If you require further information about this agenda please contact: Vid Calovski: vid.calovski@hounslow.gov.uk.

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC)

A meeting of the Joint Health Overview & Scrutiny Committee (JHOSC) will be held in the on Tuesday, 9 December 2025 at 10:00 in Room 6.10 at Hounslow House, 7 Bath Road, Hounslow, TW3 3EB

MEMBERSHIP

Borough	Representative
London Borough of Brent	Councillor Ketan Sheth (Chair)
London Borough of Hammersmith and Fulham	Councillor Natalia Perez (Vice Chair)
London Borough of Ealing	Councillor Ben Wesson
London Borough of Harrow	Councillor Chetna Halai
London Borough of Hillingdon	Councillor Nick Denys
London Borough of Hounslow	Councillor Marina Sharma
Royal Borough of Kensington and Chelsea	Councillor Lucy Knight
London Borough of Richmond upon Thames	Councillor Claire Vollum (non-voting)
Westminster City Council	Councillor Concia Albert

AGENDA

1. Apologies

2. Declarations of interest and clarification of alternate members

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

3. Minutes of the previous meetings held on 01 May 2025 and 17 July 2025 ***(Pages 3 - 24)***

   That the minutes of the meetings held on 1 May 2025 and 17 July 2025 be taken as read and signed as correct records.

4. Matters Arising

5. Urgent and Emergency Care Delivery ***(Pages 25 - 40)***

6. Implementation of the Same Day Access Model in Primary Care ***(Pages 41 - 84)***

7. Application of the Continuing Health Care Criteria ***(Pages 85 - 96)***

8. SEN Continence Service ***(Pages 97 - 119)***

9. North West London JHOSC Recommendations Tracker ***(Pages 120 - 146)***

10. North West London JHOSC 2025/26 Work Programme ***(Pages 147 - 152)***

11. Any other business

DECLARING INTERESTS

Committee members are reminded that if they have a pecuniary interest in any matter being discussed at the meeting they must declare the interest and not take part in any discussion or vote on the matter.

Mandy Skinner, Acting Chief Executive
London Borough of Hounslow, Hounslow House, 7 Bath Road, Hounslow, TW3 3EB

28 November 2025

USEFUL INFORMATION

Joining the Meeting virtually

The meeting is open to the public and can be viewed online at this Link

Attending the Meeting in person

Getting There

By Tube

- Take the **Piccadilly Line** to **Hounslow Central Station**.
- From the station, it's about a **5-minute walk** to Hounslow House. [moovitapp.com]

By Train

- Nearest train station: **Hounslow** (South Western Railway).
- From the station, walk or take a short bus/taxi ride to Bath Road. [moovitapp.com]

By Bus

- Bus routes serving the area: **110, 111, 237, 423, H28**.
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2. Stay seated.
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North West London Joint Health Overview and Scrutiny Committee
Notes of meeting by LB of Brent
10am-12pm on 1 May 2025

The meeting began at 10am.

PRESENT

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

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

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

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1 Apologies for absence were received from the following members:

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

2. DECLARATIONS OF INTEREST

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

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

3. MINUTES OF THE PREVIOUS MEETING

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

4. MATTERS ARISING

4.1 Gordon Hospital

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

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

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

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

5. COMMUNITY BASED PALLIATIVE CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. UPDATE ON MOUNT VERNON CANCER CENTRE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. **NWL INVOLVEMENT STRATEGY**

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

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

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

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

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

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

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

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

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

9. **ICS Update**

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

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

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

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

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

11. NWL JHOSC 2023-24 RECOMMENDATIONS TRACKER

11.1 The Committee noted the recommendations tracker.

13. ANY OTHER URGENT BUSINESS

13.1 None.

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

Minutes

NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

17 July 2025

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

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

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

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

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

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

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

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

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

It was suggested that action needed to be taken to identify vulnerable service users. Access was often about being competent in navigating the NHS and sometimes

women did not speak English confidently and those who were more confident would more often receive the care that they needed. Creative solutions had been initiated and family hubs, GPs and health visitors could be used to support this work. However, it was recognised that medically competent staff were not always culturally competent. Mr Hurd advised that cultural diversity was also being progressed with regard to diversity in leadership roles in the NHS. Members requested that the cultural competency plan be developed and that more information be provided in relation to the strategy for the targeted work in NWL.

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

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

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

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

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

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

Insofar as the delivery of sustainable improvements in maternity at Northwick Park was concerned, Ms Nightingale advised that the improvement plan had been completed

	and all actions had been met to achieve better safety outcomes (the stillbirth rate was 2.9 per 1,000 births). 97% of women using the maternity service at Northwick Park would now recommend it to their friends and family. Members noted that this was a great performance and suggested that it should be widely publicised. As the hospital had not received a CQC inspection since 2021, one had been requested by the Trust. It was recognised that Northwick Park was trying to rebuild trust with the community but there were still concerns about safety. Ms Nightingale advised that a strategic decision had been made that the improvements at the Hospital would not be promoted until they had bedded in. These improvements would be promoted directly to service users but maternity bookings at Northwick Park had already increased. Ms Cochrane noted that 30-50 members who had had babies within the last seven years provided feedback to 2-3 neonatal partnership leads in each service. Feedback came through to the service leaders. MDTs had received training to take feedback in relation to women's real experiences so that improvements could be made. Service leaders and users had put the maternity priorities together in 2022 so this was now due for a refresh. With regard to plans to improve maternity, it was noted that an improvement action plan was being progressed at Hillingdon Hospital. Staff had been working closely with women and their partners, particularly when they were coming back into the service. RESOLVED: That: 1. Ms Cochrane to provide Members with data on the stillbirth rates over the last 10 years split by ethnicity; 2. To ensure that the importance of capturing quality data is reliant on efficient maternity IT systems and the upgrade and investment in resources to facilitate easy extraction of data from these systems so as to be able to retrieve and analyse maternity information and enable an efficient overview of maternity outcomes by ethnicity and deprivation to address the social determinants of health; 3. That the ICB continues to work with local authorities to develop a coordinated programme of outreach and community research to engage with those at greatest risk of poor health outcomes and those in need of mental health support, pre and perinatal; 4. the discussion be noted.
4.	**RECONFIGURATION OF THE ICB AND IMPLICATIONS ON SERVICES** *(Agenda Item 7)* Mr Rob Hurd, Chief Executive at NHS North West London (NWL), advised that the organisation would need to reduce its spend on infrastructure by 41%. Although funding would reduce from £90m to around £50m, this would not be in relation to front line services. An options appraisal was currently underway and would be published on 18 July 2025. It would include the proposal for a formal merger or NWL Integrated Care Board (ICB) with North Central London (NCL) ICB. Local authorities had already sought assurance that this proposed merger would not result in the ICB become more distant from place. Whatever the outcome, consultation and engagement activity would be undertaken until April 2026. It was anticipated that some back-office functions would need to be shared, for example, human resources and it was proposed that shared leadership

roles would also be built with NCL ICB.

Mr Rory Hegarty, Executive Director of Communications and Involvement at NHS NWL, noted that the importance of service user and community engagement had been included as part of the strategic approach. Action would need to be taken to establish how NHS NWL would work with local authority colleagues and the voluntary sector going forward.

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

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

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

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

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

It was noted that hospitals in NWL currently managed demand between themselves and this seemed to work well. Concern was expressed that the proposed merger and changes to finances would negatively impact on this way of working. Mr Hurd stated that acute provider collaboratives and community services would need to organise

	themselves. Neighbourhood and specialists would need to be included but the ICB needed more financial clout to be able to organise around residents and over a much wider area. Members queried what would happen to the seldom heard communities, especially now that Healthwatch would be losing its independence. In addition, reference had regularly been made to working with the voluntary sector but their financial situation had been stretched to breaking point. Mr Hurd advised that there were many risks and massive challenges in a resource constrained environment. There had been concerns raised about the impact on Healthwatch but it was unclear what this would be. It was not inevitable that a reduction in resources would diminish how the ICB engaged with residents but more work was needed to ensure that it was meeting the needs of communities. Mr Hurd advised that the functions outlined in the report would transition within the next financial year and there would be redundancies, which would pose a big risk. The next steps would be to develop a work plan and set out how functions would go to the organisations listed in the report. It was about having a safe implementation plan, so not everything would be in place on 1 April 2026 **RESOLVED: That:** **1. as part of the work to reconfigure, NWL ICB take the views of local authorities into account on how the ICB could be improved;** **2. the ICB ensure that the voice of seldom heard communities and the voluntary sector are considered as part of the restructure and merger; and** **3. the discussion be noted.**
5.	**ADULT MENTAL HEALTH** *(Agenda Item 6)* Mr Toby Lambert, Executive Director of Strategy and Population Health at NHS North West London (NWL), advised that he had presented the Adult Mental Health Strategy and its three major themes in October 2024: 1. Raised awareness and promoting wellbeing – progress had been made in relation to this priority but there had been an ongoing debate about reducing the number of people with mental ill health presenting at the ED who could have gone elsewhere; 2. Increased equity and equality access – this priority was about making sure that services were accessible as community health teams in some areas seemed to be meeting much more often than others; and 3. Care in the right place – there was still work to do to reduce the wait in ED for specialised mental health support. A similar strategy was being developed for young people and progress would be reported to a future meeting. In addition to the core common offer, there had been bespoke services added because issues such as rough sleeping were not evenly distributed across all eight NWL boroughs. Dr Christopher Hilton, Chief Operating Officer (Local and Specialist Services) at West London NHS Trust, advised that Central and North West London NHS Foundation Trust (CNWL) and West London NHS Trust (WL) had been involved in the development of this Strategy. Although it had been delivered across organisations, the mental health trusts had been key to driving the Strategy forward. The NWL Mental Health Productivity Working Group had been looking at issues such as investment,

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

	RESOLVED: That the 2025/26 Work Programme be noted.
	The meeting, which commenced at 10.00 am, closed at 12.03 pm.

Report to the North West London Joint Health Overview Scrutiny Committee

09 December 2025

Report Title:	Urgent and Emergency Care across North West London
Report Author:	Melissa Mellett – Associate Director UEC
Committee Date:	**09 December 2025**
Report Deadline:	**28 November 2025**

This report responds to the Committee's request for an update on urgent and emergency care across North West London, with specific focus on performance, system resilience and preparations for Winter 2025/26. North West London has made significant progress this year in strengthening urgent and emergency care. We are now operating more as a single integrated system across acute, community, mental health, primary care, LAS and local authority partners, with measurable improvements in flow, early intervention, patient experience and winter resilience.

Key achievements include the launch of the Integrated Care Coordination Hub reducing avoidable ambulance conveyance, record levels of Same Day Emergency Care activity, strengthened community and mental health alternatives, improved ambulance handover and ED performance, and evidence of positive impact for high-need and underserved groups such as those supported by the High Intensity User and Homeless Health programmes. Borough-wide Optica implementation and 111 digital redirection models are improving access and visibility of capacity across the system.

System pressures remain, particularly around rising demand, mental health waits, community workforce fragility and virtual ward utilisation. These are being actively managed through joint oversight, strengthened escalation via the System Control Centre, and increased use of alternative pathways including Urgent Community Response and Pharmacy First.

Next steps focus on fully mobilising and maturing new schemes including the ICC Hub, community beds core offer, virtual ward standardisation, left-shift initiatives and mental health crisis alternatives, while monitoring outcomes and supporting winter delivery.

Member Request:	**Cllr Ketan Sheth, Committee Chair, October 2025**

Request for Report to the North West London Joint Health Overview Scrutiny Committee

09 December 2025

Report Title:	Urgent and Emergency Care across North West London
Report Author:	Melissa Mellett
Committee Date:	**09 December 2025**
Report Deadline:	**28 November 2025**

1.0) Executive Summary

North West London has made significant progress this year in strengthening urgent and emergency care, moving decisively from strategy into delivery. We are now operating more as a single integrated system across acute, community, mental health, LAS, primary care and local authorities. This has led to demonstrable improvements in flow, early intervention, patient experience and winter resilience.

Our approach is rooted in the four pillars of the NWL UEC strategy which are proactive care for complex needs, same day urgent care, efficient secondary care and integrated discharge. This is closely aligned with the National UEC Plan and the work of the Acute Provider Collaborative. Taken together, these actions are delivering a more coherent offer across the whole UEC pathway with shared accountability and visible system grip.

Key achievements this year include

- Launch of the Integrated Care Coordination Hub (ICC)

Live since October, the ICC brings senior clinical decision making into a single NWL wide function. It is already reducing avoidable ambulance conveyance and improving patient routing and is expected to manage up to 900 cases per month as it fully matures.

- Record levels of Same Day Emergency Care (SDEC)

SDEC activity is at its highest levels ever and is supporting faster assessment, reducing pressure on EDs and contributing to improved four hour performance.

- Strengthened community and mental health alternatives

New investment is enabling expanded Urgent Community Response, Frailty Hospital at Home, community beds through the core offer, Pathway 1 bridging and expanded mental health crisis alternatives. These are all critical enablers of flow and left shift.

- Improved handover, response and ED performance

Ambulance handover times are among the best in London. Cat 2 response times are very close to the national trajectory. Four hour performance has improved compared to earlier in the year and twelve hour breaches have been eliminated for general ED patients.

- Evidence based impact for high need and underserved groups

Evaluations of the High Intensity User service, Homeless Health, immunisation campaigns and mental health crisis pathways show tangible improvements in outcomes, reduced ED attendances, better housing outcomes and reduced repeat crises.

- Digital front door and Optica roll out

111 digital redirection, Pharmacy First pathways, automated dental and pharmacy triage and borough wide Optica implementation are transforming access, supporting more timely care and improving visibility of capacity across the system.

- Discharge performance and flow improvements

Pathway 1 delays have reduced to 2.3 days with continued progress toward trajectory across 21 day stays, mental health discharges and long stay reductions. These improvements mean more residents receive timely care in the right setting and system capacity is protected during periods of pressure.

Together, these achievements show that NWL is delivering a more integrated, proactive and resilient urgent and emergency care system.

Where challenges remain

We continue to face significant and rising demand, particularly for children, people with long term conditions and those with mental health needs. Variation across boroughs, community workforce fragility, virtual ward utilisation and mental health waits remain pressure points. These are being actively managed through targeted interventions, joint oversight and strengthened escalation and decision making via the System Control Centre and the NWL Flow Board.

Winter 2025 and 2026 readiness

Our winter plans have been stress tested across multiple demand and capacity scenarios and are jointly owned across acute, community, mental health and social care partners. System wide mitigations including ICC, expanded Urgent Community Response, Frailty Hospital at Home, crisis alternatives, enhanced discharge coordination, real time Optica visibility and borough surge plans provide the strongest level of resilience we have had in recent years. However, the system remains finely balanced and we are maintaining a high level of operational grip, partnership and pace.

Forward look

The next phase of work will focus on embedding ICC, strengthening neighbourhood based urgent care pathways, standardising virtual ward models, maturing digital tools and consolidating winter learning into the 2026 and 2027 planning cycle. Continued alignment with the Acute and Community Collaboratives will ensure a clear single UEC offer for residents across all eight NWL boroughs.

2.0) <u>Background/Context:</u>

Urgent and Emergency Services within NWL are provided across a variety of providers including London ambulance service, acute care (provision of Emergency Departments(ED) and Urgent treatment centres (UTC), Walk in

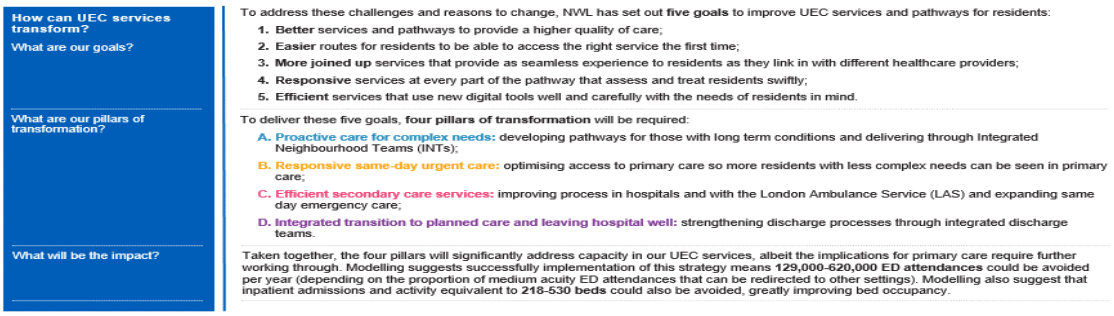
centres and community provision e.g. Urgent Community Response (UCR).Services are provided across the 8 NWL boroughs with service expenditure for 25/26 forecast as approximately £415 million (excluding non-elective admissions and community services).

The strategic vision for NWL UEC services was set in the 5 year strategy published in 2025. UEC strategic priorities are in line with the four pillars that underpin the strategy. These are:

- **Proactive care for complex needs**: developing pathways for those with long term conditions and delivering through Integrated Neighbourhood Teams (INTs);
- **Responsive same-day urgent care**: optimising access to primary care so more residents with less complex needs can be seen in primary care;
- **Efficient secondary care services**: improving process in hospitals and with the London Ambulance Service (LAS) and expanding same day emergency care;
- **Integrated transition to planned care and leaving hospital well**: strengthening discharge processes through integrated discharge teams.

The strategy details the change that will occur over the next 5 years to deliver higher quality care, more joined up and responsive services which patients can access more easily. The strategy will lead to the management of 129k – 620k attendances per year in a suitable alternative setting that would have been seen in ED. Bed capacity would be maximised through the reduction of admissions equivalent to 218-530 beds per year, from management of admissions in alternative services where suitable.

Figure 1 – NWL UEC Strategy



1.2 NWL Planning for Winter 2025

Winter planning has been undertaken including modelling for base case, moderate and extreme scenarios and review of these within a stress test exercise. Governance to support the winter process has been agreed with escalation through the System Control Centre (SCC) and weekly GOLD meetings. Plans detail the initiatives with key system wide initiatives including Integrated Care Co ordination (ICC), Community plans including expansion of UCR and Frailty Hospital at Home service and expansion of Mental Health crisis alternatives.
Key components of this year's winter planning process included the completion of comprehensive demand & capacity modelling and stress-testing to demonstrate amendments required for moderate and extreme scenarios. The plan highlights

areas for alternative provision including non-acute provision tying into the ICS ambition to “left shift” suitable activity to services outside of acute care There is system wide ownership of winter plan across collaboratives and aligned areas of focus, with escalation to the weekly GOLD meeting for action plans / mitigations for areas of activity that exceed those modelled in the plans. .

3.0) Overview of UEC Services

The urgent and emergency care (UEC) system in North West London functions as an integrated network designed to deliver the right care, in the right place, at the right time. It brings together pre-hospital triage, acute hospital services, and community-based alternatives to improve patient flow, reduce unnecessary admissions, and enhance patient outcomes. Figure 2 below highlights the main UEC services across the system

NHS 111 and the London Ambulance Service (LAS) act as the primary entry points for urgent care. They work collaboratively through shared clinical hubs and digital booking systems, enabling direct referrals to community services, Urgent Treatment Centres (UTCs), Same Day Emergency Care (SDEC), and Urgent Community Response (UCR). This integration ensures that patients are directed to the most appropriate setting without unnecessary delays.

The 111 service development of seamless telephony and digital pathways between acute, community and primary care. It enables direct electronic booking into NWL GP practices, UCR services, SDEC pathways, and also provides access to pharmacy and dental services.

Accident and Emergency (A&E) departments remain the safety net for major emergencies, while UTCs provide same-day treatment for minor injuries and illnesses. LAS crews and NHS 111 clinicians have direct access into UTCs or SDEC, reducing pressure on emergency departments and improving patient experience. SDEC offers rapid assessment and treatment within a single day, avoiding overnight admission.

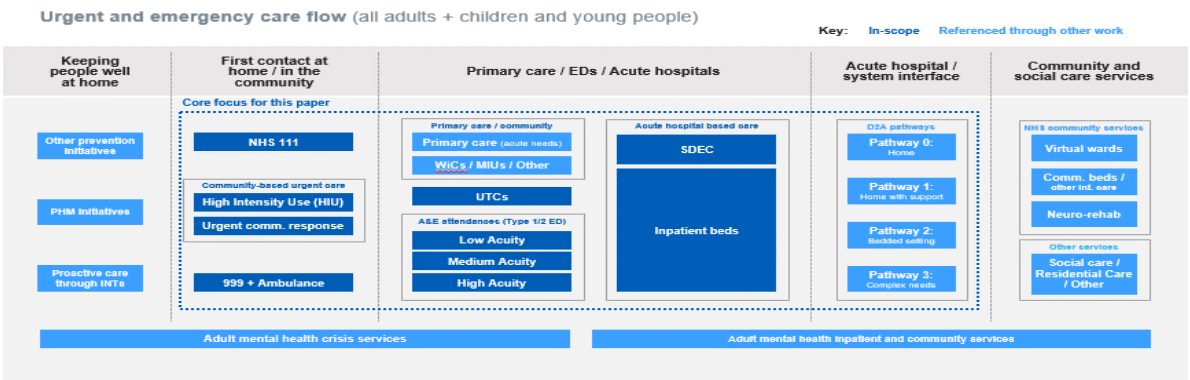
Community-based alternatives play a vital role in admission avoidance. UCR teams provide rapid assessment and treatment at home for patients at risk of hospitalisation, while virtual wards enable remote monitoring and treatment for patients who require ongoing clinical oversight but can safely remain at home, supporting early discharge and maintaining hospital capacity for those who need it most.

The system is underpinned by digital integration, with shared portals and booking systems that ensure seamless handovers and real-time visibility of capacity across services. A single point of access simplifies referral routes for LAS and NHS 111 into UCR, SDEC, and virtual wards. Collaborative, multi-disciplinary teams across acute and community settings deliver continuity of care and a patient-centred approach.

Strategically, the UEC system aims to reduce unnecessary conveyance and admissions, expand same-day and home-based care options, and improve patient

experience through timely and appropriate care. By aligning these components and enablers, the system delivers a more efficient, responsive, and integrated urgent and emergency care pathway.

Figure 2 – NWL UEC System



4.0) Recent UEC Developments

UEC service developments include services that are working collectively as one system to improve UEC outcomes improving flow, reducing conveyance, and increasing capacity. This development in line with the strategy is detailed below. It includes proactive and inclusive care models such as mobilisation of the new end of life care model and services to target inclusive health models such as homeless health care and high intensity users.

What has been achieved: Proactive and Inclusion Care Models

Key achievements as of October 2025

A **Proactive care for complex needs:** inclusion care models established, demonstrating tangible delivery of proactive, integrated, population-based care. Together these schemes contribute to reducing NEL demand and improving patient outcomes for vulnerable groups.

Aligned with our strategic goals, targeting inclusion health cohorts that put high pressure on acute sites such as **HIUs and Homeless, Frail and End of Life patients** whilst offering cross-system efficiencies, reducing duplication and spend across health, housing and social care. Resulting in fewer repeat attendances, reduced use of temporary accommodation, and less escalation to crisis services, the models are a sustainable solution preventing future cost escalation to the NWL healthcare system.

- **End of life:** Palliative Care redesign completed following extensive period of co-production, completion of public consultation, business case approval and **mobilisation of new model (30 beds)** for community-based specialist palliative care in October 2025.
- **High Intensity Users (HIU)**: evaluation completed in autumn 2025 shows **a 65% reduction in ED attendances** and improved patient & staff satisfaction as well as productivity gains. Business case approved to support the funding of model until March 2027. Work ongoing to transition service into NWL system provider baselines
- **Homeless Health**: evaluation completed in autumn 2025 show positive impact and ROI on patient outcomes with 70% of patients seen through the programme having improved housing outcomes on discharge from the service, and system flow - **for every 1,000 patients seen through the service, there was around a £60k cost saving** to the acute system through reduction in repeat acute attendances.
- **Frailty Hospital at home:** critical enabler to improved system flow and reduction in hospital length of stay for those with frailty, linked with established virtual ward model. Funding agreed with Community Trusts; awaiting mobilisation plan and agreement of data/oversight arrangements

One of the key priority areas is reducing avoidable conveyances to ED, optimising utilisation of alternative care pathways both in-hospital and in the community. The North West London wide Integrated Care Coordination (ICC) Hub, brings together an MDT of senior clinical decision makers to deliver improved patient outcomes reducing avoidable ambulance conveyance to emergency departments. Hosted by LAS, it's delivered in partnership with the Community and Acute collaboratives.

There are linkages between the ICC model, Virtual Wards, Digital enablers such as Optica and SDECs / UTCs. As shown below the impact seen from these areas includes reduction in conveyances of 600-900 per month estimated from the ICC, increased utilisation of virtual wards focused on achieving the 80% utilisation

target and continued increase in SDEC referrals (44% increase seen since September last year)

3 Our UEC strategy

What has been achieved: System Flow, ICC and Digital Integration

C	Efficient secondary care services	B	Responsive same-day urgent care	D	Integrated transition to planned care and leaving hospital well

NWL model of integrated care in action

A number of our schemes act as system enablers, aligned not just to one of the pillars of our strategy but as "the connective tissue" for all four pillars. **Optica, Integrated Care Coordination (ICC) and Virtual Wards** work together with our System Control Centre (SCC) to create system visibility and real-time flow management

- **Integrated Care Coordination (ICC): 600-900 conveyances will be reduced per month** due to alternative management of 999 calls within community. Additional community services investment to enable >UCR support
- **Virtual wards:** Capacity steady but **utilisation 64% cf target of 80%.** Focus on standardisation and increased referrals through links with ICC and community pathways. PATCH paediatric VW transition to reduce variation.
- **Digital enablers:** Optica rollout to LAs to complete before winter; evaluation estimated **>990 hrs saved annually per trust, representing £62k annual savings** from improved efficiency and reduced admin burden.
- **SDEC and UTCs: 44% increase in SDEC attendance** since Sept 24 and highest level of activity to date (9,505 in Sept-25). Ambition to hit 10,000 a month in 26/27.

Other developments include further initiatives tailored to community and mental health.

Community beds

System focus in autumn 2025 on implementing a 'core offer' across NWL in order to improve Pathway 2 discharges to a short term community bed-based setting to provide coordinated rehabilitation and recovery. The core offer is focussed on all beds adopting the three pillars of care: Coordination and Case Management Adopting Home First Principles; Trusted Holistic Assessment Function; and a Single Point of Access. These pillars coupled with common standards of care, entry criteria and KPIs means that patients across NWL can be assured that the service provided for those needing rehabilitation outside of the home is consistent, no matter where it is delivered.

Community and Mental Health Investment

North West London (NWL) Community Collaborative has received significant investment to deliver additional and enhanced capacity to support to care for NWL patients in their own homes and communities, including enhanced UCR, Discharge to Assess, neuro navigation and frailty hospital at home.
Increased UCR capacity for urgent care and short-term interventions (within 48 hours). Increasing the number of staff and resources to handle higher volumes of patients and more complex cases (including intravenous support in out of hospital settings), As well as ensuring seamless pathways from ED, Clinical Decision Units (CDUs), and other acute assessment units.

Pressures from Mental health patients have led to increases in long waits within NWL ED's with percentage of Mental health patients waits in ED exceeding 12 hours for over 30% of Mental Health patients across NWL during this year. Although performance has improved slightly, 12 hour waits remain close to the level described above. Approaches to support a reduction in waits have included additional investment in crisis beds such as the provision of additional capacity through expansion of Lakeside Crisis centre. Here 8 additional beds will provide greater capacity for diversion from ED, extended assessment, and therapeutic

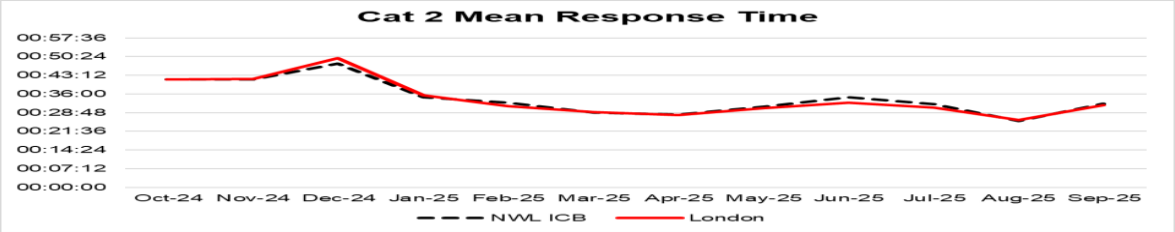
intervention to avoid inpatient admission, and address the persistent demand for crisis-alternative pathways.

4.0) Outcomes and Performance

The following diagrams detail performance across the system over the last year.

Cat 2 response times

Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Cat 2 Mean Response Time	NWL ICB	00:41:33	00:41:36	00:47:44	00:34:48	00:32:37	00:28:48	00:28:01	00:31:02	00:34:41	00:31:58	00:25:34	00:32:18
	London	00:41:32	00:41:49	00:49:49	00:35:28	00:31:18	00:29:02	00:27:47	00:30:36	00:32:34	00:30:46	00:25:52	00:31:36

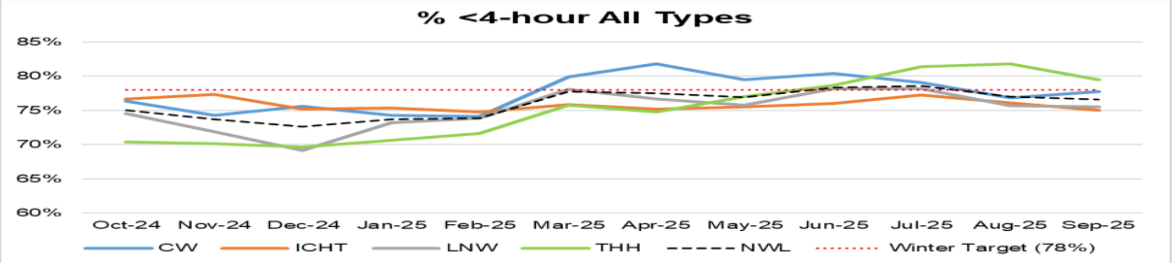


Cat 2 response times are in line with the London average, these were meeting the UEC plan target of 30 mins pre September. Although 45 minutes handover breaches do remain in North West London, hospital handover performance in North West London is the best in London, with a Year to Date average, as of Month 7, of 18 minutes 48 seconds. It is anticipated that the ICC hub will support continued achievement of the above areas.

