICB Board under the Scheme of Reservation and Delegation may be exercised by the Chair and the Chief Executive acting together outside of an ICB Board meeting where a decision is of such importance or urgency that it cannot wait until the next ICB Board meeting or appropriate ICB Board committee or Sub-Committee meeting. The power shall only be exercised by the Chair and the Chief Executive after having consulted at least two other members of the ICB Board including at least one Non-Executive Member.
- 13.2 Any decision made under clause 13.1 above shall be reported at the next formal meeting of the ICB Board.

14. QUESTIONS FROM THE PUBLIC, PETITIONS AND DEPUTATIONS

- 14.1 The ICB Board may receive questions from the public at its absolute discretion in line with the ICB's protocol for public questions which is available on the ICB's website. The People Directorate shall establish and maintain this protocol.
- 14.2 The ICB Board may receive, at its absolute discretion, petitions and/or deputations from members of the public or interested parties to make the ICB Board aware of a particular concern or concerns they have.
- 14.3 Any petition and/or deputations should be sent to the ICB Board Secretariat who will pass it to the Chair for consideration.
- 14.4 Any petitions and/or deputations must be received by the Secretariat at least three working days before an ICB Board meeting is due to take place to be eligible to be heard at that ICB Board meeting. However, where it is not possible to comply with this deadline due to the papers of the meeting being published late or due to a public holiday the deputations must be submitted within a reasonable time.
- 14.5 Any petitions and/or deputations not received within this time will not be eligible to be heard at that ICB Board meeting. However, on a strictly case by case basis there may be times where it would be highly beneficial to the ICB's business to waive this requirement due to the relevance or content of the petition and/or deputation. In these circumstances the Chair may do so on a case by case basis and without setting any precedents of future or further waivers.
- 14.6 Any petitions and/or deputations must take the form of a written request together with a statement setting out what the petition and/or deputation is about. If any petition and/or deputation fails to set out this information it will be rejected.
- 14.7 Any petitions and/or deputations which are not relevant to the business under consideration by the ICB Board at its meeting will be rejected.
- 14.8 The Chair may accept or reject any relevant and properly completed petitions and/or deputations on a strictly case by case basis at the Chair's absolute discretion and without setting any precedents for future or further decisions.
- 14.9 If a request is agreed the interested party and/or parties will be invited to an ICB Board meeting where the ICB Board will consider the deputation.

14.10 The Chair may decide how much time to allocate to any petitions and/or deputations at the Chair's absolute discretion on a case by case basis and without setting any precedents for future or further decisions on time allocated for petitions and/or deputations.

14.11 Nothing in this section 14 shall limit, prohibit or otherwise restrict the ICB Board's powers contained in section 17 (meetings held in public) or 18 (confidentiality) of these Standing Orders.

15. VIRTUAL ATTENDANCE AT MEETINGS

15.1 The ICB Board and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

16. VIRTUAL DECISION MAKING OUTSIDE OF FORMAL MEETINGS

16.1 There are circumstances where time-critical decisions need to be made by the ICB Board or by one or more of its committees and/or sub-committees and it is not possible and/or reasonably practicable and/or a good use of resources to hold a meeting in sufficient time either in person or as per section 15 above. In these circumstances decisions may be made virtually outside of formal meetings.

16.2 The corporate governance team shall establish and maintain a protocol for virtual decision making which sets out the process by which ICB Board, its committees and/or sub-committees decisions are made virtually. This protocol will be published on the ICB's website and on the intranet.

16.3 All decisions made under this section 16 shall be reported to the next formal meeting of the ICB Board, Committee or Sub-Committee to which the decision pertains.

17. MEETINGS HELD IN PUBLIC

17.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all ICB Board meetings and Committees or Sub-Committees composed a) entirely of Board members or b) which include all Board members, at which public functions are exercised, will be open to the public unless the ICB Board or the relevant Committee or Sub-Committee resolves to exclude the public from a meeting. In which case the meeting, in whole or part, may be held in private. The ICB may also exclude participants and observers. For the purposes of this section 17 references to the ICB Board include references to its Committees and Sub-Committees.

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

- a) The confidential nature of the business to be transacted; or
- b) The matter is commercially sensitive; or
- c) The matter being discussed is part of an on-going investigation; or
- d) Other special reason stated in the resolution and arising from the nature of that business or of the proceedings; or
- e) Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time; or
- f) To suppress or prevent disorderly conduct or behaviour as permitted by section 1(8) of the Public Bodies (Admission to Meetings) Act 1960.

17.3 It may be necessary for a person other than a member of the ICB Board to be present at a private ICB Board meeting to provide the ICB Board with advice and/or knowledge and/or

expertise. The ICB Board may allow this at its absolute discretion without affecting the validity of any resolution determined in accordance with clauses 17.1 and 17.2 above.

- 17.4 The ICB Board may allow any person or persons to attend a private ICB Board meeting at its absolute discretion without affecting the validity of any resolution determined in accordance with clauses 17.1 and 17.2 above.
- 17.5 For the avoidance of doubt ICB Board meetings are meetings held in public. They are not public meetings.
- 17.6 The person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the ICB Board's business shall be conducted without interruption and disruption.
- 17.7 The person presiding over the meeting may exclude any individual and/or member of the public from a meeting if they interfere with the proper conduct of that meeting.
- 17.8 As set out in clause 38.1 of the Main Body of the Constitution the Audit Committee and the Remuneration Committee shall not be held in public.
- 17.9 Nothing in this section 17 shall limit or restrict the ICB's ability to hold any of its meetings in public at its absolute discretion and without setting any precedents for any further or future meetings.

18. CONFIDENTIALITY

- 18.1 ICB Board members shall respect confidentiality requirements as set out in these Standing Orders.
- 18.2 ICB Board meetings may in whole or in part be held in private as per section 17 above. Any papers relating to these agenda items will also be excluded from the public domain. For any meeting or any part of a meeting held in private all members and/or participants and/or observers must treat the contents of the meeting and any relevant papers as strictly private and confidential.
- 18.3 Decisions of the ICB Board will be published except when decisions have been made in private in accordance with section 17 above.

19. CONFLICTS OF INTEREST

- 19.1 Conflicts of Interest shall be dealt with in accordance with sections 33 to 36 of the Main Body of the Constitution, the ICB's conflicts of interest policy and NHS England guidance for managing conflicts of interest.
- 19.2 The ICB Board shall have a Declarations of Interest Register that will be presented as a standing item on each ICB Board meeting agenda.
- 19.3 ICB Board members must recuse themselves on a case by case basis where it is deemed by the person presiding over the meeting acting reasonably that their inclusion is a conflicts of interest which cannot be appropriately managed and therefore negatively affects the integrity of the ICB's decision making processes

20. GIFTS, HOSPITALITY AND SPONSORSHIP

- 20.1 Gifts, hospitality and sponsorship shall be dealt with in accordance with sections 33 to 36 of the Main Body of the Constitution, the ICB's conflicts of interest policy and NHS England guidance for managing conflicts of interest.
- 20.2 The ICB shall have a Gifts, Hospitality and Sponsorship Register. Declarations of Gifts, Hospitality and Sponsorship shall be a standing item on each ICB Board meeting agenda.

21. STANDARDS OF BUSINESS CONDUCT

- 21.1 ICB Board members and any participants or observers must maintain the highest standards of personal conduct and in this regard must comply with:
- a) The law of England and Wales;
 - b) The NHS Constitution;
 - c) The Nolan Principles;
 - d) The standards of behaviour set out in the ICB's Constitution;
 - e) Any additional regulations or codes of practice relevant to the ICB Board;
 - f) The ICB's governance policies.

22. ICB BOARD COMMITTEES AND DELEGATION

- 22.1 In accordance with sections 26, 29 and 30 of the Main Body of the Constitution the ICB Board has the express authority and at its absolute discretion to:
- a) Establish, disestablish, dissolve, change, amend and/or merge any existing ICB Board Committee or Sub-Committee;
 - b) Establish any new ICB Board Committee or Sub-Committee;
 - c) Set, amend or change the remit and/or purpose of any ICB Board Committee or Sub-Committee save as set out by law.
- 22.2 The ICB Board shall approve the Terms of Reference for its Committees and/or Sub-Committees. Terms of Reference shall comply with the law.
- 22.3 ICB Board Committees and/or Sub-Committees may consist of or include persons who are ICB Board members, office holders and/or employees of the ICB and/or may consist of or include persons other than ICB Board members, office holders and/or employees of the ICB save as set out by law. The ICB Board has absolute discretion as to who is eligible to vote at Committee and Sub-Committee meetings.
- 22.4 The ICB Board may delegate its authority to act on its behalf to:
- a) Any member of the ICB Board;
 - b) A Committee or Sub-Committee of the ICB Board;
 - c) Individual directors of the ICB. This may include directors who are not Executive Directors and directors who are jointly appointed with one or more Local Authorities and/or one or more statutory NHS providers;
 - d) Any of the ICB's employees.
- 22.5 In accordance with section 30 of the Main Body of the Constitution the ICB Board may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies:
- a) Another Integrated Care Board;
 - b) NHS England;
 - c) NHS trust;
 - d) NHS foundation trust;
 - e) Local Authority;

- f) Combined authority;
- g) Any other prescribed body.

22.6 Any arrangement pursuant to clause 22.5 above shall comply with the requirements of section 30 of the Main Body of the Constitution.

23 SUSPENSION OF THE STANDING ORDERS

23.1 The ICB Board may suspend these Standing Orders or any provision or part contained therein at any meeting of the ICB Board provided that:

- a) A majority of ICB Board members who are eligible to vote are in agreement. The majority must include the Chair of the ICB Board unless the Chair is unable to participate in any vote due to a conflict of interest; and
- b) The suspension does not contravene English law or any direction made by the Secretary of State for Health and Social Care or by NHS England; and
- c) The suspension is reasonable in the circumstances and proportionate to the aim to be achieved.

23.2 A decision to suspend the Standing Orders or any provision or part contained therein together with the reasons for doing so shall be recorded in the minutes of the meeting.

23.3 The Audit Committee shall review the reasonableness of the decision to suspend these Standing Orders or any provision or part contained therein. For the avoidance of doubt, this may be done virtually as per sections 15 and 16 above.

23.4 Clauses 3.5, 3.6 and 3.7 of these Standing Orders may not be suspended at any time or at all either in whole or in part.

23.5 Due to the need to manage conflicts of interest robustly, the quorum for suspension of the Standing Orders shall be as set out in section 10 above.

24. ANNUAL GENERAL MEETING

24.1 The ICB shall hold an Annual General Meeting ('AGM') in public in each financial year.

24.2 The notice of the AGM, agenda and any related papers will be published on the ICB's website, and be available for inspection at the ICB's office at least twenty working days before the AGM.

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

24.4 For the AGM to be quorate the ICB Board must be quorate in accordance with section 10 above.

24.5 The Annual Report and Accounts shall be presented at the AGM.

24.6 The Chair of the Audit Committee and the Chair of the Remuneration Committee should be available at the AGM.

24.7 General requests for specific items of business to be discussed at the AGM and/or formal motions to be discussed and voted on must be made to the ICB Board Chair via the Secretariat. It is at the absolute discretion of the ICB Board Chair whether an item of business and/or a motion is discussed and voted on at an AGM on a case by case basis and without setting any precedents for any further or future decisions

24.8 Anyone seeking to move, amend or withdraw a motion on or after the twentieth working day before the AGM may only do so on the agreement of the ICB Board Chair. Any decisions taken by the Chair is made at their absolute discretion on a strictly case by case basis and without setting any precedents for any further or future decisions. If any motions are moved, amended or withdrawn the revision shall be published on the ICB's website and be available for inspection at the ICB's office.

24.9 Motions at AGMs pass by a simple majority of ICB Board members voting at the AGM. In the event of a tied decision the Chair of the ICB shall have the casting vote.

25. CORPORATE TRUSTEE AND CHARITABLE FUNDS

25.1 The ICB may act as a corporate trustee.

25.2 The functions and powers exercised by the ICB as a corporate trustee are exercised separately and distinctly from those functions and powers the ICB exercises on behalf of itself.

25.3 The ICB may hold charitable funds as a trustee. If the ICB holds any charitable funds as a trustee it is accountable for those funds to the Charity Commission.

26. CORPORATE SEAL

26.1 The ICB shall have a seal for executing documents where necessary.

26.2 Use of the seal must be approved by the Chief Executive or the statutory Director of Finance and the sealing of any document must witnessed by a member of the Governance and Risk Team.

26.3 The seal will be stored in a safe location by the corporate governance team.

27. KEY GOVERNANCE ROLES ON THE ICB BOARD

27.1 Sections 28 to 34 below set out key roles on the ICB Board which must be appointed to.

28. DEPUTY CHAIR

28.1 The Chair of the ICB shall appoint a Non-Executive Member of the ICB Board to be the Deputy Chair. The role of the Deputy Chair includes presiding over meetings of the ICB Board where the Chair is unable to participate in a meeting or part of a meeting due to absence or a conflict of interest. No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.

