North West London Joint Health Overview and Scrutiny Committee

Tuesday 18 November 2025 at 10.00 am
The Auditorium - Harrow Council Hub, Kenmore Avenue, Harrow, HA3 8LU

Agenda

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LONDON BOROUGH OF HARROW

North West London Joint Health Overview and Scrutiny Committee Agenda

Date: **Tuesday 18 November 2025**

Time: **10.00 am**

Venue: **The Auditorium - Harrow Council Hub, Kenmore Avenue, Harrow, HA3 8LU**

Membership:

Chair: **Councillor Ketan Sheth**

Councillors:
Concia Albert, City of Westminster
Nick Denys, London Borough of Hillingdon
Chetna Halai, London Borough of Harrow
Lucy Knight, Royal Borough of Kensington and Chelsea
Natalia Perez, London Borough of Hammersmith and Fulham (VC)
Marina Sharma, London Borough of Hounslow
Claire Vollum, London Borough of Richmond upon Thames
Ben Wesson, London Borough of Ealing

Contact: Chatan Popat, Strategy Lead – Scrutiny, London Borough of Brent
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Agenda publication date: Monday 10 November 2025

Agenda

1. **Attendance by Reserve Members**
   To note the attendance at this meeting of any duly appointed Reserve Members.

2. **Declarations of Interest**
   To receive declarations of disclosable pecuniary or non-pecuniary interests, arising from business to be transacted at this meeting, from all Members present.

3. **Minutes** (Pages 5 - 28)
   That the minutes of the meetings held on 1 May 2025 and 17 July 2025 be taken as read and signed as correct records.

4. **Matters Arising**

5. **Dentist Commissioning and Children's Dental Health** (Pages 29 - 60)

6. **The future of Place Based Partnerships delivering health and Care Services** (Pages 61 - 86)

7. **Special School Nursing and Update on SEN provisions** (Pages 87 - 94)

8. **North West London JOHSC Recommendations Tracker** (Pages 95 - 122)

9. **North West London JOHSC 2025/26 Work Programme** (Pages 123 - 128)

10. **Any Other Business**

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North West London Joint Health Overview and Scrutiny Committee
Notes of meeting by LB of Brent
10am-12pm on 1 May 2025

The meeting began at 10am.

PRESENT

Members of the Committee:
- Councillor Ketan Sheth (Chair) London Borough of Brent
- Councillor Natalia Perez (Vice Chair) London Borough of Hammersmith and Fulham
- Councillor Ben Wesson London Borough of Ealing
- Councillor Chetna Halai London Borough of Harrow
- Councillor Lucy Knight Royal Borough of Kensington and Chelsea
- Councillor Concia Albert London Borough of Westminster
- Councillor Andy Hale London Borough of Richmond (non-voting, co-opted)

Others Present:
- Rob Hurd – Chief Executive, NHS North West London
- Rory Hegarty - Director of Communications and Engagement, NHS North West London
- Tom Shakespeare – Director – Integrated Care Partnership, Brent
- Lesley Watts - Chief Executive of Hillingdon Hospitals & Chelsea and Westminster Hospitals Foundation Trusts
- Claire Murdoch – CEO, Central and North West London NHS Foundation Trust
- Ross Graves - Chief Strategy and Digital Officer CNWL
- Robyn Doran - Director of Transformation, CNWL and Brent ICP Director
- Lyndsey Williams – Clinical Director, Borough of Brent – NWL ICB
- Sam Lund – Medical Director, Royal Trinity Hospice
- Cathy Walker – Chief Operating Officer, Central London Community Healthcare Trust
- Navneet Willoughby – Director of Operations, Inner NW London, Central London Community Healthcare Trust
- Jessamy Kinghorn – Head of Partnerships & Engagement, NHS England (East of England)
- Melissa Mellett – Associate Director, Urgent and Emergency Care

Support Officers:
- Chatan Popat - Policy Lead – Scrutiny, London Borough of Brent
- Hannah O'Brien – Senior Governance Officer, London Borough of Brent
- James Diamond – Scrutiny Officer, London Borough of Kensington and Chelsea
- Anna-Marie Rattray – Overview and Scrutiny Officer, Ealing
- Vid Calovski – London Borough of Hounslow

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1 Apologies for absence were received from the following members:

- Councillor Nick Denys
- Councillor Samina Nagra
- Councillor Clare Vollum, substituted by Councillor Andy Hale

2. DECLARATIONS OF INTEREST

1.2 Councillor Ketan Sheth declared a personal interest that he was the Lead Governor at Central and North West London NHS Foundation Trust (CNWL).

1.3 Councillor Ben Wesson declared a personal interest that he was employed by the Nursing and Midwifery Council.

3. MINUTES OF THE PREVIOUS MEETING

1.4 The Committee RESOLVED that the minutes of the previous meeting, held on 13 March 2025 were approved as an accurate record of the discussion.

4. MATTERS ARISING

1.5 Gordon Hospital

1.5.1 The Chair reminded the Committee that they had been tracking the services at Gordon Hospital for several years, with Councillors Knight and Albert doing focused scrutiny work on it. He had requested an update following the closure of the consultation on Gordon Hospital and the formal decision taken on 8th April 2025 by the Integrated Care Board (ICB) to support the proposal to not reopen beds at Gordon Hospital. He thanked colleagues for their work on this and invited officers to provide an update.

1.5.2 Claire Murdoch began her remarks by thanking those on the Committee who took part in the many meetings and groups that had taken place over the past 2 years. She acknowledged that helpful and constructive feedback had been received regarding the proposed changes, and thanked everyone who input into the consultation. In relation to the decision taken to not reopen beds, she highlighted that this had not been an easy or straightforward decision to take and it was clear how much everyone cared a great deal about people living with mental illness, how they accessed services, how crisis was prevented and how services were accessed in a crisis. The next steps following the decision would be a further Joint Scrutiny Committee with colleagues in Westminster and Kensington and Chelsea. There would be a focus on ensuring Gordon Hospital was a vibrant mental health hub in the South of Westminster, and work with Westminster on potential further provision of crisis and step-down beds. The ICB and local authority were working on joint funding for that, and needed to find a location and agree an operating model. From the CNWL perspective, there was a need to stay focused every day on flow through beds so there was always a bed when needed, discharging patients in a timely way so that they could return to life in the community.

1.5.3 Ross Graves added that the decision making business case sat as part of a larger programme of transformation relating to the NWL mental health strategy and CNWL's own transformation. Work continued, including through winter planning and the urgent and emergency pathways, and the commitment from NWL ICB and Westminster local authority to further strengthen the proposals through the creation of further crisis and step-down beds was welcomed.

1.5.4 The Committee asked whether there were any indications at this stage of the locations of the 6 inpatient beds and 6 step down beds. Ross Graves advised that was an ongoing piece of work and he would not want to pre-empt the work happening, but there was a proposed solution for the crisis beds and progress was being made for step downs in South Westminster. He added that it could be challenging finding sites but work was ongoing with the NWL ICB and Westminster City Council to progress that, and he hoped to have a full update for the joint scrutiny committee on 22 May 2025.

5. COMMUNITY BASED PALLIATIVE CARE

1.6 The Chair led introductions of those in attendance to present an update on community based palliative care services in NWL and invited officers to present the report.

1.7 Robyn Doran reminded the Committee that officers had attended the Committee to discuss community based palliative care before going out to consultation, and had wanted to return to the Committee as a final point to hear its views before the consultation closed on 15 May 2025. She highlighted that the consultation programme had been extensive and ongoing since 2021. More recently, a formal consultation had been undertaken with a number of events hosted across the NWL boroughs, with 112 community events and 10 formal scrutiny committees. These were based on conversations with members about where engagement should take place and had garnered some good feedback. It was highlighted that the aim was to deliver a consistent, equitable, high quality, culturally competent service across all boroughs which was felt to be missing before. Whilst there were pockets of excellence in some boroughs with some providers, this was not consistent and depended on where someone lived.

1.8 The consultation tested for 2 options based on the same model of care. The preferred option was to deliver the new model of care, which included 46 new enhanced end of life care beds, without reopening the Pembridge inpatient unit. The second option was to deliver the new model of care and reopen the Pembridge unit, which would lead to a reduction in the number of beds in other hospices. Since the Pembridge unit had been temporarily closed, which happened prior to covid, the hospices in NWL had taken on extra capacity which was working well. Robyn Doran expressed gratitude for the input from residents in the borough with lived experience in shaping the model. The volunteer sector organisation 3ST was bringing together the feedback received from the engagement that had taken place since 2021, and their report was expected in the next few weeks.

1.9 Lyndsey Williams emphasised the many opportunities there had been for officers to get out in the community with face to face, online and webinar events. The engagement programme had adapted for faith groups, those with protected characteristics and particular boroughs who wanted something more bespoke. She had personally tried to attend as many events as she could as the feedback received had been eye opening in understanding that these services mattered to everyone, not just those going through end-of-life care. Engagement had been done with Black, African, Caribbean and South Asian communities due to feedback related to cultural awareness and competency. Some of the key themes from engagement were around equity of service, with people wanting to be able to access the service no matter where they lived, who they were or what faith or identity, wanting to ensure people understood who they were and their identity, and wanting to be at home or in a place that mattered to them. The move in the new care model was to increase care at home, and, for those that could not stay home but did not want to go into hospital and were not suitable for other home care settings, they were eager for the enhanced end of life care beds which had been very well received. She added it was reassuring to know that they were on the right track with the new model of care to fit the population's needs.

1.10 Detailing the new model of care, Lyndsey Williams explained that it involved an increase to 12 hours a day for the community specialist palliative care teams who went into patients' homes and contacted patients, and included adding the enhanced end of life care beds in Hillingdon. There were 8 enhanced beds in Hillingdon with the aim of 54 in total. The new model would also retain the 57 specialist palliative care beds. One

other addition to the new model was a 24/7 telephone advice line following feedback that people wanted to have someone to talk to at any time, which was not consistent across NWL. Hospice at Home also varied across different boroughs so the model looked to level up on that. The new model looked to ensure people had the opportunity for outpatient appointments and to attend the hospice setting for psychology support as there was currently a gap for those going through palliative care or experiencing bereavement. In concluding, she emphasised that the model of care was about levelling up the support outside of an impatient setting and adding those extra beds for those for whom it was not safe to stay at home, did not want to stay in hospital and did not meet the criteria to be an inpatient.

1.11 In relation to the financial implications of each option, Robyn Doran confirmed that the preferred option, which included the closure of Pembridge, was £27.6m. The option to keep Pembridge open was £29.7m. She added that both options were affordable, with option 1 more financially sustainable and quicker to improve services across all boroughs. It was highlighted that option 2 would delay implementation of the new model and destabilise funding for some hospices because they currently had that extra resource through carrying the extra beds for hospice provision.

1.12 Cathy Walker provided an update from a CLCH perspective. She highlighted that Pembridge had not been in operation since before Covid. CLCH had offered enhanced hospice at home provision and supported a more community focused provision since its closure. Throughout the review, CLCH had welcomed the introduction of the new model of care which they saw as appropriate for all boroughs. CLCH had expressed interest in delivering some of the enhanced end of life care beds for Hammersmith and Fulham, Kensington, Chelsea and Westminster and were keen to explore options around how and where that could be delivered using existing NHS estate.

1.13 Sam Lund provided an update on the role of hospices in this workstream, highlighting that hospices had been involved in the full process and were all very excited about the new model of care. She felt it important that the model strengthened and stabilised the community offer available. A small proportion of patients cared for were in inpatient beds which offered very focused, intense, short-term admission. In her hospice, there were 26 inpatient beds, but the hospice also supported up to 450 patients in the community. The new model allowed hospices to stabilise and enhance care to provide care to patients in their local communities and homes.

1.14 In summing up the introduction, Robyn Doran felt that officers had listened very carefully to stakeholders and the residents that NWL served. It had been a long consultation with Covid in between which caused a delay but allowed people the time to speak. The new model was based on equity, quality, personalisation and sustainability and she saw it as a transformative step for palliative care in NWL which could act as a pathfinder for the rest of the country. The next steps were to get the feedback of JHOSC, publish the final Decision-Making Business Case in summer 2025, and host workshops in different boroughs to plan implementation. Phased implementation would start in Autumn 2025.

5.9 The Chair thanked officers for the introduction, then invited questions to NHS representatives from members of the Committee, with the following issues raised:

6.3.1 Committee members welcomed much of the proposals to improve community palliative care services, but had some reservations. They asked whether there was any indication on where the enhanced end of life beds would be placed, and whether there would be a specialist consultant available for those beds. They also asked for

reassurance that these were new beds and not repurposed beds from existing care homes which already had huge demand. Lyndsey Williams advised that the end-of-life enhanced beds were a new model of care that had been created by Hillingdon, where patients would have a weekly consultant specialist ward around, with 24/7 care by nurses who had specialist palliative care understanding and enhanced knowledge. At any point, staff could contact the inpatient hospice where the specialist consultant was based for additional needs, and the employment of those individuals came from the specialist palliative care hospice sector for Hillingdon. NWL were supporting that model, including full financial support. The 4 funded enhanced care beds for Kensington and Chelsea were new and not repurposed, and the intention was to fund 46 in total across NWL. Navneet Willoughby added that work had started to look at the opportunities in the boroughs as to the location of the enhanced beds, looking at existing NHS estate where there was capacity. Pembridge was an option which would not be excluded from review. Robyn Doran added that they were also looking at the option to cluster beds in some way across the inner boroughs to offer economies of scale that worked well for all of the population.

6.3.2 The Committee asked what would be done with the Pembridge facility should it close, which they saw as a good community asset. Cathy Walker responded that she would not want to pre-empt that and would need to await the outcome of the review, following engagement. The unit was currently running the community palliative care services from that site and had an outpatient's service there. After the review, there would then be consideration of how else that site could be used. Work had already started on where the new enhanced beds could be located. There were multiple options across the different boroughs to get all possible options and locations, including information around inequalities and travel. It was also important to ensure Hammersmith and Fulham had Hospice at Home to make that an equitable service for patients across NWL.

6.3.3 In relation to unmet need, the Committee asked how confident officers were that the new model would lead to future demand. Robyn Doran confirmed that the business case had modelled ahead for the next 5-10 years. Currently, 25% of those who went into hospice were now in enhanced care beds, which released some specialist hospice capacity. The modelling of the population had taken into consideration single older people living alone, which came up prevalently in the consultation. Lyndsey Williams added that the model of care was co-produced with 12 members of the public on a weekly working group across 46 sessions, and the enhanced end of life care beds were proposed specifically for people living on their own without the option for hospice at home or who did not want to be at home anymore. Currently, those patients could only go to Hillingdon, so the new model aimed to meet patient's wishes and needs. She added that the Hillingdon model was now the gold standard and highly recommended in the UK.

6.3.4 The Chair invited Katherine Shaw to share what residents had been telling Healthwatch about the new model of care. Katherine Shaw highlighted that there had been concerns from residents within inner boroughs surrounding the closure of Pembridge and the move of services away from the central hub, and concerns about the timings of when these changes would happen. There was also general concern about travel and loss of services from a central location. In response, Lesley Watts highlighted that there had been concern across the sector and acute units about the number of patients dying in acute units which this model addressed. Whilst NWL ICB heard the concerns around the closure of Pembridge, it aimed to ensure specialist care was there for all patients in a coherent and consistent way and she felt the investment in this care should be welcomed. Robyn Doran assured members that they were having discussions now with the community and organisations in the 3 inner London

boroughs. In terms of concerns around the timescales, she highlighted that implementation of the preferred option would be completed by Autumn, which was soon, whereas option 2 to reopen Pembridge would take much longer due to the need to undertake capital works and recruit.

6.3.5 Relating to travel access and support, the Committee asked whether there would be any support for travel costs for low-income families, particularly if they were further away from where their loved one was placed as a result of the new care model. Melissa Mellitt responded that some hospices provided free transport based on criteria, and there was free parking available at all of the hospitals for those driving. As it was not yet clear where the enhanced care beds would be located, it was unclear whether free parking provision would be feasible, but this was being taken into consideration, alongside concerns raised from boroughs such as Ealing regarding the congestion charge, all of which would factor into the options appraisal.

6.3.6 Councillor Lucy Knight highlighted that she had written a letter to the NWL ICB in March 2025 but had not yet had a formal response, emphasising that communications could be improved. Rory Hegarty responded that he had seen a draft response to that letter and would follow that up to ensure a response was provided.

6.3.7 Noting the ageing population of some NWL boroughs, the Committee asked whether there would be enough beds for all of the NWL populations across the next 5-10 years. Robyn Doran responded that the modelling that had been done could be made available, which had looked at the ageing population and worked with each borough and their profiles to do that modelling. Specifically in relation to beds in Harrow, the Committee heard that there would be 7 enhanced care beds and an increase in the lymphedema service which Harrow was currently not receiving. A workshop was scheduled for 20 May for Harrow and Brent collectively with all providers and patient engagement links to work through the potential options for the location of the enhanced beds.

6.3.8 The Committee asked what mechanisms were being put in place for culturally competent care. Robyn Doran responded that there had been a lot of feedback in the early stages of engagement that people did not feel services were culturally sensitive and meeting their needs, so work has been done with faith and culture groups as well as those with protected characteristics around that. Lyndsey Williams added that 5 enablers had been identified under the cultural competence workstream, including inequalities, workforce and education needs. Two working groups for inequalities had already been established, one of which included patient representation across NWL and one involving stakeholders involved in health inequalities in NWL. Those groups were looking to get to the core of what the needs of certain groups were and how the NWL ICB could support with that. The Royal Trinity Hospital Hospice held an open day recently providing an open tour of the unit with faith groups to see what the facility was like, and patients involved in the health inequalities group had commended that and wanted to see other hospices do that as well. NWL ICB was also looking at literature and how information could be provided in languages that community groups understood and that referenced their cultural and religious needs and identity. There were also some cultural competency learning resources available, and the aim in NWL was to have a cultural competency education that every palliative care professional would do mandatorily. All providers were keen to enhance their knowledge and understanding of health inequalities and cultural competency. This work was being done in collaboration with residents, and the London End of Life Network were seeing the work being done on this as gold standard. Further funding would allow for training and development around this.

6.3.9 Noting the ICB's aims for levelling up services, but the preferred option to close the Pembridge unit, which members highlighted was in a deprived area of NWL, the Committee asked whether moving facilities further away from that area could be considered levelling up. Robyn Doran acknowledged that residents from inner boroughs had voiced those concerns, but levelling up was about all 8 NWL boroughs and not only the inner boroughs. She advised that for the past 4 years those Pembridge beds had already been delivered outside of Pembridge and there had been no feedback to indicate this had affected people's wellbeing or they had experienced a reduction in service. This was why NWL ICB was looking to enhance that offer and have those extra beds located in the borough and were being mindful of involving residents in terms of where those beds were placed.

6.3.10 The Committee noted that many boroughs had a shortage of nursing home beds which was creating a barrier to discharge, and asked whether the enhanced beds would add to the pressure. Robyn Doran advised members that they would look to use existing NHS estate where possible to avoid putting extra pressure on care homes, but care homes would still need to factor into the options. It was seen that these beds would release some pressure on acute hospitals and hospices. Lesley Watts reiterated that there were too many people dying in hospital who could have had a better death elsewhere, so the first option was to look to place new beds in existing NHS estate, and if not then consolidate enough to get specialist input into patient's care. An example was provided where Hillingdon's beds were currently provided in a nursing home, who had found that patients were benefiting from specialist staff and input into the nursing home.

6.3.11 The Committee asked if there would be a workforce strategy as part of the process. Lyndsey Williams highlighted that workforce was one of the enabling workstreams that was required to take place to ensure success, to ensure continuation with the workforce in the sector with enhanced palliative care skills. She advised members that NWL was in a privileged position of having many different providers providing community specialist palliative care who were coming together to ensure their offer was the same, their skillset was the same, and they could support each other in educational needs to get to a common core understanding of workforce development. There was also a separate piece of work in NWL which was a workforce development programme and she highlighted the importance of ensuring that programme reached the specialist palliative care sector. Many of the staff roles in the specialist palliative care sector already existed, and the hospice and community palliative care sector was very good at growing its own, keeping people in the system and multi-skilling staff to give them steps towards independence. It was important that the workforce remained stable, as one of the primary reasons for the Pembridge closure was instability of workforce.

6.3.12 Noting that the primary reason for the closure of Pembridge was based on staffing, the Committee asked whether there had been any further work to look at staffing to support the reopening of the unit. Navneet Willoughby explained that the consultant post was very challenging to recruit to which was a key component of the service. There had been multiple rounds of recruitment, options reviewed to look at joint posts to see if they could be pulled together with other providers, job plan reviews to make the post more enticing and innovative, and many repeated attempts by temporary staffing to recruit temporarily while recruiting substantively which had not been successful. In addition, there were large vacancy rates for specialist palliative care consultants nationally and no increase in trainees in London. Melissa Mellitt added that it was not just Pembridge where workforce was a challenge, hence the focus on the end-of-life pathway specialist element. The workforce enabling workstream was working through different ways to bring the hospital alliance and community providers together to try to

address workforce challenges collectively, such as through staff passports to move staff around. If NWL ICB were to reopen Pembridge, there would be a need to recruit a new consultant and 35 clinical staff in an area with a national shortage of specialist staff, which was highly challenging in the context, whereas there was capacity, resources and trained staff in existing hospices delivering that service, with the enhanced care beds providing career opportunities for other staff to enhance their skills.

6.3.13 Noting that the option to reopen Pembridge had been labelled as an unstable option, the Committee asked why that was. Lyndsey Williams explained that modelling had identified that 57 specialist inpatient beds were needed for the next 5+ years. If Pembridge were to reopen, that would mean there would be no need for those numbers of beds elsewhere in the specialist palliative care sector. As such, the instability would be that beds would be removed from other hospice sectors and specialist palliative care inpatient units.

6.3.14 In relation to finance, Robyn Doran confirmed that the options had never been driven by finance but by equity of service, and the financial analysis was required as part of due process and the duty as a responsible public servant to provide financial assessments. Whilst the options showed a difference in price, that price had never driven the preferred option.

6.3.15 Noting findings that the number of elderly people with dementia was set to double by 2040, the Committee asked if NWL was confident they could cope with that demand. Leslie Watts responded that this was being reviewed together with Directors of Adult Social Services and local authority colleagues, as it was a joint responsibility in terms of care and would need to be paid for together. Sam Lund added that dementia care was a very core component of the specialist palliative care provision and would form a part of the offer.

6.4 The Chair thanked health colleagues for their responses and closed the discussion. The Committee were invited to make recommendations with the following RESOLVED:

i) That NWL ICB provide a strategy borough by borough, with infographics and statistics, showing the future projections and impact of the decisions taken.

ii) That, where possible, the option for free parking was offered at sites with enhanced specialist palliative care beds.

6.5 As well as recommendations, a number of requests for information were made during the discussion, recorded as follows:

i) For the NWL JHOSC to be provided with the detailed modelling that had taken place in relation to the population and future population predictions.

7. UPDATE ON MOUNT VERNON CANCER CENTRE

7.1 Jessamy Kinghorn introduced the report, which provided an update on the Mount Vernon Cancer Centre. In providing some context, she explained that her role was Head of Partnerships and Engagement with NHSE in the East of England, who had been the commissioner for Mount Vernon as the largest number of its patients came from the East of England. As Mount Vernon was now a delegated service it was no longer commissioned by NHSE but by ICBs, so she worked on behalf of the ICB in the East of England in the context of the Mount Vernon review.

7.2 She reminded members that, in 2019, clinicians at Mount Vernon Cancer Centre expressed concerns about the long-term sustainability of the service, and an independent clinical review was carried out by clinicians from a different part of the country who made 3 sets of recommendations. Some recommendations were for immediate action which had been taken. One was for a change in the management of the cancer centre to a specialist cancer provider, following which a process identified UCLH as the preferred provider who had been working on the review since then but were not yet the provider of the service subject to a process of due diligence. The third recommendation was that Mount Vernon must be re-provided on an acute hospital site. The site was currently located on land owned by Hillingdon Hospitals with no acute services that one would expect a cancer centre to have access to, resulting in a number of patients being transferred in emergency to an acute hospital which disrupted their care. The recommendation also meant services such as haematology could no longer be provided on site because it required access to critical care, which was not onsite. Other acute specialisms sometimes required for cancer treatment were also not available to Mount Vernon easily. Whilst the team had agreements with a large number of trusts to provide different support, she highlighted that was fractured and impacted patient services.

7.3 Following the findings of the review, officers began to develop proposals for Mount Vernon working with patients, stakeholders and Healthwatch, and looked at what relocation might look like and what immediate changes were needed. A series of recommendations were made from that work, including the relocation of Mount Vernon to Watford Hospital as the closest acute hospital and the most appropriate for the population as a whole in terms of meeting all the necessary criteria. Watford Hospital would be further for some patients, but was the option that overall improved access, particularly for Luton which had a very similar demographic population to Brent but very poor cancer outcomes. As well as moving the service, there had been consideration of how to provide care closer to home, as feedback highlighted travel was a big issue. As such, a series of proposals had been developed if the Mount Vernon Cancer site was to move to Watford, including adding chemotherapy chairs to Hillingdon hospital, which it did not currently have, and more capacity into Northwick Park Hospital.

7.4 Jessamy Kinghorn advised that officers were now looking to consult on the proposals to relocate Mount Vernon, and had asked for national permission to consult without having the capital route for the proposals identified. The national team had looked at and challenged the case for change and concluded that it did need to go ahead. Officers were in consultation with the Department for Health and UCLH about alternative ways to fund the proposals as this was a unique situation involving partnership from several different organisations. The case for change was in the assurance process to ensure it included everything it needed before consultation, and ICBs had been asked to provide letters of support for the approach to evidence there was buy-in.

7.5 The Committee's attention was drawn to the report which highlighted the engagement done in London and the data including where patients were coming from. There were a lot of views on transport, particularly in relation to the expanded ULEZ. A working group had been set up to look in more detail at transport as a result and patients attending Mount Vernon were being surveyed on how they got to the site to understand how people were travelling. Work was also being done to commission a wider survey of the public around transport to hospital and with Councils around their transport strategies. The consultation document would also include questions around transport choices and mitigations.

7.2 Lesley Watts added that, currently, the way care was being provided at Mount Vernon was not where it should be. The discussions being had with the East of England was to reiterate that it was expected that the new hospital would be built and this issue would be resolved by that time so that patients in NWL could be accommodated. She added that NWL did have cancer centres with good provision. She asked for the Committee's support in lobbying to get a final decision made and capital allocated.

7.3 The Chair thanked colleagues for their introduction and invited comments and questions from the Committee, with the following raised:

7.3.1 The Committee asked whether there was any update on securing funding for the proposals. Jessamy Kinghorn confirmed there was no update on the capital, but assured members that the revenue looked good in terms of affordability once the new site was up and running. She was not confident that officers would have any information on funding before going to consultation, but was confident that there would be support behind the proposals because the alternative would be for Mount Vernon to close. The funding for the proposals affecting NWL was confirmed so those parts of the business case could go ahead. Lesley Watts emphasised the importance of taking a stance that said services could not continue in the way they were and put pressure on the Department for Health for funding for Watford.

7.3.2 The Committee asked how consultation would be addressed. Jessamy Kinghorn advised that a high-level consultation plan was shared at the last Mount Vernon Cancer Centre JHOSC, and that plan was now much more detailed and had gone out to all ICB and provider colleagues for them to populate their parts of the document. She had a constructive meeting with the NWL team around engaging traveller communities in NWL who was going to work with colleagues in Hillingdon to see how they could support the consultation plan. Lots of questions were being received from colleagues which she saw as a positive and there were plans to hold another Healthwatch workshop. More pre-consultation engagement would be undertaken and colleagues were looking for some feedback from the assurance team currently that they were on the right track. Some of the feedback from patients who had taken part in engagement was that they felt the issue was not being progressed, so it was important any further involvement was meaningful for them.

