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North West London Joint Health Overview and Scrutiny Committee

Thursday 23 September 2021 at 10.00 am

Board Rooms 4 & 5 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Please note this meeting will be held as a socially distanced physical meeting with all members of the Committee asked to attend in person.

Should any member of the Committee be unable to attend in person please contact the meeting administrator (as listed below) so alternative arrangements can be made. Please note that if unable to attend in person it will not be possible for that member to be counted as present for the purposes of quorum or to participate in the voting on any item that may be required during the meeting.

Guidance on the safe delivery of face-to-face meetings is included at the end of the agenda frontsheet.

Due to current socially distanced venue capacity, any press and public wishing to attend this meeting are encouraged to do so via the live webcast. The link to view the meeting will be made available here.

Membership:

Members	Representing
Cllr Ketan Sheth (Chair)	London Borough of Brent
Cllr Daniel Crawford	London Borough of Ealing
Cllr Richard Eason	London Borough of Hounslow
Cllr Marwan Elnaghi	Royal Borough of Kensington and Chelsea
Cllr Monica Saunders	London Borough of Richmond
Cllr Iain Bott	City of Westminster
Cllr Lucy Richardson	London Borough of Hammersmith and Fulham
Cllr Rekha Shah	London Borough of Harrow

For further information contact: Hannah O'Brien, Governance Officer
Hannah.O'Brien@brent.gov.uk

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Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

2 Declarations of Interest

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

3 Minutes of the previous meeting - 4 July 2021 1 - 12

To approve the minutes of the previous meeting as a correct record and to ratify the decisions made.

4 Matters Arising (if any)

5 North West London Acute Hospital Strategy 13 - 18

To inform the North West London Joint Health Overview and Scrutiny Committee (JHOSC) that North West London (NWL) is developing an acute strategy.

6 Integrated Care System (ICS) Update 19 - 34

To provide the NWL Joint Health and Overview Scrutiny Committee (JHOSC) with an update on the months of July and August from the NWL Integrated Care System (ICS). This includes updates on the Covid-19 vaccination programme, mental health, inequalities and population health, resident engagement, post-covid syndrome, pelvic health pilot, financial challenge, acute care, London Ambulance Service and NHS 111.

7 North West London Digital Strategy 35 - 58

To provide the NWL Joint Health Overview and Scrutiny Committee (JHOSC) with an overview of the progress being made with the development of the digital, data and technology transformation plan for the NWL Integrated Care System (ICS).

8a JHOSC Work Programme Update 59 - 60

To note the North West London Joint Health Overview and Scrutiny Committee Work Plan 2021-22.

8b Work Programme Meeting Arrangements 2021-22 61 - 62

To present a report for members to confirm the hosting arrangements for the remaining JHOSC meetings this year.

9 Any Other Urgent Business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or her representative before the meeting in accordance with Standing Order 60.

Guidance on the delivery of safe meetings at The Drum, Brent Civic Centre

- We have revised the capacities and floor plans for event spaces to ensure they are COVID-19 compliant and meet the current social distancing guidelines.
- Attendees will need to maintain the necessary social distancing at all times.
- Signage and reminders, including floor markers for social distancing and one-way flow systems are present throughout The Drum and need to be followed.
- Please note the Civic Centre visitor lifts will have reduced capacity to help with social distancing.
- The use of face coverings is encouraged with hand sanitiser dispensers located at the main entrance to The Drum and within each meeting room.
- Those attending meetings are asked to scan the coronavirus NHS QR Code for The Drum upon entry. Posters of the QR Code are located in front of the main Drum entrance and outside each boardroom.
- Although not required, should anyone attending wish to undertake a lateral flow test (LFT) in advance of the meeting these are also available at the Civic Centre and can be booked via the following link: https://www.brent.gov.uk/your-community/coronavirus/covid-19-testing/if-you-dont-have-symptoms/

Date of the next meeting: 14 December 2021

DRAFT North West London Joint Health Overview and Scrutiny Committee
Notes of informal meeting hosted online by LB of Hounslow
10am-12pm on 4 July 2021

The meeting began at 10am.

PRESENT

Members of the Committee:

- Councillor Ketan Sheth (Chair) London Borough of Brent
- Councillor Daniel Crawford (Vice Chair) London Borough of Ealing
- Councillor Lucy Richardson London Borough of Hammersmith & Fulham
- Councillor Richard Eason London Borough of Hounslow
- Councillor Rekha Shah London Borough of Harrow
- Councillor Monica Saunders London Borough of Richmond

Others Present:

- Michael Carr – Senior Policy and Scrutiny Officer, London Borough of Brent
- Judith Davey - Chief Executive, Healthwatch Brent.
- Rory Hegarty, Director of Communications & Engagement, NWL CCG;
- Pippa Nightingale, Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG;
- Dr Mohini Parmar, Long-Term Plan Clinical Director, NWL CCG;
- Dr Mando Watson, Children's Services Clinical Lead, NWL ICS; Consultant Paediatrician, Imperial College Healthcare NHS Trust
- Lesley Watts, Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust;
- Nicola Zoumidou – Policy Analyst, London Borough of Hounslow

1. WELCOME & INTRODUCTIONS

1.1. Cllr Sheth paid tribute to Cllr Collins the former Chair of NWL JHOSC for all the work he had done over the previous few years.

1.2. Cllr Eason welcomed everyone to the meeting, hosted online by LB of Hounslow. He mentioned that Hounslow had achieved a great deal in recent weeks in terms of surge vaccination and testing, and was removed from surge status a week before planned.

2. ELECTION OF CHAIR & VICE-CHAIR

2.1. The Scrutiny Officer from LB of Brent took the Chair momentarily to receive nominations for Chair for this meeting. Nominations were proposed by Cllr Shah and seconded by Cllr Saunders. Cllr Sheth was elected Chair for this meeting, and Cllr Crawford was elected Vice Chair for this meeting.

It was agreed in principle:

That Councillor Ketan Sheth be elected Chair for this meeting, and Councillor Daniel Crawford be elected Vice Chair for this meeting.

3. APOLOGIES FOR ABSENCE & DECLARATIONS OF INTEREST

3.1. Apologies from:

- Councillor Iain Bott, City of Westminster
- Councillor Marwan Elnaghi, Royal Borough of Kensington and Chelsea

3.2. Cllr Sheth declared that he was the Lead Governor at Central and North West London NHS Foundation Trust (CNWL).

4. MINUTES OF THE MEETING HELD ON 18 MARCH 2021

4.1. The Committee reviewed the minutes of the last meeting, and the Chair asked whether the action items had been completed. This will be reviewed via email after this meeting.

It was agreed in principle:

That the minutes of the meeting held on 18 March 2021 be agreed as a correct record of proceedings.

5. DEVELOPMENT OF THE NORTH WEST LONDON INTEGRATED CARE SYSTEM

5.1. Lesley Watts introduced this item and explained that she briefed Council leaders every month. The NWL ICS was well developed and the Development Plan had been submitted to NHS England. NWL was probably the biggest ICS in the UK. It was large and complex, and cared for 2.4m people, through 45 PCNs, across 8 boroughs, and with 2 specialist trusts. During the pandemic, the silver lining had been that we have learnt to work together, and integration had been accelerated.

5.2. She noted that:

- They are working towards extending life expectancy and reducing inequalities. The elective work programme is a priority: ensuring equality of access and outcome; people should not be treated more quickly in one part of the sector in comparison to the other part. Overall health outcomes in NWL are good, but can be better.
- The governance for the ICS has been set up, and the ICS aims to provide the best possible care close to where patients live, and achieving the equality of access and outcomes, might mean that there is a need to move resources between boroughs and/or between primary and secondary care settings.
- Arrangements have been made so that high volume, low complexity cases are centred in particular hospitals which concentrate on specialities and protect those elective cases, so they not impacted by Covid peaks.
- There has been an increase in emergency work, elective work, and now a growth in demand around mental health, in children and young people in particular. Consideration is required about allocation of resources between all of these.
- Collaboration is happening and is welcomed by NHS and Local Authorities, and bonding has happened through Covid. There have been open and transparent

discussion with citizens and patients, and of course there are tensions, but these are being addressed.

- Lesley paid tribute to her primary care colleagues, and the NHS is committed to dealing with long term issues.

Chair thanked all NHS staff on behalf of the Committee. The Chair then invited questions to NHS representatives from Members of the Committee.

5.3 Cllr Sheth enquired, as a complex and large ICS, possibly largest in the country, how effective was it thus far in its journey?

5.4. Lesley Watts responded that during Covid, NWL was one of hardest hit areas in London and nationally. They would not have coped if they had not worked together to share resources, staff and kit, and transferred patients between hospitals. Cancer patients and elective surgery continued through Covid and partners leant from each other how to cohort patients and control infection. Predictions from academics were used, and the Whole Systems Integrated Care Dashboard has been used.

5.5. Cllr Richardson noted that there were huge differences between inner and outer London boroughs' needs, and adequate representation was needed in the governance structure of the new ICS. Would this be taken into account?

5.6. Lesley Watts confirmed that there were regular meetings with Chief Executives of London Boroughs so there was constant contact. The Development Plan would be circulated again. It had not been designed to be rolling membership, but this was an iterative process and still needed to be ironed out.

5.7. Cllr Richardson said the ICS makes decisions regarding funding and the feedback from the community is that information is limited and difficult to interpret.

5.8. Lesley stated that the ICS tries to encourage all decisions to be taken locally as far as possible.

5.9. Cllr Eason welcomed the open discussions on Local Authority representation on the ICS board. A Kings Fund report talks about more equal balance between Local Authority and NHS. He asked where the patients/public/VCSE/carers involvement is in the governance and assurance structures.

5.10. Lesley Watts stated that representation from Healthwatch and some voluntary groups had been included in the structure. A diagram of the structure would be circulated for JHOSC members to see. Lesley Watts pointed out that not everyone can sit on the board, as some are required for scrutiny. There were a variety of users so not everyone wants or needs to be part of making decisions. They were not talking about integrating all budgets at this stage. At the moment, expenditure is from health monies, not from Local Authority budgets.

5.11. Judith Davey from Healthwatch Brent said that patients' can see the great work that has been done during Covid and the highlighting of health inequalities. It was necessary to join up services so that patients can tell their story once. What will be done differently now so that these problems are resolved going forward?

5.12. Lesley Watts agreed with this assessment and said she would speak with Judith Davey of Healthatch outside of the meeting.

5.13. Cllr Sheth asked what will happen to the existing structure which came in fairly recently, and commissioning arrangements?

5.14. Lesley Watts said that the second reading of the draft legislation is taking place today and the external contracting will be much reduced going forward.

5.15. Cllr Saunders referred to the wider context, and said that the changes sounded promising, but there was a significant workforce deficit, and it will get worse with the retirement of GPs and others. What strategic workforce planning do we have in place to deal with this?

5.16. Pippa Nightingale acknowledged that health jobs were not always favourable careers for everyone. However, the pandemic had doubled the number of applicants in nursing and midwifery, medicine, and mental health nursing. Courses were oversubscribed, and there were bursaries to encourage students. There was a push in NWL to employ people locally at entry level, then train them up into their chosen career. A bid has gone into GLA to fund that further because living and working locally anchors people in the community.

5.17. Cllr Shah asked how the ICS will be driving tangible improvements to services, in particular maternity services at Northwick Park hospital.

5.18. Lesley Watts said that this can be achieved by working together. There are different needs in different boroughs. Providers need to think about population health in each area. There is a lot of detail around this and Lesley would be happy to take it as a separate item if the committee would like.

5.19. Pippa Nightingale stated that services are under scrutiny, especially at Northwick Park. The NHS is committed to improving services in maternity across the whole of system. There is no quick fix, and a long term solution is needed. Some clinicians are being moved around to see how things work well elsewhere, and will bring their learnings back.

5.20. Cllr Sheth referenced mental health, and asked how the ICS was going to bring about the quality improvement across the whole service delivery provision? Instead of peaks and dips, there should be a flatter line in terms of service delivery to minimise having winners and losers.

5.21. Lesley Watts said there was collaboration across services to see how equality of provision can be achieved. Mental health providers are working collaboratively to ensure that they are consolidating service provision. This is being done by being clinically led, working locally, and consolidating specialist services.

