If you require further information about this agenda please contact: please contact: Yusuf Patel by email: yusuf.patel@hounslow.gov.uk

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC)

A meeting of the Joint Health Overview & Scrutiny Committee (JHOSC) will be held in the Rooms 6:06 & 6:07 - 6th Floor, Hounslow House on Tuesday, 5 December 2023 at 10:00 am

MEMBERSHIP

Cllr Ketan Sheth (Chair) London Borough of Brent
Cllr Daniel Crawford (Vice Chair) London Borough of Ealing
Cllr Perez London Borough of Hammersmith & Fulham
Cllr Addenbrooke Royal Borough of Kensington and Chelsea
Cllr Ahmed London Borough of Hounslow
Cllr Sharma London Borough of Hounslow
Cllr Denys London Borough of Hillingdon
Cllr Halai London Borough of Harrow
Cllr Vollum - London Borough of Richmond - non-voting

Chief Executive – Niall Bolger

Link to live stream broadcast:
https://www.youtube.com/@LBHounslow/streams

AGENDA

10. Any other urgent business

11. Date of next meeting - 14 March 2024

DECLARING INTERESTS

Committee members are reminded that if they have a pecuniary interest in any matter being discussed at the meeting they must declare the interest and not take part in any discussion or vote on the matter.

Niall Bolger, Chief Executive,
London Borough of Hounslow, Hounslow House, 7 Bath Road, Hounslow TW3 3EB
27 November 2023

Please note that members of public can choose to record, or report in other ways, on this public meeting. If you wish to do so then please read the Council's protocol which can be found on the Council's website. Copies of the protocol are also available at the meeting.

The Council asks that you avoid recording members of the audience who are not participants at the meeting. The Council will seek to facilitate this. However, anyone attending a public meeting does so in the knowledge that recording may take place and that they may be part of that record.

London Borough of Hounslow

Updated 6 May 2022

DECLARING INTERESTS
UNDER THE MEMBERS' CODE OF CONDUCT

Members are reminded to consider the categories of interests in the Members' Code of Conduct to determine whether they have an interest in any agenda item and any action they should take. If they have a **disclosable pecuniary interest** or **other registerable interest** in any matter being discussed at the meeting, they must declare the interest and not take part in any discussion or vote on the matter.

Members are reminded to declare the nature of the interest and the agenda item it relates to. Please note that it is the individual responsibility of each Member to declare any interests and to update their register of interests form as required by the Members' Code of Conduct. For further details, please see the attached note from the Monitoring Officer.

If in doubt as to the nature of your interest, you are advised to seek advice prior to the meeting by contacting the Monitoring Officer or Democratic Services.

GUIDANCE NOTE FROM THE MONITORING OFFICER:

DECLARATIONS OF INTERESTS AT MEETINGS

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5A of the Council's Constitution.

(1) Disclosable Pecuniary Interests (DPI)

You have a DPI in any item of business on the agenda where it relates to the categories listed in **Appendix A** to this guidance. Please note that a DPI includes: (i) your own relevant interests; (ii) those of your spouse or civil partner; and (iii) those of a person with whom you are living as husband/wife or civil partners. Other individuals, e.g. children, siblings and flatmates do not need to be considered.

Failure to disclose or register a DPI (within 28 days) is a criminal offence.

Members with a DPI, who have not been granted a dispensation, must not seek to improperly influence the decision, must declare the nature of the interest and leave the meeting room (including the public gallery) during consideration of and decision on the item – unless exercising their right to address the Committee.

DPI Dispensations and Sensitive Interests: in certain circumstances, Members may make a request to the Monitoring Officer for a dispensation or for an interest to be treated as sensitive.

(2) Other Registerable Interests

You have a registerable interest in any item on the agenda where it relates to:

(a) Any unpaid directorships;
(b) Any body of which you are a member or in a position of general control or management and to which you have been nominated or appointed by the Council;
(c) Any body:

(i) exercising functions of a public nature;
(ii) directed to charitable purposes; or
(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which they are a member or in a position of general control or management.

Where a matter arises which ***directly relates*** to a Member's financial interests or wellbeing, or to one of their Other Registerable Interests, they must declare the interest and leave the meeting room unless members of the public are also permitted to speak on the item or they have been granted a dispensation.

(3) Declarations of Interests not included in the Register of Members' Interests

Occasions may arise where a matter under consideration would, or would be likely to, affect the wellbeing of you, your family, or close associate(s) more than it would anyone else living in the local area but which is not required to be included in the Register of Members' Interests. In such matters, Members must consider the information set out in paragraph (2) above regarding Other Registerable Interests and apply the same test.

(4) Guidance on Predetermination and Bias

Members should avoid any appearance of bias or having formed a pre-determined view prior to taking a decision. Members' attention is drawn to the guidance on predetermination and bias, particularly the need to consider the merits of the case with an open mind, as set out in the Planning Code of Conduct and the Licensing Code of Conduct. For further guidance on the possibility of bias or predetermination, you are advised to seek advice prior to the meeting.

For further advice, contact:

Rachel McKoy, Assistant Director of Governance and Monitoring Officer
Email: Rachel.McKoy@hounslow.gov.uk
Tel: 07929 755 551

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(see Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012)

Subject	Prescribed description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the council) made or provided to the councillor during the previous 12-month period for expenses incurred by the councillor in carrying out his/her duties as a councillor, or towards his/her election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an unincorporated body in which such person is a director or a body that such person has a beneficial interest in the securities of) and the Council - (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the Council. 'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (alone or jointly with another) a right to occupy or to receive income.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the Council for a month or longer.

Corporate tenancies	Any tenancy where (to the councillor's knowledge) — (a) the landlord is the Council; and (b) the tenant is a body in which the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners is a partner of or a director of or has a beneficial interest in the securities of.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the councillor's knowledge) has a place of business or land in the area of the Council; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners have a beneficial interest exceeds one hundredth of the total issued share capital of that class.