29. CALDICOTT GUARDIAN

29.1 The ICB Board shall appoint a Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

29.2 The Caldicott Guardian shall perform their role in accordance with national guidance.

30. CONFLICTS OF INTEREST GUARDIAN

30.1 The Audit Committee Chair shall be the Conflicts of Interest Guardian in accordance with clause 33.6 of the Main Body of the Constitution.

30.2 The Conflicts of Interest Guardian should undertake the following in collaboration with the ICB's governance lead:

- a) Act as a conduit for members of the public, healthcare professionals and wider Integrated Care System partners who have any concerns with regards to conflicts of interest;
- b) Be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to conflicts of interest;
- c) Support the rigorous application of conflict of interest principles and policies;
- d) Provide independent advice and judgment to staff and ICB Board members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
- e) Provide advice on minimising the risks of conflicts of interest.

30.3 The Conflicts of Interest Guardian shall perform their role in accordance with national guidance.

31. SENIOR INFORMATION RISK OWNER

31.1 The ICB Board shall appoint a Senior Information Risk Owner ('SIRO') who shall be an executive ICB Board member or another senior manager as appropriate. The SIRO shall provide the Chief Executive with assurance that information risk is being managed appropriately and effectively across the organisation.

32. FREEDOM TO SPEAK UP GUARDIAN

32.1 The ICB shall have one or more Freedom To Speak Up Guardians whose role it is to help protect patient safety and the quality of care, improve the experience of workers and improve learning and improvement by ensuring that workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement.

32.2 The Chief Executive shall appoint a named lead for Freedom To Speak Up. The named lead shall ensure the ICB appoints one or more Freedom To Speak Up Guardians.

33. SENIOR INDEPENDENT NON-EXECUTIVE MEMBER

33.1 The ICB Board shall appoint one of the Non-Executive Members to be the Senior Independent Non-Executive Member ('SINEM'). The appointment of the SINEM is subject to the approval of the Chair. The SINEM shall provide a sounding board for the Chair and serve as an intermediary for the other ICB Board members. Led by the SINEM the non-officer members of the ICB Board should meet without the Chair present at least annually to appraise the Chair's performance, and on other occasions as necessary.

34. WELLBEING GUARDIAN

34.1 The ICB Board shall have a Wellbeing Guardian whose role it is to provide independent challenge to the senior leadership team to ensure the ICB has a culture of wellbeing for all employees embedded throughout the organisation, putting the health and wellbeing of its staff front and centre. The Wellbeing Guardian also champions equality, diversity and inclusion to ensure all voices are represented and heard across the organisation and within the ICB Board.

34.2 The Chair shall appoint the Wellbeing Guardian.

35. INTERIM ICB BOARD MEMBERS

- 35.1 Where a vacancy arises on the ICB Board due to an ICB Board member ceasing to hold office before the expiry of their term of office howsoever caused the ICB Board has the option to appoint an interim ICB Board member to fill the vacant position to hold office on a temporary basis.
- 35.2 Any interim ICB Board member appointed in accordance with this section 35 shall only be able to hold office as an interim ICB Board member for a period of 6 months after which they will cease to hold office as an interim ICB Board member.
- 35.3 Any interim ICB Board member must leave office immediately if a permanent ICB Board member fills the vacancy occupied by the interim ICB Board member and the term of office for the permanent ICB Board member has started. However, the Chair of the ICB Board may agree a period of grace of up to 1 month to allow for a meaningful handover.
- 35.4 Any interim ICB Board member that fills the vacant position of Partner member must pass a selection panel interview and thereafter have their interim appointment approved by the Chair of the ICB Board.
- 35.5 If the interim ICB Board member is to fill a vacant Partner Member- NHS Trusts and Foundation Trusts position the selection panel must consist of:
- a) A Chief Executive or other Executive Director from an NHS Trust or Foundation Trust in the ICB's area; and
 - b) The Chair of the ICB Board or a Non-Executive Member of the ICB Board; and
 - c) An Executive Director member of the ICB Board.
- 35.6 If the interim ICB Board member is to fill a vacant Partner Member- Providers of Primary Medical Services position the selection panel must consist of:
- a) A GP with demonstrable primary care leadership experience; and
 - b) The Chair of the ICB Board or a Non-Executive Member of the ICB Board; and
 - c) An Executive Director member of the ICB Board.
- 35.7 If the interim ICB Board member is to fill a vacant Partner Member- Local Authorities position the selection panel must consist of:
- a) A Chief Executive of a Local Authority or a person in a relevant executive level Local Authority role from a Local Authority in the ICB's area; and
 - b) The Chair of the ICB Board or a Non-Executive Member of the ICB Board; and
 - c) An Executive Director member of the ICB Board.
- 35.8 If the interim ICB Board member is to fill any vacant position on the ICB Board except for those set out in sections 35.5, 35.6 and 35.7 above the selection panel must consist of:
- a) A Partner Member of the ICB Board; and
 - b) The Chair of the ICB Board or a Non-Executive Member of the ICB Board; and
 - c) An Executive Director member of the ICB Board.
- 35.9 The interim ICB Board member must be eligible to hold office in the position they are to be appointed to.
- 35.10 The interim ICB Board member will take office on such a date and time as set by the Chair of the ICB Board.
- 35.11 The appointment of an interim ICB Board member must be recorded in the minutes of the ICB Board meeting immediately following their appointment. The appointment together with the reasons for the appointment must be reported at the next Audit Committee meeting

immediately following the appointment.

35.12 No more than two interim ICB Board members may hold office at the same time.

35.13 The period that an interim ICB Board member holds office shall not count towards their maximum number of terms of office or maximum number of years in office.

36. FLEXIBILITY OF LENGTH OF ICB BOARD TERMS OF OFFICE

36.1 The term of office for the Chair, Non-Executive Members and Partner Members of the ICB Board is three years. However, the ICB recognises that the NHS is a system that is constantly transforming and from time to time it may be necessary to have shorter terms of office for some or all ICB Board roles to meet the needs of the ICB's business. Where an ICB Board role is vacant or is due to be vacant the vacancy may be filled with the post holder holding office for a term of less than three years. It will be for the Chair of the ICB Board (or the Deputy Chair if the Chair of the ICB Board is conflicted) and the Chief Executive to jointly decide how long the term of office shall be for.

36.2 If the post holder holds office for a period of less than three years in accordance with clause 36.1 above they should not be placed at a disadvantage in terms of the overall number of terms they can potentially serve. In this instance the post holder is not prohibited from serving for more than two terms of office but is subject to a maximum total of 7 years in office.

37. EXTENSION TO TERMS OF OFFICE DUE TO SPECIAL CIRCUMSTANCES

37.1 The Chair of the ICB Board may agree to extend the term of office of any ICB Board member by up to one year where there are special circumstances. This power may only be used once per ICB Board member and overrides any limit on the maximum number of years an ICB Board member may hold office contained in the Main Body of the Constitution and/or these Standing Orders except as set out in clause 37.4 below.

37.2 The special circumstances referred to in clause 37.1 above are as follows:

- a) Where the extension is necessary to provide continuity at a time of significant organisational change or transformation; or
- b) Where the extension is necessary to provide continuity for a critical piece of work; or
- c) Where the extension is necessary to give time to put into place an alternative ICB Board member.

37.3 Prior to the proposal to extend a term of office being presented to the Chair of the ICB Board the Audit Committee shall review the reasonableness of the request and whether or not at least one of the special circumstances are met. If at least one of the special circumstances is not met the proposal to extend the term of office may not be put to the Chair of the ICB Board.

37.4 The power contained in this section 37 may not be used to extend the Chair of the ICB Board and/or Non-Executive Member terms of office beyond a maximum of 9 years. This is to retain their independence in line with the provisions of the UK Corporate Governance Code.

37.5 Before exercising the power contained in section 37.1 above to extend the term of office of a Partner Member, the organisations that jointly nominate that Partner Member must jointly agree by simple majority that the Partner Member's nomination remains valid.

38. RESET OF TERMS OF OFFICE

38.1 Subject to the provisions of the Standing Orders the Chair, each Non-Executive Member and each Partner Member on the ICB Board may only hold office for two terms totalling a maximum

of six years as set out in sections 12, 14, 15 and 16 and of the Main Body of the Constitution. This time limit is referred to as the 'Maximum Period'. The Maximum Period is personal to each individual holding these roles. Notwithstanding the time limits set out in sections 12, 14, 15, and 16 of the Main Body of the Constitution each individual's Maximum Period resets after the individual has not held office on the ICB as a Board member for a period of three years.

38.2 For the Chair of the ICB Board and Non-Executive Members clause 38.1 above is subject to an absolute maximum limit of 9 years in office in total. This is to preserve their independence in line with the provisions of the UK Corporate Governance Code.

39. VACANCIES AND DEFECTS IN APPOINTMENTS

39.1 The validity of any act of the ICB is not affected by any vacancy among ICB Board Members or by any defects in the appointment of any ICB Board Member.



North Central London
Integrated Care Board



North West London

**North Central London ICB and North West London ICB
Meeting in Common
28th January 2026**

Report Title	December 2025 - Joint WNL Performance Report Summary	Date of report	28/01/2026	Agenda Item	3.1
Lead Director / Manager	Steve Bloomer – Chief Finance Officer and Deputy CEO	Email / Tel		Stephen.bloomer@nhs.net	
Board Member Sponsor	Kunal Patel – Performance Committee Chair				
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	<p>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 for the combined West and North London system and within the two systems.</p> <p>The updates are sourced from the existing performance report formats across the respective systems (which are included as appendices to the joint summary report and combined West and North London slides).</p> <p>The report is being presented to the joint NCL and NWL Performance Committee on 22nd January 2026.</p>				
Recommendation	Members 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	<ul style="list-style-type: none"> 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. The reduction of the Total Waiting List size across West and North London is off plan. There is a risk that quarter 4 drive to reduce the waiting list, with a particular focus on treating those waiting the longest will have a knock-on impact on delivering the 18 week RTT plan. 				
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	<ul style="list-style-type: none">• North Central London ICS Operational Performance Report.• North West London ICS Operational Performance Report.

December 2025 - Joint West and North London 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 first joint ICB submission submitted on the 17th December. The interaction of planning with this in-year performance report is that under-performance against the 2025/26 plans for constitutional standards will have a detrimental impact on 2026/27 starting point.

Performance Headlines

Key messages and risks

In October 2025, the reduction of the total waiting list (PTL) across West and North London is off plan by 12,500 incomplete pathways. There are Quarter 4 'sprints' planned, supported by non-recurrent NHS England investment (£1.5 million for the WNL system), which is aiming to increase capacity for the patients who have been waiting the longest for treatment. The ambition is to reach 1% of the entire PTL is 52 week waiters.

This leads to three risks:

1. West and North London is currently non-compliant with expectations around reducing the PTL to a sustainable size by 2028/29. Under-delivery against planned PTL in 2025/26 exacerbates this.
2. West and North London may not reach the 52 week waiters 1% of PTL target by end of March 2026.
3. The quarter 4 drive to reduce the waiting list, with a particular focus on treating those waiting over 52 weeks will have a knock-on impact on delivering the 18 week RTT plan.

In November, the West and North London system is reporting a financial deficit to plan. This is primarily driven by the NCL ICS reporting a £47m deficit which is a £23.6m variance to the submitted deficit plan.

However, overall West and North London combined delivery against the 4 hour A&E, 18 week RTT, and 62-day and Faster Diagnosis cancer standards remains broadly on track. In terms of patient experience, the Friends and Family test data, albeit only one lens into patient experience, remains generally positive across the system.

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 same day appointments above the national average – 9.3% over this value for November 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.
- Performance for Children and Young People requiring treatment for mental health conditions within 4 weeks has been steady and remains above target.
- Performance for Talking Therapies 2+ contacts and discharge remains challenged in NCL, although reliable improvement and reliable recovery targets were achieved at the end of Q2 2025/26. Engagement with digital providers is underway to see how a digital front door option will improve access, signposting and increase efficiency and productivity and a targeted DNA reduction strategy is in place.

NWL:

- 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.
- In November 29.2% of people requiring mental health support experienced waits of over 12 hours in NW London emergency departments against a stretched target of 20%. This is an improvement on the 33.7% in October but remains an area of challenge for the system.
- The reliable recovery rate for Improving Access to Psychological Therapies (IAPT) services was 47.6% (48% plan), meaning patients have moved from a clinical level of anxiety or depression to a non-clinical level of anxiety or depression. 69.4% (67% target) of patients showed a reliable improvement, which is a significant but not complete recovery. NWL are forecasting the plan for both of these indicators will be met in March 2026.