5.22. Cllr Sheth asked about children's services across the 8 boroughs of NWL. How can the NHS ensure that the offer is similar across NWL in terms of services and outcomes?

5.23. Dr Mando Watson pointed out that children and young people make up 30% of the population. It is important that we have a lead on this in NWL as other ICSs do not. There is a mature data system, so we understand the needs of the general population and children's population specifically. When people focus on health and wellbeing they merge adults and children, but it's important to dis-aggregate them because getting it right for children means getting it right for the future. Organisations need to put children first too. The ICS has gathered together the assets we have in system, and is listening to children's voices through Healthwatch, and also using Imperial College resources. Joining up strengths and resources that we have given patients a better service, for example, this was done in providing information for parents of children with autism.

5.24. Cllr Sheth asked what is going to happen to the single CGG as the White Paper suggests it will no longer be a separate body, and what will happen to the commissioning aspect too?

5.25. Lesley Watts stated that the single CGG will be assimilated into the ICS if the bill goes through, and it is assumed that this will happen. Since there is no element of competition within NHS organisations, the approach is to decide together in the sector the best way to provide services together for the patient population and the needs identified. Therefore, the amount of external contracting is much reduced, and that will happen only where it is absolutely necessary.

5.26. Cllr Saunders asked what strategic workforce planning is happening to make sure these changes can happen on the ground.

5.27. Pippa Nightingale confirmed that the number of applicants for nursing and midwifery had doubled, and there was an over subscription to mental health nursing. The bursary is on offer again and a North West Academy has been developed, employing people from Job Centres at Band 2 and they progress to nurse associates and degree associates and within 5 years once they have the qualification. This helps with retention because people are living and working locally.

5.28. Cllr Richardson wanted to drill down into the question of distribution of resources and transparency of this. She gave an example of a programme where Brent had allocation £1.8m, Harrow £1.4 m but H&F was only allocated £800k.

5.29. Lesley thought this referred to the Aging Well national Public Health England programme, so not from NWL or the NHS. There are formulae to work this out, and Local Authority Leaders and Chief Executives have discussed this before. Where money needs to be spread between boroughs there will be dissatisfaction, but in order to tackle inequalities, it may mean that these discussions are needed in future. Bearing in mind there is a structural deficit in NWL of £400m every year, this will also need to be taken into consideration.

5.30. Cllr Sheth asked how the primary care lead for the ICS is going to drive quality improvement around prevention.

5.31. Dr Parmar commented that there has been a huge improvement in diabetes care in Hounslow, and prevention work is taking place. Due to Covid there is a backlog of long term conditions coming to light, and these need to be dealt with at the same time as the normal business of primary care. Due to workforce retirement, isolation and other problems, the next 6 months and getting through winter will be challenging, so there is a need to work together.

5.32. Judith Davey stated that Healthwatch is hearing from residents and patients that they understand the importance of early intervention, but access this via primary care has been (possibly understandably) problematic during recent times. This has caused additional concern recently given the emphasis on responsibility for people and families to seek early help.

5.33. Cllr Eason asked that as the ICS moving quickly in terms of development and Council leaders are being briefed monthly, could the JHOSC also received this briefing so that we can follow the journey too?

5.34. Cllr Sheth agreed that this would be would be useful, and also to have another review of this in 6 months' time.

It was agreed in principle:
to note the report and to agree the following actions:

1. **Development Plan to be shared (including ICS structure diagram and timetable)**
2. **Monthly briefings to Chief Executives of Local Authorities to be shared**
3. **Consider whether Maternity Services should be added to work programme**
4. **Consider whether development of NWL ICS should be added to work programme.**

6. NORTH WEST LONDON NHS RECOVERY AND COVID 19 VACCINATION PROGRAMME

6.1 Lesley Watts introduced the item by stating that primary care is almost at 60% face to face consultations. Due to Covid, primary care resources have been diverted to the vaccination programme. These are monitored by each NHS Trust, and reports are made public, and updated each week so Lesley will ask for these to be shared with JHOSC too.

6.2 Dr Parmar stated that prevention needs vary locally, and primary care providers are going to have their hands full dealing with the back log in the next 6 to 12 months. Each patient on a waiting list has a clinical harm review to consider physical or psychological harm. Also, their socio-economic background is taken into consideration to ensure that decision are clinically driven but also make sure that patients are being dealt with in the right order.

6.3 Lesley Watts talked about the backlog and said that work is being consolidated to get through it faster, staff are working extra shifts and operating lists into the evenings and weekend, and bank staff are being used.

6.4 Dr Parmar talked out how the Long Covid response is being integrated into primary care nationally. There has been an advanced service which looks at GPs identifying those with Long Covid and independent care is suggested with structured self-support.

6.5 Cllr Eason stated that there is a need for transparency on the backlog and how that varies according to population demographics, geography and speciality. For example is an Asian patient in Hayes as likely to get same services as a white patient in Kensington?

6.6 Pippa Nightingale responded that this changes each week, but can be shared. Clinical decisions are taken for the sickest patients, and then in date order. This is blind and data will be shared through these reports.

6.7 Cllr Eason pointed out that date order can be problematic.

6.8 Pippa Nightingale confirmed that a harm review is undertaken for all patients, and it is not only based on date order, and it is the first time that priority is being calculated in this way.

6.9 Lesley Watts pointed out that staff often come from these communities too, so can handle this sensitively but in a determined way.

6.10 Cllr Saunders referred to the 60% target for face to face consultations, and asked about how that looks geographically? How does it work with referral onto specialist services?

6.11 Dr Parmar stated that the % of face to face appointments changes each day but is generally increasing. Referral guidelines should be used to drive out variations.

6.12 Dr Watson highlighted that relationships between families and their GPs need to be strengthened. Specialist telephone and email support is available to all GPs so parents can access this through their GPs when needed.

6.13 Cllr Saunders asked a follow up questions on whether there is a link between lack of face to face contact and referrals. Can patients get the secondary care that they need as there are potential inequalities of access due to different forms of consultation?

6.14 Dr Parmar said that video consultations were a game changer. The balance of face to face, virtual, and telephone had changed, and will continue to do so. By saving time with patients online, there is more time to focus on patients who cannot use video e.g. elderly, or with learning disabilities.

6.15 Cllr Sheth asked how capacity is being created and crystallised to deal with backlogs.

6.16 Lesley Watts stated that over 100% is being achieved for outpatients' backlog to stabilise and eat into backlog. High volume and less complex cases are being dealt with in green zone (Covid free) to get through backlog. Centres are consolidating hyper specialist work, and evenings and weekend are being used. The independent sector in NWL is also being used to support work to tackle backlog, and bank agency and extra shifts are being used.

6.17 Cllr Sheth asked about the third wave and how this will be tackled as staff are tired, and need to deal with the backlog, so how will this be done?

6.18 Pippa Nightingale pointed out that it had been possible to create more detailed plans now, than for previous waves. Plans have been made for how to tackle this 3rd wave whilst continuing business as usual. Data shows that 16-20 year olds are transmitting Covid between themselves, and any admissions for Covid are needing far less ICU care.

6.19 Cllr Saunders asked about Long Covid and the surge in the Delta variant affecting younger people. This might not cause hospital admissions, but what preparations are being made for dealing with Long Covid?

6.20 Dr Parmar explained that there are 3 acute post Covid assessment centres in NWL, each borough has an integrated Long Covid response; and in primary care settings GPs identify patients with Long Covid. 85% of people will get better within 12 weeks. In the first wave, we did not know who had Covid in the community before testing was widespread. Further work is being done to on dealing with Long Covid.

7 COVID 19 VACCINATION PROGRAMME

7.1. Pippa Nightingale thanked local authorities for supporting NHS staff in relation to the vaccination programme. NWL was in the second week of a London vaccination 'sprint'.

7.2. Currently 2.54m vaccines have been delivered in NWL which is the highest in any region in the UK. Challenges were still there and these changed weekly. Whereas there had previously been concerned about vaccine supply, there was now plenty vaccine, but not enough people coming forward to take it in the 18+ age group. Centres were only working at 30% capacity as residents were not coming forward for it, and there were challenges around the second dose. The interval is 8 weeks between first and second vaccines, and there had been abuse of staff in centres who had to turn people away who are presenting with fewer than 8 weeks since their first dose.

7.3. In the previous week, 64k doses had been delivered, and 72k were expected this week. Young people were being offered vaccines at festival type events and there were promotions around protecting parents / grandparents / community. It was hoped that this will be complete by end of the following week.

7.4. A booster campaign will be Phase 3 for anyone who is entitled to the flu jab, and this will be launched at the end of September.

7.5. Cllr Eason asked for more data on vaccination rates by borough and cohort, as elsewhere this information is shared on a daily basis. There are differences, some of which are socio economic, and there is more vaccine hesitancy in certain groups. Has work been done in NWL on this? There's good practice from Hounslow where vaccinations are given on Thursdays at the Gurdwara and Fridays at the Mosque.

7.6. Pippa Nightingale explained that a vaccine pack is shared each week with Local Authorities so she is happy to share it with JHOSC too. Covid has shown that community leaders have helped with vaccines, so will be looking to do that with other vaccines too.

7.7. A vaccine bus has gone into local communities, religious groups, pop up tents on street corners. If people came to their religious groups where health care workers were present, that increased uptake. Lots of different approaches had been taken to ensure that vaccine is reaching as far as possible.

7.8. Cllr Richardson asked about the disparity between outer and inner London boroughs. H&F had low rates of vaccine take up generally and the same is also true with the Covid vaccine. A structural overview was needed to deal with this. How is the allocation of funds for vaccine engagement being coordinated across NWL?

7.9. Pippa Nightingale said that lots of different metrics were used to decide how vaccine is distributed across NWL, using MSOAs. Funds are allocated for engagement but this is discussed with Chief Executives before allocation equally across each one, because Local Authorities know best how to access their communities and communicate with them.

7.10. Rory Hegarty confirmed that weekly meetings take place with Comms teams from each borough. Different things are happening in different areas e.g. door knocking and community events, and these were coordinated weekly.

7.11. Pippa Nightingale pointed out that Brent had bid for and was given funding for a pilot scheme for dealing with communications.

7.12. Cllr Saunders referred to the large number if younger adults that still need to be vaccinated and asked whether NWL had the capacity for delivering this level of vaccines.

7.13. Pippa Nightingale stated that first and second doses should be finished by the end of August, and boosters would be offered from September. In terms of capacity, recruitment was done via Job Centres and this had been successful and will be used again for boosters.

7.14. Cllr Shah asked what is being done to improve the take up of vaccinations for those who are less engaged.

7.15. Rory Hegarty stated that there is a whole programme of engagement for vaccine hesitant residents and those who are not often reached. There had been ‘vaccine equity huddles’, community meetings and outreach and weekly communications meetings across the NHS and local authorities, so that an informed approach is taken in each community. There was a whole area of work on this and it will inform the ICS engagement approach going forward too.

7.16. Cllr Richardson said that it is a good idea to work on distributing jobs locally, and local vaccine volunteers are also good. It would be helpful to share the Comms on this to ensure that H&F can share this locally too?

7.17. Pippa Nightingale said that this would be shared.

7.18. Cllr Sheth said that he was proud and happy about the achievements in NWL, but asked how this compares to the rest of the country?

7.19. Pippa Nightingale said that we were at 78% vaccinated in London and the UK average was 80%. In NWL, 4 of our boroughs are ahead of the London average, and 3 are just behind it.

7.20. Lesley Watts reminded the committee that there was a younger population in London than on average across the UK, and that in care homes, a very high % or residents had been vaccinated.

7.21. Cllr Richardson had had feedback that the application process for vaccine volunteers can be cumbersome and slow. Could information be shared about how inclusive it is for those with disabilities?

7.22. Pippa Nightingale said that they were recruited through the job centre process, so there was no need to complete any NHS forms. The programme gave priority interviews to applicants from the local community. Already, the best social prescribers were staff who live in local communities, and local people are prioritised through job centres.

