NHS
North West London

Joint Forward Plan for North West London

Refreshed five-year plan for financial year 2025/26

15 January 2025 [DRAFT v0.61]

Contents

Foreword

Our refreshed five-year Joint Forward Plan (JFP)

We are delighted to introduce our refreshed JFP for financial year 2025/26. The plan builds on the Health and Care Strategy we published in 2023 and the JFP we published in financial year 2024/25. The plan sets out how NW London's local NHS services and eight local authorities will improve outcomes in population health, prevent ill health and tackle inequalities, enhance productivity and value for money and support broader economic and social development.

The JFP is an agreed plan across the Integrated Care Board and our partner NHS trusts, and sets out how the local NHS will prioritise, sequence and deliver measurable improvements.

A challenging environment

The past few years have been incredibly challenging for everybody working in the NHS, with the COVID pandemic, rising waiting lists and industrial action. Although NW London is one of the highest performing integrated care systems in the country (on quality of care and metrics such as primary care appointment capacity and numbers of operations carried out), these challenges have not passed us by.

We must also recognise our more recent financial challenges, having recently been placed in level 4 of NHS England's System Oversight Framework – driven by our financial position being worse than we had planned at the start of the financial year.

Prioritising our efforts

The focus of the next two years therefore has to be on transforming our services and finding the most effective balance between meeting the needs of our residents and our finite resource.

Our whole system transformation is in line with the 'three major shifts' from the government's upcoming Ten-Year Health Plan: from *hospital to community-based care*, from *analogue to digital systems*, and from a *sickness model to a preventative approach*.

All three of these will be delivered in part though our proposals for integrated neighbourhood teams (INTs). In the near term, we will implement and evolve our INTs to enable us to deliver proactive care that prevents, reduces or delays the onset of need; supports our residents to stay well; and identifies and supports people at risk of, or diagnosed with, illness.

Like last year, we will also prioritise reducing waiting times and improving productivity to provide access to a common set of high-quality services regardless of where our residents live.

Delivering the plan as a system

Delivering this JFP will require building on the significant progress we have made to working as a system. With the commitment, expertise and resources of our partners across our provider collaboratives and borough-based partnerships, we are confident that we can deliver on our ambitions.

Rob Hurd
Chief Executive Officer,
NHS North West London
Integrated Care Board

Penny Dash
Chair,
NHS North West London
Integrated Care Board

A Introduction

Who we are: our system and population

Welcome to NW London

This Joint Forward Plan sets out how the NHS will support the delivery of NW London's Health and Care Strategy, published in 2023.

NW London is one of the **biggest, most diverse and most complex integrated care systems** nationally. We have over 2.1 million residents, who come from over 200 different ethnicities.

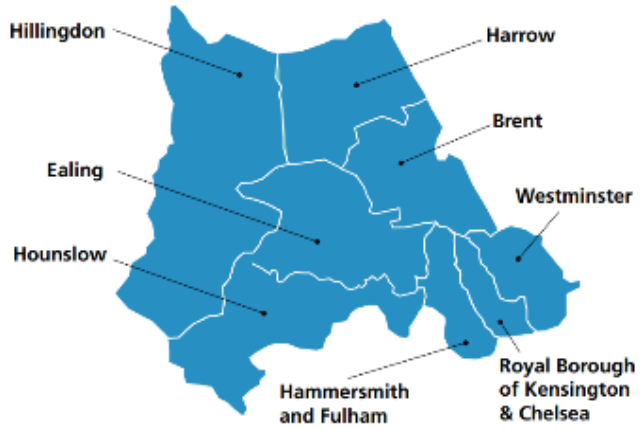
While in general our residents are **more affluent** than the national average, we also have **significant clusters of multiple deprivation** and concentrations of groups we **struggle to serve**. These include asylum seekers, travellers and members of particular ethnic groups.

NW London by numbers

2.1m resident population	**2.9m** GP registered population	**8** London borough councils	**65,000** NHS employees	**1,300** GPs (WTE)	**1,500** adult social care staff	**1** NHS integrated care board
4 acute trusts	**4** community & MH trusts	**352** GP practices	**45** primary care networks	**276** care homes	**1,500** voluntary orgs.	**1** ambulance trust

Our population is:

- **Younger than average.** The median age across our boroughs ranges from 35 to 39 compared to a median age of 40 elsewhere in England.
- **One of the fastest ageing.** We will have 48,000 more people aged over 65 by 2030 (+17%).
- **More ethnically diverse.** Our residents speak over 60 different languages. Five boroughs have a higher share of non-white people than London.
- **More affluent than the national average.** However, we do have pockets of significant clusters of residents experiencing deprivation in each borough.
- **Expected to live longer than the national average.** However, we also have significant variation between our most deprived and least deprived residents – a difference of 18 years lived.
- **Less economically active.** We have higher unemployment rates and rates of people economically inactive than the national average, and this is higher still in our most deprived populations.



Our population challenge

What our needs assessments across NW London tell us

- **Progress in improving health has regressed**. Life expectancy at birth has decreased steadily since 2017 (by ~0.5 years for females and ~1.5 years for males).
- Events like the **COVID-19 pandemic,** the **Grenfell Tower** fire, and the rising cost of living have worsened health inequalities.
- **Our recent** Shared Needs Assessment has highlighted **significant disparities** in health outcomes across NW London. Some areas such as Dalgarno, Golbourne and Southall are consistently shown to have worse health outcomes compared to others.
- **Heart diseases**, **lung cancer** and **respiratory diseases** are the three greatest drivers of preventable deaths – accounting for ~**690** preventable deaths (i.e., deaths before the age of 75) in adults each year.
- 90% of all health care interventions involve one or more medicines. The numbers of patients on 10 or more medicines has doubled over the last 20 years – with approximately **30,000 residents in NW London on 10 or more medicines**, suggesting a greater need for structured medication reviews to enable patients to get the most out of their medicines.
- Some specific population groups experience **much higher death rates** from diseases such as these (i.e., they can be effectively prevented or treated).
- While progress has been made, **stigma** persists in certain communities, particularly in **mental health**, requiring a greater focus on prevention.
- Despite efforts to improve, we have **significant variation in service availability**, timely access and quality across NW London.
- Through this five-year plan, we are committed to developing services that are **sensitive to the unique needs** of different groups.

Further insights can be found in our Shared Needs Assessment, published on our website.

What our residents and communities tell us

NHS North West London ICB works with local authorities and NHS trusts to engage with residents. We have an extensive outreach programme and hold discussions (both general and specific), organise events, use social media, and gather feedback through HealthWatch groups.

Each month, we publish a summary of community feedback, which helps shape our services. Common themes include:

- Difficulty accessing **GPs and other primary care and community services**, with an opportunity to provide more services through **community pharmacies**.
- Concerns about **mental health** services, especially waiting times and inpatient care.
- Issues with **hospital discharge**, **waiting times**, and cancellations.
- **Poor communication**, including language barriers and support for those with disabilities.
- Barriers to **dental care**, including cost and NHS availability.
- Support for greater use of **digital tools**, whilst also being concerned about digital exclusion.
- Need for **greater inclusivity** in decision-making.
- Requests for **more information** on specific health issues like cancer, diabetes, mental health disorders, and vaccinations.

Further insights can be found on our website**:** www.nwlondonicb.nhs.uk.

Our organisational challenge

Our integrated care system is still relatively new, and is managing a series of changes

The Health and Care Act 2022 introduced major reforms, including the creation of integrated care boards (ICBs) and strengthening partnerships between providers (provider collaboratives). We continue to work with local authorities and voluntary sector partners to navigate these changes, refine our ways of working and more effectively meet the needs of our residents.

We have restructured our workforce

In addition to the new responsibilities, the ICB is required to reduce its running costs by 30% by 2025/26. As a result, in 2024/25 we have reorganised our teams to align skills with responsibilities, while also reducing staff numbers. Having made significant progress against our 30% target, we are now focusing on embedding these changes and finding efficient ways to work within available resources, including in areas of high spend like continuing healthcare.

We are also refining our values and operating model

Our ways of working (our operating model), agreed with partners, places borough-based partnerships (BBPs) at its core, supported by ICS programmes and other ICB teams. By working together, we aim to simplify processes across our eight boroughs. The ICB's values of empowering communities, inclusivity, growth, innovation, and mutual accountability will help improve effectiveness and productivity. As we develop, we will refine the operating model to better enable the delivery of our four ICS objectives.

Our nascent provider collaboratives are establishing resilience

NW London currently has two provider collaboratives: acute care, and community and mental health. These collaboratives offer greater opportunity to improve efficiency, reduce variation, and build resilience within the system. Their role will continue to grow and develop over time.

We continue to build relationships with our local authorities

We are working closely with our eight local authorities, including their children's social services, adult social services, and public health teams, to better meet the needs of our residents. Our borough-based partnerships help achieve this by sharing resources and expertise across the system.

What does this mean for our Joint Forward Plan?

The ICB has established an ongoing organisational design programme to improve its effectiveness. This includes:

- Building the right capacity, capability, and culture.
- Redefining roles and responsibilities, such as aligning commissioning with local authorities.
- Redesigning structures and governance to better support our goals.
- Improving processes to help staff work more efficiently.
- Developing better ways to evaluate the effectiveness of our work.

The JFP therefore allows us to prioritise nine key objectives over five years, committing us to doing the right number of things well and tracking progress effectively, rather than attempting everything at once.

Our financial challenge (1 of 3)

Summary of our financial challenge

North West London ICB manages a **£5.1 billion** budget for NHS services, excluding specialised services currently commissioned by NHS England (NHSE). However, our funding per person* is **3% below** the national average – **£2,056** compared to **£2,093** nationally – the sixth lowest in the country.

Despite this, we submitted a break-even plan for 2024/25 – with a small deficit of **£7.5m**, albeit this was contingent on the successful delivery of substantial cost improvement programmes (CIPs) by our acute providers. Over the course of 2024/25 our deficit deteriorated to **£85.8m***, with a variance of **£78.3m** from plan attributed primarily to **increased costs within the acute sector**.

As a consequence, the NHS organisations within the North West London ICS have recently been placed in **level 4** of **NHSE's System Oversight Framework**. This means intensive external support to develop robust financial recovery plans.

Despite progress, NHS finances face ever-growing challenges, including staff pay rises, ageing populations, and high levels of inflation. Though the new government has pledged additional funding for the NHS next year, it is likely that in real terms, our **allocation growth will be relatively flat**, and we will continue to face similar financial challenges to today.

Our capital challenge

Our NHS organisations face a **£1.2 billion maintenance backlog**, straining revenue and capital budgets and adversely impacting patient care. Current capital funding is insufficient, but we continue to push for capital support for major investments, including for the rebuilding of four hospitals. Capital investment is required for **pharmacy production units** and **advanced diagnostics** in order to meet **future demand** for **personalised pharmaceutical products** – to treat patients with conditions such as cancer.

To optimise investments, our NHS organisations and local authorities are also working together to place primary care services where they're most needed; make better use of existing space; and consolidate services into fewer, higher-quality buildings to improve the experience of our residents.

Fairer financial allocations within NW London

Funding within NW London still reflects historic decisions rather than current needs. In **2024/25**, the ICB spent more than needed on acute care (**3.8%** – equivalent to **£84m**) and continuing healthcare (**13.3%** - equivalent to **£38m**) but less than needed on mental health (**11.7%** - equivalent to **£65m**).

Medicines are another area where further investment may be required to meet our population needs – for example, spending in new medicines such as GLP-1 agonists (to treat diabetes and obesity) and Alzheimer's disease modifying treatments (DMTs). New medicines (as a result of innovation in healthcare and subsequent NICE technology appraisals) are projected to account for **12% annual growth in expenditure**, with more complex treatments being shifted from hospitals to primary care.

As outlined in last year's Joint Forward Plan, we aim to:

- **More accurately record our spending** by sector and type.
- **Shift resources** from overfunded to underfunded areas.
- Commission services that **meet the core local NW London st**andard, reduce duplication, and ensure that care is provided in the most appropriate, least intensive setting, at the required level of productivity.

This means that shifting funding to better reflect need will need to be achieved through changing models of care and improving productivity (see next page).

Note: Funding per person is based on a formula that takes into account various factors such as demography, morbidity, deprivation, market forces, etc. *Accurate as of November 2024.

Our financial challenge (2 of 3): our productivity challenge

Summary of our productivity challenge

We compare favourably against other ICSs from a productivity perspective – with a lower cost base and a higher level of productivity. However, the NHS as a whole is under immense pressure, and despite increased funding and staffing, productivity has **not yet returned** to **pre-pandemic levels**.

Excess staffing is a key driver of the productivity challenge – through failing to manage demand outside of expensive acute hospital settings, and failing to deliver recurrent efficiencies in the acute sector. Our overall establishment has increased by **~20%** since 2020 – **65,000** staff in **2024/25** compared to **55,000** staff in **2019/20**.

Productivity is not about telling already pressed staff to work even harder. It is about changing **how** we work:

1. **Addressing care needs in the most appropriate and least intensive setting** (hospital to community-based care)**:** for example, supporting self-care, prevention, or community-based services
2. **Working smarter** (analogue to digital systems): for example, using technology to perform routine tasks better, or to improve scheduling and minimise waste and rework.
3. **Promoting wellness and actively managing illness** (sickness to prevention): rather than reacting to people becoming acutely unwell.

System roles in solving our productivity challenge

Each of the four levels of our ICS – system, collaborative, BBP / place and provider – has a role in bringing the system back to balance by improving productivity as laid out below:

System

- Ensure **strategic commissioning intentions** respond to population health and place-based flow initiatives.
- Recommend appropriate contracts and payment mechanisms to incentivise improved productivity.

Collaborative

- Drive high quality, consistent and best practice care
- Find long term solutions to sub-scale specialties and services and balance as a collaborative.

Borough-based partnership / place

- Ensure all parties are taking responsibility for statutory obligations.
- Deliver on BBP plans.
- Identify areas of unwarranted variation.
- Oversee flow and ensure that BCF and discharge funding enable prompt discharge from hospital.
- Ensure PCNs reduce variation and unnecessary referrals to secondary care.

Provider

- Deliver agreed financial, workforce and activity plans.
- Deliver recurrent cost improvement programmes.

Note: NW London case studies are provided on page 93.

Our financial challenge (3 of 3): our medium-term financial strategy focuses on better alignment of resource to need and targeted investment

System-level financial objectives

- **Align system funding with health needs**, using payment models to ensure care is provided in the most appropriate settings.
- **Improve urgent and emergency care** to ease pressures, prevent admissions, and lower system costs.
- **Consolidate specialist services** to improve clinical outcomes, reduce duplication, and cut costs.
- **Maximise the London Ambulance Service's potential** by enhancing 111 services, mental health support, and on-the-spot treatments.
- **Simplify non-clinical functions** across NWL, such as procurement, payroll, and business intelligence.
- **Optimise the estate footprint**, creating sustainable, cost-effective spaces across all sectors.
- **Enhance digital capabilities** to improve patient access, data quality, and continuous improvement.
- **Invest in shared NW London assets**, such as diagnostic hubs and specialist centres for common procedures.
- **Develop a sustainable workforce** with flexible roles, wellbeing support, and links to planned activities.

Provider-level financial objectives

Primary care

- Expand the NW London **'single offer'** and close funding gaps, targeting communities with the highest needs.
- Reduce unnecessary **clinical variation**, improve the use of **advice and guidance**, reduce unnecessary referrals to secondary care, and **optimise evidence-based medicines use.**
- Ensure **value for money** in CHC, prescribing (e.g., medicines optimisation), diagnostics and procurement.

Acute and community care

- Provide more **suitable alternatives to patients**, closer to home – thereby ensuring only patients deemed most clinically appropriate / necessary for an acute hospital setting are treated within an acute hospital.
- Deliver a **core common offer** for community services across NW London.
- Support integrated neighbourhood teams **(INTs)** to deliver more proactive and preventative care.
- Ensure all clinical pathways **optimised, cost-effective,** and provide a **high quality service** to patients.
- Work collaboratively to standardise the acute hospital offer and reduce the cost base.
- Improve access to and support for **medicines within patients' homes**.

Mental health services

- **Invest in mental health**, fund the Mental Health Investment Standard, and enhance staffing.
- **Enhance access**, embed a **core common offer** and **target investment** in areas of growing need – and reduce reliance on out-of-area treatments.
- Standardise reporting to **boost productivity** and manage costs effectively.

Specialised services

- NHSE will set **indicative activity plans** for 2025/26 allocations.
- **No discretionary funding** is expected for specialised services in 2025/26.
- Current **block payment arrangements** mean needs-based allocation is unlikely for 2025/26.

Transitioning to a neighbourhood model of care (1 of 2)

Transforming our care model

In recent history, it has become increasingly clear that we have seven key challenges to delivering a high-quality, equitable, and financially sustainable health and care system. In summary, these are:

1. The nature of the **care our population requires** has shifted – long-term conditions, requiring a greater degree of long-term support rather than acute and episodic support.
2. **Life expectancy at birth** for NW London residents has been **decreasing** since 2017 **–** by ~0.5 years for females and ~1.5 years for males.
3. The **shift in our population's needs** is demonstrated in our recent activity trends – with significantly more primary care appointments being delivered, and significantly more people attending A&E for higher acuity needs.
4. We also have **significant variation across NW London** in service availability, access in a timely fashion, and population health outcomes.
5. The pressure on our system will continue as our population continues to **grow and age** – **multi-morbidity** is closely linked **with age,** and our over 65 population is forecast to increase by **17% by 2030.**
6. To deliver care more sustainably, **three key shifts** have been identified as part of the national 10-year plan work: hospital to community-based care; analogue to digital systems; sickness model to a preventative approach.
7. Recent **financial challenges** have demonstrated the urgent need to shift to a more cost effective care model – our financial deficit is **£85.8m.**

Integrated neighbourhood teams

Integrated neighbourhood teams (INTs), led by general practice, present one of the **most significant opportunities** to genuinely **transform** the way our system operates. They are key to our strategy and Joint Forward Plan and have this year been embedded deeply into the five-year plans for each of our nine priorities (see section B).

INTs focus on preventing, reducing, and delaying the need for care, improving access, quality, and health outcomes, supporting overall wellbeing, and enhancing the wellbeing and productivity of our front-line teams through integrated working.

In **September 2024**, the North West London Integrated Care System set out the key next steps for the development of INTs:

- All **NW London providers**, working in their collaborative structures and partnerships, were asked to put their plans in place, strategically and operationally to enact the vision for INTs.
- **Operational teams** within core services were asked to align to our new neighbourhood structure.
- **Planning for service delivery and care pathways** will now be done at INT level by default, with a few exceptions – i.e., due to service volumes or the level of specialism required.

Note, further details are provided in **Section B** of this report, under **Priority 1**.

Transitioning to a neighbourhood model of care (2 of 2)

INTs are the core mechanism for enabling the shift to greater levels of preventative and proactive, community-based care:

- **Neighbourhood working:** Aimed at provide a demonstrable improvement in experience for staff and residents.
- **Preventative care:** Delaying the onset of LTCs and/or frailty and also supporting people with self-management of early stage LTCs.
- **Proactive care:** Reducing exacerbations and escalation of patients with LTCs and/or frail and elderly patients.
- **Reactive care:** Enabling urgent needs to be better managed in the community, or when hospital admission is required – expediting discharge.

Key expected outcomes as a result of successfully delivering INTs:

Staff working as part of a **multi-disciplinary team**, and our patients experiencing **integrated and coordinated care** (i.e., “no wrong front door” approach and no patients bouncing around between services).

Improvements in **vaccination and screening uptake**, reducing variation between ethnic groups and between deprivation deciles.

Improvement in **LTC prevalence recording and management** (particularly with cardio-renal-metabolic conditions).

Improvements in **key public health measures** such as levels of obesity, child tooth decay, etc.

Corresponding **reduction in utilisation** of both planned care and emergency care.

Reduction in admissions to permanent **residential and care home beds**.

Reduction in **A&E attendances** and **emergency hospital admissions** (particularly for high intensity users and frail and elderly patients).

Reduction in hospital bed days lost to **discharge delays**.

Summary of our Health and Care strategy, published in 2023

Support population health and well-being

NW London aims to address the wider determinants of health by partnering with others to improve education, employment opportunities, and digital skills, use NHS land for housing, ensure fair wages, support local businesses, and promote sustainability.

Efforts will also focus on working with public health partners to reduce smoking rates, improve diet and exercise, manage high blood pressure, and increase uptake of preventative services.

Improve access to care

Efforts will focus on improving access to primary care and better organising and managing access to urgent care – embracing digital technology for triage and appointments. We will also implement integrated neighbourhood teams, with general practice at their heart, to coordinate community services.

Additionally, we will also make targeted investments in mental health, learning disabilities and autism services.

Prioritise the health and well-being of babies, children, and young people

We will invest more in supporting babies, children and young people to be happy healthy adults, by addressing obesity, promoting healthy weight in early childhood, increasing breastfeeding rates, improving immunisation uptake and improving oral health.

Our efforts also aim to enhance access to mental health support, especially through schools and digital platforms, and to develop consistent models of care through child health and family hubs.

Address inequalities in health outcomes, access, and experience

We will ensure access to consistent, high-quality care regardless of location, by using population health data, by supporting unpaid carers and by addressing structural racism in healthcare.

We will also improve access and outcomes for vulnerable groups such as the homeless, asylum seekers, and those with learning disabilities or autism. We will also enhance early cancer diagnosis, better manage LTCs, and reduce mental health stigma.

Promote home-based care when possible

While hospitals and care homes may be the right place for some of our residents, for many we can provide a better service with less disruption to their lives by bringing support to their homes.

To do this we will implement joined-up care across all health and care settings, provide personalised support for LTCs, and plan proactively for end-of-life care. Closer collaboration with social care and voluntary sector providers will also help prevent hospital and care home admissions.

Enhance the productivity and quality of the health and care system

Given that funding across health and care continues to be severely limited, we need to continue to improve the productivity and quality of our services. We must therefore continue to innovate, improve and deliver care as effectively as we can within the budget available to us.

While the number of health and care staff have risen, we also continue to face difficulties in recruitment and retention – we must therefore work on valuing and developing our staff.

How our Health and Care strategy connects to our Joint Forward Plan

In **November 2023** we published our **Health and Care strategy** for **NW London,** with **six key areas of focus.**

This JFP takes the **strategy**, our JFP from last year, the nationally set **priorities and operational planning guidance**, and agreed national and local targets and translates them into meaningful milestones and activities.

This clarifies where the NHS in NW London will prioritise efforts now and where we should invest in the future. We have focused on **nine specific priorities**, supported by a number of **enabling programmes**, to deliver this Joint Forward Plan.

Delivery will require cross-system collaboration from our providers (through our provider collaboratives), ICS programme teams, clinical networks, voluntary and community sector organisations (VCSEs) and borough teams.

Our borough-based partnerships and provider collaboratives will continue to have their own specific plans to improve health and wellbeing and to deliver the operating plan. However, aligning these with the Joint Forward Plan will mean that we can concentrate resources across the system in the most effective way possible.

We published our health and care strategy in November 2023:

- Support population health and well-being
- Improve access to care
- Prioritise the health and well-being of babies, children, and young people
- Address inequalities in health outcomes, access, and experience
- Promote home-based care when possible
- Enhance the productivity and quality of the health and care system

Financial considerations + Our annual NHS operating plan

Which formed our nine priorities:

Our enabling programmes are vital in supporting all of our priorities:

Workforce + Digital & Data + Estates + Communications & Involvement

With locally-specific support driven through our boroughs:

Brent | Ealing | Hammersmith & Fulham | Harrow | Hillingdon | Hounslow | Kensington & Chelsea | Westminster

Note: NHS partners across NW London are committed to reviewing and updating this **JFP** each year. This will enable us to respond to future pressures and changing population need. In 2024/25, we agreed strategies for **Digital and Data, Urgent and Emergency Care,** and **MHLDA** – all now reflected in this plan. Next year, we will agree strategies related to Planned Care, Maternity, CYP Mental Health, and Primary Care. Once agreed, these strategies will be incorporated into next year's plan.

B Our priorities

What are our priorities over the next five years?

