NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 27 November 2026, 10:00 a.m. Camden Council, Committee Room 1, Camden Town Hall, Judd Street, London WC1H 9JE

Contact: Fola Irikefe, Principal Scrutiny Officer

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

Councillors: Zahra Beg and Caroline Stock (Barnet Council), Larraine Revah (Chair) and Arun Kumar (Vice-Chair) (Camden Council), Alev Cazimoglu and Dino Lemonides (Enfield Council), Lucia das Neves (Vice Chair) and Anne Gray (Haringey Council), Joseph Croft and Kiran Prasad (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 - 12)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 18 September 2026 as a correct record.

7. WINTER PLANNING - NHS WEST & NORTH LONDON ICB (PAGES 13 - 24)

8. NHS WEST & NORTH LONDON ICB - FINANCE UPDATE (PAGES 25 - 34)

9. NHS WEST & NORTH LONDON ESTATES AND INFRASTRUCTURE UPDATE (PAGES 35 - 44)

10. WORK PROGRAMME (PAGES 45 - 48)

This paper provides an outline of the 2026-27 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

11. NEW ITEMS OF URGENT BUSINESS

12. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

Friday 29 January 2027

Monday 19 March 2027

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

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

Thursday, 19 November 2026

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Agenda Item 6

MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 19TH SEPTEMBER 2026, 10.00am - 13.00pm

IN ATTENDANCE:

Councillors Larrain Revah (Chair), Lucia das Neves (Vice-Chair), Arun Kumar (Vice-Chair), Alev Casimoglu, Kiran Prasad, Caroline Stock and Gill Sargeant (in place of Councillor Zahra Beg)

ALSO IN ATTENDANCE:

- Natasha Benn, Chair, Joint Partnership Board, Trustee of Disability Action Haringey
- Mary Patricia Flynn, Director of Involvement, NHS (N&WL) ICB
- Fola Irikefe, Principal Scrutiny Officer
- Chloe Morales Oyarce, Head of Communications and Engagement, West & North London (N&WL) ICB
- Sarah Morgan, Chief People Officer, West & North London (N&WL) ICB

Attendance Online

- Councillor Ann Gray
- Will Maimaris, Director of Public Health, Haringey
- Melissa Mellett, Director of Neighbourhood Transformation, NHS (N&WL) ICB
- Jo Reeder, Associate Programme Director, Camden Integrator
- Simon Wheatley, Haringey GP Federation Ltd

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 Zahra Beg and Joe Croft.

URGENT BUSINESS

None.

DECLARATIONS OF INTEREST

None.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

Nove were received.

Declarations of Interest

None were received.

Terms of Reference

WEST & NORTH LONDON STRATEGY AND INVOLVEMENT FRAMEWORK

Sarah Morgan, Chief People Officer, West & North London (N&WL) ICB briefed the committee on the strategy presented at the ICB's July 2026 public board meeting. The evidence and engagement which informed the strategy included engagement with colleagues in the health, care and voluntary sector and 160, 000 residents in NCL and NWL. There were up 800 events that took place which helped shape the 10-year strategy. The aim is to increase healthy life expectancy and for residents to live healthy lives without long term conditions and the burden of disease. The biggest determinant to health problems is educational attainment and long-term employment.

Residents have reported wanting the health service to be simpler, fairer and less fragmented with a focus on prevention. The trust in statutory services, especially with certain communities is an area where they have also identified a need for improvement.
Councillor Stock enquired what would be different in respect of outcomes. The Chief People Officer explained that across the 13 boroughs there are 13 integrators whose role is to bring together social care, Trusts and the voluntary and community sector around the 53 neighbourhoods. The objective is to develop patient reported outcome to be measured at scale. The strategy will show details between years one and three but with details of the trajectory up to year 10.

Natasha Benn, Chair, Joint Partnership Board enquired about how those experiencing loneliness and depression and people at the early stage of dementia and also those who are unable to access things online are involved in consultations. The Chief People Officer explained that rather than consultation it was engagement to help inform the strategy. The engagement carried out was the broad 10-year strategy paired with data insight and more specific engagement for certain areas will be employed going forward. Mary Patricia Flynn, Director of Involvement, NHS (N&WL) ICB explained that the conversation had been ongoing, so they have insight and have been working closely with people who have mental health and anxiety with workshops.

Councillor Prasad expressed that she understood that there had been accumulated historic data and consultation, but the involvement data would be valuable with details of the split across the boroughs as there is a difference in life expectancy across the different boroughs. **Follow up action:** to provide information of consultation and engagement across the five boroughs. The Chief People Officer explained that life expectancy is also inter-borough because there are differences within borough wards as well.

Councillor Kumar enquired about the 700 responses in the consultation and the fact that the majority were from women and older people and the fact that it wasn't representative of the population of the boroughs. He expressed that there was little representation of young people, men, LGBT groups and re-iterated that borough by

borough information would have been valuable. The Chief People Officer explained that the ICB is not a trusted partner and hence this has implications on consultation responses so there is a big reliance on voluntary and community sector organisations, faith groups and local authorities. The objective is that through the neighbourhood approach, trust in statutory services will increase.

Councillor das Neves enquired how some of the work being done connected with the early thinking coming out of the Casey Review, centred on adult social care and the danger of preventing hospital admission rather than focussing on complex issues. The councillor was keen to know how insight with local authorities and communities in respect of poverty and social exclusion was being utilised. The Chief People Officer, West & North London responded that the outcomes of the Casey Review would be particularly key in the neighbourhood model as there is Neighbourhood Health Unit Team that looks at integrated practice.

The Chief People Officer explained that part of the role of integrators is development of the workforce for local level support. In respect of utilising the incite of local government, a recent piece of work was carried out looking at young people not in education and employment looking at deprivation and bringing together data sets which has shown that deprivation levels are very much inter-borough. Some of the clear indictors includes a correlation with fewer GP practices and higher deprivation. As an outcome of this they are looking across the 13 boroughs about how to commission from a need's basis requiring an analysis of local authority data as well as health data because the details around housing challenges, educational attainment all form a part of the story.

Councillor das Neves expressed that Northumberland Park, being amongst the most deprived areas in London was clearly affected in terms of health and wellbeing and enquired how the knowledge acquired will make a difference on the ground and have an impact on planning and in resources in specific areas to make the necessary improvements for that local area. The Chief People Officer explained that the conversations have taken place and the joined-up work is something she was curious to see how it would translate as an outcome for the most deprived areas across NCL and NWL. The Chief People Officer explained that this was essentially the role of the integrators.

The committee were informed that the difference between a commissioner and strategic commissioner is commissioning on a small scale and hence they were previously unable to have an impact whereas now a percentage of money will be moved to community-based provision. £120 million a year will make a difference. In respect of social value, an example of this is Tottenham Hotspur Stadium, working with partners for the benefit of the community. Councillor das Neves sought confidence that the 1%/ the £120 million will ensure the investment is on the ground working with local organisations and local primary care networks. It was explained by the Chief People Officer that they are trying to make the changes whist also dealing with a number of people challenged to due to heat exhaustion and a growing waiting lists and balancing 18 providers, over 500 primary care providers across general practice, voluntary and community sector organisations.

The Chair enquired over what was being taken on board following all the data and incite from residents and also enquired about where the respondents were acquired from and possibly the figure of 700 people out of a population of 4.5 million could be improved. The Chair expressed that the committee could be helpful and supportive in this capacity. The Chair also enquired what could be done to balance equality. **Follow up action:** ICB to provide details of individuals they have actually engaged with. The ICB are aware that there are not enough GP practices in certain areas and in term of the strategic commissioning aspect, this is a key consideration. There are developments in this area, but it can take time to demonstrate changes in outcomes.

