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
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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

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1 About this paper

Background and context / reasons for undertaking this appraisal

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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

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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

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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

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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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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]

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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.

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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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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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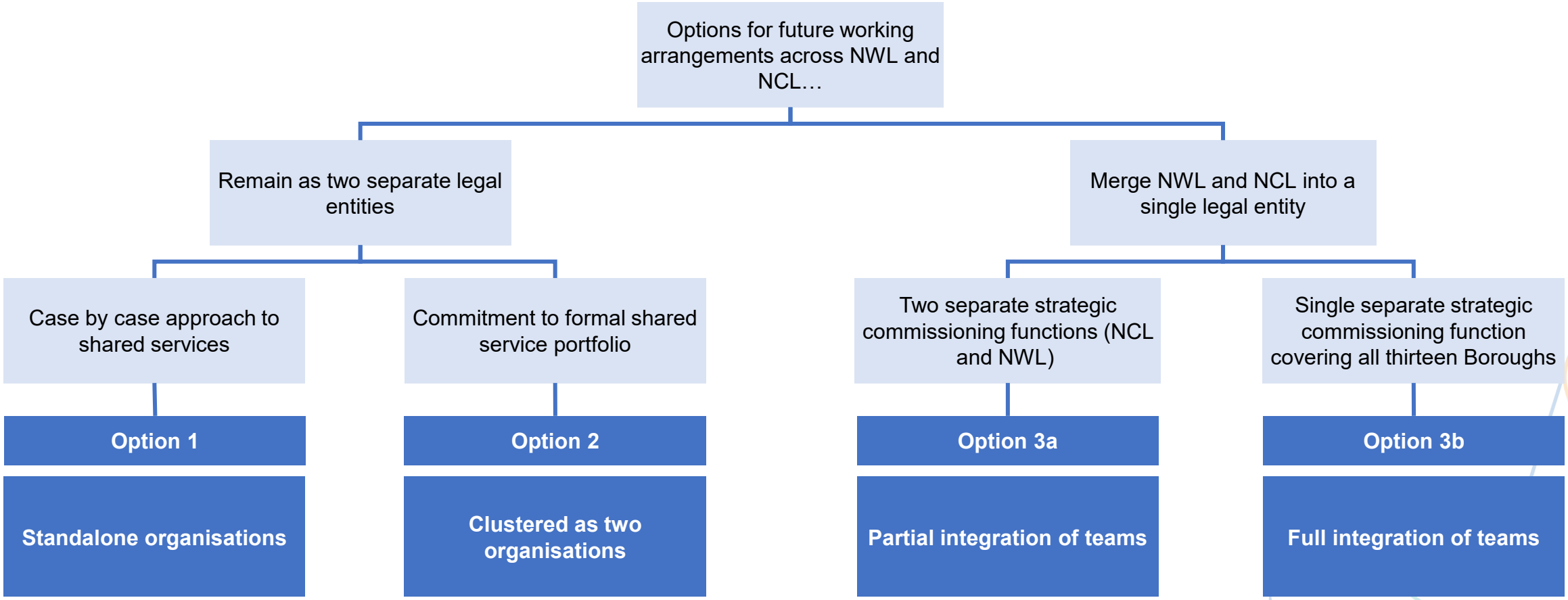

Options Appraisal - Evaluation criteria:
Five criteria will be used to analyse the four shortlisted options, with each being scored on a standardised 1-5 scale

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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

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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

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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

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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

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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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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

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5 Conclusion and recommendations

Summary of scores

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	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*

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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

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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

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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

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6 Other considerations

Safe transfer of functions\services

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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

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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

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7 Appendix: supporting analysis

