North Central London Clinical Commissioning Group

North Central London Clinical Commissioning Group
Strategy and Commissioning Committee Meeting

Thursday, 15 July 2021
10am – 12pm
Virtual Meeting

Agenda: Part 1

Item	Title	Lead	Action	Page	Time
1.	**Introduction**				
1.1	Welcome and Apologies	Chair	Note	Oral	10am
1.2	Declarations of Interest	Chair	Note	3	
1.3	Declarations of Interest relating to the items on the Agenda	All	Note	Oral	
1.4	Declarations of Gifts and Hospitality	Chair	Note	Oral	
1.5	Minutes of Previous Meeting	Chair	Approval	6	
1.6	Action Log and Matters Arising	Chair	Note	16	10.05am
2.	**Commissioning**				
2.1	Contracts and Activity Report	Mark Eaton	Note	19	10.15am
2.2	NCL Ageing Well Programme 2021/22	Shafeeq Tejani/ Alex Smith	Approve	94	10.25am
2.3	NHS 111 - future years contracting arrangements	Alex Faulkes/ Anthony Browne	Approve	To follow	10.35am
2.4	Collaborative Performance Monitoring	Ed Nkrumah	Note	127	10.45am
2.5	NCL Evidence Based Interventions and Clinical Standards Policy – progress update	Sarah Mansuralli	Note	136	10.55am
2.6	Procurement of GP Direct Access Diagnostics	Mark Eaton	Approve	147	11.05am
2.7	Update on Inequalities Investment Fund	Sarah Mansuralli	Note	164	11.15am
2.8	NCL Accelerated Elective Recovery Bids Outcome Report	Ali Malik	Note	182	11.25am
2.9	Children's Integrated Therapies Services	Mark Eaton	Agree	193	11.35am
3.	**Strategy**				
3.1	ICS Service Development Plan	Richard Dale	Note	221	11.45am
4	**Risk**				
4.1	Risk Report	Sarah Mansuralli	Note	279	11.50am

5	**Items For Information**				
5.1	Minutes of Procurement Committee Meeting on 25 February 2021	Karen Trew	Note	288	11.55am
6.	**Any Other Business**				
7.	**Date of Next Meeting: Thursday, 9 September 2021**				

NCL CCG Strategy and Commissioning Committee Declaration of Interest Register - May 2021

Name	Current Position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or Indirect?	Nature of Interest	Date of Interest			
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal			From	To	Date declared	Updated
Members											
Dr Charlotte **Benjamin**	Clinical Vice Chair of NCL CCG Governing Body Barnet Clinical Representative, NCL CCG Member of Strategy and Commissioning Committee Member of Quality Committee Member of Covid Response Oversight Committee	St George's Medical Centre JFS Brent Chelsea and Westminster NHS FT Charing Cross NHS Trust Primary Care Network 5 Barnet Federated GPs Royal Free WDOC (Wellington - Golders Green Outpatients and diagnostics Centre)	Yes No No No No Yes no	Yes Yes No No Yes Yes No	No No Yes Yes No No Yes	Direct Direct Indirect Indirect Direct Direct Indirect	GP Partner School Governor Husband is a clinical lead for ENT Husband is an ENT Consultant Practice is a member Practice is a member Stakeholder Governor Husband is a partner	04/07/2003 01/05/2017 01/04/2011 01/04/2009 01/07/2019 TBC 2017		15/08/2019 15/08/2019 15/08/2019 15/08/2019 15/08/2019 20/10/2020	15/08/2019 15/08/2019 15/08/2019 15/08/2019 15/08/2019
Simon **Goodwin**	Chief Finance Officer of NCL CCG Member of NCL CCG Governing Body NCL Finance Committee Attendee, NCL Audit committee NCL Strategy and Commissioning Committee NCL Primary Care Commissioning in Common Attend other meetings as and when required.	East London NHS Foundation Trust	Yes	No	No	Indirect	Wife is a senior manager at the Trust	14/06/2017	current	12/10/2018	11/05/2020
Claire **Johnston**	Registered Nurse of NCL CCG Governing Body Member of Primary Care Committee Member of Quality Committee Member of Strategic Commissioning Committee Member of Medicines Management Committee Member of Public and Patient Engagement Committee Member of Covid Reponse Oversight Committee Member of IFR Panel	Our Time Nursing and Midwifery Council The Guardian	No No No	Yes Yes No	No No No	Direct Direct Indirect	Chair of Trustees . A charity which provides interventions and campaigns for children and young people with a mentally ill parent. Registrant Member Spouse is Public Services Editor			12/09/2019 12/09/2019 12/09/2019	31/03/2021 31/03/2021 12/05/2020
Dr Subir **Mukherjee**	Secondary Care Clinician, NCL CCG Member of Covid Reponse Oversight Committee Member of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Individual Funding Request Appeals Panel Member of Medicines Management Committee Member of Strategy and Commissioning Committee	Health Education England, KSS	yes	no	yes	direct	Associate post graduate Dean	2003	current	05/09/2020	
Frances **O'Callaghan**	Accountable Officer of NCL CCG Member of Covid Reponse Oversight Committee Member of Finance Committee and attend other commtitees as required	NCL Provider Alliance Board	No	No	No	No	member from 27/04/2021	24/02/20	current	24/02/2020	29/04/2021
Arnold **Palmer**	Lay Member of NCL CCG Governing Body Chair of Remuneration Committee Member of IFR Appeals Panel Member of Strategy and Commissioning Committee Member of Primary Care Commissioning Committee Member of Finance Committee Member of Audit Committee Member of Public and Patient Engagement Committee	A & C Palmer Associates	Yes	No	No	Direct	Director and Owner of private LTD company, providing training, executive coaching and consultancy services (including coaching and consultancy services to the NHS but excluding NCLCCG) Spouse is also a shareholder and company secretary.	01/01/2006	current	16/04/2020	

		Mental Health & Community Service Review, led by Carnell Farrar	No	Yes	Yes	Direct	Member of the Programme Board - from May 2021 to March 2022. An acquaintance of a partner at Carnell Farrar, known of since 1995, as professional colleagues at the same NHS Trust.	05/05/2021	current	11/05/2021	
Dr Kevan **Ritchie**	Camden Clinical Representative, NCL CCG Governing Body Member of Strategy and Commissioning Committee Member of Remuneration Committee Member of IFR Appeals Panel	Bloomsbury Surgery	Yes	Yes	No	Direct	GP Practice	13/06/2017	current	02/11/2018	22/04/2020
		Camden Health Evolution Ltd	Yes	Yes	No	Direct	GP Practice is a member	13/06/2017	current	02/11/2018	22/04/2020
		Central Camden PCN	Yes	Yes	No	Direct	GP Practice is a member	01/05/2019	current	02/11/2019	22/04/2020
Dr John **Rohan**	Haringey Clinical Representative, NCL CCG Governing Body Member of Finance Committee Member of IFR Appeals Panel	Lawrence House (incoporating Lawrence House, Broadwater Farm, Dowsett Road and Tottenham Hale pracices)	Yes	No	Yes	Direct	GP Partner	15/03/2018	current	15.10.2018	15/05/2020
		Federation4Health, the pan-Haringey Federation of GP Practices	Yes	No	Yes	Direct	Practice is a member	15/03/2018	current	15.10.2018	15/05/2020
		Whiitington Health	No	No	Yes	Indirect	Wife is a consultant paediatrician and clinical lead for paediatrics	15/03/2018	current	15.10.2018	15/05/2020
		Welbourne Primary Care Network	Yes	Yes	No	Direct	Practice is a member	01/07/2019	current	08.08.2019	15/05/2020
Dr Jo **Sauvage**	**Chair** of NCL CCG Governing Body Chiar of Covid Response Oversight Committee Chair of A&E Delivery Board Member of NCL Urgent and Emergency Care Delivery Board Member of Islington HWBB Member of Joint Haringey & Islington HWBB Member of NCL Strategy and Commissioning Committee Chair of Islington Community Education Provider Network Co-Chair NCL STP Clinical Cabinet NCL CCG Chair representative on STP Transformation Group Member of NCL Local Workforce Advisory Board Also attend sub committees of the Governing Body as and when required	City Road Medical centre	Yes	Yes	No	Direct	City Road Medical Centre is a member of the Islington GP Federation - The share is formally held in the name of Dr Philly O'Riordan, one of my partners	02/02/2017	current	06/11/2018	11/05/2020
		NHS Clinical Commissioning Board	Yes	Yes	No	Direct	The practice holds a single share in the Islington GP Group Ltd trading as Islington GP Federation.				11/05/2020
		Chair of Wellbeing Partnership	Yes	Yes	No	Direct	Board member				11/05/2020
		South Islington Primary Care Network	Yes	Yes	No	Direct	Practice is a member	01/06/2019	current	30/08/2019	11/05/2020
		NHSE / I Clinical Lead for Sustainability	Yes	Yes	No	Direct	Systems and governance for London to support ICS deliver the Net zero targets of the NHS net zero plan.	01/12/2020	current	02/12/2020	
Karen **Trew**	Deputy Lay Chair of NCL CCG Governing Body Member of Covid Response Oversight Committee Member of Finance Committee Member of Primary Care Committee Member of Remuneration Committee Member of IFR Appeals Panel Member of Strategy and Commissioning Committee Chair of Audit Committee	Broxbourne School Hertfordshire	No	No	Yes	direct	Chair of the Governing Body (previously Governing Body members since Nov. 2004) Chair of the Governing Body	01/07/2015	current	15/07/2015	25/05/2020
		Wormley C of E Primary School, Hertfordshire	No	No	Yes	direct		28/06/2005	current	15/07/2015	25/05/2020
Attendees											
Anthony **Browne**	Director of Financial Strategy and Contracting, NCL CCG	No interests declared	No	No	No	No	Nil Return	22/10/2018	current	10/10/2019	
Ruth **Donaldson**	Executive Managing Director (Job Share): Enfield Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Enfield Directorate Management Team	No interests declared	No	No	No	No	Nil Return	27/02/2018	current	03/09/2019	08/05/2020
Sarah **D'Souza**	Executive Managing Director (Job Share): Enfield Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Enfield Directorate Management Team	No interests declared	No	No	No	No	Nil Return	01/03/2019	current	14/09/2019	08/05/2020

NCL CCG Strategy and Commissioning Committee Declaration of Interest Register - May 2021

Richard **Dale**	Interim Executive Director of Transtion Member of NCL CCG Executive Management Team Attend Finance Committee Attend PPEE Committee Attend Strategic Commissioning Committee Attend Covid Response Oversight Committee	No interests declared	No	No	No	No	Nil Return	03/07/2018	current	04/09/2019	28/04/2021
Sarah **Mansuralli**	Executive Director of Strategic Commissioning Member of NCL CCG Executive Management Team Exec Lead for Strategy and Commissioning Committee Attend Finance Committee Attend Covid Response Oversight Committee	No interests declared	No	No	No	No	Nil Return	07/11/2018	current	07/11/2019	08/05/2020
Sarah **McDonnell-Davies**	Executive Director, Borough Partnerships Positions held in relation to CCG business Attend Governing Body Attend NCL Committee Meetings as required e.g. Strategy and Commissioning Committee Primary Care Commissioning Committee Borough Commissioning Committee NCL CCG Executive Management Team	None	no	no	no	Direct	n/a			20/06/2018	19/11/2020
Kay **Matthews**	Director of Clinical Quality Attend Governing Body Attend NCL Committee Meetings as required Member of NCL CCG Executive Management Team Member of Barnet Directorate Management Team Attend Covid Response Oversight Committee Attend Primary Care Commissioning Committee Attend Finance Committee member of Quality and Safety Committee	No interests declared	no	no	no	no	Nil Return				11/05/2020
Ian **Porter**	Executive Director of Corporate Services • Governing Body meetings • Audit Committee • Public & Patient Engagement and Equalities Committee • Covid-19 Response Oversight Committee • Emergency Planning meetings Other Committees across NCL as required	No interests declared	No	No	No	No	Nil Return	12/10/2018	current	13/08/2019	11/05/2020
Karl **Thompson**	Senior Head of Corporate Services, NCL Attendance at the GB and various NCL Committees on an ad-hoc basis. NCL CCG SIRO	No interests declared	No	No	No	No	Nil Return	01/04/2018	current	09/08/2019	14/07/2020

North Central London
Clinical Commissioning Group

Draft Minutes
Meeting of North Central London CCG Strategy and Commissioning Committee
13 May 2021 between 10am and 12pm
Virtual Meeting

Members Present:	
Dr Jo Sauvage	**Chair** & Clinical Representative - Islington
Dr Charlotte Benjamin	Clinical Vice Chair & Clinical Representative – Barnet and Chair of Meeting
Frances O'Callaghan	Accountable Officer
Karen Trew	Deputy Chair and Lay Member
Claire Johnston	Registered Nurse
Arnold Palmer	Lay Member
Simon Goodwin	Chief Finance Officer
Dr Kevan Ritchie	Clinical Representative – Camden
Dr Subir Mukherjee	Secondary Care Representative
In Attendance:	
Sarah Mansuralli	Executive Director, Strategic Commissioning
Sarah McDonnell-Davies	Executive Director of Borough Partnerships
Richard Dale	Director of Transition
Anthony Browne	Director of Finance
Lorna Reith	Community Member
Mandeep Kaur	Community Member
Mark Eaton	Director, Strategic Commissioning Programmes
Clare Stephens	Clinical Representative - Barnet
Dennis Carlton	Programme Director
Eileen Fiori	Director of Acute Commissioning
Anna Stewart	Director of Major Reconfigurations
Jo Murfitt	Programme Director, Strategic Reviews of Community and Mental Health Services
Alex Smith	Director of Transformation
Apologies:	
Kay Matthews	Executive Director of Clinical Quality
Minutes:	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed members to the meeting.
1.1.2	Apologies had been received from Kay Matthews. It was noted that Richard Dale would be a regular attendee from this meeting forward in his role of Director of Transition.
1.2	**Declarations of Interest Register**

1.2.1	The Chair presented the Strategy and Commissioning Committee declarations of interest register.
1.2.2	Claire Johnston noted that she is the Chair of the Our Time charity which has links with one of the contracts being considered under item 2.4 but this is not a material conflict.
1.2.3	There were no additional declarations.
1.2.4	The Strategy and Commissioning Committee **NOTED** the Declarations of Interest Register.
1.3	**Declarations of Interest relating to the items on the Agenda**
1.3.1	There were no additional declarations.
1.4	**Declarations of Gifts and Hospitality**
1.4.1	The Chair invited members of the Strategy and Commissioning Committee to declare any gifts and hospitality received. No gifts and hospitality were declared.
1.5	**Minutes of Previous Meeting**
1.5.1	The Strategy and Commissioning Committee **APPROVED** the minutes of the meeting on 11 March 2021 as an accurate record.
1.6	**Action Log and Matters Arising**
1.6.1	The Chair highlighted that the actions on the log were either being addressed under items on today's agenda or were due to be brought to the July meeting.
1.6.2	Sarah Mansuralli confirmed the she had discussed Action 19 with the Governance and Risk team who had advised that the Primary Care Workforce risk should be monitored by the Primary Care Commissioning Committee.
1.6.3	The Committee agreed with her recommendation that the system wide workforce risk should be monitored and mitigated as part of the wider ICS arrangements, potentially via the People Board, and Sarah Mansuralli would make this recommendation to the Chair of the NCL People Board.
1.6.4	The Committee then discussed matters arising from the minutes of the previous meeting, making the following comments: • It was agreed that an update on the Memorandum of Understanding with CNWL would be provided outside the meeting • It was confirmed that the Mental Health Trusts review has now started and is being chaired by Jackie Smith, Joint Chair of Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust. Frances O'Callaghan sits on the Steering Group which oversees the Working Group. It is expected that the review will deliver its report in the next three to four months. The CCG's commissioning review is proceeding alongside this but it should be noted that the focus of the CCG review is on outcomes.
1.6.5	The Strategy and Commissioning Committee **NOTED** the action log.
1.6.6	Action: Mark Eaton to provide an update on the Memorandum of Understanding with CNWL.
2.	**Commissioning**
2.1	**Diagnostics Update**
2.1.1	Clare Stephenson and Dennis Carlton introduced the paper, highlighting the following points: • There has historically been a lot of fragmentation in the NCL approach to transforming diagnostic services

	• In recognition of this and to align the NCL approach with the developing regional approach, the NCL ICS restructured its various diagnostic programmes into a single governance structure – the NCL Imaging Network Board, NCL CDH development Board, NCL Pathology Board and NCL Endoscopy Board all report into the NCL Diagnostics Board, chaired by John Quinn, which reports in turn to the NCL CEO Group • From a clinical perspective, this cohesive structure has already provided clear benefits over the last few months • The paper sets out the scope of the programme which is focused on effective transformation by putting in place systems which have the highest chance of delivering recovery and therefore improving services overall, improving outcomes and reducing variations, while also creating something which has genuine future resilience for the population • The vision which has been developed and refined following feedback from CEO colleagues is "For the population of NCL to have high quality, timely, equitable access to diagnostics and ensure best use of available resources" • The CDH programme is a good example of how the system is delivering on this vision and over the past six weeks the CCG has been developing proposals for two sets of bids to significantly increase diagnostic capacity. • These are an early adopter bid for a year's worth of revenue funding for Finchley Memorial (running from 8am – 8pm) and two capital bids due to be submitted in July at Finchley Memorial and a new build at Wood Green. The choice of sites was based on Public Health analysis and interviews with primary and secondary care clinicians. • Strong engagement has taken place with stakeholders and partners. Following an extremely constructive dialogue with NHS England, NCL was strongly encouraged to bid for two sites.
2.1.2	The Committee discussed the paper, making the following points: • The strategic approach set out in the pack was welcomed • Assurance was received that the CDH proposals take into account the existing inequity of provision • It was confirmed that workforce challenges, particularly regarding imaging and endoscopy, had been identified and various mitigations are being considered, including looking at skill-mixes and the creation of training academies, but there is still more work to be done in this area • Governance arrangements are still being worked through but at this stage it is likely that the Royal Free will 'host' Finchley Memorial and Whittington Health will 'host' the Wood Green site but it will be managed under a partnership agreement • It was clarified that the Wood Green site is in the Shopping City on the High Rd but as this is a new-build this won't be up and running before February/March 2022 at the earliest • It was clarified that the lack of reference in the slides to patient engagement was an oversight and engagement has been taking place, although there is still a lot more to do • It was confirmed that the Finchley Memorial early adopter bid is intended to be up and running by July 2021 and subject to when the funding is received, the Year One Finchley Memorial bid is intended to be operational by the end of 2021. • Given the increased access anticipated in these sites, it would be helpful to have a sense of how this fits into the wider picture of reducing activity in acute sites. It would also be helpful to have an understanding of how InHealth fits into this work • Assurance was given that the system has strong oversight of the bigger picture as a result of the creation of the Diagnostics Board and therefore these proposals are consistent with the wider efficiencies sought across the ICS • Discussions have taken place with the Estates Team about the proposed locations to ensure that there was no duplication • The choice of locations is intended to maximise accessibility but it is recognised that they won't suit everybody - subject to funding it is likely that extra sites will be opened in future years as and when needed

2.1.3	It was confirmed that CDHs are intended to provide diagnostics in the context of clinical management, so there will be clinicians working on these sites, rather than just 'machinery'. The Strategy and Commissioning Committee **NOTED** the report.
2.2	**Contract and Activity Report**
2.2.1	Mark Eaton provided an overview of the Contract and Activity Report, highlighting the following points: • Planning guidance has now been received for H1 (i.e. Quarter I and Quarter 2 of 2021/22). Block arrangements will continue with NHS providers with values set centrally, based on activity for Quarter 3 of 2020/21. New contracts will need to be put in place where they are not centrally set, such as for some of the independent sector • It is likely that arrangements for the second half of 2021/22 will 'roll over' what is currently in place for the first half but this is yet to be confirmed • The draft Operating Plan has been submitted and the final submission is due on 3 June 2021 • There has been consultation regarding proposed changes to contracts and it looks highly unlikely that there will be a return to the previous Payment By Results regime. The new arrangement is likely to be a mixture of block contracts and an aligned payment and incentive scheme, with an efficiency factor built in and CQUIN (Commissioning for Quality and Innovation) forming part of the block arrangements • Primary care referrals remain low • Although the elective recovery performance is below the Phase 2 target, it should be noted that the Phase 2 plan was submitted prior to 'Wave 2' of the pandemic. NHS England subsequently set new trajectories in their Spring Plan and the CCG is above target in these new trajectories across all areas • Outpatient treatment is increasingly becoming 'virtual' by default, subject to advice, guidance and triage • NCL has been selected by NHS England as an accelerator site – this means that NCL is aspiring to deliver 120% of the baseline for 2019/20 which will have a significant impact on waiting times • NCL was required to respond to a series of Mental Health Key Lines of Enquiry relating to areas such as recovery and sustainability and this was well received by NHS England • An additional £7m cost pressure for mental health was identified as part of the Operating Plan submission but is anticipated that this will be mitigated by slippages in other parts of the £32m additional investment into mental health services. • Out of area placements are a challenge in Barnet, Enfield and Haringey and a range of actions are underway to address this • The CCG is above target for Early Intervention in Psychosis and IAPT, and referrals are increasing • Inpatient stays for patients with Learning Disabilities and autism are below plan, which is an extremely positive sign • Community Service referrals now stand at 85% of pre-Covid levels, although MSK, podiatry and respiratory services are below 80% of previous activity • Waiting times remain challenging – over 1700 people have been waiting over 52 weeks for treatment and a lot of work is underway to reduce this, while prioritising clinical need • According to Public Health estimates there are 10,000 people in NCL suffering from post-Covid syndrome, although to date only 1000 have been identified, so work is taking place to reduce this prevalence gap • Critical care occupancy has reduced to 72% • There has been a significant increase in A&E attendances over the past two weeks, which is consistent with what is also happening in NEL and NWL. The drivers are multifactorial and need further investigation. However, admissions remain low and comprise of people with low acuity urgent care needs. • The previous arrangements with the independent sector have now ended and 2021/22 activity plans are in the process of being agreed, although these plans are likely to be revised in light of the assumptions of the Accelerator Plan • The contract with InHealth is due to expire in March 2022 and an options paper is being developed

	• The Continuing Healthcare assessments backlog has been cleared and the CCG is now dealing with subsequent appeals • Patient Transport Services represent a monthly £500K cost pressure, caused in part by changes to guidance and social distancing requirements • The Covid Vaccine Programme continues to be successfully implemented – currently 50,000 – 80,000 doses are being delivered weekly.
2.2.2	The Committee then discussed the report, making the following comments: • The workforce pressures on the vaccination programme were acknowledged. At present the system needs 40 extra registered nursing professionals per day and Trust CEOs are being approached to support this. As the system prepares for the anticipated 'booster' campaign in the autumn, it will need to out in place an immunisation response, which builds on the learning from the flu and Covid programmes. Discussions are taking place with NHS England about developing this comprehensive approach to vaccinations • It was confirmed that the number of non-elective admissions is down 30% but the average length of stay is going up because patients with low-acuity needs (who would previously have stayed in hospital for up to three days) are not currently being admitted • It was acknowledged that engagement with patients will need to be carried out in a few weeks' time to gain more intelligence about the drivers for increased A&E attendances • It was agreed that clarification would be sought from the Medicines Management Team outside the meeting about hospitals prescribing for 28 days after discharge. • It was confirmed that there are currently 11 ongoing CHC appeals but this number is likely to increase over time • It was confirmed that the trajectory for out of area placements by BEHMHT was being recast in the operating plan which had just been submitted. There has also recently been some welcome mutual aid between BEHMHT and C&I NHS Foundation Trust to avoid potential out of area placements • Case finding work is taking place with primary care and Community Services to identify patients with post-Covid syndrome and an update on this will be brought to a future meeting.
2.2.3	The Strategy and Commissioning Committee **NOTED** the Month 11 Contracts and Activity Report.
2.2.4	Action: Mark Eaton to speak to the Medicines Management Team about hospitals prescribing for 28 days after discharge.
2.2.5	Action: Sarah Mansuralli to bring an update on the case finding work with primary care and Community Services to identify patients with post-Covid syndrome to a future meeting.
2.3	**Barndoc Cessation and Transfer of Services**
2.3.1	Eileen Fiori provided an overview of the paper, highlighting the following points: • The Committee was being asked to ratify the decision taken at the recent Governing Body Seminar on the cessation and transfer of Barndoc services, including the Referral Management Service, the APMS service and the Out of Hours service • The CCG continues to work closely with Barndoc, through a Transition Exit Group, comprising relevant directors to ensure the safe and secure transition of services by the end of June 2021.
2.3.2	The Committee then discussed the paper, making the following comments: • Assurance was given that communications around the changes have been jointly drawn up by Barndoc and the CCG Communications Team and have been distributed • Sarah Mansuralli had briefed Councillor Pippa Connor, Chair of the NCL Joint Health Overview and Scrutiny Committee, regarding the transfer of services as a result of a provider decision to cease trading • It was confirmed that the Cricklewood Health Centre site would be placed under caretaking arrangements and the staff would transfer under TUPE arrangements to the caretaker organisation

	• Assurance was given that the engagement strategy would highlight the need for primary care staff to remove any contact details which are now out of date.
2.3.3	The Strategy and Commissioning Committee **RATIFIED** the decision of the Governing Body meeting on 29 April 2021 that the following arrangements are to be implemented: **RMS**: • With the oversight of the weekly CCG/Barndoc exit meeting, staff will be transferred into the COO/Borough management structure: • With the support of its HR advisors, the CCG will follow legal & HR recommendations that Barndoc admin staff follow a TUPE process that retains their existing pay arrangements; • Commencement of a CCG-wide process of recruiting GPs to secure a continuation of the GP clinical triage service. **APMS** service: • Following re-procurement, this will transition to a new provider of services under the oversight and accountability of the Primary Care Committee **Out of Hours service**: • The CCG will have oversight of termination of the sub-contracting arrangements between Barndoc and the sub-contracting arrangements will cease, with LCW assuming responsibility for the provision of this service in accordance with a specification to be developed by the CCG. • This will be overseen by the UEC Think 111 First Programme via the Programme Director for Integrated Urgent Care. **Educational support:** • The process for securing alternative provision will continue to be overseen by the Primary Care Commissioning Committee.
2.4	**Borough Contract Consolidation Programme**

2.4.1	Mark Eaton provided an overview of the paper, highlighting the following points:
	• The Borough Contract Review (BCR) process is concerned with maintaining control of the 514 contracts inherited by the NCL CCG from the 5 legacy CCGs
	• The paper provided an update on the two remaining Phases of the BCR:
	  ○ Phase 4 which focuses on all contracts that are due to expire in 2021/22 (or beyond) that have not already been covered by the previous phases
	  ○ Phase 5 which will focus on consolidating contracts, tackling inequalities in provision, securing efficiencies and improving out of hospital care and provision.
	• The contracts have been divided into 13 main categories. Additional sub-categories for children's services, mental health and CAMHS are in the process of being created
	• It is currently planned that a pipeline of probable procurements will be taken to the Procurement Committee in June 2021, setting out the proposed prioritisation
	• Reviewing value for money will be a key part of the analysis as it is estimated that NCL currently overspends on average £71m across 29 planned care specialties compared to the rest of London. As part of the consolidation phase, consideration will be need to be given to how Out of Hospital investment can be better targeted to deliver improved outcomes
	• The CCG also overspends on elective activity, including general medicine, cardiology and ophthalmology when there are community services which should be reducing this activity
	• The proposals taken to the Procurement Committee will be evidence-based and prioritise the areas that the CCG wants to either re-procure or potentially decommission.
	• The decisions taken by the Procurement Committee will be brought to the Strategy and Commissioning Committee for noting following discussion at the Procurement Committee.

2.4.2	The Committee then discussed the paper, making the following comments: • Assurance was sought that decisions taken on Borough contracts will be considered in the wider context of the review of Community Services which is currently being undertaken

	• In response it was noted that there is a direct correlation between historic under-investment in Community Services and excess spend in Secondary Care and this is a particular issue in Barnet and Enfield. The reviews are primarily focused on the main national contracts • Assurance was given that the review is mindful of the need to avoid destabilisation. The emphasis is on 'doing the right thing' in terms of aligning investment and outcomes. • Once the Procurement Committee has approved the sequence which will be followed, commissioners will seek the views of clinicians, providers and patients on the process which will be clinically-led • It was confirmed that all contracts which have any degree of NHS funding, including Section 75 agreements, are 'in scope' and therefore a lot of work is taking place with the Directors of Integration to determine what lies behind various schemes before ultimately evaluating their effectiveness • The reviews of Mental Health and Community Services will help to determine the level of 'wraparound' support in each borough • This work is an essential part of due diligence prior to moving into the ICS. • The burden of contact management is a significant challenge for staff and therefore consideration will need to be given as to how this could be reduced as part of the move to a more strategic commissioning approach.
2.4.3	The Strategy and Commissioning Committee: • **NOTED** the progress on Phase 4. • **AGREED** the proposed approach to Phase 5 for each of the 13 individual categories.
3.	**Strategy**
3.1	**Children, Young People and Maternity Services Review**
3.1.1	Anna Stewart provided an overview of the paper, highlighting the following points: • The proposed work programme was being brought in draft form for comment • Extensive stakeholder engagement has taken place around the scope and governance of the transformation programme, including meetings with the Chief Executives of all the acute trusts and regional and network partners in order to develop an approach that carries wide system support before embarking on wider engagement following the formal launch • The programme has two main specific aims: o To create an ICS strategic change programme focused on children, young people's acute planned and emergency pathways, and maternity and neonatal services. o To provide a single ICS governance route for oversight of the strategic change programme • The key drivers for the review include o The national Ockenden Report providing a clear call for change in maternity services o NHS England advising that the current configuration of services in NCL does not meet the challenge of current, and future, required standards of care. o The consensus amongst the clinical and managerial leadership across providers that the pre-Covid neonatal and paediatric services need to change to meet the challenges of population health inequalities.
3.1.2	The Committee discussed the report, making the following comments: • It was agreed that further thought would be given, within the boundaries of the review, to the need to commission age appropriate environments for the provision of complex care • In response to a query about the lack of a Community Services representative on the Children, Young People and Maternity Programme Board, it was noted that the intention is to keep size of the Board relatively small but this point warrants further consideration. It was also noted some of the providers on the Board have 'dual roles' as they also provide Community Services

	• In response to a query about the rationale for homelessness being out of the scope of the review, it was agreed to that more work should be undertaken to establish the scale of the issue in order to determine what the response should be as part of the review.
3.1.3	The Strategy and Commissioning Committee **NOTED** the draft programme approach for the Children, Young People and Maternity Services Review.
3.1.4	Action: Anna Stewart to review the scale of the homelessness issue in order to determine how the review should respond to this challenge.
3.2	**Update on Strategic Review of Community Services**
3.2.1	Jo Murfitt provided an overview of the review, highlighting the following points: • Carnall Farrar have been commissioned to carry out a strategic review of Community Services, which is running in parallel with a separate review of Mental Health Services • The review will be undertaken in three stages, beginning with data gathering • Following a workshop discussion of the initial baseline analysis, four key themes have been identified as part of the case for change: o Addressing health inequalities o Optimising use of resources o Further development of relationships and integrated working o Organisational form should follow function • The workshop also considered design principles as set out in the paper under five main headings: o Patient engagement and satisfaction o Core offer development o Ways of working together o Sustainability o Population and individual outcomes • Feedback on the above themes and design principles would be welcomed from Committee members. It is planned that a series of service options will be finalised by the beginning of September.
3.2.2	Frances O'Callaghan then made the following additional points: • If it had not been for the impact of Covid, this would have been the first major piece of work undertaken by the merged CCG as it is key to the CCG's role in terms of strategic commissioning and reducing health inequalities • There has been an extremely positive response from the system. There is an understanding that the way that money is spent will have to change, even if it will inevitably involve painful decisions. Although the tension between ICS level, NCL level and Boroughs has been repeatedly raised in conversations, it has been raised in a spirit of mutuality and shared understanding and a recognition that this tension will be worked through • The work of everybody involved to date was commended.
3.2.3	The Committee discussed the report, making the following points: • The need to also consider the social care aspects of the service which have to be delivered in the community was highlighted • It was suggested that addressing the unintended consequences of Covid, including the impact of 'long Covid' warrants a separate heading • It was noted that the review needs to be clear about the need to focus on services being designed around the patient while also ensuring that what is in place to deliver this is sustainable • It is important that both reviews are used to build integration at the right level and develop a more population health-based approach to manage conditions which require a more integrated approach • The priority that the CCG is giving to Community Services was welcomed.
3.2.4	The Strategy and Commissioning **NOTED** the work of the review to date.

3.3	**Inequalities Investment Fund**
3.3.1	Sarah McDonnell-Davies introduced the paper, highlighting the following points: • As part of the CCG's response to the Planning Guidance for H1 2021/22, which places an increased focus on improving outcomes and reducing inequalities, pre-planning round conversations took place with partners to identify funding to demonstrate the system's commitment to supporting inequalities through the Borough Partnerships. • An initial £2.5m Inequalities Investment Fund has been agreed for the first six months of the year, with potentially an additional £1.25m subject to significant progress being demonstrated • The Chief Finance Officers have agreed that there will be a recurrent £5m fund from 2022/23 • This represents a significant opportunity to work closely with local communities and the voluntary sector to co-produce solutions to the gaps • Consideration is being given to how this initiative will be formally launched.
3.3.2	The Committee discussed the paper, making the following points: • The focus on long-term funding in the initiative was welcomed • The need to ensure that small grass-roots organisations are aware of the funding opportunity and how to apply was highlighted • The creation of the Investment Fund was welcomed but it was suggested that in an ideal world the overall fund should be even higher in order to have a much greater impact on the ground • It was questioned whether there is scope to increase the extra £1.25m funding available in the second half of the year to help make things more recurrent when moving into 2022/23 • The need to ensure that there is sufficient capacity to monitor and track any proposals that are approved was acknowledged but this should also be proportionate in terms of the amount of funding involved • The need to avoid overlooking smaller 'sub-groups' such as the homeless and the profoundly deaf was highlighted • It was acknowledged that the overall funding is relatively small in the context of the overall budget but it represents a cultural shift in the system, and although it is a fairly blunt instrument, this approach will become more sophisticated over time.
3.3.3	The Strategy and Commissioning Committee **AGREED** the proposed approach to the Inequalities Fund.
4.	**Risk**
4.1	**Risk Register**
4.1.1	Sarah Mansuralli provided an overview of the Risk Register, highlighting the following points: • Two new risks had been added since the last meeting: COMM18 - *Failure to have a single NCL CCG IVF policy* and AO1 - *Failure to Establish Appropriate and Effective Arrangements for the New ICS Organisation at pace* • The score for the financial risks arising from contracts had been reduced as a result of the CCG now having a balanced plan in place for the first six months of 2021/22 • The data quality risk had been mitigated, partly by the creation of an elective recovery dashboard, along with dashboards for Mental Health, Community and Children and Young People Services.
4.1.2	The Committee then discussed the Risk Register. It was agreed that it would be more appropriate for the IVF Policy risk to be renamed to refer instead to the Fertility Policy.
4.1.3	The Strategy and Commissioning Committee **NOTED** the report.
5.	**Any Other Business**
5.1	Charlotte Benjamin welcomed the fact that a large amount of much-needed work is taking place on the GP website but suggested it would be helpful if the GP Website work could be more

	aligned to the intelligence obtained through the work of Strategic Commissioning in relation to contracts.
5.2	It was agreed that further thought would be given to how this could be done offline with a verbal update back to the Committee in July.
5.3	Action: Sarah Mansuralli to review arrangements offline and report back to the next Committee.
6.	**Date of Next Meeting**
6.1	Thursday, 15 July 2021

North Central London Clinical Commissioning Group

North Central London Clinical Commissioning Group
Strategy and Commissioning Committee
15 July 2021, Action Log: Part 1

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
10.9.20	SCC10	**NCL Evidence Based Interventions and Clinical Standards Policy – Para. 5.1.6** To bring a progress report to a future meeting on the alignment of the networks which has already taken place, as well the suggested enhancements on engagement, a more structured EQIA process and ensuring that the borough primary care voice is heard through the networks.	Penny Mitchell	July	This is on the agenda for the meeting on 15.7.21.
11.3.21	SCC16	**Month 9 Contract and Activity Report – Para 2.1.2** To provide an update at a future meeting on the work of the new collaborative performance monitoring groups.	Ed Nkrumah	July	This is on the agenda for the meeting on 15.7.21.

11.3.21	SCC17	**NHS111 Contract Extension – Para 2.2.2** To discuss the financial elements of the NHS111 contract extension outside the meeting and bring back a report on future years contracting arrangements.	Anthony Browne/ Alex Faulkes	July	This is on the agenda for the meeting on 15.7.21.
11.3.21	SCC19	**Risk Register – Para 5.1.2** To ask the Governance team to reconsider the descriptor for the primary care risk and to also consider whether a broader workforce risk should be added as part of the next round of reviews.	Sarah Mansuralli	July	Sarah Mansuralli to relay recommendation about wider workforce risk to the Chair of the NCL People Board.
13.5.21	SCC20	**Action Log and Matters Arising – Para 1.6.6** To provide an update on the Memorandum of Understanding with CNWL regarding the CHC transfer.	Mark Eaton	July	Staff for the service transferred from CNWL to the CCG from 1 April 2021. As Block Contracts cannot be varied, the arrangement for covering the costs is being undertaken via a reduction in the monthly block payment to CNWL equivalent to the costs transferred to the CCG. A reconciliation and contract variation will be undertaken at the first available opportunity (likely to be Q1 2022/23) with an MoU covering the intervening period.
13.5.21	SCC21	**Contract and Activity Report – Para 2.2.4** To speak to the Medicines Management Team about hospitals prescribing for 28 days after discharge.	Mark Eaton	July	Under the current NCL Medicines Optimisation Network Prescribing Guidance, patients should be discharged from hospital with a minimum of 14 days' supply of prescription(s), unless the full course of treatment is less, a smaller supply is deemed appropriate on mental health grounds, or after assessment it is clear the patient already has appropriate supplies at home. To prescribe for 28 days would incur additional costs to the system that are as yet unquantified..

13.5.21	SCC22	**Contract and Activity Report – Para 2.2.5** To bring an update on the case finding work with primary care and Community Services to identify patients with post-Covid syndrome to a future meeting.	Sarah Mansuralli	September 2021	This report will be brought back to the September committee meeting.
13.5.21	SCC23	**Children, Young People and Maternity Services Review – Para 3.1.4** To review the scale of the homelessness issue in order to determine how the review should respond to this challenge.	Anna Stewart	November	An update will be brought to the meeting on 11.11.21.
13.5.21	SCC24	**Any Other Business – Para 5.3** To arrange for a paper on the development of the GP website to be brought to a future meeting.	Sarah Mansuralli	July	Sarah Mansuralli will review arrangements offline and provide a verbal update at the July meeting.

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	Month 12 Contracts and Activity Report	**Date of report**	6 July 2021	**Agenda Item**	2.1
Lead Director / Manager	Sarah Mansuralli, Executive Director of Strategic Commissioning	**Email / Tel**		07557 319123 sarah.mansuralli@nhs.net	
GB Member Sponsor	Not applicable.				
Report Author	Mark Eaton Interim Director of Contracts and Strategic Programmes	**Email / Tel**		07841 464916 mark.eaton1@nhs.net	
Name of Authorising Finance Lead	Simon Goodwin Chief Financial Officer	**Summary of Financial Implications** There is a financial risk associated with PTS outlined in the paper (slide 67),			

Report Summary	This Month 12 Contracts and Activity Report outlines the latest view of the following:
	• Strategic Commissioning Priorities updates
	• Elective Recovery
	• Update on Operational Planning Guidance & NTPS
	• Overview of the NHS Standard Contract for 21/22
	• Community and Mental Services Reviews
	• Service Updates on
	  ○ 111
	  ○ Primary Care Referrals
	  ○ Acute Care (including Elective Recovery)
	  ○ Community (including Recovery)
	  ○ Mental Health (including Recovery)
	  ○ Independent Sector (including InHealth)
	• CHC update
	• Borough Contracts
	• PTS updates
	• Vaccination Programme update
	• Inequalities Fund				

Recommendation	The Strategy and Commissioning Committee is are asked to: • **NOTE** the Contracts and Activity Report • **PROVIDE FEEDBACK** on any aspects they feel should be explored in more detail in the M12 Report and/or actions they feel need to be taken that are not already covered in the attached.
Identified Risks and Risk Management Actions	See Body of Report.
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.
Appendices	None.

NHS
North Central London
Clinical Commissioning Group

Month 12 Contracts & Activity Report Strategy and Commissioning Committee

June 2021

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Section 1: Executive Highlights

1.1 Executive Summary

North Central London
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General Contract & Finance Management Issues
The data contained in this pack mainly covers the period prior to 31 March 2021 and therefore reflects the impact of the second COVID wave. Local data shows that A&E attendances remain lower than historic levels with peaks in Critical Care throughout the year but it is clear that subsequent to the dates within this report that actual A&E activity has returned to pre-COVID levels albeit admissions have remained low indicating lower acuity attendances.

NCL ICS Focus meeting with NHSE - April 2021
A meeting focused on the 'Spring Plan' and Recovery was undertaken in April with NHSE focusing on four areas; Mental Health (See Slides 53-56), Elective Recovery and Protection of Elective Capacity during a 3rd wave (See Slides 37 onwards) and a Vaccination Programme Update (See Slide 69). The system has received positive feedback on the progress to date on this workstream.

NCL Bid to become an 'Accelerated System' for Elective Recovery (Slide 21)
The NCL Accelerator Elective Recovery (AER) Funding Access business case was submitted on the 19 May 2021 and confirmation has been received for the agreement of the funds. As part of the Elective Recovery programme, NCL has been designated as one of the national Accelerator Systems where additional funding of circa £20m is being made available. The aim is to increase recovery activity to 120% of baseline (19/20) by July 2021 focusing on five workstreams: Extended Hours Working, Outsourcing within the NCL Footprint, Improving Utilisation of Independent Sector Capacity, Enhancing System Demand Capabilities and creating an NCL wide Patient Tracking List (PTL) system.

Elective Recovery (Slide 36)
The expectation in the Phase 3 Guidance was that NCL CCG would achieve 100% of 2019 activity for Outpatient attendances & follow ups (face to face or virtually) by September 2020 and by October 2020 achieve 90% of 2019 activity for Electives, Day Case and Outpatient procedures and 100% for MRI, CT and Endoscopy. However the Elective Incentive Scheme paused week commencing 20 December 2020 in light of significant increase in COVID admissions associated with wave 2. National trajectories were then refreshed from 1 April 2021 with the following new trajectories applied to Electives, Daycase and Outpatients: 70% for April 2021, 75% for May 2021, 80% for June 2021 and 85% for July to September 2021. For the week ending 30 May 2021, NCL trust recovery activity positions were as below (due to the Accelerator Programme):

- Elective, **109%** against a target of 75% and
- Outpatients, **112%** against a target of 75%.

The Government has provided an additional £1bn of funding nationally for elective recovery in 2021/22. As detailed within Operational Planning guidance issued 25 March 2021, there will be no reductions in funding if these targets are not achieved, but additional funding available where there is over achievement.

1.1 Executive Summary

North Central London
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Elective & Day Case Activity (Slides 37)
At week ending 30 May 2021, NCL elective inpatient activity was at 109% of 2019/20 levels and outpatient activity was at 112% of 2019/20 levels. Note: for elective inpatient activity, this level is distorted by the May bank holiday period and underlying performance is around 100% of business as usual.

Outpatient Activity (Slides 38-39)
Outpatient activity has been ramping up in more recent weeks after a dip in activity seen during the spring bank holiday periods. At week ending 30 May 2021, NCL is at 112% of their equivalent activity week totals seen last year (excluding working days comparison). Virtual Outpatient appointments reduced slightly in Month 12 whilst face to face increased. The Month 12 year to date position shows a 23% reduction in overall outpatient activity compared to Month 12 year to date 2019/20 across the four main providers.

111 (Slide 34)
NHS 111 has shown a recovery in March 2021 subsequent to a notable reduction in February 2021 following a previous a sharp rise over the latter part of December 2020 and January 2021. The peak of NHS 111 and IUC activity during the first wave in March 2020 remains high with steady and significant increases in calls was observed up until the beginning of January 2021. It is anticipated that higher volumes of calls than historically seen will continue with the implementation of the Think 111 First – Help Us to Help You programme, which is a national initiative aimed at reducing unheralded A&E attendances.

Primary Care Referrals (Slide 35)
Routine GP referrals to acute services remain below pre-pandemic levels, rising significantly from April to October 2020 followed by a steady decline from late November to January 2021. Local data from NCL Referral Support Service shows referral rates have increased since January 2021 and in March 2021 are now at nearly 70% of pre COVID-19 levels.

1.1 Executive Summary

North Central London
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Critical Care (Slide 42)
By the end of May 2021, the critical care bed base across NCL reduced from 306 beds to 188. Occupancy of total open Critical Care beds has reduced to 59%. Despite creating extra capacity, the complexities associated with infection control management, as well as staffing challenges has meant that at times, critical care beds and wards have had to temporarily close. This affects occupancy figures across general and acute beds as well.

A&E Attendances (Slide 43)
A&E attendances remained below pre-COVID levels but are recovering and were at 95% in May 2021 compared to the pre-pandemic level in May 2019. At the height of the COVID pandemic, NCL A&E attendances fell to below 50% of pre-COVID activity levels. A&E attendances began to return towards pre-COVID levels between May and September 2020 before declining during the second wave. Year to date A&E attendances for 2020/21 were 28% lower than in 2019/20. At the same time, non-elective admissions also decreased by 29%.

Out of Sector (Slide 44)
Month 12 year to date out of sector activity was 24% lower overall compared to Month 12 year to date 2019/20. Outpatient Non Face to Face is the only POD to report an increase; 279% increase when compared to the same period last year. Outpatient Procedures (-55%) followed by Day Case (-47%) and Elective (-50%) reported the most significant variation, a trend reported since October 2020/21.

Community Services (Slides 45-51)
As part of the Phase 3 recovery, the system has a primary requirement to restore non-COVID activity to usual levels where this is clinically appropriate. To support this ambition, NCL community services have created a new Community Recovery Dashboard. Secondary objectives include identifying potential challenges with specific services, providing early warning of changes in demand and referrals and identifying any risks in relation to service waiting times, with the aim of ensuring parity of reporting across Community, Acute and Mental health Services. In addition, Recovery Plans for both Community Adults and Community CYP have been produced in partnership with providers and reviewed by the Clinical Advisory Group (CAG).

1.1 Executive Summary

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Mental Health Recovery (Slides 52-57)
NCL CCG has established a programme for transforming local mental health services as an Integrated Care System (ICS) with 5 Key Work streams detailed later in this pack. The CCG will receive funding allocation to meet the Mental Health Investment Standard (MHIS). Providers and commissioners have worked collaboratively to agree the allocation of the investment to key Long Term Plan priorities to implement sustainable improvements in mental health care. In addition, systems must progress towards their LTP goals through use of their available SDF and additional funding secured through the Spending Review to aid recovery of services from COVID-19. Specifically, a Mental Health Delivery & Recovery Plan has been developed with providers, agreed via CAG and sent to NHSE as part of the System Review Meeting.

Independent Sector Activity (Slide 58-64)
As of 31 March 2021 all NHSE contracts ceased, along with HM Treasury funding for these. Going forward into 2021/22 local commissioners and NHS trusts will assume responsibility for negotiating, managing and funding all new agreements.

Following initial contracting round meetings held in February 2021 between NHSE and NCL Independent Sector Provider leads, the local system identified a mix of NHS standard sub contracts for NHS resilience/recovery activity and contracts for CCG e-RS/Choose and book activity would be required, commissioned via the Increasing Capacity Framework Agreement (ICFA) and other routes. The framework supports award by means of either ‘direct award’ for a maximum of 6 months (with no option to extend) or ‘mini competition’ for awards for longer periods up to 4 years.

The Spring Elective Recovery Plan (known as the Baseline Plan) was submitted to NHS England (NHSE) on 12 March 2021, this covered domains 1-3 only, i.e. staff well-being, de-surge critical care and elective recovery; with an expectation that domain 4, a possible wave 3 surge, would follow later.

As at week ending 23 May 2021 utilisation of independent sector provider sites against submitted baseline plans was below plan for electives, day cases and outpatients. The Operational Implementation Group and Independent Sector Provider Sub Group continues to work with surgical hubs, acute trusts and independent sector providers, through improved coordination and communication to enhance utilisation and prioritisation and expand the capacity of daily theatre lists through June 2021 and beyond.

1.1 Executive Summary

North Central London
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Continuing Healthcare (CHC) (Slide 65) Across NCL key internal reviews are starting to look at opportunity areas to work more seamlessly across borough facing teams, to flex resources to match demand with capacity and utilise specialist clinicians. Recruitment is ongoing for vacancies in permanent posts in CHC. In addition, CHC service for Camden has recently transferred across to NCL CCG (effective 1 April 2021). NHS England oversight and monitoring for CHC has recommenced. NCL CCG is now benchmarked against other London CCGs and is required to submit trajectories to NHSE on recovery by the 24 June 2021. The key metric is the number of Decision Support Tools (DSTs) completed within 28 days and the number outstanding over 12 weeks.

Borough Contracts Review (BCR) (Slide 66)
This programme has now entered Phase 5 which is focused on the Consolidation and Equalisation of contracts across NCL. This work will occur in parallel with the Community and Mental Health Service Reviews and where possible align to our work on the core offer with our NHS Providers. The BCR will focus on other contracts outside of the main Service Level Agreements. The aim is to reduce the dependence on Single Tender Waivers, realise efficiencies where possible to consolidate contracts which also supports reducing the burden of contract administration and management.

Patient Transport Service (PTS) (Slide 67)
On 26 May 2021 NCL CAG considered a proposal to stand down social distancing requirements on PTS vehicles in line with government plans to end national restrictions (at that time planned for 21 June 2021). CAG did not endorse this plan and indicated a preference to await wider NHS guidance on the matter. CAG also did not endorse a proposal to stand down transport to Clinically Extremely Vulnerable (CEV) patients who did not otherwise meet eligibility requirements, although this is in line with the existing guidance. A further proposal will be brought to CAG when there is clarity on the lifting restrictions nationally.

Vaccine Programme Update (Slide 68)
1,500,518 vaccines have so far been delivered within NCL, comprising 897,736 first doses and 620,782 second doses. 1.1m of these doses have been given by primary care and pharmacies. NCL has begun offering vaccines to all adults aged 18 or over. Further details can be found on Slide 68.

Inequalities Fund (Slide 69-71)
NCL have committed an initial £2.5m to tackle Borough inequalities. This will be followed up by a further £1.25m for H2 21/22 with the fund becoming recurrent at £5m per year from 22/23 onwards. The schemes covered by the initial funding will be ratified by an EMT Panel and then by the Population Health Committee with further work to be done on metrics and contracting to enable schemes to mobilise.

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2.1 Commissioning Strategy

Commissioning Strategy - Building the Population Health Strategy & Outcomes framework

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NHS Planning Guidance makes it clear that tackling inequalities in outcomes at the level of entire populations for an ICS is going to feature strongly in future operational plans. The emerging NCL ICS has already taken proactive steps to tackle inequalities through the NCL Inequalities Fund and will now be developing a Population Health Strategy to address the many and varied unwarranted variations in outcomes and also to tackle the underlying health challenges faced by our diverse community. This will take a data driven approach to focus the on-going work of the ICS to improve the overall health of the population in NCL. Further details about the Population Health Strategy is shown below and on following slides.

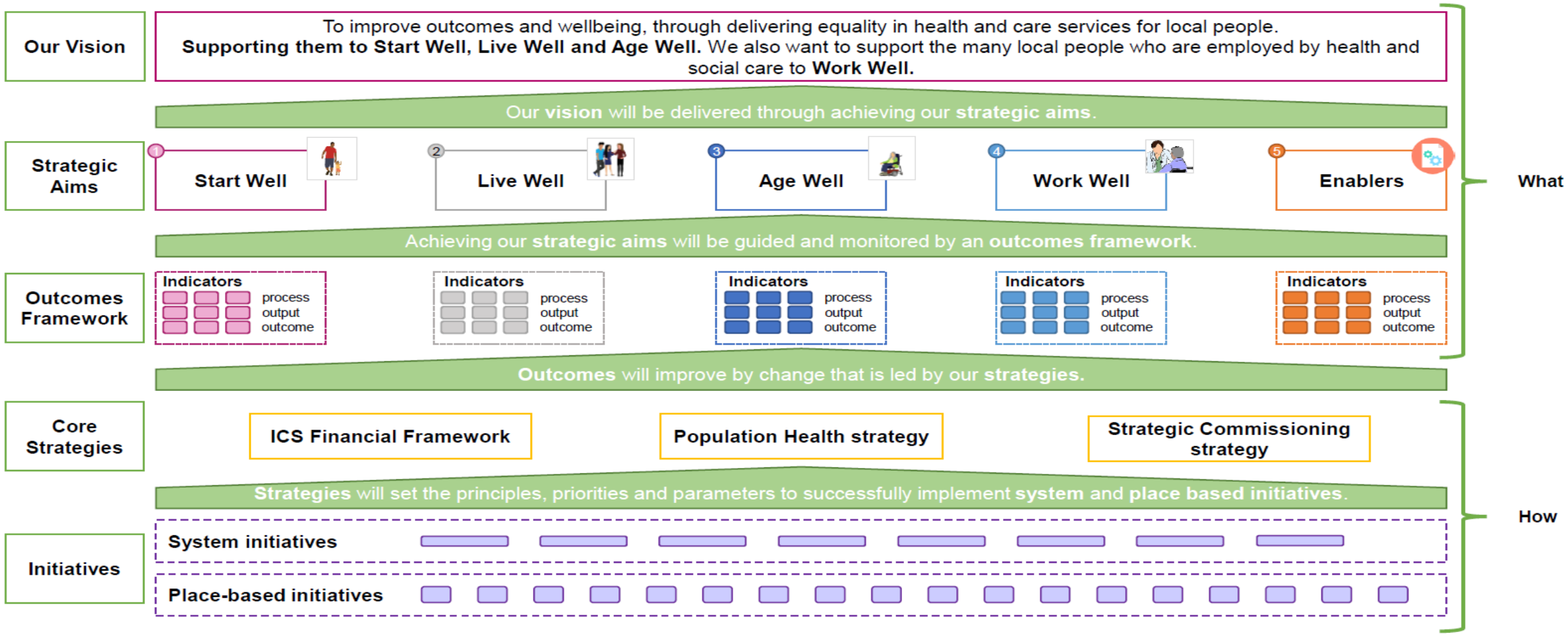
Integrated Care Systems will play a critical role in aligning action between partners to…improve outcomes and tackle inequalities

- The NCL Population Health Strategy is a **core requirement** for the ICS both as set out in Guidance and as demanded by the ICS partners themselves
- We want to develop a Population Health Strategy that is **owned by the ICS** and being implemented as the ICS commences in April 2022 (recognising many aspects of implementation will commence prior to the formal inauguration of the ICS)
- No individual or organisation can build the Population Health Strategy or Outcomes Framework in isolation.
- The Population Health Strategy is about **how we will change what we do and how we will do it**, to deliver improvements in the health and wellbeing outcomes for our residents
- We need to undertake the work that will bring together: data-driven analysis and evidence-based approaches; existing NCL programmes of work; primary prevention priorities; place based priorities & initiatives
- This will enable us to make the decisions we need to **shift resources** to those areas that will have a material impact on the outcomes
- We will need to work in an integrated way at system and place based level to deliver the priorities and programmes that achieve the outcomes

Commissioning Strategy - Building the Population Health Strategy & Outcomes framework

North Central London
Clinical Commissioning Group

The Population Health Strategy supports the achievement of outcomes



Commissioning Strategy - Building the Population Health Strategy & Outcomes framework

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Identifying the requirements of the Population Health Strategy

- The Population Health Strategy will be developed taking into consideration both “bottom up” (from place based priorities and initiatives) and “top down” (from regional & system priorities and requirements)
- It will focus on those areas where we can have the most material impact in the next 1 3 years
- It will need to demonstrate where we are going to truly do things differently particularly in regard to how we will decide where and how resources will be deployed
- It will need to align with other work underway as part of the ICS Development Plan, including the ICS Financial Framework

	Core questions to consider in the strategy	Core elements of the strategy
Population Health Strategy	• What are the current population health needs? • What are the local issues & priorities identified by our communities? • What are we doing already to achieve our outcomes? • How do we want to work together differently to achieve our outcomes? • What are the principles to be utilised to confirm the Population Health priorities? (how do we ensure priorities are sitting at the right level between ICS / ICP / other?) • What are the ICS level priorities (& their supporting objectives) for Population Health? • How will we make decisions about allocating our resources differently to respond to the priorities? • What are the proposals that we deliver to address these priorities? • How are we going to work together and with our communities to successfully implement the changes?	• As-is position • Case for change • Work already underway / making a difference • Approaches / support to enable delivery (e.g. engagement) • Principles • Priorities • Objectives • Proposals to deliver • Delivery plan

Delegation of Specialised Commissioning - National Proposed Approach to Transition

North Central London Clinical Commissioning Group

ICS legislation is anticipated to result in the delegation of specialised commissioning to ICS. In practice this will mean that specialised services will be devolved to ICS with highly specialised services continuing to be commissioned nationally by NHS England. Given the complexities and extent of provision in London, discussions are underway about the best approach but no firm agreements for decision have been reached.

The delegation of specialised services to the North London Integrated Care Systems (ICSs*), comprises of NCL, NWL, NEL and providers: UCLH, RFL, GOSH, MEH, WH, and NMUH in a phased approach from April 2022. There is a national requirement to establish joint committee within each region for delegation by April 2022, with further transfers of activity in 2023 or 2024. Further guidance on the joint committee role, remit and requirements, due diligence and assurance processes to support delegation.

Step 1 – April 22 **Joint NHSE/ICS Committees**	• **Joint committees between NHSE and ICSs** in all 7 NHSE regions established (maybe more than one per region) to provide governance for joint commissioning of all c.70 services. • Joint committees would develop proposals for further delegation of commissioning responsibilities to single or multi ICSs, to be submitted to NHSE/I board for approval. • They would agree tailored support for ICSs so that they can take on responsibilities arising from step 2 and 3
Step 2 – April 22 **Initial services delegated to ICSs**	• **Commissioning responsibility for a group of services handed over to ICSs from April 22**. • Services selected where there is the greatest case for integration with local care pathways through local commissioning. • This group would act as a pathfinder to refine the approach, governance and support offer, ahead of further services being delegated from April 23.
Step 3 – from April 23 **Delegation to ICSs**	• **OPTION 1**: All remaining non-highly specialised services will become the responsibility of ICSs from April 23, either singularly or under multi-ICS joint arrangements. • **OPTION 2:** Further groups of services are delegated to ICSs either singularly or under multi-ICS joint arrangements in April 23, with the remaining services all being delegated by April 24. • Joint committees would make recommendations, and develop underpinning delegation agreements, to the NHSEI Board, which would make final delegation decisions.

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2.2 Elective Recovery

Strategic Plans - NCL Elective Recovery Programme

North Central London
Clinical Commissioning Group

The Operational Implementation Group leads on the oversight of the various strategies for elective recovery and delivery, utilising resources with the NHS and Independent Sector. This includes using the expertise and guidance from specialty clinical networks. There is an opportunity to increase elective activity through establishing high volume surgical hubs including independent sector sites. The Operational Implementation Group discussed the impact of the second COVID surge and how plans could be developed to maintain planned care services as hospitalisations rise.

Proposal

As with other systems in London there is significant pressure on NCL's elective position with a dramatic increase in long waiters since the start of the COVID-19 pandemic. In order to continue to bring down the backlog and reduce the number of long waiters in NCL, we have a five point elective recovery action plan:

1. Deliver **Demand Management model** – with a particular focus on increasing telephone clinical advice and guidance
2. Optimise the use of the **independent sector** under the new procurement framework with more control passed onto the clinical networks where appropriate
3. Expand use of **mutual aid** – both in and out of sector – with cross ICS support in more specialised areas (plastics, vascular and transplants). In sector will increase networked hub activity over the coming months
4. Focus on **transformation and innovation** to improve productivity e.g. AI in dermatology and alignment to GIRFT / Model Hospital principles
5. Bolster system coordination of the above areas with a beefed up **Elective Recovery PMO**, which will work across organisations, including the primary care interface, and networks to optimise system demand and capacity underpinned by a data driven approach.

Data source: NCL Operational Implementation Group

Mutual Aid Transfers Agreement and Guidance

NHS
North Central London
Clinical Commissioning Group

NCL providers are working together to ensure patients prioritised for elective treatment receive this in a timely way, as well as to help trusts with large backlogs of long waiters to shorten overall waiting times for routine conditions during COVID.

The term Mutual Aid refers to one provider offering capacity to another, whether to complete the entire episode of care or provide some elements, be it staff, physical clinical space etc., with the remainder of the care provided by the sending provider.

The approach has been successfully piloted with a number of mutual aid transfers between RFL and others:

- CT to UCLH;
- MRI to Whittington;
- Endoscopy to Whittington;
- Paediatric Maxillo Facial and Paediatric Dental Day Cases to UCLH, and
- Spine Elective Inpatient activity to RNOH.

The next steps will be to set up a NCL Service Transfers Oversight Group that will:

- Monitor and oversee all transfers;
- Ensure that all providers have visibility of transfers that are proposed and have happened;
- Monitor the impact on the Elective Incentive Scheme (EIS);
- Act as first point of escalation for any issues or disputes in agreeing a transfer;
- Ensure the transfers are recorded and reported consistently, and
- Maintain the NCL Service Transfer tracker.

Data source: NCL Operational Implementation Group

Elective Recovery Fund (ERF)

North Central London
Clinical Commissioning Group

A £1bn ERF has been created to support systems to step up elective activity and is designed to ensure that systems are appropriately funded to deliver "***the highest possible levels of elective recovery".*** Systems which achieve activity levels above nationally set thresholds (as compared to 2019/20 activity levels) will be paid through the ERF. Activity levels will be an aggregate of **inpatient and outpatient activity**, be delivered by **NHS and IS providers** and include both **specialised and CCG** activity. The threshold will be calculated using a £ value based on tariff prices in the 2021/22 tariff consultation (plus MFF, specialist top-ups etc). Where there is Outpatient activity without a tariff price e.g. non-consultant led, non face-to-face, these will be priced at consultant led tariff price.

- The value of the scheme will operate **on a monthly basis,** not cumulatively, to provide incentive to schemes that do not achieve in first months. Systems can decide how to allocate the system ERF money.
- The scope of the activity covered will be:
  - elective activity (ordinary or day case), including cancer, with a published tariff price
  - outpatient procedures with a published tariff price
  - outpatient attendances for all TFCs (apart from mental health, maternity and diagnostic imaging) whether consultant-led, non-consultant-led or non face-to-face
- Thresholds have been set nationally and take in to account productivity constraints due to infection control measures, the thresholds are a % of 2019/20 activity values:
  - 70% for April 2021
  - 75% for May 2021
  - 80% for June 2021
  - then 85% from July to September 2021
- For activity delivered between the target thresholds and the estimated funded activity within envelopes (set at 85%), **systems will receive an additional payment at 100% of tariff.**
- **Additional activity above 85% will receive the equivalent of 120% of tariff** to take into account additional pathway costs that are not funded by published tariff prices (for example, critical care costs for some elective procedures).
- **There will be no downside adjustments for activity below the lower thresholds**

Accelerator Funding

North Central London
Clinical Commissioning Group

The NCL Accelerator Elective Recovery (AER) Funding Access business case was submitted on the 19 May 2021 and confirmation has been received for the agreement of the funds. As part of the Elective Recovery programme, NCL has been designated as one of the national Accelerator Systems where additional funding of circa £20m being made available.

The aspiration of this programme is to deliver elective activity projections in excess of the comparable period in 2019/20. Current plans for elective recovery and outpatients are currently 107% to 110% respectively (of the 2019/20 comparable point).

Independent Sector activity is included where Weekly Contracts Reports from ISPs have been validated by Trusts and/or ISP Discharge Summaries used by Trusts has allowed data to flow to SUS. An Independent Sector Plan has now been validated, but may be subject to further change with activity to be confirmed, as well as additional innovative opportunities with the focus on reducing health inequalities and improving overall system benefits.

Whilst the table is a summary of the combined Baseline Recovery Plan and Accelerated Recovery Plan, this is available by Trust, by POD and by speciality to aid monitoring. A future revision to plan, due imminently, will include Independent Sector sites, which will aid tracking and support conversations at Weekly Ops meetings.

As part of the Accelerated Recovery Programme, system partners were invited to submit bids from across the system to support programme delivery for initiatives.

Of the 83 bids received amounting to £31.5m against the accelerator fund, these fall mainly into two categories:

- Short term recovery acceleration: focusing on increasing recovery pace through June and July;
- Medium term transformation: focusing on improving equity of access and reducing health inequalities, as well as supporting wider system resilience in the medium term.

Baseline and Accelerated Recovery Plans

Provider		Activity May	Activity June	Activity July
Royal Free London NHS Foundation Trust	Baseline (ISP Plan Q1)	190	180	180
	Accelerated recovery Outsourced IS Activity	300	300	300
	Baseline ISP Plan + Accelerated Recovery	490	480	480
	% Change	**158%**	**167%**	**167%**
North Middlesex University Hospital NHS Trust	Baseline (ISP Plan Q1)	109	96	96
	Accelerated recovery Outsourced IS Activity	466	955	1,446
	Baseline ISP Plan + Accelerated Recovery	575	1,051	1,542
	% Change	**428%**	**995%**	**1506%**
University College London Hospitals NHS Foundation Trust	Baseline (ISP Plan Q1)	87	91	91
	Accelerated recovery Outsourced IS Activity	95	95	95
	Baseline ISP Plan + Accelerated Recovery	182	186	186
	% Change	**109%**	**104%**	**104%**
Royal National Orthopaedic Hospital NHS Trust	Baseline (ISP Plan Q1)	105	81	81
	Accelerated recovery Outsourced IS Activity	0	0	0
	Baseline ISP Plan + Accelerated Recovery	105	81	81
	% Change	**0%**	**0%**	**0%**
Whittington Health NHS Trust	Baseline (ISP Plan Q1)	53	53	53
	Accelerated recovery Outsourced IS Activity	111	159	159
	Baseline ISP Plan + Accelerated Recovery	164	212	212
	% Change	**209%**	**300%**	**300%**
Total NCL	Baseline (ISP Plan Q1)	544	501	501
	Accelerated recovery Outsourced IS Activity	972	1,509	2,000
	Baseline ISP Plan + Accelerated Recovery	1,516	2,010	2,501
	% Change	**179%**	**301%**	**399%**

Data source: NCL Elective Recovery Team

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2.3 Operational Planning Guidance

Operational Planning Guidance for 2021/22

North Central London
Clinical Commissioning Group

On 25 March Operational Planning Guidance was issued which details the financial settlement for the first 6 months only, from 1 April 2021 to 30 September 2021 (referred to as H1).

System allocations are based on actuals as at Quarter 3 20/21. No adjustment has been made for inflation or distribution of growth funding. Systems will need to plan collaboratively to determine the distribution of these resources.

Cash for the month will be paid in month (e.g. April in April) and 0.28% efficiency will be applicable to NHS contracts and deducted from the system allocations during H1.

Plans will implicitly assume the continuation of the Quarter 3 distribution of system funding (comprising allocations, system top-up, COVID-19 allocation and System Development Fund) to organisations and will not include the distribution of new funding. Systems will also be able to access elective recovery funding in addition to the H1 funding which shall also include Independent Sector funding.

CCGs are advised to set aside a contingency of up to 0.5% of their allocation to support risks to expenditure that may not otherwise be mitigated, if not done so then this requires regional assurance.

System operational plans have to demonstrate a balanced position and if there is currently a deficit against Quarter 3 then the plan needs to demonstrate improvement to achieve breakeven against the Quarter 3 levels (links to the ICS authorisation letter on expectation re finance for Commissioners and Providers). It is possible to rebalance organisational funding across the system.