4 hour A&E performance has improved from March 2025 to date compared with the 5 months prior to this. Ongoing work is occurring within trusts to support the achievement of this target (e.g. redirection of patients more suitable for alternative schemes such as pharmacy 1st and the community eye service). Performance improvements will also be enhanced through the delivery of the ICC hub.

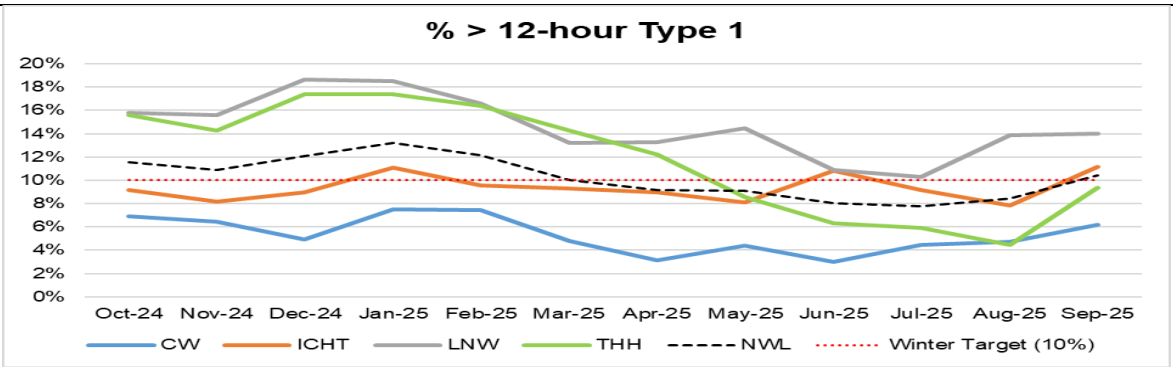
4-hour performance

Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
% <4-hour All Types	CW	76%	74%	76%	74%	74%	80%	82%	79%	80%	79%	77%	78%
	ICHT	77%	77%	75%	75%	75%	76%	75%	75%	76%	77%	76%	75%
	LNW	75%	72%	69%	73%	74%	78%	77%	76%	78%	78%	76%	75%
	THH	70%	70%	70%	71%	72%	76%	75%	77%	79%	81%	82%	80%
	NWL	75%	74%	73%	74%	74%	78%	77%	77%	78%	79%	77%	77%
	Winter Target (78%)	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%



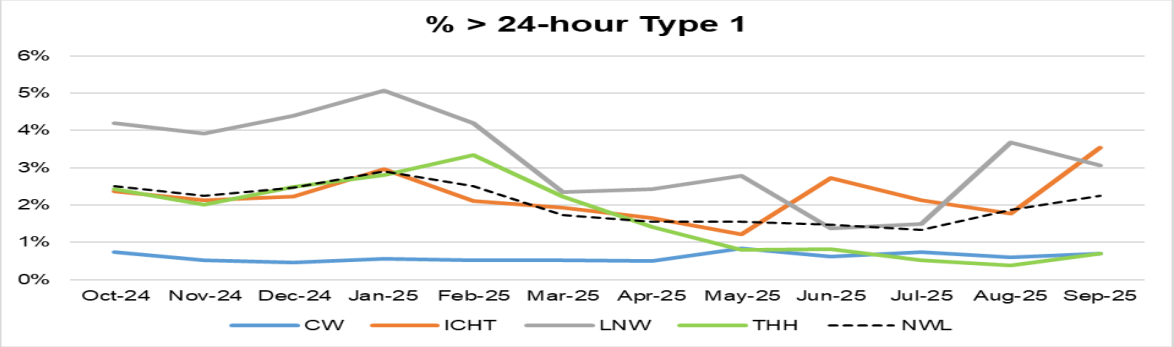
12-hour and 24-hour breaches

Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
% > 12-hour Type 1	CW	6.9%	6.5%	4.9%	7.5%	7.5%	4.8%	3.1%	4.4%	3.0%	4.5%	4.7%	6.2%
	ICHT	9.2%	8.2%	9.0%	11.1%	9.6%	9.3%	9.0%	8.1%	10.8%	9.1%	7.8%	11.1%
	LNW	15.8%	15.6%	18.6%	18.5%	16.6%	13.2%	13.3%	14.5%	10.9%	10.3%	13.9%	14.0%
	THH	15.6%	14.3%	17.4%	17.4%	16.4%	14.3%	12.2%	8.5%	6.3%	5.9%	4.4%	9.4%
	NWL	11.5%	10.9%	12.1%	13.2%	12.2%	10.0%	9.1%	9.1%	8.1%	7.8%	8.5%	10.4%
	Winter Target (10%)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%



The 12 hour breech target has been met in NWL since Mar 25. The key areas placing pressure on the achievement of this are mental health waits at some trusts (LNW and ICHT). Work is underway to support improvement here including the increase in mental health crisis beds at Lakeside Mental Health Unit Hounslow, which offer an alternative to A&E for those in MH crisis across Ealing, Hounslow & Hammersmith & Fulham.

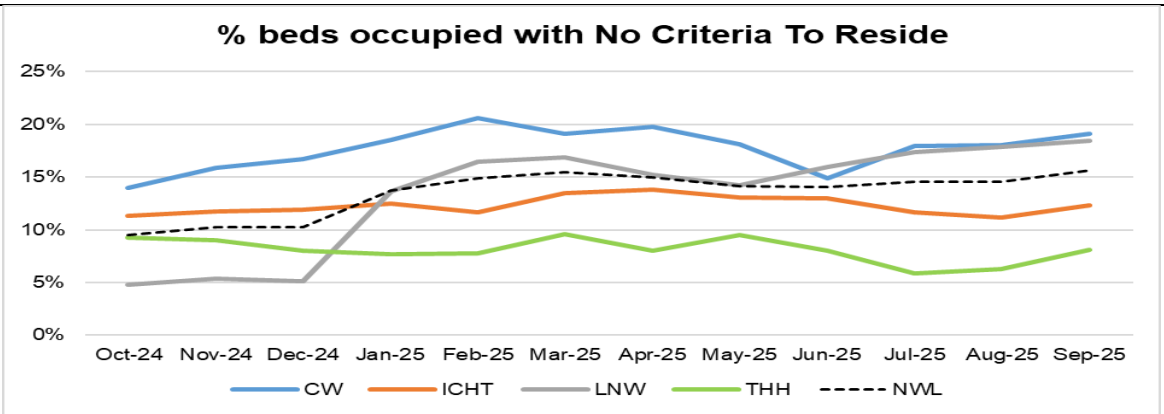
Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
% > 24-hour Type 1	CW	0.7%	0.5%	0.5%	0.6%	0.5%	0.5%	0.5%	0.8%	0.6%	0.7%	0.6%	0.7%
	ICHT	2.4%	2.1%	2.2%	3.0%	2.1%	1.9%	1.7%	1.2%	2.7%	2.1%	1.8%	3.5%
	LNW	4.2%	3.9%	4.4%	5.1%	4.2%	2.4%	2.4%	2.8%	1.4%	1.5%	3.7%	3.1%
	THH	2.4%	2.0%	2.5%	2.8%	3.3%	2.2%	1.4%	0.8%	0.8%	0.5%	0.4%	0.7%
	NWL	2.5%	2.2%	2.5%	2.9%	2.5%	1.7%	1.5%	1.5%	1.5%	1.3%	1.9%	2.3%



NCTR/ 21-day delays

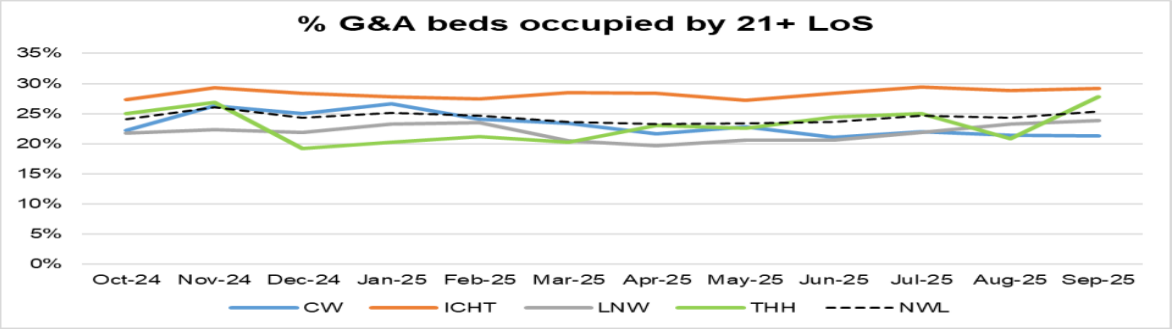
A number of people end up staying more than 21 days in hospital; we are aiming to reduce this in-year. Baseline data by trust and borough has been provided to senior decision makers and a trajectory for reductions is being monitored through the winter Gold meeting. Further data development is being completed to identify any variance by pathway, borough and trusts.

Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
% beds occupied with No Criteria To Reside	CW	13.97%	15.91%	16.68%	18.50%	20.63%	19.14%	19.77%	18.11%	14.89%	17.96%	17.99%	19.09%
	ICHT	11.31%	11.71%	11.89%	12.51%	11.67%	13.45%	13.79%	13.06%	12.97%	11.68%	11.13%	12.30%
	LNW	4.80%	5.38%	5.09%	13.63%	16.48%	16.89%	15.18%	14.20%	15.98%	17.38%	17.90%	18.44%
	THH	9.22%	9.03%	7.99%	7.72%	7.73%	9.60%	8.03%	9.48%	7.98%	5.88%	6.31%	8.10%
	NWL	9.50%	10.28%	10.24%	13.70%	14.87%	15.45%	14.93%	14.17%	14.02%	14.59%	14.60%	15.63%



Challenges remain with variation in commissioning across boroughs, which the community core offer and investment, BCF reviews and BCF shared ambition is looking to address where unwarranted. Variation across boroughs is primarily driven by differences in population need, community capacity and estate constraints, and is being addressed through the community core offer and BCF shared ambition.

Metric	Org	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
% G&A beds occupied by 21+ LoS	CW	22.3%	26.3%	25.0%	26.7%	24.1%	23.4%	21.6%	22.8%	21.1%	22.0%	21.4%	21.3%
	ICHT	27.4%	29.3%	28.4%	27.8%	27.4%	28.4%	28.4%	27.2%	28.4%	29.4%	28.8%	29.2%
	LNW	21.8%	22.3%	21.8%	23.3%	23.6%	20.5%	19.6%	20.6%	20.6%	21.9%	23.3%	23.9%
	THH	25.0%	26.9%	19.3%	20.3%	21.1%	20.3%	23.1%	22.6%	24.4%	25.0%	20.8%	27.9%
	NWL	24.0%	26.0%	24.3%	25.1%	24.6%	23.7%	23.3%	23.4%	23.7%	24.7%	24.4%	25.4%



Challenges with patients with complex needs include care home capacity and ability to accept more complex patients. This remains a challenge area, as well as delays and lack of clarity when joint agreements are needed between health and social care for non CHC patients.

5.0) Equity and Access

The section below provides details of demographic trends in UEC usage with approaches being taken to improve access and outcomes for underserved populations. Work here is data driven: golden thread of using data sources to understand both impact of services and transformational schemes as well as any unintended impacts on population cohorts or health equity that would drive actions in future eg evaluation of homeless health model in 2026. We are aiming to improve commissioning relationships with orgs (ie 3ST) that know and engage with the local and diverse population needs better than we do at system level eg via Take Home and Settle commissioning in 2026

In 2025 year-to-date, children aged 0–15 account for a notable share of UEC activity in North West London. On average, 5.6% of total UEC attendances are females aged 0–15, while 7.3% are males in the same age group. This contrasts with their representation in the registered population, where 3.6% are females and 3.8% are males aged 0–15. This highlights a disproportionate use of UEC services among both boys and girls in this age bracket. One initiative to mitigate the rise in demand within this cohort is enabling a UTC redirection pathway to primary care in Hounslow for 0-4 year old cohort which will help ensure patients receive the right care in the right place whilst supporting decompression at the front door of the hospital. Work is also occurring across the boroughs to develop child health hubs with clinics and MDT management for more complex cases to increase capacity for management of paediatric cases in the community preventing some children's A&E attendances.

Deprivation analysis shows UEC attendance is significantly higher among those in the most deprived areas (first quintile): 20% of UEC attendances versus 15% of the registered population, suggesting disproportionate utilisation among residents experiencing the highest levels of deprivation.
When ethnicity of those using A&E services is analysed, the highest A&E attendance rates were found to be from the black population and those living in a core20. This had been highlighted as an area for the development of targeted programmes to address this.

5.1 High Intensity Support Service and Homeless Health
Targeted interventions have been mobilised and evaluated - based on data-driven analysis of NWL population needs - as enablers of NWL's ambition to reduce health inequalities, improve patient outcomes, and relieve system pressure across urgent and emergency care. People experiencing homelessness are one of NWL's most underserved patient populations; they have complex health needs and are socially vulnerable. Our Homeless Health programme uses an MDT approach to provide safeguarding and legal frameworks, patient advocacy and relationship building, and holistic care. The average age of death for rough sleepers is 43 years old (women) and 47 (men) compared with 80 and 74 in the general population. People experiencing homelessness are more likely to die than housed people (4 times more likely for women, 3 times more likely for men). Case studies over the last several years have demonstrated that persistent, relationship-based, and integrated care models significantly improve outcomes for highly vulnerable populations, and highlight the critical role of the Homeless Health programme in bridging gaps between acute care and community services. The Homeless Health (HH) Service evaluation demonstrates that targeted inclusion health models reduce A&E attendances, shorten length of stay, and improve flow: critically 70% of patients seen through the HH programme have had improved housing outcomes on discharge from the service and 47% of patients seen through the HH teams in 2024/25 were no longer 'sleeping rough' on discharge.

The High Intensity Support Service (HISS) is a population-based, tech-enabled model delivered across all boroughs and EDs. It proactively identifies HIUs, coordinates multi-agency support, and provides ED-based case workers and borough care coordinators to reduce crisis-driven use of UEC. The service supports cohorts with high levels of deprivation, older patients, and complex

multimorbidity, reducing inequity by repatriating patients across boroughs and providing consistent case management regardless of where they attend. The High Intensity User programme has evidenced strong health equity impact, with higher recruitment from most deprived areas (deciles 1–3) with 1,010 patients supported (Jul 24–Mar 25) leading to fewer 65% reduction in ED attendances.

5.2 NWL Immunisation campaigns

Work continued this year to increase vaccine uptake for the cohorts identified within the vaccine campaign. The 2025-26 flu programme commenced on 1st October 2025. The NWL operational flu management group is meeting fortnightly to oversee planning and delivery of the immunisations campaign

There are 2 pilots running this year to try and increase uptake in 2 and 3 year olds, one in community pharmacies (197) and the school aged provider will be delivering vaccinations in 28 nurseries (at least 2 in each borough)

London big week is being organised from 22-30 November to help increase vaccination. Activities planned for this include:

- *Drive-through and walk through vaccination*: exploring GP/PCN-led and CP-supported sites
- *Vaccination buses*: outreach in low-uptake areas; Hounslow & Brent being considered
- *Community outreach events*: Community Pharmacy staff to attend arranged engagement events to offer vaccinations.
- *Pop-ups at major footfall locations*: football clubs (Fulham, QPR), shopping centres (where feasible).
- *Weekend/extended hours*: Community Pharmacy-led increase in opportunistic access

There will also be targeted cohort interventions including

- *Hospital in-reach*: renal/HIV clinics supported by Community Pharmacists or Trust staff aimed at immunosuppressed patients
- GP searches and recall for high-risk cohorts.
- Support for 2–3yr olds via outreach through established maternity networks.

COVID

The NWL team have been working on using QR codes for immunosuppressed patients to streamline the offer.

Consultant letters have been drafted and shared by NWL vaccination teams with sites such as Imperial for renal patients, to emphasise the importance of seasonal vaccinations with links to NWL website.

5.3 Mental Health

Mental health demand continues to grow and remains a major driver of extended waits in A&E. Although some improvements have been made, around one third of mental health patients still wait over 12 hours in ED. Additional crisis capacity, including expanded beds at Lakeside and new community alternatives, is being mobilised to reduce these waits and support diversion away from ED.

6.0) Impact of System-Wide Initiatives

The impact of key system wide integrated care approaches are detailed below. These services are focused on providing care in the right place first time, reducing

conveyance to hospital through management in alternative settings where appropriate, improved flow and providing better patient experience.

UCR

- Here over 85% of UCR referrals received a response within two hours (exceeding the national 70% target).
- This ensured rapid access to the most appropriate service was occurring for complex patients that could be managed within their home

Virtual Wards

NWL Virtual Ward continued to support patients within their homes. An evaluation of the service identified an

- Patient satisfaction was high with 94% of users rating their experience as good or above
- Average inpatient length of stay reduction 1.6 days for patients
- Approximately 530 admissions avoided across providers
- Approximately 8400 acute bed days saved from Virtual Wards
- Average readmission rate reduction between VW and a comparable group of 11%

Bridging services

Improvements here have led to reduced discharge delays meaning patient are more quickly discharged with appropriate support

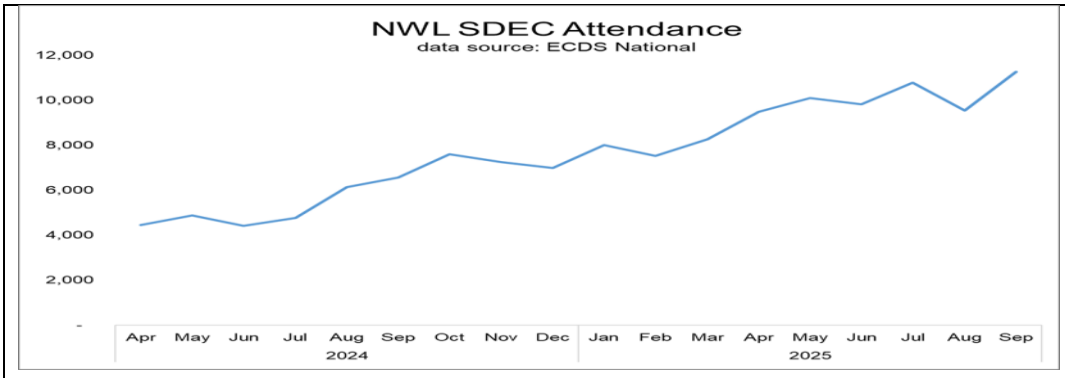
- A target was set for NWL to reduce P1 average delay days to from 4.4 to <3.6 days; this was achieved with an average of 2.34 delay days in 2024/25.
- Comparing to more recent improved Optica data, NWL has seen a further decrease for P1 discharge delays in to an average of 2.10 days in Sept 2025.

ICC Hub

ICC expected to reduce 600–900 conveyances a month at full scale. Initial data analysis has shown that in October, the ICC Hub avoided 336 conveyances to ED, with the patient supported by the Hub or an alternative service in the community or in-hospital.

SDEC

SDEC activity has consistently increased over the last year, currently at record levels enabling increasing numbers of patients to be assessed, treated and discharged on the same day, avoiding unnecessary hospital admissions and improving patient flow across the system.
This model allows ambulance crews to convey suitable patients, following an exclusion criteria, directly to SDEC without the need for pre-arrival calls. supporting faster handovers, reducing pressure on Emergency Departments, and ensuring patients receive the right care more quickly.



Universal Care Plans

A 60% increase in universal care plan uptake compared to last year. Ensuring more organisations across health and social care have access to UCP is paramount as this will support with decision-making and enhance the development of Integrated Neighbourhood Teams

Other areas have also included Digital front door and Pharmacy First redirections shifting activity away from ED

7.0) On-going Improvement

NWL Flow Board and winter gold meetings have been established with agreed data, trajectories and outcome monitoring which ensure decision making led by data rather than daily operational pressure points. Importance of using live FDP enabled tools such as SCC dashboard as well as winter D&C plans to remain data-focussed with shared visibility; Optica is also a key enabler for ensuring we stay aligned as a system to pressure points and opportunity areas. This aligns with NHSE Medium Term Plan focus on UEC transformation via digital tools and real-time flow visibility.

Winter Planning - Key Risks and Mitigation

Intervention	Risk	Mitigation
ICC	- Large volumes of ambulance conveyances to Acute Trust Emergency Departments and the ICC Hub ability to support with system flow limited by the pace of development of the Hub - Gaps in senior clinical decision maker reducing activity that can be managed by hub	- Weekly escalation meetings between LAS and the ICB, with Acute Trust representative, to track progress and unblock barriers - Interim NW London ICC Clinical Operational Manager in post whilst the post is substantively recruited to - Recruitment of Senior Clinical Decision Maker workforce for the ICC Hub underway at pace

Ambulance handover and response times	Winter pressures may lead to increase	• Development of ICC hub to identify cases that could be managed elsewhere reducing conveyances • Development of UCR, and Frailty Hospital at Home schemes to support patient management within their homes
Workforce for new initiatives	Difficulty recruiting to additional posts.	• Recruitment to be managed through workforce leads, to bring together the necessary expert resource. Leads will consider how to benefit from economies of scale to ensure sufficient resource across all boroughs. • Workforce plans will be developed and maintained at provider level to allow for flexibility in how each area responds to local challenges, recruitment timelines, and service maturity. This will include safe staffing, role mixing, early recruitment to critical roles and use of resource for organisational development to embed the model at Place. • Key roles will be prioritised for recruitment • Phased implementation will further mitigate workforce risks.
Increase in system pressures	Attendances, breaches, delayed discharges increase to levels above modelling within winter plans	• SCC dashboard will give initial early warning signs that activity is outside trajectory • Weekly GOLD meeting with escalations where activity is outside modelled activity levels
Infection prevention and control	Increase in multi pathogen infection due to increasing respiratory infections within the community	• Complete processes to minimise multi pathogen infection including cohorting patients with infections separately and discharging

		patients / supporting management at home where clinically appropriate
Beds base	Admissions are greater than bed base available	• Complete early mobilisation of schemes that support management of appropriate patients in alternative settings e.g. UCR, Mental Health and Frailty Hospital at Home schemes
Critical care	Standing up additional beds if required	• Sufficient infrastructure and equipment, (but activation remains dependent on workforce and resources availability)
Medication shortages	Ongoing supply issues with medication	• Dissemination of alerts regarding medication shortages and applying mitigations as detailed within the alert

8.0) Next Steps

Work in UEC will be over the coming months with a focus on the following areas.

- Maturing the ICC Hub with fully established senior clinical decision making and stronger links to community and mental health pathways
- Delivering the community beds core offer with consistent standards and access across all boroughs
- Increasing virtual ward utilisation and standardising AF, heart failure and respiratory pathways
- Completing mobilisation of mental health crisis alternatives
- Scaling left shift initiatives, including 111 redirection and Pharmacy First
- Implementing enhanced end of life models and developing options for expanded non acute End of Life care beds.

Member Request:	**Cllr Ketan Sheth, Committee Chair, October 2025**

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

NHS North West London

North West London

Joint Health Overview Scrutiny Committee Report: 2025/26 Primary Care Access

26 November 2025

Primary Care, NHS North West London ICS

JHOSC Report: Content Structure

Background and Context	Slides 3 – 9
• Recap: Access Programme Roadmap • Current landscape of Primary Care Access in NWL • Reference the ICB revised strategy for improving access • Online Consultations support Same Day Access	
Implementation and Performance	**Slides 10 – 18**
• Overview of Access Programme and Access Specification • Specification progress across key targets • Performance metrics across NWL (see Appendix for PCN-level metrics)	
Vision	**Slides 19 – 29**
• Vision for change management (during surges), continuous improvement (improving Access into wider Primary Care and building on Neighbourhood Health) and VFM initiatives (redirections)	
Engagement and Feedback	**Slides 30 – 36**
• Share findings from engagement activities, incl. GP Patient Survey, and 24/25 Patient and Staff feedback • ICB communication with residents and practices on Access Plans • PCN-led approaches to engage patients and communities • General Practice Action Plan to tackle unwarranted variation	
Future Planning and Risks	**Slides 37 – 40**
• Ongoing work to ensure equitable access provision across NWL • Next steps and proposed changes to access services and specifications • Key risks and mitigations	

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Background & Context

Recap: Access Programme Roadmap

2023 - 2026 | Improving Access to Primary Care

Programme Launch
Improve patient access and reduce pressure on general practice

External Consultancy Support

Collaboration
- Work with LMC and stakeholders on a revised specification
- Support PCNs to co-design tailored Access models

2023/24 I. ORIGINAL PLAN

Research & Analysis
Review good practices and analyse NWL demand & capacity

Early Adoption
Support a cohort of PCNs to redesign same-day access services

Rollout
Develop an Enhanced Services Single Offer Access specification from April 2024

Programme challenged: "One-size-fits-all"
Pause programme and remove from 2024/25 contract

2024/25 II. RESET & CODESIGN

Local Engagement (Autumn-24)
PCN-led, wide-scale engagement with patients and staff on access

Locally-led Transformation (Winter-24)
PCN-developed Access Improvement Plans, informed by engagement findings

Specification Development (Spring-25)
Draft outcome-based 2025/26 Access specification

2025/26 III. CURRENT DELIVERY

Launch Specification as part of the 25/26 Enhanced Services Single Offer
Support PCN implementation

Monitor Outcomes & Iterations

Align with the 10 Year Plan and wider Primary Care Strategy

Ongoing Objectives
- Ensure timely, high-quality patient care at local general practice.
- Enable practices to manage demand and provide continuity of care.
- Relieve system-wide pressures, i.e. urgent and emergency care.

Executive Summary:
Current Landscape of NW London Primary Care Access (1 of 2)

North West London is making progress in improving access to Primary Care, with a strong commitment to equity and patient voice. The system is moving towards more integrated, digitally enabled, and patient-centred care.

Strategic Context

- Improving access to Primary Care remains a **top priority**, aligned with the 10 Year Plan and national planning guidance. The ambition is to embed Modern General Practice principles and reduce system pressure.
- GP capacity is being optimised – the aim is for **general practice to manage primary care presentations**. It is important that resources are targeted where they will have the greatest impact
- **Key priorities** include enhancing the role of Dentistry, Optometry, and Community Pharmacy (DOPs) in delivering integrated care, building on Neighbourhood Health, expanding digital access (via the NHS App) and utilising existing pathways – all while maintaining continuity of care for our patients.

Evolution & Delivery

- The Access Programme has evolved through several phases since 2023. **Extensive engagement** with patients, staff, and system partners, has **shaped the revised 2025/26 Access specification**.
- From October 2025, all practices must offer **Online Consultations** (OC) throughout core hours to support commissioned same-day access. Compliance is monitored closely, with contractual mechanisms for non-compliance. NHSE has completed a National Audit of OC compliance, and **no NWL practices were flagged**.

Performance Metrics

- **Accessibility**: 82% of calls are answered within 10 minutes, and 88% of e-submissions are responded to by the next working day. Nearly all appointments are now appropriately coded, and NHS App registrations is increasing.
- **Continuity of Care**: PCNs are identifying high-risk patients for continuity, with ongoing audits to ensure delivery.
- **Patient Engagement**: Engagement events are held, with a focus on co-design and feedback-driven improvement.
- **Health Equity**: Access plans target underserved populations, aiming to reduce health inequalities.

Executive Summary:
Current Landscape of NW London Primary Care Access (2 of 2)

Engagement & Feedback

- The national GP Patient Survey findings show that **patient satisfaction** in NWL is slightly above the national average, with a 5.2% increase in positive experiences since 2022. However, response rates to surveys are lower, likely due to extensive local engagement efforts preceding national surveys.
- **Key feedback themes** include the importance of timely access, continuity of care, digital inclusion, and targeted support for underserved groups.
- There is a need to further **strengthen resident engagement** to ensure alignment with new models of primary care

System Integration

- The programme supports integration across Dentistry, Optometry, Pharmacy, and urgent care, with pilots and new services expanding access beyond general practice.
- Initiatives like Pharmacy First, community eye care, and dental pilots are reducing pressure on GPs and hospitals, improving patient choice, **shifting reactive care to proactive/preventive care**, and bringing care closer to home.
- Deliver **Neighbourhood Health** Models of Care that offer integrated services. Nationally, there is likely to be a focus on how primary care can **work with emerging neighbourhoods** to consider the best geography for neighbourhood working and populations with a focus on **maximising access** for primary care, continuing focus on **high risk cohorts** and having **effective interfaces** between different services.

Future Focus

- The next steps involve a 2-year contract extension for the **NWL Enhanced Services Single Offer**, ongoing monitoring, and a Task & Finish Group to oversee further development.
- There is a strong emphasis on **health equity, digital access, and continuous engagement** with patients and communities to shape future specifications and commissioning priorities.

Improving Primary Care Access:
Informed by/Respond to National Strategies and Policies

Improving access to Primary Care remains a top priority in the 10 Year Plan and Planning Guidance – embedding Modern General Practice principles and relieving wider system pressures.

10 Year Health Plan

- **Shift more care into primary care/community settings** to reduce hospital demand and make access easier.
- **Strengthen the role of PCNs** and Neighbourhood Health services to support people with complex needs, enabling **'care closer to home**'.
- Expand the use of **NHS App** and digital front-doors i.e. booking appointments
- Commit to 'digitally by default' care
- **Extend opening hours** and availability of Neighbourhood Health centres.
- **Enhance the role of community pharmacies**, and enable them to manage more long-term conditions.
- Support **proactive patient engagement**
- Focus on **prevention and early intervention**, ensure access is planned

25/26 Medium Term Planning Framework

- Ensure practices **deliver the GP contracts, improving access** by phone, online, or walk-in throughout core hours.
- All patients should **know on the day how their request will be managed**, and there should be an increase in the number of people who can **see their preferred healthcare professional**.
- **Action plans** should be put in place to improve contract oversight, commissioning, and transformation, tackling unwarranted variation and supporting those struggling to deliver access or other contract elements.
- **Additional capacity** should be commissioned to meet demand out-of-hours and over surge periods, including bank holidays and weekends.