Enhance integration across health and care services to enable proactive joined-up care

1	**Establish integrated neighbourhood teams with primary care at their heart**	Establish INTs with primary care at their heart to improve same day access to care for those with urgent needs and provide proactive joined-up care for people with LTCs or complex needs.
2	**Reduce inequalities and improve health outcomes through population health management**	Develop and embed a PHM capability and focus on areas where outcomes, access and experience vary most to reduce inequalities and improve health and wellbeing.
3	**Optimise ease of movement for patients throughout their care – right care, right place**	Deliver improvements across the system to ensure patients are treated in the most appropriate setting – avoiding admission, minimising hospital stays and supporting timely discharge

Consistent, high-quality and efficient community and mental health services

4	**Embed access to consistent high-quality community services by maximising productivity**	Maximise the productivity of community-based mental health services and increase access to mental health crisis services.
5	**Improve children and young people's mental health and community care**	Improve health and wellbeing outcomes for children and young people, including targeted interventions for our core at risk groups.
6	**Improve mental health services in the community and services for people in crisis**	Maximise the productivity of community-based mental health services and increase access to mental health crisis services.

Enhance specific services – maternity, cancer and planned care

7	**Transform maternity care**	Improve maternity services to reduce inequalities in outcomes and improve quality for all.
8	**Increase cancer detection rates and deliver faster access to treatment**	Improve early diagnosis by tackling variation in screening and deliver faster and more efficient access to diagnosis and treatment.
9	**Transform the way planned care works**	Transform planned care to reduce waiting times by better managing demand, seeing patients in the right setting, and improving throughput for hospital-based elective services.

Enhance integration across health and care services to enable proactive joined-up care

How will we sequence activities against our priorities? (1 of 3)

	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 (2027/28)	Year 4 (2028/29)	Year 5 (2029/30)
Major themes:	Embed core common offer, implement INTs, begin to shift resource to community services, recover productivity.		Evolve INTs, further shift resources to community services, quality improvement, bespoke services, innovation.		
1 Establish integrated neighbourhood teams with primary care at their heart	• Deliver INT model for two high priority cohorts: frailty, and urgent non-complex. • Expand on the 'single offer' in primary care. • Re-introduction of the Primary Care Access Programme. • Implement child health hubs against a core specification (partial implementation across). • Deliver work packages within INT plan. • Confirm estates solutions for each INT. • Re-allocate resource to support the delivery of INTs, as appropriate.	• Deliver child health hubs across all of NW London, in accordance with core specifications. • Develop operating models for all remaining priority cohorts. • Implement INT model to additional priority cohorts (e.g., those with multiple LTCs, SEND, complex needs, CAMHS). • Implement estates solutions.	• Expand INT model to all additional priority cohorts (e.g. preventative care and self-management, community empowerment models, single LTC management, etc.) • Delegate service delivery through neighbourhoods. • Deliver significant population health and financial benefits through successful implementation of INTs.		• Align effectively resource to need – with the 'right' proportion of ICS budget allocated and spent within primary and community settings.
2 Reduce inequalities and improve health outcomes through population health management	• Build Health Equity and the PHM approach into core ICB processes. • Deliver community in-reach model. • Develop PHM capability. • Specific focus on: healthy weight, COPD, mental health, employment.	• Pilot PHM in INT model with access to appropriate data and connections to community. • Roll out tailored service specs to embed health equity in health and care delivery • Specific focus on: employment, prevention pathways, maternity, COPD, diabetes.	• Fully embed PHM and health equity into INT model. • Expand PHM Academy system-wide. • Identify additional 'plus' groups based on refreshed SNA. • Specific focus on: chronic pain, gynaecological conditions.		• Align system-wide resources closer to community need to embed equity within services. • Review impact of VCS connections and deliver updated VCS and Anchor strategy • Work with additional 'plus' groups to provide bespoke services as needed.
3 Optimise ease of movement for patients throughout their care – right care, right place	• Implement urgent and emergency care items related to flow and discharge (front door services, discharge schemes, etc. • Roll out discharge / flow tool to local authorities, community, and mental health providers. • Evaluate and make decisions regarding discharge fund schemes. • Improve pathway 1 and 3 delays. • Begin implementation of Integrated Care Coordination Hub (ICC). • Work with NHSE to develop digital and telephony pathways.	• Continue to improve pathway 1 and 3 delays. • Further increase virtual ward utilisation and launch additional virtual ward pathways. • Explored expansion of the ICC in terms of pathways. • Evaluate effectiveness of ICC. • Paediatric transformation programme, supporting acute service improvement in tandem with integrated working across system services.	• Tech and innovation. • Continue to improve pathway 1 and 3 delays. • Improve pathway 0 delays. • Targeted work on reducing inequalities in access, experience, and outcomes, with the development of bespoke co-produced services where deemed appropriate. • Continue to track progress on ED waits and hospital discharges against recovery trajectory (and refreshing modelling where required). • Implement corrective actions on ED waits and hospital discharges as appropriate. • Discharge grant schemes that are deemed to be successful to be considered for move to business-as-usual. Schemes need to be high impact, enhance value for money, improve patient experience and improve health outcomes.		

Consistent, high-quality and efficient community and mental health services

How will we sequence activities against our priorities? (2 of 3)

	Year:	**Year 1** (2025/26)	**Year 2** (2026/27)	**Year 3** (2027/28)	**Year 4** (2028/29)	**Year 5** (2029/30)
	Major themes:	Embed core common offer, implement INTs, begin to shift resource to community services, recover productivity.		Evolve INTs, further shift resources to community services, quality improvement, bespoke services, innovation.		
4	**Embed access to consistent high-quality community services by maximising productivity**	• Develop standardised service specifications for all NHS-funded community services. • Mobilise core offer delivery for 6 adult and 3 children's services*. • Demand and capacity and productivity analysis across all services, but starting with podiatry, community nursing, UCR and children's SALT. • Drive productivity in community beds. • Drive productivity and reduce waiting lists in community nursing. • Development of cardio-renal-metabolic (CRM) services. Development of respiratory condition services.	• Drive productivity improvements in additional services (e.g. UCR). • Mobilise core offer delivery for additional priority services. • Implement new model for specialist palliative care. • Continue demand and capacity and productivity analyses. • Develop additional LTC services.	• Lead a sector wide approach to uplift and make stroke and neuro service provision equitable across NW London. • Development of other long term condition services on a rolling basis. • Deliver additional productivity gains through economies of scale from infrastructure.		
5	**Improve children and young people's mental health and community care**	• Develop and begin to implement CYP mental health strategy. • Partial roll out of child health hubs across NW London. • Agree and implement a core common offer for CYP community and mental health services (including neurodevelopmental services). • Additional roll out of MHSTs in schools, subject to funding. • Address gaps in child ophthalmology, audiology, videofluoroscopy and special school nursing. • Address unwarranted variation in asthma, oral health, epilepsy and diabetes / obesity services. • Provide PATCH services in an equitable manner.	• Full expansion of child health hubs across all of NW London • Continue to embed a core common offer for CYP community services. • Embed core common offer for CYP NDS (and other relevant services) into INT development. • Reduce waiting times for ADHD and autism assessments.	• Support any further areas of targeted recruitment required (for example within MHSTs in schools and eating disorder services. • Improve data on known gaps, including for children known to be at high risk of health inequity • Review of non-NHS community CYP mental health services.		
6	**Improve mental health services in the community and services for people in crisis**	• Implement strategy for adult mental health services and invest where there is greatest or growing need. • Invest in prevention and early intervention, particular for SMI. • Drive productivity improvements, particularly in community mental health teams and reduce waiting times where possible. • Develop core common offer for adult community mental health services and begin to implement in high priority services. • Link core common offer work to INT development. • Implement recommendations from mental health crisis service evaluation and deliver core coverage across NW London. • Capacity improvements in community services for those most in need. • Improve flow and quality for inpatient services.	• Continue to drive productivity improvements and delivery of core common offer. • Identify specific areas where core offers may need to be tailored. • Continue to support the development of INTs. • Review adult autism and ADHD services against London, national and international best practice, including demand and capacity.	• Continue to tailor the core common offer to serve additional areas experiencing particular inequities. • Begin to develop bespoke services to target particular inequities – through co-production. • Continue to support the development of INTs. • Continue to drive improvements in flow from the acute sector and length of stay reductions in acute mental health beds. • Continue to drive productivity improvements. • Improve capacity and reduce waiting times of talking therapies (partly through productivity).		

*Adult services: care home in-reach, community nursing, urgent community response, discharge to assess, neuro rehab, stroke ESD. Children's services: special schools nursing service, children looked after (LAC), community paediatrics.

Enhance specific services – maternity, cancer and planned care

How will we sequence activities against our priorities? (3 of 3)

	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 (2027/28)	Year 4 (2028/29)	Year 5 (2029/30)
Major themes:	Embed core common offer, implement INTs, begin to shift resource to community services, recover productivity.		Evolve INTs, further shift resources to community services, quality improvement, bespoke services, innovation.		
7 Transform maternity care	• Develop and publish maternity strategy focusing on making maternity safer, sustainable, and equitable. • Develop implement post-birth contraception service. • Improve maternity experience and outcomes for black women through co-production methods.	• Continue strategy implementation. • Achieve safe staffing standards. • All trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding.	• Continually embed learning from serious incidents (via PSIRF), variation in stillbirth rates, and the perinatal quality surveillance model. • Primary care to support end-to-end pathway of maternity care, including early perinatal mental health support and first year of life (including immunisation to the London average) – by 2027/28.		
8 Increase cancer detection rates and deliver faster access to treatment	• Reducing lifestyle risk factors, particularly tobacco. • Targeted lung health checks (TLHC) in high-risk areas. • Eliminate variation in HPV vaccine uptake. • Plan comms. campaigns for 'at-risk' populations. • Trial novel approaches to earlier detection. • Deliver and maintain faster diagnostics standard (FDS). • Support trusts to deliver models of cancer diagnostic approaches based on best evidence. • Support wider imaging, pathology and community diagnostic centres to harness rapid adoption of tech.	• Continued rollout of tobacco cessation HPV uptake initiatives. • Roll out community comms. campaigns through a phased approach. • Embed FDS in gynaecology, head and neck and lung, endoscopy; supporting other tumour specialities. • Implement new models of systemic anti-cancer therapy (SACT) approaches on a pilot basis.	• Continued rollout of TLHC into eligible population. • Roll out community campaigns through a phased approach. • Continue phased work with primary care to consistently recognise and refer patients with symptoms concerning for cancer at the earliest opportunity; to reduce the referral interval. • Spread and adopt new models of chemotherapy provision.		
9 Transform the way planned care works	• Implement phase 1 of the planned care strategy, focusing on acute services. • Develop and implement phase 2 of the strategy, covering all other referred pathways across acute and community services. • Improve patient comms. to support them to 'wait well'. • Deliver national priorities for women's health hubs. • Implement plans to eliminate all 52 week waits. • Continue activities to increase productivity in inpatient and outpatient services. • Integrate the personalisation model across primary and secondary care to improve patient-centred care. • Develop plan for delegation of specialised services.	• Continue to deliver strategy. • Implement women's health hubs alongside INT programme. • Compliance with national plan for elective recovery. • Trialling and rollout of automated triage pathways in a number of specialities. • Continue activities to increase productivity in inpatient and outpatient services. • Pilot and scale digital imaging services to improve productivity and quality in diagnostics. • Continually evaluate and improve the personalisation model as appropriate. • Evaluate and refine commissioning processes as appropriate.	• Focus on care in most appropriate setting through transformation of clinical pathways in line with INT model, moving care closer to home. • Recover performance against referral-to-treatment constitutional standard by 2029, in line with government pledge (feasibility contingent on planned care strategy).		

Priority 1: Establish integrated neighbourhood teams with primary care at their heart

Summary of priority

Integrated neighbourhood teams are key to NW London's strategy

Integrated neighbourhood teams (INTs), led by general practice, are key to NW London's strategy and Joint Forward Plan. They focus on preventing, reducing, and delaying the need for care, improving access, quality, and health outcomes, supporting overall wellbeing, and enhancing productivity through integrated working.

What are INTs?

INTs bring together primary care, community services, mental health, social care, public health, and the voluntary sector, to serve a specific neighbourhood of 50,000–100,000 people (where feasible). These neighbourhoods are designed to meet the needs of residents while ensuring efficient service delivery.

Each INT will be managed by a single leadership team, using population health data and shared care records to plan services around residents' needs. Care will be coordinated to provide a single location for services where possible, such as child and women's health hubs.

There will be a consistent operating model across NW London, led by our borough-based partnerships (BBPs), with the flexibility to offer additional services when needed.

Progress and next steps

So far, we've focused on defining the boundaries, establishing leadership, and engaging the our staff, residents and communities.

In 2025/26 we will improve urgent care for non-complex cases so that people who need urgent access to primary care, are more likely to get an appointment on the same day. We will also direct our INTs to focus initially on proactively caring for frail and complex patients.

Child health hubs will also continue to roll out across NW London, though we do not expect full coverage until March 2027.

INTs will evolve over the next five years, and services will be co-produced with our residents and delivered to ensure equal access across NW London, with specific tailoring of services to increase equity as needed.

Case for change: why is this a priority?

- **Increasing complexity:** The population in NW London is ageing and facing more long-term conditions, requiring ongoing support rather than episodic treatment. This complexity is currently creating adverse pressure in our acute hospitals.
- **Fragmentation and variation:** Currently, care outside hospitals is fragmented and inconsistent, with primary care working in small, disconnected teams and coordination with community, mental health, and social care services could be improved.
- **Poor connectivity:** Our current model is not conducive to connecting effectively and efficiently with hospital specialists. Additionally, our residents find our health and care system impersonal and difficult to navigate.
- **A proven model of care from elsewhere:** However, there are successful examples from other areas, both locally and internationally, where services are more integrated. These models bring staff together into one team, improving same-day access to care, earlier identification of ill health, better management of LTCs, and enhanced support for those living with frailty. This approach leads to higher quality care and better population health outcomes.

Priority 1: Establish integrated neighbourhood teams with primary care at their heart

What do we plan to do over the next five years? (1 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Operating model	**Neighbourhood**	• **Address issues with PCN boundaries** so that INTs are geographically aligned within boroughs, with aim for populations within 50-100k, though recognising the need to progress pragmatically where this cannot be achieved.	• Further refine boundaries as INTs evolve.	• Further refine boundaries as INTs evolve.
	Management structure and team	• **Formalise named accountability** for resource management and service delivery within boroughs (e.g., borough-based partnership managing directors). • Embed **common management team** for all services that are delivered through INTs. • Engage **our local authorities** and jointly align on a clear value proposition for alignment to a neighbourhood model.	• Further evolve accountability and management team model in collaboration with local authorities.	• Delegate service delivery through neighbourhoods. • Align effectively resource to need – with the 'right' proportion of ICS budget allocated and spent within primary and community settings.
	Seamless navigation	• Significant focus and investment on **organisational development and integration** so that our staff can easily connect to other parts of the system on behalf of our residents. • Clearly **define interfaces between services** and the INT within their operating models.		
Services	**Functions and services**	• Streamline **primary care access models** to **release capacity** for INTs activities. • Engage and secure wider primary care services (e.g., pharmacies, dentistry) in the community. • **Define services** that INTs will be able to deliver at a minimum efficient scale, with services based on good practice models.	• Continue to refine and evolve services	• Continue to refine and evolve services.
	Specialist or hospital-based advice and services	• Release specialist capacity from acute, mental health and other hospital services, aligned to specific cohorts of focus (i.e., frailty, child health).	• Further release specialist capacity from acute, mental health and other hospital services, in line with INT service expansion.	• Further release specialist capacity from acute, mental health and other hospital services, in line with INT service expansion.
	Child health hubs and women's health hubs	• Deliver child health hubs (partial implementation across boroughs). • Deliver nationally identified priorities for women's health hubs and increase uptake / compliance with priority areas and services.	• Deliver all additional child health hubs, to cover all of NW London. • Implement women's health hubs alongside Planned Care programme.	• Roll out child health hubs to remaining boroughs • Define and start implementing women's health hubs

Priority 1: Establish integrated neighbourhood teams with primary care at their heart

What do we plan to do over the next five years? (2 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Care models	**Preventative care**	• Develop and deliver core common offer and operating model for preventative care within INTs (aligned to best practice models).	• Implement INT model to priority preventative care cohorts (e.g. self-management cohorts, community empowerment models, etc.).	
	Proactive care	• Develop core common offer and operating model for frailty services (based on good practice models). • Implement model for frailty services.	• Implement INT model for additional proactive care priority cohorts (e.g., those with multiple LTCs, SEND, complex needs, CAMHS).	
	Reactive care	• Develop core common offer and operating model for urgent non-complex care, delivered mostly through primary care – in line with our urgent and emergency care strategy. • Implement model for urgent non-complex care.	• Track progress on urgent non-complex care delivery through INTs and associated impact on A&E attendances.	• Evolve urgent non-complex care model as appropriate.
Services	**Primary care access programme**	• Expand on the existing commissioned suite of services within the 'single offer' building on 2023/24 and 2024/25 plans. • Deliver new services, accessible to the entirety of NW London, including re-introduction of the Access Programme. • Deliver COVID Medicine Delivery Unit • Consider additional tailored or bespoke local services by borough. • Develop model for outcomes-based commissioning.	• Implement outcomes-based commissioning framework. • Continue to evolve primary care access through evaluating the success of services in reducing the demand urgent and emergency care in the acute sector.	
	Medicines management and community pharmacies	• Tackle overprescribing, reduce the unwarranted variation in primary care prescribing and improve the value for money of medicines use. • Deliver the national medicines optimisation priorities. • Deliver quality improvements in prescribing through clinical pharmacists (including ARRS pharmacists) in PCNs. • Further improve the uptake of Pharmacy First services, and clarify the future role of community pharmacies in delivering our neighbourhood health ambitions.	• Continue to tackle overprescribing and unwarranted variation in prescribing, and deliver the national medicines optimisation priorities. • Explore feasibility of bringing various innovations in medicines such as pharmacogenomics to NW London. • Utilise the capacity in community pharmacy to expand healthcare services to our population.	• Continue to tackle overprescribing and unwarranted variation in prescribing, and deliver the national medicines optimisation priorities. • Develop plan for enhancing personalisation of medicines through pharmacogenomics in NW London • Utilise the capacity through community pharmacy to expand healthcare services to our population.

Priority 1: Establish integrated neighbourhood teams with primary care at their heart

What do we plan to do over the next five years? (3 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Enabling functions	**Finance**	• Work with finance teams across the system to move resources as activity shifts, create headroom to invest, or tolerate deficits within the acute sector.	• Begin to deliver significant population health and financial benefits through successful implementation of INTs. • Develop approach to borough and INT leadership teams receiving transparent information about resource allocation and spend related to their borough and INT.	• Align effectively resource to need – with the 'right' proportion of ICS budget allocated and spent within primary and community settings.
	Workforce	• Maximise the impact of ARRS funded roles to enable primary care to deliver INTs. • Shared approach to workforce management agreed with community and acute providers.	• Scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of INTs.	
	Digital and data	• Deploy London Care Record to all remaining healthcare settings and tackle data quality. • Enhancement of primary care systems to enable INTs. • Requirements for shared records and cross-organisation workflows articulated and agreed. • Pilot user-friendly PHM solution, designed with significant input from end-users.	• Roll out user-friendly PHM solution that supports our proactive care interventions with input from end-users.	
	Estates	• Confirm estates solutions for each INT, primarily through addressing existing void space in the system.	• Roll out estates solutions such that core services can be housed behind a single reception for each INT.	

Priority 1: Establish integrated neighbourhood teams with primary care at their heart

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Operating model	**Management structure and team**	**2025/26**	• Clarified management structure with single team per INT. • Common range of services in place in all INTs, including early help services, voluntary and community sector, 0-19 and children's community teams and other primary care services (pharmacy, dentistry, optometry). • Population health needs mapped.
		2028/29	• Appropriate care plans in place for all population segments based on population health management approach. • Operating model that makes best use of the resource across primary, community, mental health, social and voluntary sectors and creates capacity for preventative and pro active care.
Care model	**Complex, frail and elderly patients**	**2025/26**	• Proactive care providing timely impact on people with escalating health and care risks, improved patient experience and outcomes. • Elimination of inequality and differential access to current services that support the frail population and focus on the right care, at the right place and at the right time.
	All long term conditions	**2028/29**	• Reduction in the number of people living with unidentified LTCs. • All residents and their carers / families with long term conditions have access to prevention, advice and support to help them stay well at home, with 90% of high/medium need with a care plan and 70% adherence to care plan. • Care plans make best use of local authority and community resources, alongside more traditional health services. • Increased ability of patients to self-manage and support, ensuring they access the most appropriate services in a timely and safe manner. • Improved patient experience through early and accurate diagnosis of disease. • Rapid clinical access to specialist advice and guidance which will also support elective recovery and reduce long waits.
Services	**Primary care access programme**	**2028/29**	• All residents of NW London can access primary care services on the same day if required. • Increase of availability of appointments in General Practice (5% increase). • 2-hour Urgent Community Response (UCR) first care contacts reach 90% performance.
		2028/29	• Sustainable primary care capacity to meet population needs (same day urgent care access, support to manage long term conditions).
Enabling functions	**Finance**	**2028/29**	• Resource aligned effectively to need – with the 'right' proportion of ICS budget allocated and spent within primary and community settings.
	Workforce	**2028/29**	• A safe and manageable workload for primary care and INT staff, with reduced sickness/absenteeism and increased satisfaction from staff surveys. • Clear workforce model including new and fulfilling roles with demonstrable productivity gain.
	Digital and data	**2028/29**	• Data available to enable top-down management of demand, capacity and patient flows, and decision-making across all services. • User-friendly PHM tool fully designed and embedded.
	Estates	**2028/29**	• Fit-for-purpose estate, single reception area, improved utilisation, sustainable estate, cost efficiencies.

Priority 2: Reduce inequalities and improve health outcomes through PHM

Summary of priority

Reducing inequalities

The success of our integrated care system will be measured on the extent to which we are able to reduce inequalities in outcomes, access, and experience for our residents. We will achieve this in three ways:

1. Providing a core common set of services that all residents in NW London can access.
2. Working with communities to tailor and improve access to these services, ensuring residents feel confident in using them and in the experience they will receive.
3. Addressing the wider needs of our communities by offering new bespoke services to target specific areas of inequity.

Population health management

Population health management uses data to help identify groups or individuals who need tailored or bespoke services. This approach focuses on improving equity of access, experience and outcomes for those residents living our most deprived areas. To achieve this, we will:

- Expand our Whole System Integrated Care (WSIC) database to better understand needs across our communities.
- Work closely with communities to ensure the data is supplemented by their lived experiences.
- Use activity and cost data to make better strategic decisions that maximise health and wellbeing.
- Co-produce solutions with local communities to build more effective user-centred services.
- Develop a Population Health Management and Health Equity Academy to improve skills in health equity across our integrated care system.
- Work closely with our partners and encourage a proactive approach to tackling the wider determinants of health.
- Strengthen our ability to evaluate the work of the integrated care system.
- Use population health to introduce and scale innovations across NW London.

We will implement these strategies across all care settings and ensure staff have the tools to demonstrate and measure impact.

Case for change: why is this a priority?

- In some parts of NW London, people are dying up to **eighteen years earlier** than in other parts. This issue has worsened in recent years, with health inequalities growing.
- When communities lack **basic needs** like warm homes, healthy food, and stable jobs, it can lead to chronic stress, poor health, and shorter lives. For instance, **children from lower-income households** are four times more likely to suffer from severe mental health problems. In NW London, we also have twice as many **overcrowded households** than the national average.
- **Unhealthy environments**, with factors like smoking and obesity, contribute to long-term conditions such as heart disease, cancer, and diabetes. Our high hospital admission rates demonstrate we could do more to invest in **preventative and proactive care.**
- There are also disparities in healthcare access, with some communities facing **delayed diagnoses** and inadequate culturally competent services. This leads to unequal health outcomes across our neighbourhoods.