7.3.3 Jessamy Kinghorn explained that one of the reasons residents were against Mount Vernon closing was because there was no capacity in the system to deal with the number of patients there, and so the relocation of the site helped to free up space in London.

7.3.4 The Committee asked what outreach efforts had been undertaken to engage those who were not current users of the service or may be future users, including through Healthwatch. Jessamy Kinghorn advised that Harrow and Hillingdon Healthwatch sat on the London Programme Board, and there had been a workshop held in the early stages of the programme where all Healthwatches were invited which would be repeated soon. Healthwatches were then invited to nominate some members to the patient reference group which was proportionate to the size of their patient population at Mount Vernon. There had been less engagement with Brent and Harrow so work would be done to improve that engagement in the next phase. Due to GDPR legislation it was not possible to write to previous patients of Mount Vernon but the provider could be asked to write to current patients to get their views. There would also be engagement through the community including with faith and community groups that were not specifically cancer related. Funding had been agreed to hire a consultancy to help with engagement and there would be weekly meetings to monitor where feedback was being received and where there were gaps to adjust and target work to where

engagement was low. Lesley Watts added that the consultation would not be a choice of continuing with services at Mount Vernon as it was not right to do that, and it was important to be transparent to ensure residents understood why these proposals were being made.

7.3.3 The Committee asked where the closest radiotherapy unit would be for the NWL population. Jessamy Kinghorn advised that the proposal was to move all services at Mount Vernon to Watford, and there would be an additional radiotherapy unit either in Luton or Stevenage to be determined following consultation. Some patients would be able to go to Hammersmith for their radiotherapy.

7.4 As there were no further comments, the Chair thanked those present for their contributions and drew the item to a close.

7.5 The Chair thanked health colleagues for their responses and closed the discussion. The Committee were invited to make recommendations with the following RESOLVED:

iii) That a date was set for the next Mount Vernon Cancer Centre JHOSC as soon as possible.

iv) That the NWL JHOSC would send a letter to the programme outlining their support for the proposals and a desire to see the work accelerated.

8. NWL INVOLVEMENT STRATEGY

8.1 Rory Hegarty introduced the report, highlighting the following key points:

- The basis of the involvement strategy was to be linked in with communities at all times to understand how they experienced healthcare.
- An involvement chart had been co-designed with residents several years ago who helped to guide this work, which allowed the ICB to collect resident insights to identify priorities for improvement.
- Engagement focused on talking to communities through an inequalities lens, considering who was not normally spoken to, what different communities had not been reached in the past, who might be excluded and who was the furthest from decision making.
- The in-reach programme reached hundreds of residents every month with around 40 interaction events held across NWL through the inequalities lens, sometimes in partnership with public health, Healthwatch and the voluntary and community sector.
- A co-design advisory board for excluded communities met bi-monthly to hear about the experiences of excluded groups.
- A quarterly resident forum across NWL was chaired by Penny Dash.
- 120 people were signed up to provide a resident voice on programmes and a citizens panel of 3,800 was in place, recruited in the basis of demographics that reflected NWL communities and there was ongoing dialogue with that group virtually.

8.2 In the context of the recently announced changes to ICBs across the country, Rob Hurd advised that the concept of the borough-based partnership would remain, focused on engagement and digitally enabled neighbourhood health, but there were significant challenges regarding the resources to continue the involvement work.

8.2 The Chair then invited questions from members of the committee, with issues raised as outlined below:

8.2.1 The Committee asked what the approach moving forward would be in terms of the ICB's relationship with JHOSC. Rob Hurd advised that the final numbers on the reduction of people working on involvement had not yet been received but it was likely it would not continue at the level it currently was. There would be a need to work closely with boroughs and providers on how to work with less people doing more co-ordination, as the statutory duty would remain. He advised there would be a need to eliminate duplication and there would likely be people from NHSE involved in helping to organise the changes. Nothing had progressed to a final model at this point and he expected more information the following week. He reassured members that all partners were in agreement that the quality of outcomes was enhanced by involvement, so there was both a statutory requirement to involve everyone and a desire to do so.

8.2.3 Lesley Watts added that some cuts affected providers and the ICB was working with providers on this. Communications across Chelsea, Westminster and Hillingdon were now joined to drive down some of those costs and stop duplication. She assured members that there was a commitment to work as a sector overall to get into the communities that had not been reached in the past.

8.2.4 In relation to a previous recommendation made by the Committee for the ICB to work closer with the London Ambulance Service to deliver messages specific to communities about accessing ambulance services, this was with the ambulance service for action and Rory Hegarty would follow this up.

6.6 The Chair thanked health colleagues for their responses and closed the discussion. The Committee were invited to make recommendations with the following RESOLVED:

v) To provide proposals for partnership working once they have been established, including Council by Council and NWL-wide.

9. **ICS Update**

9.1 Rob Hurd provided a high-level overview of what was described as a challenging position for ICS's across the country. He advised members that the NWL ICS had delivered its KPIs at the end of March and the balancing of overall finances continued to benchmark favourably, however, NWL ICS was not where colleagues would want it to be on a set of issues and the NWL Strategy remained in terms of reducing health inequalities, improving outcomes, better value for money and a focus on the wider determinants of health. Due to the overall financial situation of the NHS, there was a need to radically reduce back-office staff, support function staff, opportunities for AI and digital enablement except where there were opportunities to reduce fragmentation and reduce layers and duplication, headlining as a 50% reduction in support staff. Since that announcement, there had been national work taking place, which NWL ICB had been inputting into. 'The Model of ICB' was expected to be published the following week which would include details about resource implications and therefore staffing. NWL ICB had a balanced plan for the year ahead, but this depended on very significant non-frontline service reductions regarding head counts and workforce in provider organisations and the ICB. He added that whilst the ICB would need to deliver the financial reductions this financial year, it would not be possible to do the appropriate people change process this year and it would likely be 2027 that would be seen. Members were advised that there was a balanced plan for the year ahead requiring some challenging productivity and efficiency savings, as well as the potential for service changes that the ICB would be talking to scrutiny committees about and signalling throughout the year.

9.2 Lesley Watts signalled that Hillingdon Scrutiny Committee would be discussing some issues around the Minor Injury Service at Hillingdon which may be provided in a different way, and added that the ICB would be looking at every service to consider how that could continue to be delivered within the resources available.

9.2 The Chair thanked NHS colleagues for the introduction and invited comments and questions from the Committee, with the following issues raised:

9.2.1 The Committee felt that it would be useful to receive a briefing paper outlining what was being proposed following the changes announced by government and outlining the ICB forward plan and provider forward plans to align the work of the Committee with the work of health colleagues.

9.3 The Chair thanked those present for their contributions and drew the item to a close, acknowledging the emotive subject regarding the uncertainty of people's futures and expressing gratitude for the work being done.

11. NWL JHOSC 2023-24 RECOMMENDATIONS TRACKER

11.1 The Committee noted the recommendations tracker.

13. ANY OTHER URGENT BUSINESS

13.1 None.

The meeting concluded at 12.25 pm.
COUNCILLOR KETAN SHETH, CHAIR

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Minutes

NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

17 July 2025

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Ketan Sheth (Chair), Concia Albert, Nick Denys, Chetna Halai, Marina Sharma and Claire Vollum (non-voting) **Also Present:** Kate Barker (virtual), Director of Clinical Programmes, NHS North West London Victoria Cochrane, Director of Midwifery, Chelsea and Westminster NHS Foundation Trust Rory Hegarty (virtual), Executive Director of Communications and Involvement, NHS North West London Dr Christopher Hilton (virtual), Chief Operating Officer (Local and Specialist Services), West London NHS Trust Rob Hurd, Chief Executive, NHS North West London Toby Lambert, Executive Director of Strategy and Population Health, NHS North West London Pippa Nightingale, Chief Executive Officer, London North West University Healthcare NHS Trust Katherine Shaw, Chief Executive Officer, The Advocacy Project (Healthwatch) **Council Officers Present:** Vid Calovski (Hounslow), Linda Hunting (Westminster), Chatan Popat (Brent), Sandra Taylor (in part) (Hillingdon) and Nikki O'Halloran (Hillingdon)
	WELCOME Ms Sandra Taylor, Corporate Director of Adult Social Care and Health at the London Borough of Hillingdon, welcomed everyone to the Civic Centre in Uxbridge and noted that it had been almost exactly two years since a North West London Joint Health Overview and Scrutiny Committee (NWL JHOSC) meeting had been held in Hillingdon. Over the last two years, there had been significant system changes, some of which had been implemented quickly and others taking time. Colleagues across NWL had been working together and the system had benefitted greatly from being scrutinised on a NWL level as well as locally. By now, all authorities in NWL should have been inspected by the CQC which would have looked at the councils' overview and scrutiny functions. Hillingdon's inspection had been undertaken in 2024 and had prompted a closer working relationship between officers in Health and Social Care and the Borough's Health and Social Care Select Committee. Scrutiny was vital to the effective running of a council.
1.	**APOLOGIES FOR ABSENCE AND CLARIFICATION OF ALTERNATE MEMBERS** *(Agenda Item 1)* Apologies for absence had been received from Councillors Lucy Knight (Royal Borough

	of Kensington & Chelsea), Natalia Perez (London Borough of Hammersmith & Fulham) and Ben Wesson (London Borough of Ealing).
2.	**DECLARATIONS OF INTEREST** *(Agenda Item 2)* Councillor Ketan Sheth, London Borough of Brent, declared a non-pecuniary interest as he was lead governor of CNWL, and stayed in the room during the consideration thereof. Councillor Claire Vollum, London Borough of Richmond upon Thames, declared a non-pecuniary interest in Agenda Item 5: Maternity Provisions in North West London, as she was an employee at West London NHS Trust and worked as a Health Visitor in Hounslow, and stayed in the room during the consideration thereof.
3.	**MATERNITY PROVISIONS IN NORTH WEST LONDON** *(Agenda Item 5)* Ms Pippa Nightingale, Chief Executive Officer at London North West University Healthcare NHS Trust, advised that the birth rate had increased slightly over the last year but that the stillbirth rate in North West London (NWL) was lower than it had been the previous year (2.9 per 1,000 births compared to 3.5 last year) as well as lower than the national performance (3.3 per 1,000 births). There had been a national agenda to reduce stillbirths and this reduction had been achieved with improvements across all four hospitals in NWL. The Start Well programme was a major transformation initiative led by North Central London (NCL) Integrated Care System (ICS) in collaboration with NWL partners and aimed to improve outcomes and experiences for women, babies and families by redesigning maternity and early years services. Assurance had been provided that the programme would enable an additional 500 births to be dealt with within current resources - a large proportion of the additional births were likely to be in Willesden and Harlesden. This initiative would help maternity safety outcomes. Ongoing joint work between the two regions would ensure that the implementation of Start Well supported consistent, high-quality and equitable maternity care for families living or booking across both ICS footprints. NWL's centralised booking hub would ensure there was a limited impact on the women in NWL whilst also managing the activity and flow and ensuring that there was no duplication. The centralised booking hub meant that women no longer needed to go through their GP (although most continued to do so) but stopped them from double booking and hopping around different units. More work was needed to improve early access to maternity care and getting pregnant women in by 9 weeks. It was noted that women were still able to carry their hard copy notes with them if they wanted but that the digital maternity platform provided better access for professionals. Ms Vicky Cochrane, Director of Midwifery at Chelsea and Westminster NHS Foundation Trust, advised that inequalities had driven (and been at the heart of) the changes that had been made. A large Asian population lived in Brent, Hillingdon and Hounslow and, although she was proud of the improvements in the stillbirth rates overall, Ms Cochrane was aware that there were still disparities for 37+ weeks and systemic inequalities. Concern was expressed regarding the stillbirth rate amongst the Asian population in NWL and Members queried how this had changed over the last ten years. Ms Cochrane advised that she would provide Members with the data on stillbirths broken

down by ethnicity for the last decade after the meeting. Recommendation 4 of the report had looked to address these disparities. To try to address the higher stillbirth rate amongst Asian women and provide timely access, referrals were made when it was known that the women were pregnant and interpreters and double appointments were booked to provide enough time to address any language issues. Advanced scanning pathways were also used but this would not be right for everyone.

The importance of capturing quality data to address the social determinants of health, engage with those at greater risk of poor health outcomes and support those with mental ill health or complex social needs, was reliant on efficient IT systems. However, it was queried whether an upgrade of the maternity IT systems would be possible in light of the ICBs funding reduction. The report had stated that investment in resources to facilitate easy extraction of data from maternity systems was needed to provide a better overview of maternity outcomes by ethnicity and deprivation. Members queried which local authorities NHS NWL had been working with to develop a coordinated programme of outreach and community research and what lessons had been learnt.

The Equity and Equality Strategy had been produced in 2024. The sector-wide response to the Covid-19 pandemic had demonstrated the power of partnership working. Maternity Voices Partnerships, councils, voluntary groups and NHS teams had collaborated rapidly to develop multilingual communication materials, virtual antenatal education and innovative outreach strategies to target communities at highest risk of poor outcomes. These examples showed the strength and breadth of collaborative working in NWL, placing partnership with women, families and communities at the heart of efforts to deliver equitable, safe and compassionate maternity care.

The NWL ICS had introduced a priority to ensure that personalised care and support plans were available in a range of languages and formats to mitigate against digital exclusion. As part of this, effort had been made to improve data capture with regard to ethnicity and action was being taken to increase uptake of the strong maternity trauma and loss services amongst Asian and black communities.

Mr Rob Hurd, Chief Executive at NHS NWL, thanked the teams involved for the work that they had undertaken. The priorities identified aligned and supported the NHS NWL direction of travel.

Currently, there was no consistency in the offer from targeted continuity of care teams across all sites as there had been some staffing issues. Safe staffing would be the first building block to improved performance in this area. Staff needed to be culturally competent and, as such, a lead nurse and ‘train the trainer’ sessions had been adopted. Cultural competency training had also been implemented for Multi Disciplinary Teams (MDT) but it was recognised that this would not address institutional racism. Service users had provided feedback and a twelve month workplan had been put together but there was still more work to do (including a refresh of the Equity and Equality Strategy. It was suggested that action be taken to ensure that women were treated as individuals rather than reverting to treating them in a certain way because they were black or Asian and that this might need to start during clinicians’ time at university.

It was suggested that action needed to be taken to identify vulnerable service users. Access was often about being competent in navigating the NHS and sometimes women did not speak English confidently and those who were more confident would more often receive the care that they needed. Creative solutions had been initiated

and family hubs, GPs and health visitors could be used to support this work. However, it was recognised that medically competent staff were not always culturally competent. Mr Hurd advised that cultural diversity was also being progressed with regard to diversity in leadership roles in the NHS. Members requested that the cultural competency plan be developed and that more information be provided in relation to the strategy for the targeted work in NWL.

Concern was expressed that the number of natural births had been declining as a result of an overreliance on medical interventions. Ms Nightingale advised that personalised and safe childbirth had been the priority and that induction had been recommended for women of a certain age before they reached full term to reduce the number of stillbirths. Safe outcomes were prioritised and interventional births had improved outcomes.

It was queried how priorities had been established with regard to safe birth pathways as it appeared that consultants tended to be involved towards the end of the pregnancy and focused on race and age rather than looking at the woman as an individual and her health. Ms Nightingale advised that a formal risk assessment was undertaken at the booking stage to determine the best pathway. The situation was reassessed halfway through the pregnancy and then again towards the end. These assessments were based on NICE guidance but it was recognised that race was being used rather than listening to the women.

Ms Cochrane advised that perinatal mental health services had been strengthened. Women who had mental ill health before pregnancy were being supported with their mental health. A seven-day service had been introduced and it was hoped that this would be extended to 24/7, perhaps through local family hubs or another existing service. The use of family hubs would provide a longer term way to make a difference and target those residents who needed support most.

Members queried what action had been taken to ensure that women from across the whole of NWL had the same experience of maternity services. Ms Cochrane had advised that the areas to be focused on had been identified and the national recommendations from the NHS ten-year plan had been looked at from a NWL perspective. This meant that there would be clarity about the small areas where specific targeted work was needed.

When questioned about engagement with community organisations and residents, Ms Nightingale advised that reviews had been submitted by individual Healthwatch bodies and that maternity and neonatal partnerships had been embedded into the governance processes. Information was also shared with the cultural group which filtered down to each of the boroughs and in-reach models were being developed with the communities that needed to be targeted.

Ms Kate Barker, Director of Clinical Programmes at NHS NWL, noted that the maternity system had been working with 3ST NWL (a third sector alliance in NWL) to engage, listen and undertake research guided by learning from the maternity Equity and Equality Strategy.

Insofar as the delivery of sustainable improvements in maternity at Northwick Park was concerned, Ms Nightingale advised that the improvement plan had been completed and all actions had been met to achieve better safety outcomes (the stillbirth rate was 2.9 per 1,000 births). 97% of women using the maternity service at Northwick Park would now recommend it to their friends and family. Members noted that this was a

great performance and suggested that it should be widely publicised. As the hospital had not received a CQC inspection since 2021, one had been requested by the Trust.

It was recognised that Northwick Park was trying to rebuild trust with the community but there were still concerns about safety. Ms Nightingale advised that a strategic decision had been made that the improvements at the Hospital would not be promoted until they had bedded in. These improvements would be promoted directly to service users but maternity bookings at Northwick Park had already increased.

Ms Cochrane noted that 30-50 members who had had babies within the last seven years provided feedback to 2-3 neonatal partnership leads in each service. Feedback came through to the service leaders. MDTs had received training to take feedback in relation to women's real experiences so that improvements could be made. Service leaders and users had put the maternity priorities together in 2022 so this was now due for a refresh.

With regard to plans to improve maternity, it was noted that an improvement action plan was being progressed at Hillingdon Hospital. Staff had been working closely with women and their partners, particularly when they were coming back into the service.

RESOLVED: That:

1. Ms Cochrane to provide Members with data on the stillbirth rates over the last 10 years split by ethnicity;
2. To ensure that the importance of capturing quality data is reliant on efficient maternity IT systems and the upgrade and investment in resources to facilitate easy extraction of data from these systems so as to be able to retrieve and analyse maternity information and enable an efficient overview of maternity outcomes by ethnicity and deprivation to address the social determinants of health;
3. That the ICB continues to work with local authorities to develop a coordinated programme of outreach and community research to engage with those at greatest risk of poor health outcomes and those in need of mental health support, pre and perinatal;
4. the discussion be noted.

4. **RECONFIGURATION OF THE ICB AND IMPLICATIONS ON SERVICES** *(Agenda Item 7)*

Mr Rob Hurd, Chief Executive at NHS North West London (NWL), advised that the organisation would need to reduce its spend on infrastructure by 41%. Although funding would reduce from £90m to around £50m, this would not be in relation to front line services.

An options appraisal was currently underway and would be published on 18 July 2025. It would include the proposal for a formal merger or NWL Integrated Care Board (ICB) with North Central London (NCL) ICB. Local authorities had already sought assurance that this proposed merger would not result in the ICB become more distant from place. Whatever the outcome, consultation and engagement activity would be undertaken until April 2026. It was anticipated that some back-office functions would need to be shared, for example, human resources and it was proposed that shared leadership roles would also be built with NCL ICB.

Mr Rory Hegarty, Executive Director of Communications and Involvement at NHS NWL, noted that the importance of service user and community engagement had been

included as part of the strategic approach. Action would need to be taken to establish how NHS NWL would work with local authority colleagues and the voluntary sector going forward.

The ICB focussed on strategic commissioning and worked with Health and Wellbeing Boards to identify needs, plan services to meet those needs and deliver changes. There would be less money so more would need to be done in relation to strategic commissioning whilst other things (such as continuing healthcare and medicines management) would need to be addressed through place-based partnership working (Hillingdon had been identified as one of the leading partnership models in NWL). There had been no changes planned for the overview and scrutiny arrangements.

Mr Hurd advised that NWL ICB was not where it would like to be but that it was on track with the operating plan. The Board's decision on the proposal to merge with NCL was being taken very seriously with the discussion taking place at its meeting on Wednesday 23 July 2025. Concern was expressed that the merger of the NWL and NCL ICBs would result in a bigger organisation with less resource which could result in reduced clarity and a negative impact on service delivery at a local level. Mr Hurd stated that, in practice, the clarity and impact would be reliant on the quality of the implementation of the merger. In theory, a lead integrator would be assigned in each borough to drive neighbourhood health with residents being at the heart and everything else being an enabler. There would be core offerings that would be controlled by the ICB (irrespective of the local variation of need) and more delegated decision-making authority would be given to local partnerships.

Members queried the structures and responsibilities of NCL ICB and potential collaboration and how they could reassure their residents about the potential impact of a merger on the services that they received. Mr Hurd noted that they had a strategic responsibility to feed into the buying of services, ensure value for money and address health inequalities.

It was recognised that trust and transparency would be key to successful outcomes. Members queried whether there would be an opportunity for local authorities to feed into the consultation on the restructure. Mr Hurd advised that the local Integrated Care Partnerships had already been involved in the process and that, as this was a structural change rather than a service change, there was no requirement to consult with scrutiny committees. Members agreed that the reconfiguration provided an opportunity to ensure that local authorities had a say in how the ICB could be improved.

A merger would result in one organisation being responsible for 13 local authorities (which would include Barnet, Camden, Enfield, Haringey and Islington). NWL ICB would provide a response to the wants of borough-based partnership as engagement would be a fundamental part of strategic commissioning.

It was noted that hospitals in NWL currently managed demand between themselves and this seemed to work well. Concern was expressed that the proposed merger and changes to finances would negatively impact on this way of working. Mr Hurd stated that acute provider collaboratives and community services would need to organise themselves. Neighbourhood and specialists would need to be included but the ICB needed more financial clout to be able to organise around residents and over a much wider area.

Members queried what would happen to the seldom heard communities, especially

now that Healthwatch would be losing its independence. In addition, reference had regularly been made to working with the voluntary sector but their financial situation had been stretched to breaking point. Mr Hurd advised that there were many risks and massive challenges in a resource constrained environment. There had been concerns raised about the impact on Healthwatch but it was unclear what this would be. It was not inevitable that a reduction in resources would diminish how the ICB engaged with residents but more work was needed to ensure that it was meeting the needs of communities.

Mr Hurd advised that the functions outlined in the report would transition within the next financial year and there would be redundancies, which would pose a big risk. The next steps would be to develop a work plan and set out how functions would go to the organisations listed in the report. It was about having a safe implementation plan, so not everything would be in place on 1 April 2026

RESOLVED: That:

1. **as part of the work to reconfigure, NWL ICB take the views of local authorities into account on how the ICB could be improved;**
2. **the ICB ensure that the voice of seldom heard communities and the voluntary sector are considered as part of the restructure and merger; and**
3. **the discussion be noted.**

5. **ADULT MENTAL HEALTH** *(Agenda Item 6)*

Mr Toby Lambert, Executive Director of Strategy and Population Health at NHS North West London (NWL), advised that he had presented the Adult Mental Health Strategy and its three major themes in October 2024:

1. Raised awareness and promoting wellbeing – progress had been made in relation to this priority but there had been an ongoing debate about reducing the number of people with mental ill health presenting at the ED who could have gone elsewhere;
2. Increased equity and equality access – this priority was about making sure that services were accessible as community health teams in some areas seemed to be meeting much more often than others; and
3. Care in the right place – there was still work to do to reduce the wait in ED for specialised mental health support. A similar strategy was being developed for young people and progress would be reported to a future meeting.

In addition to the core common offer, there had been bespoke services added because issues such as rough sleeping were not evenly distributed across all eight NWL boroughs.

Dr Christopher Hilton, Chief Operating Officer (Local and Specialist Services) at West London NHS Trust, advised that Central and North West London NHS Foundation Trust (CNWL) and West London NHS Trust (WL) had been involved in the development of this Strategy. Although it had been delivered across organisations, the mental health trusts had been key to driving the Strategy forward. The NWL Mental Health Productivity Working Group had been looking at issues such as investment, referral levels, activity, caseloads, staffing levels, etc, and WL and CNWL had seen an increase in activity. It was recognised that the focus needed to shift from activity to outcomes and recovery.

Whilst the ambitions were applauded, it was queried how partners were being held to account to achieve. Mr Hegarty advised that a range of actions and Key Performance

	Indicators had been created and would be monitored. It was hoped that payments would be attached to outcomes so worked needed to be undertaken to better identify the required outcomes. It was noted that there had been an increase in the number of people with mental health issues but there was some debate about whether or not this was resultant from a greater willingness to report mental ill health. Whilst the intensity had remained fairly stable, there had been an increase in the prevalence of anxiety and depression amongst children and young people. Mr Hegarty advised that the budget was constrained and needed to be spent appropriately. NWL had been underfunded as a system for mental health services so needed to be careful what it invested in and every effort was made to ensure that the investment worked. Dr Hilton noted that local authorities and trusts had been working hard to provide the right interventions to meet the needs of local residents and to ensure maximum benefit. Concern was expressed that children and young people would be suffering the most and that close working with schools would help to alleviate this. Mental health teams had been installed in about half of the schools in NWL with plans in place to roll this out to the remaining schools. Furthermore, Imperial College Health (based in NWL) had been looking at what had been causing this rise in prevalence amongst young people. It would be important to get a grip on this increase so that it did not have an impact on adult mental health. Members queried how population health needs were being addressed by Primary Care Networks (PCNs rather than GPs). Dr Hilton advised that delegated decision making had been given to PCNs which gave them the flexibility to invest in the workforce. The Trust had also been working with areas that had not been performing well. At a place level, work had been undertaken with primary care colleagues to analyse how they used data to look at staffing. If there were any gaps, NWL ICB would be looking to address them. **RESOLVED: That:** **1. NWL ICB provide the Committee with an update at a future meeting on the similar strategy that was being developed for children and young people;** **2. the discussion be noted.**
6.	**NORTH WEST LONDON JHOSC RECOMMENDATIONS TRACKER** *(Agenda Item 8)* Consideration was given to the Committee's Recommendations Tracker. **RESOLVED: That the Recommendations Tracker be noted.**
7.	**NORTH WEST LONDON JHOSC 2025/26 WORK PROGRAMME** *(Agenda Item 9)* Consideration was given to the Committee's 2025/26 Work Programme. **RESOLVED: That the 2025/26 Work Programme be noted.**
	The meeting, which commenced at 10.00 am, closed at 12.03 pm.

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Report to the North West London Joint Health Overview Scrutiny Committee

18 November 2025

Report Title:	Dentist Commissioning and Children's Dental Health
Report Author:	Julie Sands, Assistant Director, Primary Care Contracting and Transformation – NHS NW London Jeremy Wallman, Head of Primary Care Commissioning; Dentistry, Optometry and Pharmacy, London Dentistry, Optometry and Pharmacy Commissioning Hub

Purpose

To provide a comprehensive report on Dentist Commissioning and Children's Dental Health provisions across the North West London region. This request was prompted by increasing concerns regarding the accessibility, equity, and effectiveness of dental services for children and young people, particularly in the context of post-pandemic recovery, rising oral health inequalities, and the evolving commissioning landscape under ICS arrangements.

Detail

Background/Context:

The 2024/25-year end data demonstrate an exceptional high level of performance against primary care (GDS) contracted levels of activity and across London this translates into just over a 2.3% increase on the 2023/24 delivery. Therefore, from a value for money perspective, the ICB can demonstrate that it is obtaining an excellent return in respect of activity delivered in comparison to the amount that has been commissioned. This ultimately results in a very low value in respect of resource to be 'clawed back,' or recouped from providers, due to underperformance. Tables 1 and 2 summarise contract delivery at both a London and ICB Level.