It was agreed in principle **to agree the report and to agree the following actions:**

1. **Vaccine data pack to be shared**
2. **Communications on recruiting local people as vaccine volunteers will be shared.**

8 COMMITTEE WORK PLAN 2021/2022

The following topics were raised as items that the Committee would like to scrutinise:

1. NWL acute strategy
2. Digital strategy
3. Mental Health strategy.

9. ANY OTHER MATTERS THAT THE CHAIR CONSIDERS URGENT

None

10. DATE OF THE NEXT MEETING - 23 September 2021

The Chair stated that the next meeting could be hosted by LB of Kensington and Chelsea at Kensington Town Hall.

The meeting ended at 11.50 am.

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North West London Integrated Care System Working together for better health and care	**North West London Joint Health Overview and Scrutiny Committee** 23 September 2021
	Report from North West London ICS/CCG

Acute Strategy for North West London

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
Appendices:	Appendix 1 – Acute Strategy for Northwest London – Presentation
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Toby Lambert, Director of Strategy, North West London Integrated Care System

1. Purpose

This report informs JHOSC that NWL is developing an acute strategy.

2. Recommendations

No recommendations – for information only.

3. Detail

3.1 North West London has four hospitals currently in the New Hospitals Programme – the three Imperial sites (St Mary's, Charing Cross and Hammersmith) and Hillingdon.

3.2 We can expect these redevelopments, if approved, to shape health and care in NWL for a long time. The ICS therefore wants to ensure that these hospital redevelopments fit into an overall acute strategy that encompasses acute care across NWL.

3.3 As NWL moves towards the formal establishment of an ICS, we will need to develop a health and care strategy for the whole of NWL. The acute strategy will be a part

3.4 The strategy will address:

- How much acute care will NWL require in 10-15 years' time?
- How is that care best organised, to optimise access and experience for residents of NWL, the quality of care, and to deliver care productively.

3.5 The strategy treats our current emergency departments as fixed points. We intend to complete the strategy in time to support the outline business cases for the new Hillingdon hospital and the redevelopment of St Mary's.

4.0 Financial Implications

4.1 The acute strategy will have financial implications; however these have not yet been worked through.

5.0 Legal Implications

5.1 The acute strategy may have financial implications; however these have not yet been worked through.

6.0 Equality Implications

6.1 The acute strategy may have financial implications; however these have not yet been worked through.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members and stakeholders will be consulted upon any proposals affecting health and care services arising from the strategy.

8.0 Human Resources/Property Implications

8.1 The acute strategy will have human resource and property implications; however these have not yet been worked through.

Appendix 1

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

Towards an acute strategy

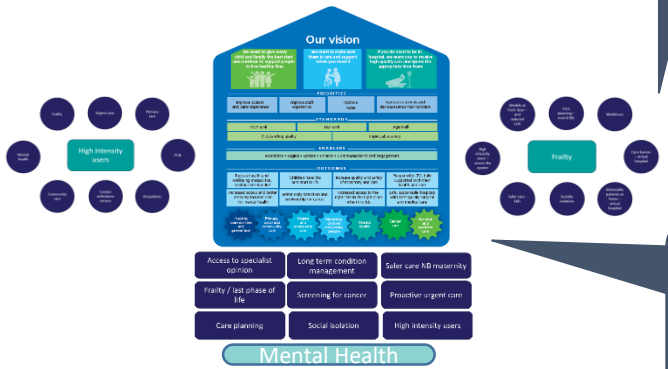
September 2021

Joint Health Oversight and Scrutiny Committee

Why an acute strategy?

- North West London has four hospitals currently in the New Hospitals Programme – the three Imperial sites (St Mary's, Charing Cross and Hammersmith) and Hillingdon
- We can expect these redevelopments, if approved, to shape health and care in NWL for a long time. The ICS therefore wants to ensure that these hospital redevelopments fit into an overall acute strategy that encompasses acute care across NWL
- As NWL moves towards the formal establishment of an ICS, we will need to develop a health and care strategy for the whole of NWL. The acute strategy will be a part
- The strategy will address:
  - How much acute care will NWL require in 10-15 years' time?
  - How is that care best organised, to optimise access and experience for residents of NWL, the quality of care, and to deliver care productively
- The strategy treats our current emergency departments as fixed points
- We intend to complete the strategy in time to support the outline business cases for the new Hillingdon hospital and the redevelopment of St Mary's.

Draft strategy and clinical strategy



Clinical strategy under review post COVID

Supporting strategies and plans

Acute strategy is the immediate ask; work on other areas continues

Acute business cases

Mary's OBC (tbd)

Hillingdon OBC (Jan 2021)

Two narratives for the acute strategy

Health and care need

Wider economic and social development

London is a highly diverse, world class city

There is wide, and unacceptable variation in health and care outcomes

This is, at least in part, caused by unmet need, difficulties in access and patient experience

The greatest health drivers of outcomes (and variation in outcomes) are heart disease and respiratory disorders

Health and care services should, where possible,
- Support prevention
- Identify need
- Heal need where possible; restore function and retard decline where not

This requires meeting needs as close to home as possible (tp manage exacerbations)

No matter how well we deliver services locally, hospitals will need to support local services and take patients where necessary

This is, at least in part, driven by wider social determinants of health that the health system, alone, cannot address

Major social determinants include social exclusion, employment and housing

Acute hospitals are major employers in their communities, and can support wider employment (e.g., universities, research, pharma)

Short term opportunity in new hospital builds (St Mary's, Hillingdon)

Wider strategic opportunity across the acute sector

Acute strategy

North West London Integrated Care System

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

North West London Integrated Care System update

August 2021

This is the July and August update from the NW London Integrated Care System (ICS) and includes:

1. Covid-19 vaccination programme
2. Mental health update
3. Inequalities and population health
4. Resident engagement
5. Post-covid syndrome
6. Pelvic health pilot
7. Our financial challenge
8. Acute care update
9. London Ambulance Service
10. NHS 111

1. COVID-19 vaccination programme

In line with other systems, the focus of the vaccination programme is now moving away from mass vaccination centres to primary care and pharmacies. We will continue to support the programme with pop-up vaccination clinics where needed. Our mass vaccination centres are now being phased out, with the exception of CP House in Ealing, which will remain open to ensure that there is enough capacity in the borough.
Phase 3 of the vaccination programme, with a focus on booster vaccinations and then moving into the flu/winter campaign, will start in September.

2. Mental health update

2.1 Vaccination of people on the serious mental illness (SMI) register

Over 60% of people aged 16-64 years on the SMI register have received at least one COVID-19 vaccination as of the end of July. Hillingdon is performing the best at 70%. People on the SMI register were in group six for the vaccination in order to reduce inequalities in outcome (notably premature mortality and morbidity) in this group.

2.2 People with a learning disability (LD)

79% of people with LD aged 16 and over had received their first vaccine, and 72% had received the 2nd vaccine as of the 4 August 2021. People with LD were also in priority group 6.

2..3 Maternity Trauma and Loss Care (M-TLC) service launch

A new service went live on 26 July as a partnership between our mental health trusts and maternity services, led by a lead midwife and clinical psychologist. The service supports

women who experience fear of childbirth, birth trauma or loss and accepts self-referrals. The first phase of the pilot service commences out of Chelsea and Westminster, West Middlesex and Northwick Park hospital sites, before rolling out across NW London by March 2022. For more information.

2.4 Community Multi-Systems Violence Reduction Programme (London Vanguard) expression of interest

NW London CCG and partners are collaborating on an expression of interest to support young people (up to aged 25 years) affected by violence. A proposal is being developed based on existing service provision, accounting for the needs of our population and working out how best the model would be delivered. The final proposal will be submitted on 3 September 2021. Funding of ~£835k is being made available with ongoing funding to 2024 and successful ICS's will be notified by the end of September.

2.5 Autism support, advice and social prescribing service (14 years plus)

A new service for autistic people without a co-occurring learning disability was launched last month. The service which is provided by the Centre for ADHD and Autism Support is being shaped and delivered by autistic people and provides pre and post diagnostic support. Specialist training and advice will be offered to employers and providers of healthcare, social care, and education, to promote autism aware communities and reasonable adjustments for autistic people.

2.6 Autism friendly environments – mental health and paediatric inpatient settings

NW London CCG has worked with partners to develop a proposal seeking £199k spending review funding to develop sensory friendly environments within five of our mental health inpatient settings (Lakeside, Northwick Park, St Charles, Collingham Children's Centre and Lavender walk Adolescent Unit). If successful, the funding will be invested in soundproofing, silent alarms, sensory equipment, portable furnishings and staff training. An expression of interest has also been submitted seeking £73k to convert an office adjacent to the main paediatric ward at Northwick Park into a low stimulus one bedded ward and sensory area to offer a safe and quiet clinical space where autistic children and young people can receive treatment and therapy and/or relax and de-escalate.

2.7 Mental health crisis care

NW London has recently completed a procurement exercise for the NW London suicide prevention service and awarded the contract to charity Rethink Mental Illness.
Rethink has now begun to co-ordinate and deliver a programme of initiatives; establishing a NW London-wide suicide prevention network, co-producing a multi-agency suicide prevention plan, providing suicide awareness training, and delivering projects and initiatives offering direct support to service users.

2.8 Digital mental health (11-25 years)

An online mental health platform (Kooth) for children and young people between 11 and 25 years offering a single, consistent digital service across all NW London boroughs from 1

June 2021. This new service provides mental health and wellbeing support through an anonymous, self-referral digital service that enables children and young adults to 'drop in' and find fast, easy and free support at a time suited to them. A social media and local press campaign has supported the go live of the service, with additional promotional work underway with schools, universities and colleges, local authorities, mental health teams as well as primary care services, such as GPs.

2.9 Children and young people's (CYP) mentalhealth

The ICS is investing in transformation funding for the provision of additional support for children and young people in the following areas:

1. Increase early intervention through the expansion of mental health support teams in schools
2. Increase access to CYP community services through consistently delivering a minimum. 35% access rate and ensuring that a minimum of 10,923 CYP aged 0-18 years can access services, as well as ensuring that a minimum of 285 18-25 year olds can access services
3. Reduce CYP mental health presentations and lengthy waits at A&E through the development of a comprehensive crisis response across NW London that provides 1) Single point of access including through NHS111 to crisis support, advice and triage, and 2) Crisis assessment and brief response within the emergency department and in community setting
4. Improve eating disorder services through reduced waiting times and more intensive outreach and home treatment in the community.

3. Inequalities and population health

Over recent weeks we have worked closely with colleagues from across the ICS to develop our strategic plan setting out how we will deliver the ICS objective to tackle inequalities in outcomes, experience and access. This work has been informed by engagement with local residents through our vaccine equity programme and the Covid-19 vaccination programme and is being taken forward as a joint NHS and local authority initiative. The aim is to have a published ICS document by the end of September, when we propose to publicly launch a programme to take this work forward, working with our local residents and communities.

In developing the plan, we have recognised key learnings we have identified during the Covid pandemic, and acknowledged that if we want to tackle inequalities we need to work differently, recognising opportunities in utero, in childhood, and in adulthood. Our plan will acknowledge the need to address historic racism through ongoing hyper-local engagement with independent facilitation.

We will expect all ICS workstreams to specifically work towards:

- Reducing inequality of access
- Reducing inequality of outcomes
- Reducing inequality of experience
- Enhancing economic impact of our work

We will set out a series of pledges and principles that will enable us to do that. Primary Care Networks operating at neighbourhood level will be a key delivery vehicle for population health and tackling inequalities.

We will share the draft plan for discussion in the autumn.

4. Resident engagement

Over the past month we have been working to consolidate citizen and community insight and intelligence to help shape our plans and priorities as well as well as shape our involvement approach.

The approach to involvement has been shaped by the learning from:

- Our 10-week Quality Improvement and Co-production 'Vaccine Equity Huddle' evaluation and the evaluation and the emerging 'design principles'
- Our lay partner co-produced programme on 'best practice approach to resident engagement'
- The Community Voices: Conversations for change recommendations on connecting with residents and communities to transform health and care
- The EPIC (Engage-Participate-Involve-Collaborate) programme in which we worked with over 100 residents to develop proposals for how we work with local residents as an ICS.

This approach is centered around:

- The application of 'Collaborative Spaces' as an approach which will require long term commitment and a plan that aims to build trusted relationships with citizens and communities at neighbourhood, place and across the system. The focus and investment will be targeted in areas of greatest inequality and the test bed for this approach will be the Co-production and Collaboration workstream as part of the ICS Anchor Institution Programme, which will be co-chaired with our Head of Partnerships and Engagement and Healthwatch.