Priority 2: Reduce inequalities and improve health outcomes through PHM

What do we plan to do over the next five years? (1 of 4)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Reducing healthcare inequalities	**Embedding a culture of tackling inequalities**	• Embedding reducing inequalities into core processes as part of the value management lifecycle, including within commissioning and contracting. • Measuring impact and driving progress against the NW London set of inequalities metrics. • Maximising impact of the Health Inequalities Transformation (HIT) funding to design and embed sustainable approaches to health equity. • Engaging and empowering colleagues through delivering the Health Equity Summit, sharing good practice, building the community of practice and developing Core20Plus5 ambassadors.	• Track progress in embedding equity into contracts and provide additional support to tailor core specs. • Continue to develop inequalities metrics, including working with providers on a joined-up cross-system approach and embedding in INTs. • Deep dive into impact and redesign of HIT funding.	• Embed ICS-wide approach to inequalities metrics • Ongoing management of HIT funding, targeted at specific inequities.
	Reducing healthcare inequalities in key focus conditions	• Improving maternity experience and outcomes for black women through embedding lived experience evidence into service change – linking into maternity strategy development. • Creating a more equitable approach to mental health through more accessible resources, early intervention and culturally appropriate care. • Addressing disparities in cancer diagnosis through greater empowerment and education. • Embedding a health equity approach to hypertension identification and management.	• Likely continued work on improving maternal outcomes for black women, given the scale of the challenge. • Increasing equity in diabetes and racial inequalities in gynaecological conditions. • Focus on additional ‘plus’ groups, following focus on black communities.	• Continued work on additional ‘plus’ groups • Increase equity in services such as chronic pain, specialist services and dementia.
	Addressing cross-cutting barriers to equity in healthcare	• Delivering a community in-reach model to build trust and connections with communities, as part of the INT approach. • Overcoming barriers to leadership so that the ICS workforce reflects the local population. • Embedding principles of digital inclusion into projects to enable more accessible use of NHS digital services. • Supporting work on interpretation and clear and accessible communication to overcome language barriers.	• Expand learnings from community in-reach model work to other communities and embed in BAU. • Refresh analysis on ICS workforce diversity and develop revised recommendations and actions. • Improve access to care through communications and language.	• Implement robust measurement of trust levels and track progress. • Identify additional barriers and prioritise.

Priority 2: Reduce inequalities and improve health outcomes through PHM

What do we plan to do over the next five years? (2 of 4)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Population health management (PHM) building blocks	**PHM skills building**	• Delivering the NW London PHM and Health Equity Academy to build skills to address inequalities, with a focus on analytics across all staff groups. • Generating a robust set of case studies that clearly demonstrate and celebrate how the system has successfully delivered the PHM approach, to increase understanding of the Focus-on methodology and encourage at scale adoption.	• Further development of the Academy with a focus on leadership and embedding into wider training offer. • Integrate training into core processes (e.g. induction, mandatory training). • Work with system partners to share, align and consolidate training opportunities	• Monitoring and maintaining training support offer in line with emergent needs. • Completion of impact review and full assimilation into core services.
	Understanding and responding to need	• Embedding population health data analytics tools, focusing on INTs. • Enhancing the quantity, quality and usage of data on wider determinants of health. • Aligning system resources to community need to achieve more equitable outcomes. • Delivering the NW London shared needs assessment and embedding into the planning and decision making process.	• Work with finance and other teams to further refine the 'should be position' of resource allocation across the system, and agreeing approach to closing the gap. • Monitor the use of PHM tools within INTs and enhance the offer	• Implement agreed approaches to closing the funding gap between most and least resourced communities
	Data and intelligence-led approaches	• Embedding research into BAU to support robust evidencing of initiatives and projects. • Delivering an evaluation toolkit to enable consistent and effective demonstration of value and impact. • Integrating qualitative and quantitative data into practice and decision-making.	• Deliver impact assessment of evaluation toolkit, embedding into practice and transition to sustainable BAU. • Broaden the research community aligned to equity	
	PHM implementation	• Delivering PHM approaches across the COPD pathway. • Supporting delivery of the organisational effectiveness project to embed PHM approaches in the lifecycle. • Supporting development of the business model for INTs to embed a PHM approach.	• Focus on implementing PHM tools, approaches and functions into practice and impact assessment. • Continued focus on COPD given the scale of the challenge.	• Evaluate and refine PHM approaches employed by our INTs.

Priority 2: Reduce inequalities and improve health outcomes through PHM

What do we plan to do over the next five years? (3 of 4)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Partnership working on healthy behaviours and wider determinants	**Promoting prevention and healthy living**	• Developing infrastructure to support a system-wide approach to prevention, including appropriate cross-system governance. • Addressing inequity in cross-system prevention programmes: oral health, immunisation and cancer screening. • Delivering a coordinated healthy weight management approach for NW London. • Developing the tobacco control programme in NW London, including smoking dependency pathways in NHS trusts.	• Embed an approach to prevention across ICB pathways and within INTs and primary care • Continued focus on weight management, working across system to align pathways • Additional work on substance abuse and alcohol aligned to existing system work and work on chronic liver disease.	• Continuation to mainstream the approach to health behaviours and build on work on substance abuse and alcohol
	Tackling wider determinants of health	• Developing a wider determinants of health strategy and plan for the NHS in NW London to focus efforts on highest priority areas. • Working with partners, including supporting delivery of WorkWell, to increase good employment as a key driver of health outcomes. • Supporting volunteering initiatives to provide wider opportunities into employment and support to communities. • Providing targeted support with system partners in specific areas of wider determinants of health as required, such as cost of living and healthy homes.	• Continue delivery of WorkWell and move into BAU • Align health equity work supporting people with SEND into volunteering and employment with wider system work and embed in mainstream • Support work between the NHS and LAs on healthier housing	• Embed wider determinants of health work into INT approach.
	VCS partnerships	• Developing the infrastructure to enable VCS organisations to partner with the ICS, including streamlined contracting and communications.	• Continue to build on effective partnerships and mainstream into all ICS programmes	• Review the effectiveness of VCS partnerships
	Anchor institutions	• Supporting the delivery of Anchor institution charter pledges and developing the Anchor community of practice.	• Review impact of the Anchor charter for Core20Plus communities, and refresh as necessary.	• Refresh Anchor charter as necessary.

Priority 2: Reduce inequalities and improve health outcomes through PHM

What do we plan to do over the next five years? (4 of 4)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Enablers	**Finance**	• Work with finance teams to understand how resource can be more effectively allocated to need, with the potential to reduce inequalities.	• Continued work on better aligning resource to need.	• Continued work on better aligning resource to need.
	Data and digital	• Link 111, 999, VCS and wider determinants of health data to our integrated care dataset. • Create population health dashboards for whole sector, with a focus on INTs • Embed principles of digital inclusion in everything we do.	• Roll out additional use cases for linked data. • Further development of technical PHM infrastructure.	
	Workforce	• Embed PHM skills in business-as-usual activities through the PHM and Health Equity Academy. • Lead work on the Anchor charter to support people from our deprived communities into employment in health and care roles • Deliver leadership training schemes for local graduates. • Support deliver of 'barriers to leadership' recommendations.	• Improve capability for data-driven decision making and engagement with communities to reduce inequalities. • Embed anchor pledges and create opportunities for Core20plus communities to access high-quality employment, including in health and care.	
	Estates	• Explore the use of estate for community benefit (anchor institution model).	• Maximise benefits of estate with INTs, including social welfare legal advice.	
	Comms. and involvement	• Improve link to our communities: focus on engagement, culture of learning from and working with our communities, and targeted and co-produced messaging.	• Support clearer messages to our communities to enable an empowered, health equity approach and embed co-production through all service change	

Priority 2: Reduce inequalities and improve health outcomes through PHM

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Reducing healthcare inequalities	**Embedding a culture of tackling inequalities**	**2027/28**	• Consistent system-wide approach to inequalities • Clearer oversight of differences across NW London and where action is needed, through core common metrics • Reduction in gap in health outcomes, access to and experience of services for least deprived communities and between different ethnicities as shown by inequalities metrics • Improved connection to local communities and improvement in how communities experience NHS services
	Reducing healthcare inequalities in key focus conditions	**2027/28**	• Reduced variation with a focus on conditions with worst outcomes/highest inequalities, complementing common offer through additional services tailored to need • Integration of actions, incentives and tools to drive equity for our population
	Addressing cross-cutting barriers to equity in healthcare	**2027/28**	• Reduced levels of digital exclusion • Fewer access barriers related to communication; communication/engagement with communities are culturally competent, build trust and reduce inequalities • Improved trust in health and care services, overcoming hesitancy and supporting delivery of the common offer • Increasing black and ethnic minority staff in senior roles to reflect NW London population
Population health management (PHM) building blocks	**PHM skills building**	**2026/27**	• PHM skills in workforce, including analytics and co-production: services to better meet community needs. • PHM approach embedded in all services • Health and care services designed around the needs of our communities and addressing inequalities • Improved value for money through delivery of services that are most appropriate for the local population • Strategic reporting to support ICB teams, BBPs and INTs, identifies inequalities and areas of need. • Development of an easy to use front-end for primary care, and other care settings, to case find patients
	Understanding and responding to need		
	Data and intelligence-led approaches		
	PHM implementation		
Partnership working on healthy behaviours and wider determinants	**Promoting prevention and healthy living**	**2028/29**	• Reduced levels of smoking and unhealthy weight • Reduced gap in late stage cancer diagnosis and incidence of tooth decay • Greater opportunities for Making Every Contact Count
	Tackling wider determinants of health	**2027/28**	• Increased local employment, with focus on Core20Plus • Reduced poor health related to housing conditions • Reduced gap in healthy life expectancy

Priority 3: Optimise ease of movement for patients throughout their care – right care, right place

Summary of priority

Patient flow

Patient flow is about guiding residents to the right care setting and moving them through the system quickly and safely. This includes directing patients to alternatives to hospital admission and ensuring timely discharge from hospital. It requires coordination between hospitals, primary care, local authorities, and community services.

Lengthy and unnecessary hospital stays can happen for several reasons. Patients may be admitted to hospital when in reality, other care options, closer to home, are more suitable. Delays in emergency departments, or waiting for discharge and transfer from hospitals to home or other services, can also lead to longer than necessary hospital stays. Delays in ambulances handing over patients to hospital staff can impact patient wellbeing and health outcomes, and it leads to longer waiting times for everyone.

Efficient patient flow improves care, reduces waiting times, and helps manage our capacity better in response to demand. It also ensures patients are treated in the most appropriate setting, reducing risk and unnecessary delays.

To improve flow, we will use technology and data to better coordinate discharges and expand the range of conditions managed at home. Our Urgent and Emergency Care Strategy, due to be published shortly, provides more detail on improving hospital flow both in and out of our emergency departments.

Our goals include:

- Fewer hospital admissions when patients can be treated at home or close to home.
- More patients spending time at home.
- Fewer delays in discharges for patients who are medically fit for discharge.
- More patients discharged directly to their home.
- Reduced harm from faster discharges when clinically appropriate.
- Shorter waiting times in our emergency departments for patients who need it most.

Case for change: why is this a priority?

- As the population ages, demand for healthcare naturally increases. But many people who are currently admitted to hospital could receive better care in other settings, while others who need a hospital bed stay in that bed for longer than clinically necessary – we know that prolonged hospital stays can increase confusion and undermine independence.
- Additionally, inefficient patient flow as currently experienced contributes to longer waiting times, reduced patient satisfaction, and higher costs, highlighting the urgency for improvement.
- Meeting performance targets and regulatory standards requirements is a directive from NHSE and often reflected in the operating plan.

Priority 3: Optimise ease of movement for patients throughout their care – right care, right place

What do we plan to do over the next five years? (1 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Overall system flow	**Strategy**	• Implement recommendations of urgent and emergency care strategy. • Better understand potential improvement on ED waits. • Understand out-of-hospital capacity and potential impact on discharges.	• Track progress on ED waits and discharges against recovery trajectory. • Take corrective actions as appropriate.	
	Transfer of care hubs	• Move towards full transfer of care (TOC) hub model, including a full-scale roll out of the OPTICA tool – focus on scoping of a TOC hub's ability to manage the entire system. • Enhance support to care homes to improve intermediate care.	• Support discharge hubs to meet priorities and standards for TOC hubs.	
	Virtual wards	• Work to increase utilisation of virtual wards – aiming for 80% utilisation by month 6 of 2025/26. • Evaluate impact of virtual wards as part of procurement/contract management. • Embed paediatric hospital at home pathway - providing assessment and treatment to children at home (PATCH)	• Further increase virtual ward utilisation. • Launch additional virtual ward pathways.	
	Integrated Care Coordination Hub (ICC)	• In line with the ICC business case, work with London Ambulance Service to provide a single hub operating across the system, working across boundaries to co-ordinate UEC, driven by the patient's condition, whereby the hub identifies the most appropriate service to meet the patient's need. • Bring pre-dispatch and post-dispatch ambulance initiatives into a single care co-ordination approach and integrate with other pathways such as 111 and UCR.	• Explore expanding the ICC in terms of pathways in and out of the hub. • Evaluate the effectiveness of the ICC.	
	Front door improvements	• Ensuring that every front door has rapid access to a Senior Decision Maker to initiate rapid assessment and treatment (RAT) and support with streaming and redirection pathways. • Enable direct referrals to SDEC services from all appropriate services, including ambulances, GPs and other HCP's • Pilot testing of an app (ED Patient Checkin) for patients to use prior their attendance to the acute front door which will expedite triage and streaming. • Establish redirection pathways external to the trust for all acute sites in NWL	• Paediatric transformation programme, supporting acute service improvement in tandem with integrated working across system services. • Implement learning form work with London Ambulance Service.	• Identify and reduce patients experiencing inequality of access, experience and outcome in UEC services
		• Develop digital and telephony pathways with the NHSE national team and London Region team.		

Priority 3: Optimise ease of movement for patients throughout their care – right care, right place

What do we plan to do over the next five years? (2 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)

Discharge improvements	**Discharge schemes**	• Evolve discharge to assess or equivalent model in line with urgent and emergency care strategy.
		• Evaluate and make decisions regarding discharge grant funded schemes, primarily focused on improving access to pathway 1 bridging services, pathway 3, and complex/challenging discharges.
		• Reduce pathway 1 delay days by 1.5 days per delay.
		• Reduce pathway 3 delays by 10%.
		• Agree funding/decommissioning decision for discharge grant schemes through evaluation.
		• Commission new pathways as appropriate:
		  • Reduce treatment gap for non-CHC health related pathway 3 patients.
		  • Implement a clear process, pathway and funding source for those patients who need a package of care when being discharged from hospital that isn't funded by the NHS (also known as non-CHC).
		• Enhanced planning for discharge at the point of attendance through predictive tools.
			• Embed initiatives to reduce the treatment gap for pathway 3 patients with behaviours of concerns, dementia and delirium.
			• Improve access to out of hospital provision to support faster discharge of patients.
			• Identify and reduce pathway 0 and internal hospital process discharge delays.
				• Discharge grant schemes that are deemed to be successful to be considered for move to business-as-usual. Schemes need to be high impact, enhance value for money, improve patient experience and improve health outcomes.

	Weekend / 7 day discharges	• Enhance weekend / 7-day discharge analytics. • Work to bring weekend discharges in line with weekday discharges.		
	Escalations	• Manage system response to escalation process and align with London-wide standard operating procedures, with a focus on out-of-area patients, industrial action events, etc. • Embed system escalations and operational support to improve access to onwards discharge destinations.		

Priority 3: Optimise ease of movement for patients throughout their care – right care, right place

What do we plan to do over the next five years? (3 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Enabling functions	**Finance**	• Close working with finance teams to understand the financial impact of discharge grant fund schemes, virtual wards and other urgent and emergency care flow-based interventions.	• Continuous tracking of value for money of all flow-based schemes requiring additional funding not in business-as-usual commissioning.	
	Digital and data	• Start to roll out OPTICA tool (built through the NHSE Federated Data Platform) to local authorities with priority trust interfaces and create a monitoring dashboard for demand and capacity. • Agree use cases for community and mental health providers and on-board providers as required. • Improve the local care coordination solution through the national NHSE Federated Data Platform so that it will span pathways across organisations. • Pilot a technological / pathway solution to optimise discharge coordination. • Develop and further implement predicted estimated date of discharge into standard processes. • Implement digital requirements to enable the ICC to have sight of clinical systems and demand and capacity across the system. Evaluate the impact and implement the model across the system	• Scale up technological / pathway solution to optimise discharge coordination to 50% sites. • Review success of the ICC and related demand and capacity work.	• Data available to enable top-down management of demand, capacity and patient flows across the system. • Launch shared digital care records which enable multi-disciplinary integrated care pathways spanning health and social care settings
	Workforce	• Improve staff mobility process for more efficient deployment of staff to areas where they are most needed. • Use the NW London Integrated Recruitment Hub to reduce priority vacancies across acute/social care/primary care, supporting patient flow	• Identify workforce requirements using evidence-based establishment setting tools or capacity and demand where evidenced based tools do not exist.	• Workforce redesign: use new roles, new ways of working and competency-based approaches to transform the workforce in line with changing patient needs and service models.

Priority 3: Optimise ease of movement for patients throughout their care – right care, right place

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Overall system flow	**System flow**	**2024/25 – 2025/26**	• Reduced length of stay for patients that are in hospital for a long time (21 days +) by at least 5% • More patients able to access virtual ward and therefore discharged from hospital faster, with virtual ward average occupancy to be at least 80% occupied.
		2025/26	• Reduced the identification gap through transformation of discharge hubs to true Transfer of Care Hubs where different services such as social care, housing and voluntary services are linked to coordinate support for those patients who need it.
	Virtual wards	**2025/26**	• Greater utilisation of virtual wards (80%+).
	Front door improvements	**2025/26**	• All Medical SDECs within the acute providers are live with LAS trusted assessor model and 111 direct booking.
		Ongoing	• Fewer patients seen in ED who could better be seen elsewhere.
Discharge improvements	**Discharge schemes**	**2025/26**	• Delays reduced for patients who are discharged from hospital and either need further support at home, care home or a community bed • More patients have access to bridging services, helping to get patients home quickly and safely after hospital. • Internal hospital delays eliminated for patients who are leaving hospital to return home with no additional care needed. • More patients are discharged back to their place of residence than in previous years.
		2026/27	• Reduced treatment gap for pathway 3 patients with behaviour concerns, dementia and delirium.
Enabling functions	**Finance**	**2025/26**	• Demonstrable financial benefit (through improving patient flow) that can be invested in integrated neighbourhood teams.
	Digital and data –	**2025/26**	• Effective usage of care coordination solution, migrating to the national NHSE Federated Data Platform spanning pathways across organisations.
		2026/27	• Real time clarity of demand, capacity and patient flows across the ICB enabling accurate clinical and service decisions. • Technological/ pathway solutions to optimise discharge coordination.
	Workforce	**2024 – 2029**	• Reduced number of priority vacancies across acute hospitals, social care and primary care. • More efficient deployment of staff to areas where they are most needed, enabled by improved staff mobility.

Priority 4: Embed access to consistent high-quality community services by maximising productivity

Summary of priority

Delivering consistent community services

We want to help people in NW London stay well and live independently. To do this, we'll provide integrated neighbourhood teams (INTs) that offer a consistent seamless service across NW London (see Priority 1). INTs bring together community health services, social care, and the voluntary sector, all around primary care.

To ensure our services across NW London are consistent, high-quality, comprehensive, and timely, we need to therefore improve productivity and reduce unwarranted variation.

This means we will:

- Develop effective and equitable community services tailored to residents' needs, using population health management approaches to support those who need proactive care, prevention, and bespoke services.
- Support our borough-based partnerships to implement a consistent set of services, starting with community nursing, urgent care response (including support to care homes), and children's speech and language therapies.
- Work with primary care to develop care models for patient cohorts such as those with frailty, diabetes, and cardiovascular disease.
- Provide consistent musculoskeletal and specialist community palliative care services across NW London.
- Use co-production as a way of developing and delivering services, ensuring patient and carer voices are central to service delivery.

Our initial focus will be on increasing productivity and reducing waiting times in the areas that will contribute most to system resilience and recovery.

Our goals include:

- Reducing waiting times for community services by an additional 5% in 2025/26.
- Increasing urgent community response for first care contacts.
- Reducing the length of stay in community hospital beds.
- Reducing emergency care demand by stabilising community services.
- Optimising clinical time and improving staff satisfaction.
- Ensuring consistent access and patient experience across NW London.
- Improving understanding of service amongst staff and residents, resulting in optimal use of resources across NW London.

Case for change: why is this a priority?

- The health and care system is currently under **significant pressure** and waits for some community outpatient services can be long – this has an adverse impact on patient experience and can result in unnecessary attendances / admissions at hospitals.
- **Data across services is not consistent**, which means that we do not have a clear picture of baseline demand and capacity or the impact that this may have on equity of access to services. It is likely that productivity and experience vary considerably.
- Some services exhibit **high levels of vacancies** (e.g., community nursing).

Priority 4: Embed access to consistent high-quality community services by maximising productivity

What do we plan to do over the next five years? (1 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Core common offer	**Consistent services**	• Develop and deliver standardised service specifications for all NHS-funded community services, including access (opening hours), referral criteria and processes, assessment and treatment times • Mobilise core offer work for 6 adult and 3 children proposed priorities for core offers for mobilisation from 1 April 2025*. • Reduce unwarranted variation in core community healthcare (therapies, LAC health assessment, community nursing, paediatrics), linked to the INT work. • Implement core offer for community beds. • Implementation of core common offer for other services – MSK. • Implementation of core common standard for care homes, linked to integrated neighbourhood teams. • Develop and agree new model of care for specialist palliative care.	• Implementation of model of care for specialist palliative care.	• Lead a sector wide approach to uplift and make stroke and neuro service provision equitable across NW London.
	Long-term conditions (Linked closely to INTs)	• Development of cardio-renal-metabolic (CRM) services for NW London (linked closely to INT work). • Development of respiratory condition services for NW London.	• Development of other long term condition services on a rolling basis. • Evaluate CRM and respiratory long-term conditions services.	• Development of other long term condition services on a rolling basis.
	Commissioning	• Development of a suite of standardised commissioning processes, built around best-national practice to support identification of needs, procurement, commissioning and decommissioning decisions.	• Evaluate and refine commissioning processes as appropriate.	
	Equity	• Conduct equity analysis across NW London – aligned to our community core offer, and highlighting where services may need tailoring. • Procure and implement services to support patients - including wheelchairs, non-emergency patient transport and other support services.	• Further refine community services to support the reduction of inequalities – this may mean designing new bespoke services.	
	Service improvement	• Embed data quality programme and quality of community care services using standardised metrics. • Implement best practice approach to enhancing our patient, staff and community voices in design of services. • Identify and drive through service change and improvement through improved productivity, standardised data, KPIs and reporting, ensuring best use of resource and maximum value-for-money.	• Further refine community services to support the reduction of inequalities – this may mean designing new bespoke services.	

*Adult services: care home in-reach, community nursing, urgent community response, discharge to assess, neuro rehab, stroke ESD.
Children's services: special schools nursing service, children looked after (LAC), community paediatrics.

Priority 4: Embed access to consistent high-quality community services by maximising productivity

What do we plan to do over the next five years? (2 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Productivity	**Improve productivity**	• Demand and capacity modelling across all services starting with (1) Podiatry, (2) Community Nursing, (3) Urgent Community Response (4) Children's SALT to better understanding capacity, productivity improvement potential, and how that compares to demand. • Review how we best use better care funding and other funding arrangements to deliver best outcomes. • Drive productivity in community beds. • Drive productivity and reduce waiting lists in community nursing.	• Demand and capacity modelling across remaining community services. • Drive productivity: focus – neurorehab and other key focus areas. • Implementation of consistent activity collection and data reporting.	• Deliver economies of scale through infrastructure.
Enabling functions	**Workforce**	• Recruitment to high impact roles community roles utilising the Integrated Recruitment Hub. • Promote volunteer-to-career pathway. • Standardisation of workforce dashboard. • Introduction/expansion of new roles. • Shared approach to workforce management agreed within INTs, enhancing capacity and demand and improving productivity.	• Expand and develop workforce now and for the future including development of future roles • Use and act on local data and insights to positively impact workforce planning	
	Digital and data	• Demand and capacity modelling to better understand capacity, productivity improvement potential, and demand, against high-priority community services. • Develop and start to implement data quality programme with QI focus. • Establish data quality strategy and procedures. • Data standardisation across partners. • Delivery of strategic reporting for community.	• Implement community collaborative digital and data strategy. • Shared records across multi-disciplinary patient pathways.	• Identify and implement consistent digital offer.
	Estates	• Implement current community estates priorities	• Implement future community estates priorities.	