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 under increasing pressure on key system flow indicators with the performance direction deteriorating as we continue through the winter months, with a particular focus on discharge delays, ICC discharge hub staffing and increases in patients being conveyed to hospital by ambulance.

West and North London (WNL):

- In November, 78.4% of people attending emergency departments in West and North London spent less than 4 hours in the department compared to 78% target.
- Performance for type 1 attendances also improved from 64.6% in October to 65.2% in November (plan 59.4%).
- Key winter actions being taken by providers to improve performance includes redirection of patients to pharmacy first and GP enhanced access services for suitable conditions.

The ICC is also supporting appropriate patients being conveyed to EDs therefore helping to reduce ED demand.

- It is anticipated that the Operating Plan 4 hour A&E targets will be met in March 2026.

NCL:

- AE attendance activity continues to be above the forecasted level of demand, across almost all NCL sites. Notably, there was a significant increase in ambulance conveyances in Q3 of 2025/26, demonstrating the higher acuity of patient attendances. This has contributed to an increase in admitted patient flow and subsequently impacted breaches.
- NHS 111 direct to GP bookings continues to improve access to primary care appointments.
- Primary care winter schemes are focussed on proactive care for those with long term conditions, delivering vaccinations and increasing capacity for paediatrics.
- Virtual ward occupancy rates performance has been below plan for the last 3 months, but the latest data for October 2025 shows an improvement from the previous month to 78% against a plan of 80.1%.

NWL:

- Although winter pressures are impacting on system flow indicators, performance improved in November with winter plans starting to take effect. Four hour ED performance improved to 77.3% in November (from 75.3% in October), as well as a small improvement in ambulance handover times.
- It is anticipated that the 4 hour and 12 hour A&E Operating Plan targets will be met in March 2026.
- Virtual ward occupancy rates have improved and are now meeting the target. Providers have increased their utilisation, as well as de-commissioning / re-purposing underutilised pathways. A review is taking place to identify whether virtual wards could be also utilised for admission avoidance.

The key mitigation across both systems remains 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.

West and North London (WNL):

Referral to Treatment Time (RTT) 18 week standard:

- The overall West and North London Elective recovery remains broadly on track (52 week and 65 week targets expected to be met in March 2026), although the target for a reduction in the overall Patient Tracking list size will most likely not be met.
- There is a degree of risk to the delivery of the 2025/26 RTT 18 weeks plan, with the percentage of patients waiting under 18 weeks in NCL reported as 60.5% against a plan of 61.8% based on validated published data for October 2025. The NW London position in October 2025 was reported as 60.6% against a plan of 58.6% and providers are currently forecasting delivery of the 2025/26 plan by March 2026.
- There are Quarter 4 'sprints' planned, supported by non-recurrent NHS England investment (£1.5 million for the WNL system), which is aiming to increase capacity for the patients who have been waiting the longest for treatment. The ambition is to reach 1% of the entire PTL is 52 week waiters – there is a risk that West and North London may not reach 1% by end of March.

Cancer 62 day treatment and Faster Diagnosis Standards:

- The West and North London ambition to treat patients within 62 days of a confirmed diagnosis continue to see improvement, albeit we are currently 3.6% below our plan. In October 2025, NCL performance was above plan at 77.1% (plan 75.7%) and NWL performance was below plan, although equivalent to NCL at 77.2% (plan 83.9%).
- The Faster Diagnosis standard is currently on plan.

NCL:

- Across all NCL providers there has been a general uplift in referral demand which is impacting the delivery of RTT indicators. This has resulted in the need for increased activity levels to meet performance, while managing the availability of workforce and financial constraints.
- The NCL system total Patient Tracking List (PTL) has continued to decrease month on month during 2025/26 and in October was 9,000 ahead of plan (198,491 compared to a plan of 207,554). Primary care colleagues are incentivised to use Advice & Guidance to reduce the need for referrals.
- NCL diagnostic 6 week waits remain challenged. Backlog performance moved adversely to 17.1% in October 2025. 2025/26 has seen an increase in backlog volumes for some modalities, and a reduction in waiting list initiatives resulting from financial constraints among providers. The most challenged modalities remain as NOUS, MRI and neurophysiology.
- Eating Disorders: Urgent treatment referral times for CYP eating disorders remains at 100.0% in September 2025. For routine referrals, performance remains above 90.0% in Q2 and Q3, but short of the 95.0% standard.
- Mental health Children & Young People (CYP) waiting times: Performance for CYP treated within 4 weeks has been steady and remains above target.
- 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:

- Elective recovery remains broadly on track (52 week and 65 week targets expected to be met in March 2026), although the target for the overall Patient Tracking list size will not

be met. In October, the total Patient Tracking List (PTL) decreased from 289,569 patients in September to 287,436 patients in October. There was a decrease in list sizes at ICHT, LNWUHT and THHT. A small increase was reported at CWHFT. It is unlikely that the Operating Plan target will be met in March 2026, with a predicted end of year position around 284,000 patients.

- Diagnostics performance (although improved in October) remains a concern, whilst 62 day cancer performance and mental health CYP waiting times remain areas for improvement. There has been additional investment into the latter with performance expected to improve in Q4 and Q1.
- There were Residential Doctors strikes in November and December which were comprehensively managed by providers, ensuring as little disruption as possible to patient care.
- Community 52 week waits remain well ahead of plan. There are now 45 patients across NW London waiting for treatment from 507 patients in August.
- Cancer Waiting Times: The 62 day cancer standard and 2WW performance remains below plan. Recovery plans (providing additional support) are in place across breast, urology and colorectal pathways. Additional funding is being re-prioritised around clinical need. A digital first pathway is being introduced for urgent suspected cancer pathways breast, GI, urology and gynaecology, with implementation overseen by The Royal Marsden Partners (RMP).

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.

Financial Delivery

North Central London ICS:

- In November, the NCL system reported a £47m deficit which is a £23.6m variance to the submitted deficit plan.

North West London ICS

- The ICS November 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).

West and North London Integrated Care System

Operational Performance Report December 2025

North Central London ICB and North West London ICB Meeting in
Common – 28th January 2026

Steve Bloomer, Chief Financial Officer

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated □ Target / plan ◇ Not validated ■ Range / mean D J F M A M J J A S O N												Health score (0-100)	Latest data	Goal
								[Visual chart area for each KPI]														
G	↗	UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	78.4	77.2	1.2	%	[Line chart showing performance over months]												88	Nov 25/26	↑
G	↗	UE079	% of ED (type 1) attendances seen within 4 hours of arrival to ED	65.2	59.4	5.9	%	[Line chart showing performance over months]												100	Nov 25/26	↑
G	↗	EL112	% RTT incomplete pathways less than 18 weeks	60.6	60.0	0.5	%	[Line chart showing performance over months]												100	Oct 25/26	↑
A	↘	EL069	RTT total incomplete waiting list	485,929.0	473,341.0	12,588.0	People	[Bar chart showing monthly data]												54	Oct 25/26	↓
G	↘	EL024	RTT incomplete Pathways > 52 Weeks	1.7	1.7	0.0	%	[Bar chart showing monthly data]												46	Oct 25/26	↓
A	↗	CA008	62-day Standard Attainment	77.2	80.8	(3.6)	%	[Bar chart showing monthly data]												54	Oct 25/26	↑
A	↗	CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	80.2	80.4	(0.2)	%	[Bar chart showing monthly data]												54	Oct 25/26	↑

Urgent and Emergency Care:

- In November, 78.4% of people attending emergency departments in West and North London spent less than 4 hours in the department compared to 78% target.
- Performance for type 1 attendances also improved from 64.6% in October to 65.2% in November (plan 59.4%).
- Key winter actions being taken by providers to improve performance includes redirection of patients to pharmacy first and GP enhanced access services for suitable conditions. The ICC is also supporting appropriate patients being conveyed to EDs therefore helping to reduce ED demand.
- It is anticipated that the Operating Plan 4 hour A&E targets will be met in March 2026.

Referral to Treatment Time (RTT) 18 week standard:

- The overall West and North London Elective recovery remains broadly on track (52 week and 65 week targets expected to be met in March 2026), although the target for a reduction in the overall Patient Tracking list size will most likely not be met.
- There is a risk to the delivery of the 2025/26 RTT 18 weeks plan, with the percentage of patients waiting under 18 weeks in NCL reported as 60.5% against a plan of 61.8% based on validated published data for October 2025. The NW London position in October 2025 was reported as 60.6% against a plan of 58.6% and providers are currently forecasting delivery of the 2025/26 plan by March 2026.
- There are Quarter 4 'sprints' planned, supported by non-recurrent NHS England investment (£1.5 million for the WNL system), which is aiming to increase capacity for the patients who have been waiting the longest for treatment. The ambition is to reach 1% of the entire PTL is 52 week waiters – there is a risk that West and North London may not reach 1% by end of March.

Cancer 62 day treatment and Faster Diagnosis Standards:

- The West and North London ambition to treat patients within 62 days of a confirmed diagnosis continue to see improvement, albeit we are currently 3.6% below our plan. In October 2025 NCL performance was above plan at 77.1% (plan 75.7%) and NWL performance was below plan, although equivalent to NCL at 77.2% (plan 83.9%).
- The Faster Diagnosis standard is broadly on plan.

Indicators	Acute trusts									
	Great Ormond Street Children Hospital	Moorfields Eye Hospital	Royal Free London	The Royal National Orthopaedic Hospital	University College London Hospitals	The Whittington Hospital	Chelsea and Westminster Hospital	Imperial College Healthcare	London NorthWest Healthcare	The Hillington Hospital
Average score	3 (Below average and/or financial deficit)	1 (High performing)	3 (Below average and/or financial deficit)	1 (High performing)	1 (High performing)	3 (Below average and/or financial deficit)	1 (High performing)	1 (High performing)	3 (Below average and/or financial deficit)	3 (Below average and/or financial deficit)
Current financial deficit	Yes	No	Yes	No	No	Yes	No	No	Yes	Yes
Rank (Q1 ranking shown in the brackets)	50 (40)	3 (1)	62 (95)	2 (2)	13 (10)	42 (41)	13 (28)	11 (11)	36 (23)	75 (105)
Performance domains										
Access to Services	Below average	High performing	Above average	Above average	Above average	Above average	Above average	High performing	High performing	Above average
Finance and productivity	Below average	Above average	Low performing	High performing	High performing	Below average	High performing	Above average	High performing	Above average
Effectiveness and experience	High performing	High performing	Above average	High performing	High performing	Below average	High performing	Above average	Above average	Above average
Patient safety	Below average	High performing	Below average	High performing	Above average	Above average	Above average	Above average	Below average	Low performing
People and workforce	High performing	High performing	High performing	Below average	High performing	High performing	High performing	High performing	High performing	Below average

- NOF meetings between NHSE and each provider are currently taking place through Quarter 4. ICB representatives are attending the meetings with providers with a summary report to be presented to the ICB Executive team. NHSE have stated that improvements to the process and indicators will be made during 2026/27. A provider who is in financial deficit automatically is placed in segmentation 3.
- The 'low performing' rating for Royal Free relates to the indicator: Finance and productivity - planned surplus / deficit and variance year to date to financial plan
- The 'low performing' rating for THHT relates to the indicator: Patient safety - E.Coli bacteremia and C.Difficile rates.
- In Q2, ICHT CWHFT, CNWL and WLT remain top performing trusts. Due to financial deficit, LNWUHT dropped into segmentation 3. Some indicators have improved at THHT (financial deficit remains), which has resulted in a move into segmentation 3.

Indicators	London Ambulance Service	Central London Community Healthcare	Central North West London	North London NHS Foundation Trust	West London NHS Trust	The Tavistock and Portman
Average score	Above average	1 (High performing)	1 (High performing)	3 (Below average and/or financial deficit)	1 (High performing)	Unavailable at time of reporting
Current financial deficit	No	No	No	Yes	No	
Rank (Q1 ranking shown in the brackets)	5 (7)	2nd highest community services	7 (14)	42 (61)	4 (10)	
Performance domains						
Access to Services	High performing	High performing	High performing	Not shown	High performing	
Finance and productivity	Above average	Above average	High performing	Above average	High performing	
Effectiveness and experience	Low performing	High performing	High performing	Below average	High performing	
Patient safety	High performing	High performing	Above average	Low performing	Above average	
People and workforce	Low performing	High performing	High performing	Below average	Above average	

- NOF meetings between NHSE and each provider are currently taking place. ICB representatives are attending the meetings with providers with a summary report to be presented to the ICB Executive team.
- NHSE have stated that as this is a new process, improvements will be made during 2026/27.
- A provider who is in financial deficit automatically is placed in segmentation 3.
- All the West and North London Trusts improved their ranking between Q1 and Q2.
- The 'low performing' rating for LAS relates to the indicators:
 - LAS - Effectiveness & experience - % of ambulance patients conveyed to emergency department
 - LAS - People and workforce - Sickness absence rate
- The 'low performing' rating for NLFT relates to the indicator: Patient Safety - NHS staff survey - raising concerns (2024 survey).