Modern General Practice

- The National Modern General Practice Programme builds on the Fuller Stocktake Report and the NHSE Primary Care Delivery Plan.
- Aims to **improve access to primary care, make every appointment count, and improve patient experience** through:
  - streamlining processes
  - aligning capacity with need
  - creating inclusive and effective access routes into practices
  - understanding workload and patient management flows
  - enhancing the digital offer
  - improving triage and navigation to both NHS and non-NHS services
- The key themes form the basis of the NW London Enhanced Services Single Offer

Improving Primary Care Access:
Informed by/Respond to NW London Strategies

Primary Care Strategy [Draft]

- Directing people to the **right care, the first time**, whether that's digital, face-to-face, pharmacy, urgent care, or neighbourhood services.
- Using **population health management** to route individuals based on their needs, preferences, and risk.
- **Equitable and inclusive**: Ensuring consistent digital infrastructure, accessible booking routes, and flexible hours.
- **Tailored, not one-size-fits-all**: Offering **continuity of care** for those who want or need it, particularly people with long-term conditions
- General Practice is not the only front door: **Collaborating with Dentistry, Optometry, and Pharmacy (DOPs) colleagues** to create opportunities.

Urgent & Emergency Care Strategy

- **General practice to manage primary care presentations**, while UTCs focus on higher-acuity patients with more urgent needs
- A significant proportion of low acuity activity and could be delivered through a **more streamlined and integrated model of care**.
- Modelling demonstrates that 236,000 ED attendances could be avoided.
- Key initiatives include: improving access and triage, implementing digital solutions, and strengthening care coordination across our system.
- The **NHS App as the NHS Digital Front Door** – primary access point for digital triage and booking

Planned Care Strategy

- **Redesign referral pathways** between Primary and Secondary Care by improving access to specialist advice, and building capability within general practice.
- **Support patients in taking a more active role** in managing their health, e.g. the use of digital patient portals for easy booking, and access to secondary prevention support
- **Increase productivity** through improved workflow design, smarter use of technology and data.
- Develop **integrated care models** tailored to patient groups with complex needs, scaling collaborative approaches incl. integrated specialist clinics in community settings and virtual MDTs.
- Promote **communities of practice**, enabling collaboration between primary care and acute specialists.

Online Consultations:
Support Same Day Access (post 1 Oct 2025)

Implementation & Compliance

- From 1 Oct 2025, online consultations (OC) must be **available throughout core hours** (8:00am - 6:30pm, weekdays excl. holidays) with no caps or restrictions.
- Patient making contact with the practice should know on the same day how their presenting issue will be handled (does **not** necessarily mean they will be seen/treated on the same/next day.)
- NWL ICB has submitted its Post-1 Oct GP Contract Compliance Return to NHSE. **Post-1 Oct checks** undertaken for 42/338 practices – confirmed that they all now had OC operational and compliant (validated from practice returns or websites)
- NHSE has completed a National Audit of OC compliance, and **no NWL practices were flagged.**
- Any **patient queries/complaints** re: OC access will prompt assurance activity with the practice involved.
- Practices are expected to notify the ICB of any **switch-off/pause** of OC, with regular updates shared with NHSE.
- The new requirements will be added to the **contract assurance framework process** for routine review.
- Sustained **non-compliance will be escalated** via assurance and contractual processes in line with GMS/PMS/APMS requirements and NHSE guidance.

Communication & Support

- **Webinars and bulletins** issued
- Direct communication from the contracts team
- **You and Your GP** added to ICB websites and confirmed active on practice websites. (It helps patients understand what to expect and get the best from their GP team, and how to provide feedback or raise concerns)
- GP IT and Digital Team **troubleshoot** technical issues
- Support provided through use of updated **NHSE FAQs**

Issues & Challenges

- General practice/BMA **still raising concerns** about capacity and safety of maintaining OC throughout core hours.
- Although all practices have OC tools that support all aspects of new requirements, **monitoring at a practice level in real time** is challenging (338 NWL practices + 176 NCL practices).
- Obtaining data on OC utilisation from practices who have procured their own tool/solution is by agreement and can mean an **incomplete** picture.

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Implementation & Performance

Improving Access into General Practice

Last year
(2024-25)

- **Over 100,000 residents and staff** took part in one of the UK's largest primary care engagement exercises in NW London, alongside the national GP Patient Survey.
- Improving access to Primary Care is highlighted by our residents as their **number one concern** for the ICB.
- Their feedback shaped 23 PCN-led local transformation proposals (funded through £4.2m investment). This **delivered over 250,000 additional activity** slots in Q4 alone.
- These insights **directly informed the new 2025/26 Access Specification** and Single Offer, offering a strong platform for long-term improvement.

This year
(2025-26)

- NWL continues to **improve access to Primary Care** (funded through £6.6m investment in addition to national funding)
- This focuses on **at-scale services** across all 45 PCNs, ensuring **full population coverage**.
- In 2025/26, **all 45 PCNs submitted PCN-led Improvement Plans** (41 plans received) to meet the agreed Access Specification targets.
- PCNs have drawn on survey findings and local analysis to design tailored plans that respond to community needs.
- Ongoing monitoring of practice performance to ensure **contractual compliance**. Statistics show the specification is embedded with good results for delivery.

Next year
(2026-27)

- Improving access to Primary Care remains **a top priority** in the 10 Year Plan and Planning Guidance – embedding **Modern General Practice** principles and relieving wider system pressures.
- Next steps are to continue monitoring performance, **apply insights to shape an outcome-based 2026/27 Access Specification**, with a view to demonstrate impact across both Primary Care and the wider system.

Improving Access into General Practice:
2025/26 Access Specification (Targets on a page)

PCNs have developed Access Improvement Plans against agreed targets and metrics to improve access, and ensure high-quality care, safety, effectiveness, patient-centredness, timeliness, efficiency, and equity.

Key themes

Key themes	Target	Metric / Activity
Accessibility of Care	Ensure patients can access **timely and safe care**, have a choice of routes into care, and are offered an appointment or alternative care on first contact	90% of calls answered within 10 minutes
		90% of e-submissions are responded to by end next working day.
	Ensure accessibility, the appropriate use of clinical time, and support **safe and effective** signposting.	• Record all direct clinical care encounters, incl. MDT case discussions. • Return 0 unmapped appointments.
		Audit use of appointment time (incl. secondary care interface contacts)
Continuity of Care	Optimise clinical time and provide continuity of care to high-risk patient with complex needs.	Identify and flag 2% of high-risk patients for continuity throughout the year, identified via WISC and local knowledge.
		Audit 10% sample to determine continuity of care has been delivered
Use of digital tools	Support patient empowerment through use of digital tools, with a focus on the NHS App.	• Increase registrations on the NHS App by 10%. • Practices with ≥ 75% NHS App registration are required to demonstrate increased utilisation of repeat prescriptions and/or appointment booking.
Patient engagement	Encourage regular engagement to track **patient experience** and satisfaction with care, and ensure diverse voices shape access over time	• A patient experience survey, developed with patient input, with >4% return. • A well-attended patient engagement event is held; attendance matches local demographics.
Health equity	Provide **equitable** access to all residents, ultimately improving population health	Access Improvement Plans should identify target populations in need of support and outline local plans to address health inequalities.

2025/26 Access Specification:
Performance metrics across NWL (see Appendix for PCN-level metrics)

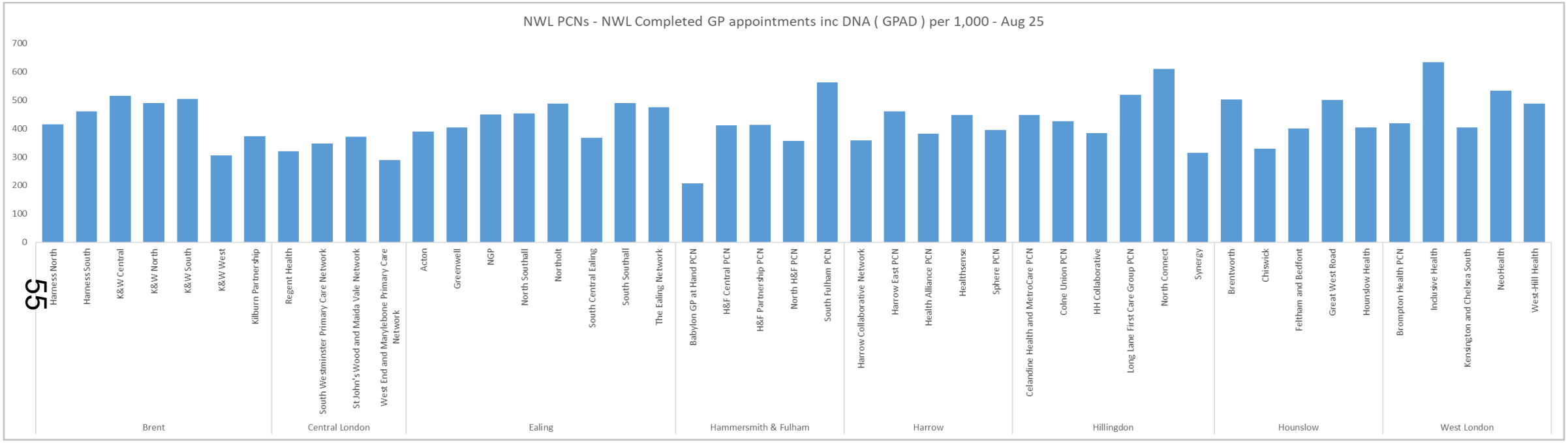
Key themes	Access metric	Progress
Accessibility of Care	90% of calls answered within 10 minutes	Q2 shows **84.6%** reached across NWL
	90% of e-submissions responded to by end of next working day	YTD average across NWL has already reached **94%**.
	• Record all direct clinical care encounters in the practice, including MDT case discussions. • Return 0 unmapped appointments.	• Dashboard indicates practices have started coding appropriately. • YTD, **98.5% of appointments were mapped**.
Continuity of Care	Identify and flag 2% of high-risk patients for continuity throughout the year.	YTD, **1.6%** of patients have been identified as high-risk
Use of digital tools	• Increase registrations on the NHS App by 10%. • Practices with ≥ 75% NHS App registration are required to demonstrate increased utilisation of repeat prescriptions and/or appointment booking data	• Q1 shows a **1.4% increase** in NHS App registrations (NWL baseline: 60.3% | Q1: 61.7%) • PCNs/Practices have been encouraged to attend NHS App training sessions via the Training Hub.
Patient engagement	• A patient experience survey, with >4% return. • A well-attended patient engagement event is held	Engagement plans across all PCNs demonstrate commitment to co-designing services with patients

- **Note** that this data set contains several data quality issues, which the ICB BI team is currently investigating. (See Appendix)

North West London Integrated Care System

NHS North West London

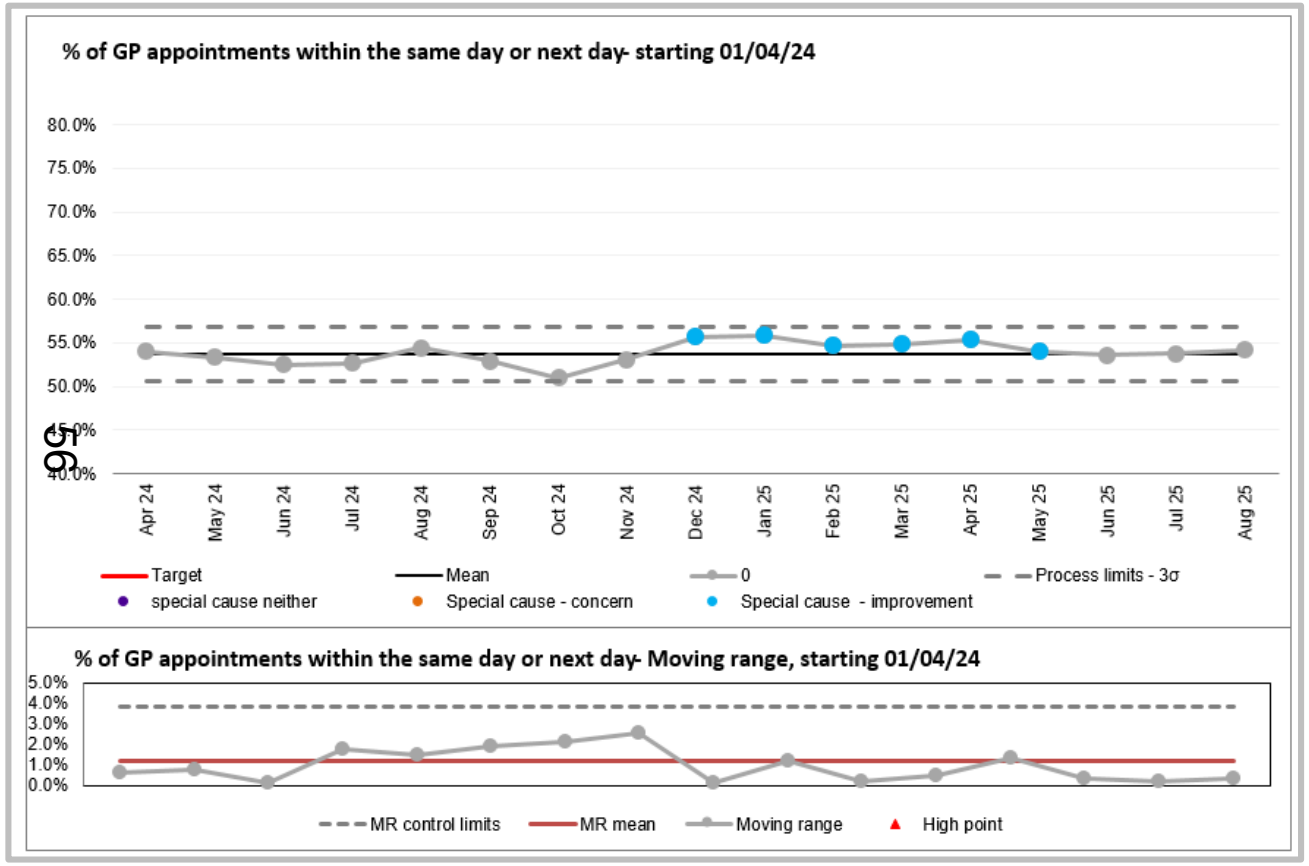
YTD Performance:
Appointments per 1,000 population, by PCN

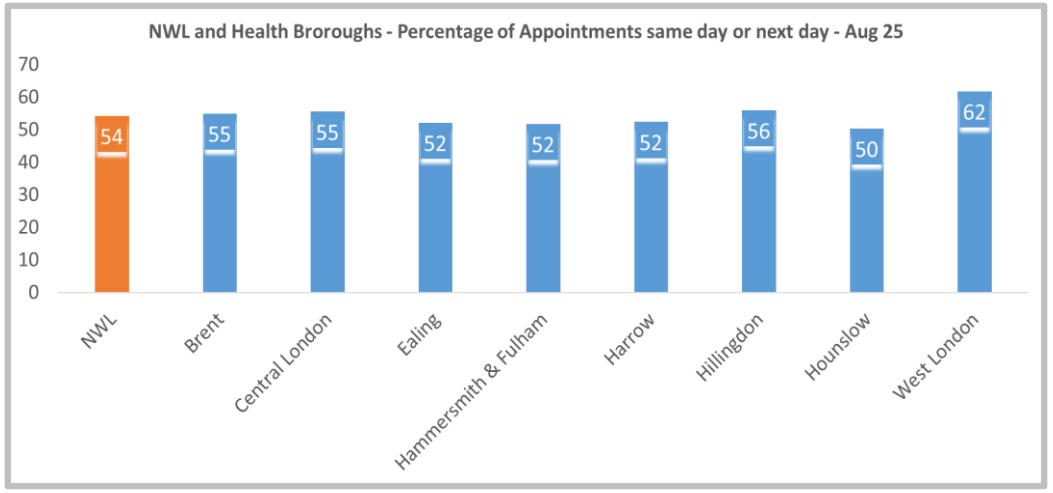


- NWL Strategies show that Primary Care appointment numbers have **risen over the past 5 years**. NWL provides **11% more appointments than other London areas**.
- In Q2 2025/26, Primary Care have offered:
  - July – 1,570,458 (68,537 above Operating Plan Target)
  - August – 1,310,844 (939 above Operating Plan Target)
  - September - 1,533,821 (101,089 above Operating Plan Target)
  - October – 1,746,241 (46,360 above Operating Plan Target)
  - April – October - 10,414,775 (285,016 above Operating Plan Target)
- **On track to deliver 17,127,907 for 2025/26.**

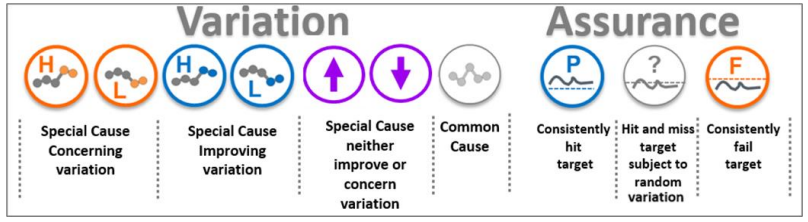
Data Source: S1/EMIS, YTD.

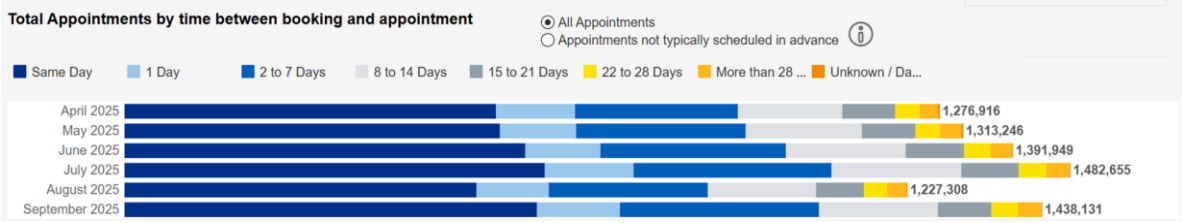
YTD Performance:
% of GP Appointments seen Same/Next day (GPAD)





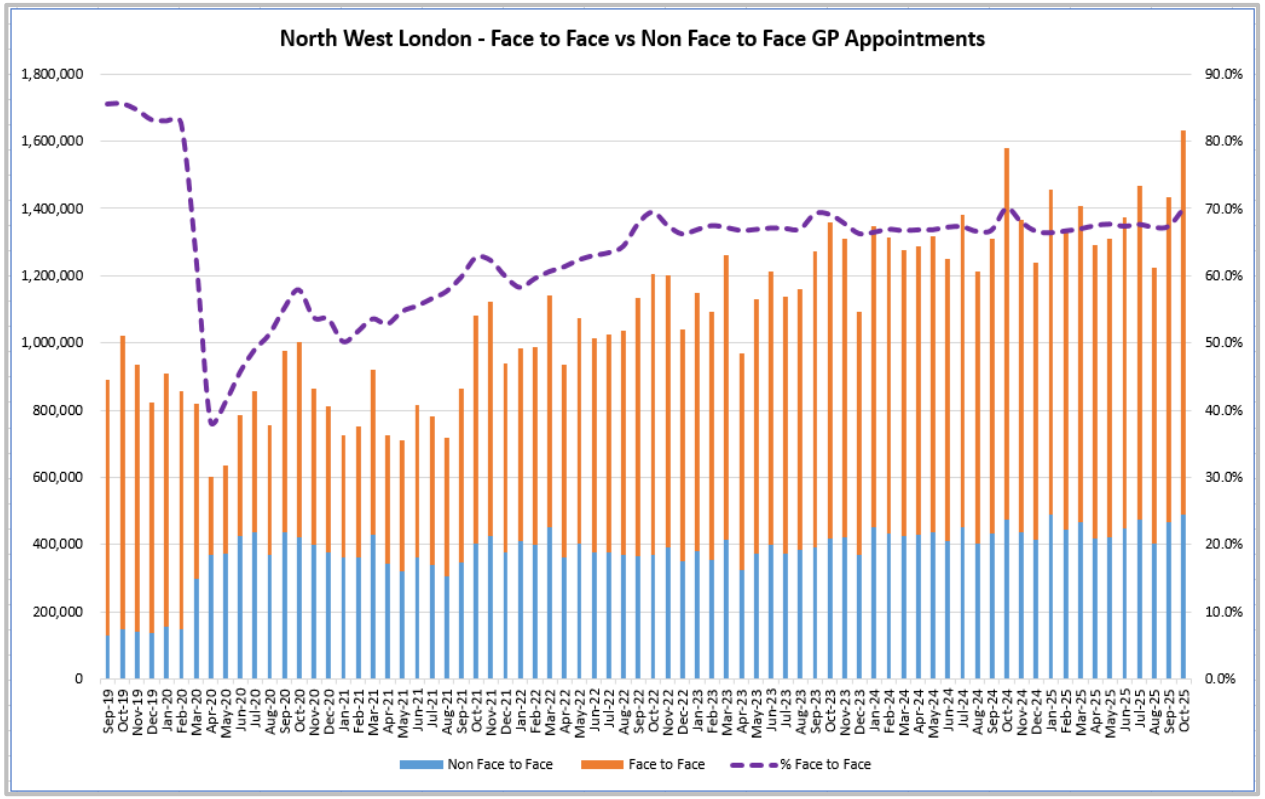
- Approx. **55% of GP appointments are same day or next day**, with little variation across month.
- There is borough variation (e.g. 62% in West London, 50% in Hounslow). These differences may reflect local population needs or operational challenges. NWL ICB is monitoring this and is **committed to reducing unwarranted variation**. (*See Slide 36*)





Data Source: % of appointment on the same or next day based of national GPAD Data. Latest data as of Aug-25.

YTD Performance:
% of Face-to-Face vs Remote GP Appointments

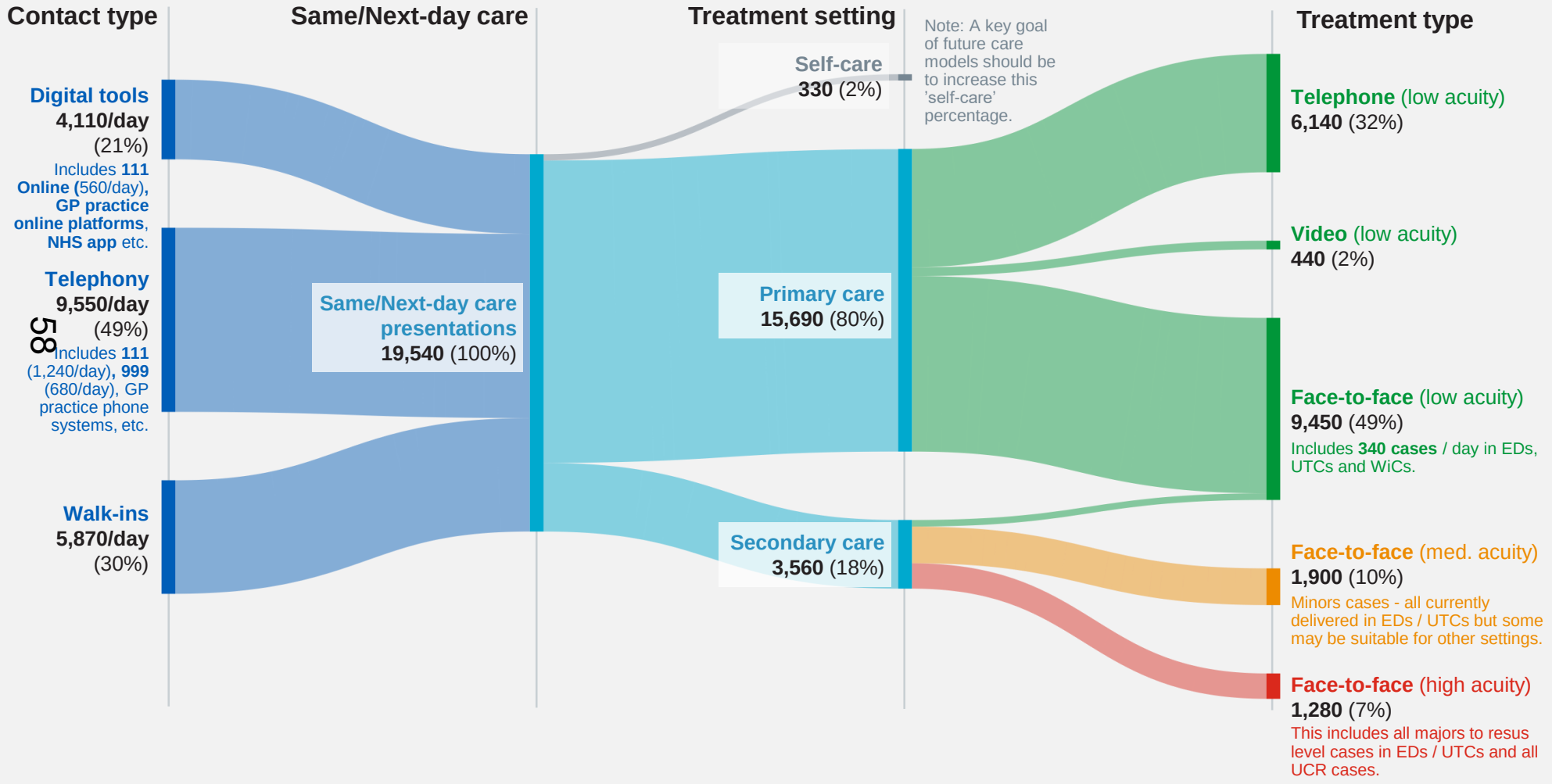


Month	% Face to Face
Apr-23	66.7%
May-23	66.9%
Jun-23	67.1%
Jul-23	67.0%
Aug-23	66.9%
Sep-23	69.2%
Oct-23	69.1%
Nov-23	67.8%
Dec-23	66.2%
Jan-24	66.4%
Feb-24	66.9%
Mar-24	66.7%
Apr-24	66.8%
May-24	66.8%
Jun-24	67.2%
Jul-24	67.3%
Aug-24	66.6%
Sep-24	66.8%
Oct-24	70.0%
Nov-24	68.0%
Dec-24	66.6%
Jan-25	66.4%
Feb-25	66.6%
Mar-25	66.9%
Apr-25	67.4%
May-25	67.7%
Jun-25	67.3%
Jul-25	67.6%
Aug-25	67.2%
Sep-25	67.3%
Oct-25	70.0%

- **70% of appointments** across NWL are Face to Face as of Oct-25.
- In Apr-20, due to Covid, approx. 36% of appointments were face to face
- During Sep-25, a total of 122,833 Online Consultations were completed across NWL which is 22,833 above target of 100,000. From April – Sept, NWL have completed 700,235 Online Consultations which is 100,235 appointments **above target**.

Data Source: S1/EMIS, YTD.

Activity volumes and trends: Every day, 19,540 people in NWL have a perceived same/next-day care need, with 83% of these needs considered to be 'low acuity'



Note: Non-urgent or routine cases delivered each day in primary care have been excluded from this diagram – equivalent to **27,950 cases / day.**

In totality, primary care contacts lead to **2,100 referrals** for specialist care / day.

This chart shows that Primary Care is already managing 80% of 'low-acuity' same/next-day care presentations, helping to maintain system flow.

The most suitable setting for each same/next-day care case is dependent on acuity, patient complexity and a patient's ability to self-manage

Source: Activity volumes derived from ECDS and GPAD data (January 2024 – December 2024). Population complexity and PAM score data derived from WSIC (extracted March 2025).

Conclusion:
Primary Care Vision

- Data shows that NWL practices continue to deliver appointment volumes **above the national target**, with same-/next-day appointments consistently seen (already managing 80% of 'low-acuity' same/next-day care presentations), strong face-to-face offer, and sustained use of Online Consultations. All practices have complied with the post-1 Oct requirements to support commissioned same-day access.
- In line with the 10 Year Plan and the NWL Primary Care Strategy and UEC Strategy, the aim is for **general practice to manage primary care presentations**, enabling urgent and emergency care services to focus on higher-acuity patients.
- **However, GP capacity is finite** – It is important that resources are targeted where they will have the greatest impact.
- Key opportunities include the following, which will be explored in later slides and discussed during the development of future specifications.

	Key Opportunities
1	Strengthen **integrated models of care**, expanding access beyond general practice through Dentistry, Optometry and Pharmacy partners, e.g. Pharmacy First and the Community Eye Service.
2	**Build on Neighbourhood Health** & population health approaches to shift activity from reactive care to proactive, preventive care.
3	**Optimise GP capacity and existing pathways**, incl. Out-of-Hours services, Enhanced Access, and improving utilisation of 111 slots
4	Ensure **continuity of care** for patients who may not require same/next-day appointments but need ongoing care.
5	Maximising the role of the **digital front door (NHS App)** and innovative tools to signpost patients to the right care, first time.

1.1

Primary Care Vision

Change Management:
Relieve System Pressure

Primary Care is one of the system's first points of contact. Our response focuses on 4 levers to stabilise access, reduce avoidable attendances, and embed Primary Care in system escalation.

1 Integrate Primary Care in System Escalation:

Pilot Primary Care OPEL in Hounslow & Brent, linked to the Federated Data Platform (FDP).

2 Mobilise Redirection at Scale:

Align Pharmacy First (7 minor ailments & 33 wider conditions), Community Eye Service (CES) and Wound Care with Urgent & Emergency Care redirections.

3 Make the Data Live and Visible:

Embed GPAD, 111 slot utilisation and Enhanced Access and Single Offer Access specification metrics into the System Control (SCC) dashboard.

4 Communications

Residents & Patients:
Coordinate Pharmacy First, Community Eye Service, Dental, 111 and GP Access messaging under a single NWL communications campaign to emphasise redirection pathways for patients with a joint system responsibility for implementation.

