NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 12 September 2025, 10:00 a.m.
Islington Council, Committee Room 5, Islington Town Hall, Upper Street, N1 2UD

Contact: Fola Irikefe, Principal Scrutiny Officer

E-mail: fola.irikefe@haringey.gov.uk

Councillors: Philip Cohen and Paul Edwards (Barnet Council), Larraine Revah **(Vice-Chair)** and Kemi Atolagbe (Camden Council), Chris James and Andy Milne (Enfield Council), Pippa Connor **(Chair)** and Matt White (Haringey Council), Tricia Clarke **(Vice-Chair)** and Joseph Croft (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 2)

Haringey Keep Our NHS Public will present a deputation to the committee.

7. NCL JHOSC ACTION TRACKER 2025/2026 (PAGES 3 - 20)

9. NCL ICS FINANCE UPDATE (PAGES 21 - 36)

To provide a finance update for the NCL including the overall strategic direction of travel, 2025/26 figures for the NCL ICB and for NHS Trusts that provide services to NCL patients.

10. NCL ICB RECONFIGURATION (PAGES 37 - 92)

The NCL ICB Board received the NCL – NWL Case for Change and Options Appraisal for Merger at their meeting on 22 July 2025.

At the board meeting the merger with NCL and NWL was agreed, a further update will be going to the NCL ICB board on 30th September.

Fola Irikefe, Principal Scrutiny Officer
Email: fola.irikefe@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Wednesday, 10 September 2025

Agenda Item 5

12 September 2025

Deputation to JHOSC from Haringey Keep Our NHS Public

Changes in Health and Care in NCL

We welcome fresh thinking about prevention and care closer to home from the Government. We recognize that these could have great benefits for everyone.

However we are concerned that the current developments in NCL and NWL ICBs will not allow those benefits to be fully realised.

We urge JHOSC to engage with the plans of the merged ICBs and provide the detailed oversight required to get the best outcome for residents.

1. The planned merger of NCL and NWL ICBs will involve a 50% reduction in their staff numbers, making for a major restructuring of NHS services much more difficult.

2. No extra funding will be provided for the changes - any new investment in Neighbourhood Hubs etc will then have to come from cuts to existing budgets - or by the new Public Private Partnerships heralded in the 10 Year Plan from the DHSC. Both very concerning.

3. **For JHOSC**

A. So far there has been very limited public engagement by the ICBs on their plans for the future. As far as we know, there has been little discussion with Councillors about the plans for the ICB merger nor the plans for “Integrators” of services and the setting up of Neighbourhood Hubs. We request JHOSC press NCL/NWL ICB for an urgent and full discussion of these plans.

B What plans are there for JHOSC after the NCL and NWL ICB merger? The new ICB will cover 13 boroughs. If plans for a future JHOSC cover those 13 boroughs, then the JHOSC is likely to be unwieldly and more remote from residents. We suggest that the existing NCL JHOSC continues and that you lobby for this outcome.

C The 10 year plan for the NHS from the DHSC says very little about Social Care as they expect a report in 2028 to cover that. However, in the meantime, the Neighbourhood Hubs will seek to offer advice on social care etc. As Social Care budgets make up a large part of Local Government expenditure, we are concerned that the ICB’s plans will seek to strongly influence policy and decision-making on social care. JHOSC should take a keen interest in these developments to ensure that Council budgets remain fully under their control.

D We are also concerned that the merged ICB will be more remote from residents, especially given the reduced role for Healthwatch. This means that the role of Councillors becomes even more important as providing democratic scrutiny of any proposals for changes to NHS services from the ICB.

5. We urge to press NCL/NWL ICB for a full discussion of their plans, especially for Neighbourhood Health Centres, at the next meeting of JHOSC. We urge JHOSC to provide detailed oversight required to get the best outcome for residents both of the issues we are raising but any other concerns JHOSC may have.

Alan Morton/Rod Wells

Haringey Keep Our NHS Public

NCL Joint Health Overview & Scrutiny Committee – Action Tracker 2025-26

MEETING 2 – 11 July 2025

No.	ITEM	STATUS	ACTION	RESPONSE
53	Community Pharmacy	**Follow up enquiry**	Exploring self-care medication through our neighbourhood teams. The new ICB way of working with local authorities is through new neighbourhood team and new hubs. Clarity on the boundaries and how the hubs will operate.	
52	Community Pharmacy	**Follow up enquiry**	Provide clear information on the self-care medication scheme and how that is being promoted. Engagement Pharmacists employed struggling, so further information on how they are actually targeting and engaging would be welcomed.	
50	Community Pharmacy Update	**Follow up enquiry**	Chart showing completed pharmacy first consultations to be broken down by borough - A snapshot over the last six months broken down by the percentage of activity in each borough could be provided	
51	Estate Update	**WORK PROGRAMME 2026/27**	Provide greater detail in the next iteration of the estates update on public/private partnership relationships and contracts including the financial risks.	
50	Estate Update	**WORK PROGRAMME 2026/27**	More detailed understanding of how funding allocated to Foundation Trust funding that isn't going to local infrastructure will be re-invested.	

	Estates Update	**Follow up from meeting**	NCL Neighbourhood Hubs – information on the vision, objectives, boundaries and how they will work in joint partnership arrangemennts.	
49	Estates Update (follow up)	**UPDATE REPORT**	Working with the voluntary community and social enterprise sector strategy (Appendix G2) 2022 to 2026 - when will the follow up will report on this be available?	
48	Estate Update (follow up)	**Follow up from information provided**	Healthy neighbourhoods - Is this happening as part of this working strategy? Update on all boroughs mentioned in the strategy, not just Haringey.	
47	Estate Update (follow up)	**Follow up from information provided**	Appendix F which is in the tracker. On page 31, we've got work well in North Central London stakeholder communication. Information received the information in the appendix, could and update be provided to see how that is actually working in practice? If there's anything actually happening with the new work and health service which begins in north central London on the 1st of October - brief update to see what pilots are happening or any actions.	
	NCL JHOSC Terms of Reference	**Follow up action**	Discussions to be arranged with Chair and Vice-Chairs of the committees with lead officers able to take decisions on budget decisions.	Scrutiny Officer and Democratic Services & Scrutiny Manager liaising with other boroughs to make arrangements to meet.

MEETING 1 – 28TH APRIL 2025

No.	ITEM	STATUS	ACTION	RESPONSE
46	Deputation from Haringey Keep Our NHS Public (KONP)	**ADDED TO 2025/26 WORK PROGRAMME**	To have site of the ICB savings plans in advance of changes. Concerns raised by Haringey KONP over the impact of changes to ICB on the NCL JHOSC. To be add to forward plan for September/ November.	
45	Mental Health Pathways - Transitions	**ADDED TO 2025/26 WORK PROGRAMME**	Follow up from action plan going to NCL and ICB board. What new processes and systems are in place following the Nottingham case to support people? The committee would like further clarity regarding where does the risk fall. Are there systems in place to mitigate the risks? Further details regarding what is happening on the ground level in terms of joined up communication.	At meeting of 11 July - Rather than an addition to the WP, further information to be provided on people accessing mental health support. More clarity Is required around responsibility for people in our community that may no longer be accessing mental health support when they should be and who holds the responsibility for them.
44	Mental Health Pathways - Transitions	**ADDED TO 2025/26 WORK PROGRAMME**	To come back to the committee in 6-12 months to provide clarity regarding the offer for those in the 17-25 age group and how this fits in with the SPA and how different groups and organisations can support that offer.	
43		**ADDED TO 2025/26 WORK PROGRAMME**	Further information to be provided to assist the committee in understanding how the contracts with the voluntary and community sector fits in with the SPA.	

42	Mental Health Pathways	**ADDED TO 2025/26 WORK PROGRAMME**	Information to be provided on how co-designing services with carers and staff in terms of discharge planning is being taken forward including details regarding consent.	
41	Mental Health Pathways	**ADDED TO 2025/26 WORK PROGRAMME**	Further information to be provided to assist the committee in understanding how the contracts with the voluntary and community sector fits in with the SPA.	
40	Mental Health Pathways	**ADDED TO WORK PROGRAMME**	To receive an update to understand how the information held by voluntary sector organisations is shared at the Single Point of Access and how it fits into different pathways. Review evidence from Barnets pilot with the results coming out in June 2025. To also consider how the NODE and SPA progresses as an outcome of the pilot.	

MEETING 4 – 3RD February 2025

No.	ITEM	STATUS	ACTION	RESPONSE
39	Health Inequalities Fund	**ADDED TO 2025/26 WORK PROGRAMME**	The Committee suggested that the community groups could be invited to provide an update on their projects in a year or two's time.	Added to draft 2025/26 work programme.
38	Health Inequalities Fund	**COMPLETED**	Details were requested on the membership of Health Inequalities Borough Partnership Meetings.	Response provided in **ATTACHMENT N** – see section **A5**.

37	Health Inequalities Fund	**COMPLETED**	The Committee requested the report on the evaluation conducted by Middlesex University on the programme's approach to co-production project.	Response provided in **ATTACHMENT N** – see section **A4**.
36	Health Inequalities Fund	**COMPLETED**	Further details were requested on the performance metrics for projects and on the consequences should projects fail to deliver on these.	Response provided in **ATTACHMENT N** – see section **A3**.
35	Health Inequalities Fund	**COMPLETED**	Written response to be provided following queries from Cllr Chakraborty on why: • Only 2 of the 56 projects in the programme were based in Barnet borough. • The criteria used for the funding of projects (i.e. levels of deprivation, etc)	Response provided in **ATTACHMENT N** – see section **A1**.
34	Workforce strategy	**ADDED TO 2025/26 WORK PROGRAMME**	The Committee suggested that future Workforce reports should include more details on: • How productivity is defined and measured. • The shift to the Neighbourhood Model and the effects of this on productivity and wider outcomes such as quality of life for patients. • What was being done to make the NHS more attractive to job seekers, including on working conditions, mentoring and on incentivising graduates.	Added to draft 2025/26 work programme.
33	Workplan	**ADDED TO WORK PROGRAMME**	To add mental health report to the agenda for April 2025.	Added to draft work programme.

MEETING 3 – 11th November 2024

No.	ITEM	STATUS	ACTION	RESPONSE
32	Winter Planning	**ADDED TO 2025/26 WORK PROGRAMME**	The Committee requested that the next winter planning report should include details on progress relating to: - High Impact Interventions. - Bringing down waiting times for patient discharges to A&E from ambulances.	Added to draft 2025/26 work programme.
31	Winter Planning	**COMPLETED**	Details to be circulated on the Local Healthcare Team Campaign, including the resources for GP receptionists and practice managers to support patients.	Response provided as **ATTACHMENT M**.
30	Winter Planning	**COMPLETED**	Details to be circulated on the targeted work on vaccine uptake including why there had been resistance from some communities.	Response provided as **ATTACHMENT L**.
29	NCL Financial Review	**ADDED TO 2025/26 WORK PROGRAMME**	The Committee requested that the next financial report should include: - Details on acute care and community services and on overview of any associated pressures and risks. - Details on the distribution of funds to voluntary sector organisations. - Details of the lines of communication between Departments and how financial decisions are reached.	Added to draft 2025/26 work programme.
28	NCL Financial Review	**COMPLETED**	Further details to be provided on: - What impact the efficiency savings were expected to have on services. - What assessment had been made of the impact of the efficiency savings on people with disabilities. - The overall impact of capital projects on the revenue budgets (e.g. costs associated with borrowing)	**Response:** NCL Trusts have provided assurance on their control processes with respect to the delivery of efficiency savings (CIP) and their impact upon services. Each Trust has a well-established Equality and Quality Impact Assessment (EQIA) process which assesses the impact of efficiency savings and reports these to a panel of Trust executives. This panel includes

				representation from senior clinicians, including the Chief Nurse (CNO) and/or Chief Medical Officer (CMO). The EQIA process requires each efficiency scheme to initially be assessed and approved by the relevant directorate management team before submission to the EQIA panel for further scrutiny. Efficiency schemes are only formally accepted into Trust savings programmes once the EQIA panel has been assured that the impacts on equality, quality and safety have been properly considered and where necessary mitigated. The Equality impact assessment covers all protected characteristics, including disability. NCL Trusts have confirmed that no 2024/25 CIP schemes were agreed which were determined to have an adverse impact upon patients with disabilities.
27	Whittington/UCLH collaboration	**COMPLETED**	Further details to be provided on Virtual Wards as part of the Hospital at Home scheme.	Response provided as **ATTACHMENT K**.
26	Whittington/UCLH collaboration	**COMPLETED**	Clare Dollery (Acting CEO – Whittington) was asked about the Rapid Response Unit which operated alongside the Home at Hospital scheme and had a two-hour target response time. She agreed to circulate data on this.	Response provided as **ATTACHMENT J**.
25	Start Well	**COMPLETED**	It was noted that the ICB had published its full report on the Start Well consultation and the Committee was invited to submit any views/recommendations in writing.	A letter from the Chair on behalf of the Committee was submitted to the ICB on 6th Dec 2024. **(ATTACHMENT I)**

24	Written Question	**COMPLETED**	A Written Question was received from a resident from Barnet: *"Given that the primary reason for absence from work is illness and the COVID pandemic is still ongoing –and is still causing illness and long-term health problems, do you think that reducing the spread of COVID with cleaner air in schools, and healthcare and public settings will be beneficial to the economy?"*	As this is a Public Health issue, this is the responsibility of local Directors for Public Health who are scrutinised by local HOSCs. The resident has been provided with the details of the local HOSC and details of the local Air Quality Action Plan for Barnet.

MEETING 2 – 9th September 2024

No.	ITEM	STATUS	ACTION	RESPONSE
23	Work Programme	**TO BE CONSIDERED FOR 2025/26 WORK PROGRAMME**	Meetings to be extended to up to three hours in duration, should the agenda items require this. Democratic Services and ICB to be consulted on the possibility of adding an additional meeting to the annual JHOSC schedule.	Democratic Services teams in the 5 NCL Boroughs are currently consulting on the resources for the JHOSC and this will be fed into that discussion ahead of the meeting schedule and work programme being developed for 2025/26. **Nov update** – Committee members were encouraged to speak to the Chief Executive/Finance Director in their Borough about this.
22	North London Mental Health Partnership	**AWAITING RESPONSE**	Further information was requested on: a) More detail on the finances associated with the merger, in particular the expected impact on the surplus/deficit and any anticipated risks. b) Evidence of how people with disabilities were being involved with working groups and consultations. c) Details on how CAMHS would fit alongside the new structure and how patients would be able to navigate this.	At the 11 July 2025 meeting – and also noted on September 2024 meeting and this remains outstanding.

			d) Most recent headline waiting list figures to be provided. e) Update on action to address concerns about breakdown in communications between families and keyworkers in some cases. f) Assurances sought that a report on suicide prevention would be considered by NLMHP and appropriate action taken (Not sure what the timescale for this report is expected to be?) g) More evidence of the internal due diligence that the Partnership had done for the merger, including Quality Governance and changes in the key clinical areas. h) Evidence that local focus on care would not be lost as a consequence of merger.	
21	Estates & Infrastructure Strategy	**TO MONITOR**	Update to be provided on St Pancras Transformation Programme.	A briefing to the Chair/vice-Chairs of Committee took place in October 2024. A follow-up briefing took place in February 2025. The issue remains ongoing and is expected to be included in the 2025/26 work programme.
20	Estates & Infrastructure Strategy	**COMPLETED**	a) Cllr James to speak to the planning inspector for health centres at Enfield Council about land being reviewed in Enfield to ensure that the ICB was aware of opportunities to acquire sites. b) It was suggested that all Boroughs should make the ICB aware of any divestments. More details were to be provided on how NCL Estate	a) This has been actioned. b) - The Borough Integration Units will be the local representative of the ICB as part of a matrix with other functions within the ICB, such as Quality, Service Development and Analytics (as examples). BIU leadership meets regularly with colleagues

			teams operate and how they work with local authority teams.	from Councils, particularly Adult Social Care, Children and Families and Public Health but as an anchor organisation have wider links with areas such as Community Wealth building, Planning, Housing, as examples. The details of leaders within the BIU team as follows: • Director lead for Enfield, Haringey and Islington (East) – Clare Henderson • Director lead for Barnet and Camden (West) – Simon Wheatley • Assistant Director Barnet – Dan Morgan • Assistant Director Camden – Jo Reeder • Assistant Director Islington – Rhian Warner • Assistant Director Haringey – Tim Miller • Assistant Director Enfield – Peppa Aubyn
19	Estates & Infrastructure Strategy	**COMPLETED**	Further information was requested on: a) Details of the membership of the Estates Forum in each Borough. b) Plans to include keyworker housing at Finchley Memorial Hospital. c) An update on keyworker housing at the St Anns site. d) NCL ICS people strategy – how will NEET individuals would be chosen for the	a) Response provided as **ATTACHMENTS C1 to C5.** b) Response provided as **ATTACHMENT D.** c) Response: "There will be 22 units of accommodation which will be available for use of NLMHP / NLFT staff, as the St Ann's site housing development progresses. The first units should be available by 2026. The

			employment, who would refer them and how they would be supported. e) Further details to be provided of sites being sold, the buyers of the sites and how the funds would be reinvested. f) Details of the critical infrastructure risk and any particular areas of or backlog and the risk associated with this. g) Details of the ICB engagement strategy to be provided.	units will be owned by Peabody, but the NLMHP / NLFT will have the nomination rights, i.e. the Trust will be able to allocate these units to some of its staff, to help in staff recruitment / retention. This was agreed in the original land sale agreement with the GLA." d) Response: WorkWell is a service open to anyone with a disability or health condition who lives in Barnet, Enfield, Haringey, Camden and Islington (or is registered with a GP or Job Centre within this area). Please see the stakeholder communication pack **(ATTACHMENT E)**. We are in the process of developing a more detailed set of FAQs that will have been tested by stakeholders and this will follow shortly. More information and details of how to refer into the WorkWell service can be found on our website here: https://nclhealthandcare.org.uk/keeping-well/workwell/ e) Details of disposals strategy development provided in **ATTACHMENT F**. f) Details of Critical Infrastructure Risk prioritisations review provided in **ATTACHMENT F.** g) ICB People & Communities Strategy provided as **ATTACHMENT G1.** ICB

				Community & Voluntary Sector Strategy provided as **ATTACHMENT G2.**
19	NMUH/Royal Free merger	**PARTLY COMPLETE**	Further information was requested on: a) The lines of governance accountability (including an organisational chart illustrating how this would work after the merger) and how sub-committees would feed into the Board. b) How NMUH governors and staff reps could feed into the governance process. c) Clarification on the longer-term plans for where Barnet patients would be treated. d) Details on the plans to safely merge the Electronic Patient Records. e) Further evidence about the consultation of patient groups.	Responses to points b) to e) provided as **ATTACHMENT H.** Response to point a) to follow in December 2024.
18	NMUH/Royal Free merger	**ADDED TO WORK PROGRAMME**	Possible issues to be considered in future update item: a) For the Committee to examine a case study into a less prominent area of care to ascertain how it was monitored before and after changes to the service, what the local priorities were and their impact on how clinical decisions were made. b) For further discussion on financial risk and, including how the debts of the Royal Free Group when be held within the merged Trust.	Added to work programme.

