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LONDON BOROUGH OF RICHMOND UPON THAMES

# North West London Joint Health Overview and Scrutiny Committee

**Meeting Date:**
Monday, 9 March 2020

Agenda

**Meeting Time:**
2:00 pm

**Meeting Venue:**
Hythe Room, York House

Paul Martin, Chief Executive

| | |
|---|---|
| **Members** | Councillor Mel Collins (Chair) (London Borough of Hounslow)<br>Councillor Daniel Crawford (Vice-Chair) (London Borough of Ealing)<br>Councillor Monica Saunders (London Borough of Richmond upon Thames)<br>Councillor Robert Freeman (Royal Borough of Kensington & Chelsea)<br>Councillor Ketan Sheth (London Borough of Brent)<br>Councillor Lucy Richardson (London Borough of Hammersmith & Fulham<br>Councillor Michael Borio ((London Borough of Harrow)<br>Attendee to be confirmed (City of Westminster) |
| **Democratic Services Officer** | Nicholas Garland, nicholas.garland@richmondandwandsworth.gov.uk |

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York House
Twickenham
TW1 3AA

**28 February 2020**

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Nese keni veshtersi per te kuptuar kete botim, ju lutemi ejani ne recepcionin ne adresen e shenuar me poshte ku ne mund te organizojme perkthime nepermjet telefonit.

Albanian

এই প্রকাশনার অর্থ বুঝতে পারায় যদি আপনার কোন সমস্যা হয়, নিচে দেওয়া ঠিকানায় রিসেপ্শন-এ চলে আসুন যেখানে আমরা আপনাকে টেলিফোনে দোভাষীর সেবা প্রদানের ব্যবস্থা করতে পারবো।

Bengali

જો તમને આ પુસ્તિકાની વિગતો સમજવામાં મુશ્કેલી પડતી હોય તો, કૃપયા નીચે જણાવેલ સ્થળના રિસેપ્શન પર આવો, જ્યાં અમે ટેલિફોન પર ગુજરાતીમાં ઈન્ટરપ્રિટીંગ સેવાની ગોઠવણ કરી આપીશું.

Gujarati

**اگر در فهمیدن این نشریه مشکل دارید، لطفا به میز پذیرش در آدرس قید شده در زیر رجوع فرمایید تا سرویس ترجمه تلفنی برایتان فراهم آورده شود.**

Farsi

إذا كانت لديك صعوبة في فهم هذا المنشور، فنرجو زيارة الإستقبال في العنوان المعطى أدناه حيث بإمكاننا أن نرتب لخدمة ترجمة شفوية هاتفية.

Arabic

اگر آپ کو اس اشاعت کو سمجھنے میں کوئی مشکل ہے تو، براہِ کرم نیچے دیے ہوئے ایڈریس کے استقبالیے پر جا کر ملیئے، جہاں ہم آپ کیلئے ٹیلیفون انٹرپریٹنگ سروس (ٹیلیفون پر ترجمانی کی سروس) کا انتظام کر سکتے ہیں۔

Urdu

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਪਰਚੇ ਨੂੰ ਸਮਝਣ ਵਿਚ ਮੁਸ਼ਕਲ ਪੇਸ਼ ਆਉਂਦੀ ਹੈ ਤਾਂ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਪਤੇ ਉੱਪਰ ਰਿਸੈਪਸ਼ਨ 'ਤੇ ਆਓ ਜਿੱਥੇ ਅਸੀਂ ਟੈਲੀਫ਼ੋਨ ਤੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਇੰਟਰਪ੍ਰਿਟਰ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ।

Punjabi

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42 York Street, Twickenham, TW1 3BW
Centre House, 68 Sheen Lane, London SW14 8LP
Old Town Hall, Whittaker Avenue, Richmond, TW9 1TP
Or any library

**1. Welcome and introductions**

**2. Apologies for absence**

To receive apologies for absence.

**3. Declarations of Interest**

In accordance with the Members Code of Conduct, Members are requested to declare any interests orally at the start of the meeting and again immediately before consideration of the matter. Members are reminded to specify the agenda item to which it refers and the nature of the interest.

**4. Minutes of the last meeting and matters arising** (PAGES 5 - 10)

To consider the minutes of the meeting held on 27 January 2020.

**5. Patient transport** (PAGES 11 - 16)

This paper provides the Joint Overview and Scrutiny Committee (JHOSC) with an update on the Patient Transport Services (PTS) implementation of PTS Quality Standards and Patient Charter in Hospital Trusts in North West London.

**6. Patient and public engagement refresh (including citizens' panel and epic)** (PAGES 17 - 24)

The NHS in North West London has launched a new programme designed to bring its approach to public involvement and engagement up to the highest standard, ahead of the development of an Integrated Care System (ICS) and a single CCG.

The EPIC programme – 'Engage Participate Involve Collaborate' – was launched in December in partnership with Healthwatch. It is a 12-15 month programme which aims to be transformative and set a new direction for resident involvement in healthcare services.

**7. Demonstration of whole systems integrated care dashboard**

(Pages 25 - 36)

**8. Work planning programme and annual review**

**9. Any other business**

**10. Next meeting**

**11. Close**

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# Joint Health Overview & Scrutiny Committee

## Draft Minutes

### Monday 27 January 2020
### (at The Town Hall, RB Kensington & Chelsea)

**PRESENT**

**Members Present:**

| | |
|---|---|
| Councillor Mel Collins (Chair) | London Borough of Hounslow |
| Councillor Daniel Crawford | London Borough of Ealing |
| Councillor Robert Freeman | Royal Borough of Kensington & Chelsea |
| Councillor Jim Glen | City of Westminster |
| Councillor Lucy Richardson | London Borough of Hammersmith & Fulham |
| Councillor Rekah Shah | London Borough of Harrow |
| Councillor Ketan Sheth | London Borough of Brent |

**NHS Representatives Present:**
Juliet Brown, Health and Care Partnership Director
Dr James Cavanagh, Chair of Hammersmith & Fulham CCG
David Cox, Strategic Estates Consultant
Janet Cree, Managing Director, Hammersmith & Fulham CCG
Mark Easton, Accountable Officer, North West London Collaborative of CCGs
Rory Hegarty, Director of Communications and Engagement, North West London Collaborative of CCGs

## 1. WELCOME AND INTRODUCTIONS

1.1 Councillor Robert Freeman, as the representative member of the host borough, RB Kensington & Chelsea, welcomed members and officers to the meeting.

1.2 Prior to attending to the business of the JHOSC Councillor Mel Collins (LB Hounslow) stated that he had attended the Public Meeting on Palliative Care hosted by RB Kensington & Chelsea on 20 January. He thought that Councillor Freeman had made a fine job of chairing this meeting under difficult circumstances.

## 2. APOLOGIES FOR ABSENCE

2.1 Received from Councillor Monica Saunders (LB Richmond) and Councillor Lorraine Dean (City of Westminster). Councillor Jim Glen was attending as substitute for Councillor Dean.

## 3. DECLARATIONS OF INTEREST

3.1 Councillor Robert Freeman (RB Kensington & Chelsea) declared he was a member of the Council of Governors of the Royal Marsden Hospital. Councillor Ketan Sheth (LB Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust (CNWL).

## 4. MINUTES OF THE PREVIOUS MEETINGS

4.1 The minutes of the 22 July 2019 meeting were agreed.

4.2 The minutes of the 30 October 2019 meeting were agreed. The following matters were noted: -

1. There was one outstanding matter (Minute 4.2 (Minutes of the Previous Meeting) point 4) – that the results of health inequality assessments carried out by the CCGs would be circulated to Members of the JHOSC as soon as they were available.

2. On Minute 5 (North West London Financial Recovery), it had been decided after discussion with Councillor Collins that it was not necessary for the CCGs to produce a map identifying QIPP (quality, innovation, productivity, and prevention) savings. The information was already regularly published.

3. On Minute 6 (NHS Long-Term Plan Submission) it was noted that the full response from North West London on Preventing Eating Disorders had been circulated.

**ACTIONS:**

- Circulation of the health inequality assessments by the CCGs (number 1. above).

## 5. UPDATE ON LONG-TERM PLAN

5.1 Juliet Brown introduced the paper that had been circulated electronically with the agenda - North West London's draft response to the NHS Long-term Plan. Over the coming months, this paper would be taken through Health and Wellbeing Boards and a number of other bodies. This was a genuinely exciting opportunity she added and notified a major workshop taking place on 19 February.