Services:
Communications to our providers to reinforce redirections ensuring that staff can confidently sign-post patients presenting inappropriately to the right service

Change Management:
Practice Closures/Diversions through Winter

Implementation & Compliance

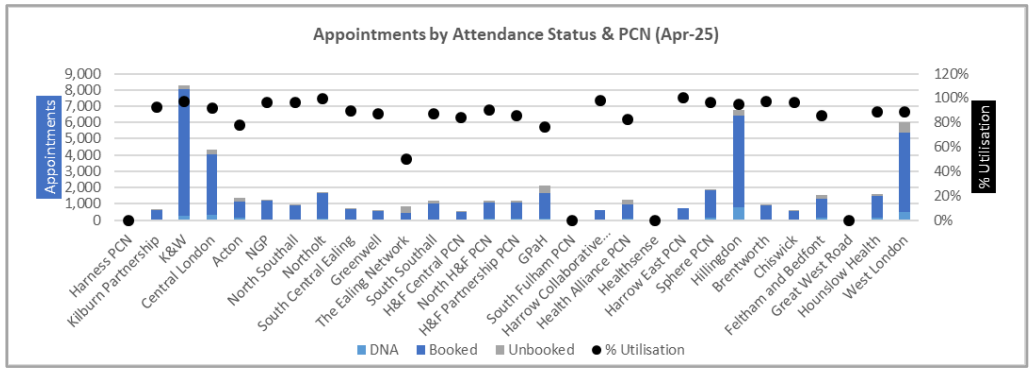
- Practice and PCN **business continuity plans** in place
- **Enhanced Access PCN services**, incl. weekends, bank holidays and the holiday periods in place.
- Confirmation of PCN enhanced access provision including **additional capacity** over holiday periods in progress.
- **Commissioned GP Out-of-Hours service** (OOH) from 6:30pm-8:00am week nights, weekends and bank holidays.
- Booked **OOH F2F appointments** available within 2 hours at **5 Primary Care Centres at based adjacent to UTC sites** or via Home Visit
- Implementation of GP contract changes from 1 Oct 2025, ensuring full compliance with Online Consultation access requirements.
- **Promotion of Pharmacy First and Urgent Dental services** through NWL comms plan, PCN engagement and UEC.
- Delivery of a **paediatric surge plan** to manage increased demand from respiratory illnesses in general practice.

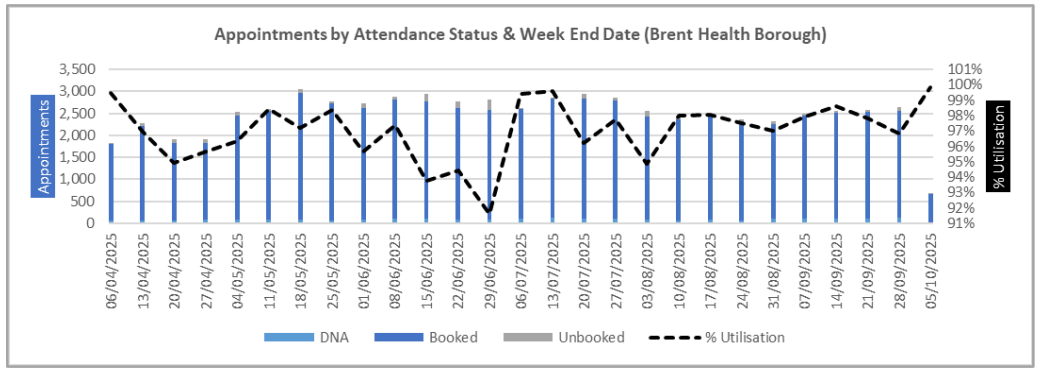
Actions & Communications

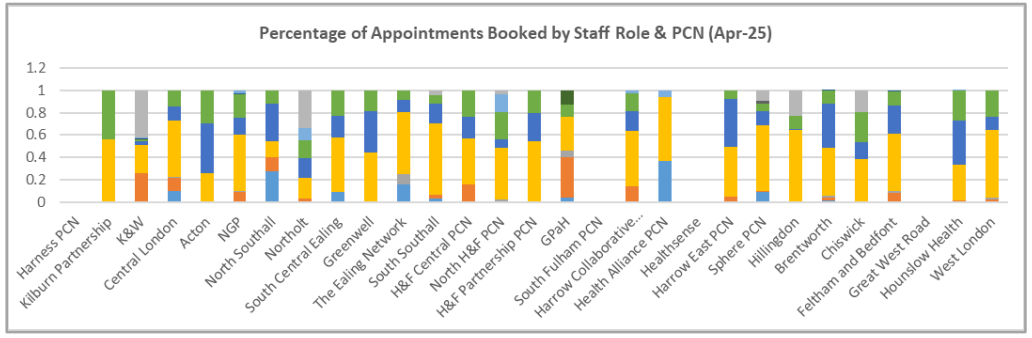
- Practice/PCN Business Continuity Plans to be reviewed/ updated to maintain key services **incl. enhanced health in care homes service.**
- Remind PCNs/practices to have robust plans now for MDT review **care home patients**, update care plans, shared/available to other agencies and escalation plans agreed with care home management.
- **Review local primary care OPEL process** to assess if it can be simplified for re-launch and engage with London work on this.
- Maximise re-directions to and utilisation of Pharmacy First and Urgent Dental service by practices and UEC pathways.
- Practices to ensure robust repeat prescription guidance & process.
- **Support from Place** to manage issues locally and co-ordinate

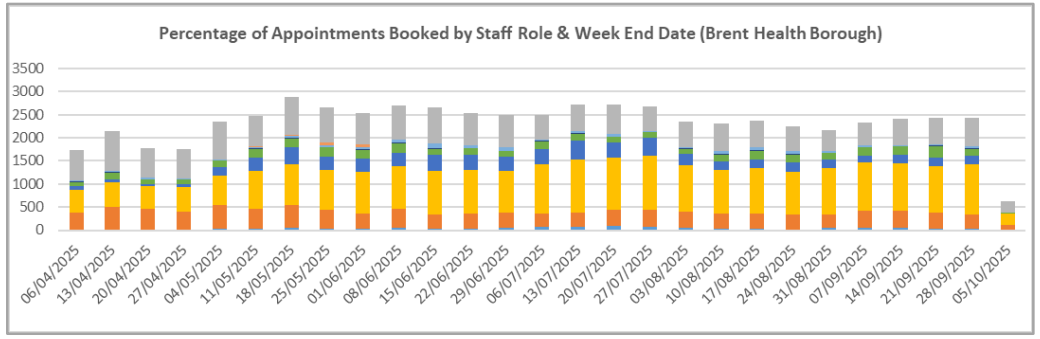
Change Management:
Enhanced Access Utilisation (Hubs evenings & weekends)

NWL ICB works closely with PCNs and Boroughs to deliver the Enhanced Access required hours. Overall utilisation is 92% (2025/26) , with 93% appointments have been F2F. 6,033 slots were booked by 111 or redirected from UTC.





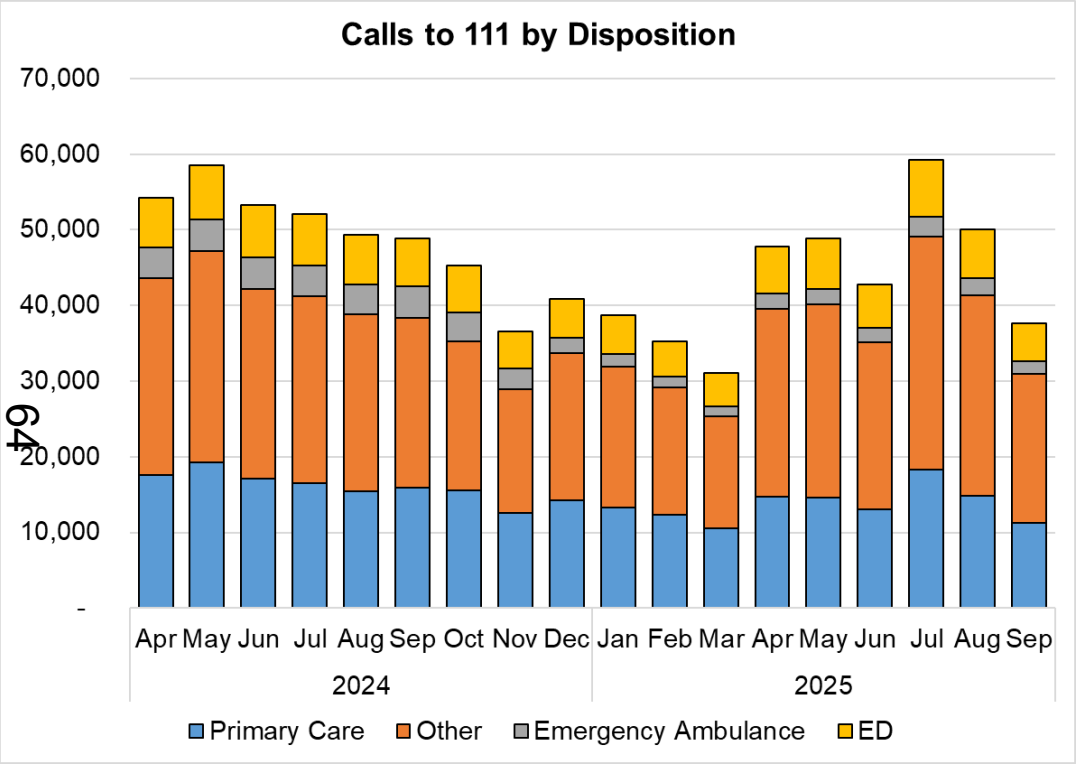


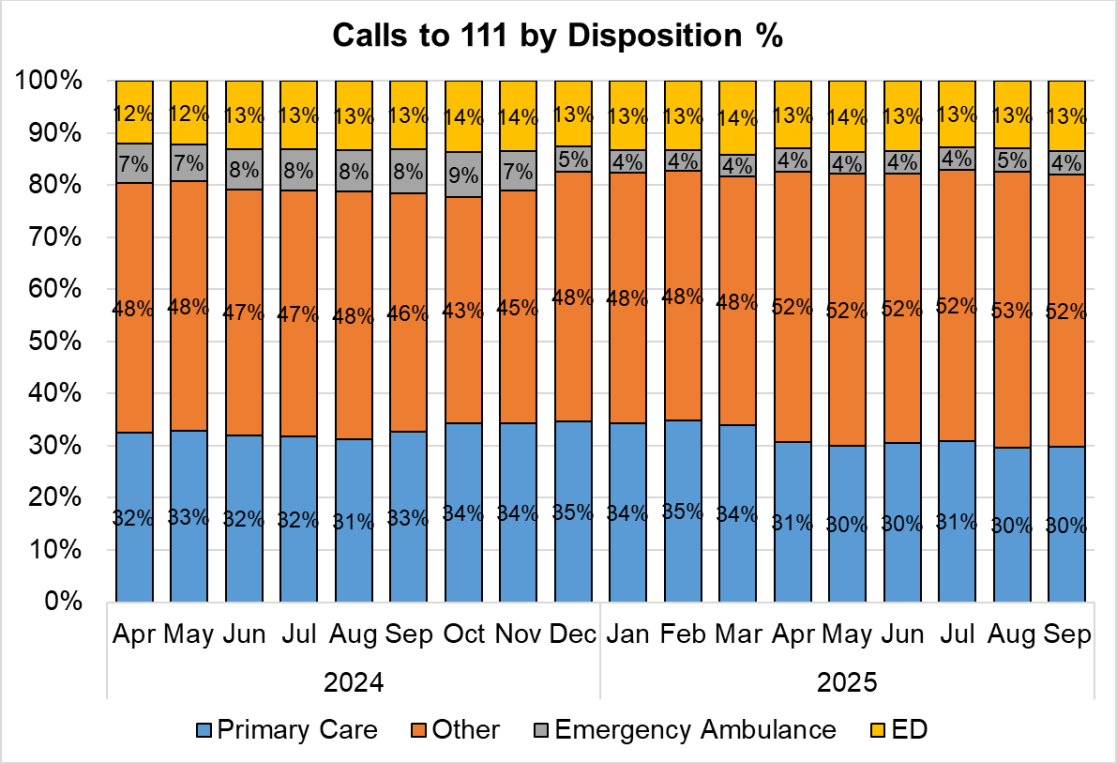


	Utilisation (%)			Staff role - Booked		Appointment Type - Booked		111/UTC Appointments		
YTD	Available = 276,960	Booked = 254,450	Utilisation = 92%	GP = 115,545 (94%)	Other = 138,905 (90%)	F2F = 166,235 (86%)	Virtual = 88,304 (93%)	Available = 10,310	Booked = 6,033	Utilisation = 59%
Sep-25	Available = 32,444	Booked = 29,963	Utilisation = 92%	GP = 12,969 (93%)	Other = 16,994 (92%)	F2F = 18,192 (91%)	Virtual = 11,802 (93%)	Available = 1,012	Booked = 724	Utilisation = 72%

Note: Data Quality Issues to note: Missing data from 11 hubs. Data being validated for 8 additional hubs. Data is being verified and will be uploaded once checks complete.

Change Management:
NHS 111 Slot Provision and Utilisation





- Approx. 30% of NHS 111 dispositions sent to Primary Care.
- General practice is contractually obliged to offer **1 slot per every 3,000 patients** that the practice has on its registered list, to NHS 111 every day. This supports directly booking patients into the most appropriate setting for their needs.
- From May to Aug-25, utilisation of GP slots was approx. 40%.
- The aim is to **increase utilisation across NWL to 50%**, which would result in an additional 18k appointments being used.
- **Directory of Service (DoS) configuration** aligned with access clinics and bank holiday arrangements to ensure real-time redirection.

Continuous Improvement:
Wider Primary Care Access

Primary care access is traditionally thought of in terms of General Practice and their Access plans, but it extends much further. Access also incorporates:

Dentistry

As reflected in the 2 new pilot schemes:

- Paediatric Dental Pilot
- Inclusion Health Dental Pilot

Community Pharmacies

Often the first port of contact for patients and just around the corner from where people live.

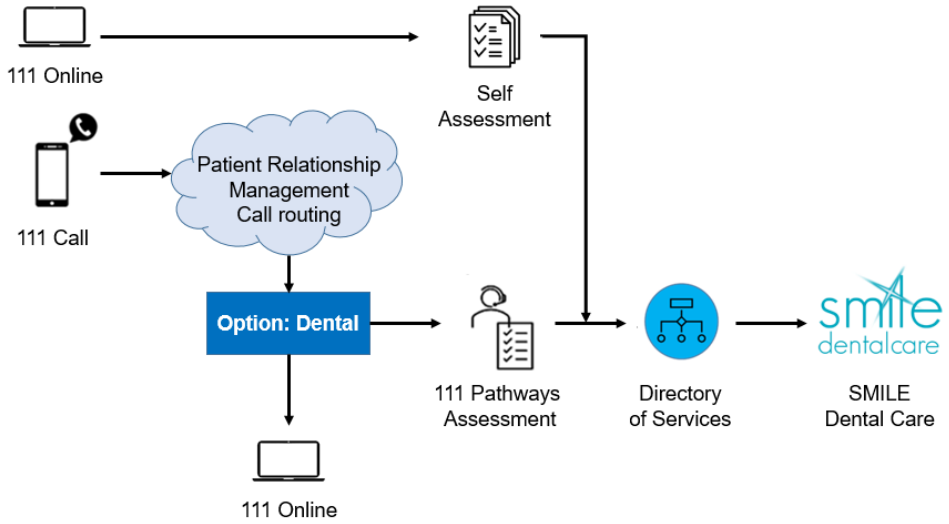
Optometry

High street opticians who are now able to provide eye care for common conditions without the need for a GP appointment.

Continuous Improvement:
Improving Access into Dentistry

Urgent Dental Care

- NWL commissioned **55,404** Urgent Dental Care (UDC) appointments for 2025-26.
- Q1 data shows under-utilisation of commissioned capacity, though sufficient provision – incl. extra capacity over Christmas – is in place to meet demand.
- Clear pathways in place **via NHS 111 and local helpline routes**, supported by a **multi-channel communications campaign** to raise public awareness of 24/7 urgent dental services.



Dental Pilots

- In 2025/26, London ICBs have used unallocated funds within the dental budgets to commission up to **3 years** of additional capacity, aimed at stabilising NHS dental provision.
- NWL launched **2 new dental pilots** in Oct 2025 to improve access, support oral health, and embed prevention across health, education, and community settings.

Pilot	Target population	Elements
Paediatric Dental Pilot **1 Oct 2025 to 2027 across 8 boroughs**	Aged 0-16 in Core20+ areas, and those identified as having higher oral health needs.	• Test/develop targeted pathways into selected NHS dental practices • Provide longer appointments and preventative care • Provide outreach into the local communities • Making Every Contact Count
Inclusion Health Dental Pilot **3-6 months from Oct/Nov 2025 in Hillingdon**	People living in temporary/ emergency accommodation (incl. asylum seeker hotels)	

Continuous Improvement:
Improving Access into Community Pharmacy

Commissioning

- **475 community pharmacies** in NW London offer a range of essential, advanced and enhanced services
- **Out of hours access** to medication and pharmacy services: 18 community pharmacies have been commissioned to be open on bank holidays.
- Access to antivirals for the treatment of Covid with **Covid Medicines Delivery Unit (CMDU):** 8 community pharmacies have been commissioned till March 2026 to supply Paxlovid. This was agreed with the 2 Local Pharmaceutical Committees (LPCs) in NWL

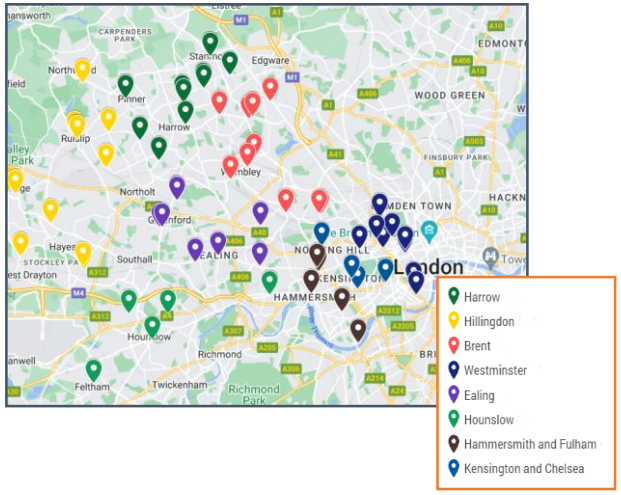
NHS Pharmacy First Service

- As of Aug-25, **91%** of NWL pharmacies (434 pharmacies) have opted in to provide the Pharmacy First service
- **Integrated Pharmacy First referral tools** from GP practices now live on both **EMIS** and **SystmOne**. This will further enable referrals and improve service delivery by reducing the time it takes to send a referral.
- The first phase of the **Pharmacy First PCN engagement project** is underway, to build partnership between community pharmacy and GP practices that supports integrated clinical pathways.
- The Pharmacy First service presented at the **NW London Primary Care webinar** to encourage practices to send pharmacy referrals to reduce pressure for GP appointments and improve access.
- A **national campaign** to promote Pharmacy First service ran from Oct-25.
- A successful **Pharmacy First redirection project** was undertaken at The Hillingdon Hospital Urgent Treatment Centre (UTC), which is now an official redirection option. The 3-month pilot ran from Dec-24 till Mar-25 with 132 Pharmacy First referrals made, 0 incidents recorded and positive feedback from patients and staff. The plan is to roll this out across all NWL UTCs, starting at the 2 Chelsea & Westminster sites.

Continuous Improvement:
Improving Access into Optometry

Commissioning

- **Optometry federation (akin to GP Federation) with 108 accredited practices** in NW London offering patient centred extended primary eye care via networks of established optometry practices.
- **Accessible locations across NWL** with good public transport links and trained workforce.



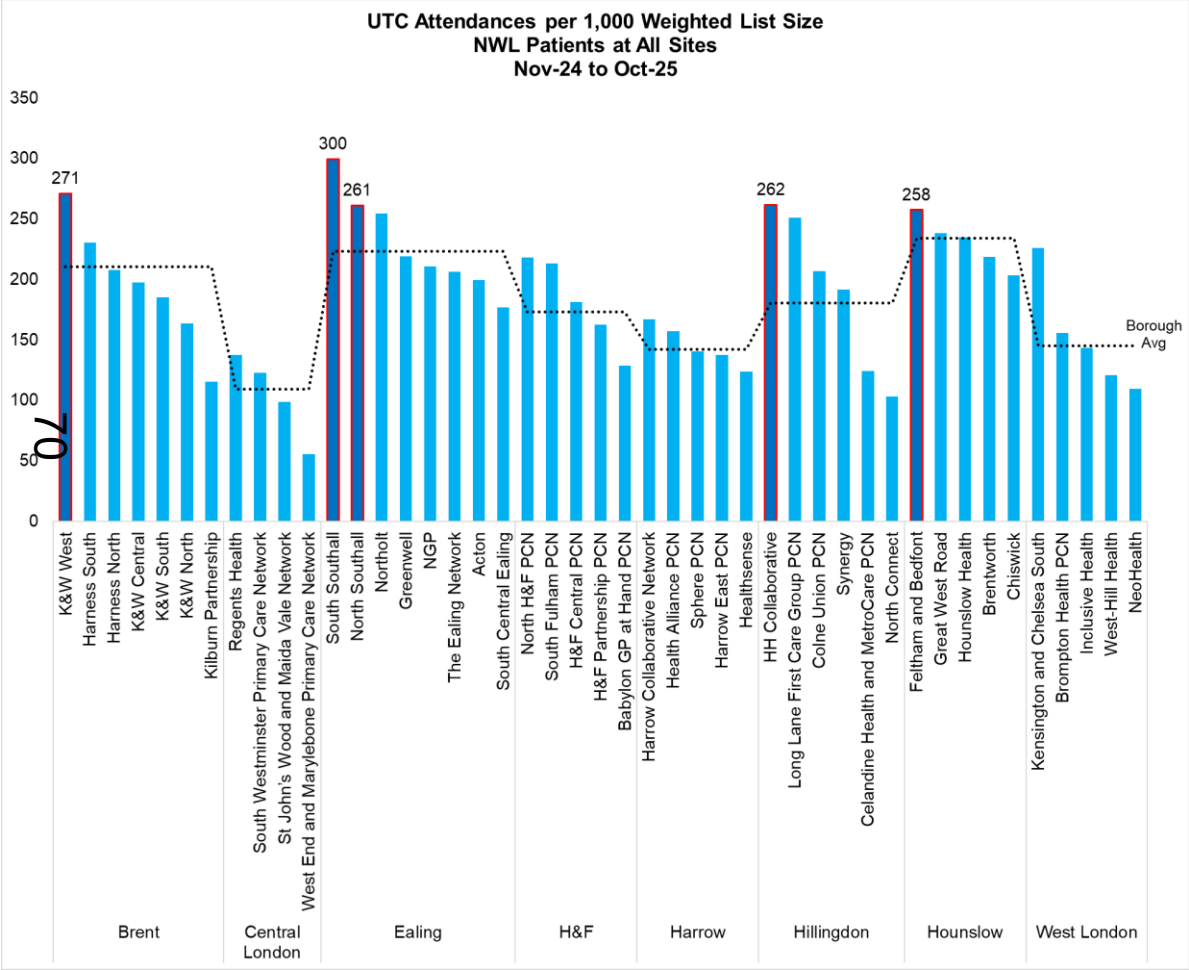
NHS NWL Community Eyecare Service

- The service went live at the end of **February 2025** and utilises established optometry workforce in the community.
- The **optometrist-led community eyecare services** offers:
  - **Minor Eye Conditions services (MECS)** - Rapid assessment of recent-onset eye problems; ~80% managed within service
  - **Pre-Cataract Assessment** - Ensures only appropriate cataract referrals reach HES; strengthens shared decision-making and improves surgical conversion rates
  - **Glaucoma Repeat Readings** and **Glaucoma Enhanced Case Finding** - Reduces unnecessary glaucoma referrals through repeat readings and enhanced diagnostics
  - Direct optometrist-to-hospital referral; eliminates need for GP involvement in most cases
- The service:
  - Reduces demand on GPs and Hospital Eye Services (HES).
  - Supports early identification of cataract and glaucoma.
  - Improves patient choice, experience and continuity in primary care.
- Since going live in Feb 2025:
  - MECS is performing very strongly and **~80%** of patients are fully managed within the service
  - Only **~11%** referred to HES as urgent/emergency (this equates to ~44 patients/month across NWL)
  - PES (Optometry Federation) continues to play an active role in supporting UTC(s) patient flow and improving signposting into community eye care pathways

Continuous Improvement: Building on Neighbourhood Health

- The Fuller Stocktake Report set out a new vision for integrated care, placing **Primary Care at the heart of Neighbourhood Health** development.
- In recent months, governance and leadership have been strengthened**, bringing together partners** across place, community, primary care, acute, local authority and VCSE to drive **place based leadership** and neighbourhood models aligned to the 10 Year Plan
- 6 of NW London's 7 Places applied for the National Neighbourhood Health Implementation Programme (NNHIP), with Bi-Borough and Hillingdon selected as national sites
- The focus has shifted from design to **delivery of Models of Care** that offer **proactive, integrated services** that meet local needs, supported by **PCNs/practices**.
    - One model of care – children's health – is demonstrating measurable impact and is being rolled out. We continue to model through / test the impact of the frailty model and the Hounslow Together model
    - The next tranche of care models – Enhanced Services Cardio-Renal-Metabolic (CRM), Health Equity incl. community in-reach, and End-of-Life Care – are to be confirmed and are currently in early development and proof of concept phases, with potential to drive a further **shift from reactive to proactive care**.
- Nationally, we are aware that there is likely to be a focus on how primary care can **work with emerging neighbourhoods** to consider the best geography for neighbourhood working and populations with a focus on **maximising access** for primary care, continuing focus on **high risk cohorts** and having **effective interfaces** between different services.
- **Primary Care Provider Collaborative** development is also underway – ensuring **all primary care voices are represented** within the system, with a focus on deep-end and high-deprivation practices, so that place-based collaboration keeps tackling inequalities at the centre of decision-making.

Value For Money Initiatives:
Redirection Opportunities



- As part of developing the 2026/27 Access Specification, scope potential **redirection opportunities** across NWL.

Redirection Area	Opportunity (attendances/month)
Pharmacy First service	1,600
Community Eye service	TBC
Wound Care	2,025
111 Appointments to GP Practices	2,580

- The aim is for **general practice to manage primary care presentations**, while urgent & emergency care focus on higher-acuity patients with more urgent needs.
- This will help ensure patients are seen in the **right place, at the right time**, in line with the strategies, while also strengthening system-wide **resilience**.
- There may be some opportunity to **transfer funding** currently utilised for Urgent Treatment Centre (UTC) activity to support the provision of care in a primary care setting.
  - UTC tariff £113 (plus MFF), services provided at a lower rate in Primary Care (e.g. currently Pharmacy First £15 per activity, wound care £20 per activity)

North West London Integrated Care System

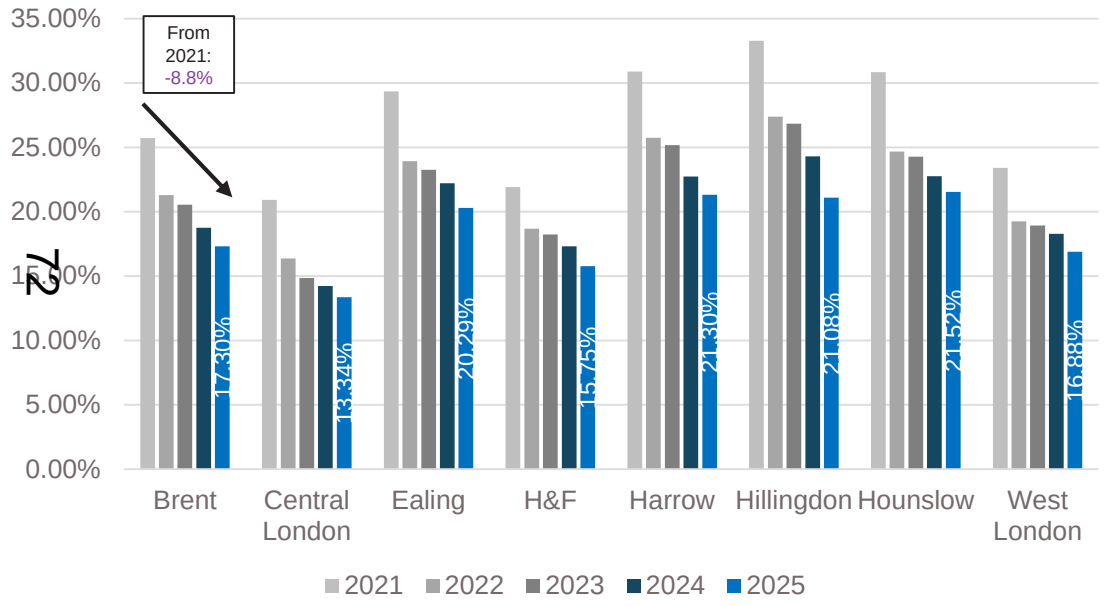
2

Engagement & Feedback

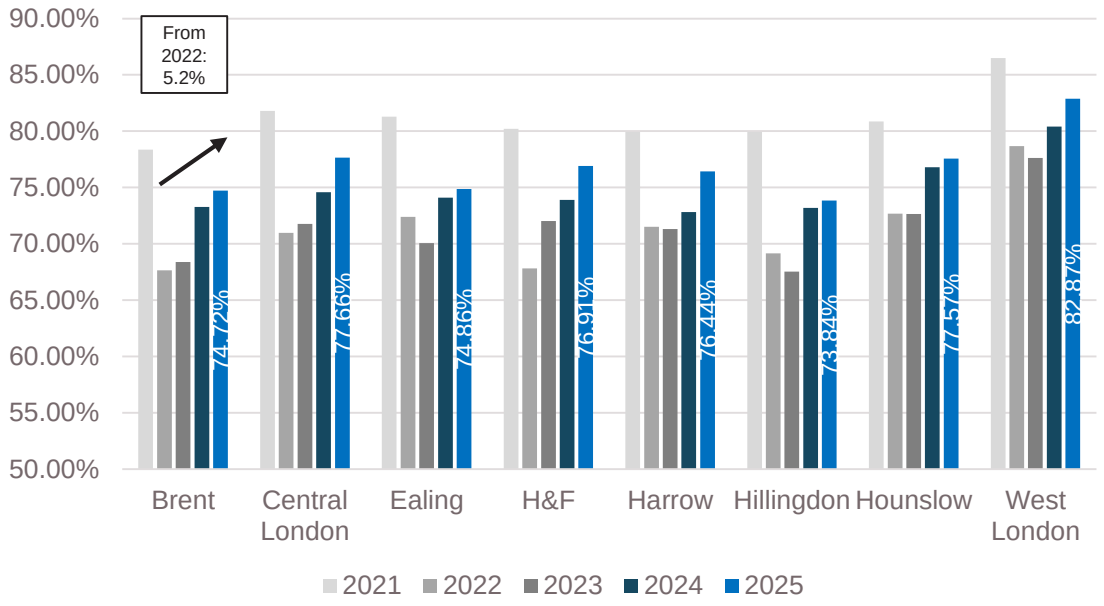
National GP Patient Survey:
Response Rate & Overall Patient Experience

In 2025, 201,150 GP Patient Surveys were sent out, with 35,403 completed in NW London.