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

Criterion 1
Supporting evidence

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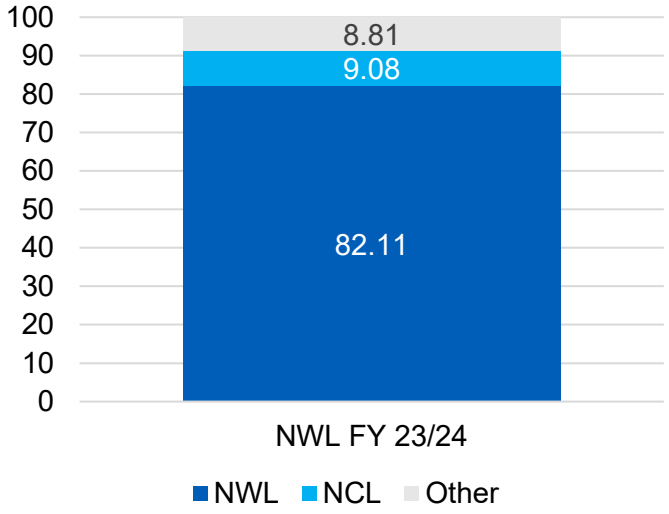
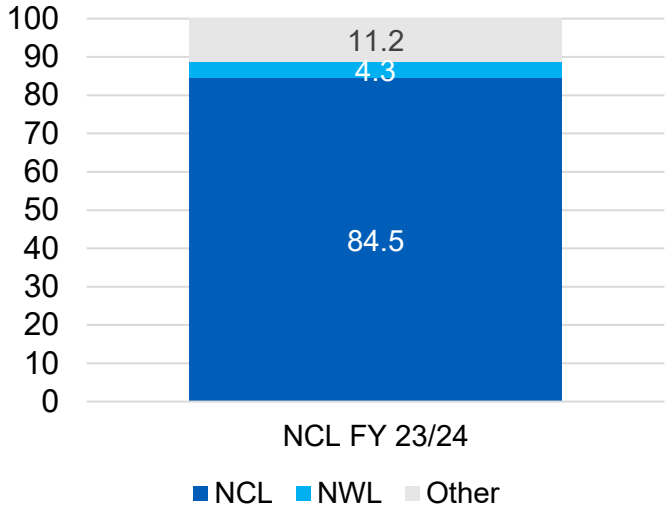
Analysis and evidence to inform this criterion

Where do NWL residents receive their care? (%)



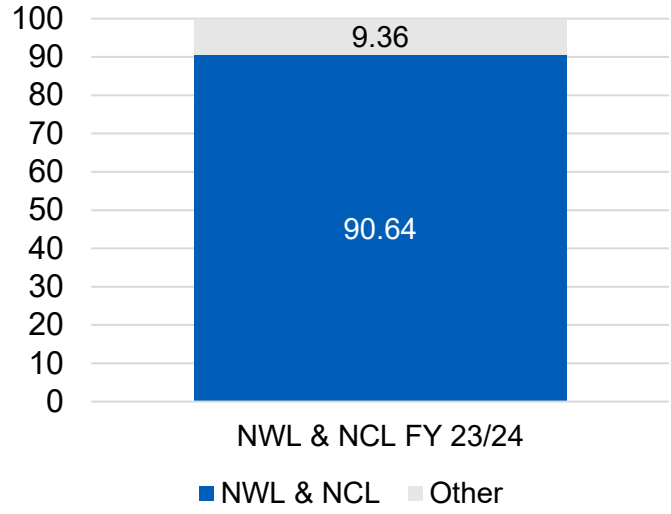
In FY 23/24, **8.81%** of activity from NWL ICB registered patients took place outside of NWL and NCL trusts.

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

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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

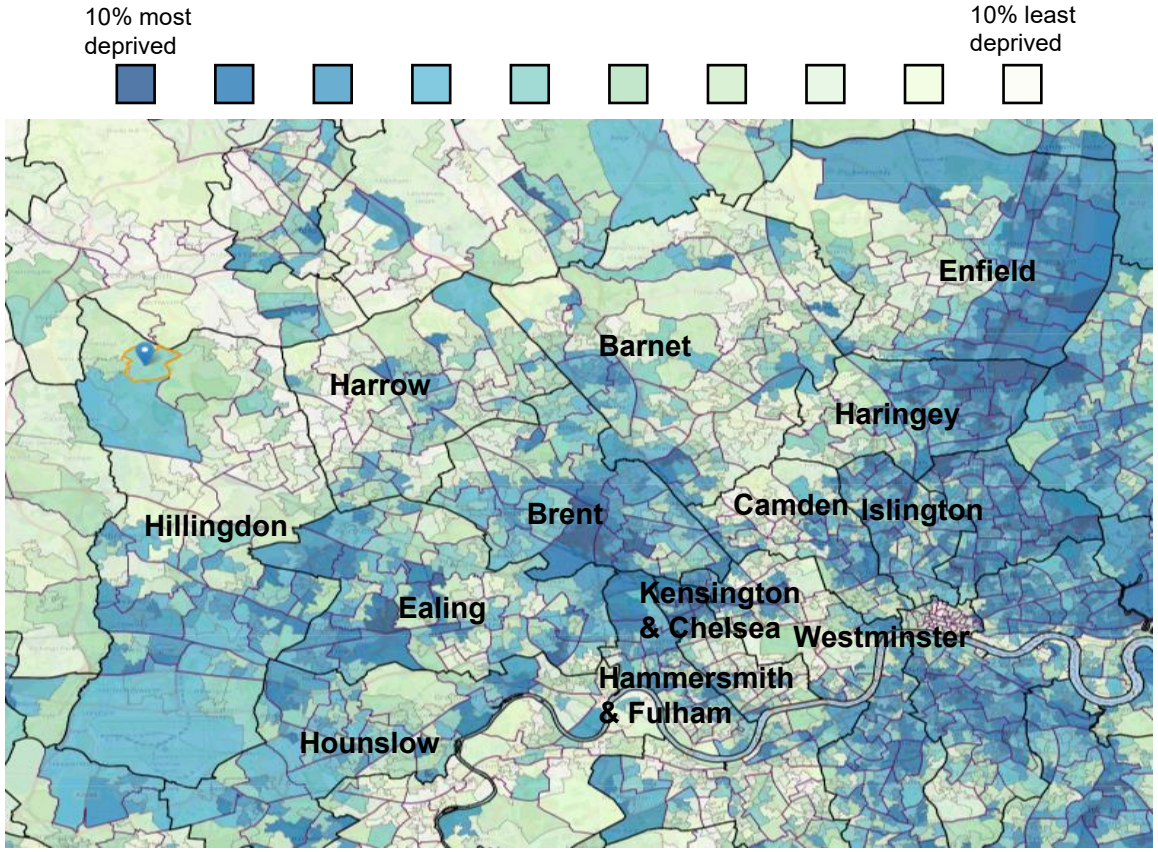
- The vast majority of contracting across core NHS services (Acute, Community and Mental Health services) is delivered within each ICB i.e. activity commissioned by each ICB takes place at providers within the respective ICB boundary. This is outlined in the table to the left.
- 80% of acute activity 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.**

