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North West London Joint Health Overview and Scrutiny Committee

Wednesday 20 July 2022 at 10.00 am
Conference Hall – Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

The meeting will be held as an in person physical meeting with all Scrutiny Committee members required to attend in person.

The meeting will be open for the press and public to attend. Alternatively the link to follow the webcast is available here.

Membership:

Members Councillors:	**Representing**
Ketan Sheth	London Borough of Brent
Crawford	London Borough of Ealing
Perez	London Borough of Hammersmith & Fulham
Addenbrooke	Royal Borough of Kensington and Chelsea
Denys	London Borough of Hillingdon
Halai	London Borough of Harrow
Sharma	London Borough of Hounslow
Piddock	London Borough of Westminster
Vollum	London Borough of Richmond - non-voting

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Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members**	
2	**Election of Chair and Vice Chair** Committee to Elect the Chair and Vice Chair for the 2022/23 Municipal Year.	
3	**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.	
4	**Minutes of the previous meeting - 9 March 2022** The minutes of the previous meeting will be considered at the next meeting.	
5	**Matters Arising (if any)**	
6	**Elective Orthopaedic Centre - Central Middlesex Hospital Business Case** To update members on the Central Middlesex Hospital Business Case in relation to the Elective Orthopaedic Centre.	1 - 72
7	**Community Diagnostic Centres** To update members on the plans to progress the new Community Diagnostic Centres in North West London with Capital Investment starting from 2022-23.	73 - 84
8	**ICS Update** To provide an update to members on the ICS.	85 - 94
9	**Health Inequalities Framework** To update members on the framework to address health inequalities in	95 - 124

North West London.

10 NWL JHOSC 2022-23 Work Programme and Meeting Arrangements 125 - 132

To update members on the Committee's work programme for 2022-23.

11 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.

Date of the next meeting: Wednesday 14 September 2022

Please remember to switch your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and a limited number of seats will be available for members of the public. Alternatively it will be possible to follow proceedings via the live webcast here.

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Proposal to develop an elective orthopaedic centre for north west London to reduce waits and improve quality

Meeting: North West London Joint Health Overview and Scrutiny Committee

Date of meeting:
Wednesday 20 July, 2022

Subject:
North west London acute care programme – proposal to develop an elective orthopaedic centre

Report authors:

Professor Tim Orchard, Chair, North west London acute care programme board; Chief executive, Imperial College Healthcare NHS Trust

Pippa Nightingale, Chief executive, London North West University Healthcare NHS Trust

Section 1 – Summary and recommendations

Summary
As previously reported to the Committee, we have been looking to build on the success of increased collaboration between acute trusts and the use of 'fast track surgical hubs' in helping to maintain high quality planned care during the Covid-19 pandemic. Our focus has been on developing a more strategic and larger scale approach to providing 'high volume, low complexity' surgery, beginning with orthopaedic surgery as a specialty with some of the longest waiting times as we emerge from the pandemic. In particular, we have been exploring the possibility of establishing an elective orthopaedic centre in north west London to improve both quality and efficiency – helping us provide better care to more patients, more quickly.

With support from the previous Committee meeting, we engaged informally with local people across north west London during June to help develop our understanding of the needs and views of our patients and local communities in relation to musculoskeletal care. We have now used the insights gathered from these engagement activities, together with a wide range of other exploratory work, to develop detailed proposals for an elective orthopaedic centre to be created at the Central Middlesex Hospital.

Recommendations:
Members are requested to approve our plan to now undertake a formal public consultation on our proposal in order to inform our next steps, including working up a full business case for a proposed elective orthopaedic centre. Our proposal for the creation of an elective orthopaedic centre is included in this paper, along with our proposed consultation strategy (appendix 1), a summary of findings from our informal engagement activities (appendix x) and an inequalities and health impact assessment for the proposal (appendix x).

Main paper

1 The case for change

The challenge

- Staff across all four acute trusts in north west London (Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust) are committed to offering the very best care to everyone in our communities. However, the pandemic has had a significant impact on waiting times for planned care across the entire NHS, particularly in orthopaedic services, where more than 25 per cent of surgical interventions are undertaken nationally. Orthopaedics is one of six priority specialties in NHS London's elective surgery recovery and transformation programme. There are over 12,000 people currently waiting for orthopaedic care in our hospitals. The proportion of people waiting more than 52 weeks for care has increased by more than a quarter during the pandemic. Even though procedures like hip or knee replacements are not usually considered to be time-critical, we know that waiting for treatment can have a very negative impact on quality of life for patients, making it much harder to go about day-to-today activities, such as getting to work or going to the shops. Conditions may also get worse over time, making them harder to treat and to recover from.

- Though we have generally positive feedback from patients that our staff are caring, kind and helpful, they are much less positive about their experience of navigating the healthcare system. In particular, patients with bone and joint problems have reported frustration with long waiting times between their initial assessment and surgery or while attending their appointments, having to chase up for their follow-up appointments or feeling worried due to re-scheduling or cancellations. Elderly or disabled patients often say travel to appointments is a problem. Patients also highlight communication problems, such as lack of coordination between GPs and hospital services or confusing information. Patients say they want more control over their care and they want us to organise our care so that it is as clear, consistent and straight forward as possible.

- Some of our orthopaedic surgery services are amongst the best in the NHS for key performance indicators. For example, for knee and hip surgery, The Hillingdon Hospitals is in the top quarter of trusts nationally for short length of stay while Imperial College Healthcare is in the top ten per cent for low readmission rates. Chelsea and Westminster is in the top ten per cent for five-year revision rates on knee surgery, while London North West is in the top quarter for revision rates on hip surgery. But aspects of clinical outcomes and experience vary within and across the trusts and there is much more we need to do to ensure we consistently the highest standard of quality across the board.

- We know that some patients also face poorer health outcomes and inequity in access to healthcare more generally. This is the case for elderly and disabled people, as well as for people from more deprived areas or those from Black, Asian and other minority ethnic groups. We want to bring all of our care up to the level of the best for all patients, regardless of where they live or have their operation.

- Without intervention, our waiting lists will continue to grow faster than our capacity to provide care. This will become particularly challenging over the next few years, as we expect that the number of people needing orthopaedic surgery in north west London will increase by almost a fifth by 2030. We also want to make sure we make the most of digital and other technological advances, without leaving anyone behind, while continuing to attract and retain great staff who love their jobs and continue to build their skills and expertise.

The opportunity

- One of the ways we were able to maintain planned care during the pandemic was by establishing 'fast track surgical hubs' that focused on specific, routine operations located

in facilities which are relatively separate from urgent and emergency care, meaning services are less likely to be put on hold in response to peaks in unplanned demand.

- These hubs work well for 'high volume, low complexity' surgery, where evidence shows that when surgical teams have more experience of the same, routine operation, there is an improvement in both quality and efficiency – helping us provide better care to more patients, more quickly.

- Building on this concept, we have been developing a more strategic, large-scale approach to improving our provision of 'high volume, low complexity' procedures – primarily knee and hip replacements and elbow, shoulder and feet surgery – in one centre.

- There is a strong evidence-base for elective care centres, especially for the provision of orthopaedic surgery. A well-established example in London is SWLEOC (South West Elective Orthopaedic Centre), which offers inpatient, day cases and some outpatient care and performs over 5,200 procedures a year, including 3,000 joint replacements. Recognised as the largest joint replacement centre in the UK and one of the largest in Europe, it reports lower than average length of stays and good feedback from patients and staff. SWLEOC is recognised as a centre of excellence and was rated outstanding by the Care Quality Commission in 2015. Elsewhere in the country, the elective orthopaedic centre for The Royal Cornwall Hospitals NHS Trust performs particularly well in all but one indicator, including top quartile performance for length of stay and readmission rates.

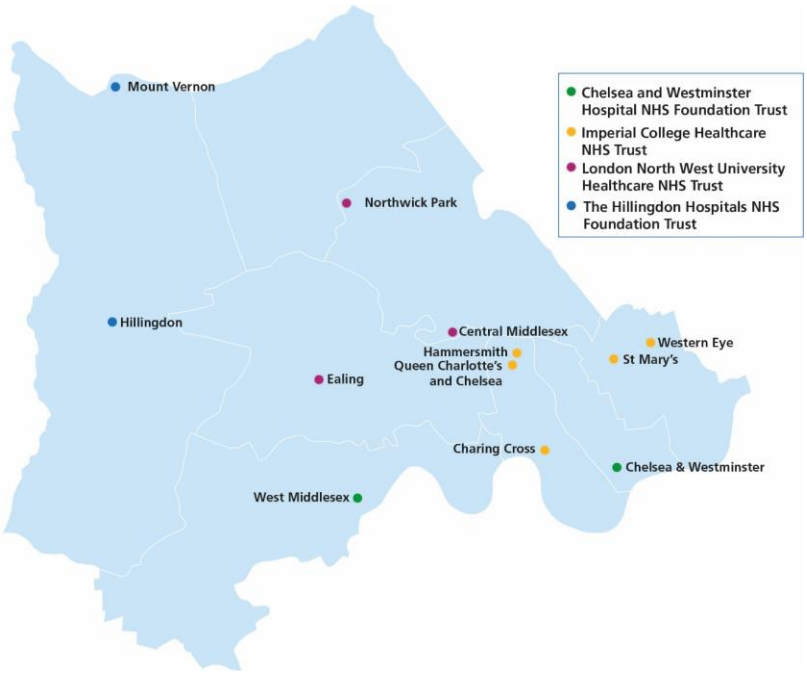
- We have been exploring whether and how we should establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. This work is being led by clinicians from across the trusts, drawing on evidence from best practice elsewhere, as part of creating an overall improved model of care for orthopaedics in partnership with colleagues and other stakeholders in primary and community care.

- Following analysis of all of our sites, we have concluded that the Central Middlesex Hospital provides an ideal location for a possible elective orthopaedic centre for our sector:
    - It is a modern and high quality estate which, with some limited expansion and remodelling, could offer facilities tailored to the provision of an elective orthopaedic centre
    - It is one of only two sites in north west London that do not provide urgent and emergency care, so is much less impacted by peaks in urgent and emergency care demand
    - None of the existing services would need to be displaced as there is plenty of room for expansion. This includes St Mark's, the specialist bowel hospital, which operates from the Central Middlesex site.
    - Our travel time analysis looked at the average time to travel to all eight of our hospital sites that currently provide 'routine' orthopaedic surgery and other sites from all parts of our sector (we analysed distances from 'lower layer super output areas' (LSOAs), small geographical areas of approximately the same population size to provide a fairer unit of comparison than boroughs which vary in size). We found that Central Middlesex has the shortest median travel time by car at 22 minutes. By public transport, Central Middlesex has the second shortest median travel time at 45 minutes, second only to St Mary's Hospital. However, although St Mary's is located very centrally with good transport links, it is one of our oldest and pressured estates and in line for complete redevelopment. It is also the major

trauma centre for the sector and, so, is impacted very significantly by peaks in urgent and emergency demand.

Our proposal

- Around 4,000 patients a year currently have 'high volume, low complexity' orthopaedic inpatient surgery at hospitals across north west London: at Mount Vernon, Northwick Park, Hillingdon, St Mary's, Charing Cross, Chelsea & Westminster and West Middlesex and Central Middlesex hospitals.



Map of all hospitals in north west London. Ealing, Hammersmith, Queen Charlotte's and Chelsea and the Western Eye hospitals do not provide routine orthopaedic surgery services.

Our analysis indicates that this total volume of surgeries could be provided at the Central Middlesex following a systematised 'high volume, low complexity' approach. This would involve transferring around 1,100 patients who currently have their surgery at Chelsea and Westminster Hospital, just over 800 patients from The Hillingdon Hospitals and approximately 1,000 patients from Imperial College Healthcare. We have concluded that providing this scale of surgeries in a systematised way would create significant improvements in quality and efficiency, and enable us to use the capacity left behind on the other sites to support other specialties.

To enable this, we need to build two additional laminar flow operating theatres, extend the first stage recovery unit and carry out some remodelling of parts of the existing estate. It would also require new ways of working and new models of staffing and training.

- All patients would continue to have their pre and post surgery care provided by the orthopaedic team at their local hospital, with surgeons moving with their patients to undertake the surgery at the specialist centre, to benefit from its permanent, specialist workforce and its systematised way of working.

- Orthopaedic day case patients would continue to have a choice of hospitals providing routine orthopaedic services, as now. This includes day case surgery at the Central Middlesex Hospital. Staff at other hospitals in the sector will retain the skills and capabilities needed to carry out day procedures.

- Other hospitals in the sector with more specialist high dependency and intensive care units will continued to offer surgery for patients with more complex healthcare needs or more complex surgeries – including patients with multiple comorbidities or those needing revision surgery.

- There would continue to be the same choice as now of hospitals for spinal surgery and children's orthopaedic services.

- We estimate it would cost around £9.4 million to develop the additional theatres and to make estate reconfigurations.

- We are currently in the process of establishing a governance management infrastructure for this new collaborative approach.

Involvement and consultation

- We are committed to ensuring staff, patients and wider stakeholders help to shape all aspects of our proposals, particularly reaching those who are most likely to be impacted by proposed changes, or those belonging to marginalised or underrepresented groups. Our involvement approach was influences by an Equalities and Health Impact Assessment and by compiling patient feedback already held by our hospitals. We were able involve over 70 members of the community in early discussions around what good looks like for orthopaedic care in north west London, while testing our thinking on the possibility of a dedicated elective orthopaedic centre.

- Our involvement programme consisted of two virtual clinician-led community events, a series of virtual and in-person focus groups, and telephone interviews, which found:

    - Overall, participants understood the need to reduce waiting times and were supportive of the work to enable this to happen as quickly as possible, even if it meant travelling further to be seen faster.
    - There was good support for a dedicated centre for routine orthopaedic surgery, which was also seen as a way of maximising staff time and developing clinical expertise.
    - Acute care was generally praised and most of the concerns raised were in relation to pathways into secondary care. We are sharing these insights widely with lead clinicians and partners within the north west London healthcare system to inform how the implementation of an elective orthopaedic centre can tackle some of these issues, as well as informing improvement and transformation projects, such as a project currently being scoped to improve and standardise the provision of community musculoskeletal services.
    - Some concerns were raised about ease of travel into the Central Middlesex site, particularly with those with further to travel. We will now explore how we can improve accessibility to the site.

- The overall positive feedback and constructive suggestions made by community members through this early involvement process indicates that our proposals are well positioned to improve bone and joint care for the patients of north west London. We are now looking to explore this further with a wider section of the north west London

population, including those most likely to be impacted by proposed changes, through a formal three-month public consultation to begin by the end of August 2022.

- As outlined in our consultation strategy (appendix 1), our consultation scope and target groups have been determined through our Equalities and Health Impact Assessment (appendix 2) and insights from our early involvement work (appendix 3). This includes:
    - Over 45+ age group as the target population for the centre and their families and carers
    - People with more complex healthcare needs
    - Black, Asian and other minority groups
    - LGBTQIA+ groups
    - People living in the most deprived areas or those likely to incur longer travel times

- Our consultation strategy also outlines a programme of involvement with a wider range of stakeholders, such as staff and our partners in primary and social care. We will be developing these plans in greater detail, alongside consultation materials to share with the JHOSC, our strategic lay forum and other stakeholders ahead of launching a formal consultation. We will also share a pre consultation business case which will be a key part of our NHS approval process.

List of appendices

Appendix 1 – Consultation strategy

Appendix 2 – Equalities and Health Impact Assessment

Appendix 3 – Analysis from community involvement programme

Consultation strategy

North west London elective orthopaedic centre

This paper sets out the scope of public consultation around developing an elective orthopaedic centre for the patients of north west London. It includes the rationale for targeting priority groups for consultation and a high level programme of activities to reach them.

1 Background

The north west London integrated care system through a collaboration of its four acute provider trusts is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery across the sector, beginning with orthopaedic surgery. The drivers are to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre (EOC) for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide urgent and emergency care services at all and there is good potential to expand and remodel existing facilities.

We have been seeking the views of patients and community groups in helping us to shape formal proposals for the EOC. These early insights indicate that members of the public see the benefit of the proposed approach to tackle the challenge in our waiting lists, while offering constructive suggestions on how to improve bone and joint care, including how to approach changes to how we organise orthopaedic surgery in the most user-focused way possible. We are now keen to explore this further with a larger number of key stakeholders including potentially affected populations, staff and colleagues in primary care through a public consultation process.

2 Services and options

Our proposal to reorganise orthopaedic surgery in north west London:

- Around 4,000 patients a year are eligible for 'high volume, low complexity' orthopaedic inpatient surgery across north west London, which is currently offered at Mount Vernon, Northwick Park, Hillingdon, St Mary's Charing Cross, Chelsea & Westminster and West Middlesex and Central Middlesex hospitals. This total volume high quality, systematised surgeries could be provided at the Central Middlesex with two additional laminar flow operating theatres, extended first stage recovery unit and some remodelling of parts of the existing estate.
- All patients would continue to have their pre and post surgery care provided by the orthopaedic team at their local hospital, with surgical teams moving with their patients to undertake the surgery at the specialist centre, to benefit from its permanent, specialist workforce and its systematised way of working.
- Day case patients would continue to retain a choice of local trust hospitals, so that care may be provided in familiar settings, with no change to expected travel times for these patients. Day case surgery will continue to be offered at Central Middlesex Hospital for local patients.
- A choice of local trust hospitals with access to more specialist high dependency and intensive care units for patients with more complex healthcare needs, such as

patients with comorbidities, or those needing revision surgery or emergency orthopaedic care.
- A choice of local trust hospitals for spinal surgery and children's orthopaedic services.

3 Consultation scope

3.1 Objectives

- To ensure the views and knowledge of a diverse range of stakeholders and service users (patients, carers, staff, NHS partners, local authorities and wider stakeholders), - particularly groups most likely to be impacted - helps to influence and inform plans to develop an elective orthopaedic centre in north west London. Key elements include the clinical pathway and workforce model, with a particular focus on addressing health inequalities.
- To test the rationale underpinning proposed changes to how orthopaedic surgery is organised in north west London with service users, building an evidence base to inform decision-making.
- To ensure a fair and transparent process for engagement/consultation, meeting all statutory requirements for health service changes.

3.2 Target groups

The consultation activities will aim to reach and include a diverse mix of the core target population for the elective orthopaedic centre, particularly those identified as at risk of experiencing barriers to access, or poorer health outcomes, as a result of belonging to minoritised groups or sharing one or more protected characteristic. These priority groups have been identified through a combination of carrying out an Equalities and Health Impact Assessment (EHIA), as well as insights gained through a programme of early involvement activities carried out to help shape formal proposals for the EOC.

Equality and diversity monitoring data gathered through the involvement activities also indicates that we need to ensure participation of residents from across all boroughs (Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster), with special focus on increasing representation from Harrow, Hillingdon and Hounslow residents.

Priority groups for patient/public consultation:

1) **45+ age group who are already on our waiting lists and their families/carers** – This group makes up the majority of the target population for the elective orthopaedic centre. Our involvement activities indicate that we need to focus on increasing participation from patients that will be eligible for HVLC surgery.

2) **People with more complex health care needs –** who may face specific challenges in accessing orthopaedic services and navigating the healthcare system, such as:
   - disabled people or people such as those with hearing impairments, learning disabilities or autism
   - specific comorbidities such as hypertension and diabetes
   - people with mental health related issues.

3) **Black, Asian and other minoritised groups** – people from minoritised ethnic groups (particularly those for whom English is their second language) are more likely to report poorer outcomes. Furthermore, the Covid-19 pandemic has highlighted structural disadvantages faced by these groups. We need to ensure plans for the EOC do not deepen these inequalities.

4) **LGBTQIA+ groups** – high incidences of prejudice experienced by people identifying as LGBTQIA+, including negative attitudes from healthcare professionals may prevent individuals from accessing treatment.

5) **Groups likely to incur longer travel times** – while the Central Middlesex site has the shortest average travel time by car and the second shortest average travel time by public transport, there is some variation in travel times for residents across the boroughs. We need to ensure we understand views on accessibility from across the sector.

6) **Residents living in the most deprived areas** – deprivation can be a barrier in access to healthcare and our EHIA indicates that over a half of the north west London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the geographical region.

Database of target groups
We will carry out desk research to updated and expand a database of potential participants/groups created for the first phase of engagement, to include:

- data held by our orthopaedic services – those on waiting lists, or those who have already had procedures and consented to being contacted
- community organisations working with groups we have prioritised for consultation, utilising existing connections within the ICS where possible, or first approach if necessary (emails, phone). This may include:
    - charities, particularly those with a health focus – Age UK etc.
    - civil society organisations – advocacy groups, cultural or faith-based groups

Staff and healthcare partners – we will ensure there are involvement opportunities for staff across all four acute trusts, as well as our colleagues in primary care, as key stakeholders in the successful implementation of any service changes.

4 Consultation collateral

Core collateral – will be hosted on the NWL ICS website: https://www.nwlondonics.nhs.uk and communications from all four trusts must direct to a dedicated landing page on this site.

- **Full consultation document** – attractively designed document with graphics (approximately 20 pages) using the ICS branding developed for the early involvement activities, and which should include:
    - introductions from the key ICS healthcare players
    - background to the proposal - challenges and opportunities
    - explanation of key terms
    - objectives and transparency around how consultation activities will inform decision making, timelines and mechanisms for reporting back

  - details of the proposal itself – clinical rational and evidence base used, what this will mean for all patient cohorts and the aspirational patient pathway
  - all feedback mechanisms

  We will develop translated and easy-read versions using insights on the commonly spoken languages in NWL.

- **Consultation questionnaire** (quantitative) to accompany consultation document, with further **topic guide** (qualitative) to be used for focus groups/community events.

- **2 x short explainer videos (possibly animated)** – sets out the way that orthopaedic surgery is currently offered in north west London, the challenges with this, including impact of Covid-19, and how we're proposing to improve based on learning from fast track surgical hubs during the pandemic. Create patient personas to make the narrative accessible to viewers.

Additional content

- Webpage content for all trust sites– adapted from core consultation document
- Printed summary leaflets for distribution
- Posters/display stands for public meetings
- Press ads
- Digital flyers/banners to direct traffic to consultation materials and to promote community events – adapted for multiple channels (newsletters, social media, partner channels)
- Tailored emails
- News stories – external and internal

5 Proposed programme of activities

5.1 North West London public meetings

We will plan and host eight in-person public meetings – one for each borough at easily accessible NHS locations, assuming 40 participants at each meeting (300-350 in total).

- Clinician-led events to include a presentation on the EOC proposals, opportunity for questions and clarifications and feedback mechanism
- Potential clinical experts *(to expand with suggestions from acute trusts):*
  - Dr Ian Bernstein (NSHE London MSK Board Chair)
  - Dr Benjamin Ellis (NWL Rheumatology CRG Chair and senior policy) advisor for Versus Arthritis
  - Dinesh Nathwani (Chairs NWL Orthopaedic CRG and NWL MSK network)
  - Imran Sajid (GP Chair for NWL MSK network)
  - Raymond Anakwe, orthopaedic surgeon & medical director, ICHT
  - Rajarshi Bhattacharya, consultant orthopaedic surgeon ICHT & clinical advisor for the parliament & health ombudsman
  - Include specialist nurses

Option 1 – deliberative methodology

- Clinicians to deliver presentation within set event timings, followed by breakout sessions facilitated by qualitative researchers, culminating in a plenary
- Will require sign-up

Option 2 – drop-in sessions

- Half-day sessions in NHS locations – participants are free to turn up at their own convenience. Consultation documents available in display format on location and explainer video played on 30 minute loops.
- Clinicians and communications colleagues available on location to answer questions and support members of the public in filling out questionnaire.
- Sign-up not needed

5.2 Community focus groups

We will run a series of at least ten more in-depth and targeted focus groups for audiences scoped-in for consultation.

- Aim for 5-7 participants per group as optimum to enable rich discussion
- Mix of geographic and specialist groups – the format would remain flexible in order to reach target groups e.g. through virtual meetings, in-clinic or at existing community group meetings. Offer telephone interviews for people with accessibility issues
- Offer remuneration to compensate for time – cash or vouchers

5.3 Cross-borough GP forum

As part of our strategy to regularly engage with colleagues in primary care, we have been running monthly GP forum events online, with good attendance across all the boroughs. This format has proved popular and convenient and so we will organise and host a dedicated GP forum event during the consultation period. Hospital clinicians will lead the conversation around the proposed changes, delivering the core presentation. This will be followed by a Q&A session, enabling GPs to input into plans and clarify or raise issues affecting their practice or patients.

5.3 Staff involvement events

We are currently socialising the proposals for the EOC with relevant staff across all four trusts, through informal meetings. During the consultation period, we will work with our HR teams to bring staff together for a series of involvement events:

- One for each Trust, with orthopaedic and Trust-level clinical leadership presenting the case for change and opportunities for patients/public
- HR-facilitated segment around possible changes for staff with an opportunity for Q&A and feedback from staff

6 Channels for promotion

Owned

- All trusts and ICS websites
- All trusts and ICS mailing lists
- Emails from NWL musculoskeletal network to their contact lists
- Emails from lay partners (or equivalent) to their contact lists
- Internal channels for staff – bulletins, intranet, emails from directorate/service
- Cascade of print materials in hospitals
- Banners on GP website and cascade of print materials in GP practices

Bought

- Traditional - press ads
- Pay per click social media campaign

Borrowed

- Social media – all trusts/ICS/clinical leadership personal accounts
- Partner websites and newsletters e.g. charity partners, research institutions, Compassionate communities funding grantees, Chelsea Football Club Foundation (Imperial College Health partners – include others).
- Banners on GP websites
- Cascade of print materials through community organisations/public spaces – libraries, community centres, housing associations
- Council communications channels – website, social media

7 Analysis and evaluation

We will commission an independent qualitative research agency to integrate responses from all sources into a single report, combining quantitative survey responses (assumed 2,000) with notes from events and meetings and formal consultation submission.

To understand the effectiveness of the consultation activities in enabling opportunities for public participation, we will track both reach and participation metrics:

Reach

- Traffic to websites
- Social media impressions, partner/influencer followers
- Sign up to events/public meetings
- Average footfall figures for sites of printed material cascade
- Circulation figures of paid media

Participation

- Number of completed questionnaires
- Attendees to community events/public meetings
- Number of focus group and interview participants
- Number of attendees at staff and GP engagement events/meetings

At the point of interaction with consultation materials, we will also capture:

- Equality and diversity monitoring data around protected characteristics including the participant's resident borough, to understand the demographics we have reached
- The promotional channels through which participants accessed the consultation materials
- Consent to be kept informed and contacted about this and further NHS developments

A full report on the outcome of the consultation will be published through all owned channels, once a decision has been made, and will be supported by further communications and involvement plans as required.

7 Indicative consultation timeline

Activity	Consultation weeks												
	Pre	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Prepare all consultation documents													
Prepare all promotional materials for design and print													
Align partners to support with promotion													
Launch - publish consultation documents on host website													
Publish supporting content on own and partner sites to promote launch													
Research and approach organisations for print material cascade													
Distribution of all printed materials													
Promote sign-ups to community events													
Start recruiting to focus groups													
Host borough-specific public meetings													
Run flexible format focus groups													
Promote consultation documents through mix of owned, bought and borrowed													

Equality Impact Analysis template

Title of document/service being assessed	Development of a north west London Elective Orthopaedic Centre at Central Middlesex Hospital
Date initial screening completed	December 2021
Date of full equality impact assessment commencement	January 2022
Date of full equality impact assessment completion	May 2022 (subject to approval)

1. What are the intended outcomes of this work? Include outline of objectives and function aims

The north west London integrated care system, through a collaboration of its four acute provider trusts, is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of “high volume, low complexity” surgery across the sector, beginning with orthopaedic surgery.