Patient Survey Response Rate, by Borough [2021-2025]



Overall patient experience, by Borough [2021-2025]



- Survey response rates in NW London (18.8%) were slightly lower than the national average (25.8%), which may partly due to NWL having engaged its population in one of the largest local access engagement exercises nationally (reached over 100,000 residents), shortly before the GP Patient Survey was issued.

Note: %Good = %Very good + %Fairly good

- Patients in NW London report a **better overall experience** with their GP practice (76.55%) compared to the national average (75%)
- An **increasing number of patients in NW London have reported positive experiences** with their GP practices – a 5.2% rise between 2022-2025.
- In 2025, the highest levels of patient satisfaction were reported in the West and Central London boroughs.

2025 National GP Patient Survey:
Pharmacy, Dentistry, and Ease of Access in NWL

Pharmacy and Dentistry

89%

had a good overall experience of Pharmacy services

National result: 88%
2024 result:

Most common Pharmacy uses:

Pick up prescription	68%
Buy medication	45%
Get health advice	20%
Get a vaccine	17%

73%

had a good overall experience of Dental services

National result: 71%
2024 result: 72%

Ease of Access

64%

of how easy it if for patients to contact their GP practice on the phone

National result: 50%
Regional result: 60%

54%

of how easy it if for patients to contact their GP practice using practice website

National result: 51%
Regional result: 52%

53%

of how easy it if for patients to contact their GP practice using the NHS App

National result: 49%
Regional result: 51%

Patient and Staff Feedback in 2024/25:
Informed the development of the Access Programme

Key themes	NW London residents		NW London Primary Care staff		
	National GP Patient Survey (GPPS)	Access Engagement Patient Survey	Access Engagement Staff Survey	PCN-led Proposals / EOIs	Access Task & Finish Group (inc. LMC)
Accessibility of Care	Most patients reported a good overall experience of contacting their practice, whether by phone or online.	Timely GP appointments remain difficult to secure, particularly in high-demand areas.	Staff prioritised good telephone access, urgent/routine appointment availability, and robust systems.	Patients should have timely access when they need it.	Reduce inappropriate appointments, and address the primary/secondary care interface issue.
Continuity of Care	Most patients who contacted their practice knew the next steps for their request.	Patients value seeing the same GP/team for ongoing conditions, supporting proactive, long-term care.	Clarity on referrals, communication, and patient follow-up was important.	Patients should be able to access named GP/team if they need to, and make use of multi-disciplinary team.	Use risk stratification to focus on patients with complex needs or long-term conditions.
Use of digital tools	Increased ease of using NHS App.	While digital tools are more common, some patients face barriers in accessing them.	Use of digital tools must be part of the solution to managing demands	Provide easier routes into practices via NHS App and Online Consultations (OC)	Utilise NHS App functionality, ensure OC availability, and improve data quality.
Patient engagement	Most patients felt involved in decisions about their care and treatment.	Language, culture, and past experiences influence engagement.	Communication quality mattered most for patient experience	Patients should be involved in their care and shaping services through engagement events.	Embed sustained, yearly patient engagement to generate meaningful insights.
Health equity		Practices in areas of higher deprivation need further support.		Targeted services for specific groups, e.g. non-English speakers, and digitally excluded people	Enable PCNs to identify underserved populations, and align with Neighbourhood Health

Communications & Outreach:
NWL ICB Engagement Approaches

The ICB has communicated the Access plans to our residents, PCNs and practices.

PCNs and Practices

- All Access plans assessed, with **tailored feedback** provided. The plans were of a consistently good standard, and key insights have been shared with the PCNs.
- **Communications**, FAQs, guidance materials, and financial information were issued in May-25 to support PCNs and Practices in implementation.
- Worked closely with Borough teams to provide **further support** and address high volume of queries, incl. IT issues.
- **Delivered training** via 2 Primary Care Webinars (S1 and EMIS) to support spec compliance and audit processes.
- **Access Dashboard** developed to automate data and reduce local reporting burden.
- Promote a **collaborative learning** approach, encourage practices with strong patient experience scores to share their successful models and innovations. E.g. peer mentoring, facilitated learning sessions, and sharing of improvement tools through PCNs and borough-level forums.

Public and Residents

- All Access plans contain sections on patient engagement and **PCNs are responsible to deliver against this**.
- PCNs were requested to share their full 2025/26 Access Plans with their patients/PPGs and have conversations with their patients to ensure meaningful involvement.
- PCNs were requested to **publish bullet-point summaries** of their Access Plans on their websites in July-25. The ICB has completed spot checks to confirm these summaries are now available online.
- **Public queries** about access have been addressed through the NWL ICB Board and Primary Care Programme Board since May-25.
- The ICB is exploring ways to enhance the use of real-time **patient feedback** – e.g. through digital tools and focus groups – to complement survey data and ensure that improvement actions are responsive to patients' current experiences.

Communications & Outreach:
PCN-led Patient Engagement Plans

PCNs are committed to engage patients and communities on current access and future needs. Building on last year's engagement learning, making patient voices central to service design and improving communication.

1	**Patient engagement**	All PCNs emphasise involving patients through surveys, patient participation groups (PPG), and regular feedback mechanisms throughout the year.
2	**Surveys & meetings**	Co-design surveys with PPGs to gather input and inform improvements.
3	**Digital access**	Improving access to care, including digital tools like the NHS App, Online Consultations, and addressing digital exclusion, is a recurring focus.
4	**Community outreach**	Many plans include community events, workshops, and targeted outreach to wider, underrepresented groups.
5	**Continuous improvement**	There is a strong emphasis on using patient feedback to drive ongoing service improvements and closing the feedback loop.
6	**Support for diverse needs**	Plans mention multilingual materials, support for those with limited digital skills, and efforts to reach seldom-heard groups

NWL General Practice Action Plans:
Tackling Unwarranted Variations

In addition to promoting the sharing of best practice and engaging residents, the ICB applies commissioning levers to manage unwarranted variation across PCNs and practices.

Contract Compliance & Assurance

- NWL ICB **prioritises practices for contract assurance reviews using a range of indicators**, incl. childhood immunisation and flu vaccination rates, overall QOF achievement, and GP Patient Survey results relating to overall experience and appointment access.
- Currently, **47 practices** have been identified as a priority for a contract assurance review. This approach ensures that the ICB can work closely with those practices where patients have reported lower levels of satisfaction, with a view to understanding local challenges and supporting tailored improvement.
- Additional routine assurance checks for practices not already flagged, to identify and address any hidden issues
- NWL has an **established record of enforcing contract compliance.**

Practice Level Support (PLS)

- To strengthen support, the ICB is implementing the **Practice Level Support (PLS) Programme** – an evidence-based, tailored improvement initiative focused on enhancing patient access, experience, and operational efficiency. **16 practices** are currently engaged or about to begin this programme.
- **National GP Dashboard** used to identify both positive and negative variation for targeted support, for additional assurance selection, and contextual understanding
- Overall, NWL ICB is **committed to reducing unwarranted variation** and ensuring that every patient, regardless of where they are registered, receives high-quality, accessible primary care.

3

Future Planning & Risks

Future: NWL Health Equity Focus

The Primary Care and Health Equity programmes have worked in close partnership, demonstrating strong commitment to ensure adequate and equitable access provision across NWL.

Learning

- **Health equity must be built into all levers of primary care** - contracts, specifications, data, workforce and commissioning frameworks.
- This requires sustained **cross-programme partnership, joint accountability, and a system-wide approach** to fairer funding and delivery

Development

- The **2026/27 Enhanced Services**, i.e. Cardiovascular-Renal-Metabolic (CRM) Specification, directs greater funding into more deprived areas and incentivises outreach and prevention where impact is greatest.
- **A joint review of the 20% allocation for locally commissioned services** is ensuring investment is targeted toward areas of greatest need, especially Core20+5 populations.
- Work together with Health Equity team to review **Fairer Funding** by ensuring practices serving those with greater need are receiving commensurate funding.
- **Risk segmentation project** is underway to identify high-risk and rising-risk patients, enabling practices to deliver targeted interventions using robust data.
- **Digital inclusion by design** – all digital transformation must make inclusion the default, not a bolt-on
- The **2026/27 Commissioning Intentions** embed a stronger population health focus and clearer accountability for tackling unwarranted variation in access, experience, and outcomes.
- **Building cultural and community competence** – continued workforce development in cultural competency, structural inequality, and community engagement is essential to sustain impact and trust

Future: Next Steps and Shaping Specifications

Next Steps

- A **2-year contract extension** (2026-2028) for the NWL Single Offer has been approved (£75m). This provides an opportunity to evolve the model toward a more outcomes-based, equitable, and data-driven model.
- **Ongoing monitoring of practice performance** via the Access dashboard to ensure contractual compliance.
- A **Task & Finish Group** has been established to oversee the next phase of development, review, and implementation across NWL Primary Care.
- **Co-design specification** with Urgent & Emergency Care, Digital Transformation, Medicines Optimisation, Health Equity, and BI teams, with a view to demonstrate system wide impact.
- Scope potential **opportunities** across NWL and improve resident engagement

Proposed Changes to Access Specification

- Ongoing engagement shapes 2026/27 commissioning priorities, and ensures the **patient voice drives change**. This will be explored further with the Task & Finish Group.

Accessibility	Timely, safe access via multiple routes and first contact/alternatives.
Continuity	Strengthening continuity of care for complex needs
Digital Access	Advance NHS App as the Digital Front Door of the NHS, creating seamless pathways across system, while maximising functionality.
Patient engagement	Improve resident engagement to ensure alignment with new models of primary care, i.e. enhancing in-reach engagement for underserved population
Health equity	Apply risk stratification for tailored support, and address deprivation, diversity, and digital exclusion.

Key Risks and Mitigations

The programme remains on track for delivery, but key risks have emerged due to ongoing uncertainties.

	Risks	Mitigations
1	ICB restructuring may lead to reduced staffing and resources, affecting delivery of the current programme and future development.	Prioritise critical tasks and ensure clear governance to maintain delivery.
2	Seasonal demand surges, particularly during winter, placing significant pressure on the system.	• Practice/PCN Business Continuity Plans in place. • Remind PCNs/practices to have robust plans for MDT review, update care plans, shared/available to other agencies. • Review local primary care OPEL process to assess if it can be simplified for re-launch and engage with London work on this. • Utilise Pharmacy First and Urgent Dental service. • Support from Place to manage issues locally and co-ordinate
2	The system relies on manual returns from PCNs/practices, and there is insufficient capacity to monitor a wide range of metrics year-round. This reduces the ability to evaluate outcomes effectively, and monitor practice-level activity in real time.	Strengthen the use of data and insights by increasing automation where possible to reduce reporting burden, improve data quality, and ensure visibility of a consistent dataset across NWL.
3	Contractually, practices cannot close their doors. However, capacity pressures may mean waits for appointments may increase, some enhanced services may be de-prioritised.	NWL has an established record of enforcing contract compliance.
4	While the intention is to move towards outcomes focused Enhanced Services specifications, the 2026/27 version remains output focused.	Use insights and analysis to shape future specifications with a stronger outcomes focus, with the specifications expected to evolve over the next 3 years.

A

Appendix

Contents:

- NWL Winter Communications Campaign
- 2025/26 Access Specification: Performance metrics by PCN

NWL Winter Communications Campaign

This year's winter communications are aligned with the NWL Communications Strategy, focusing on managing patient flow, easing system pressures, and ensuring continuity of care.

Sept 2025:

- Children's flu/pregnancy vaccinations
- Launch of national booking system flu/COVID-19

Oct 2025:

Flu over 65s, long term conditions and pregnancy and COVID-19 messages

- Out of home adverts, continued community/partner work and social media.

Nov 2025:

Pharmacy First and 111

- Out of home adverts, continued community/partner work and social media.

	Activity	Timeline	Reach
	Community radio adverts to support launch of schools flu vaccination programme.	Six weeks: 15 September to 27 October	87,232 plays (first two weeks)
	Paid social media campaign for pregnancy, children and booking system (static images).	Two weeks: 15 - 29 September Video push - from 1 Oct	106,725 impressions 2,500 clicks
	Advert space booked in all council magazines for full vaccination messaging.	Adverts booked in publications from 1 Sept through to Nov, depending on publication timeline	~800,000 homes
	Updates on focus areas shared with partners; press release , LA bulletins, Nextdoor, community groups.	Regular updates sent throughout September	Unknown
	16 community groups set-up to work with communities in focus areas of the winter plan.	October - December	18,000+ contacts over three months
111	Google adverts for emergency care at point of need - directing to 111	September to March	September's reach 75,000 impressions 28,000 clicks to 111

2025/26 Access Specification:
Performance metrics by PCN (1 of 2)

- **Note** that this data set contains several data quality issues, which the ICB BI team is currently investigating.
- Telephony metrics rely on self-reported data, while e-submission metrics are based on a mix of self-reported and automated data.
- Data highlighted in red indicates missing/unavailable data, instances where a PCN has not self-reported, or where activity has not yet commenced. Where no current data exists, we have used the most recent available figures, including baseline data. A number of practices have not yet submitted data, which is affecting the totals.
- A new national NHS App dashboard was released by NHSE over summer-25, and discrepancies have been identified when compared with existing data. The ICB is seeking clarification from the national team to ensure consistent reporting.

	Accessbility			Contintuity	Digital
	90% of calls answered within 10 mins	90% of e-submissions responded to by end next working day	Return 0 unmapped appts	2% of high-risk patients identified	Increase NHS App registrations by 10%
	YTD (Q2)	YTD (Ave.)	YTD (Aug-25)	YTD	YTD (Q1)
BRENT CENTRAL KWH PCN	51.74%	69.95%	100.00%	0.0%	62.04%
BRENT NORTH KWH PCN	76.41%	53.45%	99.99%	3.3%	56.36%
BRENT SOUTH KWH PCN	80.66%	64.24%	100.00%	3.0%	59.52%
BRENT WEST KWH PCN	63.87%	78.29%	99.92%	0.3%	73.29%
HARNESS NORTH PCN	93.60%	92.35%	99.99%	1.1%	57.78%
HARNESS SOUTH PCN	94.33%	97.07%	99.99%	0.8%	54.86%
KILBURN PARTNERSHIP PCN	90.60%	75.57%	100.00%	2.8%	58.22%
BRENT	**78.74%**	**93.80%**	**99.98%**	**1.3%**	**60.29%**
REGENT HEALTH PCN	85.75%	94.67%	96.86%	1.7%	68.35%
SOUTH WESTMINSTER PCN	86.50%	99.86%	97.41%	0.7%	69.09%
ST JOHN'S WOOD & MAIDA VALE	87.47%	99.92%	98.47%	0.6%	59.67%
WEST END & MARYLEBONE PCN	85.19%	99.81%	96.65%	1.7%	60.96%
CENTRAL LONDON	**86.23%**	**98.14%**	**97.39%**	**1.1%**	**64.52%**
ACTON PCN	83.38%	97.00%	98.38%	2.0%	59.14%
GREENWELL PCN	84.96%	100.00%	97.40%	2.1%	59.06%
NGP PCN	88.11%	96.48%	95.41%	0.7%	56.87%
NORTH SOUTHALL PCN	85.00%	87.50%	96.76%	1.3%	57.52%
NORTHOLT PCN	62.00%	0.0%	97.79%	0.0%	54.27%
SOUTH CENTRAL EALING PCN	90.00%	96.00%	98.17%	0.0%	67.76%
SOUTH SOUTHALL PCN	95.00%	96.07%	96.78%	1.1%	59.02%
THE EALING NETWORK PCN	85.09%	97.00%	97.17%	2.1%	60.74%
EALING	**84.19%**	**95.72%**	**97.13%**	**1.4%**	**59.30%**
GP AT HAND PCN	94.10%	93.35%	99.57%	2.2%	86.58%
H&F CENTRAL PCN	92.16%	91.25%	97.01%	0.2%	63.56%
H&F PARTNERSHIP PCN	83.40%	86.16%	95.51%	1.6%	60.23%
NORTH H&F PCN	87.00%	72.96%	95.41%	0.0%	53.36%
SOUTH FULHAM PCN	88.00%	99.06%	98.65%	1.0%	66.93%
HAMMERSMITH & FULHAM	**88.93%**	**91.40%**	**97.33%**	**1.4%**	**66.13%**

2025/26 Access Specification:
Performance metrics by PCN (2 of 2)

- **Note** that this data set contains several data quality issues, which the ICB BI team is currently investigating.
- Telephony metrics rely on self-reported data, while e-submission metrics are based on a mix of self-reported and automated data.
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	Accessbility			Contintuity	Digital
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	YTD (Q2)	YTD (Ave.)	YTD (Aug-25)	YTD	YTD (Q1)
HARROW COLLABORATIVE PCN	90.00%	88.86%	100.00%	2.6%	59.77%
HARROW EAST PCN	90.67%	93.66%	99.99%	2.1%	55.56%
HEALTH ALLIANCE PCN	70.00%	98.30%	100.00%	1.2%	55.48%
HEALTHSENSE PCN	89.50%	93.69%	99.95%	1.2%	66.32%
SPHERE PCN	89.50%	96.61%	100.00%	1.5%	66.52%
HARROW	**84.92%**	**95.12%**	**99.98%**	**1.6%**	**60.73%**
CELADINE HEALTH & METROCARE	90.35%	91.37%	99.96%	2.2%	69.32%
COLNE UNION PCN	90.40%	97.00%	99.99%	2.2%	62.82%
HH COLLABORATIVE PCN	91.00%	93.25%	99.99%	2.2%	56.72%
LONG LANE FIRST CARE GROUP	94.00%	88.60%	100.00%	2.6%	62.25%
NORTH CONNECT PCN	88.14%	98.98%	99.91%	2.2%	70.23%
SYNERGY PCN	87.50%	95.52%	99.99%	1.9%	68.36%
HILLINGDON	**90.23%**	**94.04%**	**99.97%**	**2.2%**	**64.95%**
BRENTWORTH PCN	87.43%	93.27%	96.99%	0.6%	65.54%
CHISWICK PCN	62.00%	86.81%	98.63%	1.6%	54.71%
FELTHAM AND BEDFONT PCN	87.44%	79.96%	96.84%	3.9%	55.82%
GREAT WEST ROAD PCN	54.00%	96.70%	97.71%	2.3%	58.16%
HOUNSLOW HEALTH PCN	87.14%	76.66%	96.68%	3.4%	58.06%
HOUNSLOW	**75.60%**	**89.07%**	**97.22%**	**2.6%**	**58.46%**
BROMPTON HEALTH PCN	89.43%	86.11%	99.18%	0.9%	62.99%
INCLUSIVE HEALTH PCN	89.00%	83.49%	95.44%	0.4%	53.83%
K AND C SOUTH PCN	74.80%	85.91%	99.21%	1.0%	60.93%
NEOHEALTH PCN	98.00%	45.18%	97.64%	0.1%	51.47%
WEST-HILL HEALTH PCN	88.39%	88.09%	98.59%	2.2%	67.20%
WEST LONDON	**87.92%**	**86.49%**	**98.19%**	**1.2%**	**59.28%**
NW LONDON	**84.60%**	**94.03%**	**98.46%**	**1.6%**	**61.71%**

Agenda Item 7

NHS
North West London

All Age Continuing Healthcare in North West London

Report for Joint Oversight and Scrutiny Committee, December 2025

Presenter/ Author: Anne Middleton
Director of Nursing (All Age Complex Care & All Age Continuing Care), NHS North West London Integrated Care Board

Executive Responsible Officer: Jennifer Roye
Chief Nursing Officer, NHS North West London Integrated Care Board

1. Executive Summary

North West London (NWL) Integrated Care Board (ICB) manages several services under All Age Continuing Care (AACC) with an active caseload at any time of around 4,400 individuals. Services include Standard Adult Continuing Health Care (CHC), Fast Track CHC, Funded Nursing Care (FNC), and Children's Continuing Care (CCC). This report focuses on adult CHC and FNC provision. The ICB would welcome the opportunity to discuss Children's Continuing Care at a future meeting.

Key messages:

- North West London ICB is the largest ICB in London and funds more CHC eligible individuals (including per 50,000 population) than any other ICB in London.
- The number of referrals and patients funded have exceeded pre-pandemic levels.
- Post pandemic, the ICB has worked to ensure consistency of approach in all of its London boroughs, this has been reflected in changes on both conversion rates (people found eligible following assessment) and numbers of individuals funded.
- Conversion rates for adult CHC funded care remain above London average across North West London, with some borough variations.
- Fast Track referrals are above London and national average.
- The number of individuals with learning disabilities and/or autism eligible for CHC funded care has increased significantly over the past couple of years.

Data summary (Q2 2025/26)

Metric	Value / Insight			
No. of Funded patients	Funding	NWL Actual No.	NWL No. of 50k pop.	London No. of 50k pop.
	Fast track CHC	810	16.78	11.89
	Standard CHC	1,171	24.25	21.35
	Total CHC	**1,981**	**41.03**	**33.24**
	FNC	2,355	48.78	61.78
	Joint funding	149	3.09	N/A
No. of Referrals	Funding	NWL Actual No.	NWL No. of 50k pop.	London No. of 50k pop.
	Fast track CHC	661	13.69	14.07
	Standard CHC	327	6.77	6.90
	Total CHC	**988**	**20.46**	**20.97**
	Negative checklists	135	2.80	N/A
Newly CHC Eligible	Funding	NWL Actual No.	NWL No. of 50k pop.	London No. of 50k pop.
	Fast track CHC	618	12.80	13.61
	Standard CHC	76	1.57	0.87
	Total CHC	**694**	**14.37**	**14.48**
Conversion rate (Standard CHC)	NWL	25%		
	London	14%		
	National	17%		
Adult Population	2,414,010			

2. What is Adult Continuing Healthcare?

Adult Continuing Healthcare (CHC) is an out of hospital package of ongoing care funded solely by the NHS for individuals aged 18 or over who have been assessed and found to have a 'primary health need' as defined in the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. This care addresses health and associated social care needs resulting from disability, accident, or illness. The patients to whom the framework applies are some of the most vulnerable in society.

To be eligible for NHS continuing healthcare an individual must be either “fast-tracked” due to a rapidly deteriorating condition (death likely within 12 weeks) or assessed by a multi-disciplinary team (MDT) and deemed to have a 'primary health need', which means that their primary need must be for healthcare, as opposed to social care. To determine if someone has a primary health need it must be demonstrated that an individual’s needs are of a particular nature, intensity, complexity or unpredictability. These are known as the four key indicators. In combination, or alone, the four key indicators will demonstrate that someone has a primary health need and thus may be eligible for NHS continuing healthcare funding.

Once CHC funding is agreed, the Integrated Care Board (ICB) will commission a package of care based on meeting the assessed needs of the individual. This care can be provided out of hospital in various settings, including the individual's own home, a hospice, nursing home or a care home.

Eligibility for NHS continuing healthcare depends on the patient’s assessed needs, and not on any particular diagnosis, medical condition, age, or disability category. CHC is not means tested, in contrast to social care. However, CHC does not guarantee a preferred placement. Care options must meet assessed needs and provide value for money to the public purse.

2.1 Fast Track CHC

Most people made eligible for CHC come through a Fast Track referral, where an appropriate clinician, defined as a registered nurse or medical practitioner responsible for the individual's care, completes the tool. The clinician must be knowledgeable about the individual's health needs and able to provide an assessment of why the individual meets the Fast Track criteria. They are trained in this assessment as a “trusted assessor” by experienced clinical staff in the CHC team.

The ICB has been working closely with the acute providers in NWL in order to streamline and digitise the fast-track process, which is planned to go live in Q4 2025/26.

2.2 Standard CHC

Referrals for standard CHC are mostly sent by social care, care homes and GPs. For standard CHC, most individuals are screened and assessed initially through a ‘checklist’ that determines whether they require a full assessment (i.e. Decision Support Tool (DST)).

If individuals are deemed not to require a full assessment then the checklist outcome is negative and therefore ineligible for CHC. However, individuals may be eligible for NHS Funded Nursing Care (FNC), which is a funding contribution for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care which is currently £254.06 a week (a nationally set standard rate).

Figure 1 – Overview of the CHC assessment process

3. CHC caseload numbers

Type of Funding	Snapshot number of funded patients	Movement in last 12 months up to end of Q2 2025/26	Update/Background
Continuing Healthcare (CHC)	**1,981**	**▲89 (5%)**	Includes people who have been fast tracked for end-of-life care support, as well as people receiving care in their own homes, nursing homes and via personal health budgets.
- Fast track CHC	**810**	**▼31 (-4%)**	A fast-track audit will be conducted to check whether referrals have been appropriate.
- General CHC	**768**	**▲77 (11%)**	Includes both physical disability and mental health conditions.
- LD/ Autism CHC	**403**	**▲43 (12%)**	The increase in LD/autism numbers will be investigated and benchmarked with other ICBs.
Funded Nursing Care (FNC)	**2,355**	**▲117 (5%)**	NHS-funded nursing care is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care. For 2025/26, this rate is £254.06 per week.
Joint funded	**149**	**▼22 (-13%)**	Joint funding was an historical arrangement that was previously put in place by CCGs (specifically in Brent, Harrow and Hillingdon). The CHC team no longer supports joint health funding for adults other than in exceptional circumstances. A significant risk was identified that people were being joint funded rather than been given CHC and were then mean tested for their care costs.
Children and Young People	**112**	**▼3 (-3%)**	The number of CYP receiving children's continuing care has remained constant over the past 6 months. There was a reduction in numbers in the previous 12 months as children transitioned into adult CHC or were no longer found eligible, following a review.

At the end of Q2 2025/26, there were 1,981 CHC funded patients. Patient numbers have remained relatively constant over the past 12 month and are currently above pre-covid levels recorded in M8 2019/20 (1,783 clients). However, the number of CHC LD/autism patients has increased by 12% (43 clients). This rise in client numbers is being investigated and will be benchmarked with other ICBs.

As of Q2 2025/26, NWL ICB holds the largest CHC caseload both nationally and within London based on actual patient numbers.

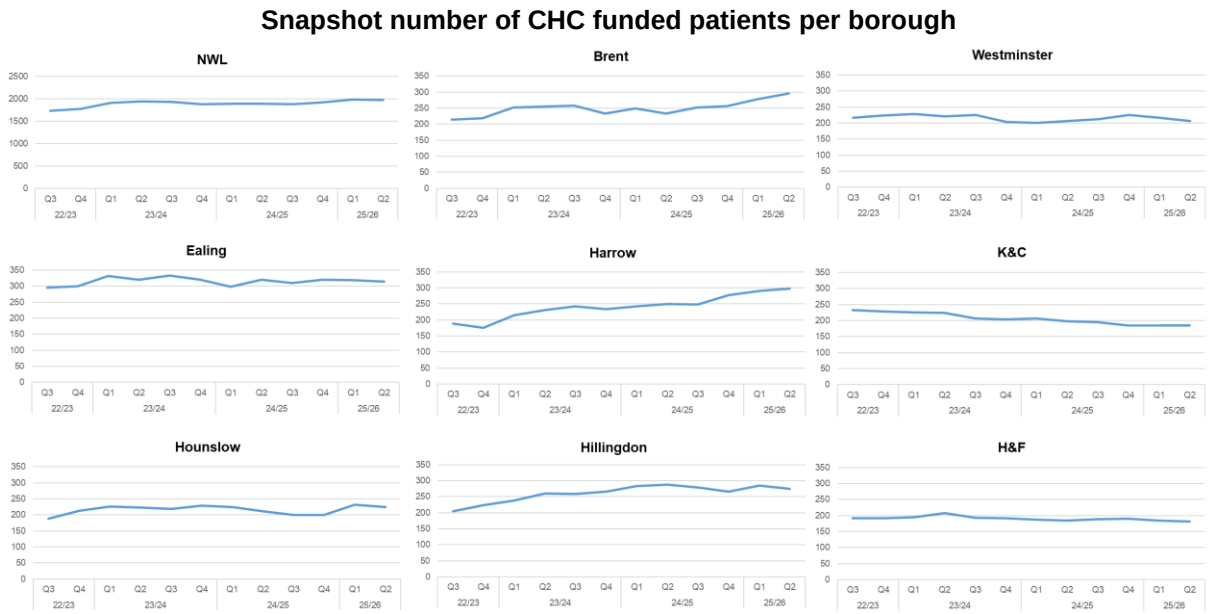


Figure 2 – Snapshot number of CHC funded patients per borough

4. Number of CHC funded patients per 50,000 population

4.1 London comparison

NWL London ICB has consistently recorded the highest number of CHC funded patients per 50,000 population across London. In Q2 2025/26, it reported 41.03 funded CHC patients per 50,000 - 23% higher than the London average of 33.24.

Over the past year, while most other London ICBs have seen a decrease in the number of CHC funded patients per 50 population, NWL has seen a rise in the number of CHC funded patients.

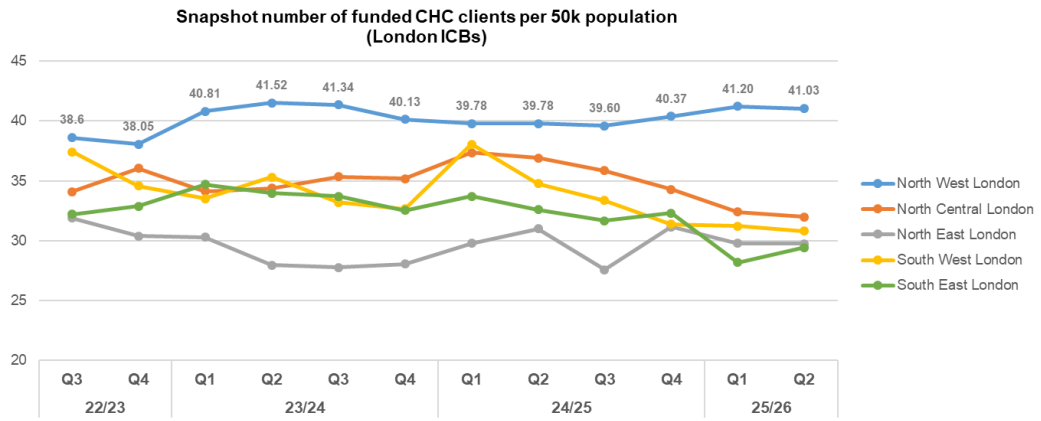


Figure 3 – Number of CHC funded patients per 50k (London ICB comparison)

4.2 Borough comparison

At a borough level, North West London experienced some changes between Q3 2022/23 and Q2 2025/26. Harrow recorded a substantial 50% increase and Hillingdon experienced a 26% increase. In contrast, Kensington and Chelsea (K&C) saw a 23% decline over the same period. This is due to the standardisation of how the national framework has been applied.

