



NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Fola Irikefe, Principal Scrutiny
Officer

Monday 9 March 2026, 10:00 a.m.
George Meehan House, 295 High Road
Wood Green, N22 8JZ

E-mail: fola.irikefe@haringey.gov.uk

Councillors: Philip Cohen and Paul Edwards (Barnet Council), Lorraine Revah (**Vice-Chair**) and Kemi Atolagbe (Camden Council), Chris James and Andy Milne (**Vice-Chair**) (Enfield Council), Pippa Connor (**Chair**) and Matt White (Haringey Council), Tricia Clarke and Joseph Croft (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 - 10)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 30th January 2026 as a correct record.

7. NHS 10 YEAR HEALTH PLAN AND NEIGHBOURHOOD HEALTH DELIVERY (PAGES 11 - 34)

The committee is required to consider and comment on the NHS 10 Year Plan and Neighbourhood Health Delivery and the impact on future service provision.

8. NCL & NWL ICB MERGER & CHANGE UPDATE (PAGES 35 - 50)

To provide committee members with an update on the reconfiguration of the NCL and NWL ICB merger.

9. WORK PROGRAMME

This paper provides an outline of the 2025-26 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

10. NEW ITEMS OF URGENT BUSINESS

11. DATES OF FUTURE MEETINGS

Future meeting dates will be published in the new municipal year.

Fola Irikefe, Principal Scrutiny Officer
Email: fola.irikefe@haringey.gov.uk

Fiona Alderman
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George Meehan House, 294 High Road, Wood Green, N22 8JZ

Friday, 27 February 2026

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**MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH
OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 30TH JANUARY
2026, 10.00am - 13.00pm**

IN ATTENDANCE:

Councillors Pippa Connor (Chair), Tricia Clarke, Joseph Croft, Paul Edawrds, Chris James, Andy Milne (Vice-Chair) and Matt White.

ALSO IN ATTENDANCE:

- Nic Alexander, Consultant Neonatal and Paediatric Surgeon
- Paul Allen, Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate, NCL ICB
- Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB
- Marco Inzani, Associate Director of Transformation, NCL ICB
- Fola Irikefe, Principal Scrutiny Officer
- Chloe Morales Oyarce, Head of Communications and Engagement
- Priyal Shah, Head of Communities and Inequalities, Strategy and Population Health Directorate, NCL ICB
- Professor Sue Richards, Islington Keep Our NHS Public (IKONP)
- Sophie Scott, Network Director for the North Thames Paediatric Network
- Dr Gillian Smith, Medical Director, Royal Free NHS Trust
- Anna Stewart, Director of Service Development, CYP, CAMHS, Maternity and Neonates

Attendance Online

- Councillors Kemi Atolagbe and Lorraine Revah (Vice-Chair)

FILMING AT MEETINGS

Members present were referred to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'. The Chair informed those present that the meeting was being recorded for the purpose of accuracy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Joseph Croft and Matt White.

URGENT BUSINESS

None.

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.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The committee received a deputation from Professor Sue Richards of Islington Keep Our NHS Public (IKONP) on the use of Palantir Technologies in the NHS. IKONP raised their concerns and briefed that Palantir was a Federated Data Platform and the main objective of the contract with the NHS was to unify patient records from multiple sources. Professor Richards acknowledged that there is general agreement to centralize and link patient data, however, there is also growing recognition that Palantir may not be suitable due to the following concerns:

- quality –some NHS trusts and data analysts have queried the functionality of Palantir’s platform, saying that it is not as good as the bespoke systems they have developed.
- Vendor lock-in - Palantir retains all the IP rights to the systems it installs, limiting the NHS's future flexibility and innovation from a wider competitive market.

- There are questions about the ethics of the other data analysis roles carried out by Palantir.
- There are also questions about how patient data may be used.

The committee were informed that there are several hospitals and Trusts that are deferring the use of Palantir products as well as the British Medical Association who voted to lobby against the continued introduction of Palantir’s software into health data systems, and to terminate existing contracts. IKONP requested for the NCL JHOSC to flag up concerns and pick it up with local trusts and hospitals and review the incorporation of Palantir.

The Chair thanked IKONP and opened the committee to ask questions:

Councillor White expressed that he would like the committee to take a stand as this also fits with the wider issue and increasing use of global financial institutions in the NHS. Investors are looking for a return and their interests may not be focussed on the public.

Councillor Clarke expressed that it was good news that some ICB’s are resisting and holding out and that at the very least, those who have signed up to a seven-year contract, shouldn’t renew but she would like further direction about what IKONP would like the NCL JHOSC to do. Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB informed the committee that she would follow up with ICB colleague who works on digital services.

ACTION: That the JHOSC ask for an update with information as to why some of our hospitals are reluctant to sign up with Palantir. It will be important to have clear evidence regarding their concerns in order to make an informed recommendation.

Minutes of the meeting held on 21st November

The Chair commented that the actions needed to be put in bold.

Councillor Clarke expressed that when she discussed the misuse of data at the previous meeting in reference to Palantir in particular, their name wasn’t highlighted and she is content with it being noted now.

Winter Planning Update, the Chair emphasised that making sure people caring for others are ok and being supported representatives to carry out an audit around support for carers taking on more than they would have done in the past. **ACTION.**

NCL Inequalities Fund

Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB gave an overview of the impact and what has been achieved through the Inequalities Fund. The Director of Strategy, Communities and Inequalities explained it was the third year of the Inequalities Fund being used to address underlying need as well as prevention. The committee were briefed that the fund was allocated based on deprivation and the Trust were aware of the intersectionality of inequality and it's not always geographical. The Director of Strategy, Communities and Inequalities informed the committee that deprivation is growing in NCL as 28% of inhabitants are now in the most deprived bracket so they aim to work with communities, developing partnerships with them for insight, backed by evidence for oversight.

The committee heard that they have used various methods for evaluation including qualitative and quantitative analysis and with every pound invested, there is a return of £1.47. Priyal Shah, Head of Communities and Inequalities, Strategy and Population Health Directorate, NCL ICB provided an oversight of the developments and the multi-dimensional review carried out to look at the outcomes and there have been improvements including mental health and wellbeing support projects with positive outcomes for children and young people in Islington, Haringey and Enfield. These interventions have also seen an improvement in terms of educational attainment and school exclusion for this cohort of children.