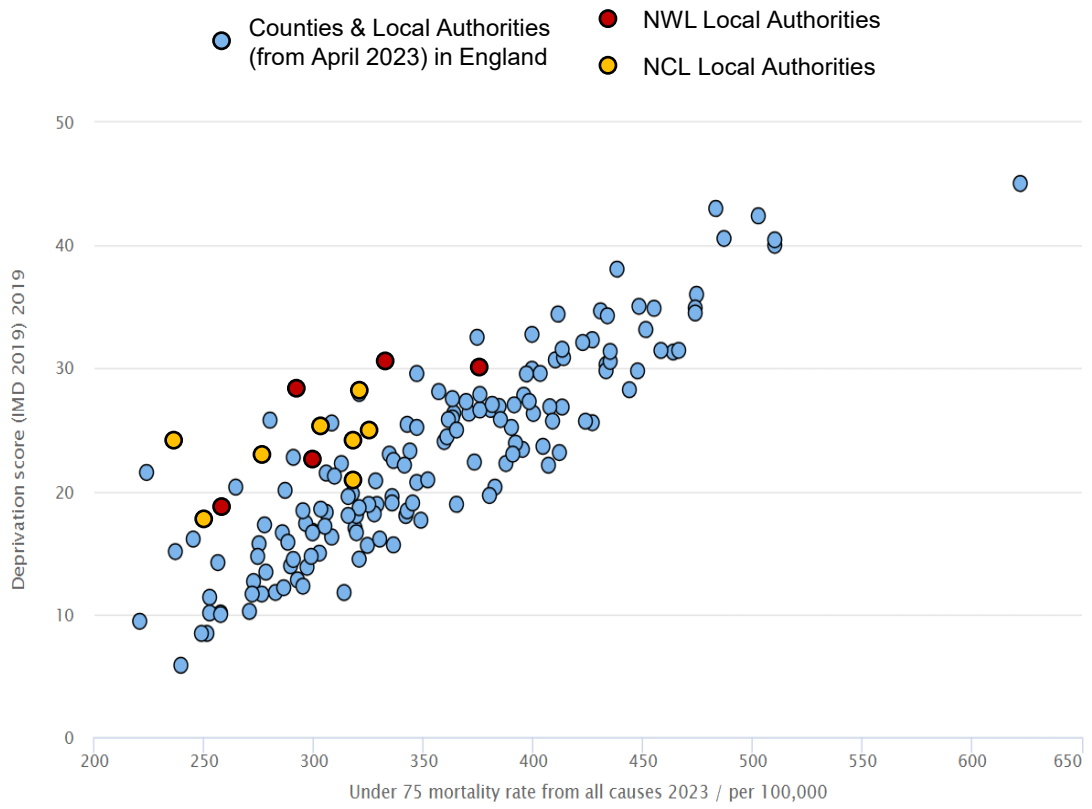
Source: Index of Multiple Deprivation (IMD), 2019