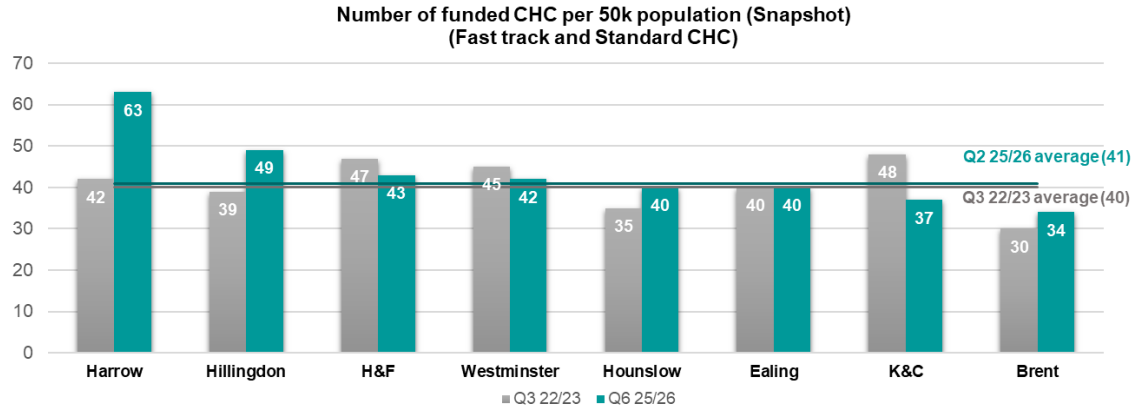


Figure 4 – Snapshot number of CHC funded patients per 50k population by borough

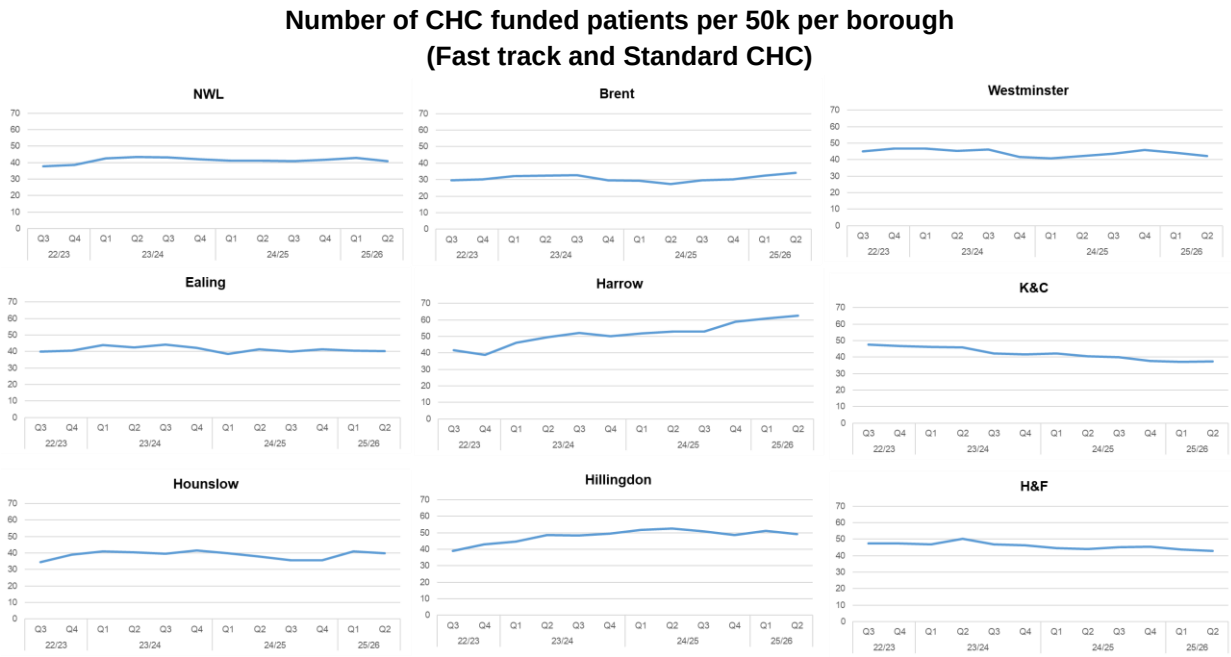


Figure 5 – Number of CHC funded patients per 50k per borough (Fast track & Standard CHC)

The historic data shows notable variation in CHC funded patients per 50,000 population across NWL. Inner boroughs such as Westminster, Kensington and Chelsea, and Hammersmith and Fulham have historically recorded higher numbers of CHC funded patients per 50,000, which may reflect differences in historic local practices and decision making among CHC teams rather than purely population health needs. In contrast, outer boroughs such as Brent, Harrow, and Hillingdon started at lower levels but have shown gradual increases over time.

This movement towards equalisation, particularly in Brent and Harrow, illustrates the principle of system-wide standardisation. By aligning processes locally across CHC teams, the system is driving greater fairness and consistency, reducing historic disparities and creating a more balanced distribution of CHC funding.

When the numbers funded per 50,000 population for over 70 years of age only (the majority of individuals funded under CHC), the variation changes considerably. This is due to variations in age demographics within each NWL borough.

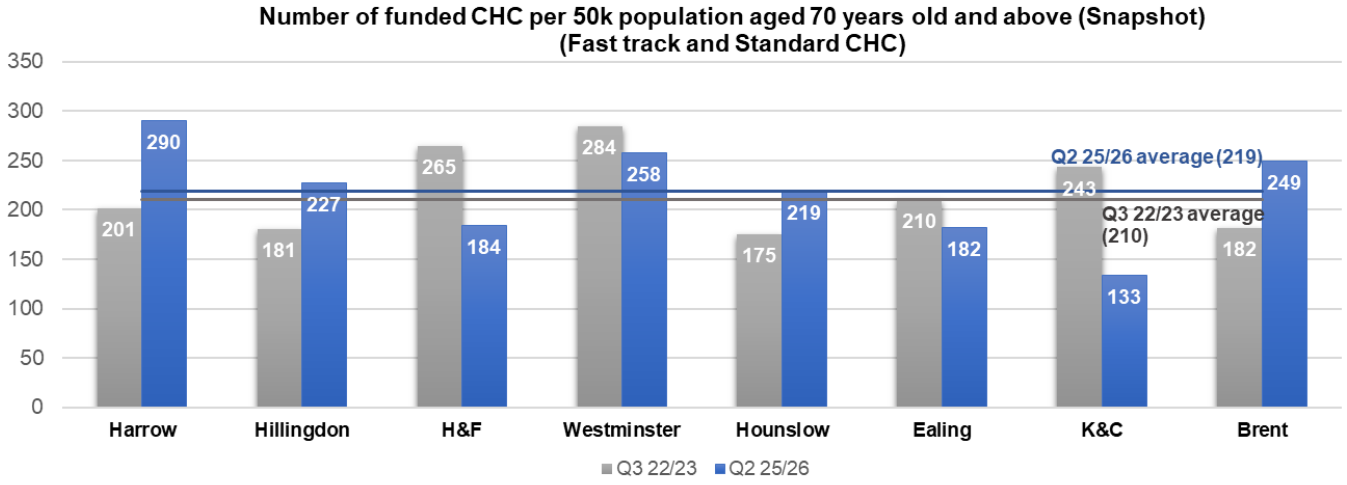


Figure 6 – Number of CHC funded patients per 50k population aged 70 years old and above

Further work needs to be done to understand demographic and population health differences across boroughs and whether this impacts CHC activity levels. The ICB is committed to identifying and addressing health inequalities across all service provision, including CHC.

5. Referral Activity

Referrals to the CHC service consist of fast track CHC and standard CHC referrals. In the chart below, overall referral volumes have remained constant over the past three quarters from Q4 2024/25 to Q2 2025/26. Most recently, at the end of Q2 2025/26, 1,123 referrals were received.

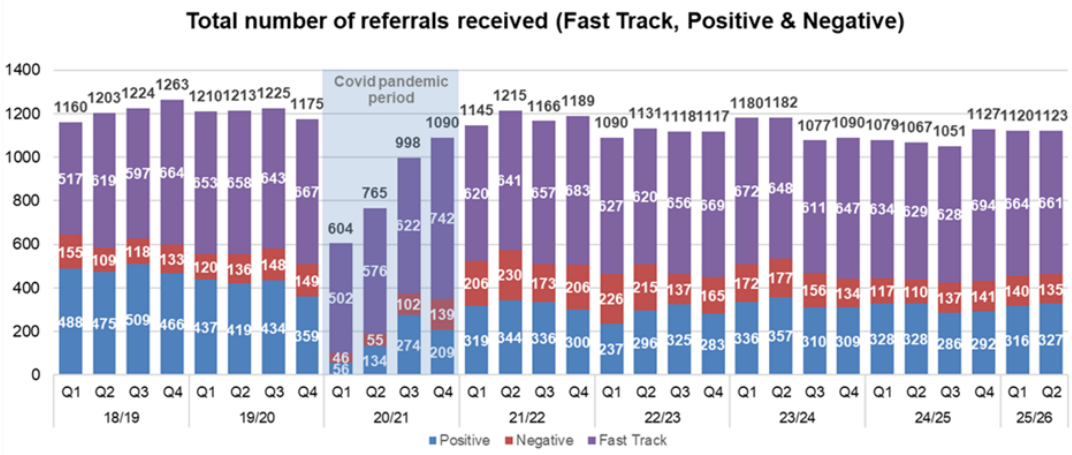
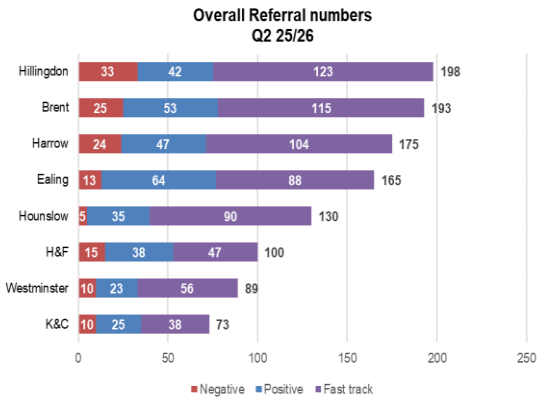


Figure 7 – Overall referral numbers - *(Standard CHC referrals have been further broken down by positive and negative checklist outcomes)*

In Q2 2025/26, overall referral numbers including fast track, positive checklists and negative checklists were highest in Hillingdon and Brent.

Hillingdon, Harrow and Hounslow reported a higher than average volume of fast track referrals per 50,000 population.



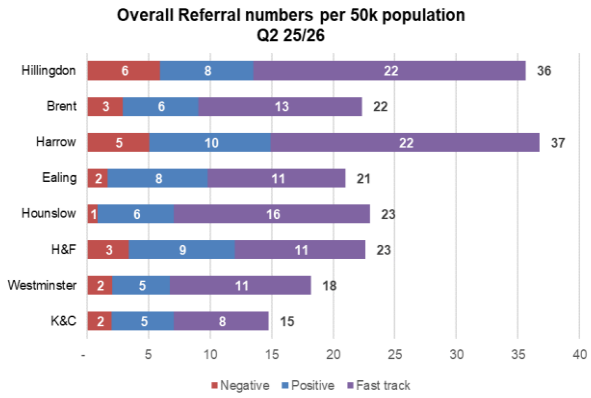


Figure 8 – Overall referral numbers - Q2 2025/26

Figure 9 – Overall referral numbers per 50k population

(Note: Hammersmith and Fulham population figures have been adjusted to account for the fact that most patients registered with the GP at Hand surgery were not residents of the borough)

6. Conversion rates

The overall NWL conversion rate for standard CHC assessments has shown a gradual increase since the pre-pandemic period, reaching 25% in Q2 2025/26. By comparison, the rate stood at 23% in Q2 2019/20. Since 2020, the organisation has undergone significant structural changes, including the consolidation of individual borough Clinical Commissioning Groups (CCGs) into a single CCG, followed by the transition to an Integrated Care Board (ICB) in 2022. These changes have contributed to greater consistency in the CHC assessment process and more aligned decision making across local CHC teams.

There have been significant shifts in conversions rates across some of the boroughs. Historically, Brent and Harrow reported the lowest conversion rates nationally, both at 9% in Q2 2019/20. By Q2 2025/26, these rates had risen substantially to 36% in Brent and 27% in Harrow. Conversely, Westminster and Kensington and Chelsea, previously among the highest nationally, have recorded reductions following the implementation of standardised processes.

Historically, one of the factors contributing to higher conversion rates in the inner boroughs has been differences in the screening process, whereby patients deemed unlikely to be CHC were screened out by Local authorities.

Other factors such as demographics, age dispersion, social economics, health issues will lead to variations in conversion rates across boroughs.

The ICB continues to monitor and audit the decision making across local CHC teams to ensure a consistency.

It should be noted that the current very high conversion rates in Brent, Harrow and Hillingdon could be affected by a backlog in completing assessments. Referrals where there is clear evidence of eligibility in the initial referral information are being prioritised and therefore artificially inflating the figures.

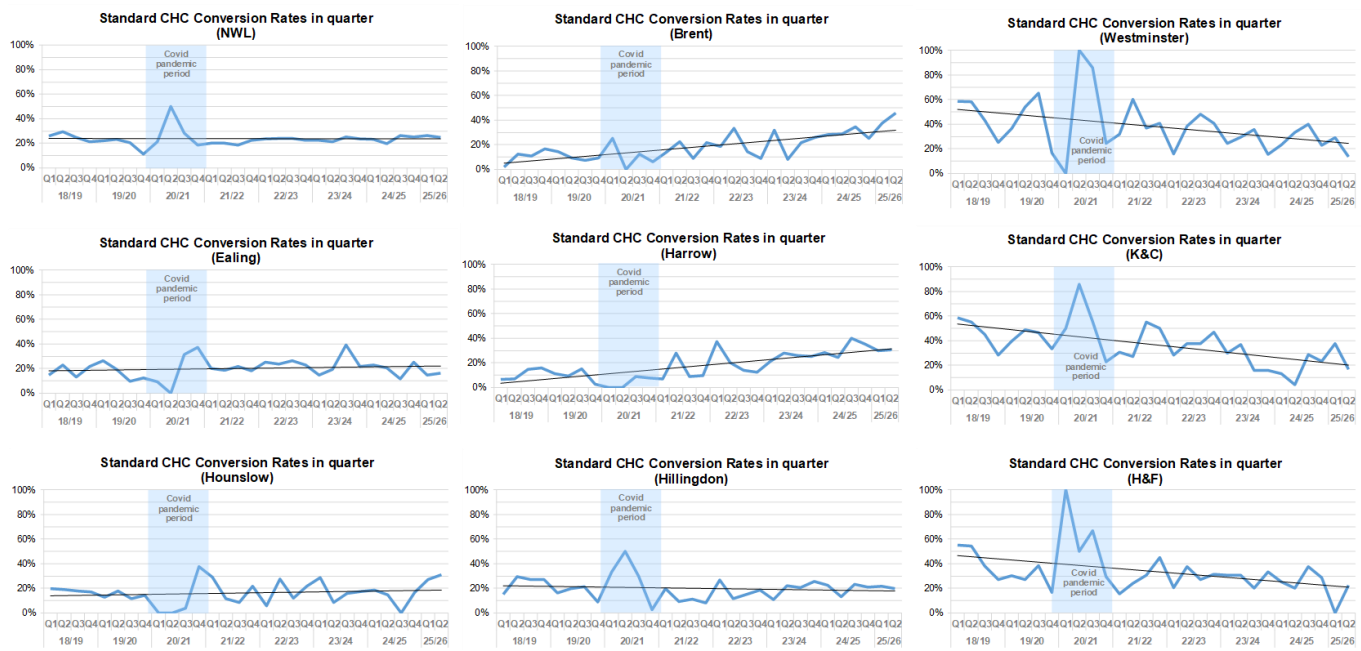


Figure 10 – CHC Conversion rate per borough

(During the COVID-19 pandemic, most assessments were paused. A small number may have been completed during this period, which could have resulted in disproportionately high conversion rates, as the majority of those assessed were likely eligible.)

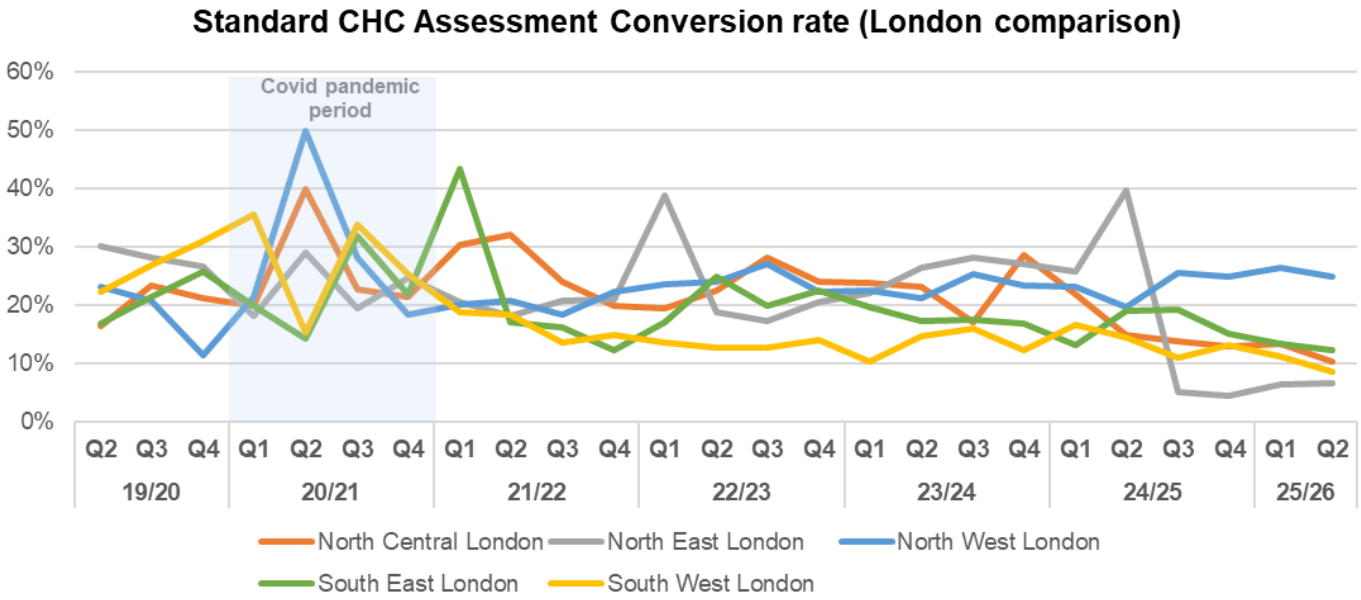


Figure 11 – CHC Conversion rate (London comparison)

Overall conversion rate activity has begun to standardise as a result of staff training (both CHC and social care) and being part of a single North West London structure. There has also been a culture change in some boroughs, where in the past there was a perception that the CCG was the gatekeeper of CHC rather than the gateway to receive CHC funded care where appropriate.

In Q2 2025/26, the average CHC assessment conversion rate for NWL was 25%, considerably higher than national and London rates of 17% and 14% respectively.

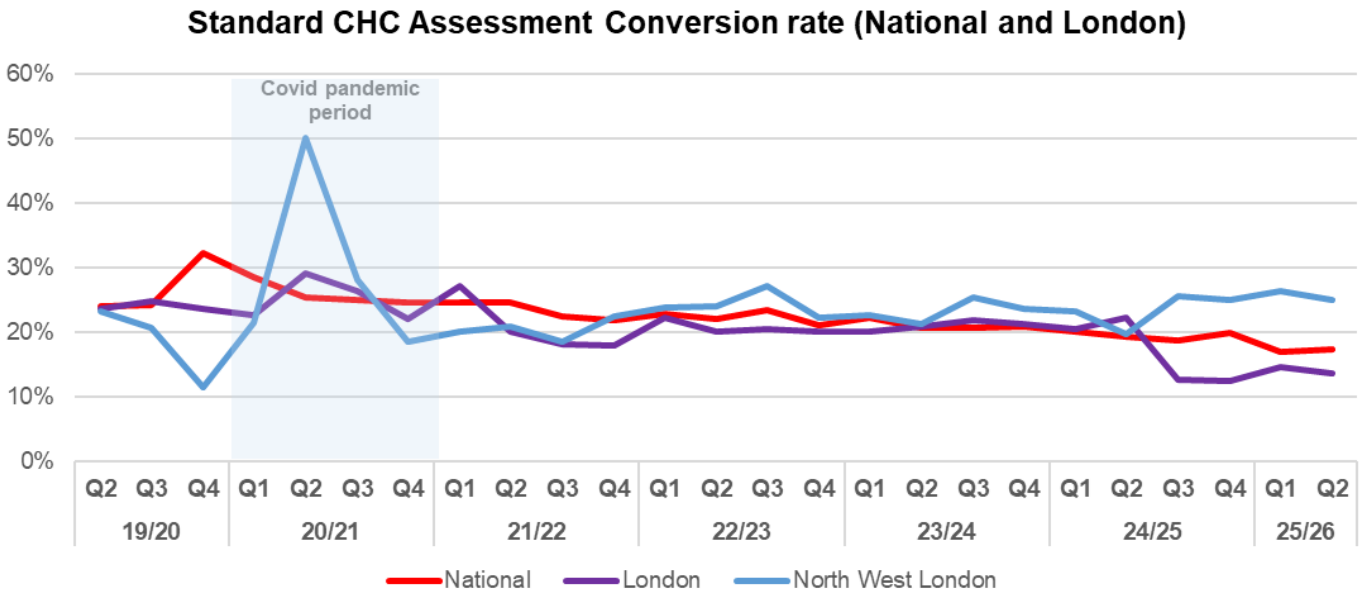


Figure 12 – CHC Conversion rate (National and London comparison)

7. Numbers of people assessed as eligible for CHC

In Q2 2025/26, North West London ICB had 14.4 newly eligible CHC patients per 50,000 population (including fast track and standard CHC patients), which was the third highest in London. The average was 14.48.

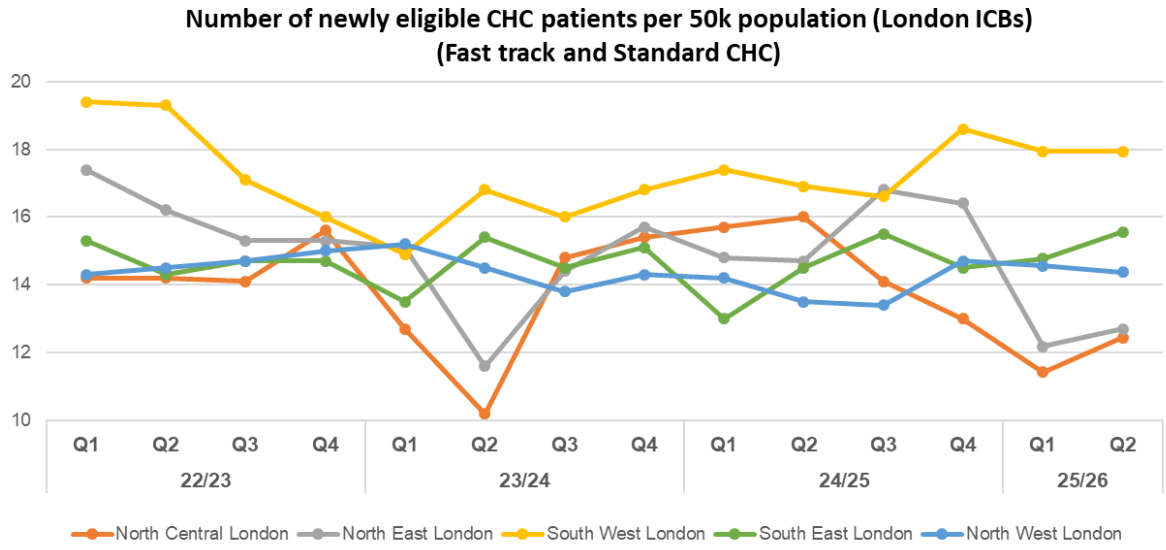


Figure 13 – Number of newly eligible CHC patents per 50k population (Fast Track and Standard CHC)

Focusing on standard CHC assessments, NWL recorded the highest number of newly eligible CHC patients per 50,000 population across London in Q1 and Q2 of 2025/26. In Q2 alone, NWL reported 1.6 newly eligible patients per 50,000, significantly above the London average of 0.9.

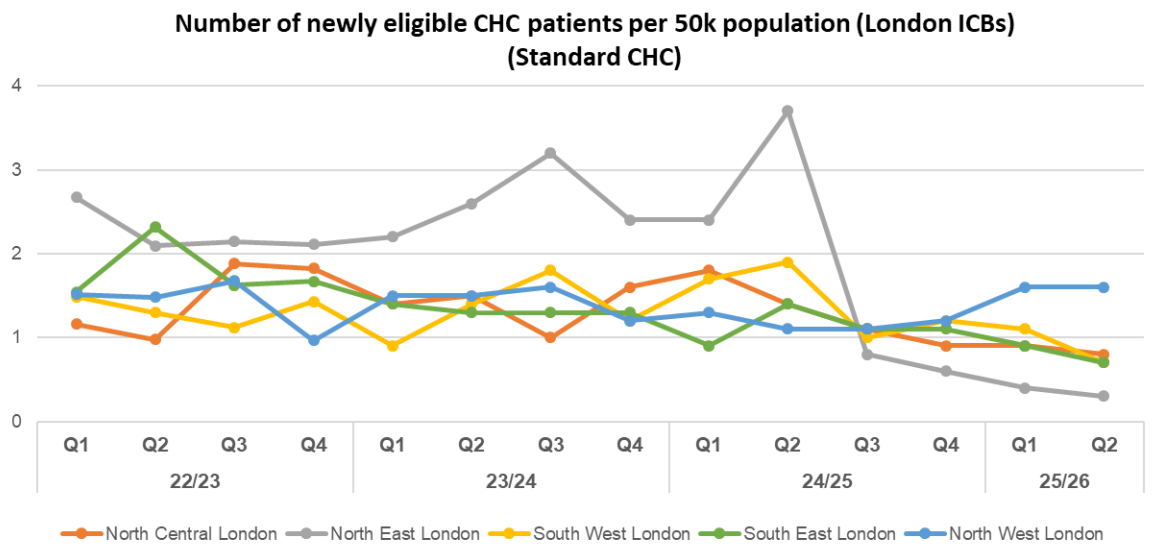


Figure 14 – Number of newly eligible standard CHC patents per 50k population (Standard CHC)

8. Future plans

The ICB is fully engaged in work across London, taking a “Once For London” approach. where feasible, to manage the healthcare out of hospital specialist market place to obtain best value for money and maximise knowledge and skills. We are signed up to the national priorities of increasing and retaining this highly specialist and scarce staffing resource and implementing training on a wider basis to nursing / care homes, hospices, acute trusts and social care partners to enable appropriate referral processes and streamline systems.

In addition, due to the expiry of current digital contracts, the ICB will be purchasing new digital software over the coming financial year. This will incorporate AI tools to streamline and speed up “back office” functions such as brokerage (purchasing of placements), invoicing and also patient records / checklist documentation.

We are keen to ensure that when this new technology is installed, there will be a cultural focus on improved completion of demographic data alongside other equality indicators to improve intelligence in this regard and enable informed, co-produced, targeted interventions with specific groups of patients and staff to further reduce inequalities.

The NHS England Model ICB Blueprint publication stated “exploration and scoping of future potential transfers” for CHC. This work is currently being undertaken. Whilst there are no plans or a potential date at present to amend legislation for CHC, the ICB remains legally responsible and accountable for all decisions and aspects of this work stream.

