NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Monday 28th April 2025, 10:00 a.m.
George Meehan House, 294 High Road,
Wood Green, N22 8JZ

Contact: Dominic O'Brien, Principal Scrutiny Officer

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

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

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 10 below).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. MINUTES (PAGES 1 - 20)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meetings on 25th July 2024 and 3rd Feb 2025 as a correct record.

7. ACTION TRACKER

To follow.

8. MENTAL HEALTH PATHWAYS (PAGES 21 - 46)

To provide an update on mental health pathways in North Central London, including:

- Improving transitions from children and young people's services to adult mental health services, and
- Strengthening how information is shared across organisations, so that care is better coordinated, people don't need to repeat their story, and decisions can be made more quickly and safely.

9. WORK PROGRAMME (PAGES 47 - 54)

This paper provides an outline of the work programme for the North Central London Joint Health Overview and Scrutiny Committee.

10. NEW ITEMS OF URGENT BUSINESS

11. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

- 7th July 2025 (10am)
- 8th Sep 2025 (10am)
- 17th Nov 2025 (10am)
- 26th Jan 2026 (10am)
- 9th Mar 2026 (10am)

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

Wednesday, 16 April 2025

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Agenda Item 6

MINUTES OF THE MEETING North Central London Joint Health Overview and Scrutiny Committee HELD ON Thursday, 25th July, 2024, 10.00 am - 1.05 pm

PRESENT:

Councillors: Pippa Connor (Chair), Tricia Clarke (Vice-Chair), Larraine Revah (Vice-Chair), Kemi Atolagbe, Rishikesh Chakraborty, Jilani Chowdhury, Philip Cohen, Chris James, Andy Milne and Matt White.

ALSO ATTENDING:

Cllr Ketan Sheth (London Borough of Brent)

13. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

14. APOLOGIES FOR ABSENCE

None.

15. ELECTION OF CHAIR

The floor was opened for any other nominations for Chair. No nominations were received. The current Chair, Cllr Pippa Connor, was re-elected.

16. ELECTION OF VICE-CHAIRS

The floor was opened for any other nominations for Vice Chairs. No nominations were received. The current Vice Chairs, Cllr Larraine Revah and Cllr Tricia Clarke, were re-elected.

17. URGENT BUSINESS

None.

18. DECLARATIONS OF INTEREST

Cllr Connor declared an interest by virtue of her membership at the Royal College of Nursing.

Cllr Connor also declared another interest by virtue of her sister working as a GP in Tottenham.

There were no other declarations of interest.

19. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

20. TERMS OF REFERENCE

Cllr White raised questions regarding the set-up of the committee and clarification of resources and finance. It was stated that officer resources in Haringey were quite pressured. A suggestion was made that other boroughs could contribute to the resourcing of the committee. It was also noted that other important regulations were missing from the Terms of Reference. It was then suggested that the Terms of Reference should have a refresh incorporating stakeholder views.

Cllr Connor then suggested that all Committee councils should have discussions with their boroughs as to resourcing. **(ACTION)**

Cllr Ketan Sheth (London Borough of Brent) offered to meet with the Chair to talk through best practice in other boroughs. **(ACTION)**

It was then proposed that Haringey's Scrutiny Office would put together a working group and then draft recommendations as to the new Terms of Reference for the Committee's approval. **(ACTION)**

21. MINUTES

In response to the Committee's request for updates on outcomes data and metrics in Mental Health, the Principal Scrutiny Officer Dominic O'Brien, explained that the updates from departments had not been forthcoming. Discussion as to why this was followed.

Cllr Connor was then asked to follow up with CEOs of the various areas to help with timely updates from departments. **(ACTION)**

Minutes of the JHOSC Meetings from 18th March, 30th May and 31st May 2024 were then **AGREED** as a true and accurate account.

22. START WELL UPDATE

Anna Stewart updated the Committee as to the progress of the Start Well project. The project had moved into its consultation phase and an update was given on the interim report. A summary of the stakeholder feedback is given here.

- 67% of stakeholders agreed that change was needed to address current challenges facing services.
- Overall agreement that all neo-natal clinics should offer the same amount of care (at least at Quality Level 2).
- However, there was less support from stakeholders for consolidating maternity and neo natal services from 5 to 4 sites.

The Committee's formal response to the interim report was requested by August 16th. **(ACTION)**

The floor was opened to the Committee for questions.

Cllr White questioned the framing of the results of the stakeholder feedback. Although the beginning of the feedback phase seemed open ended, there was a clear policy direction proposed through the case for change with the closure of one of the units. It was explained by Sarah Mansuralli that although stakeholder feedback was sought, the process was about developing the case for change, and defining the baseline of services that should be delivered. None wanted to see the units close, but stakeholders understood Level 2 Quality of Care was needed. However, this quality of care was not possible with 5 units open. Wynne Leith then added that with a smaller number of births, the numbers of deliveries would be diluted around the whole of north London. This in turn would deskill many consultants and the level of care would be at risk. Cllr White then responded that it could be made more explicit in the report that the proposals are being led by experts rather than stakeholders.

Discussion then turned to the quality of stakeholder feedback. Cllr Chakraborty required clarification as to the degree of engagement and representation and questioned whether 'reach' had been included as a 'response' in the consultation. The Committee was assured that this had not been the case. 'Reach' had been separated out from overall response statistics.

Cllr Connor then outlined that this was an *interim* report. The Committee was then advised to give feedback appropriate for a draft and not final report.

Cllr Cohen asked why the consultation had not been about closing a facility rather than the open approach that had been favoured by ICB. It was reiterated that the aim of the consultation was to look fairly at all the viable options and make sure the proposals were well informed and designed, using staff expertise and patient experience as its basis.

Cllr Clarke was pleased that 67% of stakeholders had accepted the need for change. She suggested that responses may have been skewed as feedback from the Royal

Free was included. (Royal Free Maternity and Neo Natal Services closure was deemed by all as the most likely). However, Ms Stewart denied that responses were skewed or particularly negative from the staff at the Royal Free. She outlined that there were other units that were under consideration for closure, so it was unlikely to have skewed results.

Cllr Revah noted that most of the statistics were in percentages and that a clearer picture could be given if numbers were given. Also, more detailed qualitative feedback was needed with comments included. Cllr Revah also asked for a delay in the report feedback as she wanted to discuss it with Camden's Health Overview and Scrutiny Committee (HOSC) Ms Steward stated that Camden's viewpoint had already been considered as had a rich range of feedback and that this meeting was a way to provide comments from HOSC. More detailed feedback will be in the final report.

Cllr Atolagbe pointed out that more money would be needed for these proposals. Ms Mansuralli agreed that more money would be needed for the closures. She emphasised that the reasoning behind the closure proposals was not about efficiencies but improving the quality of care that could be offered to patients.

Cllr Jones questioned the practicalities of the proposal to 'join up' policies and procedures between Royal Free and Barnet hospitals. Ms Stewart affirmed that the ICB would incorporate broader feedback into an action plan about how policies and procedures can be aligned. The final report would have more details on this. **(ACTION)**

Cllr Sheth then asked about feedback from his areas of Edgware, Brent and Harrow, and what the next steps were in taking that forward. Anna Stewart stated that the feedback would go into the modelling of the Universal Pathway. It was divulged that travel concerns and access to services dominated the localised feedback. However, stakeholders weren't adverse to the closure of the Birthing Centre in Edgware if it meant they could access wider services and a higher quality of care in another area. Cllr Sheth was assured that engagement with residents of his borough would continue.

Cllr Connor then noted that time had not allowed for Committee questions on the Children's Surgical proposals. She then highlighted questions and comments from the Committee and requested written responses to the below.

- The Committee was keen to know how the views of 'hard to reach audiences' and those not able to give feedback had been considered in the proposals. **(ACTION)**
- It was also stated that the business case should consider following up with stakeholders after the proposals have been implemented. A timescale for this should be detailed in the next report. **(ACTION)**
- The business case should also consider the knock-on effects with other hospitals and detail the extra support needed by other services. **(ACTION)**

Cllr Chakraborty asked for the date by which the final report would be published. Ms Steward stated that the report would be released in early autumn. The ICB would tell the Committee when it was published.

A formal response by the Committee on the interim report was AGREED to be given by 16th August. **(ACTION)**

23. PRIMARY CARE ACCESS

The report was introduced by Katie Coleman which is summarised below:

- Primary care or GP Services made up more than 90% of all NHS activity in North Central London, and 95% of all activity in the NHS.
- GP services in North Central London carried out more than 800,000 appointments and of those 740,000 were 'in- hours' appointments. 50% of targets were dealt with on the day.
- In North Central London, GPs were responding to an increase in demand, however it was noted that GP services were attaining pre- pandemic levels of service.
- Patient satisfaction with GPs services were declining across the country.
- It was noted that adequate recruitment and retention of GPs, as well as consistent funding of the service must be focused on, if not, GPs would not be able to keep up with demand.

The Committee was then asked for comments and questions on the report.

Cllr Connor stated that the report was extensive and needed some focus. It would be useful to include a summary of points for the Committee to consider.

Cllr Clarke also pointed out that there was no mention of the GP Federation in the paper. Katie Coleman responded that GP Federations were vital for GPs to have a consistent approach to healthcare. The GP Federations have a strong voice in North Central London in working collaborations. This is being developed further by the ICB.

Residents in Cllr Revah's ward had difficulty seeing their GPs - sometimes waiting 3-4 weeks for an appointment. Cllr Revah also stated that there are issues with patient confidence in the ability of GPs to diagnose illness over the phone. Face-to-face appointments are preferred. Katie Coleman responded that over 69% of GP appointments are face to face. And although there are still some issues with seeing patients within a suitable period, levels are returning to pre- pandemic levels.