Priority 4: Embed access to consistent high-quality community services by maximising productivity

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Core common offer	**Consistent services**	**2027/28**	• All services designed together with, and responding directly to, service users and communities.
		2025/26	• Reduce community waiting list numbers by 5%. • Specialist palliative care offer in place for all residents at end of life .
		2026/27	• Equitable access, better outcomes and reduction inequalities initially in community beds and nursing and subsequently to all community services.
Productivity	**Improve productivity**	**2025/2026**	• Best use of resources and maximum value for money at trust and system level.
Enabling functions	**Workforce**	**2028/29**	• Right sized workforce from local communities equipped with skills for new models of care, supported by the delivery arm of the NW London Health & Social Care Skills Academy.
	Digital and data	**2025/26**	• Standardised and consistent reporting across all community services and measures.
		2028/29	• Records shared across providers to enable efficient wraparound care. • Better use of digital tools to support clinical decision making.
	Estates	**2028/29**	• Most efficient use of community assets. • Interoperability across estate and infrastructure.

Priority 5: Improve children and young people's mental health and community care

Summary of priority

Giving children and young people the best start

Our aim is to ensure that children and young people have the best start in life, leading safer, healthier, and more fulfilling lives. Our strategy includes:

1. New care models: for example, integrated neighbourhood teams of primary care staff, social workers, and community paediatric teams who will reach out to families at risk, offering care through child health hubs.
2. System enablers: we will use innovative methods to engage children appropriately and incentivise preventative care through updated contracts.
3. Coordinated programmes of work: we will reduce waiting times, improve access, and focus on prevention where there are high inequalities in health outcomes.

We will continue to fully implement the Thrive Framework, improving mental health services for children by reducing waiting times and enhancing the quality of child and adolescent mental health services.

Over the next two years, we will also extend child health hubs across all boroughs and ensure equal access to specialist school nurses for children with Special Educational Needs and Disabilities (SEND) or in Local Authority Care (LAC).

In future years, we will expand Mental Health Support Teams (MHSTs) to all schools (currently in 40% of all schools) and reduce waiting times for ADHD and autism assessments. We will also provide a common offer for speech and language therapy (SALT).

We will use the Whole System Integrated Care (WSIC) dataset to share information between health, education, and social care teams – this will support long-term improvements and ensure children and families with the greatest needs have better access, outcomes and experience.

Expected outcomes include:

- Better access to timely advice and reduced reliance on emergency care.
- Core common offer for children, focusing on mental health services, early intervention in schools, specialist nursing support and SALT.
- Fewer children attending emergency departments for mental health crises.
- Equity of outcomes for vulnerable children with SEND or in Local Authority Care.

Case for change: why is this a priority?

- **Lack of data:** Far more evidence on health equity and outcomes is available for adults than children. This hampers progress to improve and integrate care for young people.
- **Inequity in health outcomes for children:** from deprived areas and low-income families; from minority ethnic backgrounds; from population groups that suffer social discrimination.
- Delays and inequity in **emotional wellbeing and resilience** from as early as Year 2 for boys, children of Black or traveller ethnicity, and children with SEND.
- We have the **longest waiting list for ADHD and ASD assessment** in London.
- The number of children and young people with **identified mental health needs** has doubled since 2019, and the severity and complexity of issues and needs has also increased. Young people consistently say that emotional health is their greatest concern
- **SALT** services have some of the highest waiting lists and variation in outcomes.

Priority 5: Improve children and young people's mental health and community care

What do we plan to do over the next five years? (1 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
CYP mental health provision and access	**Strategy**	• Develop CYP mental health strategy and begin implementation.	• Implement strategy for CYP mental health services.	
	Improve mental health community services provision	• Agree and implement a core common offer and pathway for CYP Neurodevelopmental Services (NDS). • Support implementation of the Thrive Framework • Improve access and quality of CYP community mental health services. Develop Integrated CAMHS framework. • Establish NWL forensic examination facility for child sex abuse, with direct access to emotional support service (with clinical governance aligned to specialist CAMHS). • Invest in the right areas and improve productivity to reduce waiting times for CYP community mental health sevices.	• Embed core common offer for CYP NDS into INT development. • Improvement of community-based crisis services • Integrated pathway for NW London to reduce the waiting times for ADHD and autism assessments • Improve access and outcomes for care-experienced children with mental health needs.	• Improve data on known gaps, including for children known to be at high risk of health inequity • Review of non-NHS community CYP mental health services.
	Inpatient and acute provision	• Identify innovation to improve CYP crisis provision. • Multi-agency coordination of mental health management for children in A&E departments and acute paediatric wards.	• Implement plans for sustainable provision to meet demand and changing needs. • Continue multi-agency coordination of mental health management for children in A&E departments and acute paediatric wards to reduce delayed transfers of care.	
	Mental wellbeing in Schools	• Additional roll out of mental health support teams (MHSTs) – subject to funding. • Further enable access to non-MHST equivalent for schools that are not currently partnered with an MHST.	• Additional roll out of MHSTs (subject to funding from NHS England).	

Priority 5: Improve children and young people's mental health and community care

What do we plan to do over the next five years? (2 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
CYP community support	**Community services**	• Partial implementation of child health hubs across NW London. • Develop a core common offer of community services. • Provide Assessment and Treatment to Children at Home (PATCH) in an equitable manner. • Child ophthalmology - addressing the gap in child vision screening, and reducing risk of permanent functional blindness. • Child audiology - Addressing the gap in child hearing screening, and reducing risk of delayed language development. • Child videofluorscopy - reducing the risk of children being unable to swallow any food/ nutrition. • Special school nursing: closing known gap in SEND and LAC through recruitment and retention efforts.	• Expansion of child health hubs across all of NW London • Continue to develop and embed a core common offer for community services, providing consistent access for all CYP. • Build primary care referrals for PATCH services through INTs. • Continue to target prevention in CYP oral health.	
	Acute services	• Develop role and capability of acute paediatric collaborative. • Analyse equity and enhance equity of SEND therapies (OT, SALT, physiotherapy, ND)	• Continue to enhance equity of SEND services, with a particular focus on waiting times.	
	Health equity	• Reduce unwarranted variation in core community healthcare for children and young people. • Improve equity of informed consent and immunisation uptake in children. • Roll out asthma care bundle as per GIRFT guidelines and reduce unwarranted variation in access to specialist nursing advice for asthma. • Reduce unwarranted variation in access to specialist nursing advice for epilepsy. • Reduce unwarranted variation in access to specialist advice on diabetes, including associated pathways for children that have obesity.	• Continued focus on conditions with known health inequities.	

Priority 5: Improve children and young people's mental health and community care

What do we plan to do over the next five years? (3 of 3)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Enabling functions	**Workforce**	• Reverse mentoring and co-production to upskill staff in age-appropriate techniques and to support regular engagement and co-production with children.		
		• Recruitment of specialist nurses to support SEND (for asthma, epilepsy, and diabetes management at school).	• Recruitment of staff to community CYP MH services – particularly MHSTs and eating disorder services.	• Support any further areas of targeted recruitment required
	Digital and data	• Linking data for LAC and SEND between NHS organisations and local authorities through WSIC to support equity analysis, benchmarking, and forecasting. • Improve quantitative data on health assessment notification (local authorities) and completion timeliness (NHS organisations).	• Trial and roll out digital innovations for neurodevelopmental pathways	• Further development of reporting tools in WSIC to support teams, helping them identify inequalities and areas of need e.g. Children's Social Care data • Further explore options for the Federated Data Platform to support CYP Transformation Programmes, in line with INT requirements
	Estates	• Forensic examination hub for child sexual abuse to open in NW London (NHSE, ICB, & police funded) • Start to roll out child health hubs across all NW London Boroughs	• Continue, with the aim to complete, the full roll out child health hubs across all NW London Boroughs	•

Priority 5: Improve children and young people's mental health and community care

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
CYP mental health provision and access	**Improve mental health community services provision**	**2024/25 – 2025/26**	• Reduction in waiting times, shorter waiting list and improved quality for CAMHS. • Improvement of Community-Based Crisis services to ensure 7 day service.
		2026/27	• Reduce known gaps, including for children known to be at high risk of health inequity (Y3).
	Inpatient and acute provision	**2025/26**	• Low numbers of Tier 4 admissions. • Lowest appropriate length of stay. • Thrive Framework implemented across NW London.
	Mental wellbeing in Schools	**2026/27**	• Increased access to Mental Health Support Teams across all boroughs (at least 200 contacts per team, per year in 2024/2025). • An MHST, or equivalent, is available to 100% of NW London's publicly-funded schools.
CYP community support	**Community services**	**2024/25 – 2025/26**	• Close known gap in special school nursing. • Improved consistency of services for children and young people with SEND. • Supportive care and prevention at the earliest opportunity. • Improved compliance with statutory duties relating to SEND and LAC.
		2025/26	• Equity in access and outcomes for speech and language therapy. • Reduce the waiting times for ADHD and autism assessments. • Increased access to pre and post diagnostic support.
	Health equity	**2026 – 2029**	• Reduced inequity for epilepsy and asthma. • Reduced inequity in oral health outcomes. • Reduced inequity for people with a learning disability and/or autistic people. • Reduced inequity for diabetes and healthy weigh. • Equitable access to core, essential community health services.
Enabling functions	**Workforce**		• Sufficient specialist nurses recruited to support SEND • Sufficient staff available to community CYP MH services – in particular, MHSTs, eating disorder services, and neurodevelopmental services.
	Digital and data		• Incorporate children's social care data into WSIC. • NHS and LA data linked so better able to assess need.
	Estates		• Child health hubs in place across all boroughs. • Forensic examination hub for child sexual abuse in operation.

Priority 6: Improve mental health services in the community and services for people in crisis

Summary of priority

Recent expansion in community mental health services

Over recent years, we have significantly expanded mental health services, with an additional ~£80m allocated since 2019/20.

The number of people in contact with community mental health teams has increased by around 50%, and crisis services, such as healthcare-based places of safety, liaison psychiatry teams in hospitals, our mental health crisis assessment service (MHCAS), and community crisis teams, have grown.

However, more work is needed to reduce variation in outcomes and improve productivity for a better, more consistent patient experience, available to more people in need.

Our plan

We aim to make mental health support accessible and effective, especially for vulnerable groups facing barriers to care. This will help prevent crises, reduce hospital admissions, and encourage early intervention. We will:

- Implement a core common offer of community and crisis care services for adults, tailored where needs differ.
- Reduce variation in community services, and increase productivity in caseloads.
- Continue to raise awareness so residents know how to access support, with a crisis plan for everyone currently in the care of our mental health services.
- Align community mental health services to integrated neighbourhood teams for more person-centred care and greater focus on adults with SMI.
- Work with local authorities to improve housing and employment support, helping people gain and stay in employment.

Expected outcomes include:

- Reduced unwarranted variation in outcomes.
- Better experiences for patients and staff.
- Increased community capacity to meet rising demand and prevalence.
- More people with crisis management plans, that support them to use crisis alternatives over A&E.
- People staying in mental health beds only as long as necessary.
- More people in meaningful employment.

Case for change: why is this a priority?

- Mental health disorders are the **fourth largest driver of years lost to disability and death** in NW London and therefore presents one of our biggest opportunities to improve the health and wellbeing of our residents.
- While we have expanded community and crises services significantly, many of our population **do not yet have confidence** in the services that we offer.
- Demand and complexity are increasing, demonstrated by a greater number of people presenting at A&E in mental health crisis who are not previously known to services.
- In order to be successful, we need to establish **appropriate systems and frameworks** that enable provider collaboratives to design, commission and deliver **a wide range of pathways and services**. This is key to driving the transformation and improvement of all mental health, learning disabilities and autism services across NW London.

Priority 6: Improve mental health services in the community and services for people in crisis

What do we plan to do over the next five years?

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
MHLDA-wide work	**Strategy**	• Implement strategy for adult mental health services. • Develop strategy for children's mental health services (see Priority 5). • Review dementia diagnosis and care in line with international best practice, and align to INT work.	• Implement strategy for children's mental health services • Review adult autism and ADHD services against London, national and international best practice, including a review of demand and capacity.	• Drive improvements in adult autism and ADHD services.
Community mental health services	**Core common offer**	• Develop adult community mental health specification to support our core common offer ambition – including NHS and non-NHS services. • Invest in greater prevention and early intervention and supporting people in the community, with greater targeted support to those with serious mental illness (SMI). • Invest in the right areas and improve productivity to reduce waiting times for community mental health services. • Begin to implement common offer in high priority services (e.g., those experiencing significant unwarranted variation in access). • Link common offer work with INT development. • Deliver core coverage of crisis alternative services across NW London (see next page).	• Continue to deliver core common offer for adult community mental health services. • Through health equity analysis, identify specific areas where core offers may need to be tailored, for example, specific resident cohorts – for example, with Black men. • Continue to support the development of INTs.	• Continue to tailor the core common offer to serve additional areas experiencing particular inequities. • Begin to develop bespoke services to target particular inequities – through co-production approaches. • Continue to support the development of INTs.
	Inpatient care	• Improve flow and quality for all inpatient care, including flow into acute mental health wards (from EDs, hospital wards, or elsewhere) and flow out of acute mental health wards (e.g. into social housing). • Work with urgent and emergency care programme team to embed discharge improvement initiatives. • Review of the Limes and Rehab inpatient models. • Implement inpatient quality transformation programme – embed PSIR framework, 7-day services for all disciplines, modernise environments and deliver 'purposeful admissions', 'therapeutic inpatient care', and 'proactive and safe discharge planning'.	• Continue to drive improvements in flow from the acute sector and length of stay reductions in acute mental health beds. • Widen skills mix, develop suite of therapeutic trauma informed interventions, improve recording and audit.	
	Improve productivity	• Drive productivity improvements in community mental health teams, in line with benchmarking and service specifications. • Review and share learning on year of productivity focus on community mental health services.	• Continue to drive productivity improvements in community mental health teams and other MHLDA services. • Improve capacity and reduce waiting times of talking therapies, partially through improved productivity.	

Priority 6: Improve mental health services in the community and services for people in crisis

What do we plan to do over the next five years?

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Crisis mental health	**Crisis alternatives**	• Implement recommendations from mental health crisis services evaluation (phase 1) – including improving patient throughput, expanding capacity where feasible, refining inclusion criteria and referral routes. • Deliver phase 2 of the mental health crisis services evaluation.	• Continue to drive improvements in throughput of crisis alternative services. • Continually track the impact of crisis alternatives on crisis attendances to EDs.	• Increased use of alternative care pathways and VCSE services.
	Mental health in ED	• 111 first for Mental Health implemented on a 24/7 basis. • Drive initiatives to reduce 12 hour waits in ED, including optimisation of crisis alternative services.	• Drive initiatives to reduce the use of Section 136 Mental Health Act detentions.	
	Suicide prevention and support	• Development of a multi-agency suicide prevention plan, particularly in areas of high need (e.g., Hammersmith and Fulham).	• Expansion of suicide prevention plan across NW London • Expansion of suicide postvention offer across NW London.	
Enabling functions	**Workforce**	• Recruitment to the top five hard to fill vacancies (MH nurses)	• Drive to reduce variation between mental health nursing support in NW London EDs	• Develop and implement mental health workforce models for acute providers.
	Digital and Data	• Develop joint performance and value for money dashboards to support improvement initiatives. • Implement plan for enhancement of community and mental health provider electronic patient records. • Articulate digital requirements for better sharing of MH crisis plans and requirements of community and crisis care (e.g. talking therapies data)	• Explore adoption of additional mental health digital therapy technologies, e.g. remote talking therapy apps, mental health self-management tools, etc.	
	Estates	• Support the identification of ideal estate for mental health crisis services.	• Continue to evaluate the suitability of mental health estate in terms of travel times, locality, fit for purpose, etc.	

Priority 6: Improve mental health services in the community and services for people in crisis

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Community mental health	Strategy	2025/26	• Improved dementia diagnosis rate to 66% and post-diagnostic care model delivered.
		2026/27	• Improved capacity and reduce waiting times of adult ADHD and autism.
		2025/26	• Improved access and capacity of talking therapies to enable reliable improvement (67%) and reliable recovery (48%) – aim for improvement on both these metrics.
	Core common offer	2026/27	• Core common offer of services for all residents in NW London. • Reduce variation in caseloads and staffing across all community services. • Develop an assets-based approach to promoting mental health and wellbeing.
		2025/26	• Consistent performance reporting for primary care providers.
	Inpatient care	2028/29	• High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.
		2025/26	• Improve flow and care quality for all inpatient services. • Improved integration with community mental health service provision.
		2026/27	• Improved staff culture and satisfaction across all wards
Crisis mental health	Crisis alternatives	2025/26	• Crisis alternative services achieve an average length of stay in-line with the expectations (i.e., 12-24 hours). • Crisis alternative services are able to admit all patients attending ED due to a mental health crisis (assuming they are suitable and do not have any acute physical health needs).
	Mental health in ED	2026/27	• Reduction seen in the use of Section 136 Mental Health Act detentions. • Reduction seen in 12 hour waits in ED.
		2027/28	• Increased use of alternative care pathways and VCSE services.
	Suicide prevention and support	2026/27	• Reduction in suicide rates, and increased support for people bereaved by suicide.
Enabling functions	Workforce		• Reduction in variation between mental health nursing support in EDs. • Improved recruitment of mental health nurses.

Priority 7: Transform maternity care

Summary of priority

Our ambitions

In maternity, we have four ambitions aligned to the national maternity programme:

1. Listening to, and working with, women and families with compassion.
2. Rowing, retaining, and supporting our workforce with the resources and teams they need to excel.
3. Developing and sustaining a culture of safety, learning, and support.
4. Standards and structures that underpin safer, more personalised, and more equitable care.

Our maternity services

NW London has six maternity units – three rated outstanding by the CQC, one good, and two rated as requires improvement. Following the 2015 maternity review, all are collocated with level II neonatal care units and there are no current plans to consolidate units. NW London's award winning Mum & Baby app continues to be adopted widely.

While having half of our units rated as outstanding means our maternity services are among the best in the country, this means there is still more work to do to standardise quality for all our residents. In addition to ensuring that our two units requiring improvement do continue to improve, we also need to ensure that outcomes, in particular for Black and Asian women and their babies, improve. Outcomes for these women and babies are worse than for the population as a whole. We also need to ensure that we foster a culture of safety which will benefit everyone who touches our services.

This will be achieved through improving our capabilities for transformation and assurance.

Over the next 5 years, we will aim to:

- Reduce the inequity of pregnancy care and maternal health outcomes.
- Improve the quality of our services, with more support from maternity services directed to cases with higher risk.
- Reduce numbers of still births and intrapartum brain injuries.
- Improve access to pregnancy advice (including improved digital access, and real-time translation services).

Case for change: why is this a priority?

- There is a significantly higher risk of poor maternal outcomes for Black and Asian pregnant women and their babies.
- There is a need to ensure continuity of midwife care throughout antenatal, perinatal, and postnatal care.
- There is a need to spend additional time with residents and communities to co-produce maternity service innovations.
- Pre-existing poor mental and physical health (often associated with deprivation) contribute to higher risks in pregnancy.
- In NW London, we have a large population of asylum seekers who are at higher risk when pregnant due to a lack of antenatal reviews, disrupted care, stress, and are also associated with a higher risk of infectious disease.
- Significant unwarranted variation in quality across our six maternity units means not all residents have access to the high quality maternity experience we want to deliver.

Priority 7: Transform maternity care

What do we plan to do over the next five years? (1 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Maternity strategy	**Strategy development**	• Develop and publish a NW London wide maternity strategy. The strategy should focus on making maternity and neonatal care safer and sustainable, more personalised, and more equitable for women, babies, and families. • Develop a cross-sector demand and capacity model for maternity services, taking into account various birth rate scenarios.	• Work with primary, community and acute providers to implement the maternity strategy across NW London.	• Continually track progress against the maternity strategy, refreshing demand and capacity modelling as demand.
Improvement and transformation	**Service improvements and transformation** across a range of key maternity services	• Develop business case for and implement post-birth contraception service in across NW London. • Align postnatal care in line with the NICE quality standards • Develop roles and responsibilities for diabetes midwifes. • Work to improve breastfeeding rates. • Implement common offer for pelvic health services in across NW London – to identify, prevent, and treat common pelvic floor problems. • Roll out continuity of carer in line with NHSE principles around safe staffing.	• All NW London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding. • Achieve NHSE safe staffing standards. • Align postnatal care in line with the NICE Postnatal Care Quality Standards	• Primary care to support end-to-end pathway of maternity care, including early perinatal mental health support and first year of life (including immunisation to the London average) – by 2027/28.
	Health equity	• Improving maternity experience and outcomes for black women through embedding lived experience evidence into service change – linking into maternity strategy development. • Develop in-reach offer for other communities adversely affected by poor outcomes in maternity services. • Appoint cultural safety lead midwives. • Roll out cultural safety training during midwifery education. • Evaluate cultural safety initiatives.	• Implement personalised care and support plans – all women to be offered personalised care support plans which take account of their physical health, mental health, social complexities, and choices.	
	Maternal mental health	• Work with MHLDA team to develop plan for all women to have equitable access to perinatal mental health services. • Evaluate maternity trauma & loss service.		• Primary care to implement early perinatal mental health support by 2027/28.

Priority 7: Transform maternity care

What do we plan to do over the next five years? (1 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Insight, governance and assurance	**Maternity CNST incentive scheme**	• CNST governance, sign off and final submission. • Annual learning review. • Implement patient serious incident response framework (PSIRF). • Implement perinatal quality surveillance model (PQSM). • Use the Saving Babies' Lives Care Bundle to investigate variation in stillbirth rates.	• Continually embed learning from serious incidents (via PSIRF), variation in stillbirth rates, and the perinatal quality surveillance model.	
	Working groups	• Work with Maternity Serious Incidents Oversight Group (MSIOG) to embed learning from serious incidents. • Neonatal working group • Standardise practices and guidelines through the neonatal working group and fetal wellbeing subgroup.		
Enabling functions	**Workforce**	• Support the implementation of new operational policies. • Monitor the implementation of the NHS single delivery plan. • Review workforce data across the sector. • Develop a maternity support workers apprenticeship programme. • Develop a staff retention strategy. • Highlight retention challenges and escalate them to the regional team. • Appoint cultural safety lead midwives and roll out training.	• Perform comprehensive analysis of various metrics related to maternity job roles. • Work with the workforce team to increase international recruitment of midwives. • Implement multidisciplinary training and training dashboard. • Launch apprenticeship programme. • Implement Core Competency framework V2 across NW London. • Develop and implement a plan to support for newly qualified staff and clinicians.	
	Digital and Data	• What Good looks like - digital Maturity Assessment • LMNS Dashboard review • Ensure that all Trusts submit the digital maturity report, and a gap analysis is undertaken to identify key points for improvement	• Develop a data strategy, improve and promote bioinformatics analysis, develop E&E dashboard	• Develop a mothers and babies app and explore digital models of delivering maternity services.

Priority 7: Transform maternity care

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Service improvements and transformation	**Service improvements and transformation across a range of key maternity services**	**2024/25 – 2025/26**	• Provide post-birth contraception service in all trusts within NW London. • Aligned postnatal care in line with the NICE quality standards.
		2025/26	• All NW London trusts to achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding. • Achieve NHSE safe staffing standards. • Improved outcomes for BAME women within NW London.
		2026/27	• Availability of bereavement services 7 days a week for women and families who experience loss.
		2027/28	• Equitable access to pelvic health services for all pregnant women and new mothers.
Enabling functions	**Workforce**	**2025/26**	• Increase international recruitment of midwives. • Implementation and assurance of CNST safety actions 4 and 5.
	Data & Digital	**2024/25 – 2025/26**	• Launched maternity inequalities dashboard. • Improved MISs/EPRs data.
		2025/26	• Achieved digital maternity record standard and maternity services data set standard. • System-wide data integration. • Use of digital tools and enablers at point of care. • Consistent digital maturity across all maternity units.
	Collaboration	**2025/26**	• Improved engagement and joint working between public health teams and the NHS to support healthy preconception and pregnancies.

Priority 8: Increase cancer detection rates and deliver faster access to treatment

Summary of priority

The burden of cancer in NW London

Cancer accounts for ~3,100 deaths per year (2020/21) in NW London and is the leading cause of death in the over 40s in every borough.

Over 62,000 people are living with or beyond cancer in NW London and therefore improving cancer outcomes is a key strategic aim for NW London. The key national priority for cancer is to increase survival by focusing on early diagnosis, with the ambition to ensure 75% of patients are diagnosed at stage 1 or 2. As of 2018, the early diagnosis rate across NW London stood at 55%, though this varies by borough and tumour site.