5.2 Mark Easton added that a White Paper on Health was expected. The legislation under which the health service currently operated was becoming unwieldy.

5.3 Mark Easton then referred to the ongoing arrangements leading up to merger of the CCGs in 2021. It was believed that there was scope for pooling certain functions and reducing management costs. There had been an engagement

process in respect of clusters of local councils. Consultation with staff was about to commence.

5.4 Councillor Ketan Sheth (LB Harrow) questioned Juliet Brown about the specific plans for Harrow contained in the response. She responded that the long-term plan would enable locally flexible schemes, for instance, she would shortly be meeting with Dr Melanie Smith, Director of Public Health (LB Brent) to consider innovative responses to diabetes.

5.5 In response to a question from Councillor Daniel Crawford (LB Ealing) Dr James Cavanagh stated that the aim was to keep people better for longer. People were coming together to produce more integrated and innovative services. In North West London we were responding to the long-term plan and there could be seen the early stages of recovery. Mark Easton added that exhortation to the public did not work well; within the long-term plan there was considerable scope for local innovation and the sharing of best practice.

## 6. BABYLON GP AT HAND AND ANY POTENTIAL IMPACT ON NW LONDON

6.1 Dr James Cavanagh (Chair of Hammersmith & Fulham CCG) together with Janet Cree (Managing Director, Hammersmith & Fulham CCG) gave a brief overview of the Babylon GP at Hand scheme. This digital first practice (originally offering services to patients within LB Hammersmith & Fulham but now with patients registered across many locations) had seen exceptional growth in its practice list size over the last two years. This was a popular service for the public offering increased ease of access. In addition, it was popular with staff, offering a better work life balance. The scheme had extended to Birmingham.

6.2 In response to a number of detailed financial questions from Councillor Lucy Richardson (LB Hammersmith & Fulham) Ms Cree sought to assure her that there would be full cost mitigation for the current year. The full costs for 2019/20 were expected to be £24 million; £17.4 million had already been received. This was an ongoing situation but there was not expected to be any deficit in 2019/20. Mark Easton confirmed that there was a historical deficit in place.

6.3 Councillor Collins asked about Babylon's accountability. Dr Cavanagh responded that the CQC had inspected Babylon and rated it Good. A Patients' Panel was in existence. Councillor Crawford added his concern about the administrative and financial implications on this CCG.

6.4 Dr Cavanagh sought to restate that this scheme offered better access to GP services and should be encouraged. There would be a long-term beneficial impact he believed and the financial effects were being mitigated.

6.5 Councillor Sheth asked about quality assurance and was assured by Ms Cree that an additional quality assurance process had been added. Currently the system operated under General Medical Services (GMS) contracts. This was changing to Alternative Provider Medical Services (APMS) contracts.

## 7. NHS ESTATES STRATEGY FOR NORTH WEST LONDON

7.1 David Cox (Strategic Estates Consultant) introduced the report. The condition of the estate across NHS North West London was varied with some buildings being very aged. Overall, we were currently in a process of reflection and review. Under the HIP bids North West London had applied for funding to improve the estates at Imperial (St Mary's, Hammersmith, and Charing Cross) and Hillingdon Hospitals.

7.2 Councillor Jim Glen (City of Westminster) asked for more details about the replacement structure likely at St Mary's. Beyond saying that it would be a steel frame, Mr Cox could not add any further details at present.

7.3 Councillor Richardson was interested in seeing a breakdown of the maintenance backlog and was referred by Mark Easton to the Education Resources Information Centre (ERIC) Database accessible online. Councillor Richardson also asked about hubs and it was agreed that Mark Easton would provide a current listing of the hubs across North West London and their state of development. He reminded that Hubs were not something new, they were part of an aim to renew primary care estate across North West London and many of them were overdue.

7.4 The Committee noted that Integrated Delivery Plans were borough specific and could be obtained from their authority's planning department. Mr Cox also added the important contextual point about the importance of housing and homes and the Greater London Authority's requirement to build more homes.

7.5 Councillor Sheth asked about Northwick Park, which Mr Cox confirmed was part of the Outer North West London Estate Plan.

**ACTIONS:**

- To provide the Committee with further information regarding the hubs and their state of development.

## 8. WORK PLANNING PROGRAMME

8.1 Councillor Collins informed the meeting that the work plan for the last meeting of the current year had been reviewed prior to this meeting.

## 9. ANY OTHER BUSINESS

9.1 Questions concerning Palliative Care – Cllr Collins reported that he had received a number of questions from members of the public concerning Pembridge Hospice. The response from the CCGs received to these questions **would be appended to these minutes.**

9.2 Participation of LB Hillingdon – Cllr Collins reported vigorous efforts had been made to try to get Hillingdon to join and participate in this JHOSC but without success.

9.3 JHOSC Meeting Agenda Planning Arrangements – Cllr Collins suggested, and Mark Easton agreed, that these needed to be improved for subsequent meetings.

9.4 It was noted (from a member of the public present) that there was a meeting of the North Central London JHOSC on 31 January (at 10am at Haringey Civic Centre). This meeting would consider the proposed move of Moorfields Eye Hospital. Individual boroughs had been notified of this matter. (Councillor Collins declared that he was a long-term user of this facility).

**ACTIONS:**

- Palliative care responses to be appended to these minutes.
- Agenda Planning Arrangements to be improved.

## 10. NEXT MEETING

9 March 2020 at LB Richmond upon Thames.

Meeting started: 3pm
Meeting ended: 5.05pm

Chair .....

Contact officer: Gareth Ebenezer
Governance Administrator, RB Kensington & Chelsea

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North West London
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# Joint Health Overview and Scrutiny Committee (JHOSC): North West London Patient Transport Services (PTS) Update on Quality Standards

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| **Summary** | This paper provides the Joint Overview and Scrutiny Committee (JHOSC) with an update on the Patient Transport Services (PTS) implementation of PTS Quality Standards and Patient Charter in Hospital Trusts in North West London. |
| **Date** | 28 February 2020 |
| **Owner** | Lizzy Bovill, Director Performance & Delivery |
| **Author** | Kiran Shah, Patient Transport Services Programme Lead |

## 1. Introduction

This paper provides the Joint Overview and Scrutiny Committee (JHOSC) with an update on the Patient Transport Services (PTS) implementation of PTS Quality Standards and a standardised assessment process in hospitals in North West London.

## 2. Background

During 2016 we developed North West London wide PTS Quality Standards and a Patient Charter to support our aspiration of improving the transport services provided by all acute hospitals in North West London to an agreed standard. This means that regardless of which hospital a patient is travelling to, the quality of the transport service should be consistent.

Hospitals covered are:

- Imperial College Healthcare NHS Trust
- London Northwest University Healthcare NHS Trust
- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster NHS Foundation Trust.

The North West London wide PTS Quality Standards have been developed in collaboration with PTS service users; Hospital Trust PTS leads; lay partners; transport providers and CCG

Contract Leads. In addition the standards have been informed by a North West London-wide survey of 700 patients who use local PTS services.

The PTS Patient Charter outlines the key requirements a patient should expect on *every* journey. For example, the requirement that the driver should wear a uniform and carry identification or that the transport vehicle should be clean.

A set of PTS KPIs have been developed to allow for monitoring of the PTS Quality Standards and provide an opportunity for benchmarking and supporting hospitals to achieve full implementation.

The PTS Quality Standards / Patient Charter and KPIs went into hospital contracts in April 2018.

The work to date has identified that the acute hospitals all have different assessment processes and eligibility criteria. This means that in some areas in North West London, GPs are expected to assess and determine whether a patient will have transport provided for them and in other areas the hospital will carry out an assessment and determine eligibility.

During 2018 /19 we worked with hospital teams towards developing a North West London-wide common assessment process to be implemented in all acute hospitals.

Appropriate reviews of the eligibility for transport will be undertaken dependant on medical need to ensure transport services are used appropriately.

## 3. Eligibility Assessment Process Implementation

A subgroup chaired by a lay partner who is a service user and with representatives from each of the hospitals and commissioners is responsible for working with hospital teams to ensure that a fair and consistent assessment process is implemented and highlight concerns to contract commissioning leads.