In line with guidance, contracts will not be agreed for the first six months of 2021/22 and payments to NHS providers will remain as block until the end of Quarter 2 2021/22. System allocations are based on actuals as at Quarter 3 20/21.

An Operating Plan and narrative was submitted on the 3rd June 2021. All plans are for 6 months with the exception of mental health for which a full 12 month plan is required within the above timescales.

Mandated terms of the NHS Standard Contract apply and local content in the 2019/20 particulars should continue to apply with the exception of the activity & finance schedules as the block arrangements supersede these. Financial sanctions and CQUINs (included in block values at 1.25%) remain suspended. For non-NHS providers not covered by national agreements commissioners should already have 2020/21 written or implied contracts in place.

Provider Contract and Performance Monitoring

North Central London
Clinical Commissioning Group

Managing performance and quality issues (in the absence of formal levers)

The impact of COVID-19 has led to improved ways of working through system collaboration. Performance metrics monitored in previous years did not reflect the new system demands and expectations seen in 2020/21. There is now a redirected focus on patient safety, outcomes and inequalities. The Quality Team revised its priorities in line with the COVID-19 pandemic. These focused on:

- Patient safety (patient safety specialists and infection prevention and control)
- Effectiveness (e.g. system support for the NCL vaccination programme)
- Patient experience (reducing complaints and experience variation across NCL)

The outcome of NCL system collaboration has resulted in:

- The implementation of mutual aid between providers for service areas such as community beds, elective care and diagnostics e.g. high priority cases (Priority level 2 Surgery) and the use of independent sector capacity for long waiters.
- Workforce e.g. critical care staff transfers
- ICS level meetings between providers and commissioners focussing on services, for example:
  - Referral to Treatment (RTT) Delivery Group
  - Urgent and Emergency Care (UEC) Restoration Board
  - Cancer Performance Leadership Group
  - Operational Implementation Group (OIG)
  - Community Operational Group (COG)
  - Mental Health ICS Programme Board
- System level monitoring via OIG e.g. Phase 3 and Recovery Plans via Operational Implementation Group (OIG) and COG
- Royal Free Steering Group focusing on responding to specific Referral to Treatment challenges

System Development Plans

North Central London
Clinical Commissioning Group

Systems will have access to System Development Funds (SDF) to enable delivery of the Long Term Plan (LTP) priorities. Within the Operational Planning Guidance there is information regarding SDF for a range of priority areas. Systems must progress towards their LTP goals through use of their available SDF and additional funding secured through the Spending Review to aid recovery of services from COVID-19. Systems are required to update their System Development Plans, detailing the work they will undertake to ensure their system has the necessary functions, leadership, capabilities and governance.

Date	Task
Thursday 25 Mar 21	**Publication** • 2021/22 priorities and operational planning guidance • Guidance on finance and contracting arrangements H1 • Implementation Guidance • Technical Definitions
Friday 26 Mar 21	Plan templates issued
Monday 29 Mar 21	System financial planning template & SDF schedules issued
Monday 12 Apr 21	Organisation (provider) capital and cash plan submission
Thursday 6 May 21	• System finance plan submission • Mental Health finance submission **Draft plan submission deadline** • Draft activity, workforce (primary and secondary care) and MH workforce numerical submission • Draft narrative plan submission
w/c 24 May 21	**Non-mandated provider organisation finance plan submission**
Thursday 3 Jun 21	**Final plan submission deadline,** • Activity, workforce and MH workforce numerical submissions • Final narrative plan submission

Mental Health Planning for 2021/22

North Central London
Clinical Commissioning Group

Guidance states it is essential that providers of community and mental health services are appropriately funded by commissioners to carry out the requirements set out in Schedules 2Ai (Enhanced Health in Care Homes) and 2Aii (Primary and Community Mental Health Services). This should be addressed through local discussions to agree 2021/22 local prices and contract values.

Care Programme Approach: With the publication of the Community Mental Health Framework, the Care Programme Approach has now been superseded. For 2021/22, we have therefore removed the specific reference to it from the Contract.

Contract Monitoring Reports for mental health to be mandated as and when this is specified in an Information Standards Notice.

The Service Development and Improvement Plan (SDIPS) - Commissioners are required to agree SDIPS with providers of mental health and learning disability services and with providers of mental health secure services, to set out how the provider will now roll out certified training in restrictive practices to all relevant staff.

Through the H1 financial regime, systems will have access to additional growth funding for mental health services; additional CCG programme funding and service development funding (SDF) to enable delivery of the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) priorities.

CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. For 2021/22, the MHIS requires CCGs to increase their spend on mental health services by at least 2021/22 published allocation growth.

In addition, systems must progress towards their LTP goals through use of their available SDF and additional funding secured through the Spending Review to aid recovery of services from COVID-19.

To support achievement of these objectives, a full-year planning process supported by full-year funding information has been initiated. (Guidance on the 2021/22 financial planning process for mental health services is outlined in Appendix 1. Mental health financial planning guidance).

Systems should ensure that their system plan template and mental health planning return are aligned.

Community Services Planning for 2021/22

North Central London
Clinical Commissioning Group

Funding for demographic growth has been included within system funding envelopes. Access to additional non-demographic growth will be available through SDF for transforming community services, including for accelerating the rollout of the Ageing Well Programme, which comprises three core components; two-hour crisis community health response at home, enhanced care in care homes and anticipatory care.

The latest version of the system finance plan was submitted to NHSE on 15th June including the allocation of SDF to support delivery of LTP priorities. The community element of SDF will be released subject to receipt of plans to accelerate the Ageing Well rollout in line with planning guidance and a commitment by all community service providers to provide complete, timely and accurate data to the Community Services Dataset (CSDS) throughout 2021/22.

The role of community health services is crucial and the ICS should ensure:

- The continued implementation of Lord Carter's recommendations for improving the productivity and efficiency of services delivered in the community.
- All providers, including third and independent sector providers, submit comprehensive data to the Community Services Data Set.
- Progress towards achieving full access to digital mobile services for the community workforce.
- Deliver crisis response services within two hours of referral and reablement care within two days of referral to those patients who are judged to need it. Specifically, for 2020/21, every community provider must as a minimum provide an agreed number of guaranteed two-hour home response appointments to be made available to ambulance and other agreed local services for 1 November 2020 to 31 March 2021.

Related to Community Services Planning, providers and commissioners have agreed a Recovery Plan for Community Adults and Community CYP Services focusing on clinical prioritised areas that have been agreed with the Clinical Advisory Group and shared with NHSE. These plans are being overseen via the Community Operational Group (COG) and progress will be tracked via an integrated Recovery Dashboard that has been developed.

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2.4 NHS Standard Contract & National Tariff Payment System (NTPS) 2021/22

NHS Standard Contract 2021/22

North Central London
Clinical Commissioning Group

The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care, and the Contract (in full-length and shorter-form versions) has now been updated for 2021/22.

The following sets out the interim arrangements for the immediate period from 1 April 2021 (an end date has yet to be announced) and the major contract changes that are required of commissioners and providers in 2021/22.

- There is no requirement for NHS commissioners and Trusts to sign contracts for 2021/22 by 1 April 2021.
- The nationally set financial sanctions in relation to national quality standards no longer apply.
- Where commissioners are commissioning services from non-NHS providers (other than core primary care) from 1 April 2021 onwards, the parties must agree and sign a written contract in the form of the 2021/22 NHS Standard Contract.
- Nationally mandated arrangements for block payments to Trusts will remain in place for the rollover period.
- Where a local contract is not signed by the commissioner(s) and the Trust, but services nevertheless continue to be provided, the nationally mandated terms of the NHS Standard Contract for 2021/22 will apply from 1 April 2021 onwards, and a contract incorporating those nationally mandated terms will be implied as being in place between the parties. Commissioners and Trusts must not vary from the national terms.
- Where there is already a signed multi-year contract in place with a Trust, extending into 2021/22, the payment terms of this contract must be set aside for the rollover period, and payment must instead be made in accordance with the block payment arrangements.
- No 2021/22 CQUIN scheme (either CCG or specialised) will be published at this stage. Block payments to Trusts will be deemed to include CQUIN.
- The 2021/22 Contract retains the same three-part structure (Particulars, Service Conditions and General Conditions) and much of the same detailed content as the 2020-21 version. Therefore, the existing requirements on Providers and Commissioners - including the expectation that all parties will sign a System Collaboration and Financial Management Agreement (SCFMA) – remain in place. The key aim of the SCFMA is to promote collaboration across the NHS organisations with each local system in the delivery of the system financial improvement trajectory for 2021/22 and of the sustainable management of NHS finances in the longer term.
- In nearly all cases, the contractual process of financial reconciliation will now happen quarterly, rather than monthly. Monthly reconciliation is now only required for non-NHS providers with an Expected Annual Contract Value of zero, when no regular upfront payment is made.

Data source: https://www.england.nhs.uk/nhs-standard-contract/21-22/

National Tariff Payment System Guidance 2021-2022

North Central London
Clinical Commissioning Group

- The proposed National Tariff Payment System for 2021/22 introduces new “Aligned Payment and Incentive” (API) rules which apply to:

  - All CCG-Trust relationships within the same ICS.
  - other CCG-provider relationships with an Expected Annual Contract Value of more than £10m (excluding contracts awarded under the Increasing Capacity Framework).
  - all specialised services commissioned from providers by NHS England.
  - other NHS England directly commissioned activity with an Expected Annual Contract Value of more than £10m.

  - A **fixed** element of payment expected to cover funding for an agreed level of activity, including:
    - the costs of delivering services within the system plan.
    - agreed levels of Best Practice Tariff (BPT) performance.
    - some high cost drugs and devices and other items currently excluded from national prices, such as excess bed days.
    - 1.25% to be added to reflect assumed full attainment of CQUIN metrics.

  - A **variable** element to support elective activity and to reflect achievement of Best Practice Tariffs and CQUIN criteria:
    - Activity over or under a baseline for elective activity, set out in the agreement, would be paid/deducted at 50% of national or unit prices.
    - BPT attainment above or below that assumed as part of the fixed element would be paid/deducted as per the published BPT rules.
    - CQUIN indicator attainment less than 100% (assumed as part of the fixed element) would mean payment deducted from the provider.

  The combined impact of the tariff changes are differential by region and ICS. The overall impact – driven by the move to Year 3 of the MFF glidepath – is estimated to cause NTPS revenue for NHS providers in the NCL ICS to fall by approximately 0.05% (National average is a 0.31% rise).

Data source: https://www.england.nhs.uk/nhs-standard-contract/21-22/

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2.5 Urgent Emergency Care Priorities and Actions

2.5 Urgent Emergency Care Priorities and Actions

North Central London
Clinical Commissioning Group

Over 40 system leaders including CEOs, Medical Directors, Chief Operating Officers and GP leaders joined a UEC system summit:

- There was a system commitment to:

  a) recognise every part of our system is busy e.g. primary care, EDs, community and

  b) develop system solutions to the problems we are facing

- It was agreed that the following key themes would be prioritised by the system, with work being undertaken to scope how they should best be progressed as a next step:

  1) Redirection – front door triage by senior clinician during times of significant demand
  2) Direct booking into extended access hubs to be promoted and facilitated
  3) Review extended access capacity by borough to correlate with key demand peaks (afternoon/early evening)
  4) Respiratory pathway and specific focus on paediatrics with potential for early clinical triage and remote monitoring to manage parental anxiety
  5) Greater comms and engagement to deliver the above, and also to manage anxiety of patients on the elective waiting list who may convert into urgent care attendances

Data source: https://www.england.nhs.uk/nhs-standard-contract/21-22/

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2.6 Community Services and Mental Health Services Review

2.6 Community Service and Mental Health Services Review

North Central London
Clinical Commissioning Group

NCL CCG inherited from its five legacy CCGs a varied pattern of services both for community and mental health services. The variation across NCL exists in access to services, in terms of opening hours and thresholds for clinical access to services.

The baseline reviews will set out the case for change and provide further details on the differences in provision of services, differential funding, and workforce.

The aim of the reviews is to ensure a consistent and equitable core service offer for the NCL population that is largely delivered at a neighborhood/Primary Care Network level. The core offer of equitable access to services will be based on identified local needs and fully integrated into the wider health and care system ensuring outcomes are optimised, as well as ensuring services are sustainable in line with the CCG's financial strategy and workforce plans.

Objectives For The Review:

- The provision of a core and consistent service offer that is delivered locally based on identified needs and that works to reduce inequities of access and improves health outcomes.
- The provision of community and mental health services that optimises the delivery of care across NHS Primary, Secondary, Tertiary services and the wider system with Local Authority and Voluntary and Charitable Sector (VCS) partners and services.
- It will move the CCG closer to the national aspirations around the delivery of care as close to home as clinically appropriate and ensuring it is as maximally accessible.
- It will provide a set of population health outcome measures that will help monitor progress supported by some key performance Indicators.
- Ensure that community and mental health services are financially sustainable system both now and into the future based on the growing and changing needs of our population.
- Ensure the delivery of national planning guidance including the Long Term Plan and Mental Health Investment Standards.

Data source: North Central London Clinical Commissioning Group's Strategic Review of Community and Mental Health Services /

2.6 Community Service and Mental Health Services Review

North Central London
Clinical Commissioning Group

Themes Emerging From Community Services Review:

- Need to address health inequalities; includes a recognition there are unwarranted variations and that both within and between Boroughs people do not receive the same service offer. This can lead to different population and patient outcomes
- Discrepancy between need/prevalence and provision; resources (finance and workforce) are not distributed equitably across NCL. Challenge seen as how to support those with greatest level of need and support NCL commitment to reduce health inequalities
- Relationships and Integrated Working; Reflection that historically relationships between providers have not always been good, reflecting competition and access to resources. However, the pandemic has improved how Community Providers work together. The challenge is now how to embed collaborative working
- Organisational Form; Concern that the review should focus on best models of care to meet different population outcomes and should not focus on Provider Form. This could be considered once core service offer had been designed

Themes Emerging From Mental Health Services Review

- Variation and growth in population need
- Overall gaps in access and significant service variation across NCL
- Models of care not fit for purpose e.g. focus on crisis, not prevention and early access
- Lack of integration (within mental health and with primary care etc.)
- Inequity of Funding; based on historic spends – mirroring discrepancy between need/prevalence and provision as with community services baseline review
- Outcomes; Poor data especially on clinical outcomes

Data source: North Central London Clinical Commissioning Group's Strategic Review of Community and Mental Health Services /

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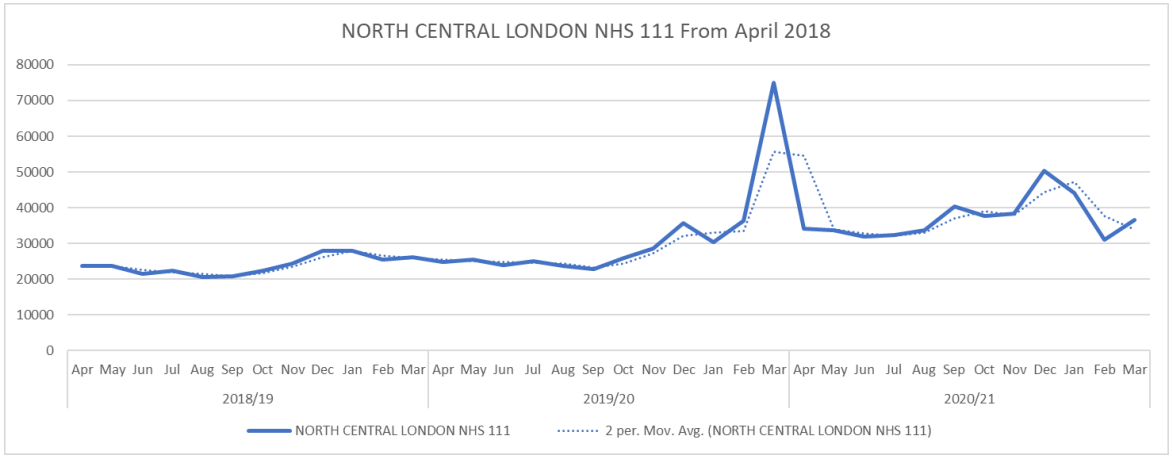
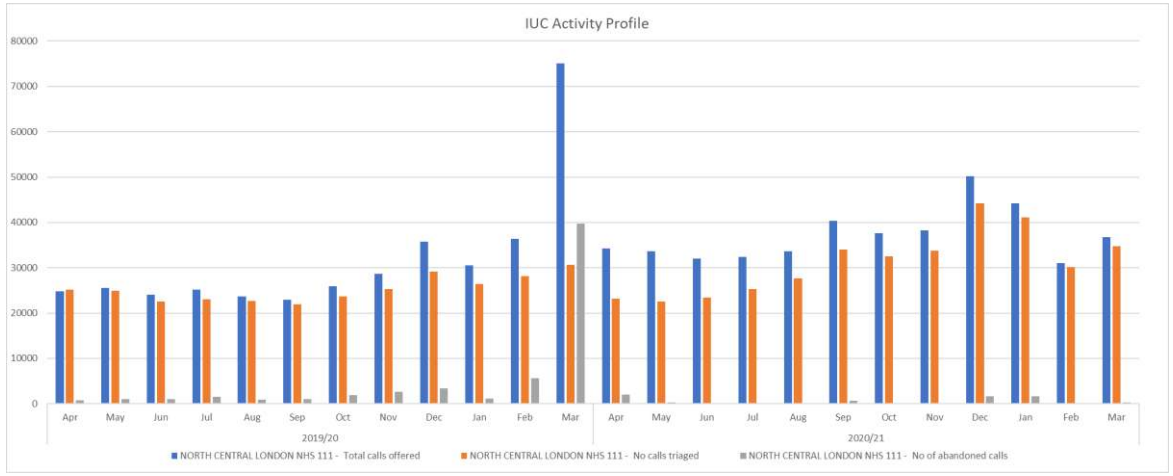
Section 3: Service Updates

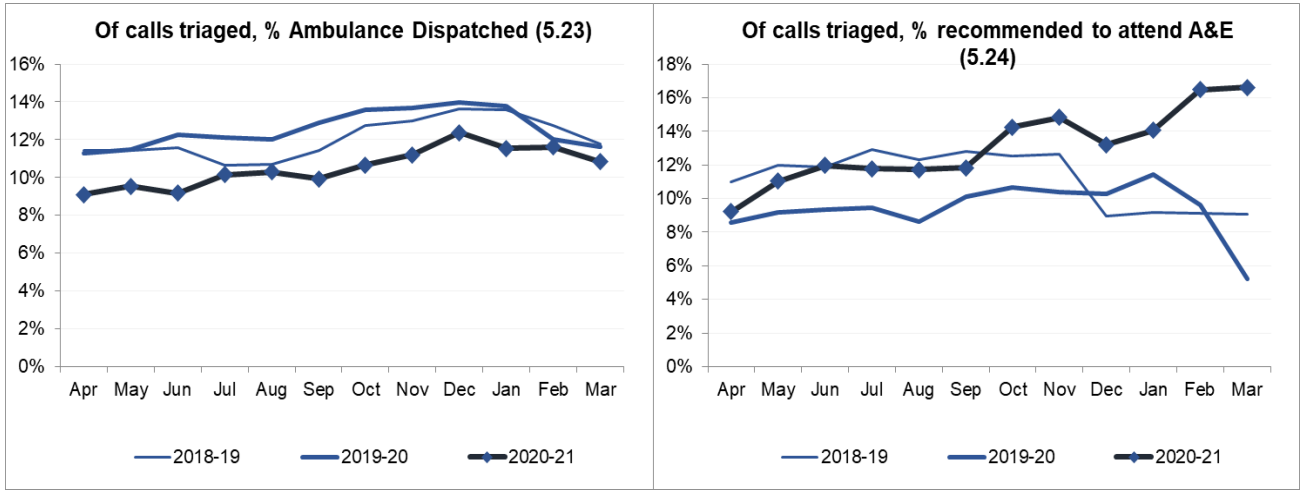
3.1 Pre-Hospital Urgent Care Activity - 111 & IUC



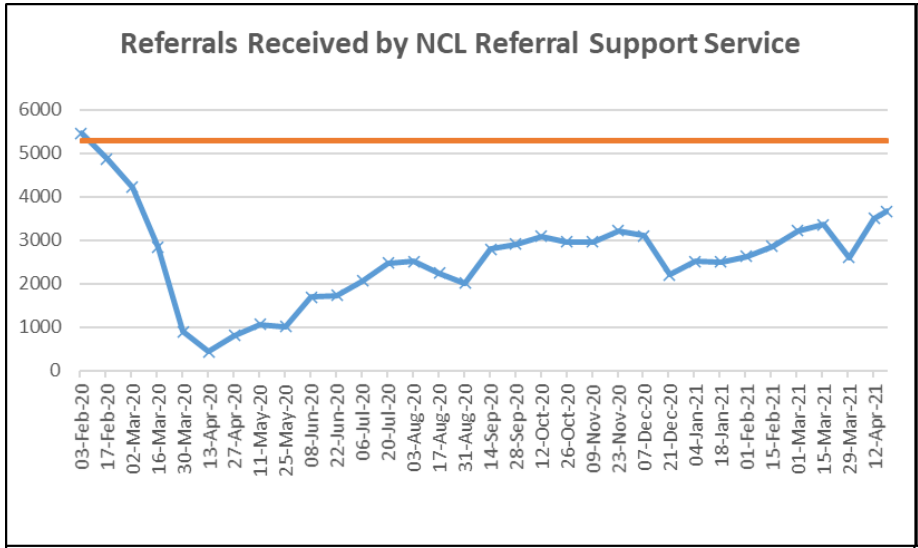


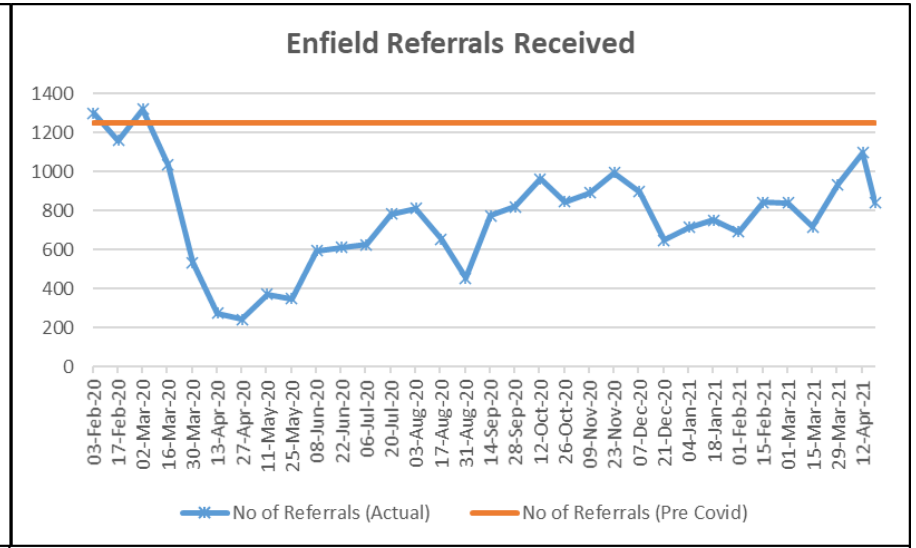
Data Source: London Central West Unscheduled Care Collaborative Reports.

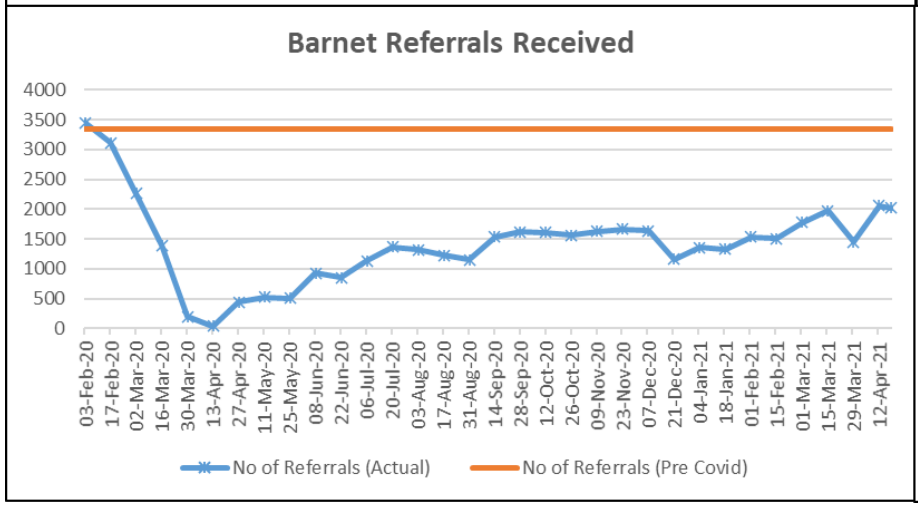
- NHS 111 has shown a recovery in March 2021 following a notable reduction in February 2021 There was a previous a sharp rise over the later part of December 2020 and January 2021.
- The rate of calls abandoned in March 2021 was 0.8% having been 3.7% in January 2021 to 0.5% in February 2021.
- NHS 111 has shown a recovery in March 2021 subsequent to a notable reduction in February 2021 following a previous a sharp rise over the latter part of December 2020 and January 2021. The peak of NHS 111 and IUC activity during the first wave in March 2020 remains high with steady and significant increases in calls was observed up until the beginning of January 2021. It is anticipated that higher volumes of calls than historically seen will continue with the implementation of the Think 111 First – Help Us to Help You programme, which is a national initiative aimed at reducing A&E.
- The rate of ambulance dispatches is close to 2020 levels at 10.8% in March 2021 compared to 11.6% in March 2020. However ambulance dispatch rate has been consistently below the pre-pandemic levels. The rate of calls directed to attend A&E continues above historical levels with 16.6% of calls recommended to attend A&E in March 2021.

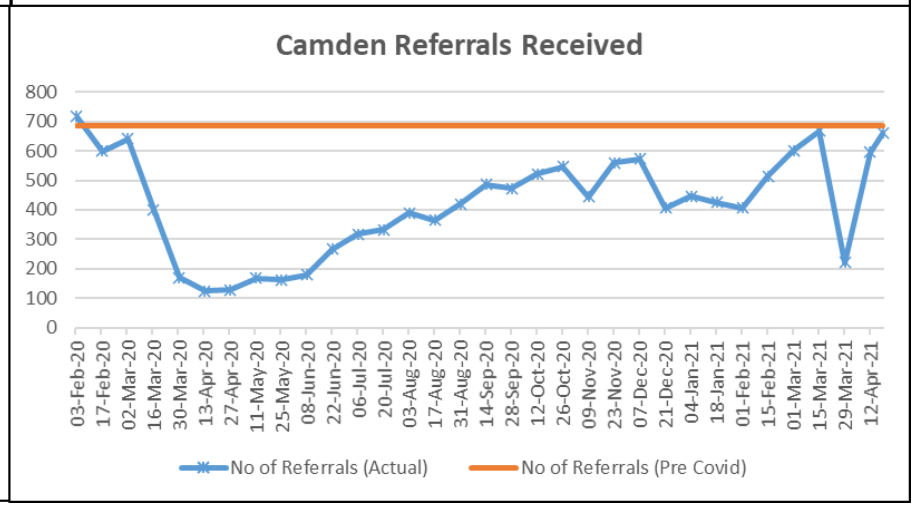


3.2 Referral Management









Routine GP referrals to acute services remain below pre-pandemic levels, rising significantly from April to October 2020 followed by a steady decline from late November to January 2021. Local data from NCL Referral Support Service shows referral rates have increased since January 2021 and in March 2021 stood at nearly 70% of pre COVID-19 levels.

A Project Group is undertaking a gap analysis to inform the system's response to reduce the risk of patient harm. The grouping is prioritising cardiology, based on feedback from clinicians, and deep diving into the factors that may have contributed to the reduction in referrals including use of advice services, diagnostics delays, and impact of virtual appointments. An inequalities impact assessment is also being carried out with initial findings showing a significant reduction in Glaucoma referrals, a reduction in Cardiology referrals for older women and a reduction in Cardiology referrals in particular Primary Care Networks.

The first table 'Referrals Received by NCL Referral Support Service' is aggregated.

Data Source: ERS Dashboard / Barnet Camden and Enfield Referral Management Service

3.3 NHS NCL Acute Care (Including Elective Recovery)

North Central London
Clinical Commissioning Group

The following information highlights the trends in acute activity in 2020/21 compared to 2019/20 and the actual performance against guidance trajectories. The impact of the second wave of COVID is evident and the system is expected to recover in a similar way to the previous recovery.

For Acute activity M12 Flex SLAM data has been used in place of M12 Freeze due to a delay in submission of M12 Freeze data from some providers. For those providers who did submit M12 Freeze data (NMUH and Whittington) there is minimal movement between Flex and Freeze.

Activity & Performance Highlights

For the week ending 30 May 2021, NCL trust recovery activity positions were:

- Elective, **109%** against a target of 75% and
- Outpatients, **112%** against a target of 75%.

Data Source: NCL OIG - Elective Monitoring Report – Week ending 30 May 2021

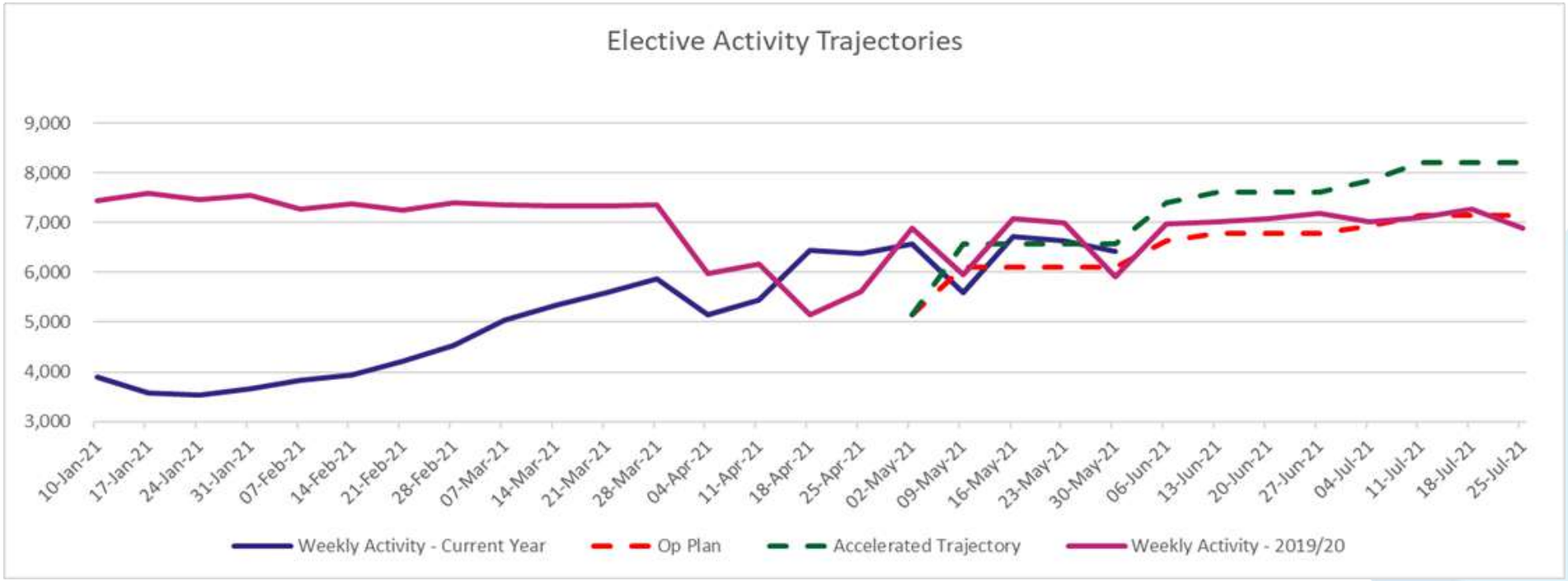
Recovery Trajectory – Elective Inpatients & Daycase

North Central London
Clinical Commissioning Group

Actual

W/E	31-Jan-21	07-Feb-21	14-Feb-21	21-Feb-21	28-Feb-21	07-Mar-21	14-Mar-21	21-Mar-21	28-Mar-21	04-Apr-21	11-Apr-21	18-Apr-21	25-Apr-21	02-May-21	09-May-21	16-May-21	23-May-21	30-May-21
Weekly Activity - Current Year	3,653	3,835	3,932	4,218	4,529	5,040	5,328	5,588	5,875	5,153	5,448	6,437	6,388	6,565	5,583	6,714	6,636	6,425
Weekly Activity - 2019/20	7,549	7,273	7,367	7,249	7,394	7,359	7,342	7,336	7,358	5,980	6,170	5,145	5,611	6,891	5,955	7,069	6,995	5,912
% of Baseline Year (2019/20)	48%	53%	53%	58%	61%	68%	73%	76%	80%	86%	88%	125%	114%	95%	94%	95%	95%	109%

Actual – w/e 30 May



At week ending 30 May 2021, NCL is at **109%** of their equivalent activity week totals seen last year.

Please note, this is compounded by the May bank holiday period seen in 2019 which has skewed the performance. It is understood, performance is around 100% of BAU.

*Bank Holiday weeks highlighted in orange, which shows lower activity than usual weeks between years.

Data Source: NCL OIG - Elective Monitoring Report – Week ending 30 May

Recovery Trajectory – Outpatients

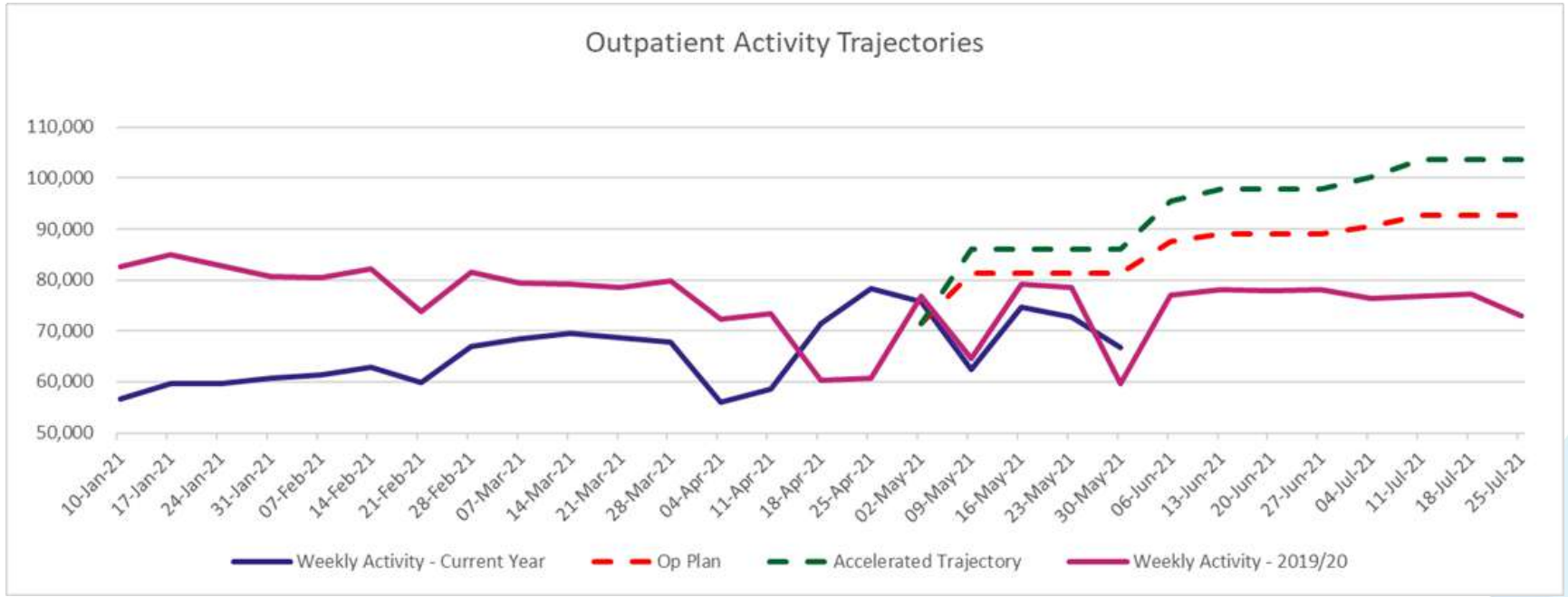
North Central London
Clinical Commissioning Group

Total Outpatients

Actual

W/E	31-Jan-21	07-Feb-21	14-Feb-21	21-Feb-21	28-Feb-21	07-Mar-21	14-Mar-21	21-Mar-21	28-Mar-21	04-Apr-21	11-Apr-21	18-Apr-21	25-Apr-21	02-May-21	09-May-21	16-May-21	23-May-21	30-May-21
Weekly Activity - Current Year	60,820	61,347	62,981	59,908	66,855	68,416	69,521	68,732	67,909	55,972	58,693	71,531	78,316	75,689	62,400	74,703	72,837	66,703
Weekly Activity - 2019/20	80,709	80,483	82,255	73,825	81,627	79,442	79,287	78,545	79,725	72,246	73,478	60,217	60,669	76,917	64,631	79,252	78,464	59,634
% of Baseline Year (2019/20)	75%	76%	77%	81%	82%	86%	88%	88%	85%	77%	80%	119%	129%	98%	97%	94%	93%	112%

Actual – w/e 30 May



Outpatient activity has been ramping up in more recent weeks after a dip in activity seen during the spring bank holiday periods.

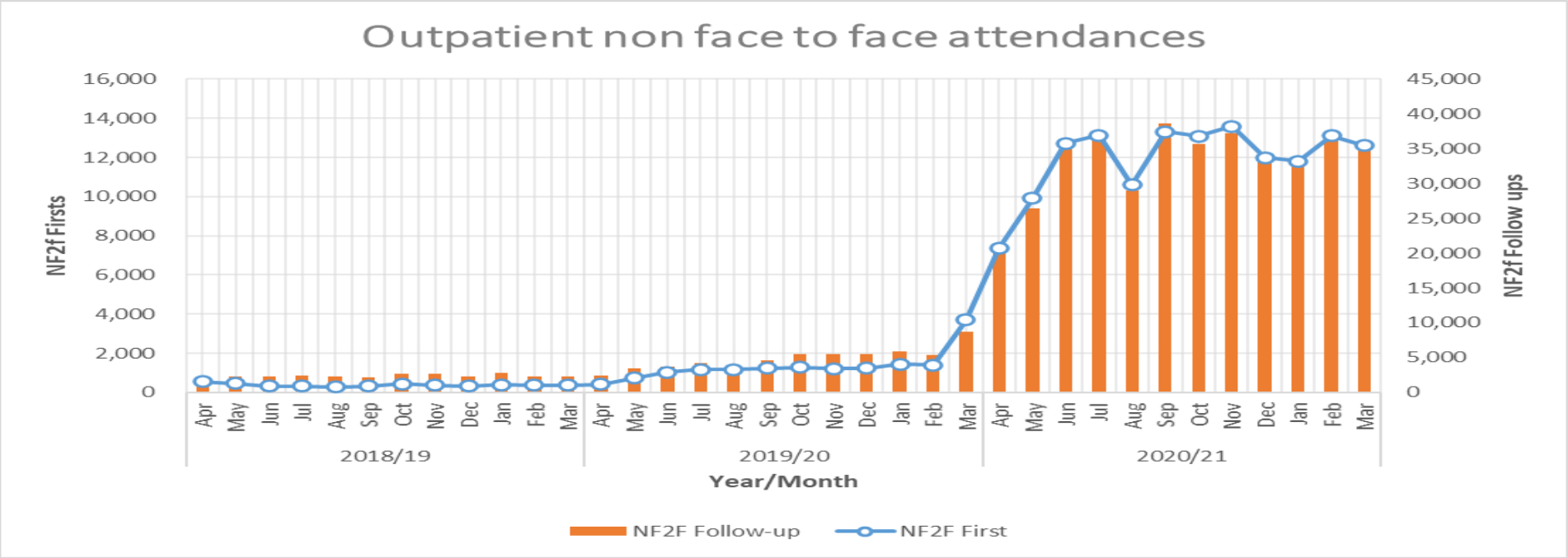
At week ending 30 May 2021, NCL is at **112%** of their equivalent activity week totals seen last year (excluding working days comparison).

*Bank Holiday weeks highlighted in orange, which shows lower activity than usual weeks between years.

Data Source: NCL OIG - Elective Monitoring Report – Week ending 30 May

Outpatients - Virtual Appointments

North Central London
Clinical Commissioning Group



- NCL Trusts have quickly adapted their services to deliver significant volumes of Outpatient activity in virtual settings. This trend is a key transformational change that Commissioners would hope can be sustained going forward and as such will be regularly monitored. 44% of all Outpatient activity in March 2021 at the four main providers was virtual compared to only 5% throughout 2019/20.

- Following a typical seasonal variation with reduced levels of activity usually observed in December, the number of non-face-to-face outpatient appointments decreased and remined lower through January during the peak of the latest COVID wave. Virtual Outpatient appointments reduced slightly in Month 12 whilst face to face increased.

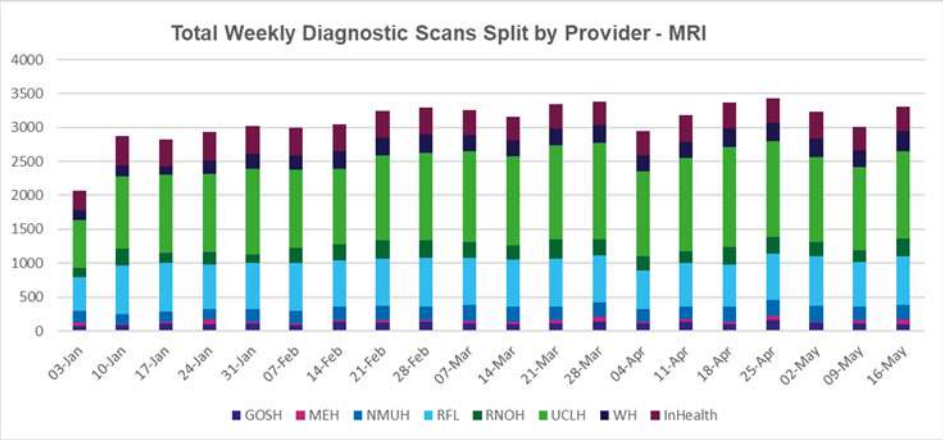
- The Month 12 year to date position shows a 23% reduction in overall outpatient activity compared to Month 12 year to date 2019/20 across the four main providers.

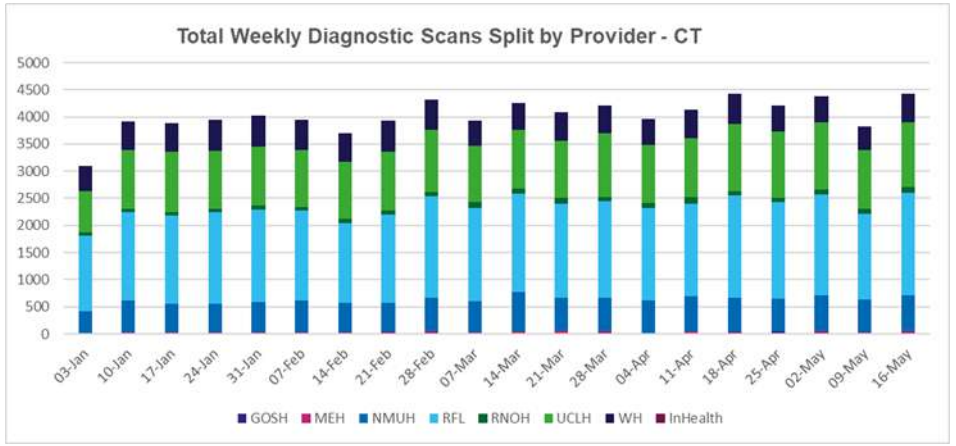
Data source: Month 11 SUS

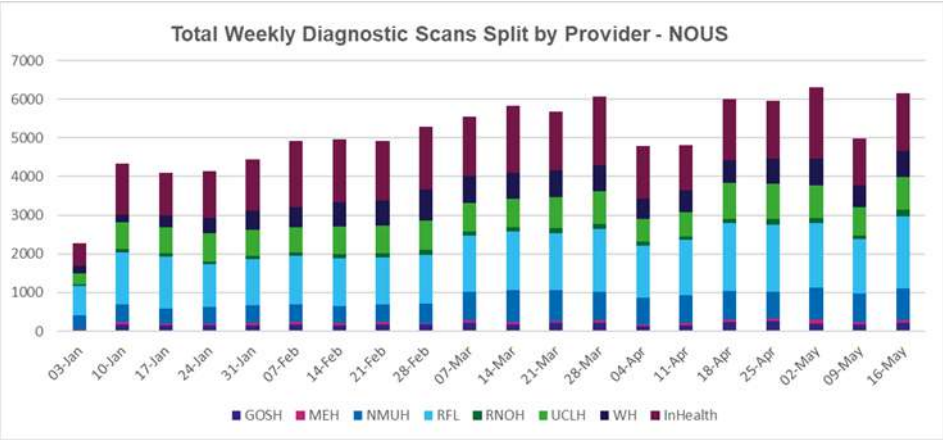
Diagnostics Activity and Performance

North Central London
Clinical Commissioning Group

For week ending 16 May 2021







For the month to 16 May 2021:

- MRI activity was below the Elective Recovery Plan by 10%.
- CT activity was above the Elective Recovery Plan by 12%.
- Non-obstetric Ultrasound activity was below the Elective Recovery Plan by 10%.

6 week waits:

- 11% of the DM01 MRI waiting list have been waiting longer than six weeks.
- 5% of the DM01 CT waiting list have been waiting longer than six weeks.
- 11% of the DM01 NOUS waiting list have been waiting longer than six weeks.

% of Total waiting 6+ Weeks with a TCI (To Come In Date)

Scan	14-Mar	21-Mar	28-Mar	04-Apr	11-Apr	18-Apr	25-Apr	02-May	09-May	16-May
Cardiology - Echocardiography	81.3%	81.4%	84.9%	83.9%	84.8%	89.8%	89.2%	87.8%	87.7%	86.0%
Cardiology - Electrophysiology										
Colonoscopy	14.0%	15.9%	19.6%	19.2%	18.7%	17.8%	23.2%	27.2%	22.9%	20.7%
Computed Tomography	61.9%	61.6%	58.4%	61.2%	72.4%	71.1%	63.8%	74.9%	74.2%	72.2%
Cystoscopy	28.2%	28.0%	28.4%	24.8%	26.8%	23.0%	31.0%	36.9%	43.2%	37.1%
DEXA Scan	62.5%	61.9%	72.9%	85.5%	77.3%	38.1%	18.9%	76.3%	47.7%	75.9%
Flexible sigmoidoscopy	6.3%	7.1%	7.1%	6.8%	5.4%	7.9%	8.3%	9.5%	9.8%	5.3%
Gastroscopy	27.8%	30.3%	27.8%	27.3%	22.9%	27.6%	24.1%	25.1%	24.6%	30.6%
Magnetic Resonance Imaging	49.4%	48.0%	43.6%	41.8%	43.7%	46.2%	48.8%	51.2%	56.0%	55.0%
Neurophysiology	33.4%	69.0%	66.0%	63.1%	65.3%	69.3%	65.6%	61.3%	55.8%	55.7%
Non-obstetric Ultrasound	51.4%	59.5%	63.9%	67.1%	64.1%	67.9%	69.9%	72.9%	69.4%	66.6%
Respiratory phyiology	25.5%	39.0%	47.0%	49.1%	40.0%	34.9%	35.3%	28.2%	29.1%	34.5%
Urodynamics	67.7%	67.8%	65.2%	66.8%	64.0%	62.9%	60.5%	62.4%	60.4%	58.6%

Data source: DM01 Provider Returns

NCL Activity all PODs – Top 4 Providers

North Central London
Clinical Commissioning Group

Activity by Provider

Activity	Year / Month	2019												2019 Total	2020											2020 Total	YTD Change from 2019 to 2020	YTD % Change from
Row Labels		1	2	3	4	5	6	7	8	9	10	11	12		1	2	3	4	5	6	7	8	9	10	11	12			
North Middlesex University Hospital NHS Trust		314,452	308,231	316,944	316,089	322,000	316,081	321,665	302,128	271,153	309,975	303,242	285,279	3,687,239	37,919	67,766	132,940	180,597	213,076	257,038	277,879	255,952	222,204	200,379	218,609	228,439	2,292,798	-1,394,441	-38%
Royal Free London NHS Foundation Trust		117,311	449,645	441,734	493,828	433,319	434,127	487,478	449,009	432,192	478,212	458,190	414,698	5,089,742	44,032	49,783	67,906	80,164	78,660	100,048	93,833	91,821	87,427	70,880	75,055	96,395	936,004	-4,153,738	-82%
University College London Hospitals NHS Foundation Trust		40,749	48,610	47,336	51,797	46,966	49,562	52,974	51,173	45,532	54,079	48,035	40,134	576,947	24,004	28,514	36,576	41,672	38,377	45,684	46,215	48,028	44,116	41,335	40,788	50,965	486,274	-90,673	-16%
Whittington Health NHS Trust		134,914	141,368	133,321	142,160	125,217	128,358	142,211	129,885	107,437	140,871	127,119	83,404	1,536,265	35,076	52,743	85,633	109,790	101,892	116,398	120,484	115,908	103,251	83,306	100,077	123,060	1,147,618	-388,647	-25%
Grand Total		607,426	947,854	939,335	1,003,874	927,502	928,128	1,004,328	932,195	856,314	983,137	936,586	823,515	10,890,193	141,031	198,806	323,055	412,223	432,005	519,168	538,411	511,709	456,998	395,900	434,529	498,859	4,862,694	-6,027,499	-55%

Activity by POD

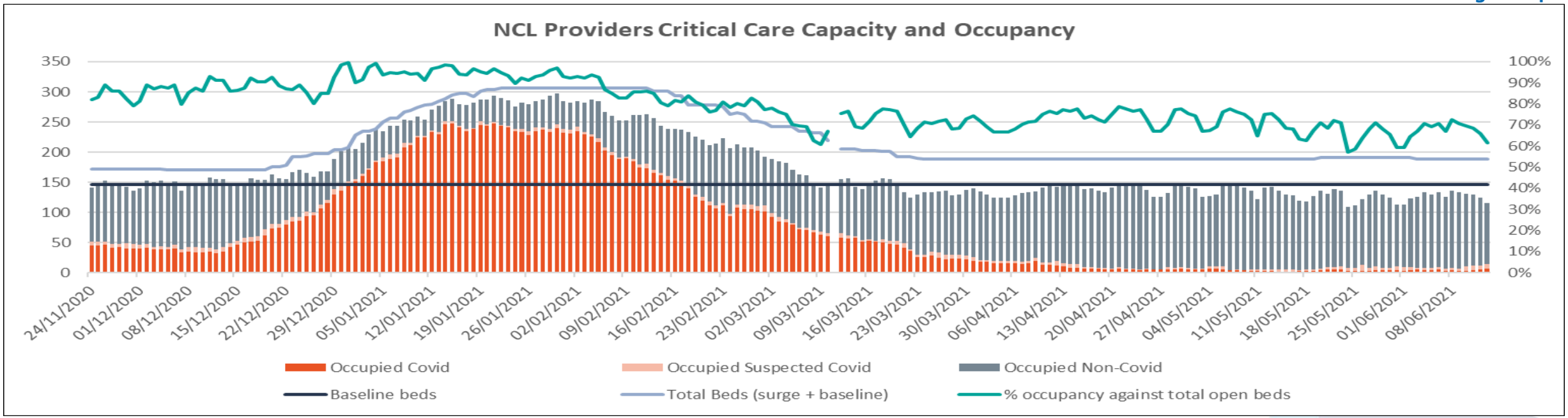
Activity	Year / Month	2019												2019 Total	2020											2020 Total	YTD Change from 2019 to 2020	YTD % Change from
Row Labels		1	2	3	4	5	6	7	8	9	10	11	12		1	2	3	4	5	6	7	8	9	10	11	12			
Accident and Emergency		45,601	46,840	45,695	47,252	42,197	44,422	46,916	48,289	50,253	48,897	44,783	33,952	545,097	19,936	26,788	31,564	34,761	36,434	37,905	35,843	35,403	35,819	29,811	29,621	40,667	394,552	-150,545	-28%
Community		394	340	323	434	339	370	296	343	308	385	297	323	4,152	127	140	249	145	130	189	196	144	182	182	167	176	2,027	-2,125	-51%
Critical Care		2,941	3,142	2,810	2,894	2,813	2,789	2,980	2,253	3,198	3,338	2,814	2,764	34,736	3,657	2,881	2,707	2,175	1,674	1,982	2,212	2,085	3,089	4,922	4,228	4,281	35,893	1,157	3%
Diagnostic Imaging		393,114	722,387	724,618	768,435	720,442	709,567	764,747	699,809	632,255	732,444	709,637	639,372	8,216,825	32,836	77,914	168,704	235,798	266,858	317,626	339,594	312,420	272,008	238,352	269,967	291,494	2,823,571	-5,393,254	-66%
Elective		9,584	10,487	10,280	11,226	9,813	10,289	11,500	10,899	9,605	10,693	10,030	7,498	121,904	1,987	2,743	4,460	6,292	6,795	8,522	9,534	8,915	7,534	4,669	5,280	7,683	74,414	-47,490	-39%
Maternity		9,715	10,658	9,834	11,168	10,461	10,605	10,959	9,972	10,095	10,897	9,885	10,081	124,330	8,785	9,320	9,462	10,101	9,296	10,187	10,156	9,616	9,691	9,257	9,304	11,213	116,388	-7,942	-6%
Non-Elective		13,357	13,847	12,886	13,623	12,358	12,207	13,219	13,320	13,602	12,758	11,560	11,563	154,300	8,436	7,932	8,651	10,081	9,031	9,672	9,797	9,354	9,243	8,389	8,151	10,088	108,825	-45,475	-29%
Other		24,837	22,684	22,810	27,921	25,713	26,221	30,765	29,505	33,601	40,561	38,375	26,045	349,039	12,712	14,603	18,723	23,119	21,324	26,648	28,279	28,378	24,160	21,900	24,738	28,665	273,249	-75,790	-22%
Outpatients		106,721	116,281	109,165	119,920	102,204	110,596	121,836	116,747	102,333	122,037	108,245	90,867	1,326,952	51,909	55,919	77,713	88,731	79,532	105,422	101,881	104,409	94,419	77,677	82,413	103,643	1,023,668	-303,284	-23%
Regular Attenders		1,162	1,188	914	1,001	1,162	1,062	1,110	1,058	1,064	1,127	960	1,050	12,858	646	566	822	1,020	931	1,015	919	985	853	741	660	949	10,107	-2,751	-21%
Grand Total		607,426	947,854	939,335	1,003,874	927,502	928,128	1,004,328	932,195	856,314	983,137	936,586	823,515	10,890,193	141,031	198,806	323,055	412,223	432,005	519,168	538,411	511,709	456,998	395,900	434,529	498,859	4,862,694	-6,027,499	-55%

- Month 12 year to date activity shows an overall reduction of -55% compared to Month 12 year to date 2019/20 across the four main trusts. However this is largely influenced by Diagnostics. A reduction of -24% can be found with the removal of Diagnostics.
- Royal Free reported the most significant reduction in activity of -82% compared to the same period in 2019/20 however this is related to Direct Access data which is missing. This is high volume, low cost activity which is missing.
- Planned care is reporting a -23% reduction in Outpatients appointments. However, the largest reductions overall were in Diagnostics (-66%), Community (-51%) and Electives (-39%).
- A&E activity is -28% below 2019/20 levels. Activity began to recover slowly but reduced significantly in Month 10 (the lowest recorded level since Month 2) due to wave 3 of COVID and lockdown.

Data Source: Month 12 SLAM Aggregate

Critical Care

North Central London
Clinical Commissioning Group



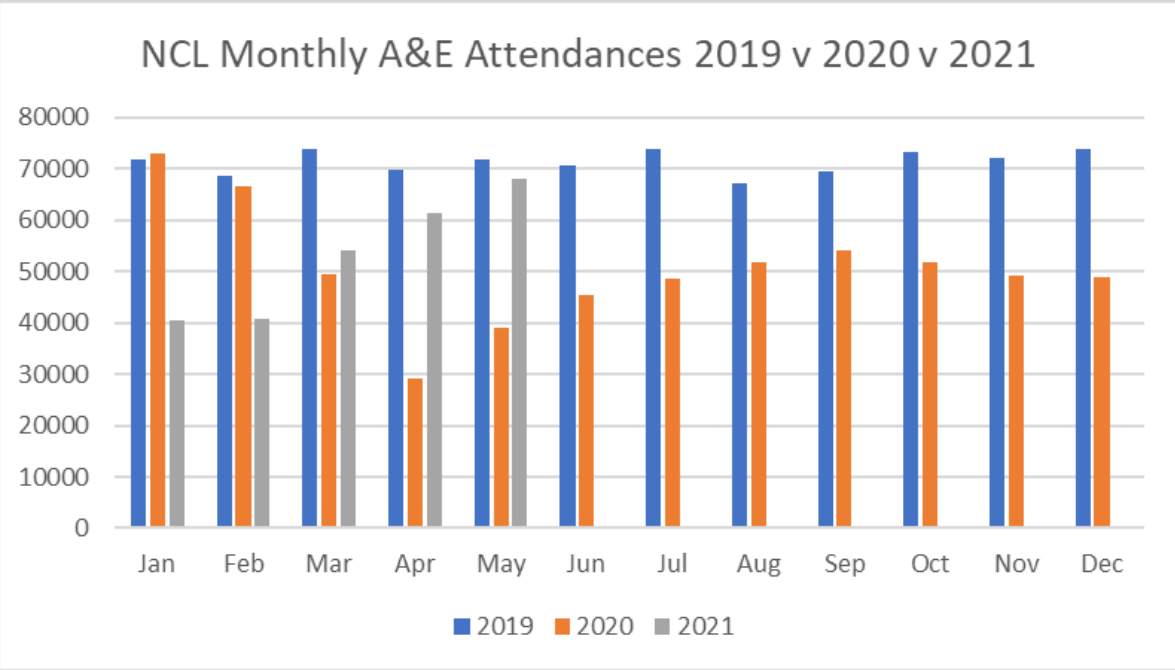
- By the end of May 2021, the critical care bed base reduced from 306 beds to 188. Occupancy of total open Critical Care beds has reduced to 59%. Despite creating extra capacity, the complexities associated with infection control management, as well as staffing challenges has meant that at times, beds and wards have had to temporarily close. This affects occupancy figures across general and acute beds as well.
- Updated DOS data has replaced the previous daily sit-rep reporting from 24/11/20 onwards as this is considered more accurate.
- Between June and October 2020 Non-COVID occupancy levels were similar to pre–COVID levels of between 120 and 145 beds per day. Occupancy by COVID patients rose again in October 2020 and had stabilised in late November 2020 at an average of 40 per day. At the height of the first wave Critical Care beds in NCL had more than doubled to 394 before settling at around 330-340.
- The overall 2020/21 Critical Care activity position charged to NCL CCG in SLAM reports shows that it was 3% above 2019/20. This is an average position with peaks of activity in April 2020 and January and February 2021 offset by lower Critical Care activity in the period from July to October 2020.

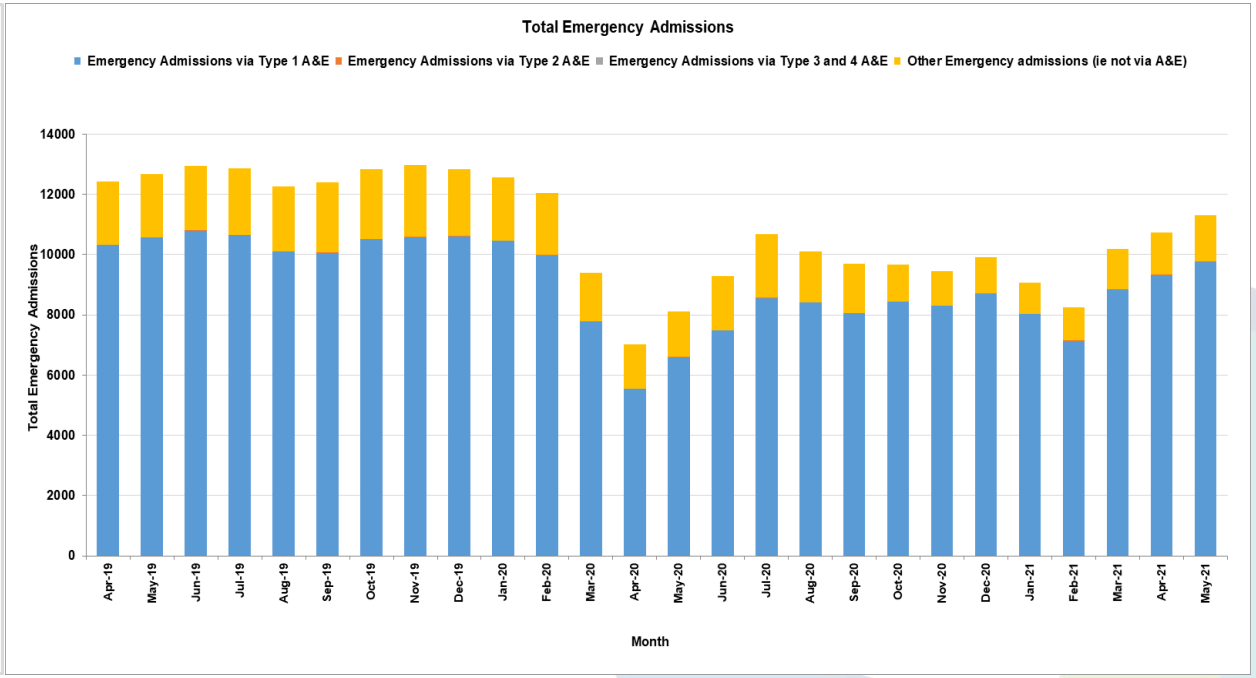
Data Source: DOS

Emergency Attendances and Admissions

North Central London
Clinical Commissioning Group

- A&E attendances remained below pre-COVID levels but are recovering and were at 95% in May 2021 compared to the pre-pandemic level in May 2019.
- At the height of the COVID pandemic, NCL A&E attendances fell to below 50% of pre-COVID activity levels. A&E attendances began to return towards pre-COVID levels between May and September 2020 but since October attendances have declined again.
- Year to date A&E attendances for 2020/21 were 28% lower than in 2019/20. At the same time, non-elective admissions also decreased by 29%.





Data Source:SMART

Out of Sector Activity

North Central London
Clinical Commissioning Group

Activity By POD

Note: The vast majority of Out of Sector activity is related to elective care and therefore non-elective activity is not analysed in the same detail.

	Year/M																										
	2019/20												2019/20 Total	2020/21											2020/21 Total	YTD Change from 2019 to 2020	YTD % Change from 2019 to 2020
POD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
DC	1,064	1,204	1,208	1,259	1,093	1,193	2,560	2,316	1,010	1,170	1,159	820	16,056	282	346	484	700	712	922	1,009	1,024	896	526	646	944	8,491	-7,565	-47%
EL	192	199	205	208	240	197	440	442	173	232	227	171	2,926	48	70	82	135	123	161	176	188	169	88	105	132	1,477	-1,449	-50%
NEL	1,246	1,286	1,267	1,264	1,278	1,154	2,474	2,366	1,277	1,209	1,119	983	16,923	726	846	972	1,114	1,161	1,109	1,132	1,004	1,085	1,057	989	1,167	12,362	-4,561	-27%
NELNE	372	422	382	397	378	355	782	754	403	371	382	381	5,379	338	361	332	429	437	378	424	419	376	406	376	418	4,694	-685	-13%
OTHER	60	67	68	65	72	59	130	180	65	68	86	95	1,015	45	38	45	65	54	59	79	86	73	91	78	87	800	-215	-21%
RA	190	209	196	258	203	183	386	358	169	184	126	136	2,598	104	153	140	221	134	180	176	188	185	155	164	180	1,980	-618	-24%
TRANSFER	53	59	68	41	37	45	120	106	45	41	51	43	709	19	38	36	41	50	27	39	37	45	33	37	48	450	-259	-37%
1st	3,578	3,827	3,500	3,898	3,325	3,562	7,700	7,456	3,262	3,867	3,560	3,084	50,619	1,911	1,978	2,880	2,560	2,290	3,013	3,092	3,106	2,939	3,031	2,661	3,244	32,705	-17,914	-35%
NF2F	703	728	703	770	675	711	1,642	1,486	770	893	769	1,228	11,078	1,747	2,174	2,813	3,426	3,059	3,916	4,098	4,341	4,019	3,824	4,045	4,572	42,034	30,956	279%
FUp	7,912	8,348	7,848	8,791	7,564	8,365	17,830	16,866	7,622	9,020	8,159	7,348	115,673	4,643	4,755	6,105	6,594	6,040	6,802	7,478	7,716	6,339	5,453	5,631	7,846	75,402	-40,271	-35%
OPPROC	2,260	2,381	2,257	2,663	2,270	2,321	5,226	4,634	2,054	2,513	2,145	1,396	32,120	535	631	947	1,333	1,163	1,345	1,526	1,568	1,400	1,175	1,266	1,503	14,392	-17,728	-55%
	17,630	18,730	17,702	19,614	17,135	18,145	39,290	36,964	16,850	19,568	17,783	15,685	255,096	10,398	11,390	14,836	16,618	15,223	17,912	19,229	19,677	17,526	15,839	15,998	20,141	194,787	-60,309	-24%

- Month 12 year to date out of sector activity has reduced by 24% overall compared to Month 12 year to date 2019/20.
- Outpatient Non Face to Face is the only POD to report an increase; 279% increase when compared to the same period last year.
- Outpatient Procedures (-55%) followed by Day Case (-47%) and Elective (-50%) reported the most significant variation, a trend reported since October 2020/21.
- Activity steadily increased since wave 1 however dropped again due to wave 2, evident from month 9 total activity figures onwards.

NOTE: Not all out of sector providers are reporting via SLAM to NCL, activity is processed through SUS as required by NHSE guidance.

Data Source: M12 SLAM

3.4 NCL NHS Community Services (including Recovery)

North Central London
Clinical Commissioning Group

As part of Phase 3 the system is required to **'Restore non-COVID activity to usual levels where clinically appropriate'.**
To support this ambition, NCL community services have created a recovery dashboard to answer the key question:

- **What level of activity has each service reached in comparison to the pre-COVID "normal" and will capacity meet future demand?**

Highlights of this dashboard are included on the following slides.

Secondary objectives include:

- Identifying potential challenges with specific services in returning to pre-COVID activity levels;
- Providing early warning of changes in demand and referrals;
- Identifying any risks in relation to service waiting times;
- Identifying potential areas for collaboration/ mutual aid, and
- Ensuring parity of reporting across community, acute and mental health services.

Areas identified for potential development include the split of activity by F2F vs Telephone/Online – not possible based on current recording practice and waiting list information.

Next steps

- Implement Recovery Plan and oversee via Communtiy Operational Group for both Adults and CYP Services;
- Implement Monitoring via an Integrated Recovery Dashboard
- Bring back to Community Provider meeting fortnightly;
- Ongoing validation of the data and mapping with providers to ensure accuracy;
- Update in Rapid Response activity and trends (acknowledging changes in service model), and
- Include face-to-face / non face-to-face – requires changes to data capture systems.

3.4 NCL NHS Community Services

North Central London
Clinical Commissioning Group

Community Service Recovery

Building on the learning from the first COVID peak, more activity has been maintained during the second peak. Services were scaled back to deliver high clinical priority work, screening and triage function (referrals) to manage red flag or urgent referrals.

As providers begin to recover community services, there is the additional challenge to maintain staff capacity for priority services and new services stood up for COVID (e.g. Integrated Discharge Teams, Post-COVID Pathway and Roving Vaccine Model).