ICB	Contracted UDAs	UDA Delivered to date	UDA % Delivery	
North-Central London	1,897,137	1,853,794	97.7%	*93.8%*
North-East London	2,421,373	2,375,659	98.1%	***96.5%***
North-West London	3,082,415	3,018,192	98.6%	*96.3%*
South-East London	2,704,286	2,636,488	97.5%	*94.3%*
South-West London	1,810,421	1,727,806	95.4%	*95.2%*
London Wide	11,919,303	11,635,494	97.30%	**95.23%**

Table 1; London ICBs Dental Contract Delivery 2024/25

NWL ICB	Contracted UDAs	UDA Delivered	UDA % Delivery
Borough/Place	FYE	M12	M12
Brent	505,562	501,245	99.1%
Ealing	554,370	556,439	100.4%
Hammersmith and Fulham	300,433	291,770	97.1%
Harrow	347,629	335,461	96.5%
Hillingdon	358,512	359,209	100.2%
Hounslow	449,153	447,554	99.6%
Kensington and Chelsea	195,527	188,604	96.5%
Westminster	371,229	357,947	96.4%
Totals	3,082,415	3,038,229	98.6%

Table 2; NWL ICB Dental Contact Delivery 2024/25

Whilst London overall, is the best performing Region in England, NWL is one of the highest performing ICBs nationally and it is worth noting that its performance has been enhanced by the commissioning of additional activity in the past two years and has been supplemented by the New Patient Premium (NPP). The combination of these factors has contributed significantly to the sustained and improved delivery of dental access across the ICB. Subsequently the commissioning of additional capacity from general dental practices is being implemented again during 2025/26 targeting the areas of highest need using the most recent Public Health data on oral health inequalities. This takes on added importance given that the NPP has been discontinued, which does remove some of the incentive associated with seeing new patients. A summary of the additional investment by the ICB to date is detailed in Table 3 below.

NWL	Number of Practices	UDAs (k)	Value £(m)
2023/24	84	103.4	3.4
2024/25	80	98.6	3.3
2025/26	TBC	83.6	2.8
Total		285.6	9.5

Table 3; Additional UDAs Commissioned; NWL ICB

New patients are key to driving up activity for dental practices with NHS contracts which has the associated benefit to the ICB of reducing the number of complaints received from residents having difficulty in accessing NHS dental care.
Investing in additional primary care dental activity increases access to routine care for patients. Due to the constraints of the GDS contract, many providers are delivering on their existing contracted activity and without additional investment will simply decline to see new patients on the basis they will not be paid to do so. The knock-on impact is that patients will seek care elsewhere and whilst there is a comprehensive urgent care offer service in place across London, this does not prevent patients seeking help via general practice both in and out of hours or accident and emergency departments, none of which are suitable for dealing with dental problems. This represents additional cost to the system and exacerbates waiting times needlessly.

Overall access levels across NWL can vary and contract delivery is not necessarily a good barometer for analysing this as it is relative to the level of activity commissioned.

Additionally general dental services are commissioned based on delivery to both adults and children and there are no specific aspects of GDS delivery that prioritise children over adults. NHS dentistry is free to children and all practices with contracts are expected to provide to any group of eligible patients, capacity allowing. Specific services to children are commissioned via the Community Dental Services (CDS) and Hospital based dentistry, however these are specialist delivery and are not a substitute for routine NHS dental services. However, with the focus on ICBs as commissioners of dental services to return activity to pre-pandemic levels, Table 4 demonstrates the increase the number of NWL residents, both adult and child, seen on a 12-month rolling basis when compared to February 2020. NWL along with its counterpart ICBS in London are the only Region in the country to have achieved this metric.

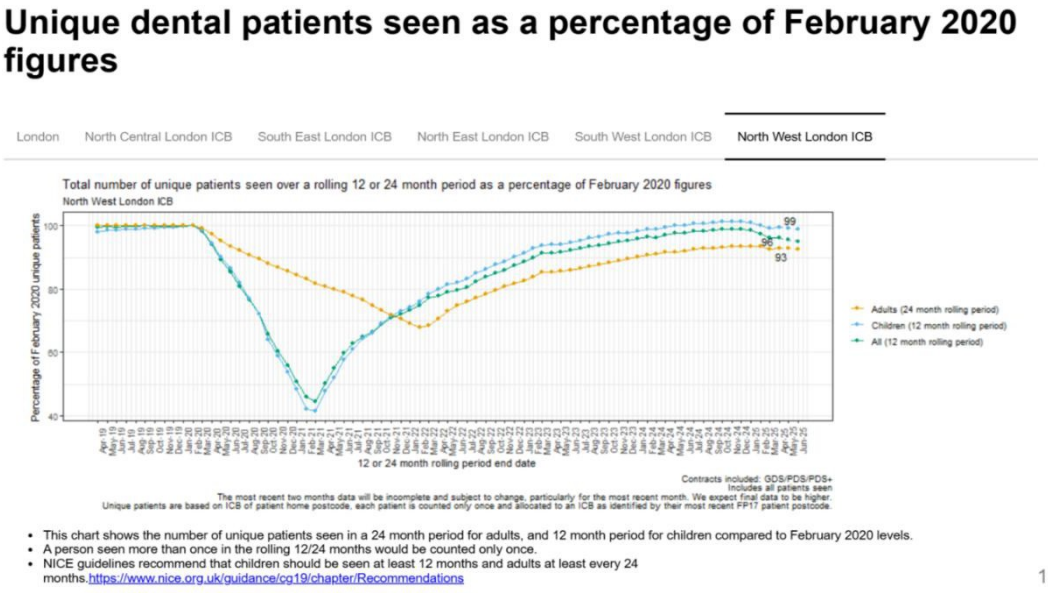


Table 4; Numbers of Patients Seen on a 12-month rolling basis

Community Dental Services

Central London Community Health Care Trust (CLCHT) provide Community Dental Services (CDS) to Hammersmith & Fulham, Kensington & Chelsea and Westminster and Whittington Health provides CDS to Hillingdon, Hounslow, Ealing, Brent and Harrow.

Services provided for adults include:

- Special Care Dentistry – groups who have physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors.
- Domiciliary Service for those patients who are unable to leave their homes to access care.
- Homeless Dental Service and Dental Service for Rough Sleepers

- Inhalation and Intravenous Sedation Services for those eligible for referral into CDS.

Services provided for children include:

- Paediatric Dental Service – groups who have physical, sensory, intellectual, mental, medical, emotional or social impairment, highly anxious children or complex dental issues such as trauma, high caries rate or anomalies. There is option for treatment under inhalation and intravenous sedation where appropriate.

Acute Contracts

- Secondary Care Dentistry / Acute Dentistry is consultant led, hospital-based care
- London has four teaching hospitals, three for undergraduates; Guys & St Thomas', King's College Hospital and Barts Health and one for postgraduates University College London Hospitals (Eastman Dental Institute)
- North-West London is served by London North West (LNW) University Healthcare, Chelsea and Westminster Hospital, Imperial College Healthcare and The Hillingdon Hospital
- Between the four hospitals, all dental specialities apart from Dental Medicine are delivered, however, patients do receive/access care in the other London ICSs
- A breakdown of Acute Dental Contract Values is detailed in Table 5.

ICB	Trust	Contract Value	ICB Value
North West	Chelsea & Westminster NHSFT	£4,630,913	£22,366,409
	The Hillingdon Hospitals NHSFT	£2,013,492	
	Imperial College Healthcare NHST	£1,251,586	
	London North West University Healthcare NHST	£14,470,418	
North Central	Royal Free London NHSFT	£8,366,852	£38,181,017
	University College London Hospitals NHSFT	£29,814,165	
North East	Barking, Havering & Redbridge University Hospitals NHST	£1,681,632	£29,160,686
	Barts Health NHST	£22,746,890	
	Homerton University Hospital NHSFT	£4,732,164	
South East	Guy's & St Thomas' NHSFT	£34,486,378	£69,761,627
	King's College Hospital NHSFT	£35,275,249	
South West	Croydon Health Services NHST	£5,327,813	£20,311,364
	Epsom & St Helier University Hospitals NHST	£2,432,778	
	Kingston Hospital NHSFT	£3,359,401	
	St George's University Hospitals NHSFT	£9,191,372	
Out of Region	Ashford & St Peter's Hospitals NHSFT	£1,681,632	£2,008,693
	Queen Victoria Hospital NHSFT	£327,061	
Total			**£181,789,796**

Table 5: London Acute Dental Contract Values 2025/26

London's unique geography and integrated transport system means that patients access care across ICB boundaries and within dentistry this can be evidenced by the patient flow information available to the ICB. Table 6 details the flow of patients into secondary care based on a resident's host ICB and approximately two thirds of NWL attendances are at providers outside the ICB boundary. Much of this is driven by patient choice and/or the specific service they require, which may not be available locally. Waiting times will also be a factor

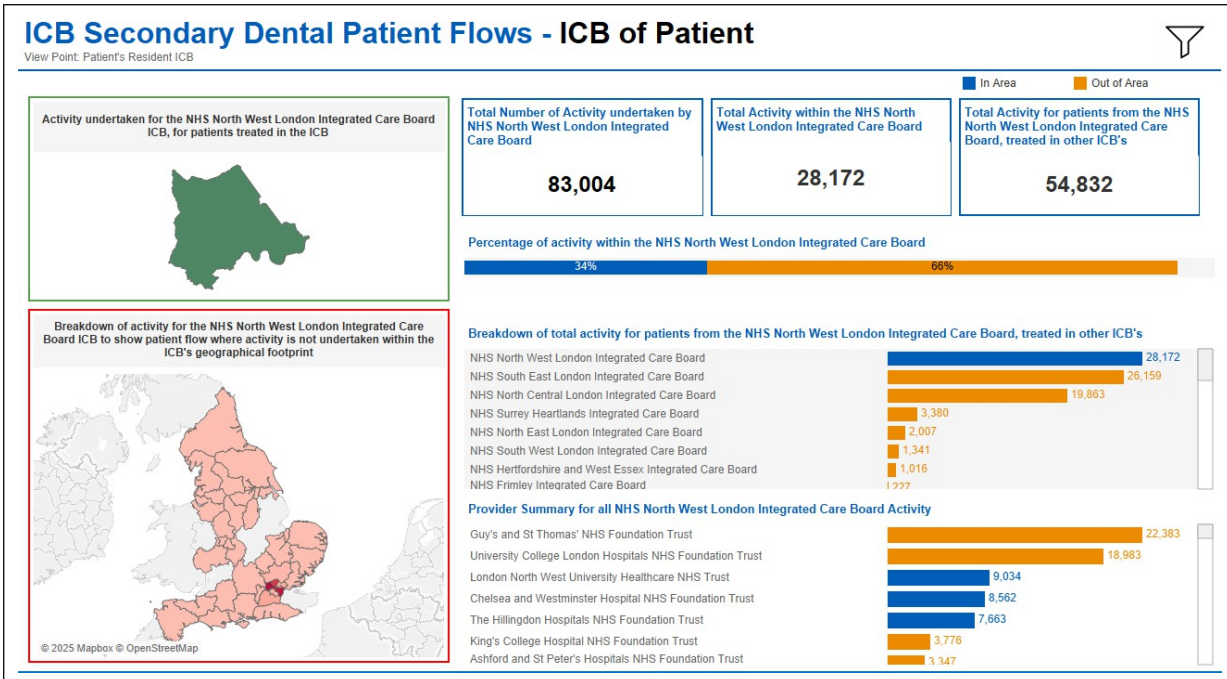


Table 6; NWL ICB Secondary Dental Patient Flows – ICB of Patient

- 83,004 dental attendances for NWL patients
- 28,172 attendances delivered within the NWL geographic area (34%)
- 54,832 attendances delivered outside the NWL geographic area (66%)
- 26,159 attendances delivered in SEL geographic area
- 19,893 attendances delivered in NCL geographic area

Outcomes and Equity Analysis

OHP and CDS

The delivery of Oral Health Promotion (OHP) activities in north west London ICB are delivered by the two Community Dental Service (CDS) providers, Whittington Health NHS Trust and Central London Community Healthcare NHS Trust. Local authorities are responsible for the commissioning of OHP and in some boroughs the funding already its within the NHS CDS contracts, in others, it is commissioned directly by the local authority. Delivery of OHP is targeted to those communities with the greatest need as identified by local authorities and Public Health oral health needs assessments.

OHP activities include:

- Supervised brushing (including the new national programme)
- Fluoride varnishing
- Training of oral health champions in various settings
- Screening and referral in residential special schools
- Distribution of brushing packs
- Distribution of Sippy cups

Attached at appendix 1 is the latest oral health and dental service profiles for NW London prepared in May 2025.

Workforce

The dental workforce is an issue for CDS and secondary care (hospital) dental services. There are insufficient specialists to fill vacant posts which has a direct impact on care

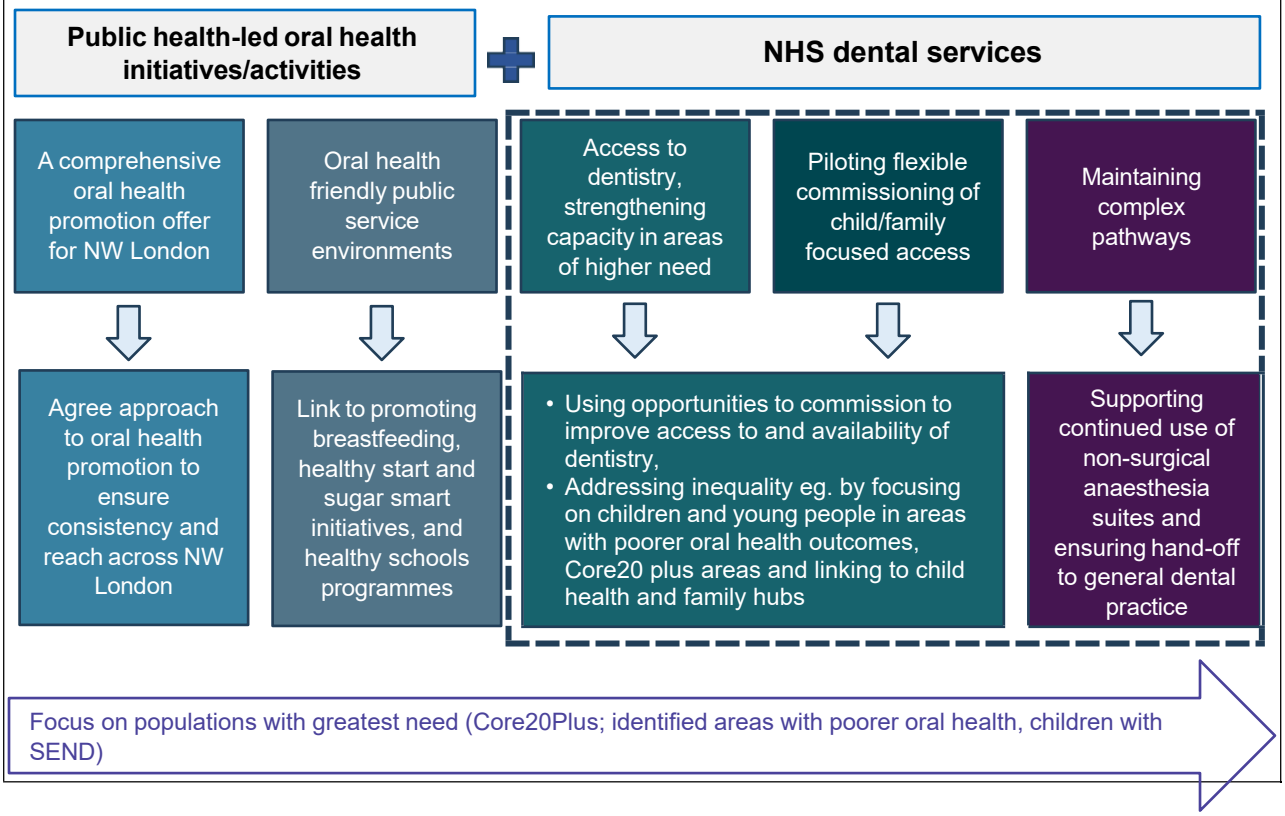
delivered. Skill mix is a vital part of the response to the workforce shortage, ensuring that clinicians are working at their full scope of practice. London CDS and secondary care settings do not experience workforce shortages to the extent that other regions do as it is a more attractive location with more high-profile employers.

Collaborative working:

Responsibility for improving oral health is shared across local authority public health and NHS dental services. Public Health teams are responsible for improving oral health and reducing inequalities, through need assessment, identifying geographical areas and communities who are at greatest risk of poor oral health, and commissioning oral health promotion activities and evidence-based initiatives, for example, supervised tooth brushing and fluoride varnishing as risk reduction interventions to mitigate.

NHS NW London has delegated authority from NHS England to commission NHS dental services. This includes general dental (high street) practices, community dental services (providing specialist care and oral health promotion), and acute dental services.

In line with the shared responsibility for improving oral health across local authorities and the NHS, the NW London ICB team has been working with public health and dental professionals to develop a comprehensive, partnership approach, to bring together oral health promotion, improved access to dentistry, and to create oral health friendly public service environments. This includes food and drink policies in early year settings and pilot dental services in areas of highest need focusing on access for children and young people and outreach into children and family hubs. Linking with community dental teams commissioned by public health to deliver oral health promotion, supervised tooth brushing and fluoride varnish in our schools is also key.



The current national NHS dental contract somewhat restricts the ability to substantially change local commissioning arrangements that could contribute to improved oral health outcomes. However, locally the ICB can use some flexible commissioning approaches to meet identified local needs.

In February 2025, the ICB committed funding to two dental services pilots. These are targeted access for children across NW London and targeted support to access dental care for people living in emergency/temporary accommodation including asylum seekers and refugees living in hotels (initially in Hillingdon).

Developed in collaboration with Public Health and dental professionals, the pilot focused on children is for two years (2025-26 and 2026-27) and will

- test and develop **targeted dental pathways** into local NHS dental practices for CYP, particularly those in Core20Plus areas and areas with identified higher oral health need,
- through the selected practices, provide longer appointments and targeted preventative care.
- commission the selected dental practices to work with **Family/Children's Hubs, schools, early years services** and primary/community care providers
- ensure the commissioned practices provide **dental champions** to support engagement and insight gathering with specific outreach sessions into family/children hubs working alongside partners to embed a MECC approach,
- improve community messaging and access through integrated comms, training and signposting.

The goal is to improve access, improve oral health, and embed prevention into everyday interactions across health, education and community settings.

This pilot is being mobilised now across all eight NW London boroughs.

It's important to note that a significant shift in overall oral health in children and young people is not short term. It will take a sustained focus and access to treatment concurrent with more effective prevention and early intervention services, that include a significant change in CYP diet and relationship with sugar. This pilot allows us to test this collaborative approach to support longer term planning.

The second pilot supporting people in temporary accommodation to access NHS dental care and preventative advice is for 6months and will commission

- a 3-6-month **pilot service** in Hillingdon targeting people in temporary accommodation including refugees and asylum seekers
- Selected dental practices to provide **longer, trauma-informed appointments**
- Key stakeholders will include **VCSEs, NHS 111, and local authority homelessness teams**
- Training for staff, named inclusion health champions in practices providing outreach alongside partner organisations providing information and preventative advice.
- Learning aligned with CYP pilot but tailored for adult needs

The goal is to test a feasible model to improve access, reduce emergency care reliance, and support wider system learning on inclusion health.

This pilot is being mobilised now Hillingdon.

Performance and staffing:

The dental workforce is an issue for CDS and secondary care (hospital) dental services. There are insufficient specialists to fill vacant posts which has a direct impact on care delivered. Skill mix is a vital part of the response to the workforce shortage, ensuring that clinicians are working at their full scope of practice. London CDS and secondary care settings do not experience workforce shortages to the extent that other regions do as it is a more attractive location with more high-profile employers.

Rapid dental access and oral health profiles to inform the delivery of additional NHS dental activity across North West London ICB

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Dental Public Health – NHS England London Region

May 2025 (V2)

Contents

Introduction

This document has been developed to inform to the identification of potential locations for the allocation of additional funding of NHS dental services, with the aim of addressing inequity in dental access across North West London Integrated Care Board (NWL ICB).

We are aware that the commissioning of NHS dental services has been delegated to each of the five ICBs since April 2022, with the dental commissioning teams working across the London region, being hosted in one of the five ICBs.

Rationale for the approach

Oral diseases follow a social gradient, and deprivation is strongly associated with tooth decay experience. Hence, this work has only considered the most deprived wards across North West London ICB with average index of multiple deprivation (IMD) scores of 1-4. There is currently no data on the oral health needs of adults by local authority. We have therefore had to rely on dental access profiles for adults. Regarding children, we have considered the oral health profiles, with the data source being the dental epidemiology profiles for 5-year-olds, which was part of an enhanced sample of the 2018-19 National Dental Epidemiology Programme.

It is important that we adopt a pragmatic approach to dental commissioning by taking population profiles into consideration. NHS dentistry continues to recover from COVID-19 and dental access to NHS dental services has been improving year on year In London. Barriers to NHS dental care are found at the individual, organisational and policy level. Hence, a pragmatic approach for the ICB (as a whole) has been taken to determine where additional funds for NHS dental activity could be allocated. However, it must be recognised that there is no dental registration, so the public are free to access care wherever possible, which included people outside of the ICB.

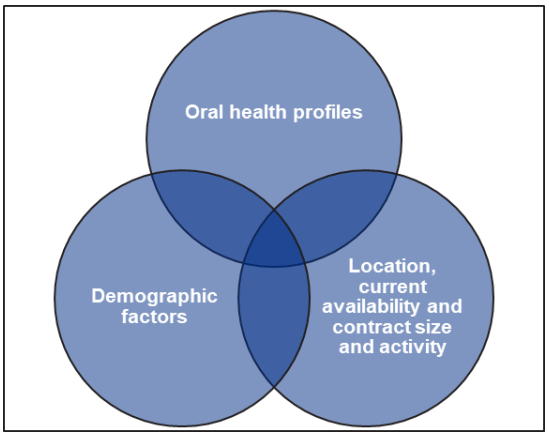


Figure 1: Three main domains considered as part of prioritisation for the commissioning of additional NHS dental activity

Figure 1 outlines the three main factors considered to inform how the location of additional dental activity can be prioritised and table 1 shows the data sources included in this document. The most recent datasets, where possible, have been used.

Overall, the following specific factors have been considered:

Demographic factors

- Deprivation at LSOA and ward level per local authority
- Availability and geographical location of general medical practitioner practices at LSOA and ward level per local authority
- Availability and geographical location of schools at LSOA and ward level per local authority
- Consideration for geography (e.g., population density, residential homes) at LSOA and ward level

Oral health

- Prevalence of experience of tooth decay for children (5-year-olds) at local authority and ward level (where available)

Existing access of dental services

- Dental access for children and adults at ward and local authority level
- The availability and location of current dental practices at LSOA and ward level
- Contract size of existing providers
- The ratio of dental practices per 10,000 population at local authority level
- The number of UDAs commissioned per head at local authority level
- The performance of current dental providers (the percentage of UDAs achieved) at local authority level

All factors listed above have been considered across each of the wards in NWL ICB to ensure that commissioning decisions are equitable, based on need and also feasible.

Scope of this document

This document is a rapid exploration of dental access and children's oral profiles in North West London ICB. We recommend that NHS dental services should be commissioned as part of a whole integrated primary care and a public health approach in improving population oral health. This document is not an oral health needs assessment.

It is a statutory requirement under the Health and Social Care Act 2012 for Local Authorities and their partners to prepare Joint Strategic Needs Assessments (JSNAs). Local Authorities and partners have equal and joint responsibilities to prepare JSNAs through local Health and Wellbeing Boards, as well as for health improvement. However, this document would be helpful fin supporting a broader oral health needs assessment.

Table 1: Data sources considered in this document

Data	Date	Source
Demographic factors		
Deprivation at LSOA and ward level	2019	Local Health (Office of Health Improvement & Disparities)
Oral health		
Prevalence of experience of tooth decay for children (5-year-olds) at local authority and ward level (where available)	2018/19	National Dental Epidemiology Programme (Office of Health Improvement & Disparities)
Dental services		
• Dental access for children and adults at ward level	2022/23	NHS Business Service Authority (NHS BSA)
• The availability and location of current dental practices at LSOA and ward level • The ratio of dental practices per 10,000 population at local authority level • The number of UDAs commissioned per head at local authority level • The performance of current dental providers at local authority level • Recorded patient ability to get an NHS dental appointment	2023/24	National Dental Commissioning and Access (Relevant sources include: Office for National Statistics, NHS BSA, NHS England, NHS Digital) Dental Statistics GP patient survey
Availability of wider health and education services		
• Availability and location of general medical practitioner practices • Availability and location of schools	Most up to date data	

Recommended wards for proposal

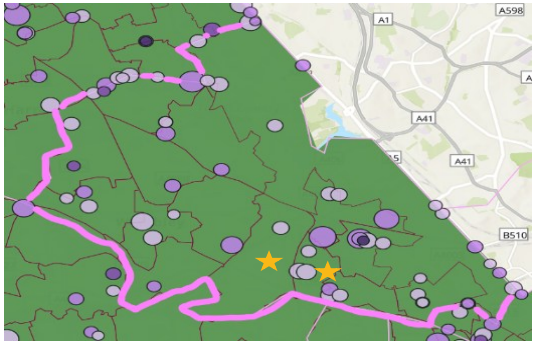
We have recommended for providers in the following wards in table 2 to have additional NHS dental activity. Some wards were unable to be selected due to the absence of existing NHS dental providers (e.g., Yeading in Hillingdon or East Acton in Ealing).

Figure 2 presents the geographical mapping of where proposed additional capacity for NHS dental providers across NWL ICB should be. This is denoted by the star, next to possible providers. Moreover, it is worth noting the importance of considering NHS dental access alongside deprivation at ward (or even LSOA level) (see figure 3). This is also due to the provision of private dental providers in these areas (which is outside the scope of this document).