North Central London

System Flow



Waiting Times



Patient Experience



Finance, Activity, W/F

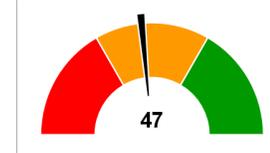


North West London

System Flow



Waiting Times



Patient Experience



Finance, Activity, W/F



System Flow:

- AE attendance activity continues to be above the forecasted level of demand, across almost all NCL sites. Notably, there was a significant increase in ambulance conveyances in Q3 of 2025/26, demonstrating the higher acuity of patient attendances. This has contributed to an increase in admitted patient flow and subsequently impacted breaches.
- NHS 111 direct to GP bookings continues to improve access to primary care appointments.
- Primary care winter schemes are focussed on proactive care for those with long term conditions, delivering vaccinations and increasing capacity for paediatrics.

Waiting Times:

- Across all NCL providers there has been a general uplift in referral demand which is impacting the delivery of RTT indicators. This has resulted in the need for increased activity levels to meet performance, while managing the availability of workforce and financial constraints.

IPC and Patient Experience:

- Friends and Family test data, albeit only one lens into patient experience, remains generally positive.
- There has been a slight deterioration in the maternity unit score from 92.5% to 89.3%.

Finance & Operating Plan Delivery:

- In November, the NCL system reported a £47m deficit which is a £23.6m variance to the submitted deficit plan.

System Flow:

- Although winter pressures are impacting on system flow indicators, performance improved in November with winter plans starting to take effect with four hour ED performance improving to 77.3% in November (from 75.3% in October), as well as a small improvement in ambulance handover times.
- It is anticipated that the 4 hour and 12 hour A&E Operating Plan targets will be met in March 2026.

Waiting Times:

- Elective recovery remains broadly on track (52 week and 65 week targets expected to be met in March 2026), although the target for the overall Patient Tracking list size will not be met.
- Diagnostics performance (although improved in October) remains a concern, whilst 62 day cancer performance and mental health CYP waiting times remain areas for improvement. There has been additional investment into the latter with performance expected to improve in Q4 and Q1.
- Community 52 week waits remain well below plan. There are now 45 patients across NW London waiting for treatment from 507 patients in August.

Patient Experience:

- In October, NW London performed the same as or better than the London and national averages in the acute hospital tests (apart from maternity antenatal services which was lower by a percent).

Finance & Operating Plan Delivery:

- The ICS November 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).

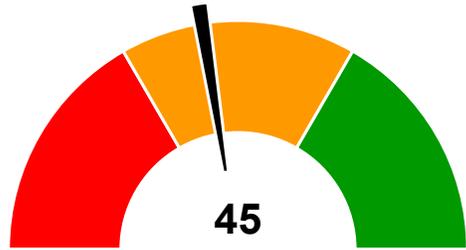
North Central London Integrated Care System

Operational Performance Report

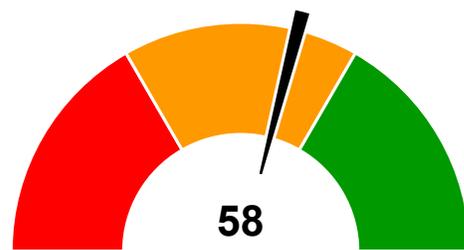
November 2025

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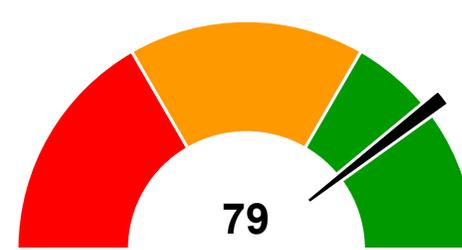
System Flow



Waiting Times



Patient Experience



Finance, Activity, W/F



System Flow:

- AE attendance activity continues to be above the forecasted level of demand, across almost all NCL sites. Notably, there was a significant increase in ambulance conveyances in Q4 of 2025/26, demonstrating the higher acuity of patient attendances. This has contributed to an increase in admitted patient flow and subsequently impacted breaches.
- NHS 111 direct to GP bookings continues to improve access to primary care appointments.
- Primary care winter schemes are focussed on proactive care for those with long term conditions, delivering vaccinations and increasing capacity for paediatrics.

Waiting Times:

- Across all NCL providers there has been a general uplift in referral demand which is impacting the delivery of RTT indicators. This has resulted in the need for increased activity levels to meet performance, while managing the availability of workforce and financial constraints.

IPC and Patient Experience:

- Friends and Family test data, albeit only one lens into patient experience remains generally positive.
- There has been a slight deterioration in the maternity unit score from 92.5% to 89.3%.

Finance & Operating Plan Delivery:

- In November, the NCL system reported a £47m deficit which is a £23.6m variance to the submitted deficit plan. This is the primary driver of the Finance, Activity and Workforce score.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
R	↘	UE050	% of ambulance hospital handovers within 15 minutes	17.1	65.0	(47.9)	%			0	Nov 25/26	↕
R	↘	UE122	% of ambulance Handovers within 45 minutes	84.1	100.0	(15.9)	%			0	Nov 25/26	↕
A	↗	UE096	Ambulance handover times (Mean)	28.3	25.2	3.1	Minutes			46	Nov 25/26	↕
R	↗	UE031	LAS Category 2 – mean response time	36.4	33.8	2.6	Minutes			12	Oct 25/26	↕
A	↘	UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	76.6	79.7	(3.1)	%			46	Nov 25/26	↕
G	↘	ME074	Patients presenting with a Mental Health crisis waiting in ED for more than 12 hours	12.9	20.0	(7.1)	%			100	Nov 25/26	↕
A	↗	UE056	Patients waiting over 12 hours in ED	10.2	8.5	1.7	%			58	Oct 25/26	↕
A	↗	UE024	Overnight general and acute beds occupied rate	92.0	91.8	0.2	%			62	Nov 25/26	↕
A	↗	LO065	Virtual Wards occupancy rate	78.0	80.1	(2.1)	%			38	Oct 25/26	↕
G	↘	LO024	Urgent rapid response referrals seen within 2 hours.	89.4	85.0	4.4	%			92	Oct 25/26	↕

- Urgent and Emergency Care:** In November 2025, A&E performance was 76.6% (3.1% off target). This was down from 77.3% in October 2025. The percentage of patients waiting 12 hours or more had been on target throughout 2025/26 but fell below plan in September and October 2025. Current performance was reported 1.7% off target at 10.2%. All NCL providers have mobilised their local winter plans, whilst system-level demand management initiatives and schemes supporting flow at the front door are also in progress.
- Ambulance Services:** For December 2025, performance for handovers within 15 and 45 minutes both improved from the previous month. The Integrated Care Coordination (ICC) Hub is progressing with integrating the urgent community response service and ICC based learnings from Hertfordshire. The ICC moved to 7-day working in December 2025, to support winter pressures.
- G&A Bed Occupancy:** Average adult bed occupancy has been equal to or within the optimal threshold of 92.0% across NWL sites during all of 2025/26.
- Mental Health:** In November 2025, 12.9% of people requiring mental health support experienced waits of over 12 hours at NCL provider sites. The Mental Health Crisis Assessment Service continues to divert patients with mental health only needs to more appropriate settings. The GP front of house initiative at the NMUH site of RFL is fully operational, offering 28 appointments per day, with a 90% utilisation rate.
- Virtual Ward (VW) Occupancy Rates:** Performance has been below plan for the last 3 months, but the latest data for October 2025 shows an improvement from the previous month. NCL VW repatriation pathways for Islington and Haringey residents (WH VW) from RFH and BGH launched in November 2025, building on existing VW repatriation pathways to NMUH (Enfield), Barnet (Barnet) and Camden Hospital at Home services. These will all work towards reducing variation and supporting equity in NCL.
- Urgent Rapid Response < 2 Hours:** Performance has slowed in recent months but remains above target. Actions in place across NCL include (1) improving the accuracy of CSDS recording and submission; (2) ensuring the capture all qualifying urgent responses per national guidance; (3) a drive on productivity gains e.g., Doc Abode; (4) utilising increased referrals via SPOA and LAS pathways.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	Legend		Health score (0-100)	Latest data	Goal
								○ Validated	□ Target / plan			
								◇ Not validated	▬ Range / mean			
								D J F M A M J J A S O N				
G	↘	EL069	RTT total incomplete waiting list	198,491.0	207,554.0	(9,063.0)	People			100	Oct 25/26	↓
A	↗	EL112	% RTT incomplete pathways less than 18 weeks	60.5	61.8	(1.2)	%			54	Oct 25/26	↑
R	↘	EL089	Number of RTT incomplete Pathways > 65 Weeks	137.0	0.0	137.0	Number			8	Oct 25/26	↓
R	↘	EL024	RTT incomplete Pathways > 52 Weeks	1.8	1.3	0.5	%			8	Oct 25/26	↓
R	↗	DI011	Patients waiting over 6 weeks for a diagnostic test	17.1	5.0	12.1	%			0	Oct 25/26	↓
A	↗	CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	79.8	81.0	(1.2)	%			65	Oct 25/26	↑
G	↗	CA008	62-day Standard Attainment	77.1	75.7	1.4	%			100	Oct 25/26	↑
G	↗	ME082	% MH CYP 1st seen within 4 weeks	94.0	58.3	35.7	%			100	Oct 25/26	↑
G	→	ME031	Urgent Referral to Treatment Waiting Times for CYP with an eating disorder	100.0	95.0	5.0	%			100	Sep 25/26	↑
A	↗	ME033	Routine Cases : 95% of CYP with eating disorders accessing treatment within 4 weeks	91.9	95.0	(3.1)	%			27	Oct 25/26	↑
G	↘	PC022	% of Primary Care Appointments within 14 days	91.4	90.0	1.4	%			77	Nov 25/26	↑

- **Elective performance:** NCL provider performance continues to be monitored through the Planned Care Deliver Group, with oversight from the Operational Implementation Group.
- **Elective Waiting List:** The NCL system total Patient Tracking List (PTL) has continued to decrease month on month during 2025/26. Primary care colleagues are incentivised to use Advice & Guidance to reduce the need for referrals.
- **Referral to Treatment (RTT) performance:** Performance is showing an upward trend during 2025/26. NCL Trusts have maximised use of validation and RTT rules to aid RTT recovery, and compliance with the 2025/26 RTT performance objectives. The validation sprints through Q1-Q3 have provided additional funding for reducing the PTL size, either through validation or activity above baseline.
- **Diagnostic 6-week performance:** Backlog performance moved adversely to 17.1% in October 2025. 2025/26 has seen an increase in backlog volumes for some modalities, and a reduction in waiting list initiatives resulting from financial constraints among providers. The most challenged modalities remain as NOUS, MRI and neurophysiology.
- **Cancer Waiting Times:** Faster Diagnosis Standard attainment has been close to or on plan all year, while 62-day achievement remains on plan. Challenges remain for skin pathways at WH, although the NCL Cancer Alliance have committed to fund 4 WLIs. For breast services at RFL, changes to the staffing model to provide greater nurse-led capacity for one-stop have been implemented. Increased capacity through radiology recruitment and an improvement programme focused on breast radiology was launched in October 2025.
- **Eating Disorders:** Urgent treatment referral times for CYP eating disorders remains at 100.0% in September 2025. For routine referrals, performance remains above 90.0% in Q2 and Q3, but short of the 95.0% standard.
- **Mental health Children & Young People (CYP) waiting times:** Performance for CYP treated within 4 weeks has been steady and remains above target.
- **Primary care:** NCL GP appointments were 734,371 for November 2025 and have averaged over 725,000 a month during 2025/26. NCL continues to provide a high percentage of same day appointments above the national average – 9.3% over this value for November 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.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated □ Target / plan ◇ Not validated ▬ Range / mean D J F M A M J J A S O N												Health score (0-100)	Latest data	Goal
								D	J	F	M	A	M	J	J	A	S	O	N			
G	↘	QU049	Friends and Family Test- Inpatients	95.7	91.0	4.7	%													92	Oct 25/26	↕
G	↘	QU029	Friends and Family Test - Outpatients	94.4	93.0	1.4	%													92	Oct 25/26	↕
G	↘	QU028	Friends and Family Test - A&E	80.1	80.0	0.1	%													92	Oct 25/26	↕
G	↗	QU032	Friends and Family Test - Maternity antenatal	93.3	90.0	3.3	%													73	Oct 25/26	↕
A	↘	QU046	Friends and Family Test - Maternity units	89.3	94.0	(4.7)	%													46	Oct 25/26	↕
G	↗	QU047	Friends and Family Test- Postnatal Ward setting	96.0	92.0	4.0	%													100	Oct 25/26	↕
G	↗	PC024	FFT % positive responses - Primary Care	91.1	90.0	1.1	%													88	Oct 25/26	↕
G	↗	QU030	Friends and Family Test - Community Health	96.4	94.0	2.4	%													100	Oct 25/26	↕
G	↗	QU031	Friends and Family Test - Mental Health	89.8	85.0	4.8	%													100	Oct 25/26	↕