We also know that people from our more deprived populations, or from ethnic minorities, wait longer before presenting with symptoms of cancer and can also experience greater delays in diagnosis – this is a significant inequity that we need to address.

Our approach to early diagnosis

Our approach to improving early diagnosis is to tackle variation in screening, time to diagnosis, and treatment by deploying both universal interventions alongside targeted interventions focused on those least likely to be diagnosed early. We will harness emergent innovations and work closely with partners involved in life science innovation to ensure more people get diagnosed earlier. We will also co-produce services and approaches with people from groups who are less likely to be diagnosed early.

Over the next 5 years, we aim to see the following outcomes:

- **Reduced variation** of stage of diagnosis at borough level by **8%** (starting with **Brent** which will have the greatest impact).
- Fewer people diagnosed with cancer in **emergency settings.**
- **Narrowing of the cancer disparities gap** faced by the Black communities in NW London; through equity in access to information, testing, pre-treatment and post-treatment options.
- **Faster diagnosis:** standardised secondary care cancer pathways, minimised handoffs, sustainable staffing.
- **Adoption of new technologies and accessible treatments** that will lead to better access and faster, more efficient treatment.

Case for change: why is this a priority?

- NW London has among the worst rates of **cervical, bowel and breast cancer** screening nationally and poor uptake in **HPV vaccination** rates.
- **Bowel screening rates** are significantly impacted by deprivation, with a **17% difference** in participation between high and low deprivation.
- **Cervical screening rates** also differ by age, with women under 30 least likely to receive cervical screening.
- There is a 10 percentage point difference in early stage diagnosis in the boroughs with the earliest and latest stage diagnoses.
- We know that there is a strong correlation with **deprivation** with a 7.4% difference in early stage diagnosis between the least and most deprived population.
- Both suspected cases of cancer and demand for treatment for cancer are rising, which means we have to plan now for the future.

Priority 8: Increase cancer detection rates and deliver faster access to treatment

What do we plan to do over the next five years? (1 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Prevention and screening	**Prevention**	• Reducing lifestyle risk factors, most significantly the use of tobacco. • Eliminate variation in HPV vaccine uptake by working with public health, through community co-design and within boroughs.	• Continued rollout of tobacco cessation programmes and HPV uptake initiatives.	• Continued rollout of tobacco cessation programmes and HPV uptake initiatives.
	Screening	• Targeted lung health checks (TLHC) - ensure all high-risk wards are invited in 2024, and ensure opportunities to stop smoking are harnessed. • Emergent screening programme to help identify early stage cancers in those identified as being at increased risk of harder to detect cancers such as pancreatic and HCC cancer.	• Continued rollout of TLHC into eligible population.	• Continued rollout of TLHC into eligible population as age extension.
Early diagnosis	**Community campaigns**	• Plan campaigns for populations least likely to present to their GP with concerning symptoms – LGBTQ+, Asian, Black, deprived, and male communities to improve symptom activation. • Develop meaningful sustained interventions, including Making Every Contact Count (MECC), targeted outreach and mass marketing.	• Roll out comms. campaigns through a phased approach.	
		• Targeted population campaigns to groups less likely to receive bowel screening.	• Support age extension awareness in all populations, focusing on known groups who do not engage.	
		• Focus community links support on Brent population to increase screening rates with real time coverage of rates.	• Focus on delivery of breast screening pathway improvement and support new contract holder in delivering equitable service.	
		• Agree actionable approaches through a series of co-production events with the Black community, reduce population differences in the access to help and information for concerns around prostate cancer, focusing on Brent population. • Adopt EBI policy which empowers men at increased risk of prostate cancer to have conversations with their GP about prostate cancer and creates a better shared decision making process.	• Spread, adopt and tailor comms. approaches to our wider population in NW London, focusing on the next two boroughs.	• Spread adopt and personalise approaches to our wider population in NW London, focussing on additional boroughs as a rolling programme.
	Primary care	• Focused support to primary care in Brent to increase early diagnosis. • Work with primary care to consistently recognise and refer patients with symptoms concerning for cancer at the earliest opportunity; to reduce the referral interval. • Continue to develop and enhance the Early Diagnosis Enhanced Support approach to address variation in early diagnosis in primary care.	• Focussed support to primary care in Ealing and Hammersmith and Fulham to increase early diagnosis.	• Focussed support to other boroughs as rolling programme and consolidate approaches across network.
	Novel approaches	• Trial novel approaches to earlier detection (e.g. multi cancer early detection tests).	• Continue trialling emergent early diagnosis approaches, ensuring spread and adoption of useful technology.	

Priority 8: Increase cancer detection rates and deliver faster access to treatment

What do we plan to do over the next five years? (2 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Reducing time from referral to treatment	**Faster diagnostics standard (FDS)**	• Deliver and maintain national performance requirements - 77% FDS target and treatment target in NW London at all trusts.	• Maintain provider relationships and facilitated delivery of CWT standards through sharing best practice and supporting operational resilience	• Reduce USC demand via telederm, breast pain, unscheduled bleeding pathway.
		• Support trusts to deliver models of cancer diagnostic approaches based on best evidence and reduce inequalities focussing on: gynaecology, lung and head and neck; embedding urology; working in partnership with endoscopy networks.	• Embed gynaecology, head and neck and lung, endoscopy; supporting other tumour specialities.	• Support other tumour specialities.
		• Support approaches to non-cancer pathways (breast and gynae.) that will relieve pressure on cancer pathways through developing integrated community models.	• Support approaches to non cancer pathways - breast and gynae. specifically that will relieve pressure on cancer pathways through developing integrated community models. • Ensure breast model is embedded as business-as-usual.	
	Secondary diagnostics	• Support wider imaging, pathology and community diagnostic centre networks to hardness rapid adoption of technology that supports patient care and management. • Facilitate prompt secondary diagnostics focusing on supporting the most vulnerable.		
Treatment, care and survival	**Treatment, care and survival**	• Map access and capacity of chemotherapy and treatment across NW London and develop workforce plan to support areas of concern.	• Implement new models of systemic anti-cancer therapy (SACT) approaches on a pilot basis.	• Spread and adopt new models of chemotherapy provision.
		• Continue to audit against best practice and NICE guidance for treatment, implement any changes required to standardise practice via tumour groups, MDTs and Trusts.		
		• Implement improvement in the genomics pathway for lung cancer to increase speed to treatment between Royal Marsden and ICHT.	• Spread approach trialled in one centre to other centres.	
Enabling functions	**Workforce**	• Implement recommendations from workforce programmes, and ensure business-as-usual approach exists. • Implement NHS England's Aspirant Cancer Career and Education Development (ACCEND) programme and novel ways of recruiting and retaining nurses and AHPs. • Implement clinical nurse specialist support programme. • Model demand and capacity requirements, and understand inequality impacts. • Implement radiotherapy physics apprenticeships at Imperial College Healthcare NHSFT (ICHT), and radiographer training supervisor post at Royal Marsden to support and retain staff in training. Spread and adopt apprenticeship model if successful, and implement next workforce approach.		
	Digital and data	• Share performance data and forecasts to enable system-wide planning.		
		• Testing and use of apps and technology and AI to improve cancer pathways (breast and haematology). Implementation of a surveillance system for gastrointestinal cancers.	• Testing and use of apps and technology and AI to improve cancer pathways (other cancers).	

Priority 8: Increase cancer detection rates and deliver faster access to treatment

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Prevention and screening	**Prevention**	**2026**	• HPV uptake in school-age children improved from current performance to national median. Reduce variation in HPV uptake by 30%. • Improve HPV vaccination uptake, tobacco cessation rates, cancer screening coverage & surveillance, with equitable access. • 25% reduction in tobacco usage among individuals invited for a TLHC.
	Screening	**Continuous improvement**	• Reduced variation in screening uptake from national screening programmes (cervical and bowel). • Increased proportion of early-stage cancer "stage shift" in lung cancer diagnosis. • Diagnose at least 65% of patients with cancer at stage 1 or 2 by 2030, with annual improvement, & reduced variation.
Early diagnosis	**Symptomatic presentation**	**2028**	• Variation of stage of diagnosis at borough level reduced by 8%, by addressing inequalities and variation. • Reduction of number of people diagnosed with cancer in emergency settings.
Reducing time from referral to treatment	**Faster diagnosis**	**2024/25+**	• Delivery of the Cancer Faster Diagnostic Standard. • Delivery of the national aspiration for 31 and 62 day treatment target.
Treatment, care and survival	**Treatment and care**	**Continuous improvement**	• Adoption of new technologies and accessible treatments that will lead to better access and faster, more efficient treatment. • A minimum of 85% of patients are treated within 62 days, with no variation by pathway or demographic. • Reduction in waits in genomic lung pathway.
	Survival	**Ambition**	• Top decile internationally for cancer outcomes and survival.
Enabling functions	**Workforce**	**2028**	• Better recruitment and retention of nurses & AHP's, through the NW London Integrated Recruitment Hub with support for retention delivered by the NW London Health & Social Skills Academy.
	Digital and data	**2028**	• Use of population health data to support interventions to improve early diagnosis, particularly in more deprived and ethnic minority communities. • More efficient use of clinical decision tools.

Priority 9: Transform the way planned care works

Summary of priority

Our elective recovery challenge

Since the Covid-19 pandemic, a key priority has been reducing the backlog of patients waiting for specialist appointments and procedures. However, waiting lists have been growing since before the pandemic, so we need to increase activity beyond historic levels.

Our immediate focus is on boosting productivity to reduce long waits, backlogs, and improve diagnostic performance. Process improvements include optimising theatre utilisation, validating waiting lists, reducing variation in clinical templates, and implementing patient-initiated follow-up (PIFU) where appropriate.

Although we have increased staffing in NW London, productivity has not kept pace with demand. Agency staff have helped, but we need sustainable staffing models that support high productivity and offer rewarding careers. We are exploring alternative ways of working, such as the Elective Orthopaedic Centre (recently opened and GIRFT accredited), an ophthalmology hub, and community diagnostic centres.

Digital transformation is key to success – including the care co-ordination solution (which provides greater visibility of patients in their treatment journey), virtual clinics, and remote monitoring.

We aim to shift services from acute hospitals to community teams with timely access to specialists.

The acute provider collaborative strategy, which was published in Summer 2024, details how we will transform elective care pathways.

Key goals include:

- Elimination of waits over 52 weeks for elective care (initially 62 weeks).
- Reduction in avoidable outpatient referrals and activity.
- Improved MDT working across primary and secondary care.
- Effective use of ‘advice and guidance’ from primary care clinicians
- Reduction in unnecessary follow-up outpatient attendances.
- Increase in percentage of patients who receive a diagnostic test within six weeks.
- More meaningful and effective communications with patients, leading to fewer DNAs and a better patient experience.
- More productive use of estate and resources across the system.
- Increase staff satisfaction and reduction in staff burnout.

Case for change: why is this a priority?

- **Long waits for elective care** and diagnostics lead to worse outcomes and a poor patient experience, affecting physical and mental health, work, finances, and relationships. As of November 2024, **287,000** of our patients are waiting for some form of acute hospital-based planned care, with **9,000** having already waited **over 52 weeks**.
- **Staff shortages** cause burnout, recruitment issues, and high agency costs.
- **Inefficient care pathways** result in unnecessary follow-up appointments and referrals, frustrating patients and increasing clinician workload.
- **Primary care clinicians** struggle to access timely advice from specialists.
- **Long waits are worsening health inequalities**. Poor communication makes patients less likely to attend appointments, and delays can lead to conditions worsening before treatment begins.

Priority 9: Transform the way planned care works

What do we plan to do over the next five years? (1 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Planned care strategy	**Planned care strategy development and implementation**	• Implement phase 1 of the planned care strategy development work, with a focus on services provided by our acute providers. Ensure work involves children and young people's services. • Develop phase 2 of the planned care strategy, which covers all referred pathways (including self-referred) across acute and community delivered services (if not already addressed within phase 1). • Begin implementation of phase 2 of the planned care strategy. • Update phase 1 and phase 2 planned care demand and capacity modelling to revise elective recovery trajectory. • Evaluate impact of community ophthalmology service and community dermatology services implemented in 2024/25. • Develop plan for delegation of specialised services.	• Work to deliver both parts of the planned care strategy. • Implement plan for delegation of specialised sevices.	• Revise planned care strategy as necessary based on regularly refreshed demand and capacity modelling. • Use demand and capacity modelling to inform service redesign.
	Women's health hubs	• Deliver nationally identified priorities for women's health hubs and increase uptake / compliance with priority areas and services. This includes patient engagement, optimising pathways, gynaecological service improvement and digital information. • Implemented paediatric sight and sound offering for NW London children which support equitable access to services across all 8 boroughs • Develop fully designed and costed implementation plan for development of women's health hubs across multiple pathways, including incorporation with INTs.	• Implement women's health hubs alongside NW London-wide INT programme.	
Elective recovery and access	**Recover elective services and eliminate backlog**	• Plans in place to eliminate all 52 week waits • Compliance with planned care strategy for elective recovery	• Compliance with national plan and local planned care strategy for elective recovery	• Recover performance against referral-to-treatment constitutional standard by 2029, in line with government pledge. • Note: The feasibility of this is contingent on the output of our planned care strategy (including demand and capacity modelling) and elective recovery funding.
	Inpatient pathway productivity	• Increase theatre utilisation – maximising time used and any one time • Increase number of throughput per list • Review length of stay (day case rather than inpatient) • Standardisation of pathways working with CRGs • Development of a long term commissioning model that encourages NW London standard delivery of services, making best use of hub & spoke services	• Continue to drive the productivity of inpatient elective services in line with national and international benchmarks.	

Priority 9: Transform the way planned care works

What do we plan to do over the next five years? (2 of 2)

Theme	Sub-theme	Year 1 (2025/26)	Year 2 (2026/27)	Year 3 + (2027/28 +)
Care quality	Communications with patients	• Improve communications with patients to reduce DNAs, including patient education, correct use of language, provision of languages other than English, etc. • Drive activities related to Making Every Contact Count (MECC).	• Explore how the NHS app can be more effectively used to support patients to 'wait well'.	
	Personalised care	• Integrate the personalisation model across primary and secondary care to improve patient-centred care.	• Continually evaluate and improve the personalisation model as appropriate.	
Outpatients transformation	Demand management / new care models	• Develop our advice and guidance offering further, to ensure demand is being appropriately managed – particularly for avoidable conditions.	• Trialling and rollout of automated triage pathways in a number of specialities. • Innovation of workforce models (nurse led clinics) .	• Focus on care in most appropriate setting through transformation of clinical pathways in line with INT model, moving care closer to home.
	Outpatients productivity	• Continue activities to increase productivity, including appointment scheduling, clinical workflow, reduction of DNAs, and clinic utilization. • Focus on reduction of avoidable follow up activity, including through continued development and implementation of PIFU pathways across all relevant specialties	• Continue to drive the productivity outpatient services in line with national and international benchmarks.	
	Diagnostics	• Implement strategy for the future diagnostics transformation programme – including community diagnostic centers (CDCs) and exploring potential ophthalmology hubs. • Implement endoscopy capital investment programme (funded by NHSE). • Explore viability of digital transformation in imaging (including image sharing platforms, imaging analytics, AI chest x-ray pilot etc.) • Embedded diagnostic centres. • Expansion of GP Direct Access modalities in imaging and physiological sciences, improving and harmonising pathology access/pathways, and targeted improvements and harmonisation of modality pathways and protocols.	• Pilot and scale (as appropriate) digital imaging services to improve productivity and quality in diagnostics. • Drive efficient use of diagnostic centres and drive down waiting times. • Continue to expand GP Direct Access through reviewing triage criteria.	
Enabling functions	Finance	• Analyse the impact of the planned care strategy (more specifically, elective recovery) on our financial position.	• Continue to monitor the impact of our planned care strategy on our financial position.	
	Workforce	• Conduct workforce gap analysis. • Deliver workstreams to address shortfalls in workforce, including training academies, international recruitment, local recruitment and staff satisfaction, wellbeing and retention programmes.	• Use new roles, new ways of working and competency-based approaches to transform the workforce in line with service models.	
	Digital and data	• Implement the local care coordination solution for elective pathways across all acute providers. • Pilot a technological / pathway solution to optimise discharge coordination. • Scale up technological / pathway solution to optimise discharge coordination to 50% of sites	• Make data and analysis available to enable top-down management of demand, capacity and patient flows.	
	Estates	• Rolling programme on major projects including developing new elective care hubs, women's health hubs and delivery of national programmes (e.g. CDCs). • Support for new hospital programme.		

Priority 9: Transform the way planned care works

What do we want to achieve, by when?

Theme	Sub-theme	Target	Outcomes
Care quality	**Communications with patients**	**2025/26**	• Better patient experience through more targeted, accessible communications with patients • More self management
		2026/27	• Improved health outcomes through supporting MECC, prehabilitation and continuing being well through recovery
Elective recovery and access	**Recover elective services and eliminate backlog**	**2025/26**	• Elimination of waits over 52 weeks for elective care (initially 62 weeks) • Reduction in avoidable outpatient referrals and activity • Improved MDT working across Primary and Secondary care
Outpatients Transformation	**Demand management / new care models**	**2027/28**	• More care closer to home in primary care through better access to specialist expertise in primary care • More efficient use of primary care resources through a more effective approach to “patient initiated follow ups” • Better use of estate, more productive workforce and increased patient satisfaction through use of digital clinics
	Outpatients productivity	**2025/26**	• More activity through more efficient utilisation of resources, increasing activity and booking • Reduction in Follow Up Outpatient Attendances without procedure
	Diagnostics	**2025/26**	• Expansion of GP Direct Access to new modalities • Increase in percentage of patients who receive a diagnostic test within six weeks through maximising use of CDCs
Enabling functions	**Workforce**	**2026/27**	• Better and more productive utilisation of staff • Increase staff satisfaction, reduction in staff burnout • Reduction in agency staff expenditure
	Digital and data	**2025/26**	• Effective usage of Care Co-ordination Solution for Elective Care across the APC, migrating to the national NHSE Federated Data Platform.
		2026/27	• Real time clarity of demand, capacity and patient flows across the APC enabling accurate clinical and service decisions • Technological/ pathway solutions to optimise discharge coordination
	Estates	**2027/28**	• Effectively utilised estate, designed to support the needs of patients and the services delivered in them

C Our enabling teams

Medicines: Our key priorities

Though not strictly an enabling function, **effective medicines are critical to the successful delivery of each of our 9 Joint Forward Plan priorities**, and therefore key to improving our population health outcomes and our clinical and financial sustainability. Our priorities related to medicines are listed below, and are designed to solve several key challenges including polypharmacy, medicine shortages, innovation, and anti-microbial resistance.

No.	Priority	Description
1	Tackling over-prescribing, variation in primary care prescribing, and value for money of medicines	• Polypharmacy (i.e., overprescribing of medicines) is associated with poor patient health outcomes and higher costs, and it also closely linked to inequalities (overprescribing is closely correlated to certain ethnic groups, lower literacy levels and deprivation). Therefore tackling overprescribing is a key priority for NW London. • Reducing variation in primary care prescribing is also of utmost importance – as it supports our key ICS objectives of maximising population health outcomes (by prescribing the most effective medicines), reducing inequalities (by ensuring consistent access to medicines), and maximising value for money (by procuring the lowest cost / most clinically effective medicines).
2	Delivery of the national medicines optimisation programme	• Delivery of the national medicines optimisation priorities* are a high priority for NW London. The programme includes improvements related to overprescribing, reducing unwarranted variation, and delivering value for money (see above). • Effective system working to implement innovations, patient safety, quality and improvements in sustainability.
3	Clinical innovation in medicines	• To provide our people the best possible healthcare and achieve the best possible health outcomes, we will need to explore new medicines such as GLP-1 agonists, new Alzheimer's treatments, new cancer treatments, and innovations in the fields of cardiology, women's health and renal diseases, etc. • We will need to implement relevant NICE technology appraisals, in line with the NHS constitution (with potential wider cost reductions driven through further investment across the system) and monitor the outcomes delivered.

No.	Priority	Description
4	Personal-isation of medicines	This priority has 2 key aspects: • Point of care testing (and its relationship to medicines – particularly with antibiotics). • Improving the personalisation of medicines – which has significant potential to maximise the value of medicines and provide treatments that will provide the greatest benefit to individuals (e.g. targeting specific weaknesses in a tumour).
5	Community pharmacies and INTs	• In line with the national Pharmacy First programme, community pharmacies have an important role to play in NW London's future, enabling greater levels of prevention, and thereby reducing the burden on other, more pressured areas of our system. • From September 2026, new legislation means that all newly qualified pharmacists will be considered independent prescribers, offering significant opportunities to redesign some care pathways to be more accessible and provide greater value for money. • Community pharmacies are key to our neighbourhood health / INT model for delivering care closer to home.
6	Medicines infra-structure	• There is a need to develop pharmacy aseptic services where medicines can be prepared and tailored to individual patients for oncology and other specialties – to enhance the quality and safety of the medicines, and enhance their value for money (through freeing up nursing time and providing care closer to home). • However, successful implementation of these services will require significant capital investment through a London-wide programme of work and collaboration (requiring a business case to be developed).

Digital and data (1 of 2): Our track record and digital and data framework

Our track record

Acute EPR convergence

Our four acute trusts run on a single instance of the Oracle Health (Cerner) Electronic Patient Record system. The journey began at Imperial College Healthcare in 2011 and the final Trust, Hillingdon Hospitals, went live in November 2023. We used this experience to produce an NHSE blueprint for a pan-ICS acute EPR.

Whole Systems Integrated Care (WSIC)

The NW London Population Health Management solution has been running for nearly a decade. It played a key role in our response to the pandemic and is helping drive our plans to improve population health. It is now being expanded across London to support the Sub-National Secure Data Environment.

Digital First programme in Primary Care

A programme of digital innovation that has focused on improving digital access, deploying technology to support patients with long term conditions, and improving efficiency in general practice.

NW London Care Information Exchange

Our patient portal using Patients Know Best is accessible via the NHS App. With over 800,000 patient accounts and 200,000 logins per month, it is the largest patient-held record in the country.

Federated Data Platform

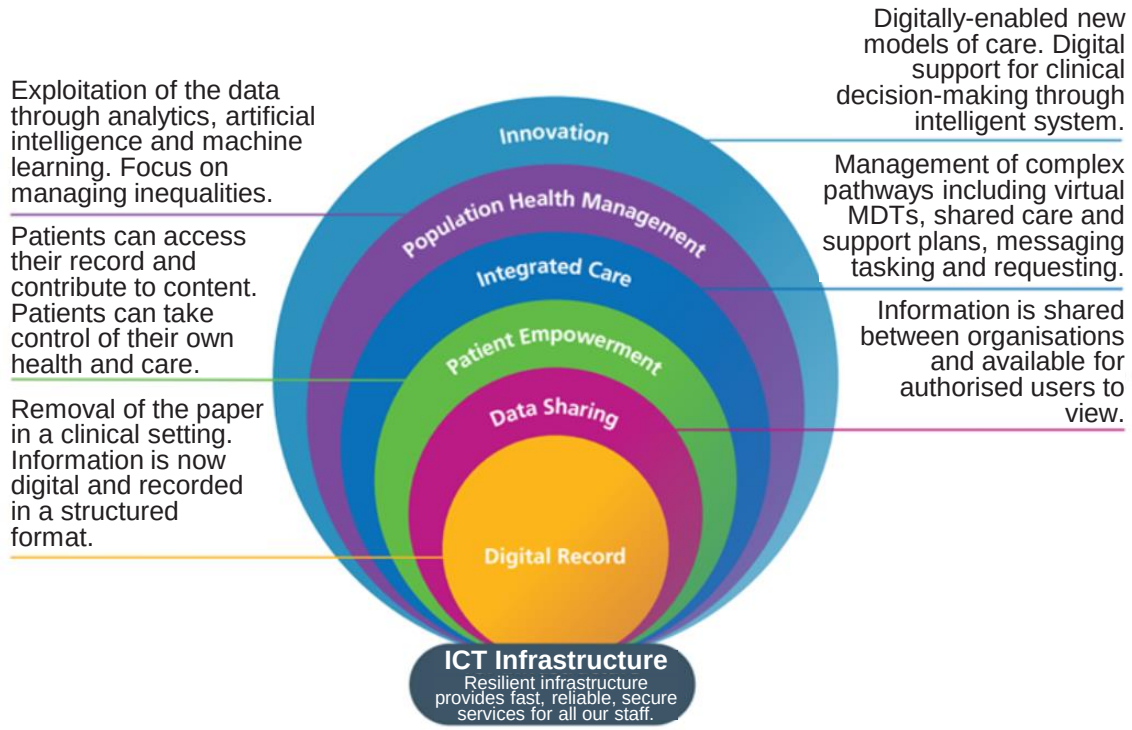
Pioneered at Chelsea and Westminster, this system co-ordinates care and manages patient flows using Palantir's Foundry technology. It is being deployed across the ICS, and its use cases have been adopted nationally.