17	Minutes (Barnet update)	**IN PROGRESS**	Cllr Cohen reported that a consultation in Barnet on primary care access had recently been concluded and that the results were expected to be published in September. He would update the Committee when this was available.	Nov 2024 update – this has not yet been presented to the Barnet Cabinet. An update will be provided when further information is available.
16	Minutes (Actions)	**TO BE IMPLEMENTED IN FUTURE MEETINGS**	The Committee requested that the action point sheet should be published as a separate agenda item for future meetings.	To begin from Nov 2024.
15	Minutes (Mental Health action points)	**TO BE FOLLOWED UP AT APRIL 2025 MEETING**	Regarding the update from the ICB on a previous mental health item (in March 2024), additional information was requested: • Item 3 (Voluntary & Community Sector contract terms) – The response noted that the Committee could be updated further throughout the year as this workstream was developed. • Item 5 (Supported Accommodation for People with Severe Mental Health Needs) – Further information was requested on how the Mental Health Trusts were working with local authorities to resolve the shortage of supported accommodation that was described. • Item 8 (Mental Health Support Teams in Schools Coverage) – Information was requested on which schools were supported.	Item 3 – Added to Work Programme.
14	Minutes	**COMPLETE**	The minutes of the meeting were not approved as the meeting was not yet quorate in the early stages when this item was discussed. The minutes would therefore need to be formally approved at the November meeting.	Minutes approved.

MEETING 1 – 25th July 2024

No.	ITEM	STATUS	ACTION	RESPONSE
13	Dental Services	**COMPLETE**	Concerns were expressed that some residents did not access dental services because of the cost and that this would have implications for long term health.	Response from Mark Eaton, Director of Strategic & Delegated Commissioning (NCL ICB): "This is a joint area of concern for both the NHS and Local Authorities. The resolution of this will require coordinated action but needs changes to be made to funding and the contracts via a national policy change."
12	Dental Services	**PARTLY COMPLETE**	The Committee recommended that improved communications with residents was required about a) available care pathways and b) preventative actions such as supervised teeth brushing for children.	a) Awaiting response. b) Response from Mark Eaton, Director of Strategic & Delegated Commissioning (NCL ICB): "Supervised brushing is a very effective preventative approach and falls within the shared remit between the NHS and Local Authorities for Oral Health Promotion. The NCL ICB is working with Local Public Health Teams across NCL to develop a consistent programme in this area given the relatively low costs v high benefits."
11	Dental Services	**AWAITING RESPONSE**	Information was requested on the definition of 'exempt' and any special provision for patients with diabetes.	
10	Primary Care	**COMPLETE**	Details were requested on the ICB response to a recent report into the safety of online consultations.	Responses provided in **ATTACHMENT B.**

9	Primary Care	**COMPLETE**	The Committee recommended that improved communications with residents was required to increase uptake in the expanded range of services provided by pharmacists.	
8	Primary Care	**COMPLETE**	Further information was requested on supervision for Physician Associates and pressures on GPs.	
7	Primary Care	**COMPLETE**	The Committee recommended: - more support for residents who cannot easily access apps/online forms in order to increase uptake. - inclusive policies for residents who do not have access to a smartphone. - the right level of training should be delivered for practice receptionists to become information-givers and gatekeepers.	
6	Primary Care	**COMPLETE**	The Committee suggested that better consistency with the same doctor was needed for those with chronic medical conditions.	
5	Primary Care	**COMPLETE**	More information was requested about improving the patient experience, decreasing long waiting times and about patients who remain under primary care because of long waiting lists for secondary care.	
4	Start Well	**COMPLETE**	NCL ICB to provide the Committee with the final full report following the consultation exercise. At the time of the meeting, only an interim report was available. Final report expected to be published in autumn 2024.	Nov 2024 update – Full feedback reports have now been published: https://nclhealthandcare.org.uk/get-involved/start-well-2/

3	Start Well	**COMPLETE**	Committee to provide formal response by letter to NCL ICB on the interim report following the consultation exercise.	Letter submitted to NCL ICB in August 2024. This letter included all of the main comments/recommendations made at the meeting. See minutes of meeting for further details. Letter provided as **ATTACHMENT A**.
2	Terms of Reference	**IN PROGRESS**	Discussions to be held with Boroughs on resourcing of support for JHOSC.	This has been passed to the Monitoring Officer at Haringey for discussion with the other 4 NCL Boroughs.
1	Terms of Reference	**IN PROGRESS**	New draft terms of reference for the JHOSC to be developed.	The Committee met on 8th Aug 2024 to provide initial input and 3rd Sep 2024 to consider a first draft. A second draft has been completed. The section on the resourcing of the Committee are currently under discussion and the draft terms of reference will be submitted for ratification by the Boroughs after this issue has been resolved.

No.	ITEM	STATUS	ACTION (succinct)	RESPONSE
29	NCL Financial Review		Acute vs community: pressures/risks overview	UEC/elective pressures and community capacity are tracked via the Board Performance & Finance reports (p.128) Link: https://nclhealthandcare.org.uk/wp-content/uploads/2025/07/NCL-ICB-Board-Meeting-22.7.25.pdf
29	NCL Financial Review		VCSE: distribution of funds	The ICB and Local Authorities, working with the NCL VCSE Alliance, have established a VCSE Investment Group to coordinate and sustain VCSE investment and infrastructure; local priorities (including the Inequalities Fund) will support delivery across all five boroughs. VCSE Strategy: https://nclhealthandcare.org.uk/wp-content/uploads/2022/10/NCL-ICB-Working-with-our-VCSE-2223_2526.pdf
29	NCL Financial Review		Decision lines: inter-department communication & financial decisions	Financial decisions follow established governance: proposals developed by relevant teams, reviewed through finance/quality committees, and decided via executive and Board routes in accordance with ICB SFIs; at Trusts, inter-department coordination runs through operational and finance committees chaired by Trust executives in accordance with Trust SFIs.

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North Central London Health and Care
Integrated Care System

NHS
North Central London
Integrated Care Board

JHOSC Finance Report

September 2025

Contents Page

North Central London Health and Care Integrated Care System

NHS North Central London Integrated Care Board

North Central London Health and Care
Integrated Care System

NHS
North Central London
Integrated Care Board

NCL ICS 2025/26 Finance Plan Submission Summary

2025/26 Planning Overview

North Central London Health and Care Integrated Care System

NHS North Central London Integrated Care Board

System Financial Bottom Line

- Following the receipt of planning returns from trusts on 27th March, the NCL system's 25/26 plan is a balanced position. NCL is planning to move from an exit underlying deficit of £247m in 24/25 to an exit underlying deficit of £185m in 25/26, an improvement of £62m.
- The system is heavily reliant on non-recurrent measures to achieve financial break-even. There are c.£185m of non-recurrent measures in the 25/26 plan and this compares to the c.£247m in the 24/25 forecast outturn position. This represents a planned improvement in the underlying position of £63m.

System Cost Improvement Plans

- 25/26 plans are underpinned by c.£318m of efficiency savings to be delivered. Based on influenceable income which is the typical NCL metric to measure savings, this represents c.5.7%. This is an increase of £89m (39%) on the total system savings delivered in 24/25.

Agency and bank spend caps

- For 25/26, NCL were set an agency spend cap of c.£71m and a bank spend cap of c.£244m. For agency spend, providers have been set a target representing between 15% and 40% decrease in 24/25 agency spend whilst a uniform 10% reduction on 24/25 spend has been applied for bank spend.

System Risk Review

- NCL have identified c.£0.25bn of gross risks in the 25/26 plans submitted at the end of March. Although it is likely trusts have taken different views of risks within their plan, it is clear there is a substantial element of risk.
- Almost 50% (c.£119m) of the risk relates to the delivery of the CIP plans. The next highest risk relates to contract income (c.£50m) which is a specific issue for many trusts in NCL who have a significant proportion of their income base from outside of NCL ICB.
- The ICB has identified c.£29m of risks relating to Prescribing & CHC, for which there have been significant cost pressures in recent financial years.

Upcoming submissions

- There is further national submission of the 25/26 Financial Plan on Wednesday 30th April where organisations have been asked for an update on the maturity of their Cost Improvement programmes.

	Movements in Bottom line position between planning returns				Memo	
Org	25/26 Plan - January Submission	25/26 Plan - Feb Submission	25/26 Plan – 27th March	Movement between March & Feb	24/25 plan	24/25 FOT (M11)*
	£'000	£'000	£'000	£'000	£'000	£'000
Providers	(224,969)	(244,416)	(27,192)	217,224	(14,552)	(14,552)
ICB	0	0	27,193	27,193	14,552	14,552
System Total	**(224,969)**	**(244,416)**	**1**	**244,417**	**0**	**1**

*At the time of writing this report, organisations had not yet confirmed the final 24/25 financial position.

2025/26 NCL ICS Capital Programm

North Central London Health and Care Integrated Care System

NHS North Central London Integrated Care Board

NCL ICS System Capital Programme

- The 25/26 Core Capital allocation for NCL ICS is £249.4m.
- The national formula provides £227.2m to NCL ICS to allocate to providers. The system is expected to receive £22.2m for achieving financial balance in 2024-25 which the ICS is currently on track to deliver. We have used this capital bonus, along with the 10% top slice to cover the commitments on strategic priorities.
- This has been distributed to providers as per the table below. There is a small overcommitment on 25/26 Capital that we believe we can manage in-year.

ICS 2025-26 National Capital Funding Allocation	
Description	**£'000**
Depreciation	172,928
Gross Assets	38,790
Backlog Maintenance	15,454
2025/26 Fair Share Allocation	**227,172**
24/25 Revenue Fair Share Allocation Adjustment	22,225
2025/26 Total Capital Allocation	**249,397**

	Fair Share allocations (excl. IFRS16)	Strategic Schemes top-slice (10% on Fair Shares)	Strategic Schemes allocations	System Shortfall to be managed in year	Core capital allocations	IFRS 16 lease allocations	Total allocations (Core + IFRS 16)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NCL Total	**183,131**	**(18,314)**	**43,051**	**(2,513)**	**205,355**	**44,041**	**249,396**

25/26 Capital Freedom & Flexibilities

- In addition to £22.2m received for delivery of break-even in 24/25 the system will also receive further funding which we have a choice on how this funding will be phased.
- We have opted to phase these further funds in 26/27 to meet the strategic priorities and contractual lease commitments we have in that financial year.

North Central London Health and Care
Integrated Care System

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North Central London
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NCL ICB 2025/26 Finance Plan Submission Summary

2025/26 ICB Financial Plan

North Central London Integrated Care Board

2025/26 ICB Financial Plan

On 30th January 2025, the ICB received financial planning guidance from NHS England detailing how it should allocate annual funding. The plan includes a set of planning assumptions outlining the expected increases for specific types of expenditure. The standard uplift is 2.15%, which assumes a price increase of 4.15% and an efficiency measure of 2.00%

There have been two submissions of the ICBs financial plan to NHS England, with the final plan submitted on 30th April 2025. The plan requires the ICB to achieve a **surplus of £27.2m**. This surplus will contribute to the broader System-wide financial position.

The plan includes a number of targets that will need to be carefully managed throughout the year. These include;

- Use of non-recurrent benefits - **£43.6m**
- Full achievement of CIP (efficiency) targets - **£29.2m**
- ICB Cost pressures - **£1.4m**
- System Cost pressures - **£5.8m**
- The assumption that all risks will be mitigated in year. These currently stand at **£69.4m**, mitigated to **£57.0m.** These address risks related to rising costs in Complex Care, High-Cost Drugs and Devices, Prescribing, as well as risks associated with CIP delivery.

It's important to note that the latest government announcements about reducing ICB costs have not yet been factored into this plan.

2025/26 ICB Plan

North Central London
Integrated Care Board

	March 25 submission £000
24/25 Re-forecast	**14,552**
Non Recurrent Items	(49,390)
24/25 Exit underlying position	**(34,838)**
Full Year Effects	(4,475)
25/26 Opening underlying position	**(39,313)**
CIP (Recurrent)	18,631
Unallocated Funding	833
ICB Cost Pressures	(1,359)
System Cost Pressures	(5,800)
25/26 Closing underlying position	**(27,009)**
CIP (Non-Recurrent)	10,559
N/R Measures	43,642
25/26 Plan	**27,193**

2025/26 Draft Plan

The table to the left details the financial bridge from the ICBs 2024/25 surplus plan (£14.6m) to the modelled 2025/26 plan based on NHS England's Planning Guidance issued on 30th January 2025.

The ICB is currently showing a surplus plan of £27.2m, on the assumption that £1.4m and £5.8m is earmarked for ICB and System Cost Pressures.

The plan assumes full delivery of the 2025/26 efficiency (CIP) targets, totalling **£29.2m**. In addition, the ICB will need to identify **£43.6m** in one-off (non-recurrent) benefits to achieve the planned financial position.

2025/26 ICB Recurrent Allocations

North Central London Integrated Care Board

NCL ICB Recurrent Allocations 24/25 to 25/26

Service Area	Recurrent Allocations		Increase	
	2024/25 (M12) £m	2025/26 £m	2025/26 £m	2025/26 %
Programme	3,054	3,180	125.7	4.1%
Primary Care Delegated Commissioning	316	358	42.0	13.3%
Primary Care Dental, Ophthalmic & Pharmacy	163	170	6.2	3.8%
Running Costs	27	25	(1.7)	(6.3%)
Total	**3,561**	**3,733**	**172.1**	**4.8%**

The table above details the expected recurrent allocations from NHS England for 2025/26. This is an increase of £172m from what was received recurrently in 2024/25. However, there has been some movements between the categorisation of non-recurrent and recurrent allocations, resulting in a like for like comparison that **equates to an overall increase of £149m.**

In addition, the ICB has been notified of £332m of non-recurrent allocations for 2025/26 these include:

- *Additional Elective Recovery funding*
- *SDF funding*
- *Community Diagnostic Centres*
- *Overseas Visitors funding*
- *Covid Testing funding*
- *Business Revenue Bonus*

North Central London Health and Care
Integrated Care System

NCL ICS Month 4 Finance Position

Board Report as at 31st July 2025

25/26 M4 Financial Position - Overview

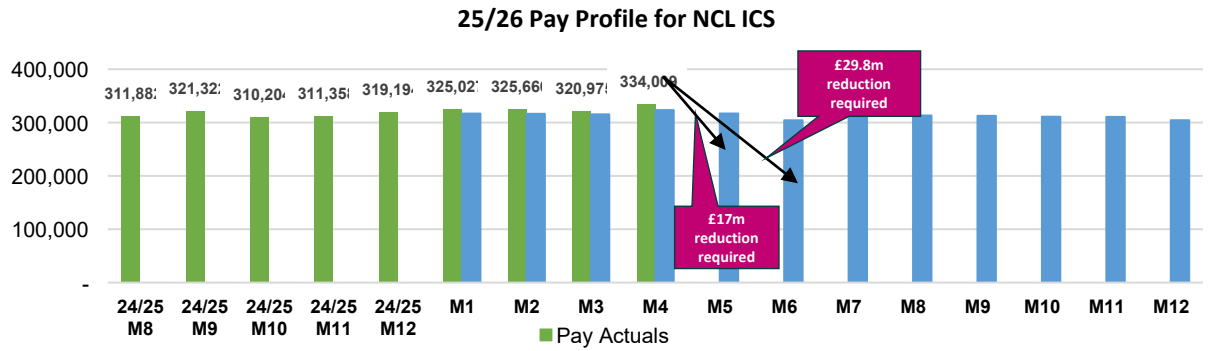
M4 Financial Position Overview – Revenue

- NCL ICS reported a YTD deficit of £66.4m at M4 which represents an adverse variance of £17.7m against the YTD plan.
- The adverse variance is entirely driven by the provider sector (£17.6m) where it mainly relates to pay pressures.
- M4 also saw Industrial Action (IA) which has impacted the system financial position by c.£4.4m, of which c.£3.1m relates to net pay costs and c.£1.3m of income loss due to IA. Unlike in previous years, we understand there is no funding to follow to offset the costs of IA
- At an organisation level, the adverse variance mainly relates to:
    - GOSH (£6.6m adv) – The trust have flagged pressures on Pay where £1.5m of the variance has been attributed to shortfalls in pay award funding.
    - Whittington (£4.6m adv) - Additional cost of delivering elective activity, enhanced care, corridor care and A&E flows.
    - NLFT (£4.1m adv) – The trust indicated a continuation of pressures from M12 of 24/25 into 25/26 M4 and slippages in delivery of planned savings as variance drivers.
    - UCLH (£2.8m adv) – Variance driven by CIP shortfall and pay pressures.
    - T&P (£0.9m adv) – Reported YTD loss of income of £0.9m on an education contract that NHSE have decommissioned from the trust.

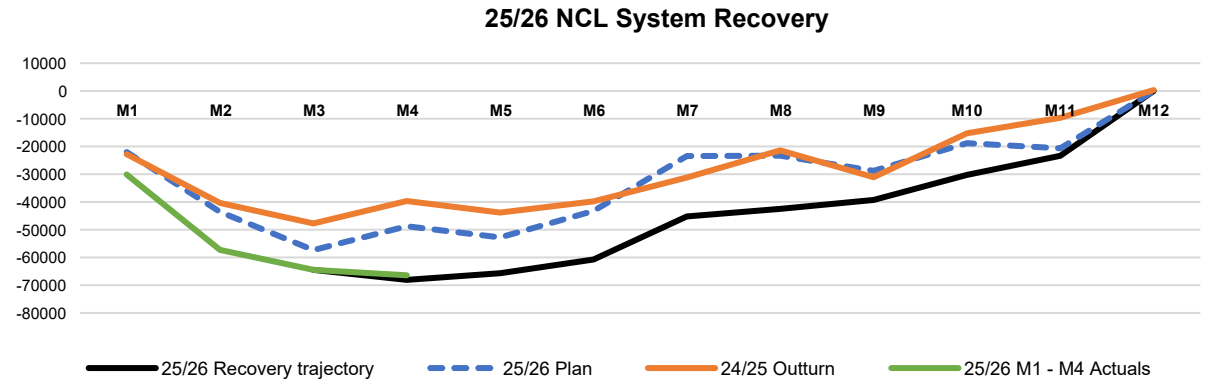
M4 Financial performance against the recovery plan

- In light of the M2 position which would have put NCL in segment 4 of NHSE's upcoming national oversight framework, we subsequently requested that every organisation in the system complete a financial recovery return in M3.
- As illustrated in the graph on the right, returns received indicated that the system intends on delivering the 25/26 plan, but recovery to plan doesn't happen until M11.
- Recovery returns submitted last month indicated the M4 adverse variance to be £19.3m across the system. The M4 system variance ended up being £2.1m better than the recovery plan.
- Financial recovery action includes Mutually agreed resignation schemes (MARS) at a number of providers, closure of unfunded capacity and vacancy freezes amongst the main interventions.