The eligibility assessment process is based on medical need and a common set of questions are used by all assessing eligibility. The questions are:

| | |
|---|---|
| 1. | *At this time, how do you normally visit your GP/ social / shopping/etc?* |

| | |
|---|---|
| 2. | *Can you travel in a car that is driven by you, a friend or relative or in a taxi to this appointment?* |

| | |
|---|---|
| 3. | *At this time, what stops you from making your own way?* |

| | |
|---|---|
| 4. | *Do you require medical assistance or medical equipment?* |

| | |
|---|---|
| 5. | *Is there a diagnosed medical reason that prevents the use of public transport or a taxi?* |

| | |
|---|---|
| 6. | *Do you have a mobility issue which prevents the use of public transport or a taxi?* |

The questions were implemented across the four hospitals during 2019 and they are all currently using the same set of questions. There are currently no plans to change the eligibility assessment process.

Where patients are deemed not eligible for patient transport based on medical need, they are sign posted to alternative support such as the Healthcare Travel Cost Scheme and Transport for London (TfL) options. All hospital websites have a link to TfL to support patients in planning their journeys using public transport.

Hospitals are working with the transport companies to address and improve on the journey duration and arrival and departure times taking into account route planning and peak traffic times.

The patient transport standards are focussed on getting patients to appointments on time and working towards patients who travel up to 6 miles not spending more than 60minutes on the vehicle. Patients are welcome to bring food and drinks with them on patient transport.

In addition hospitals are reviewing internal processes to improve on discharge planning to link with booked transport to facilitate a more efficient journey for the patient and improve waiting times.

Approximately 500,000 patient transport journeys are taken across North West London annually.

**Key Improvements over the year (2019) include:**

- Journey duration (up to 6 miles)
- Percentage of services users who spend up to 60 minutes in the vehicle for a journey that is up to 6 miles in distance.
- Threshold: ≥95%
- North West London average in 2018 – 94%
- North West London average in 2019 - 96%

Approximately 36,000 patient journeys across North West London improved with patients spending less than 60 minutes in the vehicle.

- Arriving on Time
- Percentage of Service Users who arrive 10 minutes before, but no more than 45 minutes prior, to their appointment or admission time.
- Threshold: ≥95%
- North West London average in 2018 – 70%
- North West London average in 2019 - 84%

Approximately 47,000 patient journeys improved and arrived 10 minutes before their appointment or admission time allowing timely booking in of the patient by hospital staff.

- Departing within 60 minutes
- Percentage of Service Users being conveyed by the Patient Transport Service who depart within 60 minutes of being booked ready to leave.
- Threshold: ≥95%
- North West London average in 2018 – 81%
- North West London average in 2019 - 87%

Approximately 33,000 patient journeys improved and departed from hospitals within 60minutes of being ready to leave, freeing up hospital capacity and staff time.

- Arriving after appointment time
- The time the Service Users arrive after their appointment time.
- Threshold: ≤5%
- North West London average in 2018 - 16%
- North West London average in 2019 - 9%

Approximately 26,000 patient journeys improved and did not arrive late or miss their appointments. Hospital staff capacity was freed up as they did not have to rearrange appointments or clinics. Patients did not have to spend longer in hospital and / or come back another day for missed appointments. Patient transport did not have to be booked again for a repeat journey where appointments were rearranged.

**Departure Times – Inpatients**

- Service Users will depart within 90 minutes of being booked ready to leave on the day of discharge.
- Threshold: ≥99%
- North West London average in 2018 (3 out of 4 hospitals) – 87%
- North West London average in 2019 (3 out of 4 hospitals) - 91%
- One hospital is reviewing its discharge policy for patients requiring transport.

Approximately 118, 000 patient journeys improved and departed within 90 minutes on day of discharge, releasing hospital beds and staff capacity.

## 4. Summary and next steps

Hospitals are working together to ensure that they are all providing a fair and consistent eligibility assessment process. Priorities for this year include ensuring patients get to their appointments on time and that transport providers are working towards the required quality standards.

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# Joint Health Overview and Scrutiny Committee (JHOSC): Future approach to public engagement – the EPIC programme

*28 February 2020*

| | |
|---|---|
| **Summary** | The NHS in North West London has launched a new programme designed to bring its approach to public involvement and engagement up to the highest standard, ahead of the development of an Integrated Care System (ICS) and a single CCG.<br>The EPIC programme – 'Engage Participate Involve Collaborate' – was launched in December in partnership with Healthwatch. It is a 12-15 month programme which aims to be transformative and set a new direction for resident involvement in healthcare services. |
| **Date** | 9 March 2020 |
| **Owner** | Rory Hegarty, Director of Communications and Engagement, NW London Health and Care Partnership/NW London Collaboration of CCGs |

## 1. About the EPIC programme

The NHS in NW London launched the EPIC programme – **Engage Participate Involve Collaborate** – in December 2019.

The programme aims to move our approach to resident engagement and involvement from where it is now to a leading edge, paradigm-shifting approach of which we can all be proud. As we move towards a merger of the eight NW London CCGs and an Integrated Care System for NW London, the intention is to strengthen the patient and public voice, putting in place an approach that is responsive and consistent across the patch. This includes a commitment to co-production, appropriate consultation and hearing from as many of our communities as possible. This is a 12-15 month programme which aims to be transformative. The intention is to use the discipline of programme management to put the right systems and

approach in place over the next 12 months. During this period, we will be talking to local people about our response to the NHS Long Term Plan and we will look to learn from these conversations as we develop our approach.

Above all, the EPIC programme is ambitious: we want to build on the best and look to make North West London a beacon of best practice for how the NHS works with residents and patients.

### 1.1 Working with partners

We want to **co-produce the future approach** with patient voices, Healthwatch, the voluntary sector and our local authority partners. Healthwatch Central West London co-produced the launch event and we have a steering group of around 20 volunteers from Healthwatch, the voluntary sector and local residents. The steering group is chaired by the Chair of the Joint Committee of CCGs, Alan Wells.

## 2. The four strands of the EPIC programme

There are four key strands to our approach:

- **Patient and public involvement**: how we involve local residents in shaping and co-producing our services and how we join up resident voices across a range of programmes, including development of an **Involvement Charter**.
- **Outreach engagement**: reaching out and hearing from as many of our diverse communities as possible, putting in place an ongoing dialogue and ensuring we meet or exceed equalities legislation.
- **Citizens' Panel**: a virtual panel of 4,000 local residents, demographically representative of our local communities, which we will use to gather public opinion about healthcare services and NHS initiatives and which may be drawn on for focus groups on specific issues.
- **Community Voices**: our Community Voices programme trains volunteers to have 'unprompted' conversations with local people, fathering real time feedback and views from our communities.

There are two related strands which form a core part of our work, but are not specifically part of the EPIC programme:

- **Behaviour change** programmes linked to public health, which may cross over with some elements of outreach engagement. We would very much like to work in partnership with local authorities on public health campaigns in each borough.
- **Stakeholder engagement**
  with local organisations, politicians and campaign groups.

## 2.1 Patient and public involvement

### Vision

"Local residents involved in patient participation groups, Long Term Plan workstreams and condition-specific groups work together with the local NHS and local authorities as one system, to support co-production of local services and ensure a consistent, joined up approach to wider public engagement."

### Where are we now?

There are pockets of excellent practice for resident involvement in health services, including some strong co-production models. But the public voice is not heard in a consistent way across the patch, members of the public involved at different levels are not linked or coordinated and the approach to recording and acting on feedback – and reporting this to residents – varies widely.

### Next steps and approach

- We are currently carrying out **an audit of public involvement** across the NHS in NW London, with a view to putting in place a much more coordinated approach to involving local residents in our work.
- We will look to **learn from and build on existing good practice**, including from local authorities, where models of involvement and co-production are often better developed.
- Local residents who attended our first EPIC network meeting in December suggested that we produce an **Involvement Charter**, setting out how we will involve and work with local residents, and this is something we will take forward.
- **Healthwatch, the voluntary sector and local authorities** are viewed as key partners in this work.

## 2.2 Outreach engagement

### Vision

"We are in regular dialogue with as many of our communities as possible and their perspective informs the development of and changes to NHS services. We carry out targeted engagement and consultation with specific groups that the NHS does not always reach, working in partnership with Healthwatch, local authorities and the voluntary sector."