Objectives of joint NCL Community Services recovery plan (BEH, CLCH, CNWL, Whittington Health):

- To ensure sufficient resource for the following key priority areas:

Existing services where additional capacity is required to meet demand	New services
• Rapid Response • Discharge services • Pathway 2 community beds • Urgent community nursing • Phlebotomy	• IDTs • Post COVID Rehab Pathway • Vaccine Roving Model

- To ensure a consistent offer of service across NCL to minimise a postcode lottery.
- Aim to recover services at the same time as embedding any productivity efficiencies/new ways of working (e.g. virtual working/ monitoring when clinically safe and appropriate).
- Maintain priority services and how this can be safely managed.

3.4 NCL NHS Community Services

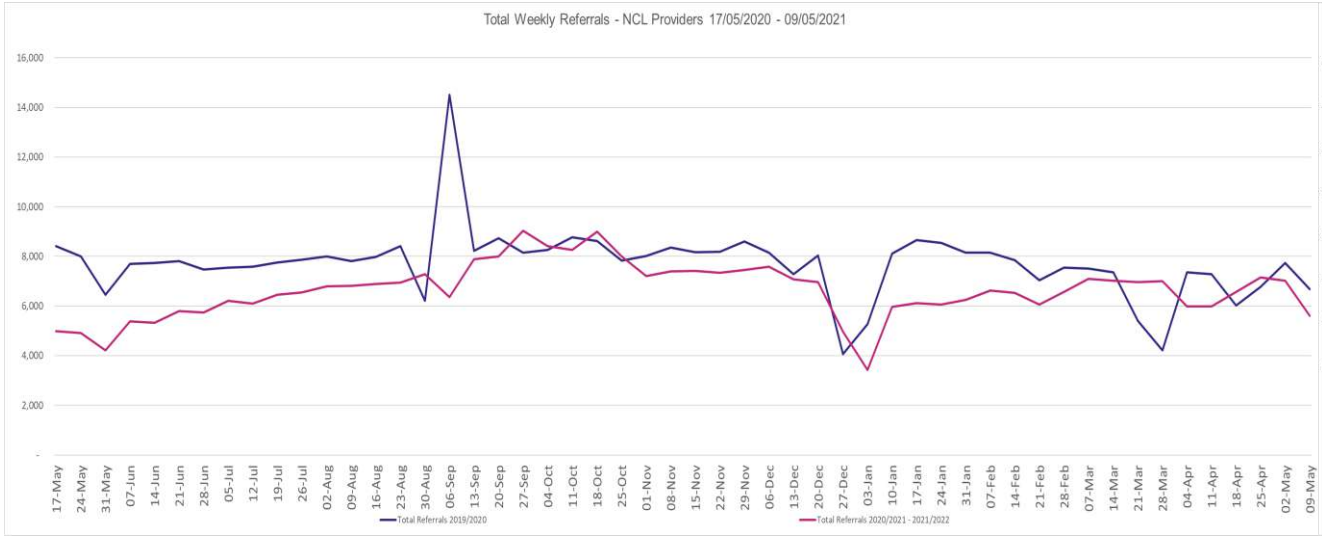
North Central London
Clinical Commissioning Group

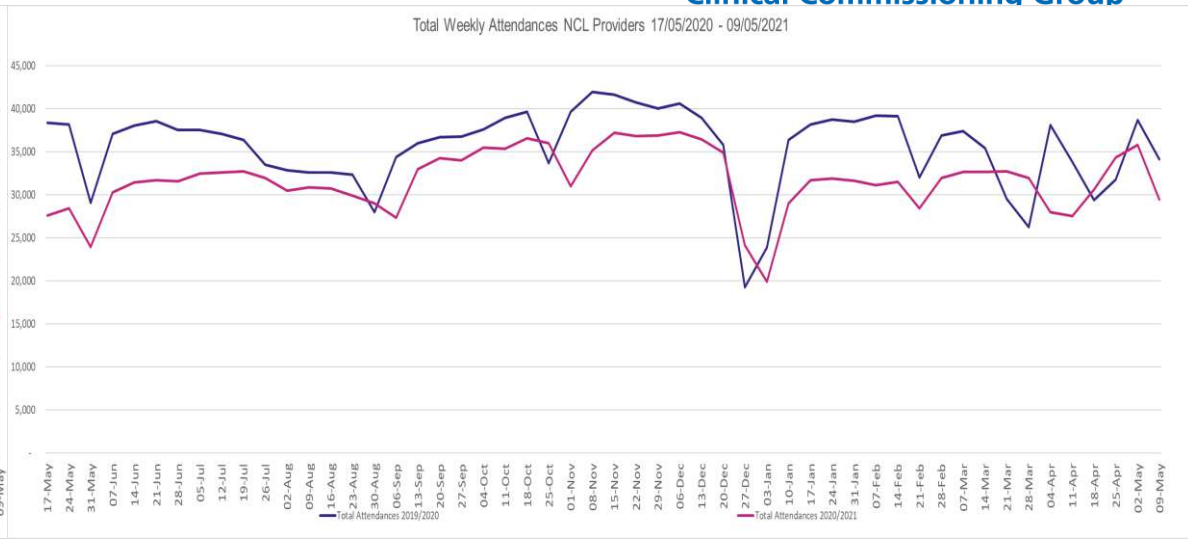
Approach to Community Services Recovery:

- Align service prioritisation list of services across the NCL footprint and identify any areas of inconsistency, agreeing actions to mitigate this;
- Priority services (cat A) services to be maintained to meet demand;
- Agree list of priority services taking into account clinical prioritisation and waiting lists;
- Monitoring the recovery via the recovery dashboard;
- Collaborative approach bringing together the NCL community providers and commissioners to work through solutions which benefit the NCL population;
- Use of analytics to support decision making with a recovery dashboard developed to provide demand, waiting time and capacity profiling for key service lines;
- Consensus on key services to recover and when (agreeing local triggers with thresholds), and
- Fosters a mutual aid approach across our providers.

3.4 Community Services – Referrals and Activity

North Central London
Clinical Commissioning Group





Summary for Week 6, ending on 09 May 2021

- Over the last four weeks:
  - Total referrals have been at 95% of the same period in 2019/20 (GP referrals are 94%; Secondary care referrals are 96%)
  - Total activity is at 96% of the same period in 2019/20 (First attendances are at 96%)

Service lines are now grouped according to national categories where possible:

- Services above 100% relative to baseline:
  - 1) Long Term Conditions; 2) Specialist Palliative Care; 3) Nutrition and Dietetics Service; 4) Diabetes Service
- Services that are below 80% relative to 19/20 baseline:
  - 1) MSK (excl CNWL); 2) Home Based Intermediate Care

Data Source: Community Services Recovery Dashboard

NCL Community Summary – Service Line Activity

North Central London
Clinical Commissioning Group

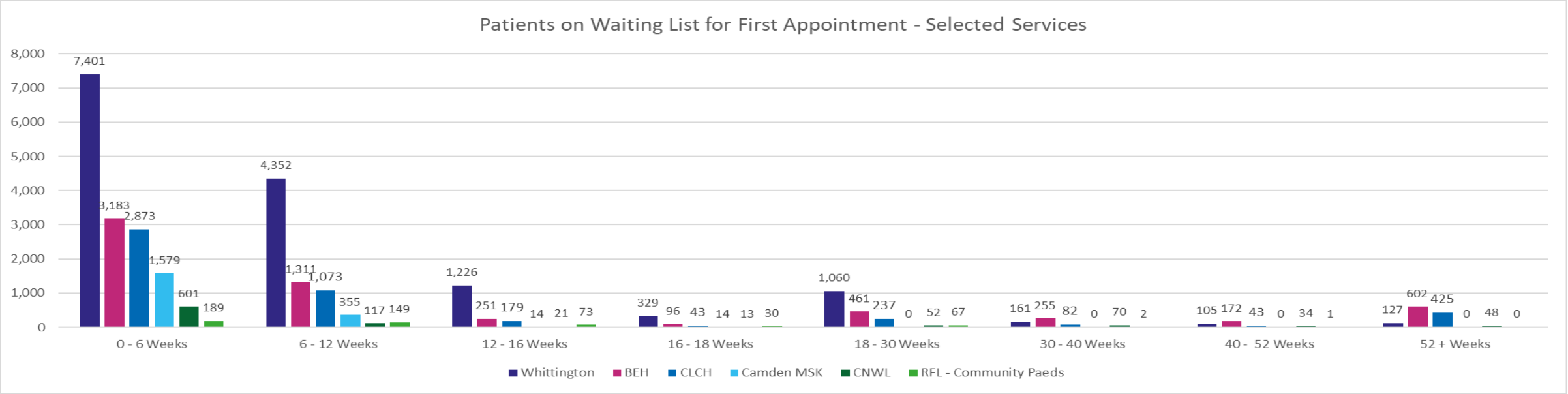
W/E	13-Dec	20-Dec	27-Dec	03-Jan	10-Jan	17-Jan	24-Jan	31-Jan	07-Feb	14-Feb	21-Feb	28-Feb	07-Mar	14-Mar	21-Mar	28-Mar	04-Apr	11-Apr	18-Apr	25-Apr	02-May	09-May	Pre Covid Total 2019/2020	% Pre Covid Total Achieved
Service Line	Week 37	Week 38	Week 39	Week 40	Week 41	Week 42	Week 43	Week 44	Week 45	Week 46	Week 47	Week 48	Week 49	Week 50	Week 51	Week 52	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Last 4 weeks (Week 3 Week 6)	
Long Term Conditions (incl. Community Matron	879	680	490	319	563	574	654	576	537	573	514	531	562	492	631	575	491	504	582	628	685	513	1,376	175%
Phlebotomy Service	575	560	348	369	565	633	542	529	465	565	597	623	641	581	493	571	415	397	587	578	522	404	1,474	142%
Nutrition and Dietetics Service	530	544	306	169	434	400	373	361	306	326	301	375	382	361	341	339	259	379	398	442	470	350	1,246	133%
Specialist Palliative Care Service	258	294	196	176	262	355	386	386	191	401	335	329	297	355	382	340	209	219	262	178	269	182	676	132%
School Nursing Service	1,983	1,700	697	359	1,305	1,583	1,634	1,495	1,489	1,632	1,108	1,817	1,783	1,882	2,089	2,002	1,442	669	736	1,981	2,110	1,644	4,959	130%
Diabetes Service	470	467	224	157	355	433	473	518	407	455	421	432	504	445	517	576	257	323	446	464	511	386	1,456	124%
Occupational Therapy Service	398	451	96	56	281	371	380	420	339	390	181	379	439	488	416	443	300	109	138	346	488	370	1,086	124%
Physiotherapy Service	1,080	1,140	635	320	948	1,051	1,063	1,010	995	979	944	1,050	1,074	1,339	1,233	1,214	1,004	882	1,086	1,262	1,325	1,122	4,376	110%
Rehabilitation Service	833	809	488	337	667	826	839	737	777	845	752	771	921	877	818	803	602	711	834	921	931	737	3,143	109%
Speech and Language Therapy Service	2,025	1,248	262	130	807	1,136	1,426	1,806	2,017	1,734	588	1,908	1,727	1,742	1,963	1,913	1,082	547	656	1,463	2,154	1,780	5,586	108%
Vulnerable Children's Service	742	624	114	44	327	481	505	460	467	456	225	599	538	722	754	751	418	185	234	616	685	757	2,224	103%
Integrated Multidisciplinary Team (jointly comm	778	703	358	241	654	681	646	532	536	564	393	521	550	541	550	501	494	559	632	681	716	514	2,590	98%
Health Visiting Service	5,326	5,690	3,748	2,428	4,658	5,778	5,458	5,389	5,141	5,205	4,917	5,001	5,122	5,146	4,781	4,619	3,938	4,277	5,178	5,492	5,313	4,285	20,712	98%
Podiatry Service	1,767	1,719	1,109	606	1,370	1,429	1,430	1,411	1,438	1,376	1,172	1,263	1,554	1,339	1,205	1,109	1,048	1,277	1,621	1,994	1,822	1,517	7,301	95%
District Nursing Service	13,292	13,095	11,880	12,078	12,147	12,321	12,305	12,454	12,335	12,413	12,713	12,641	12,663	12,567	12,512	12,321	12,714	12,709	12,647	12,614	12,780	10,874	54,874	89%
Crisis Response Intermediate Care Service (Ra	706	700	545	603	792	734	840	793	790	708	634	617	626	567	641	598	549	573	633	546	584	462	2,510	89%
Children's Community Nursing Service	483	468	290	260	382	394	417	400	456	419	383	422	467	442	512	464	314	357	333	418	383	286	1,644	86%
Respiratory Service	456	436	305	178	398	386	392	361	328	334	314	345	359	367	332	303	242	292	373	359	417	361	1,888	80%
Home-based Intermediate Care (incl. D2A & Re	581	574	409	312	524	540	562	568	610	663	599	674	591	557	568	511	420	517	476	529	536	410	2,723	72%
Musculoskeletal Service	2,095	1,927	991	303	636	545	518	431	530	531	557	691	893	918	1,089	1,016	968	1,111	1,408	1,487	1,689	1,353	8,822	67%
Total	**35,257**	**33,829**	**23,491**	**19,445**	**28,075**	**30,651**	**30,843**	**30,637**	**30,154**	**30,569**	**27,648**	**30,989**	**31,693**	**31,728**	**31,827**	**30,969**	**27,166**	**26,597**	**29,260**	**32,999**	**34,390**	**28,307**	**130,666**	**96%**

The table above shows total activity across NCL community services with services ranked (high to low) according the level of activity reported in the last 4 weeks compared to the same period last year. Note that the table assumes a mapping of services from the original data to a more standardised set of service categories in order to provide a consistent view across NCL.

Data Source: Community Services Recovery Dashboard

NCL Community Services – Waiting times by Provider

North Central London
Clinical Commissioning Group



Provider	0 - 6 Weeks	6 - 12 Weeks	12 - 16 Weeks	16 - 18 Weeks	18 - 30 Weeks	30 - 40 Weeks	40 - 52 Weeks	52 + Weeks	Total	Variance to April 2021								
										0 - 6 Weeks	6 - 12 Weeks	12 - 16 Weeks	16 - 18 Weeks	18 - 30 Weeks	30 - 40 Weeks	40 - 52 Weeks	52 + Weeks	Total
Whittington	7,401	4,352	1,226	329	1,060	161	105	127	14,761	987	-57	-832	-628	-1,253	13	-6	99	-1,677
BEH	3,183	1,311	251	96	461	255	172	602	6,331	512	308	22	47	-62	19	35	-51	830
CLCH	2,873	1,073	179	43	237	82	43	425	4,955	115	-58	-128	-75	32	9	13	6	-86
Camden MSK	1,579	355	14	14	0	0	0	0	1,962	-284	96	13	14	0	0	0	0	-161
CNWL	601	117	21	13	52	70	34	48	956	232	48	-6	8	-49	47	7	-1	286
RFL - Community Paeds	189	149	73	30	67	2	1	0	511	135	90	36	6	2	-1	1	-1	268
Total	**15,826**	**7,357**	**1,764**	**525**	**1,877**	**570**	**355**	**1,202**	**29,476**	**1,697**	**427**	**-895**	**-628**	**-1,330**	**87**	**50**	**52**	**-540**

The table above shows the provisional waiting list information across selected community services in NCL.

Data Source: Community Services Recovery Dashboard

NCL Community Services – 52 Week Wait Summary

North Central London
Clinical Commissioning Group

Provider	Adult/ CYP	Service Line Group	Reported Position Mar 21	Reported Position Apr 21	Reported Position May 21	Variance to May 21
BEH	Adult	Diabetes Service	68	70	59	-11
		Musculoskeletal Service	0	0	1	1
		Orthoptics Service	6	6	6	0
		Podiatry Service	1	0	0	0
		Respiratory Service	13	6	55	49
		Speech and Language Therapy Service	3	3	0	-3
	CYP	Child Development Services	454	455	456	1
		Children's Community Nursing Service	78	80	11	-69
		Community Paediatrics Service	419	25	11	-14
		Looked After Children	1	2	2	0
		Nutrition and Dietetics Service	5	6	1	-5
BEH Total			1048	653	602	-51
CLCH	Adult	Musculoskeletal Service	0	1	0	-1
		Podiatry Service	6	7	7	0
		Rehabilitation Service	1	1	0	-1
		Respiratory COPD	1	1	1	0
		Respiratory Spirometry	350	409	411	2
	CYP	Orthoptics Service	0	0	6	6
CLCH Total			358	419	425	6
CNWL	Adult	Respiratory Service	49	49	46	-3
	CYP	Autism Services	0	0	1	1
		Occupational Therapy Service	0	0	1	1
CNWL Total			49	49	48	-1
RFL	CYP	Community Paediatrics Service	0	1	0	-1
RFL Total			0	1	0	-1
Whittington	Adult	Diabetes Service	0	0	32	32
		District Nursing Service	0	1	0	-1
		Musculoskeletal Service	1	0	0	0
		Occupational Therapy Service	2	0	0	0
		Physiotherapy Service	5	1	0	-1
		Rehabilitation Service	0	1	0	-1
		Respiratory Service	54	3	0	-3
		Speech and Language Therapy Service	19	18	3	-15
	CYP	Child Development Services	11	4	4	0
		Community Paediatrics Service	132	0	79	79
		Haematology Service	0	0	1	1
		Looked After Children	9	0	2	2
		Physiotherapy Service	0	0	1	1
		Speech and Language Therapy Service	0	0	5	5
Whittington Total			233	28	127	99
Grand Total			1688	1150	1202	52

Data Source: Community Services Recovery Dashboard

Risks – Pressures on Activity and/or Waiting Times:

1. Pressures from COVID on unplanned services: Decision to admit, P2 Beds & Rapid Response.
2. Supporting the COVID vaccine delivery programme (in addition to business as usual).
3. Other new community services lines that have been established: Integrated Drug Treatment Service; Virtual Wards.
4. Future rehab demand: increased demand and acuity from post-COVID patients.
5. Potential impact of reduced face to face in Primary Care on referrals (e.g. Heart Failure, Rapid Response).
6. BEH Child Development Services: Commissioners are working with providers to establish how many of the long waits are actual waits and to provide a plan to reduce these long waits as part of the community recovery programme.

3.5 NCL NHS Mental Health Services

North Central London
Clinical Commissioning Group

Contracting Highlights

Mental health services have established all age crisis services and alternatives to A&E for mental health patients in crisis during the COVID period. The pandemic has had a belated impact on Mental Health services given the rising tide of social and economic challenges for both adults and young people.

Mental health priorities reflect an assessment of local needs as well as performance against key Long Term Plan and Covid-19 Recovery deliverables for mental health services.

NCL system mental health priorities:

1. **Core community offer**: Stabilisation, expansion and transformation of core community services for people with complex needs due to serious mental illness with a focus on physical health, co-produced with expanded primary care mental health, community, VCS services and service users. Including the expansion of Early Intervention in Psychosis (EIP) services in line with national standards. (NMC, IPS and SMI).
2. **Children and young people**: Achieve the ambition of 100% coverage of 24/7 children and young people crisis services, including the development of early intervention and community prevention services aligned to the THRIVE principles. Development of CAMHs T4 bed management model and integration with specialised commissioning (CYP MH).
3. **IAPT**: Increase the use of IAPT / Integrated long term conditions and voluntary sector offers to respond flexibly to need. (IAPT)
4. **Adult Crisis Pathway -** Crisis alignment to 'Think 111 First' programme and streamlined to ensure effective patient and professional navigation of the mental health crisis pathway and access points.
5. **MH Inpatient capacity**: Ensure sufficient adult inpatient bed capacity to reduce OAP, through improving DTOCs and flow and better utilisation of inpatient capacity across NCL, whilst adhering to IPC guidelines. (OAP)

Enabler priorities for the system:

- ❑ **Health inequalities:** Our ICS will pro-actively focus on reducing health inequalities. Throughout our Mental Health system planning and delivery we will reduce health inequalities and promote equality embedding NHS MH equalities guidance and innovation locally.
- ❑ **Workforce wellbeing:** Maintain psychological and well being support for NHS staff with focus on BAME staff groups.
- ❑ **COVID**: Lock in and embed beneficial COVID changes e.g. digital, expanded crisis provision, optimising use of capacity across NCL.

The CCG will receive funding to meet the Mental Health Investment Standard (MHIS). Providers and commissioners have worked collaboratively to agree the allocation of the investment to key Long Term Plan priorities to implement sustainable improvements in mental health care.

Mental Health Investment 21-22

North Central London
Clinical Commissioning Group

MHIS

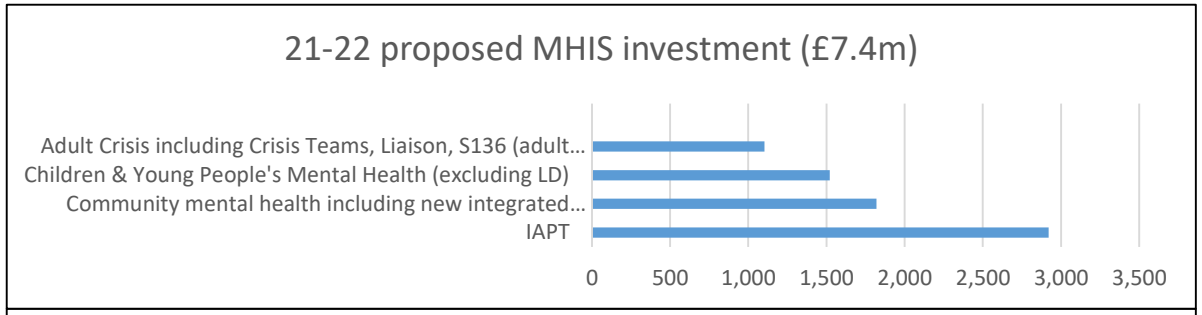
- Overall £7.4m investment.
- The largest investment being made into IAPT services
- Plus significant investment into the new community model for MH.
- Investment also crisis; in to the continuation of the 24/7 crisis lines for both Adults and CYP, as well as liaison and diversion for CYP, with additional investment in the North of NCL to ensure an equitable offer for CYP.
- Investment in to eating disorders services for CYP, recognising the increase in acuity and a drop in achievement in access targets
- Investment in adult crisis teams, liaison, S136 and MHJRC.

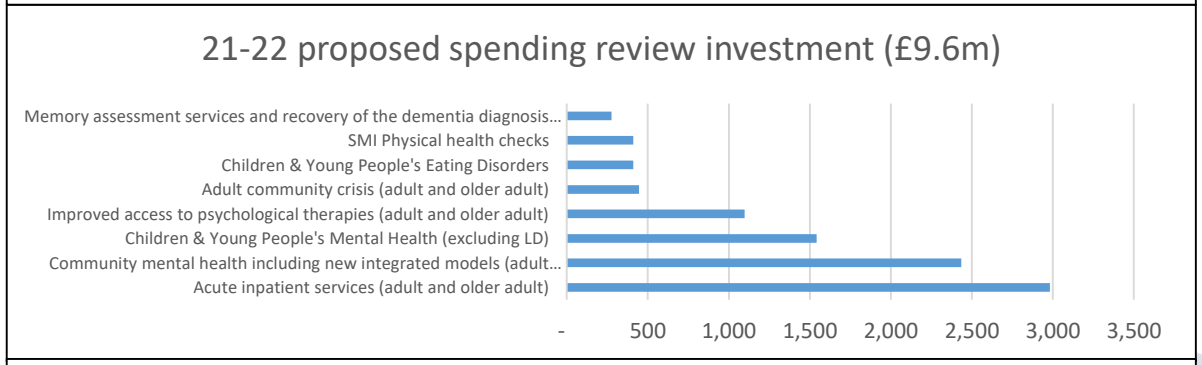
Spending Review

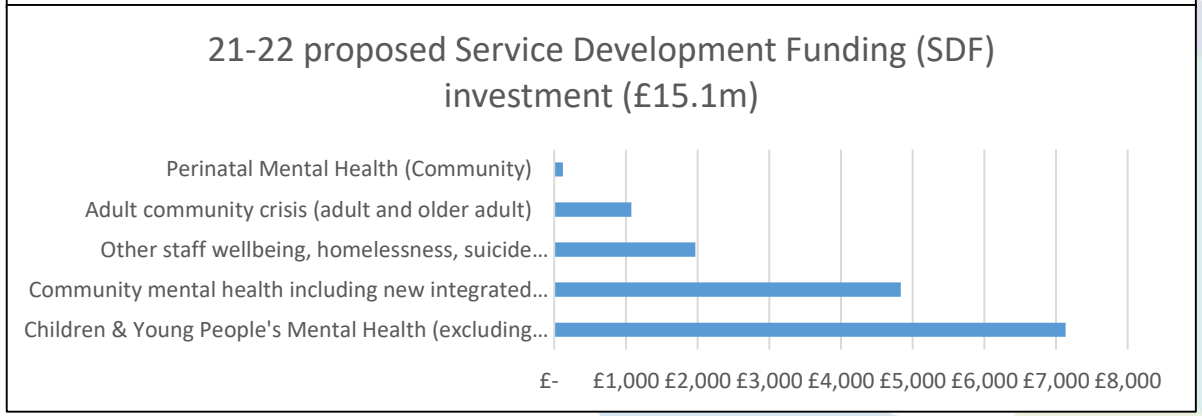
- Investment in line with national 'must dos' at £9.6.
- Largest area of investment in to adult inpatient care with the ambition to eliminate OAPs. Good progress made in this area, bolstered the continuation of winter discharge schemes Significant investment into CYP; Crisis and community, Home treatment teams and DBT as well as CYP Eating Disorders adding community provision
- Investment also in to support for SMI Physical Health Checks, IPS recognising the recovery position of both areas of service. Young adults investment supporting transitions.
- Matched significant funding in to the community mental health model to ensure rapid roll out of integrated mental health support to PCNs (ARRS).
- Topping up IAPT investment and recovery of dementia waiting lists.

Service Development Funding

- Circa £15.1m of investment, excluding the next wave of MHST funding.
- Significant investment in to the Mental Health in schools programme. The next wave of funding recognising the level of deprivation and need in parts of NCL
- Significant investment into the new community model for MH and Young Adults and Perinatal investment.
- Investment into Adult Crisis pathways – Crisis Houses and Cafes
- Staff support and resilience hubs. Suicide prevention and bereavement investment and Rough sleeping investment

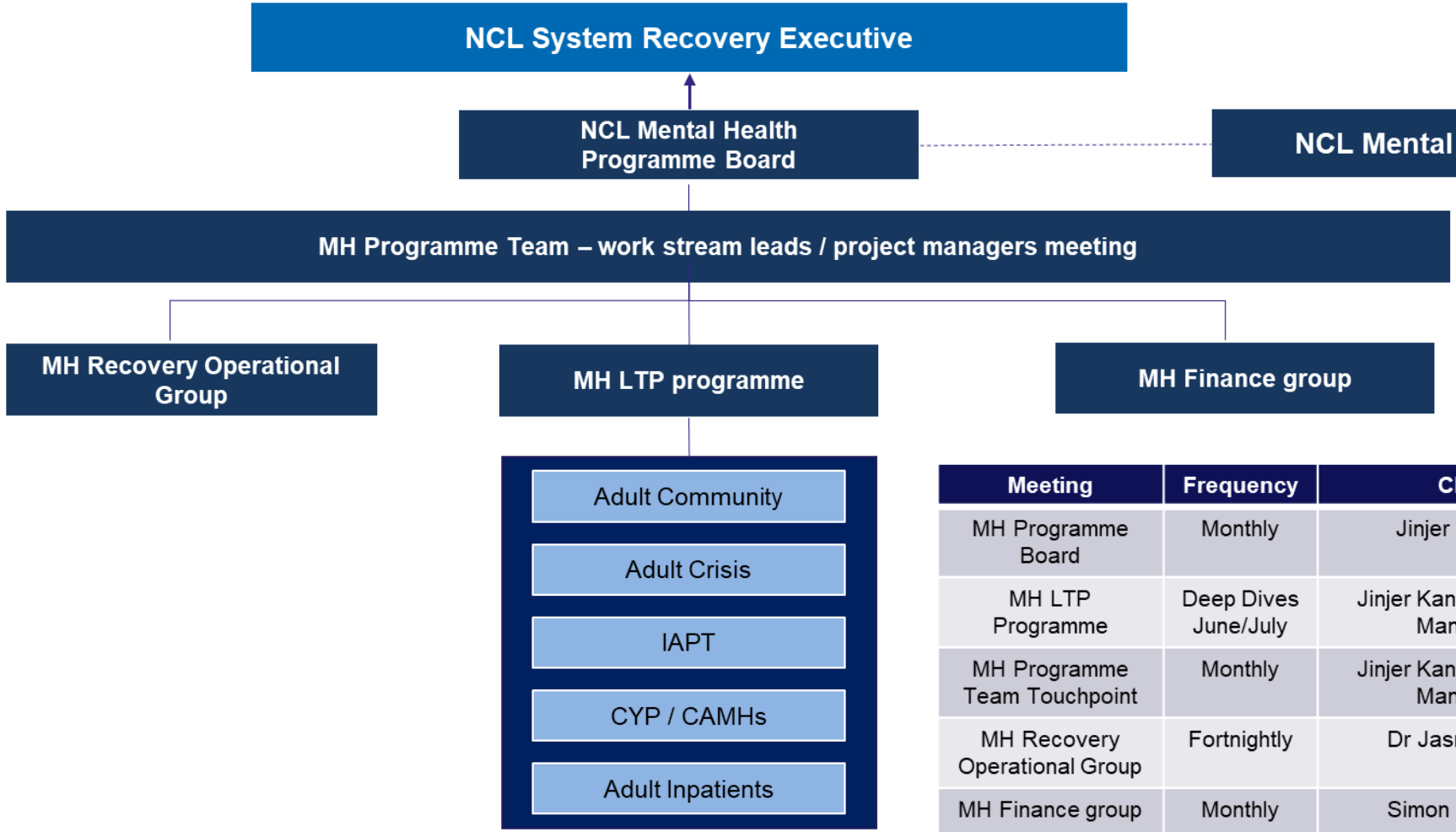






Mental Health Programme Governance

North Central London
Clinical Commissioning Group



Meeting	Frequency	Chair	Management support
MH Programme Board	Monthly	Jinjer Kandola	Dan Morgan / Carolyn Piper / Mary Morgan
MH LTP Programme	Deep Dives June/July	Jinjer Kandola / Sarah Mansuralli	Dan Morgan / Carolyn Piper / Mary Morgan
MH Programme Team Touchpoint	Monthly	Jinjer Kandola / Sarah Mansuralli	Dan Morgan / Carolyn Piper / Mary Morgan
MH Recovery Operational Group	Fortnightly	Dr Jasmin Malik	Dan Morgan / Akin Adepoju
MH Finance group	Monthly	Simon Goodwin	Mary Morgan
MH CEOs Group	Quarterly	Jinjer Kandola / Angela McNab	Dan Morgan / Carolyn Piper / Mary Morgan

Data Source: Mental Health Recovery Workstream

Mental Health Recovery

North Central London
Clinical Commissioning Group

There are a range of recovery programmes within mental health, the following is a summary of the some of those programmes:

Out of Area Placements (OAP) – The ICS submitted a phase 3 plan to limit inappropriate out of area placements to 1250 bed days in Q3, reducing to 700 bed days in Q4 of 2020/21. During wave 2 (Nov 20-Jan 21) discharges increased and peaked in December as bed demand significantly increased. Based on published data 25 new inappropriate OAP patients were reported for March. That accounted for 445 OAP bed days for NCL CCG equivalent of 14.4 beds per day.

Early Intervention in Psychosis (EIP) – EIP standard in 20/21 requires that minimum 60% of people with first episode of psychosis will be treated within two weeks of referral. In March NCL met the target at 71% for treatment started within two weeks of referral.

Improving Access to Psychological Therapy (IAPT) – North Central London achieved the 75% standard for the six weeks waiting times at 90% in March. Against eighteen weeks waiting times it achieved 99% against 95% target. In March NCL achieved a recovery rate of 39% failing to meet the standard rate of 50%. NCL failed to meet the monthly access target of 1.81% by reporting 1.75% in March. In April 2020 referrals received dropped to its lowest at 1,660 but has been steadily increasing with March reporting 5,260 referrals received, an increase of 17% compared to February. By end of March 3,890 patients were still waiting for assessment, which has decreased by 45 patients compared to February. Patients waiting for treatment increased by 3% in March compared to previous month. In March 3,210 patients commenced their first treatment compared to 2,785 in February.

Physical Health Checks for People with Severe Mental Illness (PHSMI) – The COVID 19 pandemic has negatively impacted on delivery of SMI physical health checks across NCL with primary care staff focusing on the COVID response alongside rolling out of the COVID 19 Vaccination Programme. Additional factors such as social distancing requirements and hesitancy to attend health care appointments have also further driven underperformance in this area. As per the Phase 3 recovery plan submission, the new standard to be achieved is 30.6% by Q4 2021. Q4 performance across NCL for completion of all 6 health check domains over a rolling 12 month period was 18% -significantly below the trajectory of 30.6%.

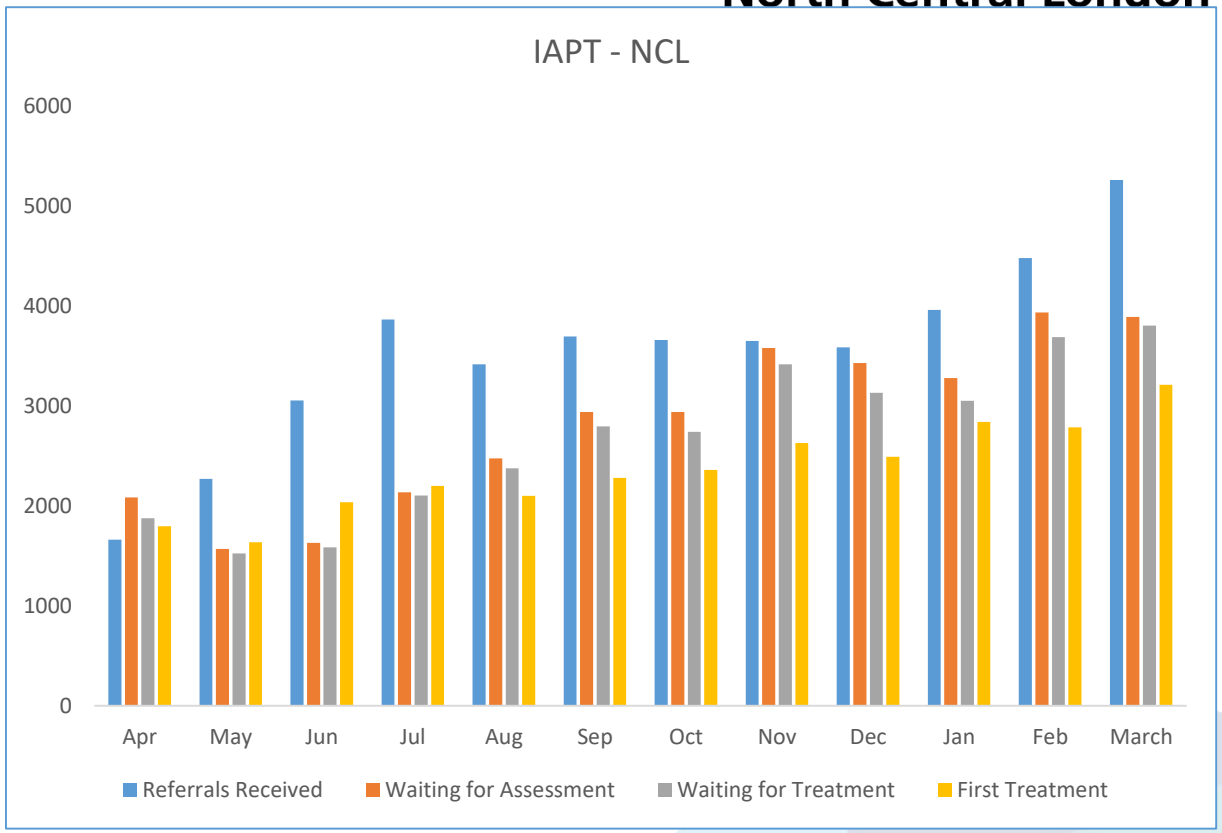
Children and Young Peoples (CYP) Mental Health Access – The crisis pathway has been effective in redirecting CYP away from acute services and service has continued to hold stable, albeit pressured through growing acuity and demand of CYP presenting in crisis. A trajectory has been agreed to achieve 35% target by March 2021 to support increased access to NHS funded community mental health services for children and young people. 12 months rolling position as of March is at 39.5%, which is well above the target. In month target for March was set at 35% which was achieved at 38.8%.

Source: MH Recovery provided to MH Silver Group.

Mental Health –Improving Access to Psychological Therapies (IAPT)

North Central London

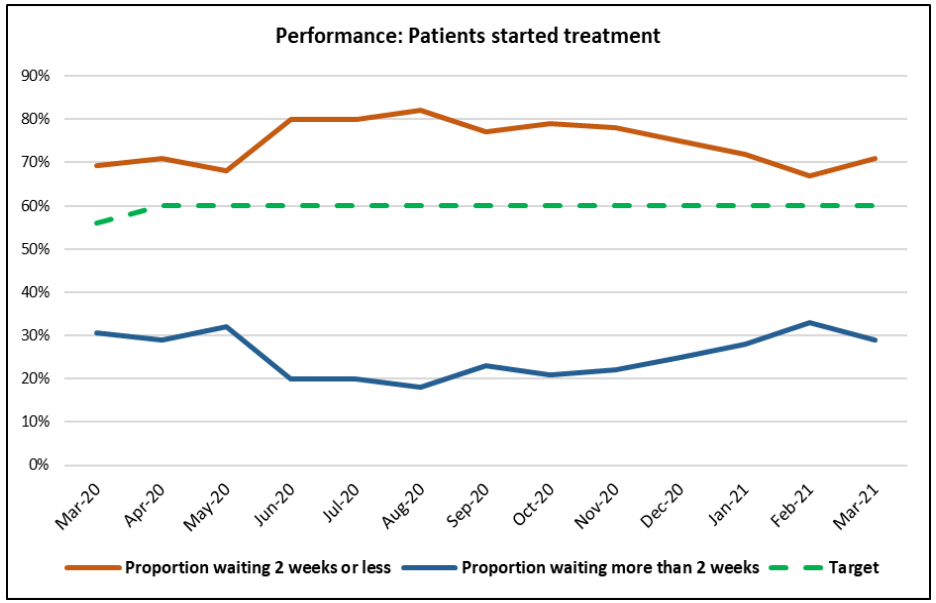
- **Waiting Times:** North Central London achieved the 75% standard for the six weeks waiting times at 90% in March. Against eighteen weeks waiting times it achieved 99% against 95% target.
- **Recovery Rates:** In March 2021 NCL achieved a recovery rate of 39% which is a 5% improvement from last month but still under the standard rate of 50%.
- **Access Standard:** In March NCL CCG failed to meet the set phase 3 target of 1.81% by achieving only 1.75% access rate.
- **Referrals Received:** In April 2020 referrals received dropped to its lowest at 1,660 but has been steadily increasing with March reporting 5,260 new referrals received.
- **Waiting time for assessment to treatment:** By end of March 3,890 patients were still waiting for assessment, which has decreased by 45 patients when compared to February i.e. 1% decrease.
- **Patients waiting for treatment** increased by 3% in March compared to previous month.
- **Patients who have had their First treatment** has increased by 15% in March compared to previous month.

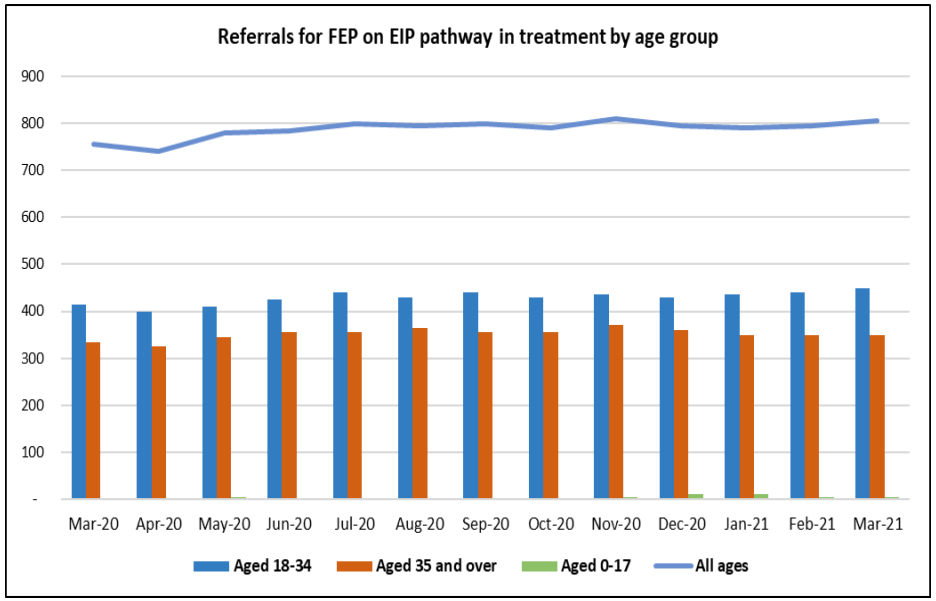


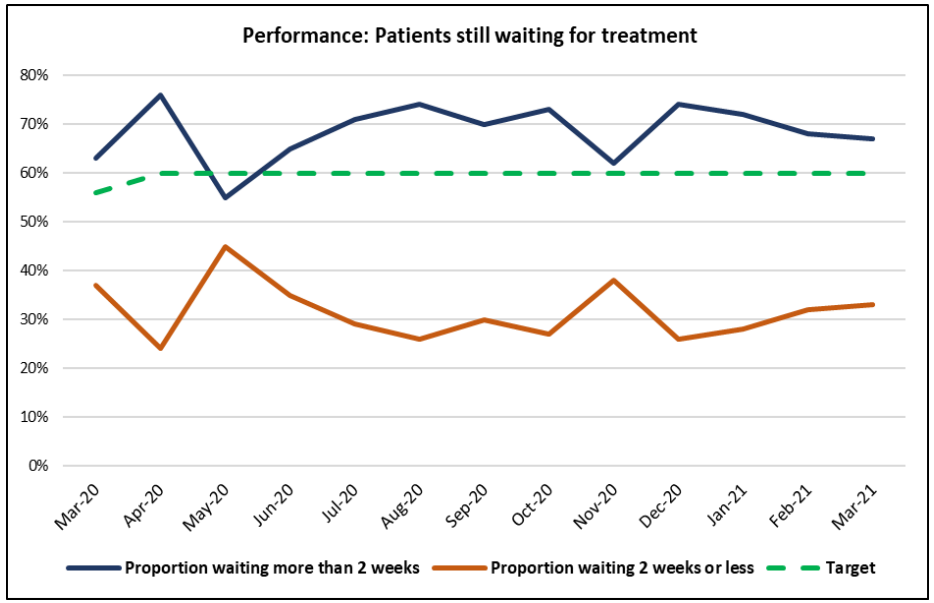
APR-MAR				
	Referrals Received	Waiting for Assessment	Waiting for Treatment	First Treatment
Median	3,655	2,940	2,768	2,320

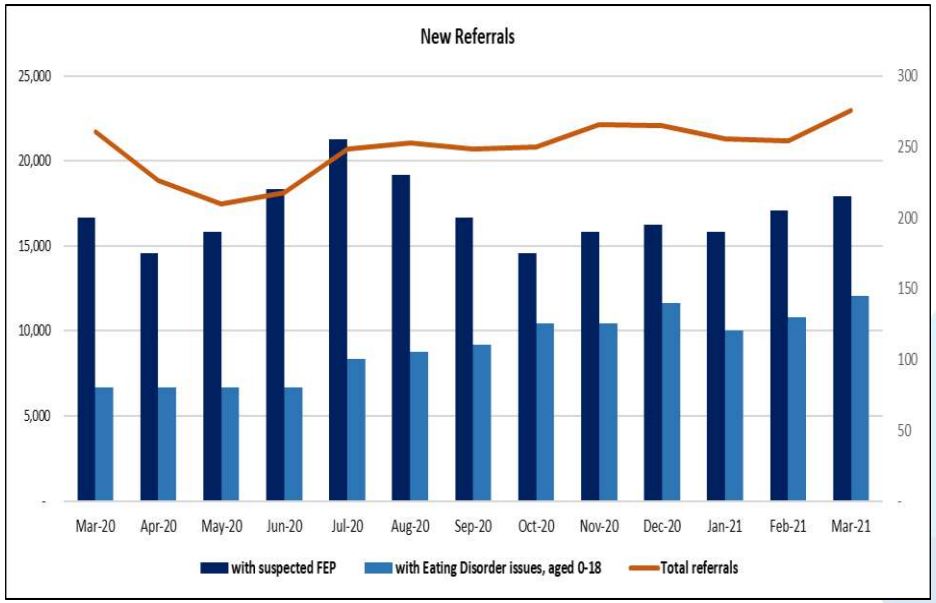
Data Source: Mental Health Report – NCL Quality Data Pack and nationally published MHDS

Early Intervention in Psychosis (EIP)









NHS
North Central London
Clinical Commissioning Group

- EIP standard in 20/21 requires that more than 60% of people with first episode of psychosis will be treated within two weeks of referral.
- Based on 3 months' rolling period from January to March:
  - NCL met the target at 71% for treatment started within two weeks of referral.
  - Of those patients still waiting to commence treatment 67% had been waiting more than 2 weeks at the end of March.
  - New Referrals with suspected First Episode Psychosis (FEP) was 215 compared to 205 reported for last rolling period, and
  - New Referrals with eating disorders issues for 0-18 years was 145 – up from 130 in the previous reporting period. These are referred to CAMHS and not the EIP pathway.

3.6 Independent Sector Providers - Contracting Highlights

North Central London
Clinical Commissioning Group

The following information highlights commissioning arrangements for Independent Sector Providers who are supporting the COVID response and elective recovery by providing additional capacity to the system.

In March 2021 Independent Sector (IS) Provider contracts provided a mix of elective and diagnostic services delivered through:

1. **Outer London** NHSE 'Block' IS Provider contracts e.g. Aspen (Highgate) and Circle formerly BMI (Cavell, Hendon and Kings Oak)

2. **Zones 1 and 2 IS Provider Framework contracts** e.g. Hospital of St John and St Elizabeth, The London Clinic (TLC), MS Reproductive Services formerly Marie Stopes or Schoen Clinic.

3. **Healthcare America (HCA)**
    - The Wellington Hospital for routine ENT procedures (excluding dental) for UCLH.
    - NHS arrangements were also established with Harley St Clinic, Princess Grace and Wellington Hospitals for urgent cancer activity (Breast, Colorectal, Thyroid, Upper GI) and additional capacity for Cardiology, Vascular and other specialities from NMUH, RFL, UCLH and Whittington.

As of 31 March 2021 all NHSE contracts ceased, along with HM Treasury funding for these. Going forward into 2021/22 local commissioners and NHS trusts assumed responsibility for negotiating, managing and funding all new agreements.

Data source: Independent Sector Contracts Team

Independent Sector Providers – Outer London

North Central London
Clinical Commissioning Group

Contracting Arrangements for Outer London 2021/22

A summary of the contracts and sub-contracts currently pending final signatures is presented in the below table for outer London Independent Sector Providers.

NHS Trusts have established sub-contracts with Aspen, Circle, MPI (diagnostics), MSI Reproductive Services and Schoen Clinic London Ltd using the Direct Award mechanism within the ICFA. This allows for agreements to be directly award for six months only, with no option to extend. Further sub-contracting beyond this period will require a competitive exercise.

North Central London CCG has established annual agreements with Aspen and Circle (at Cavell, Hendon and Kings Oak) for e-RS/Choose and Book activity. NCL CCG is also an associate to the North East London CCG contract with BMI London Independent Hospital, again for e-RS activity. RNOH has negotiated a standalone agreement with Spire Bushey, which is not part of the ICFA.

Outer London Independent Sector Providers Contracts and Sub-Contracts 2021/22

IS Provider	Site	NHS Trust (Sub-Contracts)					NCL CCG (Contracts)
		NMUH	RFL	RNOH	Whitt	UCLH	
Aspen	Highgate	Yes	Yes	Yes	Yes	Yes	Yes
Circle (formerly BMI)	Cavell	Yes					Yes
	Hendon					Yes	Yes
	Kings Oak		Yes				Yes
MSI Reproductive Services			Yes		Yes	Yes	
Schoen Clinic London Ltd						Yes	
Spire (Bushey)				Yes			
MIP						Yes	
HCA			Yes			Yes	

Data source: Independent Sector Contracts Team

Independent Sector Providers - Activity & Performance

North Central London
Clinical Commissioning Group

Activity & Performance Highlights

As at week ending 23 May 2021 utilisation of independent sector provider sites against submitted baseline plans was below plan for electives, day cases and outpatients.

Reduced performance was due to a combination of issues:

- Lack of BMI data flow (to be addressed using validated Weekly Contract Monitoring reports from Trust)
- Short list sizes or late list cancellations by NHS trusts

Due to Infection Prevention Control requirements, the latter bullet point above means that it is then too late to book another patient onto a list.

The Weekly Ops Meeting and Independent Sector Provider Programme Board continues to work with surgical hubs, acute trusts and independent sector providers, through improved coordination and communication to enhance utilisation and prioritisation and expand the capacity of daily theatre lists through June 2021 and beyond.

Data source: Independent Sector Contracts Team

Independent Sector Providers – Monitoring Arrangements

North Central London
Clinical Commissioning Group

Weekly Ops meetings have been established with Aspen and BMI and include dedicated Trust Operational Leads and Independent Sector Provider Liaison Officers identified to coordinate the transfer of patient lists and maximise effective use of the respective Independent Sector Provider sites. These will also provide an opportunity to trouble shoot and resolve issues as these arise. These meetings will track:

- Patient Tracking Lists, PTL transfers i.e.: how many patients transferred to date again agreed plan;
- PTL status i.e. of patients transferred how many have been offered a first outpatient appointment;
- Delivery against Plan (combined Baseline Plan and Accelerated Recovery Plan) i.e. Plan versus actuals

Specifically in regards to the NCL CCG contracts with Aspen and BMI, monthly contract meetings have been established, focusing on:

- Tracking finance and activity;
- Performance monitoring: Waiting lists, Referral to treatment times, 52 week waits and clinical harm reviews

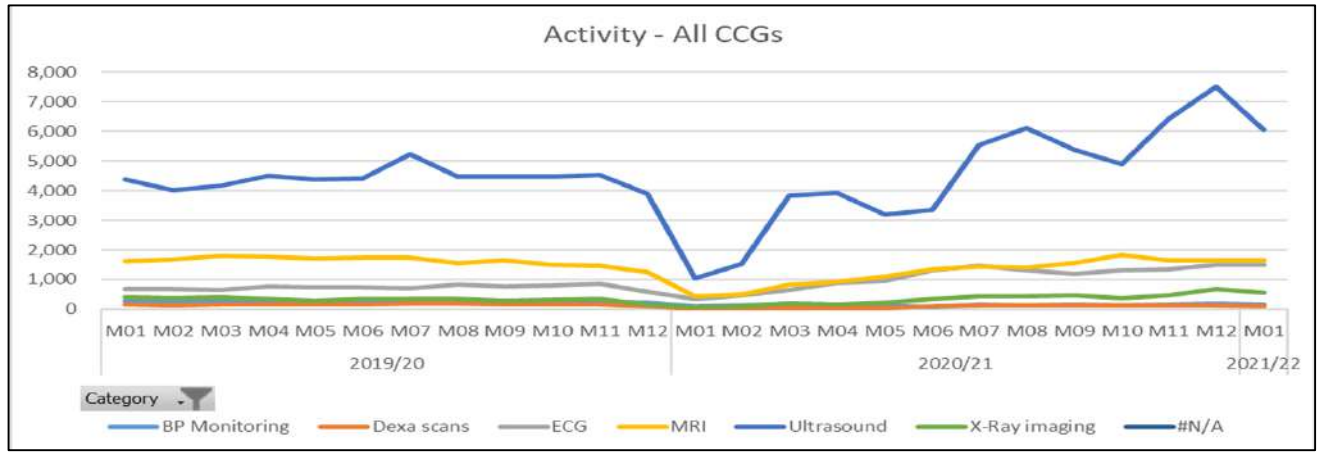
To support the transfer of PTLs from Trusts to Independent Sector Providers, parties have agreed a patient checklist (including exclusion criteria and communications script) and minimum patient documentation and dataset requirements.

For the ISP contracts there is a process of monthly reconciliation and review, including checking of technical claims and assessment of the impact upon the Elective Recovery Fund value for NCL. There is also a reconciliation of the ISP activity to the Operating Plan position, which is currently showing an achievement to plan. The current achievement is a combination of all ISP's, noting that Aspen site is currently 40% higher than planned levels while BMI sites are planning to do more activity as capacity becomes available. It is also recognised that there will be an ebb and flow to the activity during the year as capacity fluctuates at sites and between providers. The current reporting for ISP includes April and May or Months 1 and 2 of the year.

Data source: Independent Sector Contracts Team

3.7 InHealth - NCL Activity and Cost Summary (excluding Audiology)

North Central London
Clinical Commissioning Group



Activity overall in Month 1 2021/22 has decreased by -14% (1,634 scans) when compared to the previous month (Month 12 2020/21).

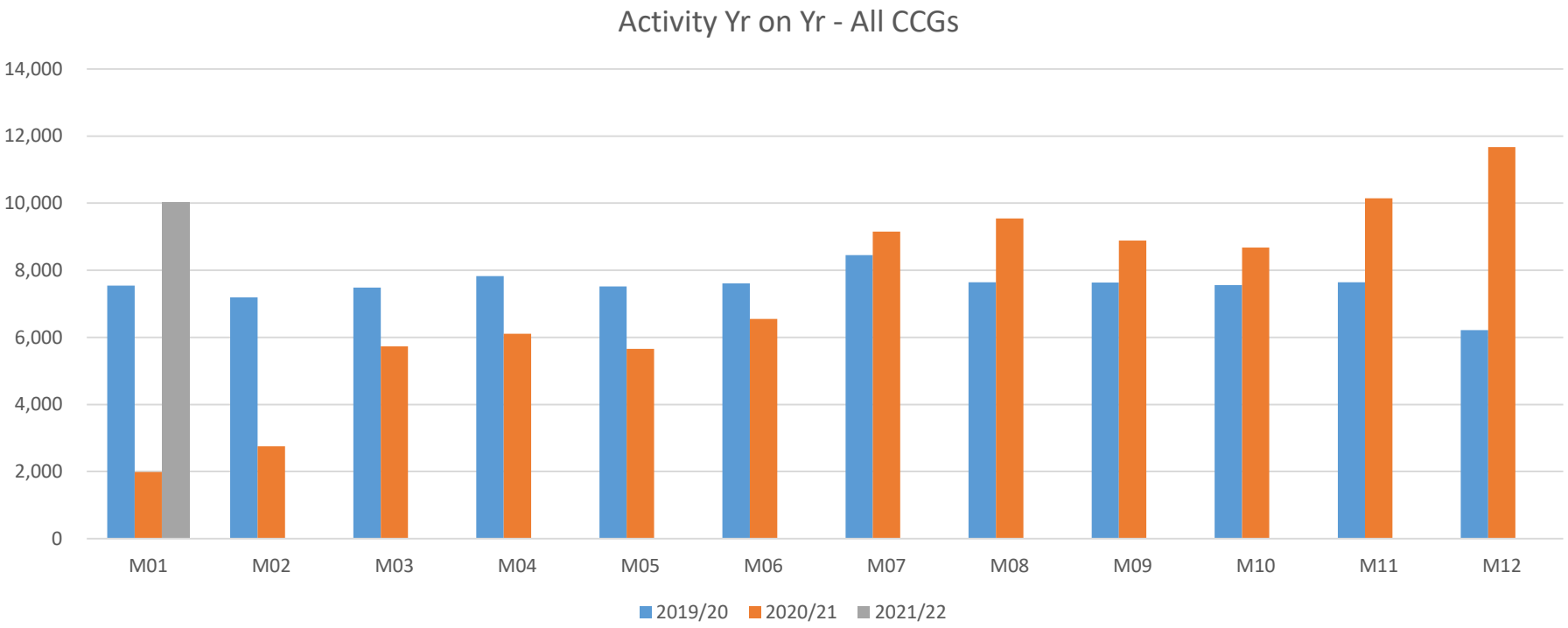
Costs in Month 1 decreased -12% (-£87,153) compared to last month (Month 12).

Application of the COVID inefficiency factor of +25% ceased in Month 10 (1 January 2021).

Modality	% Change	No. of Referrals
Ultrasound	-20%	-1,473 scans
X-rays	-20%	-141 scans
DEXA	-15%	-12 scans
Blood Pressure Monitoring	-10%	-19 scans
ECG	-0.4%	-6 scans
MRI	+1%	+20 scans

InHealth – Month 1 19/20 to Month 1 21/22 Activity (excluding Audiology)

North Central London Clinical Commissioning Group



When comparing **activity** for Month 1 2021/22 to Month 1 2020/21 activity overall is +405% higher (+8,052 activity).

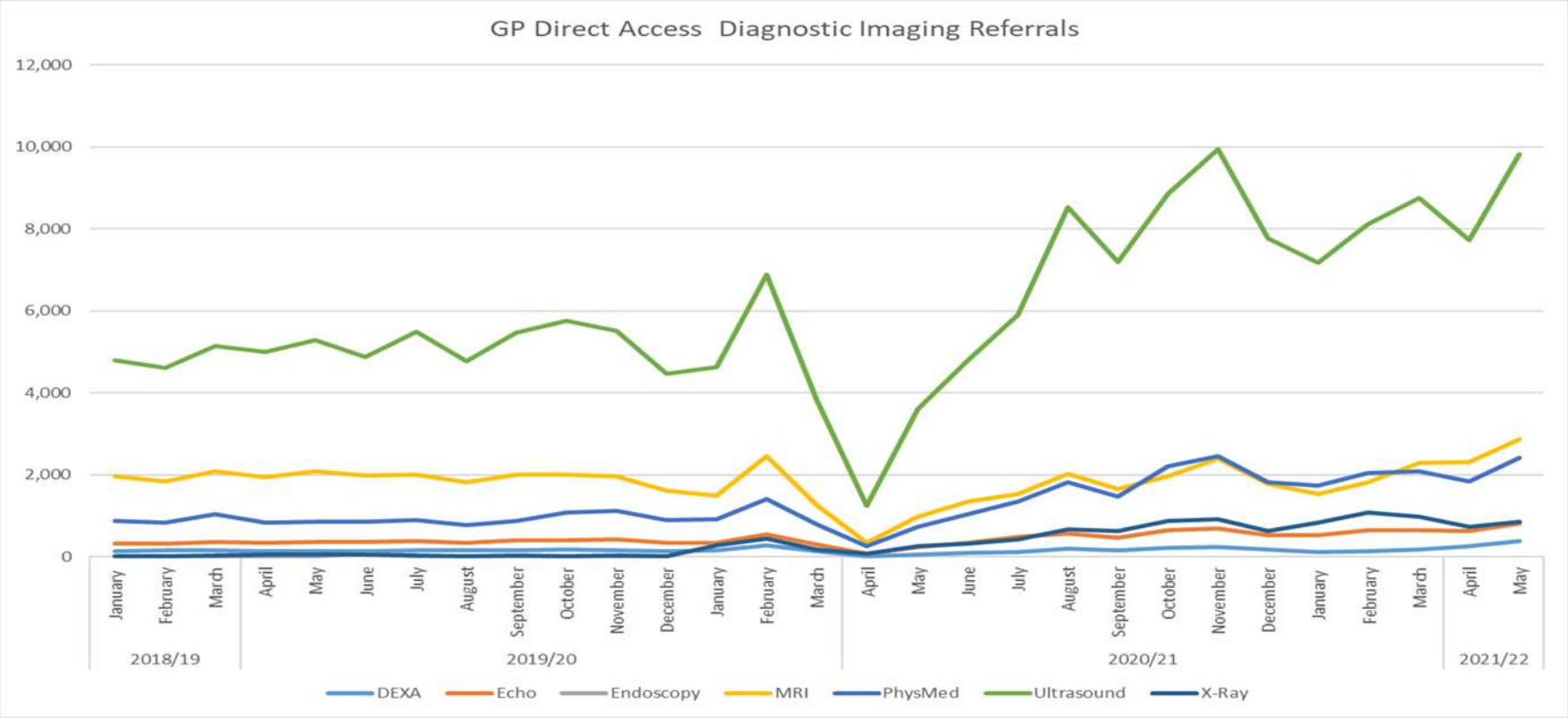
When comparing **cost** for Month 1 2021/22 (excluding inefficiency factor) to Month 1 2020/21 cost overall is +379% higher (+£501,249).

The increase in activity and cost is expected as Month 1 2020/21 was impacted by the first wave.

Data source: Provider SLAM

InHealth - GP Referral Volumes January 2018 to May 2021

North Central London
Clinical Commissioning Group



The number of GP referrals in Month 2 2021/22 is significantly higher at +191% (11,270 referrals) when compared to Month 2 2020/21.

This has been driven by:

Modality	% Change	No. of Referrals
DEXA	+577%	323 referrals
Echo	+247%	587 referrals
Phys. Med	+231%	1,687 referrals
X-Rays	+210%	578 referrals
MRI	+195%	1,900 referrals
Ultrasound	+171%	6,195 referrals

It is expected these numbers will fall as all acute trusts have reopened to GP routine referrals with the exception of Royal Free for MSK ultrasound guided injections. Royal Free is currently recruiting to vacant posts and has established mutual aid arrangements with RNOH for backlog clearance in this area.

Data source: Provider SLAM

3.8 Continuing Healthcare (CHC) Recovery and Deferred Assessments

North Central London Clinical Commissioning Group

Across NCL key internal reviews are starting to look at opportunity areas to work more seamlessly across borough facing teams to flex resources to match demand with capacity and utilise specialist clinicians. Recruitment is ongoing for vacancies in permanent posts in CHC.

In addition, CHC service for Camden has recently transferred across to NCL CCG (effective 1 April 2021).

NHS England oversight and monitoring for CHC has recommenced. NCL CCG is now benchmarked against other London CCGs and is required to submit trajectories to NHSE on recovery by 24 June 2021. The key focus is on metrics of number of Decision Support Tools (DSTs) completed within 28 days and the number outstanding over 12 weeks.

NCL CCG is currently in the challenged category (fourth out of four) in terms of national position on these metrics. The NCL CHC operational teams are currently verifying data and developing demand and capacity recovery plans to meet national requirements by Quarter 4 2021/22.

The key focus area is the completion of audit actions around the CHC audit received in February 2021.

The initial deferred assessments accrued in the COVID funding period are now open for appeal. The table below captures the position. There is a 6 month period from 31 March 2021 and/or from when they received the outcome letter to appeal.

Type of Request	Barnet	Camden	Enfield	Haringey	Islington	Total NCL
Appeal	9	2	6	4	1	22
Checklist Review	3	0	1	0	0	4
DST Retrospective	1	1	0	0	0	2
RIP	0	0	1	0	0	1
TOTAL	**13**	**3**	**8**	**4**	**1**	**29**

Data source: CHC Team

3.9 Other Matters – Borough Contracts Review

North Central London
Clinical Commissioning Group

The NCL Borough Contract Review Group commenced work in October 2020 to review all the expired contracts and contracts that were due to expire by 31 March 2021. The review included a recommendation from the commissioner for renewal or termination of each contract, including the measurable added value they deliver to the NCL population and consideration of options to increase such value or alternatives to providing the service. The review was split into the following phases:

Phase	Description	No. of Contracts	Status
Phase 1	Contract database validation		Complete
Phase 2	Contracts expired on 31 March 2021	96	Complete
Phase 3	Section 75	302	Complete
Phase 4	Contracts due to expire by 31 March 2022	18	In Progress

Phase 4: 14 of the 18 contracts in Phase 4 are currently being reviewed through their contract evaluation forms. The other 4 contracts will now be reviewed through alternative service reviews; 2 contracts will be reviewed as part of the Mental Health Services Review, 1 contract will be reviewed as part of the Community Services Review and 1 contract will be reviewed as part of the End of Life Business Case.

There are 42 additional borough contracts that are due to expire on or before 31 March 2022 (in addition to the 18) however as these are contracts held by NCL providers it was agreed that these will be negotiated as part of NCL provider contract negotiation once this resumes.

Phase 5: of the Borough Contract Review is now underway and is focused on Consolidation and Equalisation with ~300 Contracts in scope (covering £130m of spend). The paper outlining proposals was considered by the SCC in May and the more detailed proposal sits with the Procurement Committee to oversee. The intention of Phase 5 is to reduce the contracting burden, realise efficiencies and tackle inequalities. Updates will be provided via this report going forward with oversight occurring via the Procurement Committee.

Data source: NCL Borough Contracts Review Group

3.9 Other Matters – Patient Transport Service (PTS)

North Central London
Clinical Commissioning Group

- Updated NHSE PTS guidance was issued in September 2020 allowing commissioners to reinstate eligibility criteria, widened to include COVID positive patients, patients being discharged from hospital and patients classed as 'extremely clinically vulnerable' travelling to essential appointments (e.g. dialysis and chemotherapy). There is no need for a PTS vehicle or crew, transport can be provided by taxi. The cost of this transport to the sector between October 2020 and March 2021 was £300k.

- Weekly patient journeys have now returned to pre-COVID levels. However social distancing remains in place which means that PTS vehicles which previously transported up to 6 patients are currently transporting 2 or 3 patients (depending on patient escort requirements). PTS providers are at their resource limits in terms of vehicles and staffing. Providers report no additional capacity to support the demands of the accelerated elective recovery programme should the existing guidance remain in place. These pressures are echoed across London and there is no scope to secure additional resource from outside NCL.

- The estimated cost pressure above provision made in block contracts for March 2021 to October 2021 is circa £5m for the sector, to be met from COVID top up funding.

- On 26 May 2021 NCL Clinical Advisory Group considered a proposal to stand down social distancing requirements on PTS vehicles in line with government plans to end national restrictions (at that time planned for 21 June 2021). CAG did not endorse this plan and indicated a preference to await wider NHS guidance on the matter. CAG also did not endorse a proposal to stand down transport to Clinically Extremely Vulnerable (CEV) patients who did not otherwise meet eligibility requirements, although this is in line with the existing guidance. A further proposal will be brought to CAG when there is clarity on the lifting of restrictions nationally.

- NCL transport leads meet with the CCG weekly and the pan-London group hosted by LAS also continue to meet on a weekly basis to escalate emerging issues.