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

Minutes of the Meeting of the North West London Joint Health Overview & Scrutiny Committee held in the Committee Room 3, Kensington Town Hall, Hornton Street W8 7NX at 10.00 am on Tuesday, 12 September 2023

PRESENT

Committee Members

Cllr Ketan Sheth (Chair)
Cllr Natalia Perez (Vice-Chair)
Cllr Nick Denys
Cllr Chetna Halai
Cllr Lucy Knight
Cllr Angela Piddock
Cllr Marina Sharma
Cllr Claire Vollum
Cllr Ben Wesson

Others Present

Rob Hurd, Chief Executive Officer
Gareth Jarvis, Medical Director
Rory Hegarty, Director of Communications and Engagement
Toby Lambert, Director of Strategy and Population Health
Carolyn Regan, Chief Executive Officer
Michelle Scaife, Programme Delivery Manager - Last Phase of Life
Jane Wheeler, Director, Local Care
Katie Horrell, Assistant Director - Mental Health Transformation
David Harman, Communications Manager

Council Officers

Emily Beard, Governance Officer (RBKC)
David Bello, Head of Mental Health Services & Substance Use Team (RBKC)
James Diamond, Scrutiny & Policy Officer (RBKC)
Jacqui Hird, Scrutiny Manager and Statutory Scrutiny Officer (RBKC)

1 APOLOGIES FOR ABSENCE AND CLARIFICATION OF ALTERNATE MEMBERS

No apologies for absence were received.

2 DECLARATIONS OF INTEREST

The Chair, Councillor Ketan Sheth (Brent Council), declared a non-pecuniary interest that he was the Lead Governor at Central and North West London NHS Foundation Trust (CNWL).

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 18 July 2023 were confirmed as a correct record and signed by the Chair.

4 MATTERS ARISING

There were none.

5 PROPOSALS FOR CONSULTATION ON THE NORTH WEST LONDON WIDER REVIEW OF PALLIATIVE CARE

The Chair invited Jane Wheeler, Acting Deputy Director (Mental Health), NHS North West London, to introduce the report and the following points were made:

1. The proposed model of care had been co-produced.

2. Currently, not all boroughs in North West London provided the same offer of palliative care for residents within their own homes. The support for support residents received from out-patient services was also inconsistent.

3. There was currently some unmet need for people that needed to be in bedded provision which is therapeutic and provides access to a specialist team.

4. Engagement was ongoing and would progress to engagement over the options of delivery and commissioning, prior to formal consultation on the new model of care.

The Committee were then invited by the Chair to ask questions and Committee Members:

1. Questioned whether the new model of care would ensure that there would be sufficient capacity for inpatient beds in the future. Jane Wheeler shared that they had completed detailed modelling on future demand, and it showed that there were approximately 3,000 residents that needed specialist services, not bedded care. Unmet need had also been modelled and projections showed that capacity would be sufficient for seven years.

2. Asked for an update on the Pembridge Hospice and whether it was considered to be part of the inpatient capacity in the future. Jane explained that consideration of Pembridge would happen at the next stage, where options for delivery would be considered. Most of the changes were about services not in bedded units. Consultation on options for delivery, including Pembridge, would happen through the winter months.

3. Sought assurance that palliative care specialists would be recruited and retained to enable successful delivery of the model. In response, Jane shared that providers had been working closely together on workforce and had been

sharing approaches. Plans for workforce would be phased and there was a multi-year plan to bring in the proposals on workforce and organisational development. The modelling and plans took into account current activity across the boroughs and unmet need.

4. Queried how engagement would involve diverse communities. Jane shared that the engagement had included working across North West London, individual boroughs, and specific demographic groups. Outcomes of the initial work with specific groups had been published on their website, including a table of different conversations and groups. They had gone back to groups to see if the proposed model addressed issues raised initially. The key message had been about the importance of personalised care. Jane felt that the 24/7 advice line responded to that and the issue of not knowing who to call.

5. Questioned the criteria for determining the appropriate length of stay at each stage and how stepping up and down would be facilitated. Jane explained that the majority of patients would need little bits of all of the service. In the new model, the care coordination function would be enhanced, with a single person for a patient to go to and would help with stepping up and down. Michelle Scaife added that hospice inpatient beds were not for long term stays, the intention was to use them to stabilise a patient and then return them to their previous place of care. In Hillingdon, enhanced end of life care beds were currently running with a three-month stay. The idea was to meet needs every step of the way, with needs varying throughout the journey.

6. Enquired whether the review would be presented to the Hounslow Borough Based Partnership and noted that there had been review of Meadow House Hospice, which states that it was struggling to meet capacity. Jane said that they had linked in with each boroughs for opportunities to speak and they would go back to check they were booked in at Hounslow, however, they had engaged with Hounslow at the Hounslow Borough Based Partnership. They were aware of the pressures at Meadow House and noted that the south of Hillingdon and Hounslow had the worst access to inpatient units, whilst experiencing high levels of population growth. This would be taken into account when looking at placement of provision.

7. Sought assurance that resources were going towards advance care planning. Jane shared that the universal care plan was able to integrate with the ambulance service systems and they needed to promote uptake of that. There was now a dashboard to track the delivery of this. Michelle Scaife added that they were looking to support specialist palliative care teams, primary care and district nurses with advance care planning.

8. Queried whether the expectation would be for patients to travel further and where would the provision be provided, and asked how the new model of care would help those with complex needs. Jane explained that responding to residents' needs with the right support as an entire system means that those with the most specialist support have better access to the capacity and skills they need. Jane clarified that at the options stage it would be decided where provision would be located which would be focused on responding to needs with the right support. Options would be discussed with partners and

residents, there would be trade-offs as services currently span very large geographical areas.

9. Noted that the community engagement report detailed concerns about communities accessing services in a timely and appropriate way that reflected cultural and faith needs, and asked what was being done to address this. Jane acknowledged that not enough was being done on this yet, however, as options were developed the work would happen to ensure that services would be culturally competent and sensitive. Michelle Scaife added that all providers were committed to being more inclusive and some were already doing this work. The current provision did not include all religious leaders, however, there was a commitment to personalised care to meet a patients' religious needs.

10. Asked about the offer and support for unpaid carers. In response, Jane shared that support for carers was increasing, with the 24/7 advice line, as well as wellbeing and practical support. Michelle noted that there was respite support that allowed carers to leave the home for up to four-hour blocks and there were alternative options for those who could not be cared for at home. There was also advice for funeral planning and will-making. A Committee Member questioned how such block visits would be staffed. Jane clarified that there was an NHS funded caring workforce, but they were aware of pressures. Taking on additional specialisms allows for career development and would help to retain the workforce.

11. Asked about the steps taken to standardise provision for consistent quality of care across services and boroughs, and queried whether there was best practice in the NHS. Jane explained that there was best practice but there was not an off the shelf answer, which is why they had to co-design to such detail. Wellbeing services were co-founded with the charitable funding, as were some hospices. Work was being undertaken to identify such services and standardise the offer.

The Committee RESOLVED to recommend that North West London Integrated Care System:

1. Design principles around partnership working to enable patients and families to hold partners to account, following the implementation of the new model.