The Chair inquired about the areas that are urgent and whether things that can be moved forward or whether most changes be seen in three years. In response, the committee heard that for this year, the first £60 million they are commissioning immediately on some areas that they are aware don't have the right level of service including children and young people's services. In this respect, Islington is deemed as gold standard, but this is not the case in other boroughs. There is an awareness that prioritising these groups will have an immediate impact for the long term. The strategy also details six priority population groups that will be enabled. The longer-term focus is across the 13 boroughs.

The Chair enquired when feedback will be provided on the areas that will have an immediate impact. In response, the committee heard that the ICB Executive Team have considered when they will be aware they will be making a difference and will report to their board with case studies showing how they are having an impact, how it may feel different for residents and should it not feel different and impactful and improve people's lifestyle and outcomes, then there will need to be a reconsideration of how funds are allocated. The Director of Involvement explained it was too close to the feedback loop and they were aware things aren't always linear. They are trying to be open and transparent and feeding back to people through existing communication and network organisations.

Councillor Gray enquired about what could be done in respect of the quality of service of existing GPs as there is frustration when people are unable to access their GP. This can be particularly challenging for the elderly waiting on call back from GP. There is also work to be done about quality of GP services in deprived areas that are overloaded. The councillor also expressed that the quality of triage means long queues and people not being able to get through in areas of high deprivation. The issue of digitisation is also a challenge for the elderly although there have been useful sessions in libraries to support people to get on the NHS app.

The Chief People Officer explained that the quality of general practice is regularly reviewed, and a quality performance report is considered including all the GP's and includes patient surveys, patient practice groups, feedback and CQC rating. It was recognised that there is challenge in variability, looking across over the 500 GP practices. It was explained that the detail is significant and they do consider patient experience with contract renewal especially regarding how practices are meeting their vaccination rates, screening rates and long-term condition management. The ICB are on trajectory to streamline the process to better support the practices in need of improvement. The digital push is a national direction of travel but there is

work underway to ensure that people don't become isolated and there is some balance with the 'Digital First' programme.

Councillor das Neves sought clarity that despite the commitment is to 'Digital First', the three routes remained including digital, phone and in person. Melissa Mellet, Director of Neighbourhood Transformation confirmed that the three-way route was the approach, and the focus is to improve the digital approach but always with an alternative. In respect of the 1% there is a commissioning strategy for the first three years of the 10-years of the strategy and some of the elements are to address the universal gaps where the core offer in certain neighbourhoods is below par. There is also work looking at enhanced and more transformational pieces in areas in need of immediate change. The data also shows there are areas with gaps in the population with people that aren't receiving the services they need and so there is a focus on targeted interventions for particular groups with greater need. The Director of Neighbourhood Transformation explained that the 1% is stimulus money will need to be aligned as activity is shifted to the neighbourhoods including the acute contract, community contract. The three Year commissioning plan will be available at the end of December**. Follow up action:** 3 Year Commissioning Plan to be considered by committee.

Haringey Integrators

Simon Wheatey, Chief Operating Officer, Haringey GP Federation and Will Maimaris, Director of Public Health, Haringey were in attendance as the Haringey Integrators. The Director of Public Health explained that Haringey has a strong history of joint working and relationships in health and social care with a three-way arrangement between the council, GP Federation and Whittington Health. For Haringey, Integrated Neighbourhood Teams are being developed for people with long term conditions and they are building on the Multi Agency Care Collaborative Team which had been carrying out neighbourhood working for some time. The objective is to align the model to the three neighbourhoods east, central and west Haringey. Teams are able to go into residents' homes and residents only need to tell their story once and voluntary and community sector navigators help to understand the diverse needs of residents.

The team has a broader focus on prevention also looking at the whole population to tackle inequalities and prevention through voluntary and community sector partners with the challenge fund in order to meet specific health and wellbeing outcomes. The committee heard they are also developing their approach in Northumberland Park, through Community Health and Wellbeing Worker projects for a place-based approach. There is a focus on building the community and resident voice into their structures and the Integrator is accountable to the Borough Partnership Executive with the Chief Executives of the NHS trusts, officers and the VCS. The Integrators are also accountable to the Health and Wellbeing Board. There is recognition of some gaps in community involvement so the plans is to have a strengthened community advisory board for neighbourhoods and it will be important to feed the resident voice back into ICB structures.

The Chief Operating Officer, Haringey GP Federation explained the three key priorities for Integrated Partnerships includes to provide a convening voice of place, provide the drive and engine room for neighbourhood health development and to

develop relationships and operational accountability together. The test bed for neighbourhood working is a service focussed on supporting people with complex needs which brings people together, including the GP Federation, Whittington Health, the local authority and North London Foundation Trust (NLFT) for mental health with wrap around support. It was reported that the focus was on building people's confidence to manage their own needs. In respect of the partnership working with the Whittington, local authority and NLFT there are questions about clinical and corporate governance, co-locating teams and there are technical challenges in respect of varying electronic patient records that are not linked up digitally. Within the next year, the objective is to build community capacity and the deployment of community health and wellbeing officers.

The Chief Operating Officer, Haringey GP Federation also reported that they were looking at three hubs for co-location in Haringey and they are also looking at what the future tests may look like to deliver joined up care. Working with UCLH partners to connect a multi-agency digital platform to ensure that there is a system that connect with the different teams is another focus.

Camden Integrators

The Committee were briefed by Jo Reeder, the Associate Programme Director for the Camden Integrator, which is a partnership of both GP federations in Camden and UCLH. In Camden the emphasis is on GP federations leading the work because they are hyperlocal and know the patients well. The Associate Programme Director for the Camden Integrator explained that working with UCLH helps as they are aware of the challenges for people coming into the hospital. It was explained that everything is run through the Camden Borough Partnership, working with Camden Council, mental health, community providers and most importantly the community and voluntary sector in Camden. Camden has five neighbourhoods and the council recently funded five Neighbourhood Health Partners who are place based VCS to help think about what is needed in each of the neighbourhoods. Each neighbourhood team has a leadership team and they are looking at what can be done for residents with a public health consultant, primary care lead and neighbourhood health partners.

Alongside this Camden are also looking at high-priority groups of people that they need to support who may be experiencing disjointed services. There is one co-located neighbourhood team in the east of Camden which has included some clinical coordination time. It was stressed that Camden is actively working to ensure they are working with the resources available as opposed to additional funding. To support this Camden Integrators are looking at borough wide pathways, hospital at home pathway, rapid response teams and urgent community response to improve neighbourhood working.

The committee heard that there is a lot of networking amongst different Integrators in London to learn from one another including Haringey's test bed work, the Bi-Borough partnership and in Hillingdon. Consideration is also being given to populations in Camden and where they need to focus their early work including mental health and serious mental illness patients, and social isolation and loneliness. The focus for Camden is governed by a programme of work and a programme board chaired by CNWL. The objective is also to improve communications as well as embarking on a development programme with the Health and Wellbeing Board.

Councillor Stock expressed that she appreciated the ambitions, nevertheless people are reluctant to work in GP practices, hospital A&E and there is a staff retention problem (at least from the Barnet perspective), and she queried who would implement the strategies. Councillor Gill Sargeant also added that GPs in Barnet and nationally are stretched and consideration needs to be given to primary care for GPs as it isn't working at present. The Councillor mentioned a particular new practice in Colindale that has remained empty for up to a year. The Chief People Officer agreed that it remains a national challenge due to risk that individuals hold as GP's, the role is quite stressful for individuals because of the risk and many are also part-time.