	M4 Year to date			Forecast Outturn			Memo
Organisation	YTD Plan (29th April submission)	YTD Actual	YTD Variance	Annual Plan (29th April submission)	Forecast Outturn	FOT Variance	YTD IA Impact
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Trust Total	(57,821)	(75,498)	(17,677)	(27,192)	(27,191)	-	(4,415)
NCL ICB	9,064	9,064	-	27,192	27,192	-	-
System Total	**(48,757)**	**(66,434)**	**(17,677)**	**-**	**-**	**-**	**(4,415)**



Note: M12 excludes spend relating to Employer pension contributions paid by NHSE on provider's behalf.



NHS
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NCL ICB Month 4 Finance Position

Board Report as at 31st July 2025

Month 4 Summary Position

North Central London Integrated Care Board

Month 4 Summary Position

Background

The System submitted a final 2025/26 balanced plan on 30th April 2025. As part of this, the ICB submitted a surplus plan of **£27.2m**.

The ICB plan includes several efficiencies required to deliver to the surplus position. These include a CIP target of **£37.1m** and the requirement to deliver in-year non-recurrent measures of **£43.6m**.

The plan also assumes full mitigation of in-year risks, currently **£54.2m** as at Month 4 (risk adjusted).

Month 4 (July 2025)

For Month 4 (Jul'25) the ICB reports a forecast break-even position against plan. Within this however, Non-Acute reports an adverse variance of **£4.4m**, an improvement of **£8.8m** against the Month 3 reported position. The Month 4 pressure is primarily driven by increased costs for ADHD within Mental Health. Community also forecasts an adverse variance, driven in the main by overspends against Community Equipment budgets (£1.1m).

Acute reports an overspend of **£1.9m** driven by Independent Sector pressures.
The above reported pressures have been offset by a **£5.1m** pay underspend and the release of recurrent and non-recurrent benefits, enabling the ICB to report a breakeven position.

Summary financial position (£m)

	YTD			Full Year		
	Bud	Actual	Var	Bud	FOT	Var
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	**1,586.4**	**1,586.4**	**0.0**	**4,764.6**	**4,764.6**	**0.0**
Acute	697.2	697.8	(0.6)	2,091.5	2,093.4	(1.9)
Non-Acute	836.5	840.1	(3.5)	2,515.0	2,519.4	(4.4)
Other Pgrm Services	35.1	32.1	3.0	105.4	102.3	3.0
Running Costs	8.5	7.3	1.2	25.5	22.2	3.3
Total Operational	**1,577.4**	**1,577.4**	**0.0**	**4,737.4**	**4,737.4**	**0.0**
Reserves & Contingency	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Operational	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total Expenditure	**1,577.4**	**1,577.4**	**0.0**	**4,737.4**	**4,737.4**	**0.0**
Surplus / (Deficit)	**9.1**	**9.1**	**0.0**	**27.2**	**27.2**	**0.0**

Month 4 Summary Position

North Central London Integrated Care Board

Month Summary Position

Use of Non-Recurrent Funds

During the 2025/26 planning period, the ICB committed to using **£43.6m** of non-recurrent funding to deliver a planned surplus of **£27.2m** (as per the final submitted plan on 30th April) and achieve a System breakeven position. The ICB has initiated an in-year recovery programme to ensure this target is met, noting that the use of non-recurrent measures to support recurrent expenditure adversely affects the ICB's underlying position.

Risks & Mitigations

As at Month 4, the ICB is reporting **£31.3m** of net financial risk against its planned position.

This risk is being actively monitored through established executive oversight arrangements, with a clear focus on ensuring the ICB remains on course to deliver its statutory financial duties and ensuring the continued delivery of commissioned services in line with national and local planning priorities.

The ICB has strengthened its financial control environment to support the effective management and mitigation of both current and emerging risks. This includes the application of enhanced expenditure controls, a systematic review of in-year financial performance against plan, strengthening governance and decision-making processes and targeted monitoring of areas with material cost exposure. Run rate performance is subject to monthly review at directorate and system level to support the emerging risk during the year and allow for timely mitigations to be agreed.

While the primary focus remains on in-year delivery, the ICB is also maintaining oversight of risks to the underlying position as part of forward planning into 2026/27. The financial risk position is formally updated each month and reported through executive forums and the Finance Committee, providing assurance that appropriate measures are in place to support the continued delivery of statutory financial requirements.

Month 4 Risks & Mitigations

NHS North Central London Integrated Care Board

Risk Summary

Directorate	£'000 Risk value Month 4	% RAG rating	Rag Rating	£'000 Risk adjusted value Month 4	Risk adjusted Mitigation Month 4	Net Risk Month 4	Comments
RISKS							
Acute	(30,413)	65%		(19,669)	2,100	(17,569)	Driven by cost pressures within the variable elements of the NHS block contracts (£7.1m) and ERF (£10m)
Continuing Healthcare	(4,581)	75%		(3,436)	0	(3,436)	Risk of additional pressures due to increase in activity and complex cases
Community	(500)	50%		(250)	1,477	1,227	Risk of increased community spend offset by Potential underspends within the community programme budgets
Mental Health	0			0	1,290	1,290	Introduction of Indicative Activity plans (IAPs) to mitigate pressures within MH independent sector activity increases.
Primary Care	(1,138)	100%		(1,138)	1,078	(59)	Cost pressures associated with the provision of interpreting services
Primary Care - DOP	(2,508)	50%		(1,254)	8,895	7,641	Mitigation relating to additional income received for Pharmacy
Primary Care - Prescribing	(16,981)	85%		(14,484)	2,782	(11,702)	There is a potential run rate pressure of £7m above the reported position driven by cost associated with weigh loss drugs
Primary Care Co-Commissioning	(2,947)	99%		(2,917)	2,917	0	
Other Programme / R/Cost	(19,366)	57%		(11,073)	2,330	(8,743)	Additional cost pressures associated with transition and change management partially mitigated by non recurrent measures.
TOTAL RISKS	**(78,434)**	**69%**		**(54,221)**	**22,869**	**(31,351)**	

Month 4 Risk Position

For Month 4, the total identified risks amount to **£78.4m**. These risks have been evaluated and categorised using a RAG (Red, Amber, Green) rating system, which assesses the likelihood of each risk materialising. The total risk-adjusted position for Month 4 is **£54.2m**, which has been mitigated to a total net risk of **£31.4m** (Month 3 £23.8m)

Mitigations

The ICB has identified risk-adjusted mitigations of **£22.9m**, an improvement of **£5.8m** from the Month 3 reported position. The ICB therefore requires additional mitigations of **£31.4m** to fully cover the risk position at Month 3. These additional mitigations are expected to be achieved through an in-year financial recovery programme, noting that the use of non-recurrent mitigations to cover recurrent risks will impact the ICB's underlying financial position.

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North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
22 July 2025

Report Title	NCL – NWL Case for Change and Options Appraisal for Merger	**Date of report**	17 July 2025	**Agenda Item**	2.1
Lead Director / Manager	Frances O'Callaghan, Chief Executive Officer	**Email / Tel**		Frances.o'callaghan@nhs.net	
Board Member Sponsor	Paul Najsarek, Chair				
Report Author	Sarah Louise Morgan, Chief People Officer	**Email / Tel**		Sarahlouise.morgan@nhs.net	
Name of Authorising Finance Lead	Stephen Bloomer, Chief Finance Officer	**Summary of Financial Implications** • Running-cost ceiling: £19 per head from FY 26/27 equates to a £33.2 m cap for NCL • Key risks are a potential *"fair-share"* under-allocation once commissioning budgets are pooled (-£91.6 m) and slippage in delivering the 51 % admin-cost reduction already mandated. • Transitional costs (legal, ISFE2 ledger change-over) will be funded from existing reserves.			
Report Summary	Following completion of the Case for Change and Options Appraisal dated 16 July 2025, it is recommended that the North Central London (NCL) and North West London (NWL) Integrated Care Boards pursue a full statutory merger (Option 3b). **Strategic Rationale** The two Boards together commission services for approximately 4.35 million residents. Operating independently, both organisations face identical pressures: a nationally imposed running-cost ceiling of £19 per capita, rising demographic demand and significant health inequalities. A single, merged ICB would possess the scale and authority required to address those challenges more effectively than either Board could achieve alone. **Population-Health and Quality Benefits** A unified commissioner would enable coherent strategy, investment and data-driven decision-making across eight boroughs. Greater alignment is expected to accelerate existing programmes in cardiovascular disease, mental-health access and children's services, and to reduce unwarranted variation across North and West London.				

Workforce and Organisational Capacity
A single organisation will provide clearer career pathways and promote a consolidated "One London" culture, thereby supporting recruitment and retention of key staff. Borough-based partnerships will remain responsible for local service delivery, benefiting from enhanced corporate resilience and shared digital platforms.

Options Appraisal Outcome
Four structural scenarios were evaluated against population-health impact, quality improvement, financial sustainability, deliverability and risk. Option 3b (full merger) achieved the highest composite score (22/25), surpassing stand-alone, cluster and partial-integration models.

Option	Score (/25)
1 – Stand-alone ICBs	10
2 – Clustering	12
3a – Merger, partial integration	18
3b – Merger, full integration	**22**

Recommendation

The recommendation to the Board is Option 3b, which is the full merger with fully integrated teams.

The Board of Members is asked to:

- **APPROVE** the recommendation of Option 3b for formal merger of the 2 ICBs as the preferred option
- **APPROVE** the progression into the national process for approvals with final sign-off of the transaction delegated to the Chair(s) and CEO(s) at the appropriate time
- **APPROVE** the establishment of a joint executive-led Programme Board to lead and manage the merger process.

Identified Risks and Risk Management Actions

Risk	Rating	Type of risk	Potential Mitigations
Meeting timelines for 2026 merger	**M**	Transitional	Work is underway to mitigate the workload required between Board decision and 30/09
Due diligence	**M**	Transitional	Work is already underway with a merger checklist and lessons learned from previous mergers to support an accelerated process to be undertaken as soon as the decision is taken to enter any formal merger process
Meeting cost reduction timelines	**M**	Financial	Vacancy controls are in place to reduce run-rate people cost Team is lined-up to support the design of new structures and management of change process asap following the decision of the Boards Work is underway on functions that are indicated to transfer in the Model ICB

	Management of change – complexity and risk	**M**	Transitional	Conversations with staff side colleagues already underway Robust principles to be developed with employment law input Consider phased implementation of new structures, with shared enabling functions planned first
	Introduction of the Integrated Single Financial Environment (ISFE2)	**M**	Transitional	Guidance and assurance required from NHSE for how this will be managed for ICBs who are merging Support and resources made available nationally for this to be managed safely and well Discussion with national to consider a review of the approach and timeline to take into account this requirement
	People integration – culture & ways of working	**H**	Transitional	Culture and ways of working to be a key focus during and post implementation Ensuring sufficient resources are available in the new structure to support this Consideration of how structures may evolve to mitigate any significant people integration risks
	Fair share convergence	**H**	Financial	Further discussions required with NHS England to ensure NWL allocation is ringfenced
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.			
Resource Implications	Resource implications are currently being worked through for the delivery of the Merger programme and will be reported back to the Transition Committee and Board in due course. A full programme delivery plan is being developed which will clearly.			
Engagement	A range of engagement activity has been undertaken during the development of the case for change. The ICB is grateful to the input from staff and stakeholders that has helped to inform this paper and gather a broad range of views and reflections. This has included discussions with the senior leadership team, presentations at 'all-staff' briefings, updates at directorate briefings and a discussion with the ICB Culture and Operations Group, which includes representatives from Staff Networks. Conversations have also taken place with Trade Union representatives and at the staff Wellbeing Group. The ICB has made sure local stakeholders have been kept informed, including through targeted email updates and the ICB's stakeholder bulletin, through regular meetings with Local Authority Chief Executives and Political Leaders; with Provider Chief Executives through the NCL System Management Board, with the local VCSE Alliance and at the most recent NCL Community Partnership Forum. Joint workshops have been held with the NWL Executive Team. The ICB will continue to update and collaborate closely with staff and stakeholders following the Board's decision.			

Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010. An initial EIA indicates no adverse impacts; pooled resources and harmonised commissioning expected to advance equality objectives.
Report History and Key Decisions	The report has been developed with executive input across both organisations and oversight through respective transition committees.
Next Steps	Subject to the decision of NCL ICB and NWL ICB Boards, key next steps include: - Confirm to NHS England the outcome of the respective Board discussions - Inform ICB staff and stakeholders of the outcome of the Board decisions - NHS England to formally exercise the authority delegated from the NHSE Board to order dissolving the two ICBs and the creation of a new merged ICB. It is expected this will take place by the end of September - Jointly develop a full Programme Plan to deliver all aspects of the merger - Establish the joint executive-led Programme Board to lead and deliver the merger programme - Provision of regular updates and engagement with the ICB Transition Committee(s) and subsequent regular updates to the Board(s).
Appendices	None – all appendices are contained within the main body of the document

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Model ICB Options Appraisal

18 July 2025

Contents

NHS
North Central London
Integrated Care Board

1 About this paper

Background and context / reasons for undertaking this appraisal

NHS
North Central London
Integrated Care Board

Background and Context:

- ICBs in England have four core objectives. These are to:
  1. Improve health outcomes and reduce inequalities in health
  2. Ensure consistently high quality care
  3. Drive improved productivity
  4. Improve social and economic impact
- In support of these four objectives, the Government has set out three shifts for the NHS:
  - **Treatment to prevention:** through proactive community and public health initiatives, working closely with local authorities, communities and individuals
  - **Hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
  - **Analogue to digital:** Harnessing technology and data to transform care delivery and improve quality of care
- The 'Model ICB Blueprint' guidance (May 2025) and '10-year Health Plan for England' (July 2025) sets out how ICBs should become 'strategic commissioners', playing a crucial role in the future of the NHS. ICBs will need to ensure that funding is deployed optimally to improve population health, reduce inequalities, and improve access to high-quality services through:
  - Understanding Local Context: Analysing population needs and tackling health inequalities using advanced population health data and predictive modelling.
  - Developing Long-Term Strategy: Deploying staff with strong problem-solving & analytical capabilities, and a value-based understanding of healthcare.
  - Partnership Working: Collaborating with communities, clinical leaders, and stakeholders to design best-practice care pathways that meet the needs of communities.
  - Intelligent Resource Allocation and Payer Functions: Allocating resources to best align to need and value-for-money, designing and overseeing value-based contracts, working with providers, development of novel payment mechanisms, and shaping markets to ensure the effective delivery of commissioned services; and
  - Evaluating Impact: Promoting adaptive planning by embedding patient and other feedback and evaluating care outcomes through rigorous data-driven processes.
- In undertaking this transformation to strategic commissioning, all ICBs are also required to reduce their running costs to a maximum of £19 per head of population. For North Central London ICB, our weighted population of 1.75m means an administrative cost maximum of £33.2m per year, including all pay costs (admin and Programme pay) and non-pay running costs. This represents a 51% reduction in costs, when compared to our current position.
- Whilst embracing the concepts of the Model ICB we are concerned that these changes will slow the progress we have made as a system. Delivering the capability and capacity required to become an effective strategic commissioner within the £19 cost envelope presents significant challenge and carries substantial risk.
- Our work to mitigate this risk can be characterised under three main headings:
  - Developing a future Operating Model which focuses on the core requirements to be a successful strategic commissioner for our residents.
  - Continuing to evolve the model as the parameters become clearer, through our joint work with London; and
  - Collaborating with North West London ICB ("NWL ICB") to explore joint opportunities which will allow us to achieve our objectives and vision of the future, while best managing the risks associated with running cost reduction.

About this paper:

1. This paper focuses on the third risk listed above. It first sets out the 'Case for Change' for developing a 'Model ICB' serving North Central London residents and then considers four options for how this could best be achieved, working in different ways with NWL ICB.
2. **Appraising options in this way – using a structured approach will ensure that our future collaboration arrangements are in the best interests of North Central London residents.**

Background and context / reasons for undertaking this appraisal

NHS
North Central London
Integrated Care Board

About this paper:

1. This paper focuses on the risk mitigation option *collaborating with North West London ICB ("NWL ICB") to explore joint opportunities which will allow us to achieve our objectives and vision of the future, while best managing the risks associated with running cost reduction.*
2. It first sets out the 'Case for Change' for developing a 'Model ICB' serving North Central London residents and then considers four options for how this could best be achieved, working in different ways with NWL ICB.
3. The options considered are:
    - Option 1: Two ICBs with separate transformation
    - Option 2: Two ICBs with joint enabling functions
    - Option 3a: One legal entity with targeted integration of functions
    - Option 3b: One legal entity with fully integrated functions.
4. The paper appraises each option against 5 criteria, agreed with executives through deliberation. Assessing options in this way – using a structured approach aligned to our vision for the future – will ensure that our future collaboration arrangements are in the best interests of North Central London residents.
5. Where services / areas are due to be transitioned out of the ICBs (as indicated in the model ICB blueprint), this transition is assumed under all options. These services/ areas are not considered further in this paper. Further detail on this will emerge in due course.
6. The paper describes the output of scoring and moderation each option against the criteria and establishing draft recommendation that can be put forward to the Board in July for decision.
7. Moderation of scores was undertaken by the Executive Team.
8. Supporting analysis is found in the appendix at the end of this document.

- **Recommendation**

This paper has been considered by North Central London ICB Transition Committee on 14th July 2025.

North Central London ICB is facing significant transformation under any option, due to our change in role and significant reduction in funding. We need to create a positive new organisation that facilitates becoming the best strategic commissioner for the population of North Central London, maximises the opportunities afforded us by the 10 Year Health Plan and the Model ICB, and enables staff to succeed and flourish.

For this reason, we are recommending **Option 3b – full merger with North West London ICB.**

It is important that this is executed well in order to realise the intended benefits and minimise the risks.

This must be subject to an implementation plan that delivers this robust approach to organisational change. The plan needs to proactively engage with partners. The approach needs to manage staff professionally and with compassion, building the new teams with the skills and talent to deliver our vision for our residents.

- **Next steps**

1. 22 July - Board decision
2. 23 July – NWL ICB Board decision
3. Notification of the decision to NHSE
4. If merger is approved, then both organisations will progress into the national merger process

2 The Case for Change

Our vision is to … *work with residents of all ages in NCL so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death*

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Our vision, as set out in our Population Health and Integrated Care Strategy, is to **work with residents of all ages in NCL so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death**

Achieving the vision within the new NHS operating model and financial constraints, means developing an approach to strategic commissioning that:

1. Increases the number of years lived in good health for our current population
2. Closes the health outcome disparities for those communities with the worst outcomes
3. Makes commissioning decisions in a way that not only accounts for but reduces future population healthcare need
4. Ensures the long-term financial sustainability of NHS services

To achieve our vision, we have established three key transformational priorities as shown right.