The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is likely to be the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide inpatient urgent and emergency care services at all and there is good potential to expand and remodel existing facilities.

The patient benefits include:

- faster and equitable access for patients awaiting orthopaedic surgery across North West London.
- six day a week access to high quality care designed on best practice (GIRFT & NICE) principles the consistent application in a dedicated surgical centre, reducing the risk of cancellation of patients.
- strengthening and consolidating interfaces with MSK pathways pre and post operatively for patients.
- dedicated specialist pre and post operative patient care on site supported with digital care and networked teams.

The development of a NWL EOC will enable multidisciplinary teams across the NW London ICS deliver orthopaedic surgical care that:

- meets best practice standards and care as set out by GIRFT and NICE
- achieves top quartile, and ultimately top decile productivity in relation to theatre throughput and length of stay using Model Hospital data
- separates elective orthopaedics from trauma services, in line with the NHS Long Term Plan, Royal College of Surgeons' requirements and National Clinical Advisory Team reviews.
- delivers care in a purpose-designed environment separate from the pressures of emergency care.
- supports surgical skills training, new role development while offering new and flexible models of working
- continually improves and innovates patient care and modern surgical practice.

2. Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

A number of service delivery models have been explored. The preferred model is that the following elective orthopaedic patients will be treated at the centre:

- Patients referred for inpatient surgery following outpatient investigation under Imperial College Healthcare Trust, Chelsea and Westminster Hospital Trust and The Hillingdon Hospitals Trust (known collectively as the partner trusts), excluding those with complex anaesthetic needs or a need for joint revision surgery
- Patients referred for inpatient and day case surgery following outpatient investigation under London North West University Healthcare Trust (known as the host trust)

Patients requiring spinal surgery and children will not be treated at the centre.

The following approximate numbers of patients will be treated in the centre.

Admission Type	Annual Activity
Inpatient	4,500
Day case	1,500

Patients will be referred into the centre at the point of addition to the waiting list and will receive their pre-operative assessment and surgery under the care of the centre. Apart from this, they will undertake their pre- and post-operative outpatient care at their local trust (or the trust at which they chose to be referred from primary care).

The centre will employ c.330 WTE staff, from the following staff types:

Staff Type	WTE
Nursing	230
Medical	38
Allied Health Professions	35
Admin/Management	29

Of these, approximately 200 WTE are posts currently employed at partner trusts. The employment model has not been determined and is under discussion amongst the partners.

Key partners include:

- Primary care, who refer patients to acute trusts for orthopaedic care, and who provide continuity of care
- Community organisations, in particular those which support discharge
- Local authorities, which will provide support and scrutiny on behalf of their residents

3. What evidence have you considered?

List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on the last page of this template

Where local north west London data are available, analysis is provided in this document. Where this is not available, reference is made to analysis provided in the equality impact assessment for orthopaedics across London ("Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021). Reference is made throughout the document to specific resources.

Main data sources used were:

- Hospital Episode Statistics (HES) (https://digital.nhs.uk)
- Dr Foster (https://drfoster.com)
- Model Hospital (https://model.nhs.uk)
- GLA Housing Led Population Projections (https://data.london.gov.uk/dataset)
- Office for National Statistics (https://www.ons.gove.uk)
- Google Maps (https://maps.google.com/maps)
- Trust theatre systems

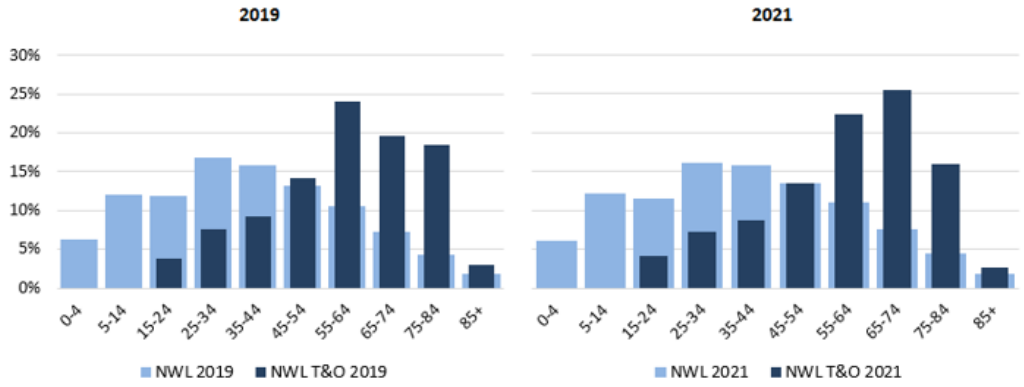
4. Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issue

The following NWL analysis confirms, as would be expected, that the NWL elective orthopaedic population is older than the general population. The older population are more likely to require inpatient than day case surgery, the primary admission type for the elective orthopaedic centre.

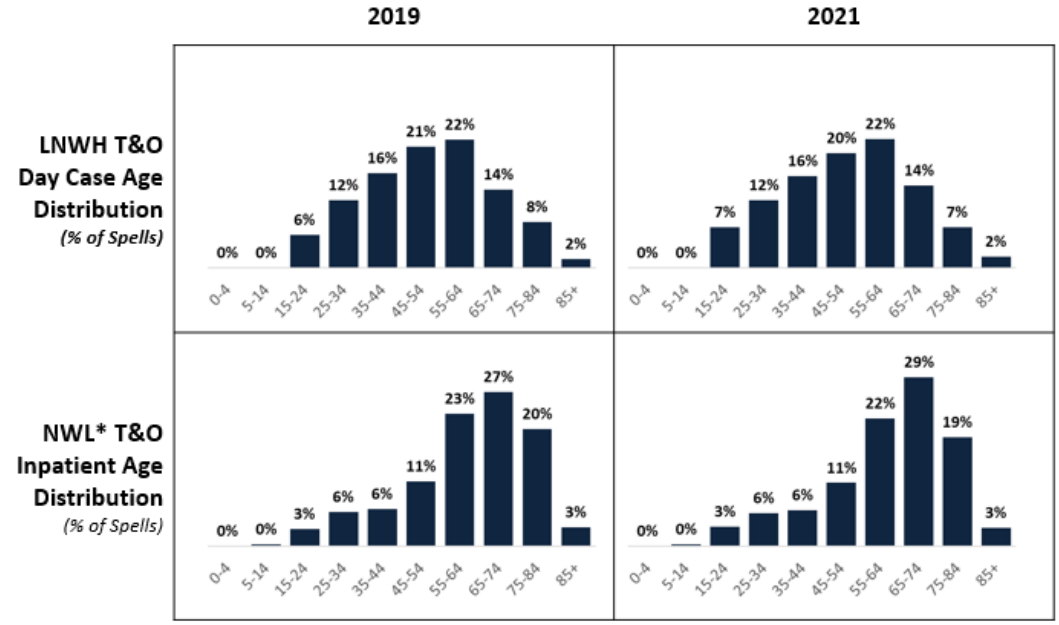
Travel and accessibility for older people, those with disabilities and individuals on low incomes could be a barrier to orthopaedic surgery. Section 13 shows that 90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time.

NWL T&O Demographics (LNWH DC & Sector IP)

Y-Axis: % of Spells per Calendar Year/% of NWL Population



Source: HES Data (Dr Foster); GLA Housing Led Projections 2020



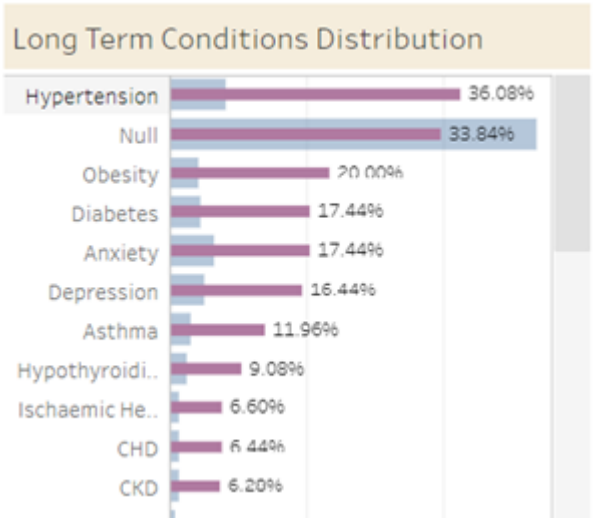
*Source: HES Data (Dr Foster); * NWL T&O includes IP activity of LNWH, ICHT, THHT & CWFT*

5. Disability. Consider and detail disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities.

Research from the London EIA (ref. “Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics” – Health Innovation Network South London and Imperial College Health Partners, Dec 2021)) identifies:

- Hearing impairment - Mask wearing creates a substantial barrier to healthcare services for individuals communicating through lip-reading, British sign language or relying on facial expressions. Additionally, for these patients with hearing impairments going to new and unfamiliar locations could present additional communication barriers.
- For people with learning disabilities making reasonable adjustments within healthcare provision is a requirement of the Equality Act 2010 (e.g., Easy-read information, avoiding medical jargon or longer appointment times). However often these are not put in place which can be a barrier to accessing healthcare settings. Research by Mencap found that hospital visiting policies during COVID restricted any family members / carers from accompanying patients with learning disabilities (LD) to provide support and assist with communication. 1 in 4 learning disability nurses they surveyed said that during the pandemic they had seen examples where carers, family members or supporters had not been allowed in hospital to accompany patients with LD. Although guidance issued on 8 April 2020 stated that someone with a learning disability or autism could have someone present if the patient has cause for distress3.
- People with autism have difficulty accessing and using online or telephone services to make appointments coupled with the fact that individuals with autism may have poor organisational skills prevent access to healthcare services. Individuals with autism have sensory sensitivities that affect how they access healthcare services. They may choose to avoid healthcare facilities or have adverse reactions in clinical settings because of their condition.
- People living with severe mental illness (SMI) experience some of the worst inequalities, with a reduced life expectancy with 2 in 3 deaths due to preventable physical illnesses such as cardiovascular disease. Diabetes is 1.9 times more prevalent compared to those without SMI. Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

Analysis of the current NWL wating list shows that hypertension, obesity and diabetes are the most frequently recorded long term conditions:



Long term conditions that are well-managed would not necessarily result in exclusion from the centre. However, those requiring additional time and medical intervention to stabilise their long term condition (in particular if it was a recent diagnosis) prior to surgery may not meet the criteria and would require surgery at their local Trust. They could, therefore, have differential waits for their procedure but would have equal clinical outcomes.

6. Gender reassignment (including transgender) Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment.

A national report published in 2016 (ref. Trans healthcare: What can we learn from people's experiences? Healthwatch, March 2020) found that trans people encounter issues when using the NHS due to the negative attitudes and lack of knowledge or understanding from some healthcare professionals. It is a criminal offence under the Gender Recognition Act 2004, to tell people about a person's previous gender without permission from the individual except when made to a health professional for medical purposes. Although Healthwatch found that trans people's experiences highlighted that often health professionals did not use their preferred or correct name, gender or pronouns in written and verbal communication. This can be highly distressing and deter trans people from using health services for fear of discrimination and prejudice.

Mitigation – Improving knowledge and cultural competency. The GMC provides a short 'top tips' video https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

7. Marriage and civil partnership. Consider and detail evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities.

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

8. Pregnancy and maternity Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.

A significant proportion of patients within the orthopaedic HVLC pathways are 50 years or over (and therefore highly unlikely to be pregnant), therefore we have assumed that this protected characteristic will impact a relatively small cohort.

Additionally, there are increased risks for pregnant women to undergo elective surgery, therefore it is unlikely there will be a high volume of patients who are pregnant will undergo elective orthopaedic surgery.

The majority of nursing staff, the largest staff group in the elective orthopaedic centre, are female. The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff's caring responsibilities.

9. Race Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.

In England, people from ethnic minority backgrounds face a range of inequalities compared to white groups in their health, as well as in their access to, experience of and outcomes from using health services. People from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their White counterparts. Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism and discrimination can reinforce inequalities among ethnic groups, e.g., housing, employment, which evidence shows in turn can have a negative impact on the physical and mental health of people from ethnic minority groups.

The COVID-19 pandemic has underlined the structural disadvantage experienced by people from ethnic minority backgrounds who have been at greater risk of contracting and dying from COVID-19. The death rate has been higher among ethnic minority populations, and early data from intensive care units found a disproportionate number of patients with COVID-19 were from ethnic minority background. Even when accounting for age and geography, there have been more deaths per capita in all ethnic minority groups (other than white Irish) than among white British people. A fear amongst ethnic minority patients of acquiring Covid 19 whilst being treated within an

hospital environment could impact upon the number agreeing to their surgical procedure.

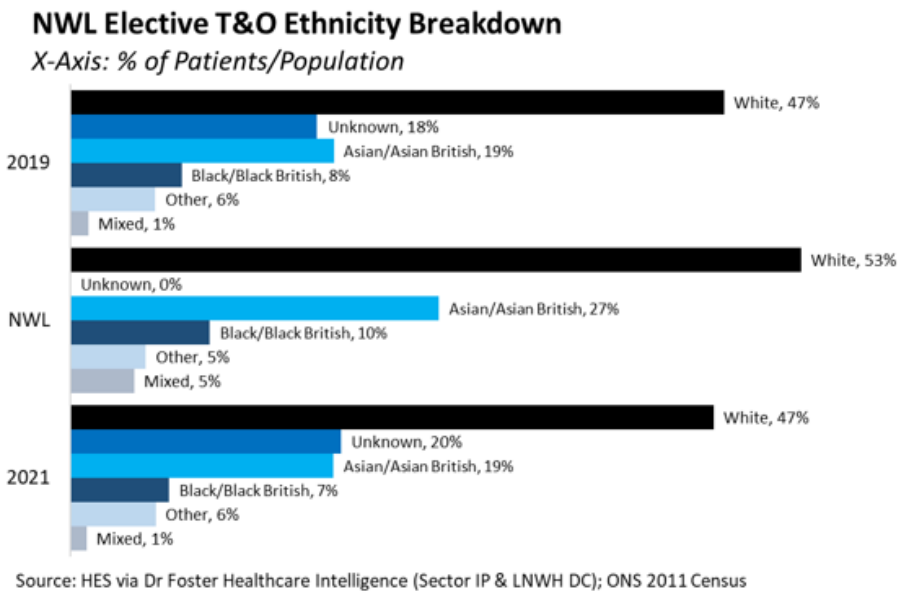
There are assumptions and stereotypes within healthcare provision that create racial bias. Research shows that healthcare professionals may have strong stereotypical views, lack cultural awareness and ability which can create barriers and generated resentment. In the US, they found healthcare professionals appear to have implicit bias in terms of positive attitudes towards white patients and negatives towards patients of colour.

Difference in literacy levels is another challenge, firstly although people may be able to speak English they might not be able to read it, thereby affecting the ability to understand written health related materials. Fewer than one third of Bangladeshi and Pakistani women and fewer than two thirds of older Bangladeshi and Pakistani men can read. Furthermore, even if letters and patient information leaflets are translated, people may not be able to read their own language. The study 'Access to health care for ethnic minority populations (Szczepura, 2005) found that over half of older Bangladeshi and Pakistani women cannot read their own language and about 20% of older men. Health literacy and understanding written information could have a negative impact upon certain ethnic minority groups including appropriate referrals for surgery, prioritisation, and outcomes if there is a lack of understanding of the surgical procedure and aftercare.

References:

- The health of people from ethnic minority groups in England, The King's Fund, Raleigh and Holmes 2021. The complexities of race and health, Danso and Danso, 2021.
- Will COVID-19 be a watershed moment for health inequalities? Institute of Health Equity and Health Foundation 2020
- Access to health care for ethnic minority populations, Szczepura, 2005; Implicit Racial / Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review, 2015

As shown below, 47% of NWL's known ethnicity is non-white. The non-white proportion is slightly greater in the elective orthopaedic cohort.



Source: HES Data (Dr Foster)

NWL ethnicity date (a/w). The centre will develop HR policies and procedures that recognise the needs of the workforce including considering staff diversity.

10. Religion or belief Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.

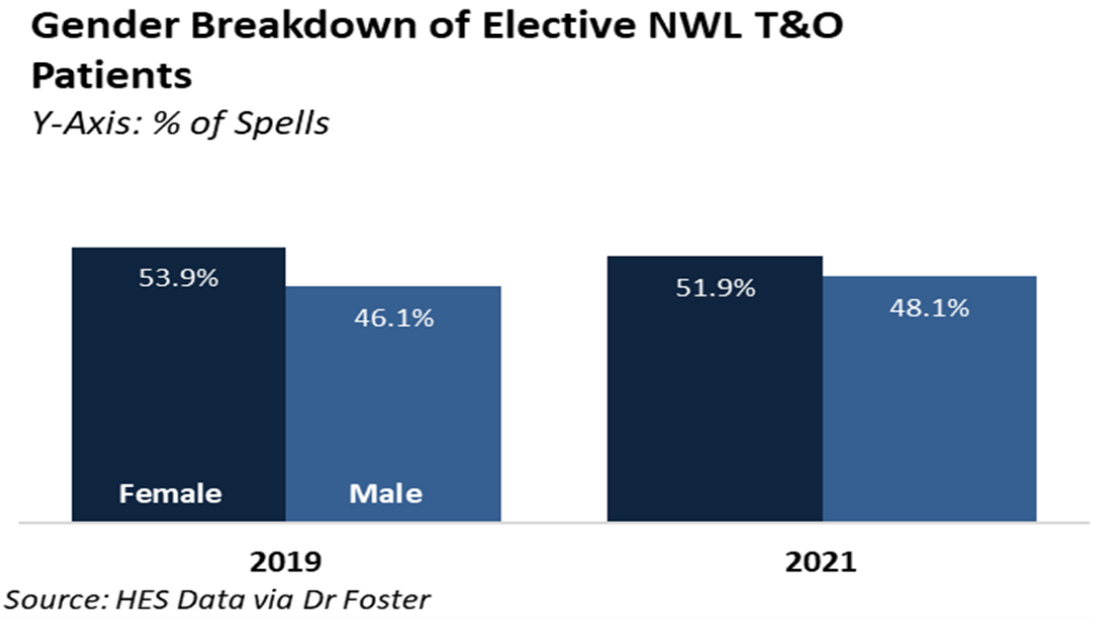
Some research for specific religious groups found lack of providers' understanding of patients' religious and cultural beliefs; language-related patient-provider communication barriers; patients' modesty needs; patients' lack of understanding of disease processes and the healthcare system; patients' lack of trust and suspicion about the healthcare system, including providers; and system-related barriers. Mitigation - Although religion and cultural awareness was not raised as specific issues within the patient interview insights, it is worth noting in relation to inclusion with any cultural awareness training included in the recommendations.

For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

11. Sex Consider and detail evidence on men and women. This could include access to services and employment.

Known higher life expectancy for women could be shown over representation on the waiting list for elective care. It is worth noting that men and women make very different use of primary care (with adult women having substantially greater consultation rates across all illness categories and women being more likely than men to consult if they have an illness episode). Ref. Do men consult less than women? An analysis of routinely collected UK general practice data. (Wang et al, 2013)).

There is an interaction between gender and ethnicity as it is often reported that women in some minority groups find it especially important to see a female doctor, but this cannot always be assumed there is no difference between different ethnic groups as it is an issue of gender, not ethnicity. (Ref. Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester (Rashid and Jagger, 1992)).



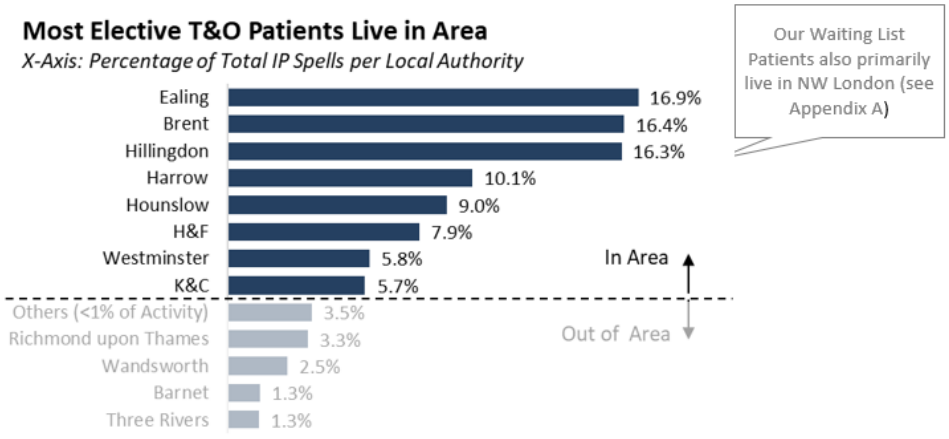
12. Sexual orientation Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

Almost one in four lesbian, gay, bi-sexual and trans (LGBT) people (23 per cent) have witnessed discriminatory or negative remarks against LGBT people by healthcare staff. In 2018 six per cent of LGBT people – including 20 per cent of trans people – have witnessed these remarks. One in eight LGBT people (13 per cent) have experienced some form of unequal treatment from healthcare staff because they're LGBT. One in seven LGBT people (14 per cent) have avoided treatment for fear of discrimination because they're LGBT (Ref. LGBT in Britain – Health. Stonewall, 2018).

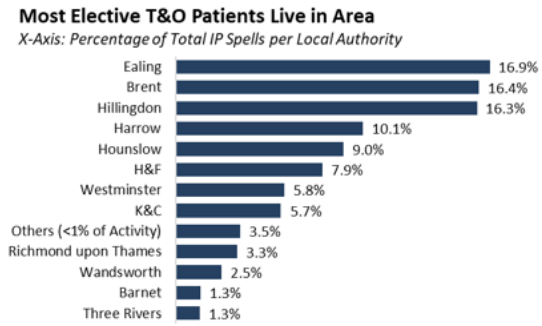
For the data analysis, the main source of data (HES or Hospital Episode Statistics) does not generally record reliable details of this protected characteristic.

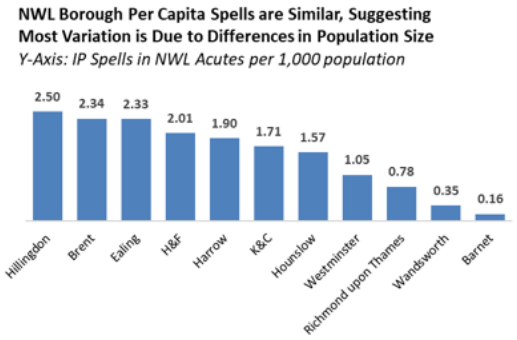
13. Other identified groups Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, Carers, geographical area inequality, income, resident status (migrants, asylum seekers).

Geography and access:
90% of the elective orthopaedic centre's target population lives in the boroughs of NWL and shows the expected travel times to NWL trust sites by public transport and car. Central Middlesex Hospital, the most likely location for the elective orthopaedic centre, has the shortest average travel time by car, and the second shortest average travel time (second to St Mary's Hospital) by public transport.

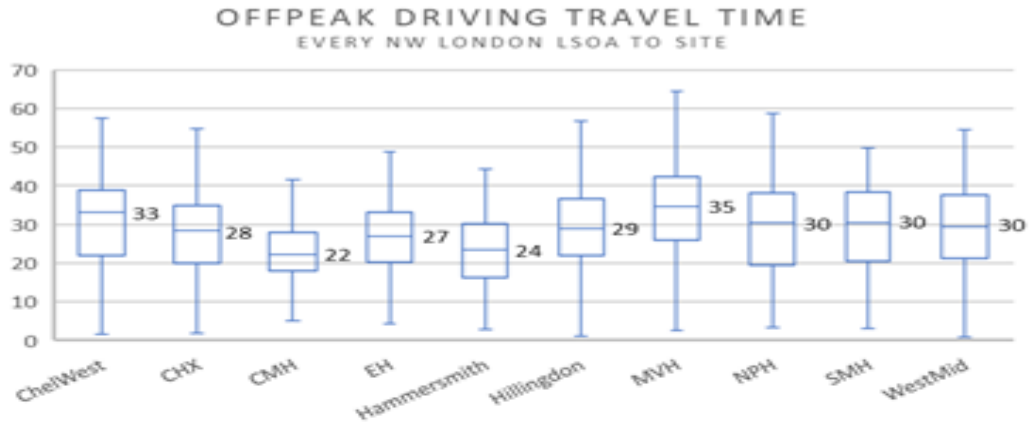


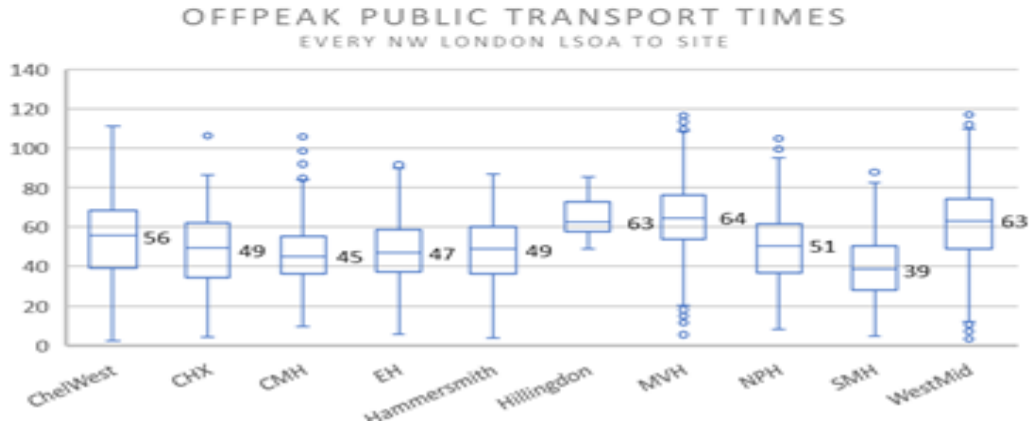
Source: HES Data (Dr Foster)





Source: HES Data (Dr Foster); GLA Housing Led Projections 2020





Deprivation:

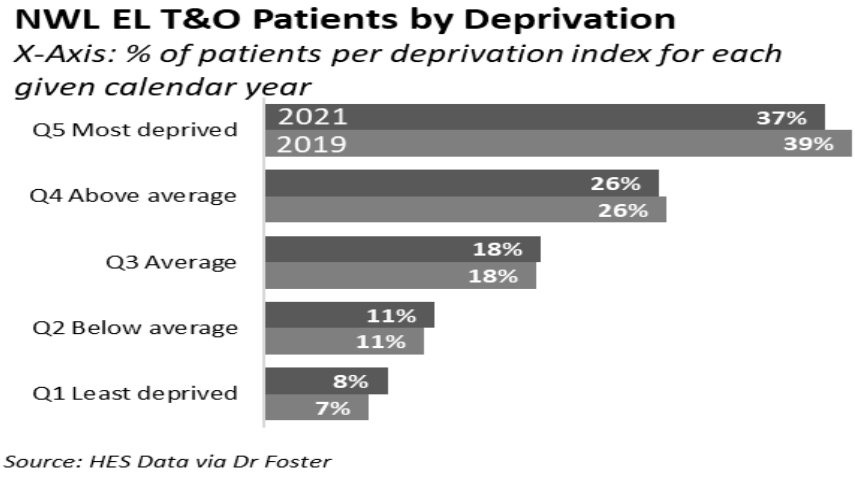
Deprivation can be a barrier to access to healthcare. In the study 'Divided by choice? For profit providers, patient choice and mechanisms of patient sorting the English National Health Service' (Beckert and Kelly, 2021). analysed whether deprivation impacted access / choice to NHS-funded hip replacement in the independent sector. Their analysis found that patients in the top three quintiles of the wealth distribution6

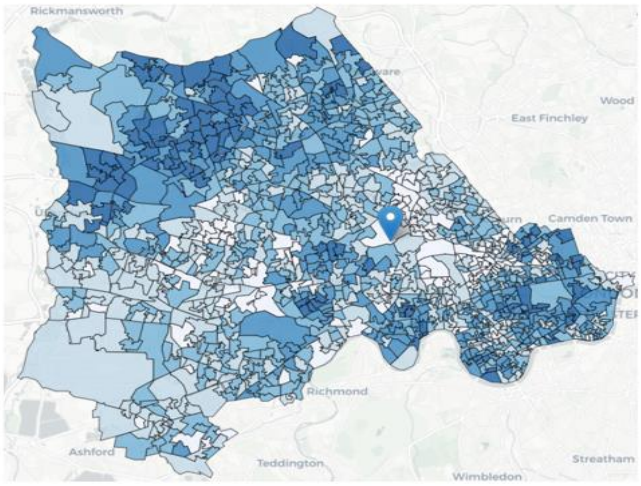
benefit twice (thrice) as much as those in bottom fourth (fifth) quintile; and have more choice of where they have their hip replacement surgery eg. access to NHS funded independent providers, while the two bottom quintiles do not). As the deep dive analysis were unable to access waiting times or activity data for the independent sector used for HVLC hubs it was difficult to explore this further.