Smoking cessation, 25% reduction in a community in Enfield where smoking is entrenched. The other benefit of the fund is the reach that it has and the community capacity building. In Camden, up to 50 mental health champions amongst the Somali and Bengali communities have been trained, improving the mental health and wellbeing of the individuals and assisting them to support their communities. Outreach in Enfield has led to improved health checks and GP registration. The committee were briefed that GP registration means that access to healthcare means improvements to health. In terms of economic evaluation, this has shown a net saving of £1.7 million. There as also been a 25% reduction in hospital admissions for those over fifty years old in deprived areas as a result of the inequalities fund.

The Head of Communities and Inequalities, Strategy and Population Health Directorate explained they they would continue to work on improving how they demonstrate impact, working with UCL. New data on deprivation means they will be thinking more about how they will allocate funding in future for smoother commissioning especially when working with the voluntary sector. The next steps for them will focus on developing neighbourhoods for the Neighbourhood Health Plans.

Councillor Clarke expressed that she was unhappy with the re-allocation of funds-based indices of deprivation 2025, as although less deprived than other boroughs overall, Islington has on of the highest rates of child deprivation. It was felt that Islington is being disadvantaged for a small improvement in deprivation across the board and enquired what the new approach to allocation will mean for Islington? The

Director of Strategy, Communities and Inequalities responded that the Indices of deprivation looked at not just rates of poverty but also volume so it has to be proportionate. Haringey and Enfield had greater volume of deprivation and funds were allocated based on data regarding and where they will have the greatest impact. It was reported that other ways and sources of funding for example smoking cessation schemes will still be funded through other means. **ACTION:** provide information on what the implications of what the figures will mean for Islington.

Councillor Edwards enquired about the impact on pockets of deprivation in a borough like Barnet which is seen to be more affluent overall. The Director of Strategy, Communities and Inequalities explained that Barnet will now be given a proportion of the Inequalities Fund due to the increase in pockets of deprivation and they have always received some due to this.

Paul Allen, Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate added that there was a finite budget as deprivation has gone up all round but they are now allocating the fund in a different way now. They are required to follow the patterns within NCL, across the board there has been a growth in the 10% most deprived and there has also been a growth in the number of those in deep poverty. The Chair expressed that it would be interesting for the committee to have a look at the Rowntree report which they were informed about and in particular get a better understanding of the pockets of poverty that is deepening. **ACTION.**

Councillor White enquired if the programmes in place for people diagnosed with Type 2 diabetes requiring less intensive treatment and managed through GP that is prevalent amongst certain demographics often also facing structural inequalities will actually be impacted by the limited amount of funding given to address the issues, what impact will it have in managing Type 2 diabetes? The committee heard about the Haringey diabetes project which is amongst the intervention projects working well. They are working with primary care to look at targets and intervention methods. Education and self-management support with information in different languages to help people better understand their condition is also a part of the approach as explained by the Head of Communities and Inequalities.

Councillor White felt that it was important to push the narrative regarding education and understanding of how diabetes works, not just in terms of health outcomes but also financial benefits for the NHS further down the road e.g. prevention and education now will mean people won't need an organ transplant.

The Director of Strategy, Communities and Inequalities informed the committee that aside from their internal evaluation, they have partnered with Imperial University to carry out an economic evaluation of the Inequalities Fund. The Chair requested that the economic evaluation information should be provided to the committee. It was also recommended that the actual data with details of the financial return should be provided to the committee. In respect of the 'what to improve' section, the Chair pointed out that there is no evidence provided in the papers. **FOLLOW UP.** The Director of Strategy, Communities and Inequalities explained that as a big part of the 10 Year Plan is focussed on prevention and that is a significant premise of the

Inequalities Fund – this can be weaved into the narrative when this is presented to the committee. **FOLLOW UP.**

The Chair enquired about the Rise Project which sounded like a positive programme supporting the Somali community but having looked on their site, there was only information from 2019. The Chair enquired if there was an expectation for the projects to have fully functioning sites as she was concerned that should people seek to access support; information was out of date. The officer expressed that the organisations are hitting their targets when speaking to the various organisations and they can provide the information and evidence. The Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate explained that monitoring is at borough level and an annual review of the projects are carried out. The Chair re-iterated that she felt that platforms such as organisations website was the first port of call for people seeking support and so should have information and evidence that a project is ongoing. **RECOMMENDATION.**

To summarise the discussions, the Chair expressed that there are still concerns that the analytic data with the evidence isn't evident in the papers and a future report should contain this. The next update should include this and also the next steps. The committee should also have site of the work being carried out with Imperial University. **ACTION.**

North Middlesex and Royal Free Merger Update

Dr Gillian Smith, Medical Director, Royal Free NHS Trust gave an overview of the North Middlesex Hospital and Royal Free Hospital merger which took place just over a year ago. The Medical Director, Royal Free NHS Trust briefed that there had been improved performance against the NHS matrix e.g. waiting times to be seen, time taken to be diagnosed and treated for cancer patients and this has been done against the challenge of pressures on NHS waiting times. NHS England have carried out a formal review of the merger process and the improvements have been noted. Where challenges remain is the impact of the merger on staff as opposed to patients.

Councillor Croft enquired over what the impact has been on staff one year on. The Medical Director, Royal Free NHS Trust explained that there hasn't been much change in terms of sickness and attendance but there has been less responsiveness to the staff survey, with the management structure changes and changes to the clinical operating model some anxieties have also been expressed by staff. There has been less efficiency in harmonising uniforms and they were working on this with clinical colleagues putting forward suggestions for improvement.

RECOMMENDATION: The Chair recommended that information and data around staff survey should be provided for the committee to carry out proper scrutiny of the impact of the merger.

Councillor James enquired about the A&E waiting times which stated they are down to four hours but anecdotally the wait at Barnet Hospital was up to 15 hours. The committee heard that all acute hospital sites had seen sustained improvements on average for their wait times. However, there are some people waiting longer and a significant number waiting more than 12 hours, and sometimes its people that need

to be admitted and with complex needs the Medical Director, Royal Free NHS Trust reported. It was also confirmed that this is in line with everywhere nationwide. In terms of national performance, the Trust is in the top quartile for waiting times.

In respect of record keeping and being able to access record from North Middlesex, Barnet and Royal Free, Councillor James was interested in knowing how it was panning out. Clinicians can access records across all three sites including remotely and the objective is to get onto a single electronic patient record for the combined organisation and they need to work through how that will be funded.