Cllr Chowdhury reiterated that the residents in his ward also had issues with getting appointments. His own experience was that patients would give up waiting in the telephone queue for an appointment. He stated that also the online consultation forms are not easy to access or use. Not all people have access to digital channels and

therefore access to emergency appointments for all, was questioned. He also raised that his feeling was that some GP surgeries are taking more patients than their capacity allows. Ms Coleman responded that it is a requirement that GP practices respond to patients on the day with information, signposting to other services or an appointment. She also stated that GPs are not allowed to deny locals access to their services, so were unable to limit patient numbers. She, however, admitted that the system was not perfect. The ICB was working with GP practices to decrease variances in how patients experienced the service across the locality. It was pointed out that funding was at the lowest level, but the service was experiencing an increase in demand. Regarding online consultations, she acknowledged the challenges patients experienced, and suggested that work may be done around training receptionists to support patients.

Discussion then turned to access for those who found digital access hard or not possible. Cllr Chowdhury suggested there may be some role for Voluntary sector organisations to help. Ms Coleman affirmed that work was already being done with some organisations to include older people. More details on the voluntary organisations working with the ICB were requested by the Committee. **(ACTION)**

Cllr Cohen then questioned the Pharmacy First approach, as he understood it certain pharmacies had hit back at this approach – as seeing a pharmacist was not a substitute for seeing a GP. Ms Coleman responded that the Pharmacy First approach was supported by over 96% of pharmacists across the nation. All have undergone training to treat seven acute presentations in patients. Some pharmacies will have the ability to prescribe in the future. Cllr Cohen stated that perhaps the ICB should sponsor a communications campaign to increase uptake in the Pharmacy First service.

The discussion then turned to the availability of patient records. Cllr Atolagbe recounted her own experience of the out-of-hours service. She related that access to GP records was not given to the out-of-hours service, making a diagnosis impossible. Ms Coleman then responded that the London Care Records will give access to patient records to all providers. It was also noted that all patients will be given access to their own file digitally as of October 1st, 2024.

Cllr Chakraborty then questioned the ‘digital first’ approach. He asked whether access to apps and online consultations actually help more patients get an appointment sooner, or whether it was just the timeliness of responses to the patient that was recorded. He also asked what recent technology had been implemented for primary care staff and whether this had improved outcomes for patients. Ms. Coleman responded that digital inclusion was something the ICB was aiming for. Technology in primary healthcare settings is used to track capacity and understand demand – this was being used as evidence.

As time was short, Cllr Connor then asked for written responses to Committee comments and questions as set out below.

- More details were needed from the IBC around improving the patient experience and decreasing long waiting times. Also, details about patients who remain under primary care because of long waiting lists for secondary care. **(ACTION)**
- It was stated that better consistency with the same doctor was needed for those with chronic medical conditions. **(ACTION)**
- It was affirmed that from experience, councillors hear patients do not easily access apps or online forms. Training and support are needed to increase uptake amongst residents. Also, the right level of training should be delivered for practice receptionists to become information-givers and gatekeepers. **(ACTION)**
- More details were requested on Physicians Associates. How supervision was being enforced and what the pressures were on GPs. **(ACTION)**
- A communications plan for pharmacies was then suggested to increase uptake in the expanded services they offer and reduce pressure on GPs. **(ACTION)**
- Details were requested as to how the ICB is responding to a recent report into the safety of online consultations. **(ACTION)**
- More research was needed into how many residents do not have access to a smart phone. Details were also needed was to the work being done to ensure their inclusion. **(ACTION)**

24. DENTAL SERVICES

The Committee then received an update on NCL access to dental care, introduced by Mark Eaton and Jeremy Wallman. Previous committee meetings had expressed concerns about funding, NHS contracts, and access for children's dental health services.

The report is summarised as below.

- The Dental, Optometry and Community Pharmacy Services were brought under ICB management in 2023 and had undergone a transformation programme.
- An extra £600k has been allocated to dental services that offer support to more vulnerable residents such as asylum seekers, rough sleepers, and those in residential care. It also went toward reducing waiting times for children and young people who need more specialist care.
- Patients in acute pain can access urgent appointments through NHS 111. A commitment has been given by the ICB to support Looked After Children and the development of Child Friendly Practices in dentistry.
- Additional investment has been made in preventative work and in supporting children with SEND.

- Community Dental Services have been used to reduce the number of patients needing to be treated in more specialist centres. Only 8% of patients referred for specialist care resulted in treatment in a hospital setting.
- The main focus for the ICB since delegation has been on expanding access to Primary Dental Services including helping practices to develop new skills, increasing workforce capacity, and reducing the number of practices handing back their contracts.
- Future work includes improving oral health for those with diabetes (who are particularly vulnerable to loss of teeth), and piloting work to identify illnesses such as cardiovascular disease in patients with oral health issues. Also, a new cross-agency pediatrics pathway will lead to improved outcomes for children and young people.

Mr. Eaton explained that the ICB could not change the contract it held with Primary Care Dentists. It was not a statutory requirement for dentists to take on NHS patients, or to deliver any NHS activity against their contracts, with some practices actively blocking NHS patients. Substantially more could be earned by dentists taking on private patients than those on the NHS. However, it was noted that better access to NHS services exist within London than in rural areas.

Cllr White asked whether there could be some incentives for dentists to take on NHS patients. Mr. Eaton responded that for an NHS patient a dentist would earn around £28 for each unit of dental activity, but for the same work the dentist could earn anywhere between £30 and £300+ privately. This acted as a disincentive for many to see NHS patients. Mr. Wallman also reiterated that dentists were not obliged to see patients under the NHS, indeed registration was very informal in some practices. However, this was a national policy issue and cannot be addressed locally by ICBs.

Cllr Clarke commented that although dentists were not getting paid more for seeing NHS patients, £28 was still expensive for most residents. For those on the breadline there were still questions as to whether they were receiving any dentistry at all. This was acknowledged by Mr. Eaton and Mr. Wallman as an area of concern.

Cllr Clarke then requested more in-depth detail around the delivery of dental treatment to the most vulnerable. Mr. Eaton and Mr. Wallman clarified that access by rough sleepers and asylum seekers was achieved through link workers. Children and young people in Looked After Care had statutory health checks. Cllr Clarke suggested that perhaps this could be linked to dental health services.

It was agreed that another update specifically on access to dental care services for vulnerable groups would be given to the committee. **(ACTION)**

Cllr Connor then asked for written responses to questions from the Committee.

- Cllr Revah requested more information on the definition of ‘exempt’ also what special provision there was for those with Diabetes. **(ACTION)**
- Cllr Chakraborty requested the ICB view on the opportunities to roll out preventative schemes in the community – such as supervised brushing amongst children. **(ACTION)**
- In reaction to the 111 dental services item in the report, Committee requests for a list of dentists taking NHS patients, as well as those skilled in child friendly practices - Cllr Connor highlighted that this information needed to be common knowledge amongst residents. There was a strong recommendation from the Committee that the ICB should investigate a Communications budget to start looking at making these pathways more accessible to residents. **(ACTION)**
- She also expressed concern at the state of dentistry. Some residents did not access dental services because of the cost, and this would have big implications on long term health. **(ACTION)**

25. WORK PROGRAMME

Cllr Connor pointed out the present time constraints at the meeting. It was then agreed that the committee would reconvene at a later date, to discuss the work plan and terms of reference in more detail. **(ACTION)**

26. DATES OF FUTURE MEETINGS

- 9th September 2024 (10:00 am)
- 11th November 2024 (10:00 am)
- 3rd February 2025 (10:00 am)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Monday 3RD FEBRUARY 2025, 10.00am – 12.30pm

PRESENT:

Councillors: Pippa Connor (Chair), Kemi Atolagbe, Rishikesh Chakraborty, Philip Cohen, Chris James, Matt White and Chris Day

ALSO ATTENDING:

- Paul Allen – Assistant Director for Strategy, Communities & Inequalities (NCL ICB)
- Sarah D'Souza – Director of Strategy, Communities & Inequalities (NCL ICB)
- Sarah Morgan – Chief People Officer (NCL ICB)
- Dominic O'Brien – Principal Scrutiny Officer
- Serena Shani – Interim Principal Committees Co-ordinator

Community Group attendees.

- Dr Akudo Okereafor – ABC Parenting
- Lucy Robinson - ABC Parenting
- Christine Rahmen – Tottenham Talking
- Kwaku Agyemang – Tottenham Talking
- Dr Geoffrey Ocen – Bridge Renewal Trust
- Trevor Blackman – Enfield Community Partnership

50. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

51. APOLOGIES FOR ABSENCE

Apologies were given for Cllrs Clarke, Milne and Revah. Cllr Milne had sent a substitute Cllr Chris Day who attended the meeting on behalf of Enfield Council.

Apologies for lateness were received from Cllr Atolagbe.

52. URGENT BUSINESS

None.

53. DECLARATIONS OF INTEREST

The Chair declared an interest in that she was a member of the Royal College of Nursing and also that her sister was a GP in Tottenham.

54. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

55. MINUTES

That the minutes of the NCL JHOSC meetings on 9th September 2024 and 11th November 2024 were agreed as an accurate record.

It was also noted that the Action Tracker would be circulated to Committee members after the meeting. **ACTION**

56. HEALTH INEQUALITIES FUND

The Director and Assistant Director of Strategy, Communities & Inequalities at NCL ICB, introduced the report. The beneficiaries of the Health and Inequalities Fund were also present and introduced to the Committee.

The Director emphasised that the experiences of COVID had highlighted a health disproportionality within the population. Deprivation was cited as a key determinant of health. It was also noted that there had been a shift in government policy to funding projects within the community. It was stressed by the Director that the Health Inequalities Fund was reviewed every year, but that input was needed to improve.

The Assistant Director began by highlighting that a £5m investment came from the NCL ICB to address health inequalities through projects in the community. He highlighted that money tended to flow to boroughs where there were larger numbers in deprivation – therefore Haringey had more projects in the area.