### Where are we now?

Again, there is some excellent practice in parts of NW London, and the NW London CCGs have an agreed approach to public consultation, which takes account of national guidance, best practice and our statutory duties under the Equality Act.

What is not yet in place is a systemic approach across NW London to ensure that we hear from and are in dialogue with all of our local communities. We recognise that most residents will not necessarily want to attend NHS meetings or participate in working groups and that we need to be engaging beyond those who are more likely to do so.

### Next steps and approach

- We are seeking good example of outreach community engagement. We are enthused by the approach taken in South West London, where funding was found to support a programme of 'grassroots engagement', with Healthwatch providing small grants to local grassroots organisations to put on enjoyable activities for their client group and NHS staff in attendance would gather their views on local health services. We will seek funding to put in place a similar programme across NW London.
- At our next network meeting on 1 April, we have asked the Consultation Institute to lead a session on outreach engagement, so that we can build on existing best practice and work with local residents, Healthwatch, the voluntary sector and local authorities to develop a best practice approach to outreach engagement.
- We will look to put the new approach in place as soon as possible.

## 2.3 Citizens' Panel

### Vision

"We have access to real time feedback and opinion from a demographically representative group of local residents who not routinely engage with the NHS. We have the capacity to run focus groups representing particular demographics drawn from the panel."

### Where are we now?

North West London was one of a number of areas successful in securing funding from NHS England and Improvement to set up a Citizens' Panel. We used a specialist recruitment agency to recruit the first 3,000 members in line with local demographics, using on street recruitment. Using the same demographic principle, we have so far recruited a further 800 members. The Panel is expected to grow to 4,000 during this year.

It should be noted that the Citizens' Panel is one bespoke strand of our engagement: it is not a substitute for the many conversations we need to have with residents and service users. It should be viewed as an enhancement to our approach rather than a replacement of any other dialogue with local people.

### Next steps and approach

- The Citizens' Panel allows us to hear from people who would not necessarily engage routinely with health and care services. Its main use will be virtual, testing public opinion and experience of health and care services and initiatives.
- Our first survey is currently live and asks a series of questions about patient experiences of health services.
- We may in future approach members of the panel to take part in focus groups where we want to hear from a specific demographic group or area.
- Membership and levels of participation will be reviewed on an ongoing basis.

## 2.4 Community Voices

### Vision

*'Our stories are our voices; a collective voice; a community voice'*

Given the Long Term Plan, changes to the role of GPs and nurses and the introduction of social movement thinking in primary care networks and social prescribing, it is the right time to begin to articulate the role systems and communities play in driving change.

Change conversations that stimulate new possibilities to understand the interface between systems and communities can be the engine room to bring about large-scale transformation in health and care.

Community Voices recognises this potential and brings together stories of change from ordinary people who are passionate about the need to improve the way health and care services are delivered. This is a rare opportunity for people across the health and care system to talk openly and authentically about the challenges of introducing change in their systems and working in an integrated and meaningful way.

A collection of stories [1]of people who have different degrees of influence and power, share their insights on the methods and actions they use to bring about change. Change conversations that matter are difficult to cultivate in a context that is shifting and changing dramatically. People who are most affected are not often the people who lead change conversations. Yet their drive, personal and professional ambitions and ability to introduce innovative change approaches provide rich insights into the potential for transformation at the grassroots level.

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[1]Fatima's Story: https://vimeo.com/292660944

Justin's Story: https://vimeo.com/289255578

Robyn's Story: https://vimeo.com/353949312/869e5dafe3

**Password: communityvoices**

.

**Where are we now?**

We continue to collect change stories from people at the front line, in communities and at system level. We are cognisant that the level of activity taking place at the grassroots level has increased significantly with the renewed interest in PCNs, and social models of health and care.

This is an opportunity for community voices to link a number of strands. Community Voices will not only represent individual stories but collective stories of change. This shift is important as we are interested in how movements work in complex systems and contexts. We will look at collaborative change conversations with community leaders who want to test new practices and approaches. The GPs at the Deep End initiative, Community Champions and Quality Service Improvement and Redesign (QISR) Programmes are key examples that illustrate the shift from individual choices, preferences actions to how stories stimulate new ideas that create movements in health and care.

There is a natural tie into PCNs, nurses at the front line, integrated care and the changing role of GPs (social prescribers).

Scaling up means that we look for connectors, and connections - people who work across different systems and outside systems to deliver change. It is the maturing of Community Voices to a level that illuminates the messages captured in the first phase of its development.

**Next steps and approach**

An action plan for the next twelve months is being developed and NHSE/I has provided £10k of funding. We will seek to bring together key connectors who have access to these communities. We will host conversations on the change that people want to see happen and how they can work together to bring about a different type of change that they individually would not be able to do. We will assess what happens when activists/connectors get together to share actionable ideas and what this means for wider system change.

## 3. Progress to date and next steps

**The programme was launched on 17 December.** Our event was the first of at least three network events with about 80 members of patient participation and other groups Healthwatch, the voluntary sector, local authorities and NHS staff.

**The response was very positive:** several attendees volunteered to sit on the programme steering group and there was commitment in principle to **an involvement charter** for North West London.

The **steering group** met in January and will co-produce and drive our future approach to public engagement and involvement.

A **programme plan** is being developed and an **audit of patient involvement** in NW London is underway.

The next network meeting on 1 April will discuss **outreach engagement** and develop the **Involvement Charter**.

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NHS
North West London
Collaboration of
Clinical Commissioning Groups

# WHOLE SYSTEMS INTEGRATED CARE (WSIC) DASHBOARDS COLLABORATION OF NWL CCGS

JHOSC

North West London
Whole Systems Integrated Care

# Introduction

**Where did WSIC come from?**

- Started approximately 7 years ago
- NWL was chosen for the Integrated Care Pilot (ICP)
- To use integrated care data to understand the population, to find innovative ways of working together to better support the needs of the population
- Years of work setting up Governance to allow information sharing between providers
    - NWL Information Governance Group established
    - Information Sharing Agreement (ISA) created
    - Data Controllers signing up to the ISA
- Dashboards were developed to support the work that developed into Whole Systems Integrated Care (WSIC)
- Clinical Advisory Group (CAG) set up to lead the direction of the development of the dashboards

**Key facts** • Over 2 Million People • Over £4bn Annual Health & Care Spend • 8 Local Boroughs • 8 CCGs & Local Authorities • 352 GP Practices • 10 Acute & Specialist Hospitals • 2 Mental Health Trusts • 4 Community Health Trusts


**What is WSIC?**

- A suite of dashboards have been built to visualise the combined Health and Social care data across NW London.
- Using the WSIC database and Tableau (visualisation software) we can give users a linked view of this data.
- It is a tool to support 'joined up' healthcare by supporting delivery of care, encouraging proactive case finding making it easy and applicable for the clinical needs and to understand population health.
- This provides far better communication and information sharing, and reduces duplication and confusion for patients, carers and staff.

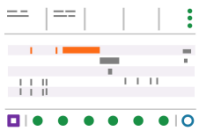
# Whole Systems Integrated Care (WSIC) solution


**Derived Measures**
Long Term Conditions
electronic Frailty Index (eFI)
Spend

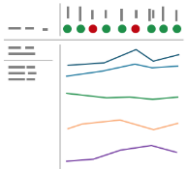
**Core Data**
Activity
Prescriptions
Demographics