1 **Knowing our population**	• Better understanding the lives of our population and the local health context through data & analytics, insight and dialogue.
2 **Developing strategic commissioning**	• Planning, investing and contracting coherently to drive value, support integration, reduce inequalities & improve lives now and in the future.
3 **Delivering the neighbourhood model**	• Transforming how care is organised and delivered at neighbourhood level via a new social model of health and wellbeing that optimises partnerships with individuals and communities.

Our vision and transformational priorities hold true in the new NHS operating model and are reinforced by the Model ICB and the 10YP. We therefore need to establish whether collaborating with another ICB, leading to potentially working at greater scale, enables us to deliver our vision and transformational objectives for the benefit of patients and residents.

We believe our vision can be best achieved if we operate at greater scale

North Central London
Integrated Care Board

How scale enables our vision

1	Enabling investment in a new strategic commissioning tool kit
2	Market shaping through greater payor influence
3	Securing delivery through place and neighbourhood
4	Retaining and attracting the best people
5	Ensuring resilient and cost-effective core functions

These are all enablers for delivering our vision to

“work with residents of all ages in NCL so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death”

The five ways in which scale enables our vision [1/3]

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Integrated Care Board

1 Enabling investment in a new strategic commissioning tool kit

Why this is important:

To deliver our vision and the vision of the 10YP, we need a strategic commissioning approach that will deliver meaningful shifts in cost base to ensure allocative efficiency against health needs, i.e. preventing deterioration and development of ill health, not just treating it. This requires we develop a new commissioning toolkit that has:

- A comprehensive model of population health needs and an ability to model the impact of changes in provision on future needs.
- A total population segmentation model.
- An analytical methodology to identify where there is poor return on the investment of current health resource in terms of outcomes.
- A shared longitudinal healthcare record to support data sharing and analysis[1].

Developing this tool kit requires investment in highly expert and technical teams covering disciplines such as health economics, epidemiology, actuarial modelling and data science, as well as teams who can develop innovative and novel contracting and payment approaches. We have concluded that this investment would be unaffordable as a standalone ICB.

2 Market shaping through greater payor influence

Why this is important:

The payor in any market should have the power to shape the market to deliver the best possible outcomes for its population. There is no high performing health system in the world that is without an effective payor function. The WHO states the payor function is one of six essential building blocks of a well-functioning system[2]. However, in the NHS landscape, the levers have not always sat with the payor – CCGs were arguably sub-scale and ICBs are hampered by poor data and nationally-set financial payment frameworks.

As a single entity with a commissioning budget of £12bn, working under the new strategic commissioning framework set out in the Model ICB and 10YP, we could be a highly innovative and influential payor:

- By investing in the specialist teams and technologies outlined left, we would be able to use data to drive evidence-based commissioning decisions.
- We would have an enhanced ability to strategically commission by market management, including the ability to look at incentive-based payments and be more creative in our approaches to commissioning.
- We would be able to work more creatively with other agencies and have a higher risk tolerance as we can spread risks wider across the wider portfolio.

Sources: 1. The new London Secure Data Environment can provide a basis for this data infrastructure but will likely need enriching from local clinical systems; 2. WHO Everybody's business strengthening Health Systems to Improve Health outcomes 2007

The five ways in which scale enables our vision [2/3]

North Central London
Integrated Care Board

3 Securing delivery through place and neighbourhood

Why this is important:

- Place and neighbourhood are more important than ever to the NHS in the context of the 10 Year Plan. We are proud of our current borough-based commitment; it allows us to respond more effectively to the diverse needs of our communities and deliver the ICB Blueprint for '*understanding local context'*.
- However, our ability to effectively engage with partners at Place and develop and implement a new model for neighbourhood health are at risk because of the reduction in ICB funding unless we find a way to use our resources more effectively.
- On a stand-alone basis, we have concluded that we would need to pull resources away from Place to deliver on the core requirements of being a strategic commissioner within the new budget envelope, and those teams who are currently working on the development of neighbourhoods would need to be materially scaled-back. This is a significant strategic risk given the requirement to deliver on the three shifts within 10 Year Plan as well as manage the significant commissioning budget and complexity that NCL holds.
- The borough-based partnership model is maturing, and we intend to remain leaders in this space. Within a larger ICB, partnerships need to develop and function with devolved autonomy and accountability, but within a clear shared framework to avoid duplication and inefficiency.
- Through an effective at-scale operating model, we can ensure local services such as Continuing Health Care (CHC); Special Educational Needs and Disabilities (SEND) and safeguarding remain hyper local in focus and have the resources they need.

4 Retaining and attracting the best people

Why this is important:

- The people we employ are our biggest asset and we will succeed or fail on the basis of the talent we are able to retain within our organisation.
- Multiple rounds of nationally dictated re-organisation over several years has arguably made ICBs unattractive employers. Against this backdrop, we must do everything we can to describe roles that are exciting and meaningful for people who share our vision and have the talent to make it a reality.
- NCL had started to build a high performing team culture and had seen an improvement in many of the people promise indicators. Reducing the size of the organisation and creating the necessary burden of wider portfolios for staff could jeopardise that cultural improvement seen over the past year.
- By working at greater scale, we can:
  - Give our colleagues the opportunity to be part of something exciting, with greater opportunities for innovation and the potential to be leading in the field of strategic commissioning.
  - Develop more exciting roles and support career progression and professional learning opportunities within the ICB.
  - Develop, procure and deploy best in class digital tools (e.g., AI) to free up colleague time for more interesting and strategic work.
  - Minimising the risk of overwhelm and burnout by being able to invest in our teams

The five ways in which scale enables our vision [3/3]

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5 Ensuring resilient and cost-effective core functions

Why this is important:

- There are a range of must-do functions for any legal entity and NHS body – finance, HR, IG, legal, governance, complaints, FTSU, FOI etc.
- Some of these functions will be incredibly fragile if we remain a stand-alone organisation – with as few as one or two employees in some areas.
- This principle also extends beyond corporate functions to areas such as primary care contracting where skills are extremely scarce across London
- If we combine these functions and provide them once, we will derive an economy of scale where we are able to reduce unit cost and improve resilience. It will also enable us to invest in automation and other technological support to free up capacity and time to focus on value adding rather than just transactional activity.
- All of this will allow us to free-up resources for the development of strategic commissioning functions and for Place and neighbourhood development.

3 Why NWL

We have considered different partnership options and concluded a strong strategic fit with NWL

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What have we considered?

- The previous section outlined five key reasons why working at greater scale will enable us to achieve our vision for the patients and residents of NCL
- For the context of exploring options to scale, it is important to emphasise that NCL is part of the London NHS family, and that any collaboration or merger does not change our appetite or ability to continue to work with all London ICBs. Indeed, we expect the opportunities to work together will increase by virtue of the changes
- We have considered a range of options when determining our preferred partner. For each option, we have considered:
  - Alignment of vision for strategic commissioning
  - Geographic boundaries and patient flows
  - Established clinical pathways and networks
  - Similarity of population demographics and population health needs
  - Existing collaborations
  - Providers in common
  - Strengths, weaknesses and opportunities for shared learning
  - Financial sustainability and financial risk posed to NCL
  - Appetite of ICB for partnership
- **In considering these factors, we have reached the conclusion that there is a strong strategic fit between NWL and NCL**

Why NWL?

- Like many areas of London, both NWL and NCL both have stark health inequalities, an inner vs. outer London dynamic, and populations that are more diverse and transient than the England average. Boundaries are somewhat porous with c. 8% of acute spells for NWL residents flowing to NCL providers and c. 4% of NCL residents flowing to NWL providers
- NWL and NCL are both high-performing systems and have both been in financial balance for the past three years. This means we are entering into collaboration discussions from a position of strength, equity and opportunity
- The two organisations are aligned in both their vision for, and approach to, strategic commissioning and there is a natural affinity between the ICBs by virtue of the number of people who have worked in both systems during their careers. Operationally, NCL and NWL working together is a good fit
- Both systems have things to learn from the other and working together can accelerate spread and adoption. This includes the wider determinants of health, where we have collaborated across the NHS and Local Authority partners already such as in Work and Health (WorkWell and Get Britain Working Trailblazer) and the NHS Care Leavers Covenant, creating employment opportunities for people leaving care
- NWL and NCL are similar systems – for example, both have large and complex provider landscapes, a high proportion of specialist services, and world-leading universities
- We have several providers in common and many of our Trusts provide care for both NCL and NWL residents, which provides us with leverage and enhances efficiency – Central London Community Healthcare NHST (CLCH), Central and North West London NHSFT (CNWL), Royal National Orthopaedic Hospital NHST (RNOH), and many of our large acute Trusts

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4 Options appraisal for working together

About the options appraisal

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Integrated Care Board

We initiated this assessment to objectively assess the options available to NCL ICB. A stepped approach to options and criteria development was taken. Subsequently, we collated and analysed information to help form our assessment. As an executive team, we have discussed analysis and arrived at a set of scores that form our decision.

While options and criteria have been jointly agreed with NWL ICB, the scoring and assessment have been undertaken independently of each other.

1

Establish a clear vision for the future ICB serving the needs of people in NCL

Through discussion with execs and our chair, we have established a vision that would inform the criteria we would use to test options.

2

Agree a set of options & criteria

Bilateral discussions with NWL have resulted in a set of options we are jointly agreed on.

In discussion with NWL, we have drafted a set of equally-weighted criteria that reflect the questions each organisation would wish to test as part of merger considerations.

3

Analysis & engagement

We identified and analysed supporting information that could be used for each criterion. We used outputs of engagement sessions with staff and senior leadership to inform the assessment.

A scoring methodology was developed and used to objectively assess options.

4

Moderation

We used moderation among the NCL executive team to test the analysis. This check and challenge allowed us to arrive at a single view and recommendation for Board.

NCL ICB arrived at a recommendation independently.

Moderation

Assessment of criteria

Options & criteria development

Establish our vision

We have developed four options for assessment through the options appraisal process

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Option		Description
1. Stand alone organisations		• Two standalone ICBs where all aspects of NWL and NCL ICBs remain separate, meaning each would develop their approaches to strategic commissioning and all enabling functions separately. • Does not preclude greater collaboration between the organisations in any area of ICB business, whether informal collaboration / sharing learning or formal collaboration including joint funding and governance arrangements. However, as now, such collaboration would take place within the context of entirely separate statutory organisations and governance and delivery structures
2. Clustering		• Both organisations remain as separate entities from a legal perspective. • Could make joint senior appointments, including Chairs and Chief Executives and possibly non-executives • Form combined teams, where relevant, whereby employees of different ICBs work together under shared management • Establish joint committees between the ICBs and delegating authority to them, so as to minimise duplication in governance.
3. Merger	**3a.** Partial integration of teams	• The two ICBs legally merge to create a new single legal entity • A single Board and Executive Team set direction to the organisation, and account for progress, with delivery through two sets of strategic commissioning functions covering NWL (NWL-wide services and services for eight Boroughs) and NCL (NCL-wide services and services for five Boroughs). • This would allow NWL and NCL to maintain and develop nuanced strategic commissioning plans (aligned to need in each area), whilst sharing learning, developing the approach to strategic commissioning and sharing key strategic objectives. • As part of this, the financial allocations for NWL and NCL would be maintained and 'reserved' for the two populations (even if this was not legally required within the merged organisation). • A single set of enabling functions would support both strategic commissioning functions / teams, providing economies of scale and specialist expertise in these areas and supporting coherence at across the organisation. • *This option could be regarded as either an end-point or a transitional option towards Option 3b.*
	3b. Full integration of teams	• The two ICBs legally merge to create a new single legal entity • All teams within the new legal entity would be integrated, creating functions / teams that cover all thirteen Boroughs. This would include a single strategy and plan and single approach to strategic commissioning, delivered through a single set of system-wide commissioning teams. • A single Board and Executive team set direction to the organisation, and account for progress. • To support a single strategy, a single financial allocation could be deployed flexibly across all 13 boroughs pending confirmation this is possible and agreeable. • The single ICB would take a fully aligned approach to Place/Boroughs and links with Local Authorities with a single set of plans for Place/Neighbourhood and a single decision-making framework. • This would also require a single approach to the transfer of functions (e.g. Continuing Healthcare (CHC), Medicines Management) to other organisations. • The organisation would also include a single set of enabling functions.

How do the options relate to one another – and to key strategic questions?

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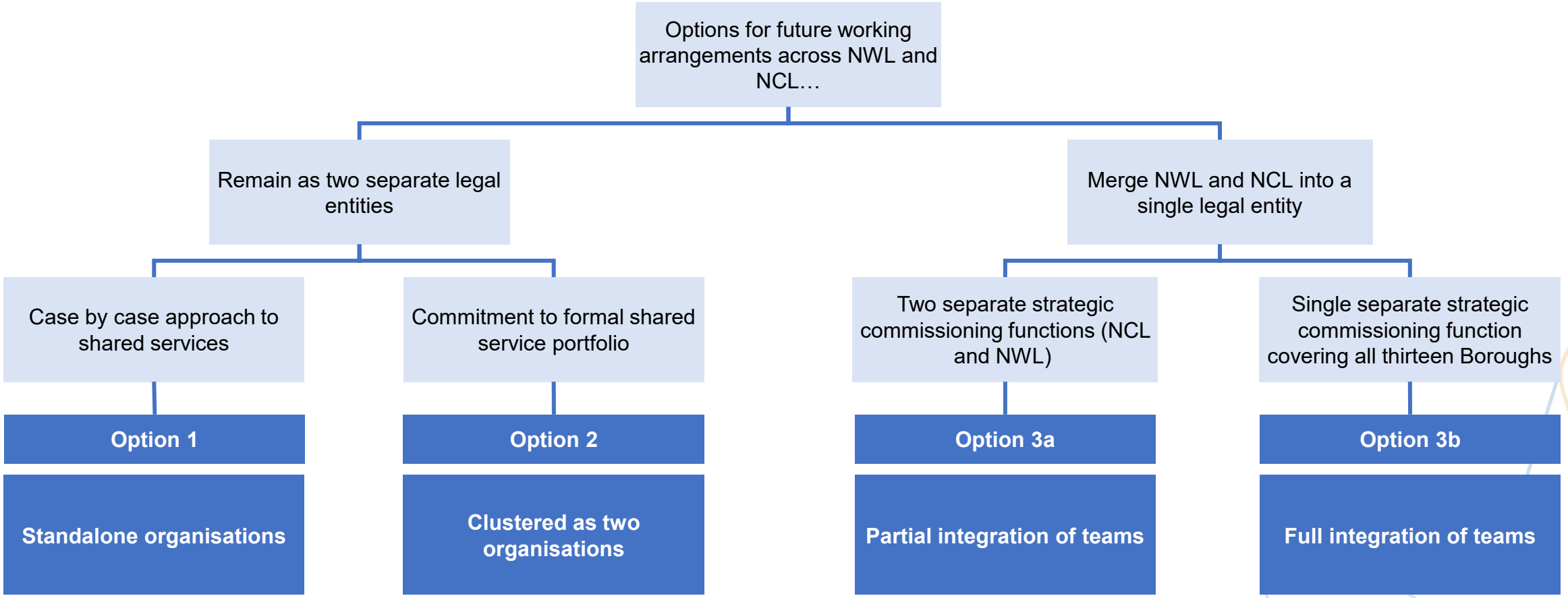
Integrated Care Board



Options Appraisal - Evaluation criteria:

Five criteria will be used to analyse the four shortlisted options, with each being scored on a standardised 1-5 scale

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Integrated Care Board

Evaluation criteria		Each option scored 1-5 on the extent to which it…
1	**Improving patient outcomes through strategic commissioning**	• Enables effective strategic commissioning (across the whole strategic commissioning cycle). • Maximises the quality, value and outcomes that can be achieved with the resources we have available. • Enables effective commissioning for the population served and reduces unwarranted variation and minimises health inequalities. • Maximises ICB influence in relation to providers, national and other key partners. • Maximises investment in strategic commissioning whilst retaining and developing skills and capacity in technology and specialised teams specifically, our at-scale ability to deliver population health. • Maximises opportunities for innovation - in both how the ICB works and the services we commission.
2	**Strengthening our Place and Neighbourhood arrangements to optimise outcomes**	• Helps the ICB engage as a commissioner in the ongoing development of Place/Borough-based Partnerships. • Helps the ICB to enhance efforts to develop and commission effective an effective Neighbourhood Model • Helps the ICB to preserve and strengthen relationships with system partners, including non-statutory bodies. • Offers stability around resource flows to the residents in each (current) ICB area whilst strategic commissioning plans for neighbourhood health are developed • Supports the relationships with Local Authorities regarding areas such as Continuing Healthcare (CHC); Special Educational Needs and Disabilities (SEND) and safeguarding • Supports the ICB to develop and commission a neighbourhood health service
3	**Retaining and attracting the best people**	• Attracts and retains the talent required to run the ICB of the future. • Provides learning and development and professional / career development for staff. • Providing culture, capability and capacity that enables people to thrive.
4	**Resilient and cost-effective functions**	• Enables the most effective use of ICB running cost resources. • Enables resilience within functions. • Support the ICB to move beyond just transactional corporate services to ensuring value added activities that underpin the effectiveness of the organisation
5	**Time and cost of change**	• Can be successfully implemented to meet national requirements. • Minimises disruption and uncertainty. • Minimise opportunity cost. • Minimises cost of change, for example legal costs. • Leads to a 'future proof' organisation – minimising the possibility of further disruptive change in future.