2. Bring a report on advanced care planning for palliative and end of life care to come to a future JHOSC meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.

6 NORTH WEST LONDON MENTAL HEALTH STRATEGY

At the Chair's invitation, Carolyn Regan, Chief Executive, West London NHS Trust, introduced the report raising the following points:

1. Data analysis was being completed to assess need, prevalence and demand and would be available by the end of September 2023. There was a Working Group which included representation from all boroughs and there had been some engagement events.

2. The approach was building on Joint Strategic Needs Assessments and setting out key principles.

3. The first phase was only looking at adult services, and children and young people would be brought in at phase two.

4. The ambition was for the first draft to be shared with stakeholders in October 2023.

The Chair then invited questions from the Committee. Committee Members:

1. Queried why a phased approach was being taken. Carolyn clarified that it has been decided to approach it in bitesize pieces and from speaking to service users, it was clear that there were key differences between adults and young people. The next phase would focus on the transition period for 16- to 25-year-olds.

2. Expressed concern that the Strategy duplicated the work of their borough's Health and Wellbeing Strategy and suggested that the Strategy should include a greater focus on ensuring sufficient community provision for mental health patients. Carolyn shared that there were differential ways of managing the beds across North West London, with one of the limiting factors in some places was supported housing.

3. Sought to understand what work was being undertaken on neighbourhood population health and questioned if the team was working with primary care networks to address where need was greatest. In response, Carolyn explained that the work was currently taking place to map community mental health teams against primary care networks and third sector partners. Gareth Jarvis added that there was variation of provision, and they were trying to find best practice examples. Gareth encouraged all boroughs to provide the data that had been requested for the analysis.

4. Asked whether the Mental Health Crisis Assessment Service (MHCAS) would continue and if additional MHCAS would be established elsewhere in North West London. Gareth Jarvis responded that it had been successful, despite originally starting as a temporary winter measure. However, there was limited funding and lots of moving parts to consider as part of the consultation. The Member emphasised the importance of communication of the MHCAS. Carolyn explained that there were alternative options to accident and emergency in all boroughs but only 50% of advance calls asked where alternative provision was located, and the NHS would like to increase this. They were exploring setting up an MHCAS in the West of North West London. Rob Hurd acknowledged that communication had been a recurring issue and it was something that they needed to continue to work on.

5. Shared that Hillington Council were completing a review of children's mental health services and enquired whether the two phases could run in conjunction, as a lot of the work needed to be done together. Katie Horrell explained that they would run in parallel. The work on children and young people had begun and it tied in with the refreshment of the transformation plan and the work of Imperial College Health Partners. They were happy to link in with any local work on this area.

6. Asked about whether they were working alongside Councils' public health team for their engagement work. Carolyn confirmed that they had been working with Council's public health teams, engagement teams and borough teams. The Committee requested further details on the engagements plans when available.

7. Noted that there was recognition in the report that priorities were not currently being met and that there were gaps in the offer and asked what those gaps were. Katie explained that this had come through during engagement and had included things such as ability to access services, support when waiting, offering services in non-traditional environments and support when experiencing loneliness and isolation. Workforce was also a big theme. Rob Hurd added that Imperial College Health Partner's Mission Three was about understanding of factors and root cause for demand.

8. Enquired whether enough preventative work was taking place, particularly in schools. Carolyn shared that there were mental health teams linked to most schools in North West London and they were conducting a stocktake of what this work involved.

9. Questioned if provision was consistent across partners. In response, Carolyn explained that they had greater infrastructure with MIND than other third sector partners. In West London, MIND ran three of the alternative safe spaces. Gareth Jarvis added that there was specific funding for each borough dedicated for the voluntary sector. Rob Hurd explained that there was £30 million of additional investment into mental health generally and this needed to be redistributed to need and outcome levels across the boroughs to produce equity of funding.

10. Asked whether school curriculums were being utilised to break down the taboo of mental health. Carolyn shared that part of their engagement work was speaking to communities they had previously had less engagement with to understand how to reach out better to these groups. There was also data to understand who mental health services were struggling to reach.

11. Queried whether there were any early indications in conversations about themes related to wider determinants and a desire for a more holistic approach. Carolyn confirmed that factors such as the cost of living and housing were coming up in a large majority of conversations. Requests for more holistic support, for example, not just prescribing medicines, was also a big theme. Gareth Jarvis acknowledged that more work needed to be done around social determinants and intersectionality. There was currently borough analysis and ward analysis being undertaken in this area.

The Committee RESOLVED to recommend that North West London Integrated Care System:

1. Provide a report to a future JHOSC meeting on the engagement with Directors of Adult Social Care at each borough around coordinated activity on mental health within the region.

2. Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To receive the details of the alternative provision to accident and emergency located across the boroughs.

2. To receive further details around on the engagement plans when available.

3. To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.

7 CONSULTATION PROPOSALS ON THE FUTURE OF THE GORDON HOSPITAL

Toby Lambert, Director of Strategy and Population Health, North West London Integrated Care Board (ICB), introduced the report and explained that it was solely about the future of acute mental health services for adult residents of the Royal Borough of Kensington and Chelsea and Westminster City Council and where to allocate mental health investment.

There were four options which had come out of the workshops, which included:

1. To return to the status quo in 2019 (prior to the closure).

2. To continue with the current provision, with inpatient services only available at the St Charles Centre for Health & Wellbeing.

3. To move the Mental Health Crisis Assessment Service to the Gordon Hospital and keep everything else the same as current arrangements.

4. To reopen some beds at the Gordon Hospital, at a smaller scale than previously.

It was yet to be decided which options would be included in the formal consultation but the ICB and Central North West London NHS Foundation Trust's (CNWL) were committed to a discussion about all options.

On invitation from the Chair, Committee Members:

1. Noted that it was concerning that the report incorrectly stated that Kensal Town was an area of high deprivation in the Royal Borough of Kensington and Chelsea, as Kensal Town was located in Brent. Toby Lambert apologised

for the error and shared that they had conducted considerable work on understanding where the patients who used Gordon Hospital had come from and where they were currently going to.

2. Enquired as to what the feedback had been from service users of the Gordon and families who had supported patients. Gareth Jarvis confirmed that service users and carers of those who had used the Gordon in the past had been part of all workshops. There had been a range of views, some of which had not been aligned with CNWL's views, whilst others did align. They all expressed that they felt heard through the process. The core demographic was previous service users of the Gordon Hospital. The Committee requested to see the feedback and the numbers of those individuals who attended the workshops. Toby confirmed that they could provide commentary and output of workshops (which was also available online), the specific engagement events with service users and carers, 2019 reports from service users of the Gordon Hospital, and the full consultation plan.