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.**

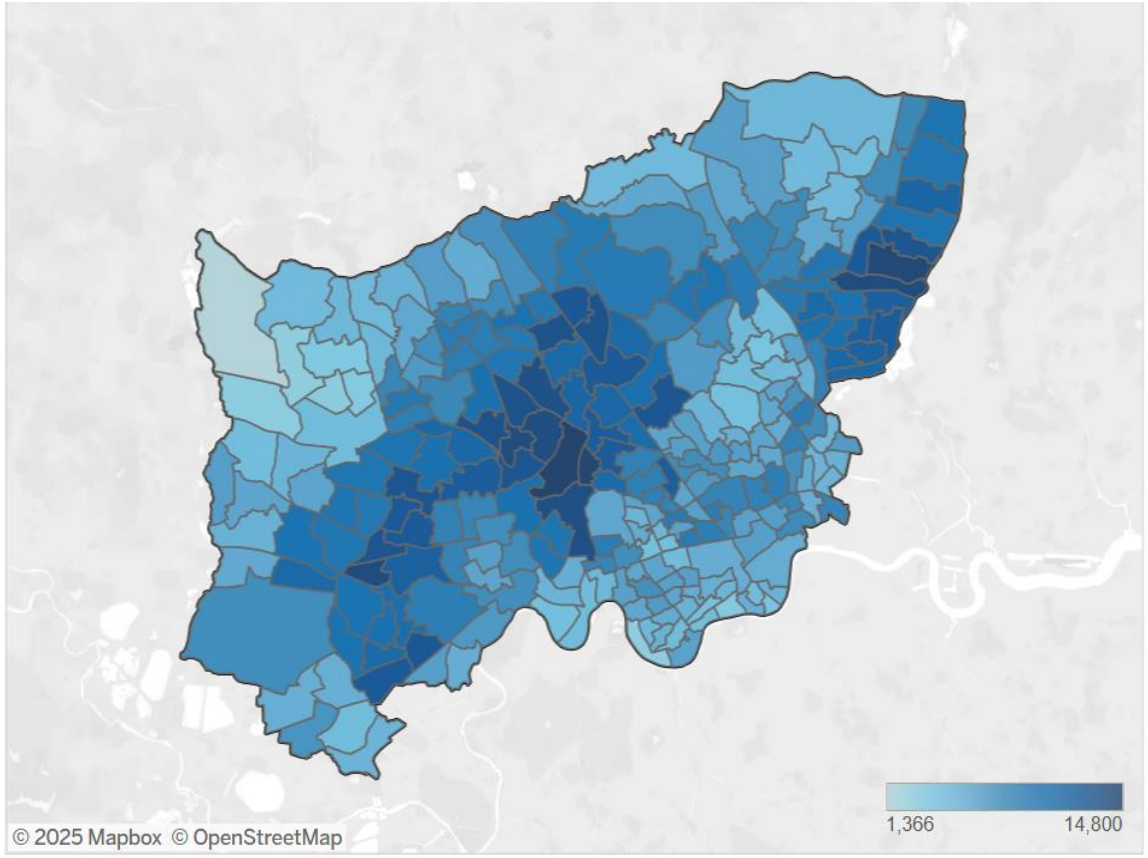
Source: Local Authority Health Profiles, Department of Health & Social Care, 2023

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.