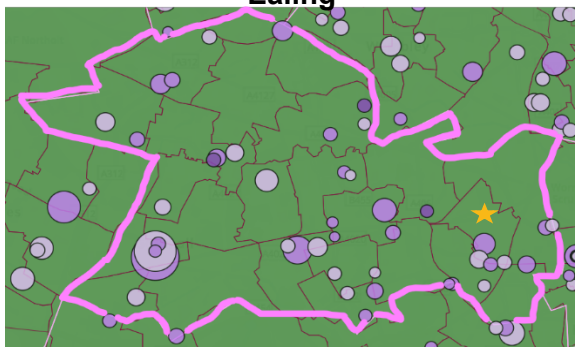
Table 2: Top eleven proposed wards for additional dental activity (1 – highest priority, 11 – lowest priority

Local authority and brief overview	Ward	Order
Harrow Has the highest average prevalence of decay in ICB and a low average number of UDAs commissioned per person, but an average ratio of dental practices per population.	**Roxeth**	**11**
Brent Has a high average prevalence of decay (second highest in ICB), with providers having a better than average performance, in terms of the UDA target delivery.	**Stonebridge**	**1**
	Harlesden	**2**
Hillingdon Prevalence of decay in line with the ICB average (but this is still higher than the London and national average). Lower than average ratio of practices per population and number of UDAs commissioned per population.	**Barnhill**	**4**
Westminster Prevalence of decay in line with the ICB average (but higher than London and national averages). Good average number of UDAs commissioned per person and ratio of dental practices per population but a lower average performance of providers.	**Church Street**	**3**
	Westbourne/Harrow Road	**5**
Hounslow Prevalence of decay in line with the NWL ICB average (but this is still higher than the London and national average). Good average number of UDAs commissioned per person and ratio of dental practices per population.	**Heston West/ Cranford**	**6**
	Feltham West/Bedfont	**7**
Hammersmith and Fulham Prevalence of decay in line with the NWL ICB average (but this is still higher than the London and national average).	**Wormholt and White City/ Shepherd's Bush Green**	**9**
Ealing Prevalence of decay in line with the ICB average (but higher than the London and national average).	**Acton Central (no practice in East Acton)**	**8**
Kensington and Chelsea Lower prevalence of decay compared to the ICB average, but still higher than the national average. Good average performance of providers.	**Colville**	**10**

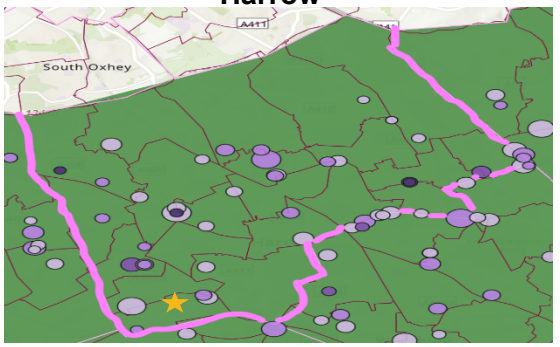
Brent



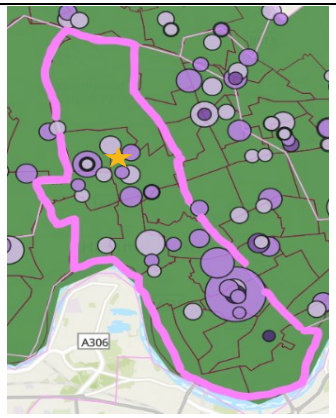
Ealing



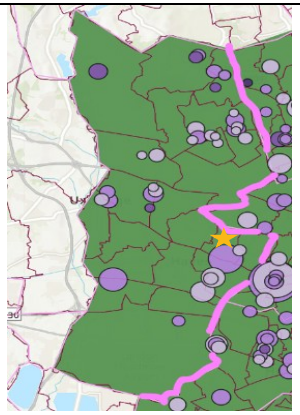
Harrow



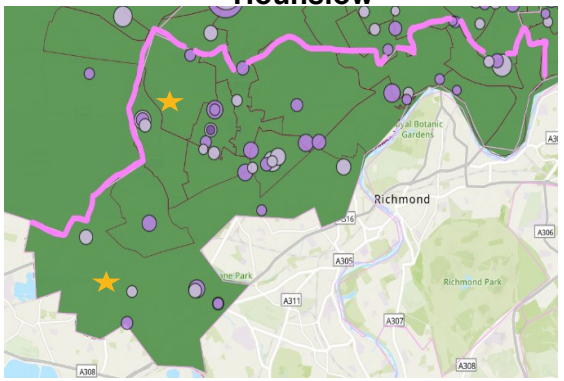
Hammersmith and Fulham



Hillingdon



Hounslow



Kensington and Chelsea

Westminster

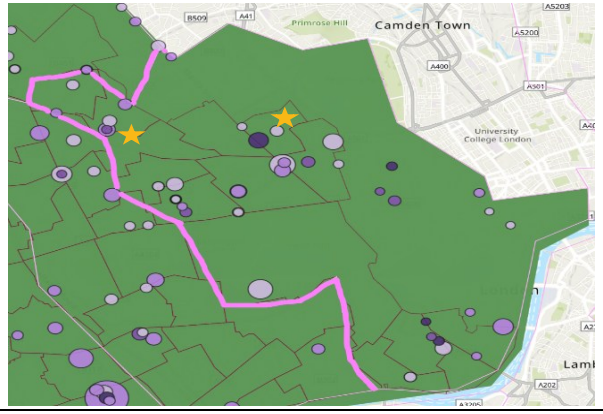


Figure 2: Map of existing and proposed additional capacity for NHS dental providers across NCL ICB (Source: National Dental Commissioning and Access 2023/24 data)

Dental Contracts (Multi-year)

- Up to 50%
- > 50 - 75%
- > 75 - 100%

Areas for proposal for additional funding

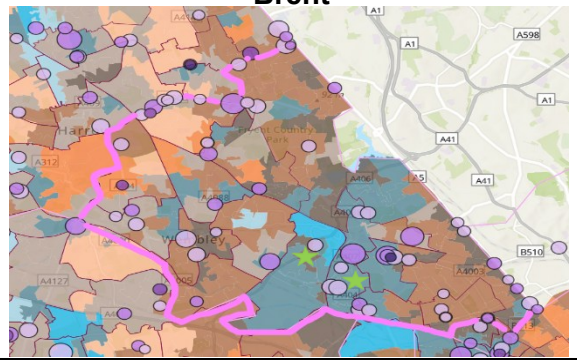
Local Authority Districts (LAD)

Ward Boundaries

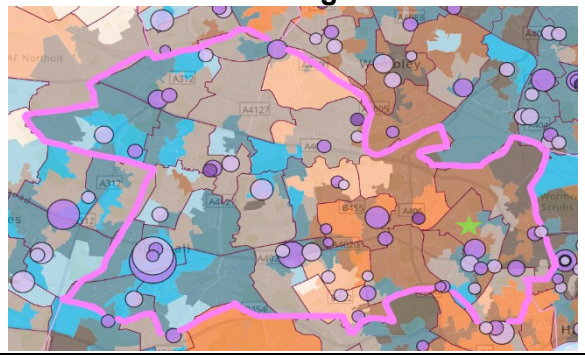
Dental Access Layer

Please note that the circles are not fully to scale when you compare each local authority, but the larger the circle the larger the contract

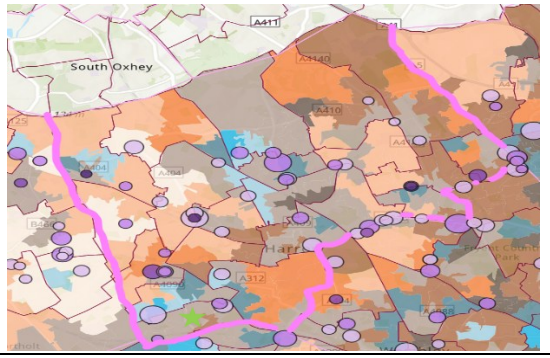
Brent



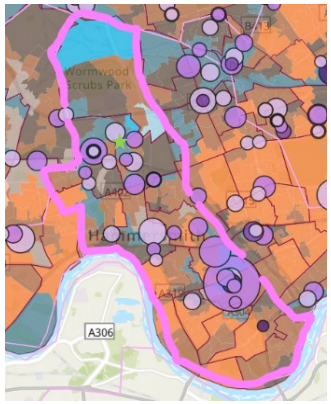
Ealing



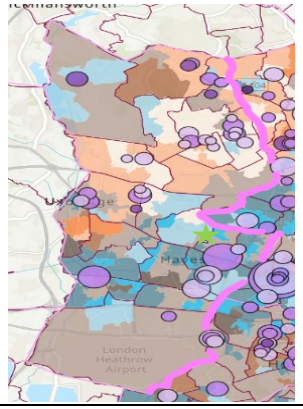
Harrow



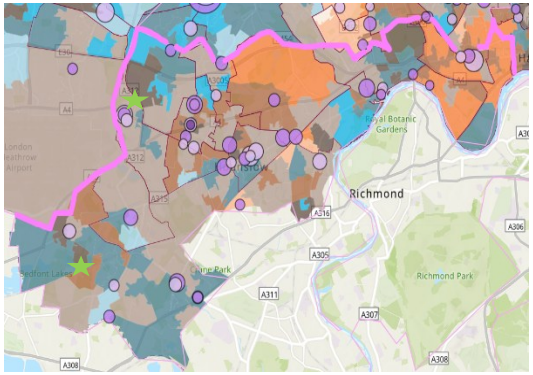
Hammersmith and Fulham



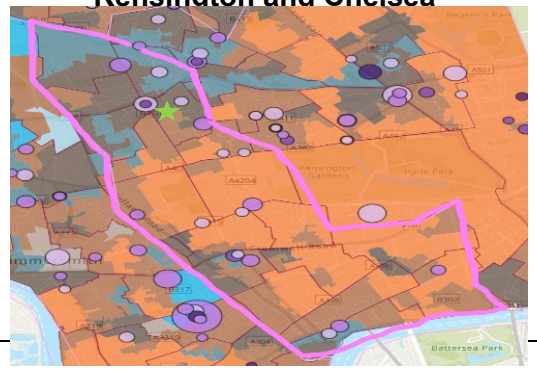
Hillingdon



Hounslow



Kensington and Chelsea



Westminster

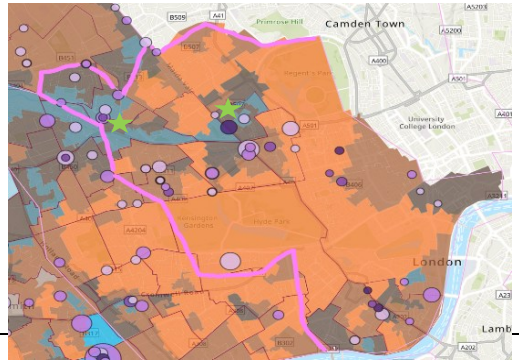
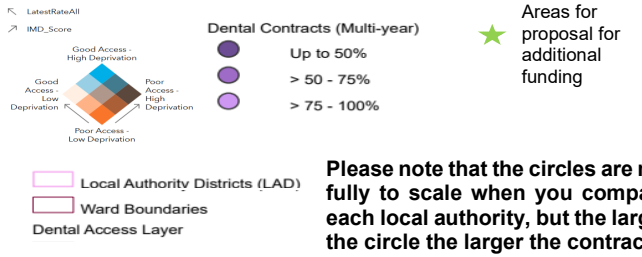


Figure 3: Map of existing dental providers in NCL ICB by deprivation at LSOA levels (Source: National Dental Commissioning and Access 2023/24 data)



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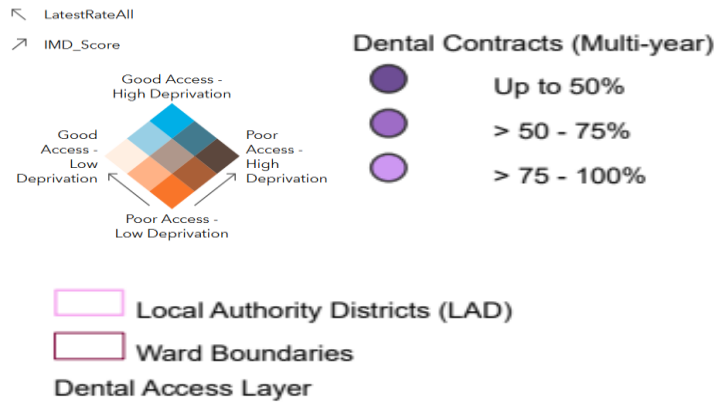

LatestRateAll
IMD_Score
Good Access - High Deprivation
Good Access - Low Deprivation
Poor Access - High Deprivation
Poor Access - Low Deprivation
Dental Contracts (Multi-year)
Up to 50%
> 50 - 75%
> 75 - 100%
Local Authority Districts (LAD)
Ward Boundaries
Dental Access Layer

Evidence

- **Existing dental access and commissioning**
- **Oral health profiles**

Dental access at local authority level

Patient report on access to NHS dental services

In terms of whether people are able to get an NHS dental appointment, data from the 2024 GP survey shows that when asked ' who have tried to get an NHS dental appointment in the last 2 years' (with patients who selected 'I can't remember' have been excluded) **80% (n = 10002**) of patients were able to which is in line with the **national average of 84% (n = 291111).**

Figure 4 shows dental access for both children and adults at a local authority level in London, with differences in the ranking of local authorities for adults and children.

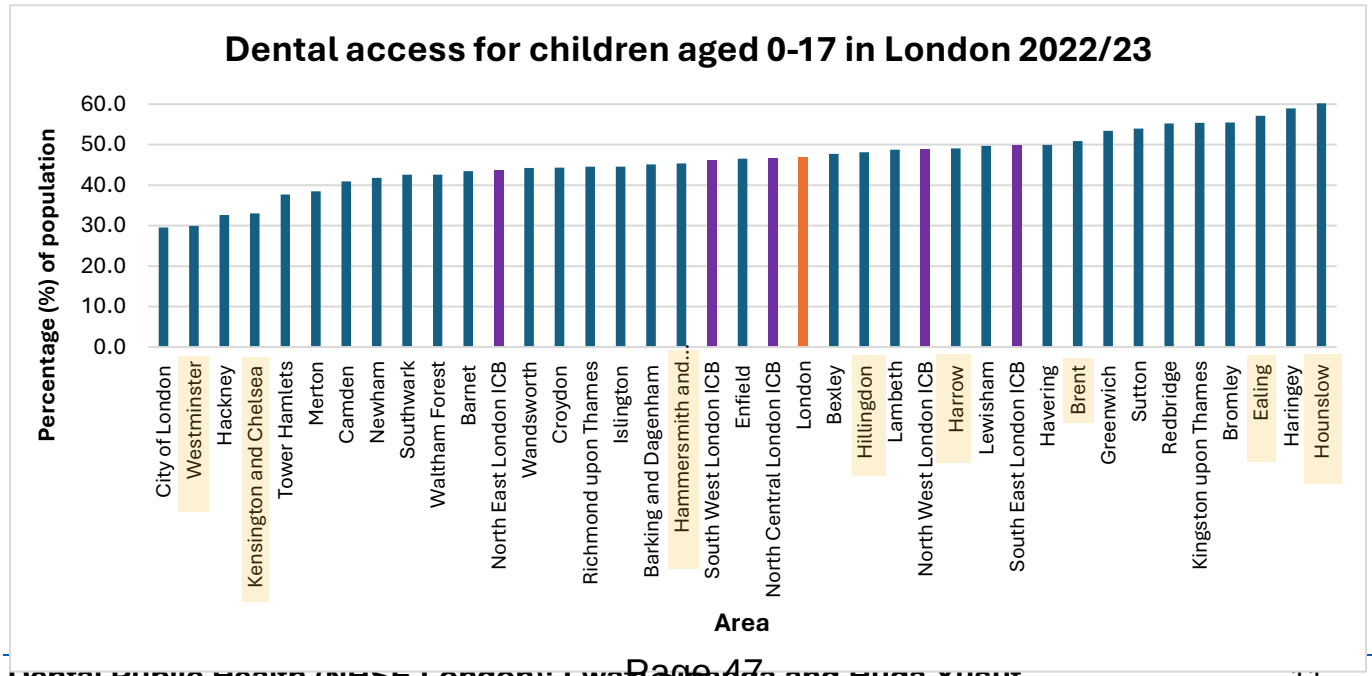
For children, local authorities in NWL ICB having the following ranking from the lowest to the highest dental access are:

1.	Westminster	**Lowest**
2.	Kensington and Chelsea	
3.	Hammersmith and Fulham	
4.	Hillingdon	
5.	Harrow	
6.	Brent	
7.	Ealing	
8.	Hounslow	**Highest**

For adults, local authorities in NWL ICB having the following ranking from the lowest to the highest access are:

1.	Kensington and Chelsea	**Lowest**
2.	Hillingdon	
3.	Westminster	
4.	Harrow	
5.	Brent	
6.	Hounslow	
7.	Ealing	
8.	Hammersmith and Fulham	**Highest**

a)



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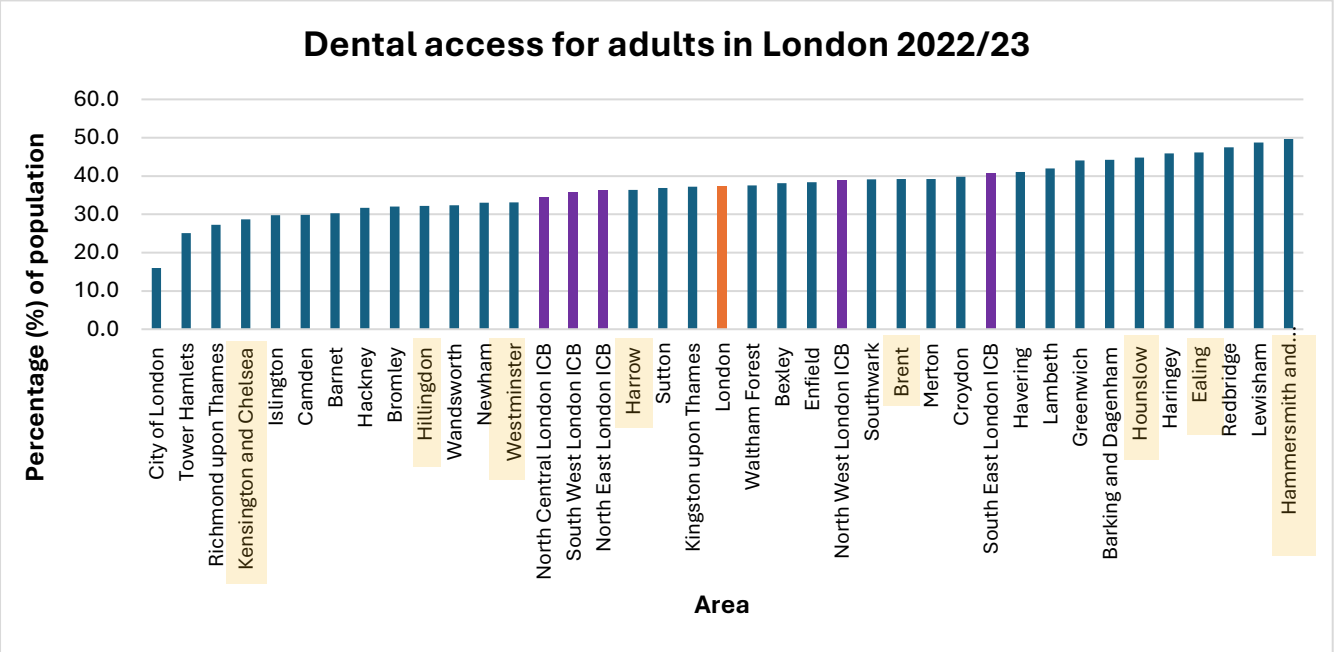

Figure 4: Dental access for a) children and b) adults for London 2022/23, with local authorities in NWL ICB highlighted (Source: NHS BSA)

Dental access at ward level

Tables 3 and 4 show the top 25 wards in NWL ICB with the lowest rates of dental access for adults and children respectively, for the most deprived wards using the index of multiple deprivation (IMD) scores of 1-4, 10 of the 25 wards were the same for dental access for children and adults by ward (table 5).

Table 3: List of the top 25 wards in NWL ICB with the lowest rates of adult dental access for 2022/23 ranging from 12.9% in St James's (Westminster) to 26.8% in East Action (Ealing). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity (Source: NHS BSA)

Red – worse than NWL ICB average amber – in line with NWL ICB average green - better than NWL ICB average

Local authority	Ward	Rank	Dental access (%)	IMD Decile	Prevalence of decay experience among 5 year olds from enhanced 2019 NDEP (when available Source: OHID)
Westminster	St James's	1	12.9	4	
Brent	Wembley Central	2	19.2	4	
Brent	Alperton	3	19.6	4	
Brent	Brondesbury Park	4	22.2	4	
Kensington and Chelsea	Earl's Court	5	22.4	3	
Brent	Mapesbury	6	22.5	4	
Hammersmith and Fulham	Sands End	7	22.7	4	
Westminster	Churchill	8	23.6	3	50.0
Brent	Sudbury	9	24.3	4	
Hounslow	Hounslow West	10	24.6	4	
Hounslow	Feltham West	11	24.6	4	
Brent	Kensal Green	12	24.7	3	28.6
Brent	Tokyngton	13	24.8	4	
Brent	Preston	14	24.8	4	
Brent	Willesden Green	15	25.5	3	23.7
Westminster	Harrow Road	16	25.6	3	
Kensington and Chelsea	Colville	17	25.7	3	13.6
Hillingdon	Heathrow Villages	18	26.0	4	
Hounslow	Bedfont	19	26.1	4	
Westminster	Westbourne	20	26.1	2	36.7
Kensington and Chelsea	Chelsea Riverside	21	26.2	3	
Hammersmith and Fulham	Addison	22	26.3	4	
Hounslow	Hounslow Central	23	26.5	4	
Hounslow	Cranford	24	26.7	4	38.5
Ealing	East Acton (no dental practices)	25	26.8	3	

Table 4: List of the top 25 wards in NWL ICB with the lowest rates of children's dental access for 2022/23 ranging from 31.3% in Earl's Court (Kensington and Chelsea) to 48.2% in Acton Central (Ealing). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity (Source: NHS BSA)

Red – worse than NWL ICB average amber – in line with NWL ICB average green - better than NWL ICB average

Local authority	Ward	Rank	Dental access (%)	IMD Decile	Prevalence of decay experience among 5 year olds from enhanced 2019 NDEP (when available Source: OHID)
Kensington and Chelsea	Earl's Court	1	31.3	3	
Kensington and Chelsea	St. Helen's	2	32.2	3	
Kensington and Chelsea	Colville	3	33.4	3	13.6
Hammersmith and Fulham	Sands End	4	33.9	4	
Brent	Alperton	5	35.9	4	
Kensington and Chelsea	Dalgarno	6	37.2	2	32.1
Brent	Kensal Green	7	40.7	3	28.6
Brent	Harlesden	8	41.2	1	45.6
Brent	Mapesbury	9	41.6	4	
Brent	Kilburn	10	42.3	3	44.2
Hammersmith and Fulham	Askew	11	42.4	3	29.6
Brent	Willesden Green	12	43.5	3	23.7
Brent	Wembley Central	13	43.5	4	
Brent	Stonebridge	14	44.1	1	32.6
Hillingdon	Barnhill	15	44.4	3	
Brent	Brondesbury Park	16	44.6	4	
Hillingdon	Yeading	17	44.8	4	38.3
Hammersmith and Fulham	Shepherd's Bush Green	18	45.2	3	29.5
Brent	Welsh Harp	19	46.7	3	
Brent	Barnhill	20	47.1	4	33.3
Brent	Preston	21	47.2	4	
Hillingdon	Botwell	22	47.3	3	
Hammersmith and Fulham	Wormholt and White City	23	47.8	2	42.9
Brent	Sudbury	24	48.1	4	
Ealing	Acton Central	25	48.2	4	

Table 5: List of wards with the lowest dental access for children and adults in NWL ICB (Source: NHS BSA). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity

Local authority	Ward Name	Rank for children	Rank for adults	IMD Decile
Kensington and Chelsea	Earl's Court	1	5	3
Kensington and Chelsea	Colville	3	17	3
Hammersmith and Fulham	Sands End	4	7	4
Brent	Alperton	5	3	4
Brent	Kensal Green	7	12	3
Brent	Mapesbury	9	6	4
Brent	Willesden Green	12	15	3
Brent	Wembley Central	13	2	4
Brent	Brondesbury Park	16	4	4
Brent	Preston	21	14	4

Mapping of current NHS dental providers

Figure 5 (next page) presents a visual presentation of existing NHS dental providers across NWL ICB by local authority. Please note that although this document solely looks at provision across NWL ICB, the availability of dental practices along local authority boundaries lines has been considered. This is because patients are likely to travel to practices which best suit them, which could include a closer practice in a local authority outside of NWL ICB.

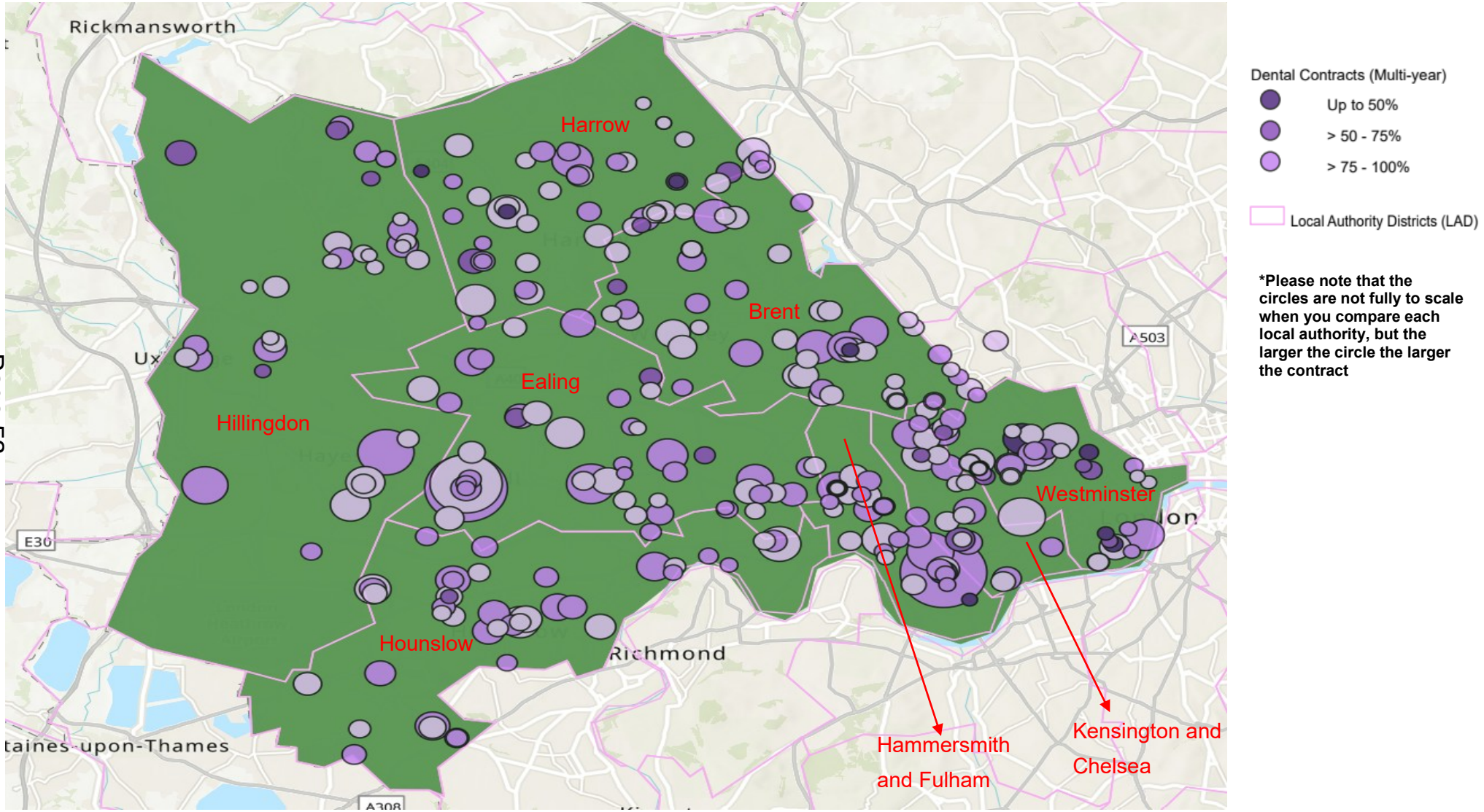

Figure 5: Map of NHS dental providers across NWL ICB by local authority (Source: National Dental Commissioning and Access)

Dental providers and commissioning across North West London ICB by local authority

Table 6 shows that overall NWL ICB has a greater proportion of providers that have achieved their UDA target, compared to the London average. However, the average prevalence of decay is greater than the London average and there is a higher ratio of dental practices per 10,000 population, and the average commissioned NHS dental activity is higher. In terms of performance of the providers half (4) of the local authorities have an average of over 95%, in terms of the percentage UDA target achieved. It is important to consider the ability of individual providers to fulfil their contracted dental activity when assigning additional UDA activity to existing providers as this helps to determine their capacity for additional delivery.

Table 6: Commissioned NHS dental activity for 2023/24 across all eight local authorities in NWL London ICB and decay prevalence.