9. Appendix

9.1 Referral activity

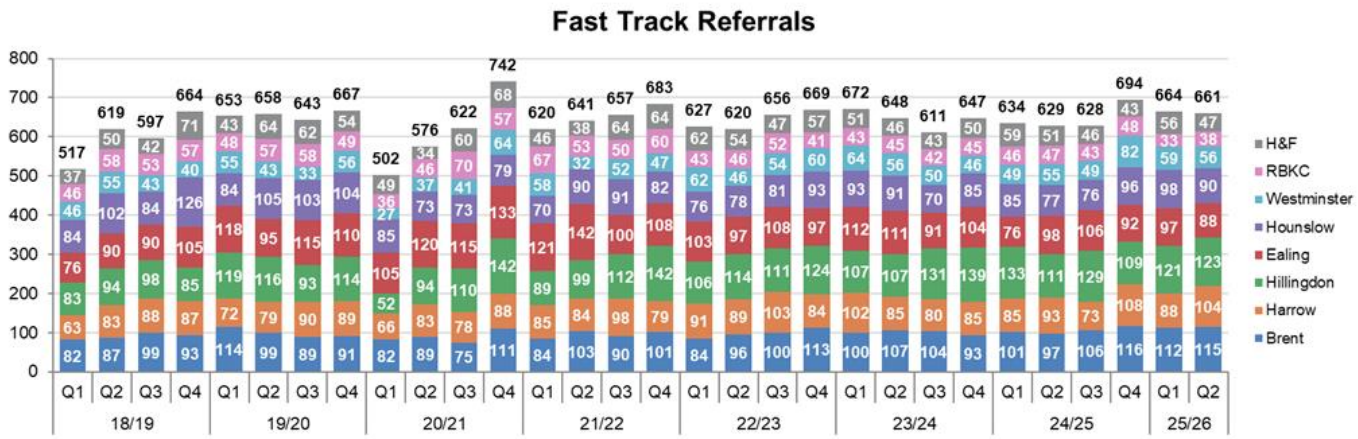


Figure 15 – Fast Track referral numbers per borough

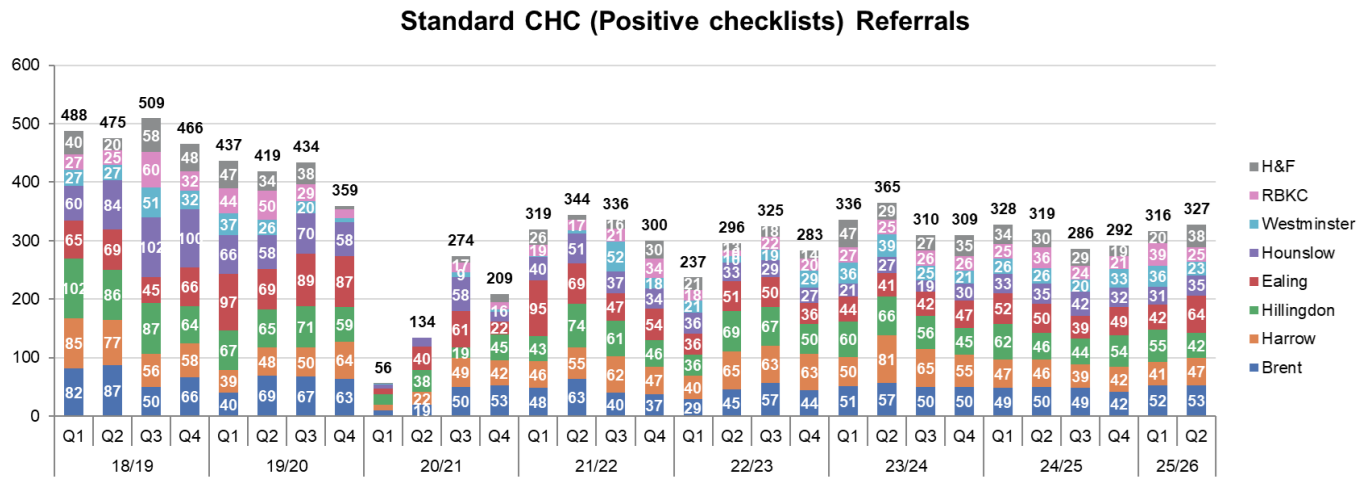


Figure 16 – Standard CHC referral numbers per borough

Report to the North West London Joint Health Overview Scrutiny Committee, 09 December 2025

Report Title	**SEN Continence**
Member Request	Cllr Ketan Sheth, Committee Chair, October 2025
Report Author	Duncan Ambrose, Assistant Director, NWL ICB Temilola Englezos, Project Officer, NWL ICB
Committee Date	09 December 2025
Report Deadline	28 November 2025

JHOSC request

Children and young people with special educational needs and disabilities (SEND) often face complex health and care challenges, including continence issues that can significantly affect their dignity, independence, and educational experience. Despite its importance, continence care for this group is frequently under-recognised and inconsistently supported.
Across North West London, there is notable variation in how these services are commissioned, delivered, and accessed. Families commonly report long waiting times and unclear referral pathways, making it difficult to navigate the system and access timely care.

Effective continence services can improve quality of life and independence, reduce avoidable hospital admissions and safeguarding risks, support school-attendance and inclusion, and alleviate pressure on families and carers. By understanding the existing landscape and addressing inconsistencies, this review helps identify opportunities to prevent the escalation of needs into more costly interventions and can be the first step in promoting a more joined-up approach across health, education, and social care.

Purpose of this report

This report offers a review of the North West London integrated care system to note current service models, highlight gaps, and support the development of more equitable, person-centred care.

Partnership contributions to the report

The request for this report was sent to NWL ICB. The Joint Health Overview Scrutiny Committee has been advised that there is no separate continence service for children with special educational needs, those with disabilities, or those with other long-term health conditions. As such, the report gives an overview of continence services, with additional contributions sought from families, and from partner agencies with duties to commission support in schools.

- The majority of this report was developed by NWL ICB, which has responsibility for commissioning level 2 and level 3 continence services. NWL ICB has also provided the population health summary included in annex 1. Additional details about services in annex 1 have been provided by a number of education, health, and care system partners, including the community provider collaborative.

- To comment on the experiences of families and carers in accessing support, contributions to this report were sought from the Parent-Carer Forums across north west London. Feedback and comments are included in this report, with an on-going survey open to support service improvement.

- To explain how schools and early years settings engage with continence services, and the impact on educational attendance and family wellbeing, contributions to this report, and representatives for the committee meeting, were sought from the

Directors of Public Health, and Directors of Children's Services, from Brent Council, Ealing Council, Hammersmith & Fulham Council, Harrow Council, Hillingdon Council, Hounslow Council, Kensington & Chelsea Council, and Westminster Council. The Directors of Public Health provided a joint statement regarding the level 1 services, and the access for nurseries, early years settings, and schools.

Background

Continence issues for children (including those who may have special educational needs) can present in a number of different ways, with a number of different professionals involved, depending on the level of need. Some needs may be considered part of a child's development milestones, or school readiness; some needs may require further investigation and specialist treatment.

There is international evidence that children with disabilities have relatively high rate of incontinence, with some issues extending into adulthood. Published evidence also suggests that independent toileting in children is associated with reduced risks of child abuse, and with improved social development.

Types of continence issues families may experience

Daytime wetting	Accidents, urgency, frequency during wake hours
Bedwetting	Accidents during sleep, often beyond age 5
Soiling/encopresis	Involuntary stool loss, often with constipation
Constipation	Infrequent, hard, or painful stools, abdominal symptoms
Frequency/urgency	Frequent or urgent need to void, small volumes
Urinary retention	Difficulty voiding, infrequent passages
UTI symptoms	Painful urination, cloudy urine, fever
Behavioural indicators	Mood changes, holding behaviours
Practical issues	Parents seeking help with supply of continence pads or washing of bed linen

Range of professionals that may be involved in providing care

General Practitioner (GP)	Many families begin by consulting their GP, who can assess, provide initial advice, manage simple cases, and refer to specialist services if needed
Health Visitor	For younger children, especially those under five, health visitors are a common first point of contact for advice on continence management, assessment, and referral
School Nurse	For school-aged children, school nurses often support families with continence concerns within the school environment and can provide direct support or refer to specialist services as appropriate
Education staff	Families may be encouraged to seek help by nurseries and schools
Social Care/Multi-Agency Safeguarding Hub (MASH)	Some local authorities signpost families to health services. This might be through a multi-agency "front door" system, such as MASH, often used for more complex or safeguarding concerns
Early Help/Family Hubs	Families can self-refer or be referred by professionals to Early Help or Family Hubs, which often act as a gateway to broader support including continence advice and coordination with schools and health professionals
Community Pharmacist	Some parents seek initial practical advice or product recommendations from pharmacists, who may signpost persistent cases to health visitors, GPs, or nurses
Acute hospital staff	This will vary from hospital to hospital, and can involve general paediatric services, specialist urology services, or other bladder and bowel specialist services

North West London context

Annex 1 shows a summary for each borough's population aged 0-25. This can give an indication of the population need for different age-groups.

All children in north west London have access to a range of continence services, ranging from advice to parents as a usual part of child development, through to specialist medical assessments for indications of serious disease and/ or abuse.

The model for children's continence services is described in the Education & Resources for Improving Childhood Continence (ERIC) Children's Continence Pathway as:

Level 1 Universal services

Provided by health visiting and school nursing teams, and sometimes GPs

- Early identification of difficulties with toilet training and bladder and bowel issues
- Knowledge of bladder and bowel development and continence milestones
- general and targeted advice on skill development for toilet training promotion of bladder and bowel health

Level 2 Children's Community Bladder and Bowel Service

Nurse-led multi-disciplinary team

- comprehensive bladder and bowel assessments
- multidisciplinary team led by a children's bladder and bowel nurse specialist
- understanding of and skills to work with children affected by neurological and developmental diversity
- specialist training, education and support to primary and community care staff delivering services at Level 1

Level 3 Medical assessment

Paediatrician-led services

- Continence issues not responding to level 2 interventions
- symptoms indicating a serious underlying disorder or complex long-term health issue
- safeguarding concerns

Experiences of families is variable across NWL, as shown by the comments from Parent-Carer Forums, below. These show the need to reduce unwarranted variation in level 1, level 2, and level 3 services.

Carol Foyle, Brent Parent Carer Forum, Nov'25:

- "*We are delighted about the new incontinence service in Brent. This is something that parents had been asking for a long time. The researching, planning and setting up of our new service in Brent is a real example of co-production where parents involvement was sought and meaningfully engaged and remain part of the monitoring process. A focus group of interested parents was established. This group was involved and kept informed at all stages in the setting up of this service ensuring it meets family's needs. We want to say a big thank you for the commitment of the health team in ensuing the voice of parents and the needs of their children are at the heart of the service delivery of this service. Much could be learnt from this experience going forward in the development or review of services in Health.*"

Reema Sharma, Parentsactive Coordinator H&F, Nov'25:

- *A parent was unhappy with blanket policies used by schools restricting bathroom use. Whilst it can be particularly difficult for young children in general (primary school) for SEN children this can be so much worse it can cause a lot of anxiety and further health problems by not being allowed to go. It is not just primary schools, but secondary schools use of these blanket policies can deeply affect children.*
- *Another parent commented "we waited over a year for input from Cheyne's clinical psychology team and Occupational Therapy for support. When it finally came it was a 2 hour zoom with 20 other parents, all at different stages, so felt so disheartening! Everything they covered was accessible online and felt like such a waste." In the end we got there ourselves! It seems like the "support" isn't actually supportive but ticking boxes*

Parent-Carer Forum survey across north west London findings, Nov'25:

- Families value health visitors, school nurses, and education staff as an initial point of contact for advice on toilet training
- *"Don't give up training the child - be patient"*

Variation across north west London

Annex 1 shows the current provision, and integration between health, education, and social care in supporting continence needs in each borough. Key areas are summarised below.

- **Level 1 services** are mostly commissioned by Local Authority public health. These provide advice and referral routes for early years and schools settings.

  The Directors of Public Health contributed to this report to describe how schools and early years settings engage with continence services, and the impact on educational attendance and family wellbeing.

November 2025, joint statement from the Directors of Public Health in Brent Council, Ealing Council, Hammersmith & Fulham Council, Harrow Council, Hillingdon Council, Hounslow Council, Kensington & Chelsea Council, Westminster Council

- "All public health commissioned school nursing services in North West London offer a Tier 1 level of support for enuresis / continence. This is through providing early advice and interventions such as toilet training support, diet and fluid advice. The ERIC – Children's Bowel and Bladder Charity - website (https://eric.org.uk/) is a key resource that parents / carers are recommended to use at this Tier 1 level."

- **Level 2 and 3 services** are commissioned by NWL ICB.
  Where there are any gaps in commissioned services, such as Hillingdon, NWL ICB complex care services considers case-by-case requests for packages of care.

Borough	Level 2 provider
Brent	Central London Community Healthcare NHS Trust
Ealing	West London NHS Trust & Ealing Community Partners
Hammersmith & Fulham	Central London Community Healthcare NHS Trust
Harrow	Primary care services & GP practice staff
Hillingdon	Level 1 health visitors and school nurses complete assessments and order any continence products. ICB complex care service supports individual cases.
Hounslow	West London NHS Trust
Kensington & Chelsea	Central London Community Healthcare NHS Trust
Westminster	Central London Community Healthcare NHS Trust
Across NWL	Level 3 providers
Paediatric services	Chelsea & Westminster Hospital NHS Foundation Trust Imperial College Healthcare NHS Trust London North West University Healthcare NHS Trust The Hillingdon Hospital NHS Foundation Trust

System-wide improvement and future opportunities

To reduce the current unwarranted variability of level 2 services, NWL ICB is working to co-design and implement a common offer for bladder and bowel services for children and adult in every borough in north west London. More consistent child and adult services will provide all-age support to any children and young people with special educational needs who also have bladder and bowel health issues.

This work is underway via the community provider collaborative (led by Jane Young, Nurse Consultant Central & North West London NHS Foundation Trust; and Mark Mbogo, Clinical Business Unit Manager, Central London Community Healthcare NHS Trust), starting with improvements to the adult bladder and bowel service offer. The intention is to develop an improved offer for children by 31 March 2026, noting that there may need to be several further phases of work and service improvement to ensure adequate engagement and co-production with families in each borough. These improvements would build on the Education & Resources for Improving Childhood Continence (ERIC) Children's Continence Pathway guidance, as well as guidance from the National Institute for Health and Care Excellence (NICE).

There may be merit if work on improvement to level 2 services was a prompt for Local Authorities to consider a standardised offer of level 1 services, thereby maximising value for money, workforce planning, mutual aid between providers, and continuity of experience for children who need continence support at home on one borough, but need continence support at nursey/ school/ college in another borough. Neighbourhood multi-disciplinary teams for children (child health hubs and family hubs) could provider a forum for case review and coordination of care. There is also a future opportunity for NWL ICB to explore with the acute provider collaborative potential care pathway productivity and efficiency improvements as part of a common core level 3 continence offer in north west London.

Relevant guidance

Bedwetting in under 19s, October 2010
https://www.nice.org.uk/guidance/cg111

National Institute for Health and Care Excellence (NICE) guidance: Paediatric continence commissioning guide: A handbook for the commissioning and running of paediatric continence services, June 2014
https://www.nice.org.uk/Media/Default/About/accreditation/Paediatric-Continence-Forum-commissioning-guide-accreditation-decision.pdf

National Institute for Health and Care Excellence (NICE) guidance: Constipation in children and young people: diagnosis and management, July 2017
https://www.nice.org.uk/guidance/cg99

NHS England Excellence in Continence Care, July 2018
https://www.england.nhs.uk/publication/excellence-in-continence-care/

National primary care clinical pathway for constipation in children, March 2023
https://www.england.nhs.uk/publication/national-primary-care-clinical-pathway-for-constipation-in-children/

Education and Resources for Improving Childhood Continence (ERIC) Paediatric Continence Forum: Children's Continence Commissioning Guide - A handbook for setting up (commissioning) and running of children's community bladder and bowel services, third edition April 2024
https://drive.google.com/file/d/1PVroeMlwma4hrI6Uz_dTnGRWRQbdsZSh/view?pli=1

Education and Resources for Improving Childhood Continence (ERIC) Children's Continence Pathway website (accessed 25 November 2025)
https://eric.org.uk/childrens-continence-pathway/

NHS North West London

Annex 1 to the SEN Continence report to the North West London Joint Health Overview Scrutiny Committee, 09 December 2025

Duncan Ambrose, Assistant Director, NWL ICB
Temilola Englezos, Project Officer, NWL ICB

28 Nov'25

This annex should be read as a companion document to the main report. It contains details per borough of the commissioning and service provision arrangements, and any key features or risks.

Additionally, the population health profile of the 0-25 population for each borough is included to provide greater insights into the equity challenges for the population.

Brent	Population 0-25: 152,529 (Whole System Integrated Care database)

Level 1 Commissioned by NWL ICB & Brent Council; provided by Central London Community Healthcare NHS Trust

Health Visitors and School Nurses provide advice regarding fluid intake and diet offered. Tier 1 Assessment by School Nurses, Health visitors, School/Special school nurses, community staff nurses. NWL ICB commissions enhanced level 1 support within the level 2 offer.

- Gaps/ risks: No provision for under 5's attending a special school or with complex medical needs.
- Changes: New service launch 06/10/25

Level 2 Commissioned by NWL ICB; provided by Central London Community Healthcare NHS Trust

Nurse-led provision offering a bladder and bowel service to children living in Brent aged 5-19. Enhanced level 1, and level 2, provision.
Level 2 service will provide a holistic assessment and medication or aids will be provided if necessary.
CLCH Brent Paediatric Bladder and Bowel services provides continence products. Personal Health Budget where products are not suitable.
The service can refer into level 3 services if treatment is unsuccessful.
A focus group of interested parents was established. This group was involved and kept informed at all stages in the setting up of this service ensuring it meets family's needs.

- Gaps/ risks: None
- Caseload: 14 currently, planned for up to 480
- Changes: N/A
- Relevant specifications: Brent Children Bladder and Bowel (SOP). Children's continence care pathway level one and two. PGD Desmopressin Brent

Level 3 Commissioned by NWL ICB as part of acute hospital services

Level 3 services provided for

- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions
- Changes: Previous pathway to specialist paediatrician in London North West University Healthcare NHS Trust

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

Data Refresh Date: 24/11/2025 03:11:41

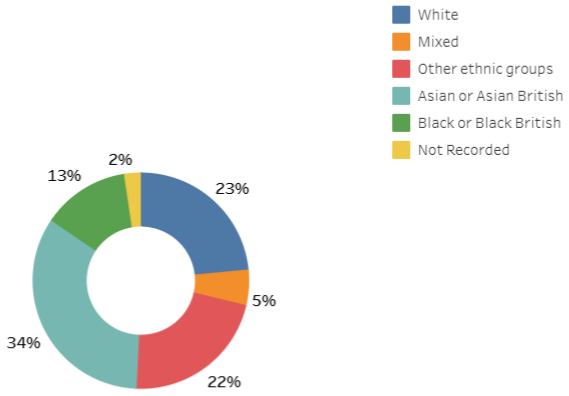
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Brent	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

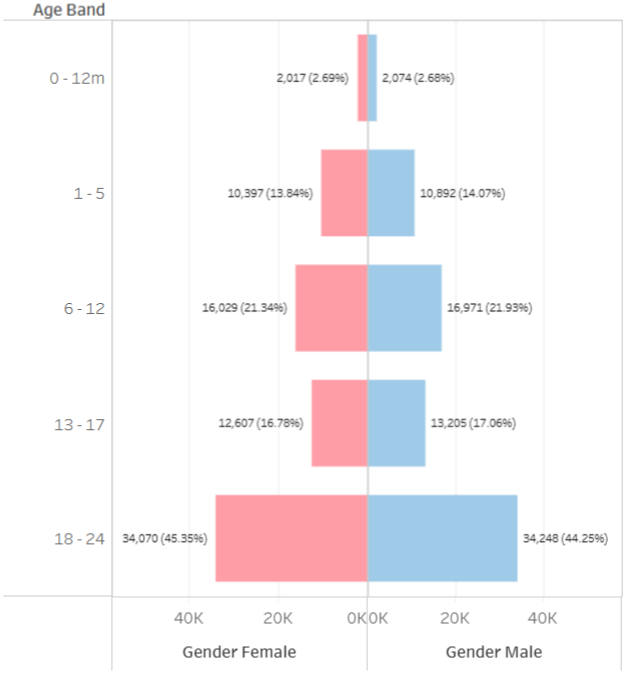
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Brent	4,091 2.68%	21,290 13.96%	33,000 21.64%	25,812 16.92%	68,336 44.80%	**152,529** 100.00%
Grand Total	**4,091** 2.68%	**21,290** 13.96%	**33,000** 21.64%	**25,812** 16.92%	**68,336** 44.80%	**152,529** 100.00%

Ethnicity



Age Band



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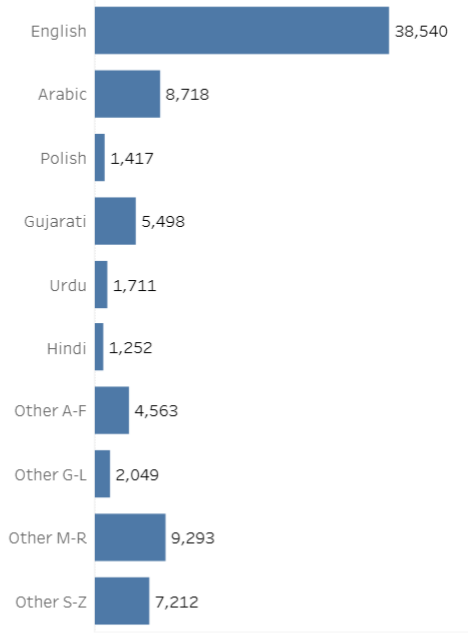

LTC Diagnosis in Last 12 Months

Ealing	Population 0-25: 133,242 (Whole System Integrated Care database)

Level 1 Commissioned by NWL ICB & Ealing Council; provided by West London NHS Trust & Ealing Community Partners

0-19 Community Services, though not commissioned to provide a continence service as such, do, within their remit, offer:
- Toileting workshops with parents for children with SEND;
- School readiness general advice and referral to the bladder and bowel nurse/ GP;
- School Nursing team general advice and referral to the bladder and bowel nurse/ GP

- Gaps/ risks: Small workforce creates service fragility. School nurses do not undertake assessments

Level 2 Commissioned by NWL ICB; provided by West London NHS Trust & Ealing Community Partners

1x band 6 specialist continence nurse. Triages and conducts all assessments and training, including home visits and clinical assessments in health centres and schools
1 to 2 monthly clinics in special schools

- Gaps/ risks: Limited capacity creates follow-up delays

Level 3 Commissioned by NWL ICB as part of acute hospital services – mainly Chelsea & Westminster Hospital NHS Foundation Trust

Level 3 services provided for
- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

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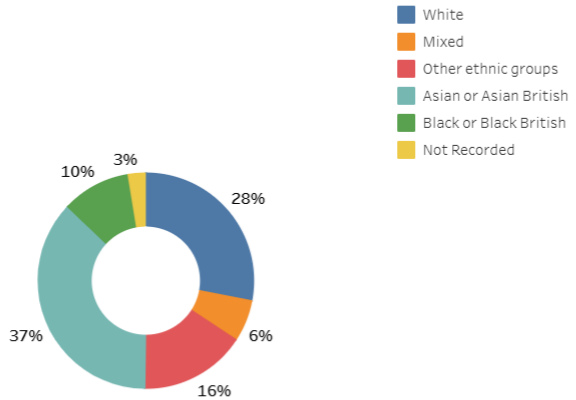
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Ealing	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Ealing	4,156 3.12%	22,182 16.65%	35,073 26.32%	28,182 21.15%	43,649 32.76%	**133,242** 100.00%
Grand Total	**4,156** 3.12%	**22,182** 16.65%	**35,073** 26.32%	**28,182** 21.15%	**43,649** 32.76%	**133,242** 100.00%

Ethnicity



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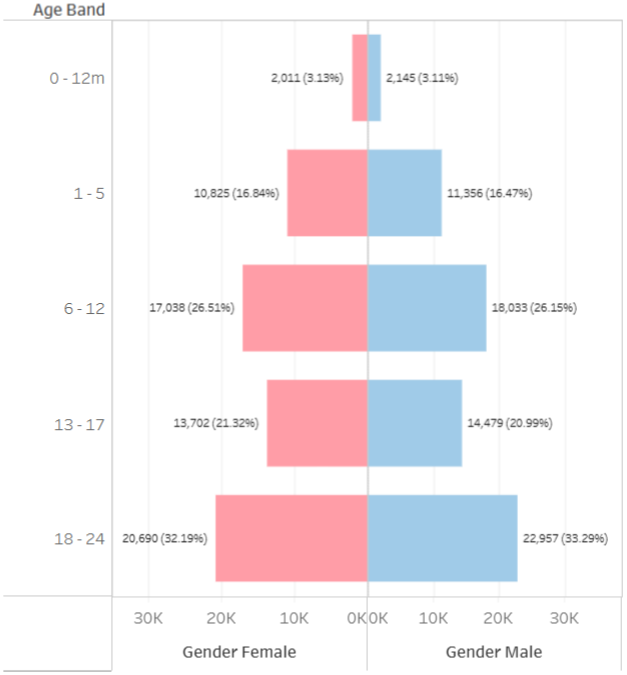

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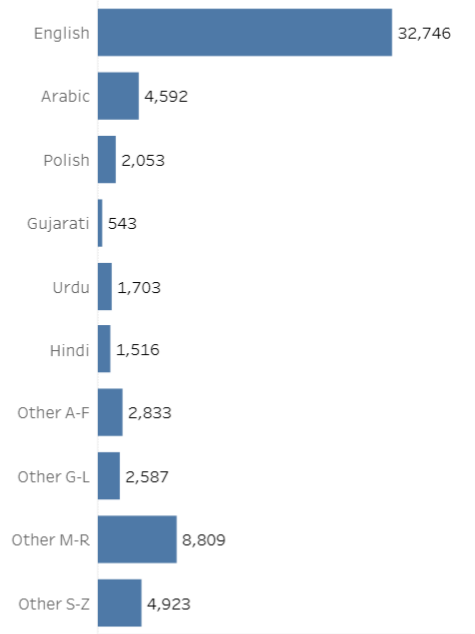
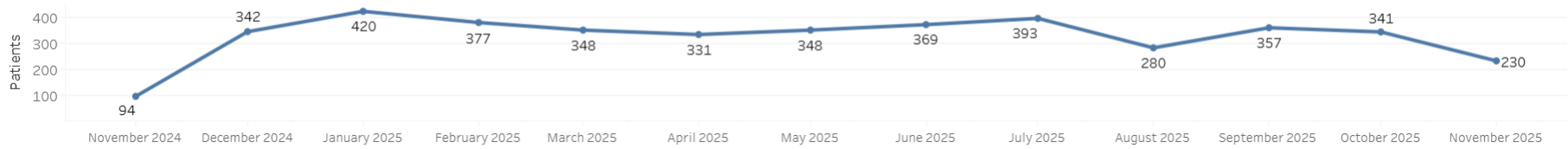


LTC Diagnosis in Last 12 Months



Hammersmith & Fulham	Population 0-25: 70,449 (Whole System Integrated Care database)

Level 1 Commissioned by Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

0-19 Community Services provide continence advice as part of general health promotion

- Gaps/ risks: Hammersmith & Fulham Council announced re-procurement from 01 Jan'27 to focus on child health surveillance, health promotion, health protection, and health improvement with focus areas of oral health, healthy weight, and immunisation uptake

Level 2 Commissioned by NWL ICB & Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

Commissioned on a historical basis via school nursing team

- Nurse-led clinical assessment, term-time, open to children from H&F (caseload 87), K&C (caseload 27), and Westminster (caseload 26)
- Nurse-led enuresis advice for children aged 4+, with clinic for children aged 7+
- Children's community nursing service provides incontinence pads for ages 5+
- Includes enuresis alarms
- Includes medication
- Personal health budget available

- Gaps/ risks: Needs formal ICB commissioning as part of community provider collaborative common core level 2 offer. Hammersmith & Fulham Council announced decommissioning of level 2 support from 01 Jan'27

Level 3 Commissioned by NWL ICB as part of acute hospital services – mainly Chelsea & Westminster Hospital NHS Foundation Trust

Level 3 services provided for

- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions
- Twice-a-month paediatric outpatient clinic

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

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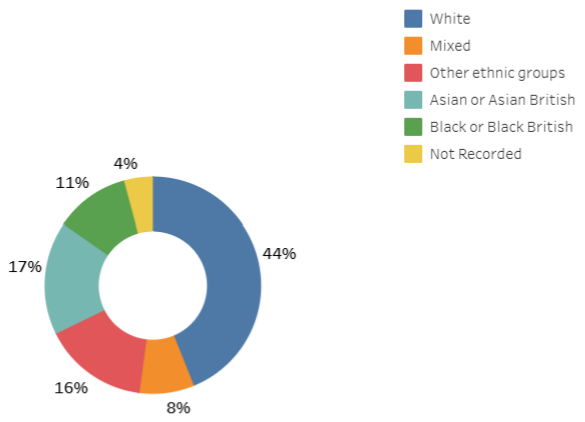
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
H&F	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

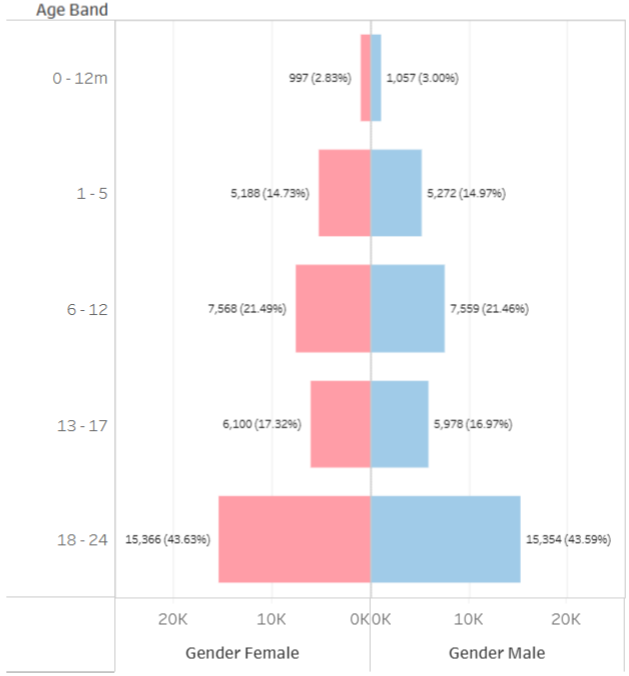
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
H&F	2,054 2.92%	10,460 14.85%	15,128 21.47%	12,078 17.14%	30,729 43.62%	**70,449** 100.00%
Grand Total	**2,054** 2.92%	**10,460** 14.85%	**15,128** 21.47%	**12,078** 17.14%	**30,729** 43.62%	**70,449** 100.00%

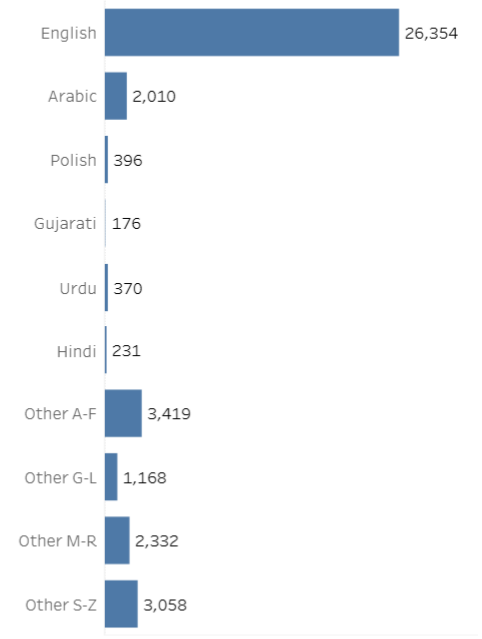
Ethnicity



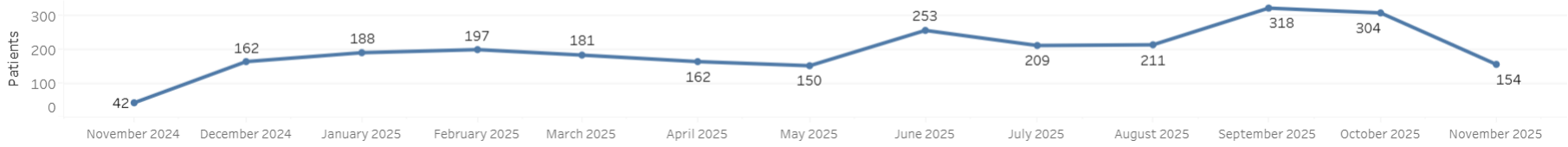
Age Band



First Language *(Hover to expand "Other")*



LTC Diagnosis in Last 12 Months



Harrow	Population 0-25: 86,527 (Whole System Integrated Care database)