It was explained that there is an Additional Role Reimbursement Scheme, which allows GP's to be hired through an additional route and so some practises have paramedics, some have additional pharmacists and social prescribers. Despite the lower than necessary numbers London is actually better served than other areas nationally and in terms of primary care there is more incidences of suicide amongst dentists. A 10-year workforce plan that will come out of DHSC soon and this will run alongside the 10-year plan. The workforce plan will detail how they will deliver the aspect of the three shifts, including hospital to community, analogue to digital, treatment to prevention.

Melissa Mellet, Director of Neighbourhood Transformation, NHS (N&WL) ICB briefed that the Director of Primary Care for West North London, held workshops with the primary care general practise family, including dentistry, ophthalmology and GPs with a plan for how they will lead and support the neighbourhood leadership model. An exercise has been carried out mapping out across North and West London for every borough where the current gaps and current risks of gaps are. **Follow up**: to be shared with the committee.

Councillor Cazimoglu expressed that good Patient Participation Group (PPG) are good as they are accessible to everybody including those that are digitally excluded, the elderly etc. The councillor explained that people can feed into their PPG for getting that engagement.

Natasha Benn, Chair, Joint Partnership Board, Trustee of Disability Action Haringey expressed that the Head of the GP Federation attended the Health and Wellbeing Board and discussed pro-active health and the challenges with issues like dementia and GPs have stressed the lack of capacity to be more proactive in this area in terms of trying to deal with the problems. The Chair of the Joint Partnership Board further described the challenge with unpaid carers for people living with dementia and that their social isolation and mental capacity was strained and asked how all the strategies being implemented would come together to support these types of patients and their carers. In response to the care model question the representative from Haringey GP Federation explained that the context of the multi-agency care co-ordination service, this was being expanded through the MAC and GPs are essentially able to refer people with complex needs that they're concerned about including those potentially with dementia, potentially frailty, for a conversation with a broader team of professionals to provide input onto their care plan in order to review and make decisions about where they go next in the system. The challenge lies with

the flat funding formula from government for the next 10 years along with limitations in the workforce.

It was explained that in Haringey, thoughts are being focussed on developing innovative ways of working together that are more efficient with proactive care by looking at how resources can be shared more effectively as the traditional route of expecting more capacity through more funding will not be available. In the case of dementia, it has previously been viewed in a medicalised way and now more consideration needs to be given to support from Community Health and Wellbeing Workers. It was explained that this approach was also helpful as there is a lack of trust in statutory healthcare and Community Health and Wellbeing Workers can help to build relationships of trust with families who are traditionally underrepresented.

It was acknowledged that various parts of the workforce are under pressure and this affects people's willingness to stay and to join the profession. The plan is to use the partnership to unlock different ways of working and different ways of delivering services. The local authorities and Public Health will also have to think more creatively and instinctively about shared resources for delivering social care and trying to improve the experience of frontline teams.

The Chair of the Joint Partnership Board further added that there was a lack of clarity in how all the strategies would actually be implemented in practise to be effective in terms of outcomes. The director of Public Health, Haringey expressed that in respect of dementia, it is complex because it spans health, social care, community support and this is why there is the importance of local structures. It was further added that there are programmes around cardiovascular disease prevention, smoking cessation services with smoking being a big risk factor for dementia and how the programmes are tailored to local communities will help make an impact. The Director of Public Health explained that something that could help is to make people aware of the services available to them and the change towards more localised care. Developing and improving the pathways, will be a longer-term piece of work and that is what the integrators will be implementing.

Councillor das Neves expressed that the Integrator works sounded positive but there had not been enough engagement with ward councillors especially in the wards like Northumberland Park, and this was essential. The councillor sought clarity on the information detailing ‘net costs used to create scale, used to create scaled integrated pathways’ and also ‘scale evidence-based big bets’ over new pilots on page 25. **Follow up**: get clarity on what this means.

Councillor das Neves commended the case study usage although they seemed some what lacking in ambition for people’s outcomes. The importance of young people is mentioned but it was unclear how the connection with young people and health could be made as many of the positive things in place for young people have been de-funded due to austerity. The councillor stressed health and in particular mental health was a key concern for young people. Councillor das Neves also enquired about the connection between the work of the Integrators and the Mayor of London. Sarah Morgan explained the priority is young people, mental health and the women so it aligns.

Councillor Kumar commented that the voice of the GPs and the voice of staff need to be included when developing operations as they know what works best in practice. In response, the committee heard that staff experience is measured through the staff survey, although this had not been the case for General Practise traditionally, it has now been introduced nationally so staff experience data has started to be measured more consistently than was the case before.

Councillor Kumar stressed that data is going to be critical in how we deal with integrating with the big shift towards the prevention-based model. The councillor felt that this will be a challenge and will prove difficult to measure. It will also need to be aligned with local authorities' objectives. Councillor Kumar was keen to know how everything will actually be executed with limited resources available in the community sector, local authority and health as well. Councillor Kumar suggested that health colleagues capitalise on AI and the fact that people seek advice online and with the huge data stored by the NHS, it can be used with personalised rank models and then people will have access to personalised health advice. In response, the Chief People Officer informed the panel that there was integrated data, but there are restrictions to some things due to NHS patient consent and the data sharing agreements. The Chair agreed that a further conversation on data would be helpful in respect of the conversations taking place, address Palantir regarding our data etc needs to take place. **Follow up action**: Item on digitisation to be scheduled.

Councillor Gray enquired about Palantir, expressing that many people had concerns with them and she was keen to know whether ICB colleagues felt the services they were providing was adequate and effective and sufficiently well protected in terms of confidentiality. Councillor Gray also mentioned that there is also the paradox that in some practices, patients are not allowed access to their own data. The Chief People Officer explained that everyone has access to their personal data.

Councillor Prasad raised the point that closer working with schools needed to take place in terms of the community work, it was responded that this was done through the local authority partnership as they essentially look after schools.

WORKWELL, WEST & NORTH LONDON UPDATE

Mary Patricia Flynn, Deputy Director for Involvement briefed that the ICB were aware that listening to people and learning about their experiences is the only way that they can improve health and care and have an equitable service for everybody. The Deputy Director for Involvement expressed to the committee that she was keen to hear their views on a local level with local communities and partners given that local government is the best place to do that. The Deputy Director for Involvement briefed that a three-year involvement framework for the ICB had been developed which sets out how they will listen to people and implement the output to embed it into the decision making at the ICB.

Councillor das Neves expressed that the engagement and feedback should include councillors and was surprised that it didn't appear in the document because councillors often work regularly with a lot of the most vulnerable people in the

community who won't be captured through their engagement. Councillor das Neves also expressed a point in relation to quality of service because trust, transparency and accountability were key for many members of the community.

The point was made by Councillor Kumar that local authorities are doing a lot of work in respect of community engagement with very specific groups e.g., disability groups, LGBTQ groups and he was keen to know what the specific constraints for certain groups. The Chair of the Joint Partnership Board echoed the comments raised by Councillor Kumar and that having the details of what each group they have consulted on is presented and detailed would be helpful. Giving evidence from councillors, the VCS, local authorities, psychologists, ethnic minority leaders, people with complex needs should be fully analysed transparently.

Councillor Cazimoglu expressed that there is a huge mistrust with the NHs and that it was important to recruit people to support those with ESOL especially in terms of trying to support the uptake of vaccinations. Councillor Prasad raised a concern regarding learning disabilities, and the fact that their life expectancy is less and what has been considered in respect of this work.

The Director of Involvement agreed that Councillors were important and informed the committee that the consultation was done through surveys and workshops and feedback was always provided. The Director of Involvement told the committee that information was shared with every communications teams in the 13 boroughs and they specifically asked them to share it with all elected members. Councillor das Neves stressed that in view of the pilot projects it's essential that engagement with councillors isn’t a missed opportunity and ward councillors are the most engaged in communities.