Red – worse than NWL ICB average amber – in line with NWL ICB average green - better than NWL ICB average (rough averages used)

Local authority	Population size (2021 census)	No. of dental practices	UDAs commissioned (UDA Target)	Percentage (%) of target UDA achieved 2023/24	Ratio of dental practices per 10,000 population	Number of UDAs commissioned per person	Prevalence (%) of experience of dental decay among 5-year-olds (2019)
London Average				94.0	1.28	1.37	27.0
North West London ICB Average				94.0	1.54	1.52	32.9
Brent	338,918	55	515,709	97.3	1.62	1.52	40.1
Ealing	366,127	45	571,279	97.1	1.23	1.56	29.4
Hammersmith and Fulham	183,295	32	330,102	89.9	1.75	1.80	28.3
Harrow	260,987	40	338,755	92.8	1.53	1.30	42.4
Hillingdon	304,792	35	358,267	94.4	1.15	1.18	32.5
Hounslow	287,940	41	450,353	96.1	1.42	1.56	34.3
Kensington and Chelsea	143,940	19	195,703	96.1	1.32	1.36	23.8
Westminster	205,087	47	385,831	88.5	2.29	1.88	32.4

Sources: National Dental Commissioning and Access, ONS, OHID

Please note units of dental activity (UDA) – refer to units of dental activity which are a way to measure the amount of dental activity performed by NHS providers within their NHS dental contract

Dental epidemiology profiles for five-year-olds

These are the oral health profiles of tooth decay experience among 5-year-olds based on the national dental epidemiology programme which was conducted in 2019. More recent surveys have occurred. However, the 2019 survey involved an enhanced sample, which was conducted in five wards across all local authorities in NWL ICB. Wards were selected by local authorities as areas of need.

Figure 6 shows that five out of the eight local authorities in NWL ICB have the highest prevalence of tooth decay compared to the London average, and that all local authorities have a higher prevalence than the national average, with those in NWL ICB highlighted in amber.

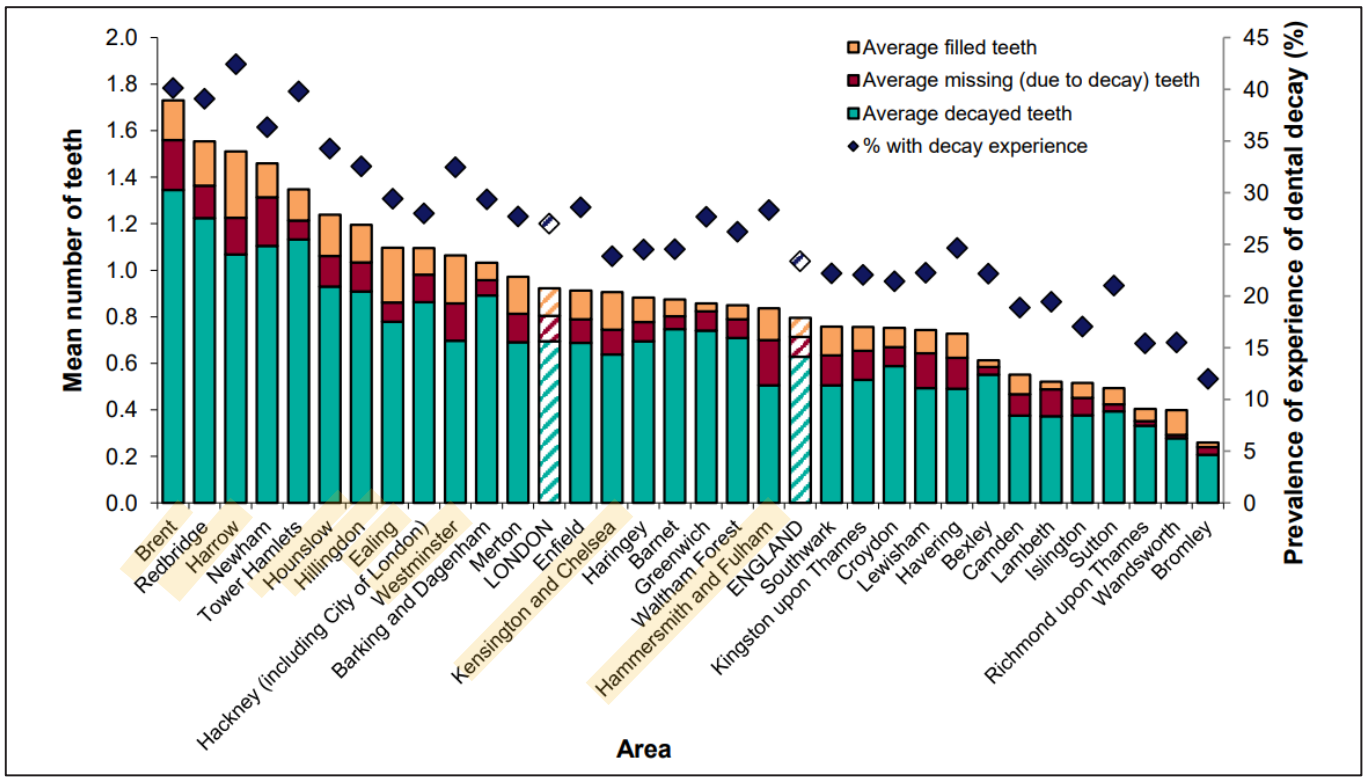

Figure 6: Prevalence of experience of dental decay and mean number of teeth with experience of dental decay in 5-year-olds by local authority in London and England (Source: OHID)

Figure 6 shows that five out of the seven local authorities in NWL ICB had dental caries experience higher than the London (and national) average. Furthermore, table 7 shows decay experience for the wards from the enhanced sample. None of the green wards (indicating a lower-than-average decay prevalence have been selected for additional capacity.

Data caveat:

Please note, there are caveats with the data as it is based on small sample sizes and the awareness that this data was collected prior to the COVID-19 pandemic.

Table 7: Prevalence and severity of experience of dental decay in 5-year-olds across wards in NWL ICB where an enhanced sample was undertaken, London and England (Source: OHID). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity.

Red - worse than NWL ICB average, amber - in line with NWL ICB average, green - better than NWL ICB average

Local authority	Ward	Prevalence of experience of dental decay (%)	Mean number of teeth with experience of dental decay in the whole sample n (95% CI)	Mean number of teeth with experience of dental decay among children with any experience of dental decay n (95% CI)
Harrow	Greenhill	55.6	1.7 (0.87 - 2.57)	3.1 (2.30 - 3.90)
Ealing	Southall Green	54.1	2.7 (1.83 - 3.58)	5.0 (3.87 - 6.13)
Harrow	Roxeth	54.0	1.9 (1.20 - 2.64)	3.6 (2.50 - 4.62)
Harrow	Wealdstone	53.4	2.3 (1.43 - 3.16)	4.3 (3.05 - 5.53)
Westminster	Church Street	51.7	1.9 (0.84 - 3.02)	3.7 (2.07 - 5.39)
Westminster	Churchill	50.0	1.1 (0.42 - 1.80)	2.2 (1.31 - 3.13)
Brent	Harlesden	45.6	1.8 (1.03 - 2.55)	3.9 (2.67 - 5.18)
Brent	Kilburn	44.2	1.6 (0.76 - 2.50)	3.7 (2.13 - 5.23)
Hammersmith and Fulham	Wormholt and White City	42.9	1.5 (0.96 – 2.06)	3.5 (2.71 – 4.32)
Hillingdon	Townfield	42.4	2.2 (1.39 - 2.96)	5.1 (3.79 - 6.49)
Harrow		42.4	1.5 (1.19 - 1.83)	3.6 (3.04 - 4.09)

Table 7: Prevalence and severity of experience of dental decay in 5-year-olds across wards in NWL ICB where an enhanced sample was undertaken, London and England (Source: OHID). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity.

Red - worse than NWL ICB average, amber - in line with NWL ICB average, green - better than NWL ICB average

Local authority	Ward	Prevalence of experience of dental decay (%)	Mean number of teeth with experience of dental decay in the whole sample n (95% CI)	Mean number of teeth with experience of dental decay among children with any experience of dental decay n (95% CI)
Ealing	Southall Broadway	42.1	2.0 (1.32 - 2.62)	4.7 (3.60 - 5.75)
Brent		40.1	1.7 (1.40 - 2.06)	4.3 (3.74 - 4.89)
Hounslow	Cranford	38.5	1.5 (0.89 - 2.13)	3.9 (2.76 - 5.11)
Hillingdon	Yeading	38.3	1.7 (1.09 - 2.27)	4.4 (3.35 - 5.43)
Ealing	Northolt West End	37.8	1.1 (0.52 - 1.74)	3.0 (1.84 - 4.16)
Harrow	Marlborough	37.5	1.7 (1.05 - 2.27)	4.4 (3.40 - 5.47)
Hounslow	Heston West	36.7	1.7 (0.96 - 2.46)	4.7 (3.57 - 5.76)
Westminster	Westbourne	36.7	1.0 (0.43 - 1.57)	2.7 (1.85 - 3.61)
Kensington and Chelsea	Chelsea Riverside	35.7	1.6 (0.63 - 2.51)	4.4 (2.93 - 5.87)
Hounslow	Isleworth	35.3	1.5 (0.59 - 2.47)	4.3 (2.54 - 6.13)
Kensington and Chelsea	Golborne	34.6	1.5 (0.47 - 2.53)	4.3 (2.40 - 6.27)

Table 7: Prevalence and severity of experience of dental decay in 5-year-olds across wards in NWL ICB where an enhanced sample was undertaken, London and England (Source: OHID). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity.

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Local authority	Ward	Prevalence of experience of dental decay (%)	Mean number of teeth with experience of dental decay in the whole sample n (95% CI)	Mean number of teeth with experience of dental decay among children with any experience of dental decay n (95% CI)
Hounslow		34.3	1.2 (0.98 - 1.49)	3.6 (3.10 - 4.13)
Ealing	Dormers Wells	33.3	1.4 (0.75 - 2.11)	4.3 (2.89 - 5.68)
Hillingdon	Barnhill	33.3	1.3 (0.67 - 1.88)	3.8 (2.74 - 4.92)
Brent	Stonebridge	32.6	1.1 (0.50 - 1.63)	3.3 (2.16 - 4.37)
Hillingdon		32.5	1.2 (0.91 - 1.48)	3.7 (3.06 - 4.29)
Westminster		32.4	1.1 (0.78 - 1.35)	3.3 (2.67 - 3.89)
Kensington and Chelsea	Notting Dale	32.3	0.7 (0.18 - 1.30)	2.3 (0.99 - 3.61)
Kensington and Chelsea	Dalgarno	32.1	0.8 (0.28 - 1.36)	2.6 (1.57 - 3.54)
Ealing	Norwood Green	30.8	1.3 (0.27 - 2.27)	4.1 (1.86 - 6.39)
Hillingdon	Yiewsley	30.3	1.0 (0.44 - 1.53)	3.3 (1.89 - 4.61)
Hammersmith and Fulham	Askew	29.6	0.9 (0.40 - 1.34)	2.9 (1.89 - 3.99)

Table 7: Prevalence and severity of experience of dental decay in 5-year-olds across wards in NWL ICB where an enhanced sample was undertaken, London and England (Source: OHID). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity.

Red - worse than NWL ICB average, amber - in line with NWL ICB average, green - better than NWL ICB average

Local authority	Ward	Prevalence of experience of dental decay (%)	Mean number of teeth with experience of dental decay in the whole sample n (95% CI)	Mean number of teeth with experience of dental decay among children with any experience of dental decay n (95% CI)
Hammersmith and Fulham	Shepherd's Bush Green	29.5	0.8 (0.30 - 1.25)	2.6 (1.52 - 3.71)
Ealing		29.4	1.1 (0.79 - 1.40)	3.7 (3.04 - 4.42)
Hounslow	Hanworth	29.2	1.2 (0.64 - 1.75)	4.1 (2.89 - 5.30)
Brent	Kensal Green	28.6	0.8 (0.30 - 1.37)	2.9 (1.65 - 4.18)
Hammersmith and Fulham		28.3	0.8 (0.64 - 1.03)	3.0 (2.51 - 3.39)
London		27.0	0.9 (0.88 - 0.97)	3.4 (3.30 - 3.53)
Hillingdon	West Drayton	24.1	0.7 (0.20 - 1.24)	3.0 (1.32 - 4.68)
Kensington and Chelsea		23.8	0.9 (0.53 - 1.28)	3.8 (2.63 - 4.97)
England		23.4	0.8 (0.78 - 0.81)	3.4 (3.36 - 3.44)
Brent	Willesden Green	23.7	0.8 (0.28 - 1.35)	3.4 (2.36 - 4.53)
Hammersmith and Fulham	Hammersmith Broadway	22.7	1.0 (0.02 - 1.89)	Data not available

Table 7: Prevalence and severity of experience of dental decay in 5-year-olds across wards in NWL ICB where an enhanced sample was undertaken, London and England (Source: OHID). Those highlighted in yellow refer to providers in wards that have been selected for additional capacity.

Red - worse than NWL ICB average, amber - in line with NWL ICB average, green - better than NWL ICB average

Local authority	Ward	Prevalence of experience of dental decay (%)	Mean number of teeth with experience of dental decay in the whole sample n (95% CI)	Mean number of teeth with experience of dental decay among children with any experience of dental decay n (95% CI)
Westminster	Queen's Park	19.5	0.8 (0.21 - 1.30)	3.9 (2.42 - 5.33)
Hounslow	Brentford	19.4	0.5 (0.02 - 1.01)	2.7 (0.87 - 4.47)
Westminster	Harrow Road	19.2	1.0 (0.08 - 1.85)	Data not available
Hammersmith and Fulham	College Park and Old Oak	19.0	0.9 (0.02 - 1.69)	Data not available
Kensington and Chelsea	Colville	13.6	0.3 (0.00 - 0.77)	Data not available

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Report to the North West London Joint Health Overview Scrutiny Committee

18 November 2025

Report Title:	**The future of Place Based Partnerships delivering health and care services**
Report Author:	David Williams - Programme Director, Integrated Care. NHS North West London ICS

Purpose

To provide a comprehensive report of Placed Based Partnerships provisions across the North West London region.

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

NHS
North West London

Developing our Place Based Partnerships in North West London

August 2025

Contents

North West London Integrated Care System

NHS North West London

01. Executive summary

Executive Summary

Context and Purpose

North West London's (NWL) Place-Based Partnerships (PBPs) have made substantial progress in improving outcomes for residents by integrating services around local needs, reducing inequalities, and making the system more sustainable - to accelerate this progress – and to support the shift to truly place-based working with a focus on prevention, community-based delivery, and digital transformation – the system is developing a more consistent and mature operating model across all boroughs.

This report sets out a maturity model for PBPs in NWL and outlines a shared framework to support local authority, health and voluntary sector partners in each Place to assess the PBP's current state, identifying development needs, and planning its journey towards greater maturity. The aim is to enable consistency where it matters while respecting the diversity of local contexts and the strengths of individual partnerships. A process is outlined to confirm roles and responsibilities within each partnership.

Why Now?

The NHS 10 year Plan and the ICB reforms set PBPs and neighbourhood development as central to improving the healthcare of patients, residents and communities. The merger of NWL and NCL ICBs moving from 8 to 13 boroughs makes the development of PBPs even more important in the new organisation and this was highlighted in the case for change for the merger.

In NWL, we have been working to strengthen PBPs. Managing Directors at Place are responsible for coordinating the local health agenda across partners and are already working collaboratively to define what mature, effective partnerships should look like under such a model.

This report outlines the conditions required to thrive within this evolving landscape and an initial process to confirm roles and responsibilities within the partnership. Over the coming months we will be working with partners to bring their input into these new arrangements. .

Our Shared Ambition

By April 2026, every borough in NWL should be operating as a mature PBP with:

- Shared strategic priorities rooted in population need
- Integrated neighbourhood teams at the heart of delivery
- Clear accountability and inclusive governance arrangements (across health and local authority)
- Coordinated infrastructure and resources to deliver effectively

This vision is not about centralising control but about enabling Places to lead—anchored in local relationships, supported by system enablers, and focused on outcomes that matter.

The Maturity Model

The maturity model defines what 'good' looks like across six key domains:

- Leadership & Governance
- Vision & Strategy
- Service Delivery & Integrated Care Models
- Population Health Management
- Workforce Development
- Patient and Community Engagement

It offers a consistent framework for self-assessment and development planning, with the expectation that each Place will complete an assessment and agree a development plan. To support this a process for Places to confirm roles and responsibilities within the partnership has been established.

This paper seeks to answer the following questions

What has **North West London's journey** been to developing its Place-Based Partnerships?

What **successes** have been achieved to date?

What is the **future direction of travel** for place?

What does a **fully mature model** for place look like in NWL?

What are the **roles of partners** to support system success?

What are our next steps in this process to enable **system success**?

02. System context

History and context of PBPs within NWL

What are Placed Based Partnerships?

Place Based Partnerships (PBPs) are stakeholders within communities that work together to deliver **better outcomes** and **improved health and well being** for residents, patients and communities. Organised around London Borough boundaries they consist of:-

- Local Authorities – including adult and children's social care, housing and public health
- NHS Providers – Community and Mental Health Trusts, primary care providers (inc. GPs and primary care networks or federations), Acute Trusts
- Voluntary, Community and Social Enterprise (VCSE) organisations
- NWL ICS – representatives from ICS Borough based teams

Partnerships have played a vital role in managing the health and social care system, keeping people out of hospital, driving prevention, supporting discharge, improving health and well being of residents, developing relationships and supporting improved joint working

What PBPs are expected to do in NWL

- Operate as borough-level alliances
- Integrate care around residents' needs - improving access, experience, and outcomes whist coordinating the flow of activity as part of reactive services and promoting the shift from hospital-based care to community care as a promotion of proactive care.
- Coordinate budgets and delivery across partners.
- Lead on reducing inequalities, developing neighbourhood working, and embedding preventative care.
- Develop neighbourhood teams to be the delivery vehicle for health and social care within populations of 50,000-100,000

Key developments:

- Local partnership structures are in place across boroughs.
- Managing Directors for Place have been appointed, with individual employment arrangements through a variety of partners
- Borough Directors (ICB) have been working with Managing Directors at Place
- Shared data and early joint investment planning are starting to inform local decision-making.
- Place MDs and BDs have been leading change and leaderships on behalf of the wider system, including INT development, finance/BCF, frailty, and mental health.
- There is a **clear commitment across the system that Place is not a passive recipient of system priorities, but an active partner in shaping and delivering them.**

How PBPs Emerged in NWL

Ongoing challenges

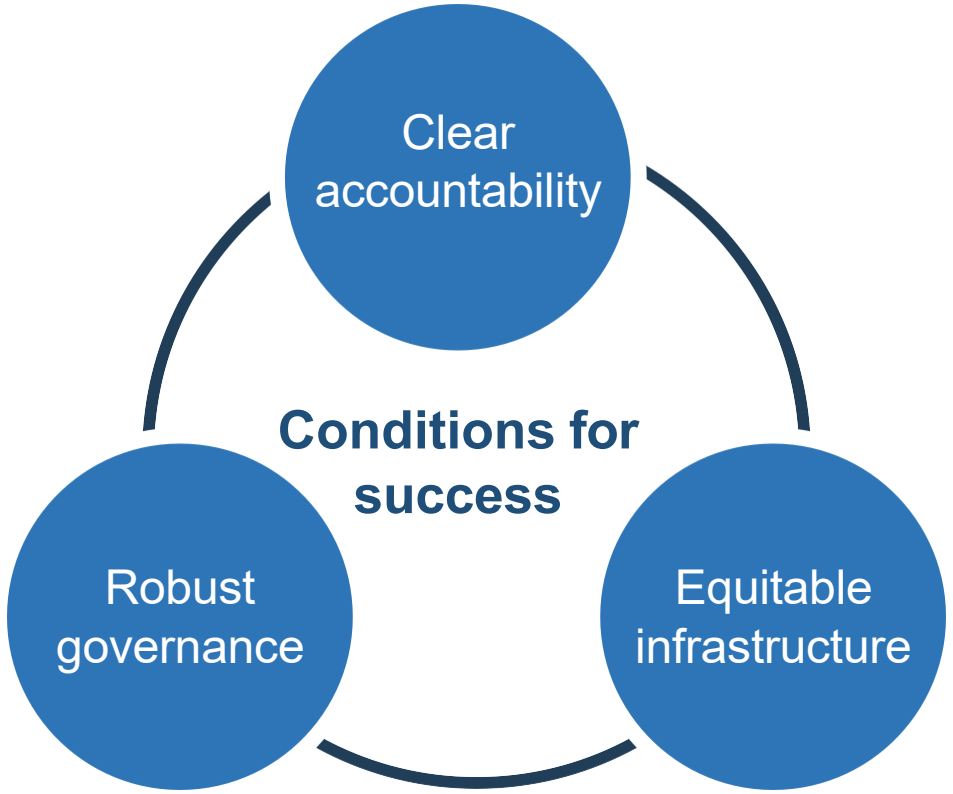
- There is a lack of a consensus around the core responsibilities of Partnerships and, by extension, the Managing Director agreement
- Legacy CCG structures continue to **blur accountability**, especially between ICB Borough Directors and PBP MDs.
- Current arrangements have facilitated varying degrees of Local Authority involvement

The opportunity and next steps

Despite these challenges, all PBPs are making a positive difference through local collaboration. As we move towards a future where place-based partnerships are central to how care is planned and delivered - as set out in the NHS 10 Year Plan and through the implementation of INTs- we have an opportunity to ensure every resident, in every borough, benefits.

To support this, NWL has developed a maturity framework that sets out what good looks like and what's needed for PBPs to take on greater responsibility for improving outcomes.

The ambition is that by April 2026, all Places will operate with clear accountability. robust governance, and equitable infrastructure. This will enable more responsive, integrated care that improves health, reduces inequalities, and delivers better experiences and outcomes for residents across North West London.



What NWL PBPs have already achieved (1/4)

NWL's place partnerships are already delivering real change, reducing inequalities, cutting hospital demand, and improving the lives of residents by integrating services around people and places – not institutions. Each borough is proving that when health, care, and community join forces, outcomes improve, and systems become more sustainable.

Hillingdon

Integrated Neighbourhoods Driving Proactive Care

- Transformed 170+ fragmented services into 3 co-located INTs aligned with community and clinical leadership.
- Same Day Urgent Care Hubs reducing A&E pressure, helping deliver on a new hospital model and aiming for an 18% cut in ED usage by 2030, whilst also delivering on same day primary care, freeing up 6% of GP appointments
- Severe Frailty admission rates are among the lowest in NWL, and NEL activity for patients under Active Case Management show a 36% reduction between pre and post intervention

What made the difference

- Trust between partners underpinning joint decision making on priority setting, management of Place based challenges, underpinned by robust data, with all partners having an equal opportunity to benefit from collaboration
- Clear agreed strategy and priorities across Place Partners including Local Authority and single governance arrangements in place underpinned by an alliance agreement and all partners (including the ICB) resourcing the Place infrastructure

Brent

Tackling Inequality and Delivering Outcomes

- Frailty interventions saved £18m, and asthma support improved care for 65% of children under 17.
- Non-elective admissions from care homes dropped steadily thanks to targeted work and enhanced support systems.
- Brent Health Matters delivered 3,000+ health checks and supported hundreds with diabetes, hypertension, mental health, and housing needs.
- CYP-focused workstreams cut CAMHS wait times, improved autism support, and expanded asthma education across schools.

What made the difference

- Jointly agreed partnership priorities, with dedicated transformation resource
- A good understanding of our population and data
- Deep connections with our communities, enabling us to work in partnership to address inequalities
- Sustained whole system focus on key problems, with a culture within teams that encourages innovation, working across silos and has a positive approach to failure

What NWL PBPs have already achieved (2/4)

NWL's place partnerships are already delivering real change, reducing inequalities, cutting hospital demand, and improving the lives of residents by integrating services around people and places – not institutions. Each borough is proving that when health, care, and community join forces, outcomes get better, and systems become more sustainable.

Hammersmith & Fulham

Rebuilding Trust and Integration

- Supported housing and brokerage model under strategic review, with a new commissioning plan in development to better align housing and mental health pathways.
- Integrated Community Access Point (ICAP) prototype launched, bringing together professionals across physical, mental health, and social care teams – providing creative, personalised support through joint visits and whole system working.
- Development of meaningful co-production in collaboration across partners, bringing together the whole range of neighbourhood support available in early years.

What made the difference

- Leadership across all partners committed to rebuilding cross-sector relationships after years of disinvestment and siloed delivery.
- Building coalitions of the willing with energy and commitment to make a difference with and for communities, by changing how we use existing resources.
- Positive, practical, hands-on leadership and support focused on building confidence, developing relationships and getting people working together around key cohorts.

Ealing

Better Discharge, Better Lives

- Step-Down Beds (MH) reduced over-60-day hospital stays significantly, showing cost-effectiveness and better recovery outcomes.
- Care Home In-Reach Liaison Service (CHILS) cut A&E attendances by 42%, slashed use of 1:1 care, and improved care home CQC ratings.
- Homeless Health Services prevented hospital readmissions and enabled smoother recovery pathways, saving nearly £100k and supporting 46 high-risk patients.
- Accelerated Reablement and Bridging Pathways led to same-day discharges and reduced P1 delay days by 24.8% year-on-year.

What made the difference

- Clear borough-wide priorities focused on discharge, flow, and supporting complex patients across mental health, frailty, and homelessness.
- Strong operational leadership and daily joint working between social care, NHS, VCSE and housing teams with a shared commitment to patient-centred care.
- Targeted investment in high-impact that unlocked flow, avoided admissions, and supported vulnerable groups to recover in the community.

What NWL PBPs have already achieved (3/4)

NWL's place partnerships are already delivering real change, reducing inequalities, cutting hospital demand, and improving the lives of residents by integrating services around people and places – not institutions. Each borough is proving that when health, care, and community join forces, outcomes get better, and systems become more sustainable.

Hounslow

Driving Change Through Joint Leadership and Targeted Investments

- A new frailty model is reducing hospital demand via admission prevention, dementia care, and integrated discharge initiatives.
- Mental Health Programme Board tackling crisis care pressures by redesigning the community offer, improving flow and reducing over-60-day inpatient stays.
- CFO group using pooled budgets and open-book finance to redirect resources into impactful, value-for-money services.
- BBP governance and leadership structure enables coordinated decision-making across health, care, and the community.

What made the difference

- Shared leadership across NHS, council, and community providers with a strong focus on delivery and accountability.
- System-wide commitment to redirecting investment based on outcomes, not organisational silos.
- SLT and Programme Boards providing forums to resolve 'knotty' issues, drive service change and track progress.

Harrow

Better Discharge, Better Lives

- CYP – three *Family Hub Networks* launched in February through close working with all CYP system partners (including schools and VCS partners) to deliver CYP services at various hubs, schools and VCS venues. The networks offer easier access to family and CYP services across each neighbourhood in Harrow.
- Adults – a multi-agency *Integrated Intermediate Care Coordination Team* is in place to offer service coordination for patients and carers upon hospital discharge
- Community Champions – a community led example of partnership working includes 3 programmes: champions, health checks and smalls grants. The champions programme involves recruiting volunteer champions for specific focus areas

What made the difference

- Senior leadership buy-in and good will from partners.
- Building trust with front-line colleagues and taking them on the journey from the start, with all models being designed 'bottom-up' through multiple workshops to support co-production of pathways
- Dedicated programme resource to drive the delivery of the model

What NWL PBPs have already achieved (4/4)

NWL's place partnerships are already delivering real change, reducing inequalities, cutting hospital demand, and improving the lives of residents by integrating services around people and places – not institutions. Each borough is proving that when health, care, and community join forces, outcomes get better, and systems become more sustainable.

Bi-Borough

From Fragmentation to Focused Delivery

- Reset governance and priorities across two boroughs, bringing partners together under a shared vision and delivery plan.
- Launched joint borough-wide priority workstreams on mental health, early years, and interface between primary and secondary care.
- Accelerated neighbourhood model, with stronger PCN and community links driving integrated support for people with complex needs.
- Embedded system flow improvements, using data and joint planning to improve discharge pathways and reduce duplication.