Data source: PTS Contracts Team

3.9 Other Matters – Vaccination Programme Update

North Central London
Clinical Commissioning Group

1,500,518 vaccinations delivered within NCL

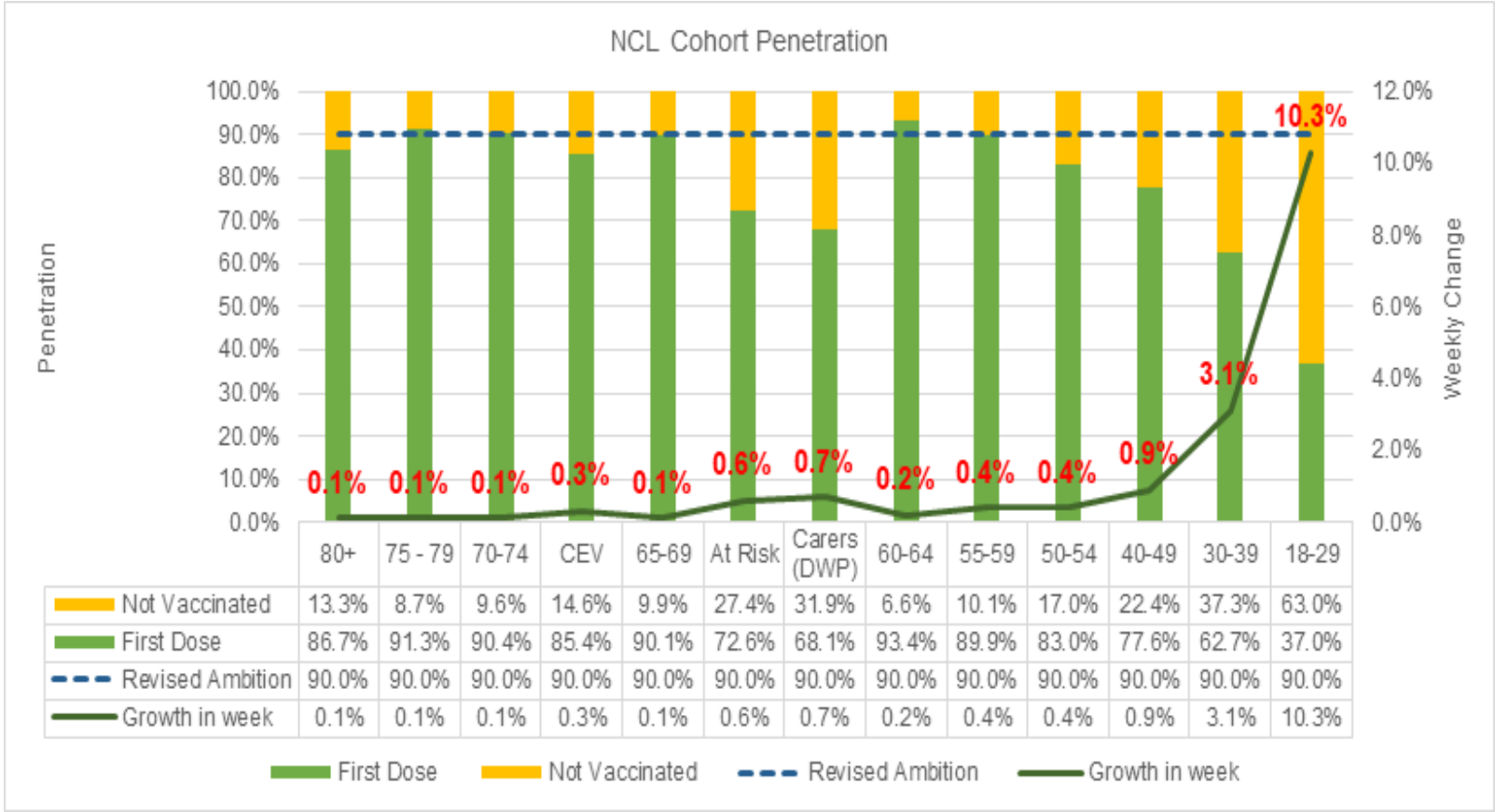
This is comprised of
879,376 First Doses
620,782 Second Doses

The vaccine type split is:
Pfizer: 578.889
AZ: 872,411
Moderna: 49,118

Hospital Hubs have delivered **153,752** vaccinations

Vaccination Centres have delivered **251,386** vaccinations

PCNS and Pharmacy sites have delivered **1,095,380** vaccinations



	80+	75 - 79	70-74	CEV	65-69	At Risk	Carers (DWP)	60-64	55-59	50-54	40-49	30-39	18-29
Not Vaccinated	13.3%	8.7%	9.6%	14.6%	9.9%	27.4%	31.9%	6.6%	10.1%	17.0%	22.4%	37.3%	63.0%
First Dose	86.7%	91.3%	90.4%	85.4%	90.1%	72.6%	68.1%	93.4%	89.9%	83.0%	77.6%	62.7%	37.0%
Revised Ambition	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Growth in week	0.1%	0.1%	0.1%	0.3%	0.1%	0.6%	0.7%	0.2%	0.4%	0.4%	0.9%	3.1%	10.3%

Data source NIMS 21 June 2021

3.9 Other Matters – Inequalities Fund

NHS
North Central London
Clinical Commissioning Group

NCL has committed to address inequalities and an initial fund of £2.5m for H1 21/22 has been identified. This breaks down as follows: £2m for Planning Guidance Priorities (mostly focused on the 20% most deprived wards); £250k for Local Priorities and £250k as a reserve

32 Bids were received for this initial tranche of money and were assessed by a panel including patient representatives, lay members of the Governing Body and Public Health. Bids had been approved by Borough Integrated Care Partnerships (ICPs) before submission and will be presented to the Population Health & Inequalities Committee (PHI) for final ratification.

Individual boroughs were given an indicative budget to work within based on their share of the 20% most deprived wards and proposals were received within these indicatives budgets as shown below:

- Camden: 8 Proposals with a total of £293,150
- Enfield: 7 Proposals with a total of £652,156
- Haringey: 5 Proposals with a total of £588,970
- Islington: 4 Proposals with a total of £366,680
- **Total: 24 Proposals with a total of £1,900,956**

Against the £250k funding for Local Priorities we received 8 proposals, of which 6 will be funded, with allocations as outlined below:

- NCL Cancer Alliance: £36,384
- Barnet: £28,500
- Camden: £25,000
- Haringey: £26,000
- Camden/RFL: £83,500
- Islington: £50,616
- **Total: 6 Proposals with a total of £250,000**

The intention is to release a further £1.25m for H2 21/22 and to make the fund recurrent at £5m/Year from 22/23 onwards and work is underway to address this with further updates available at SCC. Example bids and feedback from the panel are included in the following slides. Full details are available if required.

3.9 Other Matters – Inequalities Fund (Panel Feedback)

North Central London
Clinical Commissioning Group

- The Panel members appreciated quality, scope and level of ambition in bids received particularly given the speed these had been developed at.
- They noted that process had clearly acted as a catalyst for integrated approaches and joint working – in boroughs and across boroughs – bringing its own value to development of place and system thinking.
- The Panel placed particular importance in schemes that had been shaped by grass root engagement with local communities and VCS and that clearly articulated specific needs and how these would be differentially targeted. The importance of ownership of schemes through local partnerships in this was emphasised.
- A number of schemes covered similar needs or communities - opportunities share delivery approaches and plans, align schemes where sensible and develop more coherent/holistic approaches to working with communities.
- The opportunity for learning from successful schemes across partnerships needs to be taken forward in a systematic way. The ICPs and NCL Local Care Forum (which brings together leads from each ICP) could have a key role in this regard.
- Important in future funding process to place additional value on innovation particularly where informed by local people and their experiences.
- Although the importance of assessing impact was important, timescales for addressing health inequalities and preventative approaches longer term. Clarity needed quickly around how successful ongoing schemes would be assessed and funded if appropriate.
- The existence of other funding streams for example, the Mental Health Investment Standard or Accelerator funding to support some initiatives needed to be clarified in a number of cases.
- The value of match funding in cash or kind was really positive.
- Resilience of smaller one worker schemes was raised in a number of schemes and the importance of wider service support/integration was highlighted.

3.9 Other Matters – Inequalities Fund (Example Bids)

Borough	Focus	Expected Impact on Inequalities
Islington	Working with those communities who language, cultural, deprivation or other barriers preventing them taking control of their health and accessing services.	Reduction in barriers to accessing services and improved health outcomes as a result. This will address the holistic needs of these communities to ensure they are able to receive the correct mix of service support. This will ensure equality of access to services and support.
Enfield & Haringey	Working with >100 High Intensity Users per year to engage them with the wider health and care system.	Reduction in the frequency of urgent care needs arising, provision of more holistic support to people and an improvement in their overall quality of life.
Islington	Holistic Support for people with SMI noting the extremely poor long term outcomes for this community.	This will ensure that health outcomes for people with an SMI are improved by addressing both their MH and physical health needs as well as tackling issues around social isolation and improving employment opportunities. This will reduce the long term health outcome inequality that exists between people with SMI and the wider community.
Enfield & Haringey	Targeted interventions for people at risk of developing an LTC in deprived communities.	Through supporting people to address the social determinants of health as well as improving health education we will reduce the prevalence of LTCs in deprived communities with the aim of levelling the prevalence rates to those of more affluent communities.
Barnet	Reducing the incidence of preventable oral disease in <5s in deprived communities.	Through tackling the strong correlation between deprivation and poor oral health this programme will the incidence of oral disease and therefore bring outcomes to a level similar to more affluent communities.
Enfield & Haringey	Reducing the incidence of children <1 attending ED with preventable illnesses and diseases.	This will help educate new and young parents to better understand child health and will also address family wellbeing with the aim of improving confidence. The workshops will work out from the child to address lifestyle issues affecting long term health in the wider family.
Camden	Improving the quality of Annual Health Checks and Health Action Plans for people with LD.	This will provide assurance and consistency around both AHCs and HAPs as well as ensuring the actions identified are followed through. The aim is to reduce the health inequalities experienced by people with LD compared to the wider population and through this improve outcomes.
Haringey	Engaging MH service users at risk of an admission or following an admission to develop resilience.	Through supporting this community to develop effective crisis management strategies and engage them in activities aimed at reducing social isolation and aid recovery we will reduce the long term health outcomes experienced by MH service users compared to the wider population.
Camden	The introduction of race equality and lived experienced into working with people with Autism.	The aim is to reduce the inequalities experienced by people with Autism, which is especially poor in deprived families and some ethnic communities. This will reduce the frequency of people falling into MH Crisis and reduce social isolation with the long term aim of reduce the early mortality experienced by many autistic people.

NHS
North Central London
Clinical Commissioning Group

Section 4: Next Steps & Forthcoming Matters

Next Steps & Forthcoming Matters

North Central London
Clinical Commissioning Group

The following is a summary of next steps with an update to be provided at the next Committee meeting:

- Use Phase 5 of the Borough Contract Review to set the procurement pipeline for NCL and to address the issues identified around equality of services and the realisation of efficiencies. This pipeline will be reviewed by the Procurement Committee and SCC will remain updated through this report.
- Continue to implement the Electively Recovery programme and continue including the rollout of the Accelerator Plans and Accelerator Investments.
- Mobilise the current Inequalities Schemes and progress the decision making process around future funding.
- Progress the Strategic Review for Community Services and Mental Health and provide updates on progress and outputs plus emerging themes. The timeline for the main outputs remains August 2021.
- Finalise the decisions around the Procurement of GP Direct Access Diagnostics (currently delivered by InHealth) and establish reprocurement programme of work.
- Continue to monitor increased demand (through weekly data collection) and financial impact of PTS to ensure costs remain within the financial envelope. Review of any escalating issues through the weekly Pan London group as well as review of proposal to CAG once further information is available on lifting restrictions.
- Continue to monitor and support the development of the community adults and CYP, and mental health recovery dashboards, which will be tabled at the NCL operational meetings on a monthly basis.
- Develop a plan for Long COVID patients to access additional funding based on the guidance released in the 15 June and submit this by the 12 July 2021.
- Implement actions from UEC summit

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	NCL Ageing Well Programme 2021/22	**Date of report**	8 July 2021	**Agenda Item**	2.2
Lead Director / Manager	Sarah Mansuralli, Executive Director, Strategic Commissioning	**Email / Tel**		07557 319123 Sarah.mansuralli@nhs.net	
GB Member Sponsor					
Report Author	Shafeeq Tejani, AD Strategic Commissioning Alex Smith, Director of Transformation, Strategic Commissioning	**Email / Tel**		S.Tejani@nhs,net 07973 416343	
Name of Authorising Finance Lead	Anthony Browne	**Summary of Financial Implications** NCL CCG and ICS has been allocated a total of £7.12m Service Development Funding (SDF) for Community Service Providers to deliver the national Ageing Well priorities detailed within the Operating Plan for 2021/22. Guidance highlights that this is a recurrent funding stream for the ICS. This paper outlines the approach being taken to apportionment of the funding into community health services, based on a gap analysis and emerging findings from the Community Service Review, in line with national Ageing Well minimum requirements. In addition, NCL has been allocated a total of £238k per annum for the remainder of the long term plan for ICS programme infrastructure to support delivery and £100k per annum from Q3 2021/22 for an ICS lead in anticipatory care, again for the remainder of the long term plan period. Approval is required to begin mobilisation for each provider from m5 (August 2021).			
Report Summary	In the 2021/22 (financial year), NCL CCG and ICS has received £7.12m of SDF funding to support Community Services Providers with the national Ageing Well Programme. We are now in the second year of the Ageing Well Long Term Plan				

	programme and guidance highlights that this is a recurrent funding stream for the ICS. This national SDF funding needs to support community health services to achieve national minimum standards covering three key areas: • Urgent Community Response (UCR) • Enhanced Health in Care Homes (EHCH); and • Anticipatory Care The funding has been apportioned based on a gap analysis for each area, as well as the emerging findings of the Community Services Review. The apportionment is in line with our NCL ICS and CCG strategy to tackle inequities in service provision and inequalities as well as reducing variation. For example, maturity analysis undertaken by borough leads has highlighted that current anticipatory care models are less mature in Barnet, Enfield and some parts of Haringey, meaning providers in these areas will receive a larger proportion of the funding. This is in line with the approach taken to allocating the mental health investment standard funding. Whilst UCR and EHCH modelling based on national guidance has been the subject of a number of months work, national guidance has only recently been released for anticipatory care. We have detailed how we anticipate allocate funding for this area – and any necessary changes will be managed within the overall envelope of SDF funding **Urgent Community Response (£2,451k)** • Investment is based on a gap analysis against the national UCR operating standards, clinical guidance as well as the volume of additional 2hr responses each provider has committed to achieving within the NCL Operating Plan trajectory submission for 2021/22. **Enhanced Health in Care Homes (£2,476k)** • Investment is based on tackling gaps against the national EHCH guidance and emerging findings of the Community Services Review which has highlighted, for example, that care homes in Barnet do not benefit from a sustainable community in-reach service in line with the ECHC standards. The EHCH Board has overseen the development of these proposals alongside providers. **Anticipatory Care (£2,193k)** • A gap analysis has highlighted a high variation in maturity for anticipatory care across each of the NCL boroughs. We anticipate that funding will be apportioned in line with the following methodology: A cap on investment has been applied for those with the most mature anticipatory care models (Camden and Islington) so that the inequity gap in service provision can start to be bridged; For other boroughs, a weighted capitation model has been used to derive a 'fair share allocation' taking into account factors such as > 65 population, emergency admissions for over 65's, the ONS frailty index and historic investment. Because funding for 2021/22 will be paid on a pro-rata basis for all but the activity related elements within UCR, any resulting non-recurrent underspend will be accessible to providers who wish to increase the volume of 2 hr responses they deliver beyond the current Operating Plan trajectories. This is likely to support the system during the winter period ahead.

	Programme investment In addition to the £7.12m, NCL has been allocated £238k ageing well programme costs to support ICS capacity for clinical leadership, project management and analytics. NHSE will release 50% of this funding in qtr 1 and 50% in qtr 3. Finally, NHSE have also made available £100k for an anticipatory care programme lead from Q3 2021/23. In order to track delivery, nationally defined KPIs, as well as local measures will be included within the outcome and KPI framework that is being developed as part of the Community Services Review.
Recommendation	The Strategy and Commissioning Committee is asked to: • **APPROVE** the proposed approach to allocating the 2021/22 Ageing Well Programme funding to enable this to be released to providers in order that they can mobilise.
Identified Risks and Risk Management Actions	(r1) There is a risk of failing to meet ICS operating plan requirements/national requirements at the correct trajectory if funding allocations are not made available quickly enough for front-line staff to be recruited and in post. Management actions: • CCG decision and ICS endorsement to be finalised by mid-July • Community Provider Directors of Finance engaged via Community Services Review finance group • Quick communication of decision to Directors of Finance post decision 15th July so that it can be cascaded to Community Health COOs and mobilisation can commence (r2) There is a risk of exacerbating and perpetuating existing inequities in provision between boroughs through the funding allocations Management actions: • Gap analysis used to inform allocations • Community services review baseline report to inform allocations • Anticipatory care allocations to take into account historic investment and maturity of current models in line with ICS strategy and community services review principles (r3) There is a risk of failing to meet ICS operating plan requirements/national requirements at the correct trajectory if funding is used by organisations to mitigate pressures elsewhere Management actions: • Directors of Finance engaged via Community Services Review Finance Group • Funding tied to national requirements and specific outcomes e.g. UCR trajectory submitted in operating plan • Outcomes/KPIs re “ageing well” to be built into community services review outcomes/KPI dashboard with active reporting through NCL ICS Community Operational Group. • An update will be provided to SCC during Q4 re. progress to date.
Conflicts of Interest	None.
Resource Implications	National recurrent funding has been made available for the ageing well programme (£7.12m) in addition to funding programme costs (£238K) and an ICS lead for anticipatory care (from Q3 - £100k)

Engagement	• NCL Rapid Response Task and Finish Group • NCL Enhanced Health and Care Homes Board • NCL Anticipatory Care Task and Finish Group • NCL Executive Management Team • NCL Community Provider Meeting • NCL Community Operational Leads meeting • NCL Community Operational Group • NCL Community and Mental Health Review Steering Group • NCL Community and Mental Health Finance Leads • NCL Finance leads: Anthony Browne/Ben Catlin
Equality Impact Analysis	The national requirements within "ageing well" will be built into the community services review "core offer" which will be subject to an equalities impact assessment.
Report History and Key Decisions	**Developing and shaping proposal** • NCL DMT 26th May 2021 – Feedback from national team • NCL EMT 12th May 2021 – Programme overview • NCL Community Operation Group 1st June 2021 – UCR requirements update • NCL DMT 17th June 2021 • Community and MH Service Review steering group 24th June • Community Operational Leads 24th June • Community Providers Meeting 29th June • NCL DMT 1st July • Community finance leads 6th July **Endorsement** • NCL ICS Community Operational Group 6th July • NCL ICS Community Providers Meeting 13th July • NCL Executive Management Team 14th July • NCL ICS System Recovery Executive 14th July
Next Steps	On approval, the following actions will be prioritised: • Each Community Provider will be required to work with their ICP partners to produce a proposal for improving anticipatory care in line with national guidance – endorsement of these plans will be through at the ICS Community Operations Group. • UCR and EHCH workstreams will be required to finalise mobilisation plans. • Communication to providers through finance and management leads re the apportionment of the SDF funding (subject to above actions being completed).
Appendices	Appendix A: Urgent Crisis Response (requirements, gap analysis, detail) Appendix B: Enhanced Health in Care Homes (requirements, gap analysis, detail) Appendix C: Anticipatory Care (requirements, gap analysis, detail) Appendix D: Principles and Reporting

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Ageing Well Programme 2021/22

Shafeeq Tejani, Lisa Burgess - NCL CCG

Strategic Commissioning Committee

15th July 2021

Executive Summary

- NCL has been allocated a total of £7.12m recurrent national funding from 2021/22 to support the delivery of the Long Term Plan Ageing Well programme through Community Health providers. In addition NCL has been allocated £238k for ICS infrastructure to support delivery and £100k from Q3 for an ICS lead in anticipatory care.

- This Community Service Development Fund (SDF) is available to support three ageing well workstreams to achieve required national outcomes/targets. In brackets below are the proposed FYE amounts per workstream in 2021/22: –
    1. Urgent Crisis Response (UCR) **(£2,451k)**
    2. Enhanced Health in Care Homes (EHCH) **(£2,476k)**
    3. Anticipatory Care (AC) **(£2,193k)**
    4. Programme costs **(£338k)**

- A focus of the national programme is to provide further investment into community health services (CHS). These services have historically been underfunded despite them being critical to helping our residents stay well at home. The investment will help community providers to support system efforts to avoid admissions, support care homes better and help people to live healthy, independent lives at home. This will help drive system cost reductions as it aims to ultimately reduce avoidable admissions at acute services through, for example consistent urgent community service delivery across the ICS.

- The ICS strategy and financial strategy, as well as the principles agreed in the community services review have been used as the basis for allocating funding to address the requirements of the national Ageing Well programme. Requirements will be embedded within the community "core offer" and the funding will start to address some of the historic inequities highlighted by the review e.g. in care home community support and the maturity of anticipatory care models.

- The proposals included are aligned to national guidance and specifications for EHCH and UCR as well as the Operating Plan Trajectory for UCR (2 hr) that NCL ICS has submitted.

- These proposals have been developed collaboratively across the system and funding needs to be allocated in a timely way so that mobilisation can commence.

Introduction & recommendations

Since the publication of the national Ageing Well guidance (April 2021), NCL has:

- Raised the awareness and profile of the ageing well programme (core standards) across the ICS.
- Established a baseline positon and the gaps against the current core national standards for Urgent Crisis Response (UCR), Enhanced Health in Care Homes (EHCH) and Anticipatory Care (AC).
- Worked with providers and borough leads to establish EHCH priorities, UCR workforce requirements & 2hr trajectories.
- Developed a funding methodology for each component of ageing well in a manner that seeks to address the historic variation and inequity in community services.
- Ensuring the requirements set-out in the guidance have been incorporated as part of the community services review 'core offer'

The Strategy and Commissioning Committee is asked to:

- Approve the proposed approach to allocation for the 2021/22 Ageing Well Programme so that SDF funding can start to be released to providers in order that they can quickly mobilise.

SDF Funding allocations for ageing well will be made in line with the ICS strategy and the principles agreed as part of the Community Services Review:

1: National Policy re. Integrated Care Systems

- The foundation of integrated care systems is tackling health inequalities, providing whole person personalised care (ensuring that all patients have choice and control in their care) and population health management

2: ICS Strategy to tackle inequities and inequalities

- In NCL we have tackled historic inequities through the way we've allocated new funding across the system: MH Investment Standard; Inequalities fund

3: Principles and emerging findings of the Community Services Review

- Including equitable access to care; collaboration; early intervention; spreading good practice; maximising value for money and ensuring sustainability
- Emerging findings from baseline review:

Analysis of finance and activity show that **service provision and investment do not correspond to the level of need:**

- Enfield has over twice the prevalence of diabetes as Camden yet has a community diabetes resource that is less than half the size

This disparity appears **related to levels of historic and current funding**

- Camden spends 1.2 times as much on community health services per weighted head of population compared to Enfield
- In boroughs with lower levels of community spend, survey respondents felt patients were less likely to be effectively supported

There are **significant health inequalities and inequities in outcomes** for patients across NCL

- Barnet has 3 times as many care home beds per 65+ population as Haringey. However, Barnet also has the lowest coverage of care home in-reach
- Enfield has the lowest % of diabetics receiving the 8 care processes or attending structured education. However Enfield, has lower rates of admissions for hypo- and hyper- glycaemia

Approach to the Ageing Well investment

Urgent Crisis Response (investment will ensure delivery of minimum standards and the agreed operating plan trajectories)

- Rapid Response provider leads and borough leads led work on 2hr trajectories, workforce requirements and assessment against national minimum standards (by provider).
- The additional requirements to deliver the activity and achieve the 2hr UCR minimum standards equated to £2,104k (£2,451k fye).
  - Investment will fund additional activity (2041 additional units) - £600 per patient covering m1-12 (£1,111k)
  - Non-additive workforce requirements to achieve minimum requirements will be funded on a pro-rata basis m5-12 (£863k).
- Progress reporting and monitoring will be undertaken through the Rapid Response Task and Finish Group.

Enhanced Health and Care Homes (investment targeted in priority areas to reduce inequity in service provision)

- A gap analysis has been completed against the national requirements and coverage of care homes through the CSR review.
- Costings developed between providers and commissioners - annual investment of £2,476k to deliver on the key priorities (pro-rata £1,444k - Sept-Mar).
- This investment will help ensure all care homes in Barnet and Enfield receive community in reach for the first time – helping tackle historic inequities in provision vs. other boroughs.
- Delivery model for pharmacy in-reach to be finalised in collaboration with providers but team working to the overall envelope.

Anticipatory Care (investment will build on existing models channelling to boroughs with significant need and gaps)

- A maturity matrix per borough has been completed vs the national standards.
- The most mature systems (Camden and Islington) will only receive a capped amount of investment so that we can target resources at areas with historic inequities.
- For other boroughs, a weighted capitation model has been used to derive a ‘fair share allocation’ taking into account factors such as > 65 population, emergency admissions for over 65’s, the ONS frailty index and historic investment.
- Funding would be conditional upon each Community Health Provider working with its ICP to agree a delivery plan with the Community Operational Group during August.

The table below shows how funding will be allocated and the expected impact on activity that initiatives would have: driving system activity reductions

Full Year Effect (FYE) version

	Investment required in '000					Impact
Area	**UCR[1]**	**EHCH[2]**	**Anticipatory Care[3]**	**Programme allocation**	**Total Investment (fye)**	**Impact on UEC activity of intervention**
Barnet (CLCH)	£384	£1,111	£625		**£2,120**	1684 reduction in LAS calls 1510 reduction in avoidable admissions (numbers to be fed into Adrian Byrne for System Efficiency Plan).
Camden (CNWL)	£462	-	£193		**£655**	
Enfield (BEH)	£516	£303	£853		**£1,672**	
Har. (Whitt Health)	£383	-	£371		**£754**	
Islington (Whitt Health)	£407	-	£151		**£558**	
ICS-Wide	£300	£1,062 (pharmacy team and training[2])		£338[4]	**£1,700**	
Total Cost by Area	**£2,451**	**£2,476**	**£2,193**	**£338**	**£7,458**	

1. see appendix slide 15
2. see appendix slide 20
3. see appendix slide 25
4. £100k Anticipatory care programme lead (q3) & £238k Programme costs

The table below shows how funding would be allocated and the expected impact on activity that initiatives would have: driving system activity reduction

Pro-rata version (August 21 to March 22 – UCR & AC, September 21 to March 22 EHCH)

	Investment required in '000					Impact
Area	**UCR[1]**	**EHCH[2]**	**Anticipatory Care[3]**	**Programme allocation**	**Total Investment (fye)**	**Impact on UEC activity of intervention**
Barnet (CLCH)	£289	£648	£417		**£1,354**	987 reduction in LAS calls 1,038 reduction in avoidable admissions (numbers to be fed into Adrian Byrne for System Efficiency Plan).
Camden (CNWL)	£374	-	£129		**£503**	
Enfield (BEH)	£466	£177	£569		**£1,212**	
Har. (Whitt Health)	£333	-	£247		**£580**	
Islington (Whitt Health)	£343	-	£101		**£444**	
ICS-Wide	£300	£619 (pharmacy team and training[2])		£288[4]	**£1207**	
Total Cost by Area	**£2,104**	**£1,444**	**£1,462**	**£288**	**£5,300 & £2,158 non-recurrent[5]**	

1. see appendix slide 15
2. see appendix slide 20
3. see appendix slide 25
4. £100k Anticipatory care programme lead (q3) & £238k Programme costs
5. This is available non-recurrently in 2021/22 due to pro-rata attributions for providers to increase their UCR ambition through winter or collaborate on further collaborative proposals that are within the definition of the "ageing well programme"

KPIs to track impact will be built into the Community Services Review outcome and KPI dashboard so that we and the ICS can track delivery

Urgent Crisis Response: ***Delivery managed through NCL Rapid Response Task and Finish Group (Chair: Lyann Gross)***

- Monitoring of additional 2hr activity through CSDS; aligned to the regional reporting for Operating Plan;
- Impact on hospital attendances and admissions avoidance;
- Evidence that the 2hr activity must be additional rather than a case-mix change; and
- Nationally agreed KPIs from CSDS technical guidance will also be monitored.

Enhanced Health and Care Homes: ***Delivery managed through NCL Enhanced Health in Care Homes Group (Chair: Katie Coleman)***

- Impact on admissions to hospital for care home residents;
- Reduction in emergency calls and conveyances to hospital from care homes.

Anticipatory Care: ***A task and finish group has progressed this proposal but a new NCL Anticipatory Care Working Group will be set-up under ICS Proactive Care governance to oversee delivery.***

KPIs to be finalised but based on the key components within national guidance, they will include the number of patients on the MDT register, number of patients receiving a care plan, number of referrals into social prescribing and additional workforce recruited.

The following actions and owners are proposed to mitigate any delivery risks

Delivery Risk	Likelihood	Impact	Risk score	Proposed mitigation and risk owner(s)	Revised score
There is a risk of failing to meet ICS operating plan requirements/national requirements at the correct trajectory if funding allocations are not made quickly enough for front-line staff to be recruited and in post.	4	3	12	• CCG/ICS decision making by mid July (SMa/SH) • DOFs engaged via CSR finance group (AB) • Quick communication of decision to DOFs post 15/7 so that it can be cascaded to CH COOs and mobilisation can commence (AB and DOFs)	9
There is a risk of exacerbating and perpetuating existing inequities in provision between boroughs through the funding allocations	4	3	12	• Gap analysis used to inform allocations (ST/LB) • CSR baseline report to inform allocations (ST/LB) • Anticipatory care allocations to take into acct. historic invest./maturity current models in line with ICS strategy and CSR principles (ST/AS)	9
There is a risk of failing to meet ICS operating plan requirements/national requirements at the correct trajectory if funding is used by organisations to mitigate pressures elsewhere	3	4	12	• DOFs engaged via CSR finance group (AB/ST) • Funding tied to specific outcomes e.g. UCR trajectory submitted in operating plan (ST/COOs) • Outcomes/KPIs re “ageing well” to be built into CSR outcomes/KPI dashboard with active reporting to COG/CPM (ST/EP/CF)	6
There is a risk that there will be insufficient alignment between SDF funding, its requirements and the community services review	3	3	9	• AW national requirements to be articulated and planned for within CSR “core offer” (ST/JM/CF) • CSR finance subgroup engaged (AB/ST)	9
There is a risk to delivery if there is insufficient ICS programme capacity to enable and drive collaborative delivery between providers	2	4	8	• Commence planning on how programme allocation within AW funding can be used to support collaborative delivery (ST/COO’s)	4
There is a risk that benefits will be diminished if interdependencies to anticipatory care improvements by community providers are not worked through at ICP level with primary care/local authority partners	2	3	6	• Anticipatory Care working group to be established including provider and borough leads (ST) • Anticipatory Care framework for ICPs to be jointly refined by working group (ST/PA)	3

The proposal has been shared with the following groups for iteration

Meeting	What needs to be shared?	Focus of discussion	Date
NCL DMT	Outline of proposal	To shape proposals	17th June (Papers 15th June)
Community and MH Service Review steering group	Outline of proposal	Ensure proposals align to wider review of services	24th June
Community Operational Leads	Outline of proposal	Review and refine proposals	24th June
Community Providers Meeting	Outline of proposal	Review and refine proposals	29th June (Papers due 28 June)
NCL DMT	Draft proposal	Review and refine proposals	1st July (Papers 29th June)
Community finance leads (plus DoFs)	Draft proposal	Endorse recommendations	6th July (Papers 5 July)
NCL Community Operational Group	Final proposal	To endorse recommendation for allocating funding across the system	6th July (Papers due 2nd July)
Community Providers Meeting	Final Proposal	To endorse recommendation for allocating funding across the system	13th July (papers due 12th July)
NCL EMT	Final proposal	To endorse recommendation for allocating funding across the system	13th July (Papers due 9th July)
System Recovery Executive	Final proposal	To endorse recommendation for allocating funding across the system	14th July (papers due 12 July)
NCL CCG Strategic Commissioning Committee	Final proposal	Formally agree spending allocation in line with SFIs	15th July (Papers due tbc)

WE ARE HERE

Following approval by SCC, next steps to be taken:

- Work with CCG finance team and Provider leads to ensure funding released asap to support August 2021 phasing and mobilisation
- Plans for Anticipatory Care at borough level to be shared by community providers/ICP with delivery plans agreed via the ICS Community Operational Group in August
- Workforce tracking in place for Rapid Response/UCR to be reported through the task and finish group (July 21)
- Care home mobilisation plans in place for phasing from September 2021
- Begin recruitment for Ageing Well programme team (£238k) so they are in place by Sept 2021
- Begin recruitment for ICS Anticipatory care lead (£100k) so they are in place by Sept 2021

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Appendix A:

Urgent Crisis Response (Requirements, gap analysis and detail)

Urgent Crisis Response – CHS teams completed a self-assessment. To achieve the minimum standards and deliver an additional 2103 2hr responses further investment is essential.

Urgent Crisis Response (UCR)

1. Provide services at scale: ensuring full geographic coverage of two-hour crisis response care across systems.
2. Provide services from 8am – 8pm, 7 days a week at a minimum
3. Accept referrals into crisis response services from all appropriate sources (*excluding a hospital ward or bed)
4. Submit complete data returns to the (CSDS) on two-hour standard. *National expectation April 2021.

Providers will also need to meet the clinical standards outlined in the national guidance related to clinical scenarios, workforce and assessment and intervention.

Summary of provider self assessment on national requirements (appendix)

- Each provider maintains the minimum standard of 8:00 – 8:00, 7 days a week however further investment is required to ensure there is consistent workforce during the required opening hours and all services accept last guaranteed 2hr response at 8pm. . This will ensure optimum level of 2hr referrals from 111/999
- Accepting referrals from all providers (inc A&E) and self–referrals remains variable and investment into workforce and service development remains essential.
- Access to support from a range of clinicians remains (GP, Consultant, MH/LD) requires further work in-year and investment
- Gaps in clinical scenarios and the level of acuity accepted in each service will be addressed through additional investment through NCL projects to ensure consistency in pathways (falls pick-up/carers/access to diagnostics).
- Providers are continuing to work together to ensure that CSDS reporting is live

NCL providers currently have a number of gaps vs the UCR national requirement: NCL needs to fully deliver on the min. standards in 2021/22

	Priority	Barnet/CLCH	Camden/CNWL	Enfield/BEH	Haringey/WH	Islington/WH
Operating priorities	**1. Provide services at scale: ensuring full geographic coverage / Consistent offer**	• Gap to meet projected 21/22 2hr demand • D&C future workforce requirements	• OOH capacity nursing and therapy – also all 2hr response last year provided by redeployed CADS)	• Gap to meet projected 21/22 2hr demand • D&C to model future workforce requirements	• Gap to meet projected 21/22 2hr demand • D&C to model future workforce requirements	• Gap too meet projected 21/22 2hr demand • D&C to model future workforce requirements
	2. Provide services from 8am – 10pm, 7 days a week at a minimum	• Access to social care emergency arrangements when carer breakdown may lead to admission • Map hr demand different times of the day/night/week - D&C model to prepare for expanded hours 22/23.	• Operate to 10pm with last referral for 2hr response 8pm – need to extend nursing and therapy • Map hr demand different times of the day/night/week - D&C model to prepare for expanded hours 22/23	• Access to social care emergency arrangements when carer breakdown may lead to admission • Map hr demand different times of the day/night/week - D&C model to prepare for expanded hours 22/23.	• Operating hours 8am-10pm Therapists gap (6pm -10pm and weekends) • Map hr demand different times of the day/night/week - D&C model to prepare for expanded hours 22/23.	• Operating hours 8am-10pm • Therapists gap (6pm -10pm and weekends) • Map hr demand different times of the day/night/week - D&C model to prepare for expanded hours 22/23.
	3. Accept referrals from all appropriate sources	• 999 and 111 referrals (understand opportunity and increase appropriate referrals) • Self-referrals • LA and social care (go via GP)	• 999 and 111 referrals (understand opportunity and increase appropriate referrals) • Post pandemic patient pathways review • Self-referrals – known to services or via 111	• Self-referrals - accepts referral from patient 5 days after discharge if related to rapids condition/care	• 999 and 111 referrals (understand opportunity and increase appropriate referrals) • Self-referrals	• 999 and 111 referrals (understand opportunity and increase appropriate referrals) • Self-referrals
	4. CSDS – submit accurate 2hr data	• CSDS - submitting all fields and improving data quality	• CSDS - submitting all fields and improving data quality	• CSDS - submitting all fields and improving data quality	• CSDS - submitting all fields and improving data quality	• CSDS - submitting all fields and improving data quality
Clinical Guidance	**UCR Core Team**	• ACP • Therapist – evening and weekends	• ACP – four in training • Therapist and nursing – evening	• ACP	• ACP capacity	• ACP capacity
	Access to support from	• GP, Geriatrician, Social care • MH & LD, Paramedics, VCS	• GP • LD – improve links	• LD • VCS	• MH & LD • Paramedics • Voluntary sector	• MH & LD • Paramedics • Voluntary sector
	Assessment and intervention	• Clinical supervision for prescribing • Diagnostics capability	• Clinical supervision prescribing • Diagnostics capability	• Prescribing • Diagnostics capability	• Prescribing • Diagnostics capability	• Prescribing • Diagnostics capability
	Clinical Scenarios	• Falls pick up • Clinical scenario/pathway – unpaid carer breakdown (OOH)	• Falls pick up • Clinical scenario/pathway – unpaid carer breakdown (OOH)	• Falls pick up • Catheter • Diabetes • EOLC	• Falls pick up • Reduced function	• Falls pick up • Reduced function

Urgent Crisis Response: activity and cost assumptions:

ACTIVITY & COST ASSUMPTIONS

	Additional 2hr fye activity (from adjusted baseline)	Cost of 2 hr function @ £600 (not pro rata)	Cost of enabling functions FYE	Enabling functions (pro rata 5-12)	Total allocation (m5-12)	Total allocation (full year)	Provider workforce costs - FYE*
CLCH - Barnet	167	100,200	283,737	189,158	289,358	383,937	383,937
CNWL - Camden	330	198,000	263,757	175,838	373,838	461,757	461,757
BEH - Enfield	609	365,400	150,273	100,182	465,582	515,673	515,673
WH - Harringey	389	233,400	149,182	99,455	332,855	382,582	382,582
WH - Islington	356	213,600	193,785	129,190	342,790	407,385	407,385
NCL UCR Projects	0	-	300,000	300000	300,000	300,000	300,000
TOTAL	2,041	1,110,600	1,340,734	993,823	2,104,423	2,451,334	2,451,334

Two components of funding for UCR:

1. Full year funding on additional 2hr activity based on operating plan submission (£600)
2. Workforce costs to enable providers to deliver all minimum standards (non-additive)

- Total allocation in line with provider workforce costs submission

In addition to the UCR funding allocated to CHS providers, an additional £300k is required for ICS-wide collaborative deliverables in 2hr UCR

Project			Rationale
Falls Pick-up		£200k	• All providers have highlighted that falls pick-up is a pathway gap. • Exploratory work has been completed by Camden borough/CNWL regarding a falls pick up service • LA's provide telehealth for fallers which is not mainstreamed into pathways • CHS lead to develop pathway NCL
Access to diagnostics		£100k	• Identified as a priority from Task and Finish group for further exploration and links into NCL wide developments • Provider lead to be nominated and scope opportunities for all RR services
Total		**£300k**	

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Appendix B: Enhanced Health in Care Homes

(Requirements, gap analysis and detail)

Enhanced Health in Care Homes - Steering Group undertook a gap analysis against the ambitions set out in the guidance.

Enhanced Health in Care Homes (EHCH)

1. Deliver EHCH programme in full for care homes and explore extending this to the wider care sector
2. Develop the NHSEI care sector vision, strategy and operating model
3. Lead care sector related restoration, recovery and transformation post-COVID-19

Summary of gap•analysis/Proposals

- There are gaps in the care home In-reach services across NCL (Barnet) are some services are not available to all care homes (Enfield) > ***the proposal would enable the Barnet One Care Homes team to provide community in-reach to all care homes in the borough and allow Enfield's CHAT service to provide 7 day cover.***
- 3/5 boroughs do not have a pharmacy in-reach service available for care homes > ***the proposal would enable all boroughs to be supported by an NCL wide Care Homes pharmacy team.***
- Training and education requires further focus across NCL with further alignment required > ***the proposal would allow us to roll out an NCL wide training programme building on best practice to date.***

NCL providers have completed a gap analysis vs EHCH national requirement

	Deliver EHCH programme in full for care homes and explore extending this to the wider care sector	Develop the NHSEI care sector vision, strategy and operating model	Lead care sector related restoration, recovery and transformation post-COVID-19
Barnet	**NOT MET** • The lack of a community services in-reach team to support care homes in Barnet means that it is not possible to deliver the EHCH programme in full.	**MET** • The EHCH steering group works across all five boroughs, primary care, local authorities and community services to develop shared priorities and visioning for EHCH. • During 21/22 a separate task and finish group will be convened to establish principles for funding of care home LCS' in the future. • During 21/22 work is ongoing with Carnall Farrer through the Community Services Review to identify care home in-reach as part of the core community offer in NCL.	**NOT MET** • Lack of community services in-reach is impacting restoration, recovery and transformation post COVID-19. • Limited care home pharmacy in-reach. • Shared NCL gap around aligned care home education.
Camden	**MET**		**NOT MET** • No care home pharmacy in-reach (shared gap in 3/5 Boroughs) • Shared NCL gap around aligned care home education.
Enfield	**PARTIALLY MET** • The current community services in-reach team does not support all care homes. This has been identified as a gap to deliver the EHCH programme in full by Providers and GPs.	**MET** • The EHCH steering group works across all five boroughs, primary care, local authorities and community services to develop shared priorities and visioning for EHCH. • During 21/22 a separate task and finish group will be convened to establish principles for funding of care home LCS' in the future. • During 21/22 work is ongoing with Carnall Farrer through the Community Services Review to identify care home in-reach as part of the core community offer in NCL.	**NOT MET** • No care home pharmacy in-reach (shared gap in 3/5 Boroughs) • Shared NCL gap around aligned care home education.
Haringey	**MET**		**NOT MET** • No care home pharmacy in-reach (shared gap in 3/5 Boroughs) • Shared NCL gap around aligned care home education.
Islington	**MET**		**NOT MET** • Limited care home pharmacy in-reach. • Shared NCL gap around aligned care home education.

Funding for EHCH of £2,476,203 will fund the priorities identified by the EHCH programme board during 2021/22.

Project	Borough	What	Intended Outcomes (FYE)	FYE (000's)
One Care Homes Team (Barnet)	Barnet	New care homes team in Barnet based on Enfield CHAT model. To cover all homes.	• Reduction in LAS calls and non-conveyances • Reduction in avoidable SUS admissions from care homes	£1,111
CHAT expansion (Enfield)	Enfield	Additional Nursing and administrative capacity to expand into all Enfield care homes 7 days a week	• Reduction in LAS calls and non-conveyances • Reduction in avoidable SUS admissions from care homes	£303
NCL Care Home Pharmacy Model	All NCL	New NCL Care Home Pharmacy team	• # MDT reviews • # 'routine' reviews • # Safe & Secure handling of medicines audits within homes (routine for technicians) • # Meds information queries • Proxy Access available in at least 50% of homes in each Borough	£852
NCL Care Home Training Programme	All NCL	Building on success of training hubs and work in Islington to roll out centralised programme of training for care homes with local delivery	• reduction in safeguarding incidents • improvements in range of quality measures • reduction in acute activity	£210
			Total:	**£2,476**

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Appendix C: Anticipatory Care

(Requirements, gap analysis and detail)

The below defined national priorities for anticipatory care and the core components detailed within “ageing well” guidance

National priorities

1. Development of a co-produced comprehensive model of Anticipatory Care: Establishing a minimum standard for systems to enable them to fulfil contractual requirements for 21/22 and beyond.
2. Development of an in-reaching Anticipatory Care support offer: Building capability and competence around the AC core component in both emerging and advanced systems
3. Co-production of policy, resources and support offers: Engagement, communication and co-production with Anticipatory Care stakeholders to ensure the programme models cross-sector ways of working expected of systems.

Core components of Anticipatory care:

1) **Population cohort management** – identifying the cohorts that are most at risk of unwarranted health outcomes
2) **Proactive care needs assessment** – needs of those identified are supported in a personalised, holistic manner
3) **Personalised care and support planning** - ensure we are focussing on what matters to the person
4) **Digitally enabled MDT** – effective MDT is essential to deliver comprehensive anticipatory care including primary care, community health, secondary care, pharmacy etc.
5) **Care co-ordination** – bringing together information about a person, their needs and how this can be supported and met.

- Each of our boroughs are in a different place with regards to Anticipatory Care (see slide 23)
- One of the key aims is to prioritise this funding to tackle of historic inequalities across NCL.

We have undertaken an initial analysis of current resources in Frailty / Multi-Morbidity Anticipatory Care which has been tested with community providers

	Brief Description of Current AC Resources	Extent to which existing AC Model fulfils Core Components	Potential Areas for Strengthening	Maturity of Model & Coverage
Barnet	• Single multi-agency MDT in single PCN; • Collaboration between PCN, CLCH, Council, MH Trust & voluntary sector • Supports 65+ with moderate or severe frailty	**PARTLY MET AND NEED TO CONSIDER COVERAGE & EXPANSION** • Patient identification via frailty tool/well-known referral routes • Patients triaged and assessed with complex case MDT if needed • Holistic. personalised care & support planning coordinated & in place • MDT to support assessment, planning & review for complex patients	• **Current Pilot in single PCN** – need for additional resources to expand model to meet need across Borough • Potential to enhance condition-based scope of AC function, e.g. dementia	
Camden	• 4 multiagency MDT functions in Borough/PCNs • Multiple collaborations between primary care/ PCNs, CNWL, RSLs, Council, MH Trust & VCS • 1 function for those with nursing complex needs, 1 for frailty, 2 complex needs @ Neighbourhood/ @PCN	**MEETS MOST STANDARDS** • Patient identification via frailty tool/well-known referral routes • Patients triaged and assessed with complex case MDT if needed • Holistic. personalised care & support planning coordinated & in place • MDT to support assessment, planning & review for complex patients	• Potential to expand on current resources, particularly in relation to complex care nurses for each PNC • Additional support for infrastructure enablers, e.g. shared record	
Enfield	• 3 multi-agency MDT functions in Borough; • Collaborations between primary care, Enfield Community Services & voluntary sector • 1 function supports those with complex needs/ multi-morbidity, 1 for specific LTCs (e.g. CHF/diabetes), 1 OP with moderate frailty	**PARTLY MET AND NEEDS TO CONSIDER COVERAGE & EXPANSION** • Some patient identification via frailty tool/well-known referral routes • Patients triaged and assessed with complex case MDT if needed • Holistic. personalised care & support planning coordinated & in place • MDT to support assessment, planning & review for complex patients	• Potential to expand on current resources, particularly in relation to moderate frailty and more systematic identification of patients in Borough as part of roll out of support • Potential to enhance condition-based scope and function of AC function to incorporate larger number of patients	
Haringey	• Single multi-agency MDT across Borough; • Collaboration between GPs/GP Federation, WHT, Council, BEHMHT & voluntary sector • Supports 50+ with moderate or severe frailty/multi-morbidity/complex needs	**PARLY MET NEEDS TO EXPAND TO MEET NEED** **P**atient identification via frailty tool/well-known referral routes • Patients triaged and assessed with complex case MDT if needed • Holistic. personalised care & support planning coordinated & in place • MDT to support assessment, planning & review for complex patients	• Part of AC Service originated in west & central localities – current resources 'stretched' to meet east locality patients. Need for additional resources to more fully meet need in east • Need to enhance condition-based scope of AC function – in particular improved support for respiratory/dementia patients	
Islington	• 2 multi-agency MDT functions in Borough; • 2 collaborations between primary care, WHT, Council, MH Trust & voluntary sector • 1 function supports those with complex needs/ multi-morbidity, 1 OP with moderate frailty	**MEETS MOST STANDARDS** • Patient identification via frailty tool/well-known referral routes • Patients triaged and assessed with complex case MDT if needed • Holistic. personalised care & support planning coordinated & in place • MDT to support assessment, planning & review for complex patients	• Additional support for infrastructure enablers, e.g. improved administration of patients identified using frailty tools, to support triaging and assessment	

Approach to Anticipatory Care Service Development Funding

- The focus of the AC Service Development Fund for each borough is to build on their existing infrastructure.
- A maturity matrix per borough* has been completed vs the national standards.
- The most mature systems (Camden and Islington) will only receive a capped amount of investment so that we can target resources at areas with historic inequities.
- For other boroughs, a weighted capitation model has been used to derive a 'fair share allocation' taking into account factors such as > 65 population, emergency admissions for over 65's, the ONS frailty index and historic investment.
- Funding will be conditional upon each Community Health Provider working with its ICP to agree a delivery plan with the Community Operational Group during August.
- The NCL wide framework for this plan will require detail on:
    - The providers' approach to addressing gaps
    - An outline of additional staffing requirements inc. workforce/team development/training
    - Infrastructure requirements (IT/Digital)
    - The impact expected through the actions being taken
- Funding will be released once COG has endorsed the plan and finance have 'stress tested' the investment.
- The national operating model for AC is to be published imminently and we will need to ensure that any additional components deemed 'must-do' will be delivered in-year.

*Slide 23

Anticipatory Care – apportionment methodology

	Barnet	Camden	Enfield	Haringey	Islington
% Split based on existing funding variance (community), emergency adm rates, C&I adjusted to cap levels	28.50%	8.80%	38.90%	16.90%	6.90%
Funding Split - FYE	£624,852	£192,937	£852,868	£370,526	£151,280
Funding Split - Pro-rata	£416,568	£128,624	£568,579	£247,017	£100,853

Apportionment methodology:

- Rates of emergency admissions for over 65s plotted against current community spend per head, for each borough
- Variance in spend levels calculated for each borough against line of best fit
- Variances used to adjust each borough's proportion of the NCL estimated frail population (this takes into account the higher rates of frailty among deprived populations)
- Given the maturity of existing models in Camden and Islington, funding split has been capped
- Calculated funding over the cap levels for Camden and Islington redistributed to the other boroughs on the basis of their estimated frail population

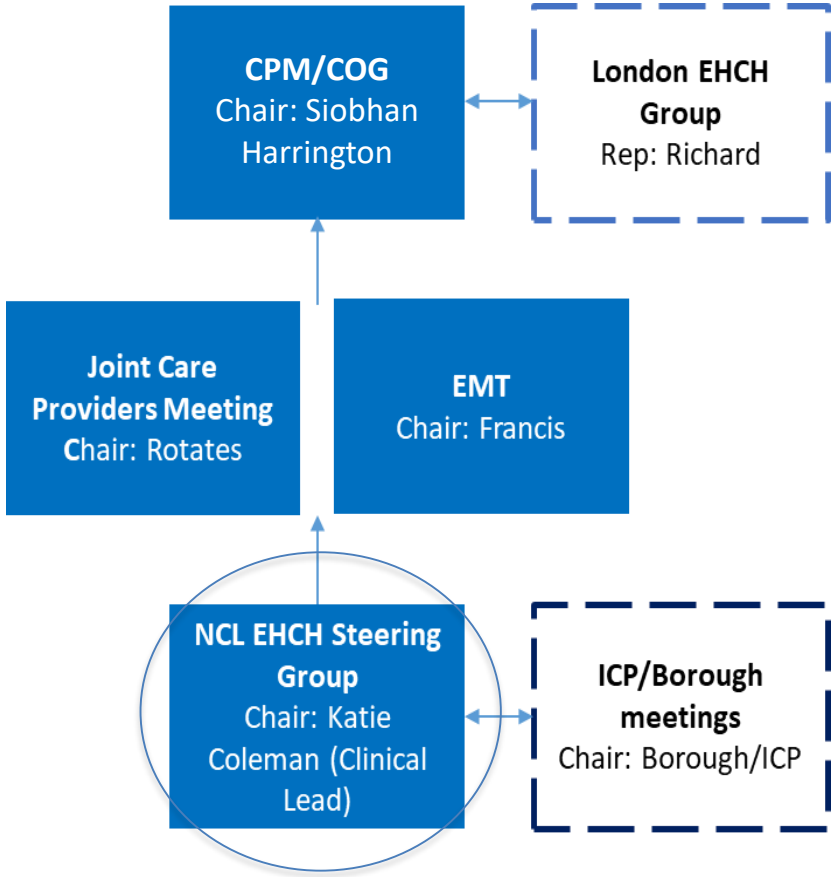
Appendix D: Principles and reporting

Appendix D: Funding allocations will be made in line with the financial strategy of the ICS and the principles agreed as part of the Community Services Review:

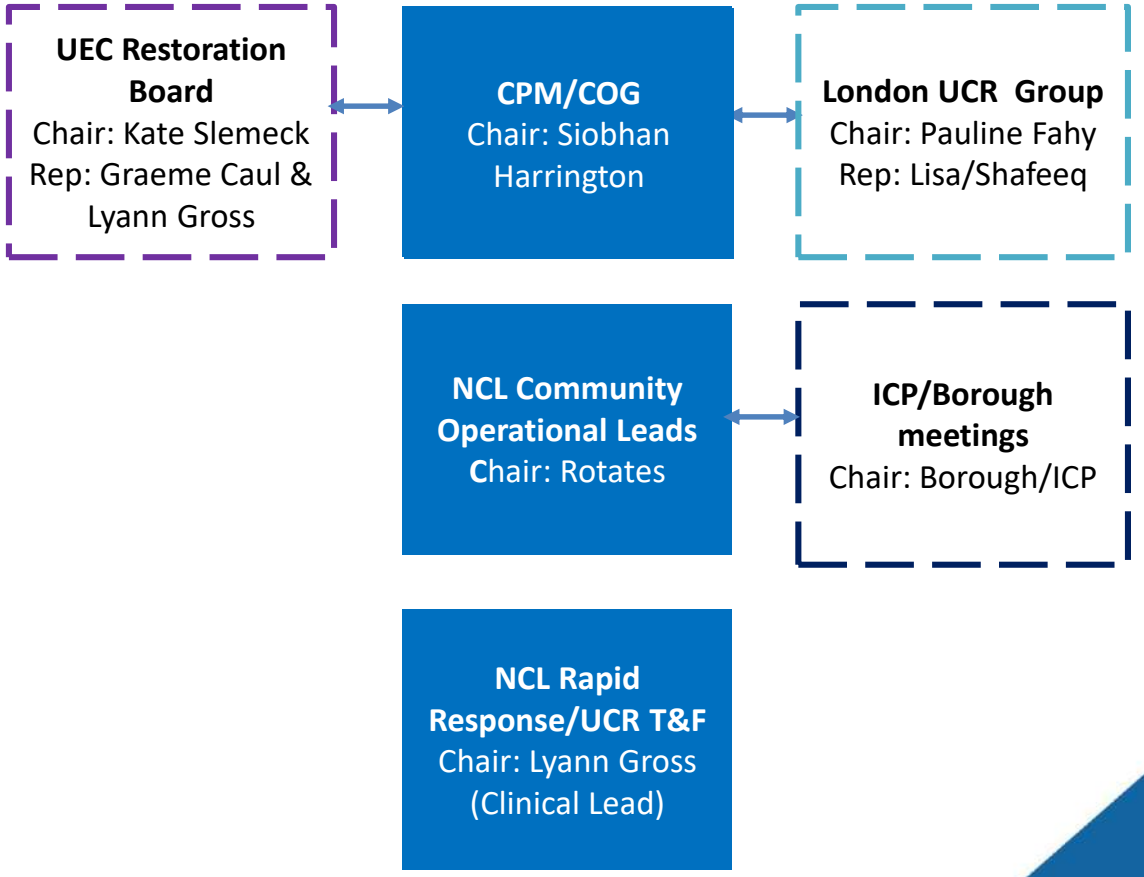
1. Put **service users at the heart of our work** so we can improve their experience of care, through a strengths-based approach to support them to live healthier, independent and high quality lives within the communities that they live.
2. Provide **equitable access to care** that best meets the current and future needs of the diverse population across NCL and that optimises accessibility for our diverse population groups.
3. Focus more on **prevention and early intervention** and supporting self care to enable people to live independently for as long as possible.
4. Collaborate with **wider community partners** and community assets to understand the impacts of **the wider determinants of health** to support residents' **good mental health and well-being holistically.**
5. Through strong relationships**, collaborate across health and care**, recognising the interdependencies of different services in different sectors, and promote joined up integrated care for children and adults across primary, community, mental health and care services reducing handoffs between organisations.
6. Build on and **spread best practice** from NCL and elsewhere, enabling innovative and transformative ways of delivering high quality care, maximising the use of technology and information to provide effective and efficient care.
7. Enable the development of a more **flexible, multidisciplinary and sustainable workforce**, strengthening it for the future and attracting staff to work and stay in North Central London.
8. Maximise **value for money**, utilising resource across the system efficiently so as to **minimise waste and duplication and ensure sustainability** recognising the need that the timescale for achieving the outcomes is considered and set realistically.
9. Organise services at the most **appropriate place level and scale,** where it best meets population needs, workforce resilience and sustainability, value for money tests and allows flexibility within the delivery of a core service offer to reflect the needs of different neighbourhoods.
10. Ensure **system leadership (clinical and managerial)** support the new ways of working and the transition to this through co-producing the solutions

The following forums will monitor progress, unblock issues and proactively manage risks to delivery:

Enhanced Health in Care Homes

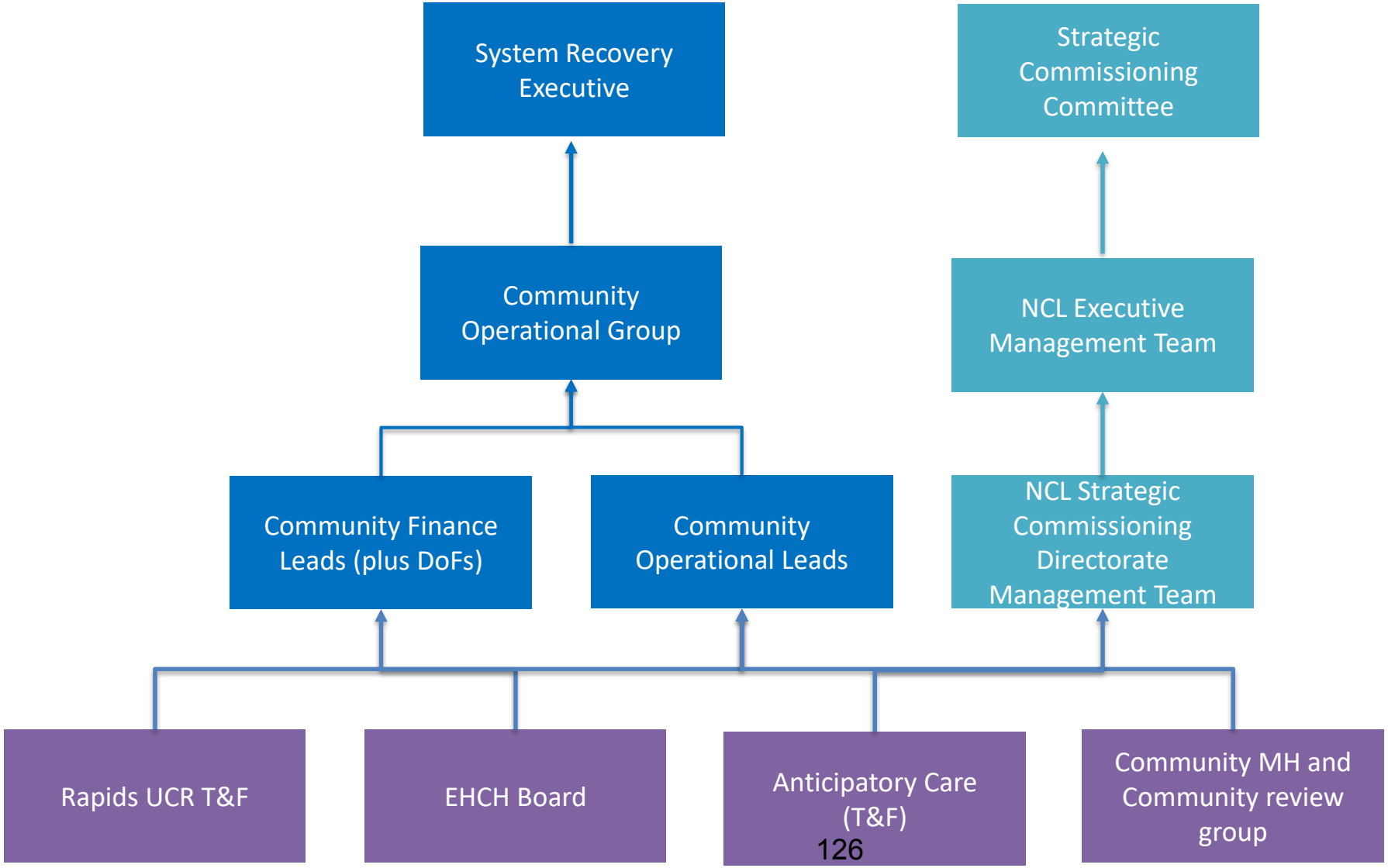


UCR/Rapid Response



*Anticipatory Care delivery architecture is to be agreed as part of Proactive Care governance and in the short-term the group will report into CPM/COG

Both ICS and CCG governance have been involved in iterating this work



North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	Collaborative Performance Monitoring	**Date of report**	25 June 2021	**Agenda Item**	2.4
Lead Director / Manager	Ed Nkrumah	**Email / Tel**		edmund.nkrumah@nhs.net	
GB Member Sponsor	Paul Sinden				
Report Author	Ed Nkrumah	**Email / Tel**		edmund.nkrumah@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	This reports sets out the CCG's approach to performance management across NCL, which is largely collaborative – consistent with ICS development. It also sets out the drivers, context and conditions for collaborative working to deliver performance improvements.				
Recommendation	The Strategy and Commissioning Committee is asked to: • **NOTE** the contents of the report and recommend any additional actions to enhance current approach to performance management.				
Identified Risks and Risk Management Actions	None.				
Conflicts of Interest	None.				
Resource Implications	Not applicable.				
Engagement	Not applicable.				
Equality Impact Analysis	Not applicable.				
Report History and Key Decisions	Not applicable.				

Next Steps	Not applicable.
Appendices	Not applicable.

NHS
North Central London
Clinical Commissioning Group

Collaborative Approach to Performance Management

Ed Nkrumah, June 2021

Performance Management – Overview

North Central London
Clinical Commissioning Group

- NCL Quality and Performance Management Framework drafted in 2019 signalled intention to take a system-level and more collaborative approach to performance management. This was accelerated by the pandemic.

- Approach is largely effective in addressing issues on a sustainable basis with commissioners acting as facilitators of mutual aid, and providing practical support as partners.

- Aligns with regulator approach to engaging with ICS where focus remains on overall system performance, with collaboration and standardisation used as a measure of system maturity. Emerging priority performance metrics draws on this strategic direction, and dis-incentivises traditional approach to performance management

Performance Management – Current Drivers and Context

North Central London
Clinical Commissioning Group

Operational Plans (national/regional)

System/CCG Oversight Framework

NHS Standard Contract

NCL Recovery Programmes

Restoration & Sustainable Recovery | Vaccination | Inequalities | Workforce | ICS Development

Programme performance vs traditional metrics

Changes to NHS Standard Contract Levers

Changes to Technical Changes to Metric Definition

Focus on stimulating demand

Focus on safety/ clinical prioritisation

Focus on inequalities

Annual CCG Assessment Ratings/ Letter

Monthly ICS Assurance/Focus Meetings

London Weekly Elective Recovery Meetings

London Cancer Hub

London Diagnostic Groups – endoscopy and imaging

Groups & Meetings

NHS
North Central London
Clinical Commissioning Group

RTT Delivery Group	Cancer Performance Leadership Group	Operational Implementation Group	NCL Information working Group
• Referrals • Inequalities • RTT waits and size • Long waiters • Standardisation • Primary-Secondary Care interface • Operational Planning	• Cancer Referrals • Treatment volumes • Patient engagement • Backlog • Faster Diagnosis Standard • Waiting times (recent)	• Update from RTT Group • Oversight of Elective Recovery, and Accelerator Programme	• Establishing data flows to support programmes and performance monitoring • Improving data quality • System approach to national, regional and local data requirements

Risk Based Meetings: Where there are provider-specific material issues (e.g. RFL RTT Steering Group for 52 week waiters)

Programme Meetings: Where performance is embedded in programme function (e.g. UEC Board, Mental Health, Diagnostics, Community Groups, IUC Group). Performance Team input variable and mainly reporting.

Sample Performance Dashboard – Provider Level

NHS
North Central London
Clinical Commissioning Group

2 - University College London Hospitals NHS Foundation Trust

		April	May	June	July	August	September	October	November	December	January	February	March
Urgent care	*A&E attendances plan*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*7,403*	*8,598*	*8,856*	*9,259*	*10,055*	*9,550*	*10,573*
	A&E attendances	3,492	4,741	5,631	6,486	7,238	7,227	7,112	6,578	6,694	5,277	5,303	6,860
	A&E conversion rate	32%	28%	26%	27%	26%	25%	26%	27%	28%	33%	26%	23%
	4 hour performance (95% Target)	84%	91%	93%	93%	89%	88%	83%	88%	88%	87%	91%	93%
	12 hour waits	1	1	1	0	3	1	5	2	0	1	1	2
	Ambulance handovers 30 min+	31	1	0	0	0	5	3	2	19	11	7	4
	Ambulance handovers 60 min+	3	0	0	0	0	0	0	0	1	1	0	0
RTT	*Total referrals plan*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*11,779*	*12,884*	*13,990*	*15,095*	*16,201*	*17,306*	*18,412*
	Total referrals	6,589	7,783	9,800	10,884	9,475	10,985	12,112	11,370	10,713	10,892	11,626	14,370
	RTT incompletes plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*44,550*	*45,218*	*46,122*	*46,584*	*46,118*	*45,657*	*45,200*
	RTT incompletes	49,294	47,256	44,746	44,412	44,927	45,002	45,770	44,815	44,606	41,592	40,912	41,858
	52+ waits plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*1,623*	*1,899*	*1,899*	*2,184*	*2,184*	*1,747*	*1,223*
	52+ waits	117	260	583	908	1,195	1,622	2,213	1,910	1,967	2,576	3,273	3,572
Diagnostics	*Imaging plan*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*12,435*	*12,558*	*12,588*	*12,365*	*12,558*	*12,558*	*12,558*
	Imaging activity	4,432	6,713	10,273	11,735	12,257	13,049	13,374	13,043	12,717	11,920	11,769	14,255
	Endoscopy plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*780*	*1,080*	*1,117*	*1,055*	*1,200*	*1,140*	*1,140*
	Endoscopy activity	33	116	223	464	932	1,128	1,062	996	855	609	680	927
	Total Diagnostic 6+ weeks	6,620	7,162	5,589	4,139	2,834	2,377	2,186	2,333	2,864	4,208	3,443	2,893
Cancer	*Urgent referrals plan*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*1,269*	*1,284*	*1,309*	*1,269*	*1,327*	*1,340*	*1,340*
	Urgent referrals	343	607	831	988	960	1,060	1,149	1,199	1,170	913	1,018	1,374
	Cancer treatments plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*220*	*230*	*234*	*241*	*237*	*251*	*251*
	Cancer treatments	162	146	212	208	220	204	241	279	292	214	198	248
	63+ backlog plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*75*	*73*	*65*	*74*	*78*	*65*	*53*
	63+ backlog	160	345	217	131	72	59	66	79	70	98	106	98
Beds	*Average G&A beds occupied plan*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*566*	*572*	*578*	*584*	*623*	*629*	*636*
	Average G&A beds occupied	247	280	377	425	447	483	511	508	484	447	442	469
	Average G&A beds available plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*627*	*642*	*642*	*652*	*694*	*694*	*694*
	Average G&A beds available	355	355	482	545	553	558	564	550	518	478	462	501
	Occupancy %	70%	79%	78%	78%	81%	87%	91%	92%	93%	94%	96%	94%

Sample Performance Dashboard – Service Level (cancer)

North Central London
Clinical Commissioning Group

Measures	Reporting Period	Type	RFL	UCLH	WH	NMUH	RNOH	GOSH	MEH	NCL Providers	NCL CCG
2 Week Wait Referrals (Operating plan definition and reporting)	Apr-21	Plan	3,400	1,108	992	856	145	0	8	6,509	5,639
		Actual	3,618	1,154	898	953	138	0	9	6,770	5,818
Total number of 1st definitive cancer treatments (Operating plan definition and reporting)	Apr-21	Plan	220	242	25	76	13	17	29	622	398
		Actual	231	145	45	58	16	15	24	534	359
62 Day Cancer Backlog following GP Referral (Operating plan definition and reporting)	May-21	Plan	150	113	60	105	6	0	0	434	No measure
		Actual	164	131	57	131	1	0	0	484	
62 Day Cancer Backlog - All Referral Routes	May-21	No Target	272	195	108	252	2	0	0	829	No measure
Faster Diagnosis Standard - Data Completeness	Apr-21	80%	96.8%	90.7%	72.7%	115.9%	79.7%	0.0%	148.4%	94.7%	No measure
Faster Diagnosis Standard -Performance	Apr-21	75%	82.7%	81.5%	83.2%	51.6%	65.1%	0.0%	100.0%	77.6%	
62-Day Cancer Waiting Time following GP Referral	Apr-21	85%	77.9%	76.2%	77.2%	41.4%	100.0%	-	-	73.5%	71.3%

Collaborative Performance Management in Practice

North Central London
Clinical Commissioning Group

- Shared responsibility for the development of system plans, trajectories and approach to performance management
- Peer review between providers using single source of data and reports
- Commissioners as facilitators of sharing of best practice, mutual aid and development of standardised processes
- Responsive and risk-based approach using clear and transparent framework with clear expectations
- Participation in provider internal meetings for assurance
- Light touch approach to recovery plans and trajectories
- Ongoing work to support CCG team to adapt new ways of working – skills and mind-set

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	Evidence Based Interventions and Clinical Standards - Update	**Date of report**	1 July 2021	**Agenda Item**	2.5
Lead Director / Manager	Sarah Mansuralli – Executive Director for Strategic Commissioning, NCL and SRO for NCL Fertility Policies Review	**Email / Tel**		Sarah.mansuralli@nhs.net	
GB Member Sponsor	Jo Sauvage – Chair, NCL CCG				
Report Author	Penny Mitchell – AD for Planned Care & Transformation (Camden)	**Email / Tel**		Penny.mitchell3@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			

Report Summary

Evidence Based Interventions and Clinical Standards (EBICS) have been a feature of commissioning and provision of services in the NHS for many years (formerly known as Procedures of Limited Clinical Evidence / Value (POLCE)). In 2018, the national Evidence Based Interventions (EBI) programme was established between four partners: the Academy of Royal Medical Colleges, NHS Clinical Commissioners (NHSCC), NICE and NHSE England / Improvement.