Councillor Milne enquired if there were staff issues in terms of one organisation viewing the other as having taken over. The Medical Director, Royal Free NHS Trust expressed that there has not been a perception of a takeover, just recognition that they would be better together to support the local populations. Along with this, each hospital site is run by its own executive team to ensure they still retain a unique profile and some individuality to work effectively locally.

The Chair followed on from Councillor Milnes point expressing that the wording in the paper, describing the North Middlesex as becoming a 'health unit' gives the perception that it is no longer a hospital. In respect of A&E timings and the fact that corridor care is a rising concern, it would be useful to know where people are experiencing it across the three hospitals in future reporting. **ACTION.**

The Chair enquired about the financial information presented which wasn't very clear. The Medical Director, Royal Free NHS Trust reported that the projected transactional benefit of the merger and the integration of the corporate structures had led to a £5.3 million saving to date. For the period 2025/26, as an organisation they had a deficit plan amounting to 88.5 million in terms of the underlying position and a financial plan targeted at £125 million with pre-existing debt. The Chair enquired about the pre-existing years impact debt to which it was clarified that both organisations entered the partnership in debt but there could be financial benefits delivered through measures such as a single electronic patient record.

The Chair sought further clarity about the savings plan for the organisation in its entirety and enquired where exactly will the savings be made and will there be impacts on particular sites and what does the impact of the merger really mean for patients. Councillor White agreed and added that it would be helpful to understand what makes up the deficit, what it is, what is causing it, is it structural and can it be addressed through the savings programme.

It was heard that efficiency plans, won't result in services being closed and key local services will continue to be run. North Middlesex efficiency target is less had they remained a stand-alone organisation. The enlarged organisation has allowed them to put more money into the urgent and emergency care infrastructure

The Chair expressed that greater financial clarity would help support better understanding for the committee in future. **RECOMMENDATION.** Further update to clarify the financial position and the questions raised. Councillor Croft enquired over how they are able to demonstrate the sharing of expertise and strengthening

leadership though the merger? It was heard that it will be measured through patient outcomes, experience, safety and performance.

In respect of the deputation earlier on Palantir system, the Chair expressed that the papers detail Royal Free as signed up but not having started yet and for North Middlesex it is listed as not using but under pressure to start. The committee will be following up on this element during discussions when considering the 10 Year Plan the Chair informed. **FOLLOW UP.**

The Chair enquired further about the new mental health A&E unit at Chase Farm which they learnt is yet to open and work continues with the ICB and with North London Partnership Foundation NHS Trust. The chair requested information regarding how many people it would cater for, the reach and the impact on other crisis units. Also, regarding the maternity service, the Chair sought re-assurance on the level of care we can provide as the maternity service has simply moved from 'inadequate' to 'requiring some improvement' and so a written update on how that is being addressed should be provided. **FOLLOW UP.**

Paediatric Services Review Update

Anna Stewart, Director of Service Development, CYP, CAMHS, Maternity and Neonates briefed that the commissioning approval for the changes to paediatric surgery was made September 2025 and they are now looking into the implementation with colleagues from the North Thames Paediatric Network. In respect of emergency surgery and planned care, the committee heard that they are focussing on under 3's and under 5s as the skills needed by anaesthetists and surgeons for very young children of this cohort is very specialist. The care for children over five will continue to be provided locally.

The case for change is around elective care and there are long waiting lists as with the rest of the country, there are skills shortages and issues with retention and recruitment. National recommendations for paediatric care in terms of paediatric surgery includes separate recovery areas and child friendly spaces. For emergency care, for NCL children the tertiary centre is at GOSH but there is no A&E so quick access for children at this stage can be difficult. Extensive consultation was carried out and presented to both the JHOSC and individual HOSC's regarding the initial set of proposals for enhancing the facilities at GOSH for an extra receiving centre and extra beds. Consultation and feedback from clinicians meant that they realised it wasn't ideal for the enhanced entryway to be at GOSH.

During the summer 2025, further engagement was carried out with staff and patient groups to develop a model and how to work with other specialist hospitals such as Royal London and Chelsea and Westminster to help manage the care pathway. For emergency care they will be partnering with Chelsea and Westminster, St Mary's and the Royal London. UCL will also take on the day cases for very young children in NCL. It was reported that there are no changes to the specialist pathways including cardiac care and neurological conditions. They will be setting up a paediatric referral hub and a 24-hour emergency call line to match specialist service with clinicians.

The Chair enquired that should parents at GOSH have concerns to raise about treatment – there were provision to support them. Assurance was provided that parents can raise concerns as a whole and should they want a second opinion they're concerns will be taken forward. Nic Alexander, Consultant Neonatal and Paediatric Surgeon, St Mary's explained that they will be building in parent and patient feedback throughout the process. The committee heard about the Marthas rule hotline (an initiative in England allowing patients and their loved ones to request independent clinical if their conditions aren't improving or concerns not being addressed) which will be advertised.

Following an enquiry about who has signed up to Martha's rule, the panel heard that all tertiary centres have signed up to Martha's rule and Hillington Hospital is the only hospital that hasn't. **ACTION:** feedback on progress of Marthas rule, how feedback is collected and assurance around paediatric services and how improvements are being made.

Councillor Clarke enquired whether Chelsea and Westminster and St Mary's were part of the new merged footprint and enquired how we would scrutinise them in the future. The Director of Service Development, CYP, CAMHS, Maternity and Neonates confirmed that this was something we would have to consider as it covers a wider space although the changes pre-date the merger.

The Chair enquired about where they felt the risks were and what is being done to mitigate them. The Director of Service Development, CYP, CAMHS, Maternity and Neonates confirmed that there are inherent risks in terms of delays, financial risks, set up of referral hub, clinical engagement and 'buy in' so when the hub is up and running there may be further issues that may come up.

The Associate Director of Transformation expressed that with any change there is a risk and to mitigate risk they ensure thorough data collation and the system is already operating informally. The Chair enquired if there has been push back from clinicians because specialist centres will have an impact on specialist staff at hospitals. The committee were briefed that they will keep the same skills and competencies in district general hospitals as they will continue to treat the over 5's. There is a skills gap nationwide of surgeons for the under 3's.