What made the difference

- A dedicated joint Place Team driving progress across borough boundaries.
- Tight focus on shared delivery goals, backed by ICB support and practical joint working.
- A move from structures to action through joint workstreams and a shared delivery dashboard.

03. Maturity Model

Supporting the shift to a more mature system

How does a mature PBP function?

In addition to the form and functions that are set previously, a mature place-based partnership will require behavioural change to ensure that there is a coordinated approach to address core needs of local population, working beyond organisational boundaries in a way that promotes sustainability across the partnership as a whole.

Governance through an integrated leadership model, where the Managing Director is the single executive leader for place-based partnership delivery, accountable to all partners, both health and the local authority. This role brings together operational delivery and system change, overseeing joint work across primary care, community services, social care, public health and voluntary sector partners, as well as supporting the flow of patients through the system in the most sustainable manner that also improves outcomes.

The partnership is underpinned by a formal board or executive group made up of senior decision-makers from constituent organisations. This board should have a clear terms of reference, defined reporting lines, shared priorities aligned to both local (e.g. JSNA, HWB strategies) and ICS goals, and mechanisms for oversight, risk management and accountability. In many Places, this includes a joint chairing arrangement between the NHS and the local authority.

Mature PBPs also manage resources effectively, which could include access to pooled or aligned budgets such as the Better Care Fund, and the ability to use this pooled resource to target health inequalities funding and planning investments to support integrated neighbourhood teams. Critically, they must be capable of understanding and managing operating and financial flows across the local system moving beyond pilots and projects into system-wide redesign.

On the delivery side, a mature PBP implements integrated neighbourhood teams that reflect local population need, bringing together GPs, social care, community health, mental health, voluntary services and acute outreach where relevant. A proactive PHM approach is embedded in how services are planned and targeted, particularly around prevention and proactive care for these most at risk. Community voices are not only heard but actively shape local priorities and service design.

Developing a consistent approach to place

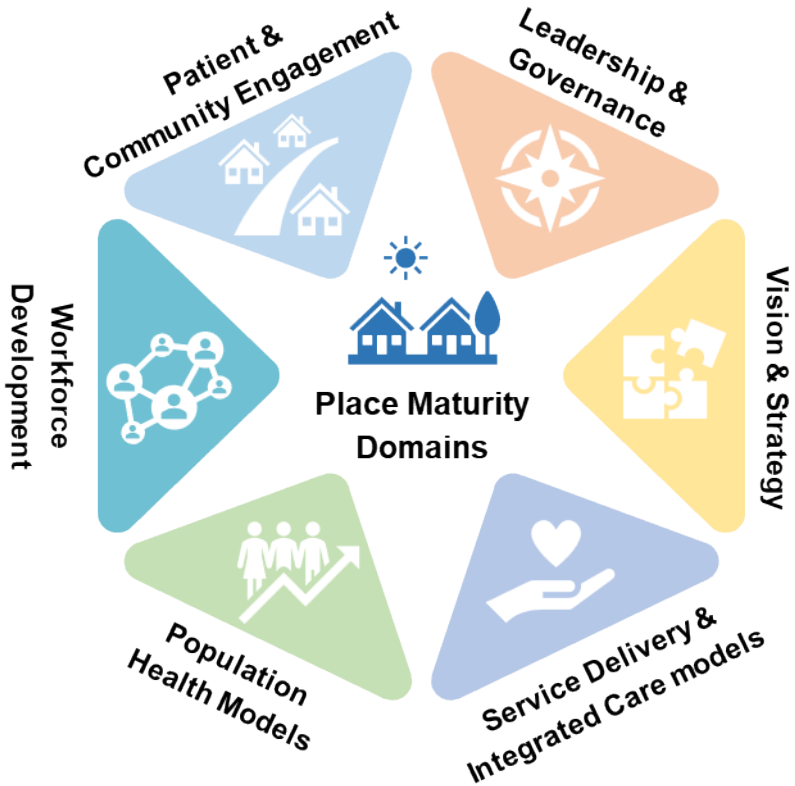
As highlighted our partnerships have grown organically to this point. To enable them to flourish, to maximise the opportunity to improve population health, and support partnerships to most effectively manage coordinated care for residents we want to:

- Systematise factors that lead to success
- Describe what excellent looks like and support all partnerships to be operating in that way
- Enable consistency through core principles, ensuring we are not inadvertently introducing high levels of variation
- Link in with the national direction of travel described in previous slides to prevent North West London diverging in its approach

We will do this through the development of a maturity framework that will provide a tool for partners to plan, assess, and develop their PBP in line with a shared vision for integrated care. Through it;

- All partners will be enabled to engage effectively in partnerships and be an active part of the development journey,
- Clarity will be provided for Lead Provider CEOs and PBP Managing Directors to develop the partnership
- We can enable the NWL PBPs partnerships to consistently work at the Lead Host/Provider model, creating a foundation to build towards an ACO model

The core challenge will be using this framework to move all Partnerships into the higher level of maturity by 25/26



Why we are developing a maturity framework

Collaboration

- Helping leaders at Place to create the right environment for effective collaboration, both within partnerships and across NWL, with defined purposes and outcomes
- Building a common language around maturity, supporting constructive conversations about strengths and areas of improvement
- Sharing best practice and collaborating for opportunities at scale

Accountability and improvement

- Supports mutual accountability, enabling partners to challenge and support one another around aspects of maturity
- Encourages evidence-based evaluation and tracking, with clear markers to demonstrate maturity and impact

Flexibility and consistency

- Recognises that each Place is different, but allows for a golden thread of consistency across the system to drive alignment
- Builds confidence within cross-Place partners such as Trusts, VCSEs and communities

The path to maturity: an overview

Domain	Early	Developing	Mature
Leadership & Governance	Unclear governance and accountability. Reliant on individual relationships and legacy structures. No formal delegation of authority.	Some boroughs have drafted governance models or terms of reference. Early examples of joint chairs and shared leadership. Beginning to define decision-making processes.	Operate as a single cohesive partnership with integrated leadership, delegated authority, and collective accountability for place-level outcomes.
Vision & Strategy	No shared strategy or common outcomes. Organisational plans focused on internal priorities. Strategy reactive rather than proactive.	Some shared purpose beginning to emerge. Links to JSNAs and local authority goals in development. Early work to align plans and develop outcomes frameworks.	Embed a shared, co-produced strategy across all partners, aligned with ICS goals and rooted in population health and community priorities, with whole system oversight of budgets to align against strategic priorities
Service Delivery & Integrated Care Models	Service design largely driven by individual organisations. Collaboration informal or personality-driven. Legacy CCG delivery models still dominant.	Emerging co-design of services. INT pilots and neighbourhood models developing. Greater clarity on place-level functions and delivery scope.	Deliver integrated, person-centred services through neighbourhood teams, underpinned by shared data, preventative care, and user involvement with the ability to shift investment as necessary to areas of need
Population Health Models	Fragmented data systems. No shared access to real-time information. Intelligence not used systematically in planning or delivery.	Some data sharing in place. Business intelligence functions emerging at borough level. Early risk stratification and PHM tools being tested.	Embed population health management and real-time data use across planning and delivery, using integrated platforms and community insight.
Workforce Development	No shared workforce planning. Separate systems and development offers. Limited visibility of staffing gaps or shared culture.	Initial joint leadership development offers. Pilots of integrated roles and shared OD programmes. Cross-organisational working in early stages.	Build an integrated workforce model with joint planning, shared roles, and consistent support for development and wellbeing.
Patient & Community Engagement	Engagement is ad hoc, often reactive, and led by individual partners. There are few formal mechanisms for involving residents or using community insight to shape decisions.	Engagement is becoming more structured, with a Place-level strategy emerging and some co-production in service design. VCSE input is sought more routinely, but representation and influence are inconsistent.	Communities are equal partners in shaping strategy, services, and governance. Insight from lived experience and VCSE partners directly informs decision-making. Inclusive, representative engagement is embedded in all planning and delivery.

04. Enabling conditions

Roles, leadership functions and governance

Delivering on ambition: what we need from each partner (1/2)

Integrated Care Board (ICB)

- **Set clear system-wide priorities and outcomes** through the Joint Forward Plan, within which PBPs coordinate local delivery.
- **Empower PBPs with formal mandates**, clear terms of reference, and joint decision-making frameworks co-owned with local authorities.
- **Strategic commissioning through lead provider** by delegating responsibility for delivery of agreed priorities, supported by defined objectives, outcomes, and shared metrics.
- **Hold commissioning functions at system level**, while enabling PBPs to plan and coordinate delivery in line with strategic priorities.
- **Ensure transparent and traceable financial flows**, with funding coordinated through Place (via a host organisation) and aligned to population health needs.
- **Provide linked multi-agency data, BI, and analytics infrastructure** to support PHM, service planning, and evaluation.
- **Facilitate PBP maturity** by investing in leadership development, organisational development, improvement capability, and integrated infrastructure support.
- **Uphold behaviours that support trust and subsidiarity**, acting as a steward not a central controller.

Lead Provider

- **Local commissioning and delivery integration**: Enable and ensure integrated delivery of delegated out-of-hospital functions, where appropriate, through a lead provider model aligned to Place priorities and governance.
- **Host for delivery infrastructure**: Provide the delivery infrastructure needed to support the PBP's core functions - including programme, finance, BI, transformation, and engagement.
- **Integrator function**: Act as a neutral integrator across partners, ensuring operational alignment, coordination of multidisciplinary teams, and proactive risk management using population health tools.
- **Accountable delivery partner**: Hold responsibility for outcomes against a defined population, reporting into joint Place governance and aligned with ICB and local authority expectations.
- **Support system goals through local delivery**: Translate ICS and PBP ambitions into neighbourhood delivery, helping manage demand, integrate care, and address inequalities.

The balance of ICB and lead provider responsibilities are likely to shift over time

Delivering on ambition: what we need from each partner (2/2)

All Providers

- **Alignment with System, Place and Neighbourhood vision and priorities:** Align organisational plans and resources to shared Place priorities and participate in co-developing the vision and outcomes framework
- **Shared accountability:** Participate in joint governance and performance monitoring; accept challenge and collective responsibility for impact, not just individual delivery, particularly around facilitating access to appropriate health and care services and supporting flow through the system
- **Workforce integration:** Enable and support integrated workforce models, including joint roles, shared training, and staff movement across organisational boundaries
- **Cultural integration:** Embrace collaborative working across disciplines, professional boundaries, and systems; build trust and shared language for joint working
- **Real-time operational collaboration:** Work as part of multidisciplinary neighbourhood teams using shared care records, population insight, and real-time data
- **Delivery Infrastructure**: Contribution to the core delivery infrastructure required to support the PBP's core functions - including programme, finance, BI, transformation, and engagement.

Local Authorities

- **Responsibilities held by all Providers**: shared accountability and responsibility for impact, workforce integration, cultural integration across boundaries, real time collaboration and contribution to delivery infrastructure.
- **Joint strategic planning:** Co-produce Place strategies and outcomes frameworks that align with local government responsibilities (e.g. social care, public health, housing, education)
- **Delegation and pooled resources:** Enter into shared governance and financial arrangements, such as aligned or pooled budgets and shared investment planning
- **Inclusive community engagement:** Lead or support inclusive engagement strategies and bring in wider determinants of health expertise and community development models
- **VCSE and community role:** Enable VCSE organisations to participate as equal partners by facilitating funding, infrastructure, and governance inclusion

05. Confirming roles and responsibilities

The integrator function

Role of the Place-based ‘Integrator’ function

There is recognition that these are future aspirations for Integrators, which will need to build and evolve over time as Place and neighbourhood working matures

01 Operational coordination & integration

- Support coordination between sectors, partners, and INTs to bridge fragmented services
- Run core integrated functions (e.g. INTs) and support transformation with Place/ BPPs
- Address practical collaboration issues such as workforce planning and interface building.

02 Facilitate Population Health Management

- Enable sharing and use of real-time data to deliver holistic, preventative care
- Support ICB efforts to provide PHM data and build capacity at regional and place levels
- Support INTs to target interventions to address health needs and inequalities

03 Leadership & delivery

- Ensure effective coordination of INTs, with primary care leading with a multidisciplinary team
- Work with primary care, local authorities, and other providers to embed agreed strategies
- Drive improvement through a test-and-learn approach
- Over time, the Integrator may become accountable for delegated NHS services, as local governance and national policy matures

04 Drive Equity in access and outcomes

- Use PHM data and local partnerships to identify and reduce disparities in care and access.
- Work with VCSE and wider partners to ensure services meet local population needs.

05 Collaboration, alignment and learning

- Coordinate place level discussions to resolve interface issues and manage care transitions
- Escalate cross neighbourhood challenges to ensure system wide alignment
- Facilitate cross borough collaboration, sharing and scaling of best practice

06 Infrastructure, risk and sustainabil

- Provide consistent, cost effective support for people, finance, governance and risk
- Enable shared estate use and maintain visibility of local assets, including VCSE
- Support manage strategic risks and support wider system resilience

What the integrator is not:

- Not currently a commissioner or contract holder
- Not a stand-alone solution – will only work in collaboration with Place leadership, local authorities, and communities
- Not a substitute for existing statutory accountability or professional leadership
- Not focused solely on high-need cohorts – the model supports whole-population neighbourhood health improvement

Success factors and criteria for an Integrator function

The integrator role will be performed by a host organisation(s), together with the place based partnership. While delivery may involve multiple partners there must be clear organisational accountability e.g., a single lead within the partnership to the place based partnership ensuring neighbourhood health service can function effectively and sustainably in each place. This role cannot operate in isolation or replace individual responsibility and accountability from partnering local organisations. The **success factors** and criteria for an integrator function include:

Credibility and maturity at place

Clear track record in delivering at scale, with the maturity to manage pooled resources, lead multi-agency working, and host integrated functions. Must demonstrate operational resilience.

Local Presence

Has well established relationships with partner organisation and knowledge of care delivery locally

Ready to manage risk and increase value over time

Able to attract, mobilise and lead staffing capacity to transform services to deliver the neighbourhood model

Operational capability to align place assets

Can deliver on neighbourhood infrastructure requirements: leadership, team, support and coordination

.

Examples of potential Integrator organisations include community service providers, MH trusts, primary care organisations, vertically integrated acute trusts, local authorities, or other locally rooted organisations with the scale and connectivity to support effective neighbourhood health delivery. Note, NW London are only seeking one nomination by each place not multiple nominations.

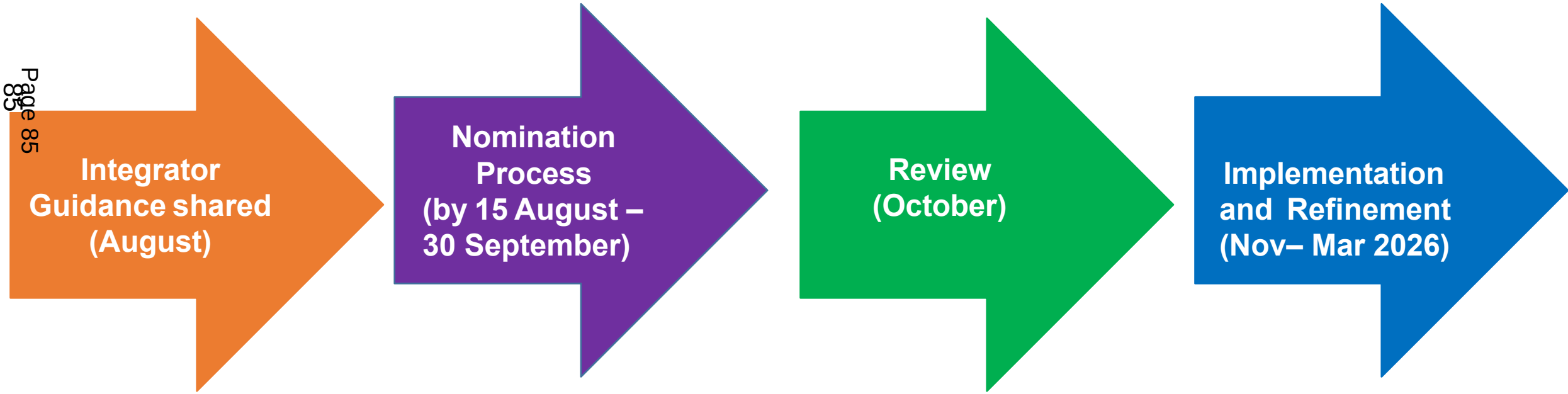
Integrator Process - Timescales

ICB share guidance (this slide pack) about the integrator role including its core functions, and success factors and specification for the place based integrator function

Place Based Partnerships to confirm and share proposals for their borough(s) by completing a integrator function nomination form by **30 September**

The ICB Executive and Place Delivery Group will endorse the nominations. ICB will also develop and share an 'integrator maturity matrix' to track development

Integrator arrangements embed across the 7 Places. Providers reflect commitments in plans, develop local approaches, and complete the maturity matrix



Nominations expected to covered the period to the **end of March 2027** for 17 months but may be reviewed earlier, if required

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Report to the North West London Joint Health Overview Scrutiny Committee

18 November 2025

Report Title:	**Special School Nursing**
Report Author:	David Williams - Programme Director, Integrated Care, NHS North West London ICS Ross Graves – Chief Strategy and Digital Officer Central and North West London NHS Foundation Trust

Purpose

To provide an update on the current position of Special School Nursing provisions across North West London.

North West London Community Collaborative

NHS Central London Community Healthcare NHS Trust

NHS Central and North West London NHS Foundation Trust

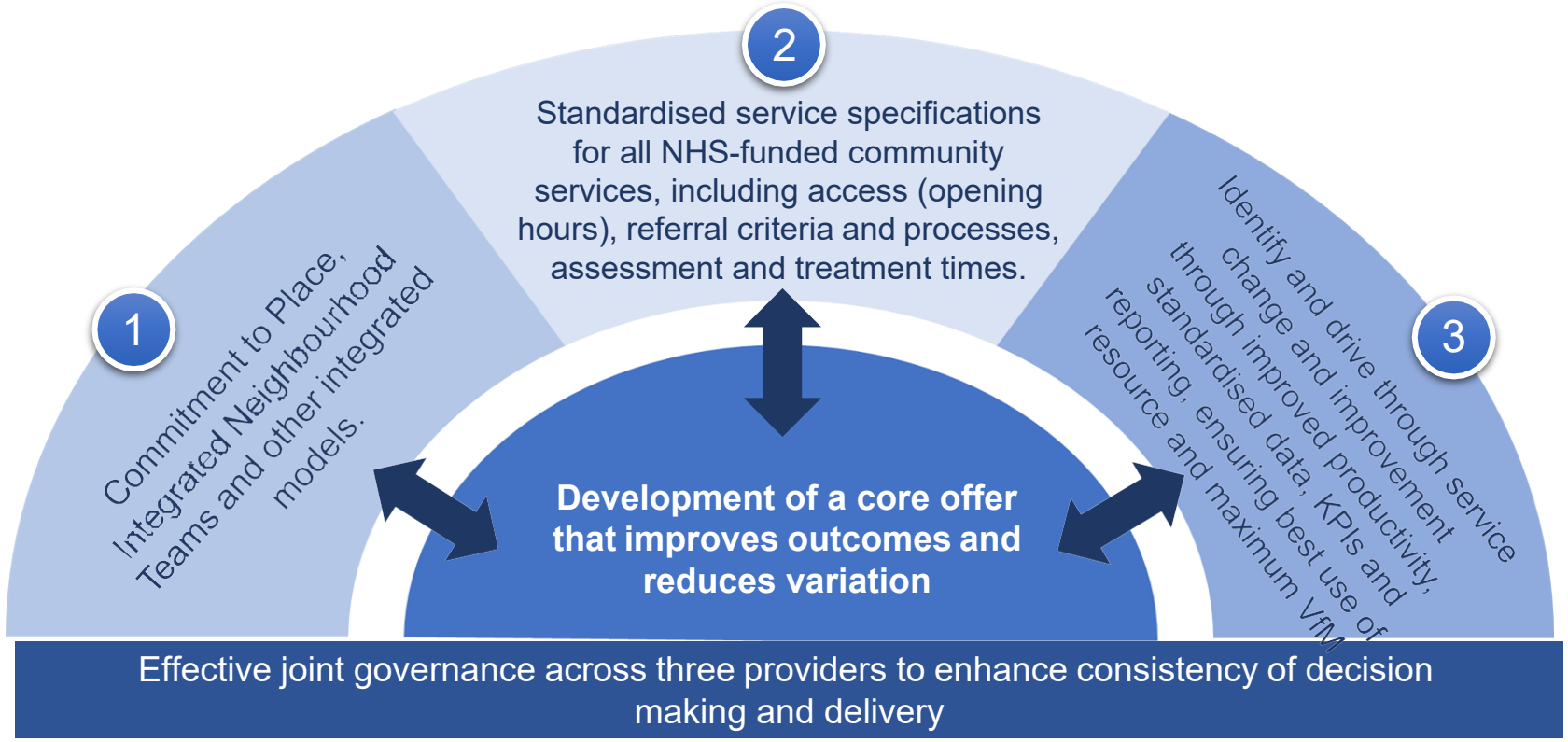
NHS West London NHS Trust

Community Core Offer Specialist School Nursing

David Williams, Programme Director, Integrated Care, NW London ICS
Ross Graves, Chief Strategy and Digital Officer, CNWL
September 2025

Developing a core offer for community services – Provider Collaborative Approach

A Core Offer for community services is a key contributor to improving outcomes and reducing variation for the NWL ICS. Community Providers, through the collaborative have committed to ***developing a consistent core offer for "any place"*** to reduce unwarranted variation and drive service consistency across North West London. Within this, providers will ***shape the future role of Place***, considering how our services are part of and enable Integrated Neighbourhood Teams. Providers will work together to ***drive efficient, high-quality care through improved productivity***, including making the best use of our digital and physical assets and infrastructure.



North West London Community Collaborative

All NHS-funded adults' and children's services are in scope of the core offer
9 adults' services and 2 children's services are in the tranche 1 services

21 Adults' services in scope:

1. Urgent Community Response
2. Community P2 Beds
3. Discharge to Assess
4. Short-term Rehab
5. Community Nursing
6. Complex Case Management / Frailty
7. Care Home / National Care Home In Reach
8. Falls
9. Heart Failure,
10. Cardiac Rehab
11. Pulmonary Rehab
12. Respiratory
13. Tissue Viability/Leg Ulcer
14. Neuro Rehab
15. Stroke ESD
16. Diabetes
17. Nutrition and Dietetics / Weight Management
18. MSK
19. Bladder and Bowel
20. Speech and Language Therapy
21. Podiatry

9 Children's services in scope:

1. Community Paediatrics
2. Occupational Therapy
3. Physiotherapy
4. Speech and Language Therapy
5. Audiology
6. Bladder and Bowel
7. Community Children's Nursing Service, Specialist Paediatrics Nursing within CCNS
8. Special Schools Nursing Service
9. Children Looked After (CLA)

Represents **100%** of NHS funded core offer services within CLCH, CNWL and WLT

Core offer services have been prioritised using the following criteria:

Our Prioritisation Criteria	
1	Impact on equality of access or high health inequalities
2	Services "at risk" of closure due to funding and/or access to resources.
3	Clinical impact e.g. poor patient outcomes or excessive waiting lists.
4	Strategic fit with the NWL/national expectation of community services.
5	System impact e.g. will it reduce acute demand and care for patients closer to home?
6	Deliverability at Place e.g. is this a priority service for Integrated Neighbourhood Teams?
7	Areas of inefficiency due to multiple providers and/or opaque pathways.
8	Impact on patient experience e.g. are patients having difficulties navigating the system and accessing the right service first time.
9	Historically key underfunded areas i.e. where current spend is not correlated to need.

Brent Place are leading on the development of a core complex/frail offer. We are engaging with this workstream to enable the community core offer element to align with this service and to that population in care homes.

Prioritised Services for Tranche 1a – from April 2025

Adults' Services:

1. Community P2 beds for Rehabilitation
2. Urgent Community Response
3. Community Nursing for patients who are housebound
4. Podiatry

Children's services:

1. Special Schools Nursing
2. Children Looked After

Prioritised Services for Tranche 1b – from Q2/Q3 2025/26

1. Integrated neuro rehab and stroke
2. Discharge to assess

Prioritised Services for Tranche 1c – from Q3/4 2025/26

1. Bladder and Bowel (all ages)
2. Tissue Viability/leg ulcer
3. Short-term Rehab

We have allocated Senior Responsible Officers, Clinical Responsible Officers and project managers to each service to take this work forward working across the three Trusts and eight NWL Boroughs

We will have prioritised Neuro-Developmental Services for children, alongside the Mental Health Core Offer work.

Represents approximately **50%** of contacts in the core offer services within CLCH, CNWL and WLT

Review Process

Collective review of the clinical model of each service historically commissioned across 8 NWL boroughs
Core model proposal agreed at high level for each service
Subject specific work stream informed by subject matter experts to progress from high level outline to full specification
Review of best practice to further inform model
Engagement with stakeholders including local authorities, primary care, acute trusts, plus other partners as appropriate to each service to inform model to inform model
Impact analysis on service users and stakeholders/partners to inform model and implementation plan
Gap analysis by each borough of current to proposed model to identify scale of change
Demand and capacity review for each borough to identify: Productivity opportunities Investment or resource reduction position per borough
Sign-off off by Collaborative COOs/CMOs/CNOs and NWL Clinical Advisory Group
Implementation/mobilisation plans and timeframes agreed with partners

North West London Community Collaborative

Special School Nursing

SRO	Clare Miller, WLT
CRO	Clare Miller, WLT
PM	Reka Benkuti, CLCH

Summary of changes and boroughs affected:

- Service specification outlines delegation model in line with national guidance in Children and Families Act 2014, with delegation of tasks to healthcare assistants and school staff.
- All boroughs will be affected to some extent, most significantly in Ealing where large proportion of work will be moved to school staff.

Workstream update July 25:

- An updated specification has been developed based on NHSE feedback (with agreement that this now aligns with national guidance) and whole day workshop for service leads on 4th June.
- Further work is needed on risk management and task allocation – to be fed into specification amendments; to be finalised by end September 2025.
- Updated spec to be shared with Directors of Children's Services; final approval from CMO/CNOs.
- Borough meetings underway to validate the model and understand feasibility; half of NWL boroughs are already mobilising the model.
- Resource implications to be identified in Aug 2025.

Escalations to ICB

- Change in offer to meet national guidance – delegation model differs from current offer in some boroughs (significantly Ealing).

Milestones	Timeline /RAG	Progress and mitigation
Undertake demand and capacity mapping.	July - Sept 2025	Sussex complexity tool and CLCH staffing skill mix tool to be used in addition to RCN guidance and clinical skills.
Agree outcome measures and KPIs.	July 2025	First draft proposed – to review once model finalised
Engage key stakeholders on proposed changes e.g. staff, partner agencies, patients, carers, public.	July – Sept 2025	Stakeholder mapping to be completed to inform engagement plans.
Review SSN workforce capacity/ skill mix and agree further resource requirements per boroughs	Sept- Oct 2025	CLCH staffing skill mix tool to be used.
Agree competency and training approach for school staff under new model.	Sept – Oct 2025	
Finalise service delivery model and timeline to achieve core offer.	Nov 2025	

Risk	RAG	Mitigation
Some schools may resist the proposed change		Creating delegation risk assessment and clear documentation for training and competency sign-off to increase confidence in the new model.
Challenges in meeting needs for future special school expansion and increase in children with SEN and HCP needs in mainstream schools		Through demand and capacity work to identify staff mix and numbers for a pupil quota to inform current and future staffing
CLCH & Sussex Tools taken longer than planned due to competing priorities within the services and the formula of the CLCH Tool had to be adjusted		Have maintained communication to stakeholders, including via NWL ICB SSN meeting it will impact on timeline to deliver sharing of documentation & transition plan
2016 Con Care Framework, which does not fit current needs and lacks a standardized tool for assessment. Different boroughs use different tools, leading to inconsistencies in care allocation, including impact on 1:1 care funding		Having to consider alternative support needs in response to CHC outcomes but it does put pressure on other aspects of the system.