NCL supports EBICS as it contributes towards our aim to give patients the optimum care and treatment in a timely and efficient manner.

In 2019, NCL launched a single NCL EBICS policy. As well as harmonising from the policies developed by the then existing CCGs, it also incorporated the outputs from the national EBI programme that had been published in November 2018. This policy was implemented into contracts with providers from April 2019.

In November 2020, the national EBI programme published guidance for EBI 2. Work has been undertaken to understand this guidance and consider the most appropriate approach for implementing EBI 2 given the current challenging and different environment that the health and care system is now operating in.

This paper provides an overview of:

- The proposals contained within EBI 2
- The approach being taken to implement EBI 2 across NCL
- A summary of next steps for this programme

Recommendation	The Strategy & Commissioning Committee is asked to**:** • **NOTE** the approach for implementation for EBI 2 in NCL • **NOTE** the proposed actions to establish the NCL EBICS Policy Review Group.
Identified Risks and Risk Management Actions	Should the approach set out in the paper not be supported, then the CCG will be at risk of: • Not complying with national guidance for EBI and not following guidance for contractual arrangements with providers • Causing confusion amongst providers and service users as to how the CCG responds to national guidance on such matters • Not achieving outcomes, e.g. reducing variation in care, minimising harm to patients, maximising effectiveness of NHS resource utilisation By following the approach suggested, it is believed that this is a pragmatic way forward given the current circumstances to support appropriate and proportionate adherence to guidance in NCL.
Conflicts of Interest	This report has been written in accordance with the Conflicts of Interest Policy.
Resource Implications	Not applicable.
Engagement	Stakeholders have been identified and work to undertake stakeholder engagement is identified in the report.
Equality Impact Analysis	Not applicable. (An EIA will be completed as part of the work to update the NCL policy)
Report History and Key Decisions	September 2020 – NCL Evidence Based Interventions and Clinical Standards Policy The Strategy and Commissioning Committee agreed the new governance arrangements and the proposed membership of the policy review group.
Next Steps	Subject to approval by Strategy & Commissioning Committee of recommendation: • Follow approach for wider engagement and liaison with appropriate groups, clinical networks and individuals on the EBI 2 guidance • Establish the Policy Review group and commence work to update the NCL EBICS policy
Appendices	Not applicable.

North Central London
Clinical Commissioning Group

Evidence Based Interventions and Clinical Standards - Update

Sarah Mansuralli
Executive Director for Strategic Commissioning

and

Penny Mitchell
AD for Planned Care and Transformation

1 July 2021
V0.6

1. Background

Evidence Based Interventions and Clinical Standards (EBICS) have been a feature of commissioning and provision of services in the NHS for many years (formerly known as Procedures of Limited Clinical Evidence / Value (POLCE)). In 2018, the national Evidence Based Interventions (EBI) programme was established between four partners: the Academy of Royal Medical Colleges, NHS Clinical Commissioners (NHSCC), NICE and NHSE England / Improvement.

The EBI programme is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the clinical evidence demonstrates are inappropriate for some patients in some circumstances and sometimes can do more harm than good. This helps improve the quality of care patients receive, reduce variability in treatments and pathways, and supports the freeing-up of valuable resources so that they can be put to most effective use elsewhere in the system.

NCL supports EBICS as it contributes towards our aim to give patients the optimum care and treatment in a timely and efficient manner.

In 2019, NCL launched a single NCL EBICS policy. As well as harmonising from the policies developed by the then existing CCGs, it also incorporated the outputs from the national EBI programme that had been published in November 2018. This policy was implemented into contracts with providers from April 2019.

In November 2020, the national EBI programme published guidance for EBI 2. Work has been undertaken to understand this guidance and consider the most appropriate approach for implementing EBI 2 given the current challenging and different environment that the health and care system is now operating in.

It is noted that this work has been subject to pauses due to the operational pressures and surge conditions facing the CCG and its partners.

This paper provides an overview of:

- The proposals contained within EBI 2
- The approach being taken to implement EBI 2 across NCL
- A summary of next steps for this programme

2. Evidence Based Interventions 2

The guidance published by the Academy of Royal Medical Colleges covers 31 tests, treatments and procedures where the evidence about their effectiveness or appropriateness has changed. To ensure independent clinical leadership in the development of EBI guidance, an Expert Advisory Committee (EAC) was established. The EAC considered each test, treatment and procedure before drafting guidance in collaboration with stakeholders including clinicians, commissioners and patients[1]. A public engagement exercise was undertaken in summer 2020 to gain final consensus and support from the public, medical royal colleges, the appropriate specialist societies, clinicians and patients.

Out of the list of 31 interventions, only two are specified as “category 1” interventions, meaning that they should not be routinely commissioned or offered because the evidence demonstrates that they do not work or have been superseded by a safer alternative (Exercise ECG and Helmet Therapy). The remainder are “category 2” interventions which should only be commissioned or offered when specific clinical criteria are met as they have been shown to be appropriate in certain circumstances.

[1] It is important to note that the EAC did not consider the cost of the intervention, or the amount of money that could be reallocated if the number of interventions was reduced.

Fig 1. List of EBI 2 interventions

2A	Diagnostic coronary angiography for low risk, stable chest pain
2B	Repair of minimally symptomatic inguinal hernia
2C	Surgical intervention for chronic rhinosinusitis
2D	Removal of adenoids for treatment of glue ear
2E	Arthroscopic surgery for meniscal tears
2F	Troponin test
2G	Surgical removal of kidney stones
2H	Cystoscopy for men with uncomplicated lower urinary tract symptoms
2I	Surgical intervention for benign prostatic hyperplasia
2J	Lumbar Discectomy
2K	Lumbar radiofrequency facet joint denervation
2L	Exercise ECG for screening for coronary heart disease
2M	Upper GI endoscopy
2N	Appropriate colonoscopy in the management of hereditary colorectalcancer
2O	Repeat Colonoscopy
2P	ERCP in acute gallstone pancreatitis without cholangitis
2Q	Cholecystectomy
2R	Appendicectomy without confirmation of appendicitis
2S	Low back pain imaging
2T	Knee MRI when symptoms are suggestive of osteoarthritis
2U	Knee MRI for suspected meniscal tears
2V	Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures
2W	Shoulder Radiology: Scans for Shoulder Pain and Guided Injections
2X	MRI scan of the hip for arthritis
2Y	Fusion surgery for mechanical axial low back pain
2Z	Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children
2AA	Pre-operative chest x-ray
2BB	Pre-operative ECG
2CC	Prostate-specific antigen (PSA) test
2DD	Liver function, creatinine kinase and lipid level tests – (Lipid loweringtherapy)
2EE	Blood transfusion

Understanding NCL EBI 2 activity and expenditure

Data analysis has been completed to understand the level of activity and expenditure for these interventions in NCL. It should be noted that it is not possible for the data to differentiate between those interventions that have met the criteria or not.

We are mindful that much of the guidance is based on best practice and may be already embedded in pathways and current ways of working – therefore care should be taken to not assume that there are necessarily significant reductions in activity (and therefore expenditure) to be achieved as a result of the EBI 2 guidance.

Data from 20/21 has been significantly impacted by Covid-19. Please note that all 20/21 data is from Month 11 and has been adjusted to provide full year estimates.

Fig 2. Total EBI activity & expenditure in NCL – 19/20 and 20/21

EBI Activity	19/20 Activity	20/21 Activity	Reduction in activity	19/20 Cost	20/21 Cost
EBI 1 – IP	14,585	6,868	-53%	£28.2m	£13.1m
EBI 2 – IP	7,505	4,575	-39%	£17.5m	£11.3m
EBI 2 – OP	9,053	5,444	-40%	£85,000	£30,000

As expected, EBI activity has followed wider activity trends with a significant drop in volumes (and therefore expenditure) during 20/21 due to the pandemic.

Total EBI 2 activity for 19/20 came to just over 16,500 procedures – higher than EBI 1 levels. However, EBI 2 guidance covers 33 interventions, whereas EBI 1 was for 17 interventions.

Fig 3. Total EBI activity by borough (per 100k population) – 19/20 and 20/21

Borough	EBI 1 – 19/20	EBI 1 – 20/21	EBI 2 – 19/20	EBI 2 – 20/21
Barnet	975	477	945	653
Enfield	1,003	512	1,068	606
Haringey	989	446	1,228	715
Camden	865	413	1,125	688
Islington	1,033	417	1,260	710

After taking into account population size, there is some variance in EBI activity between the boroughs. Focusing on 19/20 data, Islington had the highest levels of EBI activity, across those interventions listed under both EBI 1 and EBI 2. Haringey also appears to have relatively high levels of EBI 2 activity.

Fig. 4 Top 5 EBI 2 interventions (activity & expenditure) in NCL – 19/20 and 20/21

EBI 2 interventions (top 5)	19/20 Activity	20/21 Activity	Reduction in activity	19/20 Cost	20/21 Cost
Low back pain imaging[2]	8,683	5,534	-36%	£1.1m	£731,000
Diagnostic coronary angiography for low risk, stable chest pain	1,920	1,036	-46%	£4.9m	£3.2m
Cystoscopy for men with uncomplicated lower urinary tract symptoms	1,293	972	-25%	£1.0m	£545,000

[2] We are unable to confirm the total amount spent on low back pain imaging in 19/20 across all providers (missing UCLH, RFL and NMUH finance data), however we know that activity with InHealth cost £435k in 2019/20. If we use the Inhealth average cost of £132 and multiply by the NCL total activity, this equates to £1.1m.

EBI 2 interventions (top 5)	19/20 Activity	20/21 Activity	Reduction in activity	19/20 Cost	20/21 Cost
Repair of minimally symptomatic inguinal hernia	1,188	639	-46%	£2.3m	£1.3m
Appendicectomy without confirmation of appendicitis	1,122	894	-20%	£4.3m	£3.6m

As indicated from the information in fig.1, it is not surprising that for EBI 2 interventions, the general levels of activity per intervention is relatively quite low.

Low back pain imaging is the intervention with significantly higher levels of activity compared with any other intervention included in EBI 2. However, due to the relatively low cost of the intervention (assumed average price of £132), it is not the EBI 2 intervention with the highest level of expenditure. Diagnostic coronary angiography for low risk, stable chest pain and Appendicectomy without confirmation of appendicitis are the two interventions with higher levels of cost at £4.9m and £4.3m respectively.

Fig. 5 Referral source for EBI activity – 19/20 and 20/21

	EBI 1 19/20 Activity	EBI 1 20/21 Activity*	EBI 2 19/20 Activity	EBI 2 20/21 Activity*
C2C	7,637	3,921	10,480	6,152
GP	6,948	2,948	6,078	3,867

Across both EBI 1 and EBI 2 interventions, a higher volume are as a result of a Consultant to Consultant (C2C) referral, rather than a GP referral. This is unsurprising given the types of interventions included in the guidance.

Fig. 6 EBI 2 activity – interventions with highest % of C2C referrals (19/20 only)

Intervention – Top 5	19/20 C2C referrals	% of all referrals (C2C & GP)
Upper GI endoscopy – OP	2	100%
Appendicectomy without confirmation of appendicitis	1,064	95%
Upper GI endoscopy	524	88%
Surgical intervention for chronic sinusitis	93	86%
Cystoscopy for men with uncomplicated lower urinary tract symptoms	923	71%

Fig. 7 EBI 2 activity – interventions with highest % of GP referrals (19/20 only)

Intervention	19/20 GP referrals	% of all referrals (C2C & GP)
Appropriate colonoscopy	77	99%
Fusion surgery for mechanical axial low back pain	25	86%
Arthroscopic surgery for meniscal tears	319	67%
ERCP in acute gallstone pancreatitis without cholangitis	2	67%
Surgical intervention for Benign Prostatic Hyperplasia (BPH)	201	62%

Some of the volumes for interventions are very low, and therefore must be taken into consideration. Whilst there are some interventions that fall more naturally into a C2C or GP referral, it is crucial that all parts of the system consider their own individual / departmental / organisational responsibilities with regards to EBICS and supporting patients on their particular journeys.

Given the discrepancy in activity levels between the two years, and the level of disruption to 20/21, we are planning on doing a data review in the autumn to look at the half year position for 21/22, to understand where trends may lie in relation to 19/20 and 20/21. This may then inform further activities to be undertaken by the team with partners to address any findings.

3. Approach to implementing EBI 2 in NCL

a. Current environment / circumstances

When the NCL EBICS policy was implemented in 2019, the circumstances were quite different to the present environment. At that point the policy was formally incorporated into contracts with the providers and as the contracts were predominantly cost and volume based contracts, it meant that there was significantly more onus on commissioners to ensure appropriate processes, monitoring systems and if required, enforcement mechanisms were in place to support adherence to the policy.

Given recent events, we are now operating in a significantly different environment, which needs to be taken into consideration as we develop our approach to implement EBI 2:

- The system is actively working to develop as an ICS, changing behaviours and ways of working between all partners
- There are unprecedented levels of operational pressures to manage, alongside the scale of challenge for elective recovery
- Utilisation of block contracts – there is more of a shared onus for the system to avoid unnecessary or inappropriate use of resources

The EBI 2 guidance itself notes that the guidance supports the Clinical Prioritisation programme which has been part of the NHS response to Covid-19. The Clinical Prioritisation programme is designed to support the prioritisation of waiting lists as part of the recovery of elective activity and to ensure that all patients on admitted care pathways have been reviewed and clinically prioritised to support discussions with patients and reach a decision about their planned care.

Alongside this, EBI 2 also fits with the growing culture of shared decision making, and making sure that discussions about treatment and care are undertaken jointly with the patient – for them to understand what will make a difference in their individual circumstances.

b. Developing the approach to implement EBI 2

Ensuring that EBI achieves its aims cannot be done in isolation in any part of the health and care system. It will impact patients who are talking with their GP about a referral or more specialised treatment, patients who may be on a secondary care waiting list but for whom a decision about treatment has not yet been confirmed, and patients who have a confirmed diagnosis/ agreed treatment pathway and are waiting for the next steps in their treatment journey to commence.

In adhering to both the rules and the spirit of EBI, we believe that there are benefits to be achieved across the system, in alignment with all the other work being completed to support the ongoing response to Covid-19 and enable elective recovery:

- Minimisation of waste – e.g. avoidance of inappropriate referrals, stop patients "bouncing" around the system, unnecessary use of clinical capacity (workforce and equipment / facilities / other resources)
- Maximise outcome from each NHS interaction – e.g. clear pathways, appropriate diagnostics completed to support treatment plan, good and appropriate alternatives to support patient experience and outcomes

However, given the ongoing pressures facing the system, it is important that any implementation approach is not overly onerous or bureaucratic – resulting in a disproportionate impact on partners compared with the likely outcome of any implementation.

Therefore, the proposed approach to implementing EBI 2 in NCL focuses on two strands:

1. Targeting higher volume interventions
2. Updating the NCL EBICS policy
3. Supporting engagement and socialisation of the updated NCL EBICS policy

c. Targeting higher volume interventions & guidance socialisation

This first strand is about utilising our existing processes, systems, groups and relationships to:

- Remind ourselves across the system about EBICS
- Raise awareness of the EBI 2 guidance
- Understand where everyone can get involved in considering EBI as one of many "factors" to incorporate as part of the many processes and programmes that are already underway

Building on the alignment that EBICS has with much of the work being undertaken to support elective recovery, we are engaging with a range of groups and clinical networks to update colleagues on the EBI 2 guidance. Through these conversations we can then identify where organisations and individuals can take the guidance and supporting principles and apply them to their own operations, e.g. as part of provider's internal reviews of Patient Tracking Lists. Conversations may also identify situations where it would be prudent to speak in more depth with particular departments or individuals, notably if it is identified that the guidance might result in any significant pathway change.

Our starting point for these conversations have been the Operational Implementation Group (OIG – chaired by Mat Shaw), the Referral to Treatment group (RTT – chaired by Ed Nkrumah) and the NCL Diagnostics Board (chaired by John Quinn). We are also linking in with the NCL Clinical Networks – both with the clinicians in those forums and the officers supporting them.

Alongside these broader conversations, by focusing on those areas identified as higher volume, there is a greater chance that any changes made to support EBI 2 implementation on those specific treatments or

procedures is more likely to have a tangible impact on elective capacity. For example, for lower back pain imaging, we will be engaging with the Imaging Board (sub-group of the NCL Diagnostics Board) as well as the NCL Clinical Networks for Orthopaedics and Pain.

d. Updating the NCL EBICS policy

Supported by the Health Policy Support Unit (HPSU) in the CSU, we are planning to update the NCL EBICS policy to incorporate the EBI 2 guidance. This will also provide us with an opportunity to incorporate changes from other work that has been undertaken by the governance groups that were in place prior to the pandemic to work through other topics that had been raised for consideration, as well as making some minor changes to clarify language, etc.

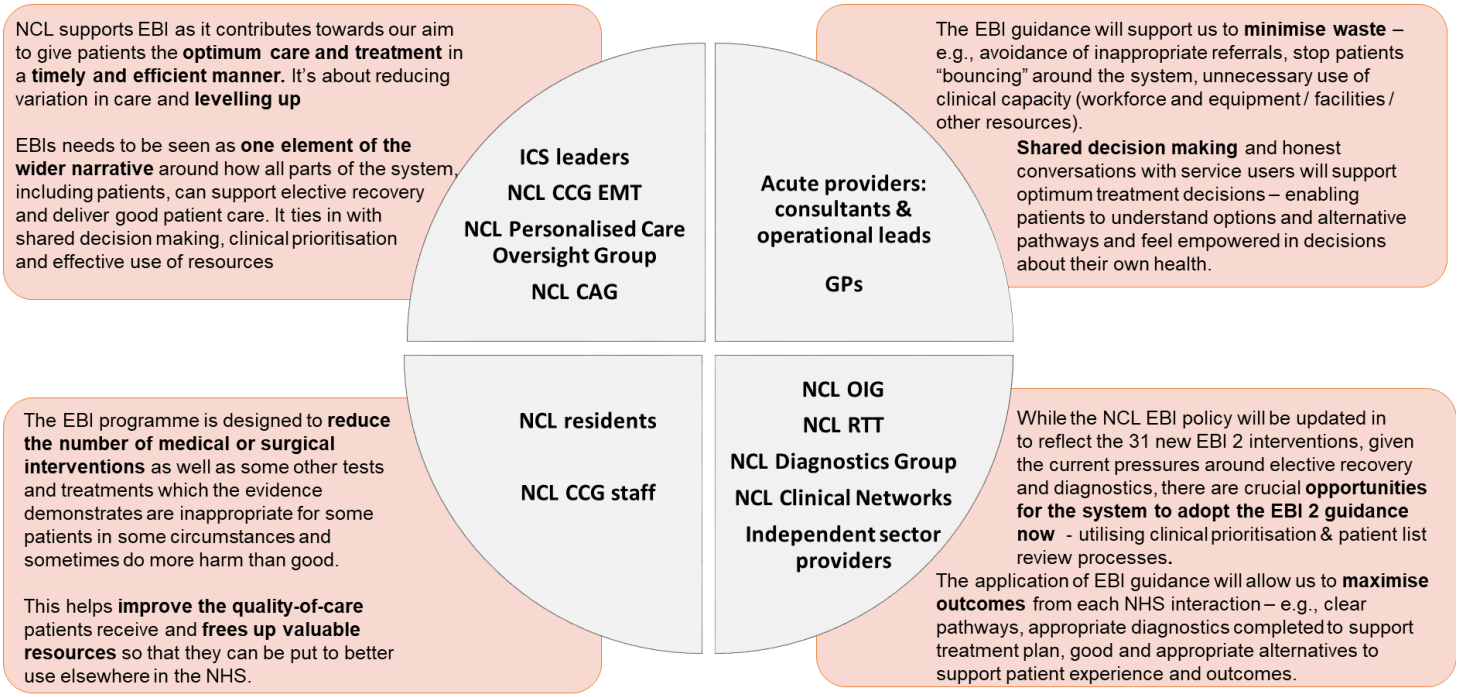
As advised to the Strategy & Commissioning Committee in Autumn 2020, we will be establishing a new governance group to act as the core group to review the work undertaken to update the policy and to recommend a new policy to the Strategy & Commissioning Committee for approval.

e. Supporting engagement and socialisation of the updated NCL EBICS policy

Stakeholder engagement is vital to this work, through all 3 stages of our planned implementation approach.

We have undertaken a stakeholder mapping exercise to support the work identified as part of the three strands to implement EBI. Many of the messages apply across a wide range of stakeholders and build into dialogue and conversations that spread across many elements of work underway – particularly in elective recovery – as well as across the different sectors in the system.

Fig. 8 – EBI stakeholder mapping and core messages



Engagement and socialisation of the updated NCL EBICS policy, once approved, will be vital and our understanding of our stakeholders and their potential concerns will underpin our conversations.

From our experiences with the launch and implementation of the NCL EBICS policy in 2019, we know that service users and residents (supported by voluntary sector organisations and patient interest / representative groups), can have significant queries and concerns about this policy, notably that it is introducing a form of “rationing” or “cut backs” via the back door of the NHS.

Therefore, some of the crucial messages for our residents in terms of supporting their understanding of what EBICS means for them include:

- Reassurance that EBICS is a clinically led programme focused on delivering the highest quality of care to all residents
- Guidance and criteria for interventions are following evidence based best practice to make sure that patients receive the right support and care at the right time and in the right way
- How they can be involved in the discussions and decisions about their care and treatment with their treating clinician – across primary, community and secondary care

We will also be able to share information about the significant engagement activity that was undertaken at a national level during summer 2020 as part of the process to develop, refine and finalise the EBI 2 recommendations. The guidance notes that opinions from patients were received, including liaison with patient advocates and patient representative groups, including the Strategic Co-Production Group at NHS England / Improvement, the Academy of Royal Medical Colleges’ Patient and Lay Committee and The Patients Association to test the proposals and understand patients’ priorities.

We will set out a more detailed engagement and socialisation plan to meet with a range of patient interest / representative groups, including the local Heatlhwatch groups and local Patient & Public Groups to support a smooth implementation following approval. We will also plan to share this with the JHOSC Chair for awareness and discussion. The engagement and socialisation plan will also cover the activities required to support communications with primary and secondary care, as well as thinking about the internal work required to support associated processes (e.g. working with Referral Support Services who provide clinical and administrative functions for referrals that require an EBICS application).

4. Next steps

The team will continue to progress the activities required to support both strands set out in this paper. These include:

- Continuing to participate in groups and individual conversations to further understand the implications of EBI 2, and identify further tasks
- Establishing the NCL EBICS Policy Review Group to consider the proposals to be incorporated in an updated NCL EBICS policy

5. Conclusion

The Strategy & Commissioning Committee is asked to **note:**

- The approach for implementation for EBI 2 in NCL
- The proposed actions to establish the NCL EBICS Policy Review Group

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	GP Direct Access Diagnostics Procurement		**Date of report** 7 July 2021	**Agenda Item**	2.6
Lead Director / Manager	Sarah Mansuralli, Executive Director of Strategic Commissioning	**Email / Tel**		Sarah.mansuralli@nhs.net	
GB Member Sponsor	Simon Goodwin, Chief Finance Officer				
Report Author	Mark Eaton, Interim Director of Strategic Projects	**Email / Tel**		Mark.eaton1@nhs.net	
Name of Authorising Finance Lead	Sangeetha Mohanarabun	**Summary of Financial Implications** The historic contract value has been ~£6.2m per year but is showing a current surge in demand suggesting a new run rate of ~£7.5m but it is unclear if this is a consistent and sustained trend. Therefore we will need to put caveats on the proposed contract value. The current contract value is based on local prices exclusive of CQUIN and MFF and offers between £400k and £700k of efficiencies compared to an equivalent NTPS/PbR funded programme. Efforts will need to be taken to ensure these efficiencies remain during the procurement and that NCL is not exposed to any additional cost pressure.			
Report Summary	This paper outlines a request to commence a procurement for GP Direct Access Diagnostics. To enable this to occur there is a further request for a twelve-month Single Tender Waiver on the current InHealth contract for GP Direct Access Diagnostic Imaging Services to allow time for the procurement to be undertaken effectively without a risk of a break in service. The delay in commencing this procurement has been driven by the need to respond to the COVID Pandemic and guidance received during this period about not introducing potential disruption that may affect the ability of the NHS to effectively respond.				
Recommendation	The Strategy and Commissioning Committee is asked to: • **APPROVE** the decision to commence procurement and the proposed timeline for the procurement of new services. • **AGREE** that the request for a Single Tender Waiver to InHealth to cover the procurement period is approved by the Procurement Committee with a recommendation of support from the SCC. • **AGREE** that responsibility for oversight of the procurement process rests with the Procurement Committee.				

Identified Risks and Risk Management Actions	Slippage in the procurement timeline is a risk however at this stage it is unclear where the delay will occur. Agreement from InHealth to continue services should mobilisation not occur on 1 April 2023 is necessary. Other risks are outlined in Section 2.7 of the report below. .
Conflicts of Interest	No specific conflicts identified.
Resource Implications	A GP Direct Access Diagnostic Procurement Working Group will be established to manage the Procurement.
Engagement	• Market engagement sessions will be required as part of the procurement process. • GP/Clinician and Service user engagement will be required in the procurement (service specification design, establishment of evaluation criteria and evaluation of tender – patient related questions only or other forms of engagement).
Equality Impact Analysis	An Equality Impact Assessment will be produced as part of the procurement process.
Report History and Key Decisions	The contract has been discussed and extended at various committees since first being awarded in 2014. An Options paper has already been shared previously with the Procurement Committee and legal advice provided (dated June 2021). This is a new paper for the SCC outlining the request to commence a procurement, the proposed timeline and a request for an STW for the current contract to enable the procurement to occur.
Next Steps	• Complete Single Tender Waiver for sign off. • Initiate Pre Procurement Process • Form Working Group
Appendices	Appendix 1: List of Diagnostics and Associated Costs in Scope for Procurement Appendix 2: Service Specification for Service Appendix 3: InHealth Ltd GP Direct Access Diagnostic Imaging Service (GP DADI):Local Prices and Other Prices 2020/21 Appendix 4: Legal Advice from DAC Beachcroft Appendix 5: Feedback from NCL Imaging Network

GP Direct Access Diagnostic Procurement Paper

Section 1: Overview & Background

1.1 Overview of Paper

The purpose of this paper is to propose a timeline for the procurement of GP Direct Access Diagnostic Imaging Services (GP DADI) as well as a timeline to extend the current InHealth contract to support the procurement timeline. The activity and therefore cost of this service is likely to vary when CDHs are established in line with the national strategy around this activity and this will need to feature as a prominent message in the procurement paperwork.

1.2 Overview of Current Contract

The GP Direct Access Diagnostic Imaging Service contract with InHealth Ltd commenced in July 2014 and, following numerous extensions of this contract, is currently set to expire on 31 March 2022.

InHealth provide a wide range of GP Direct Access Diagnostics for routine referrals for patients located within NCL including Ultrasound, MRI Scans, ECGs (including 24 Hour ECGs), X-Ray Imaging, Dexa Scans and 24 Hour Blood Pressure Monitoring. The full list of diagnostics and associated costs can be seen in Appendix 1.

The original contract was awarded through competitive tendering in July 2014 for 3 years with the option to extend for 2 years. In July 2019 there was a further Contract Variation via a Single Tender Waiver (STW) to extend the contract to March 2020 to allow time for a procurement, which was subsequently withdrawn. Due to issues arising from the COVID Pandemic in February 2021 commissioners wrote to InHealth regarding a further extension to the contract via STW for a duration of twelve months to cover the period 1st April 2021 to 31st March 2022. Local Prices (agreed April 2019) and terms and conditions remained applicable to the contract extension. The notification also stated the productivity factor applied during 2020 and which discontinued from 1st January 2021 would not be reinstated during the extension period.

Throughout both Wave 1 and Wave 2 of the pandemic as NHS Providers reduced or restricted access to routine referrals by GPs for Direct Access Diagnostic Imaging, InHealth was able to flex capacity to enable the NCL system to continue to provide GP Direct Access Diagnostic Imaging for non-urgent referrals. This has significantly contributed to reducing the waiting lists across NCL for diagnostics and enabled more care to occur outside of hospital.

1.3 Other InHealth Contracted Activity

In addition to the diagnostic activity NCL CCG currently fund the Adult Hearing Service through Any Qualified Provider (AQP) arrangement for Camden and Enfield as well as a level of non-contracted activity (items outside of the contract).

The InHealth AQP spend for Camden and Enfield breakdown shows £89k in 2018/19, £101k (estimate) in 2019/20 and £39k (estimate) in 2020/21. Caveat: The 20/21 spend has a material change due to the impact of COVID-19.

Note: This service delivered by InHealth will not be a part of the overall procurement and is provided here simply for background.

1.4 NHS Diagnostics Strategy

The NHS Long Term Plan committed the NHS to establishing imaging networks across England by 2023. For more information visit:

https://www.england.nhs.uk/publication/?filter-keyword=diagnostic&filter-category=&filter-publication=&filter-date-from=&filter-date-to=&filter-order-by=date-desc.

The formation of these networks will maximise use of existing capacity, improve access to specialist opinion and make efficiencies and economies of scale. NHS evidence shows that the modernisation of equipment, technology, and local innovation within imaging networks, increases quality of service, experience, and safety of patients. Network formation drives efficiency, making these services more resilient and sustainable. The procurement timeline will consider the upcoming implementation of an imaging network in NCL.

Following the Mike Richards' report national revenue and capital funding has been made available to implement Community Diagnostic Hubs (CDH). The NCL CDH board, overseen by the NCL Diagnostics Board, CEOs and CFOs submitted a bid in May to deliver an 'early adopter' CDH site at Finchley Memorial (for delivery this year 21/22) and will be building on this with a business case submission in June 2021 for further development and consolidation of this CDH site in 22/23, alongside the establishment of an additional CDH at Wood Green, extending community access in line with NCL population health demographics and need. The national funding criteria requires NCL to demonstrate that the CDHs will deliver additional diagnostics capacity (rather than replacement), however this can include the repatriation of work currently outsourced by the NHS.

At this time NCL has not received formal notification from London / National regarding funding the CDH 'early adopter' year 1 and year 2 bids. The development of CDHs are currently the only route that could be considered to bring additional GP DA activity back into the NHS in NCL. NCL expect feedback on what funding may be provided for CDHs later in the summer / autumn this year and therefore without this confirmation it would be a significant risk for the NCL Imaging Network to propose that NCL would be able to re-patriate the current InHealth activity. This is imaging specific and not in relation to ECG / cardiac activity.

Based on the above risks surrounding CDH implementation, the NCL Imaging Network has stated that the NCL CCG should proceed with re-procurement of activity for GP DA imaging. An important message to any potential bidders is that activity (and finance) is likely to vary as CDHs are established but at this time we are unable to advise on what impact this may have or the expected timeline. This creates a level of uncertainty for bidders that may negatively affect the number of people likely to submit a bid.

We will continue to work with the Provider Alliance and the Diagnostic Network to ensure that both the service specification and the expected activity level are aligned between the CDHs and any provider of GP Direct Access Diagnostics.

1.5 Contract Options Considered

A number of options were detailed and submitted to the Procurement Committee in May 2021 concerning the future of the InHealth Contract and the delivery of services.

The preferred option was to align to the work being undertaken by the NCL Diagnostic Imaging Network. This would involve extending InHealth's contract for a further 2 years to allow for the development of the local Community Diagnostic Hubs (CDH) and the development of the Diagnostic Strategy for NCL. Through the contract extension we could coordinate the implementation of the CDHs with the InHealth Contract to optimise capacity (and therefore costs to the system) which would not be possible under the other options discussed.

The preferred recommendation will deliver a more cost-effective service and ensure continuity of service until the NHS England guidance on the Diagnostic Imaging Network can be implemented and will ensure NCL continues to benefit from the financial efficiencies offered by the InHealth contract and that they continue to support Elective Recovery during the period when there is a potential third COVID wave expected.

In order to implement this recommendation legal advice was required in relation to the extension of the contract via DAC Beachcroft.

The recommendation from DAC Beachcroft solicitors dated 10 June 2021 advises that NCL CCG is unable to extend the InHealth contract without significant risk of challenge. This initial advice was then followed up by a discussion with DAC Beachcroft which further confirmed the risks faced by the NCL CCG should we seek to extend the current contract further without initiating a procurement.

Given the advice from the solicitors (appended to this paper) it is proposed that the procurement process start in August 2021 to allow time to gather relevant data, information and resources to support the procurement.

Therefore, the recommendation is that we commence a procurement for GP Direct Access Diagnostics as detailed in the following section.

Section 2: Procurement Overview

2.1 Procurement Scope

The procurement proposal is for the successful bidder to deliver the following Direct Access Diagnostics Imaging Service modalities:

- Non-Obstetric Ultrasound
- MRI
- X-ray
- Cardiology Diagnostic Services including:
    - Ambulatory ECG
    - Ambulatory Blood Pressure Monitoring
    - ECG
    - Echo
- Dual Energy X-ray Absorptiometry (DEXA) Scanning

Further details about the service requirements can be found in the Service Specification in Appendix 2.

An important note is that the proposal, agreed with DAC Beachcroft, is to seek a single provider capable of delivering all the above modalities.

A further note is that we are not proposing to include the ~£100k of AQP Adult Hearing Services delivered by InHealth within scope of the procurement. In the event that InHealth cease providing this service there are other AQP Providers within NCL who would be able to absorb the additional activity.

2.2 Proposed Contract Duration

The proposed contract duration for the new contract is 2+2 years. Payments will be based on ‘Cost & Volume’ and will not be subject to any form of block arrangement noting that this decision may need to be revised in light of any future guidance received.

This will enable flexibility on the contract when the Imaging Networks (and CDHs) go live at an indeterminate date in the future.

2.3 Indicative Contract Value

Evidence from historical data shows the activity and cost trend for InHealth to be as follows:

Year	Activity	Spend
2018-19	85,803	£6,289,920
2019-20	90,316	£6,119,407
2020-21	86,863	£6,149,493*

***NOTE: 25% inefficiency factor was applied from 1 July 2020 to 31 December 2020. Without the Inefficiency Factor the spend in 20/21 would have been £5,448,914 due to a reduced demand during the COVID Pandemic.**

Based on the above, the proposed annual contract value is £6.1m per year for two years (£12.2m in total). Actual costs will depend on demand.

However, it should be noted that the impact of the COVID Pandemic has been significant on demand for GP Direct Access Diagnostics especially as the NHS facilities closed their own Direct Access Pathways during the height of the pandemic. Therefore, there has been substantial variation over the last 18 months with activity varying from a low of £5.4m during 20/21 to a current run rate suggesting an annual spend nearer to £7.5m. The current up turn in activity may or may not be related to elective recovery and the reopening of Primary Care capacity to normal activity but it is too early to say whether this is a sustained trend.

2.4 Local Tariffs

Since the InHealth contract commenced in 14/15 local pricing has applied and have consistently been lower than the equivalent tariffs in the NHS for the same diagnostic activity. NHS Tariffs include both Market Forces Factor (MFF) and CQUIN as well as the National Tariff, none of which apply to InHealth's tariffs which can be considered an 'all in' price.

InHealth's local pricing translated to national tariffs falls within both Payment by Results (PbR) and Non PbR. Where activity is equivalent to Non PbR, no comparison can be drawn to national tariffs i.e. for 24 Hour BP Monitoring but also the local price has remained at the same tariff for these modalities since contract commencement in 2014/15.

In 2020/21 it was agreed that from Month 4 to Month 9 a 25% productivity uplift was applied to deal with the effects of COVID but from Month 10 the tariff reverted to pre-Month 4 prices. Using the 2020/21 data (and ignoring the short-term productivity uplift) show that reverting activity to the NHS National Tariff system would incur a cost pressure of between £400k and £700k compared to InHealth's local prices as summarised below:

- **Worst case scenario:** Applying the UCLH Market Forces Factor of 1.25 and 1.25% CQUIN shows £700k cost pressure would be incurred if activity reverted to the NHS.

- **Best case scenario:** Applying the NMUH Market Forces Factor of 1.18 and 1.25% CQUIN shows £400k cost pressure would be incurred if activity reverted to the NHS.

InHealth Spend Compared to NHS Providers (excluding short-term Productivity factor M4-M9 20/21)

Cost 2020/21, £* (National tariffs 2020/21 incl. MFF & CQUIN)**				
Inhealth Submitted Cost	National Tariff inc. UCLH 1.256153 MFF as Worst Case Scenario	**Variance** InHealth (25% removed) vs worst case scenario	National Tariff inc. NMUH 1.1811691 MFF as Best Case Scenario	**Variance** InHealth (25% removed) vs best case scenario
£5,448,914	**£6,127,682**	**-£678,768**	**£5,814,508**	**-£365,594**

It is proposed that the procurement states that MFF and CQUIN will not be paid in the procurement documentation and that Local Prices will continue to apply although these will be reviewed with a view to renegotiating these tariffs where possible to match the best prices available in London.

See Appendix 3 for current tariffs applicable to the InHealth Contract. These will be applied to the procurement but without the certainty of them being realised in subsequent bids recognised as a threat in the Risks/Issues section of the document.

2.5 Procurement Timeline

The proposed timeline for procurement is twenty months (20), commencing August 2021 with a Go Live date of 1 April 2023. This will be made up of the following:

High Level Procurement Timeline	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Pre Procurement stage																					
Procurement																					
Post Procurement (mobilisation inc. 1 month contract finalisation)																					
Start date																					

The timeline will also align to the establishment of the Imaging Network and potentially the development of CDHs.

An important note is that the timeline assumes a new provider is appointed and therefore an extended mobilisation period is required. Should the incumbent provider be successful the timeline will be significantly shortened.

2.6 Interim Contractual Arrangements

The current InHealth contract is due to expire on 31 March 2022. It is proposed that a Single Tender Waiver is established to cover period of 1 April 2022 to 31 March 2023 (twelve months in total). This will allow time for any new provider to mobilise although if there are delays may result in a further request to extend to cover any slippage. Advice received suggests requesting any more than an 12 months STW at this stage could be a risk to receiving a challenge.

The new service is expected to go live from 1 April 2023 assuming a new provider is appointed. This will ensure continuity of service delivery, time to mobilise the new contract if the current incumbent is not successful and will support a seamless transition of services. As noted previously, there will be a significant reduction in lead-in time if the incumbent provider is appointed.

If approved, the Single Tender Waiver will be drafted as soon as possible, seeking procurement advice and detailing justification of waiver prior to NCL CCG approval. The Single Tender Waiver will include a 3 month no fault commissioner break clause (as per the latest local Contract Variation) and will be used depending on the progress of the procurement. The STW will be approved by the Procurement Committee.

The STW for the InHealth contract will include all contracted activity undertaken by InHealth except for the AQP for Adult Hearing Service (due itself to expire in March 2022) on the basis that the latter will not be part of the procurement.

2.7 Feedback from NCL Imaging Network

Following discussion with Alex Pinches (CDH Board Chair), Ash Saini (Imaging Network Chair), Dennis Carlton (Programme Director Diagnostics) and others the feedback in relation on the NCL CCG re-procurement of InHealth GP DA activity was as follows.

"At this time the ICS have not received formal notification from London / national regarding funding our CDH 'early adopter'/year 1 and year 2 bids. The development of CDHs are currently the only route that could be considered to bring additional GP DA activity back into the NHS in NCL. It is expected that feedback on what funding may be provided for CDHs later in the summer / autumn this year and therefore without this confirmation it would be a significant risk for NCL Imaging Network to propose that the NCL Imaging Network would be able to re-patriate the current InHealth activity.

Based on the above risks surrounding CDH implementation the NCL Imaging Network could not suggest any other route to the CCG than going ahead with re-procurement of activity (in GP DA imaging) at InHealth."

As mentioned earlier we will continue to work with the Provider Alliance and the Diagnostic Network to ensure the procurement is aligned to the work being undertaken by both organisations to mobilise CDHs and the resulting activity plans for any provider of GP Direct Access Diagnostics.

2.8 Procurement Risks & Issues

Risks associated with the procurement of the diagnostic service is as follows:

	Risk	Mitigation	RAG Rating
1	There is a risk there will not be any bidders.	The existing provider has indicated that they very much intend to bid for this procurement so this risk is unlikely to materialise but we will keep it under review.	
2	There is a risk there will be no other bidders than existing Provider.	We will issue a contract extension to the current contract as the existing provider has indicated that they are keen to continue.	
3	There is a financial risk of bids submitted being in excess of contract envelope	We will be including indicative activity and tariff values inclusive of CQUIN/MFF that will contain the financial envelopes submitted and allow us to exclude any bids over the envelope. However, if no bids are received within the existing financial envelope we will have an unmitigated financial pressure.	
4	There is a timeline overlap with Imaging Network formation and establishment of Community Diagnostic Hubs.	We will work with the Imaging Network and are already actively involved in CDH Planning.	
6	There is a risk that there will be a reduction in the number of community diagnostic sites if an alternative IS provider is successful or activity moves to acute provider site if acute trust successful, effecting access, travel, etc.	We will require bidders to outline how they will ensure equity of access and service provision across NCL and how they will aim to improve access points. A pass/fail criteria will be the loss of access points in NCL and bids that propose this will be excluded.	
7	The developing Imaging/Diagnostic Networks will develop a plan for Community Diagnostic Hubs and we will need to ensure that the activity is appropriately distributed across the system to make the mandated CDHs viable.	We will work with both the Provider Alliance and the Imaging/Diagnostic Network to align activity levels and ensure that any provider of GP Direct Access Diagnostics is able to work in tandem with the development of NHS CDHs.	

2.9 Next Steps

Following agreement from the Strategy & Commissioning Committee to commence a Procurement and extend the InHealth contract to support transition of services the following actions will occur:

- We will produce a twelve month Single Tender Waiver to extend the InHealth contract to March 2023 to enable the procurement to occur effectively. This will be approved by the Procurement Committee.

- We will prepare the Pre-procurement documentation to be initiated for the procurement process, along with a Prior Information Notice (PIN) to be uploaded on Contracts Finder with an agreed advert go live date.

- We will establish a Programme Procurement Team to oversee the development of the appropriate procurement documentation, governance and representation (clinical/public). We will also start working to define how the required outcomes are both defined and monitored through the procurement. Lastly the Programme Procurement Team will oversee the timeline and activity plans plus also detail how we will manage the contract once awarded.

- We will provide regular updates to future SCC meetings.

Appendix 1: List of Diagnostics and Associated Cost

Cost Comparison for InHealth Local Prices vs National Prices

PBR/NPBR	HRG Code	HRG Description	2018/19 Actuals			2019/20 Actuals			2020/21 Acuals		
			Trust Submitted Cost	Trust Submitted Activity * National Tariff for PBR/Local InHealth Prices for NPBR	2018/19 Variance	Trust Submitted Cost	Trust Submitted Activity * National Tariff for PBR/Local InHealth Prices for NPBR	2019/20 Variance	Trust Submitted Cost *	Trust Submitted Activity * National Tariff for PBR/Local InHealth Prices for NPBR	2020/21 Variance
NPBR	XX06Z	24 Hour BP Monitoring	£81,378	£81,378	£0	£81,189	£81,189	£0	£52,745	£47,061	£5,684
NPBR	XX07Z	24 Hour ECG	£117,390	£117,390	£0	£121,590	£121,590	£0	£140,954	£125,335	£15,619
NPBR	RA28Z	Conventional x-ray imaging (Plain Film) one area	£63,270	£63,270	£0	£89,055	£89,055	£0	£88,476	£78,300	£10,176
NPBR	XX?	Conventional x-ray imaging (Plain Film) two or three areas	£293	£293	£0	£788	£788	£0	£10,733	£9,473	£1,260
PBR	RD50Z	DEXA Scans	£95,400	£93,810	£1,590	£117,240	£76,206	£41,034	£69,900	£41,000	£28,900
NPBR	RA22ZA	Doppler Ultrasound	£2,093	£2,093	£0	£68	£68	£0	£2,109	£2,025	£84
NPBR	XX08Z	ECG / Resting ECG	£29,352	£29,352	£0	£40,162	£40,162	£0	£133,956	£116,537	£17,419
NPBR	XX10Z	ECG 48hr ECG		£0	£0		£0	£0	£4,483	£3,878	£605
NPBR	EA45ZA	Full Transthoracic Echocardiogram	£294,124	£294,124	£0	£336,628	£336,628	£0	£429,226	£375,820	£53,406
PBR	RD02A	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, 19 years and over	£5,476	£6,105	-£629	£3,725	£3,297	£428	£2,735	£2,080	£655
PBR	RD01A	Magnetic Resonance Imaging Scan of One Area, without Contrast, 19 years and over	£2,767,187	£2,279,632	£487,555	£2,329,393	£1,842,048	£487,345	£1,923,668	£1,378,300	£545,368
PBR	RD02B	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, between 6 and 18 years		£0	£0	£194	£162	£32		£0	£0
PBR	RD01B	Magnetic Resonance Imaging Scan of One Area, without Contrast, between 6 and 18 years	£18,457	£15,851	£2,606	£11,540	£9,492	£2,048	£13,842	£10,120	£3,722
No HRG Code		MRI one area no contrast	£10,388	£10,388	£0	£16,104	£16,104	£0	£7,741	£7,741	£0
No HRG Code		MRI one area post contrast only	£740	£740	£0		£0	£0		£0	£0
PBR	RD05Z	Magnetic Resonance Imaging Scan of Two or Three Areas, with Contrast	£740	£660	£80	£609	£552	£57	£659	£561	£98
PBR	RD04Z	Magnetic Resonance Imaging Scan of Two or Three Areas, without Contrast	£460,815	£344,025	£116,790	£356,835	£270,405	£86,430	£331,323	£230,297	£101,026
PBR	RD06Z	Magnetic Resonance Imaging Scan of more than Three Areas	£36,360	£31,584	£4,776	£64,395	£49,572	£14,823	£60,468	£43,395	£17,073
No HRG Code		Patient Transport	£2,108	£2,108	£0		£0	£0		£0	£0
PBR	MA36Z	Transvaginal Ultrasound	£4,464	£11,850	-£7,387	£15,312	£46,612	-£31,301	£125,924	£382,800	-£256,876
PBR	RD42Z	Ultrasound Scan with duration of 20 minutes and over, without Contrast	£54,579	£41,538	£13,041	£32,940	£28,567	£4,373	£41,641	£33,650	£7,991
PBR	RD40Z	Ultrasound Scan with duration of less than 20 minutes, without Contrast	£2,189,891	£1,843,800	£346,091	£2,415,850	£1,983,540	£432,310	£2,650,001	£1,964,080	£685,921
PBR	RD47Z	Vascular Ultrasound Scan	£55,418	£37,766	£17,652	£85,793	£62,279	£23,514	£58,911	£38,700	£20,211
		Grand Total	**£6,289,920**	**£5,307,755**	**£982,164**	**£6,119,407**	**£5,058,314**	**£1,061,092**	**£6,149,493**	**£4,891,152**	**£1,258,342**

NOTE: 25% uplift was applied from Month 4 to Month 9 2020/21, impacting the overall spend

Appendix 2: InHealth Local Prices compared to National Prices

InHealth Ltd GP Direct Access Diagnostic Imaging Service (GP DADI): Local Prices and Other Prices 2020/21						
Local Prices 2020/21 (As recorded in CV05)						
HRG Code	**HRG Description**	**2020/21 National Tariff**	**20/21 InHealth Local Price**	**19/20 InHealth Local Price**	**2014/15 InHealth Local Price**	**Diff 20/21 InHealth Local Price vs 20/21 National Tariff**
RD01A	Magnetic Resonance Imaging Scan of One Area, without Contrast, 19 years and over	£110.00	£134.05	£134.05	£138.50	£24.05
RD01B	Magnetic Resonance Imaging Scan of One Area, without Contrast, between 6 and 18 years	£115.00	£137.05	£137.05	£138.50	£22.05
RD02A	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, 19 years and over	£160.00	£168.20	£168.20	£148.00	£8.20
RD03Z	Magnetic Resonance Imaging Scan of One Area, with Pre- and Post-Contrast	£160.00	£186.70	£186.70	£185.00	£26.70
RD04Z	Magnetic Resonance Imaging Scan of Two or Three Areas, without Contrast	£137.00	£171.50	£171.50	£181.00	£34.50
RD05Z	Magnetic Resonance Imaging Scan of Two or Three Areas, with Contrast	£187.00	£202.90	£202.90	£185.00	£15.90
RD06Z	Magnetic Resonance Imaging Scan of more than Three Areas	£165.00	£194.70	£194.70	£195.00	£29.70
RD40Z	Ultrasound Scan with duration of less than 20 minutes, without Contrast	£40.00	£47.50	£47.50	£47.50	£7.50
RD42Z	Ultrasound Scan with duration of 20 minutes and over, without Contrast	£50.00	£56.50	£56.50	£56.50	£6.50
No National tariff HRG code	US Pelvis transvaginal	Non PBR	£56.50	£56.50	none	
MA36Z	Transvaginal Ultrasound	£174.00	£56.50	£56.50	£56.50	-£117.50
RA22ZA	Doppler Ultrasound	Non PBR	£67.50	£67.50	£67.50	
RD47Z	Vascular Ultrasound Scan	£50.00	£67.50	£67.50	£67.50	£17.50
EA45ZA	Full Transthoracic Echocardiogram	Non PBR	£92.00	£92.00	£92.00	
XX06Z	24 Hour BP Monitoring	Non PBR	£27.00	£27.00	£27.00	
XX07Z	24 Hour ECG	Non PBR	£35.00	£35.00	£35.00	
XX08Z	ECG / Resting ECG	Non PBR	£23.50	£23.50	none	
RA28Z	Conventional x-ray (Plain film) one area	Non PBR	£22.50	£22.50	£22.50	
RD50Z	DEXA scans	£40.00	£60.00	£60.00	£60.00	£20.00

Other Prices 2020/21 (NOT recorded in CV05)						
HRG Code	**HRG Description**	**2020/21 National Tariff**	**InHealth Local Price**	**19/20 InHealth Local Price**	**2014/15 InHealth Local Price**	**Diff 20/21 InHealth Local Price vs 20/21 National Tariff**
RD02B	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, between 6 and 18 years	£165.00	£194.40	£194.40	£194.40	£29.40
XX10Z	ECG 48hr ECG	Non PBR	£23.50	£23.50	£23.50	
XX24Z	Colonoscopy	Non PBR	£557.00	£557.00	£557.00	
FZ52Z **(20/21 new HRG code FE31Z)**	Diagnostic Colonoscopy with biopsy 19 years and over	£528.00	£425.11	£425.11	£425.11	-£102.89
FZ55Z **(20/21 new HRG code FE34Z)**	Diagnostic Flexible Sigmoidoscopy with biopsy 19 years and over	£395.00	£425.11	£425.11	£425.11	£30.11
XX23Z	Flexible Sigmoidoscopy	Non PBR	£385.00	£385.00	£385.00	
XX05Z	Histology/Histopathology	Non PBR	£40.11	£40.11	£40.11	
InHealth Ltd Audiology: Non-Contract Activity Prices 2020/21						
HRG Code	**HRG Description**	**2020/21 National Tariff**	**InHealth Local Price**	**19/20 InHealth Local Price**	**2014/15 InHealth Local Price**	
XX13Za	Fitting of Hearing Aids & Counselling: Assessment Only	Non PBR	£64.31	£64.31	£64.31	
XX14Zb	Fitting of Hearing Aids & Counselling: Bilateral Device	Non PBR	£474.82	£474.82	£474.82	
XX14Zr	Replacement of Hearing Aids & Counselling: Single Device	Non PBR	£69.21	£69.21	£69.21	
XX14Zs	Fitting of Hearing Aids & Counselling: Single Device	Non PBR	£338.19	£338.19	£338.19	
XX16Za	Fitting of Hearing Aids & Counselling: Device Repairs	Non PBR	£31.57	£31.57	£31.57	
XX16Zr	Fitting of Hearing Aids & Counselling: Device Replacements	Non PBR	£80.81	£80.81	£80.81	

Appendix 3: InHealth Local Prices compared to other Diagnostic Providers

InHealth Ltd GP Direct Access Diagnostic Imaging Service (GP DADI): Local Prices and Other Prices 2020/21				Benchmarks				
Local Prices 2020/21 (As recorded in CV05)				NE London (2018/19)				
HRG Code	**HRG Description**	**20/21 InHealth Local Price***	**2020/21 National Tariffs**	**InHealth**	**Concordia**	**Physiological Measurements**	**SW London**	**SE London**
RD01A	Magnetic Resonance Imaging Scan of One Area, without Contrast, 19 years and over	£ 134.05	£ 110.00	£ 152.24				
RD01B	Magnetic Resonance Imaging Scan of One Area, without Contrast, between 6 and 18 years	£ 137.05	£ 115.00					
RD02A	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, 19 years and over	£ 168.20	£ 160.00					
RD03Z	Magnetic Resonance Imaging Scan of One Area, with Pre- and Post-Contrast	£ 186.70	£ 160.00					
RD04Z	Magnetic Resonance Imaging Scan of Two or Three Areas, without Contrast	£ 171.50	£ 137.00	£ 193.36				**Providers:**
RD05Z	Magnetic Resonance Imaging Scan of Two or Three Areas, with Contrast	£ 202.90	£ 187.00					a) Physiological Measurements Ltd (Bexley): Community Cardiac Diagnostics b) Express Diagnostics (Bromley): Bromley GP Led Community Cardiology Diagnostics c) Alliance Medical Limited (Greenwich): Community MSK Diagnostics
RD06Z	Magnetic Resonance Imaging Scan of more than Three Areas	£ 194.70	£ 165.00	£ 241.17				
RD40Z	Ultrasound Scan with duration of less than 20 minutes, without Contrast	£ 47.50	£ 40.00	£ 46.91	£ 50.96			
RD42Z	Ultrasound Scan with duration of 20 minutes and over, without Contrast	£ 56.50	£ 50.00					
No National tariff HRG code	US Pelvis transvaginal	£ 56.50	Non PBR					
MA36Z	Transvaginal Ultrasound	£ 56.50	£ 174.00					
RA22ZA	Doppler Ultrasound	£ 67.50	Non PBR					
RD47Z	Vascular Ultrasound Scan	£ 67.50	£ 50.00				**Provider:** No GP Direct Access community based services available	
EA45ZA	Full Transthoracic Echocardiogram	£ 92.00	Non PBR					
XX06Z	24 Hour BP Monitoring	£ 27.00	Non PBR	£ 30.27	£ 23.52	£ 24.00		
XX07Z	24 Hour ECG	£ 35.00	Non PBR	£ 39.86	£ 47.04	£ 48.00		
XX08Z	ECG / Resting ECG	£ 23.50	Non PBR					
RA28Z	Conventional x-ray (Plain film) one area	£ 22.50	Non PBR				**Local Prices:** N/A	
RD50Z	DEXA scans	£60.00	£40.00					
Other Prices 2020/21 (NOT recorded in CV05)								
HRG Code	**HRG Description**	**InHealth Local Prices**	**2020/21 National Tariffs**					
RD02B	Magnetic Resonance Imaging Scan of One Area, with Post-Contrast Only, between 6 and 18 years	£ 194.40	£ 165.00					
XX10Z	ECG 48hr ECG	£ 23.50	Non PBR			£ 48.00		**Local Prices:** Requested
XX24Z	Colonoscopy	£ 557.00	Non PBR					
FZ52Z **(20/21 new HRG code FE31Z)**	Diagnostic Colonoscopy with biopsy 19 years and over	£ 425.11	£ 528.00	£ 556.12				
FZ55Z **(20/21 new HRG code FE34Z)**	Diagnostic Flexible Sigmoidoscopy with biopsy 19 years and over	£ 425.11	£ 395.00	£ 444.87				
XX23Z	Flexible Sigmoidoscopy	£ 385.00	Non PBR	£ 493.06				
XX05Z	Histology/Histopathology	£ 40.11	Non PBR					
RA29Z	Conventional x-ray imaging (Plain Film) two or three areas	£ 22.50	Non PBR					

Local prices same for 2018/19, 2019/20, 2020/21

FOR INFO ONLY (NOT PART OF GP DADI CONTRACT)

InHealth Ltd Audiology: Non Contract Activity Prices 2020/21				Benchmarks (NE London)		
HRG Code	**HRG Description**	**InHealth Local Prices**	**2020/21 National Tariffs**	**BHRUT**	**BH**	**InHealth**
XX13Za	Fitting of Hearing Aids & Counselling: Assessment Only	£ 64.31	Non PBR	£ 62.98	£ 63.13	£ 53.08
XX14Zb	Fitting of Hearing Aids & Counselling: Bilateral Device	£ 474.82	Non PBR	£ 436.14	£ 444.32	£ 375.13
XX14Zr	Replacement of Hearing Aids & Counselling: Single Device	£ 69.21	Non PBR			£ 80.81
XX14Zs	Fitting of Hearing Aids & Counselling: Single Device	£ 338.19	Non PBR	£ 314.97	£ 321.71	£ 262.69
XX16Za	Fitting of Hearing Aids & Counselling: Device Repairs	£ 31.57	Non PBR	£ 30.05	£ 30.35	£ 30.53
XX16Zr	Fitting of Hearing Aids & Counselling: Device Replacements	£ 80.81	Non PBR			£ 143.44

PRIVATE & CONFIDENTIAL

NORTH CENTRAL LONDON CLINICAL COMMISSIONING GROUP

ADVICE ON EXTENSION OF CONTRACT WITH INHEALTH GROUP LIMITED (DIAGNOSTIC SERVICES)

1. BACKGROUND AND INSTRUCTIONS

1.1. North Central London CCG (the **"CCG"**) is party to a contract with InHealth Group Limited (**"InHealth"**) for the provision of GP direct access diagnostic imaging services (**"Services"**) (the **"Contract"**). The Contract commenced on 1 July 2014, and is based on the NHS Standard Contract for healthcare services. The Contract has been varied a number of times (the last variation was issued in August 2020 and extended the term by a further two years, which was beyond that originally advertised in the original procurement documents), and the expiry date of the Contract is now 31 March 2022. In addition to the commercial variations agreed between the parties, we understand that the CCG has also issued national variations to the NHS Standard Contract to InHealth; however, it is unclear whether the national variation for 2021/22 has been issued to InHealth – the CCG was checking this internally.

1.2. The NHS Long Term Plan committed the NHS to establishing imaging networks across England by 2023. Further, in October 2020, the NHS commissioned an independent review of diagnostic services and, as a result of the recommendations made in that report, the NHS is considering a radical overhaul of the way in which diagnostic services are delivered for patients, including the creation of Community Diagnostic Hubs (**"CDHs"**). NHS England is currently working towards setting up a pre-qualification system to allow for the procurement of CHDs using a quick and efficient procurement route in this financial year.

1.3. The CCG has developed an options paper for its procurement committee to determine how best to deal with the delivery of the Services in North Central London until the NHS implements the proposed changes to diagnostic services. The CCG has asked us to advise on "option 9" in the options paper, i.e. the extension of the Contract for a further two years (to 31 March 2024) to allow time for the development of an imaging network in North Central London, and the implementation of CDHs. Our advice is set out below.

2. ADVICE

Public Contracts Regulations 2006

2.1. The Contract commenced on 1 July 2014. The procurement for the Services would have therefore been subject to the Public Contracts Regulations 2006 (**"PCR 2006"**). Schedule 3 to the PCR 2006 divided services into two different categories: "part A" and "part B" services. Health services (i.e. diagnostic services) were "part B" services, and such services were largely excluded from the full procurement regime; however, the CCG was required to comply with certain parts of the regime, including the principles of proportionality, mutual recognition, transparency, non-discrimination and equal treatment.

Public Contracts Regulations 2015

2.2. The Public Contracts Regulations 2015 (**"PCR 2015"**) came into force on 26 February 2015. The PCR 2015 replaced the PCR 2006, and apply to any contract award procedure commenced on or after 26 February 2015. Although the original Contract was awarded pursuant to the PCR 2006, any amends to the Contract are still subject to Regulation 72 of the PCR 2015 *(Regulation 118(5C) of the PCR 2015)* as a substantial variation is considered a "new contract" in procurement law terms.

PCR 2015 – Light Touch Regime and Modifications under Regulation 72

2.3. Under the PCR 2015, services are not classified as "part A" or "part B" services. However, Schedule 3 of the PCR 2015 lists a number of services that are subject to a Light Touch Regime (**"LTR"**) and "health, social and related services" are included in that list. Had the CCG conducted its procurement for the Services under the PCR 2015, it is likely that such procurement would have been subject to the LTR. The main procedural rules of the LTR are set out in Regulations 74 to 76 of the PCR 2015, but other parts of the PCR 2015 are still relevant, and the procedure must be at least sufficient to ensure compliance with the principles of transparency and equal treatment of suppliers. Whist the PCR 2015 do not expressly state that Regulation 72 is applicable for contracts awarded using the LTR, we consider that it is applicable, in order to ensure compliance with the requirements of transparency and equal treatment.

PCR 2015 – Substantial Variations (Regulation 72(8))

2.4. Given that the Contract has already been extended for a period of five years (which includes an additional year three extension which was not accounted for in the initial procurement documents), a further two year extension of the term (to 31 March 2024) is likely to be considered as a "substantial variation" pursuant to Regulation 72(8) of the PCR 2015. This could potentially expose the CCG to a risk of challenge by other potential providers for the Services, who could argue that the variation introduces terms which, had they part of the initial procurement procedure, would have (i) allowed for the admission of other candidates than those initially selected; (ii) allowed for the acceptance of a tender other than that originally accepted; or(iii) attracted additional participants in the procurement procedure, or that the variation is a change in the economic balance of the Contract originally advertised in favour of InHealth. An extension of the contract term is generally considered to be a substantial modification, unless an exemption applies.

2.5. An aggrieved provider has six months from the date of signature of the variation to seek to have the variation declared "ineffective", i.e. to seek to have the whole Contract (not just the variation) set aside and the obligations under the Contract cancelled. This six-month period can be reduced to 30 days if the CCG publishes a modification notice or contract award notice on the UK's e-notification service, Find a Tender Service (**"FTS"**). Although publication of such notice is not an express requirement for contracts awarded under the LTR, it is considered prudent for the CCG to publish such notice. Further, the remedy of ineffectiveness could be removed altogether if the CCG publishes a voluntary transparency notice (also known as a voluntary ex-ante transparency (**"VEAT"**) notice) prior to signing the variation with InHealth. However, the CCG should note that this approach will only be successful if the CCG includes a valid justification in that notice as to why the PCR 2015 do not apply to the variation.

2.6. The aggrieved provider may also bring a claim for damages. In order to rely on this remedy, the provider must bring its claim within 30 days of becoming aware of the "breach" it was alleging. The court has the right to extend this 30 day period by up to three months if there is a good reason for doing to. However, if the CCG publishes a notice in the FTS (please refer to our comments at paragraph 2.5 above), this is likely to be viewed as "knowledge", and will start the 30 days ticking.

PCR 2015 – Permitted Variations (Regulation 72(1)) i.e. Exemptions

2.7. Regulation 72(1) lists six grounds under which modifications can be made to a contract without the need to follow a fresh procurement procedure. We have considered each of these six grounds, and the only one that potentially fits the circumstances in this case is as follows:

(i) the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen; (ii) the modification does not alter the overall nature of the contract; and (iii) any increase in price does not exceed 50% of the value of the original contract (Regulation 72(1)(c)).

2.8. The exemption under Regulation 72(1)(c) is held to a very high bar by the courts. The contents of any variation must be no more than is necessary to deal with the emergency in hand. The first two limbs (limb (i) and (ii) above) are likely to be the most difficult for the CCG to demonstrate, as the plans to establish imaging networks were announced in 2019 and Covid-19 is no longer an unforeseen circumstance. Further, as mentioned at paragraph 2.4 above, a further extension of two years will ultimately mean that the term of the Contract initially procured has doubled and, whilst this exemption is not accumulated with previous modifications, it may nevertheless influence the court. Moreover, given that the Contract is not due to expire until March 22, there is no reason on the face of it as to why the CCG is unable to commence a new procurement process now for the appointment of a new provider. With regard to limb (iii), the documents you have sent to us do not contain details of the value of the original Contract, however, the CCG has confirmed that there will not be any price increases and the value of the modification will therefore be approximately £10.8m in total (£5.4m per annum), which we assume does not equate to more than 50% of the value of the original Contract, but please do let us know if this is not correct. Where the CCG makes serval modifications, the financial cap imposed by limb (iii) above applies to the value of each modification (i.e. it is not affected by previous variations to the Contract).

2.9. For the reasons we have set out above, there are obvious difficulties in seeking to rely on this exemption, and we cannot identify any further exemptions that might apply on the facts we have.

New Procurement Process / Provider Selection Regime

2.10. In order to avoid falling foul of Regulation 72(8) (i.e. the risk of a challenge by a potential provider that the variation is "substantial"), we recommend that the CCG pursues "option 2" (the commencement of a procurement process to appoint a new provider) in its option paper. As noted in the options paper, the CCG's timescales allow for the appointment of a new provider by January 2022, which will allow for a mobilisation/handover period before InHealth ceases providing the Services on 31

March 2022. Further, as mentioned above, NHS England is looking into tools to allow for the procurement of CHDs in this financial year, which equates to further evidence against the ability to rely on the exemption in Regulation 72(1)(c) on the basis that this is an emergency of some sort that would not permit another procurement.

2.11. As the CCG is aware, the consultation for the NHS Provider Selection Regime (which will carve health services of the PCR 2015) closed on 7 April 2021, and we are now waiting for legislation to be published. As an alternative to pursuing "option 2", the CCG could therefore decide to hold fire / do nothing until this legislation comes into force as, once in force, it is anticipated that the CCG will be able to continue with its existing arrangements without a new tender process on the basis that InHealth, as the incumbent provider, is "doing a good job" and delivering against the "key criteria" (as set out in the Provider Selection Regime), and so there is no value in seeking another provider to provide the Services. The risk here is that it is not yet known when the legislation will take effect.

3. Next Steps

3.1. We note that the CCG issued a national variation to the Contract for the 2017/18 financial year, and the 2018/19 financial year, but please could you confirm whether national variations for future financial years (for 2019/20 onwards) have been issued to InHealth. Further, please could you also confirm the value of the original Contract, and the total value of any extensions to the Contract.