Options Appraisal - Evaluation criteria (continued):

Five criteria will be used to analyse the four shortlisted options, with each being scored on a standardised 1-5 scale relative to each other

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Criterion	1 (Lowest)	2	3	4	5 (Highest)
Improving patient outcomes through strategic commissioning	• Has low range of skills/roles within the strategic commissioning function • Low flexibility in resource allocation • Low influence for ICB • Low innovation & collaboration opportunities • Low resource for specialist functions • Low resource for technology investment • Few options for innovative collaboration • Low proportion and/or number of ICB staff assigned to strategic commissioning				• Has high range of skills/roles within the strategic commissioning function • High flexibility in resource allocation • High influence for ICB • High innovation & collaboration opportunities • High resource for specialist functions • High resource for technology investment • Many options for innovative collaboration • High proportion and/or number of ICB staff assigned to strategic commissioning
Strengthening our Place and Neighbourhood arrangements to optimise outcomes	• High risk to Place/Borough-based working • Low potential to promote neighbourhood health • High risk to hyper local services such as safeguarding, Continuing Healthcare (CHC) and Special Education Needs and Disability (SEND)				• Low risk to Place / Borough-based working • High potential to promote neighbourhood health • Low risk to hyper local services such as safeguarding, Continuing Healthcare (CHC) and Special Education Needs and Disability (SEND)
Retaining and attracting the best people	• Narrow range of roles • Few development opportunities • Negative staff experience, engagement and morale • Burnout and overwhelm experienced by staff				• Wide range of roles • Many development opportunities • Positive staff experience, engagement and morale • Staff reporting they are able to meet the demands of the work
Resilient and cost-effective functions	• Low non-pay savings opportunity • Low team resilience • Low economies of scale				• High non-pay savings opportunity • High team resilience • High economies of scale
Time and cost of change	• Takes long time and/or high cost to implement • Solution not sustainable in the longer-term				• Takes short time and/or low cost to implement • Solution is sustainable in the longer-term

The four shortlisted options will be scored on a standardised 1-5 scale

Scoring will then be supplemented by qualitative analysis and commentary in each area

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

1 (Lowest)	5 (Highest)
• Has low range of skills/roles within the strategic commissioning function • Low flexibility in resource allocation • Low influence for ICB • Low innovation & collaboration opportunities • Low resource for specialist functions • Low resource for technology investment • Few options for innovative collaboration • Low % resources on strategic commissioning	• Has high range of skills/roles within the strategic commissioning function • High flexibility in resource allocation • High influence for ICB • High innovation & collaboration opportunities • High resource for specialist functions • High resource for technology investment • Many options for innovative collaboration • High % resources on strategic commissioning

NHS
North Central London
Integrated Care Board

Option		Rationale
1. Stand alone orgs.	**2**	↘ In a smaller organisation, a greater proportion of resources will need to be directed towards must-do corporate activities, leaving less resource for strategic commissioning. Modelling suggests that in this option, only 38% of NCL's resources would be aligned to strategic commissioning ↘ A smaller organisation would have weaker influence and less negotiating power with large providers and national organisations ↘ Innovation and investment in strategic commissioning tool kit (specialist teams and technology) likely to be constrained by smaller budgets and lower ROI ↗ A smaller organisation may have greater ability to forge and maintain close relationships with partners and communities to inform strategic commissioning ↗ A smaller organisation may be more agile and able to rapidly respond to emerging needs
2. Clustering	**2**	↘ In a smaller organisation, a greater proportion of our resources will need to be directed to must-do corporate activities, leaving less resource for strategic commissioning. Bringing together enabling functions somewhat mitigates this but falls short of the benefits from a full merger. Modelling suggests 46% of NCL's resources aligned to strategic commissioning ↘ A smaller organisation would have weaker influence, less negotiating power with large providers and national bodies ↘ Innovation and investment in strategic commissioning tool kit (specialist teams and technology) likely to be constrained by smaller budgets and lower ROI. This option may allow for joint investment and shared specialist functions, but falls short of the benefits from a full merger ↗ Ability to innovate and spread best practices across enabling functions through joint working, including strategic commissioning ↗ A smaller organisation may have greater ability to forge and maintain close relationships with partners and communities to inform strategic commissioning ↗ A smaller organisation may be more agile and able to rapidly respond to emerging needs
3a. Merger – partial integration of teams	**4**	↗ In a larger organisation, a smaller proportion of resources will need to be directed towards must-do corporate activities, leaving more resource for strategic commissioning. Modelling suggests that in this option, 52% of resources are aligned to strategic commissioning ↗ Unified leadership will drive consistent priorities and transformation (note risk that delivery of priorities remains variable because of separate commissioning teams) ↗ Stronger ability to maintain local nuance and insight through separate strategic commissioning teams ↗ Good ability to innovate and spread best practices across enabling functions ↗ Combined purchasing power over key providers maximises influence, although alignment to strategic goals may be more challenging with separate commissioning teams ↗ Ability to maximise investment in technology and specialised teams as a single organisation, although servicing two strategic commissioning teams may make functions less effective ↘ Separate strategic commissioning teams risks development of divergent service models and competing priorities within enabling functions; this could make the operational model more challenging to navigate internally and across the system landscape
3b. Merger – full integration of teams	**5**	↗ In a larger organisation, a smaller proportion of resources will need to be directed towards must-do corporate activities, leaving more resource for strategic commissioning. Modelling suggests that in this option, 50% of resources are aligned to strategic commissioning; this includes efficiencies from merging NWL and NCL strategic commissioning functions ↗ Unified leadership will drive consistent priorities and transformation. Delivery of priorities through single strategic commissioning structure will ensure full alignment ↗ Maximum ability to innovate and spread best practice across enabling functions ↗ Combined purchasing power over key providers maximises influence ↗ Ability to maximise investment in technology and specialised teams as a single organisation ↘ A single commissioning team risks overlooking hyper-local needs without strong place-based structures. However, commissioning across all 13 boroughs is not likely to be materially different to commissioning across existing individual ICB populations. Analysis suggests there is no obvious distinction in the distribution of deprivation or demographic characteristics

Evaluation criterion 2 of 5:
Strengthening our Place and Neighbourhood arrangements to optimise outcomes

1 (Lowest)	5 (Highest)
• High risk to Place/Borough-based working • Low potential to promote neighbourhood health • High risk to hyper local services such as safeguarding, CHC SEND	• Low risk to Place / Borough-based working • High potential to promote neighbourhood health • Low risk to hyper local services such as safeguarding, CHC SEND

NHS
North Central London
Integrated Care Board

Option		Rationale
1. Stand alone orgs.	**2**	↘ In a smaller organisation, a greater proportion of our resources will need to be directed to must-do corporate activities, leaving less resource working to support each place (e.g., less resource for hyper-local services such as Continuing Healthcare (CHC) and Special Educational Needs and Disabilities (SEND) and safeguarding. ↘ There will be less resources available to focus on the development of a neighbourhood health service and a lower ability to be innovative ↘ Ability to manage the market through purchasing power for individual placements (CHC and Complex Individualised Commissioning) is more limited in this option ↗ A smaller organisation may have greater ability to forge and maintain close relationships with partners and communities in each place
2. Clustering	**2**	↘ In a smaller organisation, a greater proportion of our resources will need to be directed to must-do corporate activities, leaving less resource working to support each place (e.g., less resource for hyper local services such as CHC, SEND and safeguarding. Clustering somewhat mitigates this, but falls short of the benefits from a full merger ↘ There will be less resource available to focus on the development of a neighbourhood health service and a lower ability to be innovative. Clustering somewhat mitigates this, but falls short of the benefits from a full merger ↘ Ability to manage the market through purchasing power for individual placements (CHC and Complex Individualised Commissioning) is more limited in this option ↗ A smaller organisation may have greater ability to forge and maintain close relationships with partners and communities in each place
3a. Merger – partial integration of teams	**4**	↗ A large organisation can ensure hyper-local services such as CHC, SEND, safeguarding are resilient in each place e.g., greater economies of scale, sharing scarce resources ↗ The organisation will have greater purchasing power and ability to shape the market for individual placements (CHC and Complex Individualised Commissioning) ↗ A large organisation can allocate a greater proportion of resources to the development and delivery of a neighbourhood health service ↘ Having two strategic commissioning teams (with the potential for variable requirements / visions for neighbourhood) may impact delivery of neighbourhoods ↗ Having separate commissioning teams may lead to greater ability to forge and maintain close relationships with partners and communities in each place
3b. Merger – full integration of teams	**4**	↗ A large organisation can ensure hyper-local services such as CHC, SEND, safeguarding are resilient in each place e.g., greater economies of scale, sharing scarce resources ↗ The organisation will have greater purchasing power and ability to shape the market for individual placements (CHC and Complex Individualised Commissioning) ↗ A large organisation can allocate a greater proportion of resources to the development and delivery of a neighbourhood health service ↘ Having a single commissioning team may make it harder for senior leaders to forge and maintain close relationships with partners and communities in each place

Evaluation criterion 3 of 5:
Retaining and attracting the best people

1 (Lowest)	5 (Highest)
• Narrow range of roles • Few development opportunities • Negative staff feedback	• Wide range of roles • Many development opportunities • Positive staff feedback

NHS
North Central London
Integrated Care Board

Option		Rationale
1. Stand alone orgs.	**2**	↘ Learning and development opportunities are more limited in a smaller organisation, with potentially negative implications for recruitment and retention ↘ The organisation would be too small to provide career pathways, restricting its ability to give staff career development opportunities and to 'grow our own' ↘ Higher risk of burnout due to smaller workforce and fewer economies of scale ↗ NCL ICB identity and culture preserved (may support retention of some existing staff) ↗ No change in terms and conditions of staff currently employed and no change to base location expected
2. Clustering	**3**	↘ Learning and development opportunities are more limited in a smaller organisation, with potentially negative implications for recruitment and retention; this is somewhat mitigated for the enabling functions that are provided jointly, but falls short of the benefits from a full merger ↘ The organisation would be too small to provide career pathways, restricting its ability to give staff career development opportunities and to 'grow our own'; this is somewhat mitigated for the enabling functions that are provided jointly, but falls short of the benefits from a full merger ↘ Sharing of some functions allows teams to be more resilient and staff to feel less overstretched; risk of burnout is still present in other functions ↘ Risk potential dilution of the benefit of joint enabling functions if the shared resource is 'pulled in different directions' by the two organisations ↗ NCL ICB identity and culture preserved (may support retention of some existing staff) ↗ No change in terms and conditions of staff currently employed; base locations may change for some where there is an agreement to share resources
3a. Merger – partial integration of teams	**4**	↗ Learning and development opportunities are greater in a larger organisation, which will likely support recruitment and retention ↗ A larger organisation could provide career pathways for people to develop, grow, and progress within the organisation; this may be more limited within the separate strategic commissioning teams compared to Option 3b ↗ Allows teams to be more resilient and staff to feel less overstretched; this may not be true within the separate strategic commissioning teams compared to Option 3b ↗ Single Executive structure supports development and delivery of a clear and coherent strategy and ensures greater strategic alignment across the two systems – this is likely to be perceived as a more appealing organisation to work for, and support the recruitment and retention of high-calibre staff ↗ Working for the largest ICB in the country (with the opportunities that it creates for innovation) is likely to appeal to some individuals ↘ Change in terms and conditions of staff currently employed; base locations may change for some ↘ Could lead to microcultures emerging between the non-integrated teams that does not foster the single cultural identity and could detract from performance
3b. Merger – full integration of teams	**5**	↗ Learning and development opportunities are greater in a larger organisation, which will likely support recruitment and retention; provides the greatest opportunity to invest in services, centralised training hubs, leadership academies, and cross-sector secondments, fostering a culture of continuous learning ↗ A larger organisation could provide career pathways for people to develop, grow and progress within the organisation ↗ Allows teams to be more resilient and staff to feel less overstretched ↗ Single Executive structure supports development and delivery of a clear and coherent strategy and ensures greater strategic alignment across the two systems – this is likely to be perceived as a more appealing organisation to work for, and support the recruitment and retention of high-calibre staff ↗ Fully integrated operating model offers strongest employee value proposition – supports strong organisational alignment with downstream benefits for recruitment and retention ↗ Staff benefit from exposure to broader system challenges, enhancing skills and adaptability ↗ Working for one of the largest ICBs in England (with the opportunities that it creates for innovation) is likely to appeal to some individuals ↘ Change in terms and conditions of staff currently employed; base locations may change for some

Evaluation criterion 4 of 5:
Resilient and cost-effective functions

1 (Lowest)	5 (Highest)
• Low non-pay savings opportunity • Low team resilience • Low economies of scale	• High non-pay savings opportunity • High team resilience • High economies of scale

NHS
North Central London
Integrated Care Board

Option		Rationale
1. Stand alone orgs.	**1**	↘ Some services will be extremely fragile e.g., single person functions; this is a risk to business continuity, and it limits the ICB's ability to cope with fluctuations in demand or absences ↘ Limited ability to invest in technology and innovation to improve efficiency ↘ Lots of functions duplicated and sub-scale – this is highly inefficient ↘ Low/No non-pay savings opportunity as each ICB maintains its own functions, systems, and contracts, resulting in minimal economies of scale or purchasing power
2. Clustering	**3**	↗ Addresses fragility of services and team resilience through consolidation, although this will be limited to those functions brought together ↗ Improved ability to invest in technology and innovation, but falls short of the benefits from a full merger ↗ Somewhat reduces duplication and constitutes better use of taxpayers' money → Some non-pay savings opportunity via consolidated Corporate and Clinical functions, but with an inability to fully leverage system-wide contracts ↘ Efficiency of joint functions may be limited by having 'two masters' (e.g., risk of divergent priorities) ↘ Risk of recreating issues found with CSUs and London Shared Services
3a. Merger – partial integration of teams	**4**	↗ Addresses fragility of services and team resilience through consolidation, although some aspects of strategic commissioning portfolios may remain fragile ↗ Improved ability to invest in technology and innovation ↗ Provides non-pay savings opportunity via consolidated Corporate and Clinical functions due to the ability to leverage greater purchasing power with suppliers as single legal entity ↗ Reduces duplication and constitutes better use of taxpayers' money ↘ Risk that two strategic commissioning teams create divergent priorities for functions that are consolidated
3b. Merger – full integration of teams	**5**	↗ Addresses fragility of services and team resilience through consolidation ↗ Maximum ability to invest in technology and innovation ↗ Provides non-pay savings opportunity via consolidated Corporate and Clinical functions due to the ability to leverage greater purchasing power with suppliers as single legal entity ↗ Reduces duplication and constitutes better use of taxpayers' money

Evaluation criterion 5 of 5:
Time and cost of change

1 (Lowest)	5 (Highest)
• Takes long time and/or high cost to implement. • Solution not sustainable in the longer-term.	• Takes short time and/or low cost to implement. • Solution is sustainable in the longer-term.

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Integrated Care Board

Option		Rationale
1. Stand alone orgs.	**3**	↘ Management of change process to reduce staff by 50% will require incur significant time and costs ↗ Redesigning structures within a single organisation, where there is a single 'designing mind' and aligned ways of working is easier than bring two organisations together ↗ Avoidance of costs related to the legal transaction ↗ No requirement for non-people integration (e.g., ledger, IT systems, policies, processes, etc.), making it less challenging from a transitional perspective ↗ This option does not require cultural alignment, making it less challenging from a transitional perspective ↘ Risk that this option is not future proof; as the landscape matures, further consolidation of ICBs may be required and NCL would be one of the smallest ICBs
2. Clustering	**2**	↘ Management of change process to reduce staff by 50% will require incur significant time and costs ↘ Differences in structures and roles (e.g., differential banding for similar roles) will need to be redressed, but this is limited to shared enabling functions ↗ Avoidance of costs related to the legal transaction ↗ Limited requirement for non-people integration (e.g., ledger, IT systems, policies, processes etc.), making it less challenging from a transitional perspective ↗ This option does not require cultural alignment across all teams, making it less challenging from a transitional perspective ↘ Risk that this option is not future proof; as the landscape matures, further consolidation of ICBs may be required and NCL would be one of the smallest ICBs ↘ Retaining two leadership teams risks diverging priorities through the transition period, which could incur additional time, risks, and costs
3a. Merger – partial integration of teams	**2**	↘ Management of change process to reduce staff by 50% will require incur significant time and costs ↘ Differences in structures and roles (e.g., differential banding for similar roles) will need to be redressed ↘ Costs to fulfil the requirements of the legal transaction ↘ Requirement for non-people integration (e.g., ledger, IT systems, policies, processes etc.), making it more challenging from a transitional perspective ↘ In this option, the leadership team would strive for a single organisational culture – this would be harder to achieve if commissioning teams remain separate ↖ Single leadership team ensures unified priorities through the transition period ↖ Allows for more variation between teams, which is easier to design and implement (short term benefit only) ↘ Risk this option is only suitable for a transitional period, which may result in putting people through multiple cycles of change
3b. Merger – full integration of teams	**3**	↘ Management of change process to reduce staff by 50% will require incur significant time and costs ↘ Differences in structures and roles (e.g., differential banding for similar roles) will need to be redressed ↘ Costs to fulfil the requirements of the legal transaction ↘ Requirement for non-people integration (e.g., ledger, IT systems, policies, processes etc.), making it more challenging from a transitional perspective ↗ This option would enable a single organisational culture to be created and embedded ↗ Single leadership team ensures unified priorities through the transition period ↗ Allows for more variation between teams, which is easier to design and implement (short-term benefit only) ↗ Likelihood of requirement for future change and reorganisation is low

5 Conclusion and recommendations

Summary of scores

NHS
North Central London
Integrated Care Board

	1. Stand alone organisations	2. Clustering	3. Merger	
			3a. Partial integration of teams	3b. Full integration of teams
Improving patient outcomes through strategic commissioning	2	2	4	5
Strengthening our Place and Neighbourhood arrangements to optimise outcomes	2	2	4	4
Retaining and attracting the best people	2	3	4	5
Resilient and cost-effective functions	1	3	4	5
Time and cost of change	3	2	2	3
Total Score	10	12	18	22

The scoring, using the evaluation criteria and the supporting evidence in the Appendix, concludes that the option 3b is most beneficial

** Excludes risks associated with all options and/ or the change programme such as redundancy costs, provider landscape and readiness for transfer*

Risks associated with the recommended option*

NHS North Central London

Risk	Rating	Description	Type of risk	Potential Mitigations
Meeting timelines for 2026 merger	M	• Risk that we do not meet the NHS England deadline of 30/09/25 for issuing of technical guidance for all 2026 mergers. This would delay the legal transaction until 2027	Transitional	• Work is underway to mitigate the workload required between Board decision and 30/09
Due diligence	M	• Time taken to properly undertake due diligence processes to understand any outstanding legal, financial or clinical risk liabilities that may novate to the new organisation	Transitional	• Work is already underway with a merger checklist and lessons learned from previous mergers to support an accelerated process to be undertaken as soon as the decision is taken to enter any formal merger process
Meeting cost reduction timelines	M	• The ICB's budget will be £19 per capita from FY26/27, with no identified route for transitional funding. The 51% cost savings therefore must be delivered in FY25/26 • Pursuing merger could prolong timelines for implementing headcount reductions and therefore risk overspend in 2026/27	Financial	• Vacancy controls are in place to reduce run-rate people cost • Team is lined-up to support the design of new structures and management of change process asap following the decision of the Boards • Work is underway on functions that are indicated to transfer in the Model ICB
Management of change – complexity and risk	M	• Designing structures across two organisations increases the complexity of the management of change process – for example, in relation to how respective headcount reductions are applied, how individuals are pooled and differences in banding for similar roles • This may create a risk to the implementation timelines and an HR risk	Transitional	• Conversations with staff side colleagues already underway • Robust principles to be developed with employment law input • Consider phased implementation of new structures, with shared enabling functions planned first
Introduction of the Integrated Single Financial Environment (ISFE2)	M	• National plan in October to introduce a new ledger system into all ICBs • Challenges for stretched finance teams in the two organisations to manage the implications and technical requirements for the merger in tandem with the introduction of a new ledger system that requires ledgers to be built back up from scratch	Transitional	• Guidance and assurance required from NHSE for how this will be managed for ICBs who are merging • Support and resources made available nationally for this to be managed safely and well • Discussion with national to consider a review of the approach and timeline to take into account this requirement
People integration – culture & ways of working	H	• Both organisations will have different cultures and different ways of working. Bringing teams together will be complex and it will take time to embed a new shared culture and ways of working • If not done well, this could risk organisational effectiveness and recruitment and retention	Transitional	• Culture and ways of working to be a key focus during and post implementation • Ensuring sufficient resources are available in the new structure to support this • Consideration of how structures may evolve to mitigate any significant people integration risks
Fair share convergence	H	• NHSE fair share analysis shows that NCL is slightly overfunded (1.2%), and NWL is underfunded (2.9%). Combining the commissioning budgets in a single legal entity creates a risk that these two factors partially offset, such that the new ICB is slightly underfunded. This may bring the ICB within an acceptable 'tolerance zone' and no additional funding may be received	Financial	• Further discussions required with NHS England to ensure NWL allocation is ringfenced

Conclusion

North Central London
Integrated Care Board

North Central London ICB is facing significant transformation under any option, due to our change in role and significant reduction in funding.