- The recruitment and development support of Lay partners from diverse backgrounds and communities to be involved in the delivery of Local Services and ICP Priorities.

- Supporting the development of PCN Patient Participation Groups

- The gathering of community, patient and citizen insight and intelligence as well as the creation of a central repository of qualitative data that is accessible across the ICS in our communities.

In terms of gathering insights and intelligence, data for monthly reports is collected from over 100 community, voluntary and Healthwatch based events and outreach; insight and

feedback was also gathered through community-based Q&A sessions as well as published reports by equality groups.

The four overarching messages to the ICS from the community and voluntary Sector have been embedded in the ICS Population Health and Health Inequality Strategy.

A summary of the messages:

a. Communities do more when they decide for themselves -in particular, **having a say over the estates and neighbourhoods that they live in and shaping the services that they use**, this is the only way we will be able to manage the rising demands for health and care services.

b. Community and faith spaces are the lifeblood of local action - the starting point for all health and wellbeing programmes should be in these spaces first and foremost and that we **prioritise building a local and diverse workforce to deliver the programmes and activities**.

c. Systemic Inequalities have a negative impact on the health of our population in particular the health and wellbeing of vulnerable and excluded communities - **equipping communities that experience the greatest inequality with resources, tools and investment** so that they can decide on sustainable solutions to reducing inequalities.

d. Measure what people value - work with residents and communities to **agree a shared purpose and locally defined** individual, community and system **outcomes**

As part of the EPIC programme, we worked with residents to co-design an Involvement Charter, which sets out standards for involving local people in our work and on which we are currently seeking views. The Charter sets out five standards as follows.

Involvement charter (draft)

	Standard	Evidence
	We will make sure:	
1	You can be involved in all decisions that affect you.	The process for involving the public before decisions are taken and evidence that we have followed it.
2	You will know how your views have shaped and influenced the decisions we have taken.	Evidence of their views from the public have been taken into account in making decisions and shaping services.
3	We will co-design services with local people, working with all the communities we serve.	The process for involving local communities in shaping our services, especially those most affected.

4	We will provide you with information that is in plain language, timely, balanced , objective and in different formats when needed.	Information and material provided for the public.
5	We will be transparent in everything that we do.	A clear and transparent decision-making process.

5. Post Covid syndrome

Work on Post-Covid |Syndrome (sometimes called Long Covid) is ongoing and pathways have been defined. GPs have had guidance on what they need to do for patients presenting with symptoms and when/how to refer them onwards. For those discharged from hospital after severe Covid, general post-discharge clinics will identify those patients with probable post Covid syndrome and pass them to Post Covid Assessment Clinics where required.

Post Covid Assessment Clinics are provided across five locations in NW London, to make the service as accessible as possible for patients. The clinics meet regularly to ensure that they provide a consistent model of care across the sector. Where patients have had the necessary investigations and then need treatment, they are passed on to multidisciplinary teams covering each NW London borough.

Both the clinics and the community teams are closely monitoring the data, showing who is accessing their services, what their needs are and how long they are having to wait for assessments.

Material is being co-developed with a user group of experts by experience in order to support self-management of the condition. This includes written material, a website and recorded webinars. Patient groups have been set up with people who have been diagnosed with post-Covid syndrome and on the pathway or who are self-diagnosed. There are currently 12 members who attend the user group and to date, there have been three meetings. The patient group is an important step in providing the insight needed to design the support and communications tools under development and has provided valuable insight. Some of the key findings from the last meeting were:

- The group accept that post Covid syndrome is new to the NHS but pointed to a distinct lack of information Those referred are either still waiting or unsure with the service, due to there being sparse information.
- There seems to be a difficulty with referrals to the assessment centres. Members felt GPs are unsure about the diagnosis or how to refer and post COVID referral seems to be the last option
- In terms of symptoms, every member spoke about brain fog, lack of energy and/or an exacerbation of their previous long term condition. Those with children and/or working had further anxieties with their mental health and well-being. All members, were relieved to hear each experiences and stories.

Work has begun to build the platform for a webpage that will host post Covid information and resources for people to help them manage their post-Covid conditions. This will include information on post Covid syndrome, FAQs, case studies and links to local support services. The patient group will be used as a useful resource to test the information we provide and enhance the support offered. We will be carrying out a schedule of planned activity in conjunction with our local authority partners in September, when the materials are ready to go live.

Another element of self-management will be the introduction of an app which gives patients guidance on how to manage their symptoms and also provides a platform for patients to give updates to the professionals treating them.

6. Pelvic Health Service Pilot

A national pilot study is underway to improve the care of women's pelvic health during pregnancy and after. NW London ICS is one of the 14 regions across the England chosen to participate in the pilot.

As part of the pilot, we will review the support, education and services available for women and staff providing care to these women. This will include elements of pelvic floor education as well as how to direct people with changes to their pelvic floor and genital tract as a consequence of pregnancy and childbirth to help.

To kick off the project in NW London a survey will be widely distributed throughout August/September to capture women's experiences and an understanding of whether those that need help and support are getting it. The survey will be also supported by a series of webinars.

The outcomes will help to shape the development of services in each of the four NW London Trusts.

7. Our financial challenge

It is well known that NW London faces a significant financial deficit. We have carried out an analysing of the drivers of this deficit and we have a plan to move back to a position where we operate within our financial allocation. This includes addressing the shortfall in our national financial allocation and areas where we currently overspend or pay too much for services. Our plan also commits us to spending less money on non-clinical services and to running all our services more efficiently, so that we can protect frontline services as we tackle our underlying deficit. Working as a single system across NW London, with reduced duplication and resources targeted to where they are needed most, can only support this. During the financial year 2020/21, the way in which NHS organisations were funded changed. We are now funded at system (ICS) level and resources are allocated as appropriate across the local system. Non-recurrent additional funding to tackle the Covid-19

pandemic was included in budgets for the last financial year, NW London was able to manage within its allocated budget.

For 2021/22, the national team has confirmed that we will move back to previously published allocations for each ICS. This reduces our available funding by 16%. We have an underlying financial deficit of £453m, which rises to £502m when allowing for winter. This deficit breaks down broadly as £100m in commissioning, £97m in regional services (London Ambulance Service) and £256m in our providers.

A further reduction of £107m (5%) is expected in the second half of this financial year. In 2022/23, a reduction in the Elective Recovery Fund and a further reduction of £120m is expected. We have set up a Financial Recovery Board to address the challenge of continuing to deliver services within our reduced budget.

Analysis of the deficit

We have analysed the underlying deficit (excluding LAS, for which NW London is responsible for only 20%) and drawn the following initial conclusions:

- Funding is based on raw GP list size and we have analysed this against ONS and GLA population data. It does not currently include ongoing Covid costs, which we expect to be an important factor. Even allowing for NW London currently being 1% over its target funding, we are 1.3% under-funded as a system by population. Our population has grown by 3.3%; we are funded at 1% for this. In income terms, this creates a shortfall of £70m.
- In 2019/20, NW London spent 60% more than the London average, having planned for 15%. All areas apart from running costs were more than the rest of the capital. The biggest gap between acute and actual spending was on acute care and this would have been higher if we did not have risk share arrangements in place.
- When removing the £36m of additional Covid funding, the CCG spends £64m more than it can afford.
- The unit costs of some of the healthcare we provide are higher than we would expect: the quantum of this cost is between £300-463m.
- Our acute provider collaborative has identified £230m of excess costs. A work programme is underway to look at nine specialities where there is consistency across providers and this cover £96m of the over-cost. However, it is important to recognise that the analysis may over-state the financial opportunity as there will be financial attribution issues. For this reason, the data will not be used on its own but we will also draw on national Model Hospital data.
- Our out of hospital collaborative, primary care and mental health are also looking for opportunities to improve productivity and efficiency. We will of course continue to meet the Mental Health Investment Standard and to invest in primary and community care: this exercise is about ensuring we get value for money and deliver services as efficiently as we can.

Financial recovery plan

Our Financial Recovery Board is developing a financial recovery plan, which will be brought to future meetings of the statutory NHS bodies (CCG and Trusts) and shared with Health and Wellbeing Boards and scrutiny committees.
Our immediate actions include the following.

- Continue to evaluate Covid costs and work with the national team on funding. Locally, work with our borough (ICP) teams on GP lists and population data to inform these discussions.
- Our Local Care workstream is pulling together a standard definition for the expected specifications for community services
- We are looking at all contracts to ensure a more standard offer and no duplication across NW London.
- Our provider collaboratives are looking at over-costs and targeting variances, including the £96m identified by the acute provider collaborative.
- Working with the London and national teams to agree a resilient specification with benchmarked cost for the London Ambulance Service.

8. Acute care update (Chelsea and Westminster Hospital, The Hillingdon Hospitals, Imperial College Healthcare and London North West University Healthcare)

1 Overview

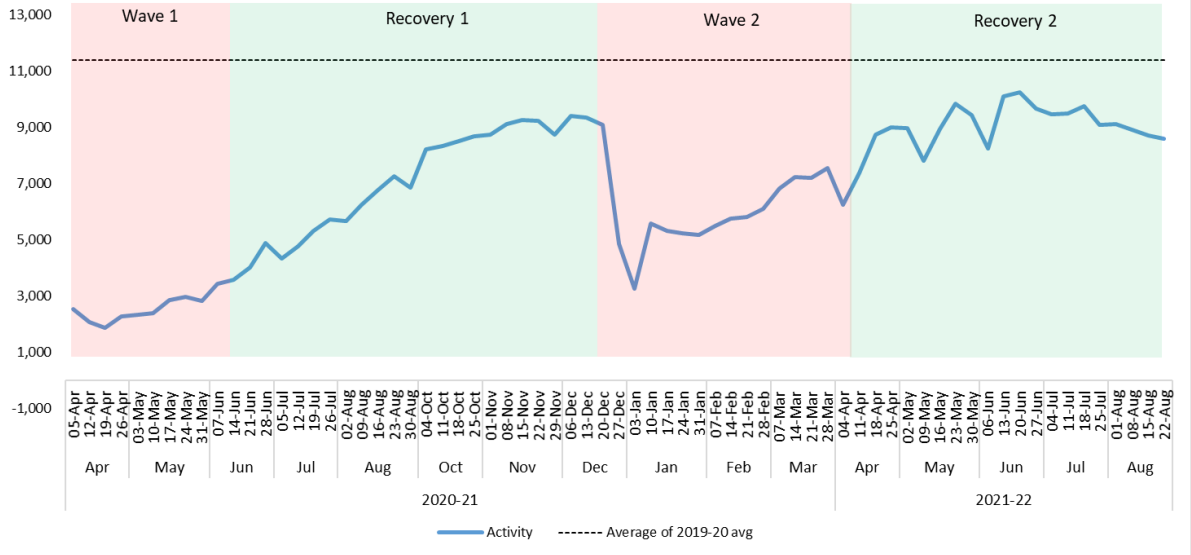
We are continuing to recover our services following the peak of the Covid-19 pandemic. As reported previously, we are continuing to offer acute patients who have been waiting a long time for treatment the option of being treated in another NW London hospital. We are looking to ensure that cases are prioritised fairly across NW London, recognising that a significant backlog developed due to the pandemic. We are working as quickly and efficiently as we can to tackle the backlog cross all services. Infection prevention and control guidance remaining in place on NHS premises and we continue both face to face and digital appointments as appropriate for patients.

2 Returning to pre-pandemic capacity and improving care pathways

2.1 Planned surgery

We are learning much during the pandemic and working hard to apply that learning rapidly. While we treated more patients with Covid-19 in the second wave of infections, we also managed safely to maintain more planned care. In wave one, planned surgery activity dropped to as low as 15 per cent of pre-pandemic levels while we maintained 50 – 60 per cent of our pre-pandemic activity levels throughout the vast majority of the second wave.

Table 1: Surgery activity for north west London acute trusts (patient episodes per week during the pandemic and compared with pre-pandemic)



In August 2021, we averaged 83 per cent of pre-pandemic planned care activity levels. We achieved 87 per cent in June and took the decision to reduce activity slightly through July and August in order to help ensure our staff had an opportunity to rest and recuperate. In addition, our hospitals are under pressure from unplanned admissions. This includes continuing admissions due to Covid-19, albeit at a much lower and steadier level than during the second wave of infections. A national target has been set for planned care recovery which, if we meet, gives us access to additional central income through the elective recovery fund (ERF). The national target was up to 85 per cent for the first quarter of 2021/22, which we met. The target was increased to 95 per cent from July and we are working to meet that level from September.