3. Enquired whether there was historical demographic data of Gordon Hospital service users. Toby confirmed that they could provide data broken down by age, ward, and ethnicity. They also had data on those who were attending St Charles Centre for Health and Wellbeing who would have previously attended the Gordon Hospital and the associated travel time.

4. Asked whether the voices of other residents in North West London had been heard. Toby explained that 85 to 90% of the service users were residents of the Royal Borough of Kensington and Chelsea or Westminster City Council. The next largest group was Brent Council whose residents accounted for almost all of the remainder of service users.

5. Questioned how the consultation would be accessible for those less competent with technology. Toby Lambert shared that they had data on the particular wards with high levels of usage, which can be broken down by ethnicity and age. Groups have been identified and there was an extensive schedule of engagement to reach such groups and a planned programme with messages and outreach.

6. Queried whether they had taken into account any of the London Mayor's six conditions. Toby explained that they had done some preliminary work on this. The Mayor of London had confirmed that he would be applying the six tests on the process. The first four tests would run in conjunction with the first part of the consultation and the last two tests, would follow afterwards. Rory Hegarty added that there were also NHS England tests and scrutiny in forums such as the JHOSC.

7. Enquired whether there had been any learnings from mental health beds in Ealing. Carolyn responded that learnings had included the importance of engagement at a very early stage and making information clear. Rory Hegarty invited feedback on areas that they may be missing or areas of particular focus.

The Chair then asked a question on behalf of a member of the public who:

1. Sought assurance that there would be information available on the resource and funding issues and how the options would provide better outcomes. Toby responded that there was information available in the report about the pre-consultation workshops, however, acknowledged that it may not be easily digestible for someone who did not attend. The Committee emphasised the need for jargon-free, understandable information. Rob Hurd added that this was not about saving money, as mental health investment had increased over recent years.

The Committee then discussed the proposal of a separate Joint Health Scrutiny Committee being established by the Royal Borough of Kensington and Chelsea and Westminster City Council for the purpose of continuing the scrutiny of the Gordon Hospital proposals. The discussion included the following points:

1. It would provide more focus and benefit the residents of the boroughs who are most effected by the proposals.

2. Legally, only one Joint Health Overview and Scrutiny Committee could provide the formal feedback to the consultation and thus, there would need to be clarity on this.

3. It would be difficult for other boroughs to contribute to the scrutiny as the impact was minimal to their residents, however, would be happy to support the two boroughs to scrutinise.

4. Would value the opportunity to input to the scrutiny, in the spirit of collaboration.

5. There was value in all eight local authorities contributing even where the impact is more limited, especially to understand best practice models.

The Committee supported the Royal Borough of Kensington and Westminster City Council's intention to form a Joint Health Overview and Scrutiny Committee comprising the two boroughs to carry out the formal scrutiny. It was decided that the Chair would decide in due course if an update was required in December 2023 at the next Joint Health Overview and Scrutiny Committee meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To provide the following:
    - The commentary and output of the pre-consultation workshops.
    - Completed and upcoming events with service users and carers.
    - Service users' experience of Gordon Hospital.
    - A more detailed consultation plan.
    - Historical reports of Gordon Hospital service users over the last 5 years.
    - Historical demographic data of Gordon Hospital service users.

8 LONDON JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE RECOMMENDATIONS TRACKER

A Committee Member suggested adding two items to the Work Programme:

1. Oversight of the review of the Better Care Fund.

2. The national programme for Integrated Care Systems to reduce overhead costs and the associated impact on local NHS commissioning.

9 ANY OTHER URGENT BUSINESS

There was none.

The meeting ended at 12.02 pm

Chair

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

NHS
North West London

ICS Workforce Strategy and Programmes

Agenda Item 5

Draft 0.2

Our Workforce Strategy supports the NW London Health and Care Strategy

NW London ICS Vision

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 by NHS England.

Health and Care Strategy for North West London

The Integrated Care Partnership has now published the Health and Care Strategy. The strategic priorities are to:

1. Support health and well being for our population
2. Reduce inequalities in outcomes, access, and experience
3. Improve access to care
4. Keep people at home wherever possible
5. Support babies, children, and young people to lead happy and healthy lives, and become happy and healthy adults.
6. Ensure our health and care system is as productive and high quality as it can be.

All priorities are supported by how we work together with our residents and communities.

Workforce strategy

.. is a key enabler strategy

Our ambitions for our workforce is that North West London is a great place to work for all of our staff, in particular for our local population and communities, and we will transform and enable our workforce to meet future needs.

We have reviewed the future NW London workforce challenges and potential opportunities and identified key interventions at Place, Organisation, Collaborative and System levels.

At system level, we have developed three interconnected strategic workforce programmes, which align to local, regional and national requirements.

Refreshed ICS Workforce priorities

Workforce priorities following consultation with senior leaders and publication of NHS Long term workforce plan

Our ICS Workforce Plan

ICS Workforce priorities grouped together into two strategic intentions:

A great place to work by bringing together our ICS wide collective **recruitment** and **retention** initiatives to ensure availability of the workforce capacity required, minimise attrition and maximise the capability of the registered and non-registered workforce.

Transform for the future by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and productivity and to maximise the opportunities afforded by **digital and technological innovations.**

Great Places to work

- Expand and diversify **routes into employment** whilst maximising the use of apprenticeships
- Develop a multi-professional **education and training strategy** to focus the planned investment in the long term that aligns with areas experiencing workforce challenges
- Drive **positive action** interventions that shift the dial to increase black and ethnic minority staff in senior roles by delivering the model employer goals across NW London.
- Improve **retention** through a continued focus on **career progression**, flexible working, access to affordable accommodation, leadership development and supporting staff wellbeing

Transform

- Implement **new ways of working to support new models of care** through the deployment of enhanced, advanced and associate roles.
- Develop a dynamic **productivity tool** jointly with CFOs, COOs and CIOs to improve workforce planning, efficiency and productivity.
- Improve the commitment, capability and confidence of our staff in **digital and technological innovations.**

Our Workforce Programme focuses on the NW London challenges and opportunities but also aligns with the NHS Long term workforce plan

North West London Integrated Care System

Recruit: Grow the Workforce

Retain: Embed the right culture and improve retention

Reform: Working and training differently

NHS North West London

Context for NW London

Fewer people are taking health and social care educational qualifications and joining a health or care career. At the same time, local educational attainment is better than that nationally. We need a strategy to encourage local talent into professional clinical, managerial and support careers in health and social care.