We need to create a positive new organisation that facilitates to deliver our vision to **work with residents of all ages in NCL so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death**, and enables us to become one of the most effective strategic commissioners in the NHS.

We have established that scale will enable us to develop capacity and capability to enable us to continue to work across the different spatial levels from hyper-local neighbourhoods, through Borough-level place-based priorities as well as contribute and play an influential role in the wider regional strategies such as London Growth Strategy and Inclusive Talent Strategy and national mandates such as the 10 Year Plan.

Through the development of this options appraisal, it is clear the best route to scale is through a legal merger with NWL ICB and the creation of a fully-integrated operating model that will serve the c4.5m population across the footprint of the two organisations.

For this reason we think the most advantageous option for NCL ICB is **Option 3b – full merger with North West London ICB**.

It is important that this is executed well in order to realise the intended benefits and minimise the risks.

This must be subject to an implementation plan that delivers this robust approach to organisational change. The plan needs to proactively engage with partners. The approach needs to manage staff professionally and with compassion building the new teams with the skills and talent to deliver our vision for our residents. An initial view of implementation tasks is set out on the following page.

Recommendation

This paper has been considered by North Central London ICB Transition Committee on 14 July 2025.

The Board is asked to carefully consider the options and evaluation put forward in this case for change.

Given the outcome of the options appraisal, the recommendation to the Board is **Option 3b, which is the full legal merger with fully integrated teams.**

The Board is asked to:

- **Approve the recommendation of Option 3b for formal merger of the 2 ICBs on 1st April 2026 as the preferred option**
- **Approve the progression into the national process for approvals with final sign-off of the transaction delegated to the Chair(s) and CEO(s) at the appropriate time**
- **Approve the establishment of a joint executive-led Programme Board to lead and manage the merger process**

Noting the risks set out within the case, a formal due diligence process should be undertaken as set out through the national process and to satisfy both Boards of the risk mitigation.

A framework for identifying and managing equalities and quality risks has been approved by the Quality and Safety Committee on 01 July 2025, subject to minimal amendments. To fully understand the risks and enable a targeted mitigation strategy, the EQIA will need to be applied at function-level as structures are designed.

Indicative timeline plan

NHS
North Central London
Integrated Care Board

We have provided an indicative plan of activities that are likely to be necessary considerations following board approval. The timelines are subject to further testing and a full programme plan would need to be developed in tandem with NWL

	July-Dec 2025	Jan-Jun 2026	Jul-Dec 2026
Approvals	• Communicate with NHSE shared intentions between NCL and NWL. Obtain regional approval • Secretary of state/parliamentary sign off process.	• Completion of approval to dissolve current ICB*	
Due Diligence	• Clinical, financial and workforce due diligence • Seek legal advice on closure of statutory organisation • EQIA, EIA to assess impact of proposed change		
Organisation design	• Build new organisation vision • Leadership appointments • Design future organisation structures • Design safe transfer of functions that will transfer out • Engage and consult with staff on future design • Implement change in accordance with organisation change policy	• New structures in place • New policies • Recruitment/appointment to new structures • Negotiate transfer of functions (where applicable) • Supporting staff to exit the organisation • Launch new teams and organisation	• Organisation development and cultural integration • Embed and develop new teams
Governance & Finance	• Establish joint transition arrangements and establish merger programme • Resource transition planning (programme team)	• Dissolve existing ICB & register new organisation* • Prepare new constitution * • Draft governance structures and policies for new organisation* • Build technical infrastructure of new organisation and transfer of assets* etc	

* = We would anticipate these being completed by the end of March 2026

6 Other considerations

Safe transfer of functions\services

North Central London
Integrated Care Board

As North Central London develops to become the best possible strategic commissioner for our residents, there are a broad range of functions for which we will no longer hold responsibility (as laid out in the Model ICB). We have been working with Regional and National colleagues to develop thinking and planning around these. The functions can be divided into a number of categories:

1. Functions where we can develop the model & structures and prepare for the transfer to providers (e.g. CHC, Complex Care)
2. Functions where the decision to transfer is less clear, therefore we will need to develop the model & structures, and concurrently develop an options appraisal to inform next steps (e.g. Medicines Optimisation, GPIT & Integrator function)
3. Functions where we will be unable to transfer before the end of the year due to their critical delivery over winter, but will need to discuss the future mechanisms with partners over the coming months (e.g. SCC)
4. Functions where further guidance is required from NHS England, as they have complex legislative issues intertwined (e.g. Safeguarding, SEND)
5. Functions transferring to region (e.g. EPRR, Performance Management, Strategic Estates) - we continue to engage with London Region on the next steps for these

As we progress with implementing the Model ICB guidance and developing our new ICB form, we welcome the opportunity to work with partners and staff to further develop our approach with these functions; ensuring a safe transfer of responsibility and understanding the implications for our staff.

Distance to Target

North Central London
Integrated Care Board

Distance from target analysis (to determine allocations)

Based on the distance from target calculation in 25/26 NWL ICB is £228m underfunded whilst NCL ICB is overfunded by £54m

In the current rules, in 26/27 NWL would expect to receive an additional £30m as 0.5% maximum movement

If the organisations merge, the combined position would be underfunded by £174m and we would receive 0.5% which is £52m and this is £22m more than NWL would receive on its own creating a gain

The national team have signalled that they will move to a distance from fair shares funding as the basis for the 26/27 financial year. Using this methodology the 25/26 position shows NWL ICB as being £291m (4.3%) underfunded and NCL ICB £78m (1.75%) overfunded. The methodology deems there to be a 2.5% tolerance so any organisation falling within this tolerance is not adjusted

If the organisations merged the difference would be an underfunding of £213m which would represent 1.9%. This is within the 2.5% tolerance range and the new organisation may not receive an uplift.

In 26/27 the NWL uplift would have been £120m whilst NCL is within the tolerance and would be adjusted

The combined organisation would receive £120m less under the fair shares rules when it combines f the national team do not agree to putting us on target or making no worse off

Therefore, we have entered into discussion with both the national and London regional colleagues to ensure that the merged organisation is not disadvantaged by the transaction.

Source: NHSE 24/25 allocations data

7 Appendix: supporting analysis

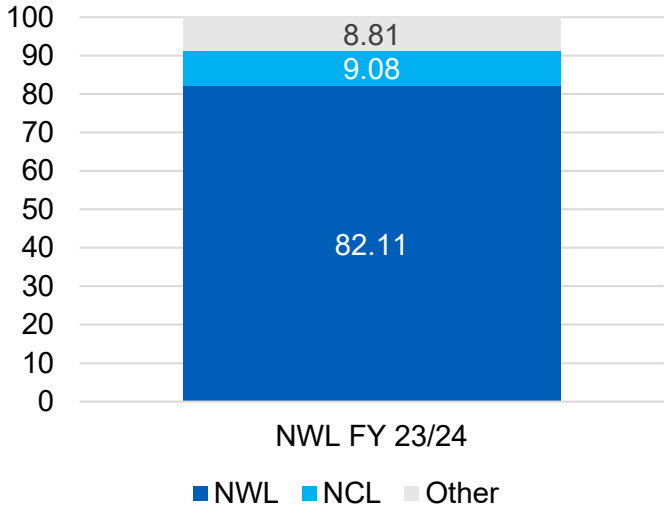
Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

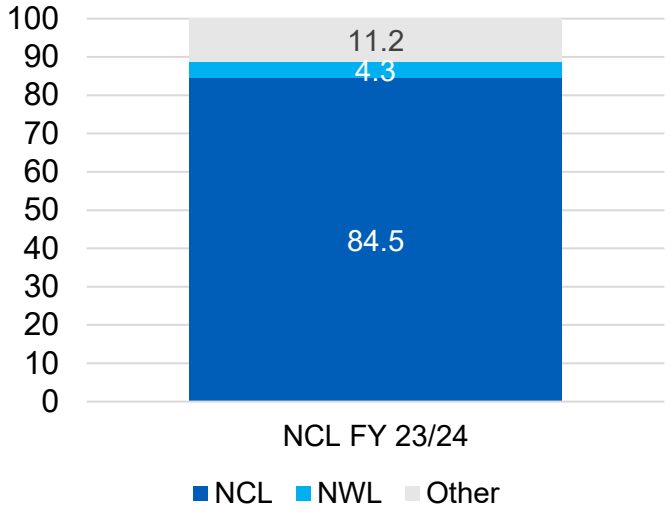
Analysis and evidence to inform this criterion

Where do NWL residents receive their care? (%)



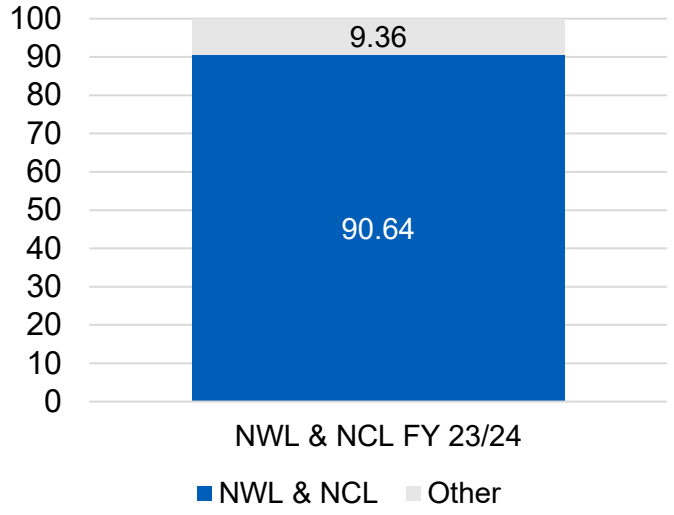
In FY 23/24, **8.81%** of activity from NWL ICB registered patients took place outside of NWL and NCL trusts.

Where do NCL residents receive their care? (%)



In FY 23/24, **11.2%** of activity from NCL ICB registered patients took place outside of NWL and NCL trusts.

Where would care have been received following a merged ICB? (%)



In a hypothetical merger between the two ICBs in FY 23/24, only 9.36% of patient activity would have occurred outside of the newly merged ICB, that serves the boroughs of NWL and NCL.

Source: NWL Patient Flow Analysis, 2025

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion

Commissioned spend and market share by provider and ICB (Acute, Community and Mental Health services in 2024/25)

Provider	Annual Income 2024/25 (£m)	NWL ICB spend (£m) (% of annual income)	NCL ICB spend (£m) (% of annual income)	Combined provider share under merged scenario
London North West	1,138	783 (69%)	22 (2%)	71%
Imperial College Healthcare	1,876	778 (42%)	24 (1%)	43%
Chelsea and Westminster Hospital	940	493 (52%)	-	52%
The Hillingdon Hospital	392	343 (88%)	-	88%
University College London Hospitals	1,606	83 (5%)	409 (25%)	30%
Royal Free London*	1,535	75 (5%)	1,024 (66%)	71%
Whittington Health	470	4 (<1%)	361 (77%)	78%
Central London Community Healthcare	430	151 (35%)	62 (14%)	49%
West London	530	282 (53%)	-	53%
Central and North West London	791	393 (50%)	51 (6%)	56%
North London**	654	5 (<1%)	350 (54%)	55%

Source: 24/25 contracts data provided by NWL ICB and NCL ICB

There are no examples of contracting at providers whereby merging contracting across NWL ICB and NCL ICB would significantly increase purchasing power

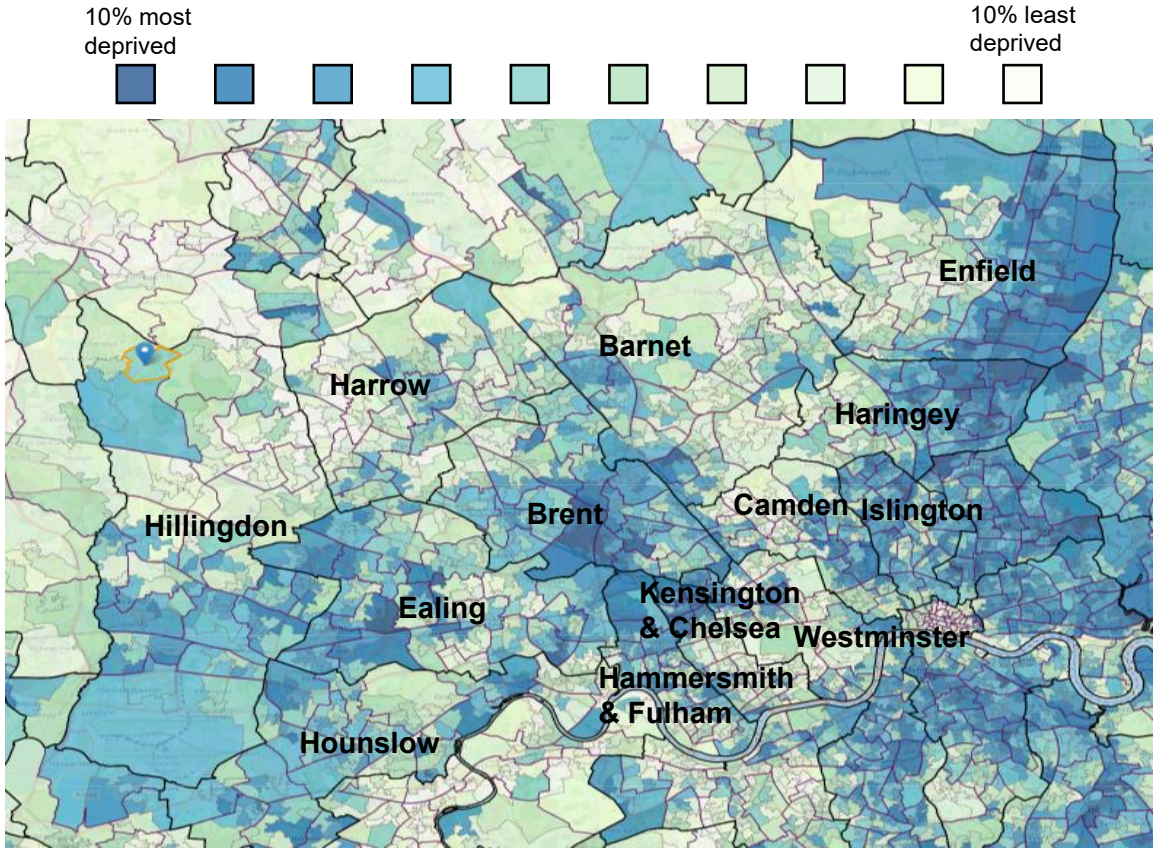
- The vast majority of contracting across core NHS services (Acute, Community and Mental Health services) is delivered within each ICB i.e. activity commissioned by each ICB takes place at providers within the respective ICB boundary. This is outlined in the table to the left.
- 80% of acute activity commissioned by NWL ICB in 2024/25 (c. £2.4bn) was delivered by four providers: *London North West, Imperial College Healthcare, Chelsea and Westminster Hospital and The Hillingdon Hospital*
- 83% of acute activity commissioned by NCL ICB in 2024/25 (c. £17bn) was delivered by three providers: *Royal Free London, University College London Hospitals and Whittington Health.*
- *Note 1: The Acute entry for Royal Free London also includes spend denoted under North Middlesex University Hospital within data provided by NCL ICB
- **Note 2: The Mental Health entry for North London includes spend denoted under Barnet, Enfield & Haringey Mental Health and Camden & Islington.

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



NCL and NWL ICBs share similar population profiles, each covering a mix of inner and outer London boroughs with both affluent areas and pockets of more significant deprivation. Inner boroughs face concentrated urban poverty, while outer areas experience more dispersed but still notable deprivation – highlighting a strong alignment in population health challenges across both ICBs.

- Affluence increases in outer areas like northern Harrow, Barnet, and Enfield.
- Deprivation intensifies toward central London, especially in Brent and Islington.
- Wealth is also concentrated near the river Thames in Camden, Westminster, and Hammersmith & Fulham.
- **This mirrored pattern of deprivation and affluence suggests that a merged ICB would be well-positioned to design and deliver targeted interventions addressing common drivers of health inequality.**

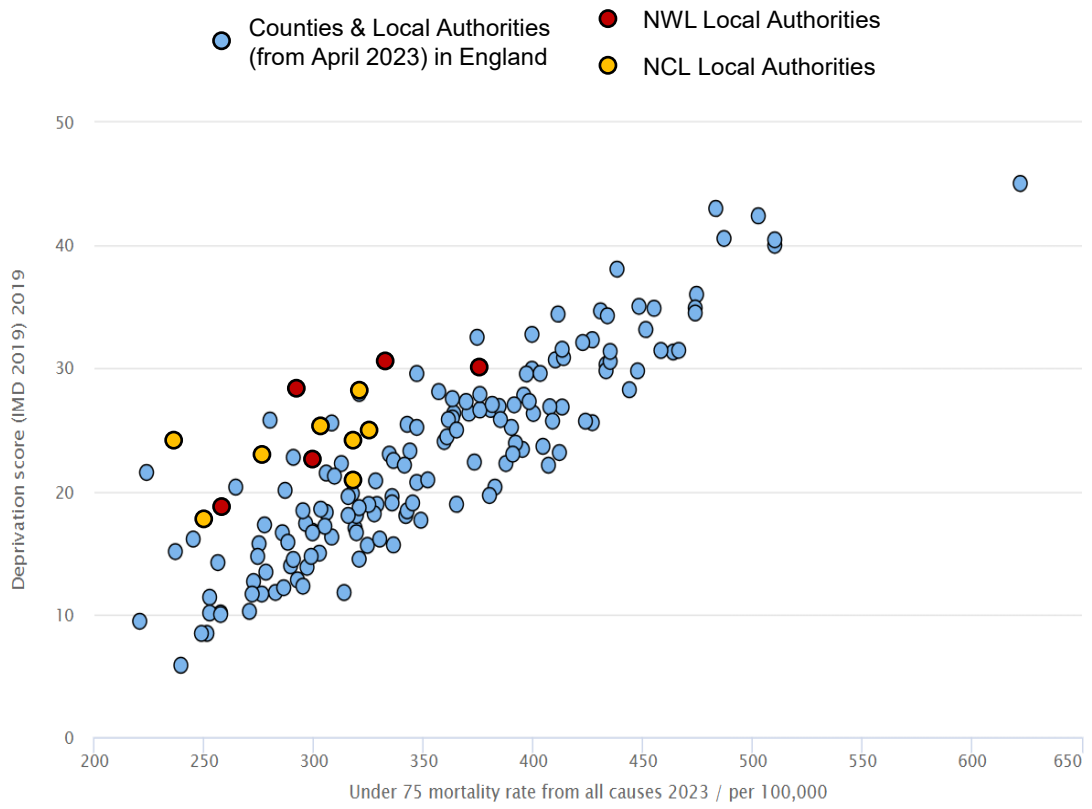
Source: Index of Multiple Deprivation (IMD), 2019

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



The boroughs within both the NWL and NCL ICBs exhibit broadly aligned patterns of deprivation and health need (displayed by the under 75 mortality rate from all causes), reinforcing the strategic and operational case for integration.