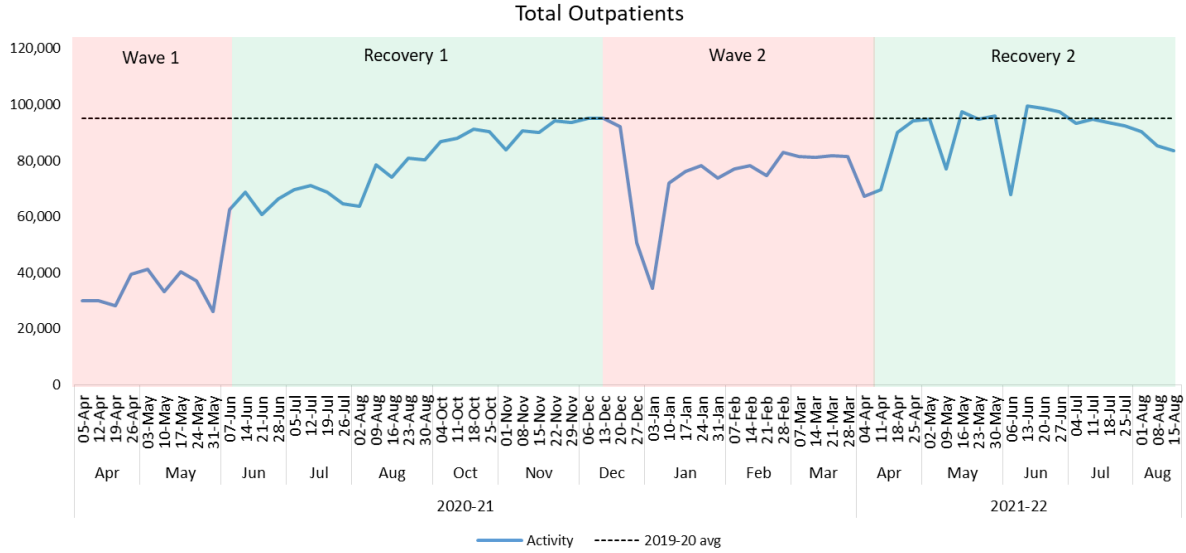
To help us boost capacity, we are maximising the use of our existing facilities, using national benchmarks and best practice (supported by the national Getting It Right First Time (GIRFT) programme) to help us understand where we should focus our improvements. Our clinical and operational leaders meet regularly through joint 'speciality huddles' and sector wide clinical reference groups to review data visualisations to aid analysis and agree actions.

The GIRFT approach also underpins the further development of our fast track surgical hubs -14 surgical facilities across our hospitals dedicated to one or more types of routine operation where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of that procedure systematically. The hubs focus on six clinical specialties characterised by 'high volume, low complexity' procedures.

For a small number of services with particular capacity challenges, we have brought in an external specialist organisation to provide additional capacity within our own facilities or contracted with an independent sector hospital to provide surgery or treatment for our patients.

2.2 Outpatient care

Table 2: Outpatient care activity for north west London acute trusts (appointments per week during the pandemic and compared with pre-pandemic)



During the second wave of Covid-19 infections, we managed to maintain outpatient activity at around 80 per cent of pre-pandemic levels. In August, we averaged 97 per cent of previous levels, continuing to exceed the national target which was 85 per cent for the first quarter of 2020/21, increased to 95 per cent from July.

We are continuing to provide around 25 per cent of our outpatient consultations via telephone or video. We had to move quickly to virtual appointments at the start of the pandemic and, while we need to continue to improve the user experience and our own processes, the vast majority of patients and clinicians welcome the new approach and want it to continue.

A further significant development for outpatient services will be the implementation of a common and consistent approach to how our hospital clinicians work with GPs to provide specialist advice and guidance earlier in a patient's care pathway. This will help determine whether and how a patient should be referred for hospital care or whether their condition is
better managed in the community or at home. The approach is being supported by investment in a sector-wide digital platform for GPs and hospital clinicians, to be integrated with core patient administration and referral systems so that a referral can be progressed automatically if required. The system is already being used by The Hillingdon Hospitals and London North West University Healthcare and will be rolled out to Chelsea and Westminster and Imperial College Healthcare this autumn.

2.3 Cancer care

Urgent cancer referrals (on the 'two-week' pathway) have increased since March 2021 and are now above the average for 2019/20. We have still managed to improve performance against the national 'faster diagnosis' standard, with 73 per cent of patients being informed whether they have cancer or not within 28 days of urgent referral as of July 2021, equivalent to an additional 400 patients month.

The significant increase in referrals is having an impact throughout the cancer care pathway. Overall, as of July 2021, cancer first treatments are up 8 per cent against of the baseline of 2019/20. Total cancer surgical treatments (excluding skin and breast) are up 16 per cent against the 2019/20 baseline, with an additional 139 surgeries compared with the 2019/20 average. This increase in demand is creating capacity and operational pressures and longer waits for cancer care than planned. Performance against the 62-day wait (between an urgent referral and the start of treatment) standard is stable at 78 per cent. Together with RMP Cancer Alliance and wider partners across the integrated care system, we are working through how we can best achieve greater, sustainable improvement.

The increase in referrals is a positive development following a fall-off in patients presenting with cancer concerns during the pandemic. There continues to be a major sector-wide focus to help increase awareness amongst local communities, GPs and other partners of the importance of investigating cancer symptoms as soon as possible. The overall 'gap' (between actual and expected cancer diagnoses and 'first treatments') for patients resident in north west London has significantly reduced since March 2021 - from a starting deficit of 471 patients to a deficit of 233 patients in July 2021.

2.4 Diagnostics and imaging

Activity for all but one imaging modalities is now above 2019/20 levels. The exception is non-obstetric ultrasound which is running at 60 per cent of 2019/20 activity levels though referrals have also reduced due to the introduction of more detailed referral guidance. We are addressing some specific capacity challenges in the same way as for planned surgery, by offering care in our hospitals where there is more capacity and making use of independent sector capacity.

Greater collaboration and coordination is enabling a major upgrade and expansion of imaging equipment, funded by a national programme, to deliver greater benefits to our local population. Following replacement of two MRI scanners at St Mary's Hospital in February 2021, a further two new scanners are now being installed at Ealing and West Middlesex hospitals. A wider transformation programme is in development.

3 Minimising clinical harm and engaging with patients

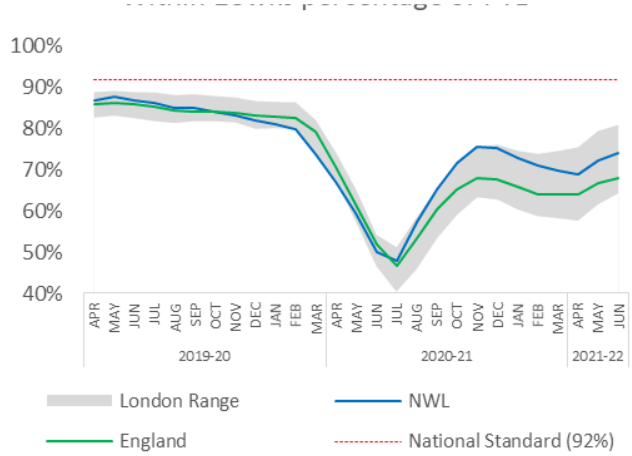
Our clinicians continue to prioritise all patients according to clinical need and regularly review patients waiting for treatment for potential clinical harm. They aim to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify appropriate remedial action. We are following principles established by the medical royal colleges which have been adapted for local use by the clinical leaders across north west London who make up the clinical reference groups for the different specialties.

We are beginning to roll out a pilot to improve communications and engagement for patients who have been waiting a long time for outpatient care and planned surgery, beginning in ear, nose and throat services at Imperial College Healthcare. It includes a letter and materials apologising to patients for the delay, providing information and

advice about their care and asking them to confirm their details and whether they still need their appointment. Initial results have been positive, with the vast majority of patients who respond saying they feel more reassured and some letting us know that they no longer need care or rearranging their appointment or changing their details, helping us to make best use of our resources.

4 Tackling long waits and making waiting fairer

Table 3 Percentage of patients who have been waiting 18 weeks or less from referral to treatment



In line with expectations, our combined waiting list increased during the first quarter of 2021/22 though our sector has the lowest per capita list in London. As of June 2021, an overall total of 179,753 patients were waiting for planned care, equivalent to 85 patients per 1,000 population. As of June 2021, 74 per cent of patients had waited 18 weeks or less from referral to treatment, still under the pre-pandemic national standard of 92 per cent but significantly up on a low of less than 50 per cent in July 2020. As a sector, we are also above the average for England.

Like the rest of the NHS, though, a significant number of patients on our list have been waiting for a long time. Alongside ensuring we treat patients with urgent clinical needs within the safest timescales, we have also put a special focus on treating those with the longest waits.

We have reduced the number of patients waiting 52 weeks or more from a peak of 6,802 in February 2021 to 3,883 as of June 2021. Currently, 2 per cent of patients on our list are waiting more than 52 weeks, compared to 4 per cent for the whole of London and 6 per cent across England. We have reduced the number of patients waiting more than 104 weeks from a peak of 126 on 17July 2021 to 112 patients at the end of August. Almost all of these patients now either have a booked date for their treatment or have chosen to postpone their treatment further for personal reasons. We are committed to having no one waiting over 104 weeks by the end of 2021/22.

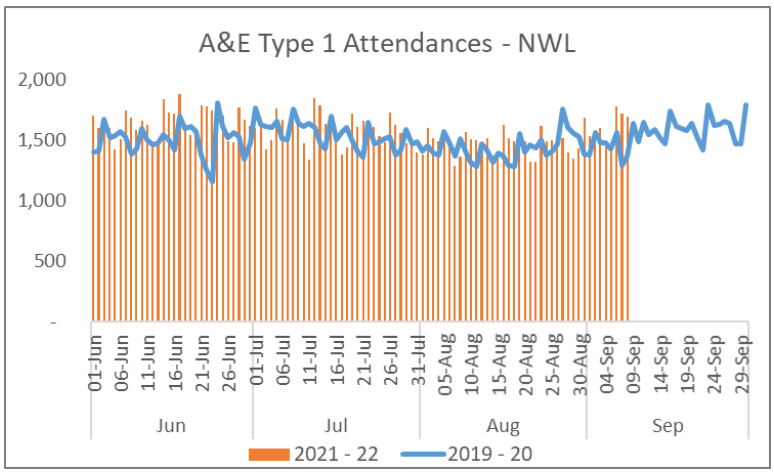
Closer collaboration has been one of the key ways in which we have been able to tackle our longer waits and it is also driving a strategic development to make waiting

times fairer overall. We have been creating a single view of waits across our hospitals to understand where a service in a hospital that has good capacity might be able to support the same service in another hospital that has long waits. In recent months, we have been able to offer faster care for patients waiting for gynaecological surgery, cataract surgery and endoscopy.

Longer term, we want to create a common and consistent approach to managing waiting lists across specialties and hospitals as effectively as possible. We're working towards common definitions and processes and beginning to explore digital systems to help provide up to date information and booking support to hospital clinicians and GPs, as well as to patients.

5 Urgent and emergency care

Urgent and emergency attendances continue to be significantly higher than expected for this point in the year. We have a major focus on Trust and sector-wide plans and improvements to help manage demand as we head into the winter. This includes: an expansion of 'same day emergency care'; optimising our 'front door' pathways, including encouraging the use of NHS111 First, to avoid waits in A&E and urgent treatment centres; and closer working to reduce delays in discharging patient who are medically fit to leave hospital.