Special Schools Engagement Work Plan

Priority	Description	Action	How?	Deliverable	When?
Designated Clinical Officers for SEND	Engage their clinical expertise into the service design and skill mix and delegation requirement for delivering of the proposed specification and its component 4 levels	DCO's to attend SSN session 1. To share the specification and 4 levels to input into the final draft ahead of wider stakeholder engagement and 2 to review the capacity and demand analysis and assess the skills required	Through a clinical meeting Draft specification has been shared with DCOs, comments are being received	Outputs to be reported to the ICB Clinical Effectiveness Group, Community Collaborative Clinical Board and NWL Clinical Advisory Group for clinical endorsement	End September 2025
Directors of Childrens Services and Local Authorities – e.g. Directors of Education	Engage their expertise into the demand and capacity analysis, enabling them to provide local insight into their own borough needs and understand the variation across NWL, and implications for main stream schools. Engage their input into the roll out of the proposed specification in their borough	ICB Director of Clinical Programmes (DoCP) to link with DCS in Westminster to plan LA engagement Asst Director CYP and SSN SRO bring in learning from boroughs where new model is already working and where agreements have been reached with school unions in Ealing DoCP to bring in learning from NHSE/national	Borough Directors meet with their respective DCS and LA teams as per the outlined agreement with Sarah Newman Follow up NWL wide meeting between central ICB team/ Community Collaborative Programme team and the LA to compare demand and capacity analysis across NWL and to agree engagement and implementation plan for roll out of specification	Local insights added to the respective demand and capacity analysis for each borough Implementation plan informed by borough, school union and national insights	September – November 2025
Special Schools	Engage their lived experience into the challenges and issues with respect to the proposed specification and the operational delivery of the four levels outlined in the specification	Borough Directors alongside DCOs respective community provider and LA colleagues meet with special schools, parent and carer forums and if possible YP forum	Workshop style meetings with follow up with individual schools as necessary	Agreement on implementation plan of new specification and delivery of levels	October – November 2025
All partners and stakeholders including JHOSC	Contribute to the NWL ICB special schools needs assessment document	Borough Directors with their respective boroughs and the ICB CYP and health equity team engage partners in informing health needs assessment document	Through surveys, interviews workshops Initial briefing to JHOSC 9th September 2025	Needs assessment informed by stakeholders Report to be shared at ICB Strategic Commissioning Committee	September October 2025

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Report to the North West London Joint Health Overview Scrutiny Committee – 18 November 2025

North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

No. of Appendices:	**3** Appendix 1: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker Appendix 2: 2024/25 North West London JHOSC Recommendations and Information Requests Tracker Appendix 3: 2025/26 North West London JHOSC Recommendations and Information Requests Tracker
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Chatan Popat, Strategy Lead - Scrutiny Democratic and Corporate Governance Brent Council chatan.popat@brent.gov.uk

1.0 Purpose of the Report

1.1 To present the latest 2023/24, 2024/25 and 2025/26 scrutiny recommendations trackers to the North West London Joint Health Overview Scrutiny Committee (NWL JHOSC).

2.0 Recommendation(s)

2.1 That:

The committee note the latest scrutiny recommendations tracker for the 2023/24 municipal year in Appendix 1, the 2024/25 municipal year in Appendix 2 and the 2025/26 municipal year in Appendix 3.

3.0 Detail

3.1 The North West London JHOSC, according to its Terms of Reference can make recommendations to the North West London Integrated Care System and its

Integrated Care Board, NHS England, or any other appropriate outside body in relation to the plans for meeting the health needs of the population.

3.2 The North West London JHOSC may not make executive decisions. Recommendations made by the committee therefore require consideration from the relevant NHS body. When the North West London JHOSC makes recommendations to NHS bodies, the relevant decision maker shall be notified in writing, providing them with a copy of the committee's recommendations and a request for response.

3.3 The 2023/24, 2024/25 and 2025/26 North West London JHOSC Recommendations and Information Requests Trackers (attached in Appendices 1, 2 and 3) provide a summary of scrutiny recommendations made during the previous two and current municipal years. These track decisions made by NHS colleagues and gives the committee oversight over implementation progress. It also includes information requests, as captured in the minutes of its committee meetings.

3.4 Updates to the tracker from the previous meeting are highlighted within the table.

Appendix 1: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker

Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
18 July 2023	Acute beds	Information Request	For the JHOSC to receive ongoing updates regarding extra capital funding for acute beds in relation to winter pressures	Slides around this have been shared with wider council colleagues, as suggested by the JHOSC in July. We should have some more clarity on next steps later in September.	
		Information Request	For the JHOSC to receive updates on the work undertaken by Acute Trust and the ICS to progress the work at delayed hospitals in the New Hospitals Programme.	**Imperial College Healthcare Redevelopment update - August 2023** Following the concerns we raised about the delays announced for our schemes (at St Mary's, Charing Cross and Hammersmith hospitals), we hosted a visit at St Mary's in July from Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care. We were able to show the minister the very damaging impact of our failing estate on patients and staff and set out the many benefits of our redevelopment plans, including for the local and national economy. We had a good discussion about the work we have underway to explore the feasibility of potential partnership opportunities that could accelerate the St Mary's redevelopment, leveraging the value of the land that will be surplus to requirements once we have a new hospital on a less sprawling footprint. We are due to meet Lord Markham again in early autumn to update him on the outcome of this work. We have also had significant engagement with the New Hospital Programme team and we are currently working through a process with them to test our capacity and cost modelling for all three of our schemes. We are still hoping to complete a first stage business case for Charing Cross and Hammersmith this autumn and, depending on the outcome of the St Mary's partnership feasibility work, to secure first stage business case approval for St Mary's by the end of the year. While there is still much to be clarified in terms of further	

				process and decision making, progressing our business cases has to be a priority whatever route we take. Meanwhile, our estates team is working hard to delay any further major buildings failures for as long as possible. You may have seen the extensive scaffolding in place at Charing Cross and, more recently, St Mary's. Works include an extensive weather-proofing programme for our oldest buildings at St Mary's, roof repairs at Charing Cross and essential inpatient ward refurbishments across our sites to ensure we are able to maintain infection prevention and control standards. We are keen to continue to share our thinking and plans as they evolve. We also want to engage more broadly with our patients and local communities as soon as we have a little more clarity on next steps.	
	Ophthalmology	Information Request	For the JHOSC to receive more details on the ongoing engagement work related to the standardisation of ophthalmology services.	Engagement so far has been through a series of online and face to face sessions, supported by surveys. As part of the new community service the selected provider will be expected to work with the Integrated Care Board in undertaking focussed patient engagement, looking at experiences of using the service and opportunities to improve the service to better meet the needs of all of our communities. As we further develop the standardisation, the intention is to work with patient representatives to co-design pathways in partnership with primary and secondary care clinical stakeholders. These co-design workshops will be supported by targeted community engagement activities where co-designed pathways will be introduced and feedback from our communities gathered to support further improvements.	

				These activities will commence later this year and continue for the duration of this contract (i.e., 3 years).	
		Information Request	For the JHOSC to receive more information on how the standardisation of ophthalmology services will address health inequalities in North West London.	Standardisation of our ophthalmology service will support the drive to address health inequalities in NW London by: Ensuring that there is a standard service offering available to all NW London residents – in particular this includes ensuring that all NW London residents have access to a community ophthalmology service. Ensuring that residents are able to access primary eye care through the large number of optical practices available across NW London, which will make it more convenient for patients to access care. The ICS will work in partnership with all of the key stakeholders in our communities, bringing them together with colleagues from primary and secondary care and public health to understand how we can better support communities in accessing eye care.	
		Information Request	For the JHOSC to receive baseline data on performance in ophthalmology services in order to measure performance in North West London against national and London standards. With a breakdown by paediatric and adult ophthalmology service performance.	We are developing a data pack for ophthalmology across the ICB footprint, in partnership with clinical colleagues through our Clinical Reference Group. This will be shared with JHOSC later in the summer when completed with validated and evidenced data.	
	Musculoskeletal (MSK)	Recommendation	To ensure that diagnostic capacity across North West London is properly linked to musculoskeletal services to best benefit residents across North West London.	Diagnostic delays were identified as a specific issue in Harrow due to historic local arrangements. These have now been addressed and brought in line with other parts of the ICB.	
		Information Request	For the JHOSC to receive baseline access wait times for musculoskeletal	We are completing a review of the waiting times data for the new service in partnership with the provider, as part of our	

			services and details on how the new service standards will improve waiting times for treatment.	regular contract review and management process. When this data has been formally reviewed, we will share with all partners and ensure that patients are kept informed of likely waiting times.	
		Information Request	To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.	Separate paper supplied on 27/11/23 to Chatan.	
		Recommendation	Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.	We are currently working through the Children and Young People Mental Health Steering Group to refresh our Children and Young People Mental Health transformation plan and also intend to focus the strategy work on Children and Young People in 2024. Suggest that this is timetabled for later on in the year, following agreeing the scope of the CYPMH part of the strategy.	
		Information Request	To receive the details of the alternative provision to accident and emergency located across the boroughs.	An interactive map can be found here	
			To receive further details around on the engagement plans when available.	Everything is on the website, including the engagement report: https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london	
		Information Request	To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.	As we further develop the mental health strategy, this will include a strengthened focus on inequalities. The strategy is being presented at the October 22nd, 2024, JHOSC.	
	Proposals on the future of The Gordon Hospital	Information Request	To provide the following: • The commentary and output of the pre-consultation workshops.	This information is published on the ICB website.	

			• Completed and upcoming events with service users and carers. • Service users' experience of Gordon Hospital. • A more detailed consultation plan. • Historical reports of Gordon Hospital service users over the last 5years. • Historical demographic data of Gordon Hospital service users.	Acute mental health consultation: North West London ICS (nwlondonicb.nhs.uk)	
05 December 2023	ICS Workforce Strategy and Programme Update	Recommendation	Provide an update to the Committee once NHS have assessed the Government's new position on immigration and how this might affect recruitment and workforce within North West London.	The main impact will be on social care rather than health care professionals. From March 2024, care workers and senior care workers will not be able to bring dependents and only CQC-registered providers in England will be able to sponsor Health and Care Visa applicants. Ahead of this, 53 Senior Carers completed pre-employment compliance through NW London International Recruitment Team. The first Cohort of Senior Carers landed in UK; induction completed with employers supported by NWL Health & Social Care Skills Academy.	
		Recommendation	Provide an update of progress by the Race Equality Steering Group.	The Race Equality Steering Group is Co-Chaired by Rob Hurd and Linda Jackson. The Steering Group commissioned an Independent Report into Barriers to Leadership. The Report and strategic recommendations will be published as a Call for Action.	
		Information Request	Provide regular updates on progress of the seven priority workstreams.	Progress is reported monthly to the Strategic Chief People Officers Meeting and bi-monthly to the ICS People Board. There has been good progress on the pipeline for acute roles following two International Recruitment events, offers made to: 67 Registered Nurses, 40 Registered Midwives, 2	

				Sonographers, 2 ODP, 26 Radiographers, 5 physiotherapists, 2 ODPs. There has also been a strong response to the launch of the ICS Graduate Scheme for future leaders. An undergraduate scheme is also in development. A Spring EDI Summit is being planned to agree sustained medium-term interventions that will embed equality, equity, social and racial justice. Work also continues to deliver new ways of working to support new models of care.	
	NWL Elective Orthopaedic Centre	Recommendation	Report to the Committee on the success against metrics and targets identified for the Orthopaedic Centre and also get feedback from staff and patients. It would be interesting to get some reports from staff and patients after March on - how they feel things have been going and what could be improved and what the NHS system can learn going forward.	In January 2024 the EOC operated on 140 patients. Of these 64 were admitted to the EOC ward, with an average length of stay of 2.8 days. Unfortunately, 14 lists (35 patients) were cancelled in January due to the Junior Doctors' industrial action. The Friends and Family Test has reported 100% satisfaction with the service. A selection of patients were contacted for further feedback. Generally, the feedback was positive with all patients highly satisfied with their experience and very likely to recommend the EOC to others. Areas of suggested improvement were around the early morning theatre admission process and clearer signage about where to wait. The EOC's current operating capacity of three theatres will increase to five theatres (full capacity) in March 2024 at which point reporting against metrics and targets can be better undertaken.	
		Recommendation	Report to the Committee on the operation of the dedicated transport provision.	In January 2024 there were 12 EOC patients that used the free patient transport service. Three journeys were from the	

				patients' homes to the hospital, and nine journeys were from the hospital to patients' homes. The earliest arrival at the hospital was 7.30am and the latest departure was 6pm. Eleven journeys were by ambulance, and one was by car ambulance. Except for two occasions where the patient wasn't ready, journeys were able to commence on time or earlier than scheduled. Journeys were made to/from Brent, Ealing, Hounslow, Harrow and Hammersmith & Fulham.	
	ICS Updates: ICS Running Costs Reduction	Recommendation	To bring a report to the Committee once there are more detailed plans available on the redesign and consultation.	There is no impact on services, so our focus will be on how we work with partners and our organisational effectiveness.	
14 March 2024	Primary Care Access And Same Day Access Model	Recommendation	That NWL NHS undertake an Equality Impact Assessment and Human Rights Impact Assessment prior to implementing any changes in the way patients access primary care.	Same day access proposals are not currently being implemented. Any significant change at a practice or PCN level would be subject an EHIA at that level.	
		Recommendation	That the Committee should seek meaningful consultation with patients, communities and GPs. Any engagement undertaken should be representative of the whole patient voice.	PCNs are leading a process of engagement and co-design at local level.	
		Information Request	For the NWL JHOSC to be provided with feedback and analysis of the impact of the early adopter PCNs, including case studies that have been learned from.	An update has now been given to the NWL JHOSC at the meeting on 22 October 2024.	
		Information Request	For the NWL JHOSC to receive full details of how patient safety and effectiveness would be measured against the proposals.	The proposals previously discussed are not currently being pursued.	

		Information Request	For the NWL JHOSC to receive information on the outcomes of the work done by KPMG in a way that was easy to understand and that related to patient outcomes.	An update has now been given to the NWL JHOSC at the meeting on 22 October 2024.	

Appendix 2: 2024/25 North West London JHOSC Recommendations and Information Requests Tracker

Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
22 October 2024	NWL Adult Community-based Specialist Palliative Care (CSPC) Review	Recommendation	That NWL NHS consider lessons learnt from previous consultations such as the Gordon Hospital to ensure that the complexity in working with multiple and hard to reach communities and stakeholders is considered throughout the consultation and engagement processes to ensure meaningful insights are acquired resulting in effective decision making.	This has been considered and has been factored in with the design and implementation of the consultation.	
		Recommendation	That NWL NHS take proactive actions with hospitals and clinicians to ensure patients and families have all the information they require in advance regarding their options for end-of-life care planning and support available for families.	The Urgent Care Plan (UCP) is an NHS service that enables every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital. NHS North West London has identified the further roll-out of the UCP to north west London residents and clinicians as a priority and is in the process of putting together a plan to do so.	
		Recommendation	That members of the committee provide a list of locations in their borough to Chatan highlighting suitable places for drop-in sessions and consultation activities to take place as this could result in enhanced engagement with residents. Chatan to then collate a list and pass on to the NWL NHS Engagement Team.	A list of locations from some boroughs has been received and subsequently forwarded to NWL NHS to consider.	
	NWL Mental Health Strategy	Recommendation	For the JHOSC to be presented with a further, more detailed report on the NWL Mental Health Strategy detailing what the strategy actually entails, it's priorities and	The Mental Health Strategy has been signed off and published. The ICB board made a final decision on acute	

			a plan on how the new strategy will deliver on outcomes and priorities.	mental health inpatient services in April. This is also published on the ICB website. New model of mental health care approved for Westminster and Kensington & Chelsea: North West London ICS	
		Information Request	To provide a borough-by-borough breakdown of those with Severe Mental Illness (SMI) across NW London. The information should include a more detailed breakdown of what has already been provided to the committee including conditions per borough and actual numbers on prevalence rather than percentages.	Data on prevalence of severe mental illness and CMH caseload across boroughs can be found below. This has also been included in the report presented to the committee (pages 19 and 49.  **CMHT Treatment Met & Unmet Need** *Latest 12-Months (01/07/2022 - 30/06/2023)* | Service	Av. Caseload	Av. In-Treatment Caseload	Av. Waiting List (Caseload Waiting for First Contact)	SUs With At Least 2 Contacts in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
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CMHT - Brent	2,503	1,770	476	3,506	4,235	-729	236,907	1.48%
CMHT - Harr	2,182	1,342	460	2,635	2,842	-207	181,646	1.45%
CMHT - Hill	2,562	1,349	519	2,469	3,581	-1112	221,491	1.11%
CMHT - K&C	1,700	1,217	252	2,388	2,767	-379	120,664	1.98%
CMHT - Westm	2,621	1,736	403	3,390	2,370	1020	210,025	1.61%
MINT - Ealing	4,313	1,710	933	3,419	4,751	-1332	243,031	1.41%
MINT - H&F	3,178	1,053	739	2,034	2,525	-491	139,004	1.46%
MINT - Hounslow	3,668	1,185	787	2,766	3,361	-595	194,848	1.42%
Total	**22,565**	**11,346**	**4,569**	**22,607**	**26,433**	**-3826**	**1,547,616**	**1.46%**	 Further information in regard to the number of adults rather than percentages and a further drilled down layer of data per borough has been shared with the committee.	

	NWL Primary Care Access	Recommendation	That future communication plans and survey questionnaires, not only for this item, but also for future planned work and consultations are shared with the committee in advance for comments to ensure effective questioning and constructive discussions can take place at JHOSC meetings.	This has been agreed by the engagement team, and such information will be shared to JHOSC in advance as part of the consultation process whenever possible.	
05 December 2024	North West London Winter Campaign and London Ambulance Performance Update	Information Request	That the Committee receive information about critical care bed capacity, delays and discharges from hospitals and vaccination data.	As data becomes available, it is being circulated to members electronically via Chatan.	
		Information Request	That the Committee receive a breakdown of GP face to face appointments across the NWL NHS eight boroughs.	NW London has consistently had the highest level of face-to-face appointments across London. The published data is per ICB (NW London wide). • November 24: 68.0% • December 24: 66.6% • January 25: 66.4% • Feb 25: 66.6% • March 25: 66.9%	
		Information Request	That the Committee receive information about how the Ambulance Service anticipates managing the changes for domestic abuse coming into effect in early 2025 under Raneem's Law.	This request has been accepted at the meeting. The London Ambulance Service will contact all relevant parties and authorities (individually or through the NWL JHOSC) once an approach has been confirmed.	
		Recommendation	That NWL NHS work more closely with the local authorities to deliver messaging to specific communities and groups about accessing the Ambulance Service.	NHS North West London has asked LAS to share their public facing materials with the local authority communications teams.	

	North West London Health Equity Programme	Information Request	That the Committee receive the information about how the Health Equity Fund of £8 million is divided between the boroughs annually.	This information has now been circulated electronically to all members. Below is a breakdown of the allocation of funds by borough. HIT funding allocation by Borough Based Partnership Borough / % / Allocation in 24/25 Brent / 18.6 / £865,904 Ealing / 17.2 / £800,729 Hammersmith and Fulham / 8.0 / £372,432 Harrow / 11.7 / £544,682 Hillingdon / 14.6 / £679,688 Hounslow / 13.3 / £619,168 Bi-Borough / 16.6 / £772,796 North West London Integrated Care System 2 NHS North West London	
		Information Request	That the Committee receive information about what support is provided by the NHS for lower socio-economic patients with the cost of prescriptions.	To address the request for information on what support is available for lower socio-economic patients with the cost of prescriptions, the **NHS Cost of Living** webpage outlines the range of support provided accessible via https://www.nwlondonicb.nhs.uk/your-health-services/cost-living. Individuals may be entitled to free NHS prescriptions if, at the time of dispensing, they meet specific exemption criteria. This typically includes those in receipt of qualifying benefits such as Income-related Employment and Support Allowance (ESA), Universal Credit, or those who qualify through age-related exemptions. For patients who require regular medication and do not meet exemption criteria, a Prescription Prepayment Certificate (PPC) offers a cost-effective option to help manage ongoing prescription charges. In March 2018, NHS England issued guidance advising that certain items available over the counter (OTC) should not routinely be prescribed in primary care. This guidance applies	

				to 35 minor or self-limiting conditions, as well as probiotics and vitamins and minerals, where self-care is generally. considered more appropriate and should not be routinely prescribed in primary care because: • there is limited evidence of clinical effectiveness for the item. • the item would be prescribed for a condition that is self-limiting and will clear up on its own without the need for treatment. • the item would be prescribed for a condition that is appropriate for self-care. Importantly, note being exempt from NHS prescription charges does **not** automatically override this guidance. However, the policy does recognise the impact of health inequalities. It allows for clinical discretion in exceptional cases, including where a patient may be unable to self-care due to significant **medical, mental health, or social vulnerabilities.** In such situations, treatment may be prescribed if deemed clinically appropriate by the prescriber. Prescribers are advised to consider safeguarding concerns and use their professional judgement where reliance on self-care could adversely affect a patient's health or wellbeing.	
	Integrated Care System Update	Information Request	That the Committee receive an outline of the new ICB structure and key contacts for each borough.	Rory has provided key contacts to Chatan for circulation. The ICB will be developing new structures, either internal or merged, over the next few months.	
		Information Request	That the Committee receive the communication plan and venues for the palliative care consultation.	The communications plan, venues for the consultation and details of all online sessions have been shared with the NWL JHOSC electronically.	

				Additionally, members have now also been sent links to all online consultation video recordings for their reference.	
		Information Request	That the Committee receive the details about the Work Well scheme which launched in October and that supports residents with health conditions back into employment.	The details of the Work Well scheme have been circulated to all members. Attached below is a detailed document providing further information on the scheme. WorkWell latest information.docx	
		Information Request	That the Committee receive information about the London Refugee Employment Programme.	The Partnerships, Population Health and Reducing Inequalities team connect into this as a programme, but don't take a strong leadership role within. Interested parties can contact Anthony Sembatya at Anthony.Sembatya@westlondon.nhs.uk for more detailed information.	
13 March 2025	Integrated Care System Update	Information Request	NWL ICB to update the committee on the Mount Vernon Cancer Centre relocation providing information on alternatives to relocation to Watford and any further updates arising.	Paper submitted / agenda item for the May JHOSC meeting.	
		Information Request	NWL ICB to update the NWL JHOSC on the impact of the Government's proposed 50% cuts on ICS and ICB services.	Rob will keep the committee updated as things develop	
	North West London Planned Care Strategy	Recommendation	For NWL NHS to conduct investigation / research into the possibility of bias in AI technology being used for Planned Care both in relation to gathering data and assisting with care arrangements and appointment handling.	• Artificial Intelligence technology has numerous possible benefits in healthcare delivery supporting patients, administration and clinical decision making. For example, this includes: ○ Summarising live audio recordings of appointments to generate first drafts of clinic notes, letters and follow-up actions saving clinicians time and allowing them to focus more on the patient discussion	

				○ Searching and synthesising a patient's record to help clinicians prepare for an appointment and understand their previous, relevant interactions with the healthcare system. ○ Support patients access information, provide information and schedule appointments, including through using voice calls with natural language models available in multiple languages to address potential risks to digital isolation if patients are not comfortable using smartphones. ○ Population health analyses across multiple data sources to identify unmet needs, prevention opportunities and quality improvement opportunities. • While there are demonstration products that support these tasks, none have been adopted at more than a pilot scale for example in individual GP practices using AI-products such as Heidi or Tortus which summarise live audio recordings. • Governance frameworks to support AI-integration into clinical workflows and systems have been designed at the acute hospitals in North West London. These will support further pilots and research of further AI tools. The risks of clinical adoption are well recognised. For example, the positive first impressions these tools often create on their capability create a human factor risk of being too trusting in the future outputs of these tools, which could mean they are not adequately reviewed or edited into a final record. • AI-Tools will need to be an important component of any future planned care and healthcare strategy because of the benefits they offer, including improved patient experience, clinical experience and productivity. NWL institutions will continue its work with academic and industry partners, such as	

				Imperial College London and Imperial College Academic Healthcare Science Network, to evaluate AI-tool pilots, their impact on patients and clinicians, and their risks including bias and hallucination (when AI-models make up something that is not real). This research and support will complement broader national and international efforts and understanding in this rapidly emerging field of technology.	
		Recommendation	For NWL NHS to further assess the impact of the new strategy on the elderly population.	• A significant proportion of planned care activity relates to chronic health conditions such as heart failure, hypertension, rheumatology, diabetes, COPD and chronic kidney disease. The likelihood of developing one, and then more than one, chronic condition increases with age. This means that older people are high uses of planned care and may need planned care support from multiple different specialties simultaneously. • During the development of the strategy patients and local communities were invited to offer their ideas and experiences to support its development. Older people formed a significant element of this feedback, including in forums such as the local resident's groups. Clinical stakeholder feedback has also highlighted the importance of older people and how their needs and ability to access care can be different to others. • The strategy is organised around these pillars, all of which will directly and positively impact older people and their experience of planned care. They are: ○ Redesigning primary and secondary care pathways - this includes integration of greater planned care specialist support into neighbourhood health teams. These are closer to where people live, will support	

				more integrated work with primary care and other community healthcare providers, and enable greater focus on coordinating care for individuals whose needs cross multiple specialties. This could have benefits for example in balancing medication needs and reducing the risk of polypharmacy. ○ Improving patient activation and communication - this will support older people through targeted focus on communication and scheduling processes, so that everyone knows how long they should need to wait to their appointment, allow multiple ways to schedule and reschedule appointments, improve the quality of administrative information they receive, and expand how patient initiated follow-ups when suitable are used so that patients do not need to wait for a pre-determined period if they need specialist help more quickly. This will help join visits together, ensure better information is available and make it easier to get follow-up advice. ○ Improving productivity - this will increase the overall level of planned care activity through current available resources. Greater activity will reduce waiting lists more quickly, benefitting the whole population including older people. • The strategy development has held equity central to its development. While there will be an expansion of digital tools and ways of working to support patient experience and productivity, it is recognised that this is not suitable for the whole population. However, using these tools frees up capacity for equitable support to mitigate risks of digital exclusion. • When subsequently implementing major changes identified in the strategy, such as new pathways, tools or projects, Quality and Equality Impact Assessments will be conducted. This is a step in all significant changes made to understand the impacts on different quality issues and population groups	

				including older people, agree how to mitigate their risks and impacts, and sometimes stop initiatives altogether when the risks or impacts are felt to outweigh potential benefits. This means that even as the strategy implementation progresses in future years, impacts on all population groups including older people will remain an important consideration.	
		Information Request	NWL ICB Communications and Involvement Team to provide further information in regard to communications with residents and patients linked to the NWL Planned Care Strategy.	**Engagement and involvement activity on planned care strategy** Engagement with the residents of across North West London in relation to the planned care strategy took place through a mix of online digital engagement and face to face discussions at events in all eight boroughs. There were a total of 303 responses to the online survey. Insight received from the public focused not only on waiting times, but on communication, preparation, access, and system responsiveness. The feedback gathered a mix of quantitative and qualitative data and identified recurring themes such as the emotional toll of uncertainty, the importance of feeling informed and remembered, and the desire for more proactive, practical engagement while waiting for care. As part of the wider engagement on planned care, *The Advocacy Project* facilitated Easy Read engagement sessions with people with learning disabilities in Brent and Westminster. This approach ensured that those with communication and cognitive access needs had the opportunity to share their views in a meaningful and supported way. A total of 32 individuals from learning disability communities attended sessions which used Easy Read formats, visuals, and supported discussion. These	

				sessions were delivered in familiar community settings with facilitators trained in accessible communication. Communications and engagement activity included: • a new webpage on the NHS North West London website outlining what planned care is and the work underway. • issues paper and briefing document on the ICB website. • issues papers and survey shared directly with key stakeholders, patient/public and community groups and in NHS North West London e-bulletins. • news articles copy for acute provider intranets and NHS North West London websites. • borough involvement team cascade to VCS and borough-based stakeholders • newsletter text shared with local authorities for resident and staff email newsletters. • newsletter text sent to providers for patient and staff bulletins, provider intranets and NHS North West London websites. • social media posts shared on NHS North West London channels. • information and survey link shared with North West London Citizen's Panel • information and survey link shared on Next Door social network. • update to PPG forum • presentation with question-and-answer session at NHS North West London Residents Forum • email sent to resident forum participants with information and survey link. • issues paper and survey sent to Healthwatch representatives. • meeting held with NHS North West London Healthwatch representatives.	