Councillor James enquired about transport costs if parents arrive at North Middlesex and they then must go to St Marys. It was heard that in this instance there is usually ambulance transfer, but should a child be admitted parents can be supported by re-imburement. It was suggested that once a child is admitted, a questionnaire should be prompted to ask parents how they get to hospitals as travel costs can be an added strain for parents and there should be an easy system put in place to go about getting re-imbursed. **RECCOMENDATION.**

Councillor White asked about the algorithm for deciding where cases are sent and what happens when there are changes. The committee heard that everything is data driven to put children in the right place, but the system is pliable to changes. The Chair expressed that a future update should provide information on the 'enablers' and information on how data is working to support services and an overview of the

finances, any risks and the communication and engagement regarding how things are progressing. **FOLLOW UP.**

NCL JHOSC Terms of Reference

The Chair requested that the committee agree the final terms of reference presented which stipulated that once JHOSC support, currently provided by Haringey has done six months in post, supporting the next officer where the Chair is from, following that the other officer will fully manage the JHOSC meetings and work programme. The chair explained that a commitment from all authorities of the JHOSC to contribute to the post was not agreed and so this proposal was the next bet option.

The chair recommended that once the Chair has been appointed in the new municipal year, the terms of reference should be re-visited in the new municipal year.

Councillor White expressed his strong disappointment that there wasn't a commitment to contribute to the support officer post whilst local authorities still attend the meetings. All members re-iterated the disappointment. The Chair also stressed the importance of the JHOSC given that Healthwatch would become an internal organisation within the NHS. The Chair highlighted that once the new chair is appointed, the level of work involved will become apparent and a resolution will need to be found.

Councillor White suggested that it is agreed with a clear point that the rotating officer is not likely not to work and that officers should be permanent and all boroughs contribute in the future. The Chair recommended that the officer should ideally be from the same authority as the chair to make the support more seamless.

RECOMMENDATION.

The committee agreed that they would send a formal letter to their Chief Executives and finance officers with all the signatures of the whole committee. Councillor Milne suggested that the joint letter with everyone's signature should be sent by members of the JHOSC from themselves individually. **ACTION.** Following the new municipal year, the letter that goes out should emphasise the statutory role of JHOSC and Healthwatch becoming an internal organisation within the NHS.

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North Central London
Health and Care
Integrated Care System



JHOSC

NHS 10 Year Health Plan and
Neighbourhood Health Delivery
March 2026





National NHS 10 Year Health Plan: context

- The Government have said the health and care system needs to modernise and evolve to better meet people's needs.
- We have an ageing population, and a population that is living more years in poor health.
- We also have significant demand for unmet social need, and we don't always have the right services to support people.



The NHS 10 Year Health Plan - The ‘three shifts’

- **From hospital to community;** better care, closer to home, including neighbourhood health, better dental care, quicker specialist referrals, convenient prescriptions, improved community mental health support.
- **From analogue to digital;** creating a better experience through digital innovation, with a unified patient record eliminating repetition, self-referrals via the NHS App, and improved online booking for equitable NHS access.
- **From sickness to prevention;** shifting to preventative healthcare by making healthy choices easier and supporting people before they get sick.





What local people said



Change NHS was a national consultation launched by the government in October 2024 to help inform the development of the NHS 10-Year Plan. Between **January and February 2025**, we held five engagement (two online sessions and three in-person), bringing together over **150** residents from across North Central London.

Care from hospitals to communities

- Moving care closer to home can be beneficial but must meet diverse needs.
- Residents need clear points of contact for any issues.
- Services must be well-supported, staffed, visible, inclusive, and responsive.
- Carers and families should be informed and involved.
- Recruiting and retaining community-based staff remains a key concern.

Making better use of technology

- Technology can enhance care but shouldn't replace human interaction.
- Offline options must always be available.
- AI can support some tasks but should be used wisely.
- A shared patient record with easy patient access is essential.
- E-consult systems need to be more user-friendly.

Focusing on preventing ill health

- Prevention should be a priority
- Health education is vital across all age groups.
- The NHS must provide timely support when needed.
- Collaboration with families and communities is essential.