Workforce insights

- Diverse workforce (55.2% BME) but not at senior level
- Overall vacancy rate reduced from 11.9% to 10%* although workforce supply is a key risk
- Turnover is at 12.3%* - an eleventh month of improvement but remains challenging
- The wider labour market in NW London is competitive with an increase of 38,000 employee jobs (3.9%) from pre-pandemic levels[1]
- This compares to an increase of 3.6% both in London and the UK

Recruitment opportunities

- The employment rate across NW London was 72.6% in 2022, compared to 76.2% in London[2]
- Unemployment rate across NW London was 5.4% in 2022, compared to 4.4% in London[3]
- There is a significant refugee community in NW London - a potential recruitment pipeline
- 80% of health outcomes are related to the wider determinants of health[4]
- There is an opportunity to maximise the NW London Academy and associated funding to support the ICS 'anchor organisation' ambitions

Capacity challenges

- The overall actual v plan position for total staffing in 3.9% over plan
- The rolling 12-month sickness rate is over target at 4.2% - down from 4.9%
- Trusts are focussed on right-sizing their workforce to deliver planned activity
- Of the current 6000 vacancies, 6% are medical, 17% clinical support roles, 8% are AHPs, scientists & pharmacists, 6% are Ambulance paramedic & technician roles. A further 24% are non-clinical and 39% are qualified nurses & midwives
- Requires sustained transformation that matches strategy with resource and capacity to re-design roles, teams and staffing structures to improve productivity

Educational & training opportunities

- There is a need for a greater collaborative vision for education and training for clinical, managerial and support staff.
- We need a multi-professional Forum in North West London to develop the broader relationship with university partners.
- There is an opportunity to use education and training to support service innovation and new ways of working to address health inequalities and service transformation

Northwest London has a number of specific operational and financial challenges, and opportunities, that require a review of models of care or ways of working to improve services to patients/service users.

North West London Integrated Care System

1. *Payrolled employee jobs, March 2020 to May 2023. Source: HRMC, RTI data.*
2. *Employment rate for population aged 16-64 in Jan-Dec 2022. Source: ONS, Annual Population Survey.*
3. *Unemployment rate for population aged 16+ in Jan-Dec 2022. Source: ONS, Annual Population Survey.*
4. *What makes us healthy? An introduction to the social determinants of health, The Health Foundation, March 2018*

* *ICS workforce summary September 2023*

NHS North West London

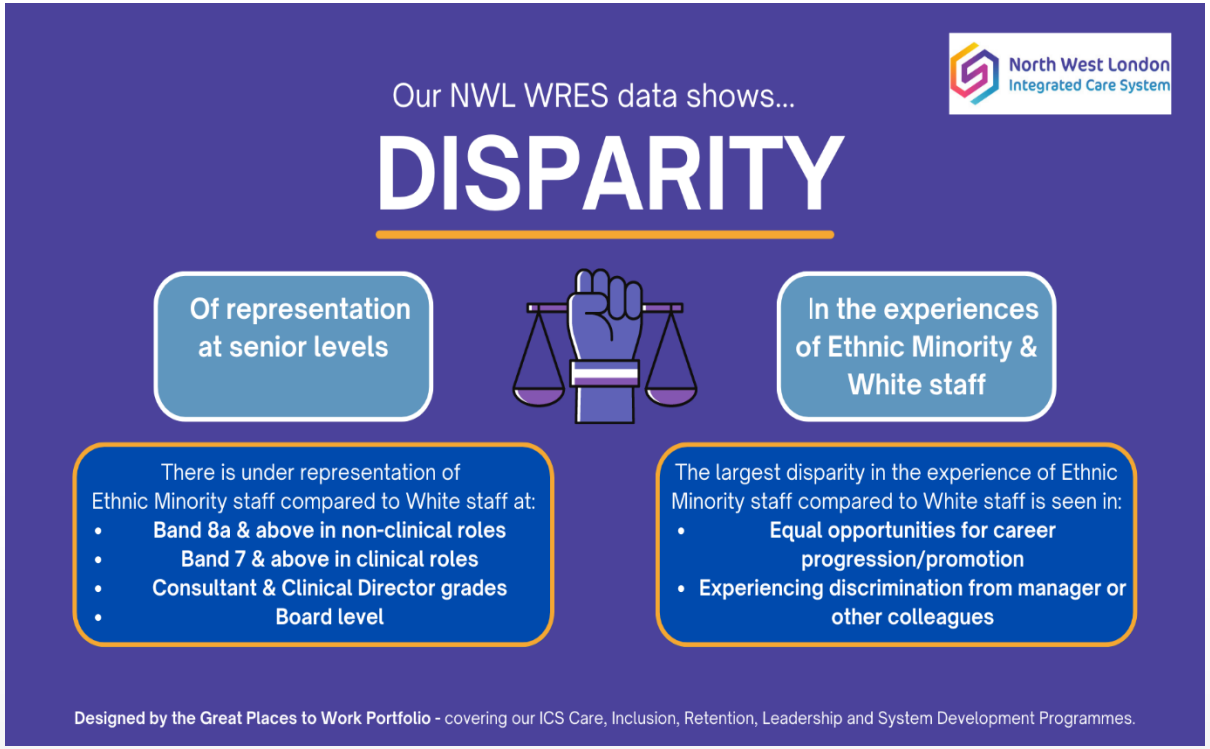
Race inequalities

A leadership focus on Health Equity. There is a linked Health Equity Programme that aims to improve health outcomes for all, reducing the gap in healthy life expectancy between the most and least healthy in our communities.

The work is underway through three pillars with an interdependency with the Workforce Programme, specifically around the disparity of representation at senior levels and in the day to day experiences of black and ethnic minority staff.