**Reference Data**
Organisation
BNF
Postcode 'out codes'

**WSIC Data Warehouse**


Integrated Patient Summary

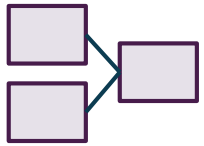

Case Finding Tools


Long Term Condition Management Tools

DE-IDENTIFIED


Population Health


Benchmarking


De-identified dataset


District Nurses


Care Coordinators


GPs

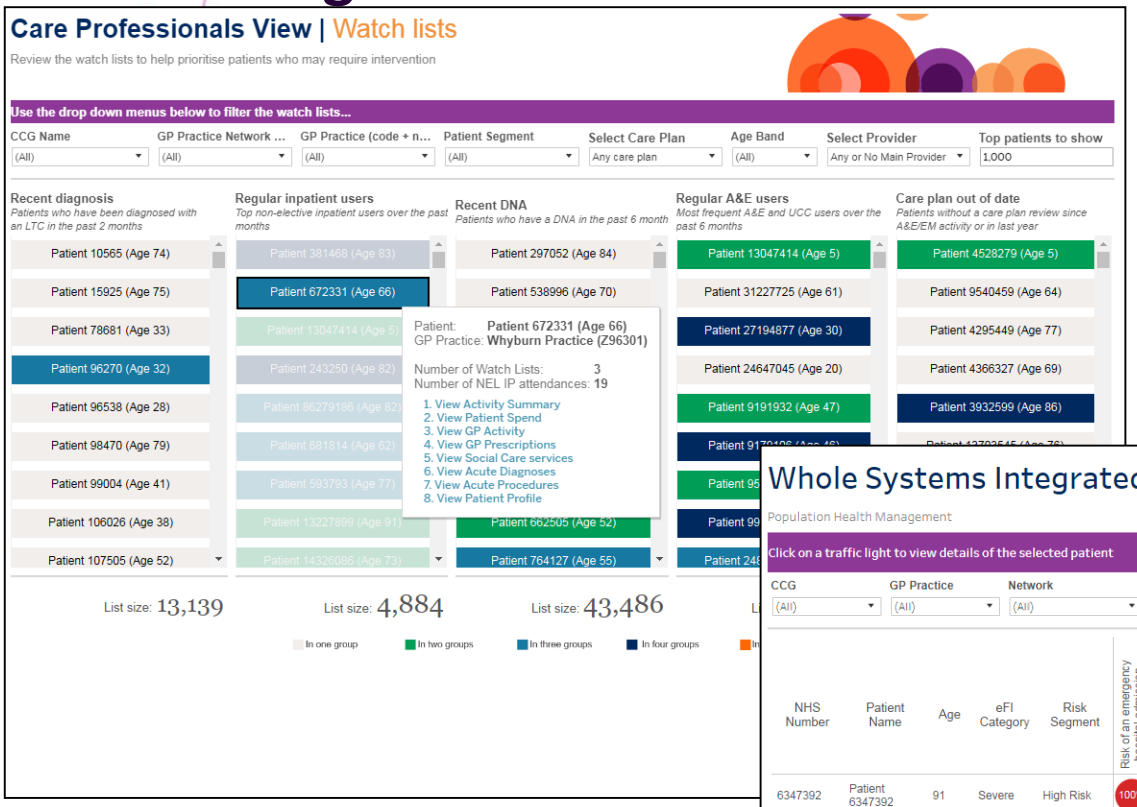

Clinical teams in secondary care

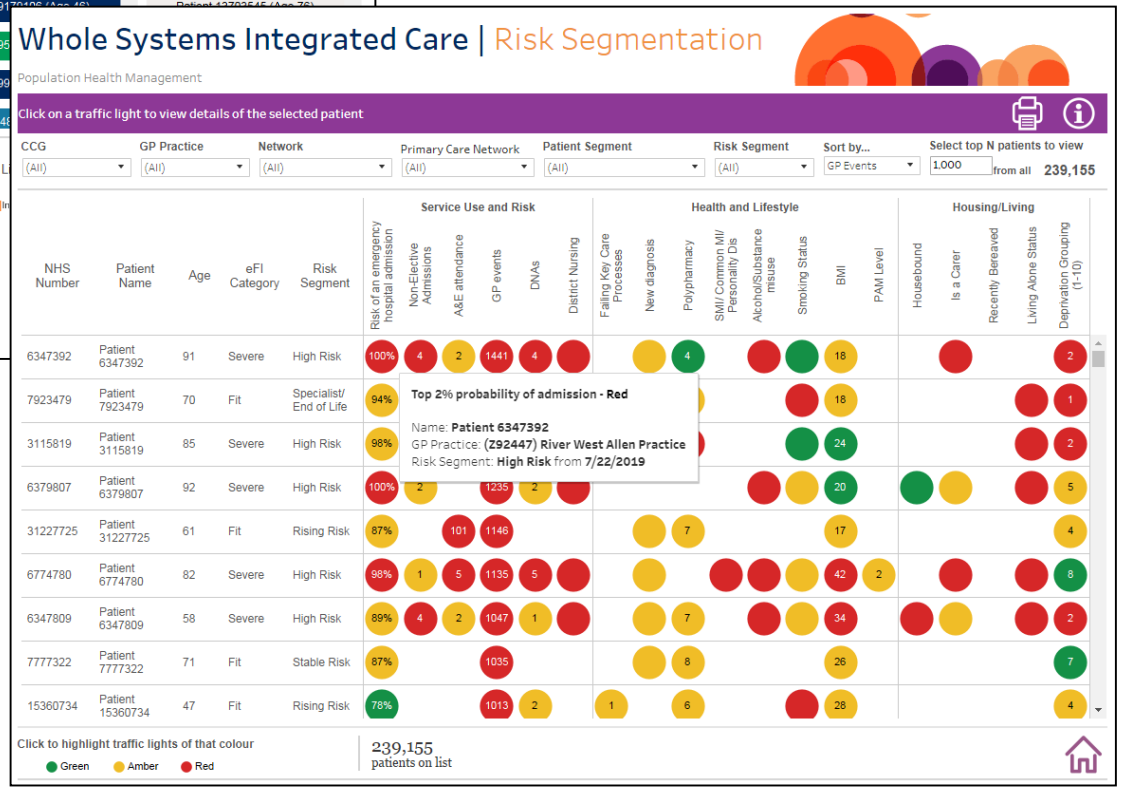

PCNs


Analysts and Researchers

North West London
Whole Systems Integrated Care

# Case Finding

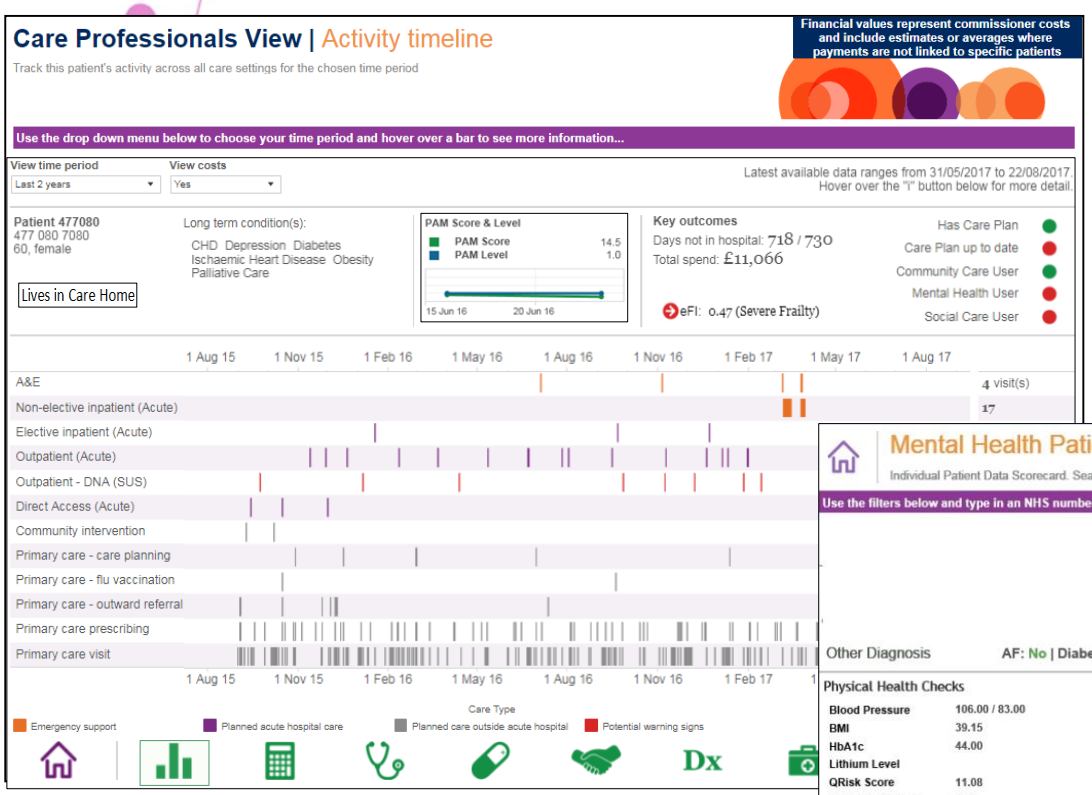


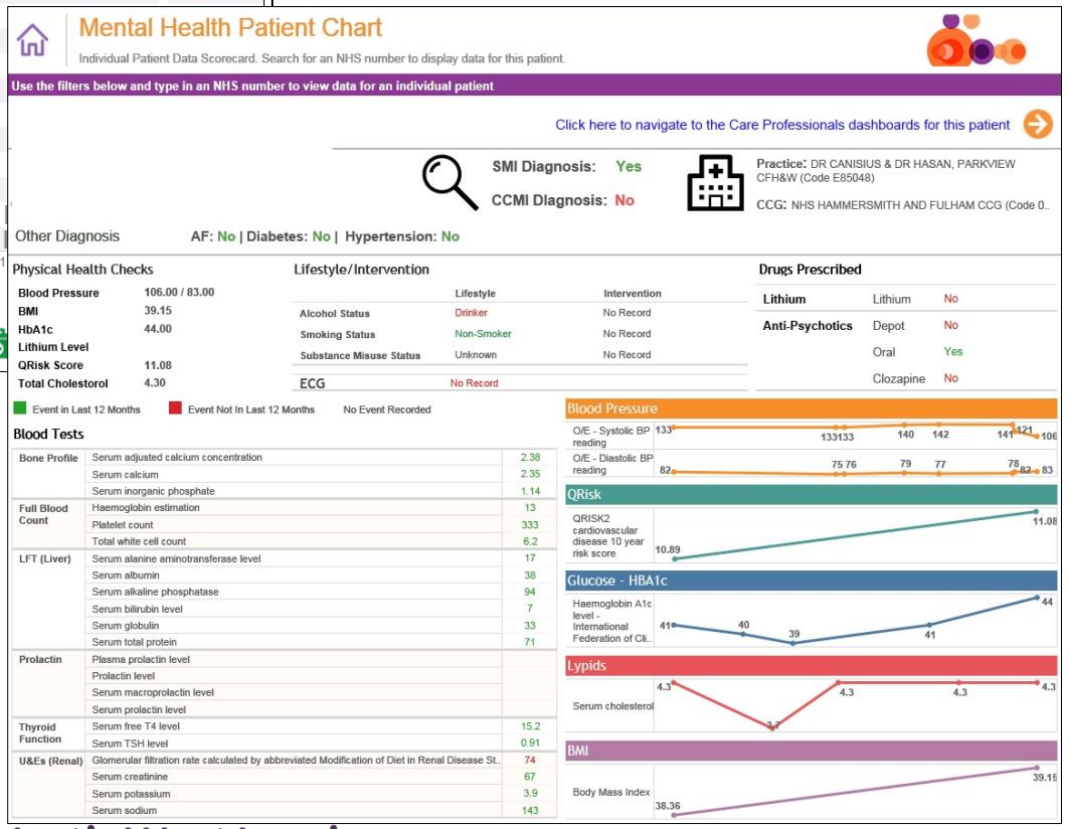




Find cohorts of patients by different determinants.