North Central London
Health and Care
Integrated Care System

Community conversations

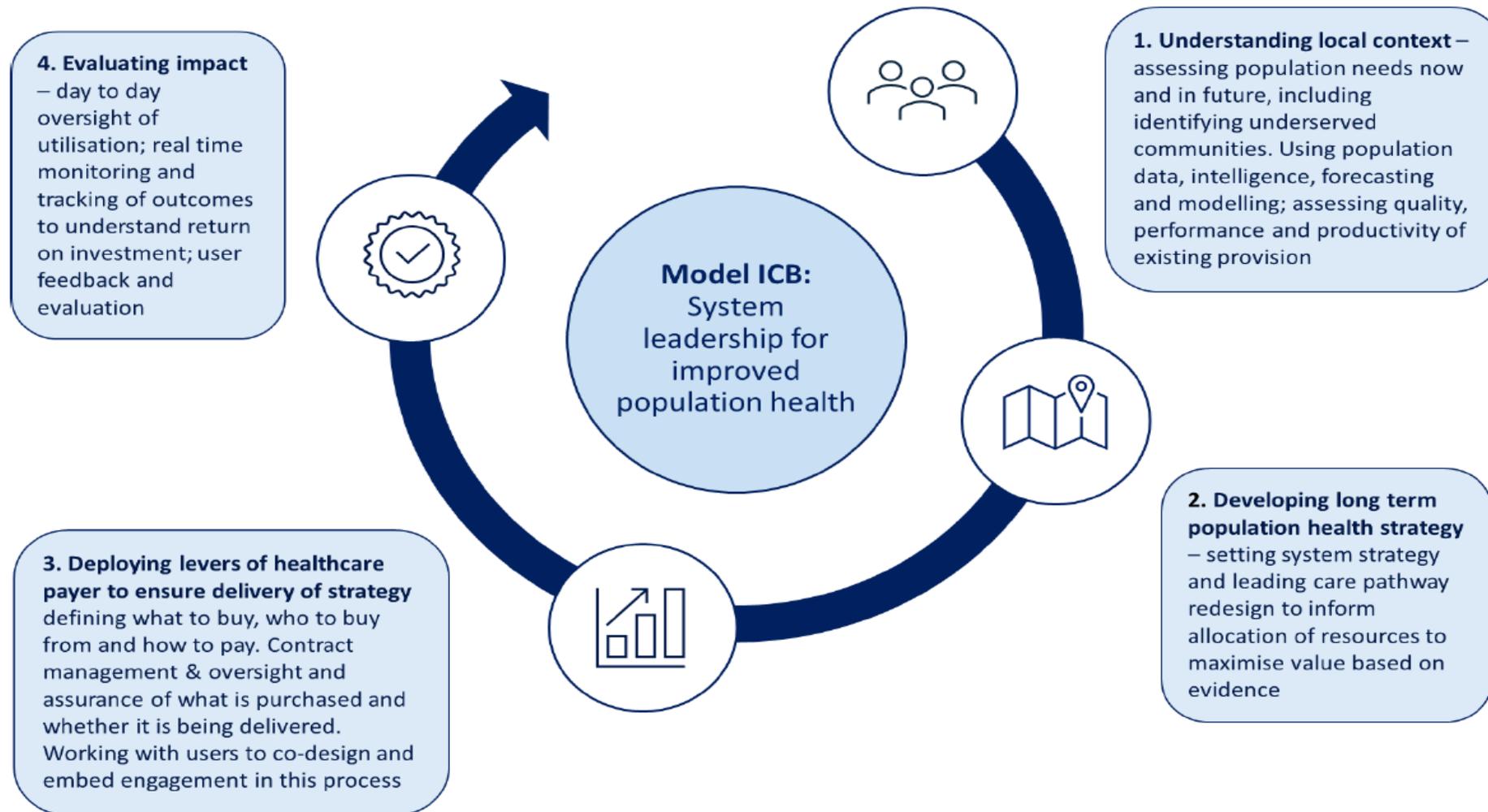


- Following the Change NHS conversations in 2024/25 we wanted to keep talking to local people about the 10 Year Plan and neighbourhood health.
- We've reached out to groups who may find it harder to influence us, from specific age groups, ethnic groups, orientations etc.
- We partnered with local VCSE to deliver conversations where residents are.
- Feedback to date has included:
- **Ensuring resources genuinely follow need, including prevention and VCSE:** Residents repeatedly worried that shifting care to communities would not be matched with funding, leaving VCSE groups asked to do more without support
- **Supporting staff across health, social care, VCSE and recognising unpaid carers:** Migrant, neurodivergent, LGBTQ+, and older adult groups all highlighted gaps in GP, mental health, and social care training and warned that without proper staffing and skills, carers (mostly women) would absorb the extra burden.
- **Clear, consistent communication so residents understand what neighbourhood care offers:** Across nearly every group, people said they were confused about who provides what and had often not seen local communication campaigns.
- **Using data intelligently while not losing nuance or lived experience:** Neurodivergent residents stressed that data-led pathways often overlook the reality of fluctuating needs, sensory barriers, and communication differences that never show in datasets.





The 'Model ICB'





How we're implementing the 10 Year Plan

- From digital to analogue – data improvements
- From sickness to prevention – neighbourhood health
- From hospital to community – virtual wards and self management



From digital to analogue: Digital improvements

We are working with other ICS areas across London to make improvements to our use of digital technology and to bring health and care information together for better patient care, planning and research to help communities stay healthy.

London Care Record

- The London Care Record is a secure view of a patient's health and care information over time across different parts of the NHS and social care.
- It lets health and care professionals involved in patient care see important health information at the point of care wherever they are in London and some neighbouring areas.
- This helps patients get the best possible joined-up care as safely and quickly as possible, instead of having to tell their story over and over again.

London Secure Data Environment

- In London we have a new Secure Data Environment which securely bringing Londoners' health and care information together. [London Secure Data Environment](#)
- The SDE keeps patient data safe, using the highest safety standards. Data is encrypted, meeting NHS and social care standards. to ensure information is protected and more secure than ever.
- You also have the right to choose how your information is used to benefit you and others. You can find out more about [how your data is protected and your rights](#)



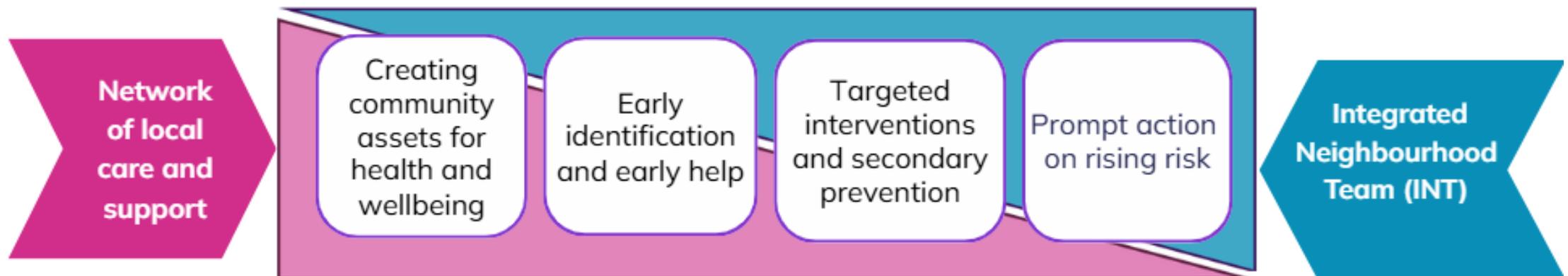
Using data to improve the health of residents

- We will use data to **better understand who in our communities are at the greatest risk**, and have the greatest health needs. This will feed into neighbourhood model, identifying who needs to be helped by Integrated Neighbourhood Teams (INTs) at any given moment.
- **Data will be enable us to help us to diagnose people earlier** and offer proactive treatment, rather than treating people at crisis point
- **We can reduce health inequalities** by better understanding why some communities experience poorer health outcomes than others, and direct resources and investment to those areas
- **Better and more efficient insights through the London Secure Data Environment (SDE) will allow us to track access, experience and outcomes** in a more consistent way, using what we learn to adapt our approaches.



From sickness to prevention: neighbourhood health

- Organising care at neighbourhood level will enable more coordinated, proactive support and better outcomes.
- Dedicated multidisciplinary Integrated Neighbourhood Teams (INTs) will work alongside existing local health and care services to improve access, experience and outcomes for people and families with the most complex needs, particularly those who can otherwise become stuck navigating gaps between services.
- These teams will not replace the role of a person's GP, but will strengthen continuity and coordination around individuals and communities.