- Friends and Family test data, albeit only one lens into patient experience remains generally positive.
- There has been a slight deterioration in the maternity unit score from 92.5% to 89.3%. Patient experience performance has been below the 94.0% target across every month except July 2025.
- Maternity ante-natal patient experience performance was on or above target each month April – July 2025 but fell below target in August and September 2025, before recovering back to 3.3% above target in October 2025.
- Primary care patient experience performance was below target April – June 2025, before improving in subsequent months. Performance has been at least 89.0%, which is just 1.0% below the target of 90.0%.
- Community health patient experience performance has been consistently above target across every month except for July 2025 when performance at 93.8% was just 0.2% below target.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	Legend		Health score (0-100)	Latest data	BOG										
								○ Validated	□ Target / plan													
								◇ Not validated	— Range / mean													
								D	J	F	M	A	M	J	J	A	S	O	N			
R	↗	FI001	Total System reported YTD position (variance against plan) £'m	(46,975.0)	(23,324.8)	(23,650.3)	£'M			8	Nov 25/26	↑										
R	↗	FI010	System reported efficiency YTD (CIP)	198,209.4	206,704.0	(8,494.6)	%			8	Nov 25/26	↑										
A		FI021	YTD Productivity compared with 19/20	(4.9)	0.0	(4.9)	%			50	Jul 25/26	↑										
G	↘	WO019	Total Staffing WTE(Staff in post+bank+Agency)	53,443.6	53,887.5	(443.9)	Number			92	Nov 25/26	↓										
A	↗	EL112	% RTT incomplete pathways less than 18 weeks	60.5	61.8	(1.2)	%			54	Oct 25/26	↑										
R	↘	EL059	Elective daycase compared to Ops Plan	105.8	100.0	5.8	%			54	Oct 25/26	↕										
R	↗	EL060	Elective ordinary compared to Ops Plan	94.9	100.0	(5.1)	%			8	Oct 25/26	↕										
A	↘	UE103	A&E Attendances (All Types)	73,033.0	72,620.0	413.0	Number			46	Nov 25/26	↓										

- In Month 7, the NCL system reported a £47.0m deficit which is a £23.7m variance to the submitted deficit plan.
- Current RTT performance for the percentage of patients waiting under 18 weeks is off target based on validated published data for October 2025.
- Based on weekly unvalidated data flows, the NCL expectation is that during November 2025, it is unlikely that there will be a material change in the reported position. This is likely to be the case up to March 2026.
- 18ww performance has been detrimentally affected by the recent focus on reducing the longest waiting patients, specifically to eradicate 65ww and further reduce beyond plan 52ww patients to and below 1.0% of the PTL size.

NHSE Operating Plan 2025/26 performance

NCL Key Operating Plan Performance (1/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal										
								D	J	F	M	A	M	J	J	A	S	O	N			
G	↗	CA008	62-day Standard Attainment	77.1	75.7	1.4	%	○	■	100	Oct 25/26	↑										
A	↗	CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	79.8	81.0	(1.2)	%	○	■	65	Oct 25/26	↑										
G	↗	CA023	31 day 1st Treatment standard (From DTT)	95.2	93.2	2.0	%	○	■	85	Oct 25/26	↑										
R	↗	DI003	Diagnostic Tests - CT	22,743.0	20,844.0	1,899.0	Number	○	■	0	Oct 25/26	↕										
A	↗	DI004	Diagnostic Tests - MRI	15,715.0	15,217.0	498.0	Number	○	■	62	Oct 25/26	↕										
R	↗	DI005	Diagnostic Tests - NOUS	26,700.0	28,131.0	(1,431.0)	Number	○	■	23	Oct 25/26	↕										
A	↘	DI012	Diagnostic Tests 6-week performance - MRI	7.1	6.5	0.6	%	○	■	65	Oct 25/26	↓										
G	↘	DI013	Diagnostic Tests 6-week performance - CT	2.8	6.9	(4.1)	%	○	■	100	Oct 25/26	↓										
R	↗	DI014	Diagnostic Tests 6-week performance - NOUS	20.6	5.6	15.0	%	○	■	0	Oct 25/26	↓										
R	↗	DI021	Diagnostic Tests Activity - Colonoscopy	1,743.0	1,653.0	90.0	Number	○	■	42	Oct 25/26	↕										

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal										
								D	J	F	M	A	M	J	J	A	S	O	N			
G	↗	DI022	Diagnostic Tests Activity - Flexi sigmoidoscopy	377.0	388.0	(11.0)	Number	○	■	69	Oct 25/26	↕										
R	↗	DI023	Diagnostic Tests Activity - Gastroscopy	2,039.0	1,922.0	117.0	Number	○	■	31	Oct 25/26	↕										
R	↗	DI024	Diagnostic Tests Activity - Cardiology – echocardiography	5,267.0	4,892.0	375.0	Number	○	■	38	Oct 25/26	↕										
R	↘	DI025	Diagnostic Tests Activity - DEXA	1,727.0	1,541.0	186.0	Number	○	■	8	Oct 25/26	↕										
R	↗	DI026	Diagnostic Tests Activity - Audiology	1,974.0	1,639.0	335.0	Number	○	■	0	Oct 25/26	↕										
R	↗	DI027	Diagnostic Tests, 6-week waiting time - Colonoscopy	14.6	6.4	8.2	%	○	■	27	Oct 25/26	↓										
R	↗	DI028	Diagnostic Tests, 6-week waiting time - Flexi sigmoidoscopy	10.0	4.5	5.5	%	○	■	27	Oct 25/26	↓										
R	↗	DI029	Diagnostic Tests, 6-week waiting time- Gastroscopy	17.7	6.2	11.5	%	○	■	0	Oct 25/26	↓										
R	↘	DI030	Diagnostic Tests, 6-week waiting time - Cardiology – echocardiography	15.5	2.9	12.6	%	○	■	8	Oct 25/26	↓										
G	↘	DI031	Diagnostic Tests, 6-week waiting time - DEXA	1.0	1.3	(0.3)	%	○	■	73	Oct 25/26	↓										
R	↘	DI032	Diagnostic Tests, 6-week waiting time - Audiology	23.2	11.5	11.7	%	○	■	8	Oct 25/26	↓										

NCL Key Operating Plan Performance (2/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
D J F M A M J J A S O N												
R	↓	EL024	RTT incomplete Pathways > 52 Weeks	1.8	1.3	0.5	%	○	■	8	Oct 25/26	↓
R	↓	EL108	Outpatient first attendances without a procedure - ERF scope	83.6	100.0	(16.4)	%	○	■	31	Oct 25/26	↕
R	↓	EL109	Outpatient follow up attendances without procedure - ERF scope	89.7	100.0	(10.3)	%	○	■	31	Oct 25/26	↕
R	↑	EL059	Elective daycase compared to Ops Plan	105.8	100.0	5.8	%	○	■	54	Oct 25/26	↕
R	↑	EL060	Elective ordinary compared to Ops Plan	94.9	100.0	(5.1)	%	○	■	8	Oct 25/26	↕
G	↓	EL069	RTT total incomplete waiting list	198,491.0	207,554.0	(9,063.0)	People	○	■	100	Oct 25/26	↓
A	↓	EL107	Outpatient procedures - ERF scope	96.3	100.0	(3.7)	%	○	■	42	Oct 25/26	↕
R	↑	EL116	RTT - The number of completed admitted RTT pathways in the reporting period	10,074.0	10,443.0	(369.0)	Number	○	■	8	Oct 25/26	↕

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
D J F M A M J J A S O N												
A	↓	EL118	RTT incomplete Pathways < 18 Weeks for a first appointment %	65.1	69.0	(3.9)	%	○	■	46	Oct 25/26	↑
G	↑	EL120	RTT - The number of completed non-admitted RTT pathways in the reporting period	50,673.0	50,331.0	342.0	Number	○	■	77	Oct 25/26	↑
A	↑	LO065	Virtual Wards occupancy rate	78.0	80.1	(2.1)	%	○	■	38	Oct 25/26	↑
R	↑	LO073	Urgent Community Response (UCR) referrals	1,704.0	2,131.0	(427.0)	Number	○	■	8	Oct 25/26	↑
R	↑	LO074	Community services waiting list over 52 weeks	1,169.0	791.0	378.0	Number	○	■	0	Nov 25/26	↓
R	↑	LO075	Community services waiting list over 52 weeks - CYP	1,044.0	791.0	253.0	Number	○	■	0	Nov 25/26	↓
R	↑	LO076	Community services waiting list over 52 weeks - Adults	125.0	0.0	125.0	Number	○	■	0	Nov 25/26	↓
R	↑	ME014	CYP with a learning disability or autism in an inpatient setting	7.0	6.0	1.0	Number	○	■	54	Oct 25/26	↓
G	↑	ME016	CYP accessing NHS funded mental health services	29,990.0	24,726.0	5,264.0	Number	○	■	100	Oct 25/26	↑
G	↑	ME024	Women receiving access to perinatal services	2,027.0	2,010.0	17.0	Number	○	■	100	Oct 25/26	↑

NCL Key Operating Plan Performance (3/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
A	↗	ME032	Access to Individual Placement and Support Services	1,159.0	1,211.0	(52.0)	Number			42	Oct 25/26	↑
A	↘	ME060	% of People with learning disability (14 years old and above) with an annual health check	6.7	6.8	(0.1)	%			73	Nov 25/26	↑
A	↘	ME075	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	1.0	0.0	1.0	Number			42	Oct 25/26	↓
A	↘	ME076	Reliable recovery rate for those completing a course of treatment and meeting caseness - Talking Therapies	44.1	48.0	(3.9)	%			46	Oct 25/26	↑
R	↘	ME077	Reliable improvement rate for those completing a course of treatment - Talking Therapies	44.1	67.9	(23.8)	%			0	Oct 25/26	↑
R	↗	ME083	Reliance on mental health inpatient care for adults with a learning disability	18.0	16.0	2.0	%			0	Oct 25/26	↓
-	↘	PC036	Appointments in general practice	734,371.0	-	-	Number			0	Nov 25/26	↑

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
A	↗	UE056	Patients waiting over 12 hours in ED	10.2	8.5	1.7	%			46	Oct 25/26	↓
A	↘	UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	76.6	79.7	(3.1)	%			46	Nov 25/26	↑
A	↗	UE096	Ambulance handover times (Mean)	28.3	25.2	3.1	Minutes			46	Nov 25/26	↓
-	↗	UE103	A&E Attendances (All Types)	73,033.0	-	-	Number			0	Nov 25/26	↓

Operating Plan Performance Overview – Non-Acute

Mental Health – Talking Therapies

- Performance for 2+ contacts and discharge remains challenged in NCL, although reliable improvement and reliable recovery targets were achieved at the end of Q2 2025/26.
- Engagement with digital providers is underway e.g. Limbic to see how a digital front door option will improve access, signposting and increase efficiency and productivity.
- 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 implementation entails a review of 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.

Mental Health – Individual Placement Support

- Performance remains below target throughout 2025/26.
- As vacant posts are being filled following a recruitment process, it will take time for new staff to be onboarded and be able to take on full caseloads. The anticipated timeline of Q2 of 2025/26 for improved performance continues.

Mental Health – CYP Access

- Continued achievement is driven by the North London Foundation Trust (NLFT), where enhanced data capture regarding Mental Health Support Teams has allowed targets to be achieved.

Mental Health – Perinatal Access

- Performance continues to improve despite falling birth rates with work reviewing how to increase referrals into the service.
- NLFT continue to look at how existing resources could be used to offer targeted assessment and interventions for women and families with more complex presentations and reduce DNA rates.

Community Services – Waiting List>52w

- **(CYP):** for under-5s autism services, 100% of additional substantive staff have now been recruited as of August 2025 in Camden, Haringey, and Islington. Progress is also being made in Enfield and Barnet. SLT waits remain high due to workforce shortages, though temporary funding has enabled recruitment of bank and fixed-term staff to increase capacity.
- **(Adults):** NCL is currently updating the Community Outcomes Framework for adult services to better demonstrate its impact. A Task and Finish group has been established to progress the understanding on how to measure outcomes.