This includes a number of dashboards to case find within specific LTCs

# Patient Summaries

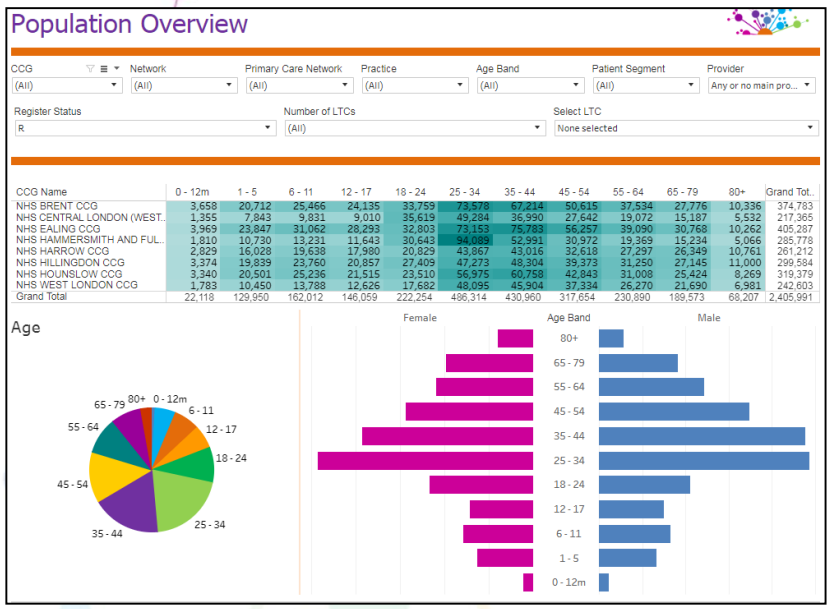


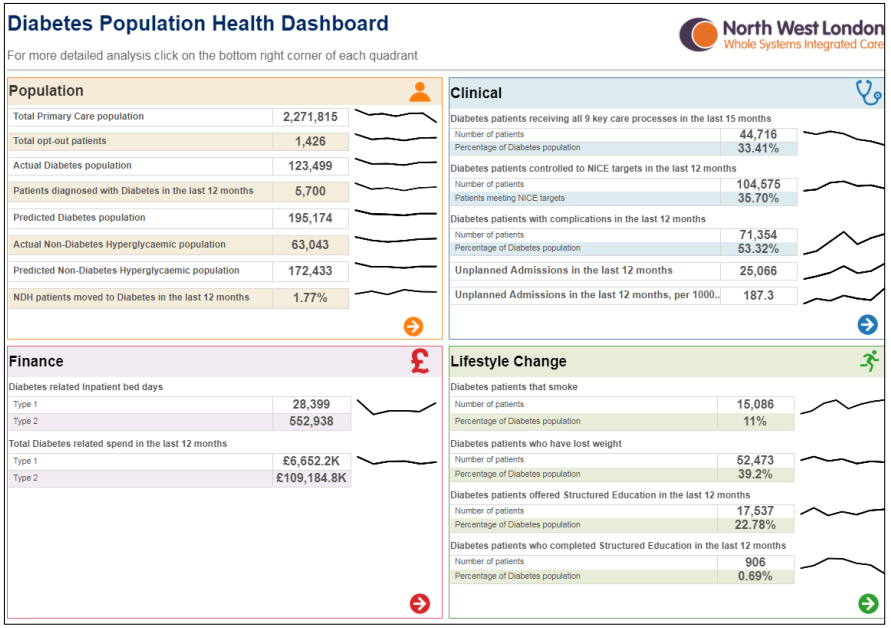



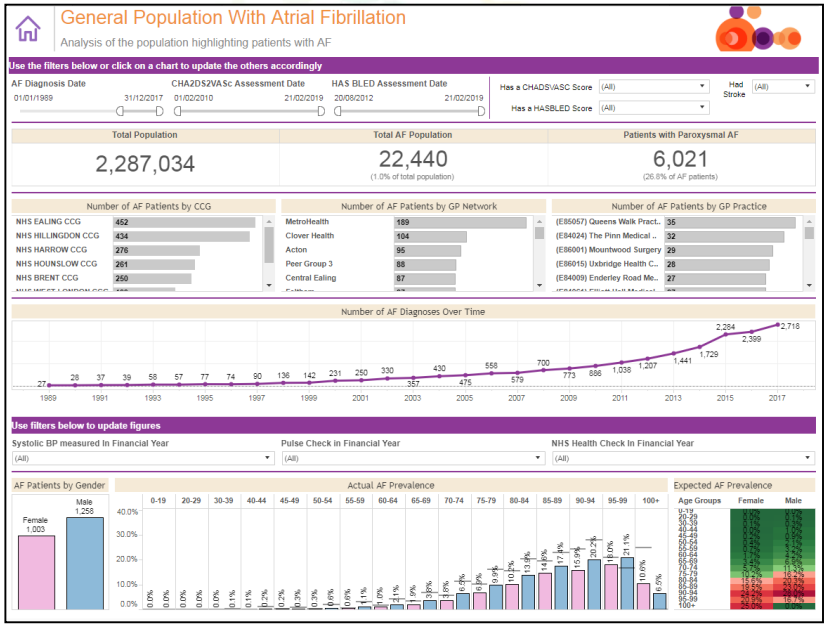

Search by NHS number for access to individual patient summaries

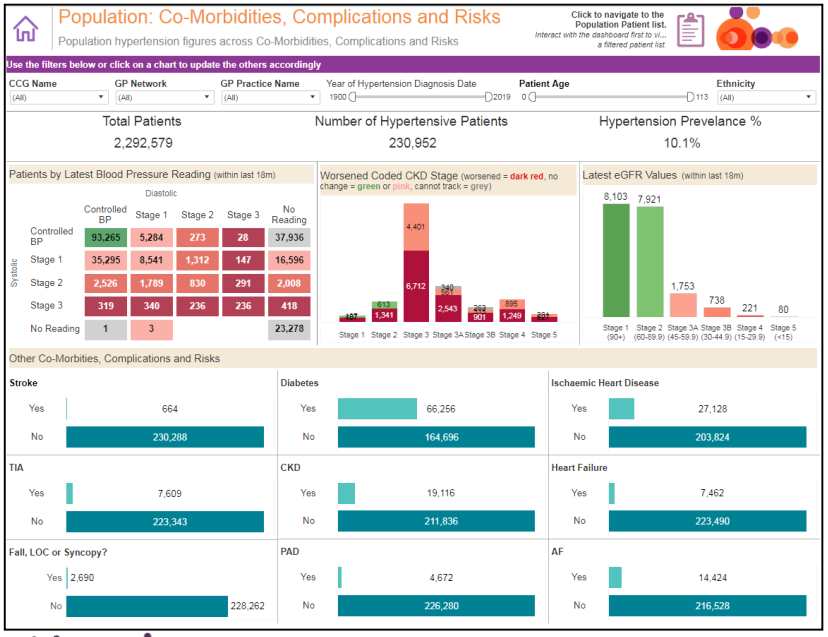
North West London
Whole Systems Integrated Care

# Population Health management



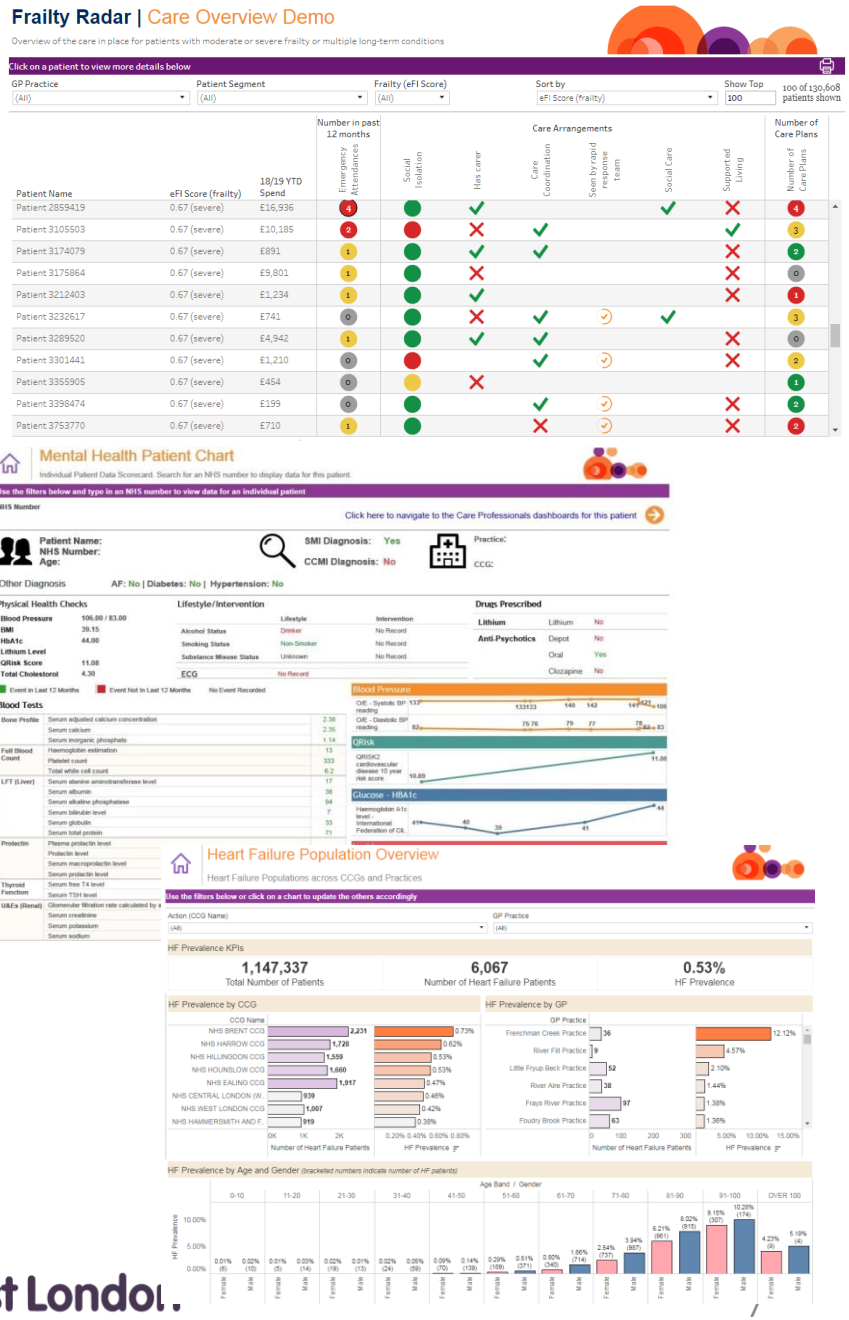



# Benefits

- **Identify and support patients for targeted care**. Identifying gaps in the patients care pathway and highlight patients who are more at risk from serious deterioration
- **Facilitates discussion and co-ordination between care professionals**. from different settings by providing a holistic view of the patient record
- **Aiding continuity of information between MDT members** Reduce reliance on hard copies of notes, manual data access and tracking
- **Support discussion with the patient** printable versions are available so the clinician can annotate and hand as support documentation to the patients
- **Reduction of duplication** Test results are available with date of result therefore allowing the clinician to decide if the patient is required to have the same test again
- **Understanding of the impacts health and social care** Integrated health and social care data to provide a holistic picture of the patient's care
- **Understand the needs of the population** inform discussions between systems about how to mobilise resource efficiently and support the specific needs of that area
- **Strategic planning and analysis of the populations care needs** Ability to view the population data at different levels




North West London
Whole Systems Integrated Care

# Governance arrangements

There are two user **access pathways to the WSIC Dashboards** (all access requests are approved by the caldicott guardian of the relevant organisation)

- The Patent Identifiable Data (PID) level Access: For care professionals who have direct care relationship with Patients. Ex. GP's, Nurses etc.
- The Population Health (Non PID) level Access: for users who don't have direct care relationship with patients. Ex. Commissioning staff of CCGs

**Access to de-identified data service**

- De-identified data is also made available as a data service – Commissioning analysts, PH analysts and research analysts from NWL organisations can apply for access to this.
- The access forms are approved by NWL Information Governance sub-group before access is granted. The forms need to state the projects the analysts will be carrying out and for which organisation in NWL, with a number of IG regulatory questions in order to be approved.

ACCESS IS NOT PROVIDED TO COMMERCIAL ORGANISATIONS AND THEY CANNOT APPLY directly.