3.2. The key issue for the CCG is risk mitigation. When making its decision regarding next steps, the CCG should have regard to the principles of equal treatment, transparency and proportionality. The CCG should also carefully document its conclusion, and the reasons for it (including any justification for the decisions it has taken in all stages of the process, e.g. communications with InHealth as well as any internal deliberations, and preparation of any documents relating to the Services or the Contract).

3.3. If an extension to the Contract is agreed, we would strongly recommend that the CCG publishes notices to that affect in the FTS. The Contract contains a termination provision, which provides that the CCG may terminate the Services, and re-procure them at speed and litigation avoided, should a claim be made or threatened, and it should be made clear in any variation that this clause must be retained (in any event, this termination right is included in the General Conditions, so cannot be contracted out of by the parties, but we have flagged this for completeness).

3.4. Once you have had an opportunity to consider the above options, please do not hesitate to contact Hamza Drabu (hdrabu@dacbeachcroft.com) or Louise Kane (lkane@dacbeachcroft.com) with any questions / to discuss next steps.

DAC Beachcroft LLP
10 June 2021

Appendix 5: Feedback from NCL Imaging Network

Dear Mark

Following discussion with Alex Pinches (CDH Board Chair), Ash Saini (Imaging Network Chair), Dennis Carlton (Programme Director Diagnostics) we would like to feed back the following in relation to the CCG re-procurement of InHealth GP DA activity. Please do note that this is imaging specific and other colleagues within the CCG would need to provide information on the ECG / cardiac activity.

At this time we have not received formal notification from London / national regarding funding our CDH 'early adopter'/year 1 and year 2 bids. The development of CDHs are currently the only route that could be considered to bring additional GP DA activity back into the NHS in NCL. We expect feedback on what funding may be provided for CDHs later in the summer / autumn this year and therefore without this confirmation it would be a significant risk for NCL Imaging Network to propose that we would be able to re-patriate the current InHealth activity.

Based on the above risks surrounding CDH implementation we could not suggest any other route to the CCG than going ahead with re-procurement of activity (in GP DA imaging) at InHealth. As mentioned when we met it is likely to be useful to avoid stipulation of certain levels of GP DA activity in the new procurement so that should the CDH capacity be delivered in the next few years we are able to bring activity back in where possible and / or provide the external provider with reasonable notice.

Hope this is of help.
Many Thanks
Sophie

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North Central London CCG
Strategy & Commissioning Committee
Thursday, 15 July 2021

Report Title	Inequalities Investment Fund Update	**Date of report**	5 July 2021	**Agenda Item**	2.7
Lead Director / Manager	Sarah Mansuralli Executive Director of Strategic Commissioning Sarah McDonnell-Davies Executive Director of Borough Partnerships	**Email / Tel**		Sarah.Mansuralli@nhs.net	
GB Member Sponsor	Simon Goodwin, Chief Financial Officer				
Report Author	Mark Eaton, Interim Director of Strategic Projects	**Email / Tel**		mark.eaton1@nhs.net 07841-464916	
Name of Authorising Finance Lead	Anthony Browne, Director of Strategic Commissioning Finance	**Summary of Financial Implications** A £2.5m 'top sliced' fund has been created for NCL.			
Report Summary	This paper provides an update on the first tranche of £2.5m for the NCL Inequalities Fund covering proposals for H1 21/22 (and into H2 21/22 with mobilisation). The initial funds are expected to be followed up by a further £1.25m later in 21/22 and to become a recurrent £5m investment from 22/23 onwards funded via System Growth. For this tranche, we received a total of 32 Proposals. 24 of these were against the £2m allocated for Planning Guidance Proposals and the remaining 8 were against the £250k allocated for Local Priorities. An assessment panel consisting of Lay Members of the Governing Body, patient representatives and Public Health colleagues assessed the bids on the 22nd June and made a recommendation to the Population Health & Inequalities Committee for ratification. This was received on the 29th June. Appendix 1 provides the details of proposals submitted, those approved (without conditions), those approved (with conditions) and those rejected for approval.				
Recommendation	The Strategy and Commissioning Committee is asked to **NOTE** the update in Appendix 1.				

Identified Risks and Risk Management Actions	Inaction on inequalities will only lead to the gap in outcomes growing over time and an increasing burden on overstretched physical and mental health services.
Conflicts of Interest	None identified.
Resource Implications	The Evaluation Panel consisted of Lay Members of the GB, Secondary Care Clinician, Patient Representatives and Public Health input.
Engagement	These have been discussed within the ICPs and agreed by partners. Engagement (where required) will be monitored via the PH & Inequalities Committee.
Equality Impact Analysis	This is inherent in the programme as we are targeting areas with the highest levels of deprivation.
Report History and Key Decisions	This was considered by EMT in May before launching. Decisions were ratified by the Population Health & Inequalities Committee.
Next Steps	Mobilisation of programmes and monitoring of impact as well as preparing for the next phase of funding.
Appendices	Appendix 1 – Update on Inequalities Fund.

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NCL Inequalities Fund

Overview for Strategy & Commissioning Committee

July 2021

NCL Inequalities Fund: Summary

NCL have agreed an initial £2.5m fund for H1 21/22 to address Inequalities with the funding allocated as follows:

- £2m targeted at the 20% most deprived wards (in line with Planning Guidance)
- £250k for Local Priorities in each Borough
- £250k Reserve Fund (yet to be allocated)

Integrated Care Partnerships (ICPs) were encouraged to work together on Borough, Multi-Borough or NCL Wide programmes that would address identified inequalities. Initial feedback has been that this approach has improved local engagement and driven a different way of thinking around addressing inequalities as a key to improving health (and care) outcomes.

32 Proposals (24 for Planning Guidance Priorities and 8 for Local Priorities) were assessed by a panel comprising lay members of the CCG, patient and community representatives as well as public health colleagues.

Overall there has been significant support across the board for the direction of travel and cross partner new ways of working/thinking about inequalities which support our transition to ICS.

The following slides provide detail of how the fund will be allocated based on panel recommendations as discussed and agreed at the Population Health and Inequalities Committee on 29th June 2021.

This document also summarises the panel commentary supporting the process, anticipated impact on inequalities for a selection of proposals and next steps in relation to the inequalities fund.

NCL Inequalities Fund: Panel Recommendations

Individual boroughs were given an indicative budget to work within based on their share of the 20% most deprived wards and proposals were received within these indicatives budgets as shown below:

- Camden: 8 Proposals with a total of £293,150
- Enfield: 7 Proposals with a total of £652,156
- Haringey: 5 Proposals with a total of £588,970
- Islington: 4 Proposals with a total of £366,680
- **Total: 24 Proposals with a total of £1,900,956**

Against the £250k funding for Local Priorities we received 8 proposals, of which 6 will be funded, with allocations as outlined below:

- NCL Cancer Alliance: £36,384
- Barnet: £28,500
- Camden: £25,000
- Haringey: £26,000
- Camden/RFL: £83,500
- Islington: £50,616
- **Total: 6 Proposals with a total of £250,000**

NCL Inequalities Fund: Panel Commentary

- The Panel members appreciated quality, scope and level of ambition in bids received particularly given the speed these had been developed at.
- They noted that process had clearly acted as a catalyst for integrated approaches and joint working – in boroughs and across boroughs – bringing its own value to development of place and system thinking.
- The Panel placed particular importance in schemes that had been shaped by grass root engagement with local communities and VCS and that clearly articulated specific needs and how these would be differentially targeted. The importance of ownership of schemes through local partnerships in this was emphasised.
- A number of schemes covered similar needs or communities - opportunities share delivery approaches and plans, align schemes where sensible and develop more coherent/holistic approaches to working with communities.
- The opportunity for learning from successful schemes across partnerships needs to be taken forward in a systematic way. The ICPs and NCL Local Care Forum (which brings together leads from each ICP) could have a key role in this regard.
- Important in future funding process to place additional value on innovation particularly where informed by local people and their experiences.
- Although the importance of assessing impact was important, timescales for addressing health inequalities and preventative approaches longer term. Clarity needed quickly around how successful ongoing schemes would be assessed and funded if appropriate.
- The existence of other funding streams for example, the Mental Health Investment Standard or Accelerator funding to support some initiatives needed to be clarified in a number of cases.
- The value of match funding in cash or kind was really positive.
- Resilience of smaller one worker schemes was raised in a number of schemes and the importance of wider service support/integration was highlighted.

NCL Inequalities Fund: Anticipated Impact on Inequalities

Borough	Focus	Expected Impact on Inequalities
Islington	Working with those communities who language, cultural, deprivation or other barriers preventing them taking control of their health and accessing services.	Reduction in barriers to accessing services and improved health outcomes as a result. This will address the holistic needs of these communities to ensure they are able to receive the correct mix of service support. This will ensure equality of access to services and support.
Enfield & Haringey	Working with >100 High Intensity Users per year to engage them with the wider health and care system.	Reduction in the frequency of urgent care needs arising, provision of more holistic support to people and an improvement in their overall quality of life.
Islington	Holistic Support for people with SMI noting the extremely poor long term outcomes for this community.	This will ensure that health outcomes for people with an SMI are improved by addressing both their MH and physical health needs as well as tackling issues around social isolation and improving employment opportunities. This will reduce the long term health outcome inequality that exists between people with SMI and the wider community.
Enfield & Haringey	Targeted interventions for people at risk of developing an LTC in deprived communities.	Through supporting people to address the social determinants of health as well as improving health education we will reduce the prevalence of LTCs in deprived communities with the aim of levelling the prevalence rates to those of more affluent communities.
Barnet	Reducing the incidence of preventable oral disease in <5s in deprived communities.	Through tackling the strong correlation between deprivation and poor oral health this programme will the incidence of oral disease and therefore bring outcomes to a level similar to more affluent communities.

NCL Inequalities Fund: Anticipated Impact on Inequalities

Borough	Focus	Expected Impact on Inequalities
Enfield & Haringey	Reducing the incidence of children <1 attending ED with preventable illnesses and diseases.	This will help educate new and young parents to better understand child health and will also address family wellbeing with the aim of improving confidence. The workshops will work out from the child to address lifestyle issues affecting long term health in the wider family.
Camden	Improving the quality of Annual Health Checks and Health Action Plans for people with LD.	This will provide assurance and consistency around both AHCs and HAPs as well as ensuring the actions identified are followed through. The aim is to reduce the health inequalities experienced by people with LD compared to the wider population and through this improve outcomes.
Haringey	Engaging MH service users at risk of an admission or following an admission to develop resilience.	Through supporting this community to develop effective crisis management strategies and engage them in activities aimed at reducing social isolation and aid recovery we will reduce the long term health outcomes experienced by MH service users compared to the wider population.
Camden	The introduction of race equality and lived experienced into working with people with Autism.	The aim is to reduce the inequalities experienced by people with Autism, which is especially poor in deprived families and some ethnic communities. This will reduce the frequency of people falling into MH Crisis and reduce social isolation with the long term aim of reduce the early mortality experienced by many autistic people.

NCL Inequalities Fund: Next Steps

There is system commitment to ensuring that the Inequalities Fund becomes recurrent and incrementally grows over time. To give partnerships a longer lead time we will planning now for the allocation of the remaining £1.25m for the second half of 21/22 (inequalities fund total for 21/22 is £3.75m – part year effect).

The evaluation and monitoring will inform how we will utilise the £5m inequalities fund in 22/23 recognising that some of this may be needed to further or scale current schemes.

We are keen to harness the energy and collaborative spirit that drove the development of these bids and continue to build on this as we move into the delivery stage. We will therefore work with partnerships to establish a process to track mobilisation, delivery and impact.

Recognising that ongoing measurement of impact and evaluation is key, including link to wider system costs and benefits, it is proposed to establish a small group to oversee this as a single programme. Membership proposed as Public Health, ICS Finance, System Performance and Strategic Commissioning.

Next steps need to be set in the context of a longer term programme that takes into account learning from Marmot and Fenton and *value of community connectivity and asset building.*

We will secure a learning partner that: supports this objective; helps inform the future approach/direction; supports co-production of an evaluation framework (including qualitative and quantitative measures); and, an approach to generating insights as we go to be shared across the system.

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Appendix 1

Overview of Bids Received

NCL Inequalities Fund: Planning Guidance Proposals

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	21/22
1	Camden	Healthwatch Camden NCL CCG	Camden	Barriers to Accessing Post-Covid Syndrome Services in NCL	Healthwatch Camden will engage with residents who suffer health inequalities to discuss PCS. We will work with the voluntary sector, Camden Council and NCL CCG to identify the groups most at risk of not coming forward. The programme will be focussed on Camden's two most deprived wards, St Pancras & Somers Town and Kilburn. Future iterations of the programme can be broadened out to a Camden or NCL footprint.	£13,700
2	Camden	Camden Borough NCL CCG Children's Services, Camden LA Central Camden PCN West Hampstead PCN West and Central PCN	Camden	Camden Childhood Immunisation Programme	This proposal seeks to address the inequalities in the uptake rate of childhood Immunisations in Camden	£28,500
3	Camden	Hopscotch. South Kentish Town PCN. Free Space Project	Camden	Complete Care Communities – Facilitating Mental Health Empowerment in Camden's Bengali and Somali Communities	Empower mental health resilience in Camden's Somali and Bengali residents, by their community for their community. Using and enhancing the community's assets by engaging them in designing a self-sustaining model to reduce stigma, engender resilience and increase access to mental health support.	£29,167
4	Camden	Camden Integrated Commissioning Camden Integrated Commissioning NCL CCG CLDS	Camden	LD Annual Health Check Quality Audit	The programme will audit the quality of Annual Health Checks (AHCs) and Health Action Plans (HAPs) in Camden. It is designed as a supportive tool to enable joint working to improve outcomes for people with Learning Disabilities (LD). It will focus on the GP practices in Camden's most deprived wards (St Pancras and Somers Town, and Kilburn wards).	£25,116
5	Camden	C&I Kentish Town South PCN Talk for Health Health Education England	Camden	Primrose A	The ambition of this programme is based on the Primrose study led by UCL , which found that a primary care intervention focussed on physical health, led to a large reduction in psychiatric hospital admission costs and significantly reduced total healthcare costs.	£57,317

NCL Inequalities Fund: Planning Guidance Proposals

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	21/22
6	Camden	Camden CCG Camden Training Hub	Camden	Self-Care Community Champions	The proposed programme aims to empower those at risk of health inequality with confidence in self-care through locally identified Champions who will cascade self-care information and resources to the diverse communities of Camden in the target areas.	£16,350
7	Camden	Brondebsury Medical Centre Camden Council/VSO	Camden	Kilburn Ward outreach	The aim of the programme is to reduce the barrier of access to healthcare for people in this region by Partnering with our colleagues Camden council. Camden have commissioned a second vaccine bus for outreach to under-represented population who speak little/no English, are sometimes illiterate or have no digital literacy.	£72,000
8	Camden	Brondesbury Medical Centre	Camden	Health Equalities Programme	The aim of the programme is to mitigate against digital exclusion, ensure datasets are complete and timely and accelerate Preventative programmes that proactively engage those at greatest risk of poor health outcomes..	£51,000
9	Enfield	NCL CCG, Enfield Caribbean and African Health Network CAHN London Borough of Enfield	Enfield	Black Health Improvement Programme (BHIP) for Enfield Primary Care, NHS North Central London CCG and development of Enfield Caribbean and African Community Health Network	BHIP provides ways to improve engagement between the Black service user and the professional and is used to highlight a number of pertinent challenges for Black people including how we communicate and understand Black people. The programme acknowledges bias within individuals and helps professionals to recognise that health interventions that lead to better outcomes for all will only happen when we begin to tackle those biases.	£37,000
10	Enfield	NCL CCG GP Federation PrImary Care Networks ECS: BEH	Enfield	Enhanced Health Management of People with Long-Term Conditions in Deprived Communities in Enfield	This involves identification, management and interventions for adults at risk of developing/with LTCs targeted in Enfield's eastern deprived neighbourhoods. A focus on CHD/CVD, diabetes, COPD/respiratory and multi-morbidity is particularly relevant to underlying need and associated with high NEL admissions/complications, in these communities.	£159,000

NCL Inequalities Fund: Planning Guidance Proposals

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	21/22
11	Enfield	Enfield Connections Enfield Council Haringey Council NMUH	Haringey & Enfield	Enfield Connections at North Mid	This proposal requests funding for Enfield to match Haringey's offer at NMUH. In an expansion of the successful model with Haringey, two workers based within 'Enfield Connections' will support patients at North Mid to access support for what is important to the resident's good life whilst tackling known factors in health inequalities.	£72,000
12	Enfield	NCL CCG NMUH NHS Health Trust Voluntary Sector Organisations	Haringey & Enfield	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services	This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey & Enfield who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services.	£41,000
13	Enfield	North Middlesex University Hospital and voluntary and community sector partners	Haringey & Enfield	Parentcraft Programme	Research suggests that parents present in A&E and primary care more frequently due to anxiety and a feeling of 'helplessness'. This is reflected at the paediatric emergency department at NMUH with higher attendances than national benchmarks for health problems which could be managed elsewhere.To address this issue, since May 2019, NMUH has been piloting workshops (basic child health and family wellbeing curriculum) covering child health concerns, Basic Life Support (BLS), illness prevention, and health services education.The ambition of the program is to roll out the pilot in the most deprived wards in both boroughs, aiming to increase parent confidence, create networks of peer-to-peer support for parents and improve appropriate use of services across health and social care (reducing A&E visits).	£87,970
14	Enfield	London Borough of Enfield NCL CCG, Enfield	Enfield	DOVE project (Divert and Oppose Violence in Enfield) Public Health approach to reducing Serious Youth Violence	Funding for a Violence Reduction Social prescribing case worker based in primary care settings, supporting children and young people identified at risk of serious youth violence through case work and signposting to wider Early Help services providing advice, support and access to family and youth support.	£55,186
15	Enfield	London Borough of Enfield CCG & Medicus Health Partners CCG & Enfield Care Network Enfield GP Federation	Enfield	VCS & Primary Care based smoking cessation	To reduce the number of residents experiencing severe and multiple disadvantage in the east of Enfield. To reduce the prevalence of smoking among Enfield residents in 20% most deprived wards and communities with evidence of higher than average prevalence. To reduce smoking related mortality. To improve healthy life expectancy experienced by residents in wards of highest deprivation compared to least deprived wards.	£200,000

NCL Inequalities Fund: Planning Guidance Proposals

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	21/22
16	Islington	Whttington Health & Camden & Islington Foundation Trust Age UK Islington, Public Health, GPs and PCNs UCLH, Manor Gardens Welfare Trust Help on your doorstep (HOYD)	Islington	The Islington Respiratory Wellness Programme	The proposed programme is focused on adults already identified as having a higher rate of emergency hospital admissions in relation to their respiratory condition, in the most deprived wards in Islington. We will deliver a personalised service that also addresses high levels of underlying mental health need and other physical comorbidities. We will utilise Peer Coaches, who reflect the diversity of the local community, operate with a strength-based approach linking service users with community resources and build patient capacity to self-manage their long-term condition(s).	£100,000
17	Islington	London Borough of Islington	Islington	Early Prevention Programme – Black Males & Mental Health	Utilise this funding to rigorously test out culturally competent community crisis and trauma interventions to address systemic inequalities in high ward deprivation areas. Creating a 'test bed' for culturally competent interventions will inform wider system change and learning across Fairer Together and NCL, provide scaling opportunities borough wide as well as attract other LA's interest in trailblazing change and innovation.	£130,259
18	Islington	C & I, River Place Health Centre, North Islingotn PCN, Talk for Health Health Education England	Islington	Primrose A	The ambition of this programme is based on the Primrose study led by UCL , which found that a primary care intervention focussed on physical health, led to a large reduction in psychiatric hospital admission costs and significantly reduced total healthcare costs.	£76,421
19	Islington	London Borough of Islington Islingotn GP Federation North London Partners in Health and Care	Islington	Reducing inequalities through systematically embedding a population health management approach in Islington's four most deprived wards	To embed and further develop the use of a population health management (PHM) approach within Islington's most deprived wards and housing estates to reduce inequalities.	£60,000
20	Haringey	North Middlesex University Hospital and voluntary and community sector partners	Haringey & Enfield	Parentcraft Programme	Research suggests that parents present in A&E and primary care more frequently due to anxiety and a feeling of 'helplessness'. This is reflected at the paediatric emergency department at NMUH with higher attendances than national benchmarks for health problems which could be managed elsewhere.To address this issue, since May 2019, NMUH has been piloting workshops (basic child health and family wellbeing curriculum) covering child health concerns, Basic Life Support (BLS), illness prevention, and health services education.The ambition of the program is to roll out the pilot in the most deprived wards in both boroughs, aiming to increase parent confidence, create networks of peer-to-peer support for parents and improve appropriate use of services across health and social care (reducing A&E visits).	£87,970

NCL Inequalities Fund: Planning Guidance Proposals

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	21/22
21	Haringey	Open Door Deep: Black, Tottenham Hotspur Foundation Education Psychology (EP) Haringey Council, Haringey CAMHS/Trailblazer Early Help/Youth Service, Haringey Council, Bespoke support via a range of providers	Haringey & Enfield	Engaging our most vulnerable Haringey young people with mental health support through creative arts, activities and sports	The project aims to support young people with histories of multiple Adverse Childhood Experiences (ACEs), who would not normally engage with mental health services, through the arts, sports, creative ventures or other activities co-produced and designed by the young people themselves and delivered by people trained in trauma awareness and supported by therapists	£146,000
22	Haringey	BEH-MHT NHS Bridge Renewal	Haringey	Tottenham Talking	Barnet, Enfield and Haringey Mental Health NHS Trust (BEH) and The Bridge Renewal Trust (Bridge) have formed the Talking Tottenham project partnership to support service users at risk of admission, or needing support following admission, with access to a variety of groups and activities in order to reduce isolation, develop resilience and effective crisis management strategies The project, which was initially funded through using short term winter pressures funding up until May 2021, is based at the Chestnuts Community Centre. It offers a community, social, mental health and recovery, strength-based focus for beneficiaries (and their families as appropriate building on the Triangle of Care model). The project plans to have activity based in a variety of locations across the borough for face to face and offer online sessions extending to the south Tottenham area	£155,000
23	Haringey	WHT, Public Health Haringey, NMUH, GP4Health, east PCNs, Bridge Renewal Trust. Being developed with Enfield	Haringey	Enhanced Health Manage-ment of People with Long-Term Conditions in east Haringey	Building on existing infrastructure to provide multi-disciplinary proactive support to people with LTCs in east Haringey. This includes in-reach, triage and co-work between NHS, LB Haringey, east PCNs and voluntary sector with adults 'at risk' of acquiring, or who have, specific LTCs (CHD/CVD/diabetes) in under-served communities. Funding for: voluntary sector engagement/support, Community Health specialists, consultant PAs	£159,000
24	Haringey	NCL CCG NMUH Voluntary Sector Orgs BEH MHT	Haringey & Enfield	Supporting People with Severe & Multiple Disadvantage (SMD)1 who are High Impact Users (HIUs)2 in Healthcare Services	This involves multi-agency identification, intensive management and coordinated interventions for predominantly working age adults with SMD in east Haringey who are primary and secondary care HIUs. It aims to improve health, well-being, independence and life-chances of its clients and reduce their utilisation of healthcare and other services. Hosted at NMUH, it builds on good practice (Blackpool/RightCare model) and current support within NMUH (extends existing ED MDT and Haringey's Making Every Adult Matter approach). The Haringey/Enfield service will work with >100 clients/year, and provides coordinated support with, and across, voluntary and statutory partners.	£41,000

NCL Inequalities Fund: Local Priority Programmes

The following proposals were approved for funding without conditions:

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	
4	NCL Cancer Alliance	NCL Cancer Alliance Public Voice Bridge Renewal Trust	Haringey & Enfield	Supporting earlier cancer presentation through community development	This proposal is for a Community Development Worker in the most deprived areas in Haringey and Enfield to improve earlier diagnosis.	£36,384
5	Barnet	London Borough of Barnet Public Health CLCH	Barnet	Early Years Oral Health	Reduce inequalities and the burden of children's preventable oral disease through the introduction of a targeted supervised toothbrushing programme in Early Years' (EY) settings in the most deprived areas of the London Borough of Barnet (LBB).	£28,500
6	Camden	Camden Autism Partnership Board. Camden autism and race equlity working goup & organisations represented within the Co-Researcher group	Camden	Focused autism and race equality project		£25,000
7	Haringey	North Central London CCG Haringey Council BEH	Haringey	Haringey Complex Autism pathway		£26,000

NCL Inequalities Fund: Local Priority Programmes

The following proposals were approved for funding with conditions:

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	Rationale
2	Camden	RFL Group NCL Public Health	Barnet & Enfield	NCL & integrated approach to prevention: Lifestyle Hubs	Pilot a seamless system-wide approach with an acute trust, community counterparts and other stakeholders, co-designing and co-developing integrated lifestyle hub offer as proof of concept for NCL.	This proposal is supported and will be funded (£83,500) but further work is required to identify how people will be referred into the hubs and how this is connected to local offers. We will work with the provider to resolve these issues.
8	Islington	Archway Primary Care team Whittington Health NHS Islington N2 PCN MIND Islington Haringey GP Federation BEH MHT Camden & Islington FT Islington Rough sleepers outreach team Haringey Homeless Health Inclusion Team	Islington	Ambulatory outreach interventions on marginalised and hard-to-reach groups for health screening, disease prevention, case-finding and improving medicines use.	Ambulatory outreach interventions on marginalised and hard-to-reach groups for health screening, disease prevention, case-finding and improving medicines use.	Further work is needed to align with wider schemes as concerns that this duplicated. Clarity around how this links to work of Find and Treat team. Need clearer metrics and concerns re cost/value for money. The scheme is partially approved for a smaller trial scale - eg 2-3 estates rather than 12 with a maximum budget of £50,616.

NCL Inequalities Fund: Local Priority Programmes

The following proposals were not approved for funding:

ID	Lead Organisation	Other Partners	Boroughs Impacted	Proposal Name	Description	Rationale
1	NCL	NCL CCG Whittington Health NELFT BEH	All	NCL Children's Therapies -Speech & Language	Speech and language services are best organised using a tiered framework based on a continuum of need: universal, targeted and specialist - children can have varying needs and benefit from interventions at different levels. The aim of this proposal is to therefore draw funding down for a preventative, early intervention and universal speech and language service in the early years, targeted at those living with the highest level of deprivation and/or inequity of access to services.	Whilst viewed as an extremely important priority this was not felt to be aligned to the priorities outlined within the Inequalities Fund but should have consideration for first call on the reserve funds.
3	Camden	NCL CCG	All	Digital Care Coordinators pilot in NCL's primary care networks	Pilot *Digital Care Coordinator* role in 5 primary care networks to empower digitally excluded patients to actively engage with healthcare. Specifically, enabling patients to engage with proactive care and remote monitoring pathways which are heavily reliant on self-monitoring devices, text/email communication, and smartphone apps.	Whilst this is in the right area the scheme needed stronger metrics and it was unclear how we measure impact.

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	NCL Accelerated Elective Recovery Bids Outcome Report	**Date of report**	15 July 20/21	**Agenda Item**	2.8
Lead Director / Manager	Ali Malik, Director of System Productivity	**Email / Tel**		ali.malik3@nhs.net / 07947 876269	
GB Member Sponsor	Richard Dale, Executive Director of Strategy				
Report Author	Marco Inzani, Deputy Director of Elective Recovery	**Email / Tel**		marco.inzani@nhs.net / 020 3688 2780	
Name of Authorising Finance Lead	Anthony Browne, Director of Finance	**Summary of Financial Implications** £20m of funding confirmed received by the CCG in the M3 21/22 allocation. £33.6m worth of bids were submitted; £14.6m of these have been approved with a remaining £5.8m awaiting decision (further clarity required). • 41 bids to Acute Trusts = £8.5m • 3 bids to community gynae providers = £0.4m • 10 CCG bids = £5.6m Committee are advised that there is a risk that bidders would rely on this short term funding for a systemic issue that needs a longer term solution. However, this has been mitigated through sign off from relevant CFO noting the principle regarding financial sustainability and the need for an exit plan.				
Report Summary	North London Partners in Health and Care agreed to release £15m from the budget for Accelerated Elective Recovery to fund system wide initiatives that best align to the required elective recovery investment criteria (Appendix 1). An Accelerated Elective Recovery (AER) Bid Review Panel was appointed from members of the System Recovery Executive (SRE). The panel had representation from NCL CCG, primary care, acute trusts, community health trusts and local authorities. The role of the panel was to approve the AER bids that would be funded. A decision was made to ask for bids in two lots: short term bids that could deliver immediately and have an impact before 31 July 2021; and medium term bids that could be delivered within year and have an impact before 31 March 2022. 88 AER funding bids were received, five short term bids (£2.95m – two of these bids were subsequently transferred to the medium term bids) and 85 medium term bids (£31.5m), totalling £33.6m. The elective recovery PMO screened the bids and formed recommendations for the bid review panel to discuss and approve in two meetings: Short Term Bids were reviewed at panel 1 on 9 June 2021; and Medium Term Bids were reviewed at panel 2 on 23 June 2021.				

	Feedback from panel 1, was to ensure that bids were joined up across the system where applicable and that a hurdle criteria is adopted around duplicate funding (i.e. where a proposal can be funded via the Elective Recovery Fund (ERF) or other means it should not be considered in the accelerator bids). Taking this feedback on board, the PMO categorised all bids by functional area and sought feedback from NCL Clinical Networks, the Cancer Alliance, CCG Commissioning Leads and Subject Matter Experts where applicable. Where bids were not endorsed or had duplicate funding routes these were not considered for accelerator funding. The remaining bids were scored out of 70 based on pre-defined investment criteria (Appendix 1), and bids scoring above 40 were put forward to the panel to approve (some with conditions where further planning or clarification was required). The outcomes of both Bid Review Panels were: 13 bids approved with no conditions totalling £1.89m, including: • PMO for Primary and Secondary Care Interface - £0.2m • Integrated Discharge Team at each hospital and social care brokerage staffing - funding to the end of the year - £1.1m • Community audiology - £0.1m 34 bids approved with conditions totalling £9.7m (decisions were made to part fund some bids eg for shorter periods or specific elemnts), including: • Community Phlebotomy (for three months) - £0.24m • 3 SDEC bids - £1.1m • Community gynae (triage element only) - £0.4m • Various diagnostics bids (assumed not covered via ERF) - £0.9m • RNOH MSK community health hub - £0.7m • Expansion of primary/secondary interface team - £0.5m 18 bids not approved due to funding via other routes (e.g. ERF) totalling £3.5m, including: • RFL abdominal walls outsourcing to IS (should be ERF) - £0.7m • Children's autism – may have other funding routes for over 5s - £0.9m • But on the whole these are good bids and trusts are asked to work with bid owners to find a route to funding 17 bids not approved due to not meeting the required bar totalling £1.55m, including • 10 that were not endorsed (or needed more join up) • 3 related to areas harder to link back to elective recovery • 2 related to estates (RFL & WH room booking systems) • 2 with significant concerns over deliverability in 21/22 7 bids had an approval of concept totalling £13m, including: • 3 bids related to system triage and personalisation programme and linked to the approved Primary/Secondary Care PMO interface team. It was agreed that a ring-fenced pot of £2m would be held against the proposals so that they could be aligned and developed further. • 2 Provider Alliance proposals linked to identifying at risk 'unknown patients' and developing a public facing waiting times dashboard. It was agreed to ring fence £1m for Provider Alliance proposals to ensure they covered the whole ICS and didn't duplicate other initiatives. • Mobile theatre for spinal work at Stanmore site of RNOH - £3.4m. This required further work on system impact and would be held in a future pipeline.

	• A high volume low complexity hub at Whittington - £2.5m. This required further work on system impact and would be held in a future pipeline. In total £14.58 of accelerated elective recovery funding has been agreed. Appendix 2 summarises the decisions on bids by sector, organisation and specialty.
Recommendation	The Strategy and Commissioning Committee is asked to: • **NOTE** the outcome of the review of the NCL Accelerated Elective Recovery Bids
Identified Risks and Risk Management Actions	1. There is a risk that funding will not be fairly distributed. This was mitigated by having a bid review panel consisting of a representative from the different organisational sectors; summarising bids by organisation, organisational sector, and specialty; engaging clinical leads and subject matter experts in screening of bids. 2. There is a risk of double funding activity delivered by providers. This was mitigated by engaging all Chief Finance Officers to develop principles regarding the distribution of funding and that initiatives could not be double funded. Successful bids were also required to get sign off from their Chief Finance Officer via a template. 3. There is a risk that activity will not be delivered within the specified timescales. This is mitigated by one of the deciding principles for bids being ease and speed of delivery. All concerns with this were logged and would need to be addressed before funding could be released. 4. There is a risk that bidders would rely on a short term fund for a systemic issue that needed a longer term solution. This was mitigated through a principle regarding financial sustainability and successful bids requiring sign off from their Chief Finance Officer reiterating the parameters of funding and the need for an exit plan.
Conflicts of Interest	Not applicable as noting the outcome
Resource Implications	The Accelerated Elective Recovery Fund has been developed from additional funding awarded to North London Partners in Health and Care in recognition of its achievement in improving elective activity from April 2021. This funding has been awarded across the system with the key principles of financial sustainability and benefits realisation.
Engagement	The Accelerated Elective Recovery Fund process was communicated out to all relevant stakeholders via: • NCL Clinical Advisory Group • NCL Operational Implementation Group • NCL System Recovery Executive • NCL Primary Care leads – (went to Paul Sinden, Katie Coleman and Sarah McIlwaine to coordinate on behalf of PC) • NCL IPC group – via Sarah Hayes • Local Authority colleagues – via Dawn Wakeling and Zina Etheridge Individual bids were developed through engagement with relevant stakeholders and each bidder had to demonstrate that within their application. Where this wasn't possible within the timescale a recommendation was made to engage and involve to support delivery.
Equality Impact Analysis	Two of the four key principles for selecting bids related to reducing inequity of access and health inequalities. In addition all bids over £100k have to submit an Equalities Impact Assessment to more fully demonstrate their impact.

<table>
<tr><td>Report History and Key Decisions</td><td>The following governance process was undertaken for the 2021/22 AER Bids:-
<table>
<tr><th>Date</th><th>Action</th></tr>
<tr><td>8 Jun 2021</td><td>AER Bids deadline for submission</td></tr>
<tr><td>8 June 2021</td><td>AER Short Term Bids review & scoring by Elective Recovery PMO</td></tr>
<tr><td>9 June 2021</td><td>AER Bids Review Panel (Short Term) ratification</td></tr>
<tr><td>9 June 2021</td><td>SRE AER Bids (Short Term) approval</td></tr>
<tr><td>10 June 201</td><td>AER Short Term Bid Outcomes communicated to Trust COOs & Bid Leads</td></tr>
<tr><td>10 June 2021</td><td>Acute OIG COOs/Leads requested to prioritised AER Medium Term Bids</td></tr>
<tr><td>11 June 2021</td><td>Acute AER Medium Term Bids prioritised deadline</td></tr>
<tr><td>11 June 2021</td><td>AER Bids categorised by Elective Recovery PMO</td></tr>
<tr><td>14 June 2021</td><td>AER Medium Term Bids sent to Clinical Networks for assurance/endorsement</td></tr>
<tr><td>16 June 2021</td><td>AER Medium Term Bids Clinical Networks assurance/endorsement deadline</td></tr>
<tr><td>16-18 June 2021</td><td>AER Medium Term Bids review & scoring by Elective Recovery PMO</td></tr>
<tr><td>23 June 2021</td><td>AER Bid Review Panel (Medium Term) ratification</td></tr>
<tr><td>23 June 2021</td><td>SRE AER Bids (Medium Term) approval</td></tr>
<tr><td>24-25 June 2021</td><td>AER Bid Outcomes with requirements communicated to Trust COOs, CFO, Clinical Networks & Bid Leads</td></tr>
<tr><td>29 June 2021</td><td>Approved AER Bids document timelines communicated to COOs & Bid Leads</td></tr>
</table></td></tr>
<tr><td>Next Steps</td><td>All approved bids to respond to PMO with: any conditions addressed (as required); CFO approval; and for bids over £100k, a project plan and Equality Impact Assessment by 23 July 2021.

A monitoring framework is being finalised and will be proportionate to the bid value.</td></tr>
<tr><td>Appendices</td><td>Appendix 1: NCL Accelerated Elective Recovery Fund Investment Criteria
Appendix 2: Summary of Decisions by Sector; Organisation; and Functional Area</td></tr>
</table>

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NCL Accelerator Fund for Elective Recovery

Appendicies

15 July 2021

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Appendix 1 – Investment Criteria

NORTH LONDON PARTNERS in health and care

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Scoring criteria

Category	Criteria	Description	Maximum score
Outcomes and strategic fit Proposals must look to meet at least one of these principles.	1a. The initiative leads to an improvement/reduction in the elective waiting times for our patients	• Does the proposal improve the waiting times for patients on NCL's elective waiting list population? Does it reduce the hidden clinical risk we have on our waiting lists? Will it improve patient outcomes / experience? Does it ensure that we maintain the wellbeing of our staff?	10
	1b. The initiative supports resilience in our wider system partners in supporting the elective recovery programme (e.g. Primary Care and Community Care)	• Does the proposal support our whole system in delivering elective recovery? For example: primary care with personalisation, or community care for discharge management. This may also include proposals to alleviate waiting list pressures through OOH initiatives such as community offerings.	10
	1c. The initiative leads to a reduction in the inequity of access in accessing our elective services across NCL providers	• Does the proposal lead to a smoothing of demand and/or capacity across our provider sector to equalise waiting times across the system?	10
	1d. The initiative leads to a reduction in health inequalities that may exist on our waiting list	• Does the proposal lead to addressing the inequalities in provision across the five boroughs in NCL? How will it reduce variation in care? • Will it improve patient outcomes or reduce the risk of patients waiting on our waiting lists?	10
Use of resources	2. Ease & Speed of Delivery	• How easily can the proposal be implemented, what impact will this have on current resources? • How quickly can the proposal be implemented and start to deliver the expected benefits?	10
	3. Financial sustainability	• Does the proposal have a viable return on investment. This may also include investments in one part of the system that release savings in another. In order that it can be self sustained after the non-recurrent funding window expires. • Are all wider enablers fully understood (i.e. estates, digital, workforce)?	10
	4. Benefits realisation	• How will we measure this/benefits realisation and evaluate this proposal	10
Maximum score			**70**

Appendix 2 – Summary of Decisions

NORTH LONDON PARTNERS in health and care

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Summary of decisions by Sector

Sector	Number of bids submitted	Total funds requested	Approved – with no conditions	Approved – with conditions	Proposals with approved concept but need further refinement	Total Approved bids	Proposals with approved concept - funding not agreed in current round	Not approved - proposal to be funded via alternative means.	Not approved because bid did not meet bar	Total not approved
Acute	69	23,661,809	365,543	6,623,639	3,000,000	**9,989,182**	**9,641,038**	2,661,795	1,323,793	**13,626,626**
Community Health	11	7,219,429	934,000	2,125,922	-	**3,059,922**	**-**	860,500	130,000	**990,500**
Mental Health	1	-	-		-	**-**	**-**	-	-	**-**
Primary Care	6	2,419,332	279,000	945,988	-	**1,224,988**	**372,000**	-	97,500	**469,500**
Social Care	1	309,500	309,500		-	**309,500**	**-**	-	-	**-**
Grand Total	**88**	**33,610,070**	**1,888,043**	**9,695,549**	**3,000,000**	**14,583,592**	**10,013,038**	**3,522,295**	**1,551,293**	**15,086,626**

NORTH LONDON PARTNERS in health and care

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Summary of decisions by Organisation

Organisation	Number of bids submitted	Total funds requested	Approved – with no conditions	Approved – with conditions	Proposals with approved concept - funding agreed	Total Approved bids	Proposals with approved concept - funding not agreed in current round	Not approved - proposal to be funded via alternative means.	Not approved because bid did not meet bar	Total not approved
BEHMHT	1	-	-	-	-	-	-	-	-	-
Collaboration of NCL's Community Gynae Providers	3	3,569,007	-	400,000	-	**400,000**	-			-
GOSH/ Royal Free (Provider Alliance)	2	1,825,200	-		1,000,000	**1,000,000**	**825,200**	-		**825,200**
Moorfields	1	75,250	-	75,250	-	**75,250**	-	-	-	-
NCL CCG	11	6,564,682	1,418,500	2,163,838	2,000,000	**5,582,338**	-	930,500		**930,500**
NCL Urology Network Board (RFL as host)	1	67,809	67,809		-	**67,809**	-	-	-	-
NMUH	15	2,021,778	-	1,425,264	-	**1,425,264**	-	319,285	277,229	**596,514**
RNOH	2	4,084,238	-	707,400	-	**707,400**	**3,376,838**	-	-	**3,376,838**
Royal Free	13	7,413,335	222,589	2,215,000	-	**2,437,589**	**3,297,000**	739,260	266,489	**4,302,749**
UCLH	28	2,844,985	179,145	1,639,797	-	**1,818,942**	-	147,465	832,578	**980,043**
Whittington	11	5,143,785	-	1,069,000	-	**1,069,000**	**2,514,000**	1,385,785	175,000	**4,074,785**
Grand Total	**88**	**33,610,070**	**1,888,043**	**9,695,549**	**3,000,000**	**14,583,592**	**10,013,038**	**3,522,295**	**1,551,296**	**15,086,629**

NORTH LONDON PARTNERS in health and care

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Summary of decisions by Functional Area

Functional Area	Number of bids submitted	Total funds requested	Approved – with no conditions	Approved – with conditions	Proposals with approved concept but need further refinement	Total Approved bids	Proposals with approved concept - funding not agreed in current round	Not approved - proposal to be funded via alternative means.	Not approved because bid did not meet bar	Total not approved
Cancer	8	864,975	191,514	60,000	-	**251,514**	-	70,000	543,461	**613,461**
Cancer / Dermatology	2	435,000	-	435,000	-	**435,000**	-		-	**-**
Cancer / Diagnostics	1	213,000	-	213,000	-	**213,000**	-		-	**-**
Cardiology	1	264,000	-		-	**-**	-	264,000	-	**264,000**
Cardiology / Diagnostics	1	330,000	-	330,000	-	**330,000**	-		-	**-**
Diabetes	2	104,000	-	84,000	-	**84,000**	-	20,000	-	**20,000**
Diagnostics	5	1,592,650	-	785,040	-	**785,040**	-		82,766	**82,766**
Discharge	2	1,139,500	1,139,500		-	**1,139,500**	-		-	**-**
ENT	6	466,859	145,667		-	**145,667**	-	321,192	-	**321,192**
Estates	2	163,720	-		-	**-**	-		163,720	**163,720**
General Surgery	6	3,373,107	13,478	37,360	-	**50,838**	**2,514,000**	778,068	30,201	**3,322,269**
General Surgery / Diagnostics	1	15,100	-	15,100	-	**15,100**	-		-	**-**
Gynaecology	10	4,609,292	-	453,000	-	**453,000**	-	987,285	3,169,007	**4,156,292**
Health Inequalities	3	396,873	-	344,373	-	**344,373**	-		52,500	**52,500**
Learning Disabilities	1	-	-		-	**-**	-	-	-	**-**
Neurology	6	929,782	-	828,532	-	**828,532**	-	71,250	30,000	**101,250**
Ophthalmology	2	215,250	-	75,250	-	**75,250**	-	140,000	-	**140,000**
Orthopaedics	4	4,373,246	-	996,407	-	**996,407**	**3,376,838**	-	-	**3,376,838**
Paediatrics	9	2,825,792	60,000	1,379,223	-	**1,439,223**	-	870,500	516,069	**1,386,569**
Provider Alliance	2	1,825,200	-		1,000,000	**1,000,000**	**825,200**	-		**825,200**
Respiratory / Diagnostics	1	480,000	-	480,000	-	**480,000**	-	-	-	**-**
Triage/RTT	8	8,528,075	270,075	2,915,000	2,000,000	**5,185,075**	**3,297,000**	-		**3,297,000**
Urology	4	344,649	67,809	264,264	-	**332,073**	-	-	12,576	**12,576**
Workforce	1	120,000	-	-	-	**-**	-	-	120,000	**120,000**
Grand Total	**88**	**33,610,070**	**1,888,043**	**9,695,549**	**3,000,000**	**14,583,592**	**10,013,038**	**3,522,295**	**4,720,300**	**18,255,633**

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	Children's Integrated Therapies Services	**Date of report**	1 July 2021	**Agenda Item**	2.9
Lead Director / Manager	Jess Baines-Holmes Director of Integrated Commissioning	**Email / Tel**		jess.baines-holmes@nhs.net	
GB Member Sponsor					
Report Author	Victoria Wicks Senior Children's Commissioning Manager	**Email / Tel**		Victoria.wicks2@nhs.net	
Name of Authorising Finance Lead	Ben Catlin	**Summary of Financial Implications** The total budget for this contract is £3.3m. Of which the CCG contributes £2.7m and London Borough of Barnet contribute £600k			

Report Summary

Background

North Central London (NCL) Clinical Commissioning Group (CCG) is the lead commissioner of Children's Integrated Therapy Services (CITS) in Barnet. The service is commissioned through a Section 75 agreement with the London Borough of Barnet (LBB). The current budget is £3.3m and is split between NCL CCG and LBB, see table 1 below for 2020/21 budget amounts

Table 1 – 2020/21 budget breakdown

Total budget	£3,300k	100%
NCL CCG contribution	£2,700k	82%
LBB contribution	£600k	18%

The therapies contract with NELFT is due to expire on 31 August 2021. There is an option to extend for a further year, however NELFT have recently given notice on this contract. As the contract ends on 31st August 2021, NCL CCG has less than two months to ensure adequate provision is in place from 1 September 2021.

There is a significant level of interest in the service from existing providers of services within NCL and options and therefore a Negotiated Process was necessary to ensure a fair and transparent process. The attached paper lays out the options that were considered and why a 'Negotiated Procedure without Prior Publication / Request For Proposal' has been undertaken.

As the mini procurement is open to existing NCL CCG providers will have opportunity to bid for the service, the service can be commissioned under a contract variation with whoever is the ultimately successful provider.
In order to ensure safe transfer of services there will be a six month transitional period from NELFT to the new provider. The transitional period will end on 31 March 2022.

The following table outlines the milestones to be met in order to ensure a new provider is in place by 1 September 2021. Permission to proceed with a limited procurement was a chair's action of the Strategy and Commissioning Committee.

Table 2 – Milestones for the CIT procurement

Milestone	**Date**
Issue of RfP documents	18 June 2021
Deadline for receipt of Clarification Questions (CQ's)	30 June 2021
Deadline for submission of Bids	7 July 3pm
Evaluation of Bids	14 July
Post-Bid Clarifications (if required)	16 July
Notification of Contract Award	23 July
Service Commencement	1 September 2021

Due to due diligence required for London Borough of Barnet to participate on the panel, the timescales have been adjusted.

The assessment panel will meet on 14 July to assess the bids. It is intended that a paper will be written as soon as possible after the assessment panel and will be circulated to the Strategy and Commissioning Committee in order to receive virtual approval of the decision.

Recommendation

The Strategy and Commissioning Committee is asked to **AGREE** to approve the outcome of the procurement virtually.

Identified Risks and Risk Management Actions

There is a risk that:	**This would result in:**	**Mitigation**
The new provider will not be able to provide services from 1st September 2021	The children and young people not receiving statutory services	Transition period till 31st March 2022 to ensure safe handover of the service.
Uncertainty around the contract will result in staff leaving the service and not going through the TUPE process	A shortage of therapists impacting on service delivery	Current provider are working with staff to alleviate concerns about the future of the contract and a comprehensive comms and engagement plan in relation to staff transfer and TUPE forms part of the procurement exercise.

Conflicts of Interest

Not applicable.

Resource Implications

The budget for this contract is outlined in the table below:

Total budget	£3,300k	100%
NCL CCG contribution	£2,700k	82%
LBB contribution	£600k	18%

Engagement

There has been significant discussion at the parent/carers group. Although the details of the paper have not been discussed, it is clear that there is dissatisfaction with the current provider.

	Conversations have taken place with London Borough of Barnet who we commission the service with under an s75. Two Parent carers representatives are on the procurement panel.
Equality Impact Analysis	As a children's service, marriage/civil partnership and pregnancy/maternity are not applicable. In all other areas of the assessment protected and vulnerable groups will be positively impacted upon by the service. Not commissioning the service will negatively impact upon CYP with SEND. Assessment will be submitted with the approval papers.
Report History and Key Decisions	Due to the extreme urgency of the procurement, a decision was agreed to request Chair's Action on the 18 June 2021. This was granted by Dr Jo Sauvage and Frances O'Callaghan in line with NCL CCG Standing Financial Instructions.
Next Steps	• Preferred provider to be notified of the outcome • NCL CCG to work with new and existing providers to ensure smooth transition
Appendices	Appendix A – Barnet Children's therapies Provision Paper Appendix B – Barnet Children's therapies Supporting Data Appendix C – EqIA Appendix D – Chair's Action Approval

NHS
North Central London
Clinical Commissioning Group

Barnet Children's Community Therapies Services Provision

11th June 2021

1.0 Introduction

Speech, language and communication needs (SLCN) can occur in childhood as primary difficulties or secondary to other developmental conditions. It is estimated that 10% of children have a long term, persistent communication disability and between 50-90 % of children with SLCN go onto experience reading difficulties. SLCN is also strongly linked to deprivation and poverty in the early years and research demonstrates that the presence of SLCN can have a detrimental impact on quality of life and direct impact on educational outcomes, employment, health and wellbeing throughout life.

2.0 Background

The 2014 SEND Reforms and the 2015 Children & Families Act introduced a range of reforms related to children and young people (CYP) with special educational needs and disabilities. The introduction of Education, Health and Care Plans (EHCPs) has provided definitiveness about the therapies required and as a result has contributed to an increase in demand for therapy services within mainstream schools. EHCPs are legally binding documents, which outline a child's special educational, health and social care needs. They are co-ordinated by Local Authorities who have 20 weeks from agreement to issue a plan to the implementation of the plan. It is the responsibility of health to provide an initial assessment for the EHCP within these timeframes, to provide the interventions written into the EHCP, and to annually review the EHCP. In addition there are children without an EHCP who require early intervention to prevent an EHCP from being needed. Increased need for therapies provision in combination with other factors, such as increasing complexity in schools e.g. rise in autism diagnosis, and the impact of COVID-19 has highlighted issues which casts doubt on the sustainability of the service.

The culmination of these factors had had a substantial impact in Barnet where there is a significant shortfall in therapists for a number of reasons. Increased number of EHCPs, decrease in the number of available therapists (exacerbated by COVID-19), limited availability of increased funding, and distance of North East London Foundation Trust (NELFT) to Barnet, have all contributed to gaps in service provision.

North Central London (NCL) Clinical Commissioning Group (CCG) is the lead commissioner of Children's Community Therapy Services (CCTS). The service is commissioned through a Section 75 agreement with the London Borough of Barnet (LBB). The current budget is £3.3m and is split between NCL CCG and LBB, see table 1 below for 2020/21 budget amounts.

Table 1 – 2020/21 budget breakdown

Total budget	£3,300k	100%
NCL CCG contribution	£2,700k	82%
LBB contribution	£600k	18%

The therapies contract with NELFT is due to expire on 31st August 2021. There is an option to extend for a further year, however NELFT have given notice on this contract. As the contract ends on 31st August 2021, NCL CCG has less than three months to ensure adequate provision is in place from 1st September 2021.

3.0 Current Position in Barnet

Since the start of the contract NELFT have struggled to provide services. At the start of the contract 600 EHCPs were handed to the provider, above the number in the initial modelling. This resulted in a shortfall in therapists. In addition NELFT have struggled with recruitment for a number of reasons which include:

- Proximity of Barnet to East London (impacting on retention of staff)

- COVID-19 which resulted in:
    - Staff redeployment
    - Fewer therapists coming to the UK to work

As a result the services provided have not been sufficient to meet need, and has resulted in Initial assessment and intervention undertaken outside mandated timescales, growing waiting lists, and a decrease in quantity and quality of interventions. Statutory obligations have not been met and this has resulted in an increasing number of complaints and Judicial Reviews against the service.

Key stakeholders including parent carers and schools have lost confidence in the service as have the London Borough of Barnet (LBB) who jointly commission the service. NELFT have formally given notice on the contract and therefore will not be providing services past the initial three years of the current contract.

Having reviewed the options available and scoped the interest in the service with current providers, it is clear that a mini procurement will need to take place. There are potentially three organisations that provide services in Barnet who have indicated interest in providing the service.

4.0 Process of finding a new provider

NCL CCG has to commission a provider to take responsibility for children's community therapies from 1st September 2021. There are different mechanisms that can be used to commission a provider. The options are laid out in Table 2 below:

Table 2 – Options for commissioning a new provider.

Option	Advantages of this option	Disadvantages of this option
Option 1- Full procurement	Competitive process which would allow any organisation to bid for the service. **NOTE:** Under PCR2015 Regulations we are not required to undertake this option due to the urgency of the decision needed.	There is not sufficient time to carry out a procurement process, to award this contract and give sufficient time to the winning bidder to mobilise and commence the service. It is extremely time consuming and there is insufficient capacity in the children's commissioning team to effectively manage this process.
Option 2 – Negotiated Process	Due to the extreme urgency brought about by the above situation which was previously unforeseeable, as per Regulation 32(2)(c) of the Public Contract Regulations (PCR) 2015, the NCL CCG will be undertaking a Negotiated Procedure without prior publication of a Contract Notice (advert) to award an interim contract to an existing in-sector provider. Whilst we could simply do a direct award on this basis the advantage of taking this approach is that where more than 1 viable provider expresses an interest we can avoid an in-sector dispute arising.	The timescale for undertaking a mini-procurement and mobilising for 1st September is extremely tight.
Option 3 – Direct award	Mobilisation would be quicker to implement as no formal process would take place and is allowable.	Unsuccessful providers may feel that they were not given sufficient opportunity to bid for the service and could dispute the decision.

Preferred Option

With more than one in-sector provider indicating they have an interest in delivering the service **OPTION 2 (Negotiated Process)** is the preferred option.

5.0 Transition Period

In order to ensure there is a safe transition of this service, there will need to be a six-month transition period. Due to the timeframes involved, the six month handover will start on 1st September 2021 and will conclude on 31st March 2022. During this period a staged transfer will take place and by 31st March 2022 the new provider will provide the full portfolio of therapies services.

During this period finances will be managed between the incumbent provider (NELFT) and the new provider to ensure that the transition does not present an NCL Cost Pressure.

6.0 Risks & Mitigations

The following is a summary of the main risks of this programme:

There is a risk that:	This would result in:	Mitigation
There is insufficient time for a new provider to take over the contract.	Risks arising to children in Barnet.	1) All providers currently provide services within the Barnet area. Therefore they are familiar with the needs of the Barnet population. 2) The six month handover of the service up to 31st March to ensure smooth transition.
Staff currently in the service will not want to be TUPE'd to another provider	A shortage in therapists available to provide services	1) Local therapists currently being sought to cover shortfalls in this school year. 2) The six month handover will allow additional time for recruitment of staff.
We may receive an external challenge to our process.	We would potentially have to undertake a full procurement.	1) Section 32(2)(c) of the PCR 2016 sets out our right to undertake the proposed process.

7.0 Key Milestones

In order to recommission this service, a demand modelling exercise needs to be undertaken. The Table 4 below outlines the major milestones for this project including key timeframes around governance.

Table 4 - Milestones

Milestone	Milestone Date
Approval to enter into the negotiated process with in-sector providers	18th June 2021
Procurement documents made available to providers	18th June 2021
Deadline for bid submission	25th June 2021
Procurement panel to take place	25th June 2021
Internal Approval from Procurement Panel	Date TBD
Commence negotiations with selected provider	Date TBD
Contract negotiations to be completed	31st July 2021
Contract to be issued	31st August 2021
Transition of the service to new provider to commence	1st September 2021
Transition complete and service fully owned by new provider	31st March 2022
Contract Option to extend for 1 Year exercised	1st September 2022
Need for full procurement determined and undertaken	1st September 2022

8.0 Recommendation

It is recommended that we commence a negotiated process with in-sector providers as outlined above. The resulting contract will be issued via a Contract Variation with the new provider. To facilitate this we would also extend the NELFT Contract for six months (as allowed within the contract) on a diminishing financial basis to support the transition. This latter point has already been agreed with NELFT.

NHS
North Central London
Clinical Commissioning Group

Barnet Children's Community Therapies Services Provision – June 2021

EHCP Funding Responsibility

High Needs Funding Operational Guide (2020-21)

NHS North Central London Clinical Commissioning Group

- CCGs and LAs have a responsibility to fund the therapy provision written into section F of the EHCP, however this is based on local decision making. The below responsibilities are written into the *High Needs Funding Operational Guide (Education and Skills Funding Agency 2020-21)*
- Responsibility for securing the provision specified in the EHC plan sits with the relevant statutory bodies: the local authority for education and the Clinical Commissioning Group for the health provision
- The costs of securing health provision (specified in section G of an EHC plan) should be met by the Clinical Commissioning Group

'However, the Children and Families Act 2014 acknowledges that specific types of health provision may be considered as education or training. This particularly applies to therapies such as speech and language therapy, physiotherapy and occupational therapy. The Children and Families Act 2014 requires that health provision which educates or trains a child or young person must be treated as special educational provision. This means that it will be recorded in Section F of an EHC plan and will be treated as special educational provision and, therefore, in scope of the high needs budget. However, all decisions about whether health care provision or social care provision should be treated as special educational provision must be made on an individual basis.'

Therapies Offer

NHS North Central London Clinical Commissioning Group

- The therapies offer includes **speech and language therapy, occupational therapy and physiotherapy**
- The offer is across early years, mainstream schools, special schools and specialist provision e.g. Pupil referral Units, resource bases.
- There is **variation across the NCL boroughs** regarding the offer/model which will include a mixture of:
  - **Universal Offer** (Borough level training, website resources, signposting). Please note that some boroughs have no/very limited universal offer.
  - **SEN support** (1-1, group therapy, referral triage, assessments and reports, individual group therapy, coaching school staff, drop in sessions
  - **EHCP** (1-1, group therapy, referral triage, assessments and reports, individual group therapy, coaching school staff, drop in sessions)

Barnet Current Offer

NHS North Central London Clinical Commissioning Group

Provider/ Borough	Early years	Primary	Secondary	Specialist	Special schools
NELFT/ Barnet	Universal, SEN, Targeted	Universal, SEN, Targeted/EHCP	Universal, SEN, Targeted/EHCP	Universal, SEN, Targeted/EHCP	Universal, SEN, Targeted/EHCP

Current Provision in Barnet

North Central London
Clinical Commissioning Group

In 2015 the Children & Families Act introduced a range of reforms related to children and young people (CYP) with special educational needs and disabilities. The introduction of Education, Health and Care Plans (EHCPs) has provided definitiveness about the therapies required and as a result has contributed to an increase in demand for therapy services within mainstream schools. This in combination with other factors, such as increasing complexity in schools e.g. rise in autism, and the impact of COVID-19 has highlighted issues within current service provision, which casts doubt on sustainability of the service.

The impact in Barnet has been substantial and has contributed to a significant shortfall in therapists for a number of reasons. Increased number of EHCPs, decrease in the number of available therapists (exacerbated by COVID-19), limited availability of increased funding, and distance of North East London Foundation Trust (NELFT) to Barnet, have all contributed to gaps in service provision. Currently there is a focus on ensuring that the statutory requirements are fulfilled, and this is prioritised over early intervention.

Current Budget

North Central London
Clinical Commissioning Group

North Central London (NCL) Clinical Commissioning Group (CCG) is the lead commissioner of Children's Community Therapy Services (CCTS). The service is commissioned through a Section 75 agreement with the London Borough of Barnet (LBB). The current budget is £3.3m and is split between NCL CCG and LBB, see table below for 2020/21 budget amounts:

Total budget	**£3,300k**	**100%**
NCL CCG contribution	£2,700k	82%
LBB contribution	£600k	18%

Current Position

North Central London
Clinical Commissioning Group

- NELFT have struggled to provide services for a number of reasons:
  - Proximity of Barnet to East London (impacting on retention of staff)
  - COVID-19 which resulted in:
    - staff redeployment
    - Fewer therapists coming to the UK to work
  - Numbers of EHCPs increasing disproportionately to the level of funding
- This has resulted in
  - Initial assessment and intervention undertaken outside mandated timescales
  - Growing waiting lists
  - Quantity and quality of interventions are reduced.
  - Increased numbers of complaints and JRs against the service. (creation of failure demand)
- The NELFT contract is due to expire on 31st August 2021. There is an option to extend for a further year. The Local Authority being a key stakeholder, have advised they have lost confidence in the current provider and support a managed transfer of service.
- As the contract ends on 31st August 2021 there is less than four months to find a new provider.

Referrals/EHCP case load 2020/21

NHS
North Central London
Clinical Commissioning Group

Referrals

Therapy	Referrals received 2020/21	Average wait for initial assessment
Speech and language therapy	1361	25 weeks
Occupational therapy	509	34 weeks
Physiotherapy	330	18 weeks

Current case load (please note some children will be known to more than one caseload)

Therapy	Number of children on the caseload
Speech and language therapy	3951
Occupational therapy	1077
Physiotherapy	620

Statutory requirements 2020/21

Requirement	Number of cases	Additional information
Number of CYP with EHCPs 20/21	1680	There are 1680 children with EHCP known to the service with 2550 individual referrals across all therapies
Number of Tribunals in 20/21	35	commissioned for 30 requests per calendar year. However in the 2020 there were 35 tribunals. Equating to 60 assessment and reports across SLT / OT / PT

Current Establishment 2020/21

NHS
North Central London
Clinical Commissioning Group

Therapy	WTE (in budget)
Speech and language therapy	19.95
Occupational therapy	6.23
Physiotherapy	4.5
Administrative support	7.15 (Including 2WTE clinical liaison officers)

Barnet Therapies Funding & Key Data

NHS
North Central London
Clinical Commissioning Group

	BARNET
CCG / LA funding (Pay only)	CCG £1,842,301 LA £404,407.62 Total: £2,246,709
Percentage funding split CCG/LA	CCG 82% LA 18%
Primary/Secondary Pupil population	58,926
CCG/LA funding per pupil	£38.12
CCG funding per pupil	£31.26
LA funding per pupil	£6.86

North Central London
Clinical Commissioning Group

EQUALITY ANALYSIS
(Equality Impact Assessment)

Service/Policy title	**Children's Integrated Therapies**
Service/Policy type	
Author	**Victoria Wicks**
Lead Director	**Sarah Mansurali**
Email	**Victoria.wicks2@nhs.net**
Date approved	
Review date	

Before completing the Equality Analysis (EQIA) please read the guidance on the intranet.

For further help and advice please contact Emdad Haque at emdad.haque@nhs.net
Tel: 07753836900

Brief description of the policy/service

Please provide only a brief description covering what this policy/service aims to achieve and which groups it will benefit.

In 2014 the Children & Families Act introduced a range of reforms related to children and young people (CYP) with special educational needs and disabilities. The introduction of Education, Health and Care Plans (EHCPs) has provided definitiveness about the therapies required and as a result has contributed to an increase in demand for therapy services within mainstream schools. This in combination with other factors, such as increasing complexity in schools i.e. the increase in the number of children with a diagnosis of autism, and the impact of COVID-19 which has affected the number of therapists available to provide service services, has put significant pressure on the provision of therapies services across North Central London (NCL) Clinical Commissioning Group (CCG), in particular Barnet and Haringey. Additionally in Barnet, the distance between, North East London Foundation Trust (NELFT) head quarters in East London, and the place of service provision also has a significant impact on recruitment and retention.

Therapies are important to enable children's needs to be understood so that they can access the curriculum. Whilst children with special, education needs and or a disability form part of the cohort affected, this is a much broader issue which affects a wide range of children and young people. These needs are, for example, strongly linked to deprivation and poverty in the early years and research demonstrates that their presence can have a detrimental impact on quality of life and direct impact on educational outcomes, employment, health and wellbeing. Having access to early intervention can significantly improve quality of life and dependence on the system into adulthood. Without this early intervention the impact on individuals can be irreversibly detrimental.

The service will support children and young people between the ages of 0-25 where therapy support has been identified within their EHCP. It will also support children without an EHCP who are identified as needing additional support

This is a stage 1 EqIA, which will be kept under review as the NCL Strategic position and services are developed. This being reviewed as part of the Community Services review.

The reason for the fast procurement is to prevent any negative impact on an already vulnerable cohort of CYP.

We want to use information collected from contract of this service to inform the future NCL service development.

Engagement with patients and stakeholders

Please provide a brief summary about engagement with patients, clinical leads, voluntary organisations Healthwatch- and the outcomes. If no engagement has been carried out then please explain why.

There has been significant discussion at the parent/carers group. Although the details of the paper have not been discussed, it is clear that there is dissatisfaction with the current provider.

Conversations have taken place with London Borough of Barnet who we commission the service with under an s75.

Impact analysis

This section should be used to analyse the likely impact of the policy/service on protected and disadvantaged groups. It should be noted that the CCG's default policy intent is to maximise opportunity (positive impact) for all groups by removing barriers so that they can access the service they need and enjoy good outcomes.

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
Age	This is a specialist service that is aimed at children and young people between the ages of 0-25. Having access to early intervention can significantly improve quality of life and dependence on the system into adulthood. Without this early intervention the impact on individuals can be irreversibly detrimental impacting on educational outcomes, employment chances, health and wellbeing. The younger the interventions can take place the better the life changes and health outcomes for the CYP. Early intervention can prevent a child from needing a formal EHCP. Add some evidence about early years	Positive	4 and 5
Disability	This service is aimed at children with SEND where therapies services have been identified as a need in EHCP. This cohort of children have specific needs around communication, and behavior. This service also will support children prior to having an EHCP, in order that they can benefit from early interventions.	Positive	4 and 5

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	The intention of the procurement is to ensure a good experience of the service, and to ensure good outcomes. Section 7.6.1 of the Barnet JSNA references the need to ensure that children with SEND should be supported to build resilience. https://jsna.barnet.gov.uk/7-children-young-people		
Gender	This service is open to all patients who meet the criteria, regardless of gender/gender identification. https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/sexuality-research-and-statistics	Positive/unknown	2, 4 and 5
Gender reassignment	CYP who identify as transgender will be better able to communicate their needs with input from therapies services. Speech and language therapy is a key element of the service.	Positive/unknown	2, 4 and 5
Marriage and civil partnership	N/R	N/R	
Pregnancy and maternity	N/R	N/R	
Race/ethnicity	The service is family focused and will provide as a combination of face to face and remote appointments. There is the flexibility to ensure that patients/carers that need to have a face to face appointment due to their language needs are accommodated. An NCL Elective Recovery Accelerator Headline Bid Proposal for NCL children's therapies has been submitted in order to access funding for the more	Positive/Unknown	1, 3, 4 and 5

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	disadvantaged communities. This bid includes funding for Barnet to support children in the most deprived areas. This will include children from BAME communities who are underrepresented.		
Religion/belief	The service is family focused and therefore will respond to the needs of the family. The services engage with parents and schools to ensure a rounded approach to the needs of the child/YP	Positive/Unknown	1, 3, 4 and 5
Sexual orientation	CYP with all sexual orientations will be better able to communicate their needs with input from therapies services. Speech and language therapy is a key element of the service.	Positive/unknown	2, 4 and 5
Disadvantaged groups [homeless, unemployed, single parents, asylum seekers, victim of domestic violence]	Children with SEND are much more likely to be living in deprivation, receiving free school meals, being bullied, excluded from school, suffering from poor emotional wellbeing and mental health, entering the youth justice system, leaving school with low or no qualifications and being unemployed in later life https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england This service will support CYP with SEND enabling them to achieve to their potential. An NCL Elective Recovery Accelerator Headline Bid Proposal for NCL children's therapies has been submitted in order to access funding for the more disadvantaged communities. This bid includes funding for Barnet to support children in the most deprived areas	Positive	3, 4 and 5
Human Rights [how the policy/service will	The Human rights Act 1998 includes the tight to an education. Therapies services are essential in ensuring that children with SEND are able to access the curriculum.	Positive	4 and 5

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
impact Human Rights of patients]			

Recommendations/mitigating actions

No	Recommendation/mitigating action	Which protected group/ strand does this cover	Lead Person and Organisation	Deadline/ Review date
1	Data collection for this service to include ethnicity, religion and first language	Race/ethnicity Religion/belief	Victoria Wicks	Review August 2021 and 2022
2	Data collection for this service to include sexual orientation/gender identification	Gender Gender orientation Sexual orientation	Victoria Wicks	Review August 2021 and 2022
3	Review data requirements on the back of the NCL Elective Recovery Accelerator proposal outcome	Race/ethnicity Religion/belief Disadvantaged groups	Victoria Wicks	TBC depending on approval of scheme.
4	Information from discussion with parent/carers to inform service development on the back of the community services review	All group	Victoria Wicks	TBC depending on approval of scheme.