- There are no significant outliers among the thirteen local authorities, and the close clustering of NWL (red) and NCL (yellow) boroughs further demonstrates the comparability of the two care boards.
- Crucially, there is no material or consistent disparity in overall deprivation levels between the two footprints.
- **This supports the case for a unified approach to planning and resource allocation that is both equitable and impactful.**

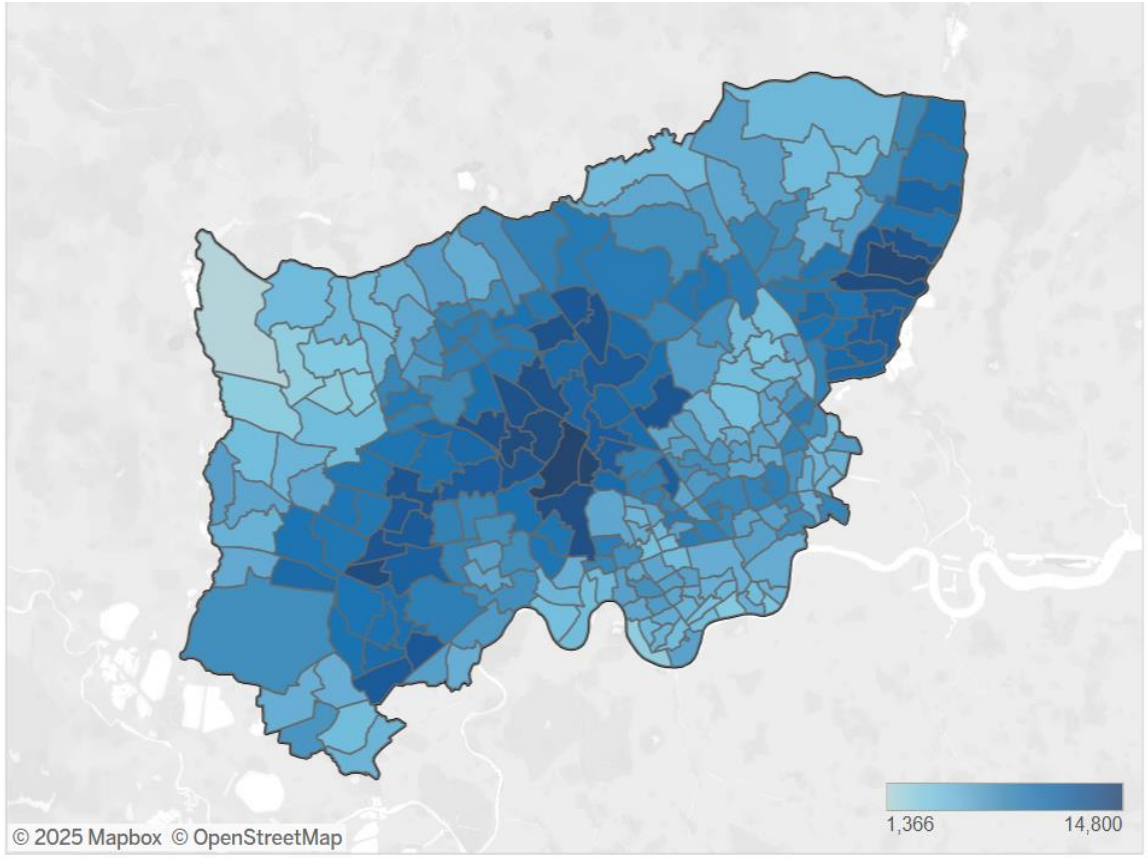
Source: Local Authority Health Profiles, Department of Health & Social Care, 2023

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



Source: London Data Store, 2025

The map to the left shows the number of people in the NWL and NCL ICB patches who identify as non-British (000s). The two ICBs have similar ethnic patterns, with more non-British residents in central boroughs and fewer as you move outward. However, in some inner areas like Hammersmith & Fulham, Kensington & Chelsea, and Westminster, there are lower proportions of non-British residents compared to nearby central zones.

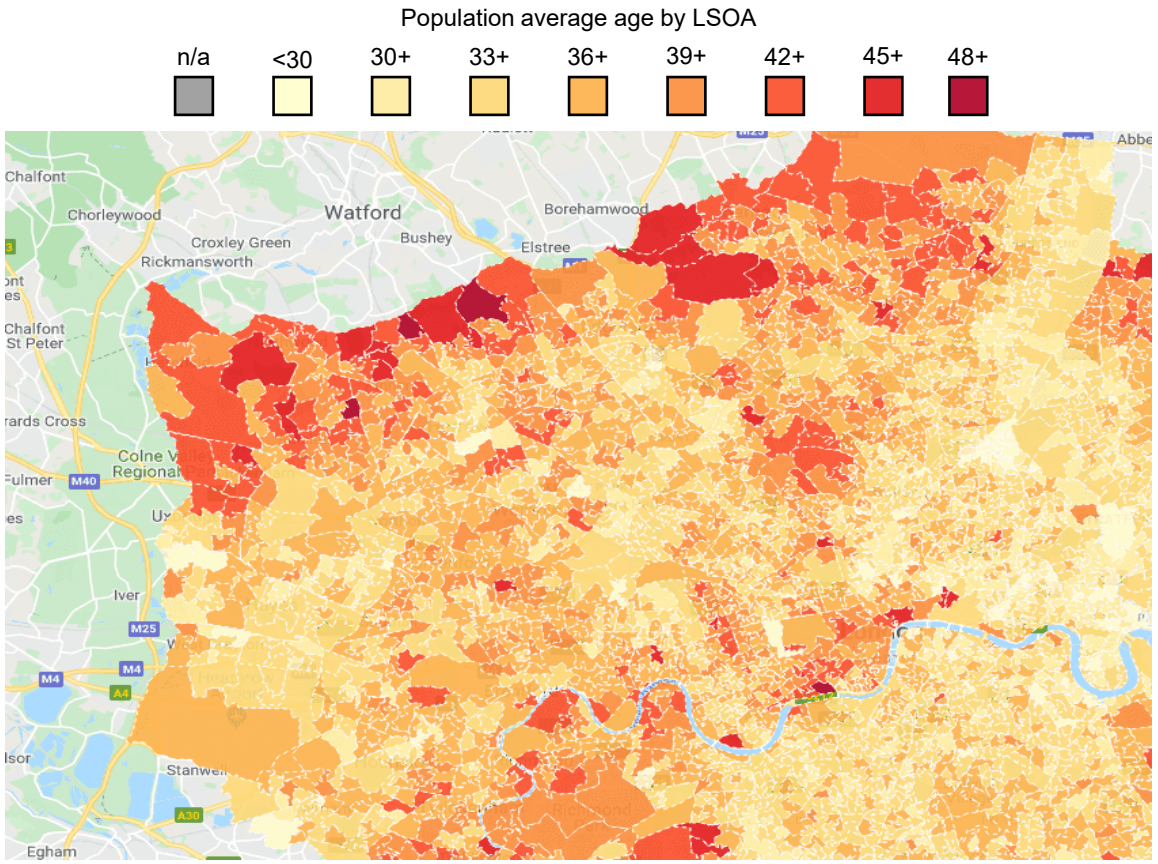
- According to the 2021 Census, over 50% of residents in Brent, Harrow, and Newham identify as non-White.
- Brent alone reports that 65% of its population is non-White.
- Camden, Islington, and Haringey in NCL each have non-White populations over 40%, showing a shared demographic profile.
- **This supports a unified approach to tackling health inequalities and delivering culturally competent care under a merged ICB.**

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



This map displays how the populations of both NWL and NCL are relatively young and demographically similar, with median ages ranging between 34 and 37 years across most boroughs.

- Inner boroughs such as Camden, Westminster, and Hammersmith & Fulham tend to have younger populations, driven by student and professional demographics.
- Outer boroughs like Harrow, Barnet, and Enfield show slightly older age profiles, though still within a narrow range.

This consistency in age structure across the two footprints suggests that a merged ICB would not face significant variation in age-related health needs, enabling more streamlined commissioning and coordinated service design.

Source: Plumplot, 2018

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion

Both sexes, All ages, 2021, DALYs per 100,000

Higher rank — Lower rank

	Barnet	Brent	Camden	Ealing	Enfield	Hammersmith & Fulham	Haringey	Harrow	Hillingdon	Islington	Kensington & Chelsea	Hounslow	Westminster
Neoplasms	1	1	1	1	1	1	1	1	1	1	1	2	2
Respiratory infections & TB	2	2	2	2	2	4	2	3	2	2	2	1	1
Cardiovascular diseases	3	3	5	3	3	5	5	2	3	5	5	4	5
Musculoskeletal disorders	4	5	4	4	4	3	4	4	4	4	3	3	4
Mental disorders	5	4	3	5	5	2	3	5	5	3	4	5	3
Neurological disorders	6	6	6	6	6	6	6	6	6	6	6	6	6
Other non-communicable	7	7	7	7	7	7	7	7	8	9	7	7	7
Chronic respiratory	8	8	8	8	8	9	8	8	7	8	8	8	9
Diabetes & CKD	9	9	11	9	9	10	9	9	9	10	9	9	11
Unintentional inj	10	10	10	11	10	11	10	10	11	11	10	10	10

Source: Greater London Authority – Snapshot of Health Inequalities in London, 2021

This graphic shows that across the selected London boroughs, the distribution of disease burden is closely aligned across both ICBs, with minimal variation and no significant outliers.

- The top three contributors to disease burden (measured in DALYs) are consistently neoplasms, respiratory infections, and cardiovascular diseases.
- Neoplasms are the leading cause in 11 of 13 boroughs, particularly in central areas like Camden, Islington, and Westminster.
- Respiratory infections dominate in outer boroughs such as Ealing, Enfield, and Hillingdon, highlighting a shared public health challenge.
- **While local nuances exist – such as mental health disorders ranking second in Hammersmith & Fulham – these conditions remain consistently high across the wider footprint, reinforcing the case for integrated planning and delivery.**

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion

Both sexes, All ages, 2021, DALYs per 100,000

Higher rank — Lower rank

	Barnet	Harrow	Kensington & Chelsea	Brent	Camden	Ealing	Enfield	Hammersmith & Fulham	Haringey	Hillingdon	Hounslow	Islington	Westminster
High body-mass index	1	1	1	2	2	2	2	2	2	2	2	2	2
Tobacco	2	2	2	1	1	1	1	1	1	1	1	1	1
High fasting plasma glucose	3	3	3	4	3	4	4	4	4	3	3	3	3
Dietary risks	4	4	5	3	5	3	3	5	3	4	4	5	5
High blood pressure	5	5	6	5	7	6	5	6	6	5	6	7	7
High alcohol use	6	6	4	6	4	5	6	3	5	6	5	4	4
Occupational risks	7	9	8	8	8	10	7	8	9	7	10	8	8
High LDL	8	8	10	7	11	7	8	9	8	8	7	10	11
Kidney dysfunction	9	7	9	10	9	8	9	10	10	9	9	11	9
Drug use	10	11	7	9	6	9	11	7	7	10	8	6	6

Source: Greater London Authority – Snapshot of Health Inequalities in London, 2021

The graphic above shows that there is a consistent pattern of upstream health risks across all boroughs within the patch.

- High BMI, tobacco usage, and high fasting glucose rank as the top three risk factors.
- Elevated blood pressure and poor diet also frequently appear in the top five.

The alignment between disease and risk profiles across NWL and NCL boroughs is both clear and compelling. The previous slide highlights a consistent burden of chronic conditions, while this slide shows a near-identical pattern of upstream risk factors.

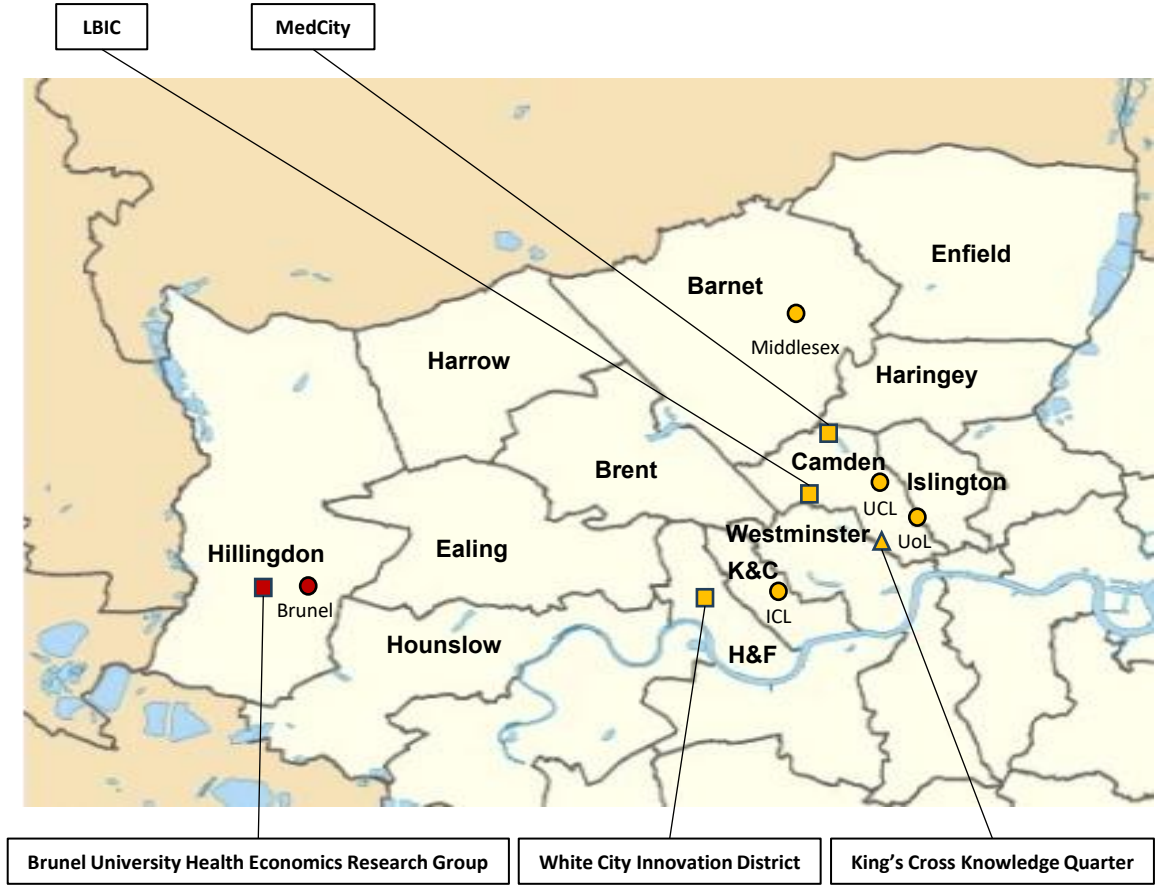
This strong correlation between modifiable risks and disease outcomes reinforces the case for merging the two ICBs. A unified system would be better placed to deliver integrated, preventative interventions at scale, targeting shared drivers of ill health with greater efficiency and impact.

Evaluation criterion 1 of 5:
Improving patient outcomes through strategic commissioning

Criterion 1
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



Key: ○ University □ Institution △ King's Cross Knowledge Quarter

The boroughs within NWL and NCL together form a dynamic health innovation corridor, underpinned by globally recognised institutions and cutting-edge science parks – making this one of the most powerful hubs for health research, development, and delivery in the UK.

- **King's Cross (NCL):** Home to the Knowledge Quarter, with UCL, the Francis Crick Institute, the Alan Turing Institute, and the Wellcome Trust leading in biomedical science.
- **White City (NWL):** Imperial College's campus drives innovation in health and life sciences.
- **Hillingdon:** Brunel University contributes to health economics and MedTech.
- **Barnet:** Middlesex University supports applied health research.

The proximity of these assets across NWL and NCL creates a highly connected ecosystem of universities, science parks, and NHS providers. A merged ICB would enable unified access to talent, infrastructure, and innovation, supporting a more coordinated approach to population health and care transformation.

Evaluation criterion 2 of 5:
Strengthening our Place and Neighbourhood arrangements to optimise outcomes

Criterion 2
Supporting evidence

NHS
North Central London
Integrated Care Board

Place and neighbourhood remain critical to the NHS and NCL. We are proud of our borough-based commitment and want to build on this. It is only in this way that we can respond effectively to the diverse needs of our population. However, our ability to effectively engage with partners at Place and develop and implement a new model for neighbourhood health could be at risk as a result of the ICB cost reductions if we don't work effectively with partners to ensure this approach into the future.

The borough-based partnership model is maturing, and we intend to remain leaders in this space. We want to support partnerships to develop and function with real autonomy and accountability, within a clear shared framework to avoid duplication and inefficiency.

We recognise that empowered local teams can be more agile, are trusted in communities, and able to innovate for their communities

Previous reorganisations indicate that true transformation in population health happens closest to communities; we want to use the opportunity given to us by the 10-year plan and the focus on neighbourhoods in the Model ICB to accelerate this.

Development of neighbourhood and place-based partnerships is core to successful delivery of the NHS Plan. The Model ICB Blueprint highlights that this responsibility will transfer to neighbourhood health providers over time.