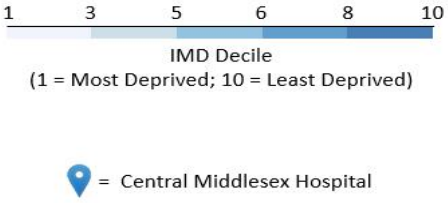
Based upon the areas covered by the 5 Integrated Care System areas in London, previous data has been analysed to identify if patients living in more deprived areas have equity of access to surgery in the six specialties (including orthopaedics). Analysing the number of total hip replacements and total knee replacement (per 100,000 population) carried out on patients living in the most deprived and least deprived Index of Multiple Deprivation (IMD) deciles for each ICS. This found that in 2020 South West London (SWL) and North West London ICS have patients living in deprived areas who are less likely receive their hip replacement compared to London and national average. However, this could be due to more stringent referral management process

Graphs below show that over half of the NWL London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the NWL sector.

Analysis of travel times shows that residents of the most deprived parts of the NWL sector have significantly reduced travel times to Central Middlesex Hospital, by car and public transport.

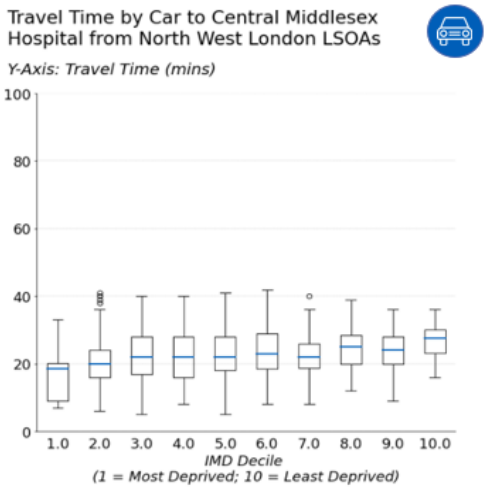


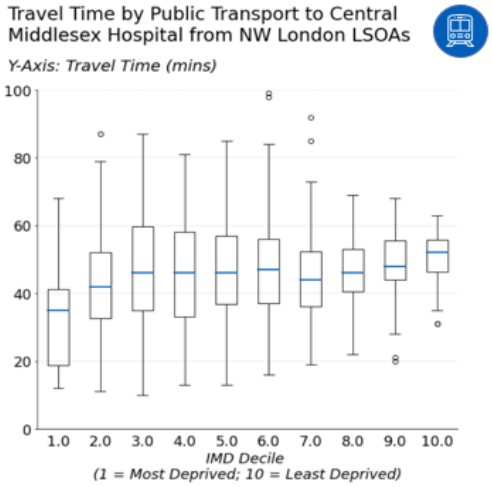




Source ONS: 2019 IMDs by LSOA

Deprivation | The most deprived LSOAs have statistically significantly reduced travel times to CMH by car and public transport





At an individual level, those from deprived areas may not necessarily have improved access as it depends on numerous other factors e.g. car ownership, and ability to pay for transport, parking and/or ULEZ

14. Engagement & Involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

The engagement plan is summarised in Appendix A.

15. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?

Previous research, and local analysis, suggests potential negative impacts for patients for whom access to a healthcare setting is a challenge, in particular:

Elderly patients
Disabled patients
Black and Minority Ethnic patients for whom English is a second language
Patients from deprived areas

Consideration has been given to these groups in the option appraisal for a preferred site within NWL, and Central Middlesex Hospital has been shown to be the most accessible viable site for an elective orthopaedic centre.

As the centre plans for implementation it will develop detailed operational policies to address the specific needs of patients, for example virtual pre-operative assessment to avoid hospital attendance where appropriate.

Staff's needs will be considered by the workforce group, which is developing an employment model. Best human resource practice will be followed in any negotiations or consultations with affected staff.

The following are recommended to mitigate the impact on patients (ref "Equality and Health Inequalities Impact Assessment: High volume low complexity surgical hubs – Orthopaedics" – Health Innovation Network South London and Imperial College Health Partners, Dec 2021):

- Improved population level data dashboard should be set up at ICS level to analyse patient data (including co-morbidities) to provide assurance that HVLC hubs are not creating health inequalities, particularly those with communication issues, translation needs, serious mental illness, learning disabilities and deprivation
- Ensure consistent application of the HVLC criteria so that patients are prioritised based upon their clinical requirements, with a particular focus on better preparation for surgery patients with co-morbidities requiring additional medical intervention from both primary care and pre-operative team to stabilise their long-term condition.
- Improved monitoring of waiting lists for HVLC procedures to ensure all patients are seen in a reasonable and equitable time period. Action should be taken to monitor and mitigate against greater impact upon certain groups that face inequalities (e.g., patients with disabilities, economic deprivation and lack of support network).

16. Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).
17. Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).
18. Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).
19. Risk Scoring You will also need to score each of your negative impacts from the information/data for each Protected Characteristic and from the outcome of Engagement & Involvement exercise and record the scoring in your Action Plan. Use the Matrix below

Matrix for Full Equality Impact Assessments

1. PROBABILITY -What is the likelihood of the service, policy or function having an impact on staff or patients of the Trust? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The service, policy or function will only impact under exceptional circumstances
Unlikely	2	The service, policy or function is not expected to have an impact but will do in some circumstances
Possible	3	The service, policy or function may have an impact on occasion
Likely	4	The service, policy or function is likely to impact, but not on a persistent basis
Almost Certain	5	The service, policy or function is likely to impact on many occasions and on a persistent basis

2. SEVERITY OF IMPACT -Identify the highest possible impact of the service, policy or function. (Use this table as a general guide)

Examples of Discrimination according to descriptor

Descriptor	
Negligible 1	Patient complaining that their dignity has been infringed due to having to wait in reception after eyes being dilated.
Low 2	Temporary relocation of Clinic due to refurbishment. Patients required to travel longer distance to attend clinic.
Medium 3	Uneven surfaces making it dangerous for wheelchair users to manoeuvre across.
High 4	Service excludes particular patients due to their religious requirements.
Very High 5	Emergency Fire Escape: Lack of accessible escape routes for disabled patients.

Action Plan

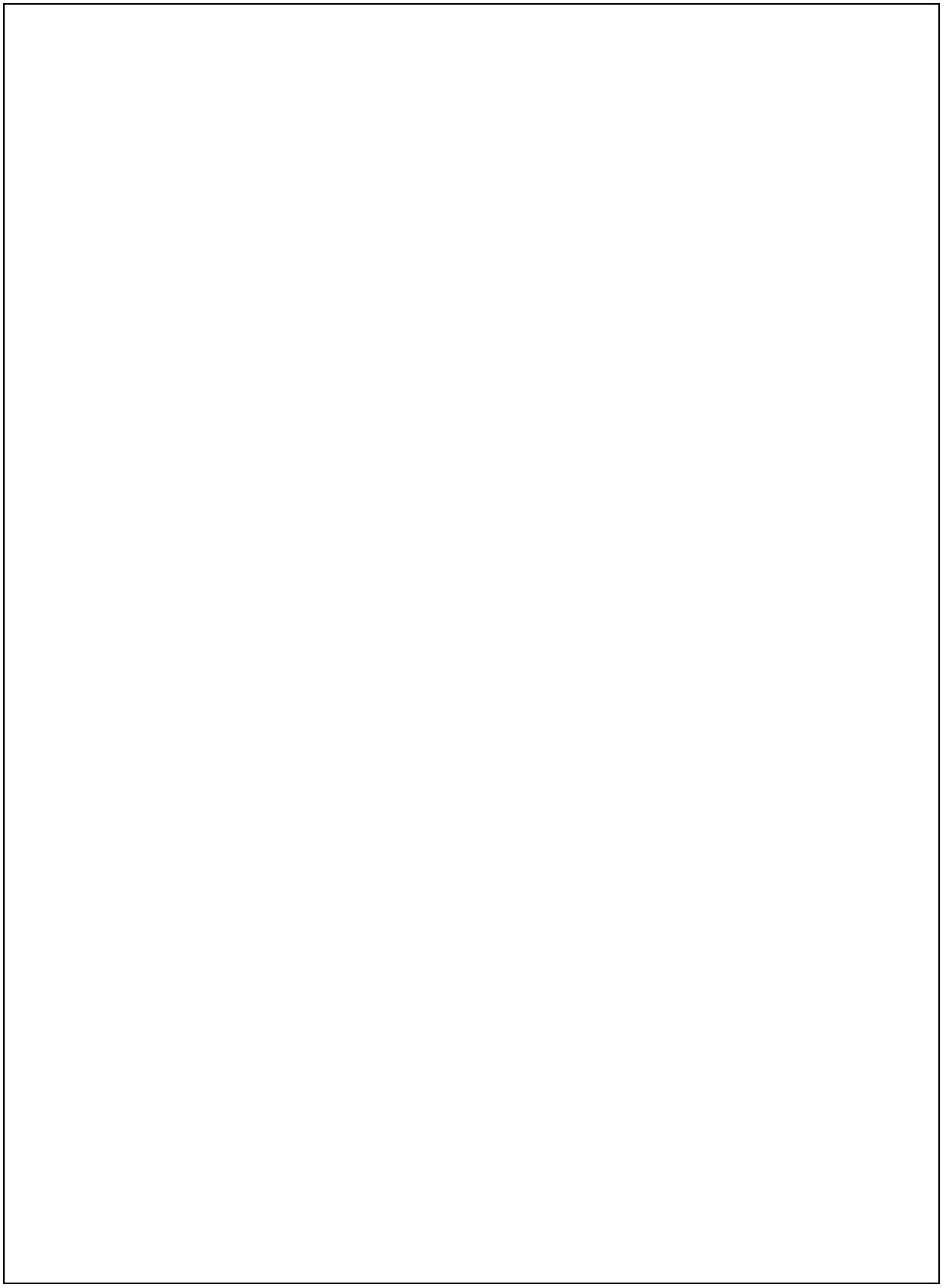
Equality Impact Score - Use the matrix below to grade the risk. E.g. 2 x 4 = 8 = Yellow or 5 x 5 = 25 = Red

	Severity of Impact				
Probability	**Negligible 1**	**Low 2**	**Medium 3**	**High 4**	**Very High 5**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

What is the negative/adverse impact?	Risk Score Current Target	Actions required to reduce/eliminate negative impact	Resources required	Who will lead on the action?	Target completion date
Older patients experiencing difficulty accessing the centre	4x3=12 Target 4x2=8	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Centre design compliant with current legislation • Collaboration with community colleagues to ensure effective discharge from hospital	• 7 day therapy services • Virtual POA package • Discharge SOPs • Targeted wayfinding in the EOC	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Disabled patients experiencing difficulty accessing the centre	4x3=12 Target 4x2=8	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Centre design compliant with current legislation, including disabled access/parking • Collaboration with community colleagues to ensure effective discharge from hospital	• 7 day therapy services • Virtual POA package • Discharge SOPs • Targeted wayfinding in the EOC • Disabled access to all facilities	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Patients whose first language is not English facing barriers to accessing the service	4x3=12 Target 4x2=8	• Written and virtual material in multiple languages • End-to-end pathway designed with NWL musculoskeletal network • Links to local community partners	• EOC partnership board with MSK and community membership • Comms team support	EOC Managing Director LNWH EDI Lead	Spring 2023

			• Trust equality and diversity expert input		
Patients experiencing longer journey to their inpatient orthopaedic acute provider	3x3=9 Target 3x2=6	• Minimise visits to centre, i.e., outpatient care provided at local trust • Virtual pre-operative assessment where suitable • Adequate car parking • Public transport links	• Virtual POA package • Clear directions and written materials at all stages of the pathway	Acting Director of Estates, LNWH	Spring 2023
Patients experiencing deprivation facing additional barriers to accessing care	3x3=9 Target 3x2=6	• Hospital transport available • Adequate car parking • Public transport links • Pre-operative assessment to address access barriers	• Suitable POA package • Hospital transport contract for whole of NWL	EOC Managing Director Acting Director of Estates, LNWH	Spring 2023
Staff experiencing longer journeys to work impacting on caring responsibilities	3x3=9 Target 3x2=6	• Staff consultation for those affected in accordance with best practice • Employer flexibility where possible • Adequate car parking • Public transport links	• ICS-wide staff consultation process	HR Director, ICHT (EOC workforce lead)	December 2022

Descriptor	Potential Impact on Individual(s)	The Potential for complaint/ Litigation	Potential Impact on Organisation
Negligible 1	• No impact or adverse outcome	• Unlikely to cause complaint/ litigation	• No risk at all to organisation
Low 2	• Short term impact	• Complaint possible • Litigation unlikely	• Minimal risk to organisation
Medium 3	• Semi-permanent impact	• Litigation possible but not certain. • High potential for complaint.	• Needs careful PR • Reportable to SHA • External investigation (e.g. HSE)
High 4	• Permanent impact	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities • Local publicity
Very High 5	• Permanent and severe impact	• Litigation certain expected to be settled for > £1M	• National adverse publicity • Threat to Trust objectives/priorities



Appendix A: Draft Engagement and Involvement Plan

Emerging proposal to develop a north west London elective orthopaedic centre

1. Background

The north west London integrated care system through a collaboration of its four acute provider trusts is building on the concept of fast-track surgical hubs to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery across the sector, beginning with orthopaedic surgery. The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years. We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is likely to be the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide urgent and emergency care services at all and there is good potential to expand and remodel existing facilities.

A high level core narrative to support exploration of an elective orthopaedic centre has been developed and presented to key stakeholders at the NWL Joint Health Overview and Scrutiny Committee. This narrative sets out the case for change and work required to develop a fuller proposal, including putting in place effective project management, governance and a programme of engagement and involvement. Read the high level narrative as part of the acute care programme briefing: Exploring a north west London elective orthopaedic centre

This engagement and involvement planning document aims to set out the core activities and deliverables required for all key phases including pre-consultation engagement, as well as formal public consultation, with key stakeholders.

2. Objectives

- To ensure the proposals for the NW London elective orthopaedic centre reflect and respond to the needs and views of all users (patients, carers, staff, NHS partners, local authorities and wider stakeholders) by enabling opportunities to influence and co-design key elements including the clinical pathway and workforce model and with a particular focus on addressing health inequalities
- To build widespread support for the change and investment required
- To ensure all statutory requirements for service change engagement/consultation are met

3. Engagement and involvement timeline

Timeline	Activity	Objectives/other comments	Responsible
March 2022	Draft service change/develop options report for acute care programme board with	*Covered through engagement involved in development of the OBC*	Project team – *completed*

	approval to move to pre-consultation/informal engagement		
March 2022	Initial approach to key stakeholders at Joint Health Overview and Scrutiny Committee (JHOSC) on emerging proposals for NWLEOC Informal discussions with other stakeholders through one-to-one meetings and sharing paper on emerging proposals – HFSON, Healthwatch, MPs and councillors	• Gain support to continue developing detailed proposals • Commitment to developing an engagement/involvement programme and to return to JHOSC with fuller proposals	Acute care comms group – *completed*
March 2022	Early communications with all staff to introduce the emerging proposal and intention to engage further	• Publication of acute care briefing • Item in staff briefings *(completed at ICHT)* • Video for staff briefing (CCG/ICS*)*	
March 2022	Alert NHS England London to our approach and future need for consultation Explore advice of specialist consultation experts on same (possibly Consultation Institute)	To check and get support for approach	
March 2022	Align/coordinate engagement approach with other MSK/T&O developments in NWL – develop a high level narrative?		
March 2022	Agree involvement approach and establish support, including administrative support to deliver engagement activities	Scheduling and invitations for virtual meetings, agenda, note-taking	
March 2022	Gather and collate existing user data/insights, with special focus on health inequalities impact	Findings to inform detailed involvement plan and approach	
March 2022	Share/check high level engagement approach with strategic lay forum and equivalent	Validate the plan	

March 2022	Set up a steering/reference group to focus on engagement, define ToRs and include: • operational leads • clinical leads • workforce leads • representation from all providers (general managers/service managers) • Healthwatch/patient representatives • lay partners.	• Use the group to check/challenge ongoing engagement plans • Requires dynamic leadership to chair and enable inclusion of a variety of voices • Project team to support with identifying invitees	
April to mid-May 2022	***Electoral period (purdah) – restrictions on engagement with stakeholders***	***Period to be used for involvement, to inform more formal proposal for next JHOSC***	
April 2022	Hold first steering group meeting and agree terms of reference, frequency and work streams • Recommended four meetings - kick off to input to draft involvement plan – including sharing initial user insights work - second to discuss findings and inform plans for formal consultation - third ahead of formal consultation to validate plans - fourth to review consultation outcome report, to guide implementation plans		
April 2022	Set-up small communications working group with leads from each trust/ICS and include a lead for user insights	Lead on ensuring communications actions/activities for respective trusts and CCQ/ICS are carried out	

April 2022	Design involvement plan based on areas of interest and concern emerging from existing user insights e.g. series of themed workshops/focus groups/interviews Develop a set of broad, open-ended questions for testing, based on collated user insights sets of broad and open-ended questions to accompany the collateral - tailored sets for public/patients and for staff groups	Other channels available: • A north west London-wide 'collaborative space' virtual event – open forum for discussion around proposals for the entire MSK pathways	
April 2022	Commission external communications agency to produce collateral for engagement with patient/public groups and staff, which includes: • an explainer of what we are trying to achieve • what possible change models can look like • supplementary content to use as promotion for websites/intranet/social media (should include proposal for what suggested workforce model might be).	• Aligned with narrative around MSK pathways • NCL have produced a video that can be used as a guide	
April 2022	Commission qualitative researchers to carry out the involvement activities		
April 2022	Identify and create lists of patients/public groups for pre-consultation engagement. Target these groups via all four trusts and CCG/ICS channels to promote involvement activities (all four trusts and CCG/ICS channels)	• Understand the need and benefits • Raise concerns • Opportunity to feed into design principles for ideal elective orthopaedic centre	
April 2022	Identify and create lists of multi-disciplinary staff for engagement including:	• Opportunity for staff to understand how proposals will affect	

	• staff likely to be directly affected • staff indirectly affected • staff representatives and trade unions Targeted communications to promote involvement activities	them and raise concerns • Enable co-design of the work force model Dependency – baselining of staff affected from each Trust	
April 2022	Agree, establish and brief clinical leads for engagement with all stakeholders	• Assert clinical gravitas behind emerging proposal	
Involvement period			
April-May 2022	Carry out involvement activities with public and patients Carry out involvement activities with staff groups	Opportunity for groups to raise issues/concerns and contribute ideas towards the design of MSK pathways	
June 2022	Forward planning for imminent public consultation including all documents (full, summary and easy-read documents) and start preparing materials for consultation activities.	Build on collateral already developed during the involvement phase	
June 2022	Organise NHSE assurance activities including required evidence and documents	Visits and reports by clinical senate and programme assurance teams	
End June – early July 2022	Findings of involvement activities to inform worked up proposals/outline business case for the NWLEOC to be presented back to JHOSC and other elected stakeholders (via existing Trust contact programmes). Potential deliverables include updated narrative, report from involvement activities and briefs documents	• Next JHOSC meeting to be held in July (dates TBC) • Official decision on level of public consultation required – expected to be the full 12-week period for a service change of this size	
End June – early July 2022	Report to acute care programme and ICS board with recommendations for moving to consultation		
End June – early	Final approval to launch full public consultation from ICS		

July 2022			
End June – early July 2022	Final sign off for consultation documentation		
Formal public consultation			
Mid-July	**Launch public consultation with possible deliverables:** • Consultees database • Content for website section/interactive response form • Content for Intranet section/internal channels • PowerPoint presentations: internal/external • Newsletter articles • Email address/Freepost address • Consultation documentation • Distribution of consultation materials • Launch introductory letter/email • Newspaper advertisements • Internal staff meeting events • Attend OSC meeting • Programme of consultee/stakeholder meetings • Patient/user group meeting/s • Public meeting/s • News releases • Social media channels		
Mid July 2022	12-week public consultation period	NB – possibility we may be asked to carry out a 14 week consultation as this falls during the summer months	
Mid July 2022	Undertake formal staff consultation process aligned with change management	Notify trade unions of upcoming staff consultation ahead of undertaking	

	policy and processes across the four trusts		
Mid Sept 2022	Consultation period closes		
Post-consultation period			
Mid – Sept – mid Oct 2022	Analysis of consultation responses to inform a consultation outcome report and final business case	To be presented to steering group to formulate response and outline implementation plan	
Mid – Sept – mid Oct 2022	Consultation outcome report to go through governance channels with recommendations, for response and decision-making business case • Acute care programme board • ICS board • All trust boards?		
October 2022	Inform consultees of response and decision		
October 2022	Produce consultation outcome/response publication		
October – Nov 2022	Implementation of decision for service change/development – construction of elective orthopaedic centre	Eight months for construction of centre (building new theatres as per emerging proposals)	
TBC	Develop detailed communications plan to support implementation of the centre, including potential staff recruitment campaign		
TBC	Commission and open centre to receive sector wide patients and teams		

Appendix 5

Equality Analysis – Due regard process

LNWH as a public body has a duty to have Due Regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not.
   This involves considering the need to:
   - Remove or minimise disadvantages suffered by people due to their protected characteristics
   - Take steps to meet the needs of people with protected characteristics that are different from the needs of people who do not share them
   - Encourage people with protected characteristics to participate in public life or in other activities where their participation is law
3. Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

It is necessary to actively seek opportunities to fulfil the above duties.

Protected Characteristics

- Age
- Disability (& carers)
- Gender Re-assignment
- Marriage & Civil Partnership
- Pregnancy & Maternity
- Race
- Religion & Belief
- Sex
- Sexual Orientation

Questions to consider

- Does Due Regard apply and why/why not?
- Which Protected Characteristics / Human Rights could potentially be impacted negatively?
- What is the potential impact?
- What data and information sources would you use to inform your work to help apply Due Regard?
- Who do you need to talk to / involve?
- What are the relevant factors?
- Have all views been considered?
- What mitigations could be considered? Are they practical/ doable?
- If the mitigations are not practical / doable, what is the justification?

Human Rights; 5 principles

- **F**airness
- **R**espect
- **E**quality
- **D**ignity
- **A**utonomy

Think NHS Constitution;

- Duty to protect and promote Human Rights for every individual

If challenged:

Are you confident that the decisions made and the outcomes of this project are:

- ✓ Non discriminatory
- ✓ Promote equality of opportunity
- ✓ Foster good relations between people with any of the protected characteristics

- Can you produce evidence that Due Regard has been conscientiously and proportionately undertaken and all the necessary views have been considered before any decisions were agreed?
- Can you, if after starting a course of action and a problem relating to a protected characteristic materialises, evidence that Due Regard was then undertaken and used to determine whether to continue or not and therefore influencing the decision?
- Can you evidence that the substance and reasoning of any decisions are not based upon personal bias and values and can be fully supported with documented evidence?

verve

REPORT

North West London Orthopaedic services engagement

Author: Sue Clegg and Clive Caseley

Date: July 2022

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EXECUTIVE SUMMARY

The North West London Integrated Care System (NWL ICS) offers orthopaedic services at eight hospitals across its patch. The orthopaedic and musculoskeletal (MSK) teams across North West London believe that waiting times - which increased due to the Covid-19 pandemic – need to be reduced, care should be more patient focussed and health inequalities need to be reduced by levelling up to provide the best standards for all patients. Using lessons learned during the pandemic and building on models in place in other parts of London, NWL ICS's orthopaedic and musculoskeletal teams have proposed changes to improve services in the future.

This engagement work, undertaken by Verve, gathered feedback on the proposed approach for improvement from people across North West London in a series of focus groups, telephone interviews and two online community events.

Seventy eight people took part in the engagement – having been recruited by contacting stakeholders and community groups in the area.

The engagement showed that:

- People understood the need to reduce waiting lists, and were grateful work was being done to enable this. There was an appetite for change to happen quickly so that waiting lists did not continue to grow
- People did not usually understand the complexities of NHS systems
- The model proposed, including one centre for routine surgeries, was generally welcomed, however some concerns were expressed:
    - People were worried that the plans could result in a two tier system from two perspectives:
        - could fast tracking routine surgery be detrimental to people with more complex needs?
        - would increasing the use of digital technologies leave behind people who could not use them?

Several barriers to care were identified, including:

- Being lost in the system
- Not having face-to-face appointments especially for diagnosis and being starting physiotherapy
- The digital divide for people unable or unwilling to use technology
- Travel to and parking at hospitals
- Lack of access to therapies

For most people having a choice of where to have routine surgery (and possibly having to travel further) was less important than shorter waiting times.

Practitioners who took part in the engagement felt that the plans were too focussed on secondary care and raised concerns about whether in the future more people would be referred to them, for example for physiotherapy, as they were already having capacity problems.

Participants thought that good care needed to be timely, appropriate, co-ordinated and effective. They had further suggestions relating to interactions with clinicians, communications, continuity of care, access and taking account of people's additional needs.