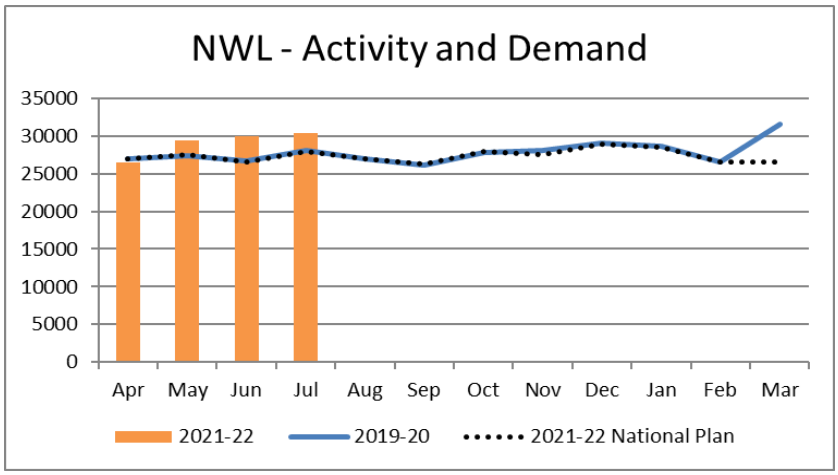
6 Specialist care

While not formally part of the acute care programme, the four acute providers are also working collaboratively, along with NHS England, to improve the quality of specialist care services. So far, the vascular care teams from Imperial College Healthcare and London North West University Healthcare have come together to provide complex surgery for abdominal aortic aneurysms in one centre at St Mary's Hospital in line with research demonstrating best practice and outcomes. This service change was completed in July 2021, with engagement and input from our local authorities and wider stakeholders. The two clinical teams are continuing to work together in order to explore further improvements.

Clinical leaders for a number of other specialist services in the four acute providers, including complex colorectal cancer, pouch surgery, head and neck cancer and

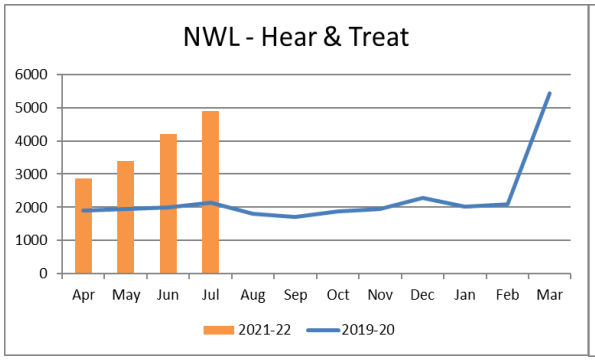
clinical haematology, are also coming together to explore opportunities to improve quality through greater collaboration and, potentially, some service consolidation.

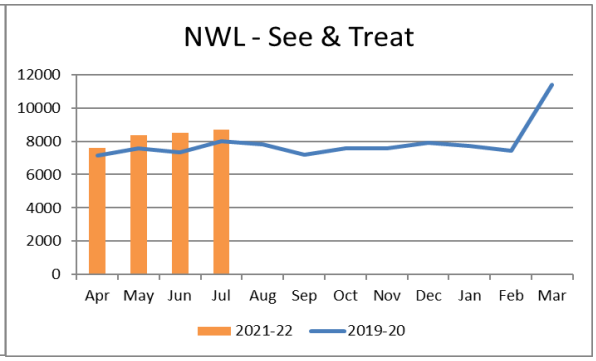
9. London Ambulance service



At month 4 (July 2021), total incident activity has risen above 2019/20 levels adding pressure to LAS services.

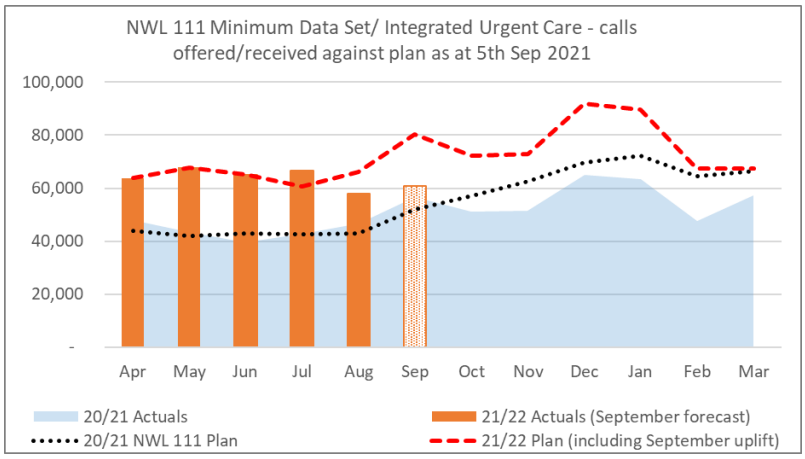
London continues to have low rates of conveyance to hospital relative to other parts of the country. This has been achieved through a significant increase in interventions where more cases are closed without conveyance to hospital. allowing ambulance crews to be diverted to more serious, high priority incidents.





10. NHS 111

NHS 111 has also seen increased levels of demand. Demand connected with lower acuity health conditions has been a factor, in line with a resurgence of patient demand for all healthcare services, particularly primary care.


NWL 111 Minimum Data Set/ Integrated Urgent Care - calls offered/received against plan as at 5th Sep 2021
100,000
80,000
60,000
40,000
20,000
-
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
20/21 Actuals
21/22 Actuals (September forecast)
20/21 NWL 111 Plan
21/22 Plan (including September uplift)

North West London Integrated Care System Working together for better health and care	**North West London Joint Health Overview and Scrutiny Committee** 23 September 2021
	Report from North West London ICS/CCG

NW London ICS Digital Strategy

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
Appendices:	Appendix 1 - Digital Data and Technology Transformation Plan - Presentation
Background Papers:	None.
Contact Officer(s): (Name, Title, Contact Details)	Kevin Jarrold – Joint Chief Information Officer Email: Kevin.jarrold@nhs.net

1. Purpose

The purpose of this report is to provide the NWL JHOSC with an overview of the progress being made with the development of the digital, data and technology transformation plan for the NW London Integrated Care System.

2. Recommendations

The NWL JHOSC is asked to note the progress being made, provide feedback and any comments and to receive further updates as the digital and data transformation plan is finalised over the coming months.

3. Detail

3.1 The attached slides set out an overview of the NWL digital, data and technology transformation plan. We are seeking to answer the question 'What digital, data and technology capability will the North West London Integrated Care System need' We are looking at a timescale that covers then next 5 years.

3.2 This first draft of the plan had to be submitted before national guidance on What Good Looks Like, Who Pays for What and the Unified Technology Fund was issued.

3.3 We are now working on a further iteration of the plan which will take account of this national guidance, feedback from stakeholders across NW London, Regional feedback and calibration against the other London ICS digital transformation plans.

3.4 The document describes the way in which the plan has been developed building on lessons learned through the response to the pandemic, taking account of the ICS strategic priorities and discussions with service users including workshops about digital inclusion.

3.5 The slides provide an overview of the drivers for change and describes our collective approach (slide 9 provides the digital strategy on one page). We then summarise seven focus areas that will be prioritised over the coming year:

1. Patient flow and capacity
2. The end to end patient pathway
3. Digital First in primary care
4. Digital Inclusion
5. Shared Records
6. Rationalise clinical systems
7. Resilient Infrastructure

4.0 Financial Implications

4.1 Further work on costing the requirements is underway – this will be influenced by the national guidance that was published at the end of August.

5.0 Legal Implications

5.1 None for the purposes of this report.

6.0 Equality Implications

6.1 The need to ensure that there is an approach to digital inclusion and addressing the challenge of digital exclusion is an important theme of the plan.

Appendix 1

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

North West London Digital, Data and Technology Transformation Plan

July 2021

The exam question: ‘What digital and data capability does the NW London ICS need’

- This overview of the digital, data and technology plan for the NWL Integrated Care System was submitted at the end of July and will now go through further iterations in the light of:
  - Feedback from NWL stakeholders
  - National Guidance (see below)
  - Regional feedback
  - Calibration against other London ICS Digital Transformation Plans
- National guidance was released at the end of August covering:
  - What Good Looks Like
  - Who Pays for What
  - The Unified Technology Fund

North West London Integrated Care System

Development of the plan

This plan has been developed based on:

- Lessons learnt from the pandemic, the collaborative working across the ICS, and the digital capability required to support it
- The need to prepare for future waves of the pandemic and to deal with the backlog of care
- The commitment to provide the best health outcomes for the population of NW London
- The ICS Transformation Plan and programme strategies
- Frameworks for digital transformation provided by national NHS leadership
- Discussions with service users, including workshops about digital inclusion and exclusion

ICS Leadership is asked to support this plan, which will continue to evolve in line with the changing clinical and operational needs of the ICS.

Introduction

This Digital, Data and Technology Transformation Plan sets out how the ICS can provide the digital enablement required by our staff and patients to realise the ambitions of the ICS Transformation Plan, learning from the experiences during Covid and supporting the post-Covid recovery.

Digital technology has for some time been a critical enabler for the delivery of health and care. Paper records have been replaced by digital clinical systems in almost every care setting. Digital messages and documents are essential for safe and efficient transfers of care between settings. And citizens increasingly wish to use technology to interact with the health and care system.

Covid gave us a new imperative to treat patients remotely to avoid the risk of infection, which has greatly increased our reliance on digital technology. And it demonstrated the dependency on data to manage supply and demand across the ICS.

The Covid pandemic has also highlighted health inequalities. We can use digital technology to increase inclusion. We need to support and encourage people to access digital routes and ensure that there are always ways for everyone to access services.

Our previous achievements…

ICT Infrastructure

- The rapid transition to remote working and the shift from face-to-face to virtual consultations
- Enabling intensive care patients to communicate with their families

Digital Records

- Digital care records in almost all care settings
- Our two global digital exemplar acute trusts share their electronic patient record system, with a plan for the other two to join

Data Sharing

- Health Information Exchange has gone live and gives the potential for pan-London data sharing
- Our work on data protection is an exemplar for England

Patient Engagement

- NW London Care Information Exchange is the largest personal health record in the country
- Digital-first consultations in all care settings

Integrated Care

- Single ICS patient tracking list (PTL) for capacity management
- Work on the end to end patient pathway - progress towards a single platform for advice and guidance

Population Health

- Our Whole Systems Integrated Care platform is at the forefront of population health management
- It provided data for ICS capacity management during the pandemic

Innovation

- CW Innovation tests and scales innovations
- NW London is a leader in remote monitoring
- Brent is a Digital Accelerator for Primary Care Digital First
- A range of partnerships

North West London Integrated Care System

Drivers of change

ICS transformation plan

Vision: to improve life expectancy and quality of life, reduce inequalities and achieve health outcomes on a par with the best global cities

- Improving outcomes in population health and health care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader economic and social development

NHSX strategy

National Digital Transformation Plan

- **Digitise**: level up NHS and social care services to ensure they have a core level of infrastructure, digitisation and skills
- **Connect**: join services together through technology, allowing providers to share information and take a shared approach to procurement and implementation
- **Transform**: using a digitised, interoperable, connected health and care system to deliver services more effectively and productively, and with the citizen at the centre

Covid

Capitalise on the new digital solutions we developed

- Being prepared for further surges of Covid
- Dealing with the accumulated backlog of care
- New technology was implemented and adopted very quickly in response to the pandemic
- We now need to consolidate, strengthen and capitalise on those advances, and move ahead with that agile approach

Drivers of change

Demands of our citizens

Citizens increasingly wish to use technology to interact with the health and care system, because of its greater convenience and efficiency

- 80% of Londoners believe it is vital we look at new ways to manage our health, including using high-quality health apps (Source: Orcha survey)
- Currently there are different systems and apps citizens can use to access their health records, interact with care providers to book appointments and attend virtual consultations, and view documents such as test results. These systems need to converge.

Digital Inclusion

The Covid pandemic has also highlighted health inequalities

- Digital technology can be used to increase inclusion and access to services, and we need to make sure that those who are not able to access services via digital means are not left behind.
- Access to services in future should operate on a digital first principle, with a focus on digital inclusion, whilst providing non-digital options wherever needed.

One London

Shared care records across London are important to NW London – 16% of our acute activity takes place outside NWL, 9% of acute activity is for patients from other ICS

- The One London programme has three levels:
- Level 1 – shared records for clinicians across London via Cerner Health Information Exchange
- Level 2 – shared data for London, via Discovery Data Service
- Level 3 – shared Personal Health Record to include records for a citizen from across all London care settings

Our ambition

Digital data and technology help our people provide great care for our patients and communities by giving them easy access to the information they need for clinical decision making, wherever they are.