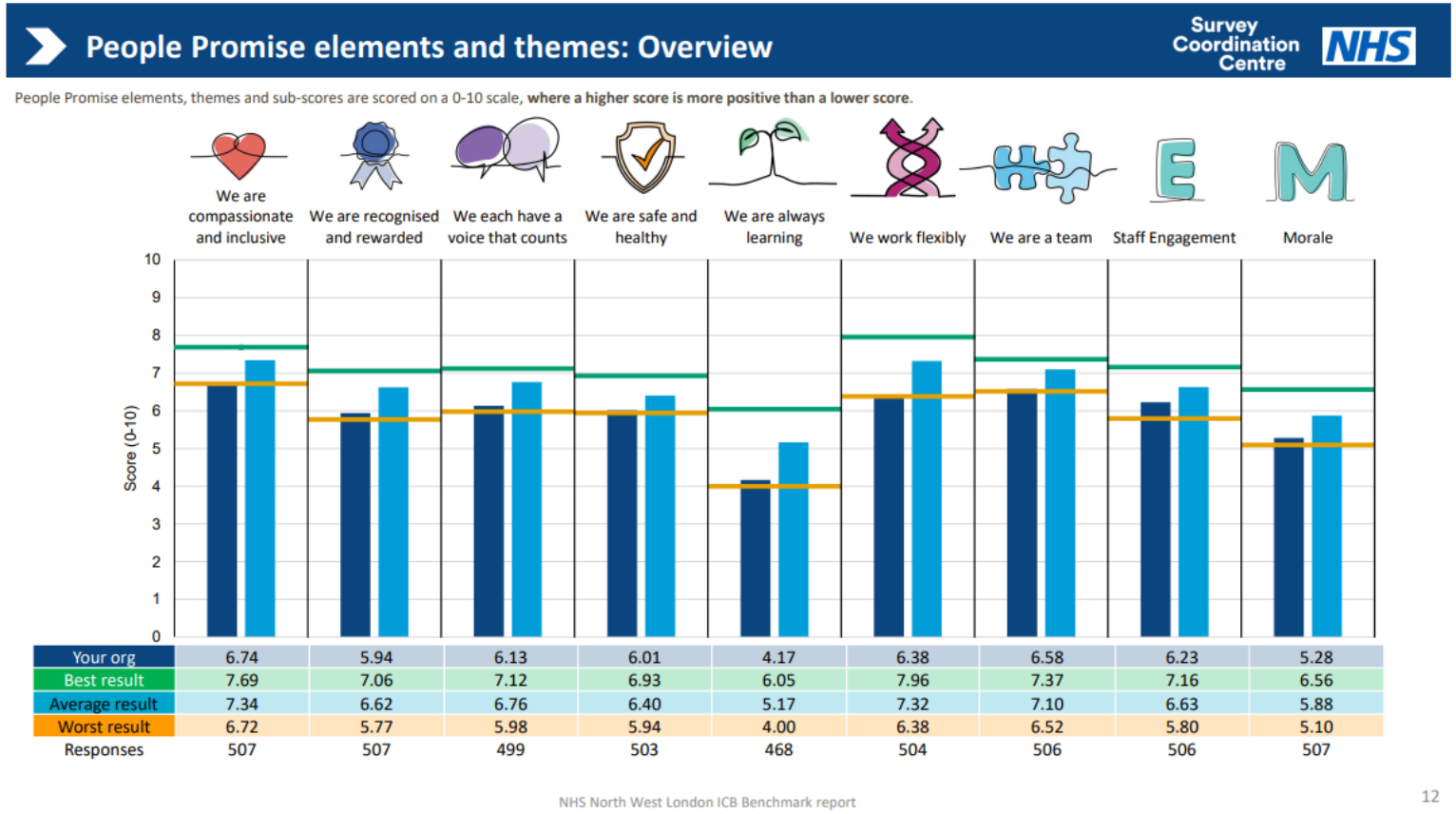
Through this process we want to make sure we work with partners to embed mature, accountable local partnership structures, with the right resources and devolved influence, working to deliver agreed outcomes and reduce inequalities.

Evaluation criterion 3 of 5:
Retaining and attracting the best people

Criterion 3
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



Source: North West London ICB NHS Staff Survey Benchmark report, 2024

This graphic shows how the NWL ICB performs across nine key areas from the NHS Staff Survey – seven based on the 'People Promise' and two additional themes: Staff Engagement and Morale. These elements reflect what NHS staff say would most improve their working experience, offering a clear view of how well NWL is supporting its workforce.

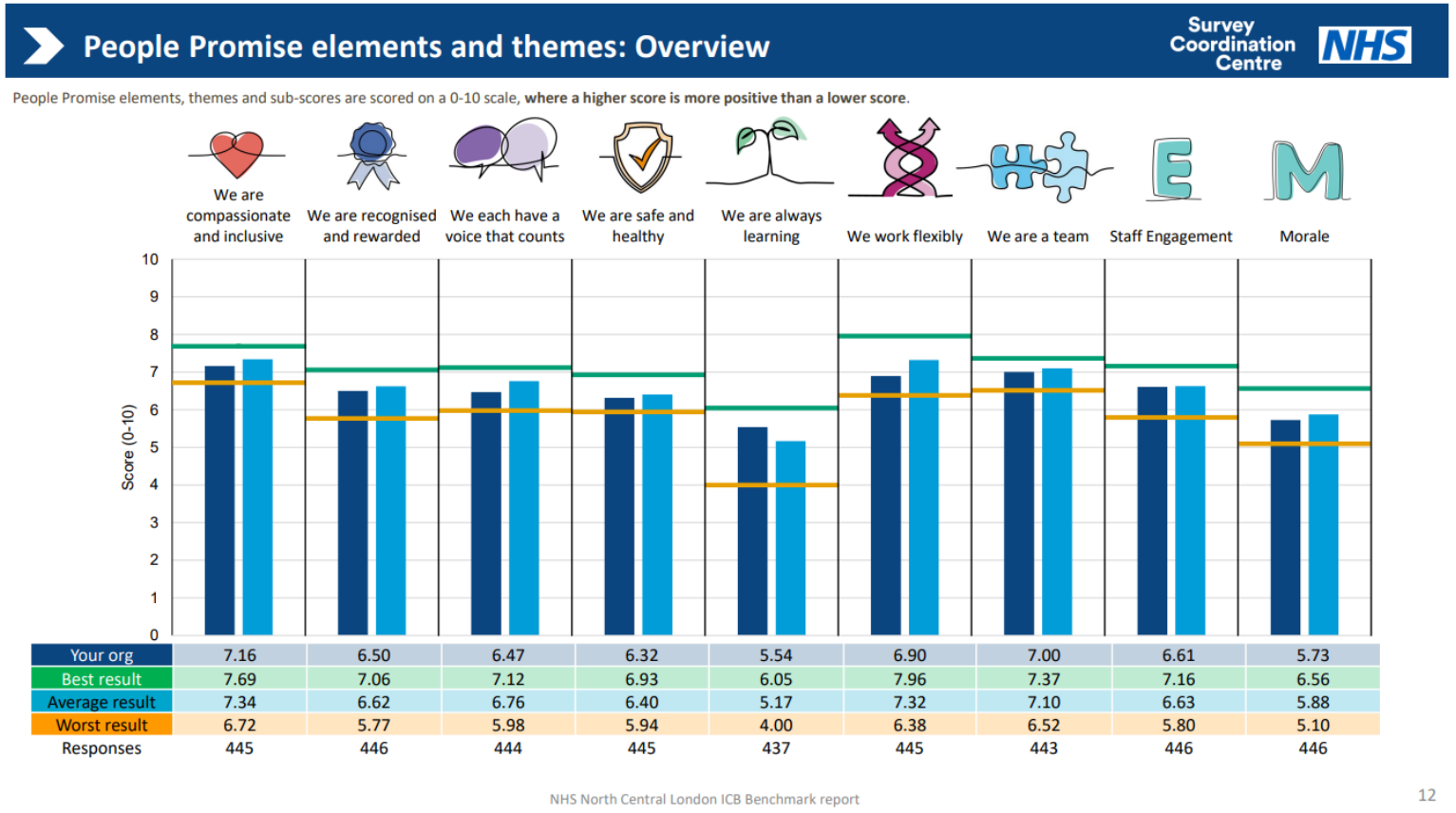
- The ICB scores below average in all categories
- The strongest scoring area in the survey was *We are compassionate and inclusive*.
- Team working and staff engagement remain stable and relatively strong.
- **This suggests that NWL ICB could benefit from learnings relating to culture and staff performance from other ICBs that operate in a similar environment.**

Evaluation criterion 3 of 5:
Retaining and attracting the best people

Criterion 3
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



Source: North Central London ICB Staff Survey Benchmark report, 2024

This graphic shows the same data for NCL ICB, which scores below average in most categories but performs on par in Staff Engagement and above average in Always Learning.

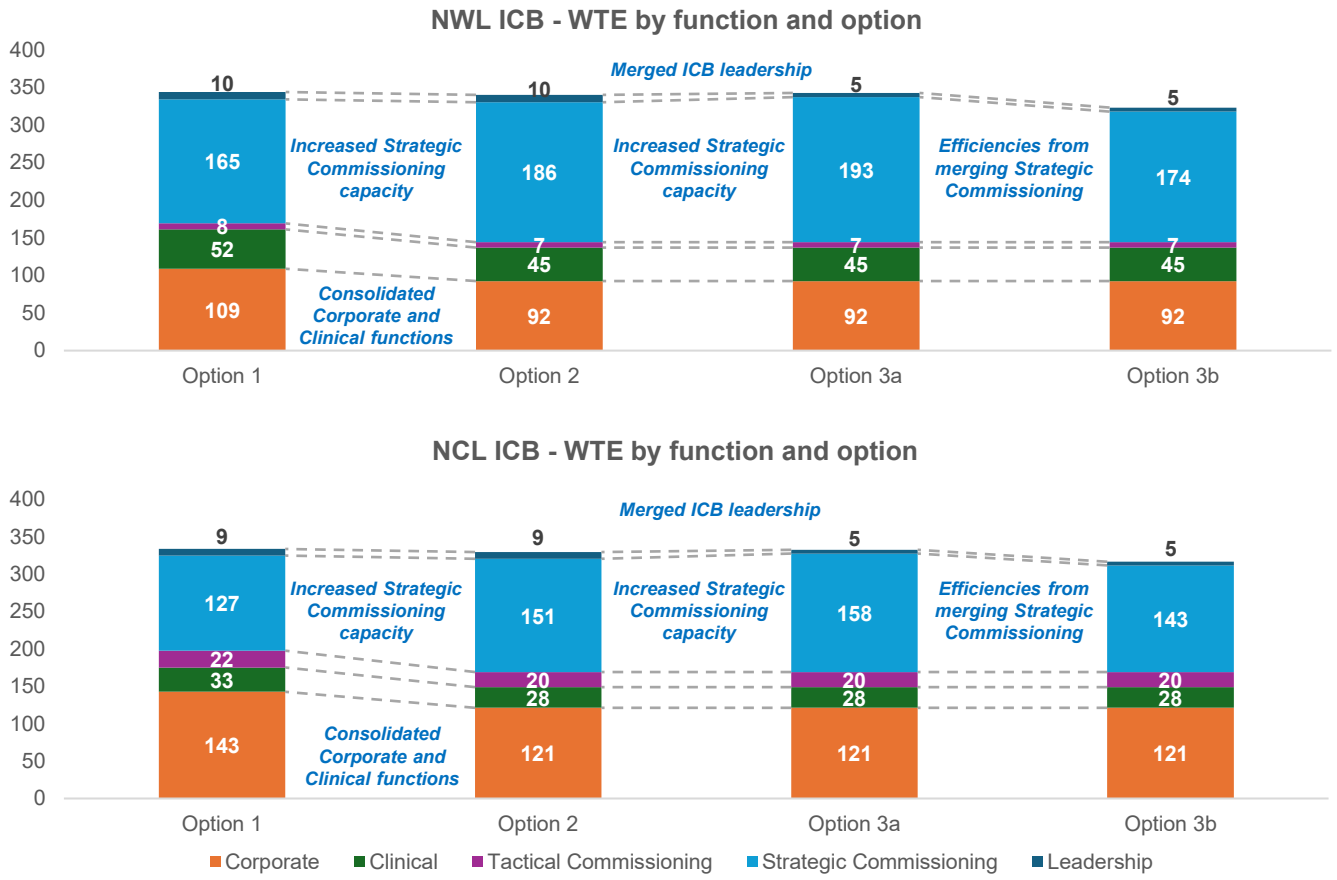
- Across the five London ICBs, NCL ICB scored the highest in the *We are always learning* and *We are a team* themes.
- NCL ICB also scored the second highest of the five London ICBs across all other themes.
- NCL ICB outperforms NWL ICB across all staff survey categories.
- **This suggests NCL ICB is better placed to support staff satisfaction and could share learnings with NWL ICB. However, a merger risks lowering NCL ICB's performance or prompting staff shifts toward NCL ICB.**

Evaluation criterion 4 of 5:
Resilient and cost-effective core functions

Criterion 4
Supporting evidence

NHS
North Central London
Integrated Care Board

Analysis and evidence to inform this criterion



A merger could realise greater efficiencies via economies of scale, whilst also leading to more resilient teams with more specialist roles.

A high-level, hypothetical analysis has been carried out to indicate the potential impact on WTEs at both ICBs as a result of a merger, according to the key assumptions outlined below.

This is a modelling indication rather than an absolute. The actual structure, and use of financial resource, will be determined through a formal developmental process and subject to agreed consultation processes.

Staffing efficiencies could be realised as a result of merging NWL ICB and NCL ICB, in order to enable investment in functions outlined in the Model ICB. Both ICBs would still operate within the running cost envelope set out in the 30/05 submissions.
In this model 75% of all efficiencies have been reallocated to Strategic Commissioning roles

Option 1
- Standalone ICBs as per individual 30/05 submissions

Option 2
- Consolidated Corporate and Clinical functions (15%)
- Consolidated Tactical Commissioning (10%)

Option 3a
- Ae per Option 2, plus consolidation of ICB leadership (45%)

Option 3b
- As per Option 3a, plus consolidation of Strategic Commissioning (15%).

25% of efficiencies have been ringfenced for non-pay development, including OD, technology, estate and innovation.
- **Option 1:** No efficiencies
- **Option 2:** £1.5m p.a. across both ICBs
- **Option 3a:** £2.0m p.a. for a merged ICB
- **Option 3b:** £5.4m p.a. for a merged ICB

Evaluation criterion 5 of 5:
Time and cost of change

Criterion 5
Supporting evidence

NHS
North Central London
Integrated Care Board

Historical evidence (1997) from NHS Trust mergers [1] show that while financial savings were often a key goal, they rarely materialised quickly. Integration challenges, governance issues, and restructuring led to higher short-term costs and delays. Though based on older evidence, this highlights the need for caution with ICS mergers, especially around assumptions of fast savings, underscoring the importance of realistic planning, clear cost baselines, and strong monitoring.

- **Lessons from CCG mergers** [2]: The NAO found that while CCG mergers aimed to cut costs and support system integration, restructuring often caused disruption, delayed progress, and diverted focus from service improvements. These lessons stress the need for careful planning and phasing in ICS mergers to avoid inefficiencies and protect local responsiveness.
- **The King's Fund** [3]: The King's Fund warns that major ICB changes – like mergers or rapid cost-cutting – require significant planning and can cause disruption, staff uncertainty, and short-term focus shifts away from patient care. Savings often take longer than expected, so careful management and clear communication are essential to minimise impact.
- **The Health Foundation** [4]: The Health Foundation notes that ICS mergers are complex, costly, and often disrupt service improvement efforts. Past reorganisations show that benefits and savings are usually delayed, with early challenges around resources and stability. Strong leadership and realistic timelines are key to managing the transition effectively.
- **HSJ** [5]: A HSJ article highlights ICB leaders' concerns about the rapid move to consolidate 42 ICBs into 27 clusters, citing poor national coordination and uncertainty around staffing, leadership, and redundancy funding. The pace and top-down nature of the change pose serious risks of disruption, staff anxiety, and major implementation challenges.

Taken together, the evidence from past NHS reorganisations and recent expert commentary consistently show that large-scale mergers and structural changes are associated with significant upfront time and cost, disruption, and risk. Efficiencies and savings are often realised later and are rarely as immediate as anticipated. For ICSs considering major integration or merger, it is essential to plan for extended implementation timescales, invest in robust change management, and set realistic expectations about both the costs and achievable pace of transition. This underlines the importance of a measured, well-communicated, and phased approach to organisational change to minimise risk and disruption while maximising the potential for eventual effectiveness and sustainability.

Sources: 1. https://www.nuffieldtrust.org.uk/research/mergers-in-the-nhs-made-in-heaven-or-marriages-of-convenience; 2. https://www.nao.org.uk/wp-content/uploads/2018/12/Review-of-the-role-and-costs-of-clinical-commissioning-groups.pdf; 3. https://www.kingsfund.org.uk/insight-and-analysis/blogs/icb-cuts-what-does-it-mean; 4. https://www.health.org.uk/features-and-opinion/blogs/merging-integrated-care-systems-risks-and-implications; 5. https://www.hsj.co.uk/integrated-care/exclusive-icbs-to-shrink-to-27-clusters/7039399.article

NCL ICB Board of Members Meeting (22 July 2025)
Questions from the public

Agenda item	Question	ICB response
Item 2.1	1. With the merger of 2 ICBs, the Board meetings will physically be more distant from the public and any meaningful scrutiny. How will all 13 local authorities scrutinise health decisions from one merged ICB? Will there still be JHOSCs or other overview committees carrying on this function?	The Ten-Year Health Plan is clear local Health and Wellbeing Boards retain a critical role in local planning and ICBs will draw on these to inform their commissioning decisions. It is also clear that democratic oversight and accountability remains critical and will evolve alongside the NHS and reforms to local government. Health Overview & Scrutiny Committees remain in place and ICBs will continue to engage accordingly. We continue to be committed to working closely with local authorities, including with Joint Health Oversight and Scrutiny Committee colleagues, whatever decision is made. Consideration will need to be given to locations of future Board meetings for a merged ICB; we would expect all Board meetings to continue to be virtually accessible by the public.
Item 2.1	2. As there are two reorganisations taking place with the two ICBs (i.e. Neighbourhood Health and the ICB Merger), will there be a Neighbourhood Health Committee like the Primary Care Committee that will be co-ordinating the process toward Neighbourhood Health Organisations?	It is too early to confirm the details of what the governance structures will be should there be a merger. We are committed to delivering the neighbourhood model set out in the Ten-Year Health Plan and are working closely with local partners to shape this important work. We have strong and valued relationships with our local partners and our borough partnerships have a key role in the development of neighbourhood health. Whatever decision is made, we will ensure that robust governance arrangements are in place and decisions are taken with an understanding of local need and informed by local data and insight.

Item 2.1	3. What consultation with local authority councillors/ JHOSCs/HWBs of all the Boroughs involved with the two ICBs has been carried so far or will be there be more consultation once the decision has been made on the merger? How will the public in all 13 boroughs be engaged and informed?	We have engaged with staff and stakeholders during the development of the case for change, gathering a broad range of views and reflections that have helped to inform the paper. The ICB has made sure local stakeholders have been kept informed, including through targeted email updates and the ICB's stakeholder bulletin, through regular meetings with local authority chief executives and leaders; with provider chief executives through the NCL System Management Board, with the local VCSE Alliance, through discussions with the Joint Health Oversight and Scrutiny Committee and at the most recent NCL Community Partnership Forum. We have undertaken engagement with our Board which has our local authority Leader (Haringey) and CEO representation (Islington). This was discussed at last week's Strategic Leadership Group this week, which is the five local authority CEOs and also the lead Director of Adult Social Care, and Director of Children's Services and we have regular meetings with local authority leadership. Re safeguarding, continuing health care, and special educational needs and disabilities, our Chief Nursing Officer has led listening exercises with local authority colleagues to help us design the next phase. We have also spoken to our local cabinet members for health in our usual monthly meeting with them. We are committed to working with partners and these relationships will remain important to the ICB, whatever decision is made by the Boards. Whilst there is no requirement to formally engage the public or patients (as this does not directly affect the services they access)

		we are committed to communicating openly and transparently with the public. We have shared details of the case for change and promoted the paper and the Board meetings via our LinkedIn channels and via news stories on our website. We will continue to communicate proactively with the public following the Board decisions.

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