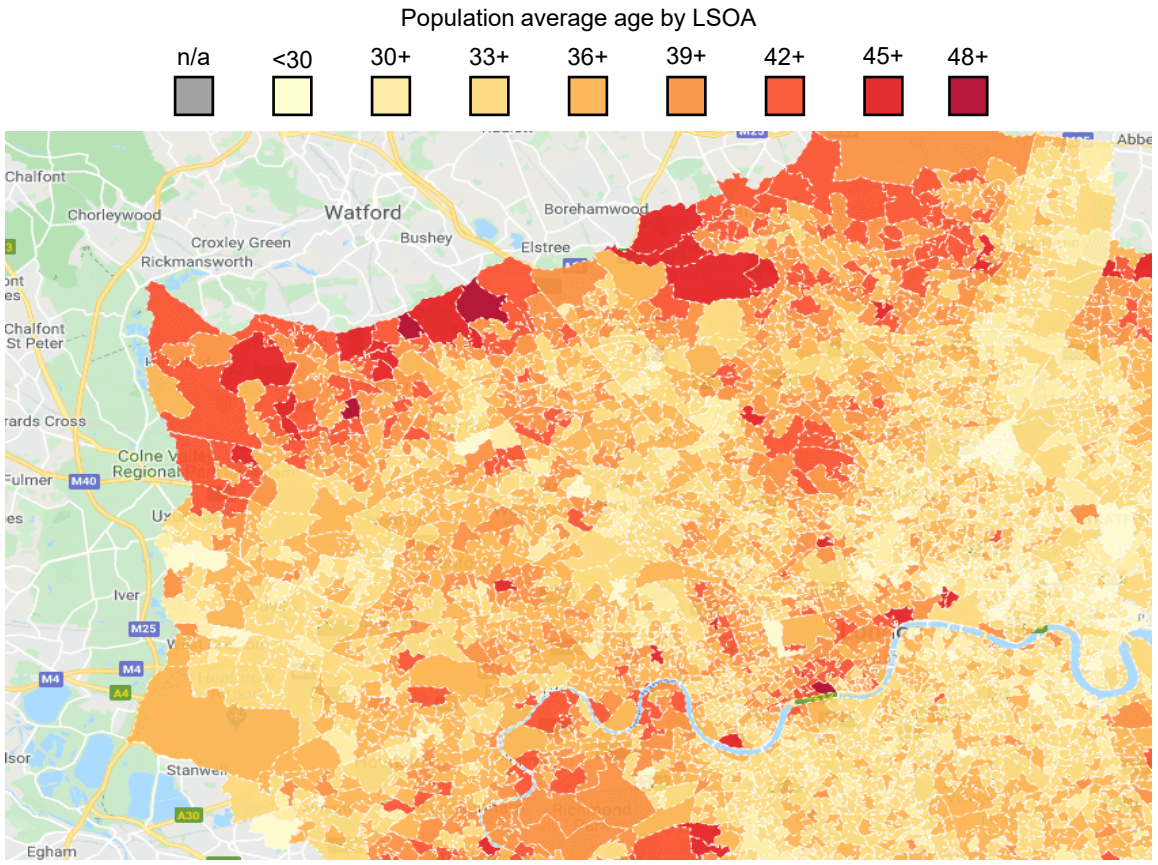
- According to the 2021 Census, over 50% of residents in Brent, Harrow, and Newham identify as non-White.
- Brent alone reports that 65% of its population is non-White.
- Camden, Islington, and Haringey in NCL each have non-White populations over 40%, showing a shared demographic profile.
- **This supports 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



Source: Plumplot, 2018

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.

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.

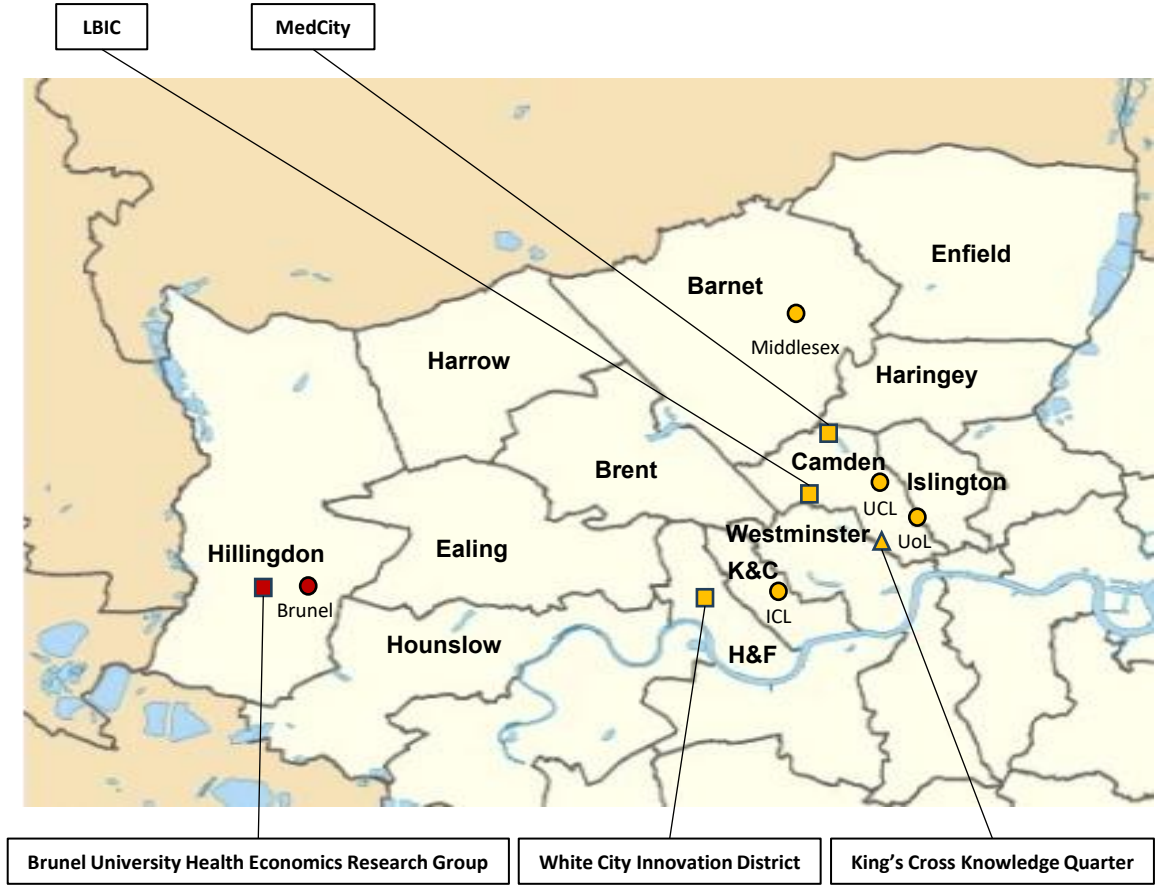
This strong correlation between modifiable risks and disease outcomes reinforces the case for merging the two ICBs. A unified system would be better placed to deliver integrated, preventative interventions at scale, targeting shared drivers of ill health with greater efficiency and impact.