From sickness to prevention: long-term conditions focus

- **The new role of strategic commissioner allows us better support those who have long-term conditions.**
- **Support available for long-term conditions:** We will strengthen the support available to people with long-term conditions, and identify people earlier and provide proactive, ongoing support before problems escalate. This includes better routine monitoring, earlier intervention when someone's health starts to deteriorate, and more consistent follow-up to prevent avoidable crises and hospital admissions.
- **Better self management will be a core part of long-term conditions services:** including education, health coaching, peer support and community-based approaches. This will help people understand their condition, recognise early warning signs, and access the right support at the right time, preventing deterioration and loss of independence.



Example prevention outcomes



Proactive identification and prevention

- ↑ Early community diagnoses
- ↑ Community diagnostic capacity
- ↑ Vaccination and screening
- ↓ Late-stage acute diagnoses
- ↓ Preventable disease progression



Coordinated care

- ↑ People with named care coordinator
- ↑ Single holistic assessments completed
- ↑ Shared care plans
- ↓ Fragmentation / duplication
- ↓ DNAs / cancelled appointments



Long Term Conditions management

- ↑ Patient / resident involvement
- ↑ Confidence in self-management
- ↑ Clinical target achievement
- ↓ Condition-specific complications
- ↓ Unnecessary outpatient appt.



Sustainable and effective workforce

- ↑ Staff satisfaction and wellbeing
- ↑ Time on direct patient care
- ↑ Workforce retention
- ↓ Staff burnout and sickness absence
- ↓ Vacancies



Preventing crises

- ↑ Community-based crisis response
- ↓ Non-elective admissions
- ↓ A&E attendances
- ↓ Care home admission



Equity, access and community connection

- ↑ Inclusion health group engagement
- ↑ VCSE referrals and community asset use
- ↑ Economic outcomes for working age
- ↓ Health inequalities/unwarranted variation
- ↓ Social isolation and loneliness





From hospital to empowering communities

"Health is your right as well as your responsibility. People need to be empowered and supported more to take control of their own health and have the confidence to access the right services for them"

"Establishing and building relationships is key to meaningfully engaging with communities. Needs to be organic and takes time."

"My husband was picked up by their GP practice as being pre-Diabetic. They then went to a community venue where there was peer support, people could learn from each other and clinical people about diet and exercise and how to reduce the risk of Diabetes. We know it worked because his blood test results improved and risk went down."

"My wife had a gym referral and then discounted membership. We knew it worked because she got fitter. She could walk into the high street without getting out of breath, which was important to her"

"The way local health centres work is really improving. The opening hours are more flexible and they can refer you to other larger, local centres so you don't need to go to hospital and into voluntary sector organisations so you get a wider range of support."

Thoughts on
Neighbourhood Health
from our Community
Advisory Group, October
2025



Empowering people to take be involved in their health and wellbeing

- Evidence shows that **people who are more involved in their care have 18% fewer GP contacts and 38% fewer emergency admissions** than those with the lowest levels of engagement (North West London).
- Empowering people to take control of their care is about building confidence, trust and understanding, not just using digital tools. Many **people want to manage their health better but need the right support, information and relationships to do so.**

We will support people to take action earlier by:

- Running clear, accessible campaigns about **how residents can look after their health**
- Offering **better practical self-management support** for people living with long-term conditions.
- **Working with community organisations**, and empowering them to build community assets to better support residents
- Encouraging **face to face outreach, community settings and local networks** to reach people who may not engage with traditional services.



Integrators

- Integrators are a key part driving Neighbourhood Health forward.
- As part of the Integrator criteria, they have been asked to create plans to engage with residents and the voluntary sector. The VCSE alliance in North Central London recently met with integrators in all NCL boroughs to discuss how to better involve the VCSE at the earliest stage.
- **Integrators are not replacements for existing Borough Partnerships, and report into Borough Partnerships.**

Borough	Integrators
Camden	Camden GP Fed and UCLH
Islington	Islington Council, Whittington Health, UCLH and Islington GP Federation
Barnet	CLCH and Barnet GP Federation
Haringey	Haringey Council, Haringey GP Federation and Whittington Health
Enfield	Royal Free Trust and North Mid and Enfield GP Federation



Community Advisory Group engagement

Last year we formed a Community Advisory Group (a group made up of residents and VCSE orgs from NCL's five boroughs) to engage residents and community groups on NCL's approach to neighbourhood health.

As a result of engagement and feedback from the Community Advisory Group:

- The Model Outcomes Framework is more focused on community and resident experience
- We developed videos to show local examples of neighbourhood health (see slide 18).
- We have strengthened pillars '1 and 2' in our neighbourhood approach, to better incorporate more holistic support e.g. gyms, youth clubs, social prescribing and more.
- We are refreshing our VCSE commissioning approach to prepare for neighbourhood health commissioning.



Test bed site for neighbourhood health

- Haringey is being used as a test borough to accelerate the pace of delivery of neighbourhood health services.
- This means they will trial new approaches to local healthcare, so that we can quickly learn what works well (and what doesn't) before other boroughs adopt similar methods. This work will begin during Q1 and move at pace.
- Haringey is in a strong position to take on this work. It has a mix of strong relationships, structures and community assets in its neighbourhoods programme already so can accelerate this approach at pace. In particular, the well-established MACC team already brings together partners across health, council and the voluntary sector, with several years of positive outcomes.
- **Every borough will continue progressing its own neighbourhood plans in parallel.** Our role as a strategic commissioner will be to share learning across all 13 boroughs, to ensure everyone benefits from work happening in different areas across different cohorts.



Local delivery: What's happening in each borough

We have produced a video in each of the boroughs across North Central London to highlight what fantastic work is already underway. As we move forwards, we

See the links to these here:

- **Enfield's Health Hearts Service:**
<https://www.youtube.com/watch?v=myKlumg2BZI>
- **Enfield's Ageing Well Service:**
https://www.youtube.com/watch?v=QzFkBi_36JA
- **Haringey's MACCT service**
<https://www.youtube.com/watch?v=jmBOrylRxe0>
- **Islington's Integrated Care Teams:**
<https://www.youtube.com/watch?v=O4t2NQpHnow&pp=ygUbY2FtZGVulG5laWdoYm91cmhvb2QgaGVhbHRo>
- **Camden's Kentish Town centre:**
<https://nclhealthandcare.org.uk/news/health-secretary-visits-james-wigg-practice-to-see-neighbourhood-working-in-action-2/>



Enfield's Healthy Hearts service – Neighbourhood Health in action (medium edit)



Local delivery: mental health integrated working

- In Haringey, we have just launched a pioneering **multi-purpose neighbourhood mental health centre** named in honour of Roger Sylvester - who tragically lost his life in 1999.
- The disused building has been transformed into a **hub for integrated mental health support, bringing together vital services from the council, NHS, and voluntary sector under one roof.**
- The co-located model reduces fragmentation and improves access to care by enabling professionals to work collaboratively around the needs of individuals.