The Director of Involvement said that coming to the committee is amongst the steps they are taking to ensure engagement locally with politicians and a lot more work needs to take place. The committee heard that they are utilising Resident Engagement Teams and Community Safety Teams and trusted community leaders to improve their engagement and ensure there isn’t repetition and asking people the same questions. The Director for Involvement stressed that they are very keen on a two-way relationship with the local authority and the focus of work is looking at what can be done, going forward.

It was explained that they are currently carrying out a piece of work and received over 700 responses and the workshops concentrated on reaching out to people they haven't heard as much from in the past two to three years The workshops looked at any gaps and they reached out to communities identifying as black, British, black, and black Caribbean as they knew they were underrepresented in the responses from the survey. The committee heard that they were working with grassroots organisations to ensure particular communities with issues with vaccinations due to historic experiences can feel more supported.

The Director of Involvement explained that they had a database of relationships that had been built up over many years of people within the VCS that go out and talk to community groups, work with engagement teams and look to see if there's any network missing. It was explained that they were aware of the need to have ongoing

relationships so that they can build trust because without trust they won't get to know people.

The Chair requested a breakdown of the people that they had been engaged with and who has said what along with how all the engagement had been advertised. The Chair emphasised that better engagement with all the councillors would be essential as councillors know their communities best. **Follow up action**: provide timeline on when they can bring a progress report regarding the follow up of the engagement exercise to send draft principles that underpin the strategy in advance of presentation to their board in January. Information on the co-design workshop as enquired by Councillor Gray to also be included.

Councillor das Neves stressed that in order to gain trust, starting with ward councillors is a good way to begin and it will need explaining to ward councillors as well as many councillors were new. Councillor Cazimoglu stressed that real outreach and going out into the community e.g. like with the covid jab was successful as they took things out of the usual setting, utilising health buses. The Councillor emphasised that there is a level of mistrust e.g. with something like the flu vaccine but it is also the case that some people just don't have the opportunity and time as they are working etc. The Head of Involvement agreed and added the point that the NHS was also not so good at explaining when they aren't able to implement certain suggestions, there is a need to develop more honesty and transparency about their capabilities as well.

Councillor Sargeant made the point that it was a big change and a strategy has been developed to underpin it, but the difficulty is there are no resources, she felt this was a worry.

The meeting ended at 12.55

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NHS
West and North London

WEST AND NORTH LONDON ICB

Winter readiness plan

2026/27

Alignment to strategy, investment, provider delivery and system assurance

EXECUTIVE REVIEW • November 2026

Prevention • alternatives to hospital • safer flow

NHS
West and North London

Executive summary

The winter plan sets out implementation priorities. Readiness depends on confirmed delivery capacity and clear escalation arrangements.

Winter implementation combines prevention with operational readiness and delivery oversight

1 Preventative actions and care planning

Promote vaccination and targeted sprints for key populations. Focus active care planning on the top 5% of people at high risk.

2 Capacity and workforce readiness

Provider plans align on alternatives to hospital and safer flow. Confirm additional capacity, staffing and seven-day cover, including discharge support.

3 £20m tied to additional delivery

Use £20m for integrated, additional schemes that support prevention and care at home. Confirm targeted improvement and exit arrangements.

4 Implementation oversight and assurance

Track readiness through sector flow boards and the SCC, with clear escalation triggers. Assure place-based delivery mechanisms.

EXECUTIVE TEST **Confirm which services are ready to start, who will act and what remains unresolved. Link funding to executable plans with clear outcomes and exit arrangements.**

West and North London ICB strategy

NHS
West and North London

A 10-year clinically led plan to improve outcomes, reduce avoidable demand and create a financially sustainable health and care system.

4.5m residents • **13** boroughs • **£12bn** annual health and care spend • **17-year** gap in healthy life expectancy across neighbourhoods

01 Bend the outcome curve

Improve population health and equity

Prevent long-term conditions, improve early detection and target support where need and inequality are greatest.

02 Bend the demand curve

Reduce avoidable pressure on services

Shift from reactive treatment to proactive, community-first care through neighbourhood health and transformed planned care.

03 Bend the cost curve

Deliver financial sustainability

Reduce unwarranted variation, improve productivity and commission for outcomes and value.

HOW THE STRATEGY WILL LAND

Six priority population groups

Early years & families • Young people • Early-stage LTCs
Adults with complexity • Serious mental illness • End of life

Two care-model shifts

Neighbourhood health
Planned care transformation

Investment ambition

£360m additional recurrent investment in proactive, community-based care and mental health by 2028/29

Strategic commissioning will connect population need, evidence and lived experience to resource allocation, delivery and measurable outcomes.

NHS
West and North London

£20m winter investment accelerates Step 1

Use the non-recurrent allocation as a focused bridge from winter response to prevention, earlier detection and targeted support.

WINTER ENABLER

£20m

non-recurrent investment

Focused, time-limited support
over winter

CHANNEL THROUGH STEP 1

PREVENT	long-term conditions
DETECT EARLIER	and intervene sooner
TARGET SUPPORT	where need and inequality are greatest

01 Bend the outcome curve

Improve population health and equity

Winter action is explicitly tied to the first strategic step — improving outcomes and narrowing inequality.

The £20m is a catalytic bridge into the 10-year strategy — not a standalone winter intervention.

Four interventions shift winter care upstream

NHS West and North London

The BAS concentrates effort on identifying risk earlier, protecting vulnerable people and expanding alternatives to hospital.

01

Identify risk

- Risk stratification tool available from October
- Single Offer / CRM and LTC models
- Proactive review of vulnerable cohorts

02

Protect early

- RSV, flu, COVID-19 and pneumococcal programmes
- GP / PCN, outreach and care planning for high risk patients
- Targeted checks and antiviral access

03

Open more routes

- Enhanced Access / Bridging access service evenings and weekends
- Extra NHS 111 bookable capacity: 1 per 2,000
- Pharmacy First, urgent dental and public campaign

04

Keep people at home

- £20m for UCR, virtual wards, H@H and discharge
- Whittington: 40 H@H / virtual-ward beds; use 68→80%
- 7-day D2A; 20-place P1 bridge vs 16 beds

Together, these interventions move the winter response from reactive treatment to proactive, community-first care.

Seven acute providers converge on one Type 1 ED model

NHS West and North London

Plans differ in scale and maturity, but consistently aim to redirect demand, accelerate decisions and restore whole-hospital flow.

01 ARRIVAL	02 FRONT DOOR	03 ALTERNATIVES	04 FLOW
Redirect before ED	**Decide earlier**	**Avoid admission**	**Release capacity**
ICC / LAS trusted-assessor routes	Rapid senior assessment and streaming	SDEC, hot clinics and frailty pathways	Discharge lounges and ready units
Digital triage and self-registration	Model ED / first-72-hours standards / discharge planning on admission	Virtual wards and Hospital at Home	Seven-day pharmacy, therapy and transport
UTC, primary care and Pharmacy First	Live occupancy and handover oversight	Mental-health alternatives and liaison	OPEL, escalation beds and command centres

SHARED SUCCESS MEASURES	4 hours	12 hours	>45 min	corridor care
	improve	reduce	eliminate	eradicate

System dependencies recur across plans: community capacity, mental-health placements, diagnostics, pharmacy, transport and social care.

Provider commitments expose different pressure points

NHS West and North London

The strongest plans set measurable ED standards; readiness risks concentrate in flow, estates, workforce and downstream capacity.