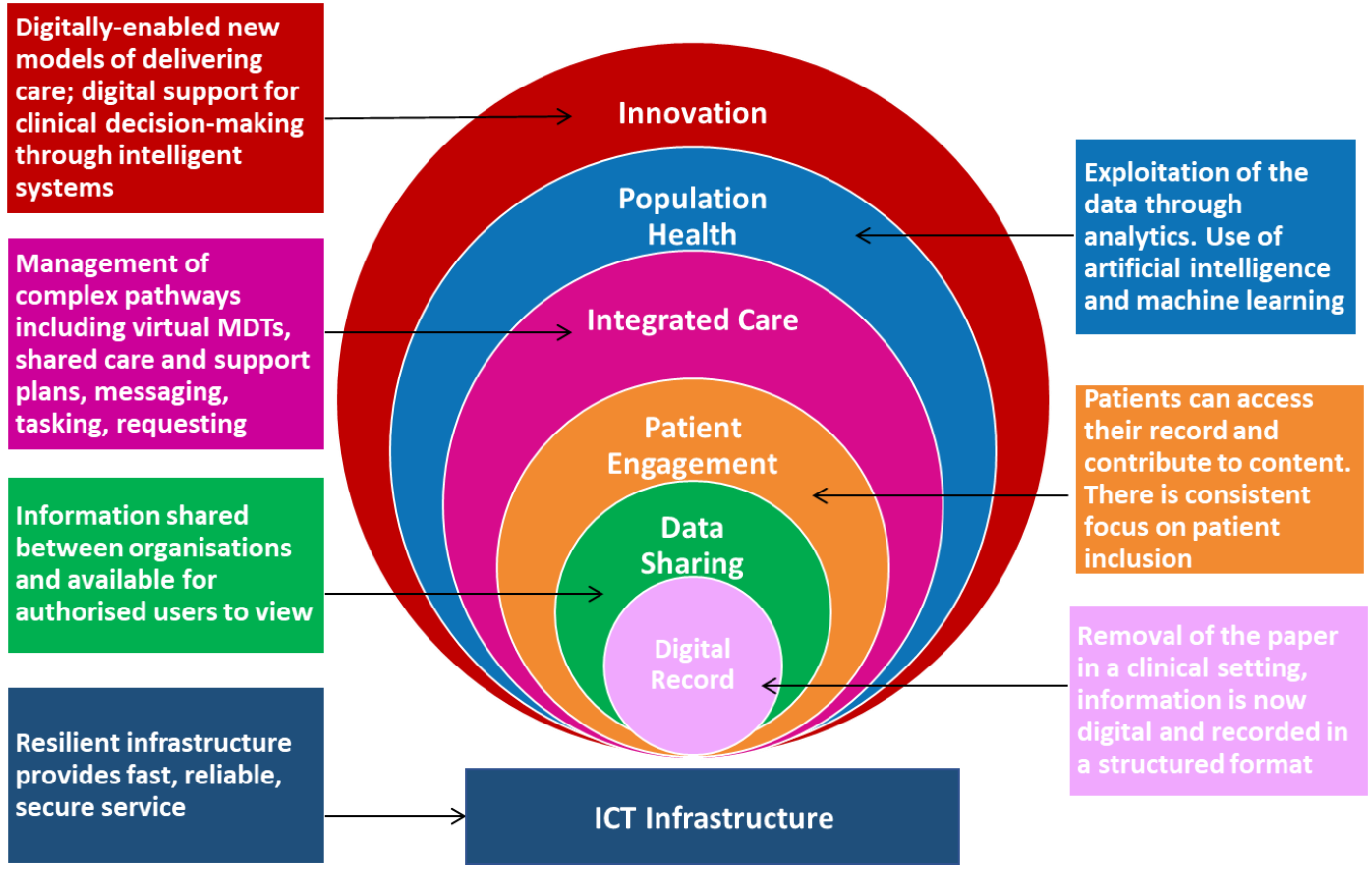
Our patients and service users have digital options for interacting with our services – with a non-digital option always available.

Collaborative working across the ICS is made easier though having the right technology.

North West London Integrated Care System

Our collective approach

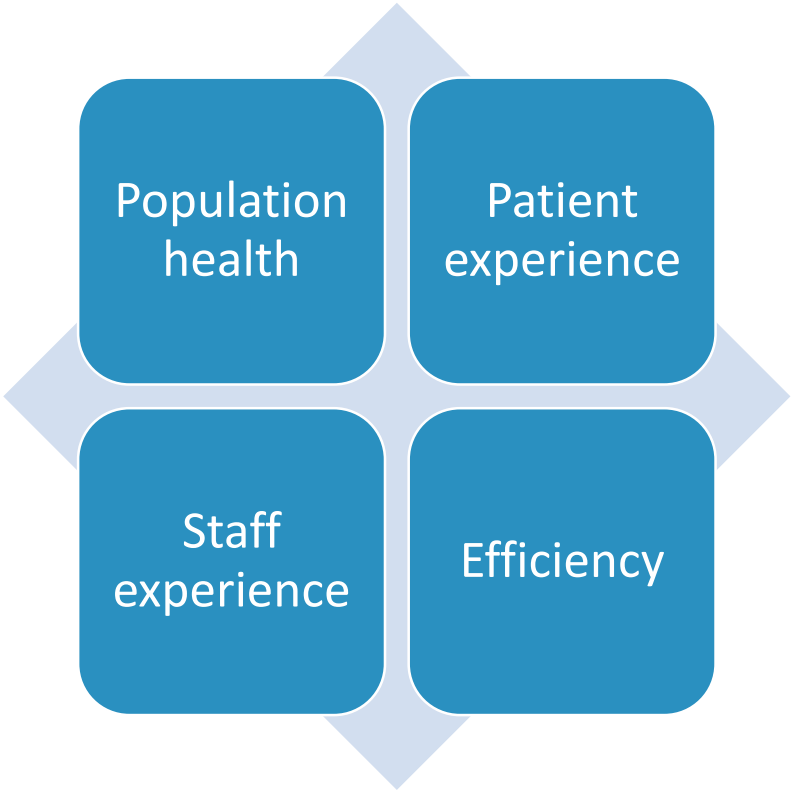
We want leaders across the ICS to sign up to this approach.



North West London Integrated Care System

The outcomes

Delivering the Digital, data and technology transformation plan will enable significant improvement in all four areas of the quadruple aim.



North West London Integrated Care System

What do we want to achieve?

We want North West London to be known as a centre for excellence in the use of digital, data and technology for helping our citizens stay healthier for longer.

What will it feel like for our patients and service users?	What will it feel like for our staff?
• I can choose how I want to get the care and treatment I need including digital if it suits me. • I can see my health and care records on my computer, my phone or my tablet. • I can access information about my health and care in North West London via the NHS app • I am in control of my appointments with health and care professionals. • I know that my health and care professionals can see information about me from the NHS and social care. • I can get involved in clinical research if I want to.	• I can get all the information I need about my patients and service users through the electronic patient record system that I use every day. • I can use digital tools to collaborate with colleagues from other care settings. • I have the skills and knowledge that I need to make use of digital, data and technology. • I can give my patients and service users options in the way they receive care. • I have more flexibility in the way I choose to work. • I can use population health data to inform the decisions I make about treatment and care.

North West London Integrated Care System

2021/22 Focus areas mapped to our framework

		Resilient infrastructure	Digital record	Data sharing	Patient engagement	Integrated care	Population health	Innovation
1.	Managing patient flow and making best use of capacity					✔	✔	✔
2.	End to End Patient pathway a) Virtual consultations b) Advice and Guidance c) Remote Monitoring				✔	✔	✔	✔
3.	Digital first primary care				✔	✔	✔	✔
4.	Increase digital inclusion			✔	✔	✔	✔	✔
5.	Shared patient records across London			✔	✔	✔	✔	
6.	Rationalising clinical systems a) Roll out Cerner to LNW and THH b) Develop plans for primary care, community and Mental Health	✔	✔	✔				
7.	Resilient infrastructure	✔	✔	✔	✔	✔	✔	✔

Focus area 1: Patient flow and capacity

Provide innovative digital and data tools, including visualisation, across the ICS that enable us to:

- Better plan for peaks and troughs in demand
- Deploy our capacity flexibly across the ICS in response to changing demand

Manage patient flow and make best use of capacity	
Why we need to do it	The Covid pandemic highlighted the need to be able to monitor system capacity and demand and manage patient flows to make optimum use of resources. To support the recovery from Covid, the ICS needs better digital and data tools to continue to manage this process.
What we will do in 2021/22	• Analyse current landscape – ICS requirements, data available, tools for reporting and analysis • Market review – consider alternatives to existing data and tools, identify Business Case for any investment required • Confirm target architecture (feed into ICS Data Strategy) and seek funding • Develop implementation plans and report on progress • Deliver Patient Tracking List as soon as possible.
What we will do in 2022/23 and subsequent years	Deliver and continuously develop the digital and data tools needed to meet demand and capacity management requirements
Impact on service users and staff	• ICS leadership will have the tools needed to identify capacity issues and direct patient flows in the most efficient ways • Service management will have better information to support data-driven decision-making • Support reductions in waiting times for patients where possible
How we will measure success	• Delivery of the tools agreed with ICS leadership • Success of efforts to manage and reduce waiting lists

North West London Integrated Care System

Focus area 2: End-to-end pathway

Integrate care and improve population health and patient engagement through:

- Develop a strategic solution for virtual consultations
- Implement a single system for advice and guidance
- Demonstrating the case for remote monitoring in improving outcomes

Support the end-to-end patient pathway: virtual consultations, specialist opinion, remote monitoring	
Why we need to do it	• During Covid, face-to-face patient consultations were replaced with virtual consultations. This will continue to be a requirement. Currently systems provide different experiences for service users, making them more difficult to use. • Recovering from Covid will require efficient use of specialist provider resources. A unified approach to accessing advice and guidance can provide an efficient way to transmit, process, and enter advice given in clinical records and measure requests – feeding into capacity and demand management. • Remote monitoring enables patient vital signs to be reviewed by clinical teams. During Covid this approach was adopted in Primary Care Hubs to help avoid hospital admissions, and in Acute Virtual Wards to enable safe early discharge of inpatients
What we will do in 2021/22	• Procure a strategic replacement for the current virtual consultation solutions. • Deploy a tactical advice and guidance solution in acute trusts and GP practices. Agree requirements for a long-term strategic solution. • Extend remote monitoring to a defined set of conditions and scenarios. Develop a business case for wider deployment, if evaluation supports this.
What we will do in 2022/23 and subsequent years	Identify and implement strategic solutions for video consultation and advice and guidance. Deploy remote monitoring in long-term condition pathways if the business case justifies this investment.
Impact on service users and staff	Consistently good clinician and patient experience for virtual consultations. GPs will be able to receive specialist opinion within an agreed response time. Patients will be safely managed at home, avoiding hospital visits, and will be better able to self-manage.
How we will measure success	Usage, patient and staff satisfaction with the technology, reduction in face-to-face referrals while maintaining clinical outcomes, formal evaluation.