[Watch more here:](https://www.youtube.com/watch?v=af4zw7E2Dfk)

<https://www.youtube.com/watch?v=af4zw7E2Dfk>



West and North London approach

- We will be moving into a newly merged Integrated Care Board on the 1 April and as part of this we are operating in a changing health and care context.
- We spend around £12 billion a year on health and care across West and North London (WNL), for a population of approximately 4.5m people
- Most of this money is currently used when people are already unwell, in hospitals and crisis services. While this has helped manage short-term pressures over the years, it is not delivering fair outcomes and is unsustainable, with rising acute spend and increasing demand. We have an opportunity to change this.
- At our core, NHS West and North London will have a focus on reducing health inequalities. This is both a moral imperative and a practical necessity, and it is also the way we create the capacity for everyone.
- We have already been working with colleagues in North West London to work together to align our approach to neighbourhood health, learning from the experiences and approaches of both systems.



North Central London
Health and Care
Integrated Care System



Appendices



National Federated Data Platform

The national NHS Federated Data Platform connects vital health information across the NHS, helping staff deliver better care for patients and work more efficiently. A connected NHS will allow teams to deliver their services seamlessly with patients at the heart.

The NHS Federated Data Platform safely connects information across the NHS, making it easier for staff and clinicians to do their jobs. Already funded and established it's designed to turn insight to action.

Benefits will be:

- Quicker access to critical insights
- More coordinated care
- Enhanced productivity
- Improved patient outcomes



National Federated Data Platform

Find out more...

- An [animation which simply explains NHS FDP](#) and the impact on patients.
- This [animation describes the benefits](#) being realised by NHS Trusts in England that are currently using the NHS Federated Data Platform.
- This [Privacy and Security animation](#) that explains how the NHS FDP keeps information safe and secure.



North Central London
Health and Care
Integrated Care System



Thank you

ICB Change Update

JHOSC 2026

A recap of the changes to ICBs

- In March 2025, ICBs were asked to reduce running costs by around 50% (an operating budget now set at £19.00 per head of population) and shift to a **new role as strategic commissioner**.
- In July, the Boards of NCL and NWL ICBs agreed that the two organisations should merge. This process is now underway and we will **legally merge** on 1 April 2026, forming a new organisation, **West and North London ICB**.
- It is important to note that to meet these nationally set cost reductions, we will have to make substantial changes to how we operate and how we work with partners, as we reset relationships and priorities in the new organisation.
- We are committed to **keeping our partners informed** and communicating as far as possible as we develop our new operating model.

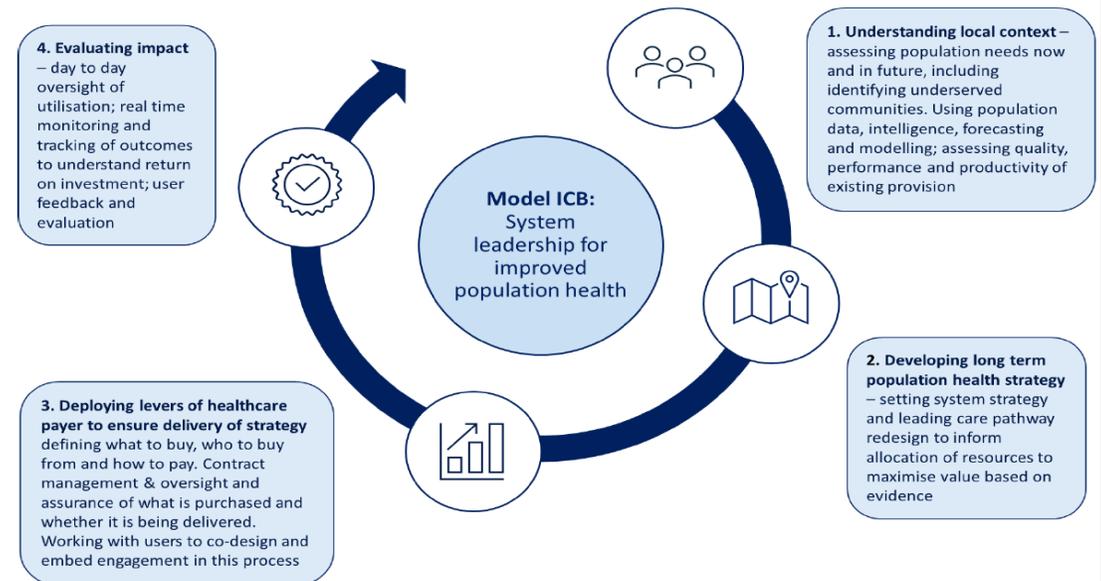
'Model ICB' blueprint

Purpose

- Reinforcing the role of ICBs as strategic commissioners
- Moving away from clinical delivery and provider management

Core functions and activities

1. Understanding local context
2. Developing population health strategy
3. Delivering the strategy through payer and commissioning functions and resource allocation
4. Evaluating impact
5. Governance and core statutory functions
6. The model also presumes each ICB will also continue to need a set of enabling functions



The challenge and the opportunity

- Across West and North London, **we spend around £12 billion a year** on health and care for a population of approximately 4.5m people.
- **Most of this money is currently used in hospitals and crisis services.** This has been important to manage hospital demand, and short-term pressures over the years, but it is not delivering fair outcomes. It is unsustainable, with rising acute spend and increasing demand.
- **Life chances across West and North London are not equal. There is a 17 year variation in healthy life expectancy across neighbourhoods,** with people in our most deprived communities experiencing significantly poorer outcomes.
- **As a newly formed ICB we have the opportunity to truly reshape where investment goes.** By proactively looking after those with greater need, we can make it easier for everyone to access urgent care when they need it.

Setting up a new organisation

- **Katie Fisher has now joined as our interim CEO for nine months** with a focus on supporting the two ICBs through merger and the launch of the new organisation.
- There is still a lot of work to do before merger, including extensive NHS England assurance and starting the process to recruit a permanent CEO.
- There is huge complexity in the practicalities of bringing two organisations, with distinct cultures and ways of doing things, together and we want to make sure we are designing ways of working that sets WNL ICB up for success.
- On 1 April we will ensure that the foundations are in place to support our staff, and meet our statutory obligations, with clear points of contact for key services.