Our recommendations include:

- Ensuring clarity of communications by reducing unnecessary detail, providing explanations of terminology and reducing jargon
- Being clear about how the changes will benefit all patients, not just those eligible for routine surgery
- Offer more explanation about the proposed hub, and how it will work and how and where patients having routine surgery will be offered pre and post operative care
- Explain what choices people will have
- Give more detail about care co-ordination
- In the next stage of consultation ensure the inclusion of groups who are potentially disproportionately or differentially affected by the changes, people who would be eligible for routine surgery and people from all boroughs in NWL

1. INTRODUCTION

1.1 BACKGROUND

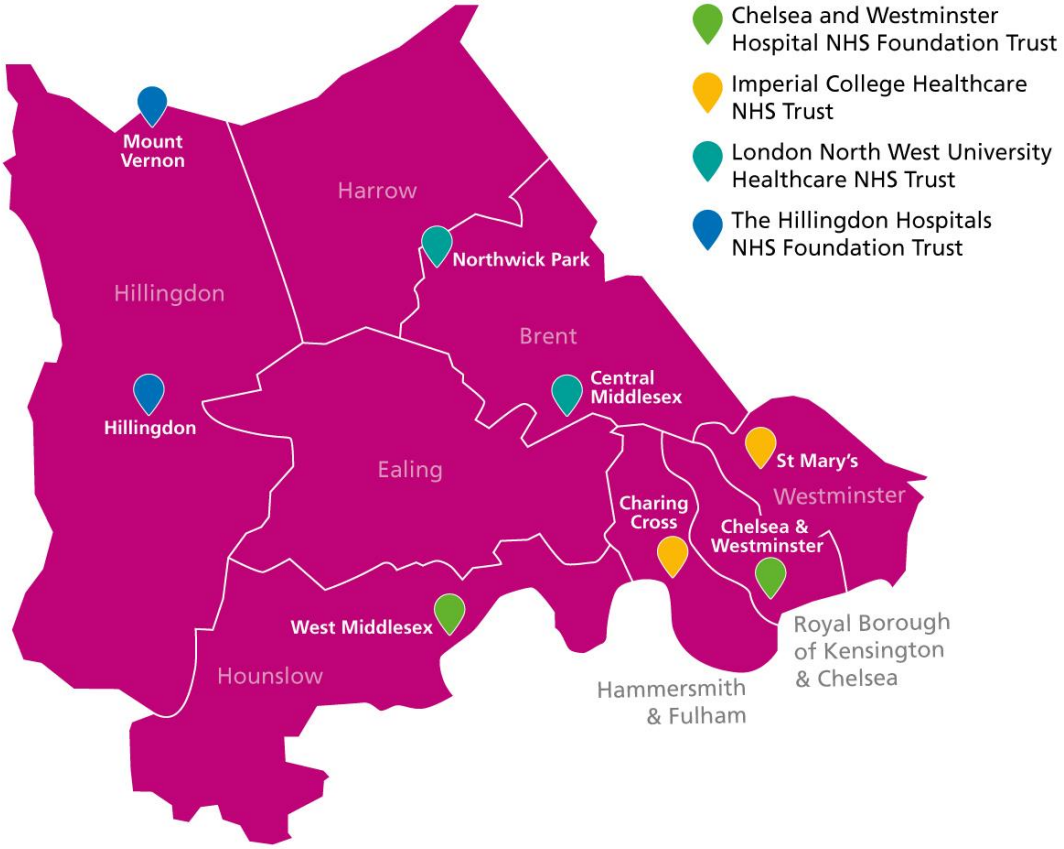
The North West London Integrated Care System (NWL ICS) covers the boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

Approximately 2.2 million people live in the eight boroughs.

NWL ICS provides hospital, community health and general practices services, including the following NHS acute trusts:

- Chelsea & Westminster Hospital
- The Hillingdon Hospitals
- Imperial College Healthcare
- London North West University Healthcare

Orthopaedic services are offered at eight hospitals:



Several issues led the orthopaedic teams across North West London to look at how orthopaedic services are currently delivered:

The Covid-19 pandemic had a negative impact on waiting lists for orthopaedic surgery, with more than 12,000 people currently waiting for orthopaedic care; the proportion of people waiting more than 52 weeks for care has increased by more than a quarter during the pandemic. Waiting for treatment can have adverse effects on quality of life, making it harder for people to go about their day-to-day activities. Further, conditions may get worse over time making them harder to treat and recover from.

NWL ICS is also keen to ensure that care is more patient focussed. Previous engagement revealed that patients with bone and joint problems had several concerns: frustration with long waiting times between initial assessment and surgery and when attending appointments; having to chase follow up appointments; worrying about having their surgery re-scheduled; communication problems such as lack of co-ordination between GPs and hospital services and being given confusing information; and some patients, including elderly people and those with disabilities, find travel to appointments problematic. The overall message was that patients wanted more control over their care, which they wanted to be organised in clear, consistent and straightforward ways.

NWL ICS has some excellent clinical outcomes for orthopaedic surgery, including low readmission and 're-replacement' rates for knee and hip surgery. However, this varies across the hospitals and it is known that some patients face inequalities in accessing care and have poorer health outcomes – particularly patients who are elderly, those who have disabilities, people from more deprived areas and those from Black, Asian and other minoritised groups. The aim for the future is to level up to the best standards for all patients.

To prepare for the future of orthopaedic services NWL ICS wish to reduce waiting lists, make the most of digital and other technological advances – whilst ensuring that no one is left behind, and attract and retain staff.

Using lessons learned during the pandemic and building on models in place in South West London NWL ICS's orthopaedic and MSK teams are working towards a plan to improve services in the future.

1.2 AIMS AND OBJECTIVES

The aims of this engagement exercise were to gather feedback on the proposed approach for improvement and to identify thematically any issues which need to be considered as the programme progresses.

To meet these aims the people were invited to attend two online community events, one of eight focus groups (seven online and one in person) or be interviewed by telephone. The engagement was designed to:

- Identify patient and public views on the case for change and the positives and negatives relating to a centre for routine surgery
- Understand the likely impacts of the plan, particularly on people sharing protected characteristics or otherwise at risk of health inequalities

The engagement will be used to inform the more detailed proposals for the next stage of the process to enable the development of a high-quality consultation.

1.3 VERVE

Verve is an independent full-service agency specialising in supporting NHS organisations in delivering transformation and change.

Verve was commissioned by North West London Integrated Care System to undertake engagement with people living in its patch for early stage discussions about the future of orthopaedic and musculoskeletal services. This document has been produced independently by Verve and represents our own analysis and recommendations.

We are grateful for the assistance and support of NWL ICS colleagues, the wider group of stakeholders and the residents of North West London who took part in the engagement. We would especially like to thank the community groups who helped us to recruit people to the focus groups, particularly Kensington and Chelsea Over 50s Forum[1] who arranged for a facilitator to visit a specially convened meeting to talk to some of their members and the Hear Women GarGar Foundation[2] who recruited members to fill an online focus group.

1.4 THIS REPORT

This is an independent report written by Verve.

The report describes the methodology used, the findings of the engagement and presents recommendations based on the findings. Anonymised quotations are used in the report to illustrate points made.

[1] https://www.kensingtonandchelseaforum.org.uk/
[2] http://www.hearwomen.org/

3. METHODOLOGY

3.1 ABOUT QUALITATIVE RESEARCH

This engagement used qualitative methods to ensure that people's views and experiences could be explored in detail.

The aim of qualitative research is to define and describe the range of emergent issues and to explore linkages, rather than to measure their extent. The use of qualitative methods means that we do not collect, or report, on the numbers of people holding particular views or experiences.

3.2 DESIGN

The engagement exercise was designed to hear the views of people about orthopaedic and MSK services in North Central London. Two online community events, eight focus groups (seven online and one in person) and four telephone interviews took place in June 2022. Seventy eight people took part in the engagement.

3.3 RECRUITMENT

NWL ICS compiled a list of stakeholders and community groups who were sent information about the engagement, including a flyer with a brief outline of the purpose of the work and details of how to book on to the community events (see Appendices).

Recruitment to the community events was via Eventbrite – people could connect via an URL or a QR code and book on to either of the two dates offered. Sign ups were capped at 50 per event to allow for attrition to a capacity of 40 at each event. Both events reach the cap of 50 sign ups. Some people contacted the Verve after the cap was reached and were invited to take part in a focus group instead of a community event.

Verve compiled a supplementary list of community organisations across the eight boroughs. NWL ICL emailed all community organisations introducing the project and Verve. Verve's specialist recruiter followed up with emails and phone calls inviting the community organisations to promote the focus groups and community events to their members.

Two community groups each recruited enough of their members to fill a focus group: the Kensington and Chelsea Over 50s Forum arranged a special meeting and invited a Verve facilitator to run the meeting as a focus group in person as their members could not use technology to attend online sessions; and the Hear Women GarGar Foundation recruited enough of their members to fill an online focus group. We are grateful to all who helped with our recruitment.

People who took part in focus groups and telephone interviews were offered a £20 gift voucher as a thank you for taking part.

3.4 FIELDWORK

Seventy eight people took part in the engagement in total, 36 in community events and 42 in focus groups and interviews. All fieldwork took place in June 2020. All the questions asked by participants during the fieldwork are collated in the Appendices and will be used by the NWL ICS team to formulate a set of FAQs for the next stage of the work.

Many participants said they were grateful for the opportunity to take part in the engagement – one person said:

"It's important for us to know that you are listening to us"

3.4.1 COMMUNITY EVENTS

The online community events were designed to give people the opportunity to listen to clinicians talk about why they thought change was needed to orthopaedic and MSK services, what the changes might look like and what benefits they saw the changes bringing. After the presentations the participants split into small groups, with a Verve facilitator, to give their thoughts and views; facilitators used a short topic guide to lead the discussions (see Appendices). Each small group formulated questions to take back into a final plenary session to put to a panel of clinicians. The groups were offered the opportunity to ask questions about the information they had heard in the presentations and about their own bone and joint problems, if they had any. People could also use the Zoom chat function to leave comments and ask questions. Whilst some people commented about their own bone and joint problems the questions asked all related to the information from the presentations. The community events were 90 minutes long.

3.4.2 FOCUS GROUPS AND INTERVIEWS

Eight focus groups and four interviews were help. Seven focus groups were online and 1 was face-to-face. Verve facilitators undertook all the fieldwork. Facilitators explained why change was thought to be needed, what the changes might be, and what benefits the changes could bring and used a topic guide to lead the discussions (see Appendices). The focus groups were approximately 90 minutes long. Telephone interviews used the same topic guide and lasted between 20 and 45 minutes.

3.5 ANALYSIS

Qualitative methods produce many hours of recordings from events, focus groups and interviews. In this engagement there were 2 community events and 8 focus groups of 90 minutes and four telephone interviews of approximately 30 minutes.

The researchers involved in the fieldwork used their notes and recordings to synthesise the material thematically.

At the end of the fieldwork the researchers and the analyst have a debriefing session where they discussed the main themes arising out of the engagement and any outliers.

The analyst familiarised themself with all the data and themes, looking for similarities and differences. There is constant checking between analysis and original data to check for veracity.

The report is based on the findings from the thematic analysis.

4. FINDINGS

The findings represent the views of participants analysed and presented thematically. Where particular types of people held a view, or where there are outlying views we make clear how and why they differ.

4.1 THE NEED FOR CHANGE

4.1.1 UNDERSTANDING THE NEED FOR CHANGE

People understood that waiting lists had increased during the pandemic and that there was a need to reduce them; they welcomed the work being done to enable this to happen. There was a call for the proposed changes to happen quickly so that waiting lists would start to reduce sooner rather than later.

More people expressed positive opinions about the potential changes than Verve have seen in similar engagement exercises.

People were positive about the idea of centralised provision of routine orthopaedic care, saying that it was a good way of maximising staff usage and developing clinical expertise. One participant said:

> *"It seems a good idea to centralise it so that everything gets fed in to one area and can be dished out with shorter waiting lists, because otherwise it's only going to get worse and at the moment I just can't see that it can carry on the way it is"*

For many people having a shorter wait for surgery outweighed any inconvenience of travelling to a hospital further from their home.

4.1.2 CONCERNS EXPRESSED

Some concerns were raised about having to travel further for surgery by people who would have longer or more difficult journeys, for example a group of people from Kensington & Chelsea worried about how they would get to Central Middlesex Hospital. However, this group was mainly made up of older people, some with complex health problems, who would be unlikely to be offered 'routine' surgery, and some could see the benefit for other people.

Parking at Central Middlesex Hospital was deemed to be bad, including for blue badge holders, and concerns were expressed about how people would get there if they could not use public transport.

Some people questioned whether the waiting times for physiotherapy would be reduced, as well as the waiting times for surgery.

Concerns were expressed about whether the plans could result in a two tier system on two counts: questions were asked about whether patients having routine surgery would be fast tracked to the detriment of people with more complex needs; and people worried that a move to more digital and technological systems would leave behind people who could not interact in this way.

4.2 BARRIERS TO CARE

4.2.1 BEING LOST IN THE SYSTEM

Generally people who had experience of secondary care praised it highly. However, people said that the pathway to getting secondary care was problematic. Many described a disconnect between GPs and other services – with difficulties getting referrals to physiotherapy, occupational therapy and secondary care. A participant said:

> *"There's no proper line of communication between the GP and the hospital and it just leaves you in the dark"*

Many people had experienced poor co-ordination of services and being 'left in limbo', not knowing where they were in the system, and not knowing to whom they could talk to progress their treatment or to find out what was happening. A participant said:

> *"Just being discharged home from one borough to another, the communication isn't good. Things take time to be connected and people can sometime wait 2-3 weeks for a physio"*

One participant wrote their own care plan and visited each team involved in her care, copying all of them into emails because there had been no communication between the teams until the patient took control.

People had also experienced long waits between appointments, again, meaning that they felt lost in the system.

4.2.2 THE IMPORTANCE OF FACE-TO-FACE APPOINTMENTS

For many people not having face-to-face appointments was a concern. Some had experienced being diagnosed with a bone or joint problem over the telephone and had been given physiotherapy exercises by phone or email. This led to worries about whether diagnoses were correct, whether exercises were being done properly or could be doing more harm than good. A participant who had been diagnosed in a telephone call said:

> *"On the basis of the phone call, I got sent some exercises, which then I had to log on online to get to. I just wanted an email with some exercises, but more than that, not seeing someone f2f is worrying"*

For most people having a face-to-face appointment for diagnosis and initial physiotherapy sessions was desirable and increased their confidence that they were getting the right care. A participant said:

> *"If it means either constantly waiting in the unknown or somebody doing something, to physically see somebody, I'd hire a jet. I'm prepared to do whatever it takes for someone to actually look at my knee, rather than try to describe it over the phone to a GP"*

4.2.3 THE DIGITAL DIVIDE

Some people liked the idea of having access to information about their condition and their patient journey in an app or by other digital means. When Joint School was explained during the community events several people thought this was a very good idea and would overcome the feeling of being lost in the system. However, many people were anxious about care being

provided remotely or digitally for a variety of reasons: some people did not have access to the internet, nor a smart phone; some people were not confident of their abilities to use apps or technology generally, even if they had the means to do so; people who were blind or had vision impairments were concerned about whether apps or other offers would work with their technology such as screen readers; and some people simply did not want to engage digitally.

For people who could not, or did not want to, engage digitally there was a fear that online services would replace face-to-face services, and this was seen as unacceptable. For these participants there was a view that being directed to digital services was being 'fobbed off'. Many of the participants who felt they could not engage digitally were older people, but there were also concerns from some people for whom English is not their first language. One person said:

"I feel we're being brushed off to the far corners"

4.2.4 TRAVEL TO CENTRAL MIDDLESEX HOSPITAL

It should be noted that many of the people who took part in the engagement were unlikely to be offered routine orthopaedic surgery at Central Middlesex Hospital as they had co-morbidities; during all sessions there were explanations about the hub being used for routine surgery for people who were very unlikely to need more than a minimum hospital stay, consequently, some views about travel relate to problems for people with disabilities and co-morbidities.

People who knew Central Middlesex Hospital said that parking is bad and felt that this would need to be improved. There were also concerns about getting to the hospital by public transport, and participants pointed out that people with bone and joint problems can find walking difficult, so proximity to public transport was important. A participant said:

"The problem is when you have got bone and joint pain, transport is difficult, walking is difficult"

People who had used patient transport for hospital appointments reported several problems, for example, transport arriving on time – or being very early and then having a long wait at the hospital, or not turning up at all. One person had experienced difficulties because she was a wheelchair user – she had once been refused patient transport because of her wheelchair and at other times she had been 'tied' into the front seat – she said:

"They tie me up like a fly in a spider's web. I had to travel in the front seat like that and was crying with pain"

4.2.5 LACK OF ACCESS TO THERAPIES

There were some concerns expressed about whether there would be sufficient aftercare if people are discharged from hospital very soon after an operation – people asked whether services such as physiotherapy would be able to cope with the proposed changes.

People thought that free or reduced cost gym memberships should be available for people with bone and joint problems, saying that this would encourage people to do their physiotherapy exercises and possibly become generally fitter. There was a perception that there was a lack of gym facilities for older people.

Some women prefer women only sessions in gyms and swimming pools, and participants reported that there were very few of these available. Women from some ethnic backgrounds found this particularly problematic.

4.2.6 ACCESS PEOPLE WITH DISABILITIES

Wheelchair users reported that waiting areas and consulting rooms were often too small for wheelchair users – they might be able to get into a consulting room but they could not manoeuvre their chair once in there. Waiting areas were too small, particularly if there was more than one wheelchair in there at a time. Beds and examination couches often did not go down far enough for wheelchair user to transfer onto them. There was a lack of hoists, for example, for people needing MRI scans.

People with vision impairments said their needs were often not taken into account by healthcare professionals – for example they might need more time in an appointment. People said that if they needed support to find their way in hospitals they sometimes had to wait too long to be assisted to their appointment.

People with vision impairments who use assistive technologies on their smartphones or other devices sometimes find that health related software is not compatibly meaning they cannot use the apps etc.

4.2.7 OTHER CONCERNS

Participants did not like going to clinics where all patients had been given the same appointment time, saying that it led to long wait times in clinics and very busy waiting rooms. This was thought to be for the benefit of the providers rather than the patients, and there was a call for a more patient-centred approach. One patient said:

> *"They say patients come first and yet they say everyone come in at the same time because it's more convenient for them. They ask everyone to be there at 7a.m. If you come from further afield you'd have to get up at 3a.m."*

Some people expressed a concern that if they made a complaint their care would be compromised, meaning that they either did not make a complaint or they waited until their care was over. They were not reassured by information from hospitals and care providers about complaint handling procedures and felt that there was a need for an independent moderator to ensure a more arms' length approach.

People with extra needs, including disabilities, co-morbidities, caring responsibilities and language needs thought that the system in general needed to support them better, not least by finding out at the beginning of their patient journey what their needs were and accommodating them as much as possible throughout their care.

Patients sometimes felt that hospitals did not have enough time to properly involve them in their own care, which led to people feeling that they were not able to discuss care options or be part of the decision making process.

4.3 PATIENT CHOICE

The potential changes to orthopaedic and MSK services in North West London would see routine surgery offered on one site only, at Central Middlesex Hospital, rather than across eight hospitals across the patch as it is now. Participants discussed whether effectively reducing their choice of where to go for routine surgery in this way was a problem. Generally people did not consider a lack of choice of location for routine surgery to be a problem, saying that a reduction in waiting times and other benefits such as very experienced clinical teams outweighed not being able to choose a hospital, possibly one closer to home.

Some people wondered whether there would be other opportunities for choice, for example, choosing which consultant or surgeon they would see if they were referred to the hub. For some participants this would be important, and they would like to have information about clinicians to enable them to make a choice.

People who had had surgery in the past said they would prefer to go to hospitals where they had already received care from, saying that they thought the clinical teams would understand their condition better and there would be continuity of care. For some people treatment in familiar surroundings was important and was likely to lead to them feeling they had some control over their care.

Participants with complex needs also preferred to have care in familiar surroundings, where they had been seen before, whether for orthopaedic/MSK care or for other conditions. Again, there was a perception that continuity of care would be better, their patient records would be readily available and clinical teams would understand their conditions and needs. A participant said@

> *"Continuity is very important, having someone who understands you, your history, your pain, who knows whether things are changing over time. You get tired of telling your story all the time, you just want someone who knows you."*

For many people it was important to be able to choose whether they used technology or not – even if they had the means to do so. Many older people did not want to be made to embrace technology to access care and felt that they would almost certainly miss out in some ways if this happened – for example, by not being able to use apps, respond to messages or download exercise instructions. There was a fear that establishing technology as the way forward would create a two tier system, with those unable or unwilling to use it 'going to the bottom of the pile'. Further, views were expressed by some participants that the quality of healthcare would diminish if more were delivered digitally. A participant said:

> *"I'm wary of the drive towards using technology to replace interactions with healthcare professionals… I think this will inevitably reduce the quality of healthcare you receive"*

4.4 PRACTITIONERS' VIEWS

Information about the community events was sent to many stakeholders across North West London. Some service providers chose to attend the community events and their views about the possible changes to services are presented separately in this section.

Practitioners expressed a concern that the plans seemed to mainly relate to secondary care; they questioned how services such as physiotherapy and occupational therapy fitted into the scheme. There was a strong view expressed that there were already capacity issues for therapies across the whole pathway and they questioned what would be done about this as at the moment most cases practitioners saw were complex, adding in routine patients for after-care would increase their workload. One person said:

> *"I think they may have a rose-tinted opinion of what we can offer in the community. There's a lot of stress in the system currently. A lot has to happen prior to a patient getting to the elective hub and that needs to be looked at"*

Questions were raised about whether GPs had a good understanding of alternatives to surgery, with practitioners expressing the view that a lack of understanding led to patients being pushed towards a surgery pathway as a default.

Practitioners thought that polyclinics were needed to give access to a variety of services such as mental health, obesity clinics, exercise and therapies. Further, practitioners were of the view that there was need for primary and secondary care to work more closely together.

4.5 WHAT GOOD LOOKS LIKE

People discussed what good care looked like.

4.5.1 TIMELY, APPROPRIATE, CO-ORDINATED AND EFFECTIVE

The most important things people identified were that care should be timely, appropriate, co-ordinated and effective. That is, waiting times should be as short as possibly, they should be referred to appropriate services, care should be co-ordinated by providers and the outcomes of care should be good.

Other elements which contributed to good care were:

4.5.2 INTERACTIONS WITH CLINICIANS

- Face-to-face appointments, especially at the time of diagnosis and first appointments with physiotherapists to ensure patients understand what they are being asked to do, and are doing exercises correctly
- Clinicians working with patients to include them in decisions about care – and taking time to explain care to patients, and listening to concerns and complaints
- Good communications between clinicians and with patients
- Being treated with respect and in a friendly way

4.5.3 COMMUNICATIONS

- Being kept informed about what is happening – and understanding what the care pathway is
- Clear, jargon free communications

- Easy to use and easy to understand systems, for example, how to reschedule appointments
- Having systems in place so patients do not have to explain their conditions and circumstances at each appointment

4.5.4 CONTINUITY OF CARE

- A holistic approach from diagnosis onwards, with support all along the care pathway
- Continuity of care – by seeing the same clinicians at appointments
- Pain management should be offered whilst people are waiting for operations

4.5.5 ACCESS

- Good access, including public transport links and good parking – including for people with disabilities. It was suggested that a shuttle bus could operate between hospitals to alleviate travel issues and higher travel costs
- If travelling further for surgery pre and post operative care should be close to home
- Having good information about how to get to hospitals, how parking works – including costs and how payments are made, and transport routes – including proximity of stations and bus stops

4.5.6 ADDITIONAL NEEDS

- Ensure that additional needs are understood and accommodated, for example, checking whether people with vision impairments can use apps and other technology with screen readers and other assistive devices

5. DISCUSSION AND RECOMMENDATIONS

People tended to be supportive of the plans outlined in the engagement, and welcomed the work being done to reduce waiting lists – there was an appetite for change to happen quickly. There was a relatively positive response to the idea of a centre for routine planned surgery. Some concerns were expressed about the disconnect along the current pathway, including difficulties getting referrals and being 'lost' in the system – and people hoped a new system might sort some of these issues out. A strong negative response was heard from many people about the over-reliance on digital technologies. Some fears were expressed that the plans could result in a two tier system on two counts – if routine cases are fast tracked for care to the detriment of more complex cases and people being left behind if they could not use technology.

Generally people did not understand the complexities of NHS systems, and often found explanations of how they work confusing – this included which Trusts provide care, what primary and acute care was, who commissioners were, the acronyms used, how systems worked together and why some care appears to be delivered by private providers. It is important to note that for many people understanding the intricacy of the system is far less important than being in receipt of good care – as discussed above the most important elements identified as crucial to good care were that it is timely, appropriate, co-ordinated and effective.

We recommend that for the next stage of the process the NWL ICS team consider the following:

- Ensure that communications are jargon free – including:
  - Clarify what 'routine' surgery is
  - 'Elective surgery' was not understood – consider 'planned surgery' and explain the difference between planned and emergency surgery
  - Explain what musculoskeletal service are

- The case for change document will give a lot of detail about who is involved in the system, how they will work together, financial considerations etc. Assuming this will be available to the public if they wish to read it, consider how much of this sort of detail is needed in the engagement sessions

- Explanations should be provided for terms including:
  - Primary care
  - Acute care
  - Secondary care

- Be clear how the changes will benefit ALL patients, not just those eligible for routine surgery at the hub – explain how people with more complex needs will get their care, and whether there will be any changes directly affecting them

- Explain in more detail why the hub would be sited at a hospital without an A&E

- Explain what will happen if something goes wrong during a routine surgery – how will patients receive extra care they need? For example, would they be taken by ambulance to another hospital?

- Explain in more detail how and where patients receiving routine surgery at the hub will receive pre and post operative care

- Explain whether/where patients will be able to make choices – for example, will patients be able to choose which surgeon they see?

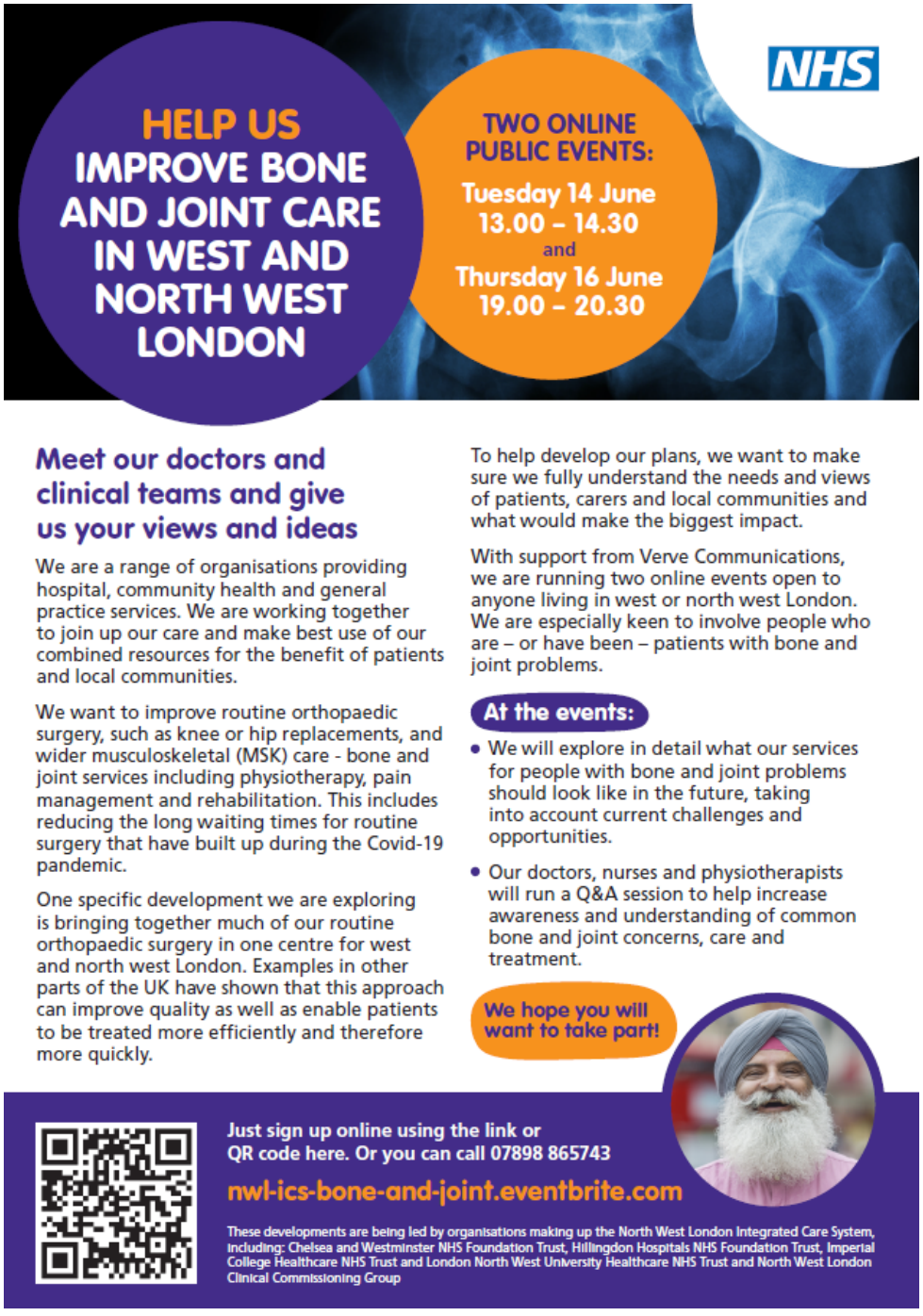
- Explain in detail how care will be co-ordinated between different clinicians and hospitals

- In the consultation stage ensure the following groups are included:
    - Groups potentially differentially or disproportionately impacted, for example transgender people taking hormone therapies and people with some types of disabilities
    - People who would be eligible for routine surgery
    - People from all the boroughs in NWL

6. APPENDICES

6.1 FLYER

This flyer was sent to contacts across North West London by the NWL ICS team, including colleagues, other service providers and community contacts.