North West London Integrated Care System

Focus area 3: Digital first primary care

Support GP practices and Primary Care Networks to improve population health through innovative approaches to digitally enabled online consultations, remote long term condition management, and social prescribing

Deliver on the Digital First Primary Care programme	
Why we need to do it	The nationally funded NWL Digital First Programme aims to: enable and encourage digital innovation across primary care; drive digital innovation through accelerator initiatives; rapidly evaluate digital solutions and innovation pilots; share lessons learnt from those that have trialled digital solutions; support implementation, sharing and scaling best practice.
What we will do in 2021/22	• Online Consultations: review use of the e-Consult tool and feed into re-procurement • PCNs: work with primary care to optimise the use of digital tools, such as remote monitoring in care homes to support the Directed Enhanced Service, and titration for hypertension • Social Prescribing: provide digital tools such as support directory and case management • Digital Inclusion: trial the use of new patient-facing digital tools to reduce exclusion • Workforce: initial deployment of new approaches to train and support staff
What we will do in 2022/23 and subsequent years	This programme is funded by NHSE from year to year; priorities for 2022/23 will be confirmed during the latter part of 2021/22
Impact on service users and staff	• Better digital tools for staff, which they are better equipped to exploit for patient care • More accessible and effective tools for patients to interact with primary care
How we will measure success	• Evaluation of each programme work stream In terms of uptake and efficacy

Focus area 4 : Increase digital inclusion

Use digital technology to increase inclusion and access to services

Support and encourage people to access digital tools

Ensure that there are always ways for everyone to access service

Increase digital inclusion	
Why we need to do it	The Covid pandemic gave us a new imperative to treat patients remotely to avoid the risk of infection, which has greatly increased our reliance on digital technology. We can use digital technology to increase inclusion and access to services. As a community we will have to invest to help people with the devices, connectivity, skills and motivation to engage digitally with the health and care system.
What we will do in 2021/22	• Create a framework to ensure digital devices are made available to vulnerable groups of people • Identify the impact and risks associated with digital solutions for people with long term conditions who are unable to use specific technologies • Ensure care pathways provide a non-digital route to access services (e.g. by phone or face to face) alongside the digital routes • Provide training to targeted groups of people to enhance confidence and skills to access health and care services online with the help of a network of Digital Champions in each borough • Hold health and care organisations accountable for providing digital solutions that are accessible to everyone in their care pathways and local communities
What we will do in 2022/23 and subsequent years	• Evaluate the success of the programme in 2021/22 in reducing digital exclusion • Continue to invest in proven effective ways to increase digital inclusion
Impact on service users and staff	• Service users will be able to engage more fully with their health and care through digital tools • Those unable or unwilling to use digital tools will have access that is just as good, via non-digital channels
How we will measure success	• Increase in the number of people using digital health and care tools successfully • Reduction in the proportion of the population who do not feel able or comfortable in using digital tools

North West London Integrated Care System

Focus area 5: Shared records across London

Enable data sharing to support integrated care across London by giving clinicians relevant information from any digital record in London

Broaden data sharing and analysis through Discovery Data Service and WSIC

Engage patients through access to their own Personal Health Record

Shared patient records across London – OneLondon programme	
Why we need to do it	• Shared records between care settings are required to support the ICS aim for patient-centred, cross-organisation, multi-disciplinary integrated care pathways • The OneLondon programme, led by NHSE London, has a strategy to share patient information to support direct patient care across all care settings, across all five London ICS • Shared care records across London are particularly important to NW London – 16% of our acute activity takes place outside NWL, 9% of acute activity is for patients from other ICS
What we will do in 2021/22	• Complete interfaces from clinical systems in all NW London care settings into Level 1, 2 and 3 • Communicate the availability of these new tools to our clinicians, and help them start to exploit the information now available into their pathways
What we will do in 2022/23 and subsequent years	• Ongoing development and exploitation of the pan-London tools to support integrated care, including education and pathway transformation as appropriate
Impact on service users and staff	• Clinicians will be able to see details of treatment delivered outside NW London in HIE • Patients will be able to see details of healthcare outside NW London in CIE • The ICS will have access to more information on activity delivered outside NW London
How we will measure success	• Achievement of the published milestones for Level 1, 2 and 3 • Evaluation of the clinical impact of access to the additional information

North West London Integrated Care System

Focus area 6: Rationalise clinical systems

We aim to rationalise our clinical systems landscape to:

- Standardise and improve ICT infrastructure
- Remove paper and digitise records, reducing cost and improving patient safety
- Enable low friction **data sharing**, improving patient care and patient and staff experience

Rationalise clinical systems	
Why we need to do it	Roll out the Cerner Electronic patient record to LNW and THH to enable them to: • Record clinical interactions digitally (some records are currently still on paper) • Support transfers of care with digital messages • Share records with other staff and patients • Measure and report on activity more efficiently • Feed into population health data to drive decision making A shared system will help acute trusts work together to manage patient flow across the system. Better for patients, and better for staff. Review options to rationalise clinical systems across primary care, community and mental health
What we will do in 2021/22	• Complete the early phases of the Cerner implementation project • Develop an ICS-wide clinical systems strategy covering all care settings
What we will do in 2022/23 and subsequent years	• The Cerner implementation is a very complex implementation and full deployment will be spread over a number of years • The clinical systems strategy will be a long term strategy that will require investment
Impact on service users and staff	• Services will be run more efficiently and safely • Patients will be able to view their own records via CIE • Hospital clinicians will use digital systems rather than paper (e.g. prescribing) • GPs will receive information digitally rather than on paper (e.g. prescription advice) • We will deliver a consistently good electronic patient record across all care settings
How we will measure success	• Clinical services successfully migrated to Cerner • Adoption of the system • Clinical system strategy implemented delivering good clinician and patient experience

North West London Integrated Care System

Focus area 7: Resilient infrastructure

This is the foundation for our digital data and technology objectives

Our strategic ambition is to provide ICT infrastructure that gives staff access to digital records from wherever they are working – enabling remote, flexible and agile working

In the short term we need to level up our organisations to modern levels of security to ensure our systems are protected

Resilient infrastructure – ensure sufficient investment to maintain patient safety and address cyber security risk	
Why we need to do it	• A resilient infrastructure provides the fundamental platform for fast, reliable, secure clinical systems, and protects health and care organisations from external cyber risks • NW London's ICT infrastructure works adequately, but some organisations have had inadequate funds to invest in modern systems and security, with resulting "digital debt" • We managed the transition to more remote working at the start of Covid (with NHSE funding) but some of the technology was implemented at very short notice, and needs to be reprocured and improved – many different technical solutions are deployed across the ICS • An effective remote working infrastructure will reduce our need for buildings
What we will do in 2021/22	• Assess investment required to modernise infrastructure and cyber security, develop Business Cases, understand funding options and initiate the modernisation programme • Review the ICT architecture of ICS organisations and develop a convergence plan, to support multi-disciplinary working across sites, rationalise systems and reduce overall costs
What we will do in 2022/23 and subsequent years	• Seek business case approval for infrastructure convergence and start implementation
Impact on service users and staff	• Staff will be able to access systems wherever their jobs require them to work – rather than having to travel back to the office
How we will measure success	• Achievement of the milestones in the modernisation and convergence programmes

North West London Integrated Care System

Summary of the plan (1/2)

	2021/22	2022/23 and onwards
ICT Infrastructure	• Bring all organisations up to modern cyber security standards • Architecture and Business Case to manage technical debt and converge ICS infrastructure	• Ongoing investment in infrastructure, cyber security and convergence
Digital Records	• Continue acute Cerner single domain programme • Reprocure GP Primary Care systems • Assess opportunity for convergence of clinical systems in acute specialities, community and mental health	• Complete acute Cerner single domain programme • Rationalise other clinical systems: specialist acute systems, community and mental health systems • Ongoing investment in digital skills of staff
Data Sharing	• One London Levels 1, 2 and 3: implement sharing from all clinical systems across the ICS	• One London Levels 1, 2 and 3: transform integrated clinical services using shared records
Patient Engagement	• End to end patient pathway: confirm strategic requirements for virtual consultations; replace current e-consultation and video consultation products across primary and secondary care • End to end patient pathway and Digital First: scale up remote monitoring • Expand One London Level 3 (Care Information Exchange) to a larger patient cohort • Develop plans and secure funding for Digital Inclusion	• Deploy strategic virtual consultations solution • Deploy remote monitoring as part of long-term condition pathways, if justified by evidence • One London Level 3: new patient-centric pathways exploiting Care Information Exchange (e.g. Patient Initiated Follow Up) • Convergence of patient-facing apps and systems • Implement

Summary of the plan (2/2)

	2021/22	2022/23 and onwards
Integrated Care	• End to end patient pathway: implement tactical Advice & Guidance solution (Vantage Rego) across ICS; confirm strategic requirements for A&G and Referrals • Invest in One London Level 2 (WSIC) – ICS Patient Tracking List for supply and demand management	• Implement strategic A&G and Referrals solution • Exploit One London Level 1 capabilities for integrated care
Population Health	• Invest in One London Level 2 (WSIC) – platform, data, analytical tools • Develop ICS Data Strategy	• Implement ICS Data Strategy • Educate staff in data-driven decision making and tools
Innovation	• Remote Monitoring to wider cohort • Evaluate deployments and develop business case at population level if justified • Develop plan for consolidation and convergence of back office and corporate systems	• Population level remote monitoring for LTCs • Seek partnerships for innovation • Implement back office and corporate systems consolidation

Overseeing delivery of the plan

The NW London Digital, Data and Technology Plan is the responsibility of the CEO-led **Digital Transformation Board**, reporting into the ICS Executive and sitting alongside the other ICS-wide programmes.

Clinical and digital leadership of the Plan is provided by the **Digital Transformation Forum**, reporting into the Digital Transformation Board, managing the relationship between the ICS and digital leadership in NHSEI, NHSX and One London, and overseeing the detailed work via:

- **Digital, Data and Technology Steering Groups** in each care setting – Acute, Primary Care and Community/Mental Health
- **Governing groups for technical and enabling workstreams**: New Systems and Technical Change Board, Information Governance Board, Data and Analytics Board, Digital Inclusion Steering Group
- **Steering groups** for individual programme work streams.

North West London Joint Health Overview and Scrutiny Work Plan 2021-2022

At the meeting on 14 July 2021, the following topic was raised as an item that the Committee would like to scrutinise:

- Mental Health Strategy.

This item needs to be allocated to a particular meeting of the committee below.

14 July 2021

Agenda Item	NHS Organisations	Host Borough
1. North West London NHS Covid 19 Recovery and Vaccination Programme	North West London Clinical Commissioning Group	London Borough of Hounslow
2. Development of the Integrated Care System in North West London	North West London Integrated Care System North West London Clinical Commissioning Group	London Borough of Hounslow

23 September 2021

Agenda Item	NHS Organisations	Host Borough
1. North West London NHS Acute Strategy	North West London Clinical Commissioning Group North West London Integrated Care System	The London Borough of Brent

2. North West London NHS Digital Strategy	North West London Clinical Commissioning Group	The London Borough of Brent

14 December 2021

Agenda Item	NHS Organisations	Host Borough
1. North West London NHS Estates Strategy	North West London Clinical Commissioning Group North West London Integrated Care System	TBC
2. North West London NHS Workforce	North West London Clinical Commissioning Group North West London Integrated Care System	

9 March 2022

Agenda Item	NHS Organisations	Host Borough
1. Implementation of the Integrated Care System in North West London	North West London Integrated Care System North West London Clinical Commissioning Group	TBC

Joint Health Overview & Scrutiny Committee – 23 September 2021

2021-22 Work Programme & Meeting Arrangements

1. Background

1.1 Having considered the Committee's Work Programme members of the Joint Health Overview & Scrutiny Committee (JHOSC) are also being asked to confirm the arrangements to host and administer each meeting.

1.2 The JHOSC meets 4-6 times per calendar year and, although not specified in the Terms of Reference, current practice established amongst member authorities, with the agreement of the chair, is that the administrative & democratic support for each meeting is rotated between member authorities on a meeting by meeting basis. In effect, this means that the authority hosting a meeting will be responsible for providing a venue and any AV/technical hybrid support along with the democratic services support for that meeting. This will involve issuing the meeting invites, preparing and circulating the agenda, clerking the meeting and producing the minutes.

1.3 The main policy and scrutiny support for the JHOSC is provided by the authority whose member serves as chair, which is currently Brent. This will involve supporting the chair and committee in terms of work programme planning, scoping of work and liaison with the necessary stakeholders to ensure relevant information is provided for each meeting.

1.4 Brent has agreed to host the September meeting but the committee is now asked to agree the arrangements for hosting of the remaining meetings this year, which have been scheduled as follows:

14 December 2021 – host to be confirmed

9 March 2022 – host to be confirmed

To assist members, those boroughs who have hosted the JHOSC since January 2020 are as follows:

- January 20 – Kensington & Chelsea
- March 20 - Richmond
- Sept 20 - Hammersmith & Fulham (online)
- Jan 21 - Ealing (online)
- March 21 - Kensington & Chelsea (online)
- July 21 - Hounslow (online)

2. Recommendation

2.1 The JHOSC is therefore asked to confirm the arrangements outlined within this paper as the basis for support to the Committee moving forward and to agree on a host borough for the December meeting.

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