5	Using the dataset to inform service development on the back of the community services review	All groups	Victoria Wicks	TBC depending on approval of scheme.

Please send a copy of the EqIA with the original business case or policy for review to Emdad Haque at emdad.haque@nhs.net

Keys explaining the impact-

- Positive- Evidence including the policy/service objectives indicate that this protected group/strand will benefit equally like their counterparts. It should be noted that the default policy intent of the CCG is to maximise opportunity for all groups.
- Negative- Evidence including the policy/service objectives indicate that this protected group/strand may not benefit and experience disadvantage compared to their counterparts.
- Positive/unknown- The policy/service intent is clear about the equality in access and outcomes in its objectives/goals – and evidence is required to demonstrate the actual positive impact.
- Negative/unknown- There is no hard evidence of likely negative impact but anecdotes and engagement outcomes suggest the likelihood of negative impact.
- Not relevant- The policy/service is not relevant to equality or this protected group/strand. The general rule of thumb is that all patient facing services are equality relevant.

PURPOSE	**Barnet Children's Integrated Therapies Services**
DATE	15/06/2021
LEAD DIRECTOR	*Sarah Mansuralli, Executive Director of Strategic Commissioning*

EXECUTIVE SUMMARY

This paper is being presented for Chair's Action on the basis that waiting for this to go through the respective committees will involve a delay that could put the current service end date at risk. Following approval it is proposed that the paper is considered at the next Strategy & Commissioning Committee (SCC).

Background

North Central London (NCL) Clinical Commissioning Group (CCG) is the lead commissioner of Children's Integrated Therapy Services (CITS) in Barnet. The service is commissioned through a Section 75 agreement with the London Borough of Barnet (LBB). The current budget is £3.3m and is split between NCL CCG and LBB, see table 1 below for 2020/21 budget amounts

Table 1 – 2020/21 budget breakdown

Total budget	£3,300k	100%
NCL CCG contribution	£2,700k	82%
LBB contribution	£600k	18%

The therapies contract with NELFT is due to expire on 31st August 2021. There is an option to extend for a further year, however NELFT have recently given notice on this contract. As the contract ends on 31st August 2021, NCL CCG has less than three months to ensure adequate provision is in place from 1st September 2021.

There is a significant level of interest in the service from existing providers of services within NCL and options are outlined in the accompanying paper with the only viable option being Option 2 – Negotiated Process.

As it will be existing NCL CCG providers will have opportunity to bid for the service, the service can be commissioned under a contract variation with whoever is the ultimately successful provider.

In order to ensure safe transfer of services there will be a six month transitional period from NELFT to the new provider. The transitional period will end on 31st March 2022.

RECOMMENDED ACTION

The Chair and Accountable Officer of North Central London CCG are asked to take a Chair's Action to **APPROVE**:

1. The recommended option for a Negotiated Process to commence.
2. Approve the decision to extend NELFT's current contract to support the transition to a new provider on a declining financial basis. The extension is allowed within the terms of the current contract and therefore does not need a Single Tender Waiver.

DECISION

We approve the recommendation under Chair's Action.

……..
Dr Jo Sauvage, CCG Chair
Date: 18th June 2021

……..
Frances O'Callaghan, Accountable Officer
Date: 18th June, 2021

TWO NON OFFICER MEMBERS OF THE GOVERNING BODY WHO WERE CONSULTED PRIOR TO THIS DECISION BEING MADE

1. Karen Trew
2. Arnold Palmer

NEXT STEPS

The Chair's Action will be discussed at the next Strategy & Commissioning Committee and reported to the following formal meeting of the Governing Body.

Completed forms must be sent to the Governance and Risk Team at: ncl.governance@nhs.net

North Central London CCG
Strategy and Commissioning Committee
Thursday, 15 July 2021

Report Title	NCL System Development Plan	**Date of report**	30 June 2021	**Agenda Item**	3.1
Lead Director / Manager	Richard Dale	**Email / Tel**		Richard.dale@nhs.net 07950 887838	
GB Member Sponsor	Frances O' Callaghan				
Report Author	Richard Dale	**Email / Tel**		Richard.dale@nhs.net 07950 887838	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	Our System Development Plan builds on the November 2020 version, and outlines our progress towards becoming a truly integrated care system (ICS) that helps tackle health inequalities and improves access to health and social care for our residents across North Central London (NCL). This document draws from existing engagement and planning across NCL to help establish a roadmap for our transition as a system. This System Development Plan also provides a framework to measure our progress against the 16 conditions for ICS success as described by NHS England (London). There are a range of NCL-wide system strategies that sit as appendices to this document covering key enablers- including our workforce, digital and estates strategy As next steps we will continue to engage with partners across multiple areas including: • Impact and benefit of becoming an ICS • Our Population Health and Inequalities Strategy • Principles for collectively agreeing priorities at borough level • Impact of the System Oversight Framework **This is a working draft of the Plan. Over this summer, we will continue to engage with our partners to further refine our system development and transition plan; incorporating additional suggestions, emerging guidance and other system imperatives.**				

Recommendation	The Strategy and Commissioning Committee is asked to: • **NOTE** the current draft of the draft of the plan, as well as the suggested next steps for future engagement, to provide additional suggestions and feedback to further strengthen these plans.
Identified Risks and Risk Management Actions	There is a risk associated with transition timelines before NHSE/I guidance is confirmed. Our system development plan remains a working draft as we continue to await additional guidance on some of the key next steps from NHSE/I. A summary of these areas is available on **Page 8** of the document.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	Apart from being shared for feedback with our CCG EMT, Directors of Public Health, Directors of Integration, NCL People Board, the document has also been reviewed in the following system meetings - NCL System Recovery Executive – 9 June - NCL CEO Meeting- 25 June
Equality Impact Analysis	
Report History and Key Decisions	Apart from being shared for feedback with our CCG EMT, Directors of Public Health, Directors of Integration, NCL People Board, the document has also been reviewed in the following system meetings - NCL System Recovery Executive – 9 June - NCL CEO Meeting- 25 June Parts of the document have been reviewed by the regional ICS steering team.
Next Steps	Over the summer we will continue to engage with the following to further strengthen our plans - Directors of Public Health - Our Council Colleagues - NCL Trust Boards - Local Care Forum - Borough Meetings - Population health and inequalities committee - NCL People Board - HWBs - CAG; and others
Appendices	Not applicable.

NORTH LONDON PARTNERS
in health and care

This ICS System Development Plan is a work-in-progress draft and we will continue to update it every quarter through engagement with stakeholders from across the system to reflect our progress.
Please email comments and feedback to:
northcentrallondonics@nhs.net

NCL ICS System Development Plan

Refreshed Plan

DRAFT for Submission to NHSE/I
v1.0
30th June 2021

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Purpose of the document

- Our System Development Plan builds on the November 2020 version, and outlines our progress towards becoming a truly integrated care system (ICS) that helps tackle health inequalities and improves access to health and social care for our residents across North Central London (NCL).

- This document draws from existing engagement and planning across NCL to help establish a roadmap for our transition as a system.

- Our Principles through this transition are as below.
  - ✓ We will **work as one system to benefit the whole population of North Central London** and work together to drive health equality.
  - ✓ We will **retain the local patient, resident and clinical voice** in the commissioning and delivery of health and care, by working effectively across our system.
  - ✓ **We will value our staff, our partners and their expertise** to deliver the best health and care possible for the patients and residents of North Central London.
  - ✓ **We will work on a population health basis**, planning for population needs as a system, and through local partnerships and neighbourhoods/networks.
  - ✓ We will work to deliver joined-up care for our population, **planning around residents not organisations**.
  - ✓ **We will emphasise the value of subsidiarity**, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London.
- This System Development Plan also provides a framework to measure our progress against the 16 conditions for ICS success as described by NHS England (London).
- There are a range of NCL wide system strategies that sit as appendices to this document covering key enablers, these are listed on slide 56.

This is a working draft of the Plan. Over this summer, we will continue to engage with our partners to further refine our system development and transition plan; incorporating additional suggestions, emerging guidance and other system imperatives.

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Sections
Strategic Direction & Measure of Success: There is a clear post-Covid narrative for health and care which partners and stakeholders support	**In Place and Ongoing** We have made significant progress towards embedding a post-Covid narrative in our system through our recovery programme across acute, mental health, community and primary care.	• Work with our partners to embed both the findings from our resident engagement as well as an evidence-based understanding of our population's post-Covid health needs	*Our Local Population and Population Health Approaches*
Strategic Direction & Measure of Success: There are appropriate measures and metrics of success with which we can measure progress and hold ourselves to account for continuous improvement	**In Place and Ongoing** We have developed in-depth life course analysis of the residents of our 5 boroughs and established the Population Health and Inequalities Committee.	• Developing an Outcomes Framework as a key measure of our success in reducing population health inequities. • Building an inequalities lens into our regular system performance metrics; such as waiting lists.	*Our Local Population and Population Health Approaches*
Place Based Elements of the ICS: Health and care resources at a neighbourhood/LCN/ PCN level are well developed, integrated and resourced to be effective in providing high quality local care	**Well developed** With 32 PCNs and six established GP Federations, primary care representation in the Provider Alliance and in ICS Senior Leadership; our Primary Care Networks are well embedded in our ICS	• Establishing a sector-wide GP Alliance. • In-depth primary care commissioning review to inform next steps of PCN development	*Partnerships in Place and Provider Collaborative/ Governance*
Place Based Elements of the ICS: Borough based integrated care partnerships are up and running and delivering intended benefits, community and primary care are integrated with local acute care	**Well developed** Five effective borough based partnerships that agree local priorities in partnership with local acute, community, mental health trusts, local authorities and primary care.	• Developing ICP interface with ICS • Comprehensive OD programme to help further strengthen these borough partnerships.	*Partnerships in Place and Provider Collaborative*
Place Based Elements of the ICS: Provider collaboratives are up and running and delivering the benefits and outcomes we expect of them as pan borough vehicles (and not becoming additional layers or provider monopolies).	**In Place and Ongoing** All NCL providers (acute, mental health and community trusts, primary care) have established a single provider alliance; and appointed a Managing Director to move into delivery of priroty programmes.	• Progress programmes of work with agreed outcomes across four priorities identified- Waiting times, Workforce, Research to Action and Lead Provider models • Establishing a sector-wide GP Alliance.	*Partnerships in Place and Provider Collaborative*
Place Based Elements of the ICS: The existing statutory institutions of health and care systems (e.g. NHS Trusts, FTs, Governors, HWBBs) are delivering positive benefit of focus on institutions without disbenefit on lack of focus across the system	**Well developed** We have role-modelled effective balancing of institutional and system focus via decision making through our GOLD arrangements and Covid Vaccination programme throughout the pandemic.	• Continue to stress test through ICS Steering Committee and Partnership Council, forerunners of ICS Governance • Embed System Oversight Framework • Develop place-based oversight into our framework	*Governance*

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Section
Strong Partnerships: The role of local councils as critical partners in achieving long-term aims for prevention and health and wellbeing is fully recognised and reflected in the approach to strengthening health and care partnerships at all levels of the ICS	**Well developed** NCL Councils are critical partners in our ICS Steering Committee, NCL Population Health & Inequalities Committee, part of the exec chair of our Borough Partnerships (jointly chaired), and members of the ICS Partnership Council. They also play a key role in helping develop and embed our population health approach.	• Engage with our local councils on embedding a shared understanding about the role of an Integrated Care System; • Ensure local council involvement in transformational programmes of work such as our mental health and community services review	*Governance*
Strong Partnerships: A strong set of clinical leaders and clinical networks within the ICS who are sufficiently empowered to improve system performance	**Well developed** The emerging ICS Leadership has well established roles for clinical leadership- such as those of a Primary and Secondary Care Chief Medical Officer and a Chief Nurse. NCL has successfully developed Clinical Networks, and our Clinical Advisory Group has provided essential oversight and scrutiny to our decision making during our Covid response.	• Engagement across clinical and multiprofessional leadership during this summer to design a framework for clinical leadership at system, place and neighbourhood level in our ICS building from our current clinical leadership	*See slide 44 for further details*
Strong Partnerships: Resident and patient engagement is strong at all levels of the local system and supports decision making quality and legitimacy	**Well developed** We are committed to embedding our resident voice in defining the role and purpose of our Integrated Care System. Our borough partnerships have close links with their local HealthWatch and we continue to engage with residents through multiple forums including an Engagement Advisory Board.	• Establishing a Community Partnership Forum to make resident voice more integral to our plans. • Embedding patient voice in Population health approach • Looking at new ways to work with our communities as evidenced in the recent vaccine roll out	*Listening to our communities*
Strong Partnerships: Health and care staff are supported by workforce strategies, cultures and plans which help them to operate effectively at institution, ICS and regional levels as appropriate	**Well developed** This can be evidenced through the NCL People Plan, and ICS level workforce mission and vision, our commitment to staff wellbeing as part of our recovery plans, and ongoing programmes of OD at all levels.	• As next steps, our NCL People Board will continue to work together to co-design and promote the strategic vision for workforce across the ICS and amongst its member organisations and staff. Examples of system working include the Redeployment Hub.	*See Enablers: Workforce* *See slide 46 on ongoing OD interventions*

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Next Steps	Section:
Effective ICS Governance & Decision Making: The formal governance of the ICS is lean and fit for the purpose of it's legislative function and system leadership mission (whilst avoiding becoming a "super CCG")	**In Place and Ongoing** We have established a NCL Partnership Council and ICS Steering Committee as a forerunner of future ICS Governance that works across the health and care system.	• Continue to adapt in line with emerging guidance; ensuring a whole system approach to partnership working, as we move towards ICS shadow governance	*Governance*
Effective ICS Governance & Decision Making: There is increased freedom to move money around the health and care system to support sustainability through improving quality, reducing costs and increasing equality	**In Place and Ongoing** We have agreed financial principles and system ways of working; piloted a financial approach to tackle health inequalities through the Health Inequalities Fund; and supported innovative ways of working across the system through the Accelerated System Recovery Fund	• Embed a whole system comprehensive financial strategy • Determine approach towards areas where less clarity is available such as specialised commissioning (that constitutes a significant share of NCL health services)	*Finance*
Effective ICS Governance & Decision Making: There are effective cultures, mechanisms and support for mutual aid and holding each other to account for continuous improvement in system performance and reduction in unwarranted variation	**Well developed** Our principles of mutual aid- role modelled through the pandemic across acute, community, mental health and primary care – have played a critical role in pandemic response and elective recovery across the system.	• Work through our Operational Implementation Group to ensure a system-wide framework for elective recovery. • As an accelerator site, work towards a "One NCL" approach to our waiting list.	*Enablers Mutual Aid Principles, Governance*
Effective ICS Governance & Decision Making: Decision making at all levels is supported by excellent population health data and management supporting improving health outcomes and reducing health inequalities	**In Place and Ongoing** We have embedded population health data in programmes such as Covid vaccination through HealtheIntent (PHM system); and also established a Health Inequalities Fund as a step towards supporting a population health approach.	• Continue to work with wider system partners to onboard onto HIE/HealtheIntent • OD to embed a population health approach into ongoing programmes of work, helping our workforce to use data for effective decision making.	*Our Local Population and Population Health Approaches*
Regional Added Value: *There is sufficient standardisation of ICS governance approaches, specifically in core structures and mandated performance metrics, which allows for London-level sharing, line of sight and accountability*		*These two conditions of success have been earmarked as those for which a "single regional approach would be necessary".* *The NCL ICS Executive Leadership and ICS Transition team continues to engage with the regional team to feed into regional thinking and respond to emerging guidance.*	
Regional Added Value: *The regional role and operating model has a clear focus centred on added-value to ICSs plus holding them to account; and the respective roles for region and ICS are clear and appropriate*			

North Central London ICS – Progress to Date

- ✓ In April 2020 the five Clinical Commissioning Groups in North Central London – Barnet, Camden, Enfield, Haringey and Islington – **merged to form one CCG** in line with the NHS Long Term Plan.
- ✓ Alongside this, **borough partnerships have been formed in each borough** to support working at a 'place' level and we have **32 thriving primary care networks** across the area.
- ✓ Over the last year the single **CCG, Councils, providers, general practices, voluntary and community organisations**, have continued to work collaboratively to respond to the pandemic.
- ✓ Earlier this year, our 13 acute, mental health and community NHS Providers that service populations in NCL and beyond came together with UCL to form a **Provider Alliance.**
- ✓ The last year of the pandemic has both **strengthened our ability to work as a system and helped build mutual accountability**, but also further **highlighted the inequities in health and social care among our residents.**

As part of our post-covid recovery we are committed as a system to:

- ➢ **moving to a population health approach to commissioning**
- ➢ **re-visioning our community and mental health services**
- ➢ **ensuring equitable elective recovery with the aide of the accelerated recovery fund**
- ➢ **supporting primary care recovery focused on interfaces,**
- ➢ **ensuring the wellbeing of our staff.**

- ➢ We are committed to **ensuring a smooth transition for our staff and partners** as we progress towards an ICS.
- ➢ This will only be possible with the help of strong system enablers in the form of a **robust financial strategy**, inclusive system-wide **digital footprint**, a **capital and estates programme** focussed on efficiencies, **workforce transformation** and through **mutual aid** within the system.

As we continue working on our transition plan to becoming an ICS, we will continue to incorporate updated national guidance on ways of working for the System Oversight Framework, ICS Design and Recruitment of Executive posts as issued.

NORTH LONDON PARTNERS in health and care

NHS

Ongoing development of North Central London ICS

We are committed to developing our ICS transition plan in order to meet the needs of our local population with the core objectives of:

- Improving outcomes in population health and care
- Tackling inequalities in outcomes experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

We will continue to develop and further refine our transition plans as additional guidance is made available

Areas identified for continued work, that will evolve as guidance and policy develops:

1

System Leadership
- Established processes for ICS leadership development
- ICS Constitution

2

Financial Frameworks
- Clarity of funding flows
- Allocation of risk and reward

3

System Assurance
- Development of MOU with NHS E
- System data and reporting metrics

Risks and areas of specific further work for North Central London

North Central London's Trusts'(including UCLH, GOSH and Royal Free) service health needs beyond our local borough boundaries from across the country. For some this is a majority of their activity. We will continue to work with the national and regional teams to determine the implications of this for our financial and integration strategies.

System Development Plan: Engagement to date

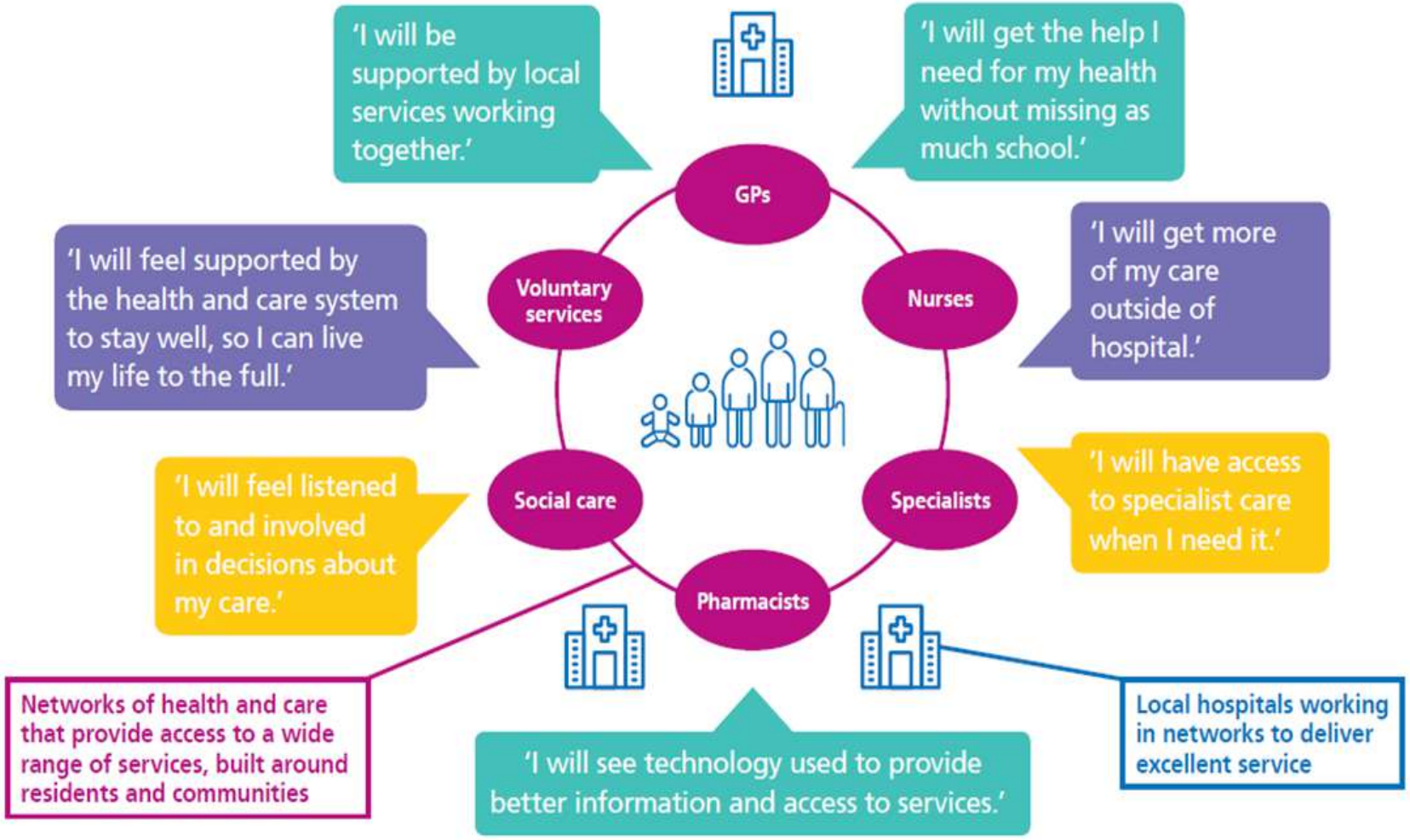
Over the last month, relevant sections of the NCL System Development Plan have been shared with the following forums, with plans in place to continue engagement over the summer.

Stakeholders	Engagement to date	Next steps
NCL ICS Steering Committee	Reviewed	*Review every quarter*
NCL ICS System Recovery Executive	Reviewed	*Review every quarter*
NCL People Board	Shared and initial feedback incorporated	*Continue engagement to further develop our People Plan and Clinical and Professional Leadership Framework*
NCL Estates Board	Ensured alignment with NCL Estates Strategy	*Continue to review alignment*
NCL Digital Board	Ensured alignment with NCL Digital Strategy	*Continue to review alignment*
NCL CEOs/ NCL Trust Boards	Shared with NCL CEOs and initial feedback incorporated	*Share summary with Trust Boards for endorsement*
NCL Directors of Integration/ and NCL Local Care Forum	Shared and initial feedback incorporated	*Continue engagement to further strengthen plan for place and agreeing borough priorities*
NCL Population Health Committee	Shared and initial feedback incorporated	*Continue engagement with Directors of Public Health to embed narrative and further develop plan on Population Health Management*
Wider NHS staff e.g. CCG staff	Shared and initial feedback incorporated	*Continue engagement to appraise of transition and embed system working*
Borough Teams incl. DASS and DCS	Shared for initial feedback	*Continue engagement to develop integrated ways of workings*
Borough HWBs and HASCs	Shared for initial feedback	*Continue engagement to develop integrated ways of workings*

Our Vision for an Integrated Care System in NCL

We want to enable our residents to Start Well, Live Well and Age Well

We asked our residents what Integrated Care means for them; and this is what they told us…



What will the integrated care system mean for our residents?

Our Integrated Care system can not just focus on how healthcare services operate. Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare.

Therefore we need to work with partners to look at the bigger picture, including:

- Fulfilling work
- Education and skills
- Our surroundings
- The food we eat
- Money and resources
- Transport
- Housing
- The support of family, friends and communities

What will be different?

"Joan is 80 years old and lives in Camden. She has heart disease and diabetes, and recently has been forgetting to take her medication. She has found it more difficult to manage over the last six months but wants to keep living at home. Joan's GP and social worker have developed a Care Plan in discussion with Joan. This means that the GP practice, district nursing and social care know how to work together to help Joan stay well and at home safely. If Joan's GP becomes concerned about something, he uses the 'Rapid Response' service to assess her the same day at home, which helps avoid trips to A&E. When Joan did fall last year and needed to be seen in hospital, she was assessed within 2 hours and a plan was in place quickly to get her home as soon as she was ready. Joan was supported to stay at home with *a care package provided by social care, her domiciliary care* workers were increasingly concerned about her forgetfulness so referred her to the memory clinic for a dementia assessment."

How integrated care can help

- ✓ Clearer information about local services and how to use them will be available to help residents access the right support.
- ✓ Better access to mental health care, with residents given more support to find the help they need.
- ✓ Patients ready to leave hospital will be discharged, through hospitals, community services and social care working together.
- ✓ Ensuring all people have their mental health care needs met, and providing interim support for when people are on waiting lists for complex care treatment.

Our ambition and purpose is to improve lives in NCL

We are working to deliver improvements in outcomes for local people – through changes in the way we plan and deliver health and care services.

The future success of our health and care system depends on the health and wellbeing of local people. We have made good progress in recent years but there are still too many health disparities and inequities within and between North Central London communities that prevent our residents getting the **same opportunities to start well, live well and age well.**

We know that, in particular, we have the need and the opportunity to improve children and young people's health. Focusing on public health and the quality of health and care services for children and young people means we can help **make a real difference to key determinants of good health such as reducing childhood obesity and increasing immunisation rates.**

We know that the economic climate impacts health. Poor health and care, in turn, affects individuals, their quality of life and their ability to contribute to the local economy. Health and care services and the staff and carers that work in them can impact and help break this cycle. This can help avoid urgent or long-term care for problems that could have been **identified earlier, managed better or prevented altogether.**

Our purpose is: To improve outcomes and wellbeing, through delivering equality in health and care services for local people.
Supporting them to Start Well, Live Well and Age Well. We also want to support the many local people who are employed by health and social care to **Work Well.**

We will be guided by a shared set of outcomes based objectives (an 'Outcomes Framework'), **setting out the difference we will make for the population in NCL** and how we will be monitoring that we are achieving our strategic aims.

- NCL has an ambitious vision for the local population of 1.5 million people. We want to put our residents at the heart of our health and care system so that we can work together to address inequalities and provide consistent, high-quality services and health outcomes.
- We know what we have achieved already, we have a clear ambition for what we want to achieve, and we understand the actions we need to take to succeed in our ambition.
- Our plans look at how we can meet the immediate challenges as health and care services begin to recover, and also how our partnerships can continue to ensure long term improvements in the health and wellbeing of our residents.

Our Strategic Aims

We have identified five strategic aims to deliver our ambition and achieve our purpose. We have mapped life courses for residents from all our boroughs (see appendix) and are in the process of developing a set of outcomes that will enable us to track our progress towards achieving these aims. We continue to refine and further develop these aims with our system partners and residents.

Start well

Strategic Aim 1:

By working collaboratively with schools and communities, our children and young people will have:

- tools to manage their own health
- access to high quality specialist care
- safe and supported transitions to adult services.

Live well

Strategic Aim 2:

Our residents will have early support for health issues including:

- equitable access to high quality 24/7 emergency mental and physical health
- world-class planned and specialist care services
- true parity of esteem between physical and mental health.

Age well

Strategic Aim 3:

Our residents will:

- be supported to manage their long term conditions and maintain independence in their community
- receive seamless care between organisations
- experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can.

Work well

Strategic Aim 4:

Our workforce will:

- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels.

Enablers

Strategic Aim 5:

We will provide key enablers for success, including:

- digital technologies to connect our health and care providers with our residents and each other
- a fit for purpose estate in each locality
- being a financially balanced health economy driving value for money for the taxpayer.

Benefits of developing into an ICS in NCL

Our transition to an ICS will help us progress further on the road to system working, focused on improving population health outcomes for our residents. In particular it will create:

Improved Outcomes

Enable greater opportunities for working together as 'one public sector system' – ultimately delivering improved patient outcomes for our population and reducing health inequalities

Working at Place

Support the further development of local, borough-based Integrated Care Partnerships and Primary Care Networks

Single Voice for NCL

Provide a single, strong and consistent vision and voice for our partners

Efficient and Effective

Help us build a more efficient and effective operating model tackling waste and unwarranted variation.

New Ways of Working

Accelerate our work to build new ways of working across the system

Economies of Scale

Help us make better use of our resources for local residents and achieve economies of scale

System Resilience

Help us become an organisation with much greater resilience to face changes and challenges to meet the needs of our local population

What will be the benefits for Robert?

"53 year old Robert undertook screening at his community pharmacy, which picked up hypertension, a risk factor for cardiovascular disease. As he is self-employed he doesn't like to take time off work and see the doctor. But when he does visit his local surgery, the GP can see information from different health and care organisations across NCL about his wider care. With this information the GP can easily see any gaps in his care, such as the medication he has been given, if he has had his flu jab yet this winter and whether he has received support to stop smoking. The GP and Bob can discuss together how to act on information about his whole care, including his mental health. This means they can make decisions together to help Bob stay well, reducing the amount of time he and his family need to spend in health and care settings."

Our local population, tackling health inequalities and embedding population health

Overview of population health needs and Covid-19*

- North Central London has a population of about 1.5 million people which was predicted to increase by 4% over the next 10 years. The population is relatively young, with more adults under 30 than other areas particularly in Camden, Haringey and Islington. The area has historically had a lot of migration both from other areas of the UK as well as internationally. This will have been impacted by Covid-19 and Brexit. The data from the 2021 Census will be able to provide an assessment of this impact when published.
- While some of the communities in NCL are wealthy and lead long, healthy lives, others experience large inequalities in health which Covid-19 has put into stark relief.
- These inequalities are seen between and within boroughs, with poorer health outcomes among the more deprived communities, as well as between those of different ethnicities, or with mental health illness or learning disabilities.
- The impact of Covid-19 continues and work needs to continue to protect local communities and the health and care workforce from its direct impacts through vaccinations and health protection interventions, with a specific focus on addressing gaps in vaccine uptake by different communities to reduce the disproportionate impact of Covid.
- The indirect impacts of Covid-19 on mental health wellbeing, loss of jobs and household incomes, and gaps in early years and education will lead to medium to long term impacts on health. There will be shorter term impacts from delays in health and care service delivery, and particularly routine and planned care.
- In the short and medium term, there will likely be increases in avoidable mortality from cardiovascular disease and cancer due to missed opportunities for diagnosis, management and treatment.
- Longer term impacts will be related to the loss of employment and income, social isolation, mental health, and the widespread impacts on children and young people. All of this will likely widen health inequalities.

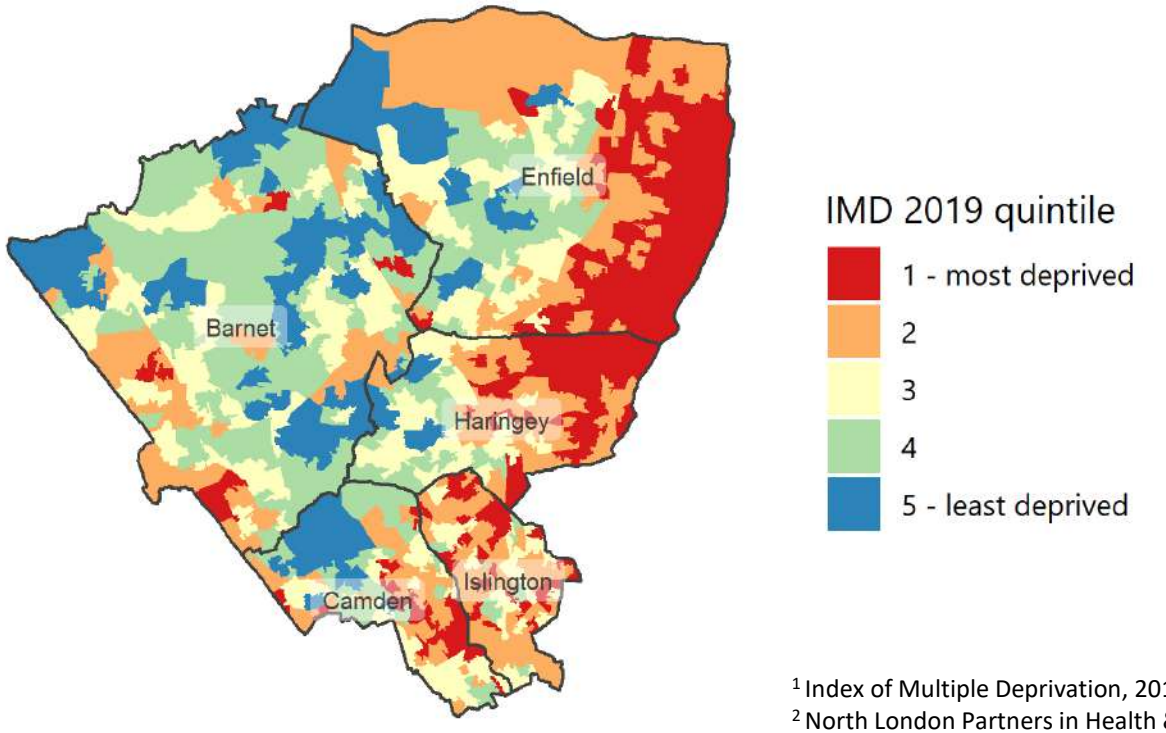
**A comprehensive overview of NCL and our Population Health is available on request*

Deprivation across NCL

Across North Central London there is a high level of population health needs and inequalities. This is driven by a high level of deprivation among some communities, affecting all aspects of people's lives from their childhood, education, employment, income, and housing.

Deprivation quintile by LSOA

North Central London boroughs, IMD 2019



High level statistics

- Haringey, Islington and Enfield have on average, higher rates of deprivation compared to London, although pockets of deprivation are dispersed across NCL[1].
- The high levels of deprivation are strongly associated with poor health outcomes and large health inequalities: those living in the most deprived communities have a 50% higher death rate from avoidable causes of death compared to the NCL average[2].
- Just over 50,000 children and young people in NCL were living in poverty in 2019/20, ranging from 18-19% of children in Haringey, Enfield and Islington to 14-15% in Barnet and Camden[3].

[1] Index of Multiple Deprivation, 2019
[2] North London Partners in Health & Care, Avoidable mortality by ethnicity and deprivation, March 2021
[3] HM Government, Children in Low Income Families, 2019/20. Defined as under 16 years living in a families with less than 60% of the median income in 19/20 (relative measure before housing costs)

Impact of Covid-19 on our local populations

Much of the COVID response and associated shift in delivery models (total triage, digital first) has been well received. But resident experiences vary, with Black Asian Minority & Ethnic residents feeling significantly less secure and fearful as we move out of lockdown and into recovery and rising need and risk in some areas. Last summer, NCL commissioned a detailed piece of engagement review work (including communities at risk of health inequalities) to inform our approach to engagement.

Experiences shared by our patients and communities:

- New and exacerbated Mental Health problems including stress, anxiety and depression.
- Carers are living in heightened fear of catching COVID and not being able to support their loved ones.
- Largely positive response to the shift to digital and telephone models, but evidence of digital exclusion for some and challenges supporting more complex CYP and MH cases.
- Primary, community and adult social care models adapted quickly but more work is needed to empower people to manage long term and complex needs.
- Safeguarding (adults and children) is more important than ever – with hidden risk and a rise in reported incidents of domestic abuse and violence.

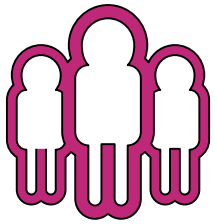
Impact of COVID on patient and resident experience and perceptions:

"*Everyone is going out …they think it's over. But I cannot take my children out. It's not safe.*" – Black Asian Minority & Ethnic respondent

"*Not only are we dealing with feeding our kids, home schooling, working, and keeping safe, now we also have to explain this [increased risk for Black Asian Minority Ethnic communities] to our kids who hear things on the news and they are scared*." – Black Asian Minority & Ethnic respondent

"[*GP] was very helpful on the phone and we decided I didn't need to go in to see him*."

"*If I have a medical emergency I would avoid going to A&E*." – Black Asian Minority & Ethnic respondent



"*My GP consultation was by WhatsApp video. The service was excellent, as usual*."

"*With all the news and statistics around increased risk for Black Asian Minority Ethnic communities we do not feel safe*." – Black Asian Minority & Ethnic respondent

"*My issues are recurring so it's usually very daunting and a physical strain to get to the GP. I often put off going as I don't have the energy to get there. But this time they did everything over the phone. It was really quite liberating…it's made me feel like I've got a little bit of control back over my own care. I wasn't expecting that.*"

"*I hear the government guidelines…but I have to use my own* judgement." – Black Asian & Minority Ethnic respondent

Healthwatch Camden engagement (>1,600 survey responses followed up with phone interviews and focus groups conducted during the initial COVID period)

Our progress against five priorities: health inequalities

Restore NHS services inclusively	• Ensuring that all analysis undertaken in relation to the restoration of NHS services specifically considers equalities dimensions, including ethnicity and deprivation, for example, in our elective recovery and waiting lists, and community diagnostics hubs. • Continuing to build up our population health management platform, HealtheIntent. In six months' time, we plan to have all acute and mental health trusts on HealtheIntent, alongside GPs and Royal Free that are there now. We will have also started onboarding community trust and adult social care data onto the platform.
Mitigate against digital exclusion	• Commissioning an Equalities Impact Assessment report into the causes and contributing factors to digital exclusion, views from local stakeholders, the impact of Covid, and recommendations for action to address digital exclusion. • Establishing a pilot in Haringey, as a joint initiative with North Middlesex and the local Haringey ICP, that focuses on practical steps that can reduce digital exclusion for those already in the system, i.e. purchasing of hardware. • Prioritising digital exclusion in our most deprived wards through the utilisation of NHS Charities funding.
Ensure datasets are complete and timely	• Use of our population health management platform, HealtheIntent, to understand where care teams can make improvements in recording of equalities data. • System-wide audit on ethnicity data collection, including the use of "other" category in ethnicity data.
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes	• Ongoing work with NHSE/PHE to encourage commissioning and delivery of a more culturally and socially competent school-aged flu vaccination programme, with appropriate equity monitoring during the coming winter. • Using HealtheIntent for: deploying a registries for COPD, diabetes, childhood asthma, atrial fibrillation and physical health checks among people with serious mental illness; developing a similar registry for learning disabilities and for care beyond cancer; analytics dashboards on population health needs, childhood immunisations, frailty, quality improvement for long term conditions, and flu and Covid vaccinations. • Working closely with PHE as part of our ICPs, to identify key priorities and implement changes in line with national guidance and the recommendations of publications including Beyond the Data. For example, Enfield is focusing on their most deprived communities, and is jointly funding (with the local authority) community participatory research and community engagement to look closely at childhood obesity.
Strengthen leadership and accountability	• Reducing inequalities is integral to population health. A Population Health and Health Inequalities Committee has been established, led by our ICS Chair and with broad stakeholder engagement across local authorities, primary, community, CCG and acute services. The aim of this Committee is to embed a population health approach across the system, including a focus on reducing health inequalities.

We have established a Population Health and Inequalities Committee to develop a single integrated approach to population health

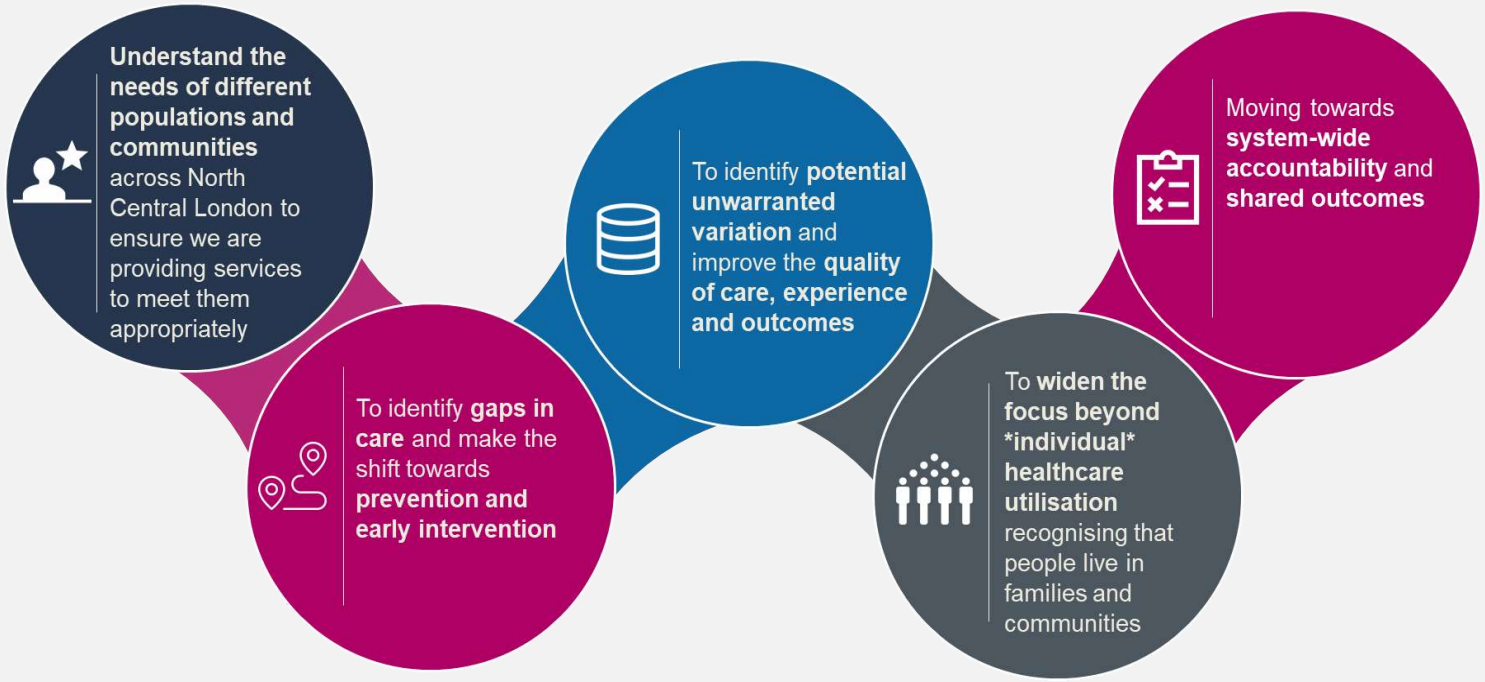
The **Population Health and Inequalities Committee for NCL** was formally established in spring 2021. The group has been established to be the driving force for changes and how we commission services for NCL.

The **purpose of the committee** is for health and care organisations in NCL to collectively design and implement NCL's population health strategy which aims to ensure that there is a step-change in making whole partnership working the foundation to deliver a difference to population health and wellbeing outcomes, including:

- ✓ Developing a single integrated system wide approach to population health and the culture, ways of working and strategies that underpin it. This will be across the full breadth of partners that make up the NCL health and care system and be aligned at system and local level.
- ✓ Utilising consistent methodical approaches to assessing population health needs at system and place based levels, and embedding population health management to support place-based action and system transformation.
- ✓ Planning and prioritising how to meet population health needs, including consideration about what additional resource may be required and how it will be released to deliver improvements.
- ✓ Addressing health inequalities and inequity of access, experience and outcomes through greater integration and holistic care.
- ✓ Ensuring that population health is embedded in all policies and frameworks – delivering a clear set of ICS priorities that are supported with the right financial, operational and commissioning frameworks.

To support us to deliver improvements we will continue to embed Population Health approaches in everything we do.

Our vision of what we want to achieve with population health management in North London



To help us achieve delivering improvements through population health management we will:

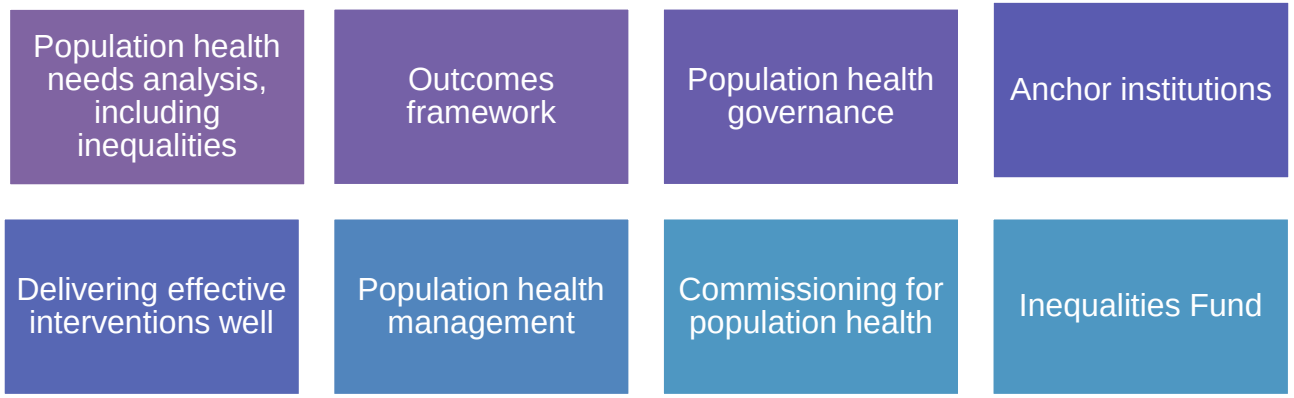
- ✓ Commit to ensuring that **there will be a focus on tackling health inequalities and improving the overall quality of care for our residents in line with NCL's priorities-** an integral component being recovery of services to pre-pandemic levels in an equitable manner.
- ✓ **As a step towards this we have established a Health Inequalities Fund worth £2.5 million.** The majority of this initial funding will be targeted at addressing the Planning Guidance priority areas, these being the 20% most deprived wards in the system
- ✓ Our NCL-wide **Population Health and Health Inequalities Committee** will continue to progress work on further developing a **Population Health Roadmap** aligned with our ICS Vision to ensure a system wide agreement on priorities that emerge from the needs of our population.

To support us to deliver improvements we will continue to embed population health approaches in everything we do

To help us achieve delivering improvements through population health we will:

- ✓ Commit to ensuring that **there will be a focus on tackling health inequalities and improving the overall quality of care for our residents in line with NCL's priorities** – an integral component being recovery of services to pre-pandemic levels in an equitable manner, **supported by the finance framework**.
- ✓ **As a first step towards this we have established a Health Inequalities Fund worth £2.5 million.** The majority of this initial funding will be targeted at addressing the Planning Guidance priority areas, these being the 20% most deprived wards in the system.
- ✓ Our NCL-wide **Population Health and Inequalities Committee** will continue to progress work on further developing a **Population Health Strategy** aligned with our ICS Vision to ensure a system wide agreement on priorities that emerge from the needs of our population.

Our key deliverables for population health:



Next steps for population health

As next steps we will continue to work through the Population Health and Inequalities Committee with Borough Partnerships, Local Authorities, Engagement committees and Trust Boards to:

- Develop and refine the outcomes framework.
- Embed a population health approach – including dependencies with supporting frameworks, such as finance and commissioning.
- Determine
  - the key areas of variance in outcomes across NCL
  - the common areas we should work on together at a system level
  - support development of priorities at a place based level
  - what we should do as a system over the next nine months to embed a Population Health Approach.

Our outcomes framework once developed will act as key input to our ability to measure our success as an Integrated Care System.

Using population health management to improve population health through data-driven planning and delivery of proactive care

The story so far

- NCL has a history of collaborative working across public health and digital to embed population health data and tools in our strategic programmes and priorities.
- We have been using our population health management platform, HealtheIntent, to support care teams in Covid and flu vaccinations, identifying population health needs and inequalities, childhood immunisations, long term conditions management, frailty and elective recovery, with a strong focus on equity.
- We have commenced work on establishing an outcomes framework and towards developing life-course journeys for our residents across all of our boroughs.
- We are building our internal Population Health Management (PHM) capability and capacity, including to support the embedding of data-driven and evidence based approach to population health commissioning.

Our digital and technology enablers

- We are engaging technology and applications to move from reactive to proactive care (Health Information Exchange- HIE, HealtheIntent).
- Full details of our digital and technology enablers can be found in our NCL Digital Strategy.

Next steps for population health management

As next steps we will continue to work through the Population Health and Inequalities Committee and its clinically and care led PHM sub-group to:

- Make best and full use of the system-wide integrated, near-real time health and care record (will be completed for main data sources by end of 2021/22).
- Further develop analytical and registry tools aligned to system, borough and neighbourhood priorities, with design driven by clinicians and care workers.
- Enable and support care teams to adopt a PHM approach in their work, and to make best use of HealtheIntent and evidence-based interventions.
- Work to build better datasets for planning and research, aligned to regional and national initiatives.
- Work with the North Thames NIHR Applied Research Collaborative (ARC) to evaluate the impact of PHM in NCL.

Listening to our communities and residents

Themes from resident engagement

Insights generated through our engagement with residents will inform the development of our NCL Integrated Care System, building on work we are already doing in response to what they have told us is important.

What residents told us was important	Examples of what we are doing...
Better access to services	Introducing care navigators to signpost people to the right services
Patients involved in discussions and shared decisions about their care	Children and young people with epilepsy and their families being involved in the development of local epilepsy services
Access to clear and accessible information, including easy read versions and access to interpreters	Healthy Futures providing clear, accessible information for people with diabetes on how to look after their condition
Empathy and understanding around cultural or disability-related needs	Trialling a new pathway for self-sampling smear tests
Patients given knowledge about how to keep themselves well and support wellbeing	Social prescribing in GP practices to support people to stay active, eat well, reduce isolation and contribute to their communities
Patients given choice and care is planned and delivered to meet each individual's needs	Residents supported to have personal health budgets, including for mental health, to best meet their individual needs for care
Use of technology both to increase access to services and to health information	Residents having access to online and video consultations and supported to feel digitally included
Better joint working between health and social care	Working across services to proactively support people at risk of long term conditions
A focus on prevention and proactive care	Increased community teams and ensure physical health checks for adults with serious mental illness and learning disabilities are being carried out
Everyone gets the same quality of care regardless of where they live	Whole system approach to tackle some issues, such as childhood asthma, to ensure everyone gets the same high-quality care

Residents' Experiences During the Pandemic

During the pandemic, NCL health and care organisations have been engaging in a wide variety of ways with patients, residents and communities. We analysed the feedback from 44 engagement projects (July 2020 and August 2020) and identified 42 main topic areas reflecting residents' experiences and concerns during Covid.

Some of the main themes were:

- ✓ Inability of some service users to access 'everyday' services moved online or by telephone from face-to-face
- ✓ Access to consistent information about Covid-19 and how to 'stay safe' was difficult for some to find
- ✓ Rapid service changes were not always communicated to service users effectively
- ✓ Mental health – exacerbated by the pandemic and lockdown measures
- ✓ Health inequalities, particularly impacting our Black, Asian, and Minority Ethnic communities, carers and parents, older people
- ✓ Physical impacts of Covid and lockdown.

To facilitate conversations with stakeholders, local residents and community groups we have developed some materials which we continue to use with community groups.

- Resident and health care professional stories online to reflect our experiences of health and care during the pandemic: https://conversation.northlondonpartners.org.uk/ncl-coronavirus-stories/
- Template to feedback insight from community engagement activities.

Community Involvement and Engagement as an ICS

We have a strong foundation to build a future ICS model of community involvement and engagement.

- We will be forming an ICS Community Partnership Forum – to be a pivotal and strategic forum to enable resident involvement, support the development and design of strategies and services. This will have representation from voluntary and community sector (VCS) organisations and patient participation groups (PPGs), alongside health and care partner representatives.
- Conversations are ongoing with system partners on resident and patient engagement and VCS involvement (at system, place and neighbourhood level).
- We are holding regular discussions with NCL's Engagement Advisory Board, NCL CCG's Patient Public Engagement and Equalities Committee, Council Leaders and elected members from our five boroughs, and Healthwatches.
- At a special NCL Joint Health Overview and Scrutiny Committee (March 2021) we discussed discuss plans and sought assurance for our approach.

Community Involvement & Engagement as an ICS

Health and Wellbeing Boards

Health and Wellbeing Boards are linked to all borough partnerships

- Most boroughs have updated their Health and Wellbeing Board Terms of Reference to include a link to the Borough Partnerships.
- Councillors are largely engaged through the HWBB although there is increasing interest in direct involvement.
- Borough scrutiny committees also regularly request reports on the development of integrated care locally.

Patient / resident involvement and engagement

Patient and resident engagement is being undertaken in different forms across borough partnerships

- All partnerships have their local Healthwatch as members on their partnership groups.
- Some Healthwatch members lead on specific areas of focus/priorities within the partnership.
- Most ICPs have engagement groups (e.g. Haringey Citizen Health & Care Advisory Board, Camden Citizens Assembly, Islington conducts regular community engagement events).
- Some CCG borough teams also support a patient engagement forum, with resident and VCS representation.
- CCG Community Members sit on many of our committees and support wider engagement work.

Engaging the VCS

Voluntary and community sector organisations play a role in all partnerships

- VCS is represented on all partnership groups across all boroughs. In some, VCS leads on priorities areas (for example MIND in Camden alongside CIFT).
- In all others they are “plugged into” the work and have played an increasingly significant role in delivery of partnership plans (social prescribing, mental health and wellbeing support, delivery of equipment, support to access services, support to comms campaigns such as flu).

Community Involvement and Engagement as an ICS

Ongoing work to do at system-level

- Ensure transparent governance – public board meetings; resident, service user and carer representatives in governance etc.
- Developing shared principles and methods for involving people and communities, and co-production.
- Capturing insights to build a picture of resident priorities and needs, and acting on this as a system.
- Develop a shared approach to involvement / decision making with Voluntary, Community and Social Enterprise Sector (VCSE), supporting a resilient third sector.

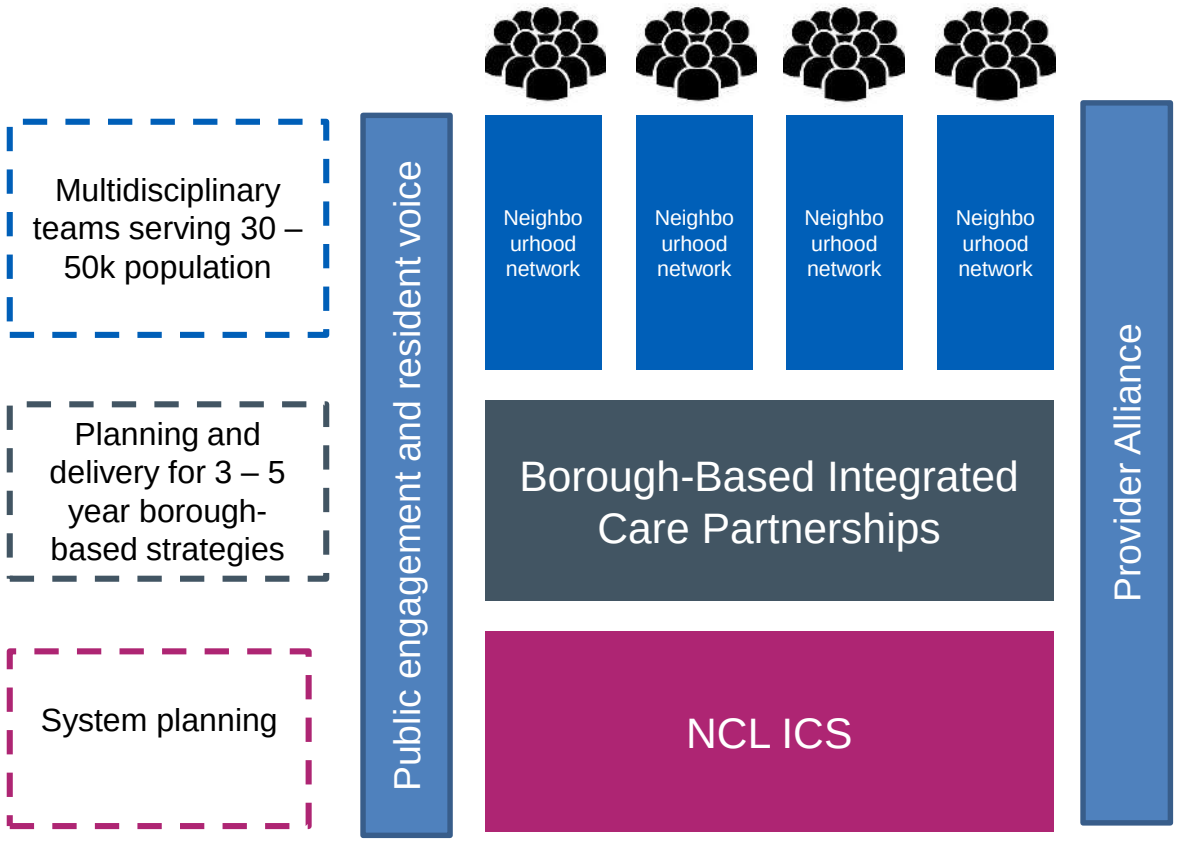
Ongoing work to do at place-level

- Develop place-based partnership approaches on engagement and involvement, linked to ICS framework.
- Ensure partnership links with HOSCs, HWBB, Healthwatch and VCSE sector are strong and effective.
- Support Primary Care Networks and neighbourhood team links into communities.
- Make every contact count to signpost residents to services and support

Our governance and leadership arrangements

Working towards an NCL Integrated Care System

Together, system partners have begun to design what our Integrated Care System (ICS), with borough-based Integrated Care Partnerships, would look like



Neighbourhoods build on the core of the primary care networks and **enable greater provision of proactive, personalised, coordinated and more integrated health and social care** through multidisciplinary teams taking a proactive population based approach to care through consistent pathways.

Boroughs are the **critical point of integration of planning and coordination of services**. All boroughs have a **strong sense of defined population being coterminous with local authorities**. The work at borough partnerships is focussed on bringing together partners **to plan, develop and coordinate services based on agreed outcomes.**

The NCL ICS will focus on activities that are better undertaken at an NCL level **where a larger planning footprint increase the impact or effectiveness** of these functions. It will also be responsible for **system planning, ensuring system efficiencies and delivering measurable outcomes** towards our goals of reducing inequalities and improving health outcomes.

Developing system governance and mutual accountability

To support delivery at system and place level we have been working to develop a sense of shared purpose.

Lessons from the COVID response suggest a blend of the three elements (below) are needed to create the environment for mutual accountability and collective decision making on difficult issues. A shared purpose is the foundation for these. Without this shared purpose, governance can be a stumbling block rather than an enabler.

Shared purpose	Well-defined **reasons to work together** collaboratively	• Mutually agreed upon system-wide **short term (urgent) and long term (ambitious) strategic objectives**. • **External drivers that could create a sense of urgency** to take difficult collective decisions such as Covid-19, financial resilience considerations, national directives to focus on ICS. • A **uniform narrative** to engage with partners, stakeholders and communities.
Agreed ways of working	An agreement on **how to work together** sustainably	• Mutually agreed **guiding principles** for collective decision making. • A **programme of OD** to empower people and organisations within the system to take joint decisions. • An agreed-upon **outcomes framework** underpinned by a population health approach.
Nimble governance and shared data	Supportive **processes and mechanisms**	• **Governance** that both fits statutory requirements and allows difficult decisions to be made collectively, for example, MoU, Alliances, Programme Boards etc. • **Data** that supports mutual accountability on performance. • Processes **that facilitate collaborative working, information sharing and effective communication** across all partner organisations.

NCL ICS – Key Interim Governance Arrangements

	NCL Partnership Council	ICS Steering Committee	Community Partnership Forum	Borough Partnerships
Overview	This Board / Council will be the focal point for the health and care partnership across our boroughs. It will get its significance, its ability to influence and to make a difference from the capabilities and statutory functions of all the key partners including but not limited to local government, the NHS and other key partners.	For 2021/22 there is an increasing need to have a forum for some Board level 'steers', and sometimes decisions, that arise from the day to day running of the ICS: this body will provide this needed, timely direction. It will be an early forerunner of the Board for the ICS NHS Body envisaged in the White Paper, (although noting that the CCG will continue to fulfil its statutory role as a separate Body during next year).	This will be a key forum that ensures effective community and citizen participation in the work of the wider ICS. The aim is for it to be an active expert reference group on community engagement as well as a forum for discussion and debate on emerging proposals and strategies. By definition, it will be important to enable community representatives to co-design this forum and how it works.	Our 5 Borough Partnerships Partnerships are maturing locally Place-based leaders are working together to shape the ICP role, priorities, local structures & teams and ways of working. There are common features, but local nuances within each partnership. Each Partnership has a "Partnership Executive" as well as a "Delivery Board" in place
Membership	• Independent Chair; • All NCL NHS trust Chairs, • CCG Chair, • Local authority leaders x 5; • System Executive Leaders x 2 ; • Provider Alliance Managing Director, • Primary Care Provider Representative	• Independent Chair; • System Exec Leads x2; • CCG Chair and Clinical Leader; • LA Leader and LA Chief Executive; Provider Alliance Chair; • Provider Chairs [4] and Provider Chief Executives [2]; • Primary Care representative. ***Non-core attendees invited for specific items (Agenda dependent)*** ICS Execs: • Finance: lead CFO • Medical Lead CMO(Secondary Care): • Lead Nurse CNO • Workforce lead CPO	• Independent Chair • Provider Alliance Representative Local Authority Representative (1), System Leads, • Health Watch Reps from all 5 boroughs • PPG reps • NCL Director of Strategic Commissioning; and VCS representation from all boroughs; **(TBC: this is under review)**	Varies by Partnership but includes 1. Leaders of Councils 2. Local Governing Body Clinical Lead 3. Local Trust CEOs (Acute and/or Community) 4. CCG Borough Director
Purpose	• To agree the overall wider partnership ambitions, strategies and policies designed to improve the health and wellbeing of our residents and to address the health inequalities in our communities; • to oversee and review progress to achieving the desired improvements in outcomes; • to oversee and act to improve the integration of health and care. • To agree any strategies requiring whole partnership decisions	• Provide a board level review of the quality and performance of the ICS, and to sponsor system improvement steps where needed; • Oversee the financial strategy and performance of the ICS. • Keep under review the interface between health and care to ensure it works to optimal effect. • Sponsor any service changes needed to deliver the ICS strategies and ambitions. • give board level partnership oversight on the transition to the new statutory arrangements.	• To be a pivotal and strategic forum to enable residents to be involved in developing strategies and improving services across the NCL health and care system, that in turn improves the health and wellbeing of residents.	• To enable the integration of health and care services to ensure a joined up, efficient and accessible services for residents and • To agree borough based ambitions, strategies and policies designed to improve the health and wellbeing (including healthy independent living) and address inequalities of borough residents
	Established	***Established***	***To be established in Q3***	***Well Established***

Our partnerships at place and provider collaboratives

As an ICS we are committed to integration between system partners at place, to improve outcomes for our residents

Place-based arrangements

Borough Partnership Executive Boards x 5

Borough Delivery Boards x 5

Working Groups / T&F Groups (numerous in place to progress partnership priorities)

***Purpose**:*

- *Agree shared borough priorities & ambitions (feeding into Joint H&WB Strategies)*
- *Shape and deliver integrated health & care locally (relationships, systems, processes)*
- *Ensure joined up, efficient and accessible services for residents*
- *Address inequalities in access, experience, outcomes*
- *Develop Population Health, with emphasis on prevention and develop proactive care models*
- *Address the wider determinants of health*
- *Co-design with patients / residents*

Partner organisations

NHS Trusts

Local Authorities

PCNs x 32 and GP Federations x 6

Local VCSE partners

Healthwatch x 5

Other key partners:

- Care Providers
- Patient groups
- Cllrs
- Other statutory services (Police, Fire)

Working with:

- Local patients/residents and communities

Provider Alliance

Provider Alliance Board

Provider Alliance Partners Group

Purpose:
The purpose of the NCL Provider Alliance is to create a membership organisation where members work together to improve health value (health life expectancy/ costs) for the population we collectively serve; by improving the quality and reducing costs of health services for patients / service users / residents and staff above and beyond what each member organisation could achieve working on its own.

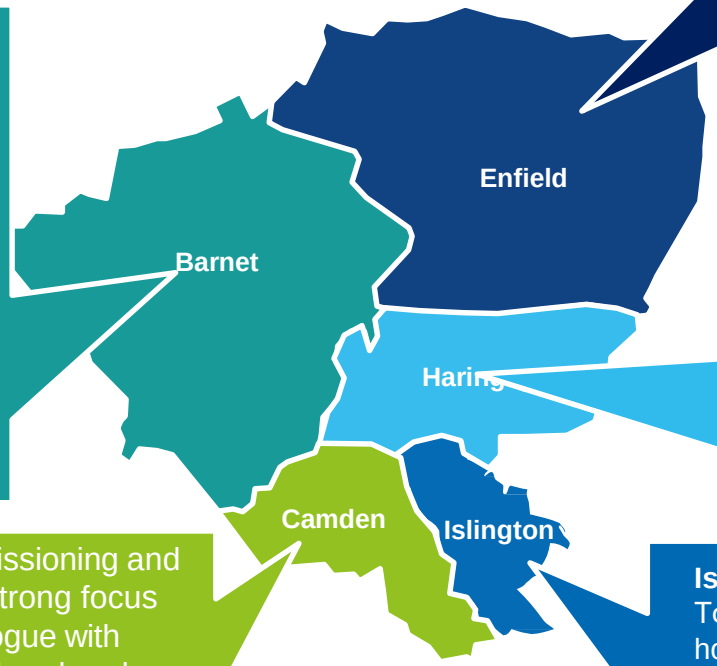
Borough Partnership and provider collaborative priorities align with our overall ICS vision

Our five Borough Partnerships (ICPs): Key Features

- Partnerships are maturing locally. COVID and the acceleration of the ICS has furthered existing partnership working.
- Place-based leaders are working together to shape the ICP role, priorities, local structures & teams and ways of working.
- There are common features, but local nuances within each partnership.

Barnet – partnership accelerated in last 18 months. Significant NHS engagement plus strong community and co-production focus and local govt leadership. Older population gives rise to focus on proactive care, same day urgent care and support to remain independent. Strong focus also on MH & Dementia and CYP, as well as developing a 'Neighbourhood' model.

- 425,395 registered population
- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs
- Chair of Exec: rotating (CCG, Council, Barnet Hospital, GP Federation)
- Co-chairs of ICP: Dawn Wakeling (DASS), Colette Wood (CCG Director of Integration)



Enfield – Newly formed partnership. COVID has helped accelerate integrated working. Priorities have been expanded from an initial focus areas following success around flu and Covid vacs. Provider Integration Partnership oversees delivery.

- 425,395 registered population
- 10 'organisations' represented (25+ members of delivery board)
- 4 PCNs (not geographical – neighbourhoods within @ 50k)
- Chair Exec: Binda Nagra and Dr Chitra Sankaran
- Co-Chairs of ICP – Mo Abedi BEH and Alpesh Patel Enfield GP Federation

Haringey – established and ambitious partnership with strong relationships. Focused on expansion of community based care models, MH, wider determinants and inequalities and a local strengths based approach that also addresses risks driven by deprivation.