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.

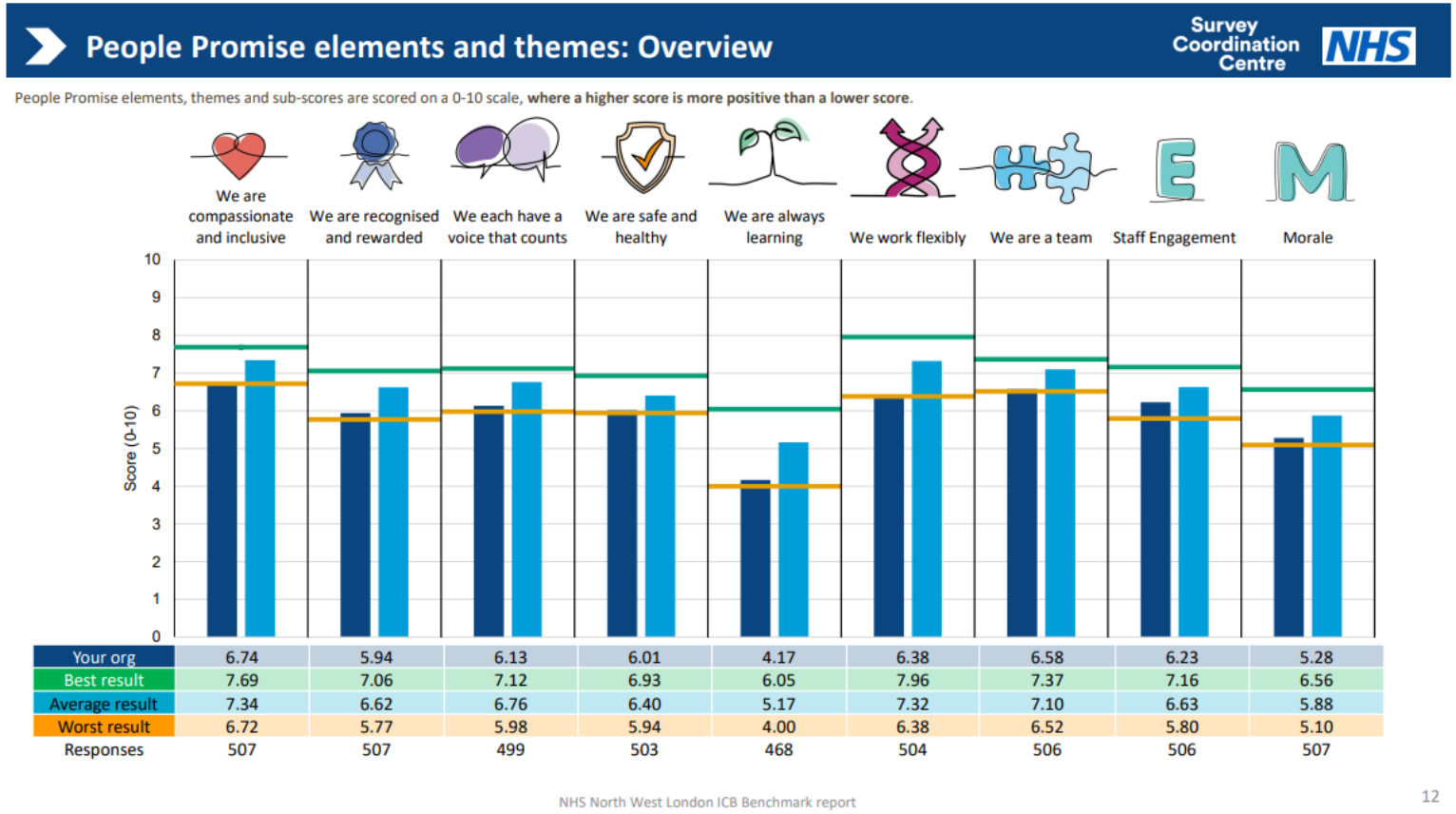
Through this process we want to make sure we work with partners to embed mature, accountable local partnership structures, with the right resources and devolved influence, working to deliver agreed outcomes and reduce inequalities.