<table>
<tr><td></td><td></td><td></td><td></td><td>information provided to Local Authority partner communications teams on ICB led sector call including survey link.
in person discussions with residents across all eight boroughs with feedback gathered at an average of five in-person events in each borough during February and March</td><td></td></tr>
<tr><td></td><td></td><td>Information Request</td><td>To provide the Committee with comparative data surrounding wait times across the ICB’s different boroughs.</td><td>This is data on the length of time patients have been on waiting lists at a borough level –

<table><tr><th></th><th>0-17wks</th><th>18-51wks</th><th>>52wks</th></tr><tr><td>Brent</td><td>51%</td><td>45%</td><td>3.8%</td></tr><tr><td>Central London</td><td>58%</td><td>39%</td><td>2.4%</td></tr><tr><td>Ealing</td><td>53%</td><td>44%</td><td>2.9%</td></tr><tr><td>Harrow</td><td>48%</td><td>48%</td><td>3.8%</td></tr><tr><td>Hillingdon</td><td>48%</td><td>50%</td><td>1.7%</td></tr><tr><td>Hounslow</td><td>58%</td><td>40%</td><td>1.7%</td></tr><tr><td>H&F</td><td>59%</td><td>39%</td><td>2.6%</td></tr><tr><td>West London</td><td>58%</td><td>39%</td><td>2.3%</td></tr><tr><td>Non-NWL</td><td>58%</td><td>40%</td><td>2.1%</td></tr><tr><td>4 Provider Total</td><td>54%</td><td>43%</td><td>2.7%</td></tr></table>
There is variation between boroughs, reflecting historic referral practices and individual NHS provider performance, hence why patients in Brent, Ealing, Harrow and Hillingdon are waiting relatively longer given the tendency of these patients to be referred to THH and LNW.

It should be noted that this data is based upon unvalidated datasets and could change (slightly) in proportions as a result of individual pathway validation. However, the basic trend of</td><td></td></tr>
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				variation seen across the boroughs reflects the overall performance of the 4 main NHS providers in the sector. The national objective to improve Referral to Treatment Time, including the target to achieve 65% by March 2026, will help improve this situation and local provider and place-based variation will be monitored and used to help target appropriate interventions.	
01 May 2025	NWL Adult Community-based Specialist Palliative Care (CSPC)	Recommendation	Enhanced Care Bed Locations: Ensure that the placement of any new enhanced care beds considers, wherever possible, the availability of parking for patients, families, and staff.	To support the introduction of a new model of community-based specialist palliative care across North West London, a structured, three-stage process is being followed to develop and implement service delivery options for enhanced end of life care beds. • Stage 1: Developing service options. • Stage 2: Listening to communities and refining options. • Stage 3: Implementation and service launch Parking, along with broader accessibility, will be one of the considerations when determining the options for delivering these beds.	
		Recommendation	Resident Communication: Increase communication with local residents to provide clear, timely, and accessible information about proposed changes, with the aim of offering reassurance and reducing uncertainty.	We are committed to keeping local people informed and involved as proposals develop. We will build on the principles of the North West London Involvement Charter by listening, learning, and working in partnership with residents, local councils, and the JHOSC. We will continue to strengthen how we communicate and the CEO Board report for May 2025 provided an update on the ICB involvement strategy. Our aim is to make information as open, honest and easy to understand as possible, helping to reduce uncertainty and support meaningful involvement in any future decisions.	

				An example is the work we will be undertaking in the coming months with local communities to develop appropriate information and guidance resources on palliative care and the Community-based specialised Palliative Care (CSPC) services available to people in north west London.	
		Recommendation	Consultant Recruitment Options: There be a future commitment to allow adequate time to thoroughly explore all recruitment options for consultants before deciding on service closures or reconfigurations. This is particularly relevant in light of previous decisions such as those related to Pembridge, where challenges in recruitment were a key factor.	While the ICB aims to provide adequate time to explore all options, urgent safety concerns may necessitate swift action, with wider engagement following as soon as possible. One of the key enablers identified to support the implementation of the new model of care is workforce development. This will be led by a collaboration of our CSPC providers across north west London, with the priority focus on defining the workforce we need to deliver CSPC Services now and in the future, as well as improving cultural competency amongst specialist palliative care staff.	
		Recommendation	Travel and Access Inequalities: Address additional inequalities that may arise from changes that affect patients' ability to travel. While the use of a bus service was mentioned, this will not benefit all patients, and the feasibility and logistics of such a solution must be accurately assessed and clearly communicated.	North West London ICB is committed to providing equity and reducing health inequalities and one of the most effective ways of tackling inequity resulting from travel is to remove the need for travel where possible, through maximising Community Specialist Palliative Care services available in people's own place of residence, which is a core part of our new model of care. This meets the needs of what many of our residents tell us they would like – more care available at home. Care at home however, is not appropriate for all. For these patients, north west London already provides patient transport along with some of our hospices who provide transport, and most hospices have parking available.	

		Information Request	Borough-Level Strategies: Provide a clear explanation of the impact in each borough of the agreed strategy. This will support transparency and ensure localised needs are clearly understood and addressed.	The changes and impact per Borough are outlined in the table in Appendix 1 of the report presented to NWL JHOSC in May 2025. We are working with leads at local and place level to plan for the implementation of the new model of care and local discussions will shape how it will be implemented. Early planning discussions are focused on identifying local needs, addressing service gaps, and exploring potential delivery options.	
	NWL Involvement Strategy	Information Request	To provide the NWL JHOSC with proposals for partnership working Council by Council as well as at NWL level.	Awaiting clarity on the future ICB structure and possible merged structure before we can determine how this will work in the future.	

Appendix 3: 2025/26 North West London JHOSC Recommendations and Information Requests Tracker

	Item	Recommendation / Information Request	Detail	Response	Status
17 July 2025	Maternity Provisions in North West London	Recommendation	To ensure that the importance of capturing quality data is reliant on efficient maternity IT systems and the upgrade and investment in resources to facilitate easy extraction of data from these systems so as to be able to retrieve and analyse maternity information and enable an efficient overview of maternity outcomes by ethnicity and deprivation to address the social determinants of health.	The NW London Local Maternity and Neonatal System note the three recommendations from the JHOSC committee. We will take these to our next LMNS Board in September, to review and agree a more detailed response by end of September.	
		Recommendation	That the ICB continues to work with local authorities to develop a coordinated programme of outreach and community research to engage with those at greatest risk of poor health outcomes and those in need of mental health support, pre and perinatal.	The NW London Local Maternity and Neonatal System note the three recommendations from the JHOSC committee. We will take these to our next LMNS Board in September, to review and agree a more detailed response by end of September.	
		Information Request	To provide NWL JHOSC with data on the stillbirth rates over the last 10 years split by ethnicity.	The NW London Local Maternity and Neonatal System note the three recommendations from the JHOSC committee. We will take these to our next LMNS Board in September, to review and agree a more detailed response by end of September.	
	Reconfiguration of the ICB and implications on services	Recommendation	As part of the work to reconfigure, NWL ICB take the views of local authorities into account on how the ICB could be improved.	We are always receptive to input from our partners and local authorities are represented on our Board and Integrated Care Partnership. The merger and restructure process will be subject to staff consultation but is not subject to public consultation.	

		Recommendation	That the ICB ensure that the voice of seldom heard communities and the voluntary sector are considered as part of the restructure and proposed merger.	We are not required to consult or engage the public on NHS structures, but we will of course ensure there is an involvement strategy for the new ICB that builds on our success in reaching seldom heard communities.	
	Adult Mental Health	Recommendation	NWL ICB provide the Committee with an update at a future meeting on the similar strategy that is being developed for children and young people.	The strategy development is in progress, led by the ICB Mental Health, Learning Disabilities and Autism (MHLDA) Programme Director working closely with the Bi-Borough Director of Children's Services. The Case for Change is going to the Integrated Care Partnership (ICP) in September, and we will bring the strategy back to JHOSC in due course.	

Report to the North West London Joint Health Overview Scrutiny Committee – 18 November 2025

North West London Joint Health Overview Scrutiny Committee 2025/26 Work Programme

No. of Appendices:	1 Appendix 1: North West London JHOSC 2025/26 Work Programme
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Chatan Popat, Strategy Lead - Scrutiny Democratic and Corporate Governance Brent Council chatan.popat@brent.gov.uk

1.0 Purpose of the Report

1.1 To present the North West London Joint Health Overview Scrutiny Committee's (NWL JHOSC) 2025/26 Work Programme to the committee.

2.0 Recommendation(s)

2.1 That:

The committee note the changes since July 2025 and confirm the committee's work programme outlined in Appendix 1.

3.0 Detail

3.1 The North West London Joint Health and Overview Scrutiny Committee's work programme outlines the decisions and health policy areas the committee plans to review during the municipal year, according to its Terms of Reference. The committee's principal role is: To scrutinise the plans for meeting the health needs of the population and arranging for the provision of health services in North West London; in particular the implementation plans and actions by the North West Integrated Care System and their Integrated Care Board, focusing on aspects affecting the whole of North West London. Taking a wider view than might normally be taken by individual local authorities

3.2 The NWL JHOSC undertakes 4 formal committee meetings each municipal year. Though there is scope for other scrutiny activities to take place throughout the year, at the chair's discretion.

3.3 The NWL JHOSC is formed of Councillors from the 8 Boroughs of North West London: Brent, Ealing Harrow, Hammersmith & Fulham, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster. The committee also has a non-voting representative from the London Borough of Richmond upon Thames.

3.4 The committee held its annual work programming meeting on 10 June 2025. During this meeting the committee undertook a process of prioritising items for inclusion in its work programme based on a set of criteria. Prioritisation is considered best practice by the Centre for Governance and Scrutiny (CfGS) and is an effective tool for a scrutiny committee to develop a coherent work plan for the year[1], which ensures that the work of the NWL JHOSC is effective.

3.5 The committee's updated work programme for the 2025/26 municipal year is detailed in Appendix 1.

3.6 There is a possibility that the committee's work programme may change during the municipal year. This is so that the committee can work flexibly to review emerging items as they arise. It is imagined that the work programme will evolve over the municipal year, according to the committee's needs. At times it may also be necessary to move items from a particular committee date for practical reasons, in these cases the work programme will be updated, and a new version will be presented at the next formal NWL JHOSC meeting.

[1] *The Good Scrutiny Guide* (Centre for Public Scrutiny, June 2019), p26

North West London Joint Health Overview and Scrutiny Committee Work Programme 2025/26

The North West London Joint Health Overview and Scrutiny Committee's work programme is designed to be flexible and adaptable to the needs of the Committee; it is therefore likely that items may change over the municipal year.

Confirmed Meeting Dates:

- **Thursday 17 July 2025, 10am – London Borough of Hillingdon**
- **Tuesday 09 September 2025, 10am – London Borough of Harrow**
- **Tuesday 09 December 2025, 10am – London Borough of Hounslow**
- **Thursday 16 March 2026, 10am – London Borough of Hammersmith and Fulham**

Thursday 17 July 2025

Agenda Item	NHS Organisations	Host Borough
Maternity provisions in NWL including outcomes and equity across the region	North West London Integrated Care System	London Borough of Hillingdon
Adult Mental Health	North West London Integrated Care System	London Borough of Hillingdon
Reconfiguration of ICB and implications on services	North West London Integrated Care System	London Borough of Hillingdon

Tuesday 09 September 2025

Agenda Item	NHS Organisations	Host Borough
Dentist Commissioning and Children's Dental Health	North West London Integrated Care System	London Borough of Harrow
The future of Place Based Partnerships delivering health and care services	North West London Integrated Care System	London Borough of Harrow
Special School Nursing	North West London Integrated Care System	London Borough of Harrow

Tuesday 09 December 2025

Agenda Item	NHS Organisations	Host Borough
Urgent and Emergency Care Delivery	North West London Integrated Care System	London Borough of Hounslow
Implementation of the Same Day Access Model in Primary Care (building on previous scrutiny in March 2024)	North West London Integrated Care System	London Borough of Hounslow
Application of the Continuing Healthcare Criteria – including specifics on funding, equity and financial implications relating to recent announcements	North West London Integrated Care System	London Borough of Hounslow
SEN Continence Service	North West London Integrated Care System	London Borough of Hounslow

Thursday 19 March 2026

Agenda Item	NHS Organisations	Host Borough
Cancer Screening & Early Diagnosis	North West London Integrated Care System	London Borough of Hammersmith & Fulham
Digital Health, Data Use, AI and Digital Inclusion	North West London Integrated Care System	London Borough of Hammersmith & Fulham
Weight Loss Drug Supply and Roll Out	North West London Integrated Care System	London Borough of Hammersmith & Fulham

LONDON BOROUGH OF HARROW

North West London Joint Health Overview and Scrutiny Committee Supplemental Agenda

Date: **Tuesday 18 November 2025**

7. **Special School Nursing and Update on SEN provisions** (Pages 3 - 10)

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Report to the North West London Joint Health Overview Scrutiny Committee

18 November 2025

Report Title: **Special School Nursing**

Report Author: David Williams - Programme Director, Integrated Care, NHS North West London ICS

Ross Graves – Chief Strategy and Digital Officer
Central and North West London NHS Foundation Trust

Purpose:

To provide an update on the current position of Special School Nursing provisions across North West London.

North West London Community Collaborative

North West London Community Collaborative

NHS Central London Community Healthcare NHS Trust

NHS Central and North West London NHS Foundation Trust

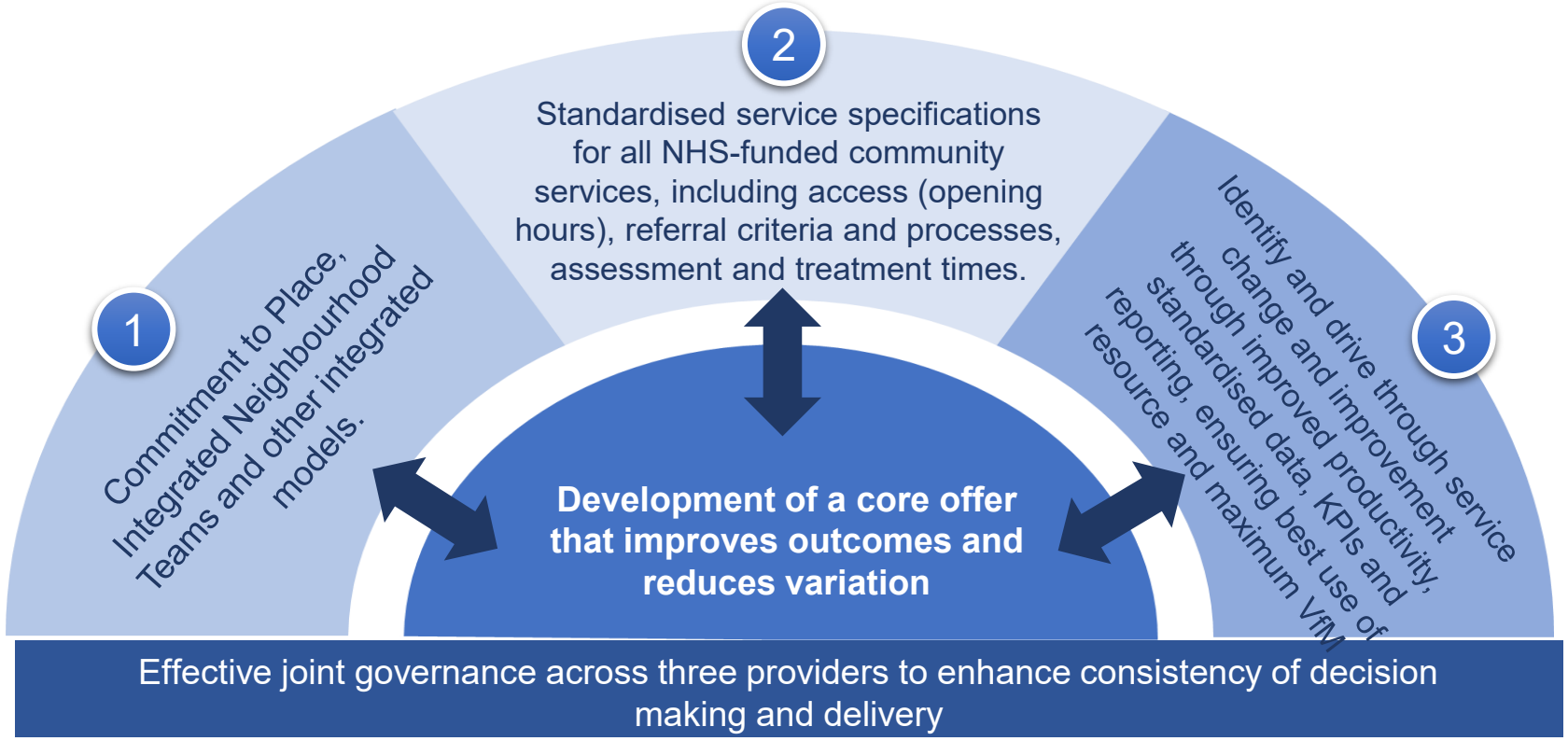
NHS West London NHS Trust

Community Core Offer Specialist School Nursing Update to NWL JHOSC November 2025

David Williams, Programme Director, Integrated Care, NWL ICS
Ross Graves, Executive Director of Partnerships and Commercial Development, CNWL
Clare Miller, Deputy Director Clinical Services, West London NHS Trust.

Developing a core offer for community services – Provider Collaborative Approach

A Core Offer for community services is a key contributor to improving outcomes and reducing variation for the NWL ICS. Community Providers, through the collaborative have committed to ***developing a consistent core offer for "any place"*** to reduce unwarranted variation and drive service consistency across North West London. Within this, providers will ***shape the future role of Place***, considering how our services are part of and enable Integrated Neighbourhood Teams. Providers will work together to ***drive efficient, high-quality care through improved productivity***, including making the best use of our digital and physical assets and infrastructure.



North West London Community Collaborative

All NHS-funded adults' and children's services are in scope of the core offer
9 adults' services and 2 children's services are in the tranche 1 services

21 Adults' services in scope:

1. Urgent Community Response
2. Community P2 Beds
3. Discharge to Assess
4. Short-term Rehab
5. Community Nursing
6. Complex Case Management / Frailty
7. Care Home / National Care Home In Reach
8. Falls
9. Heart Failure,
10. Cardiac Rehab
11. Pulmonary Rehab
12. Respiratory
13. Tissue Viability/Leg Ulcer
14. Neuro Rehab
15. Stroke ESD
16. Diabetes
17. Nutrition and Dietetics / Weight Management
18. MSK
19. Bladder and Bowel
20. Speech and Language Therapy
21. Podiatry

9 Children's services in scope:

1. Community Paediatrics
2. Occupational Therapy
3. Physiotherapy
4. Speech and Language Therapy
5. Audiology
6. Bladder and Bowel
7. Community Children's Nursing Service, Specialist Paediatrics Nursing within CCNS
8. Special Schools Nursing Service
9. Children Looked After (CLA)

Represents **100%** of NHS funded core offer services within CLCH, CNWL and WLT

Core offer services have been prioritised using the following criteria:

	Our Prioritisation Criteria
1	Impact on equality of access or high health inequalities
2	Services "at risk" of closure due to funding and/or access to resources.
3	Clinical impact e.g. poor patient outcomes or excessive waiting lists.
4	Strategic fit with the NWL/national expectation of community services.
5	System impact e.g. will it reduce acute demand and care for patients closer to home?
6	Deliverability at Place e.g. is this a priority service for Integrated Neighbourhood Teams?
7	Areas of inefficiency due to multiple providers and/or opaque pathways.
8	Impact on patient experience e.g. are patients having difficulties navigating the system and accessing the right service first time.
9	Historically key underfunded areas i.e. where current spend is not correlated to need.

Brent Place are leading on the development of a core complex/frail offer. We are engaging with this work stream to enable the community core offer element to align with this service and to that population in care homes.

Prioritised Services for Tranche 1a – from April 2025

Adults' Services:

1. Community P2 beds for Rehabilitation
2. Urgent Community Response
3. Community Nursing for patients who are housebound
4. Podiatry

Children's services:

1. Special Schools Nursing
2. Children Looked After

Prioritised Services for Tranche 1b – from Q2/Q3 2025/26

1. Integrated neuro rehab and stroke
2. Discharge to assess

Prioritised Services for Tranche 1c – from Q3/4 2025/26

1. Bladder and Bowel (all ages)
2. Tissue Viability/leg ulcer
3. Short-term Rehab

We have allocated Senior Responsible Officers, Clinical Responsible Officers and project managers to each service to take this work forward working across the three Trusts and eight NWL Boroughs

We will have prioritised Neuro-Developmental Services for children, alongside the Mental Health Core Offer work.

Represents approximately **50%** of contacts in the core offer services within CLCH, CNWL and WLT

Review Process

Collective review of the clinical model of each service historically commissioned across 8 NWL boroughs
Core model proposal agreed at high level for each service
Subject specific work stream informed by subject matter experts to progress from high level outline to full specification
Review of best practice to further inform model
Engagement with stakeholders including local authorities, primary care, acute trusts, plus other partners as appropriate to each service to inform model to inform model
Impact analysis on service users and stakeholders/partners to inform model and implementation plan
Gap analysis by each borough of current to proposed model to identify scale of change
Demand and capacity review for each borough to identify: Productivity opportunities Investment or resource reduction position per borough
Sign-off off by Collaborative Chief Operating, Medical & Nursing Officers and NWL Clinical Advisory Group
Implementation/mobilisation plans and timeframes agreed with partners

North West London Community Collaborative

Special School Nursing

SRO	Clare Miller, WLT
CRO	Clare Miller, WLT
PM	Joe Robertshaw, CNWL

Summary of changes and boroughs affected:

- Service specification outlines shared care/ delegation model in line with national guidance in Children and Families Act 2014, with delegation of tasks to healthcare assistants and school staff.
- All boroughs will be affected to some extent, most significantly in Ealing where large proportion of work could be moved to school staff

Workstream update October 25:

- An updated specification has been developed based on NHSE feedback (with agreement that this now aligns with national guidance) and whole day workshop for service leads on 4th June.
- Further work is needed on risk management and task allocation – to be fed into specification amendments; to be finalised by December 2025.
- Updated spec to be shared with Directors of Children's Services; final approval from CMO/CNOs.
- Borough meetings underway to validate the model and understand feasibility; half of NWL boroughs are already mobilising the model.
- Resource implications to be identified in November 2025.

Escalations to ICB

- Change in offer to meet national guidance – delegation model differs from current offer in some boroughs (significantly Ealing).

Milestones	Timeline /RAG	Progress and mitigation
Undertake demand and capacity mapping.	July - Nov 2025	Sussex complexity tool and CLCH staffing skill mix tool to be used in addition to RCN guidance and clinical skills.
Agree outcome measures and KPIs.	July 2025	First draft formulated, to be finalised spec signed off
Engage key stakeholders on proposed changes e.g. staff, partner agencies, patients, carers, public.	July – Oct 2025	Stakeholder mapping completed, one round of consultation with DCOs with second round booked ; ICB BCYP Board and Integrated Care Board in Nov
Review SSN workforce capacity/ skill mix and agree further resource requirements per boroughs	Sept- Nov 2025	CLCH staffing skill mix tool to be used.
Agree competency and training approach for school staff under new model.	Sept –Nov 2025	
Finalise service delivery model and timeline to achieve core offer.	Dec 2025	

Risk	RAG	Mitigation
Some schools may resist the proposed change which requires school staff JDs to include delegated health tasks		Creating delegation risk assessment and clear documentation for training and competency sign-off to increase confidence in the new model.
Challenges in meeting needs for future special school expansion and increase in children with SEN and HCP needs in mainstream schools		Through demand and capacity work to identify staff mix and numbers for a pupil quota to inform current and future staffing
CLCH & Sussex Tools taken longer than planned due to competing priorities within the services and the formula of the CLCH Tool had to be adjusted		Have maintained communication to stakeholders, including via NWL ICB SSN meeting it will impact on timeline to deliver sharing of documentation & transition plan
2016 CHC Framework and packages may not be sufficient to cover in school and home support sufficiently, leading to inconsistencies in care allocation, including impact on 1:1 in schools		Having to consider alternative support needs in response to CHC outcomes but it does put pressure on other aspects of the system.
ICB and education commissioners cannot agree		

North West London Community Collaborative

Special Schools Engagement Work Plan

Priority	Description	Action	How?	Deliverable	When?
Designated Clinical Officers for SEND	Engage their clinical expertise into the service design and skill mix and delegation requirement for delivering of the proposed specification and its component 4 levels	DCO's to attend SSN session 1. To share the specification and 4 levels to input into the final draft ahead of wider stakeholder engagement and 2 to review the capacity and demand analysis and assess the skills required	Through a clinical meeting Draft specification has been shared with DCOs, comments are being received	Outputs to be reported to the ICB Clinical Effectiveness Group, Community Collaborative Clinical Board and NWL Clinical Advisory Group for clinical endorsement	End October '25
Directors of Childrens Services and Local Authorities – e.g. Directors of Education	Engage their expertise into the demand and capacity analysis, enabling them to provide local insight into their own borough needs and understand the variation across NWL, and implications for main stream schools. Engage their input into the roll out of the proposed specification in their borough	ICB Director of Clinical Programmes (DoCP) to link with DCS in Westminster to plan LA engagement Asst Director CYP and SSN SRO bring in learning from boroughs where new model is already working and where agreements have been reached with school unions in Ealing DoCP to bring in learning from NHSE/national	Borough Directors meet with their respective DCS and LA teams as per the outlined agreement with Sarah Newman Follow up NWL wide meeting between central ICB team/ Community Collaborative Programme team and the LA to compare demand and capacity analysis across NWL and to agree engagement and implementation plan for roll out of specification	Local insights added to the respective demand and capacity analysis for each borough Implementation plan informed by borough, school union and national insights	September – November 2025
Special Schools	Engage their lived experience into the challenges and issues with respect to the proposed specification and the operational delivery of the four levels outlined in the specification	Borough Directors alongside DCOs respective community provider and LA colleagues meet with special schools, parent and carer forums and if possible YP forum	Workshop style meetings with follow up with individual schools as necessary	Agreement on implementation plan of new specification and delivery of levels	October – November 2025
All partners and stakeholders including JHOSC	Contribute to the NWL ICB special schools needs assessment document	Borough Directors with their respective boroughs and the ICB CYP and health equity team engage partners in informing health needs assessment document	Through surveys, interviews workshops Initial briefing to JHOSC November 2025	Needs assessment informed by stakeholders Report to be shared at ICB Strategic Commissioning Committee	September to November 2025

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