Federated Data Platform

Our NHS trusts have committed to capital plans for a technology refresh of £545m (adjusted for inflation) over the next 10 years. However, further Frontline Digitisation investment will be required to achieve the Digital Capabilities Framework and the associated productivity benefits.

Our seven-step digital and data framework

Our seven-step digital and data framework underpins our digital and data strategy – further details are provided on the next page.



Digital and data (2 of 2): Our five year vision against our seven-step framework

ICT Infrastructure

- Staff will be able to access key clinical and business systems seamlessly and reliably from any location, via a high performing IT infrastructure.
- Systems will meet statutory and regulatory standards for security and data protection.
- Infrastructure costs will be reduced through rationalisation of systems and IT support services.
- Corporate systems will enable ongoing productivity and efficiency improvements through robotic process automation of manual processes, and use of AI.

Digital Record

- Clinical systems will be consistent across providers in each care setting, for staff and patients
- Primary care, acute, community and mental health systems will enable accurate recording and sharing of patient information to support integrated care.
- Our single acute EPR system will be optimised to support common pathways across our hospitals.
- During and after implementation, systems, processes and staff skills will continue to be enhanced to ensure that clinical systems are fit for purpose.

Data Sharing

- Shared records will support integrated care in a secure and reliable way – informing care professionals of activity in other care settings and enabling transfers.
- Data used to drive decisions and measure organisational performance will more accurately reflect actual activity in the system.
- The national Federated Data Platform will bring data together from across acute providers at an ICS, regional and national level – and be shared with other providers, e.g. to support discharge planning.

Patient Empowerment

- Staff will be able to access key clinical and business systems seamlessly and reliably from any location, via a high performing IT infrastructure.
- Systems will meet statutory and regulatory standards for security and data protection.
- Infrastructure costs will be reduced through rationalisation of systems and IT support services.
- Corporate systems will enable ongoing productivity and efficiency improvements through robotic process automation of manual processes, and use of artificial intelligence.

Integrated Care

- Data will be available for top-down management of demand, capacity and patient flows across the ICB, Boroughs and Neighbourhoods, and for clinical and service decision-making.
- The national NHS Federated Data Platform will span pathways across organisations.
- Multi-disciplinary integrated care pathways across health and social care settings will be enabled via shared digital care records, tasks and plans.

Population Health Management

- A single ICS-wide dataset of timely, granular information will be fully exploited for direct care, PHM, detecting and helping to drive out inequalities, and available securely and de-identified for research.
- Collaborative data strategies will deliver data at a provider level.
- Our organisations will be helped to transform to make more effective use of WSIC and other data tools.
- We will have a modern IT platform for storage and reporting.
- We will support the pan-London strategy for a sub-national secure data environment.

Innovation

- Innovative technologies will be applied regularly to support clinical decision making.
- New, transformational models of care will be made possible by digital innovations such as ambient documentation.

Workforce:
Our priority workstreams and initiatives

The strategic drivers behind our priority workstreams and initiatives are:

- A **provider staffing establishment** that is significantly higher than originally planned for in 2024/25. This will require collaboration and focus on best practice, pay controls, and productivity.
- The shift to a neighbourhood model of care and the **development of INTs** has significant ramifications for workforce.
- There is a need to develop the capability for workforce redesign and change management initiatives.
- The national policy direction to be set out in the new **NHS 10-year plan**.
- We expect service transformation-led reform, education and skills building will continue to be high priorities within the updated **long-term workforce plan**.
- There is a need to accelerate a small number of high impact initiatives related to equality, diversity and inclusion as we will not to meet the **model employer goals** at the current rate of progress. Our recent 'barriers to leadership' report and subsequent summit highlighted significant issues that must be rapidly addressed.

1 Expand and diversify routes into employment

Mayor's Skills Academy programme: raise awareness in our population of jobs and careers in health and social care and support our residents to gain entry-level jobs.

Academy Recruitment Hub: engage with communities and candidates within our CORE20Plus5 population cohorts and help them develop the necessary 'job ready' skills to fill vacant positions.

International recruitment: run tailored in-country events to recruit talent for hard-to-fill roles. Run all pre-employment checks to WHO standards, and support recruits with training needs.

Displaced international recruits in social care: provide direct pastoral and job-matching support for overseas care workers displaced by licence revocations.

2 New ways of working to support new models of care

Understanding the **workforce implications of each system-wide ICS programme** plan and strategy and developing workforce plans for each, focusing on enabling new ways of working.

Workforce redesign development programme: upskilling staff across the ICS that are involved in workforce redesign/transformation initiatives and providing effective support during delivery.

Development and implementation of a **digital and data initiative** for staff across the ICS to enable our organisations to maximise the use of digital tools and data.

Implementation of **digital staff passports** across ICS organisations.

Improving the operationalisation of the **'London staff movement agreement'**.

Develop or identify a **dynamic workforce planning tool** to support the improvement of workforce productivity and efficiency.

3 Multi-professional education and training

Develop an **education strategy** that sets out a clear vision for education and training across the ICS.

Provider chaired Education and OD Leads Group as delivery group for Education Board

Progressing the **ICS graduate scheme** – focusing on the Autumn 2025 cohort.

Working with providers across the ICS to **secure placements** for 2024 and 2025 staff cohorts.

De-biasing people processes across the ICS – focusing on recruitment and progression, particularly with promotion of staff above Band 7.

Development of a **cultural competence** framework and delivering a cultural competency skills programme across NW London.

Developing talent: accelerating career progression for high-performing mid-level staff to senior positions across the system.

Estates:
Our priorities and detailed action plan (1 of 2)

Priorities for the Estates programme include:

1. **Future proofing** our existing estate footprint, whilst supporting the delivery of **INT working**, **primary care at scale** and **out of hospital** service delivery.
2. Supporting the introduction of new **digital and IT enablers**.
3. Promoting **value for money** for the ICB, minimising unnecessary capital and revenue expenditure.
4. Enabling NW London's **COVID Recovery Plan** and developing plans for **affordable housing** for healthcare staff.
5. Reducing significant **'void'** and other associated costs across the ICS (currently circa £9m) and improving **building utilisation** (to 86% across sites).
6. Working collaboratively with **One Public Estate** and other local partners to make **better use of our existing estates** and respond to population growth/health inequalities following new developments.
7. **Coordinating ICS sustainability activity**, as aligned to national and governmental targets, to reduce our carbon emissions and operate more sustainably.

Major projects	
Community Diagnostic Centres – Ealing/Brent	Completed FY23/24
Grand Union Village	Completes FY24/25
Hillcrest Surgery Relocation	Completes FY24/25
Wembley Park Practice (GP scheme)	Completed FY24/25
South Kilburn GP Scheme	Completes FY24/25
Chiswick Health Centre Rebuild	Completes Q4 FY24/25
Dedicated OPDC Development Responses (e.g. CMH)	FY25/26 onwards
Willesden Centre for Health Hub Development/GP Move	FY25/26 onwards
Foreland Medical Centre	FY25/26
Northwood & Pinner Rebuild/Refurbishment	FY25/26
Golborne Medical Centre / Kensal Road	FY25/26
Abingdon Health Centre Solution	FY25/26 onwards
Earl's Court Solution	FY25/26 onwards
Various GP relocations in collaboration with LAs and One Public Estate	FY25/26 onwards
North Acton Solution	FY25/26 onwards
Dedicated INT enabling support	FY25/26 onwards
Central Ealing/Corfton Area Solution	FY25/26 onwards
Lisson Grove Hub	FY26/27 onwards
Southall Park Avenue Solution	FY26/27 onwards
Uxbridge & Pembridge Hub Solution	FY26/27 onwards
Heston Solution	FY26/27 onwards
Newcombe House	FY26/27 onwards
Alperton Health Centre	FY26/27 onwards
Brentford Solution	FY26/27 onwards
Hayes/Nestle Solution	FY26/27 onwards
North Ealing Hub Solution	FY27/28 onwards
Southall Gasworks Solution	FY27/28 onwards

Estates:
Detailed action plan (2 of 2)

Right size, right place	
Lease negotiations and relocations - Hounslow, Ealing, Brent, Harrow and Hillingdon	Complete – FY24/25
Renting floor space at Marylebone Road offices	Ongoing across FY25/26
Void management	
Scrutinising Annual Charging Schedule Costs with NHS PS and CHP	FY22/23 ongoing
Handback of Wealdstone Health Centre	Concluding - Q4 FY24/25
Restacking of The Meadows with WLT/Borough	FY24/25 onwards
Strategic Review of all unused void, bookable and sessional NHS PS and CHP space	FY24/25 onwards
Void reduction and hub development at Heart of Hounslow	FY24/25 onwards
St Charles INT Hub Development/Void Reduction	FY24/25 onwards
Restacking Alexandra Avenue	FY25/26 onwards
Void reduction and hub development at S/Westminster	FY25/26 onwards
Void reduction at Jubilee Gardens	FY25/26 onwards
Void reduction at Feltham Centre for Health	FY25/26 onwards
Hub development at Parkview	FY25/26 onwards
Hub development at Soho Square	FY25/26 onwards
Wembley Centre for Health	FY26/27 onwards
Digitisation of records	
Across Primary Care Estate in collaboration with IT.Will ideally include conversion where possible of space into clinical, consulting or administrative space (e.g. using London Improvement Grant funding)	FY24/25 ongoing

Infrastructure planning and delivery	
Responding to large scale planning applications	Ongoing
Infrastructure Delivery Plans and Local Plan updates	Ongoing
S106 and CIL funding management and bidding	Ongoing
Business-as-usual (BAU) schemes	
All Estates BAU (e.g. rents reimbursements, lease management, etc)	Ongoing
Lift/PFI building management and lease expiration solutions for NHSPS and CHP sites (incl. handbacks)	Ongoing
New Hospital Programme	
Enabling support and oversight with respective trusts	Ongoing
London Improvement Grant	
Allocating national LIG funding to GP sites across NWL and monitoring delivery/expenditure with LEDU	Annual
Sustainability	
Coordination of sustainability activity across ICS/reporting into ICS Exec and Greener NHS Programme.	Ongoing
Green Plan Refresh	Jun 2025

Communications and involvement (1 of 2): How we work with people and communities across NW London

We use a flexible, continually evolving range of methods to involve people across NW London, some of which are listed below. Alongside these, our communications and involvement function also plays a critical role in responding to parliamentary, mayoral, media, and freedom of information act questioning and also supports the JHOSC and various MPs and politicians.

Borough/neighbourhood engagement

- **Community outreach**
- **Healthwatch**
- **Community champions networks**
- **Regular 'open to all' resident forums (at borough level)**
- **Co-design with voluntary sector**
  Our voluntary sector partners play a key role in our work, with a group of charities in working together under the name Third Sector Together (3ST).
  3ST is helping us develop the voluntary and community sector as a key strategic partner and strengthen connections with local communities. They support the NHS in areas like reducing health inequalities, engaging with patients and residents, and contributing to strategy and policy development.

NW London-wide engagement

- **ICS residents' forums and webinars**
  + independent patient participation group (PPG) forum
- **Co-Design Advisory Body (DAB)**
  Helps shape decisions and includes representatives from marginalised groups
- **Citizens' Panel**
  Consists of 4,000 randomly selected local residents taking part in surveys and online discussions.
- **'Next Door social media network**
- **100+ patient and public representatives**
- **Consultations on major service change proposals and procurement**
- **Board and other meetings held in public with questions**

Provider-led engagement

- **Patient participation groups in GP practices**
- **Provider complains and PALS feedback**
- **Lay partners, reference groups and other NHS trust-led patient involvement**
- **Friends and family tests**
- **CQC surveys**
  (e.g. CQC inpatient survey, etc.)
- **Volunteers**
  Over 300 volunteering role types in health and care available across NW London

Communications and involvement (2 of 2): Key actions against each Joint Forward Plan priority

In support of this Joint Forward Plan, our communications and involvement team will deliver several key actions aligned to our nine priorities (see below), as well as overarching priorities such as palliative care, primary care, mental health, vaccination, 'right care', and putting more resident insight into action.

1	**Establish integrated neighbourhood teams with primary care at their heart**	• **Support PCN public involvement on primary care access programme.** • Maximise understanding and involvement across system and communities.
2	**Reduce inequalities and improve health outcomes through population health management**	• **Targeted engagement to increase vaccination uptake.** • Continued communication of population health approach including strategic advice and specific support to initiatives. • Key metrics to be applied to ICB communications and involvement team.
3	**Optimise ease of movement for patients throughout their care – right care, right place**	• **ICS winter plan; 'right care, right place'**. • Co-design of solutions with residents e.g. primary care changes. • Communication of changes to residents.
4	**Embed access to consistent high-quality community services by maximising productivity**	• **Public consultation on palliative care.** • Involve residents in developing standardised services. • Potential for further public consultations where changes proposed.
5	**Improve children and young people's mental health and community care**	• Involvement of children, young people, parents and schools. • Development of communications materials.
6	**Improve mental health services in the community and services for people in crisis**	• **Publication and communication of mental health strategy.** • Communicating decisions on Gordon/Hope and Horizons proposals. • Resident involvement on mental health strategy.
7	**Transform maternity care**	• Support acute provider collaborative with messaging and reaching community groups.
8	**Increase cancer detection rates and deliver faster access to treatment**	• **Further work with residents and the cancer alliance to address barriers to screening uptake and presenting to GP if concerned about cancer.**
9	**Transform the way planned care works**	• To be led by acute provided collaborative communications teams.

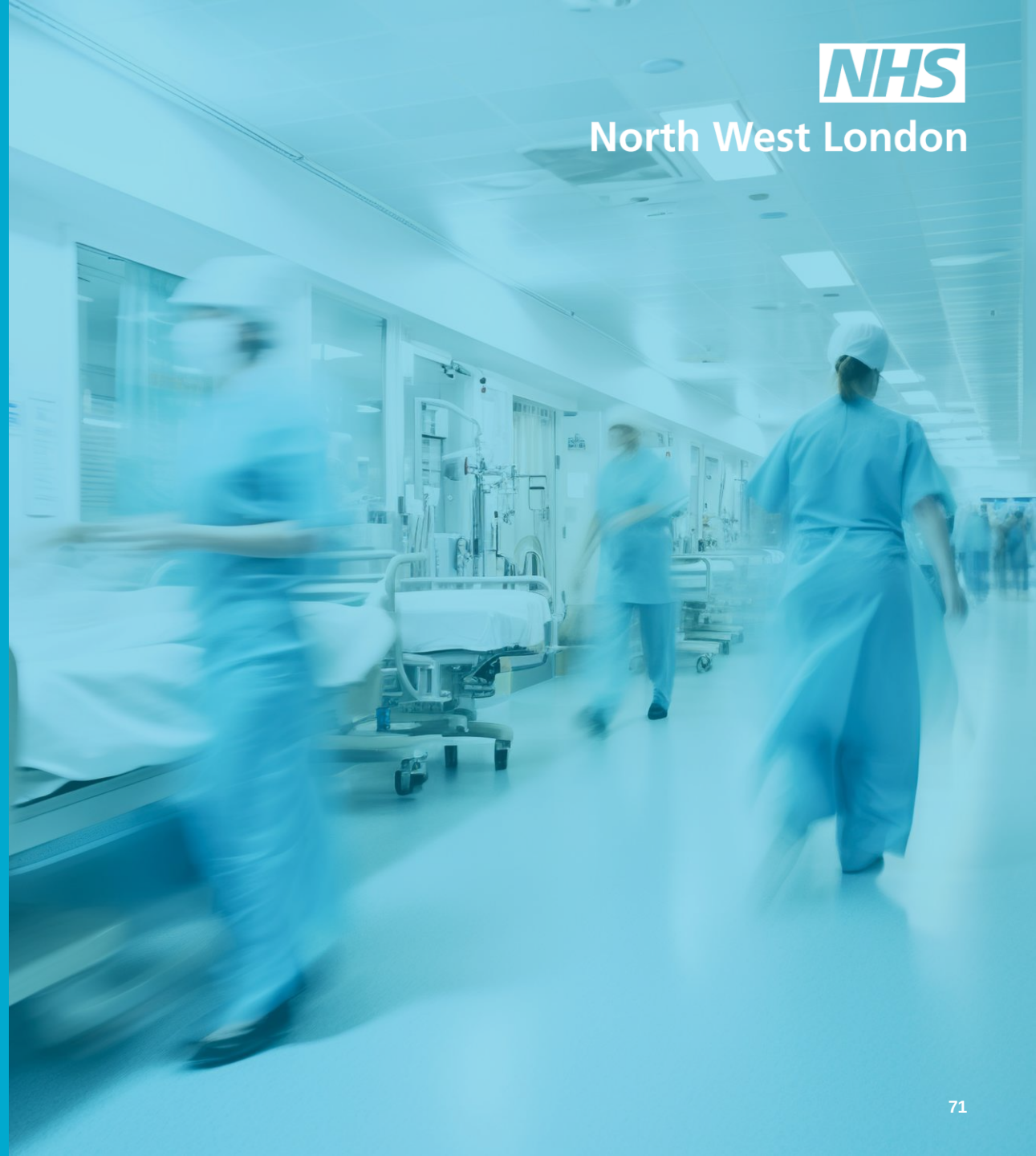
Research and Innovation: our priorities

Priority / mission		Priority themes	Immediate priorities
1	**Cardiovascular disease (CVD)** **Goal:** "By March 2029, we will have prevented 25% of heart attacks and strokes in NWL, whilst actively addressing health inequalities." **[Aligns to priorities 1 and 2]**	• **Prevention:** Prioritise primary prevention through a PHM approach for key groups • **Detection:** Reduce unwarranted variation • **Treatment optimisation:** Treat to target and create equitable access to innovations • **System enablers:** E.g. education, CVD champions	• Community detection evaluation guidance pack • Lipid point of care testing project with PocDoc • Evaluation of Harrow cardio-renal metabolic hub • Prioritisation of prevention activity
2	**System flow** **Goal:** "By 2026, our health and care system will enable 50,000 residents to spend 180,000 more days at home, with the right support for them and their families." **[Aligns to priority 3]**	• **Optimising discharge:** Implementation of technology solutions to optimise discharge coordination • **Predictive length of stay:** Application of data science to predict long LoS, and implementation of proactive interventions	• Evaluation of deployment of OPTICA on the FDP platform over winter 2024/25 • Creation of blueprint for spread and adoption • Securing funding for test of Trendlytics
3	**Children and young people's mental health** **Goal:** "By 2026, we will reduce the number of children presenting in crisis to acute settings by 25%. With a particular focus on neurodevelopmental pathways." **[Aligns to priority 5]**	• **Crisis:** Reduction in the presentation of CYP in crisis to acute settings through improved prevention • **Neurodevelopmental pathways:** Addressing the significant waiting lists and lack of support for those on ND pathways	• Test the integration of mental health practitioners into the child health hub model • Select priority enabling innovations e.g. proactive case finding, patient support tools, AI enabled administration

Our approach to research and innovation:

- In NW London, we have a rich ecosystem of innovation partners across industry, academia, local government and VCSE.
- To achieve more for our residents, we are delivering missions – an evidence-based, innovation approach that focusses on fewer priorities for longer in the hope we generate more impact.
- Imperial College Health Partners, NW London's health innovation network, plays a leadership role in convening the system to achieve these missions.
- For each mission, we will create innovation networks comprised of implementation sites, which adopt innovations in partnership with industry to address the mission goal.

D Our provider collaboratives



Acute provider collaborative (1 of 2): our vision and objectives

NHS North West London Acute Provider Collaborative

The acute provider collaborative

The acute provider collaborative is a formal partnership of the four acute NHS trusts in NW London:

- Chelsea and Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust

Overall, we run 12 hospitals and employ 33,000 staff.

Our shared vision

We will use our collective expertise, resources, and partnerships to:

- Set and raise the standards of care for our patients
- Offer the best care available to everyone, and
- Be one of the best places to work in the NHS.

Objectives

(extracted from the North West London Acute Provider Collaborative strategy, 2024)

Measurable steps towards achieving our shared vision:

Patients – access to timely, personalised and more equitable care

Partners – consistent ways of working, sharing information and progressing shared priorities

Staff – better career opportunities, stronger organisational networks with easier movements between sites or trusts, and strong use of data to drive improvements.

How we will work together

Collectively we have developed a structured approach to collaborative working across the 4 Trusts:

"Do it once" – improvements we can only make by doing something once or fewer than four times across our trusts

"Do it the same" – Improvements we make by standardising what we measure and our best practice ways of working across our four trusts

"Do it locally" – Improvements we will get on and do within each of our four trusts

We will collaborate with patients, partners and communities to agree the best outcomes, identify and align to best practices that achieve these, and use data and insights to continuously improve and raise standards:

Acute provider collaborative (2 of 2): our priorities

NHS North West London Acute Provider Collaborative

Clinical outcomes and improving specialty pathways

- All 28 specialties across the four trusts have clinical and operational leadership groups, each sponsored by a CEO.
- Each specialty will identify one pathway annually to align with best practices that improve outcomes, equity, and productivity.
- Examples for 2024/25 include:
  - Respiratory: standardising COPD discharge bundle
  - Geriatrics/Frailty: improving 4AT assessment completion
  - Urology: acute stones service with virtual MDT

Quality

- Developing a stronger user insights focus
- Care of the deteriorating patient
- Maternity and neonatal – delivery plan
- Mental health in an acute setting
- Incident and risk management system

Productivity and performance

- Delivery of the activity targets in the operational plan
- Reducing medically optimised patient LOS
- Outpatient Transformation
- Theatre productivity

Research and innovation

- Address variation in access to research participation and innovation for different population groups
- Expand staff participation in research
- Attract academic and industry partners and investment

Data and digital

- Finalise the APC digital and data strategy
- Optimisation of Cerner system
- Improving productivity using FDP/care coordination solution

People

- Recruitment hub for hard-to-fill vacancies
- Career hub and staff transfer scheme
- Reduce violence, aggression, bullying, and discrimination

Estates and sustainability

- Share best practices in maintaining/enhancing physical assets
- Support movements towards net zero
- Leverage buying power as a collaborative to reduce costs

Other non-clinical and support services

- Cost efficiencies through applying best practices to standardize, automate and consolidate support services
- Realise benefits of procurement, ERP and workforce programmes

Anchor institution responsibilities

- Promote recruitment from our local communities
- Use collect buying power to support local businesses
- Share expertise in supporting population health and wellbeing

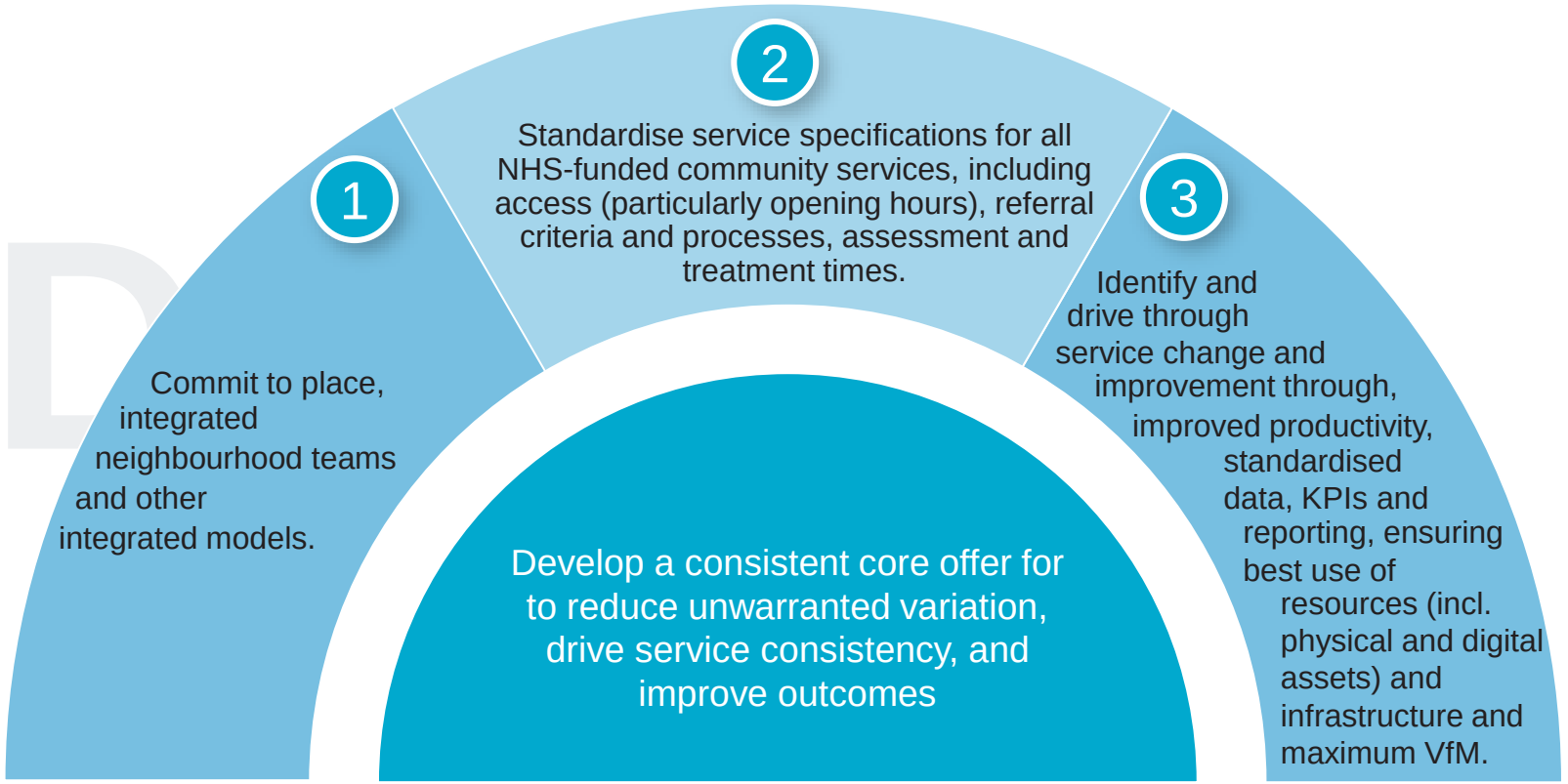
Community and mental health provider collaborative (1 of 3): A core offer for all community and mental health services

The community and mental health provider collaborative

The community and mental health provider collaborative is a formal partnership of the three community and mental health trusts in NW London:

- Central & North West London NHS Foundation Trust
- West London NHS Trust
- Central London Community Healthcare NHS Trust

A core offer for community and mental health services is a key contribution to the development of a neighbourhood health service in NW London:



Effective joint governance across the three providers to enhance consistency of decision making and delivery.