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.

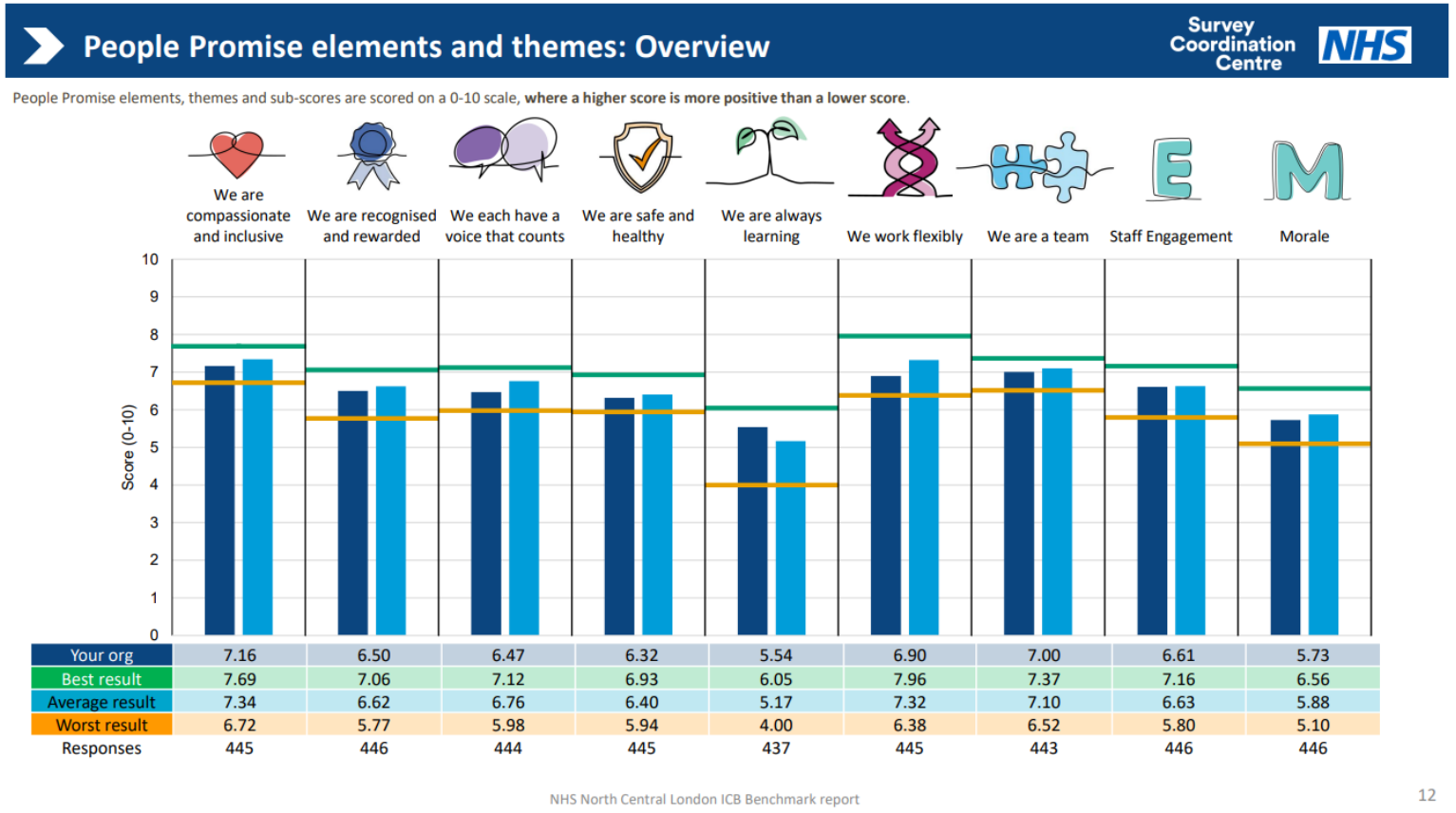
- The ICB scores below average in all categories
- The strongest scoring area in the survey was *We are compassionate and inclusive*.
- Team working and staff engagement remain stable and relatively strong.
- **This suggests that NWL ICB could benefit from learnings relating to culture and staff performance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