The projects all built on community power. There were more than 50 projects being funded by the NCL ICB. The team had produced an evaluation process based on findings from individual projects. Examples of Key Performance Indicators (KPIs) included the numbers of people helped, how many from the target populations and whether projects were making a major impact on diverting patients or potential patients away from NHS services.

In totality, the Assistant Director stated, NCL ICB Health Inequalities projects have helped over 26,000 people – this represents 10% of people living in the 20% most deprived areas nationally. In addition, 75% of project objectives had been met however there had been less success when it came to health determinants.

Commissioned research by Middlesex University indicated to the NCL ICB that co-production needed to be strengthened across the board. It was noted that community groups were successful in achieving project aims as the populations involved were already known.

ABC Parents

- Project founder Dr Okereafor introduced her charity. Through her work in a Paediatrics department, she stated, she observed that approximately 50% of her patients attended hospital because of parental feelings of fear and powerlessness when their child was ill. This was brought on by a lack of basic medical knowledge and confidence. In conjunction with Paediatrics, she developed first aid courses aimed at parents to build their knowledge and resilience. The outcome of the courses were to help avoid inappropriate attendances at hospitals - but also to provide support to those who needed it most. The Charity now delivers eight courses a week in a variety of languages, on topics vital for new parents.
- The project's Champions Lead built on co-production principles and encouraged parents who had been supported by the charity, to then become supporters of new parents and a wider network of knowledge in their communities. These new supporters were helping to spread the knowledge in communities that professionals traditionally found 'hard to reach'.

The floor was then open to questions.

- The Chair enquired whether funding was long term. She asked about the possibility of the pilot project being extended out to hospitals. Dr Okereafor stated that the funding was spread between the ICB, Bridge Renewal Trust and Every Parent and Child charity. She stated funding was annual and this had presented obstacles for the charity as staff could only be hired for short periods of time leaving gaps in resource towards the beginning of the year as funding was renewed. However more planning has enabled funding to be sought earlier - meaning there was a stronger cohort of staff this year and less gaps in resources. Dr Okereafor stated that the charity had been approached by more Trusts to roll out the project.
- Cllr Atolagbe then asked about target setting and annual checks. Dr Okereafor stated that mid-year reviews occurred in October. KPIs included the delivery of 2,500 activities throughout the year and tracked the number of beneficiaries' living in areas of deprivation. The charity also screened for individual poverty amongst its service users.

Tottenham Talking.

Mr Kwaku Agyemang and Geoffrey Ocen introduced the case study from Haringey. The Committee learned that:

- Haringey had particular issues with deprivation and a lack of mental health funding even though demand in the borough is very high.
- Tottenham Talking is a partnership between the North London NHS Foundation Trust and the Bridge Renewal Trust. Tottenham Talking produce a range of preventative services for Haringey residents struggling with mental health. They provide support to residents without direct diagnosis, and provide early intervention services, so that primary and secondary services aren't needed.
- Tottenham Talking goes back to 2018, and operated out of the Chestnuts Community Centre, where those who suffered mental health issues could engage with social therapeutic activities such as cooking and art to try to change the mindset of the beneficiaries. This approach has been successful, and many have gone on to train and gain jobs in different sectors.
- Co- production and peer support was a vital element of the programme.
- The centre ran activities and one to one sessions, run by art therapists, occupational therapists, and psychologists – to support mental health. Other activities include trips and podcasts to keep connected.
- The charity is targeting mental health particularly amongst men and have recently started a men's group which has been well received. Topics cover relationships, medication and more. The charity's targets include men in the 18-25 age range and the LGBTQ+ community.

The floor was open to questions.

- The Chair enquired about funding - and whether evidencing was adequate to ensure sustainability. She also asked how the charity quantified whether beneficiaries were engaging with the service to the extent that primary and secondary services were not needed. The Assistant Director responded that outcomes were monitored by the ICB. The Return On Investment (ROI) was calculated to be that for every pound spent on Tottenham Talking, one pound fifteen was saved. Mr Ocen affirmed that work was being done in partnership with the ICB to define meaningful outcomes within the community. He also emphasised there was a need for more support with knowledge of funding and also a need to move from a one year to a three-year settlement to allow for more impactful work.
- Cllr White commented that it wasn't just impact on NHS services that should be considered but its effect on Policing and other public services. He enquired whether research opportunities had been investigated to see how projects had saved money across the public sector, as a good argument could be made for rolling similar projects out more widely. The Assistant Director responded that some work had been done in partnership with universities to look at the wider impact of a homelessness project. This had helped to make the case for longer term funding. They would consider applying these techniques to the Health and Inequalities Fund. However, funding was locked up in crisis care. Creating a clear Return on Investment

(ROI) would help with accessing this money for projects moving away from the clinical model.

- Cllr Cohen commented that Tottenham Talking clearly did impactful work with reducing stigma faced by those with mental health issues. He enquired whether this was something that mainstream services could replicate. Mr Agyemang responded that the Tottenham Talking model could be replicated easily within acute settings, however funding was a factor. He stated that the Tottenham Talking model was a socially creative approach to mental health however the medical model of dealing with mental health issues was still dominant in clinical thinking and funding. However, he stated, there had started to be a shift in thinking -as more NHS professionals were conducting workshops in the community. Mr Ocen added that the project worked closely with psychiatrists, however, more could be done with Integrated Level Teams (which included social services, housing etc) to inform practices and address the stigma faced by many.
- Cllr Chakraborty enquired what the criteria was to qualify for the Health and Inequalities Fund and what factors determined where a project was, and what the focus should be. The Assistant Director explained that projects were loosely scored. Sustainable funding was deemed as problematic, however good evidencing and qualitative research can help with longer term funding. The Assistant Director also added that the criteria focus was still on the 20% nationally most deprived areas. If a project was to become part of mainstream Inequalities work, then the team had to ensure that deprived communities were still being reached as part of their remit. The Assistant Director also added that the ICB did not make decisions as to where the funding was distributed. This was done through Borough Partnerships. The ICB provided broad outcomes as to what success would look like in each borough. However, the main decisions were made at the Borough Partnership meetings which included local authorities, local community organisations as well as the NHS .
- Cllr Atolagbe enquired whether there were any groups with protected characteristics that were not being targeted. Ms Robinson responded on behalf of ABC Parents. They had identified audiences and carried out extensive co production with the neurodiverse community around the training programmes. Other target areas were single parents. Ms Robinson stated that Champions had pointed out training programmes should also be tailored to those who had experienced loss or infertility. She stated that statistically those with neurodiverse or mental health issues traditionally have less support, so the project was responding to this by setting up peer support groups.
- Cllr Chakraborty pointed out that only two out of the 56 projects that the ICB had funded was in Barnet. He enquired further about the criteria for funding of projects. He stated that there had been highlighted in the report that there

was difficulty with engaging in scattered geographies. He enquired whether there averages of deprivation were taken from areas and if this was the criteria.

- As time was short, the Director offered to write a written response to Cllr Chakraborty. **ACTION.**

Health Heroes United/Edmonton Community Partnership Alliance

- Mr Trevor Blackman, spoke on behalf of the Edmonton Community Partnership Alliance, which was a coalition of 20 primary, Special Educational Needs and secondary schools in Edmonton and the Ponders End area. The charity's aim was to improve the life chances of children and families in the area – and was especially focused on education, health and social mobility.
- He explained to the Committee that the charity had conducted two reports around health inequalities experienced by Gypsy, Roma and Traveller (GRT), Bulgarian and Black residents. The Committee learned that there had been a historic lack of trust in public services from these areas. Moreover, many GRT communities were under the radar as far as public health services and more were concerned. He stated that many were not registered with a doctor and used the A&E department to see to medical issues. Language barriers and awareness of services available was cited as an issue. Residents cited that activities such as after school events and health workshops would be beneficial. The charity has worked with the communities to produce events such as a showcase of services with professionals from North Middlesex Hospital. The charity has helped support 2,800 residents this way. The remit has now been widened to the South Asian residents. In addition, the Alevi Community had set up their own men's group, which had included three LGBTQ+ men talking about common issues. The result has been the Alevi Community's first LGBTQ+ awareness day. Mr Blackman then made a case to the ICB and beyond for wider help with public research, to help inform KPIs and make a positive impact to long standing health issues in the community.

The floor was opened to questions.

- The Chair asked what the charities needed to be able to support their aims in the community. Mr Blackman responded on behalf of the Edmonton Community Partnership Alliance and stated that although work had been ongoing with the Research Engagement Network to give insight into communities, resources were needed the most to research, manage coproduction, support events and create relationships within groups. Translators were also needed to break down language barriers and budget needed for promotions and printing.
- Cllr Atolagbe enquired whether targets had been met and what the goals were for next year. Mr Blackman stated that the project had aimed for 3,000 to be reached – so far 2,800 had been reached this year. Goals next year included work with the Kurdish community, and further work with the black community –

specifically targeting Somali and East African groups. Also, more in-depth work with the Gypsy, Roma and Traveller and Bulgarian residents.

- The Chair explained the Committee's capacity to make recommendations, and asked the charities to input what they would like to see.
    - Dr Okereafor stated that more support was needed in reaching communities earlier, as well as funding help with embedding projects.
    - Geoffrey Ocen emphasised the need for longer term funding to help with project sustainability. He also suggested that opportunities for 'mainstreaming ; or opportunities for funding within mainstream public sector's aims towards addressing inequalities needed to be exploited. He emphasised help was needed to promote the importance of the social offer alongside the medical offer within mental health.
    - In addition, Trevor Blackman emphasised that for his charity measuring impact was vital, as well as a better overall understanding amongst funders that in terms of co-production one size doesn't fit all - and more robust research is essential. Help with funding for this would be welcome.
- The Chair suggested that the community projects return within a years' time to update the Committee about their activities. **ACTION**
- A written response from the NCL ICB was requested by the Committee to explain more about the projects' activities, performance metrics and what happens to projects which do not deliver on the ICB metrics. **ACTION**
- The Committee requested sight of the report on the evaluation conducted by Middlesex University on the programme's approach to co-production project. **ACTION.**
- The Committee also requested further clarity from the ICB on how it was decided that projects should be funded in given areas and the decision-making process at Borough Partnership level. More information was requested as to who was on the Borough Partnership Boards. **ACTION**

57. WORKFORCE UPDATE

The Chief People Officer to the NCL ICB introduced the report.