6.2 DEMOGRAPHICS OF PARTICIPANTS

Participants were asked to fill in a short online form to collect anonymous demographic data. Seventy-eight people took part in the engagement. Thirty-three filled in the demographic survey. The findings from the survey were as follows:

Boroughs people lived in:

Brent	4
Ealing	4
Hammersmith & Fulham	9
Harrow	0
Hillingdon	0
Hounslow	0
Kensington & Chelsea	7
Westminster	9
Other	0

Age groups:

18-24	0
25-34	1
35-44	4
45-54	4
55-64	7
65+	17
Prefer not to say	0

Gender:

Female	23
Male	10
Transgender	0
Non-binary	0
Prefer not to say	0
Other	0

Gender the same as the sex assigned at birth:

Yes	30
No	1
Prefer not to say	2

Sexual orientation:

Heterosexual	26
Lesbian	0
Gay	0
Bisexual	0
Prefer not to say	4
Other	1
No answer	2

Ethnic background:

White	21
Mixed	0
Asian or Asian British	5
Black or Black British	4
Prefer not to say	0
Other	1
No answer	2

Disabilities or long term health conditions:

Yes	21
No	9
Prefer not to say	3

Disabilities or long term health conditions – type:

Physical disability	16
Speech impairment	0
Mental health condition	9
Blind or impaired vision	0
Deaf or hard of hearing	3
Wheelchair user	6
Learning difficulties	0
Prefer not to say	6

NB: people could choose more than one category so adds to more than 33

Marital or civil partnership status:

Married	12
Registered civil partnership	0
Never married/registered civil partnership	10
Divorced	2
Separated	0
Widowed	4
Prefer not to say	4
No answer	1

Religion:

Atheist	0
Buddhist	2
Christian	13
Hindu	0
Jewish	2
Muslim	7
Sikh	0
No religion	6
Other	0
Prefer not to say	3

6.3 RESEARCH MATERIALS

6.3.1 TOPICS DISCUSSED IN COMMUNITY EVENT BREAKOUT GROUPS

The breakout groups in the community events discussed the presentations they had heard in the opening plenary group.

Facilitators in the breakout groups guided the discussions around:

- The case for change
- The opportunities which changes could bring
- Views on a centre offering routine orthopaedic care
- Participants' views on what good care looked like.

In the final part of the discussion participants agreed on questions to be asked in the final plenary.

6.3.2 TOPICS DISCUSSED IN FOCUS GROUPS AND TELEPHONE INTERVIEWS

Facilitators briefly explained why change was considered necessary and what the future services might look like. Participants then discussed the following topics in relation to current and future services:

- What good care looks like and what affects people's viewpoints, including their own experiences of what worked well and what could be improved
- Patient choice, and views about one site offering routine orthopaedic care
- Views on travelling, including potentially travelling further for surgery, and what could make things easier for people
- Barriers and enablers in accessing healthcare

6.4 QUESTIONS FROM PARTICIPANTS

This section brings together the questions participants asked in the community events (in breakout groups, plenary sessions and Zoom chat) and in the focus groups. The questions are grouped under themes.

About the model

- How many people will benefit from this?
- What are the criteria for 'routine' surgery?
- Will people be able to choose which surgeon they see?
- Is this project able to carry the clinicians forward to the hub as some might be reluctant to move?

About the pathway

- What will the new pathway look like? How will it be any different/better than the current pathway? Will it be any quicker?
- Will the pathway mean quicker access to care?
- Where will people's first appointments be?
- What kind of emergency care would be available if there were difficulties with routine operations?
- Where will aftercare happen, including rehab?
- Will community physio/OT pilots continue?

About the hub

- Do you think these hubs will reduce the length of stay post-operatively and how will you accommodate this if there are complications – e.g. illness, DC planning, step down care etc? What impact will this have on patient flow if patients end up staying longer to recover?
- Has there been follow up with people who participated in the 'trial' hubs during the pandemic? How satisfied were they, what was the recovery time post-surgery, what was the impact on quality of life?
- Will Central Middlesex Hospital be the hub for ALL MSK?
- Will patients with complex/multiple conditions be seen at the hub?
- Will car parking at Central Mid improve? It is terrible at the moment.

Co-ordination along the pathway and across the system

- Will the care pathway be co-ordinated by SPOC to prevent the patient having to co-ordinate their own care pathway?
- How do you foresee this pathway working with a multitude of different providers across NWL from start to finish of the patient journey given the complexity of the system?
- How will discharge planning work across so many boroughs?
- How will you ensure good communication, including image sharing, between different service providers?

About the programme and implementation

- How will the plans be implemented?
- What are the next steps in the process?
- What are the timelines for getting this up and running?
- How long will it take to set up the new system? When will it happen?
- How soon will the new hub be set up? (The faster the better)
- Do you see a role on Health and Wellbeing boards?
- Will there be pilots for the plans? If so, how will they be implemented? Where will it start? Will it be an iterative process so that you can learn from the pilot?

About resources and finance

- How will this be financed? Where are resources coming from? How is it being set up?
- How much will all this cost?
- How will this hub be achieved on an operational level? Are they taking staff away from existing hospitals?
- If people are fast tracked it creates more demand on physio and OT services as more people will be going through the system – does the current system have capacity?

Support along the pathway

- Is there opportunity for pre-habilitation e.g. physio exercises before surgery to maximise the chance of fast post-op recovery?
- How will you monitor whether people are doing physiotherapy correctly if they have been given exercises by email or over the phone?
- Hackney has a service with a paramedic in a car, could something like this be adapted in North West London for post operative orthopaedic surgery?
- Could you provide free limited gym membership for people to do physiotherapy exercises – in the past there was a scheme for people with arthritis.
- What role will social prescribing have?

Condition-specific questions

- Will gait analysis be available?
- How is osteoporosis part of the plan?
- Can joint replacements be made to last longer?
- Will special equipment on loan be available to all patients?
- How will people with complex conditions fit into the plan – what will the hub do for them?
- In France they offer pelvic care during childbirth – why does this not happen here?
- Can they put a hydro-therapy pool in the Middlesex?

Communication and clarity

- Will the new pathway be transparent so that patients know where they are on the pathway and what to expect will happen next?
- At the moment everything is called a hub – it doesn't mean a lot because there is a lot of confusion

About access

- How is access for people with disabilities, such as parking, going to be managed?
- How will people with hearing impairments be able to access care?
- Will there be fewer remote diagnoses, for example, over the phone?
- I hope you can take feedback seriously because at the moment the system is a rollercoaster.

About technology

- Will there be opportunity for more face-to-face contact with clinicians than there is currently – especially for diagnosis and monitoring?
- How will you work with people who do not have internet connection or smart phones? It looks as though a lot of care will be on mobile apps.
- Paramedics have apps on their tablets which allow them to scan a patient – will this type of facility be available in primary care?

[Covering Report]
Report for: NW London Joint Health Overview and Scrutiny Committee

Date of meeting:
Wednesday 20 July, 2022

Subject:
North west London acute care programme – Developing new Community Diagnostic Centres

Responsible officer:
TBA

Report authors:

Professor Tim Orchard Chair, North west London acute care programme board; Chief executive, Imperial College Healthcare NHS Trust

Pippa Nightingale Chief executive, London North West University Healthcare NHS Trust

Section 1 – Summary and Recommendations

Summary
As previously reported to the Committee, new Community Diagnostic Centres are a national initiative to build diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. This 'one stop' approach for checks, scans and tests will be more convenient for patients and help to improve outcomes for patients with cancer and other serious conditions.

National funding of £2.3bn has been allocated for developing diagnostic services and a national assurance and business case approval process has been issued for schemes. We are planning to have new community diagnostic centres situated in two areas of north west London where there are significant clusters of deprivation – the area of Hanwell, Southall and Greenford; and the area of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen's Park and Church Street in North Westminster. We have worked up plans and obtained business case approvals to progress three new Community Diagnostic Centres in north west London with capital investment starting from 2022/23.

Recommendations:
Members are requested to note the enclosed update and to support the development of further information and engagement activities to ensure the plans reflect and respond to the needs and views of all users in order to build widespread awareness and knowledge of the new Community Diagnostic Centres and maximise their uptake and usage.

North west London acute care programme – Developing new Community Diagnostic Centres

1. The case for change

Even before the pandemic, the case for change in diagnostics services in the NHS was clear. Covid-19 has simply amplified the issue and demonstrated the urgent need for expansion and reform.

We need more physical capacity. England has one of the worst diagnostic equipment to population ratios compared to other OECD countries.

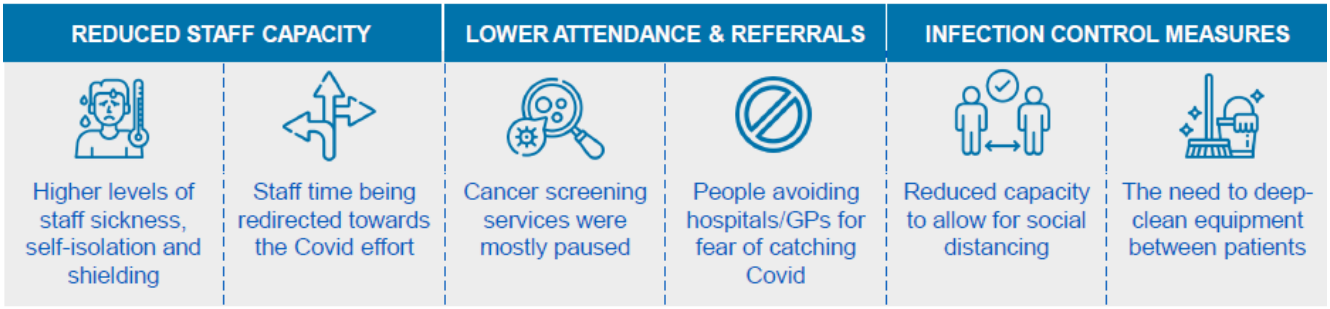
Over the last 5 years, demand for diagnostic services in England has risen significantly. Increased demand has been outstripping increases in diagnostic capacity leading to longer waiting times:

- CT scans: up 6.8 per cent per year
- MRI scans: up 5.6 per cent per year
- Echocardiogram: up 5.7 per cent per year

Diagnostic services in the NHS were already reaching a tipping point and the pandemic has intensified the issue. The need for enhanced infection prevention and control measures, reduced the capacity of existing services and reduced the number of available appointments for diagnostic tests.

The NHS standard for non-urgent diagnostics is a six weeks wait. People should not wait longer than this for a test, but for a growing number patients this target was being missed even before the pandemic.

Several factors have played a part in increasing waiting times and creating a backlog:



The pandemic has also been a real driver for innovation, with changes previously considered too difficult made within weeks – for example, the shift to virtual consultations.

As we seek to tackle the current challenges there is a unique opportunity to develop new models of service delivery, particularly around where and how diagnostics are delivered.

One part of a wider national plan to respond to these challenges is the establishment of Community Diagnostic Centres (sometimes referred to as CDCs).

Community Diagnostic Centres seek to reduce health inequalities, improve accessibility, improve productivity, support integration of care and deliver a more personalised patient experience.

The new Community Diagnostic Centres for north west London would provide additional diagnostic capacity in more locations for the benefit of the entire regional population. The delivery of high-volume, low complexity diagnostics by the Community Diagnostic Centres, will release additional capacity within existing hospital based diagnostic services, enabling increased capacity to support the provision of more urgent diagnostics, such as cancer.

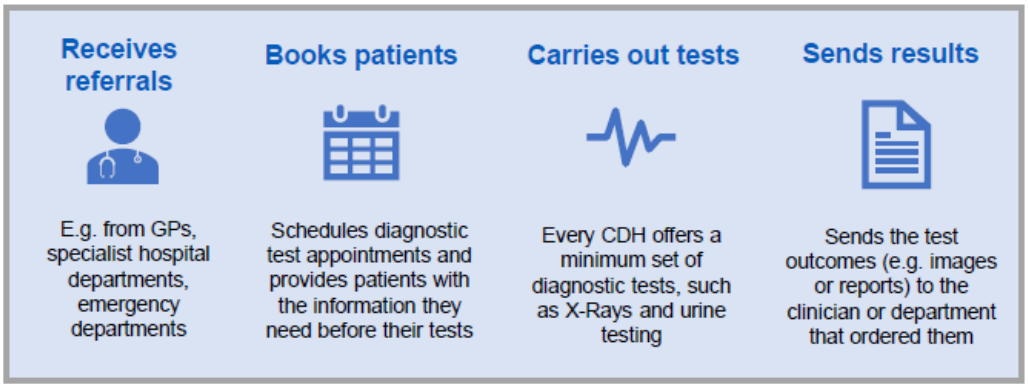
2. What Community Diagnostic Centres aim to achieve

Community Diagnostic Centres aim to expand capacity of diagnostic provision in England by providing a broad range of diagnostic services at additional sites. The sites will likely be located away from hospitals with urgent and emergency services and closer to communities, providing easier access to patients and reducing hospital outpatient attendances.

Six primary aims of the Community Diagnostic Centres programme	
Improve population health outcomes	Reaching earlier, faster and more accurate diagnoses of health conditions.
Increase diagnostic capacity	Investing in new facilities, equipment and training new staff, contributing to recovery from Covid-19 and reducing pressure on acute sites
Improve productivity and efficiency	Streamlining provision of acute and elective diagnostic service, redesigning unnecessary steps, tests or duplication
Contribute to reducing health inequalities	Reducing unwarranted variation in referral, access, uptake, experience and outcomes of diagnostic provision
Deliver better and more personalised experience	Providing a single point of access to a range of diagnostic services in the community
Support integration of care	Supporting integration of care across primary, community and secondary care

3. What is a Community Diagnostic Centre?

Community Diagnostic Centres are part of a national approach to increasing diagnostic testing capacity by creating new additional facilities all with the same basic functions:



4. What tests will be carried out at a Community Diagnostic Centre?

Again, there is a national approach which recommends which diagnostic tests should be included at a minimum within Community Diagnostic Centres:

	Example tests	Examples of related clinical areas
Imaging	• X-Ray • Ultrasound • MRI • CT scan	Chest infection Liver/kidney damage Slipped disc Lung cancer
Pathology	• Blood tests – some of which provide results right away • Urine samples • Simple biopsies (tissue samples)	Anaemia Diabetes Kidney damage Skin cancer
Functional testing	• Heart function tests e.g. electrocardiogram (ECG), echocardiogram (ECHO) • Lung function tests e.g. spirometry	Heart disease Asthma COPD

These types of tests have been chosen because they are felt to best support the main aims of the Community Diagnostic Centres – and because they are required for many priority clinical areas, such as cancer and cardiovascular health.

5. What do people in London think so far about new Community Diagnostic Centres?

In 2021, the NHS in London organised a two-phase engagement and involvement process to inform the design and delivery of Community Diagnostic Centres in the capital. This process provided an understanding of patient, public and staff expectations on the implementation of Community Diagnostic Centres.

In this two-phase process, experience-based co-design workshops were held with a diverse range of stakeholders, including patients, staff and the public from across London:

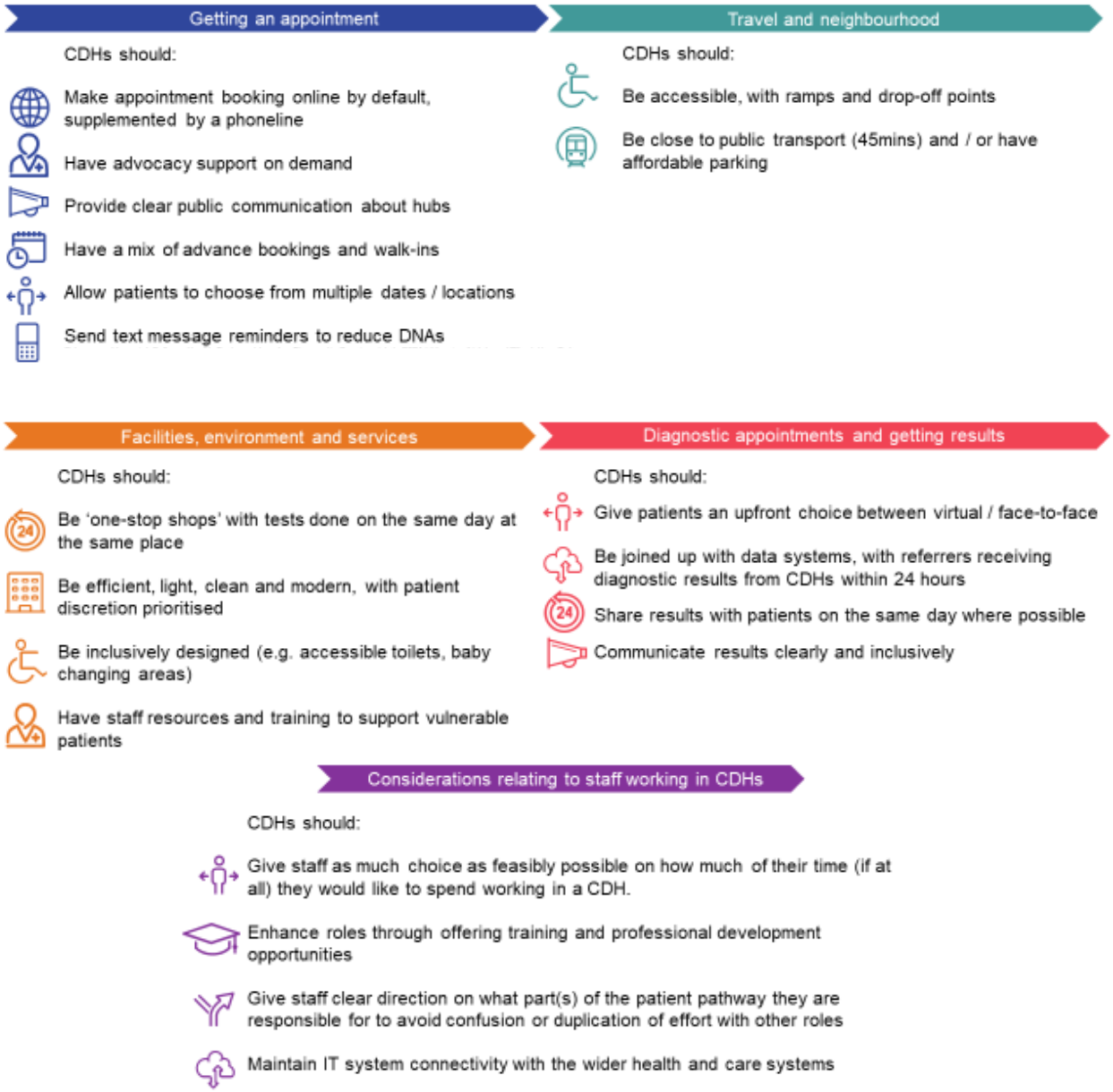
- Phase 1 – public/patient and staff participants were asked for their current views on diagnostic services in London and their feelings about potential new ways of accessing diagnostic services, through workshops and interviews.
- Phase 2 – this brought together a smaller group from Phase 1 across public/patients, diagnostics staff and advocates to co-create principles for the roll-out of Community Diagnostic Centres, with input from clinical experts to provide check and challenge.

Key findings

Cross-cutting themes from Phase 1:

- Staff and patients emphasised the importance of retaining choice of where to work or access services to fit people's different life situations.
- Waiting times were seen as more important than travel time, but patient advocates highlighted the potential adverse impacts on disadvantaged groups if CDHs were harder to access than current services.

Phase 2 design principles (summarised):



[Note: The abbreviation 'CDH' above has been updated since the co-design workshops were held to 'CDC' for Community Diagnostic Centre]

6. Plan for Community Diagnostic Centres in north west London

As described above, Community Diagnostic Centres are a national NHS initiative to build additional diagnostic capacity for planned care, based in the community and separated from urgent and emergency services in hospitals. These 'one stop shops' for checks, scans and tests are designed to be more convenient and accessible for patients.

The triple aim is to increase diagnostic capacity, improve the health of the entire population of north west London (achieving better outcomes for patients with cancer and other serious conditions) and reduce health inequalities.

National funding of £2.3bn has been allocated for developing diagnostic services and a national assurance and business case approval process has been issued for schemes to deliver new Community Diagnostic Centres.

Over time, it is expected that a large proportion of diagnostic testing in England will take place in Community Diagnostic Centres.

The new Community Diagnostic Centres for north west London will be fully integrated into the existing network of diagnostic services across the region.

For north west London, the central capital funding to create new Community Diagnostic Centres is expected to reach £44.3m over three years from 2022/23 to 2024/25.

Using this central funding we plan to establish three new Community Diagnostic Centres using existing NHS estate and situated in two areas of north west London where there are significant clusters of deprivation:

- the area of Hanwell, Southall and Greenford
- the area of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen's Park and Church Street in North Westminster

Residents in these areas are more likely to experience poorer health outcomes.

The plan is to establish three new Community Diagnostic Centres on existing NHS sites in north west London:

- a main 'Hub' with a larger facility – located at Ealing Hospital
- and two 'Spoke' facilities – one at The Wembley Centre for Heath and Care and another at The Willesden Centre for Health and Care (working together to provide the same suite of diagnostic tests as the Ealing 'Hub')

An additional 300,000 diagnostic tests per year are planned at the three Community Diagnostic Centres by 2024/25.

Proposed diagnostic tests at three Community Diagnostic Centres in north west London		
Ealing	Imaging	CT MRI Ultrasound Plain X-Ray DEXA
	Physiological Measurement	Electrocardiogram (ECG) including 24 hour and longer tape recordings of heart rhythm monitoring Ambulatory blood pressure monitoring Echocardiography (ECHO) Oximetry Spirometry, including reversibility testing FeNO, (Fraction of exhaled Nitric Oxide) Exhaled carbon monoxide for assessing smoking status Full lung function tests (volumes and gas transfer) Blood gas analysis via POCT Simple Field Tests (e.g. six min walk)

		Issuing of multichannel (>4) equipment for recordings without EEG for home sleep studies
	Pathology	Phlebotomy Point of Care Testing Simple Biopsies NT-Pro BNP Urine testing D-dimer
Willesden	Imaging	Ultrasound Plain X-Ray DEXA
	Physiological Measurement	Electrocardiogram (ECG) including 24 hour and longer tape recordings of heart rhythm monitoring Ambulatory blood pressure monitoring Echocardiography (ECHO) Oximetry Spirometry, including reversibility testing FeNO, (Fraction of exhaled Nitric Oxide) Exhaled carbon monoxide for assessing smoking status Full lung function tests (volumes and gas transfer) Blood gas analysis via POCT Simple Field Tests (e.g. six min walk) Issuing of multichannel (>4) equipment for recordings without EEG for home sleep studies
	Pathology	Phlebotomy Point of Care Testing Simple Biopsies NT-Pro BNP Urine testing D-dimer
Wembley	Imaging	CT MRI

The timeline for the three new Community Diagnostic Centres to be established and operational is based on the programme of works necessary at each of the three existing NHS sites, with anticipated opening dates as follows:

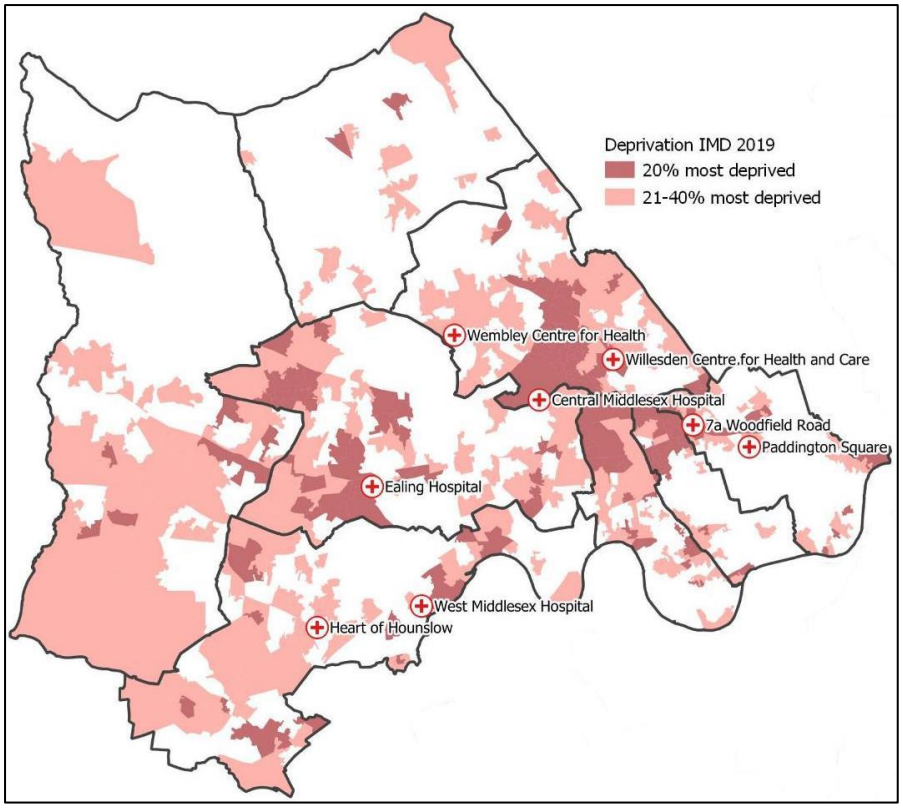
- Willesden – January 2023
- Wembley – October 2023
- Ealing – Phase 1 (Imaging) October 2023 and Phase 2 (Physiological Measurement and Pathology) April 2024

7. Reducing health inequalities and improving access

The three new Community Diagnostic Centres are strategically located in relation to two clusters of deprivation and disadvantaged communities in north west London.