Community Services – Average Length of Stay

- NCL has launched initiatives, including **(1)** embedding the NCL ICB clinical and operating model to increase consistency across units, particularly for referral management and screening, alongside early discharge planning; **(2)** service expansion – development of community stroke units for repatriation from hyper-acute stroke units for medically stable patients, bypassing acute stroke units; **(3)** continuing to use the NCL flex criteria to support occupancy and flow.

NW London Integrated Care System

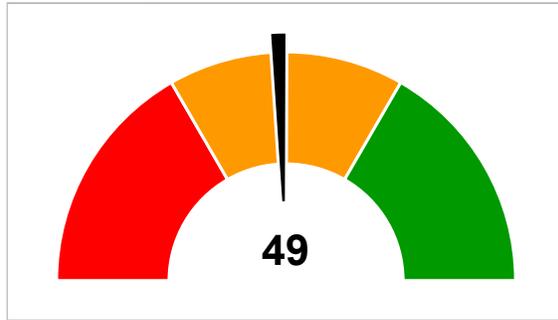
Operational Performance Report December 2025

Joint ICB Meeting – 28th January 2026

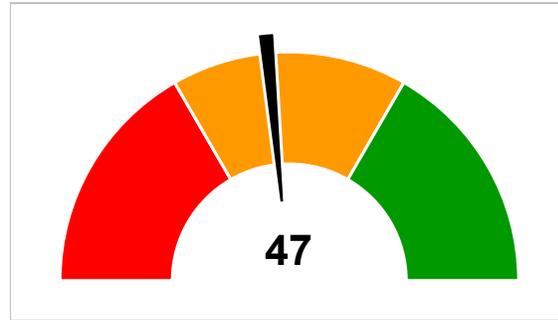
Steve Bloomer, Chief Financial Officer

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2.1	System Flow	Slide 4
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2.3	Patient Experience	Slide 6
3.1	Plan Triangulation - Finance, Workforce and Activity	Slide 7
4	Operating Plan 2025/26 Performance	Slides 8 - 12

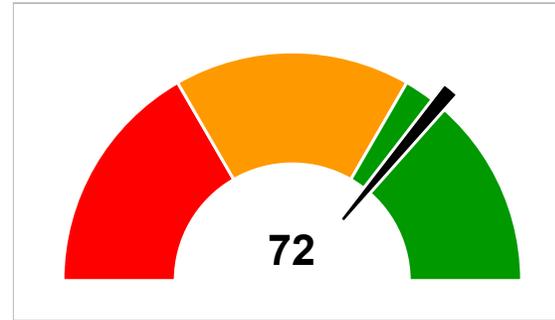
System Flow



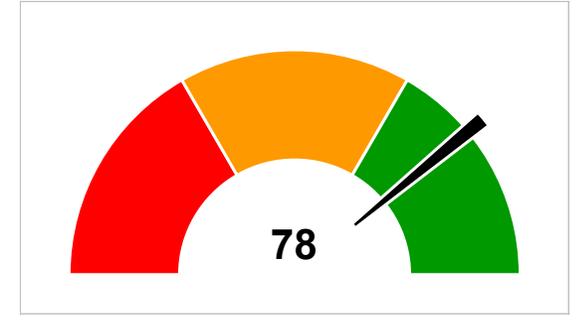
Waiting Times



Patient Experience



Finance, Activity, W/F



System Flow:

- Although winter pressures are impacting on system flow indicators, performance improved in November with winter plans starting to take effect – see slide 4.
- Four hour ED performance improved to 77.3% in November (from 75.3% in October), as well as a small improvement in ambulance handover times. There has also been a decrease in hospital discharge delays. Delays are monitored at a pathway, borough and provider level, with actions taken accordingly.
- 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.
- It is anticipated that the 4 hour and 12 hour A&E Operating Plan targets will be met in March 2026.

Waiting Times:

- Elective recovery remains broadly on track (52 week and 65 week targets expected to be met in March 2026), although the target for the overall Patient Tracking list size will not be met.
- Diagnostics performance (although improved in October) remains a concern, whilst 62 day cancer performance and mental health CYP waiting times remain areas for improvement. There has been additional investment into the latter with performance expected to improve in Q4 and Q1.
- There were Residential Doctors strikes in November and December which were comprehensively managed by providers, ensuring as little disruption as possible to patient care.
- Community 52 week waits remain well below plan. There are now 45 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).
- Sixty percent of the Operating Plan metrics are either green (exceeding target) or amber (just below target) rated. Half of the red rated metrics are diagnostics modality related. for 2025/26 we want diagnostic activity to be on plan so significant over performance is assessed as red, as is significant under-performance.

National Oversight Framework (NOF):

- In Q2, ICHT CWHFT, CNWL and WLT remain top performing trusts. Due to financial deficit, LNWUHT dropped into segmentation 3. Some indicators have improved at THHT (financial deficit remains), which has resulted in a move into segmentation 3.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
R	↘	UE050	% of ambulance hospital handovers within 15 minutes	46.0	65.0	(19.0)	%			0	Nov 25/26	↑
A	→	UE122	% of ambulance Handovers within 45 minutes	95.0	100.0	(5.0)	%			31	Nov 25/26	↑
A	↗	UE096	Ambulance handover times (Mean)	19.6	18.2	1.3	Minutes			58	Oct 25/26	↓
G	↗	UE031	LAS Category 2 – mean response time	30.4	33.8	(3.4)	Minutes			92	Oct 25/26	↓
A	↗	UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	77.3	78.0	(0.7)	%			54	Nov 25/26	↑
G	↗	UE079	% of ED (type 1) attendances seen within 4 hours of arrival to ED	62.2	59.4	2.9	%			73	Nov 25/26	↑
R	↘	ME074	Patients presenting with a Mental Health crisis waiting in ED for more than 12 hours	29.2	20.0	9.2	%			8	Nov 25/26	↓
A	↗	UE056	Patients waiting over 12 hours in ED	9.7	9.5	0.2	%			46	Nov 25/26	↓
A	↗	UE024	Overnight general and acute beds occupied rate	95.1	92.0	3.1	%			46	Nov 25/26	↓
G	↘	LO023	Occupancy rate in rehab beds	90.4	85.0	5.4	%			92	Nov 25/26	↑
G	↗	LO065	Virtual Wards occupancy rate	85.0	85.0	0.0	%			88	Nov 25/26	↑
G	↘	UE115	Discharge: Average Delay Days (P0) in Optica	0.2	1.0	(0.8)	Days			100	Nov 25/26	↓
R	↘	UE108	Discharge: Average Delay Days (P1) in Optica	2.5	2.0	0.5	Days			8	Nov 25/26	↓
R	↘	UE109	Discharge: Average Delay Days (P2) in Optica	6.0	5.0	1.0	Days			8	Nov 25/26	↓
A	↘	UE110	Discharge: Average Delay Days (P3) in Optica	7.7	7.0	0.7	Days			38	Nov 25/26	↓

- Urgent and Emergency Care:** In November, 77.3% (up from 75.3% in October) 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 improved from 58.7% in October to 62.2% in November (plan 59.4%). The percentage of patients waiting 12 hours or more improved, with performance at 9.7% from 10.9% in October. Actions being taken by providers to improve performance includes redirection of patients to pharmacy first and GP enhanced access services for suitable conditions. The ICC is also supporting appropriate patients being conveyed to EDs therefore helping to reduce ED demand. It is anticipated that the Operating Plan A&E 4 and 12 hour targets will be met in March 2026.
- Ambulance Services:** Handover targets particularly focus on the reduction of waits over 45 minutes. In November 45 minute performance improved. Mitigations in place include the Integrated Care Coordination Hub, optimising referrals into alternative pathways to ED and targeted work on care home calls to 999. Between August and November 2025 a total of 1764 cases were managed by the ICC resulting in 48% of these not being conveyed to an ED. 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. Additional bed capacity has been commissioned during the winter period.
- Mental Health:** In November, 29.2% of people requiring mental health support experienced waits of over 12 hours in NW London emergency departments compared to 33.7% in October (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 November, discharge performance for all pathways remained over target. Delay days are being tracked at borough and pathway level on a monthly basis, reporting into System Flow Oversight Board. Particular areas of focus include pathway1 discharge within the Bi-borough and Hammersmith & Fulham. Equipment provider during this period led to some of the emerging delays, which have since stabilised.
- Virtual ward occupancy rates** have improved and are now meeting the target. Providers have increased their utilisation, aswell as de-commissioning / re-purposing under utilised pathways. A review is taking place to identify whether virtual wards could be also utilised for admission avoidance. This is taking place to some degree in NCL.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit		Health score (0-100)	Latest data	Goal
								D J F M A M J J A S O N			
R	↗	EL069	RTT total incomplete waiting list	287,438.0	266,983.0	20,455.0	People		0	Oct 25/26	↓
G	↗	EL112	% RTT incomplete pathways less than 18 weeks	60.5	58.6	1.9	%		100	Oct 25/26	↑
R	↗	EL089	Number of RTT incomplete Pathways > 65 Weeks	157.0	0.0	157.0	Number		0	Oct 25/26	↓
G	↘	EL024	RTT incomplete Pathways > 52 Weeks	1.7	2.0	(0.3)	%		100	Oct 25/26	↓
R	↗	DI011	Patients waiting over 6 weeks for a diagnostic test	21.1	5.0	16.1	%		0	Oct 25/26	↓
G	↗	CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	80.4	80.0	0.4	%		73	Oct 25/26	↑
R	↗	CA008	62-day Standard Attainment	77.2	83.9	(6.7)	%		8	Oct 25/26	↑
R	↗	CA004	Cancer - two weeks waits	81.4	93.0	(11.6)	%		8	Oct 25/26	↑
R	↗	ME081	% MH CYP Treated within 18 weeks	79.2	89.0	(9.8)	%		8	Oct 25/26	↑
G	↗	ME082	% MH CYP 1st seen within 4 weeks	73.1	58.3	14.8	%		88	Oct 25/26	↑
G	↗	ME031	Urgent Referral to Treatment Waiting Times for CYP with an eating disorder	100.0	95.0	5.0	%		77	Oct 25/26	↑
G	↗	ME033	Routine Cases : 95% of CYP with eating disorders accessing treatment within 4 weeks	95.5	95.0	0.5	%		46	Oct 25/26	↑
G	↘	PC022	% of Primary Care Appointments within 14 days	87.4	85.0	2.4	%		92	Oct 25/26	↑

- Elective Waiting List:** In October, the total Patient Tracking List (PTL) decreased from 289,569 patients in September to 287,436 patients in October. There was a decrease in list sizes at ICHT, LNWUHT and THHT. A small increase was reported at CWHFT. It is unlikely that the Operating Plan target will be met in March 2026, with a predicted end of year position around 284,000 patients.
- Referral to Treatment (RTT) performance:** In October the plan for patients waiting 18 weeks or more for treatment was met. NWL are predicting the Operating Plan target will be achieved in March 2026. 52ww volume continues to reduce and is within local target (2%) but exceeds the national 1% goal. Additional funding is being made available by NHSE in Q4 to support additional activity to increase the number of clock stops in the 52ww cohort.
- Residential doctor Industrial Action remains to be actively managed by providers.
- Diagnostic 6 week performance:** performance improved for the second consecutive month and is now at 19.3% of patients waiting longer than 6 weeks. In August this was at 22%. This is on the back of consistent prior deterioration in performance over the last 3 years. ICHT (5% improvement from September) and THHT (7% improvement from September) drove the improved position, primarily through re-starting WLIs and insourcing arrangements coming online supported shifts in MRI, Ultrasound and Endoscopy.
- Cancer Waiting Times:** The 62 day cancer standard and 2WW performance remains below plan. Recovery plans (providing additional support) are in place across breast, urology and colorectal pathways. Additional funding is being re-prioritised around clinical need. A digital first pathway is being introduced for urgent suspected cancer pathways breast, GI, urology and gynaecology, with implementation overseen by The Royal Marsden Partners (RMP).
- Eating Disorders:** Urgent treatment referral times for CYP eating disorders improved to 100% in September and October, with improved in performance also achieved for routine treatment times (target met in October).
- Mental health Children & Young People (CYP) waiting times:** Performance for CYP treated within 18 weeks has improved. 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.