- 298,418 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs
- Chair Execs: Zina Etheridge, Siobhan Harrington
- Chair of ICP: Rachel Lissaeur (Director of Integration)

Camden – long partnership history with integrated commissioning and partnership development of integrated delivery models. Strong focus on CYP, MH, citizen's engagement/coproduction and dialogue with families and communities, as well as a developing Neighbourhood model. New areas of focus include accelerating provider developments at PCN and borough level and connecting with local communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of ICP/8 PCNs)
- Chair Exec: Martin Pratt, Deputy Chair Kate Slemeck
- Chair of ICP: Graeme Caul, CNWL

Islington – active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (including police, fire, housing). Senior leadership from Islington Council and CCG. Emphasises joint commissioning, operational joint working and expansion of neighbourhood level delivery. New Delivery Board established to drive key workstreams:

- 257,135 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs
- Chair Exec: Dr Jo Sauvage (CCG), Cllr Kaya Comer-Schwartz (Leader)
- Co-Chairs of ICP John McGrath (CCG GB) and Stephen Taylor(Islington Borough)

Summary – Borough Priorities at a Glance

All five partnerships:

- **Shift to proactive care (early intervention and prevention)** – partnerships are focused on how they can make the move to delivering more proactive care through the use of population health management tools (e.g. risk stratification, case management, etc).
- **Inequalities and deprivation** – all boroughs are gathering data related to inequalities are working towards addressing them as part their priority areas of work.
- **Cross-sector workforce planning and skills development** – partnerships have identified the need to develop collective workforce plans.
- **Supporting care homes/providers**– all partnerships are focused on providing enhanced and integrated support to care homes and their residents
- **Digital inclusion** – partnerships have acknowledged the need to emphasise digital inclusion and learn from resident experiences related to the use of technology over the pandemic.
- **Vaccinations and Immunisations** – partnerships are working together to deliver COVID vacs and delivered and highly successful flu campaign.

Development of Place-Based Partnerships

The story so far

- NCL has **5 established mature Borough Partnerships** that continue to co-create and develop priorities aligned with their local needs and ICS ambitions
- Each partnership has deepened during COVID with local relationships and partnership working underpinning the COVID response and vaccine programme.
- Primary Care (general practice), local authorities and community-based providers have played a key role as community leaders and have a deep and rich understanding of their communities.

Recent progress

ICPs **regularly review and refresh priorities** – the work programme for the local partnerships is growing and **teams supporting are being formed from across the partners**. NCL partners have **cosponsored a programme of design and development**, providing some external support and challenge as place-based partnerships:

- Develop ways of working post COVID and in the context of the ICS (developing the approach at neighbourhood, place and system)
- Articulate the role Place-Based Partnerships want within an ICS (practically focused, shared narrative) and consider how we operate across the interface between system and place
- Agree the individual and collective responsibilities each NCL partner should have at place level
- Consider the accountabilities each partner in a place-based partnership has to residents/patients, staff, each other and the system/ICS and the different identities people might have in this regard
- Agree the contributions required from each partner to make the partnership 'real' day to day (shared commitments and individual contributions e.g. skills, expertise, capacity, resource)
- Identify areas it would be helpful to work on cross-borough / as a group of ICPs and with the ICS leadership. Our **Local Care Forum** provides a space for ICP leaders to come together, share learning and influence the development of local care in NCL

We are also delivering our new **Inequalities Fund** – with initiatives shaped by local partnerships to address inequalities & resource weighted towards areas of greatest deprivation (top 20%)
We will build from our **Community & Mental Health Strategic Reviews** to determine how well the needs of our local population are met in each borough and neighbourhood
We will work with NHSE/I to **assess the implications of the new System Oversight Framework for place-based arrangements.**

Next steps

- Continue to work with NHSE/I to better understand the implications of delegation of accountability and work with Place Based Partnerships to transition into increased accountability and decision making.
- Continue engagement with borough partnerships, local authorities and local teams to determine a formal role in ICS priority setting, working to the principle of subsidiarity but with coherence across our system

Our provider alliance

As part of our commitment to becoming an ICS, **NCL has established a single multi sector alliance of 14 members**

Purpose

To be the principle vehicle for service delivery in NCL.

Collaboratively seek to improve:

1. **Quality**
2. **Cost effectiveness**
3. **Resilience**

Governing objective: we exist to improve health value (healthy life expectancy/ costs) for the population we collectively serve; we do this by improving the quality and reducing the cost of health services above and beyond what can be achieved by partners working on their own.

Scope

The scope will cover health services, education and research.

The focus will be on both physical and mental health needs and consider whole pathways, working with other partners, from prevention through to complete tertiary treatment to address health inequality and access to treatment and care.

Members

- NCL GP Alliance
- Barnet, Enfield and Haringey Mental Health Trust
- Camden and Islington NHS Foundation Trust
- Great Ormond Street Hospital
- Moorfields Eye Hospital
- North Middlesex University Hospital
- Royal Free Hospital
- Royal National Orthopaedic Hospital
- The Tavistock and Portman NHS Foundation Trust
- UCLH
- Whittington Health NHS Trust
- Central London Community Healthcare Trust
- Central and North West London Foundation Trust
- University College London

Initial priorities

Waiting times: Work together to radically increase the pace of addressing NCL's waiting list challenge and substantially reduce the risk of poor outcomes for patients.

Workforce: Improve the morale, effectiveness, efficiency and inclusiveness of our combined workforce through shared sector-level initiatives which complement work at individual partner level.

Research into Action: Work to champion, facilitate and expedite translation of research into consistent change in practice and generate new research findings, above and beyond what individual partners and UCLP already deliver.

Lead roles: Map out the short, medium and long term programme for devolving to partners lead roles for providing, coordinating and supporting services on behalf of the wider alliance where that reduces costs and increases quality; start proof of concept and benefits by getting going in a few areas.

A multi sector alliance for North Central London, that models collaboration, joint accountability, person-centred care and an outcomes focus throughout our system.

Finance as a critical enabler to build accountability and ensure sustainability of our systems

The underlying financial position of the NCL ICS remains unsustainable

- Pre-Covid, the NCL system had a significant gap between available funding and underlying costs, with deficits (some sizeable) in most NHS organisations, additional pressures in local authorities and challenges in primary care. This gap and these challenges will return when we exit the Covid financial regime.
- We have a responsibility to work together as a system so that we spend the “NCL pound” where it is most needed, taking full advantage of the excellent organisations and brilliant leadership we have across the ICS.
- It is therefore important that we work together across all parts of the system including NHS providers, NCL CCG, primary care networks and local authorities to:
    - ensure strong short-term financial control, governance and accountability
    - have a strategic plan to achieve financial sustainability over the longer term whilst improving the care that is delivered to NCL residents and beyond and reducing inequality of access and health outcomes by aligning resource to where investment is most needed
    - acknowledge that all NCL partners have an important role to play in moving towards system financial sustainability and living within our means
    - help shape and inform the role that ICSs will have in funding for specialised services to ensure that these remain a key part of our financial strategy.

Scope of Our Strategy

Our financial strategy primarily focusses on NHS organisations – particularly those whose financial performance forms part of the overall ICS financial performance that we as an ICS are held to account to. However, the system financial principles (such as making decisions based upon system cost) stretch beyond NHS organisations and into primary care, local authorities and other partners, in support of the overall strategy to reduce health inequalities, invest in prevention and out of hospital services, and work across organisational boundaries to improve care pathways and overall value.

Overall financial strategy and vision

We have agreed the following top priorities for NCL's financial strategy, underpinned by principles for how we will work together. These have been agreed and endorsed through NCL organisations' boards and work in support of the financial principles described later in this document.

1. We are focussed on improving the health of the population in North Central London within our available resources
2. We will address health inequalities across the sector and within our boroughs as a priority
3. We will maximise what we do locally in North Central London

The way we work

- We will focus on the benefit to the system, not on the impact to the individual organisation
- We will ensure no individual organisation loses out for doing something in the benefit of the wider system
- Strong clinical and operational engagement in everything we do
- Close working with primary care and with local authority partners
- Shared acknowledgement that system working will be required to address the challenges we face
- We will be open and transparent with each other, sharing data and financial information
- We will implement joint planning and more standardised processes across the system
- We will hold each other individually and jointly accountable for system sustainability
- We will focus on reducing the cost of service delivery, not income generation

Agreed NCL ICS Financial Principles

- For an integrated care system to work successfully it is essential to ensure strong financial governance and accountability – it is necessary for all working in the system to always think in terms of overall system impact, but this is insufficient and may lead to loss of financial control if we are not also clear what we expect from each part of the system.
- NCL ICS brings together 15 NHS organisations, primary care networks and five local authority partners to work as a system to the benefit of the population we serve. This level of collaboration is a new way of working and requires a new set of behaviours.
- Additionally some of the regulatory frameworks, as they currently stand, are not conducive for individual organisations to work in the interest of the whole system, as this is sometimes against their own individual benefit.
- NCL organisations have agreed financial principles that we will follow to encourage joint working between organisations within the system, which are designed to ensure that organisations are financially better off by acting in the overall system interest.
- In doing so these principles seek to **avoid** the need for Boards to act in a way that is against their own individual benefit in order to do the right thing for the system – the overarching principle is that contracts between organisations within the system should not have financial barriers to organisations acting in the best interests of the system as a whole.

Four key principles

1. **Provider to provider arrangements** – gain share arrangements to ensure no individual provider is disadvantaged from doing what is in the benefit of the system.
2. **Reductions in activity through removing secondary care demand** – recognition that activity reductions will lead to reasonable stranded costs within providers which will need to be funded.
3. **Change in model of care** – principles for sharing the benefit of new models of care.
4. **New ICS investments** – guiding principle that ICS investments should generate a system financial saving.

Our journey towards shared financial accountability and sustainability

The story so far

- **Strong established Chief Financial Officer (CFO) Community –** weekly CFO meetings and good engagement from all organisations including those in neighbouring ICSs that provide community services to NCL.
- Established **ICS Finance Lead**.
- System working to **agree distribution of System Funding.**

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Recent progress

- Agreed **ways of working and financial principles** across NCL organisation Boards.
- Establishing a clearer **ICS finance leadership team.**
- System working to develop an ICS Financial Strategy and position through an NCL Finance and Oversight Committee with representation from NCL Trusts and CCG.
- **Establishment of the NCL Inequalities Fund,** top sliced from system allocation with agreement that this should be recurrent and incremental

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Next steps

- **Continue to build and develop ICS finance function** ,ensuring there is a pool of resource to support the work of the three pillars:
    1. Finance as an enabler of system working
    2. Finance support to programmes of work
    3. Strategic plan towards financial sustainability.
- **Engagement with Trust Boards, CCG GB, Heads of Finance**, dedicated workshops to continue to embed financial strategy.
- **Review specialised commissioning** and document an agreed approach.
- Continue to **integrate a population health based approach to finances.**
- Working with **wider system partners** to develop a whole-system view to finances.

Our Plan for Transition

To prepare for our transition to an ICS, NCL has established a dedicated ICS Transition team lead by an Executive Director of Transition.

Over the next nine months, NCL will continue to build on past experience of system working, and our strong partner relationships at both borough and system level to:

- Prepare for statutory changes in line with emerging guidance from the White Paper and ICS Design Framework, working towards establishing a shadow form of ICS Governance by Q3 *(slide 41)*
- Ensure we continue to engage with our residents, system partners and staff as we progress key areas of system development *(slides 42 – 45)*
- Support a culture of system working through focussed organisational development (OD) interventions at system, place and borough level *(slide 46)*
- Support all CCG staff affected by the organisational changes, through our HR Transition Framework *(slide 47).*

NCL Transition Plan in line with national milestones

PRG-Programme Team, HRT- HR Transition, FGA-Functions, Governance and Accountability, FF-Financial Framework

Updated for ICS Design Framework 16 June: Please note: still subject to national changes

		Milestones	April '21	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan '22	Feb	March
PRG	1.	System Development Plans												
HRT	2.	Designate board level recruitment												
HRT	3.	Other executive roles recruitment												
HRT	4.	Remaining key ICS role recruitment												
HRT	5.	CSU in housing												
HRT	6.	CCG staff formal TUPE consultation												
HRT	7.	All CCG & staff in scope transferred to ICSB												
FGA	8.	System Oversight Framework MoU												
FGA	9.	ICS partnership board arrangements												
FGA	10.	Implement statutory guidance on safeguarding /public involvement												
FGA	11.	Develop provider collaborative arrangements												
FGA	12.	ICS constitution (based on model) & related governance / op model												
FGA	13.	ICS body MoU agreed												
FF	14.	Property/estate transfer to ICS – legal docs signed												
FF	15.	Develop financial framework, post guidance release												
FF	16.	Agree delegation to place and provider collaboratives												

NHS Body Chair and Chief Exec confirmed

Update of November Plan. To be reviewed every quarter between now and April 2022

Clinical Leadership to be incorporated as part of board level recruitment

First Partnership Council in June 2021

Draft proposed new ICS NHS body MoU arrangements for 2022/23

The activities and plans local work will be tailored around these national milestones

Key areas where we are working together with partners to develop

Area	System forum	Working with…	Example questions to explore with partners…
The impacts and benefits of becoming an ICS	ICS Steering Committee	• ICP meetings • LA meetings • CCG Governing Body • Trust boards	• What does the change to a statutory ICS mean we could do differently for residents to improve outcomes/reduce health inequalities? • What does this mean to your organisation – what would work differently? • What changes are needed between now and April 2022 to get us closer to our vision?
NCL's Population Health & Inequalities Strategy	NCL Population Health and Inequalities Committee	• Local Care Forum • ICP Meetings • NCL Finance Groups	• How should we adapt to embed a population health approach? • What are the key areas of variance in outcomes across NCL? • Where are the common areas we should work together? • What might we do at a borough level? • What should we do as a system over the next nine months to embed a Population Health Approach?
Principles for collectively agreeing priorities at a place level	ICS Steering Committee	• NCL Population Health Committee • Local Care Forum • ICP Meetings	• How will each place / borough partnership agree priorities? • How do we work to the principle of subsidiarity? • What should the interface between ICS and ICP priorities look like?
Impact of system oversight framework	System Recovery Executive	• System Recovery Executive • Trust Boards • ICP meetings • NCL Finance Groups	• Do we have transparency of process, shared accountability and joint decision-making? • How do we continue to embed that across the system? • What is our approach to aligning system-wide operational and strategic plans?
ICS Financial Framework	NCL Finance Groups	• NCL Finance Groups • NCL Population Health and Inequalities Committee • ICP Meetings	• How do we best spend the NCL pound? • What is our plan for sharing financial risk and opportunity? • How do we balance system financial sustainability with organisational sustainability?
Clinical Leadership Development	NCL People Board	• NCL People Board • NCL Clinical Advisory Group • CCG Governing Body • Trust boards	• How do we establish appropriate clinical and professional leadership? • What is the role of leadership within system, place and provider collaboratives? • What is our approach to achieving multi-professional leadership including primary care and speciality representation?
Role of Strategic Commissioning	CCG Governing Body	• CCG Governing Body • Local Care Forum • ICP Meetings	• How can strategic commissioning lead to better outcomes for our residents and patients? • What changes are needed in the way we engage with local authorities and other system partners? • What additional skills and competencies should commissioners have to embed a strategic commissioning approach?

Next steps towards engaging with partners on the System Oversight Framework

The story so far

- NCL **submitted a system response to the System Oversight Framework consultation on behalf of the CCG and ICS** after review by the CCG Executive Management Team and ICS Leadership on 14 June 2021 with a few additional comments and questions including:
  - A **suggestion that the framework for 2021/22 should be as simple as possible**, with measures consistent with the NHS Long Term Plan and existing oversight measures as far as possible.
  - Questions about **how NHS E/I will work with CQC, and other regulators** to provide a framework that covers the four fundamental purposes for establishing an ICS.
  - Questions about **how the oversight model could be used at place level in NCL borough partnerships.**
  - A suggestion that the focus of the oversight model should **be on end-to-end pathways and include measures of primary care resilience over and above the previous oversight framework.**

Next steps

- NCL will continue to engage with NHS E/I to work through the implications for development of the System Oversight Framework.
- We have an agreed oversight framework in NCL, with a risk-based approach to quality and performance oversight at a system, place and organisational level. The oversight model has an emphasis on inequalities and wider determinants of health including all organisations' role in the ICS as an anchor institution.
- Next steps for the NCL oversight model will be to:
  - Embed our system Quality Board and Quality Surveillance Groups.
  - Work with Trusts to agree their risk-based level of support (routine, targeted, or enhanced).
  - Work with system partners to develop place-based oversight within our model.
  - Linked to the above develop clarity on transparency of process, shared accountability and joint decision-making.
  - Develop the NCL model for 2022/23 in light of ICS legislation and London/national oversight model.

Next steps towards establishing a system-wide Clinical Leadership Framework

The story so far

- NCL's **Health and Care Cabinet** – comprised of cross-sector clinical leadership – supported system decisions and provided clinical review and scrutiny to our initial plans as an STP.
- A **comprehensive, independently led review of clinical leadership** in 2019/20 helped inform the **role of GP clinical leadership in NCL CCG Governing Body and boroughs.**
- Clinical roles have been established in the **emerging ICS leadership.**
- **NCL CAG (Clinical Advisory Group**) played a crucial role in providing clinical oversight and scrutiny to decisions during the pandemic.
- At the borough level, **clinical leaders continue to work with ICPs to help establish priorities.**
- NCL has also progressed towards developing **clinical networks** (orthopaedics, ophthalmology, ENT, gynaecology, general surgery, urology alongside dermatology- all at different stages of maturity) to support key clinical needs of our population.

Recent progress

- Commenced a comprehensive **programme of listening and engagement** to help inform the next phase of clinical leadership in NCL, both at system and place level.

Next Steps

- Wider **engagement around the role and competencies for system clinical leadership in NCL,** to include current clinical leaders (including GB members), NCL People Board, social care, secondary care clinicians, dentistry, optometry, pharmacy and specialist services, and deploy one-to-one interviews as well as forums such as the Local Care Forum, Borough Partnership Boards etc.
- Feedback from engagement sessions to inform **transition to new system-wide and place-based clinical leadership driven by local needs of our population.**
- Ensuring a **minimally disruptive transition for current clinical leadership.**

Next steps towards embedding strategic commissioning

The story so far

The aim of NCL Strategic Commissioning has been to assess population needs and to develop plans to prioritise resources to address these needs in line with our priorities for local people. This includes a key focus on addressing inequalities of access to care as well as variation in outcomes for local residents. The role of Strategic Commissioning will be developed further through enhanced engagement with our NCL CCG staff and system partners.

Core purpose and functions

- Lead the development and implementation of a population health strategy that embeds integrated and person-centred care for all population cohorts, based on an ICS wide outcomes framework
- Integrated urgent care/London Ambulance Service (LAS) transformation, commissioning and contracting.
- Development of new forms of contracting for ICPs and NCL ICS that deliver ICS outcomes and address inequalities.
- Strategic commissioning programmes for acute, mental health and community, including urgent care, for example, maternity, stroke, urgent community standards and Think 111 first.
- Contracting and contract management of CCGs contract portfolio
- Learning disability and autism programme.
- Development and implementation of the strategy to support specialised commissioning delegation to the ICS

Strategic commissioning responsibilities

1. Undertake key strategic commissioning reviews across NCL (Community Services; Mental Health; and Children, Young People, Maternity and Neonatal Services).
2. Embed and deliver the commissioning pipeline.
3. Tackle health inequalities and strengthen the system approach to population / place-based health and care management.
4. Joint commissioning arrangements with NCL Councils
5. Embed robust approach to complex individualised commissioning and deliver the continuing healthcare recovery programme.

Current Strategic Commissioning Programmes:

- ✓ Transformation of Community Services (including the Community Services Review).
- ✓ Urgent and Emergency Care Transformation and Redesign.
- ✓ NCL Transforming Care Programme.
- ✓ Planned Care Transformation.
- ✓ Supporting Integrated Care and personalised care
- ✓ Strategic review of borough contracts.
- ✓ Due diligence of contracts in advance of ICS transition.

Next Steps

- Continue to engage with borough partnerships, commissioners, community and mental health providers **on the outcomes of the community and mental health commissioning reviews, and in conducting a primary care commissioning review.**
- Continue to engage with commissioners, partners and local authorities to establish:
  - How can strategic commissioning lead to better outcomes for our residents and patients?
  - What changes in the way we engage with local authorities and other system partners?
  - What additional skills and competencies should commissioners have to embed a strategic commissioning approach?

We Are Working on a Series of OD Interventions at Neighbourhood, Borough and System Level to Support System Development

Focus area	Timeframe	Scope	Intervention	Level
ICS System leadership development	Start in May 2021 12 Months	NHS & LA CEOs, clinical leadership (primary and secondary care), lead finance director, lead HR director supported by ICS Transition Director	• 'On the job' space for reflection and learning to adopt, adapt, abandon ways in which we are making decisions, solving problems, and leading change programmes • Using existing forums for more reflective discussion • Additional interventions in development	System
Development of place and neighbourhoods	May - September 2021	CCG staff, and Five borough-based teams (with dotted lines for joint commissioning), plus 'hub and spoke' team arrangements - 400 staff in our organisation (from Band 3 to Band 9) plus approximately 80 clinical leads, Governing Body members and Executives.	Mix of large and small group work, consider the need for interviews, drop in sessions, surveys, and consider a blend of OD and practically focused events/workshops. Sessions may need to be held within and across boroughs	Place
OD in primary care	TBC June	CCG heads of primary care and NCL team	A workshop to work through how we best resource these priority areas, while managing BAU in primary care in borough teams	Neighbourhood
Ongoing CCG OD linked to Staff Survey results	April 2021- April 2020	CCG Staff	Range of activities from developmental to insuring key process are in place across the CCG	System (focussed on CCG staff)
OD support to the NCL People Board	May - September 2021	People Board members	Structured interviews, observations, group session, individual and board development plans	System (focussed on Trust staff)

Our HR Transition Priorities

Transition Management

- There will be a requirement for seamless transitional arrangements for services and staff who feel engaged and supported in all areas of the transitional process
- Management of risks relating to the workforce will be regularly monitored, reported to appropriate Board's and action taken to remedy as appropriate
- Business continuity to ensure stability of service delivery

Staff Satisfaction/Engagement and Wellbeing

- Develop and deliver collaboratively with staff, staff survey interventions and action plans to support staff feeling valued and listened to
- Partnership working with staff side colleagues
- Effective communication/team time to enable engagement and involvement in service changes
- Promotion of the positive elements which affect staff whilst facing challenges during transitional period e.g., Training and development opportunities, flexible working.
- Appraisals to assist in clarity of role and contribution to the organisation
- Promotion of Equality and Diversity and the health and wellbeing of staff
- Continue and further develop a robust Health and Wellbeing Programme

Retaining Talent/Supporting Staff Through Transition

- Staff to access co-design workshops to identify how working in an ICS will need to be different
- Identify what support is needed to adapt to new ways of working
- Roll out "lunch and learn" programmes to support staff development
- Embed and monitor appraisal process during transition to ensure staff have clear objectives and development plans to support career development
- Continue to further develop staff briefings to enable effective two way communications with staff
- Develop and circulate regular FAQ's to support staff engagement and alleviate uncertainty

Capacity Planning

- Support Executive Directors and Directors in undertaking effective workforce planning skill to ensure sufficient capacity and capability
- Adopting new technologies which support more efficient/new ways of working
- Understanding staff turnover and vacancies in the local system economy to consider potential career opportunities for existing employees
- Regular monitoring of sickness absence rates to ensure appropriate capacity is maintained and staff feel supported
- Increased flexibility of workforce via agile working arrangements
- Regular monitoring and updating of all Structure Charts to ensure openness and transparency
- ESR data cleansing process to be regularly monitored to enable robust workforce planning processes

Our Progress is Supported by Key System Enablers

- An established **Workforce programme** responsible for the NCL People Plan, Workforce, Vision and Mission that underscores our commitment to building a best in class workforce, and our focus on staff wellbeing and enrichment- *Slide 49*

- An approach to support and **accelerate the delivery of strategic estates priorities**, to focus on both system and project delivery and by so doing, influence and shape organisational development as the ICS and the borough-based integrated care partnerships, and enable PCNs to gain definition- *Slide 50*

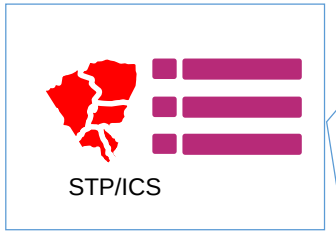
- A well developed **Digital Programme** with a focus on enabling single care record for each patient in NCL with the help of **HealtheIntent** and supporting digitisation at place and neighbourhood level through the Digital First programme - *Slide 51*

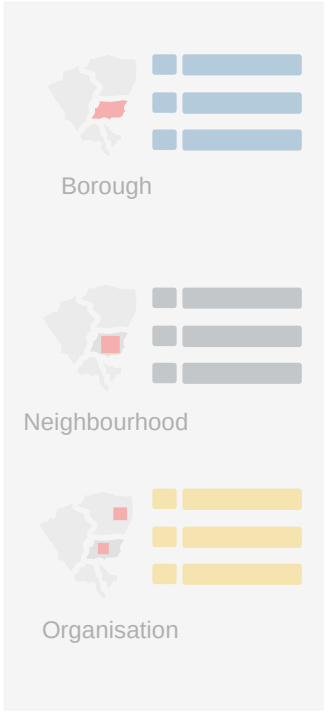
- Agreed principles and shared language around **mutual aid** to support system recovery and staff wellbeing- *Slide 52*

NCL Workforce High-Impact Priorities

Our developing ***North Central London ICS vision*** *for workforce is for* ***our community to receive high quality health and care services delivered by a representative and diverse workforce. A workforce where people are supported to achieve their full potential in an inclusive and compassionate environment free from discrimination.***

Responsibility level of People Plan actions





Our identified NCL Workforce high impact priorities are aligned with the London and People Plan priorities

NCL high–impact priorities	London priorities	People Plan Priorities
Retention		
1.Equality, Diversity & Inclusion	Caring for and celebrating our people	Looking after our people
2. Staff wellbeing & tailored programmes	Training and development for critical care	Belonging in the NHS
3. Talent management, progression and career pathways		
Recruitment		
4. Local workforce recruitment routes into health and care employment	Attracting people into the NHS	Growing for the future
5. Workforce planning and modelling based on population	Sustaining and growing nursing	
System change		
6. Working with & across sectors & NCL People Board	Enhancing medical education	New ways of working and delivering care
	Ensuring productive working across London	Supporting our NHS people for the long term

Responding to new challenges and opportunities

Additional details of NCL People Plan available on request

NCL Estates Priorities 2021/2022

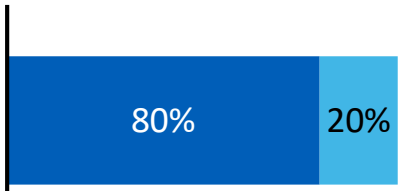
We reviewed and updated our Estates priorities to reflect our learning during COVID, progress made and progress needed. Our workstreams will pursue key themes for the estate.

Our areas of focus for the next 12-18 months

- Estates Locality Planning Phase 3 – estate for local care services
- Supporting the ICS's ongoing response to COVID-19
- Supporting the renewed focus on health inequalities and the wider determinants of health
- Supporting the development and delivery of our strategic projects and identifying additional funding needed
- Updating our process and criteria for prioritising investments
- Closer working between Estates, Digital and Finance
  - Implementing NCL financial principles in (pilot?) projects
  - Incorporating digital and finding the balance for service delivery
- Continue our productive relationships with strategic estates partners:
  - One Public Estates partnerships
  - NHS Property Services
  - Community Health Partnerships
- Supporting the transition to an ICS
- Using the tools and approaches developed by NCL and London to support robust scheme development and oversight
- Playing an active part in London Estates and Infrastructure devolution
- Remaining a key conduit on Estates matters with national partners

Additional details of our plans submitted to NHSE/I as part of our Estates Strategy

Current Digital Progress & Future Plans

Digital Programme	Funding Status	Overview	Progress
HIE Shared Care Record		HIE shared care record provides access to real time or near real time information to the care team at the point of care to optimise care delivery. Currently, there are 194 GP practices, BEHMHT, CLCH, CNWL, Royal Free and Other London Cerner Millennium acute providers contributing to HIE.	*See slide 52*
HealtheIntent Population Health Management	*This is subject to finance approval of the remainder of the submitted business case	HealtheIntent Programme provides near real time normalised and standardised data from health and social care providers to support more proactive direct care and population health management through a range of registries and dashboards.	*See slide 53*
Digital First[1]		Digital First is a Four Year NHSE/I funded Programme that helps to pilot and scale digital innovation in Primary Care. Programme funding is for primarily for change management to enable the development of digital maturity.	*See slide 54*

The progress of each one of the projects is based on initial scope defined at the funding stage and additional extensions secured to that.

Additional details of NCL Digital Strategy Available on Request

[1]Digital First is primary care only programme

HIE Shared Care Record

	Progress[1]	Planned[2]	Future Potential[3]
Programme Scope	**NLP HIE record contributors:** • BEHMHT, CLCH, CNWL, Royal Free, LCW • 194 NCL GP practices (all boroughs) • NEL, SEL, SWL GP practices with connection to the MIG • Other London Cerner Millennium acute providers (Barts Health; Croydon; Homerton; Kingston; Lewisham & Greenwich; St George's) • Camden & Islington, North Middlesex, UCLH, Tavistock & Portman **NLP HIE record viewers:** • BEHMHT, CLCH, CNWL, Tavistock & Portman, Royal Free, UCLH, NMUH, Moorfields, North London Hospice, Marie Curie Hospice • 102 NCL GP practices (Barnet, Enfield & Islington) • London Boroughs of Camden, Enfield & Haringey. • LCW (111 and Out of Hours) • Users of NEL, SEL and SWL HIE record (GP and Royal Free data only) • Councils of Haringey & Camden	**Planned HIE record contributors:** • GOSH • Councils of Barnet, Camden, Enfield, Haringey & Islington • Moorfields • North London Hospice • RNOH • Whittington Health **Image exchange** • NMUH, Royal Free, UCLH, Whittington involved in One London PACS to PACS and HIE image exchange project planned for October to December 2020	• Other NLP **hospices** • **Care Homes** • **Community pharmacists** • **Community optometrists** • Other **London organisations** able to contribute via One London hub • **Coordinate My Care** • **HSL Lab Results**

[1] Completed up to date of the writing of the report
[2] Planned refers to work defined in the scope of this funding cycle
[3] Future Potential refers to Programme scope and what can be achieved beyond progress and planned, quantifying monetary and non-monetary benefits could not be identified at this stage of the analysis

Population Health Management

	Progress[1]	Planned[2]	Future Potential[3]
Programme Scope	**Data onboarding and testing** • GP practice data (all 5 boroughs) onboarded and tested • Royal Free and Moorfields. **Whole Life Registries** • AF, COPD, diabetes, CYP asthma registries released • New registries - measures scoped by NLP and in development by Cerner (Early Years, CAMHS, Autism and Carers, End of Life Care, Frailty, Adults with SMI, Cancer in primary care, Dementia, Learning Disabilities) **Analytics Dashboards** • Quality Improvement : AF, COPD, diabetes, CYP asthma Case Finding: Frailty • Population Health needs and inequalities • Population Health Interventions: Childhood Immunisations, Flu and Covid vaccinations. • Covid: Transfers of care, Hospital Discharges	**Data onboarding and testing** • Onboarding, linkage, standardisation, normalisation and testing of datasets from all 12 NHS provider Trusts and 5 Local Authorities • BEH/C&I, NMUH, UCLH, • LAs (ASC) • Plans to onboard adult and children's social care datasets into the analytics data warehouse **Whole Life Registries** • Implementation of new registries (Early Years, CAMHS, Autism and Carers, End of Life Care, Frailty, Adults with SMI, Cancer in primary care, Dementia, Learning Disabilities) • SMI physical health checks registry, LD physical health checks and living after cancer. **Analytics Dashboards** • SMI, LD and cancer QI dashboards • Elective Recovery • Critical Care • Poorly Controlled Long -Term Conditions • Medicines Optimisations, Diagnostics System utilisation	**Data onboarding and testing** • Further scoping to be completed once the current programme deliverables are met **Whole Life Registries** • Going through a reprioritisation exercise following Covid-19, with other registries being scoped and prioritised based on ICS system needs. **Analytics Dashboards** • Based on ICS system needs and priorities new registries and dashboards will be developed beyond the ones already planned.

[1] Completed up to date of the writing of the report
[2] Planned refers to work defined in the scope of this funding cycle
[3] Future Potential refers to Programme scope and what can be achieved beyond progress and planned, quantifying monetary and non-monetary benefits could not be identified at this stage of the analysis

Digital First

	Progress[1]	Planned[2]	Future Potential[3]
Programme Scope	**Online Consultations (OC) and Video consultations (VC)** – 100% of GP Practices implemented solution. Enfield Borough highest users. **Digital Social Prescribing** – Barnet (case management software mapping requirements) and Enfield (open data standards across main Directory of Service providers) pilots. **Care Homes** – scoping the areas of priority by doing the digital maturity survey. **PCN development** – scoping training offer with NCL training hub for primary care digital pathways	**OC / VC -** increasing adoption and utilisation for 2021/22. **Digital Social Prescribing –** completing the phase 1 of pilots to implement across all NCL boroughs. **Care Homes –** Upscale remote monitoring to 100 Care Homes (50% coverage). Scope proxy access. **PCN development –** developing clinical and non clinical **d**igital champions to support new ways of working and sustainability	**OC and VC** – algorithm based solutions, more sophisticated products. Determined by the national priorities – annual basis, second cycle of planning. **Digital Social Prescribing –** Integration with NHS App and One London PHR programme. **Care Homes** – Further scoping to be completed based on results of the survey. **PCN development -** Further scoping around working in a hub model.
Monetary and Non-monetary benefits	Digital First funding is available to pump prime innovation, pilot and scale solutions and approaches, with change management as the golden thread. Monetary benefits are not required to be quantified as part of the Digital First Programme. Non-monetary benefits which are expected by implementing the whole portfolio of programmes are • helps to free up phone lines through providing online alternative, • improving patient pathway by creating a digital access point, • patient choice, • facilitate prioritisation of care and provides more time to GPs in face-to-face appointments • and enhancing the patient experience. Specific benefits per programme are: **Online Consultations (OC) and Video consultations (VC)** – patient access and choice **Digital Social Prescribing** – creating open data standards, so that social prescribing can be done in a digital way. Including the voluntarily second and social care as part health and care offer to patients (holistic care) **Care Homes** – understating the baseline digital maturity, so that we can address the gaps **PCN development** – helping new ways of working for the primary care networks and workforce resilience		

[1] Completed up to date of the writing of the report
[2] Planned refers to work defined in the scope of this funding cycle
[3] Future Potential refers to Programme scope and what can be achieved beyond progress and planned, quantifying monetary and non-monetary benefits could not be identified at this stage of the analysis

Defining Mutual Aid in NCL

There is opportunity, through working collectively as the NCL system, to review whole patient pathways from point of referral through to treatment to ensure that referrals are appropriate, waiting times are optimised and the potential risk of clinical harm to patients is minimised.
NCL providers are working together to ensure patients prioritised for elective treatment receive this in a timely and equitable way, as well as to help trusts with large backlogs of long waiters to shorten overall waiting times for routine conditions during and post COVID-19 as part of elective recovery.

Defining Mutual Aid

Mutual Aid includes:

1. Temporary transfer of activity and/or resource to support reduction of long pathway waits across NCL
2. Planned care activity covered by Phase 3 priorities – elective inpatients, daycases, outpatients, diagnostics (CT, MRI, non-obstetric ultra-sound, endoscopy)
3. Planned arrangement by two (or more) parties within NCL
4. Sharing of ideas, processes and learning to embed sustainable practice across NCL

What Mutual Aid is not:

The Mutual Aid workstream has not been established to cover:

1. Normal transfers of inpatient care from one provider to another (including ICU/HDU transfers) where patient transferred from an inpatient bed in one organisation to another
2. Unplanned shifts in demand or activity (the Elective Incentive Scheme covers this for planned care)[1]
3. Independent sector transfers

[1]For example:

- A&E activity numbers going up at UCLH and down at RFL - there is no mechanism for this at the moment, assumed block funding cover;
- Ophthalmology daycases go up at Moorfields, down at RFL - EIS deals with this.
- The point being that we're not trying to shift money around due to random changes in flow of patients. Rather, for mutual aid we're just interested in deliberately stood up capacity from one to another.

List of Appendices Available on Request

- ✓ NCL Digital Strategy 2021-2022
- ✓ NCL People Plan Response 2021
- ✓ NCL Spring Elective Recovery Plan 2021
- ✓ NCL Estates Strategy 2021-2022
- ✓ NCL ICS Financial Strategy (draft) 2021
- ✓ NCL SOF Consultation Response- May 2021
- ✓ NCL Impact of Covid on Our Population- June 2021
- ✓ NCL Life Course Analysis by Borough 2021
- ✓ NCL Mutual Aid Principles

North Central London CCG
Strategy and Commissioning Committee Meeting
Thursday 15 July 2021

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Report Title	Strategy and Commissioning Committee Risk Register	**Date of report**	2 July 2021	**Agenda Item**	4.1
Lead Director / Manager	Sarah Mansuralli, Executive Director of Strategic Commissioning	**Email / Tel**		sarah.mansuralli@nhs.net	
GB Member Sponsor					
Report Author	Chipo Kazoka, Governance and Risk Lead	**Email / Tel**		chipo.kazoka6@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** This report helps the CCG to manage the financial implications arising from the strategic risks within the Committee's remit.			
Report Summary	This paper is the Strategy and Commissioning Committee Risk Register. It contains the CCG's most significant strategic commissioning risks. There are 11 risks on the Committee's Risk Register. Since the last Committee meeting there are 2 new risks, 1 risk has reduced below the Committee reporting threshold (of 12 or higher), and 1 risk has closed. The Risk Register can be found here. **Key Highlights:** **COMM8:** *Failure to Support System Financial Recovery through Contracts that are not shifting activity into out of hospital settings (Threat)*: H1 Guidance and our work on Recovery Plans as well as our bid for the Accelerator Programme all demonstrate the system's commitment to working together to reshape how care will be delivered in each setting across North Central London (NCL). This work will be further informed by the ongoing Strategic Reviews of Community and Mental Health Services whose outcomes we expect to start being formulated by September 2021. In the meanwhile, we await formal H2 21/22 Guidance on the new financial regime that will be put in place. Current Risk Score: 12 **COMM12:** *Inaccuracy of Provider Data (Data Quality) (Threat)*: The Integrated data dashboard (based on the integrated recovery pack) is now available and is being used in System Recovery and Operational Group meetings. The Mental Health and Community Services Reviews are both progressing with a key focus				

	being on data and the development of a consistent data set. In the meanwhile, we continue to await the H2 21/22 planning guidance. Current Risk Score: 12 **COMM14:** *Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat)*: A London-wide STP discussion on the current pressures and key drivers was held on Monday, 14 June 2021. Further NCL discussions are planned to be held at a summit which will consider the options that could be pursued in response to the significant growth in demand on Urgent Treatment Centres (UTC) and walk-in clinics. 111 activity has also increased significantly. Performance against call answering times and call abandonment rates has fallen over the last 3 weeks. Clinical validation of emergency disposition calls has also dipped. The issue has been raised with the CCG's Urgent and Emergency Care (UEC) Clinical Lead and as well as with its Quality Lead. Both have confirmed that this poses a low clinical risk as urgent patients will be diverted either to Urgent Treatment Centres (UTCs) or to Emergency Departments (EDs). On-call directors have also been informed of the issue should London Central West Unscheduled Care Collaborative need to escalate matters. Internal discussions, to consider interim additional funding whilst approval for the 111 business approved through the CCG's governance process, were initiated during the week commencing 14th June 2021. Current Risk Score: 12 **COMM16:** *NHS Acute Contracts for 21/22 (Threat)*: NHS Providers' Contract values for H1 21/22 were set centrally. In the meanwhile, we continue to progress the Accelerator Bid and manage our internal recovery. We still await guidance relating to acute contracts for the second half of the year (H2 2021/21) and will respond accordingly when this is issued. Current Risk Score: 12 **COMM18:** *Failure to have a single NCL CCG Fertility policy (Threat)*: The Scope of the Review and the Terms of Reference (ToRs) of the Review Steering Group were approved at the January 2021 meeting of the Strategy & Commissioning Committee (S&C). Due to the surge conditions and significant operational pressures brought on by the latest wave of Covid-19 cases, the S&C's January 2021 meeting made a decision to temporarily pause further work on the Review. Options for a 'restart' were presented to the S&C's March 2021 meeting which supported Option 1: Pre & post policy development engagement. Work on the Review was set to restart with revised timelines (and an engagement 'go- live' date was set for 10th May 2021). In the meantime, the 5 different fertility policies remain in place. Current Risk Score: 12 **STR1:** *Unsuccessful Delivery of NCL's Long Term Plan Transformation Priorities During the Covid-19 Response and Recovery Phase (Threat*): This risk recognises the additional strain on the system created by the response to, and recovery from, the COVID-19 pandemic and the likely impact of this on the delivery of our system transformation priorities as set out in the NCL response to the NHS Long Term Plan, as well as the transition to an Integrated Care System ('ICS').

	In recognition of the move to greater system working and the development of our ICS, reviews are underway to determine which transformation programmes are of the greatest priority for the system, how they can best be delivered, and who will lead them under the ICS leadership arrangements. The aim of this work is to focus programme delivery and clinical leadership resources on the transformation initiatives that: a) will have the greatest impact, and b) definitely require a programme approach to deliver. The areas requiring development align with plans to take forward system actions in the NCL system development plan. This aims to ensure the transition accelerates rather than distracts from the recovery of the system. Current Risk Score: 12 **STR5:** *Recovery - Capacity Challenges Associated with Recovery (Threat)*: As part of recovery, programmes are being established across the health system alongside plans to ensure continued response to the pandemic and potential third wave. NCL has been chosen as a national "accelerator" site which supports further investment in recovery work across the system. Current Risk Score: 12 **QUAL24:** *Failure to base the CHC Commissioning cycle and service on reliable data (Threat)*: An increased focus on data quality is being developed within this area of operation. Standardisation and training in new procedures will effectively manage this risk, once controls are embedded. Caretrack platforms have now been merged and the data cleansed, including the harmonisation of the rate cards. Further, historical practices are being managed as they will affect the maintaining of the cleansed data. Additional client groups' data is being added, including Mental Health, Learning Disability and Children and Young People. This data will also need to be cleansed in order to mitigate this risk. A further training programme will need to be established to support the ongoing standardisation of data entry This remains a high priority risk given the impact Data Quality has on broader CHC business, including ensuring patient care and effective back-office functioning. Current Risk Score: 16 **AO1:** *Failure to Establish Appropriate and Effective Arrangements for the New ICS Organisation at pace (Threat)*: NHS England published its ICS Design Framework Guidance in June 2021. However, we are awaiting legislation to be passed on the new ICS organisations and the accompanying guidance. Once this has been released, the Strategy Team will work with the Governance and Risk Team to develop proposals for the new organisation. A programme plan has been established to ensure smooth transition to the new organisation on 1st April 2022. An ICS steering group has been established along with a Partnership Council to help to deepen the relationships between ICS partner organisations and to start to help shape the strategic direction of travel with the first meetings having been held. Current Risk Score: 12

Reducing risk:

The following risk has reduced below the Committee threshold and will be monitored below that level:

COMM13: *Failure to Achieve NHS Constitutional Targets - Elective Recovery (Threat)*: Whilst the enforcement of constitutional targets remains suspended - due to the current phase of the pandemic - our recovery plans have taken an increasing focus on clearing backlogs, prioritising waiting lists (for those patients within the highest levels of clinical need) and recovering activity back to pre-COVID levels. This is expected to remain the key focus for 2021/2022. Further updates are dependent upon the publication of the H2 21/22 Planning Guidance, which is still awaited.

Due to the suspension of constitutional targets, the risk rating has dropped from 12 to 9 which is below the Committee reporting threshold. The risk will continue to be monitored by the relevant Director. Enforcement through penalties will not occur next year, but achievement will be rewarded through funding.

Current Risk Score: 9

Closed risk:

The following risk has been closed:

BP1: *Unsustainable Model of Care for Care Homes (Threat)*: This risk has now been mitigated through the introduction of the following controls:

- Identified support of Mental Health/Learning Difficulties settings, with a plan for ongoing monitoring and discussion;
- Local Care Home health priorities aligned with the Phase 3 recovery letter, an enhanced health in care home framework and 2021/21 operations plan and guidance;
- Programme of work and associated governance completed for CCG and Council;
- Medium and Long term commissioning plan finalised.

As such the risk is now closed.

New Risks
The following risks have been added to the Committee's Risk Register:

FIN10: *Failure to in-house the CSU within available time-frame (Threat)*: NHS England (NHSE) has not yet approved the CSU in-housing business case. The risk is increasing as time goes on and mitigating it will be difficult for as long as NHSE's approval of in-housing business case remains fixed to the 1st October 2021 timescale.

Current Risk Score: 12

COMM19: *Variation in Community and Mental Health Services across NCL (Threat)*: Due to historical funding differences across the 5 legacy CCGs there are variations to Community and Mental Health services within NCL CCG, with possible consequences for service access and effectiveness, health inequalities, and resource management.

	The CCG is undertaking Community and Mental Health service reviews. The Community Services Baseline Report was approved by at the Community Services Review Programme Board on 7th July 2021. The Mental Health Baseline Report is being presented to the Mental Health Services Review Programme Board on 21st July 2021. There is currently a number of workshops being held to further discuss and work out the core offer and these are due to be finalised at a workshop in early September 2021. Further to the review and its implementation, the CCG will establish an on-going monitoring programme for the outcomes of the review. Current Risk Score: 12
Recommendation	The Strategy and Commissioning Committee is asked to **NOTE** the report and provide feedback on the risks.
Identified Risks and Risk Management Actions	This paper assists the CCG to effectively manage the key risks to its strategic commissioning.
Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the CCG's Conflict of Interest Policy.
Resource Implications	This report supports the CCG in making effective and efficient use of its resources.
Engagement	The Strategy and Commissioning Committee Risk Register is presented to each Strategy and Commissioning Committee meeting. The committee includes clinicians, lay members, Community Members and other key stakeholders.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The risk register was last presented to the Strategy and Commissioning Committee in May 2021.
Next Steps	For the risks on the Strategy and Commissioning Risk Register to continue to be monitored robustly with control actions to mitigate enacted as appropriate.
Appendices	The following documents are included: • Strategy and Commissioning Committee Risk Register; • Risk Tracker; • Risk Scoring Key.

STRATEGY AND COMMISSIONING RISKS - Highlight Report

Risk ID	Risk Title	Risk Owner	Key Updates	2021/22 JAN	2021/22 MAR	2021/22 MAY	2021/22 July	Movement From Last Report	Target Risk Score
COMM8	Failure to Support System Financial Recovery through Contracts that are not shifting activity into out of hospital settings(Threat)	Sarah Mansuralli, Executive Director of Strategic Commissioning	H1 Guidance and our work on Recovery Plans as well as our bid for the Accelerator Programme all demonstrate the system's commitment to working together to reshape how care will be delivered in each setting across North Central London (NCL). This work will be further informed by the ongoing Strategic Reviews of Community and Mental Health Services whose outcomes we expect to start being formulated by September 2021. In the meanwhile, we await formal H2 21/22 Guidance on the new financial regime that will be put in place.	16	16	12	12	→	9
COMM12	Inaccuracy of Provider Data (Data Quality) (Threat).	Sarah Mansuralli - Executive Director of Strategic Commissioning	The Integrated data dashboard (based on the integrated recovery pack) is now available and is being used in System Recovery and Operational Group meetings. The Mental Health and Community Services Reviews are both progressing with a key focus being on data and the development of a consistent data set. In the meanwhile, we continue to await the H2 21/22 planning guidance.	12	12	12	12	→	9
COMM14	Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat)	Sarah Mansuralli, Executive Director of Strategic Commissioning	A London-wide STP discussion on the current pressures and key drivers was held on Monday, 14 June 2021. Further NCL discussions are planned to be held at a summit which will consider the options that could be pursued in response to the significant growth in demand on Urgent Treatment Centres (UTC) and walk-in clinics. 111 activity has also increased significantly. Performance against call answering times and call abandonment rates has fallen over the last 3 weeks. Clinical validation of emergency disposition calls has also dipped. The issue has been raised with the CCG's Urgent and Emergency Care (UEC) Clinical Lead and as well as with its Quality Lead. Both have confirmed that this poses a low clinical risk as urgent patients will be diverted either to Urgent Treatment Centres (UTCs) or to Emergency Departments (EDs). On-call directors have also been informed of the issue should London Central West Unscheduled Care Collaborative need to escalate matters. Internal discussions, to consider interim additional funding whilst approval for the 111 business approved through the CCG's governance process, were initiated during the week commencing 14th June 2021.	12	12	12	12	→	9
COMM16	NHS Acute Contracts for 21/22 (Threat)	Sarah Mansuralli, Executive Director of Strategic Commissioning	NHS Providers' Contract values for H1 21/22 were set centrally. In the meanwhile, we continue to progress the Accelerator Bid and manage our internal recovery. We still await guidance relating to acute contracts for the second half of the year (H2 2021/21) and will respond accordingly when this is issued.	9	12	12	12	→	9
COMM18	Failure to have a single NCL CCG Fertility policy (Threat)	Sarah Mansuralli, Executive Director of Strategic Commissioning	The Scope of the Review and the Terms of Reference (ToRs) of the Review Steering Group were approved at the January 2021 meeting of the Strategy & Commissioning Committee (S&C). Due to the surge conditions and significant operational pressures brought on by the latest wave of Covid-19 cases, the S&C's January 2021 meeting made a decision to temporarily pause further work on the Review. Options for a 'restart' were presented to the S&C's March 2021 meeting which supported Option 1: Pre & post policy development engagement. Work on the Review was set to restart with revised timelines (and an engagement 'go- live' date was set for 10th May 2021). In the meantime, the 5 different fertility policies remain in place.			12	12	→	4

COMM19	Variation in Community and Mental Health Services across NCL (Threat)	Sarah Mansuralli, Executive Director of Strategic Commissioning	Due to historical funding differences across the 5 legacy CCGs there are variations to Community and Mental Health services within NCL CCG, with possible consequences for service access and effectiveness, health inequalities, and resource management. The CCG is undertaking Community and Mental Health service reviews. The Community Services Baseline Report was approved by at the Community Services Review Programme Board on 7th July 2021. The Mental Health Baseline Report is being presented to the Mental Health Services Review Programme Board on 21st July 2021. There is currently a number of workshops being held to further discuss and work out the core offer and these are due to be finalised at a workshop in early September 2021. Further to the review and its implementation, the CCG will establish an on-going monitoring programme for the outcomes of the review.				12		→	6
STR1	Unsuccessful delivery of NCL's Long Term Plan Transformation priorities during the Covid-19 response and recovery phase (Threat)	Richard Dale, Executive Director of Transformation	This risk recognises the additional strain on the system created by the response to, and recovery from, the COVID-19 pandemic and the likely impact of this on the delivery of our system transformation priorities as set out in the NCL response to the NHS Long Term Plan, as well as the transition to an Integrated Care System ('ICS'). In recognition of the move to greater system working and the development of our ICS, reviews are underway to determine which transformation programmes are of the greatest priority for the system, how they can best be delivered, and who will lead them under the ICS leadership arrangements. The aim of this work is to focus programme delivery and clinical leadership resources on the transformation initiatives that: a) will have the greatest impact, and b) definitely require a programme approach to deliver. The areas requiring development align with plans to take forward system actions in the NCL system development plan. This aims to ensure the transition accelerates rather than distracts from the recovery of the system.	12	12	12	12		→	8
STR5	Recovery - Capacity Challenges Associated with Recovery (Threat)	Richard Dale, Executive Director of Transformation	As part of recovery, programmes are being established across the health system alongside plans to ensure continued response to the pandemic and potential third wave. NCL has been chosen as a national "accelerator" site which supports further investment in recovery work across the system.	12	12	12	12		→	8
FIN10	Failure to in-house the CSU within available time-frame (Threat)	Simon Goodwin, Chief Finance Officer	This is a new risk. NHS England (NHSE) has not yet approved the CSU in-housing business case. The risk is increasing as time goes on and mitigating it will be difficult for as long as NHSE's approval of in-housing business case remains fixed to the 1st October 2021 timescale.				12		→	4
QUAL24	Failure to base CHC Commissioning cycle and service on reliable data (Threat)	Kay Matthews , Executive Director of Quality	An increased focus on data quality is being developed within this area of operation. Standardisation and training in new procedures will effectively manage this risk, once controls are embedded. Caretrack platforms have now been merged and the data cleansed, including the harmonisation of the rate cards. Further, historical practices are being managed as they will affect the maintaining of the cleansed data. Additional client groups' data is being added, including Mental Health, Learning Disability and Children and Young People. This data will also need to be cleansed in order to mitigate this risk. A further training programme will need to be established to support the ongoing standardisation of data entry This remains a high priority risk given the impact Data Quality has on broader CHC business, including ensuring patient care and effective back-office functioning.	12	16	16	16		→	6
AO1	Failure to Establish Appropriate and Effective Arrangements for the New ICS Organisation at pace (Threat)	Frances O'Callaghan, Accountable Officer	NHS England published its ICS Design Framework Guidance in June 2021. However, we are awaiting legislation to be passed on the new ICS organisations and the accompanying guidance. Once this has been released, the Strategy Team will work with the Governance and Risk Team to develop proposals for the new organisation. A programme plan has been established to ensure smooth transition to the new organisation on 1st April 2022. An ICS steering group has been established along with a Partnership Council to help to deepen the relationships between ICS partner organisations and to start to help shape the strategic direction of travel with the first meetings having been held.			12	12		→	6

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

Risk Scoring Key

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

1. Overall Strength of Controls in Place

There are four levels of effectiveness:

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

2. Risk Scoring

This is separated into Consequence and Likelihood.

Consequence Scale:

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

Likelihood Scale:

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

3. Level of Risk and Priority Chart

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

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

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

North Central London
Clinical Commissioning Group

North Central London Clinical Commissioning Group
Procurement Committee
Minutes of the Meeting held on Thursday, 25th February 2021

Meeting held via MS Teams

Present:

Voting Members:	
Ms. Karen Trew	Chair and Lay Member for Audit and Governance
Mr. Arnold Palmer	Lay Member (General Portfolio)
Dr. Dominic Roberts	Non-conflicted GP
Dr. Subir Mukherjee	Governing Body Secondary Care Clinician
Mr. Simon Goodwin	Chief Finance Officer
Mr. Ian Porter	Executive Director of Corporate Services

In Attendance:	
Mr. Shaju Jose	Head of Procurement, NEL CSU
Mr. Mark Eaton	Interim Director of Strategic Projects NCL CCG
Mr. Keith Spratt	Head of Contracts NCL CCG
Mr. Andrew Tillbrook	Deputy Board Secretary NCL CCG
Mr. Christopher Hanson	Governance and Risk Lead NCL CCG

1.	**Introduction**
1.1	**Welcome and Apologies**
1.1.1	The Chair welcomed everyone to the meeting.
1.1.2	Apologies were received from Sarah Mansuralli, Executive Director of Strategic Commissioning
1.2	**Declarations of Interests Register**
1.2.1	The Register was noted by the Committee. Members were also invited to amend their entries in the Register of Declarations of Interest. No amendments were made.

1.3	**Declarations of Interest Relating to Items on the Agenda**
1.3.1	The Chair invited Members to declare any interests in respect to items on the agenda. No interests were declared.
1.4	**Declarations of Gift and Hospitality**
1.4.1	The Chair invited Members to declare any gifts and hospitality received. No gifts and hospitality items were declared.
2.	**Business**
2.1	**Procurement Committee Terms of Reference**
2.1.1	The Chair presented the Committee Terms of Reference, highlighting they had been approved by the Governing Body.
2.1.2	The Committee then discussed the Terms of Reference: • It was noted that there may be procurements below the Committee's threshold that would benefit from the Committee's scrutiny, particularly with regards to reducing health inequalities and service model change. • It was agreed that the Terms of Reference would be amended to make reference to 'Novel or Contentious' procurements coming within the Committee's remit, for approval at the March 2021 Governing Body meeting.
2.1.3	The Committee **NOTED** the Terms of Reference and recommended their amendment.
2.1.4	Action: Ian Porter and Simon Goodwin to amend the Terms of Reference to make reference to 'Novel or Contentious' procurements coming within the Committee's remit.
2.2	**NCL CCG Procurement Policy**
2.2.1	Christopher Hanson presented the Clinical Procurement Policy, outlining the following key points: • The Policy scope is limited to Clinical Procurements only; • The Policy provided a flexible and proportionate approach to procurement, aligned across all North Central London, whilst ensuring Conflicts of Interest are managed appropriately; • The Chair, Executive Directors, Directors and Manager Team, and the CSU were engaged in the development of the Policy;

	• Further work will be required to reflect Procurement changes arising from the UK's exit from the EU, and to strengthen provisions on social value.
2.2.2	Shaju Jose added that the new NHS Procurement Regime was out for consultation until April 2021, and the consultation documentation would be circulated to the Members.
2.2.3	The Committee then discussed the policy, making the following comments: • It was confirmed that the CCG would still be complying with the regulations relating to the Official Journal of the European Union ('OJEU') following the UK's EU exit, utilising a UK specific platform "Find a Contract" • Assurance was given that further work is taking place concerning how the CCG will address Health Inequalities through the Policy and as an 'Anchor Institution'. It was noted that the Policy makes provision for 10% Social Value weighting at the Pre-Procurement stage.
2.2.4	The Committee **REVIEWED** the Procurement Policy and **RECOMMENDED** it for approval by the Strategy and Commissioning Committee at its meeting in March 2021.
2.2.5	The Committee asked that the further work due to the development of the Integrated Care System, EU exit, and Social Value be brought to the attention of the Strategy and Commissioning Committee.
2.3	**NCL Any Qualified Provider Policy**
2.3.1	Mark Eaton presented the Any Qualified Provider Policy, noting that the Policy is: • Aligned with the Clinical Procurement Policy; • Influenced by the Enfield CCG Any Qualified Provider Policy.
2.3.2	The Committee then discussed the Policy: • It was confirmed that the Procurement Committee's Terms of Reference exclude matters within the remit of the Primary Care Commissioning Committee • It was suggested that the Procurement Committee could have some role in contentious Primary Care commissioning to ensure the correct oversight is in place • Assurance was given that procurement within both committees' remits are supported by NEL CSU Procurement experts

	• It was agreed that action would be taken to increase organisational awareness of the Clinical Procurement Policy and the Any Qualified Provider Policy.
2.3.3	The Committee **REVIEWED** the Any Qualified Provider Policy and **RECOMMENDED** it for approval by the Strategy and Commissioning Committee at its meeting in March 2021.
2.3.4	Action: Ian Porter to arrange for the Clinical Procurement Policy and the Any Qualified Provider Policy to be promoted to CCG staff.
2.4	**NCL Contracts Register**
2.4.1	Mark Eaton presented the Contracts Register, outlining the following key points: • It is an evolving document and future versions will include end dates; • All NHS contracts that the CCG holds are expired, as the CCG was instructed not to sign further contracts and centrally allocated figures are in place until Quarter 1 of next year; • It covers £1.8 Billion spend; • It is categorised, including non-contract spend in excess of £1 million to indicate overall spend; • It is to be published once the Procurement Committee approves.
2.4.2	The Committee then discussed the Register: • It was agreed that blank entries against personalised care provisions, where appropriate, would be amended to a 'multiple contracts' entry instead; • Assurance was given that publishing financial data was appropriate given NHS transparency in working.
2.4.3	The Committee **NOTED** the Contracts Register.
2.4.4	Action: Simon Goodwin would review the detail prior to publication.
3.	**Items for Decision**
3.1	**Review of CCG Business case proposal**
3.1.1	Mark Eaton presented the Phase 2 Borough Contract review, outlining the following key points: • c.400 of c.450 contracts, with a total value of c.£275 million, inherited from the 5 legacy CCGs will expire by March 2021; • Phase 1 was to collate a list of all borough contracts;

	• Phase 2 was to determine disposal of contracts above £10,000. Recommendations have been taken to Executive Management Team ('EMT'). Decisions regarding contracts valued at less that £250,000 were made by Simon Goodwin and Sarah Mansuralli, those which were for contracts valued £250,000 and above but below £500,000 were made by Simon Goodwin and Frances O'Callaghan. Those above £500,000 are on this meeting's Agenda under Single Tender Waivers. • Phase 3 will address s75 contract disposal, and SFIs are being developed that will streamline this process and are expected in March 2021. It is hoped that Phase 3 will come to the next Procurement Committee meeting. • Phase 4 will be the review of borough contracts across NCL CCG and a papers is going to EMT shortly. The review will consider the contracted services in each borough and their impact on health inequalities.
3.1.2	Mark Eaton added that a further 40 contracts are expected to expire in the next financial year, and will be subjected to the Borough Contract review process. They will be presented to this Committee in April 2021 as well as any Phase 3 Single Tender Waivers within the remit of the Committee and a report on the Phase 4 disposals.
3.1.3	The Committee then discussed the paper: • It was noted that the work was important for review and standardisation, in particular in advance of the Integrated Care system, and in addressing health inequalities within the context of Borough Delegation; • It was noted that there was a tension between standardisation and delivery against the needs of 'Place', and the Strategy and Commissioning Committee will need to consider this from a strategic perspective and the Procurement Committee needs to make decisions informed by this. ; • Confirmation was needed that the CCG had sufficient capacity and resources to deliver the work within the necessary timeframe; • It was noted that whilst the majority of contracts were on standard NHS Terms, there was some diversity particularly in relation to section 75 agreements. The Committee was assured standardisation of contractual terms was a goal of the review diversity would remain, and the priority was to get these services under contract; • It was agreed that inclusion should be monitored whilst rationalisation was carried out;

	• It was noted that Borough-level Any Qualified Providers are increasingly interest offering services across NCL, however, their contracts' remit remain borough-specific and not Pan-NCL.
3.1.4	The Procurement Committee **NOTED** the paper and **AGREED** to receive Phase 3 and 4 updates in April 2021.
3.1.5	Action: Mark Eaton will report back to the Procurement Committee in April 2021 on resources available.
3.2	**Review of CCG Business case proposal**
3.2.1	Mark Eaton presented the Interpreting Service Business Case paper, outlining the following key points: • The intention is to rationalise all 14 existing interpreting service contracts over NCL of which 10 are with Language Line, including remedying the absence of British Sign Language video services in Camden and provide an option for Islington to join the contract after terminating their current contract; • Language Line is the only provider that can deliver integrated interpreting services; • Language Line would be contracted on an existing Framework contract with new Key Performance Indicators ('KPI'), to support contract management, and patient-lead efficiencies.
3.2.2	If approved by the Procurement Committee, a proposal from Language Line will be requested. This will be reviewed by a panel of clinicians and commissioners and if approved the CCG will do a Direct Award to Language Line.
3.2.3	The Committee then discussed the Business Case: • It was assured that Language Line is the only provider on the Framework, which was published on OJEU; • It was noted that this is not a change of provider but a rationalisation and an expansion of service provision into the Camden Borough; • It was assured a contract drawn down from the Framework, if signed prior to the 30th April 2021, would be valid; • It was assured that the service provision was largely in line with previous services, save for the inclusion of certain KPIs and that there were some patient-lead efficiencies; • It was assured that there would be no change to access of existing face-to-face services; • It was agreed that the capture and measuring of Inclusivity data should be added as a KPI; • It was noted that a number of local contracts will remain in place and that these may need review during 2021/22.

3.2.4	The Procurement Committee **APPROVED** the Business Case and agreed to delegate to the review group the review of the proposal and progression to a Direct Award. If the Proposal is not approved then the matter is to come back to the Procurement Committee, otherwise the Procurement Committee will receive a report that the service is in place.
3.3	**Review and approval of Single Tender Waivers**
3.3.1	Mark Eaton presented the Single Tender Waivers ('STW') paper, outlining the following key points: • Audiological sciences is to be extended a further 6 months to allow for a review of these services at that time. In the meantime this remains 80% of tariff rate offering value for money; • The two End of Life services are to be brought back in to contract until end of March 2021, though a review of services is being carried out which would come back as a business case; • The Gynaecological Partnership contract is to be extended for 1 year only as the services will be included in the Community Services review; • Language Line is an expired contract to be brought up to date until the end of March 2021 after which the Procurement addressed above will take effect.
3.3.2	The Committee then discussed the STWs: • It was noted that the commissioners were not to hamstring the ICS in the future; • It was assured that the CCG is looking at different service provision models and not merely rolling over contracts; • Commissioners were encouraged to meet review dates and avoid the risk of repeated STW processes, further to some business case development being delayed due to COVID-19 redeployment;
3.3.3	The Procurement Committee **APPROVED** the STWs until 31st March 2021 but if business cases were not agreed and implemented by that date the relevant STWs are extended until 30th June 2021 or the date the business case is implemented whichever is the earliest.
3.4	**Review and approval of Single Tender Waivers**
3.4.1	Keith Spratt presented the Primary Care Extended Access and 4 Locally Commissioned Services ('LCS') STW paper, outlining the following key points: • Extended Access is for evening and weekends Primary Care appointments required due to a delay in a national directive for

	delivery through the Primary Care Networks. The STW is to cover the time gap due to the delay through to 2022; • The LCSs are grouped by Borough covering a range of services and outcomes, and are a rollover for this coming financial year. These are largely commissioned from the General Practices, and in some cases include Federations; • Enfield's LCS was approved by the legacy CCG through the Enfield Single Offer.
3.4.2	The Committee then discussed the STWs: • It was assured that the STWs had been reviewed by the Finance Directorate; • It was noted that the IT contracts were not being presented to the Procurement for approval at the current time, however, they were being reviewed to achieve alignment and greater value for money; • It was noted that there was scope for overlap with the Primary Care Commissioning Committee, notwithstanding the remits set out in the respective Terms of Reference. However, the overall commissioning strategy behind business cases presented is a question for Strategy and Commissioning Committee. • The Committee was assured that changes to core primary care contracts have not included any of these services and therefore STWs were needed to continue these services. It was noted that the KPIs are still relevant but that the baselines need to be reviewed to reflect current performance.
3.4.3	The Procurement Committee **APPROVED** the STWs.
3.4.4	Action: Simon Goodwin to raise with Strategy and Commissioning Committee the strategy behind the Locally Commissioned Services.
4.	**Governance and Committee Administration**
4.1	**Register of Procurement Decisions**
4.1.1	Mark Eaton presented the Register of Procurement Decisions, outlining the following key points: • This is the 2nd iteration, and now includes previously omitted spend since April 2020; • It will be cross-referenced against the Finance Ledger to ensure full capture of contracting activity.
4.1.2	The Procurement Committee then discussed the paper: • It noted that the formatting and governance entries required further review before re-submission to the Committee, but accepted the document was still in draft form.

4.1.3	The Procurement Committee **AGREED** that the amended Register of Procurement Decisions be circulated to the members with the potential Procurement Option being put to the Committee via the Virtual Decision-Making Protocol.
4.1.4	Action: Mark Eaton to liaise with Governance and Risk to finalise the Register of Procurement Decisions.
5.	**Any Other Business**
5.1	Mark Eaton introduced the need for a decision to be made using the Virtual Decision-Making Protocol regarding a North West London CCGs' Wheelchair contract, to which Barnet CCG was an associate. The contract is coming to an end and North West London CCG need to know whether the CCG will continue to be an associate to the contract. The Procurement Committee **AGREED** to receive the paper virtually.
5.2	The Procurement **AGREED** to meet bi-monthly, and utilise the Virtual Decision-Making Protocol in the interim, where necessary.
6.	**Date Of Next Meeting**
6.1	Thursday 29th April 2021.
6.2	Action: Christopher Hanson to schedule bi-monthly meetings commencing in April 2021.