Around 13 per cent of areas in north west London fall into the 20 per cent most deprived nationally. Areas of deprivation have been decreasing over time but remain persistent in two main areas:

- Neasden, Stonebridge, Harlesden, White City, Ladbroke Grove, Queen's Park and Church Street
- Southall, Hanwell and Greenford



Map of Deprivation across North West London (IMD, 2019)

There are a larger proportion of older people in the 'outer areas' of north west London, particularly in the boroughs of Harrow and Hillingdon. While 'inner' north west London boroughs – Hammersmith & Fulham, Kensington and Chelsea, and Westminster – have a larger proportion of working age adults. This has an impact on decisions around provision and placement of a Community Diagnostic Centre:

- A higher activity of X-Rays, CT and PET scans may be required in the outer boroughs, as provision increases with age for these exams
- However, age is less of a factor for the provision of MRI and Ultrasound, where provision is more level across age groups, so provision will be more universal.

The analysis of diagnostic tests uptake and access across north west London can be summarised as follows:

- X-Ray uptake is lower in some boroughs, however waiting times are comparable to London and England
- Ultrasound uptake in some parts is amongst the lowest in England, and in other parts waiting times are comparably longer
- CT uptake and waiting times are comparable with England
- MRI uptake is lower in some parts, but waiting times are shorter, where uptake is high the waiting times are longer.

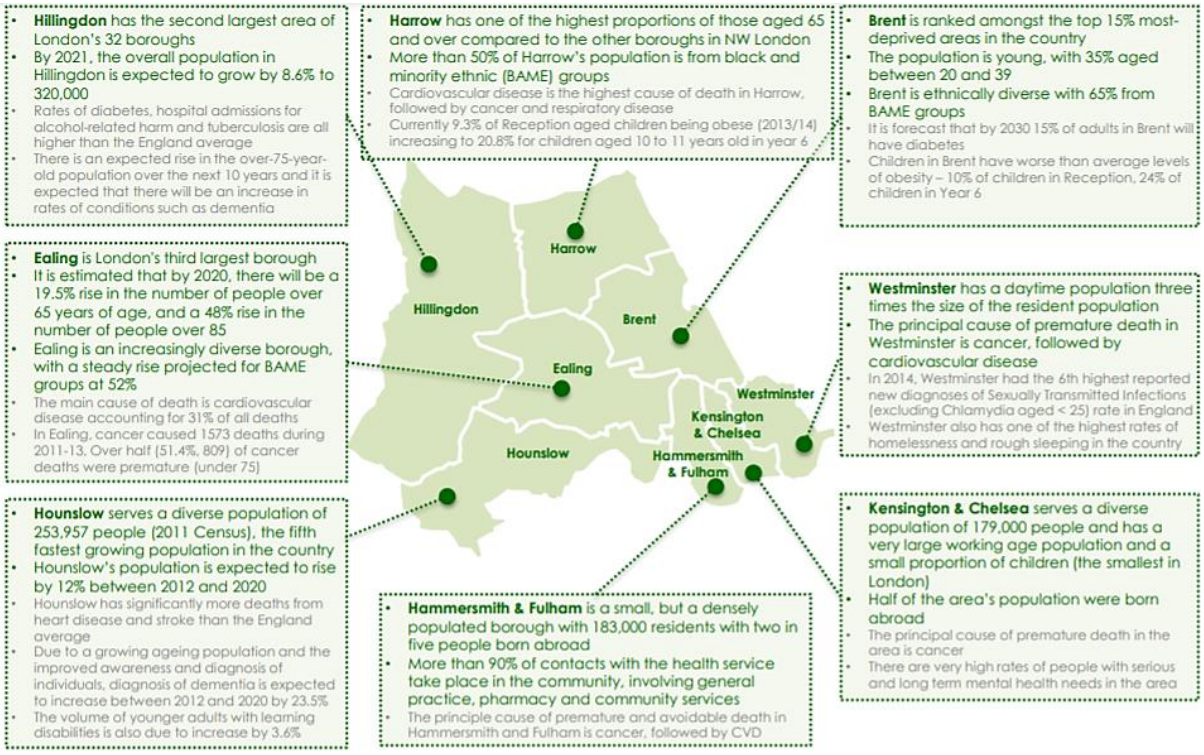
Population health data highlights that cardiovascular disease (heart disease and stroke) is impacting life expectancy, with five of the eight boroughs in north west London having a higher rate of premature death compared to both the London and national average. The boroughs of Brent and Ealing, where the Community Diagnostic Centres are proposed to be located, have the highest rates of the premature death related to cardiovascular disease than all boroughs apart from Hounslow.

While the generally aging population in north west London is likely to lead to increased demand for diagnostic services, the largest impact on future demand is expected to be from new housing developments. For example, the Old Oak Common and Park Royal areas are anticipating significant growth in population in the next 15 years with the arrival of new homes and improved transport links. These areas are currently home to some of the most disadvantaged communities within the region of north west London.

Establishing efficient and effective clinical pathways will provide additional capacity in more locations and improve the overall accessibility of diagnostic services. The new Community Diagnostic Centres will be fully integrated into the network of diagnostic services across north west London and fit with the pathway development work being undertaken across London as a whole.

The north west London Community Diagnostic Centres programme is prioritising the following pathways:

Priority Pathways	
Symptoms of possible cancer	• Targeted Lung Health Check Programme
Cardiac Symptoms	• Chest Pain • Breathlessness
Respiratory Symptoms	• Breathlessness • Asthma • COPD • COPD - Emphysema • Interstitial Lung Disease
MSK/Neurological Symptoms	• Spinal conditions (back pain)

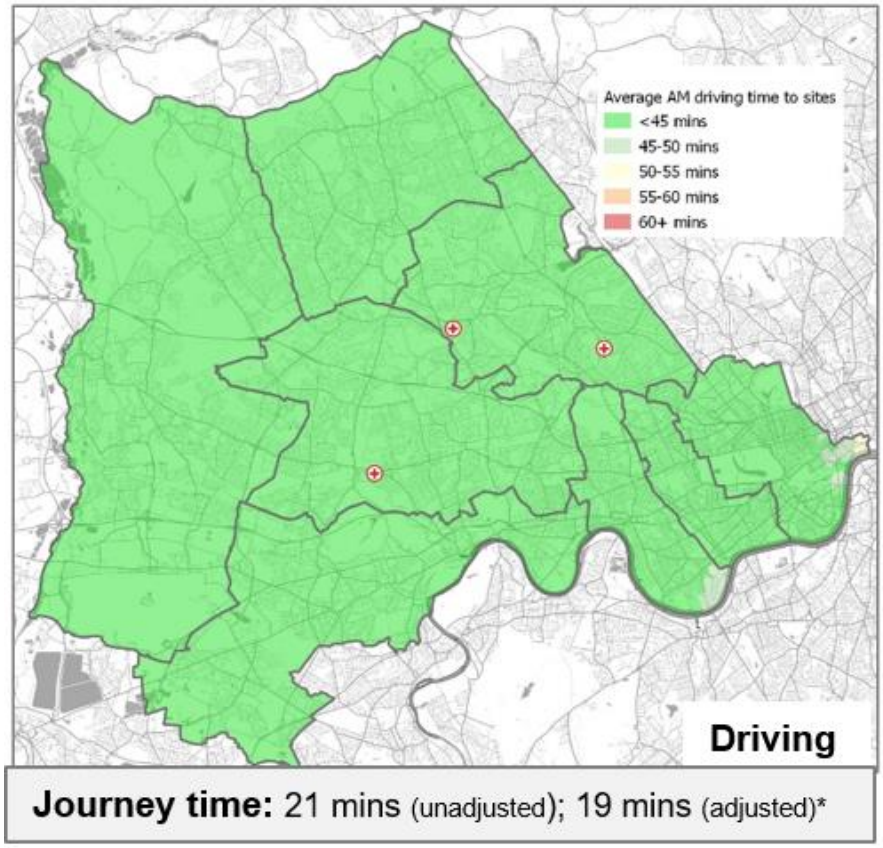


Summary of north west London population characteristics in each local borough

8. Travel times

The locations for the three new Community Diagnostic Centres are also based on the travel times to each site, projected forecast population growth (new housing developments - such as Park Royal and Old Oak Common) and new transport links (HS2 and Crossrail).

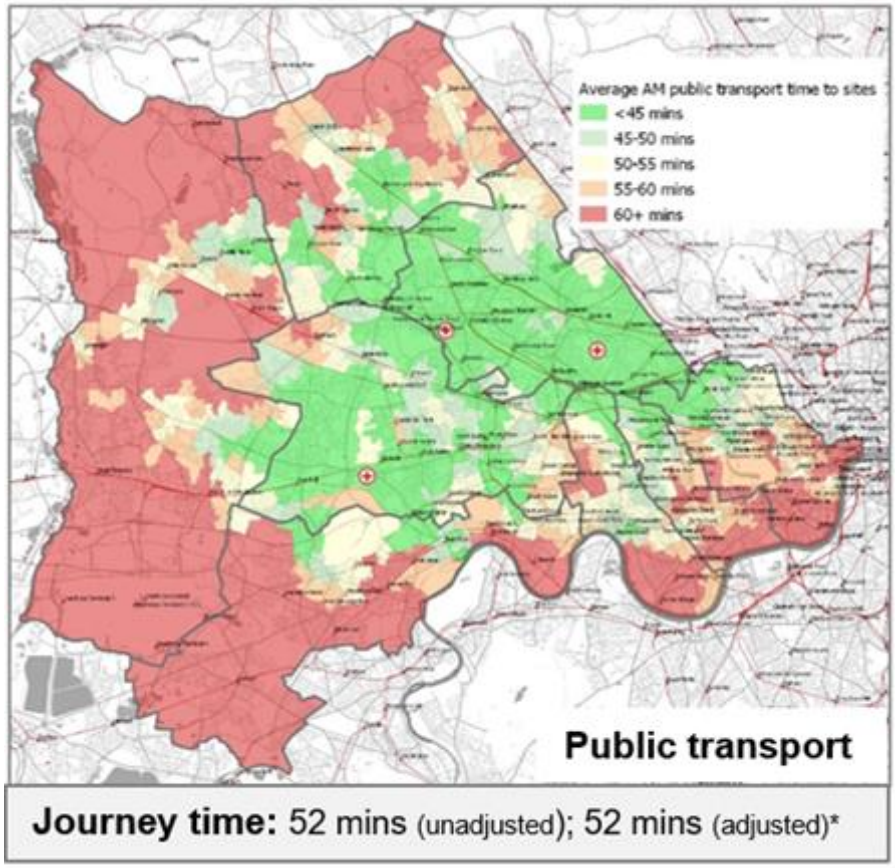
Of the total 2.4m population of north west London, 2,041,294 residents (85 per cent) would be within a 45 minute drive of one of the three new Community Diagnostic Centres.



North west London Driving Travel Times to three new Community Diagnostic Centre Sites

594,362 residents (25 per cent) could access a new Community Diagnostic Centre within a 45 minute journey via public transport.

Locating the three Community Diagnostic Centres at Ealing, Wembley, and Willesden would result in around a third of north west London residents being closer to a new Community Diagnostic Centre than their existing diagnostic testing sites.



North west London Public Transport Travel Times to three Community Diagnostic Centre sites

For the catchment area of 45 minutes travel time to a Community Diagnostic Centre, an average 15 per cent of all residents live within a deprived area.

Placing a Community Diagnostic Centre at Ealing Hospital represents the only viable NHS estate option to serve the cluster of deprivation of Hanwell, Southall, and Greenford. Ealing Hospital is the primary healthcare facility in the area and has the greatest catchment for the overall population and improved accessibility to deprived and disadvantaged communities.

The Community Diagnostic Centres at Willesden Centre for Health and Care and Wembley Centre for Health and Care would work together to serve the deprived and disadvantaged communities of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen's Park and Church Street. The two sites also complement each other – the Wembley site provides the greatest catchment area to the overall population of north west London both by car and public transport – and the Willesden site serves the highest proportion (22 per cent) of deprived residents within its catchment area.

9. Referrals

Patients would be referred to the Community Diagnostic Centres through the centralised referral system for north west London, which receives and processes referrals from primary, community and secondary care. Referral criteria for the agreed diagnostic tests are already in place and the system is already up and running.

Further improvements to the referrals process will be delivered through the introduction of an online healthcare appointment platform.

10. Staff and workforce

The increase in diagnostic capacity through the Community Diagnostic Centres programme requires a substantial increase in the workforce to provide these services. Noting both national and local challenges in the availability of the NHS diagnostic workforce, this remains a significant issue and is likely to mean using new models of working and taking a phased approach to implementation. The introduction of new roles, the clinically effective design of the new facilities and the use of technology to support the effective use of our staff are all examples of how we plan to address this challenge.

11. Digital connectivity

The NHS in north west London recognises the need to improve its digital connectivity and is already working hard to improve its systems.

Digital connectivity is key to successful delivery of each Community Diagnostic Centre particularly in relation to the access and transfer of clinical information and data. Doctors and clinicians across north west London should be able to refer for diagnostics and receive the results.

12. Further information and engagement

As described in section 5 above, initial engagement and involvement in the Community Diagnostic Centres programme was led by NHS London who organised experience-based co-design workshops in 2021 with a diverse range of stakeholders, including patients, staff and the public.

The outputs of this engagement exercise informed our approach and we are now planning to conduct more localised engagement and involvement activities across north west London ahead of the delivery of the three new Community Diagnostic Centres to assist with finalising the designs and operations.

The objective is to ensure the plans reflect and respond to the needs and views of all users in order to build widespread awareness and knowledge of the new Community Diagnostic Centres and maximise their uptake and usage.

The Community Diagnostic Centres programme aims to achieve a range of benefits as outlined in section 2 above:

- Improve population health outcomes
- Increase diagnostic capacity
- Improve productivity and efficiency
- Contribute to reducing health inequalities
- Deliver better and more personalised experience
- Support integration of care

An Equality Health Impact Assessment has been completed for each Community Diagnostic Centre business case which demonstrate there are no adverse impacts identified against any protected characteristic groups – conversely, positive impacts have been identified. Therefore, we anticipate these plans and the benefits we aim to realise will be positively received.

North West London Integrated Care System update

July 2022

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

- ICB update
- Elective care update
- Orthopaedic centre
- UTC procurement
- Primary care update
- Extended access
- Mental health update
- Vaccination programme

ICB update

- The Integrated Care Board in North West London (NW London) is called NHS NW London.
- Launched on 1 July
- It is now the statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in NW London.
- Now ICBs are legally established, clinical commissioning groups (CCGs) have been abolished.
- NHS NW London takes on the NHS planning functions previously held by clinical commissioning groups (CCGs) and is likely to absorb some planning roles from NHS England in the future.

The Board

The NHS NW London Board is the statutory decision making board of NHS NW London.

The responsibilities of the Board include:

- Developing a plan to meet the health needs of the population (based on the ICP's strategy)
- Allocating NHS resources to deliver the plan and deliver financial sustainability
- Establishing joint working arrangements to deliver the plan
- Assuring plans and metrics in place to review delivery against strategy
- Agreeing capital plans for the NHS
- Securing the provision of health services
- Holding all parts of system to account for delivery of the NW London ICS objectives and programmes (where NHS funds are used)
- Planning for, responding to and leading recovery from incidents
- Supporting collaborative problem solving and driving transformation.

Our Leadership Team is led by Rob Hurd as Chief Executive Officer. The Leadership Team members include ICB Executive Management Team and other key system leaders

ICB executive:

- **Chief Executive Officer:** Rob Hurd
- **Chief Finance Officer:** Steve Bloomer
- **Chief Medical Officer:** Dr Charlotte Benjamin
- **Chief Nursing Officer:** Charlie Sheldon
- **Director of Strategy & Population Health:** Toby Lambert
- **Chief of Staff:** Merav Dover
- **Lead Chief People Officer:** Charlotte Bailey*
- **Lead Chief Information Officer:** Kevin Jarrold*
- **Lead Director of Communications & Engagement:** Rory Hegarty*

The Leadership Team also invites:

- **ICS Lead Local Authority Officer,** Carolyn Downs
- **ICS nominated NHS Provider Trust Partner Member,** Lesley Watts
- **Lead ICS Gold Chief Operating Officer,** Rob Hodgkiss

When relevant programmes are on the agenda, additional invitees may include:

- ICS Programme Senior Responsible Officers and Programme Directors;
- potentially other ICB partner members;
- Kevin Croft as the ICB HR Director.

Elective care update

- In the latest fully validated data (May), there was a total of 230,358 patients on our (inpatient and outpatient) waiting lists. *This is an increase from the*

March figures and up significantly from the April 2021 position of 165,210. The (patient list) PTL is seeing a pattern of around 5000 patients increase each month for the past year.

- We have managed to achieve 85 per cent of pre-pandemic planned care activity and we are working towards the national target of 104 percent of cost weighted activity or Q1 2022/23. We are regularly monitoring theatre utilisation across all sites, drawing on comparative data nationally and regionally.

- We continue to prioritise according to clinical need while also bringing down very long waits. Our two-year waits are down from a peak of 127 in July 2021, to nine in April 2022 and a commitment to have no one waiting two years in June 2022. *The 52 week wait position for May 2022 is 43,064. This is down from last month and significantly down from the April 2021 position of 5727.* Working collaboratively, in 2021/22, we were able to offer over 3,500 patients the opportunity to have their surgery faster by transferring to another local hospital with more capacity and shorter waiting lists. *This reduces variation in waits across our boroughs.*

Exploring a NW London elective orthopaedic centre

- Building on the concept of fast-track surgical hubs, we have begun to explore a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery, beginning with a specialty with some of the longest waits. The driver is to improve quality as well as to significantly expand access and shorten waiting times. A public involvement programme to help shape proposals is underway.

Real-time, single view of our waiting lists and capacity

- We have established a common data infrastructure with a single view of our waiting lists and we have also begun to pilot a new digital platform to give clinicians – and eventually, we hope, patients – better visualisation of demand and capacity data and greater ability to use that data to schedule work and priorities within their services.

Addressing our waiting lists

- In the coming months the acute Trust's activity levels are planned to increase to an average 107% of BAU (based on 19/20 activity levels) in order to achieve the 22/23 target of 104% of cost weighted activity throughout the year.

Other new models of care

- With partners in north west London, we are beginning to explore how we can develop improved models of care across all key specialties. One priority is ophthalmology care as the specialty has high waiting times and there is potential for much more integrated working across different teams and services. We also have a particular challenge with ophthalmology capacity currently with fire safety issues causing the temporary, partial closure of the Western Eye Hospital.

Outpatient care

- We are at over 99 per cent of our pre-pandemic outpatient activity, and working towards the national targets of 104 – 110 per cent for 2022/23.

- Now rolling out a digital GP advice and guidance platform. This will make it simpler and faster for GPs to access specialist opinion without having to make a formal hospital referral, helping them to support patients in the community where possible and enabling automatic conversion into a referral if a patient does need to see a hospital specialist.

Cancer care

- Urgent cancer referrals (on the 'two-week' pathway) continue to remain higher than pre pandemic levels. 748 more patients were seen in March 2022 compared with 2019/20 pre-pandemic baseline. Performance against the national 'faster diagnosis' standard is stable at over 75 per cent against the target of 75 per cent of patients being informed whether they have cancer or not within 28 days of urgent referral as of March 2022.

Overall, as of March 2022, 491 more patients have received their first treatment for cancer against the 2019/20 baseline.

Urgent treatment procurement

The current contract for provision of Urgent Treatment Centres (UTCs) at seven of the acute sites in North West London expires in November 2022.

NHS North West London is running a process to re-procure these services. This process will be run according to competitive dialogue principles and will assess bids against the nationally-mandated UTC standards. In a departure from the previous contracting round, we have taken the decision split the procurement into four lots, based around the geographies of the Trusts which host the UTCs.

This approach is intended to improve the number and quality of the bids we receive, encourage bids from providers (such as NHS Trusts) with less interest in running a large number of different UTC sites, and maximise the focus on local populations and service configuration.

A letter has been drafted with further details of the procurement, which also details the approach to public engagement.

Primary care

- GP appointments available in NW London continue to be above the April 2021 baseline with an additional 23.7% appointments in May/June 2022.

Month	Finished/Completed GP Appointments (Brent excluded)	NWL Finished/Completed GP Appointments	Estimated NWL GP Appts (inc DNAs)	% Difference
Apr-21	724,405		905,506	Baseline Month
May-21	709,304		886,630	97.9%
Jun-21	814,162		1,017,703	112.4%
Jul-21	780,690		975,863	107.8%
Aug-21	719,477		899,346	99.3%
Sep-21	862,558		1,078,198	119.1%
Oct-21	921,886	1,080,313	1,152,358	127.3%
Nov-21	963,168	1,124,325	1,203,960	133.0%
Dec-21	795,330	937,705	994,163	109.8%
Jan-22	837,587	984,454	1,046,984	115.6%
Feb-22	842,937	988,119	1,053,671	116.4%
Mar-22	973,346	1,142,415	1,216,683	134.4%
Apr-22	782,463	935,277	978,079	108.0%
May-22	895,809	1,063,623	1,119,761	123.7%

Moving from Covid recovery to Fuller Stocktake

- The 'Next steps for integrating primary care: Fuller Stocktake report' was published outlines a new vision for integrating primary care. At the heart of the document is the need to evolve Primary Care Networks into 'neighbourhood teams of teams'.

Therefore, the previously defined primary care recovery and reset model has now been aligned to the ambitions outlined in the Fuller Review. The main areas of focus are:

- Accessible same day care
- Enhancing long term conditions management
- Improving population health and wellbeing

Work is ongoing to align existing primary care programmes of work to the above focus areas.

Extended access

Currently, "extended" access is provided in three ways:

- PCNs deliver extended hours' access under the Network Contract DES (£1.44pp) at 30min/1000 population delivered mostly by member practices

- Previously - CCGs commission extended access services locally, across 7 days a week, 8-8 cover, 30mins/1000 population (£6pp). Many of these services are currently delivered by federations and other at-scale providers, with large variation across the country

- Practices also receive £30m in global sum (approx. £0.50 pwp) to support 100% coverage of extended access.

The new Network DES arrangements from 1stOctober 2022:

- Aim to remove variability across the country, help improve patient understanding of the service, and address inequalities. They will bring the ARRS workforce more consistently into the offer, and support PCNs to use the EA capacity for delivering routine services.

- PCNs are able to choose to deliver the service themselves or sub-contract delivery to another provider. Commissioners will help to support any transition of arrangements and planning.

- PCNs have flexibility to use the EA capacity where it is most needed. They will be able to provide a proportion of Enhanced Access outside of EA hours, for example early morning or on a Sunday, if aligns with patient need locally and agreed with the commissioner.

- 15,000 residents responded to our survey on hours to help us develop hours that best suit local need.

- The aim of the changes is to help PCNs to have greater control and flexibility over how EA capacity can support them in caring for their patients. These changes aim to maximise the benefit of this capacity.

Mental health update

Community mental health

- **Outreach funding** to support uptake of physical health checks by people with serious mental health issues is being used to mobilise support from VCSE partners to ensure NW London meets the target of 60% of those on the SMI register receiving all six checks.

- Continued progress has been made on recruitment to **mental health practitioner** roles within primary care networks with 33 WTE in post and discussion underway for further expansion. These roles are supporting people to access mental health support locally at their GP practice.

- A **single service specification for dementia** services in NW London has been developed with the aim of setting out standards expected of memory assessment services, primary care and improving variation in post diagnostic support.

- Kensington & Chelsea CNWL Employment service was awarded **Team of the Year for delivering outstanding employment outcomes** during the pandemic.

- London **perinatal mental health service access** saw an achievement of 72% of our planned trajectory. None of the 5 London ICSs met the national target, however **North West London the highest achiever at 84% of trajectory.**

- **IAPT access is below trajectory in London**; no ICSs have met the targets. Focus remains on workforce expansion, retention and increasing referrals directly from primary care.

- An **evaluation report** of community mental health transformation work has been produced with recommendations for future development.

Crisis care

- Performance remains good across **community crisis services and liaison psychiatry** in A&E departments.

- Walk-throughs of each acute site A&E department were completed in May with key themes feeding into a **NW London-wide system Mental Health and UEC Summit** in June to agree next steps along with actions to address system-wide challenges.

- There is a **renewed focus on 111 First for Mental Health** and developing a model for NW London that provides a single ICS solution is being progressed.

Children & Young People

- NW London **exceeded the access target in 2021/22**. In total, 16,900 CYP with a diagnosable mental health condition accessed NHS-funded community services (1 contact) in the 12 months to February 2022, a 13% increase compared to the previous year (15,000). It is anticipated that core CAMHS will continue to exceed the access target throughout 2022/23.

- Performance against the **eating disorder waiting time standards has improved** in NW London. From January-March 2022, 95.7% of urgent referrals were seen within one week; a year-on-year improvement of 3 percentage points. Over the same period, 88.1% of non-urgent ED cases were seen within four weeks – up by 14 percentage points compared to the previous quarter.

- Mental Health Support Teams (MHSTs) continue to develop across NW London with a focus on additional support for specific issues, such as staff turnover, implementing the Whole School Approach, and data reporting, arriving at consensus-based solutions with support from the Programme Team as needed. It is expected that this will **drive up the output and quality of MHSTs**.

Learning disabilities and autism

- 78% of people with LD aged 14 and over received an **annual health check** in 2021/22, exceeding the national target (75%). A letter has been circulated to all practices in NW London accompanied by an email from our primary care clinical leads outlining the importance of providing annual health checks for people with LD who did not receive a 2021/22 by 30 September 2022 and to reinforce the importance of face to face appointments.

- Continued **investment in community and crisis services** and strengthened **Dynamic Support Registers** has had a positive impact on preventing inpatient admissions and reducing length of stay - NW London met the end of year 2021/22 targets for inpatient numbers for CYP (9) and adults (52).

- An improvement plan arising from the 58 **Safe and Wellbeing Reviews** of patients with a learning disability and / or autism placed in mental health and specialist LD inpatient settings has been developed and work is being progressed to strengthen oversight arrangements to address quality concerns and barriers to discharge.

- Work is underway to finalise the **annual LeDeR report for 2020/21** which includes an analysis of the findings from the reviews of the deaths of people with LDA. The report highlights good practice and areas for improvement and recommends actions to reduce health inequalities. An expert panel of people with LD will contribute to the development of an Easy Read version.

Vaccination programme

- With the rise in Covid-19 rates we continue to push the Spring Booster

- More than 94,420 doses delivered to all eligible populations.

- The wider roll out to 5-11s group overall remains low with uptake currently sitting at 7.6% (as of 20th June).
  The NW London Operations (roving) Team continue to provide an enhanced offer for 5-11s with multiple pop-ups to
  create a greater range of options for parents. The Health Hopper Bus was launched at the end of May to further
  support uptake for children and their families.

- Overall uptake for 5-11s in these settings mirrors wider uptake figures in other vaccination locations but feedback suggests that pop-ups offer a greater range of options for parents in terms of access and therefore will continue for foreseeable future.
- The planning guidance for the autumn campaign has now been issued, systems are asked to plan for a maximum cohort of 1-9 and minimum of 1-6. We awaiting final inclusion criteria from the JCVI. The campaign is expected to commence in early September and we are required to submit our plans to NHSE by the end of July. This submission will collate the sites interested in participating in the autumn campaign and the planning team will have discussions with each borough to consider and reflect their implementation plans.
- NHSE have recently published additional guidance and information on Making Every Contact Count (MECC) with expectation that all sites provide the minimum level of intervention e.g. using promotional materials at vaccination sites to highlight health issues and also where people can find support if required. NWL Operations Team (CP House) are in the final stages of developing an implementation plan for wider MECC delivery and have created referral and signposting pathways for use by the operations team where high risk factors e.g. hypertension are identified. Local Authority colleagues have supported by providing information on locally commissioned services enabling a comprehensive borough by borough directory. This service is expected to go live w/c 27/6 and will be rolled out in a roving model in July and continue throughout the autumn.