Community and mental health provider collaborative (2 of 3): Community services

Our priorities

The **key priority for community services** is the development of a NW London community core offer that ensures **equal access** to services across all 8 boroughs. We will:

- **Focus on NHS-funded services**, with 6 adult and 3 children priorities identified for mobilisation from April 2025.
- **Deliver the core offer within current funding** through service integration and productivity improvements.
- **Conduct a gap analysis** to compare current resources with the core offer requirements (a preliminary gap analysis is provided below).
- **Create a case for change** outlining the purpose, objectives, benefits, and outcomes of implementing the core offer.
- **Implement the core offer in phases starting from April 2025.**

Preliminary gap analysis	Night nursing	Neuro rehab	Stroke	Pulmonary rehab	Respiratory service	Lympho-edema	In reach care home	Bladder and bowel service	Complex case mgmt. / frailty	Discharge to assess	Cardiac rehab
Brent		x				x				x	x
Ealing			x			x	x				
H&F						x		x			
Harrow		x	x			x	x		x	x	
Hillingdon	x	x		x	x	x					
Hounslow			x			x					
K&C						x					
Westminster						x					

Core offer services

Adults' services in scope:

- Community therapies
- Complex case management / frailty
- **Care home in-reach**
- **Community nursing**
- **Urgent community response**
- **Discharge to assess**
- Falls
- Heart failure
- Cardiac rehab
- Pulmonary rehab
- Respiratory
- Tissue viability, leg ulcer
- Lymphedema
- **Neuro-rehab & stroke ESD**
- Diabetes
- Nutrition and dietetics / weight management
- Musculo-skeletal
- Bladder and bowel
- Speech and language therapy
- Podiatry
- Community beds
- Single point of access (SPA)

Children's' Services:

- Occupational therapy
- Physiotherapy
- Speech and language therapy
- Audiology
- Bladder and bowel
- Children's nursing service
- **Special schools nursing service**
- **Children looked after (LAC)**
- **Community paediatrics**

Community and mental health provider collaborative (3 of 3): Mental health, learning disabilities and autism services (MHLDA)

Our priorities

A core aspect of the MHLDA plan is to drive productivity improvements to enable greater consistency in patient outcomes and better enable our ability to manage rising demand. This will also ensure equal access to services across all 8 boroughs. The MHLDA providers across NW London intend to focus on four key priorities:

Priorities		Recent achievements	Key initiatives
1	**Mental health / urgent and emergency care programme**	• Completed an evaluation of crisis alternative services, enabling greater alignment of service offer across NW London.	• Optimising crisis alternative services – core coverage across NW London • Flow improvement and winter planning • Improve pathways of significant delay
2	**MHLDA productivity**	• Agreed a new set of processes (including dashboards, best practice guides, etc.) and trajectory for productivity improvement in community mental health services.	• Shared productivity culture across all MHLDA services, divided between: - Community mental health services - Inpatient mental health services
3	**Inpatient quality transformation programme**	• Launched new programmes for the inpatient quality transformation programme. • Launched delegated provider collaborative for perinatal mental health services.	• Purposeful admissions • Therapeutic inpatient care • Proactive and safe discharge planning
4	**Core offer**	• Trusts supported the development of core specifications for community MH and CYP NDS services, eventually taking on pathway development and final modelling.	• Community MH Services • NWL CYP neurodiversity services

E

Our borough-based partnerships

Working together at place: Our Borough-based partnerships

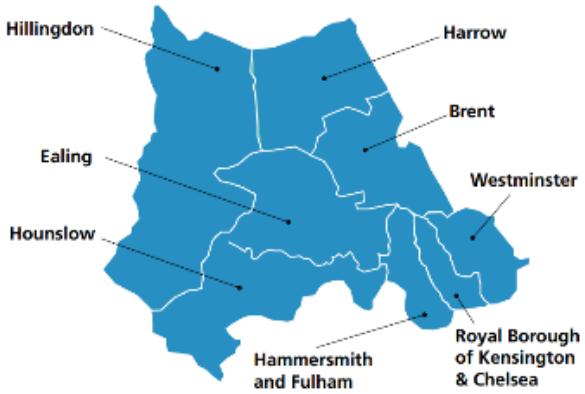
We are clear that the key to addressing the health and care needs of our local people lies in each of our **seven borough-based partnerships (BBPs)**

Recently, local health and care partners refreshed local health and care strategies, of a which a core number align with the NW London common priorities.

Our local BBPs bring together NHS organisations, our eight local authorities and public health teams, Healthwatch, voluntary and community sector organisations and local residents to work together to understand and meet local needs.

We want to make sure that our Joint Forward Plan and the nine priorities we have identified take appropriate account of local health and wellbeing strategies.

In this section we have summarised the plans of each of our Borough-based partnerships. Plans have been summarised and edited into 'one-pagers' for the purpose of the JFP, but there are detailed plans underpinning all of these summaries.



Bi-borough of Kensington and Chelsea and Westminster: our priorities

Our vision and ten ambitions

"People want to live healthy and happy lives, to their fullest and in ways they choose, in communities that are fair and safe."

- Healthy happy young people
- We can all be happy in our health
- Support people's mental wellbeing
- Good quality home
- All financially stable
- Safe and part of our communities
- Healthy environments
- Access to the best services
- All treated with fairness
- Supported independent living

The above is extracted from the bi-borough Health and Wellbeing Strategy 2023-2033), which can be found at: https://www.rbkc.gov.uk/media/document/health-and-wellbeing-strategy-2023-to-2033

Our priorities over the next five years include:

Integrated Neighbourhood Teams (INTs)

- The bi-borough has already established INT **leadership and governance structures**, and **an 'INT Guide'** describing the operating model was also recently published
- **Communities of practice** have also been developed through the 'Octopus' model in Westminster and the navigation workstream in Kensington and Chelsea.
- **Future efforts** will focus on **prevention** (vaccinations, immunisations and screening, as well as health checks), a **starting well** programme for children and young people and an **ageing well** programme for our older people.

Vibrant and healthy communities

- **Screen, Detect, Protect** – we have recently funded 16 VCSE organisations to tackle barriers to **cancer screening** and improvements in uptake have already been realised.
- Future efforts will focus on **improving health outcomes defined by our communities** – as described in the bi-borough Health and Wellbeing Strategy 2023-2033.

System flow

- Significant improvements have already been made in **reducing delays** in hospital through additional **step-down beds** and improved integrated working between providers.
- System flow will **continue to be a focus**, including tackling root causes of delays effective winter planning.

North Kensington recovery

- The community engagement programme is expected to achieve a Phase 2 outline business case (OBC) by 1st April 2025.
- Future efforts will focus on implementing a **supplementary health assessment** and further developing our **community-led recovery** programme.

Enablers: Work continues on **estates, data and digital** and **workforce** to deliver the four priorities outlined above. For example, INTs will require the deployment of PHM approaches – therefore investment has been made into BI capacity and expertise, and development continues in this area. Further work related to estates and workforce is also required.

Our case for change

Our population:

- The population is younger than the most parts of England, with high turnover.
- In Westminster, 39% of residents, and in Kensington and Chelsea, 31% of residents, identify as belonging to Black, Asian, or Multiple Ethnic backgrounds.

Areas of inequality:

Despite areas of financial affluence, disparities still exist, including:

- 1 in 4 children live in poverty.
- An 18-year gap in male life expectancy within Westminster – the highest in NW London.
- A high number of people experiencing homelessness.
- The Grenfell Tower Fire highlighted the level of inequality within some local communities, and the impact this has on recovery from the tragedy.

Key priorities for local residents include:

- All children to have good physical and emotional wellbeing.
- Focus on prevention of ill health.
- Support to better manage their own mental wellbeing.
- Access health services where and when they need to.

Brent: our priorities

Priorities	Key deliverables	Progress	Challenges	Next steps
Integrated neighbourhood teams (INTs)	Integrated care pathways, streamlined service access and robust data connectivity.	Strengthened partnerships and commenced the implementation of smoother data sharing.	Aligning systems and workflows across a range of organisations and resource constraints.	Rollout of data systems, expanding training initiatives and addressing gaps in digital literacy.
Health equity	Coproducing health and wellbeing initiatives to empower communities to improve their health.	Links with 428 orgs., 234 events delivered, with 11k attendees, 10k health checks completed and 4.5k emotional wellbeing interventions.	Embedding the tackling of health inequalities into 'business-as-usual' for all services.	Reaching out to additional communities and supporting Brent's adult social care team to deliver community assessment days.
Primary care	Improved access and patient choice to reduce avoidable hospital admissions and improve capacity.	Improved access and patient choice to reduce avoidable hospital admissions and improve capacity.	Access, recruitment and retention, a paediatric hub in Kilburn and changing demographics.	An access programme to ensure patient needs are addressed, staff engagement surveys, patient focus groups.
Mental health	PHM, prevention models and care strategies, awareness Raising, effective treatments and recovery-focused practices.	A new service model developed for NW2, NW10 and HA9, aimed at improving crisis response, outreach and psychologists.	Increased demand on specialist CAMHS with these pressures also reflected in general practice, schools and voluntary sector.	Reduce waiting times for specialist CAMHS and neurodivergent services and increase dementia diagnosis rates.
Community services	Reduction in hospital admissions for patients with frailty and readmissions in patients with dementia.	Partnering with Brent Public Health's Asthma Friendly Initiative – 23% of schools now have emergency asthma supplies and trained staff.	Resources remain a challenge, particularly with hospital discharge schemes, Tier 2 and 3 children continence and specialist school nursing.	Measure the outcomes of schemes being implemented with KPIs established for each.

Our case for change

Population and deprivation

- Brent is the second most ethnically diverse borough in London and the UK.
- Median age of 36 – four years below the England average.
- 1 in 4 people aged over 65 live alone.
- Significant socio-economic challenges, including a low employment rate of 64%, high levels of deprivation, and a large proportion of children living in poverty.

Long-term conditions

- 8% of adults have diabetes
- 11% of adults have high blood pressure.

Health equity

- At birth, people living in the most deprived areas can expect to live 6.4 years less than people in the least deprived areas.
- Significant disparities in hospital admissions, with admissions for mental health, heart failure, and diabetes disproportionately high for people from black ethnic groups.

System challenges

- Fragmented data sharing, workforce shortages, and insufficient digital infrastructure hinder service delivery.\\\

Ealing: our priorities

Together in Ealing:

See communities thrive in their health and wellbeing, supported by fairness and justice as the foundation.

Putting communities at the heart of everything

Listen to and **learn from communities**, enhance the power of the **voluntary and faith** sectors, and develop new **co-production** models.

Systems and structures to leave no one behind

Drive excellence in a **shared DEI agenda**, ensure services meet the diverse needs of our communities, and ensure we are **well-equipped** to serve them effectively.

Connecting the building blocks of health and wellbeing

Apply an **inequalities** lens to the **building blocks** of health and wellbeing, and lead a **whole-systems approach** to their development.

Our vision for INTs and primary care

INT priorities include: Further development of **neighbourhood teams**; development of **neighbourhood priorities**; **care navigation network**; **communication** and stakeholder engagement; **integrator roles** established.

We want to **serve 50-100k residents** with a transparent, well-planned approach, involving all major health and social care services.

Primary care is key to this, our primary care priorities include: Access; enhanced services (local); primary care quality.

In primary care we want to partner with providers to streamline entry points and strengthen service resilience.

Our priorities: We have several additional priorities (other than the development of INTs).

Children and young people

- **Child health hubs**
- Early years and youth justice pilot
- School nursing capacity
- Mental health pathway improvement (Thrive model)
- Asthma

Seasonal summit and patient flow

- **Optimise system flow**
- Seasonal summits
- More MDT meetings
- Discharge schemes

Population health and inequalities

- **Target health inequalities**
- **Healthy Ealing Team** to support vulnerable groups
- HWB strategy development
- Asylum seekers and homelessness
- Alcohol and illicit drug misuse
- High-intensity users support
- Immunisations and vaccinations
- Health inequalities transformation schemes

Older people and frailty

- **Community frailty**
- Care homes support
- Frailty model in INT
- End of life
- Dementia

Digital

- Data management
- New technologies
- Digital strategy – interoperability for INTs

Engagement

- Strategic engagement group across partnership
- **Embed co-production in all projects**
- Resident forums

Estates

- Estates strategy for INT
- Fully utilise existing estate
- Align 7 town estate plan to INTs

Workforce

- Workforce strategy
- Training hub
- GP recruitment and retention
- Race equality

Our case for change

Ealing has the **highest resident population** across all NW London boroughs, with the population **forecast to increase significantly** in the future. This requires all providers to plan and work collectively to ensure resources are deployed effectively.

Life expectancy, the prevalence of long-term conditions, and inequalities vary across the borough from north to south and east to west.

The Local Authority is working to its 7 towns strategy and pledged to become a Borough of Sanctuary, welcoming people in need of support.

Key statistics for Ealing include:

- High prevalence of **diabetes** and **hypertension**, Ealing has the highest prevalence rate across all 6 key LTCs.
- Net importer of residents into **care homes**, with the largest bed base - with increasing acuity of patients
- High (2nd highest in NW London) rates of **homelessness**
- Most **ethnically diverse** borough in London
- Highest areas of **deprivation** in Southall, Acton and Northolt.
- Highest rate of **alcohol admissions** in London

Hammersmith & Fulham: our priorities

Priorities:

Our priorities are framed around **creating health** and **integrating services**, as core parts of the integrated neighbourhood team agenda. The mandate for INTs will need to build over time through formal governance mechanisms.

Health Creation:
Including reducing inequalities, supporting independence, focusing on children, addressing wider determinants, empowering communities, etc.

Integrating Services:
Including joining-up services for people with complex needs, sharing risk collectively, reducing duplication, etc.

Workstreams: Develop once, then organise at neighbourhood level. Likely focus areas are described to the right.

Health creation and community empowerment
- Bring community, mental health, and LA services together and co-produce with local people.
- Focus on **frailty and diabetes**
- Reconfigure **Parkview Centre for Health** to ensure it is better utilised and available to the local community.

Adult mental health
- Review **supported housing and brokerage and develop** a plan to reshape services.
- Build **integrated ways of working** across care sectors.
- Develop arrangements for **discharge and flow** including protocols and governance between organisations.

Older people and dementia
- Progress MDT approach to fully **integrated teams**.
- Build on existing secondary care interface work with **older adult mental health services.**
- Develop PHM approaches in South Fulham with all organisations and VCSE (co-production).

INT development:

North H&F INT | **Central H&F INT** | **South H&F INT**

Note: The initial focus of INTs will be on strengthening relationships and developing one or two workstreams. Each INT will develop a key area for the H&F population, developing a model of care that can then be rolled out wider.

Place level development and organisation (incl. enablers)

Children and young people crisis pathways

Workforce and OD | Estates | Data, insights and digital | Engagement and co-production | T&F group on contract gaps / overlaps

Note, other key areas of work include: General practice transformation and same day access; future arrangements for the three APMS contracts; estates at Parkview, Bush Doctors and Fulham Medical Centre.

Our case for change

Population and deprivation
- While the fifth most deprived in NWL by IMD, H&F have the third-highest Core 20 population, with outcomes worse than expected for its average IMD ranking.
- Pockets of deprivation, particularly in White City, face significant challenges including food and fuel poverty, overcrowding, high crime, male unemployment, and poor general practice access.

Health equity
- The borough has the lowest 3-year life expectancy at birth in NWL.
- Hammersmith and Fulham has the highest rates of preventable mortality in NWL.

System challenges
- Residents perceive services as fragmented and difficult to access,
- Community nursing and therapy services are split, and both hospital trusts deliver some community services. This leads to inefficiencies and contributes to worsening patient experience and outcomes.
- Mental health crises, inpatient admissions, and readmissions have all been highlighted as critical issues for both adults and children.

Harrow: our priorities

Our vision: At the heart of our plan, we will build and drive change through our three **integrated neighbourhood teams (INTs)**. We will build these teams so that they are able to take accountability for the **overall health and wellbeing** of their neighbourhood population and deliver **seamless and coordinated services** across health and care for that population, with **staff who are engaged and supported** by the wider system to care for people in the community.

Preventative care and reducing health inequalities

- Ensure our work is driven by an **in-depth understanding** of our population and the inequalities they experience (PHM).
- Focus on promoting **mental wellbeing.**
- Focus on key prevention priorities: **cervical screening, child tooth decay, physical activity** and **falls.**
- **Long-term condition management:** focus on prevention and management of hypertension, diabetes, chronic kidney disease and cardio-vascular disease.
- **Get people back to work** where health is a driving factor – linking our wider employment schemes and anchor roles to this focus.

Complex and reactive care management

- Secure the **right community service offer** for the Harrow population so that we can provide care within the community, delivered through our INTs – preventing unplanned hospital admissions.
- Ensure robust **pathways to support people home from hospital** and provide them with the right care and support to avoid a readmission.
- Address the causes of the rise in urgent attendances at hospital, focusing on **primary care access models, digital inclusion, asthma management,** etc.
- Develop awareness and appropriateness of our **mental health crisis pathways.**
- Robust and integrated **safeguarding** arrangements in place.

Families, children and young people

- Implement **family hubs** within our neighbourhood footprints – focusing specifically on early years to secure school readiness for our whole population by reception year.
- Further **develop the team** around the family model.
- Integrate health and care services for **children and young people** more widely.
- Deliver **hyper-local approaches** to family support that looks at the wider needs of the family unit and builds confidence.

Our priorities will be supported by:

- Developing our integrated workforce and harnessing the talents in our local teams.
- Driving new ways of working through adoption of digital technologies.
- Sharing information across teams more effectively.
- Engaging effectively with communities.
- Exploring estate that supports our integrated care ambitions and is ready for future population growth.

Our case for change

Harrow's previous three-year plan (2021-2024) had a focus on reducing health inequalities, delivering integrated out of hospital teams and transforming care pathways. Whilst we made significant progress against all three aims, we still face a number of challenges:

The views of our residents

- The need for greater community service provision for mental health and wellbeing.
- Primary care challenges, including waiting times, short consultations and difficulties with booking.
- Housing challenges, including asthma, mental health and isolation, and cost of living.

Population and deprivation

- The population is growing faster than nationally.
- Harrow has a higher proportion of adults aged over 65 compared to the rest of London, with 10% of these people living with frailty.
- 1 in 3 people are physically inactive.

Health equity

- Harrow has the highest rates of diabetes, hypertension, chronic kidney disease and people with comorbidities in NWL.
- Over 40% of young children have visible dental decay.
- 1 in 3 children are overweight by Year 6 in school.

System challenges

- Rising numbers of people presenting to emergency services.

Hillingdon: our priorities

Our vision: is to implement a new **7-day place-based operating model** that integrates 32 existing local care services into **3 integrated neighbourhood teams** and a **single borough-wide integrated reactive care service** to optimise system flow.

Key deliverables include reductions in UTC/ED presentations and hospital admissions; improved productivity; improvement of financial position; improvement of key population health outcomes, reduction of health inequalities; and supporting people back into employment where appropriate.

Integrated neighbourhood teams (INTs):

Our vision includes provision of 3 'at scale' **same-day urgent primary care hubs** for people with non-complex needs; proactive care through risk stratification, case finding and enhanced case management; and preventative and anticipatory care for a ange of population health priorities.

Recent achievements:

- 3 INTs established with neighbourhood director and clinical leadership in place.
- 3 same-day urgent primary care hubs.
- Second lowest admission rate for severe frailty across NW London.

Key initiatives:

- Integration of community MH hubs and MSK therapy into INTs.
- Same-day urgent primary care hubs: at-scale working.
- Review of proactive care case management model (frailty).
- Transformation of prevention and early intervention models.
- Population health (HIT).

Key next steps:

- Completing staff consultation and embedding teams into INTs, including MH teams

Optimising system flow:

Our vision is to implement a **single borough-wide reactive care service** in order to reduce non-elective presentations and promote earlier discharge.

Front door initiatives:

- Home-based active recovery service.
- Single point of coordination to hospital front door and digital triage.
- SDEC and EAU capacity utilisation.
- Community OPAT.
- Improved use of MH crisis alternatives.

Back door initiatives:

- Implement bed-based active recovery service.
- Integrated place-based therapy team.

Key next steps:

- Implementing pathway changes to support system flow across the winter plan and embedding into BAU activities.
- Commencing implementation of active recovery service.

End-of-life care:

Our vision is to implement effective end-of-life care through both developing our integrated neighbourhood teams and optimising system flow:

Recent achievements:

- Integrated end-of-life hub and integrated teams implemented across acute, community and hospice providers.

Key initiatives:

- Palliative integrated care service, coordination hub expansion
- Acute to hospice pathway
- Integrated team working
- UCP and early identification

Key next steps:

- Completion of end-of-life care transformation and embedding into BAU.

Key enablers: key enabling initiatives include planning for neighbourhood estates; workforce passport; and digital integration between organisations.

Our case for change

Population demographics

- The population has grown by 16% since 2017, doubling the number of people now living with one or more LTC; 127k (48% of adult popn.).
- The 65+ age group, although comprising only 14% of the total population, utilise up to 40% of all healthcare.
- 4,400 patients (1.6% of the adult population) account for 50% of all non-elective episodes in Hillingdon.

Demand and capacity, and performance optimisation

- Aimed reductions in Urgent Treatment Centre (UTC)/Emergency Department (ED) attendances (-18%) and non-elective (NEL) admissions (-10%) based on 2019/20 benchmarks.

Service transformation

- Transforming 170 fragmented, overlapping local care services to meet demand and access requirements.