Some workforce interventions:

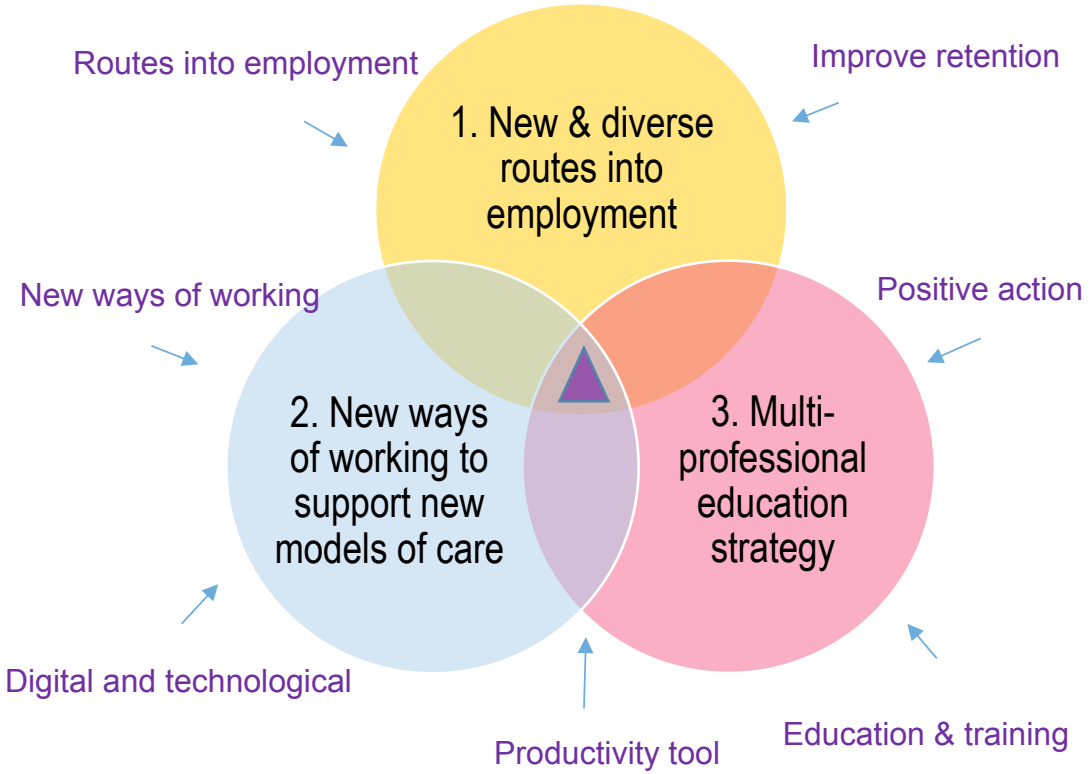
- Approaches across the ICS include: making **recruitment processes** more inclusive (for instance through diversity champions and the requirement to justify non-selection of ethnic minority candidates).
- **Leadership programmes** and mentoring, increased **accountability** at a Board level and in divisional action plans, **cultural awareness**/ unconscious bias training and '**just culture**' approaches to conflict and employee relations cases.
- A **Barriers to Leadership** review seeks to engage staff and local people to help us better understand the barriers to career progression for black and minority ethnic staff members
- An ICS wide **Model Employer Goal** target of at least 50% black and minority ethnic staff at senior levels by 2025. This is monitored via the Strategic Overview Meetings between the ICB and trusts as well as with primary care.
- **Workforce Race Equality Standard** (WRES) Action Plans published by each trust and ICB monitoring progress.



- The ICB Board is undertaking the **Building Leadership for Inclusion Initiative.** The aims are to raise the level of aspiration on inclusion, quicken the pace of change; and ensure that our leadership community is equipped to achieve a sustainable legacy of inclusion.
- A **Race Inequalities Steering Group** is established to address health inequalities that impact our black and ethnic minority communities the greatest. It is co-chaired by Rob Hurd (ICS/ICB CEO) and Linda Jackson (Executive Director L.B. of Hammersmith & Fulham).

Our future priorities for 2023/25

- We have reviewed the future NW London workforce challenges and potential opportunities. The agreed workforce priorities are based on feedback from Trust and ICB senior leaders and take account of the new NHS Long Term Workforce Plan.
- The priorities have been discussed with the ICB Leadership Group, the People Board, the Chief People Officers Group, the Chief Executives and the Strategic Commissioning Committee.
- We have used a structured programme management approach to build up the refreshed programmes of work over the next 18 months. The programme leads have set out the deliverables against each priority using a prioritisation matrix.
- This has included a 'check and challenge' by the ICB Joint Lead Chief People Officers and the Programme Director to refocus and add pace to existing initiatives as well as setting up a multidisciplinary approach with clinical, educational and workforce colleagues.
- From this process, we have identified at system level, **three high impact Workforce Programmes.** Central to all three workstreams is a strategic workforce planning and data insights function.



Collaborative Workforce Initiatives at System Level (2023/25)

1.Expand and diversify routes into employment

At system level, we will maximise the investment in the Health and Social Care Skills Academy to raise awareness of health and care roles, create more diverse entry routes; focus on key system wide retention initiatives; and design skills programmes.

2. New ways of working to support new models of care

The lack of staff to fill traditional roles, high temporary staffing costs and the need to maximise productivity require us to re-design roles, teams and staffing structures to improve productivity through a more efficient use of skill mix within teams.

3. Multi-professional education and training strategy

The NHS Long term workforce plan signals a significant expansion to fund additional education and training places. Each ICB also has a duty to promote education and training as an essential lever of an integrated workforce plan.

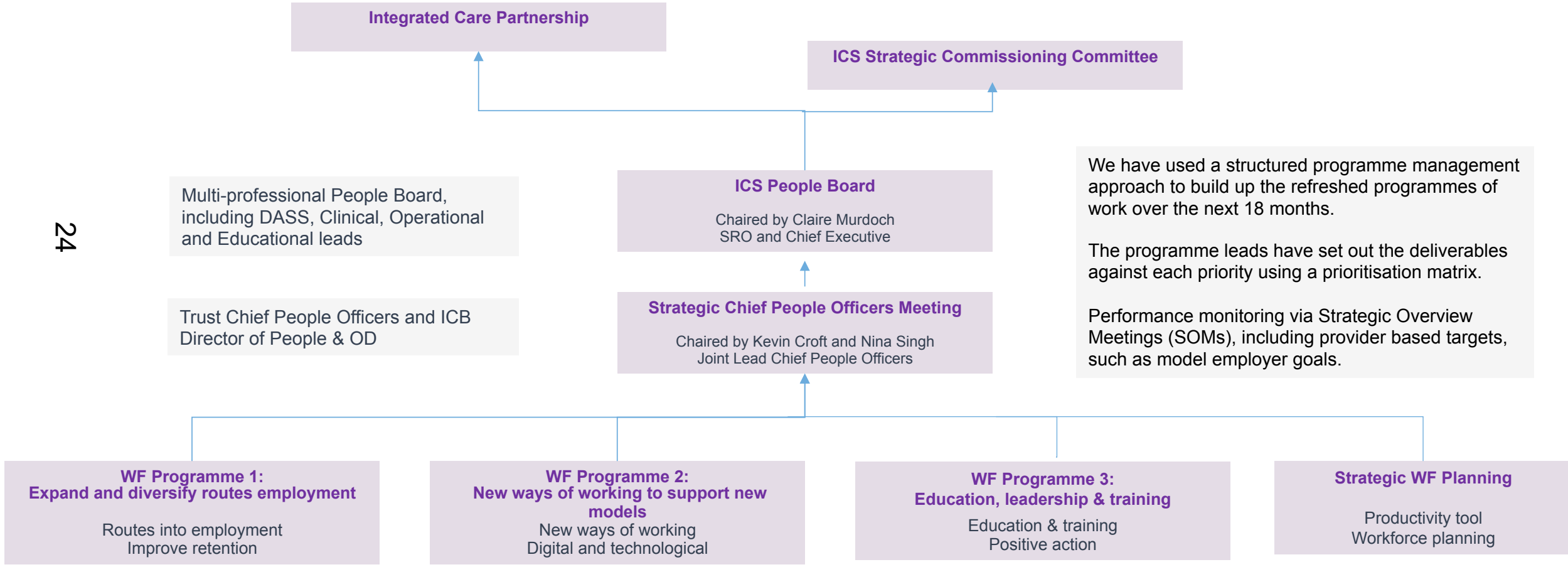
The key workforce initiatives to take forward following prioritisation

- Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage (B5 nurses/ midwives, MH nurses, Community Nurses, OTs and social workers)
- Provide a pipeline of staff into our entry level roles, to enable progressive employment with career pathways
- 100% of NW London's NHS Trusts to be fully accredited as London Living Wage employers by October 2024
- Support local people from CORE20 populations who attend pre-work programmes so that at least 20% go on to be recruited into employment in the NHS
- Recruit 50 Senior carers into roles across 8 boroughs; 70 refugees and 50 volunteers into employment across health and social care by March 2025
- 40 Care Leavers into NHS employment by March 2024
- 5 best practice cases to increase apprenticeships by April 2024
- Deliver 75 units of affordable staff accommodation to recruit and retain internationally recruited staff by September 2024

- There is a two phased approach within acute, primary, community and mental health services
- The **first phase** covers the current known priorities: NWL EOC initial launch Dec 23 and full implementation from Apr 24; LNW Ophthalmology Hub by Nov 23; ICH Ophthalmology hub by Mar 24; Phase 1 of Ealing CDC by Mar 24 and Wembley CDC by Dec 23
- Identifying and supporting the key workforce deliverables for the community nursing collaborative
- Maximise the available ARRS funds (circa £58m) by Dec 23 to enable Primary Care to deliver ongoing programmes, including Integrated Neighbourhood teams, GP Access and joint MH ARRS roles
- The **second phase** will be to scope the workforce elements of the system wide ICS programmes to enable new ways of working in support of new models of care
- Improve capability of staff in making best use of digital systems towards more data-driven decision making

- Set up the Multi-professional Education Forum by Dec 23, to oversee education and training planning and delivery across the system.
- Develop an Education strategy that sets out a clear vision for education and training in NW London with a Delivery Programme for 2024/25 onwards by Apr 24
- Launch the NW London Graduate Leadership scheme in February 2024 with a first cohort of 12 to complete two placement roles and a Level 7 qualification by April 2026
- Set up a NW London Undergraduate placements scheme to fill hard to recruit roles. First cohort to complete 12-month placement and gain work experience in a digital role within the NHS by September 2025
- Develop an ICS Oliver McGowan Mandatory Training Hub by Jan 24 to deliver training to Trust and primary care staff. Support 6,000 (10% of the eligible workforce) to complete Tier 1 training by March 24.

Programme structure



North West London Integrated Care System

NHS North West London

NHS North West London Winter Resilience programme and London Ambulance Service Performance

Background/Context

Winter is traditionally the most pressured period for health services with higher demand and higher acuity of presentation to healthcare services. The winter planning process supports the increase of capacity and operational resilience by funding and mobilising a range of initiatives across health and social care to tackle winter pressure, largely by improving flow so that people can wait less and be treated faster.

Since 2020, demand for UEC services has been highly volatile with unpredictable surges demand linked to a number of factors, including but not limited to COVID and respiratory infection. All services have seen unprecedented peaks in activity as well as higher acuity and additional factors such as lower social resilience.

North West London (NWL) has prepared for winter by working in partnership across the integrated care system (ICS) to configure services and pathways by increasing capacity and developing new integrated pathways that can meet patients' needs earlier and in more appropriate ways. This is supported by a methodology is embedded in NWL as a year round approach with a cycle of planning, delivery, review and ongoing implementation to meet peak demand irrespective of season.

Each element of the winter planning and delivery process is covered routinely in the Sector UEC Board and Trust focused UEC Delivery Boards, discussing increased demand for healthcare as a routine process than an exceptional one for the winter process. This supports ongoing engagement with providers, ICB boroughs and other parties such as Local Authorities.

This winter's context:

COVID and flu continues to circulate in and across communities in NWL but overall at a national (England) level the impact on hospital admissions is falling as table 1 below outlines.

Table 1: England View of Patients admitted to hospital due to COVID (up to 16th November 2023)

Patients admitted to hospital in previous 7 days for COVID (England view)	Position (%) compared to previous 7 day period	Patients in ventilation beds (number)
2,302	-8%	79

Source:
https://coronavirus.data.gov.uk/details/healthcare?areaType=nation&areaName=England

Monitoring the spread of COVID infections is now made more difficult without the systematic community testing of individuals but it is clear that the severity of illness has lessened over time either because people have been vaccinated or due to less virulent strains of the virus are emerging.