Our priorities and future strategy

As we move into being West and North London ICB across 13 boroughs, we will be shaping our future strategy to focus our priorities for the new organisation. We aim to have this process complete by Summer and will be involving stakeholders at key points.

We will be considering key areas as part of our strategy, including:

1. Reducing inequalities
2. Investing strategically to prevent ill health
3. Better supporting people with the greatest needs, so everyone stays well
4. Make care more local and easier to access
5. Empowered local people that feel more confident about their health and wellbeing

Why we are here

To strategically commission healthcare services that improve the health and lives of West and North London residents, both now and in the future

How we add value



Understand the needs of our population

- Using data and engagement to understand population need and preferences
- Population segmentation and risk stratification
- Identification of health inequalities



Make decisions on how to best meet their needs with the money we have

- Resource allocation
- Deciding what services to commission
- Commissioning for health equity
- Evaluating impact and value



Shape the provision of healthcare services

- Driving transformation and innovation in healthcare delivery
- Shaping the provider market and encouraging supply
- Holding providers to account for the delivery of high-quality services



Where we fit



ICB

- Commission local and delegated healthcare services for our population
- Convene the system to ensure aligned strategic direction and an integrated plan
- Shape the provider market
- Ensure providers deliver high-quality services in line with their contracts
- Work with partners to address the wider determinants of health and to secure innovation



Providers

- Deliver high-quality healthcare services to the population – including hospitals, GPs, community providers, and mental health services
- Working closely in partnership with each other to ensure services are integrated and to address operational challenges
- Drive innovation and transformation to improve quality, access and productivity



NHS England

- Set policy and direction
- Determine funding allocation
- Regulate providers and ICBs
- Directly commission some highly specialised services

Defining our changing role

What the ICB continues to hold 'tightly'

Essential for system leadership, assurance and statutory duties

- **Strategy and priorities** – System wide commissioning strategy, outcomes and population health priorities
- **Resources and frameworks** - Funding envelopes, commissioning frameworks, contracting and assurance
- **Governance and assurance** - Quality, safety, finance, decision-making and statutory accountability
- **System enablers** - data, analytics, digital, capital and estates strategy

What the ICB might hold more 'loosely'

Stops or moves to new arrangements across partners

- **Operational work** - clinical delivery, flow, escalation, discharge and winter
- **Detailed service design and tailoring** - Pathways, models and local adaptation
- **Delivery of Partnership work programmes** – local programmes and projects, delivery of system programmes, neighbourhood models and integration
- **Day to day oversight of provision** - Oversight of delivery, budget utilisation, issue resolution and operational forums
- **Convening within place** – e.g. Borough Partnerships, local forums, local operational issues

Page 43

WNL ICB Governance

- West and North London ICB Board of Members is proposed to comprise 20 voting members: the Chair, Non-Executive Members, Partner Members (local authority, Trusts/Foundation Trusts and Primary Care) and ICB Executives. Role profiles have been developed for Non-Executive and Partner Members – and the recruitment will take place in February and early March.
- A top-level committee structure has been developed – with the objective of ensuring a robust governance framework that reflects the new purpose and operating landscape for ICBs.
- Detailed work will continue to develop the full corporate governance arrangements. The new Board of Members, at its meeting on 1st April 2026, will be asked to approve the Terms of Reference of the committees that are directly accountable to the Board.

Statutory duties

- The ICB will still retain our statutory responsibility post-transfer.
- We will work to ensure we continue to work effectively with partners to maintain quality for residents
- There will need to be a reduction of ICB staff, but we have put risk assessments in place for each function and LAs will be engaged in workshops to develop services and integration with partners in the coming months

Approach to Neighbourhood Health

- Across West and North London we will have approximately **50 neighbourhoods and be serving over 4.5 million people**. These exact boundaries will be shared when they are agreed.
- **Across WNL we have now established an integrator in each of the 13 boroughs**, these are a mix of primary care organisations, councils, acute organisations and community trusts. Their role is to work in partnership with the local place to deliver neighbourhood health, whilst reporting into the Borough Partnerships.
- **To accelerate this ambition, there are some services that are moving further faster towards neighbourhood health**. These services have the foundations in place already to deliver integrated working to those with long-term conditions. These places are: Haringey, Hillingdon and the Bi-Boroughs (largely Kensington, Chelsea and Westminster). They will have a responsibility to share learning across the system to help others deliver neighbourhood health too.
- **The forming of the new organisation coupled with the commitments of the wider system provide a major opportunity to accelerate the development of the neighbourhood work** and a shift towards a providing equitable, proactive, integrated and person-centred care.

What we heard from stakeholders

Question area

What we know currently

How will place based work be reflected in the new organisation?

We remain committed to working with our local authority partners – individually and collectively – to commission, deliver against statutory duties, set local priorities via Health and Wellbeing Boards and engage with elected members. Each ICB Directorate has a role to play here.

Given the job of strategic commissioning, the scale of reductions in capacity and the further delegation of duties to ICBs from national and regional teams – we have had to compromise on some of the work we have done historically. In particular, operational support. The NHS ‘face of place’ will be increasingly provider-led.

Our new Neighbourhood Commissioning and Transformation Unit (NCTU) will connect with borough partnerships but also work across boroughs & closely with the ‘integrator’ functions.

How will clinical leadership change?

The new medical and nursing directorates will provide clinical leadership to support strategic commissioning and the government's three shifts. Clinical leadership will support innovation and transformation while ensuring we fulfil our statutory responsibilities and business priorities.

What will happen to the statutory duties?

We will retain our statutory responsibility even post-transfer. We are transferring individualised commissioning teams to a delegated provider. There will be no immediate or noticeable change for service users when these services have been delegated. The same staff will provide the service.

What we heard from stakeholders

Question area	What we know currently
Will you still be focused on reducing inequalities?	Reducing inequalities remains a strategic priority for the new organisation. We are currently shaping a strategy for the new organisation and this will remain a key priority area.
Could decentralisation increase inequalities and variation across boroughs?	We will continue to work with partners on our approach to neighbourhood health and delivery of the government's three shifts towards providing equitable, proactive, integrated and person-centred care. We'll share learning and approaches across West and North London.

Indicative timeline