Financial sustainability

- Addressing a significant Place financial deficit of approximately £50 million.

Hounslow: our priorities

Our vision: In line with the Hounslow health and wellbeing strategy, a **life-course approach is emphasised**, with a focus on **local communities**, **prevention**, and **early intervention**. **Recent achievements** include 'Dementia Friendly Community' status; exceeding dementia diagnosis targets; 'Pentagon Model' for improving discharges for pathway 1 patients; 'stay steady and active' falls prevention campaign; training 146 staff members in PHM; Core20Plus5 workshops with VCSE partners and other stakeholders being held – attracting over 100 attendees; and the borough-based partnership website being shortlisted for a HSJ Award.

Priorities	Key deliverables	Key initiatives	Key next steps
Integrated neighbourhood teams (INTs)	• Reduced ED attendances and hospital admissions by high intensity users (HIUs).	• HIU service. • NHS & Housing forum. • Various initiatives to be delivered by each Hounslow INT*	• Significantly advance the INT programme, prioritising INT objectives, and reduce unnecessary acute hospital usage by focusing on the HIU cohort.
Hospital prevention and discharge / frailty	• Reduce falls-related hospital admissions. • Reduce dementia-related hospital admissions. • Implement revised frailty care model.	• Falls prevention service. • Enhanced dementia care service. • End-of-life care.	• Agree new operating model for frailty. • Agree targets for year 3 of the falls prevention service. • Roll out the 'stay steady and active' campaign and develop the community falls prevention offer underpinning it. • Continue to embed ECDS models.
Prevention and health inequalities	• Improve preventative health services uptake in Core20Plus5 groups.	• Health outreach team. • Core20Plus5. • Befriending service.	• Design and implement a response to the Core20Plus5 data findings and initiatives.
Children with disabilities, SEND and complex needs	• Reduce waiting times for CYP NDT assessments.	• CYP MH: return to school service. • CYP MH: youth and family service.	• Assess interventions to reduce emergency hospital attendances related to children.
Primary care	• Enhanced access and quality improvement.	• Primary care access programme. • Primary care network development. • Quality improvement (e.g. local enhanced services and standard contracts).	• Roll out access programme.

Our case for change

The Hounslow borough-based partnership is driven by:

1. Alignment with national and local directives to deliver resident-focused care.
2. Resident expectations for personalised and joined-up care.

Population demographics

- The over 65 population is growing faster than the national average with a projected 51% increase by 2040.
- Approximately 28% of residents experience significant deprivation, including 20% of children living in poverty.
- Rising life expectancy, though this is accompanied with poorer health, driving increased demand for services.

System challenges

- Frailty-related metrics, such as falls require improvement.

***Key initiatives for specific INTs include**: **Hounslow Health INT** - diabetes, hypertension, smoking, obesity; **Great West Road** INT – CYP, women, working age population; **Brentworth INT** – anxiety and depression; **Chiswick INT**: adult mental health and neurodiversity; **Feltham & Bedfont INT** – healthy lifestyles and healthy weight.

F Supporting plans

NHS
North West London

Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (1 of 2)

Quality

We have a responsibility to coordinate the approach to oversight patient safety incidents response to all the services within the system. The current SI process is currently being transitioned to the Patient Safety Incident Response Framework (PSIRF) and the ICB is responsible for reviewing provider's PSIRF policies and processes and endorsing their move to the new system. Quality and safety information which is discussed and challenged at System Oversight Meetings and areas of concern are raised at the ICB Performance and Quality Meetings. To review opportunities for learning and improvement plans and lessons learnt at the System Quality Group meetings. Promote a positive safety culture, encouraging staff to gain insight and share learning from good and poor practice. Providing Patient Safety Specialist advice to the ICB. We will use the learning from complaints to improve patient experiences.

The complaints team receives and manages complaints that are received at the ICB. They mainly involve complaints regarding Primary Care and CHC. Complainants are encouraged to engage with the service for which they have raised concerns. The ICB provides clinical oversight of complaints as required.

Key actions:

- Support providers in the transition to PSIRF. This will also involve support in closing SIS that are currently in the system.
- Work with NHSE regarding delegation of specialist commissioning and clinical networks.
- Review the ICB Quality Impact Assessment process for procurement.
- Assume responsibility for maternity services which will need to be embedded within current roles and responsibilities.
- Work with the CQC following their new inspection process which includes inspection of ICSs.
- Support the development of Primary Care Quality Improvement and Assurance Framework
- Work with independent providers to provide quality assurance data
- Manage complaints that are sent to the ICB in line with best practice and ensure that learning is reviewed and shared.

Continuing Healthcare

The function of the continuing healthcare service (CHC) is to provide comprehensive and ongoing healthcare and support to individuals with complex, long-term health needs. Following being assessed as eligible for continuing healthcare. The eligibility outcome is based on the use of national frameworks and in line with the statutory responsibilities of the ICB for CHC.

The key objectives of the service include undertaking; assessment, care planning, brokering care, monitoring and review of care packages, quality assurance of care providers. As well as providing an appeals process for individuals who have been assessed as not eligible for CHC. We will also ensure that people who have multiple care health and social care conditions are supported in an environment to keep them safe and provide high quality care.

Key actions:

- Promote and support collaboration to ensure high quality offer across key areas that affect provision of care for patients, such as, CAMHS, children community nursing, adult community nursing and mental health to reduce inequalities and the need for individualised commissioning.
- Understand he domiciliary and care home market capacity across NW London against future demand, including the type of beds, and support into nursing homes to ensure adequate provision and what they need to manage increasingly complex people.
- Promote and support the provision of consistent bladder and bowel support for nursing homes. This is to ensure, appropriate evidence based continence assessments and appropriate containment products are in place.

Our commitment to delivering the ICB statutory functions relating to quality, safeguarding and infection prevention and control (2 of 2)

Safeguarding

We Strategic leadership and partnership working support the efficiency of the safeguarding system in place across all boroughs. Assurance is achieved through working closely with Safeguarding Adult Boards, Children's Safeguarding Partnerships, health providers and partner agencies. The ICS Safeguarding group and ICS Violence against Women and Girls group ensures that the profile of Domestic Abuse and Sexual Violence is high on the agenda, with due regard to provisions of the Domestic Abuse Act 2021. Updates and system learning is discussed within the ICS System Quality Group. In addition, in line with legislative change (Police, Crime, Sentencing and Courts Act, 2022), and to support reduction of serious violence, implementation of the Serious Violence Duty is achieved through utilisation of health based data collection initiatives that support borough based strategies in each local area. Equity of health offer for children and young people in care is monitored through review of service provision and for children placed in and outside of NW London. The Safeguarding Strategy ensures practice is aligned with NHS England recommendations and ICS ambitions. The ICB has a statutory responsibility to review child deaths on behalf of the Child Death Partners, the ICB and Local Authorities across NW London. The ICB also has a similar duty to review adult deaths where Learning Disability and Autism are identified.

Key actions:

- Review the ICB's function following publication of Working Together to Safeguard Children (2023).
- Continue to progress with work initiatives related to Domestic Abuse and Violence against Women and Girls including White Ribbon accreditation and Sexual Safety in Healthcare.
- Work with providers to ensure that Children Looked After health assessments are completed in a timely manner.
- Work and support providers to ensure statutory safeguarding responsibilities are met.

Infection Prevention and Control (IPC)

To provide oversight and scrutiny of ICS and individual provider progress against IPC related ambitions / thresholds / regulatory and contractual requirements / intelligence and improvement programmes. Oversight of local compliance with IPC training. Support to local networks re professional development opportunities and succession planning. Seek assurance that local services are commissioned against and are working to national IPC guidance and policy. Work towards the Antimicrobial Resistance agenda (AMR) with colleagues in pharmacy and diagnostics for an integrated approach for individuals and communities at greater risk of ill-health.

Key actions:

- With Provider organisations develop a robust IPC assurance system ensuring that IPC related risks and learning are identified and shared and improvement programmes are put in place and develop and implement strategies for preventing and reducing avoidable HCAIs.
- With local authorities review and understand provision of IPC and continence services in care homes and ensure policies and processes are in place to identify and manage patients with infections.
- With Urology and Continence leads to undertake a mapping of Trial without Urinary catheter services across NW London to ensure that all patients have the same access to urinary catheter services.
- Support the development of the IPC services across Acute, Primary Care and Community, ensuring leadership, capability, capacity, and succession planning in all roles and areas of IPC.

Alignment of the Joint Forward Plan to our legislative requirements (1 of 2)

As an ICB we have several statutory duties that we are required to fulfil by law. The key priorities outlined through this Joint Forward Plan details how these duties will be delivered. We have outlined below a summary response in how we are fulfilling each requirement:

Legislative requirement	Description	North West London ICB response
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: improve quality of those services reduce inequalities in access and outcomes.	Our Joint Forward Plan outlines how the ICB will meet the health needs of our population in an integrated way. This is worked through each priority – in particular please see *Priority 1* and *Priority 3*.
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	We have outlined the health services we will make arrangements for in the section on *'Who we are'.* Additionally, each priority outlines the services in which it will impact.
Duty to consider wider effect of decisions	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the triple aim of: (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	North West London ICB is committed to the 'triple aim' and our Joint Forward Plan outlines our plans to reduce inequalities – see *Priority 1*, improve quality of our services – see *quality section* and ensure sustainability of our services – see our *medium term financial strategy summary*.
Implementing any JLHWS	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	Within our Joint Forward Plan we have outlined for each of our places (our Boroughs) their plans, as reflected in their JLHWSs, please see *'Borough section'*.
Financial duties	The plan must explain how the ICB intends to discharge its financial duties.	Our financial duties are outlined in detail through our medium term financial strategy, we have summarised this in the *'Our financial challenge'* section and ensured our priorities align to the plan and it's expenditure limits.
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illnessoutcomes including safety and patient experience.	Ensuring quality of services is a key priority for the ICB and is woven through each of the priorities in our Joint Forward Plan. Please see the '*Quality, safeguarding and IPC section'* for further detail.
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: improve quality of those services reduce inequalities in access and outcomes.	Our Joint Forward Plan outlines how the ICB will meet the health needs of our population in an integrated way. This is worked through each priority – in particular please see *Priority 1* and *Priority 3*.

Alignment of the Joint Forward Plan to our legislative requirements (2 of 2)

As an ICB we have several statutory duties that we are required to fulfil by law. The key priorities outlined through this Joint Forward Plan details how these duties will be delivered. We have outlined below a summary response in how we are fulfilling each requirement:

Legislative requirement	Description	North West London ICB response
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to: (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	Involvement of both residents and patients are key in every decision we make. We have outlined how we include them in our decision making in the Joint Forward Plan – please see the section '*How we have engaged and continue to work with our residents*'.
Duty to involve the public	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	
Duty to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in: (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	North West London ICB has a range of ways in which it gathers advice – predominately this is through its various governance forums which cross a broad range of professional expertise. Our CRGs are integral in providing clinical advice.
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	North West London ICB has a dedicated programme whose purpose is to research and develop innovative solutions to support our health services. These are key activities with our priorities.
Duty in respect of research	Each ICB must facilitate or otherwise promote: (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	
Duty to promote education and training	Each ICB must have regard to the need to promote education and training[i] so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.	Promotion of education and training is integral part of our workforce strategy, we have summarised.
Duty as to climate change	Each ICB must have regard to the need to: (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets) and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	North West London ICB is committed to NHS England's net zero targets. In 2022 we published the North West London ICS Green Plan http://www.nwlondonics.nhs.uk/download_file/view/329, which outlines how we aim to deliver our commitments on sustainability and climate change.
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	Addressing the needs of victims of abuse is covered within the safeguarding section of the JFP. North West London ICB safeguarding policy covers the provisions of the Domestic Abuse Act 2021, accompanying Serious Violence Duty Statutory Guidance, and relevant safeguarding provisions.
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	Our commitment to the particular needs of children and young people is key and outlined in *Priority 2.*

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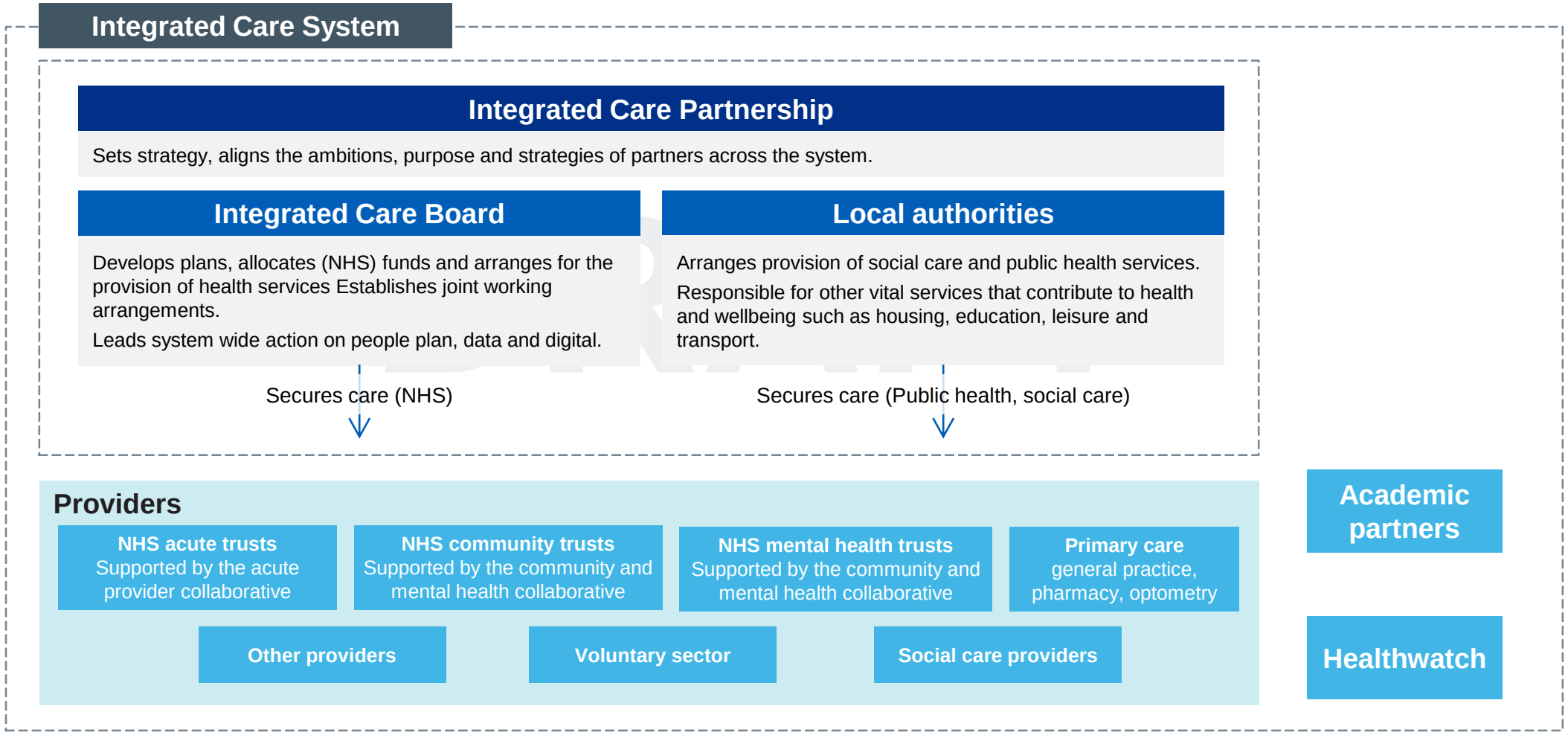
Appendix i:
Supplementary information

How is health and care organised now?

Integrated care systems (ICSs) are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration.



Examples of productivity improvements that we have delivered or are in the process of delivering

NW London Elective Orthopaedic Centre (EOC)

In autumn 2023, the APC opened a **centre of excellence** for planned **orthopaedic care** at **Central Middlesex Hospital**. The EOC will deliver productivity and quality of care for patients that consistently meets best practice and delivers value for money.

It **supports productivity** through dedicated facilities, staff and economies of scale which together embed best practice pathways, support efficient scheduling and enable optimal outcomes.

The EOC opened **3 theatres** in **December 2023** and **5 theatres** in **April 2024**, achieving so far:

- An average length of stay of 2.8 days in the first 10 weeks of operation, already almost reaching the year 2 target of **2.3 days.**
- **Productivity benefits of £545k** (full-year effect) in 2023/24.
- **100% patient satisfaction.**

Improving flow through the autism diagnostic pathway – community paediatrics

The **community paediatrics service** was struggling to cope with **increased referrals** and had received complaints from parents that children had to wait too long following their first appointment for assessment and diagnosis.

The multidisciplinary team used **quality improvement methodology** to identify and test changes to the clinical pathway to reduce wait times.

This resulted in:

- A **reduction in time** from assessment to diagnosis for children under 11 from an average of 25 weeks to 3 weeks.
- Tested **new pathway for children** over 11 years which has reduced journey time from referral to diagnosis from an average of 82 weeks to an average of 48 weeks.
- **Improved staff morale**, despite rising workload and ongoing challenges.
- Encouraged a **culture of improvement** and learning across the department.

National Wound care strategy

Community services in Goodall, hosted by **Central North West London Community Services** (CNWL) is an early implementer site for the national wound care strategy. We have focused on more **consistent**, and **improved pathways** which has resulted in **wounds being healed quicker**, but also not having recurring wounds which has reduced pressures on a range of services that include district nursing, complex wound care but also primary care services and acute hospitals. **Patient experience** has also improved.

Healing rates at 24 weeks have improved from **14**% in April 2023 to **57%** in December 2023 for venous leg ulcers.

There is now **greater awareness** across the system to identify and support wound care earlier, the new pathways support a preventative rather than reactive approach, and there is increased capability and confidence across all the teams to support patients with wounds.

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Appendix ii:
Glossary of key acronyms and terms

Glossary of key acronyms

Acronym	Definition	Description
BCYP	**Babies, children and young people**	
BI	**Business intelligence**	
CHC	**Continuing healthcare**	A package of care for adults aged 18+ who have complex, long-term needs.
CQC	**Care Quality Commission**	The independent regulator of health and adult social that make sure services provide people with safe, effective, high-quality care.
DAB	**Co-design advisory body**	A group of representatives of community groups, voluntary groups and watchdogs who share their views to support the development of local healthcare and NHS services.
EPR	**Electronic patient record**	all staff involved in a patient's care have access to their health record, giving them a complete overview of patients' care needs.
FDP	**Federated data platform**	Software that will bring together data from across different NHS organisations – currently stored in separate systems – so that staff can access the information they need in one safe and secure place.
GP	**General Practice**	A clinic made up of medical professionals, including doctors, who treat all common medical conditions or refer patients to services that can help.
ICP	**Integrated are Partnership**	A joint committee run by NHS organisations and local authorities to improve local health, care and wellbeing.
INT	**Integrated neighbourhood team**	Teams made up of health and care workers, volunteers and wider partners who will work together to deliver services that respond to local residents' needs.
JFP	**Joint forward plan**	A 5-year plan that all integrated care boards must produce on an annual basis, in collaboration with their NHS provider partners.
LAC	**Looked after children**	Any child / young person who needs support with emotional wellbeing.
MECC	**Making every contact count**	A national initiative encouraging public-facing workers to make contact with patients and the public as an opportunity to support or enable them to consider healthy behaviour changes.
ODG	**Operational delivery group**	
OPTICA	**Optimised patient tracking and intelligent choices application**	Software that provides clear visibility of all tasks needed before a patient is safely able to leave hospital.
PGD	**Patient group directions**	A legal framework that allows some registered health professionals to supply or administer specified medicines to certain patients.
PHM	**Population health management**	The analysis and representation of data in an understandable way.
RAT	**Rapid assessment and treatment**	The process of quickly assessing and determining what immediate response is needed for patients initially attending an emergency department.
SDEC	**Same day emergency care:**	Certain emergency patients can be rapidly assessed, diagnosed and treated without being admitted to a hospital ward.
SEND	**Special educational needs and disabilities**	A child or young person has special educational needs and disabilities if they have a learning difficulty and/or a disability that means they need special health and education support.
UEC	**Urgent and emergency care**	Services that provide care for patients who need urgent care. This ranges from life-threatening emergencies to illnesses or injuries that requires immediate attention.
VCSE	**Voluntary and community sector organisations**	
WSIC	**Whole System Integrated Care**	A database providing a summary of patient's health and social care data to help build a better understanding of need across our communities.

Glossary of key terms (1 of 2)

Definition	Description
Organisations, teams and groups	
Anchor institution	Large organisations that are unlikely to relocate and have a significant stake in their local area, such as trusts and local authorities.
Borough-based partnership / place	Partnership between local authorities, primary care, community care, mental health, acute trusts and the voluntary sector to tackle local challenges and improve health and wellbeing.
Local authority	The organisation responsible for public services and facilities in a borough, often referred to as councils.
Mental health support teams	Increase access to early intervention for common mental health problems such as anxiety and low mood in schools.
Multi-disciplinary teams	Teams that bring together a range of expertise with a common goal to improve health outcomes.
Provider collaboratives	Partnership that brings together two or more NHS trusts.
Task and finish group	A group that focuses on an existing issue to identify what concerns there are, if any, with a certain project and resolve these.
Trust	An NHS organisation that provides services to patients, e.g., hospital treatment, mental health care, ambulance service.
Schemes, programmes and platforms	
Additional roles reimbursement scheme	Initiative to grow capacity through new roles in general practice and by doing so, helping to solve the workforce shortage
Cancer faster diagnostic standard	National target is that you should not wait more than 28 days from referral to finding out whether you have cancer or not
Foundry	A solution that helps doctors, nurses and other NHS professionals by organising information that trusts hold on different databases in one place.
Health equity programme	Working to tailor services to the level of need in our communities, rather than providing a one-size-fits-all approach.
High intensity use programme	Making contact with the most frequent attenders of the local A&E to find out how the local health and social care system could better meet their needs
NHS single delivery plan	A plan for maternity and neonatal services intended to provide support to services in achieving safer, more personalised care
Paediatric transformation programme	A collaboration of organisations working to improve health outcomes for babies, children and young people in London
Population Health Management and Health Equity Academy	Population health management resources and case studies for health and care professionals (see PHM above for information on population health management)
Frameworks and approaches	
Anchor charter	Sets out the ways which our partners aim to have a positive impact on their local communities through their role as employers, land and asset owners and in the way they impact the environment
Core20PLUS5	**Core 20:** the most deprived 20% of the population; **PLUS:** Population with protected characteristics as defined by the Equality Act 2010; **5:** five areas of focus which require accelerated improvement: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.
Discharge to assess (pathway 1, 2 or 3)	Ensures that patients are able to leave hospital safely by directing them to the right next step in their care; **Pathway 1:** discharged to their home or to a usual place of residence with new or additional health and/or social care needs; **Pathway 2:** discharged to a community bed-based setting which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover; **Pathway 3:** discharged to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care.

Glossary of key terms (2 of 2)

Definition	Description
NHS initiatives	
Transfer of care hubs	Different services such as social care, housing and voluntary services are linked to coordinate support for patients who need it
Virtual wards	Also known as hospital at home, patients can be cared for at home safely and in familiar surroundings, helping speed up recovery while freeing up hospital beds for patients that need them most
Additional terminology	
Acute care	Patients treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery
Capital	The money used to build, run, or grow an organisation
Care pathway	A plan for patient care that is comprehensive and may include care from multiple services
Elective care	A way of working that involves people who use health and care services, carers and communities in equal partnership
Estates	Non-urgent services, usually delivered in a hospital setting
Health equity	NHS buildings and the grounds they are on, or around them.
Health outcomes	Everyone has a fair and just opportunity to attain their highest level of health
Health outcomes	Broadly agreed, measurable changes in health or quality of life that result from delivery of care
Hospital discharge	When patients formally leave a hospital after review that it is safe for them to do so
Inpatient	A person who stays one or more nights in a hospital in order to receive medical care
Outpatient	A person who visits a hospital for diagnosis or treatment without staying overnight
Patient flow	The movement of patients across the healthcare system, including how they interact with and between services and the systems needed to get them from the first point of contact to being discharged.
Primary care	The first point of contact in the healthcare system, including general practice, community pharmacy, dental and eye health services
Protected characteristics	It is against the law to discriminate because of: age, disability, gender reassignment, pregnancy, race, religious beliefs, sex and sexual orientation