PROVIDER	DISTINCTIVE TYPE 1 ED PLAN	QUANTIFIED COMMITMENT / WATCHPOINT
Royal Free London	Digital Front Door; UTC/SDEC and specialist alternatives; virtual care; strict flow standards.	**83%+ within 4h • <10% at 12h • zero corridor / >45m • H@H >90%**
Chelsea & Westminster	Cross-site streaming, SDEC growth, front-door frailty and command-centre oversight.	**SDEC 1,000/month/site • ≥80% 4h, >82% year-end • ambulance 35→30m**
Hillingdon Hospitals	Direct SDEC streaming and ICC trusted assessor; QED unit; ED redevelopment mitigations.	**4% redirected off-site • ~80% handovers <15m • ED/UTC demand +10.1%**
London North West	Rapid assessment, Fit to Sit, SDEC and virtual wards; Ealing flow works and Digital Front Door.	**Type 1 demand +3.9% • handover 26m42s • no corridor care by Mar-27**
Imperial College Healthcare	Expand medical SDEC and acute virtual ward; senior front-door decisions and extended discharge support.	**82% 4h by Mar-27 • SMH lounge 08:00–20:00, 5/7 • enabling capacity unresolved**
UCLH	Model ED staffing, 24/7 mental-health support, 16 winter beds and predictive capacity control.	**NEL model +2.6% vs 4% recent growth • 16 beds • discharge and MH flow remain key risks**
Whittington Health	UTC see-and-treat; GP to 22:00, 7/7; 24/7 EEMAC; weekend discharge and community alternatives.	**40 H@H/VW beds • use 68→80% • NCTR <45 • 16 Eddington beds or 20-place bridge**

Across providers, the critical test is whether front-door gains are matched by timely specialty response, inpatient flow and community discharge capacity.

Mental-health plans shift crisis care away from ED

NHS West and North London

CNWL, West London and NLFT converge on earlier crisis support, alternatives to ED and seven-day discharge grip.

01 PLAN EARLY	02 DIVERT	03 ASSESS FAST	04 RESTORE FLOW
Prevent escalation	**Offer alternatives**	**Resolve ED waits**	**Create headroom**
Risk stratification, crisis and relapse plans	111 option 2, crisis lines, safe spaces and MHCAS	Liaison triage, senior decisions and MHA escalation	Daily discharge, seven-day working and OPEL grip

PROVIDER COMMITMENTS

CNWL

Standardise liaison and Home Treatment Teams; escalate ED waits at 8 and 10 hours; review every avoidable 12-hour breach.

5% fewer MH A&E attendances Jan–Apr 2026 YoY

Pressure point: bed availability and external MHA / out-of-area dependencies / parity for mental health discharges

WEST LONDON

Use 24/7 crisis lines, MHCAS, safe spaces and CATT; enhance liaison triage and daily ward discharge.

MHCAS ~12 spaces Jan-27
1 discharge / ward / day

Pressure point: 1-hour liaison response and adult / older-adult occupancy.

NLFT

Operate 24-hour MHCAS and seven-day discharge; use tailored crisis plans and Operation Lagopus to build headroom.

90% occupancy target
10.3-bed avg deficit forecast

Pressure point: surge capacity; enhanced crisis options depend on funding.

System test: acute EDs, AMHP capacity, local-authority discharge support and cross-provider pathways must operate as one.

Community services are the system's safety valve

NHS West and North London

CNWL and CLCH set the core model; Whittington adds quantified acute-to-community capacity, discharge and admission avoidance.

01 IDENTIFY	02 RESPOND	03 TREAT	04 RELEASE
Find risk early	**Act rapidly**	**Care at home**	**Discharge earlier**
Risk stratification, care homes and proactive review	SPA triage, UCR and Rapid Response	Virtual wards and Hospital at Home	Home First, D2A and seven-day flow

PROVIDER DELIVERY

CNWL

UCR and H@H combine crisis response, admission prevention and supported discharge.

2-hour UCR • prevent • divert • step-down

Care-home pathways reduce A&E use and conveyance.

CLCH

SPA links UCR, Rapid Response, VW and H@H with acute, primary and social care.

5 divisions • 7-day flow • daily calls

Home First and D2A support tested surge.

WHITTINGTON

Rapid Response, H@H/VW and in-reach support admission avoidance and earlier discharge.

40 H@H/VW beds • use 68→80%

7-day D2A • OPAT 10–15 • P1 bridge +20

EARLY PLACE SIGNALS **2 OF 13**

EALING **15-bed step-down • P1 target <2.5 days • CHILS: 42% fewer ED attendances**

11 PLACE PLANS OUTSTANDING

HOUNSLOW **24/7 SPA • up to 10 H@H virtual beds • P1 triage target within 12 hours**

Whittington adds quantified capacity and discharge levers; 11 Place plans still constrain WNL-wide assurance.

Governance converts system pressure into timely action

Operational flow is managed across two sectors and the WNL SCC, with unresolved issues escalated through assurance to commissioning decisions.

NHS West and North London

COMMISSION

Local Care Board

Commissioning decisions • longer-term issues and themes

ASSURE

WNL Winter Assurance Group – Adhoc (Chairs of Flow Boards and ICB SRO)

Escalated risks • system assurance • funding delivery

SECTOR FLOW Board – Monthly

NWL SFOB

Operational flow • provider COO's and Borough partners

In hours escalation against triggers
COORDINATE

SCC

Early warning and escalation

SECTOR FLOW Board – Monthly

NCL SFOB

Operational flow • provider COO's and Borough partners

READINESS ACTION **Finalise named leads, escalation triggers, expected actions and the interface with the London region before winter pressures rise.**

Moving from planning to implementation

NHS
West and North London

Proposed delivery checklist for turning the winter plan into operational readiness across providers and Place partners.

1 Preventative actions and care planning

Publicise and promote vaccinations, targeted vaccination sprints for key populations, active care planning, targeting top 5% high risk population.

2 Capacity and workforce ready to operate

Confirm additional capacity, staffing and seven-day cover. Check referral routes, discharge support and mutual aid before mobilisation.

3 Funding linked to executable delivery

Release the £20m against integrated, additional plans with clear outcomes. Confirm targeted improvement and exit arrangements for funded schemes.

4 Active monitoring and escalation

Track readiness and agreed outcomes through sector flow boards and the SCC. Use clear triggers to escalate unresolved risks to winter assurance.

READINESS CHECK **Confirm which services are ready to start, what remains unresolved and who will act. Agree corrective actions before winter pressure rises.**

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NHS
West and North London

West and North London ICB Finance Update

JHOSC Meeting



Agenda Item 8

What has changed since last year?

The financial position now sits within a different organisational and commissioning model

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2025/26	2026/27	What this means in practice
NCL ICB	West & North London ICB	The ICB now serves 13 boroughs and around 4.5 million residents, rather than the five NCL boroughs alone.
5-borough footprint	13-borough footprint	Decisions draw on the needs, inequalities and experience of a much larger and more diverse population.
NCL budgets & contracts	WNL budgets & contracts	Budgets and provider contracts are set for the combined area. Figures are therefore not directly comparable with last year's NCL position.
System coordination	Strategic commissioning	A sharper focus on understanding need, setting priorities, buying services and testing outcomes and value, while continuing to work with councils and providers.
Collective NHS system position	Clearer organisational accountability	The ICB balances its commissioning budget; trusts remain accountable for their own finances, with continued joint work on service and financial sustainability.
Greater use of fixed funding	More activity-related payment	More provider income responds to care delivered, including a blend of fixed and activity-related funding for urgent and emergency care.
Plan for the NCL population	Plan across WNL, deliver locally	The wider footprint supports comparison and shared learning, while borough and neighbourhood partnerships continue to shape local services.

Larger footprint, same local focus: local needs, local accountability and partnership with councils remain central.