# Usage of WSIC in Clinical practice – A real example

# ASTHMA RADAR

## Whole Systems Integrated Care | Asthma Radar

Identify patients with asthma who may be at high risk and/or in need of review

**Click on a traffic light to view details of the selected patient**

| GP Practice | Patient Segment | RCP Review Filter | Sort by... |
|---|---|---|---|
| (All) | Children | No filter selected | Number of Exacerbations |

9,165 patients on list

| Patient Name | Age | Number of Risk Factors | Number of A&E/UCC Attendances (past 12 months) | Number of Exacerbations: Exacerbations | Number of Prescriptions (past 12 months): Short-Acting β-Agonists | Number of Prescriptions (past 12 months): Inhaled Corticosteroids | Asthma Care: Asthma Review | Asthma Care: Inhaler technique | Asthma Care: Symptom Control Test | Asthma Care: Personal asthma plan | Lung Function: Peak Flow | Lung Function: FEV1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient 22121886 | 16 | 1 | 6 | 17 | 15 | 10 | | | | | | |
| Patient 5192202 | 10 | 1 | 0 | 15 | 1 | 0 | | | | | | |
| Patient 2434246 | 5 | 0 | 10 | 11 | 5 | 7 | | | | | | |
| Patient 11418090 | 15 | 2.1 | 4 | 10 | 12 | 3 | | | | | | |
| Patient 10664729 | 15 | 3 | 6 | 9 | 4 | 6 | | | | | | |

**Patient 22121886, 16**
**NHS #: 22121886**

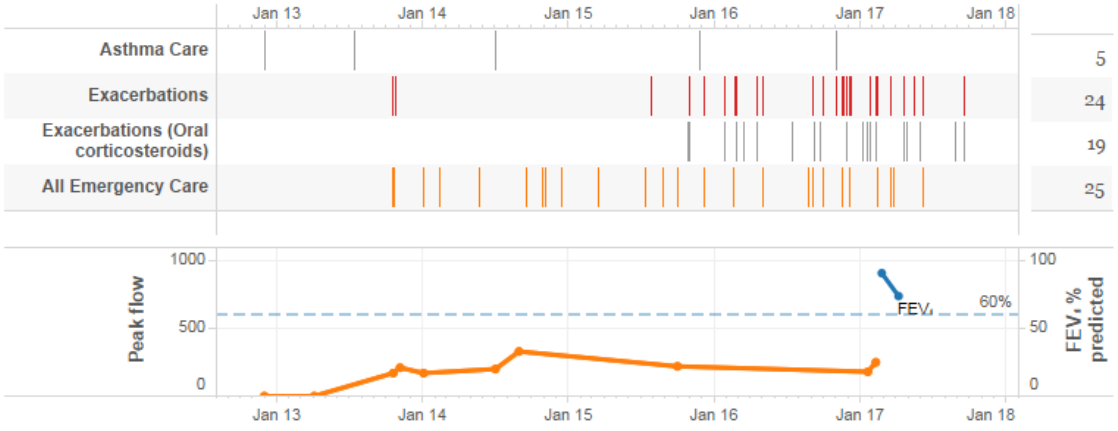
Latest practice update: 25/02/2017 ...

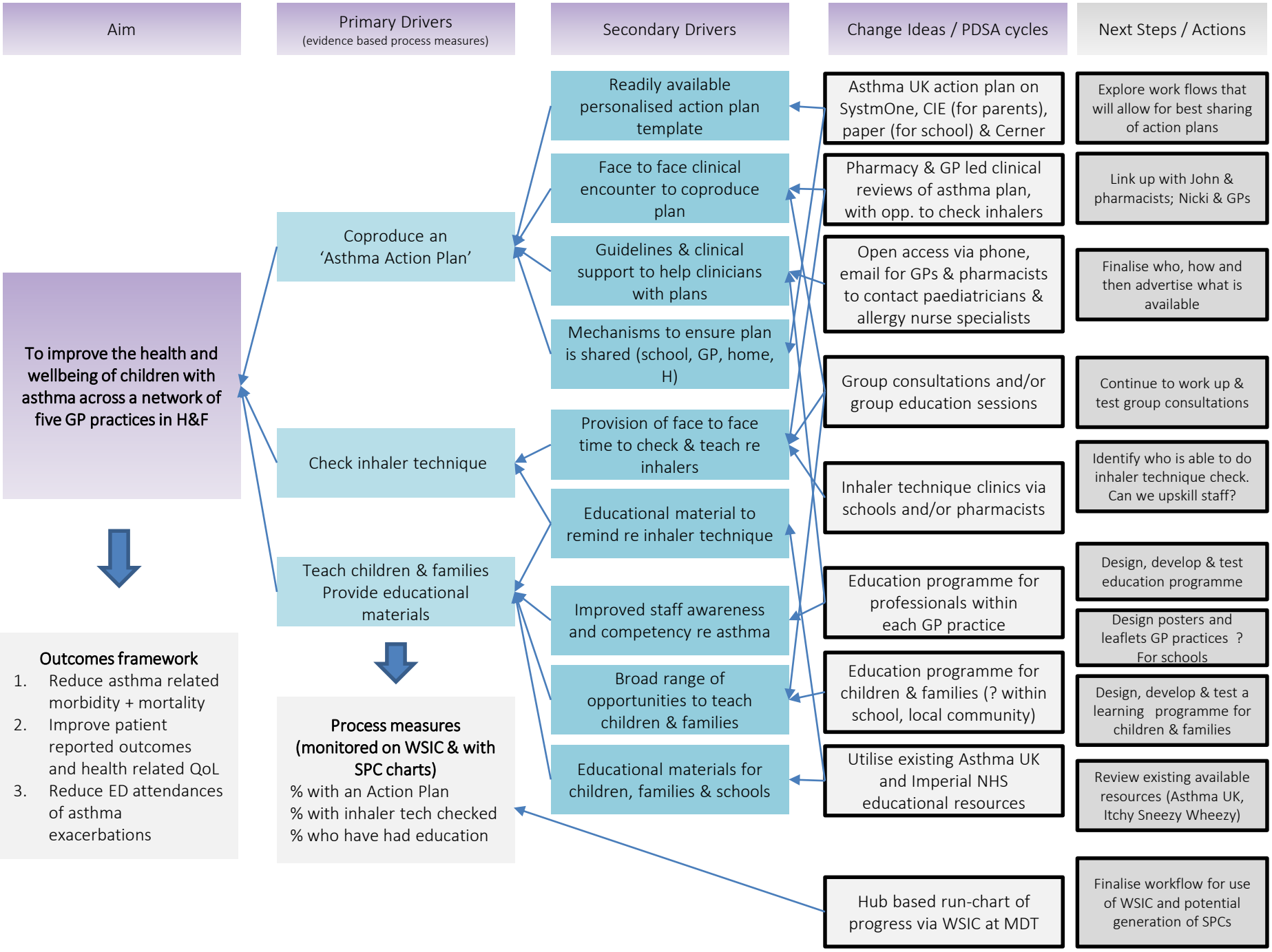
**Risk Factors**

Multiple courses of oral corticosteroids

Click to highlight traffic lights of that colour

Green Flag Amber Red Flag Neutral/Unknown




Aim
Primary Drivers
(evidence based process measures)
Secondary Drivers
Change Ideas / PDSA cycles
Next Steps / Actions
To improve the health and wellbeing of children with asthma across a network of five GP practices in H&F
Outcomes framework
1. Reduce asthma related morbidity + mortality
2. Improve patient reported outcomes and health related QoL
3. Reduce ED attendances of asthma exacerbations
Coproduce an 'Asthma Action Plan'
Check inhaler technique
Teach children & families Provide educational materials
Process measures (monitored on WSIC & with SPC charts)
% with an Action Plan
% with inhaler tech checked
% who have had education
Readily available personalised action plan template
Face to face clinical encounter to coproduce plan
Guidelines & clinical support to help clinicians with plans
Mechanisms to ensure plan is shared (school, GP, home, H)
Provision of face to face time to check & teach re inhalers
Educational material to remind re inhaler technique
Improved staff awareness and competency re asthma
Broad range of opportunities to teach children & families
Educational materials for children, families & schools
Asthma UK action plan on SystmOne, CIE (for parents), paper (for school) & Cerner
Pharmacy & GP led clinical reviews of asthma plan, with opp. to check inhalers
Open access via phone, email for GPs & pharmacists to contact paediatricians & allergy nurse specialists
Group consultations and/or group education sessions
Inhaler technique clinics via schools and/or pharmacists
Education programme for professionals within each GP practice
Education programme for children & families (? within school, local community)
Utilise existing Asthma UK and Imperial NHS educational resources
Hub based run-chart of progress via WSIC at MDT
Explore work flows that will allow for best sharing of action plans
Link up with John & pharmacists; Nicki & GPs
Finalise who, how and then advertise what is available
Continue to work up & test group consultations
Identify who is able to do inhaler technique check. Can we upskill staff?
Design, develop & test education programme
Design posters and leaflets GP practices ? For schools
Design, develop & test a learning programme for children & families
Review existing available resources (Asthma UK, Itchy Sneezy Wheezy)
Finalise workflow for use of WSIC and potential generation of SPCs

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