ICB involvement strategy

Following a process of co-design with local; residents over the last three years, we have published a draft North West London public involvement strategy. Comments on this are sought by 29 July and it will be discussed at our first open NW London Residents' Forum on 27 July. The draft strategy has been shared with members and builds on many previous conversations we have had at this committee.

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North West London
Integrated Care System

Addressing health inequality across North West London

Health inequality is a major problem for North West London

People in less well off areas are more likely to have a disability and/or be living with a long term condition. People from a Black, Asian or other ethnic minority background are more likely to live in less affluent areas, as are people who are less well educated or working in lower paid jobs.

People from these populations can find it harder to access healthcare, receive a high quality service and get a good health outcome. They have fewer opportunities for better paid jobs.

The Covid-19 pandemic has both increased health inequality in North West London and shone a spotlight on it.

Over the next five years, we're determined to transform care to ensure greater equality of access, experience and outcomes. This will include tackling difficult issues like structural racism and poverty.

We know we can only achieve our aims by working directly with people and communities, we set out our ambition inside

Addressing health inequality across North West London

The levels of health inequality, globally, have been made worse by the Covid-19 pandemic.

On a local level, our populations have been heavily impacted by the challenges of the pandemic and the pandemic has shone a light on a range of inequalities across North West London. We need to act now to ensure we identify and address them.

Did you know...?

many boroughs across North West London have wards where babies born (especially baby boys) have a shorter life expectancy than in other wards by as much as 15 years.

We are determined to work with our local communities to ensure equality of access, experience and outcomes

- Reduce inequalities in health outcomes
- Reduce inequalities in access
- Enhance economic/ employment impact of our work
- Reduce inequalities of experience

North West London at a glance

North West London has a diverse population of over 2.4 million people across eight London boroughs, comprised of over 173 wards and served by over 470 councillors.

We have over 360 GP practices arranged into 46 Primary Care Networks, and 12 hospitals, including two major mental health providers.

Below is just an illustration of some of the key challenges we face

Westminster has the highest **overall number of people sleeping rough**, most of whom will have mental health needs and they will be less likely to access primary care services

Life expectancy is

7.2 years lower for men

5.5 years lower for women

in the most deprived areas of Hillingdon than in the least deprived areas

Nearly four times as many children live in poverty in Hammersmith & Fulham's poorest ward

45%

as in its richest ward

12.2%

In Hammersmith and Fulham, **20.7%** of children in Year 6 are **classified as obese**

29%

of children in Westminster are **from low income families**, versus 13.9% in Harrow

17.1% of people in Hillingdon smoke, versus **9.2%** of people in Ealing

33%

In Brent, 33% of **people live in poverty**, higher than the London average of 28%

Rates of emergency hospital admissions for **self-harm are twice as high in Hounslow** as they are in Harrow

Alcohol admissions in Ealing are above the average in England, with over 2,200 admissions per year

Kensington & Chelsea has the **greatest income inequality** in London

Inequalities in health outcomes - our challenges

Racial inequality

North West London benefits from a diverse population. More than 50% of the population in some of our boroughs come from a black, asian and other minority ethnic (BAME) background.

This is something we should be celebrating, yet, we know that our BAME populations are often disproportionately affected by health inequalities.

At around the peak of first wave of the pandemic, compared to White Londoners, Black Londoners were up to to three times more likely to die with COVID-19 (within 28 days of diagnosis) and people of Asian ethnicity were up to twice as likely.

The proportion of our Black residents who are reluctant to take the Covid vaccine has also exposed a long-standing lack of trust and confidence in the healthcare system as a result of lived experience.

If we want to tackle these differential outcomes, we need to build confidence and trust with our communities.

To do that, we need to work with and truly understand our communities, their different views and cultures and their experience of our services. We need to work together to come up with solutions that influence long-term change and start to tackle our differential outcomes

More than 50% of the population in some of our boroughs come from a black, asian and other minority ethnic (BAME) background

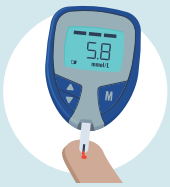
Long term conditions

21% One in five (21%) of our population is classed as having complex health needs.

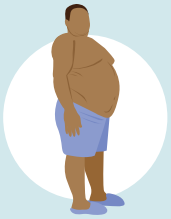
16% of the population has one or more long term condition.

Our data and information tells us some of our most prevalent long term conditions across North West London include:

Hypertension



Diabetes



Obesity

Anxiety and Depression

Sickle Cell

We'll take a new approach towards reducing long-term illness. This will include understanding and tackling the impact of deprivation and race.

Waiting times for planned care

We also know that the pandemic has led to many residents waiting longer for planned specialist care in our hospitals

18 WEEKS

As of September 2021, there were over **50,000** people waiting longer than 18 weeks from referral to treatment. This is **more than double the number from the same time in 2019**.

52 WEEKS

The number of people who have been waiting over one year from referral to treatment had risen more from **384 in April 2020 to 4,351 in September 2021.**

Before Covid, health inequalities in North West London were already stark. Covid has made them worse.

If we continue to work in the same way, not enough will improve. So we need to think and act differently.

Economic Impact

Covid has worsened economic inequality in North West London. Unemployment and lack of opportunity disproportionately affect those living in the most deprived areas, which include many people from BAME communities.

In 2020, West London's economy took a proportionally harder hit from the impact of the pandemic than other places, contracting by 10.7% (£8.1bn)[1], higher than the 9.4% decline across London or 10% nationally. This wiped out all growth since 2013.

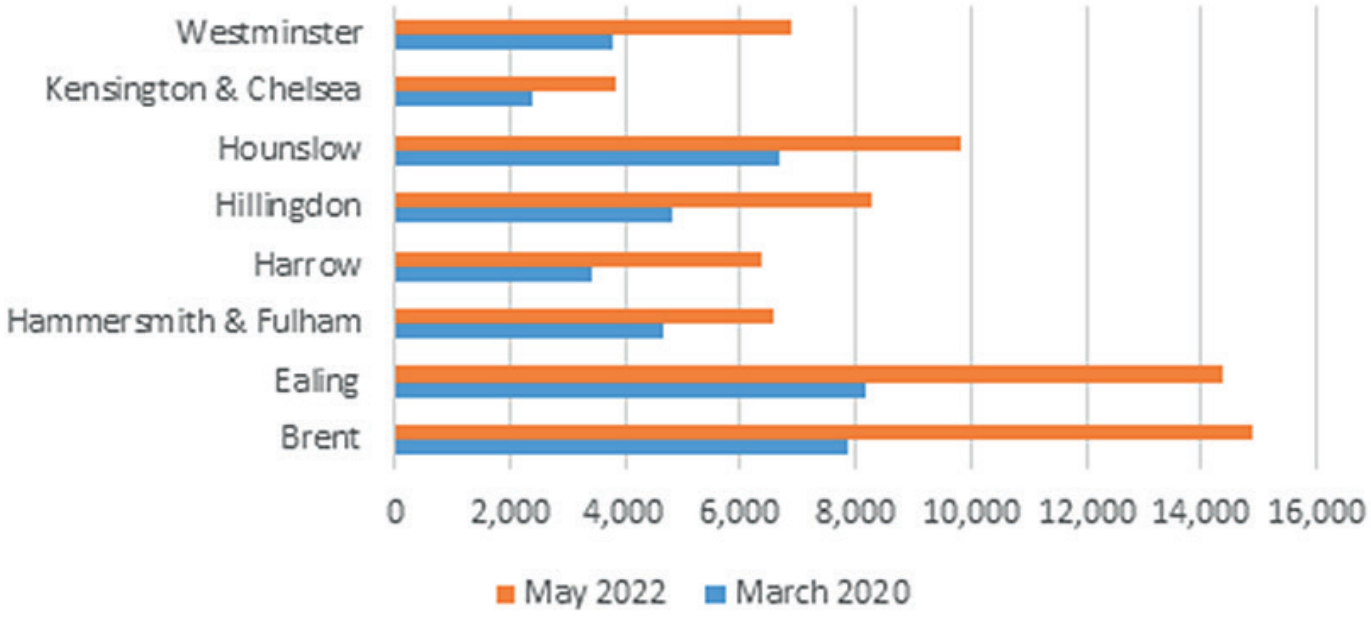
While numbers out of work have begun to recover, the number of people across North-West London claiming out-of-work benefits was some 29,000 higher in May 2022, compared to March 2020 – 70% higher, compared to the rate across Great Britain being 29% higher. In March 2020 the average claimant count rate in North West London was the same as across Great Britain (3.0%); in May 2022 it was one percentage point higher, at 4.9%. Job numbers are not expected to recover to pre-pandemic levels until 2023.

In 2020, West London's economy contracted by

10.7%

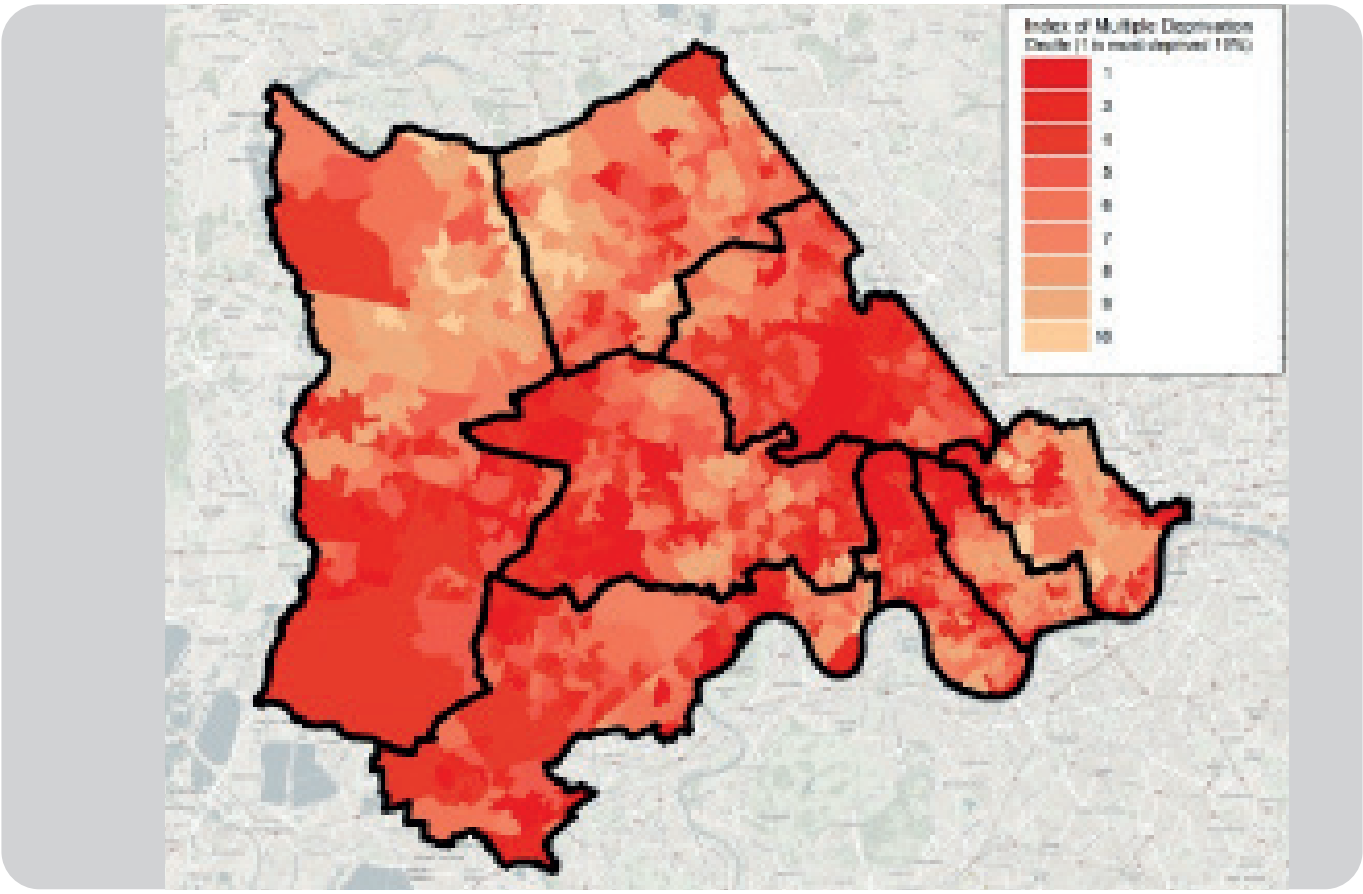
or £8.1bn, higher than the 9.4% decline across London.

Numbers of residents claiming out of work benefits in March 2020 and May 2022



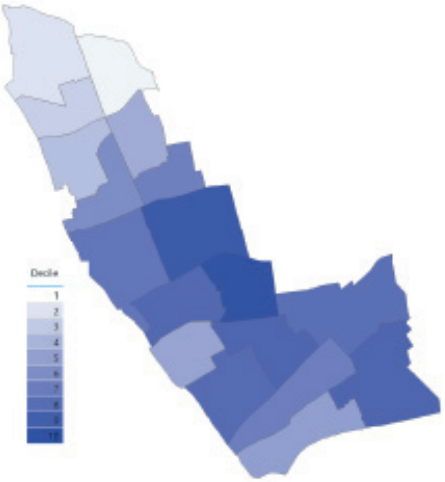
A decile is a dimension which places the deprivation scores of individual areas into one of ten groups of equal frequency, ranging from the 10% most deprived areas to the 10% least deprived areas.

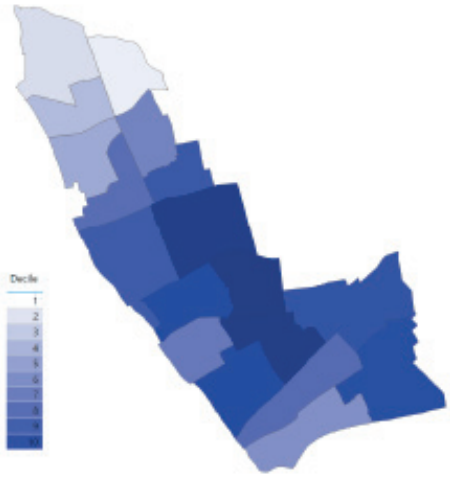
This graphic to shows the levels of deprivation across the 8 North West London ICS boroughs. The darker the red, the more deprived that areas is.



An Index of Multiple Deprivation (IMD) is used to identify how deprived an area is. It uses a range of economic, social and housing data to create a single deprivation score for each small area of the country.

Income Deprivation Affecting Children Index (IDACI)





Unemployment was

70% higher across North West London May 2022 compared to March 2020 (29,190 people);

the rate nationally in May 2022 is **29%** higher than March 2020

2023 year by which job numbers are expected to recover to pre-pandemic levels

---

66,100 number of working age people across North West London with no formal qualifications[2]

Average unemployment in May 2022 across North West London was **4.9%** compared to **3.9%** nationally

---

People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both men and women.

*This data covers the West London Alliance geography, so includes Barnet but not Westminster or Kensington & Chelsea.

What will this work mean for the people of North West London?

In recent months our Covid vaccination programme has demonstrated how we can make a real difference with our communities, using data to identify the most vulnerable, targeting support based on this, providing accessible healthcare that fits in to peoples lives. We want to build this approach into all our work.

Our work over the next five years will be informed by using good data, gaining first-hand insight from local communities and working in a new way.

We're at the start of this journey and we recognise we'll improve and mature as a system and learn as we go along.

Our activity will build on insights from our outreach and engagement work to date, including how Covid has affected different groups, especially people in the most deprived areas; improving vaccine uptake and equity of access; and the need to achieve equality beyond Covid, listening to community voices to reframe how we offer services.

We will be guided by the following overarching principles in all that we do

1. **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

2. **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.

3. **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

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

We recognise this new approach may be challenging for people at all levels of the health service. Those heading organisations will need to lead by example. We'll develop a series of Leader Pledges – specific commitments around changing cultural and corporate barriers to health equality. We'll embed rapid improvement, co-production and learning methods throughout our programmes.

We will deliver on these pledges aligned to our guiding principles:

- All of our programmes will have a central focus on our four objectives (shown on pages 11 and 12)
- Our organisational leaders will lead by example and be clear about what this means to the people of NW London
- Based on service access, citizen experience and outcomes, we will work with communities to build indicators to measure success for an equal society in NW London.
- Shift power – to ensure patients, citizens and local communities are at the heart of the work and are directly benefitting at all stages of the process
- Develop a series of Leader Pledges that provide tangible commitment(s) to changing the organisational culture and corporate barriers to address health inequalities
- Acknowledge structural racism as one of the key causes of current health inequalities and listen to and work with our BAME communities to develop solutions that influence long term change and tackle differential outcomes and experience.
- Be really clear about WHAT it is we want to achieve; and HOW we think our actions will lead to that desired outcome
- Build insights and monitor progress by combining quantitative data with qualitative insights and sense-making gained through community engagement
- Embed rapid improvement, coproduction, and learning methods throughout our programmes
- Actively build partnership and trust by bringing together people from local authorities, community groups and NHS organisations
- Utilise the energy and expertise of existing networks, communities, work streams and people we have across our system, rather than re-inventing new structures
- Build trust through growing a culture of openness and transparency around the work – be clear about which conversations, meetings and groups are for listening, learning and sensemaking, and which are for decision making
- Demonstrate vulnerability, humility and honesty where we don't have answers
- Listen to local people, demonstrating humility and honesty where we don't have answer

Our four objectives

1. Reduce inequalities in health outcomes

2. Reduce inequalities in access

3. Enhance economic/employment impact of our work

4. Reduce inequalities of experience

So what do we plan to do?

Our commitment

Starting from now and over the next five years, we want to see North West London rapidly progress towards a place full of healthy communities, where we can – as individuals, families, and friends – all contribute to (and benefit from) inclusive economies, lead flourishing lives, and maximise our wellbeing and independence.

5 YEARS

Guided by our pledges, our focus on ensuring equity of outcomes, access and experience in all our services will enable us to deliver on this commitment. We'll deliver our work in three domains:

1. Building health equality

In our first year our focus will be on reducing the gap in outcomes, experience and access for our residents across.

- Covid-19 and flu vaccinations
- Planned hospital care
- Long-term conditions.

2. Strengthening local economies

Race equality will be at the centre of all our work to support an inclusive economy and healthy communities to maximise life chances and opportunities through direct and indirect employment.

3. Measuring our impact

To ensure we continue to learn and improve.

DOMAIN 1:

Building Health Equity

Our ambition is to further the existing population health management work we already do and build on this to ensure we have a consistent approach across all of our boroughs.

To stop dealing with the symptoms (e.g. acute care), we have to do more to address the causes. These are not simply clinical interventions, but require leadership, co-ordination, and co-production across NHS, local authorities and local communities. Covid-19 vaccination highlights this approach well.

One lesson from the Covid pandemic is that people are more likely to get vaccinated when this is made easy, eg through pharmacies, vaccine buses and pop-up hubs. We'll shape accessible healthcare that fits into peoples lives, based on listening to what they tell us.

We'll involve residents directly and genuinely in shaping the health services they receive, working in 'co-production'. Rather than just ask them to agree or disagree with our ideas, we'll develop the ideas together with them from the start. And we'll ensure authentic engagement between NHS organisations, local authorities, community groups and residents, expanding on existing networks and arrangements.

We'll demonstrate vulnerability, humility and honesty where we don't have answers. And we'll be inclusive, working with disparate communities, listening hard, valuing everyone's voice and thinking about the language we use at all times.

We'll extend our population health management activity, taking a consistent approach to care across North West London that actively tackles the causes of ill health as well as the symptoms. This will make better use of data about things like people's behaviour; service access, usage and quality; and the social determinants of health, such as where people are born, grow up, live, work and age, and the opportunities they have.

Insight from community engagement suggests that building equity and, indeed, trust in our services will require us to work in a new way with BAME residents. Our first step will be to listen – to understand at first hand BAME residents' lived experience. We'll then work with them directly to improve how they are treated, making any systemic changes required so as to build equity of access, experience and outcomes.

Our initial focus will be on supporting three specific areas:

Covid and Flu vaccinations

Covid-19 continues to present challenges for our community. We have made great progress in vaccinating many of our North West London residents to date but our work is not done. We will make vaccination as easy to access as possible.

Planned hospital care

As a result of the pandemic, many people across North West London have faced long delays in accessing planned hospital care appointments for services. We will ensure we do everything we can to fulfil appointments as soon as possible so the number of people waiting for support is reduced quickly and equitably.

Long term conditions

Supporting primary care networks and borough teams to work closely with residents, including those from differing BAME communities, to agree the main areas of focus – such as diabetes, cardiovascular disease, respiratory challenges and sickle cell disease – and work to improve outcomes.

DOMAIN 2:

Strengthening Local Economies

As mentioned, North West London is facing a major economic challenge, with a knock-on impact on our residents' health. The NHS and local councils are 'anchor institutions' – often the biggest employers and spenders in their boroughs.

Hospitals, GPs, health organisations and councils already employ more than 60,000 people across North West London. West London councils 'Build and Recover Plan' is working to mitigate the damage caused by Covid and support local communities, especially those hardest hit. We can do more together.

Our councils, hospitals, GPs and health organisations employ over 60,000 people across our community, in a wide range of jobs.

However, we can build on this further. Specifically we will focus on:

1. Vaccination centre staff retention

Offering continued employment and volunteering opportunities to all our locally-recruited staff and volunteers, many of whom were previously unemployed or furloughed.

2. A new model for NHS recruitment in NW London

A new model for NHS recruitment across NW London which draws on the diverse NW London talent pool, providing local jobs for local people.

3. Skills and training

Helping residents get work in healthcare by identifying pre-employment training needs and offering training through a local Health and Care Skills Academy.

4. Volunteering to employment strategy

Building on our current best practice to develop a clear career pathway to employment for our many NHS volunteers.

5. Special educational needs and disabilities

Increasing inclusion in volunteering and pathways to employment of people with a learning disability and autism to improve employment and health outcomes.

6. Procurement

Social Value is generally recognised as achieving extra community benefits through procurement.

NWL is developing a Social Value (SV) policy that is aligned to NHSE to empower suppliers to give back to local communities.

A significant part of our Build and Recover Plan will be our focus on 'green recovery'. This will bring focus to three specific ambitions:

- Improving energy-efficient standards and development of low carbon heating networks
- Supporting West London to be a national leader in key elements of the green economy
- Redefine town centres and neighbourhoods as low carbon, low pollution economic hubs, through a systemic change to town planning

DOMAIN 3:

Monitor and measure our impact

To measure how well we're achieving our goals and to hold ourselves publicly to account, we'll use health data better and work collaboratively with residents, to build indicators that monitor progress and outcomes (a 'quantitative and qualitative' approach).

We'll develop a dashboard that shares insights across North West London boroughs, from clinical data to BAME residents' perceptions.

This will provide evidence for identifying the priority areas of health inequality to tackle. Alongside the data, listening to what our community is telling us will give us further evidence.

The dashboard will make full use of our Whole Systems Integrated Care toolkit, which is one of the most complete health and care datasets in Europe. We'll look locally and nationally to identify areas of best practice and benchmark our performance.

Whole Systems Integrated Care (WSIC)

is one of the most complete data sets for health and care in Europe and will be a crucial part of our dashboard build. The skills and experience of our analytical teams allow us to analyse our data and pull out some of the key priority areas for NWL.

The voice of our community will be essential in helping provide information that can be used alongside our dashboard.

We will continue to work closely with organisations such as Healthwatch and local community and voluntary sector groups to capture this insight and apply learning from it.

This part of our work will also support our local boroughs' public health leaders and our hospitals, to feel confident in interpreting data and information.

We will look locally and nationally to identify areas of best practice and benchmark our performance.

The key part of this domain will be in holding ourselves to account and ensuring we deliver against what we set out to do.

Jargon buster

- **'Population health management':** By this, we mean an approach to improving the physical and mental health of our whole population.
- **'Health outcomes':** By this, we mean the outcomes residents have when they receive treatment or advice from healthcare services. We know that outcomes vary widely between different populations.
- **'Health inequalities':** Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.

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

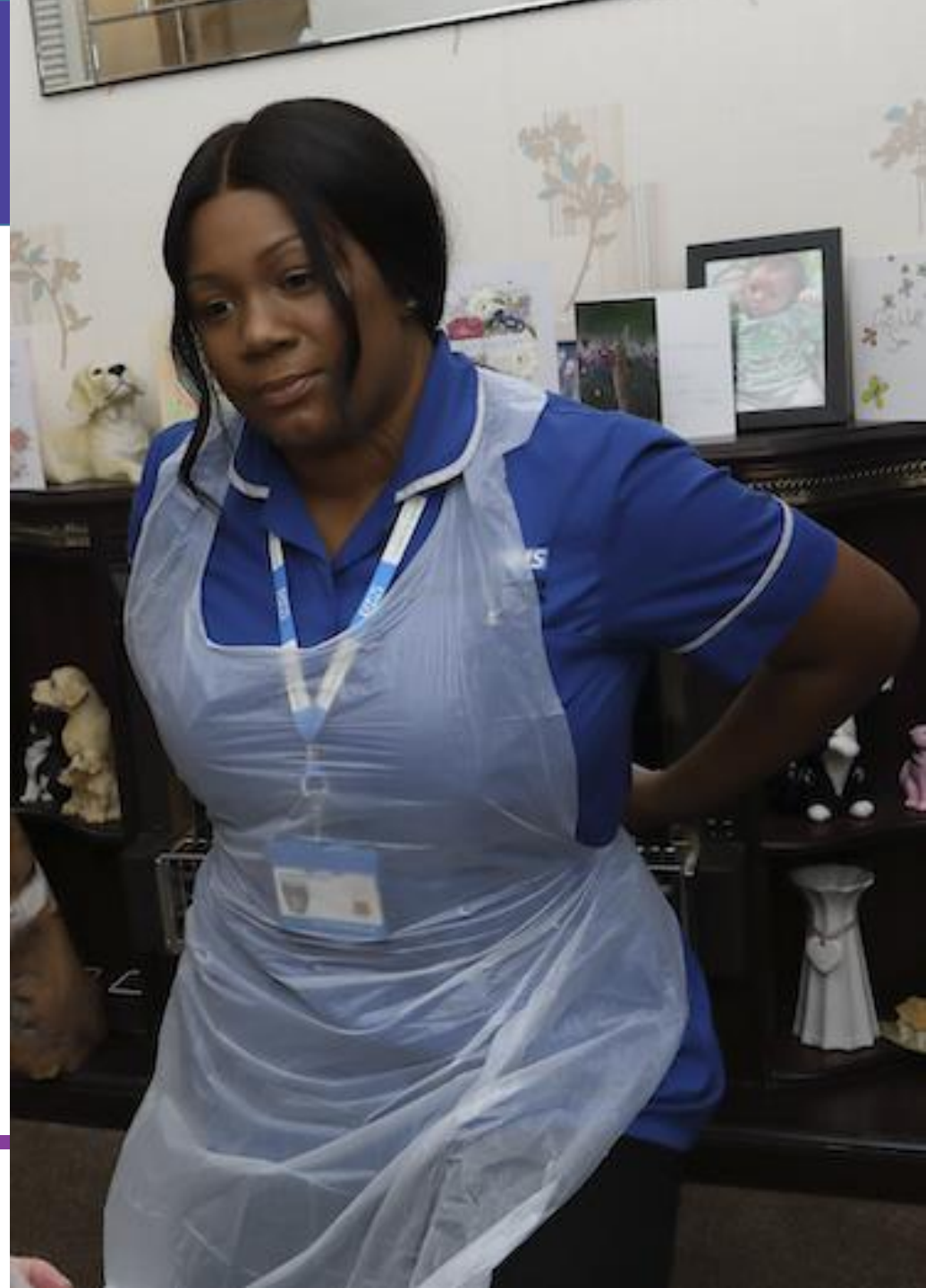
Joint Health Overview & Scrutiny Committee
Addressing Health Inequalities Framework Briefing

Carolyn Regan Joint SRO ICS Population Health/Inequalities Programme
Toby Lambert Director of Strategy and Population Health


0300 1234 244

Executive Summary

- This briefing updates NWL JHOSC on how we propose to engage our communities and residents to co-produce solutions and interventions that will overcome barriers to reducing health inequality
- We recognise that Covid-19 has exacerbated those inequalities within our communities. As one of the key drivers is a lack of trust, particularly amongst our black community, we include understanding barriers from a structural racism perspective as part of the approach.
- The approach includes publishing an NWL-wide Health Inequalities framework which summarises and highlights where our communities and residents currently experience inequalities. This framework includes the wider determinants of health and the proposed approach to addressing these, and acknowledges what our communities have already told us.
- The framework was developed in partnership across the system including local authorities (both officers and elected members), our voluntary sector and stakeholders from our communities



Executive Summary

- Our proposed approach fits will with the ‘Core20 Plus 5’ framework (developed by NHS England’s health inequalities team) - the ‘Plus’ element stresses engaging communities on what matters to them.
- We intend to publish the framework this month and ensure that it is cascaded to stakeholders. We are planning engagement events collectively with local teams (local authorities, voluntary sector, NHS) that will start in September. Feedback from the events will be an important input into the ICS’ strategy
- The approach consciously builds on the extensive existing work already undertaken by local authorities, the voluntary sector and the NHS in each borough. Insights will be collated, analysed and built into future decision making. It is important that there is transparency, commitment and visibility that we are building future interventions together with our communities.