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	Legend		Health score (0-100)	Latest data	Goal										
								○ Validated	□ Target / plan													
								◇ Not validated	▬ Range / mean													
								D	J	F	M	A	M	J	J	A	S	O	N			
G	→	QU049	Friends and Family Test- Inpatients	95.0	95.0	0.0	%			100	Oct 25/26	↑										
G	→	QU029	Friends and Family Test - Outpatients	94.0	93.0	1.0	%			92	Oct 25/26	↑										
A	→	QU028	Friends and Family Test - A&E	78.0	80.0	(2.0)	%			73	Oct 25/26	↑										
G	→	QU032	Friends and Family Test - Maternity antenatal	91.0	90.0	1.0	%			46	Oct 25/26	↑										
G	→	QU046	Friends and Family Test - Maternity units	96.0	94.0	2.0	%			58	Oct 25/26	↑										
G	→	QU047	Friends and Family Test- Postnatal Ward setting	94.0	92.0	2.0	%			73	Oct 25/26	↑										
G	→	PC024	FFT % positive responses - Primary Care	90.0	90.0	0.0	%			88	Oct 25/26	↑										
A	→	QU030	Friends and Family Test - Community Health	93.0	94.0	(1.0)	%			54	Oct 25/26	↑										
A	→	QU031	Friends and Family Test - Mental Health	82.0	85.0	(3.0)	%			62	Oct 25/26	↑										

Patient Experience – Friends and Family Test:

- In October, NW London performed the same as or better than the London and national averages in the acute hospital tests (apart from maternity antenatal services which was lower by a percent).
- A&E 78% (London 74%, England 77%), inpatients 95% (London 95%, England 94%) and outpatients 94% (London 93%, England 94%). In the maternity services scores were antenatal 91% (London 92%, England 92%), units 96% (London 93%, England 94%) and postnatal 94% (London 93% and England 93%).
- Primary care (90%) scored slightly lower than the London average (91%). The national average was 93%. NW London generally scores well in national and local surveys. The Primary Care Programme Board regularly monitors survey results, with feedback help shaping plans.
- The Community Health score (93%) was just below the 94% target.
- The mental health response rate was extremely low in October (113 responses compared to 1539 responses for NCL). This is being investigated by the NW London quality team. The September performance was above target at 86% (target 85%).

Finance

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data
G	↓	FI001	Total System reported YTD position (variance against plan) £'m	0.0	0.0	0.0	£'M			92	Nov 25/26
R	↑	FI010	System reported efficiency YTD (CIP)	94.0	100.0	(6.0)	%			8	Nov 25/26
G	↑	FI021	YTD Productivity compared with 19/20	3.7	0.0	3.7	%			100	Jul 25/26

Finance Key messages:

- The ICS November 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.

Workforce

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data
G	↓	WO019	Total Staffing WTE(Staff in post+bank+Agency)	66,160.0	67,023.0	(863.0)	Number			100	Sep 25/26
G	→	WO013	Agency spend as % of total Paybill	0.9	2.0	(1.1)	%			100	Oct 25/26

Workforce Key messages:

- **There is 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

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data
G	↓	EL059	Elective daycase compared to Ops Plan	99.9	100.0	(0.1)	%			69	Oct 25/26
G	↓	EL060	Elective ordinary compared to Ops Plan	101.5	100.0	1.5	%			77	Oct 25/26
G	↑	UE103	A&E Attendances (All Types)	105,438.0	109,141.0	(3,703.0)	Number			81	Nov 25/26
A	↑	UE034	Total SDEC activity	7,221.0	8,339.0	(1,118.0)	Number			54	Nov 25/26

Activity Key messages:

- RTT activity was to plan in October. In 2025/26 we want activity to be on plan.
- All type A&E attendances were below plan for October and November. Four-hour performance has remained consistent during this time, and improved in November.

NHSE Operating Plan 2025/26 performance

NWL Operating Plan Performance (1/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data
								D J F M A M J J A S O N			
R	↗	CA008	62-day Standard Attainment	77.2	83.9	(6.7)	%	○	■	8	Oct 25/26
G	↗	CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	80.4	80.0	0.4	%	○	■	73	Oct 25/26
G	↗	CA023	31 day 1st Treatment standard (From DTT)	97.3	96.0	1.3	%	○	■	100	Oct 25/26
G	↗	DI003	Diagnostic Tests - CT	28,098.0	28,939.0	(841.0)	Number	○	■	100	Oct 25/26
R	↗	DI004	Diagnostic Tests - MRI	14,774.0	16,756.0	(1,982.0)	Number	○	■	8	Oct 25/26
R	↗	DI005	Diagnostic Tests - NOUS	23,096.0	30,175.0	(7,079.0)	Number	○	■	8	Oct 25/26
G	↘	DI012	Diagnostic Tests 6-week performance - MRI	14.1	14.6	(0.5)	%	○	■	65	Oct 25/26
G	↘	DI013	Diagnostic Tests 6-week performance - CT	4.5	11.6	(7.1)	%	○	■	100	Oct 25/26
G	↘	DI014	Diagnostic Tests 6-week performance - NOUS	15.0	19.5	(4.5)	%	○	■	73	Oct 25/26
R	↗	DI021	Diagnostic Tests Activity - Colonoscopy	1,577.0	1,920.0	(343.0)	Number	○	■	8	Oct 25/26

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data
								D J F M A M J J A S O N			
R	↗	DI022	Diagnostic Tests Activity - Flexi sigmoidoscopy	460.0	502.0	(42.0)	Number	○	■	8	Oct 25/26
R	↗	DI023	Diagnostic Tests Activity - Gastroscopy	2,058.0	2,551.0	(493.0)	Number	○	■	8	Oct 25/26
R	↗	DI024	Diagnostic Tests Activity - Cardiology – echocardiography	5,580.0	6,293.0	(713.0)	Number	○	■	8	Oct 25/26
R	↘	DI025	Diagnostic Tests Activity - DEXA	1,154.0	1,883.0	(729.0)	Number	○	■	0	Oct 25/26
R	↗	DI026	Diagnostic Tests Activity - Audiology	2,622.0	4,508.0	(1,886.0)	Number	○	■	8	Oct 25/26
R	↘	DI027	Diagnostic Tests, 6-week waiting time - Colonoscopy	23.7	14.1	9.6	%	○	■	8	Oct 25/26
A	↘	DI028	Diagnostic Tests, 6-week waiting time - Flexi sigmoidoscopy	17.3	12.7	4.6	%	○	■	27	Oct 25/26
R	↘	DI029	Diagnostic Tests, 6-week waiting time- Gastroscopy	26.7	11.3	15.4	%	○	■	8	Oct 25/26
A	↗	DI030	Diagnostic Tests, 6-week waiting time - Cardiology – echocardiography	37.3	34.1	3.2	%	○	■	46	Oct 25/26
G	↘	DI031	Diagnostic Tests, 6-week waiting time - DEXA	0.1	14.5	(14.4)	%	○	■	100	Oct 25/26
R	↘	DI032	Diagnostic Tests, 6-week waiting time - Audiology	31.9	19.9	12.0	%	○	■	8	Oct 25/26

NWL Operating Plan Performance (2/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	○ Validated ◇ Not validated D J F M A M J J A S O N	□ Target / plan ■ Range / mean	Health score (0-100)	Latest data	Goal
G	↘	EL024	RTT incomplete Pathways > 52 Weeks	1.9	2.0	(0.1)	%			100	Sep 25/26	↓
G	↗	EL108	Outpatient first attendances without a procedure - ERF scope	97.4	100.0	(2.7)	%			77	Oct 25/26	↕
G	↗	EL109	Outpatient follow up attendances without procedure - ERF scope	99.4	100.0	(0.6)	%			100	Oct 25/26	↕
G	↘	EL059	Elective daycase compared to Ops Plan	99.9	100.0	(0.1)	%			69	Oct 25/26	↕
G	↘	EL060	Elective ordinary compared to Ops Plan	101.5	100.0	1.5	%			77	Oct 25/26	↕
R	↗	EL069	RTT total incomplete waiting list	289,569.0	267,340.0	22,229.0	People			12	Sep 25/26	↓
A	↗	EL072	Patient Initiated Follow Up discharges	0.9	3.1	(2.2)	%			54	Sep 25/26	↑
R	↘	EL107	Outpatient procedures - ERF scope	105.4	100.0	5.4	%			38	Oct 25/26	↕
R	↘	EL116	RTT - The number of completed admitted RTT pathways in the reporting period	8,069.0	8,327.0	(258.0)	Number			0	Sep 25/26	↕
G	↗	EL118	RTT incomplete Pathways < 18 Weeks for a first appointment %	61.0	60.0	1.0	%			46	Oct 25/26	
R	↘	EL120	RTT - The number of completed non-admitted RTT pathways in the reporting period	47,132.0	52,251.0	(5,119.0)	Number			0	Sep 25/26	
G	↗	LO065	Virtual Wards occupancy rate	85.0	85.0	0.0	%			88	Nov 25/26	
R	↘	LO073	Urgent Community Response (UCR) referrals	1,335.0	2,289.0	(954.0)	Number			0	Oct 25/26	
G	↘	LO074	Community services waiting list over 52 weeks	45.0	813.0	(768.0)	Number			100	Oct 25/26	
G	↘	LO075	Community services waiting list over 52 weeks - CYP	18.0	761.0	(743.0)	Number			100	Oct 25/26	
G	↗	LO076	Community services waiting list over 52 weeks - Adults	27.0	52.0	(25.0)	Number			92	Oct 25/26	
G	↘	ME014	CYP with a learning disability or autism in an inpatient setting	11.0	11.0	0.0	Number			58	Oct 25/26	
R	↗	ME016	CYP accessing NHS funded mental health services	17,520.0	23,940.0	(6,420.0)	Number			8	Oct 25/26	
R	↘	ME024	Women receiving access to perinatal services	1,556.0	2,905.0	(1,349.0)	Number			0	Oct 25/26	

NWL Operating Plan Performance (3/3)

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	 D J F M A M J J A S O N	Health score (0-100)	Latest data	Goal
R	↗	ME032	Access to Individual Placement and Support Services	730.0	1,743.0	(1,013.0)	Number		8	Oct 25/26	↑
R	↘	ME060	% of People with learning disability (14 years old and above) with an annual health check	29.0	51.0	(22.0)	%		23	Nov 25/26	↑
R	↗	ME075	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	9.0	0.0	9.0	Number		0	Oct 25/26	↓
A	↘	ME076	Reliable recovery rate for those completing a course of treatment and meeting caseness - Talking Therapies	47.6	48.0	(0.4)	%		58	Oct 25/26	↑
G	↗	ME077	Reliable improvement rate for those completing a course of treatment - Talking Therapies	69.4	67.0	2.4	%		100	Oct 25/26	↑
G	↘	ME083	Reliance on mental health inpatient care for adults with a learning disability	27.0	28.0	(1.0)	%		77	Oct 25/26	↓
G		ME085	MH Adult Acute Inpatient LoS (average)	42.0	42.5	(0.5)	Days		100	Aug 25/26	↓
G	↗	PC036	Appointments in general practice	1775,252.0	1699,881.0	75,371.0	Number		77	Oct 25/26	↑
A	↗	UE034	Total SDEC activity	7,221.0	8,339.0	(1,118.0)	Number		54	Nov 25/26	↑
G	↘	UE053	Non-elective spells with a length of stay of 1 or more days	11,968.0	18,630.0	(6,662.0)	Number		100	Sep 25/26	↓

RAG	Direction	KPI ID	KPI name	Latest Value	Target or plan	Variance to target	Unit	 D J F M A M J J A S O N	Health score (0-100)	Latest data
G	↘	UE054	Non-elective spells with a length of stay of zero days	6,453.0	6,920.0	(467.0)	Number		88	Sep 25/26
A	↗	UE056	Patients waiting over 12 hours in ED	9.7	9.5	0.2	%		46	Nov 25/26
A	↗	UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	77.3	78.0	(0.7)	%		54	Nov 25/26
G	↗	UE079	% of ED (type 1) attendances seen within 4 hours of arrival to ED	62.2	59.4	2.9	%		73	Nov 25/26
A	↗	UE096	Ambulance handover times (Mean)	19.6	18.2	1.3	Minutes		58	Oct 25/26
A	↘	UE102	% of ED (all other types except type 1) attendances seen within 4 hours of arrival to ED	97.0	97.4	(0.4)	%		46	Nov 25/26
G	↗	UE103	A&E Attendances (All Types)	105,438.0	109,141.0	(3,703.0)	Number		81	Nov 25/26
G	↘	UE106	Number of specific acute non elective spells in the period	18,421.0	18,630.0	(209.0)	Number		73	Sep 25/26
R	↘	UE107	Non elective spells with a length of stay of 7 or more days.	3,697.0	2,971.0	726.0	Number		8	Sep 25/26

Operating Plan performance overview

- Of the 59 RAG rated performance metrics, 22 (37%) are green (meeting or exceeding plan), 10 (20%) are amber (just off plan) and 27 (43%) are red (below plan). **This represents a similar position from the last report.**
- Virtual Wards occupancy rates have improvement with increased usage across providers. A review is taking place to identify whether these wards could be further utilised for admission avoidance.
- 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.
- The Talking Therapies improvement and reliable recovery rates are expected to be achieved in March 2026. The reliable recovery target has been met for each month of 2025/26. Conversations are taking place between NHSE, the ICB and providers to identify required activity levels for 2026/27.
- Plans to improve access to individual placement and support services and reducing inappropriate adult out of area placements are including in the 2026/27 Operating Plan submission.