In addition to the report, the Committee learned that:

- It was a challenging year for people managers. Industrial action and a spike in respiratory illnesses nationally had put strain on the workforce.
- With regards to medical and dental clinical and nursing roles, vacancies had dropped and there was good sustainability in the workforce currently.
- The WorkWell project had enabled better joint working between medical departments. Patients who needed support where automatically being referred to a Health and Wellbeing Coach for extra support.
- The Shaw Trust had supported 3,000 residents into work.

- There was work to support care leavers and care experienced young people into employment with the NHS. Forty care leavers had been engaged. The project was funded by Drive Forward and NHS England would be supporting 25 extra places.

The floor was opened to questions.

The Chair enquired for further information on Health and Social Care Hubs. The Chief People Officer explained that the General London Assembly had funded five Health and Social Care academies across London to support the least represented in the workforce in London. In addition, work was carried out with every employment hub to support those in care.

The Chair pointed out that although 40 care leavers had been supported only 10 had been offered employment at the end of the year- she questioned whether this was value for money. The Chief People Officer responded by stating that the Care Leavers Programme is funded by the third sector. She explained that intensive support into work was needed for those in care, as many had mental health issues, and were transitioning from a life in care into work. She added that Line Managers needed support to help keep Care Leavers in work – the ICB had created training programmes to address this.

The Chair then asked further about access to the extra micro funding to help care leavers into work -such as free prescriptions, help with transport costs and interview costs. The Chief People Officer explained that councils and multiagency groups were responsible for these.

Cllr Atolagbe enquired how long this extra support was given to care leavers. The Chief People Officer explained that the line manager training should support care leavers throughout employment, however the intensive mentoring programmes for those entering employment was twelve-weeks. She added that there was a challenge around the availability for entry level jobs in the NHS, which is why 10 employment placements was considered a success.

Cllr Atolagbe referred to the metrics in the WorkWell report. She enquired as to why there was a ‘Did not start’ category (on page 58). The Chief People Officer responded that some did not qualify for the programme. For example, those who worked but did not live in North Central London would not qualify. She added that residents would also have to commit to time with the Work and Health Coach - who would support them in or back into work if needed.

Cllr Chakraborty highlighted the positive steps that had been made in decreasing vacancy rates. He enquired what policies work well to reduce these rates. The Chief People Officer responded that the main driver for filling vacancies was reducing bank and agency staff. Managers enjoyed the flexibility (especially in terms of budget) when employing agency staff however there was a balance between this flexibility and

providing and monitoring more substantive roles. Performance in these more substantive roles, was also key, as the ultimate aim would be to reduce the work force through increasing productivity as budgets were tight. Cllr Chakraborty responded that productivity was only part of the puzzle, he asked whether the ICB had sufficient platforms to talk to government about policies that effect domestic supply. The Chief People Officer responded that there was still heavy reliance on international recruitment especially for areas such as mental health and advanced medical practice. Steps to grow domestic supply was hampered by the curriculum in higher education in the UK, as changes to the curriculum can take up to five years . She added that work with NHS Change had identified this. She also added that there were very high rates of anxiety and mental health issues amongst young people in London, which led to low rates of employment. Also, the NHS was not seen as an attractive career choice by many.

Cllr White commented that there was a disconnect as to what the Committee scrutinised in terms of policies and strategies and what was experienced everyday by the NHS. Cllr White asked how the Committee could scrutinise the theory that reducing staff would increase productivities and not lead to reduction in services. The Chief People Officer replied that there was a shift in providing care - from a Hospital to a Neighbourhood Model, where changes to funding meant more projects and care being provided in community settings, more focus on prevention and more focus on digital services. This would ensure that reducing staff did not mean a reduction in services. She added that since the COVID pandemic, the UK particularly had seen more direct links of the determinants of health as wealth. She stated in this sense the UK was the opposite to Europe.

Cllr White suggested that next year, the Committee should consider more in-depth information about productivity and the shift to the Neighbourhood Model. The report should focus more on what is meant by ‘productivity’ and what the effects are on the wider outcomes - namely have patients quality of life improved in anyway as a result of this. **ACTION**

Cllr Atolagbe enquired about the metrics in the report. The Chief People Officer clarified that the metrics dashboard was actually indicative as it was under development. She clarified that some metrics especially on the Workforce Race Equality Standard, and Workforce Disabilities Equalities Standard was only measured during a time period, once a year.

The Chair requested that next year more information about the Neighbourhood Model be presented as part of the Workforce presentation and in addition other service delivery partners should be involved. This was in order to understand how the shift to the Neighbourhood Model would affect the outcomes to patient in greater depth. She stated that this should be given a minimum of an hour on the agenda to allow for greater scrutiny. **ACTION**

Cllr Chakraborty added that more information was needed on what was being done to make the NHS more attractive to job seekers. He acknowledged the increase of training of domestic talent but highlighted that conditions had to be attractive for people to stay. He asked for more information around working conditions, and what could be offered to those graduating as an incentive as it was acknowledged that the pay was not competitive. **ACTION**

The Chair added that information be provided on the kind of mentoring that could be offered to help those at entry level grow within the organisation and across the public sector. **ACTION**

Ms Morgan suggested bringing this information back to the Committee when the NCL ICB ten year plan had been approved. She added that she felt there was much more that could be offered by the ICB to become an attractive employer to young people especially when it came to flexibility.

58. WORK PROGRAMME

The Chair stated that the April JHOSC meeting would be themed as a community-based meeting.

It was proposed that the topic of mental health should be covered again and that the report should cover progress from last year and actions from the previous meeting. It was pointed out that metrics should be presented by borough. **ACTION**

It was also suggested that more information was needed from the ICB as to what difference was being made to patients/residents and whether information was being shared with central government. **ACTION**

The London Scrutiny Network was then discussed, and an invite was extended to the rest of the Committee.

59. DATES OF FUTURE MEETINGS

- Mon 28th April 2025 (10am)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

North Central London
Health and Care
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NHS

JHOSC update

28th April 2025

Executive summary

North Central London Health and Care
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- This update provides a **summary of mental health pathways** in North Central London. It focuses on two important areas of ongoing work:
  - **Improving transitions from children and young people's (CYP) services to adult mental health services**, with new teams, earlier planning, and personalised support for those aged 18–25.
  - **Strengthening how information is shared across organisations**, so that care is better coordinated, people don't need to repeat their story, and decisions can be made more quickly and safely.
- These services are designed to support people with a **wide range of mental health needs**, from mild to complex and severe.
- Since 2022, we have taken **steps to reduce variation** in services between boroughs. A Core Offer for Mental Health Services has been developed and is being implemented across a multi-year programme to ensure more consistent, high-quality support across the area.
- **Significant investment has been made** to address historical gaps, particularly in Barnet, Enfield, and Haringey, where levels of variation have been higher.
- We have also made it **easier for people to access help**. Crisis services are available 24 hours a day, 7 days a week, through phone lines, walk-in Crisis Cafés, home treatment teams, and emergency support via the Mental Health Crisis Assessment Service (MHCAS).
- For those needing longer-term care, Community Mental Health Teams provide personalised support for mental, physical, and social needs, including therapy, medication, and help with housing and employment.
- We **recognise that challenges remain and that need continues to increase amongst our population.** Further challenges include the consistency of support and coordination between services. However, we are actively working to address these issues through improved planning, partnership working, and investment in neighbourhood-based care and digital tools.
- Our **aim is to create a joined-up, equitable, and proactive mental health system** that helps people get the right support at the right time, in a way that works for them.

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Adult mental health services