NW London ICS brings together a wide range of health, care and related organisations

We are:

65,000 NHS employees

1,500 Adult social care staff

1,500 Voluntary organisations

1,300 (FTE) GPs

350 GP practices

276 Care homes

45 Primary Care Networks

9 NHS Trusts – four acute trusts, **4** community and mental health trusts, **1** ambulance trust

8 London Councils

8 Boroughs

1 NHS Clinical Commissioning Group
(until ICS/ICB established)

Acute trusts
Chelsea and Westminster NHS Foundation Trust

Imperial College Health Care NHS Trust

London North West University Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Community and mental health trusts
Central and North West London NHS Foundation Trust

Central London Community Health Care NHS Trust

Hounslow and Richmond Community Healthcare NHS Trust

West London NHS Trust

Other NHS organisations
London Ambulance Service NHS Trust

National Institute of Clinical Research Network North West London

NHS England/London

NHS Health Education North West London

NHS North West London Integrated Care Board

North West London Integrated Care System

Our vision is to improve people's life expectancy and quality of life, reduce inequalities and achieve health outcomes on a par with the best global cities: we have four key objectives as set out nationally

A Improve outcomes in population health and health care

B Prevent ill health and tackle inequalities in outcomes, experience and access

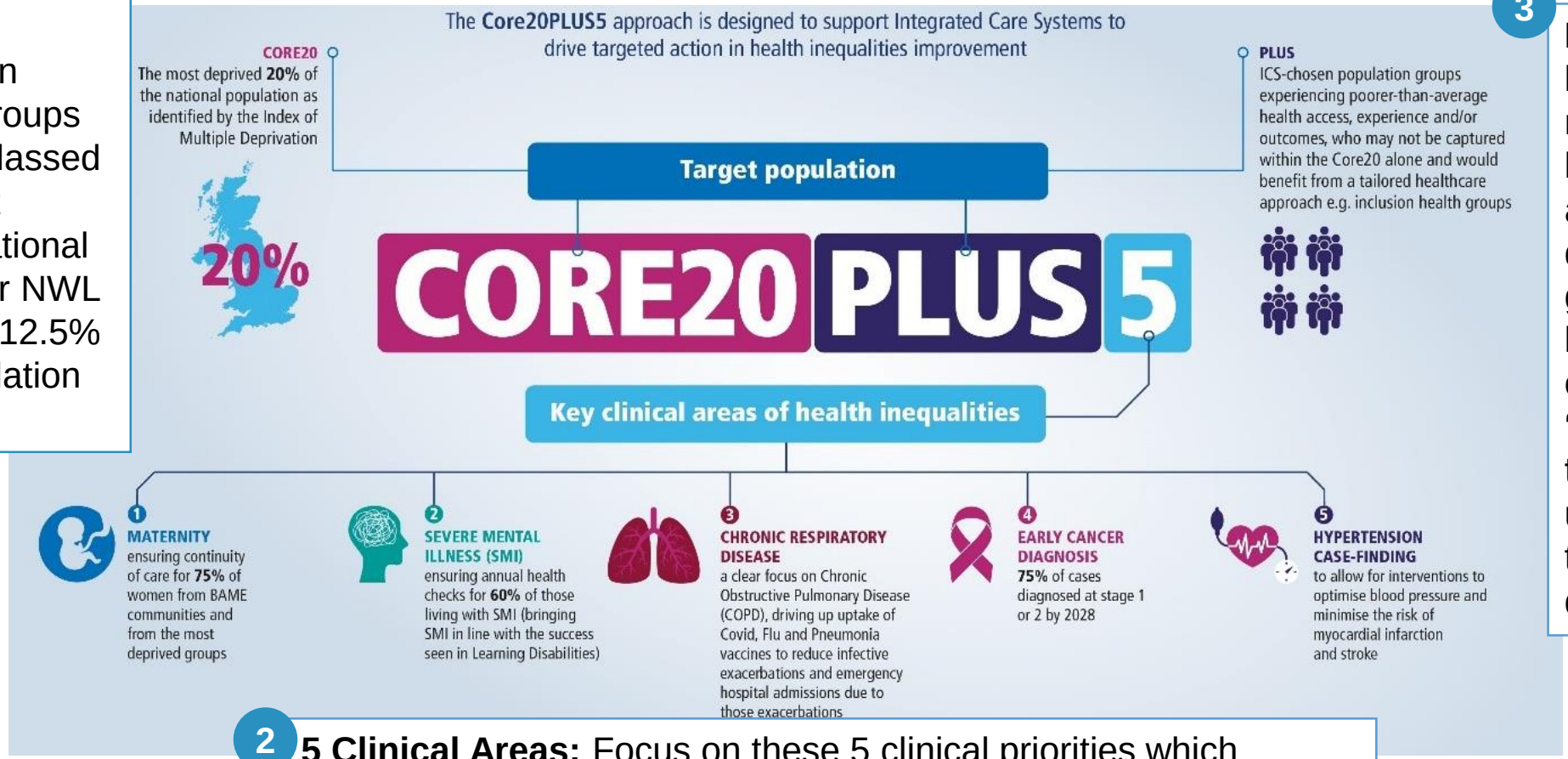
C Enhance productivity and value for money

D Support broader economic and social development

WHAT: A national framework '**CORE20 PLUS 5**' has been developed to help us focus, understand priorities and address these complex issues at an integrated care system level - tackling health inequalities bringing health, social care and other agencies.

1

CORE20: Identify, then focus on, groups which are classed as the most deprived national quintile – for NWL this means 12.5% of the population we serve



3

PLUS: Also look at your most pressing local needs and where disparities are greatest; ask local communities 'what matters to them'; understand the key social determinants

2

5 Clinical Areas: Focus on these 5 clinical priorities which require considerable improvement to address inequity in clinical outcomes (national and regional programmes of work)

North West London Integrated Care System

Working through three pillars, we will set an overall goal and adopt a systematic approach that combines quantitative data and insights from our communities to both set priorities and co-produce solutions

Overall goal:
Using population health management as a technique,
reduce unacceptable variation in outcomes, access and experience, maximise how partners across the ICS
contribute to broader economic and social development and thereby improve the outcomes that are most important to our residents and communities

IDENTIFICATION

(1) Identify and address inequalities in (a) access to (b) experience of and (c) outcomes achieved by each of our existing health and care services

Use quantitative data to identify inequalities in access, experience or outcomes; then ask the people who are disadvantaged for their insights (qualitative data) and help in designing & testing solutions

- Apply the FOCUS-ON improvement methodology across all of the key measures within each of our ICS programmes
- Work with our local communities to further understand and systematically tackle the issues around structural racism that we have started to learn about (from our vaccine improvement work) as being a key barrier to equity in health outcomes

INFRASTRUCTURE

(2) Put in place the building blocks of a population health approach – that will help us to reduce inequalities - across all of our work within the ICS

- Develop analytical tools to support population health management and improvement so we can reliably focus initiatives at priority groups with the highest need and then measure their impact
- Prioritise improving equity in the five key clinical areas identified in the NHS national health inequalities framework “Core20PLUS5”
- Embed new ways of involving communities in co-producing priorities that matter to them, and designing the way we deliver care (“the PLUS”)
- Support local teams in boroughs and neighbourhoods to test and implement these co-produced interventions; then scale the ones that make the most impact

PARTNERSHIPS

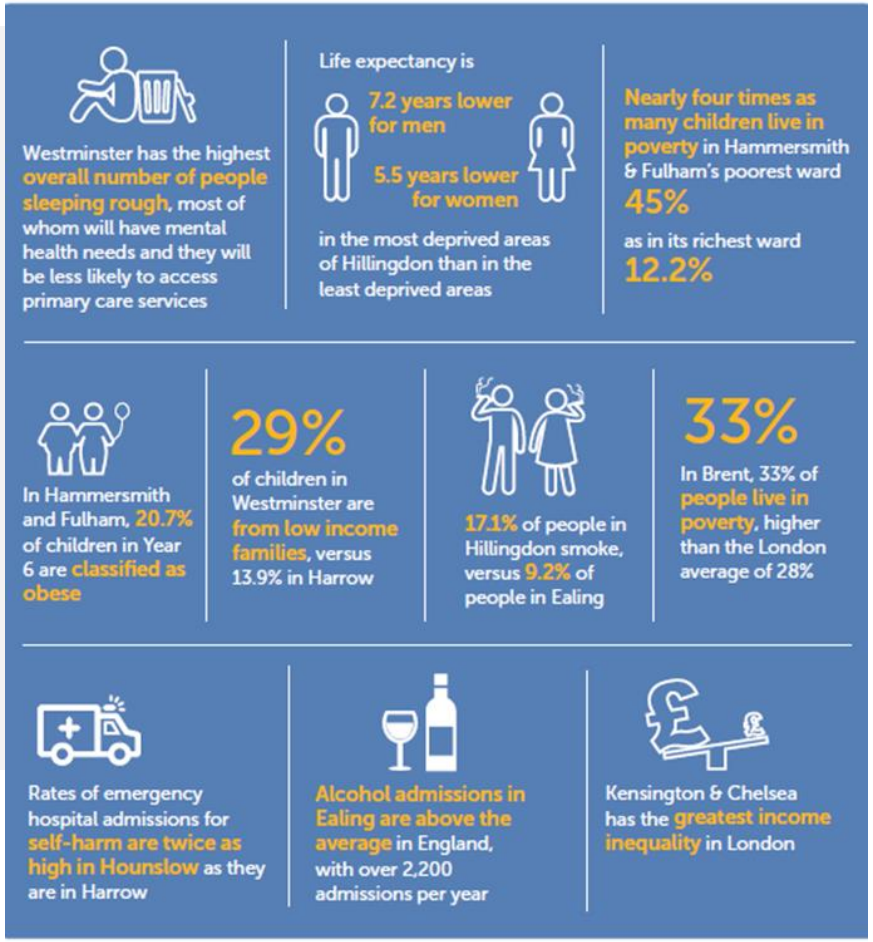
(3) Work together with all of the partners in our ICS to improve social, environmental and healthy living factors that adversely affect health and well-being

- Work in partnership across local communities, the NHS, local government, voluntary sector and business to improve access to education, training and employment opportunities for our most disadvantaged communities – and to support local businesses through more local procurement e.g. the role of local authorities, large businesses and NHS providers as “anchor organisations”
- Support the Mayor’s plan for health through working more sustainably; promoting active travel, improving air quality, increasing green spaces
- Work in partnership to improve healthy behaviours especially within our most disadvantaged communities; focusing on smoking cessation, reducing obesity, tackling local issues & the 5 key clinical areas identified in Core20PLUS5

North West London Integrated Care System

WHY this work is so important, now more than ever

Significant health inequalities exist in north west London; the high levels of deprivation across our eight boroughs correspond to poorer health outcomes in those areas



Covid-19 has exacerbated many existing health inequalities, both the direct impact of the disease itself and the lasting economic and social effects the pandemic is continuing to have

Unemployment rose by

152% (64,000) **across North West London between March 2020 and June 2021, compared to 116% nationally**

2023 year by which job numbers are expected to recover to pre-pandemic levels

Our local economy is getting worse

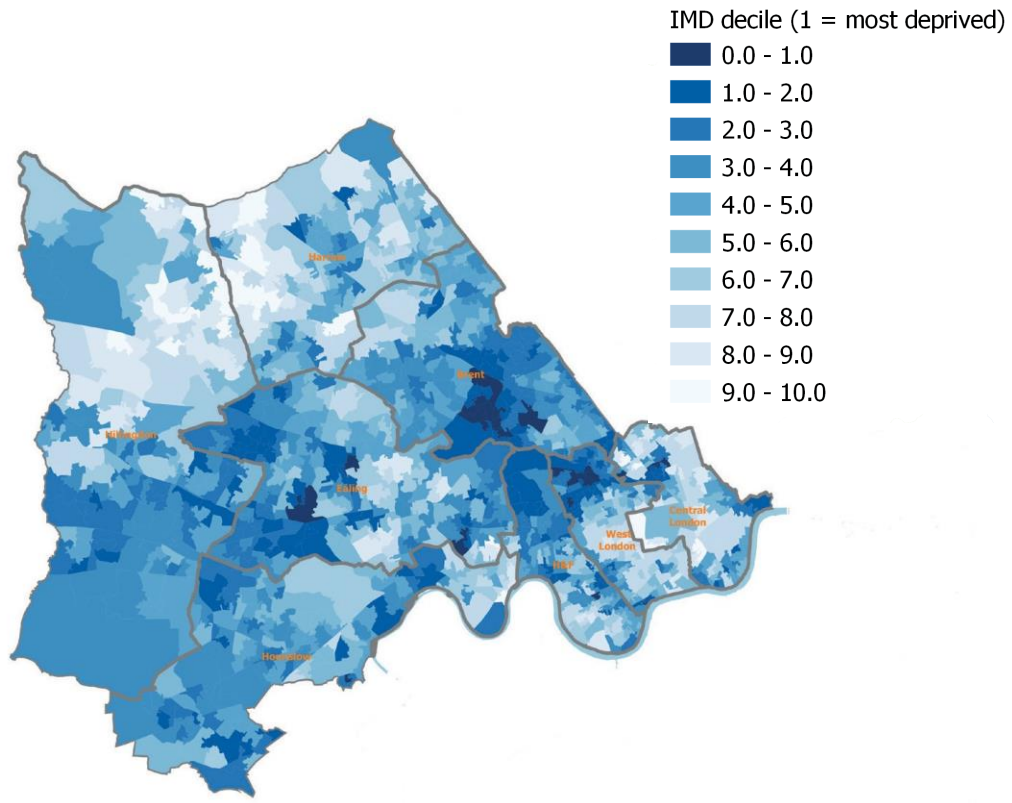
£8.1billion contraction of West London's Gross Value Added in 2020 – offsetting cumulative growth since 2013

Average unemployment (June 2021) across North West London was 7.4% compared to 5.6% nationally

North West London Integrated Care System

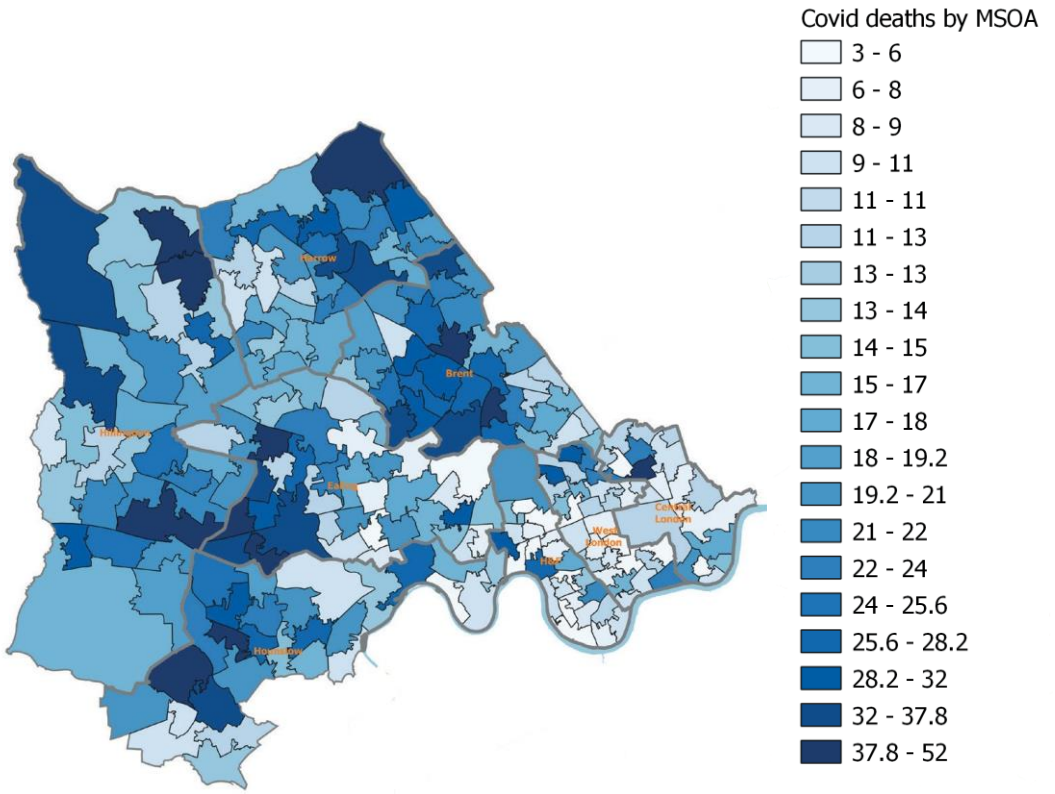
Example: COVID pandemic

Deprivation



Covid-19 has starkly illustrated the inequalities we have

Covid-19 deaths



LSOA level data covers Covid-19 deaths March 2020 - April 2021 (wave 1 and 2 peaks - 83% of total deaths to-date)

North West London Integrated Care System





Why are we involving people?
Involvement is a critical part in the development of the strategy and plan.

Involvement activities will be developed at place, supported by the NWL Engagement team, reflecting the needs and characteristics of each borough but united by common principles.

Our involvement principles will ensure that we maximise the value of these activities, and remain true to our desire that this strategy should be led by the views and preferences of residents, staff and stakeholders.

- We will co-develop the strategy and plan with our residents and staff. This means involvement at all stages – not simply 'testing' our thinking after it has been developed. It also means listening to residents on the priorities which they want to talk about, rather than 'the system' setting the agenda.
- We will be guided primarily by the views of residents in relation to the strategy's key decisions – how and where we should prioritise our efforts and resources to make the most difference for them. The things which matter most to residents will form the 'currency' which we can use to compare competing priorities.
- We already know some of what our population wants – and what is and isn't working for them – through current and recent work. There is a large amount of both qualitative and quantitative information available. The strategy and plan need to draw on insights from this work, rather than duplicating.
- We also need to use – and build on – the extensive networks, forums and relationships which are already in place, across NWL, for involving people.
- We need to engage people on what matters to them – the services they are receiving. The ICS (and the North West London geography) is not 'real' for most people. This is true for staff as well as people who use services.
- Discussions should reinforce our 'whole person' approach. Learning from recent activity, discussions with residents need to be about the totality of their experience, not individual parts of it (such as individual services).
- Resident and staff involvement needs to be an 'ongoing process' within our strategy and planning, rather than a one-off event. Careful thought will be needed to build this into the strategy and planning timetable (e.g. plan will need to be 'locked down' at specific points, meaning that involvement activity linked to them will then need to move to implementation).

North West London Integrated Care System

Next Steps

- The document will be / was published on 12 July 2022.
- Open public events in each borough are being jointly planned by local authorities and the NHS. At these events – to be locally determined, but in most cases a ‘drop in’ approach is suggested – we will share information about inequalities with local people and ask ‘what matters to you?’ type open questions. We will also share the feedback we think we have heard from residents on these issues in the past.
- Events will be agreed with each borough but could also contain public health information and offer health advice and activities such as screening/vaccination
- Events to start in September and run over the months ahead.
- Insights from the events will inform our strategy – as will insights from further community engagement.

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Report to the North West London Joint Health Overview Scrutiny Committee – 20 July 2022

Scrutiny Committee Work Programme & Meeting Arrangements 2022-2023

No. of Appendices:	Appendix 1 – Work Programme 2022-23 Appendix 2 – Terms of Reference
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	George Kockelbergh Strategy Lead – Scrutiny, Strategy and Partnerships, Assistant Chief Executive's Department, Brent Council George.Kockelbergh@brent.gov.uk Tel: 0208 937 5477

1.0 Purpose of the Report

1.1 This report updates members on the committee's work programme for 2022/23.

2.0 Recommendation(s)

2.1 The committee to discuss and note the contents of the report and work plan in Appendix 1, and for the committee to confirm the arrangements outlined in this paper as the basis for support to the Committee moving forward.

3.0 Detail

3.1 The North West London Joint Health Overview Scrutiny Committee is set to meet 4 times this municipal year, though there is potential for other scrutiny activities to take place throughout the year at the chair's discretion. Though 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.

3.2 The North West London Joint Health Overview Scrutiny Committee is formed of Councillors from the 8 Boroughs of North West London: Brent, Ealing Harrow, Hammersmith & Fulham, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster. The committee also has a non-voting representative from the London Borough of Richmond upon Thames.

3.3 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.

3.4 The work programme outlines the policy areas and decisions that will be reviewed by the North West London Joint Health Overview Scrutiny Committee during the municipal year according to its remit set out in the committee's terms of reference: to scrutinise the 'Shaping a Healthier Future' reconfiguration of health services in North West London and the Sustainability and Transformation Plan for North West London

3.5 To ensure effective scrutiny members of the committee prioritised items for inclusion in the work programme based on a set of criteria. This methodology of prioritisation is considered best practice by the Centre for Governance and Scrutiny (CfGS) and is an effective tool for a scrutiny committee to develop a coherent work plan for the year.[1]

3.6 The committee's work programme for the 2022/23 municipal year is detailed in Appendix 1.

3.7 The terms of reference for the North West London Joint Health Overview Scrutiny Committee are set out in Appendix 2.

3.7 There is scope for the scrutiny committee's work plan to change during the municipal year with capacity and flexibility to review emerging issues when they arise. It is intended that the work programme is a living document that will evolve according to the committee's needs. It may also be necessary at times to move items to a particular committee date for practical reasons, in these cases the work programme will be updated accordingly.

[1] *The Good Scrutiny Guide* (Centre for Public Scrutiny, June 2019), p26

Appendix 1 – Draft NWL Joint Health Overview and Scrutiny Committee Work Programme

20 July 2022

Agenda Item	NHS Organisations	Host Borough
ICS Update	TBC	Brent
Community Diagnostic Centres	TBC	Brent
Health Inequalities Framework	TBC	Brent
Elective orthopaedic centre – Central Middlesex Hospital Business Case	TBC	Brent
NWL JHOSC 2022-23 Work Programme & Meeting Arrangements	TBC	Brent

14 September 2022

Agenda Item	NHS Organisations	Host Borough
Primary Care Performance and Strategy including GP access	TBC	TBC
A&E pathways & performance. Combined with LAS performance	TBC	TBC
Palliative Care Review	TBC	TBC
ICS/ICB update	TBC	TBC

7 December 2022

Agenda Item	NHS Organisations	Host Borough
Winter Planning	TBC	Kensington & Chelsea

Elective Recovery & Cancer looked at with pan NWL remit.	TBC	Kensington & Chelsea
Workforce strategy.	TBC	Kensington & Chelsea
TBC / Emerging Item	TBC	Kensington & Chelsea

8 March 2023

Agenda Item	**NHS Organisations**	**Host Borough**
Estate Strategy across NWL ICS	TBC	Ealing
Mental Health (focus to be decided)	TBC	Ealing
TBC		Ealing

TBC		Ealing

Appendix 2: NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE 22/23

TERMS OF REFERENCE

NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE 22/23

Membership
One nominated voting member from each Council participating in the North West London Joint Health Overview and Scrutiny Committee plus one alternate member who can vote in the voting member's absence. In addition, one non-voting co-opted member of the London Borough of Richmond. The committee will require at least six voting members in attendance to be quorate. The North West London Joint Health Overview and Scrutiny Committee will elect its own Chair and Vice Chair. Elections will take place on an annual basis each May, or as soon as practical thereafter, such as to allow for any annual changes to the committee's membership.

Terms of Reference
1. To scrutinise the 'Shaping a Healthier Future' reconfiguration of health services in North West London and the Sustainability and Transformation Plan for North West London; in particular the implementation plans and actions by the North West Integrated Care System and its Joint Committee, focusing on aspects affecting the whole of North West London.

2. To review and scrutinise decisions made or actions taken by NWL ICS and/or other NHS service providers, in relation to the 'Shaping a Healthier Future' reconfiguration and the Sustainability and Transformation Plan for North West London, where appropriate.

3. To make recommendations to NWL ICS, NHS England, or any other appropriate outside body in relation to the 'Shaping a Healthier Future' plans for North West London and the Sustainability and Transformation Plan for North West London; and to monitor the outcomes of these recommendations where appropriate.

4. To require the provision of information from, and attendance before the committee by, any such person or organisation under a statutory duty to comply with the scrutiny function of health services in North West London. The stated purpose of the North West London Joint Health Overview and Scrutiny Committee is to consider issues arising as a result of the Shaping a Healthier Future reconfiguration of health services and the Sustainability and Transformation Plan for North West London, taking a wider view across North West London than might normally be taken by individual Local Authorities. Individual local authority members of the North West London Joint Health Overview and Scrutiny Committee will continue their own scrutiny of health services in, or affecting, their individual areas (including those under 'Shaping a Healthier Future' and the Sustainability and Transformation Plan for North West London).

Participation in the Joint Health Overview and Scrutiny Committee will not preclude any scrutiny or right of response by individual boroughs. In particular, and for the sake of clarity, this joint committee is not appointed for and nor does it have delegated to it any of the functions or powers of the local authorities, either

individually or jointly, under Section 23 of the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Duration

The Joint Health Overview and Scrutiny Committee will continue until all participating authorities decide otherwise. This does not preclude individual authorities from leaving the Committee beforehand. The Committee will keep under review whether it has fulfilled its remit and any recommendation of the Committee will be reported to a Full Council meeting of each participating authority.