Level 1 Commissioned by NWL ICB & Harrow Council; provided by Central & North West London NHS Foundation Trust, and primary care GP practice staff

0-19 health visitors and school nurses provide continence advice as part of general health promotion, but do not assess for referral to level 2 services
Special school nurses provide annual assessment of pad requirements
Primary care GP services assess for referral to level 2
Around 180 children receive continence products

- Gaps/ risks: Harrow Council re-commissioned service with revised scope in July 2025, and need a capability to refer to level 2

Level 2 Commissioned by NWL ICB; provided by Primary care services & GP practice staff

Commissioned from primary care GP services to lead multi-disciplinary assessments, and refer on to level 3 if required

- Gaps/ risks: Needs formal ICB commissioning as part of community provider collaborative common core level 2 offer

Level 3 Commissioned by NWL ICB as part of acute hospital services

Level 3 services provided for

- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

Data Refresh Date: 24/11/2025 03:11:41

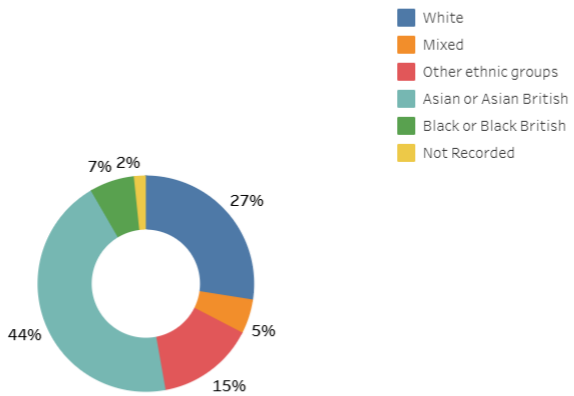
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Harrow	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

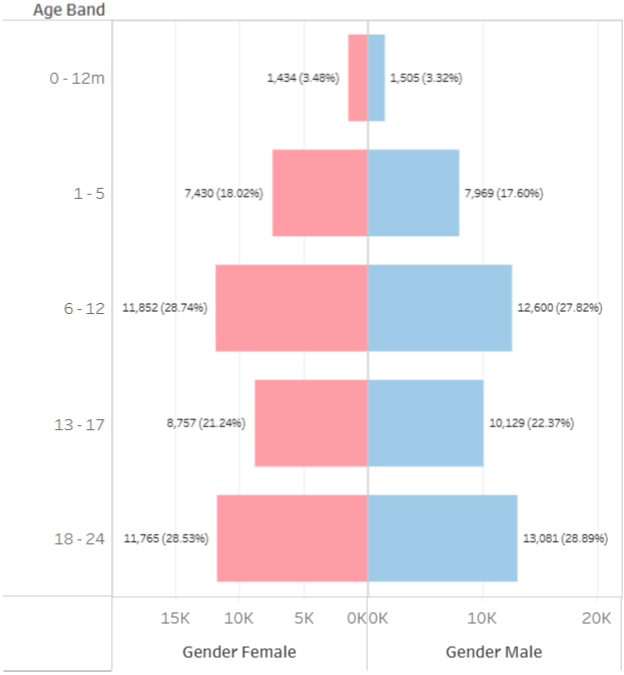
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Harrow	2,939 3.40%	15,399 17.80%	24,453 28.26%	18,886 21.83%	24,850 28.72%	**86,527** 100.00%
Grand Total	**2,939** 3.40%	**15,399** 17.80%	**24,453** 28.26%	**18,886** 21.83%	**24,850** 28.72%	**86,527** 100.00%

Ethnicity



Age Band



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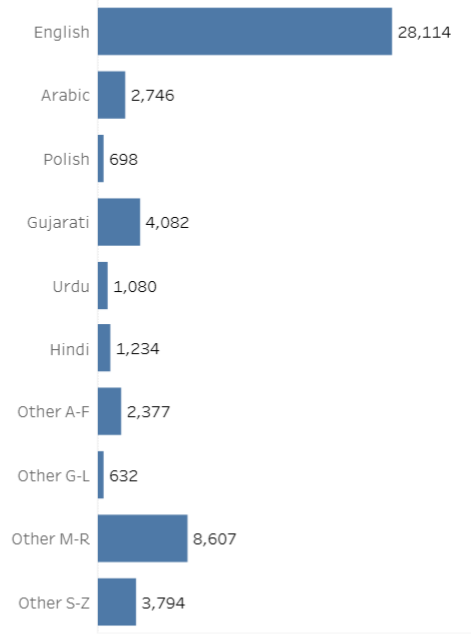
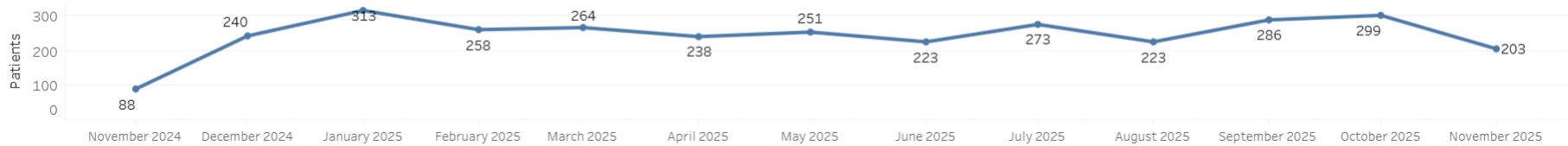


LTC Diagnosis in Last 12 Months



Hillingdon	Population 0-25: 104,088 (Whole System Integrated Care database)

Level 1 Commissioned by Hillingdon Council; provided by Central & North West London NHS Foundation Trust

0-19 health visitors and school nurses provide
- continence advice as part of general health promotion
- specialist SEND advice on toilet training
- continence product sizing

- Gaps/ risks: Potential re-structure of the service, as SEND and onward referral are not formally commissioned

Level 2 Commissioned on a case-by-case basis by NWL ICB complex care team

Relies on level 1 health visitors and school nurses complete assessments and order any continence products.
ICB complex care service supports individual cases.
Adult bladder and bowel service do provide some continence products

- Gaps/ risks: Relies on level 1 enhanced offer. Needs formal ICB commissioning as part of community provider collaborative common core level 2 offer

Level 3 Commissioned by NWL ICB as part of acute hospital services – mainly via The Hillingdon Hospital NHS Foundation Trust

Level 3 services provided for
- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

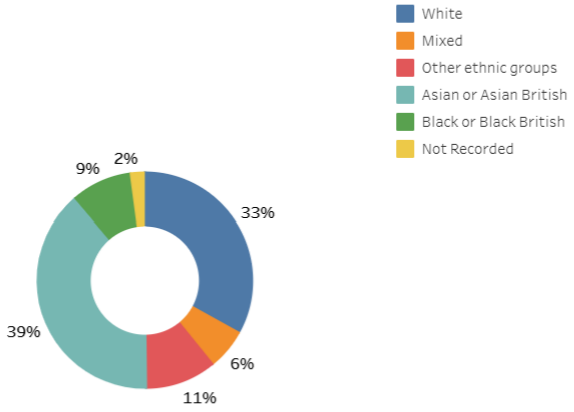
Data Refresh Date: 24/11/2025 03:11:41 Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Hillingdon	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

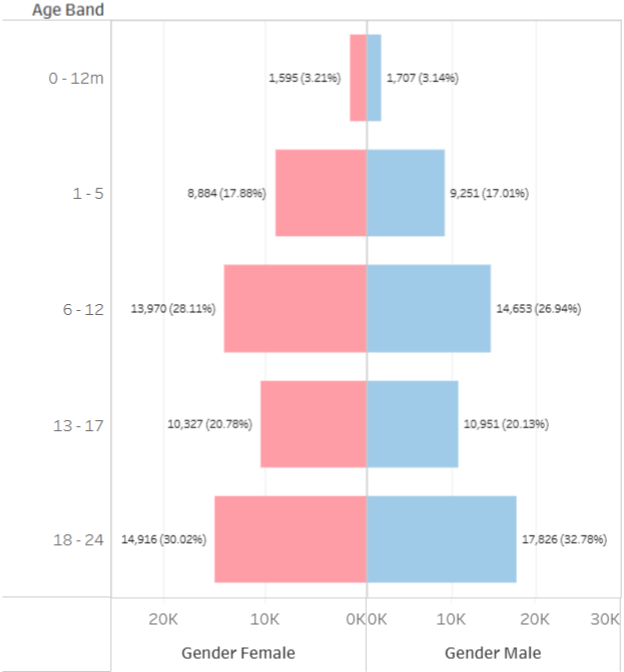
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Hillingdon	3,303 3.17%	18,137 17.42%	28,624 27.50%	21,279 20.44%	32,745 31.46%	**104,088** 100.00%
Grand Total	**3,303** 3.17%	**18,137** 17.42%	**28,624** 27.50%	**21,279** 20.44%	**32,745** 31.46%	**104,088** 100.00%

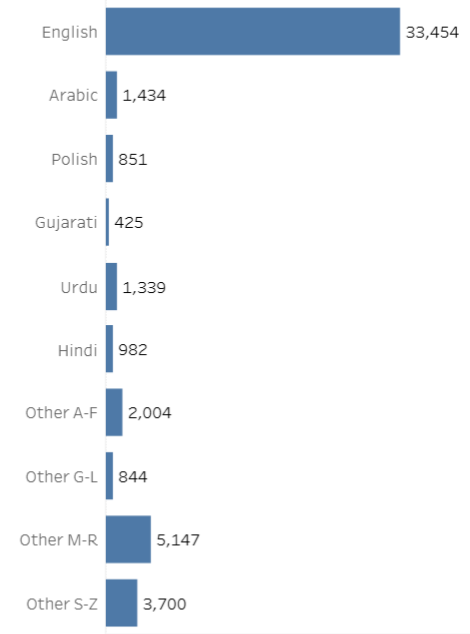
Ethnicity



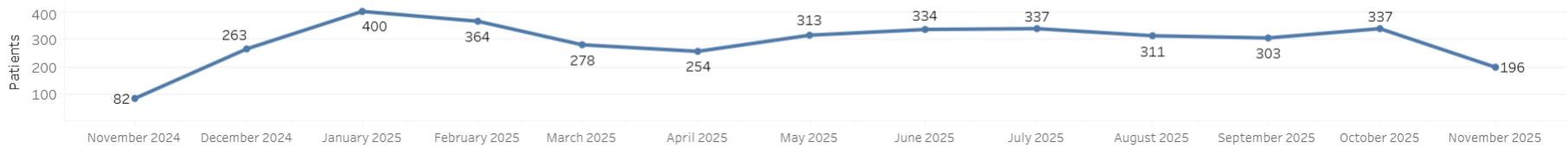
Age Band



First Language *(Hover to expand "Other")*



LTC Diagnosis in Last 12 Months



Hounslow	Population 0-25: 101,393 (Whole System Integrated Care database)

Level 1 Commissioned by Hounslow Council; provided by West London NHS Trust

0-19 health visitors and school nurses provide
- Toilet training for under 5s
- support to families with school-age children
- referral to occupational therapy for sensory and motor skills

- Gaps/ risks: Distinction between level 1 and level 2 service may benefit from clarification

Level 2 Commissioned by NWL ICB: provided by West London NHS Trust

Level 2 bladder and bowel specialist nurse
- twice-a-week clinics (caseload around 73)
- Support to community children's nursing team
- Support to education settings
- Full assessment, and onward referral to GP (medication), occupational therapy (sensory and motor issues)
- Provide 4 pads per day, unless there is significant health need for more (caseload 234). Exploring washable products

- Gaps/ risks: Distinction between level 1 and level 2 service may benefit from clarification

Level 3 Commissioned by NWL ICB as part of acute hospital services – including via Guy's & StThomas' NHS Foundation Trust

Level 3 services provided for
- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

Data Refresh Date: 24/11/2025 03:11:41

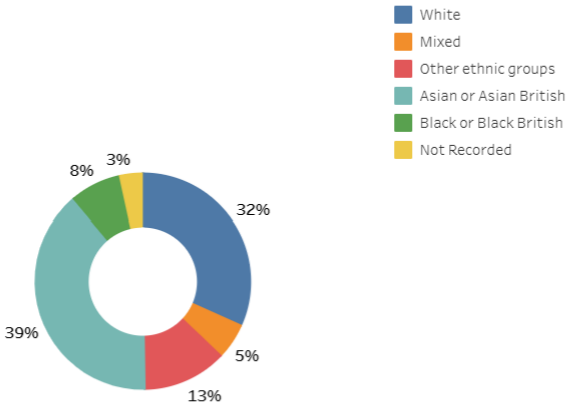
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Hounslow	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

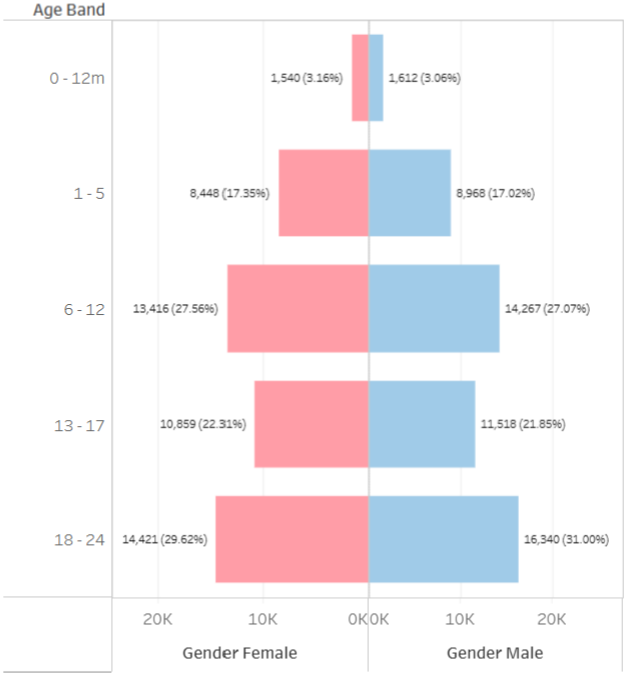
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Hounslow	3,152 3.11%	17,416 17.18%	27,683 27.30%	22,378 22.07%	30,764 30.34%	**101,393** 100.00%
Grand Total	**3,152** 3.11%	**17,416** 17.18%	**27,683** 27.30%	**22,378** 22.07%	**30,764** 30.34%	**101,393** 100.00%

Ethnicity



Age Band



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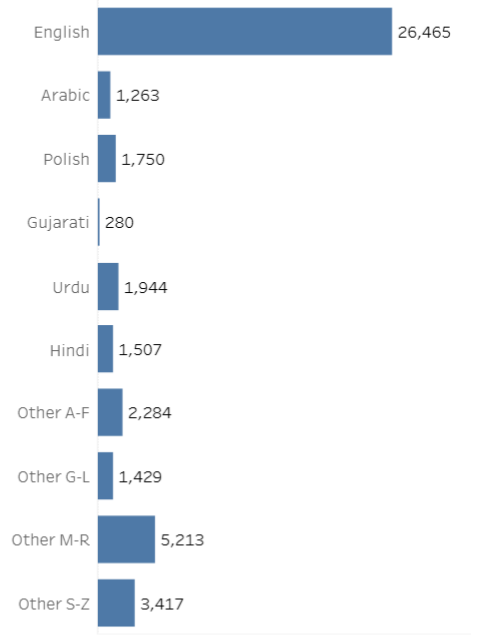
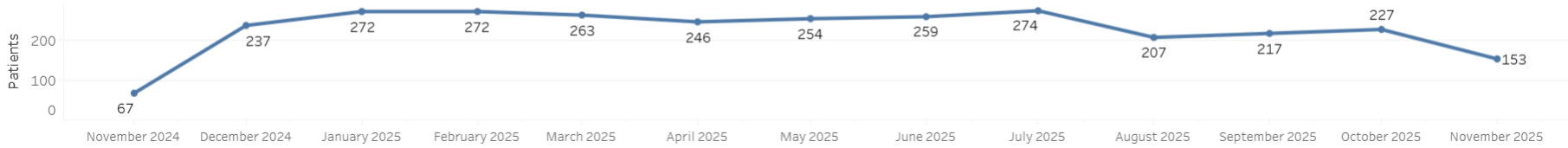


LTC Diagnosis in Last 12 Months



Kensington & Chelsea	Population 0-25: 63,347 (Whole System Integrated Care database)

Level 1 Commissioned by Kensington & Chelsea Council via Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

0-19 Community Services provide continence advice as part of general health promotion

- Gaps/ risks: Hammersmith & Fulham Council announced re-procurement from 01 Jan'27 to focus on child health surveillance, health promotion, health protection, and health improvement with focus areas of oral health, healthy weight, and immunisation uptake

Level 2 Commissioned by NWL ICB & Kensington & Chelsea Council via Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

Commissioned on a historical basis via school nursing team

- Nurse-led clinical assessment, term-time, open to children from H&F (caseload 87), K&C (caseload 27), and Westminster (caseload 26)
- Nurse-led enuresis advice for children aged 4+, with clinic for children aged 7+
- Children's community nursing service provides incontinence pads for ages 5+
- Includes enuresis alarms
- Includes medication
- Personal health budget available

- Gaps/ risks: Needs formal ICB commissioning as part of community provider collaborative common core level 2 offer. Hammersmith & Fulham Council announced decommissioning of level 2 support from 01 Jan'27

Level 3 Commissioned by NWL ICB as part of acute hospital services – mainly Chelsea & Westminster Hospital NHS Foundation Trust

Level 3 services provided for

- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions
- Twice-a-month paediatric outpatient clinic

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

Data Refresh Date: 24/11/2025 03:11:41

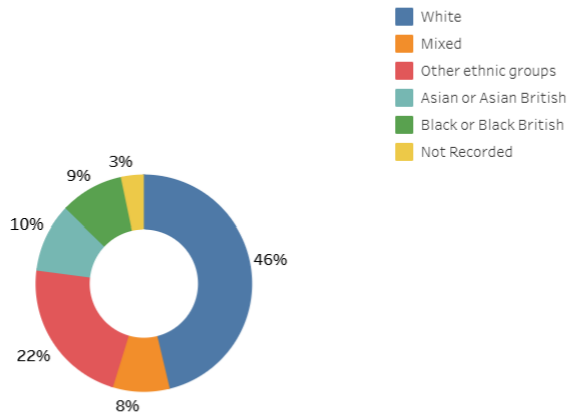
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
West London	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

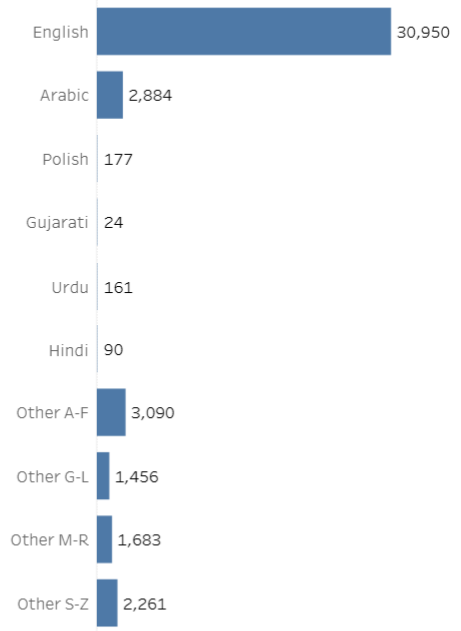
Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
West London	1,835 2.90%	9,672 15.27%	15,934 25.15%	12,827 20.25%	23,079 36.43%	**63,347** 100.00%
Grand Total	**1,835** 2.90%	**9,672** 15.27%	**15,934** 25.15%	**12,827** 20.25%	**23,079** 36.43%	**63,347** 100.00%

Ethnicity

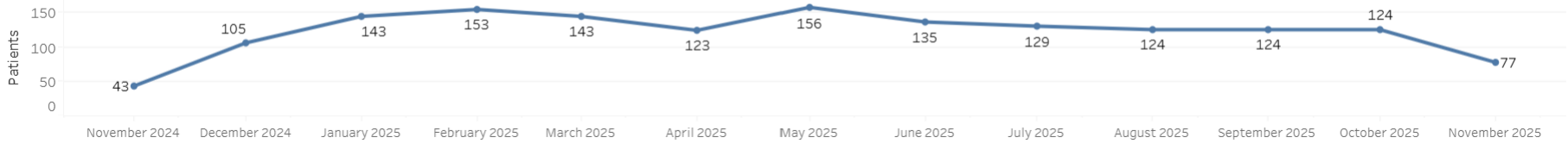


Age Band

First Language *(Hover to expand "Other")*



LTC Diagnosis in Last 12 Months



Westminster	Population 0-25: 72,913 (Whole System Integrated Care database)

Level 1 Commissioned by Westminster Council via Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

0-19 Community Services provide continence advice as part of general health promotion

- Gaps/ risks: Hammersmith & Fulham Council announced re-procurement from 01 Jan'27 to focus on child health surveillance, health promotion, health protection, and health improvement with focus areas of oral health, healthy weight, and immunisation uptake

Level 2 Commissioned by NWL ICB & Westminster Council via Hammersmith & Fulham Council; provided by Central London Community Healthcare NHS Trust

Commissioned on a historical basis via school nursing team

- Nurse-led clinical assessment, term-time, open to children from H&F (caseload 87), K&C (caseload 27), and Westminster (caseload 26)
- Nurse-led enuresis advice for children aged 4+, with clinic for children aged 7+
- Children's community nursing service provides incontinence pads for ages 5+
- Includes enuresis alarms
- Includes medication
- Personal health budget available

- Gaps/ risks: Needs formal ICB commissioning as part of community provider collaborative common core level 2 offer. Hammersmith & Fulham Council announced decommissioning of level 2 support from 01 Jan'27

Level 3 Commissioned by NWL ICB as part of acute hospital services – mainly Chelsea & Westminster Hospital NHS Foundation Trust

Level 3 services provided for

- continence issues as part of a complex long term health issue
- continence issues not responding to level 2 interventions
- Twice-a-month paediatric outpatient clinic

NHS North West London

Population Overview

Use the filters below or click on a chart to update the others accordingly

Data Refresh Date: 24/11/2025 03:11:41

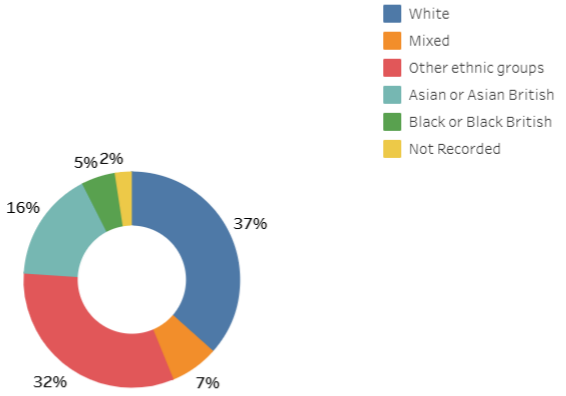
Latest Data Date:22/11/2025

Health Borough	Primary Care Ne...	Practice	Age Band	Ethnicity	Ethnic Category	Patient Segment...	Provider	Highlight Health...	Deprivation	LA Borough	Gender
Central London	(All)	(All)	(Multiple val...	(All)	(All)	(All)	Any or no mai...	Highlight He...	(All)	(All)	(All)

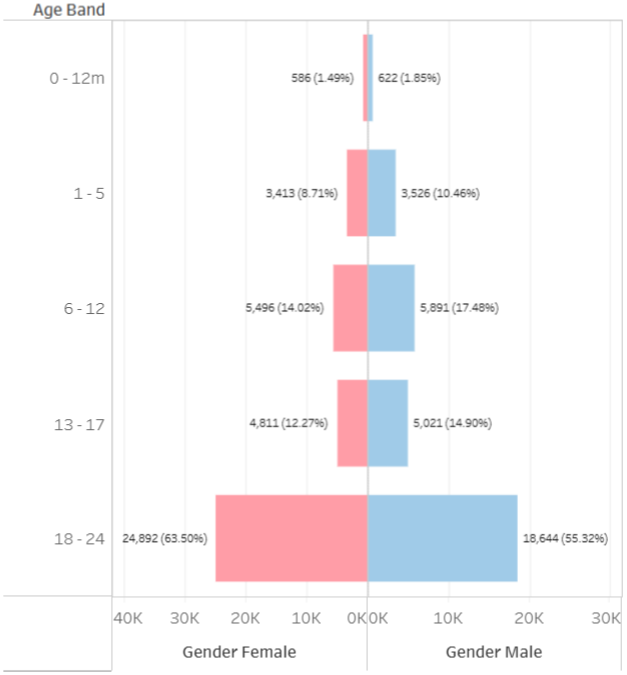
Register S...	Number Of...	Long Term ...	Risk Segm...	Pregnancy ...
R	(All)	(All)	(All)	(All)

Health Borough Name	0 - 12m	1 - 5	6 - 12	13 - 17	18 - 24	Grand Total
Central London	1,208 1.66%	6,939 9.52%	11,387 15.62%	9,832 13.48%	43,547 59.72%	**72,913** 100.00%
Grand Total	**1,208** 1.66%	**6,939** 9.52%	**11,387** 15.62%	**9,832** 13.48%	**43,547** 59.72%	**72,913** 100.00%

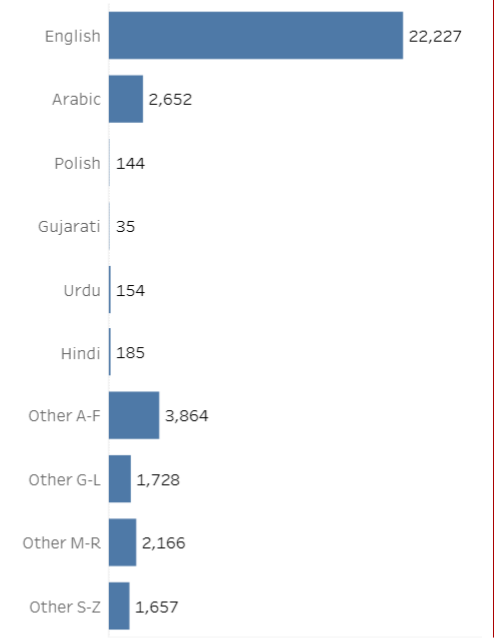
Ethnicity



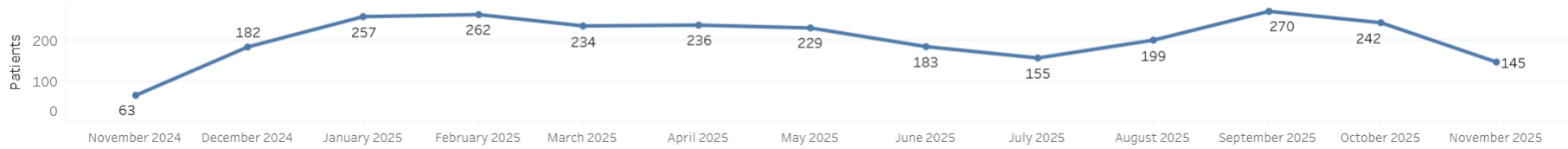
Age Band



First Language *(Hover to expand "Other")*



LTC Diagnosis in Last 12 Months



Report to the North West London Joint Health Overview Scrutiny Committee – 09 December 2025

North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

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

1.0 Purpose of the Report

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

2.0 Recommendation(s)

2.1 That:

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

3.0 Detail

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

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

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

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

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

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

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

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

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

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

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

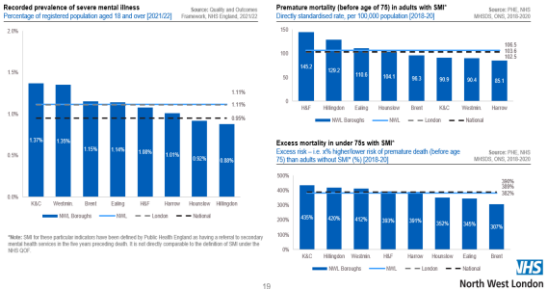
				Sonographers, 2 ODP, 26 Radiographers, 5 physiotherapists, 2 ODPs. There has also been a strong response to the launch of the ICS Graduate Scheme for future leaders. An undergraduate scheme is also in development. A Spring EDI Summit is being planned to agree sustained medium-term interventions that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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	0-17wks	18-51wks	>52wks
Brent	51%	45%	3.8%
Central London	58%	39%	2.4%
Ealing	53%	44%	2.9%
Harrow	48%	48%	3.8%
Hillingdon	48%	50%	1.7%
Hounslow	58%	40%	1.7%
H&F	59%	39%	2.6%
West London	58%	39%	2.3%
Non-NWL	58%	40%	2.1%
4 Provider Total	**54%**	**43%**	**2.7%**

There is variation between boroughs, reflecting historic referral practices and individual NHS provider performance, hence why patients in Brent, Ealing, Harrow and Hillingdon are waiting relatively longer given the tendency of these patients to be referred to THH and LNW.

It should be noted that this data is based upon unvalidated datasets and could change (slightly) in proportions as a result of individual pathway validation. However, the basic trend of

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

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

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

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

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

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

Report to the North West London Joint Health Overview Scrutiny Committee – 09 December 2025

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

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

1.0 Purpose of the Report

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

2.0 Recommendation(s)

2.1 That:

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

3.0 Detail

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

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

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

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

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

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

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

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

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

Confirmed Meeting Dates:

- **Thursday 17 July 2025, 10am – London Borough of Hillingdon**
- **Tuesday 09 September 2025, 10am – London Borough of Harrow (rescheduled to 18 November 2025)**
- **Tuesday 09 December 2025, 10am – London Borough of Hounslow**
- **Thursday 16 March 2026, 10am – London Borough of Hammersmith and Fulham**

Thursday 17 July 2025

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

Tuesday 09 September 2025 (rescheduled to 18 November 2025)

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

Tuesday 09 December 2025

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

Thursday 19 March 2026

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