The Mental Health Core Offer

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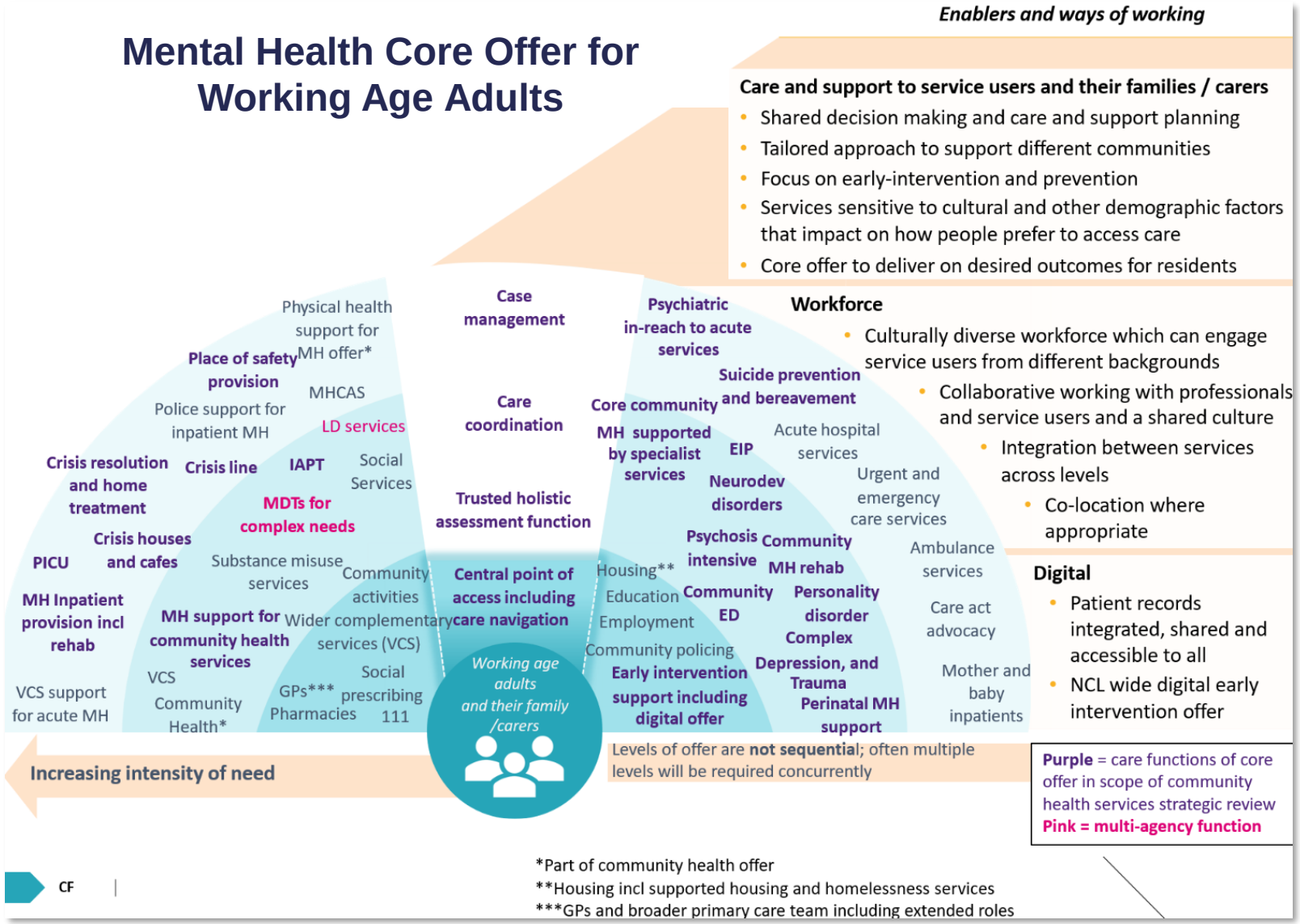
- In 2022 we conducted a review of services across boroughs which highlighted there was variation in service provision across these areas
- We developed a Core Offer for Mental Health with the aim of addressing this inequity in provision and improve the standardisation of services.
- Since the start of the programme we have invested c.£50m to meet growing need and start to reduce this variation, a large proportion of this has been directed towards services in Barnet, Enfield and Haringey to address historical gaps in funding.



A set of coordinating functions act to support, integrate and navigate care for service users across the layers of the core offer

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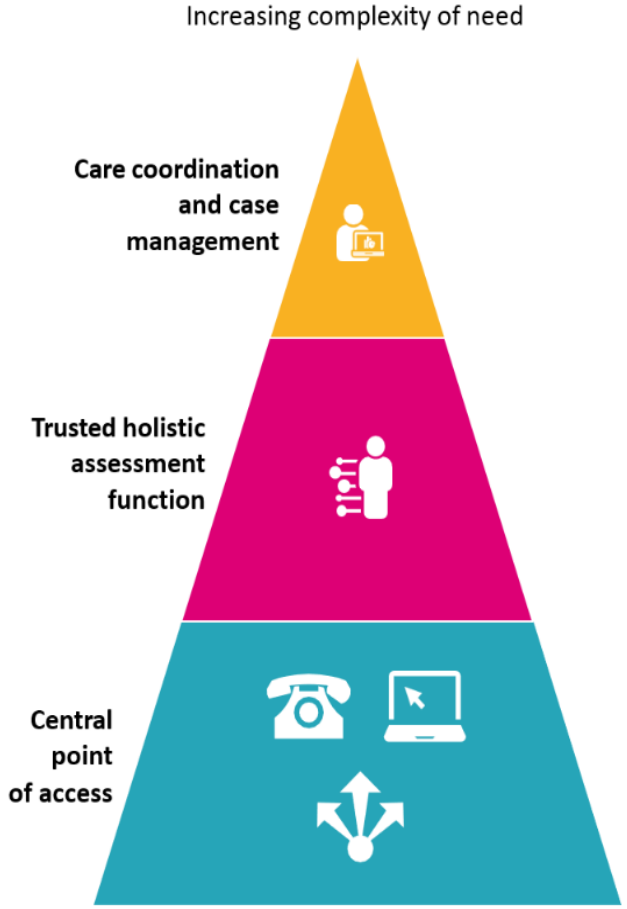
It is designed to be simple, supportive, and to make sure you get the right help when you need it

- There's a single point of contact (phone or email) to help you or someone you care for get in touch with the right mental health service quickly and easily.
- One Joined-Up Assessment – You only have to tell your story once. A senior professional will do a full assessment of your health needs, home situation, and preferences.
- Ongoing Support for Complex Needs – If you need more ongoing care, a dedicated case manager will help you create a personalised care plan and coordinate appointments and support.

The **Single Point of Access for Core Community Teams** that is in development is one such example. Further details are provided in on slide 20 of this pack.



- Service users with complex needs are allocated a clinical **case manager**. This individual leads the development of a **holistic care plan and its delivery**
- Care coordinators support this through **organising MDT meetings** and supporting service users and their families and carers to **navigate health and care appointments**

- Service users have **a single up front holistic assessment of their health needs, functioning, living environment & preferences**
- This is conducted by a senior professional with trusted assessor competencies who has the trust of the full MDT
- Service users and their families and carers **only have to tell their story once**

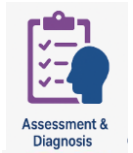
- Central point of contact at borough or NCL level for initial referrals and contacts with local community and MH health services
- Provides telephone and/or email hub which **directs referrals or queries to the right individual or service**
- Accessed by any health/care professionals, by service users and families / carers
- Administrators have access to directory of local services and assets and are able to **help service users and professionals navigate the wider available support**

There are a range of mental health services in NCL to support people with differing levels of need

Need	Early intervention and prevention	Mild or moderate to complex

Support available

Voluntary and community organisations, along with public health teams, offer local support that helps people stay well, spot early signs of mental health issues, and get help before things reach a crisis.



Understanding your mental health through in-depth conversations and evaluations to identify any conditions or concerns.

Creating a personalised care plan with you, including therapy, medication, and support focused on your recovery goals.

Creating a personalised care plan with you, including therapy, medication, and support focused on your recovery goals.

Helping you stay well by spotting early signs of struggle, planning ahead, and offering support after hospital stays.

Support with things like housing, employment support, money, and linking you with helpful local services.

Keeping an eye on your physical health as a way of integrating MH and physical health to reduce premature mortality

Support for people dealing with both mental health challenges and drug or alcohol use.

Listening to and supporting your family or carers, and involving them in your care when appropriate.

Support teams

Talking Therapies	Community mental health Core Teams	Crisis Resolution Home Treatment Teams	Homeless Community Mental Health Teams

Examples of conditions treated

- Common MH disorders (i.e. depression, anxiety)
- Eating disorders
- PTSD (where long-term community support is needed)

- Severe depression and anxiety Personality disorders
- Schizophrenia
- Bipolar disorder

Need

Support available

Complex to severe

By calling 111 * 2 you can speak to trained professionals who can listen, support you, and connect you with the right services. This support is available 24 hours a day, 7 days a week.

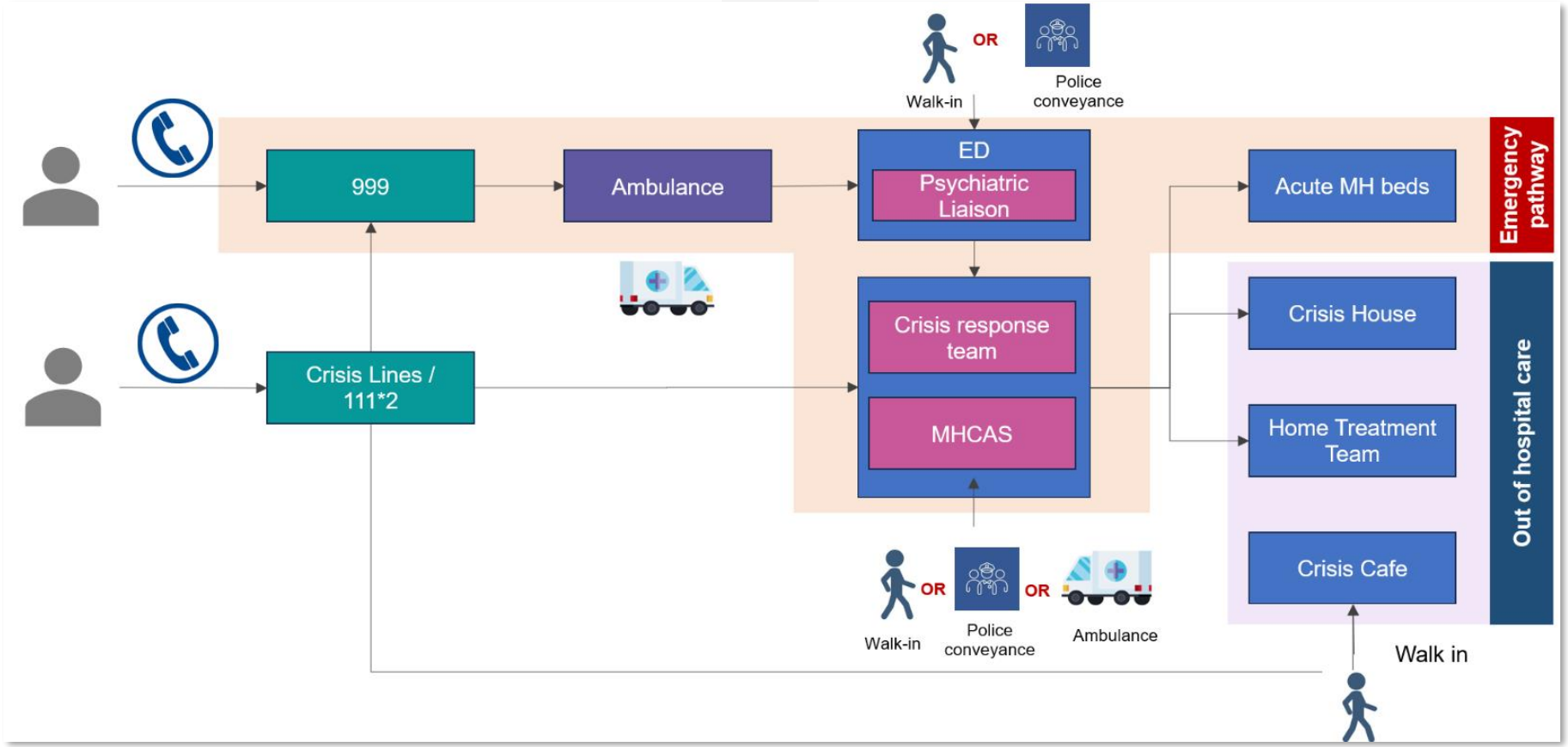
MHCAS provides emergency mental health assessments and care planning, staffed by a diverse team including support workers, peer coaches, nurses, and doctors. They handle various aspects of emergency mental health care, from GP referrals to Mental Health Act Assessment.