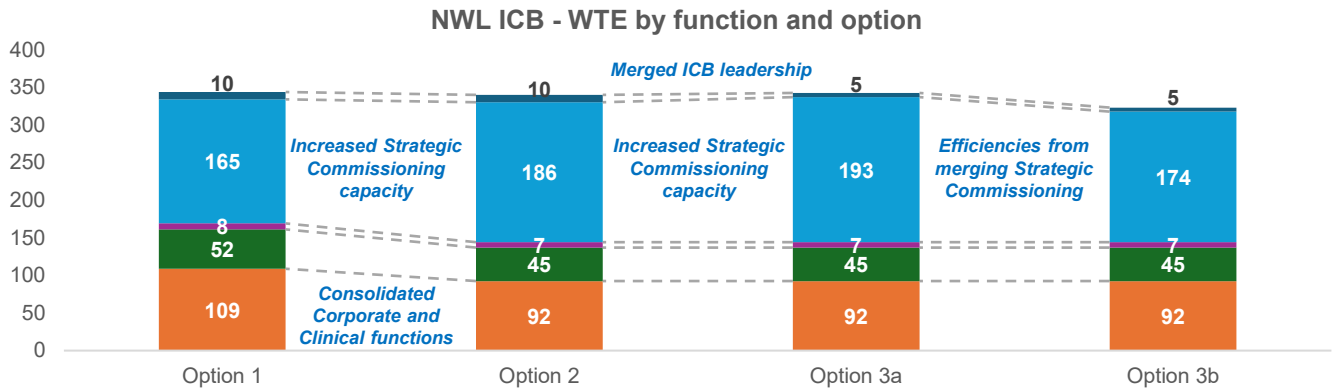
- Across the five London ICBs, NCL ICB scored the highest in the *We are always learning* and *We are a team* themes.
- NCL ICB also scored the second highest of the five London ICBs across all other themes.
- NCL ICB outperforms NWL ICB across all staff survey categories.
- **This suggests NCL ICB is 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.**

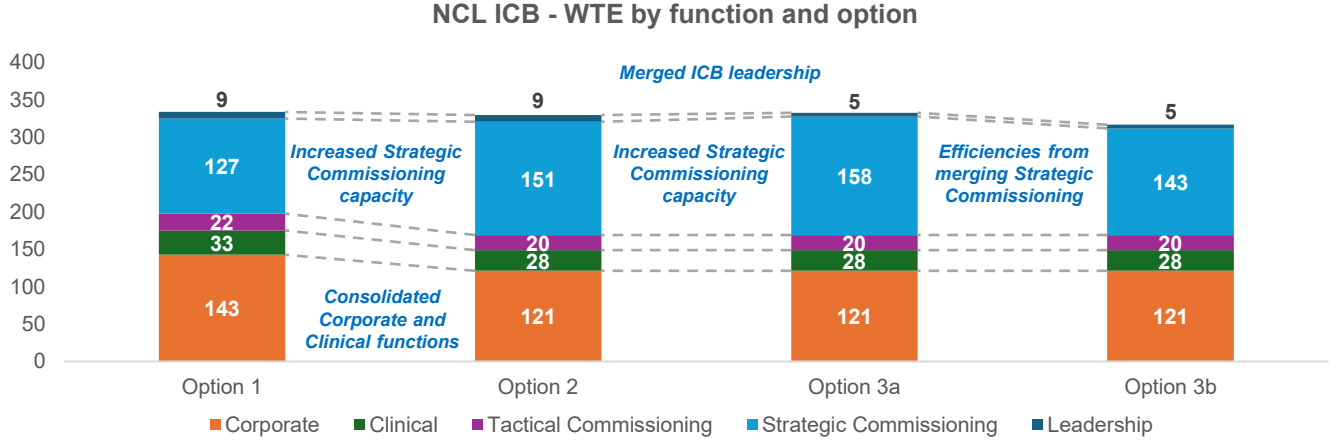
Evaluation criterion 4 of 5:
Resilient and cost-effective core functions

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