25/26 Financial Outturn Summary

NHS
West and North London

North Central London System

- The NCL system have reported a surplus of £0.8m in 25/26 against the original system balanced plan.
- Despite a difficult start to the financial year with unfunded industrial action from July 2025 and difficulties to deliver in-year savings on pay, the system agreed a recovery plan where we confirmed the system's intent to deliver a balanced position in 25/26.
- Mitigating financial recovery actions throughout 25/26 have included MARS at a number of providers, closure of unfunded capacity and vacancy freezes amongst the main interventions
- GOSH (£4.9m adv) – Reported pressures on Pay due to efficiency savings under delivery and private patient income underperformance driving the £4.9m adverse YTD variance.
- MEH (£5m fav) – Reported a £5m surplus primarily due to slippage in major projects Oriel, EPR and IT schemes.

	M12 – North Central London System		
Org	Annual Plan	YTD Actual (excl DSF)	YTD Variance
	£'000	£'000	£'000
GOSH	-	(4,980)	(4,980)
MEH	-	5,000	5,000
NLFT	4,868	4,868	-
RFL	(42,663)	(42,663)	-
RNOH	-	77	77
T&P	-	6	6
UCLH	12,029	12,031	2
WHIT	(1,426)	(1,176)	250
Trust Total	**(27,192)**	**(26,837)**	**355**
NCL ICB	27,192	27,591	399
System Total	**-**	**754**	**754**

W&NL ICB – 26/27 Financial Plan

NHS
West and North London

26/27 Financial Planning Overview

- West and North London Integrated Care Board (W&NL ICB) submitted a **breakeven financial plan for 2026/27** as part of the final national planning submission on **12 February 2026**. The plan was developed in the ICB's role as a **strategic commissioner**, rather than as an operational system convenor, and there is no expectation that the ICB ensures a balanced position for all hosted providers.
- Despite this, the ICB remains committed to creating the best possible financial environment within its resource limit to support delivery of system priorities.

Strategic Priorities and 1% Transformation Investment

- The plan reflects a clear strategic intent to **reduce reliance on secondary care** and to increase investment in **neighbourhood, community and mental health services**.
- This transformation of care is central to improving long-term sustainability, reducing demand on acute services and addressing health inequalities. The approach ensures that investment decisions align with the system's strategic aims while avoiding financial destabilisation of providers.
- **£120m has been earmarked for transformation investment in neighbourhoods**. Around **£60m** has been committed in-year to mental health (£20m) and community services (£40m).
- The remaining transformation funding will be held as a **trading reserve** to manage in-year pressures, particularly within acute services.
- Growth allocations to urgent and emergency care, CNST, high-cost drugs and devices, the Better Care Fund and independent sector provision will result in a **£10.7m deterioration in the underlying position**, which is managed within the overall breakeven plan.

Delivery of Constitutional Standards and Productivity

- The financial plan supports delivery of **constitutional standards**, including RTT and A&E performance, through consistent commissioning approaches and contractual mechanisms.
- A **1% productivity requirement** has been applied to acute providers, alongside improvements in first-to-follow-up ratios and a consistent approach to earned and unearned income.
- The **Mental Health Investment Standard** is fully met, ensuring continued growth in mental health investment.

Area	Annual Plan
	£m
Allocation	**12,002**
Acute Services	5,505
Mental Health Services	1,255
Community Health Services	911
All-age Continuing Care Services	535
Primary Care Services	714
Other Programme Services	68
Primary Medical Services	950
Delegated Primary Care (POD) Services	480
Delegated Specialised Commissioning Services	1,520
Running Costs	63
Total Expenditure	**12,002**
Surplus/(Deficit)	**0**

W&NL ICB – M6 Financial Position

West and North London

Month 6 (September 2026)

- As of Month 6 (Sep '26), the ICB reports a year-to-date and forecast break-even position against plan.
- The forecast includes a £15m overspend within Acute Services, primarily driven by higher than planned activity across NHS and independent sector providers, and a £16m overspend within Continuing Care arising from activity and inflationary pressures.
- These pressures have been offset by favourable forecast variances within Specialised Commissioning (£11m), Running costs (£19m) and Primary Care (£3m).
- Release of non recurrent measures of £15.2m (reported within Other programme services) supports delivery of the overall forecast break-even position.

Area	M6 Year to Date			26/27 Full Year		
	YTD Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast Outturn	Variance
	£m	£m	£m	£m	£m	£m
Allocation	**5,887**	**5,887**	**0**	**12,054**	**12,054**	**0**
Acute Services	2,712	2,725	(14)	5,491	5,506	(15)
Mental Health Services	612	613	(1)	1,243	1,243	0
Community Health Services	442	443	(1)	913	912	1
All-age Continuing Care Services	267	275	(8)	535	551	(16)
Primary Care Services	344	343	1	719	718	0
Other Programme Services	53	45	8	136	140	(3)
Primary Medical Services	443	444	(1)	952	952	0
Delegated Primary Care (POD) Services	238	234	3	480	476	3
Delegated Specialised Commissioning Services	746	744	2	1,521	1,511	11
Running Costs	32	20	12	64	45	19
Total Expenditure	**5,887**	**5,887**	**0**	**12,054**	**12,054**	**(0)**
Surplus/(Deficit)	**0**	**0**	**(0)**	**0**	**0**	**0**

Our strategy aims to help people live longer, healthier and more independent lives

NHS
West and North London

Our ambition
More children get the best start in life, more adults stay healthy and well, and more older people remain independent and connected to their communities for longer.

To achieve this, we want to achieve three connected things:



Improve outcomes and equity

Help people spend more years in good health, with the fastest improvements in communities experiencing the greatest inequalities



Reduce avoidable demand

Prevent illness, identify needs earlier and provide proactive support before people reach crisis.



Create financial sustainability

Use every pound of our £12 billion budget for greater value and shift resources towards prevention, community-based care and mental health.

We must move from a system organised around illness and crisis to one built around prevention, earlier support and healthier lives.

Six population priorities, two care-model shifts, nine key foundations

NHS West and North London

Our strategy is framed around the life course, putting people at the heart, with a clear strategic shift towards prevention, proactive care and neighbourhood delivery and a focus on reducing disease progression, demand and inequalities.

Healthier beginnings
Pregnancy, babies, children and young people

Healthier lives
Working-age adults

Healthier ageing
Older adults and end of life

POPULATION PRIORITIES: where need and the case for change are greatest

1 **Early years and family support:** Give every child the best start in life, targeting support where families face the deepest inequalities.

2 **Young people:** Support young people to build independent lives, focused on mental health and employment.

3 **People at risk of, or living with, early-stage LTCs:** Prevent LTCs, detect them earlier, and manage them more effectively.

4 **Adults with complexity:** Integrated care for adults with multiple, interacting health, care and social needs.

5 **Adults with SMI or LD:** Improve health and life outcomes for adults with serious mental illness (SMI) or learning disabilities (LD).

6 **End of life:** Support a dignified death for all.

CARE-MODEL SHIFTS: applied across the life course

A **Neighbourhood health:**
Health and care organised around our **53 neighbourhoods**, not institutions: health, care, voluntary and community services working as one to keep people well, act earlier and join up care close to home, starting with adults with complexity.

B **Digitally-enabled care at scale:**
Care that comes to residents: **one front door, same-day urgent access**, prompt specialist advice and problems picked up earlier.

KEY FOUNDATIONS: what we need in place to deliver the priorities and shifts across the whole life course

a **Building trust and empowerment:**
Building trust, reducing barriers and empowering residents.

b **Digital, data and artificial intelligence:**
Connected data, proactive care and responsible AI.

c **Commissioning for our population need:**
Outcomes-based, place-based commissioning arrangements.

d **Research, innovation and evaluation:**
Generating evidence, adopting and scaling what works.

e **Finance and contracting:**
Aligning money, incentives and risk behind the strategy.

f **Workforce development:**
Building the workforce for future models of care.

g **Estates:**
Co-location and neighbourhood health centres.

h **Communications, involvement and insight:**
Decisions informed by data and lived experience.

i **People, culture and organisational development:**
A fit-for-purpose strategic commissioner.