If you're struggling but don't need emergency hospital care, these are calm, welcoming places where you can speak to someone in person and get support. They're a great alternative to going to A&E

A safe place in the community where people can stay for up to two weeks if they're experiencing a mental health crisis or need extra support before returning home or moving into hospital care.

Some services can visit you at home to provide mental health support, helping you recover without needing to go into hospital.

Acute inpatient services provide round-the-clock care and treatment in hospital for people experiencing serious mental health crises. These services offer a safe and supportive environment to help individuals stabilise and begin their recovery.



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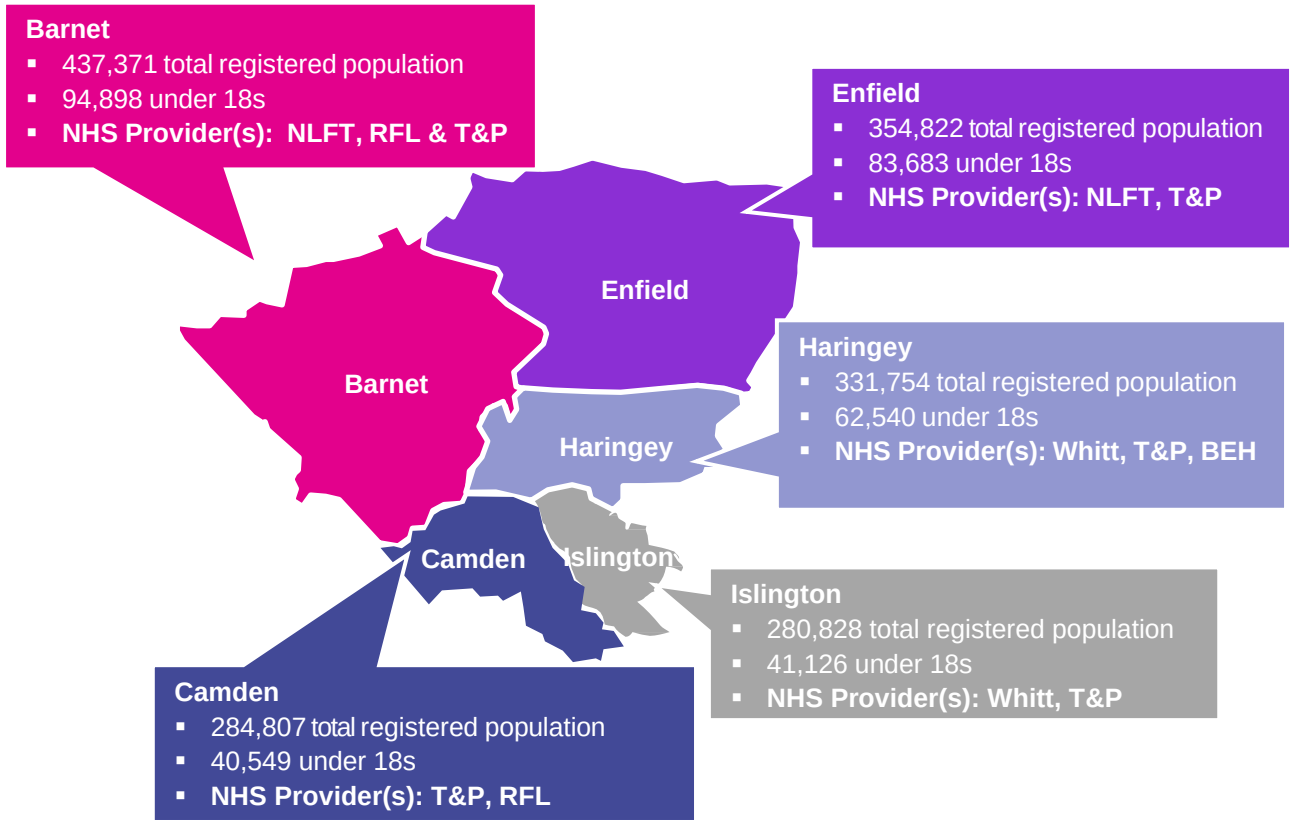
Children and young people's services (CYP)

Existing NHS CYP provider and service landscape

- North Central London (Barnet, Camden, Enfield, Haringey and Islington) has a population of approximately 1.7 million residents, of which 323,000 are under 18 years of age.
- Each borough has **multiple NHS providers and services** operating as a result of the five legacy CCGs commissioning in isolation Due to these legacy arrangements, no borough has a single provider of CAMHS.



**Child and Adolescent Mental Health Services*

Community CAMHS provision from NHS providers includes:

- Access teams and general Children and Adolescent Mental Health Services (CAMHS)
- Provision in schools, including Mental Health Support Teams (MHST) across 45% of schools and provision within Pupil Referral Units
- Services for assessment and treatment of neurodevelopmental needs, including Autism and ADHD
- Specialist provision for young adults and adolescents
- Specialist support for Looked After Children
- Provision within Youth Offending Services (YOS) and police custody
- Support for those with eating disorders
- Crisis provision
- Inpatient and outpatient support for children and young people under the care of acute providers

Transitions for young people aged 18–25

Why this matters

- Turning 18 can feel like a cliff edge for young people leaving CYP mental health services
- Without appropriate adult services, some fall through the cracks
- Continuity and developmentally appropriate support are critical
- Transitions are life-changing processes

Challenges for 18-25 yr olds

- Inconsistent service availability
- Disruption to therapeutic relationships
- Repetition of story due to poor info sharing
- Lack of tailored adult services (ASD, ADHD, emotional needs)
- Gaps for those not meeting adult mental health service thresholds ("missing middle")
- Variable planning and engagement

The NCL challenge

- Multiple children and young people's mental health providers feed into a single adult mental health provider this can lead to inconsistency
- Boroughs vary in policy, thresholds, and provision
- Some transitions are rushed and poorly coordinated
- Young people with special educational needs and disabilities (up to 25) need tailored pathways

Supporting Young People Aged 18–25 Through Transitions:

What we are doing to make the move to adult services easier

We're committed to making sure young people feel safe, supported and empowered as they move into adulthood

What we already have in place

- A clear plan to support young people moving from children's to adult mental health services, based on national guidance.
- Planning begins at age 17½ so there's time to get things right.
- Special teams focused on 18–25 year olds in both children's and adult mental health services.
- Extra help for young people with additional needs or disabilities.
- Joint planning meetings that focus on each young person's needs.
- Handovers are done gradually—with support—not suddenly or without preparation.

What's working well

- Professionals work together to create shared plans, so care is more joined up.
- 18–25 transition workers help young people stay engaged with services.
- A Youth Board helps shape training and policies—based on real experiences of young people who've been through it.

Improvements we are working on

- Getting different services to work more closely together via the CYP provider collaborative.
- Setting shared standards across all boroughs.
- Making the move into adult services smoother and more consistent.
- Coordinating services better across the whole system.

What's next

- SOON One single transition team for all five boroughs.
- SOON Training for staff that's co-designed with young people and families.
- SOON Keeping young people involved in shaping services and giving feedback.
- SOON Creating flexible, person-centred plans through the CYP collaborative
- SOON Providing clear and simple information for young people and families.
- SOON Making sure support is based on what someone needs, not just their age.

A young person's journey : Kwame

Kwame is a 17-year-old who has been supported by CAMHS (Child and Adolescent Mental Health Services) since he was 14. He has complex needs, including autism (ASC), ADHD, and has also spent time in care.

- As Kwame approached his 18th birthday, professionals became increasingly concerned about his safety and the risks he was taking.
- To help with the transition to adult services, a transitions worker joined a CAMHS meeting before he turned 18.
- This made sure that Kwame would see a familiar face in future appointments.
- A keyworker who knew Kwame and his family well was also involved and kept them informed every step of the way as his care was transferred.

About a month after his 18th birthday, Kwame was admitted to hospital after taking a serious overdose.

- During his time in hospital, his keyworker visited him every week to make sure there was continuity of care.
- The keyworker also pushed for Kwame to be given a long-term healthcare worker from the adult services team.
- They worked closely with a specialist in complex emotional needs to support Kwame in practising adapted Dialectical Behaviour Therapy (DBT) skills, which are particularly helpful for people who are neurodivergent.
- The keyworker also attended Kwame's discharge meeting and stayed in contact with him once he returned to the community.