North Central London
Integrated Care Board



North West London

**North Central London ICB and North West London ICB
Board of Members Meeting in Common
28 January 2026**

Report Title	Chief Executive Officer's Report	Date of report	21 January 2026	Agenda Item	3.2
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's Report

1. Introduction

- 1.1 This report presents key updates from the work of the North Central London (NCL) and North West London (NWL) Integrated Care Boards (ICBs), and our partners. It covers issues for the Boards' consideration not addressed elsewhere on the agenda.
- 1.2 This will be my final Chief Executive's Report, ahead of my departure from the ICBs on 31st January. It has been a privilege to lead North Central London over the past 6 years, working alongside extraordinary colleagues and partners to strengthen our system, improve services and tackle health inequalities for our communities. More recently, I have been equally proud to work with teams across North West London, and to see the depth of collaboration and shared purpose that has emerged as we have come together around common ambitions. I offer my sincere thanks to everyone who has contributed, day in, day out to the delivery of improvements in health outcomes for our residents and patients.

2. Organisational Change Programme

- 2.1 Work to establish West and North London ICB (WNL ICB) on 1 April 2026 is progressing through a structured change programme, aligned to the national Model ICB Blueprint and London's emerging operating model. A formal staff consultation on the proposed operating model and organisational structures commenced on 8 December 2025 and concludes on 25 January 2026. This is being delivered under a single, harmonised Change Management Policy and Procedure agreed in partnership and with executive oversight. The consultation covers the proposed transfer of staff into the new statutory body (subject to national approvals), the proposed target operating model structure and working arrangements, and a small number of specific service/team hosting changes planned alongside the transition.
- 2.2 The programme is designed to be transparent, fair, and evidence-led, with multiple routes for staff and trade unions to shape the final proposals as we move towards the Model ICB blueprint. Partnership working with trade unions is embedded throughout, with a schedule of regular engagement to surface and resolve issues quickly. Alongside the consultation, a voluntary redundancy scheme has been opened to provide additional flexibility and support to colleagues.
- 2.3 Equality and inclusion have been built in from the outset. A joint Equality Impact Assessment has been completed for the consultation and the

voluntary redundancy scheme, drawing on workforce data and setting out mitigating actions, with further assessment planned once consultation outcomes are confirmed. A comprehensive package of wellbeing, careers and financial wellbeing support is in place to support staff through change, complemented by a bespoke staff survey (with strong response rates across both ICBs) and follow-on focus groups to ensure cultural and organisational development needs inform implementation.

- 2.4 Following consultation closure, feedback will be reviewed through late January/early February, outcomes communicated in mid-February, and subsequent processes will begin in March - ensuring readiness for staff transfer and the new operating model to stand up from April 2026.
- 2.5 A more detailed update on the ICBs' transition work is covered in item 2.1 at the Board meeting.

3. System Pressures

- 3.1 Across North Central and North West London, operational performance is under increasing winter pressure, with sustained demand and higher patient acuity affecting flow across urgent and emergency care. There are pressures around timely discharge, workforce capacity in system coordination and discharge functions, and increased ambulance activity in some areas. While overall A&E four-hour performance has remained broadly close to plan, the systems continue to see pressure on ambulance handovers and bed availability, requiring close day-to-day coordination, agreed escalation processes and senior oversight to maintain safe and effective services.
- 3.2 Planned care also remains challenging across the footprint. The combined waiting list (PTL) is behind plan, and targeted Quarter Four actions are in place - supported by non-recurrent NHS England investment - to prioritise those waiting the longest while sustaining progress against wider Referral to Treatment (RTT) standards. Diagnostics continues to be a key constraint, with performance impacted by a small number of high-volume modalities and capacity pressures within providers and work is ongoing through recovery plans, mutual aid and waiting list initiatives, alongside continued monitoring through system performance and delivery forums.
- 3.3 Mental health demand continues to affect system flow, including delays for some people in crisis who require onward admission, reinforcing the importance of strengthening crisis alternatives and improving pathways between acute and mental health services.
- 3.4 Financial pressures across the systems also remain significant and require careful prioritisation of operational mitigations to ensure they are sustainable and deliver the greatest benefit for residents. Overall, both systems are maintaining a strong grip through winter plans, daily oversight arrangements, and coordinated demand management - supported by measures such as

Pharmacy First, enhanced access routes and system coordination - while keeping performance and risk under continual review. We continue to provide our full support to the systems, across both ICBs, through the System Co-ordination Centres' (SCC) in meeting the winter challenges.

4. Winter wellness campaigns

- 4.1 Across NCL and NWL, our Winter Wellness communications have focused on helping residents to stay well, protect themselves through vaccination, and use the right services first time - particularly NHS 111 and Pharmacy First - thereby easing pressure on urgent and emergency care. In NCL, the campaign has been our most targeted and data-led to date, prioritising residents with long-term conditions and parents of young children and using clear calls to action delivered through trusted local clinicians and community voices. Reach and engagement have been strong, but we recognise we need to translate this into further improvements in uptake and timely access, particularly for groups and places where coverage remains below our ambition.
- 4.2 There is early evidence of positive impact. In NCL, flu vaccination uptake has improved across several key groups and the system reports being one of the most improved in London at this point in the programme, with an estimated 15,000 more people vaccinated compared to the same point last year. The campaign has also supported community pop-up delivery to reach low-uptake communities, with clinics and workshops delivered through VCSE partnerships and culturally tailored engagement (including multi-lingual sessions) to address persistent inequalities in uptake. While this progress is welcome, overall uptake is still not where we want it to be, and targeted outreach will continue through the remainder of winter.
- 4.3 In NWL, the winter campaign has similarly blended vaccination promotion with practical access messaging—highlighting walk-ins and catch-up clinics, and supporting residents to navigate services such as NHS 111, 111 online, and Pharmacy First. Activity in December included radio and digital advertising, extensive outdoor placements, and a strong programme of community engagement, with 19 community groups mobilised, 20+ events delivered, and around 4,200 face-to-face contacts/conversations reported. Campaign reach has been substantial, with hundreds of thousands of impressions for flu, NHS 111, and Pharmacy First, and sustained digital engagement since early September.
- 4.4 Taken together, the campaigns demonstrate a balanced, prevention-led approach: increasing protection through vaccination, improving public understanding of alternatives to A&E, and using community-led delivery to reach residents who may otherwise face barriers to access. Both systems will

complete a full evaluation at the end of the winter period, bringing together communications performance, community insight, and service-demand indicators to inform continuous improvement and planning for future seasons.

5. NCL Emergency Preparedness, Resilience and Response Assessment

- 5.1 The ICB completed its annual Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment, with NHSE confirming a rating of Fully Compliant. System-wide assurance reviews were also undertaken across all NCL Trusts, with all organisations receiving positive assurance outcomes (Fully or Substantially Compliant). Preparations are in hand to ensure a smooth transition of the EPRR function into the merged organisation from 1 April, with continuity of assurance and system oversight maintained.
- 5.2 With NWL having previously completed the assessment, as reported to the December Board, both ICBs are assured and fully compliant.

6. Primary Care Access Recovery

- 6.1 As part of delivering the national Primary Care Access Recovery Plan and in supporting practices more generally, NCL and NWL ICBs are taking a data-driven, insight-led approach—combining performance and patient experience data with local intelligence, including on commissioned services, to identify where practices need targeted support and tailoring interventions accordingly. Early signs are positive, with results of the GP Patient Survey 2025 showing improvement across many NCL and NWL practices and overall.
- 6.2 NCL has the second-highest proportion in London of residents rating their experience of contacting their practice as ‘good,’ exceeding both London and national averages. Performance in NWL is also improving, with more residents reporting that general practice has improved over the past 12 months. In addition, NWL has the highest proportion of patients in London reporting that they were able to see or speak to their preferred clinician when contacting their practice, again outperforming both London and national averages.
- 6.3 All PCNs are also delivering annual Capacity and Access Improvement Plans supported by PCN Development Funding, underpinned by infrastructure upgrades such as cloud-based telephony across all practices with call queuing and call-back functionality. Finally, we continue to support adoption of the NHS App to improve access and release capacity: both ICBs have recruited NHS App Ambassadors and have increased the number of registered patients who are signed up to the App.

6.4 Despite this progress, pressure points remain. Same-day demand continues to be high and the “8am peak” still puts acute strain on phone access in some practices, with variation in experience between localities—particularly for residents who rely on telephone access or need additional support to navigate care. We will continue targeted support, strengthen care navigation and signposting (including Pharmacy First and NHS 111), and use insight to focus additional help where access, continuity and experience indicate the greatest need.

7. Dentistry Recognition

7.1 Access to NHS dental care remains a significant challenge for many residents, driven by sustained demand and capacity constraints across the dental workforce and estate, and we continue to work with partners to improve availability and reduce inequity in access. As part of our efforts, our Dental Clinical Lead, Dr Rakhee Patel, recently received a warm letter from the Mayor of London, Sir Sadiq Khan, in recognition of the success and impact of our Dental Transformation Programme, which won an HSJ award recently, and it is work worth celebrating.

7.2 By reinvesting NHS dental underspend and allocating a modest recurrent budget, we have successfully expanded access to primary dental care and implemented community-led prevention initiatives, addressing long-standing oral health inequalities. At a time when money is more constrained than ever, we thought it's important to demonstrate how positive results can come from this kind of activity, and the impact it has, particularly on underserved communities.

7.3 Fifteen workstreams have been put in place, built on strong partnerships with community dental services, local authorities, public health teams, schools, and charitable organisations. It aligns with NHS England's Core20PLUS5 framework, demonstrating how targeted investment and co-created initiatives can improve access, prevention, and equity in healthcare.

8. Continuation of WorkWell service

8.1 NCL and NWL ICBs have welcomed the news that following local pilot schemes, the WorkWell service which provides support to help people get into, and stay in, work, will be launched nationally, along with confirmed local funding for it to continue.

8.2 WorkWell is a voluntary service, jointly sponsored by the Department for Work and Pensions and the Department of Health and Social Care, designed to offer optional support to disabled people, or people with health

conditions, who would like support to stay at work, are planning to return to work after an absence, or who are looking for a new job.

- 8.3 The service offers support to people aged 16 or older who live in (or are registered with a GP within) 13 of the boroughs in North West and North Central London. It's delivered through a partnership including local NHS trusts, GPs, local authorities, Jobcentre Plus, and a delivery partner – employment charity, The Shaw Trust.
- 8.4 Since its launch in October 2024, WorkWell has supported over 6,400 disabled people and/or people with health conditions across North West and North Central London to find, remain in, or return to work after a period of absence.

Participants are matched to a Work and Health coach, with referrals possible from a number of routes, including self-referral, via their GP, or Jobcentre Plus (three of the most frequently used). The coach supports the participant to develop a personalised work and health plan.

9. Bacon Lane Surgery Visit

- 9.1 As the Chief Executive, I have very much valued opportunities to visit colleagues across the systems delivering front-line care to our patients. In January, I visited Bacon Lane Surgery in Edgware alongside our Chief Medical Officer, Dr Jo Sauvage, to recognise the practice's 75 years of service to its local community and to hear directly from the team about both their achievements and the challenges they face. The visit highlighted a practice with strong local roots that is also looking ahead—embracing multidisciplinary working and innovation, including the use of digital tools to improve access and day-to-day patient care.
- 9.2 The visit also reinforced the importance of ensuring our primary care estate can support modern models of care. The practice shared their current premises constraints and the need for upgrades to enable future service development. It was also a timely opportunity to celebrate local workforce development, including the completion of a clinical apprenticeship programme within the practice team - an example of how primary care is contributing to the NHS Long Term Workforce Plan and building capacity for the future.

10. Closing Reflections

- 10.1 As I close this report, I am confident, given the existing significant strengths in North Central and North West London, that strong foundations are in place for

the new West and North London ICB to successfully continue the delivery of improvements in health outcomes for patients and residents. These foundations will support the delivery of the nationally driven three shifts in the provision of health care: moving care closer to home through neighbourhoods, accelerating digital transformation, and strengthening prevention.

10.2 Population health sits at the heart of our approach, informed by a strong understanding of our communities, targeted strategic commissioning, and effective delivery through borough and neighbourhood-based partnerships.

10.3 I would like to thank our staff, board members, providers, and partners across all sectors for their continued commitment and contributions. The momentum across both NCL and NWL will provide the new West and North London ICB with a solid foundation. Moving forward, the new organisation will be well positioned to translate this shared ambition into sustained, measurable improvements in access, experience, and outcomes for the residents we serve.

Frances O'Callaghan
Chief Executive Officer