Note: Inclusion health is a lens through which we will design, commission and evaluate services for every population priority cohort, ensuring that people experiencing the greatest disadvantage are visible in our data, considered in our decisions and benefit proportionately from improvement.

We will invest an additional £360m in proactive care by year 3

Recurrent investment in community-based care and mental health will rise over three years, equivalent to around 1% of the commissioning budget redirected incrementally each year.

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£360m by year 3

£120m recurrent in **year 1**, rising to **£240m** in **year 2** and **£360m** by **2028/29**.

Around 1% of our commissioning budget each year.

How the shift will be funded

Allocation growth

Directing growth towards proactive and community-based care.

Cost avoidance and productivity

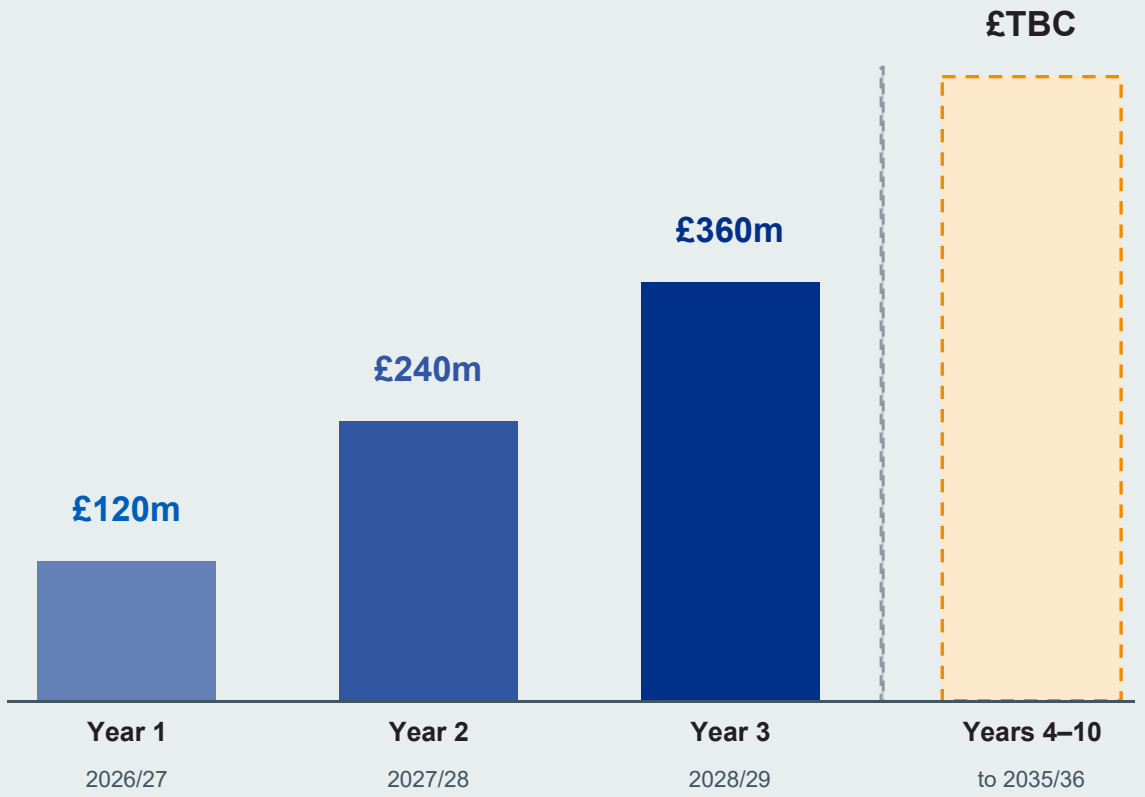
Avoiding future demand and using resources more effectively.

Recommissioning for value

Moving funding from lower-value and reactive care, where clinically and financially appropriate.

Cumulative recurrent investment

Proactive, community-based care and mental health



Four key links between the 10-year strategy and the 2027/28 planning round

The key commitment in the strategy is £360m to be invested in proactive, community-based care and mental health by 2028/29. Beyond that, we have several suggestions to ensure the operational and financial plan aligns with the strategy.

1 Incentive schemes for at least three cohorts

For example:

- **Adults with complexity (Cohort 4), e.g.** emergency admissions and bed days per 1,000 weighted population; care plan and named contact coverage.
- **Children (Cohort 1) and young people (Cohort 2), e.g.** recorded against expected prevalence of mental health conditions; access to support; transition plans; neurodevelopmental waits.
- **Adults with serious mental illness (Cohort 5), e.g.** health checks acted on; crisis and emergency admissions per 1,000; smoking; employment and housing.
- Full measures: see the full strategy at the following link (summary of measures on page 10 and full sets in section 3B).

2 Do nothing and do something positions

- **A robust 'do nothing' position** for each sector and point of delivery, built on *long-term* historic trends (or similar evidence) in the planning model.
- **A clear 'do something' position that balances,** with activity, finance and performance triangulated so the three reconcile.
- **A productivity assumption of at least 2% a year** in all contract negotiations, in line with national planning guidance, varied only where evidence supports it.
- **The remaining difference is what the SCP schemes must deliver,** each tagged to a cohort or care-model shift.
- **All schemes must have evidence of effect on one of the three curves** (outcomes, demand, cost).

3 Clear one-page summary per strategic initiative:

Each strategic initiative needs a clear summary of:

- **How it supports achieving the 'five resident tests'** (making services simpler, fairer, more integrated, more preventative and more relationship/trust-based)*.
- **Which of the six cohorts or two care-model shifts** it serves, and executive owner responsible for the scheme.
- **Which of the six ambition measures it is likely to affect,** with a clear stated logic for how it will improve that ambition measure.
- **Impact on each of the three curves** (outcomes, demand, cost).
- **Payment basis** and contract type.
- **Evidence** and level of confidence in it.
- **Evaluation plan,** with a 'stop-or-scale' date.
- **Health equity check:** which groups it reaches, to what extent it narrows the gap, and how we will check.

4 Evidence of the left shift

- **Left shift:** spend by setting, 2027/28 against 2026/27; acute share down, other settings up.
- **Proportion of spend on proactive care and prevention,** up in 2027/28 compared to 2026/27.
- **'Shadow budget' per neighbourhood:** a notional need-based budget for each neighbourhood, published with the plan to show where spend currently sits (or should sit).
- **Low-value services that will be reviewed:** named in the commissioning intentions, giving a year's notice before changes in 2028/29.
- **Cost of change:** the plan is open about any double-running or stranded costs, how long we will carry them, and what the new service must show before the old one is stood down.

Further 10-year strategy related work that needs to be in place before the next planning round:

- **Local needs formula by sector, patient demographic, and neighbourhood,** with a clear trajectory for aligning resource to those needs.
- **Outcome-linked payment extended to all six cohorts and both care-model shifts,** each with a shared activity baseline, shared outcome baseline and agreed targets.
- **Triangulated workforce plan** aligned to the care model, reconciled with activity and finance.