Since then, Kwame has been doing really well. He has been living in the community without any incidents for over 12 months.

- His visits from the transitions keyworker have reduced from weekly to monthly.
- There is a plan in place for him to eventually move on from the transitions service, but he will still be able to attend the Creative Recovery Drop-in.
- Kwame is now regularly going to a DBT skills group and continues to receive support from the adult mental health team.

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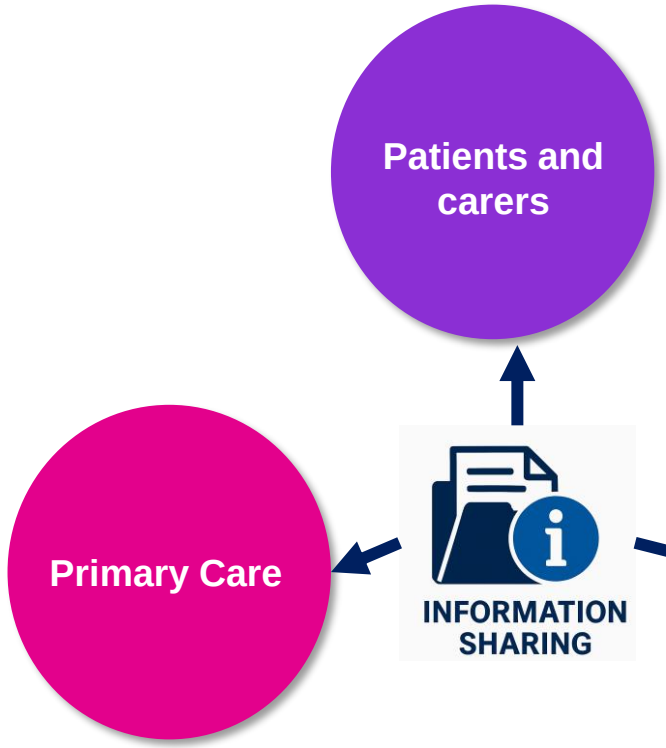
Information sharing

Effective information sharing

Good communication between services means people get better care. When professionals can easily share important information, it helps with quicker decisions, smoother care, and better health outcomes—especially when multiple services are involved



The triangle of care, developed by the Carers Trust, aims to foster collaboration in mental health care by involving carers, service users, and health professionals

GP interface meetings attended by medical director of NLFT, focused on identifying solutions that primary care face managing patients with mental health issues, improving communication and processes

Appropriate policies and procedures are in place to identify and address safeguarding concerns

DIGITAL ENABLERS

There are several initiatives in place to enable better sharing of information across organisations digitally

Making Support Better for Carers – A Simple Overview

Initiative	What it's about	Challenges	What's next
Triangle of care	**Helping carers be recognised and included right from the start.** ✓ Carers are identified early. ✓ Staff are trained to understand and support carers. ✓ Carers are introduced to the services available and included in care planning.	• Carers aren't always involved in decisions. • It can be hard to know who the carer is. • Policies don't always match what happens in real life.	Work together with carers, community groups, councils, and staff to improve and track progress.
North London NHS Foundation Trust's Carer Strategy	**Making sure carers get emotional, practical, and timely support.** ✓ Carers are supported early on. ✓ Staff are trained to work well with carers. ✓ Information is shared while still respecting privacy.	• Support isn't always offered soon enough. • Carers' voices aren't always listened to. • Services could be better signposted.	Continue co-designing improvements with carers, staff, councils, and local communities.
Working Together Across Health & Social Care	**Different services teaming up to give carers a smoother experience.** ✓ Strong partnerships across services. ✓ Better links between health and social care. ✓ Mental health services that work well for carers too.	• Some areas don't yet have formal agreements. • Staff face practical challenges working across services. • Social care teams are under pressure.	Create joint action plans with carers and local organisations to make services more joined up
Equality, Diversity & Inclusion (PCREF)*	**Making sure services are fair and accessible for everyone.** ✓ Services are designed to be inclusive. ✓ Help is available in different languages and formats. ✓ Action is taken to reduce bias and discrimination.	• Racial bias still needs tackling. • Outcomes aren't always fair for all groups.	Keep improving with the help of diverse voices—ensuring fairness is at the heart of everything.

Sharing Information Effectively: *digital enablers*

We are embedding and improving the use of digital tools to improve the way share and use information collectively across health and social care

Initiative	What it enables us to do
London Care Record (LCR)	Allows professionals across London view a person's health and care details (like test results, medications, allergies, and care plans) in one place—so everyone involved is on the same page.
GP Connect and MESH	These systems help send information directly to a person's registered GP practice automatically and securely.
Patient Knows Best (PKB)	Allows people see their own health information through the NHS app and share it with others—like a family member, carer, teacher or another healthcare professional.
NHS Wayfinder Services	It helps people and carers view appointments and referrals via their NHS app, linked with Patient Knows Best. NLFT is the first mental health trust to go live with this.
Lab Results Integration	Blood test results from labs like Health Services Laboratories and RiO can now be shared more easily between services through LCR and PKB—so nothing gets missed.

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Improvements for 2025/26 and beyond

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NFLT adult community single point of access (SPA)

An overview of the Single Point of Access

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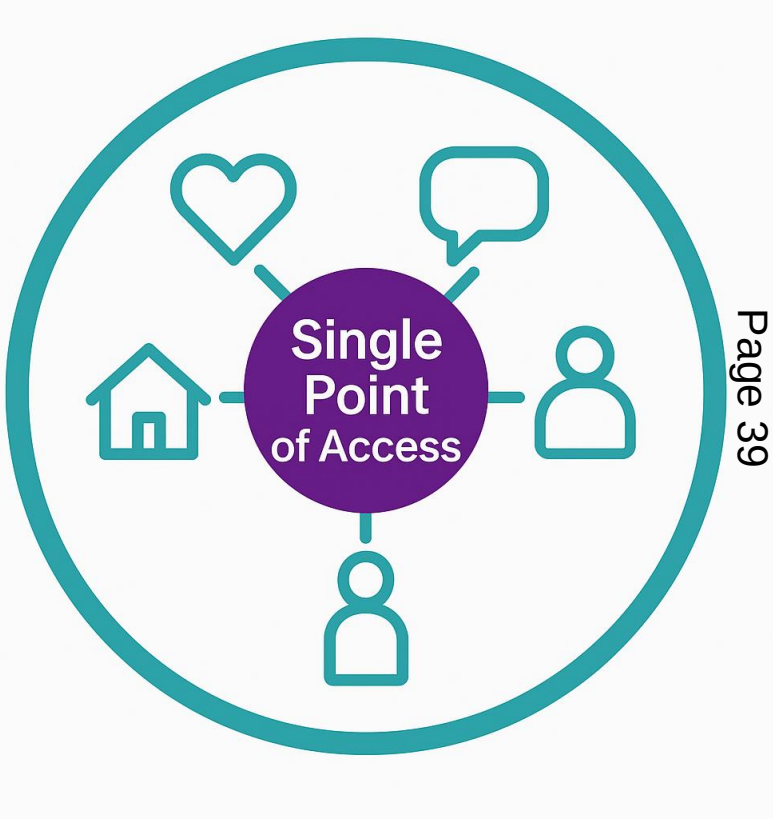
What is the Single Point of Access?	• **Currently:** When a GP refers a patient to a mental health service the referral can be bounced between teams, delaying care by weeks • **With Community Adult SPA:** The referral will be processed efficiently through a single point of access, ensuring the referral is directed to the right service immediately.	
How will it will improve the experience for patients and staff?	**For patients:** ✓ Faster access: Quicker connections to appropriate services ✓ Less confusion: A single, clear referral pathway ✓ Improved outcomes: Timely and relevant care interventions	**For service teams:** ✓ Simplified referrals: One standard referral form ✓ Better co-ordination: No multiple handovers or hand back of referrals ✓ Quicker response times: A more streamlined process for faster decision-making
How will digital tools help make processes more efficient for patients and staff?	✓ Easier self-referrals & tracking using online tools ✓ Faster triage & response times ✓ More seamless care transitions	✓ More efficient resource allocation & productivity ✓ Data-driven improvements in care pathways ✓ Reduction in duplicate referrals
When will this be implemented?	• The plan is to establish this in Barnet by June 2025 • Lessons learned from the Barnet implementation will be incorporated into the extension of the service to the remaining five boroughs by the March 2026	



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NCL's neighbourhood model

We are working to translate and act on 2025/26 national guidance on neighbourhood health

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Core components of an effective neighbourhood services:

1. **Community-Based Care:** Shift services from hospital to community, enabling individuals to receive mental health support within their local areas, maintaining independence and reducing hospital admissions.
2. **Preventative Measures:** Implement early intervention programs that focus on preventing mental health deterioration
3. **Digital Integration:** Utilise digital tools and infrastructure to enhance care delivery

Systems are asked to build on current momentum for a neighbourhood health approach by:

- Standardising 6 core components of existing practice
- Bringing together the different components into an integrated service offer
- Scaling up
- Rigorously evaluating

With a specific focus on supporting individuals with complex health and social care needs who require support from multiple services and organisations

Core components of an effective neighbourhood services:

- Population health management
- Modern general practice
- Standardising community & mental health services
- Neighbourhood multidisciplinary teams
- Integrated intermediate care
- Urgent neighbourhood services

Evidence has identified elements critical for effective implementation of neighbourhood health:

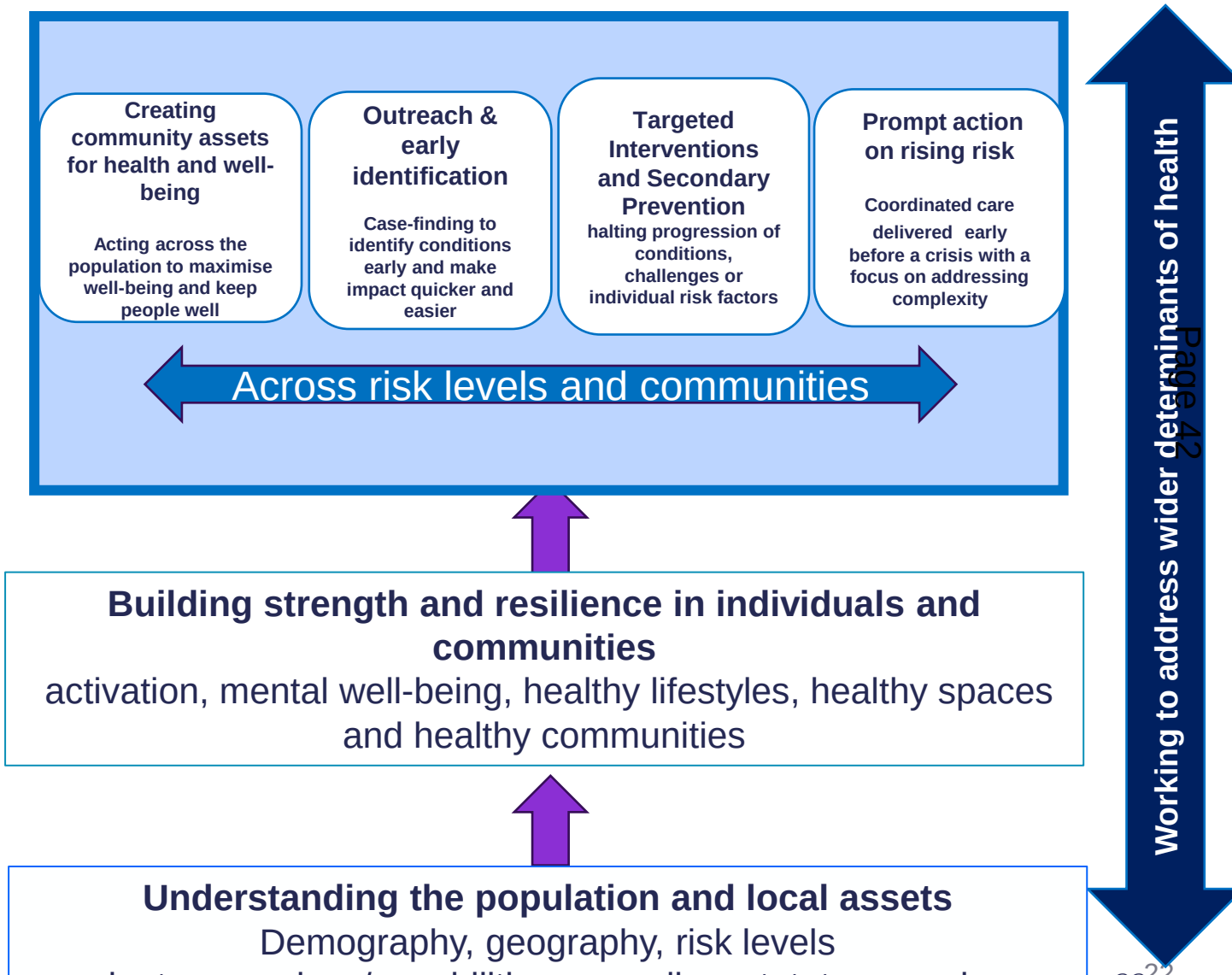
- **Mechanism for joint senior leadership** in each place
- **Collaborative high-support, high-challenge culture** supported by shared values, objectives, organisational structure and lines of accountability
- **Visible clinical and professional leadership** and management at all levels to co-develop the model
- **Effective processes and workforce development** to enable collaboration
- **Maximise shared incentives** to facilitate partnership working

Source: NHS England » Neighbourhood health guidelines 2025/26

The Vision for Neighbourhoods in NCL

What is going to be different; and how the integrated neighbourhood team is going to look and feel

- **Ring-fenced time** to focus on prevention, early intervention and proactive care – weekly at minimum – to focus on the four pillars
- **Teams that know each other and know local resources**
- A **leadership team** made up of statutory services across housing, employment, public health, community care, primary care, and nominated VCSE
- **Neighbourhood Manager** to facilitate and coordinate
- Able to deploy **range of case management/care coordination/health navigators**
- **Act as a place to problem solve**, unblock or take additional action
- **Able to connect with the Borough Partnership** to discuss gaps or strategic need
- **Links to local services** to coordinate action
- **Insightful integrated data** linked to each of the pillars which can be seen in aggregate to understand trends and at individual level to build targeted lists; risk stratified and segmented
- **Coordinated specialist input** to reduce duplication and provide streamlined support (eg geriatrician, LTC consultant)
- A growing **network of traditional sites moving toward becoming holistic, MECC-focussed neighbourhood hubs focussed on proactive care and early intervention**



What could this mean for residents accessing mental health services in NCL?

North Central London Health and Care
Integrated Care System

Treating mental and physical health equally

Making care accessible and equitable for everyone, and targeted to those with the highest need

Looking after the whole person, not just their illness

Neighbourhood Working

Bringing different experts together to provide better care

Helping people with mental illness live longer, healthier lives

Making sure care is given by people with the right skills and knowledge

North Central London
Health and Care
Integrated Care System

NHS

Appendix

Abbreviations

NCL	North Central London
NLFT	North London Foundation Trust
T&P	Tavistock and Portman
RFL	Royal Free London
CYP	Children and Young People
SPA	Single Point of Access
MH CAS	Mental Health Crisis Assessment Services
CAMHS	Child and Adolescent Mental Health Services
DBT	Dialectical Behavioural Therapy
HCP	Health Care Practitioner
ASD	Autims Spectrum Disorder
ADHD	Attention Deficit Hyperactivity Disorder
MHST	Mental Health Support Teams in schools

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2025-2026	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 28th April 2025

SUMMARY OF REPORT

This paper reports on the 2025/26 work programme of the North Central London Joint Health Overview & Scrutiny Committee and also requests proposals for the reports for the next meeting.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the current work programme for 2025-26;

b) Propose agenda items for the next meeting which is currently scheduled to take place on 7th July 2025.

1. Purpose of Report

1.1 This item outlines the possible areas that the Committee could focus on for the 2025-26 work programme.

1.2 The next meeting of the JHOSC is scheduled to take place on 7th July 2025.

1.3 The JHOSC's work programme for 2025/26 is listed in **Appendix A**. The work programme is currently vacant but Appendix A also includes a list of standing items that the Committee usually schedules each year and also a list of as yet unscheduled items on which the Committee has previously indicated that it wishes to receive further updates.

2. Terms of Reference

2.1 In considering suitable topics for the JHOSC, the Committee should have regard to its Terms of Reference:

- "To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross-borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people."

3. Appendices

Appendix A – 2025/26 NCL JHOSC Work Programme

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Appendix A – 2025/26 NCL JHOSC work programme

7 July 2025

Item	Purpose	Lead Organisation
TBC		
TBC		
TBC		

8 September 2025

Item	Purpose	Lead Organisation
TBC		
TBC		
TBC		

17 November 2025

Item	Purpose	Lead Organisation
TBC		
TBC		
TBC		

26 January 2026

Item	Purpose	Lead Organisation
TBC		

TBC		
TBC		

9 March 2026

Item	Purpose	Lead Organisation
Community-based meeting	TBC	

Usual standing items each year:

- **Estates Strategy Update**
- **Workforce Update**
- **Finance Update -** The Committee requested that the next financial report should include:
  - Details on acute care and community services and on overview of any associated pressures and risks.
  - Details on the distribution of funds to voluntary sector organisations.
  - Details of the lines of communication between Departments and how financial decisions are reached.
- **Winter Planning Update.** The Committee requested that the next winter planning report should include details on progress relating to:
  - High Impact Interventions.
  - Bringing down waiting times for patient discharges to A&E from ambulances.

Possible items for inclusion in future meetings

- Terms of Reference – revised version for JHOSC ToR to be discussed/approved by Committee.
- St Pancras Hospital update – Expected to be scheduled in 2025/26.
- Health Inequalities Fund – Last item heard in Feb 2025. It was suggested that the community groups involved in delivering local projects could provide an update to the Committee in a year or two.
- NMUH/Royal Free merger – Last item heard in Sep 2024. Possible follow-up areas: a) For the Committee to examine a case study into a less prominent area of care to ascertain how it was monitored before and after changes to the service, what the local priorities were and their impact on how clinical decisions were made. b) For further discussion on financial risk and, including how the debts of the Royal Free Group when be held within the merged Trust.

- Smoking cessation & vaping.
- The efficacy of online GP consultations (including how the disconnect between the public and the medical profession could be addressed, how the public could be reassured that outcomes would be equally as high as face-to-face consultations and how capacity can be improved in this way.)
- Developing technology and its role in the management of long-term chronic conditions.
- Strategic role of GP Federations.
- Vaccination initiatives tailored to specific local needs in each NCL Borough including outreach work with community pharmacies.
- Paediatric service review.
- Primary care commissioning and the monitoring of private corporations operating in this area.
- Increases in number of people being charged for services that they were previously able to access free of charge through the NHS (e.g. dentistry/ear wax syringing).
- Mental Health & Community/Voluntary Sector – In August 2024, the ICB/Mental Health Trusts provided an update on Community & Voluntary Sector contract terms. It was noted that further updates could be provided to the Committee as this area of work developed.

2025/26 Meeting Dates and Venues

- 7 July 2025 - TBC
- 8 September 2025 - TBC
- 17 November 2025 - TBC
- 26 January 2026 – TBC
- 9 March 2026 – TBC

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