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NHS
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West and North London Local Care Estates Update to NCL JHOSC

27 November 2026

Executive Summary

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- A four-year programme of 104 schemes / programmes, with a total pipeline value of £146.69m.
- Confirmed NHS capital allocation of £93.09m for 2026/27 to 2029/30 across four principal funding streams.
- A further £9.972m of DHSC Neighbourhood Health Centre Wave 1 funding takes identified funding to £103.062m.
- Investment supports more care closer to home, better use of existing estate and integrated neighbourhood services.
- 45 Wave 2+ hubs have been submitted against an indicated WNL allocation of £4m per year.
- Two National programmes working towards transfer of core Community/Primary Care estate held by the DHSC owned NHS property companies within WNL to NHS Trusts
- As ICB moves towards a Strategic Commissioner, with ICB support there are 12 integrator partnerships within WNL transitioning to delivery of Neighbourhood estate schemes

Capital pipeline and funding position

NHS
West and North London

104	£146.7m	£93.1m	£10.0m
schemes / programmes	total pipeline value	four-year confirmed allocation	NHC Wave 1 funding

Funding sources for the wider pipeline

- Four-year NHS settlement from 2026/27
- NHS capital secured before 2026/27
- S106 / CIL
- NHS property companies and other sources

Key point

The pipeline exceeds identified funding, so sequencing and strategic prioritisation remain essential.

WNL confirmed four-year capital allocation

NHS
West and North London

Funding stream	26/27	27/28	28/29	29/30	Total
BAU Capital - Estates	£3.0m	£3.3m	£2.9m	£2.9m	£12.1m
Utilisation & Modernisation	£4.0m	£4.0m	£4.4m	£4.4m	£16.8m
Strategic Primary Care Capital	£13.9m	£14.4m	£14.7m	£14.9m	£57.9m
Return to Constitutional Standards	£3.8m	-	-	£2.5m	£6.3m
TOTAL	**£24.7m**	**£21.7m**	**£22.0m**	**£24.7m**	**£93.1m**

Strategic Primary Care Capital represents the largest element of the settlement.

2026/27 schemes progressing

NHS
West and North London

BAU Capital - Estates	**6**	schemes	**£3.0m**
Utilisation & Modernisation	**10**	schemes	**£4.0m**
Strategic Primary Care Capital	**17**	schemes	**£8.4m**
Return to Constitutional Standards	**1**	schemes	**£3.1m**

Programme emphasis: capacity, utilisation, modernisation and expansion of out-of-hospital care.

Neighbourhood Health Centres – DHSC Wave 1

NHS West and North London

£10.0m identified for WNL in 2026/27

£1.7m	£3.2m	£5.1m
Jubilee Gardens Primary Care Centre	Hornsey Neighbourhood Health Centre	Alexandra Avenue Health & Social Care Centre

- Supports the shift from hospital to community settings.
- Brings GP, pharmacy and wider health, care and voluntary-sector services together locally.

Neighbourhood Health Centres - Wave 2+

NHS
West and North London

45	£4m	10	Allocation announcement deferred to Nov / Dec 2026
hubs submitted	per year indicated for WNL	potential PPP new builds	

Priority 1 - 5 schemes

Priority 2 - 5 schemes

- Awaiting further announcement on the PPP Investment Programme for new buildings.

The scale of submissions compared with available funding reinforces the need for transparent strategic prioritisation.

Strategic considerations

Align estates and primary care strategy	Plan investment around services required in neighbourhoods, not individual premises alone.
Prioritise against finite funding	Use a transparent approach linked to the future configuration of primary care and neighbourhood services.
Maximise existing estate	Consider utilisation, refurbishment, repurposing, rationalisation and disposals together.
Prepare for future opportunities	Position priority schemes for further NHC funding and potential PPP investment.

National Programmes - Property Transfers

NHS West and North London

Community Health Partnerships Ltd - Securing the Future

National programme managing expiring leases across 308 NHS LIFT primary and community care buildings. Leases begin expiring from 2029.

WNL position

19 LIFT properties expire between March 2030 and March 2045; 11 expire before 31 December 2033.

NHS Property Services Ltd - NHS Property Transfer Programme

Voluntary transfers are restricted to NHS trusts and foundation trusts. Core clinical buildings are prioritised, with financial and governance review required.

WNL position

Expressions of interest were made for 44 local core properties in March 2026. Business cases are being submitted, with first national decisions expected in Q4 2026/27.

Estates investment is an enabler of more integrated care closer to home.

Key Messages for JHOSC

NHS
West and North London

- The scale of the WNL capital pipeline and the confirmed four-year settlement.
- Four funding streams and additional DHSC Wave 1 Neighbourhood Health Centre funding.
- Demand substantially exceeds available Wave 2+ funding and requires clear prioritisation.
- Support continued alignment of estates investment with primary care and neighbourhood service planning.
- Maintain strategic oversight as further NHC allocations and PPP arrangements are announced.
- Two National Programmes – Property transfer in progress

Estates investment is an enabler of more integrated care closer to home.

2026/27 NCL JHOSC - DRAFT WORK PROGRAMME

Friday 17 July 2025 – HARINGEY

Item	Purpose	Lead Organisation
JHOSC ToR & Membership		JHOSC
West & North London ICB Update		W&NL ICB
Whittington Health NHS Trust Quality Account		Whittington Health NHS Trust
Work Programme		JHOSC

Friday 18 September 2026 –ENFIELD

Item	Purpose	Lead Organisation
West & North London ICB Update • Involvement Strategy • Integrators		W&NL ICB
WorkWell Strategy		W&NL ICB
Work Programme		JHOSC

Friday 27 November 2026 – CAMDEN

Item	Purpose	Lead Organisation
Winter Planning Update *including impact of Increased Heat*	TBC	W&NL ICB
West & North London ICB Finance Update	TBC	W&NL ICB
ICB Estates & Infrastructure Strategy	TBC	W&NL ICB

Friday 29 January 2027 – BARNET

Item	Purpose	Lead Organisation
NCL Health Inequalities Fund		W&NL ICB
North Middlesex & Royal Free Hospital Merger Update		
End of Life Care	Invite North London Hospice, consider issues such as Hospice at home. TBC	
West & North London ICB Update		

Monday 19 March 2027 – ISLINGTON

Item	Purpose	Lead Organisation
West & North London ICB Update		W&NL ICB
StartWell (including maternity)		
St Pancras Hospital Programme Update		W&NL ICB
What is a good Quality Account?	Preparation in advance of consideration of Quality Accounts from: • Royal Free • Whittington • NLFT Explore best practice in order to support the Committee in their work of scrutinising them.	Scrutiny Officer

Usual standing items each year:

- **Estates Strategy Update**
- **Workforce Update**
- **Finance Update**

- **Winter Planning Update**
- **London Ambulance Service Update**
- **West & North London ICB Update**
    - Clarity and key contact list following the merger to be shared with the Committee
    - Paper marking out responsibilities of Trust, ICB and NHS England to be scheduled into work programme

Possible items for inclusion in future meetings:

- Digital Service Provision in the NHS
    - JHOSC to 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.
    - The committee to ask hospitals within the JHOSC area if they are using Palantir to run their data sourcing for them and if not, what was the reason behind their choice not to use them.
    - Once the information is retrieved by various Trusts on if they are using the platform, the next stage would be to contact NHS England and express concerns and seek re-assurances that our resident's data was being protected.

- NHS 10 Year Plan & Neighbourhood Health

    - Health and Wellbeing Board – strengthened role
    - Pooled NHS & Social Care Budgets (discussion with ICB & Heads of Social Care)
    - Integrators – Information on who they are and how they are progressing in all 5 boroughs, information on the memorandum of understanding about how they will work together.
    - Training and development for the VCS – ICB colleagues to liaise and seek advice from the Joint Partnership Board to support this work.
    - People's Strategy – pick up on the work undertaken in NWL and whether it can also be implemented in NCL
    - Virtual Wards – work underway monitoring carers to be presented to the Committee including information on unpaid workers packages
    - Update on Inequalities work being carried out by Imperial University.

- St Pancras Hospital update
  - Royal Free merger with North Mid, clarity about savings plans in its entirety and what makes up the deficit and is causing it and should form an action when considering finances in 2026/27.

- Health Inequalities Fund – See details of January 2027 action tracker

- NMUH/Royal Free merger