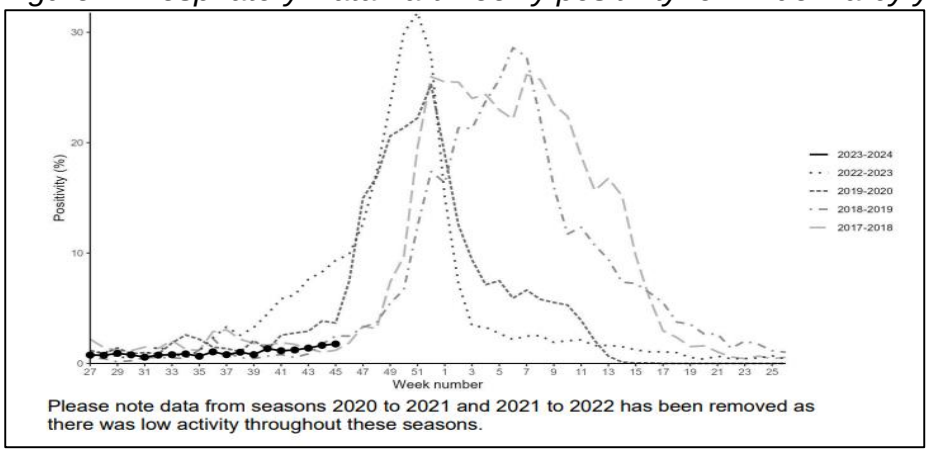
Vaccinations continue to provide the most effective way to minimize illness and in NWL the COVID programme has focused on ensuring that access and availability are made as easy as possible for residents.

Compared to the equivalent week in the 2022 to 2023 season, vaccine uptake remains higher for those aged 65 years and over, pregnant women and 2 and 3 year olds but is lower for those under 65 years in clinical risk groups.

Flu surveillance reporting shows that influenza activity is still at low levels with some suggestion of increasing activity in children. The Respiratory DataMart shows that influenza positivity remained stable in early November compared to previous weeks.

Figure 1 provides an overview of positivity for flu as of week 45 of campaign.

Figure 1: Respiratory DataMart weekly positivity for influenza by year (England



Overall, influenza hospitalisations remain within baseline activity levels and Influenza intensive care unit (ICU) or high dependency unit (HDU) admissions also remain within baseline levels compared to the previous week suggesting overall hospital admissions for these areas at present remain within manageable limits.

However other indications suggest that the system will face significant pressures, with wider modelling and context suggests that there will be significant strain on the system. Demand for healthcare is rising and flow throughout the system from presentation to A&E, through to admission and then discharge is challenged. A range of factors are in play, from the impact of industrial action, the availability of resources for all health and social care partners and issues such as the cost of living crisis and rising energy prices which have a significant impact on illness, particularly for vulnerable residents and those on low incomes. Demand for mental health services is increasing and delays in discharging patients from a hospital bed to a community setting remains a major focus.

In planning for a busy winter there is also an imperative to ensure we continue to provide timely treatment for cancer and patients requiring planned care.

National guidance for the delivery of Urgent and Emergency Care over the winter 2023/24 has set out two key ambitions for the delivery of services:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2023, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

There are four focus areas for systems in order to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place
2. Completing operational and surge planning to prepare or different winter scenarios
3. ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community intermediate and social care and the VCSE sector.
4. Supporting our workforce to deliver over winter.

Key Risks and actions being taken to mitigate them

Workforce Capacity

Key workforce risks in relation to winter are:

- Increase in demand for services
- Further industrial action
- Increase in staff sickness absence.

These are being mitigated through:

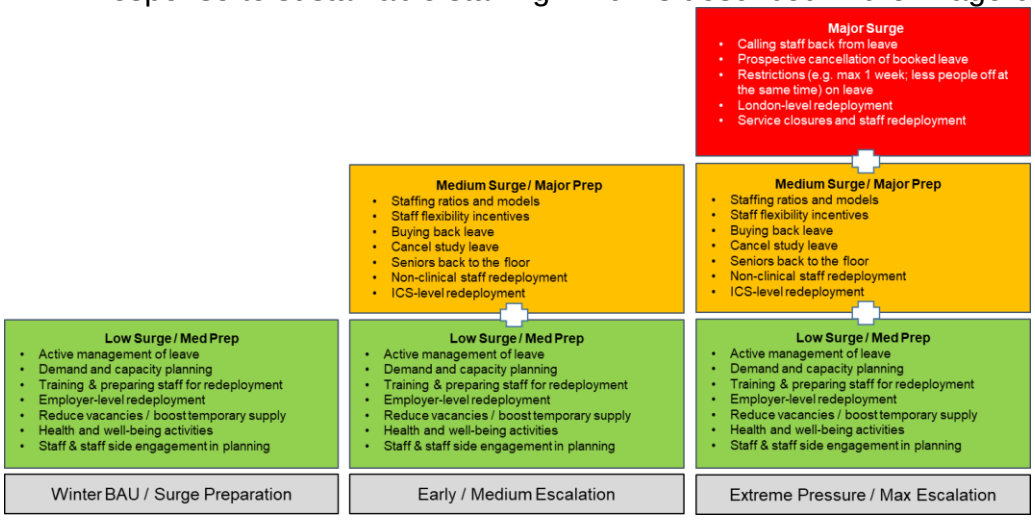
Staffing to deliver planned operating plan capacity (including temporary staffing and plans to maximise community workforce)

- NWL ICS closely monitors staff turnover, vacancies, sickness for all staff groups by trust and department and reports on risks and issues in these areas to a weekly GOLD meeting and monthly through the ICB Performance Report that is presented at the NWL ICS Executives meeting, System Quality Group, the NWL ICB Performance Committee and the ICB on a monthly basis.
- The temporary workforce requirement annual profile is detailed in the 2023/24 NWL ICS agreed workforce Operating Plan
- NWL ICS has an agreed workforce Operating Plan for 2023/24 that takes account of the service requirements (including intermediate care capacity staffing) relating to winter pressures.

Overview of key workforce actions in relation to winter pressures

- Maximising vacancy reduction through recruitment and forecasting future staffing levels from pipelines of supply.

- Redeployment principles and system – mechanisms and triggers for redeploying staff, other clinical and non-clinical staff / roles that could be utilised over and above current staffing structures and staff groups, staff working non-standard shift patterns or daytime hours.
- Use of non-directly employed staff and volunteers – plans for utilising partner agencies, volunteers, reservists, academic staff and students.
- Maximising staff availability – attendance management, management of leave, temporary staffing, staff incentives for working extra hours.
- Holiday plans – rostering to optimise substantive staff availability, support for staff required to work and opportunities for rest and recuperation during peak holiday periods.
- Health and well-being – maximising and co-ordinating initiatives within and across employers and plans for utilising the keeping well service.
- London MOU – cross system redeployment primary, community, acute, social care – we are ensuring that all parts of the system are familiar with the MOU and able to deploy staff where necessary across organisations.
- Staff digital passport to be used as a system – we have pilot sites for the staff digital passport which we will look to expand as quickly as we are able to.
- We have expanded the collaborative staff banks and Trusts have undertaken recruitment campaigns to increase the number of staff on staff banks as well as increase the amount of work that staff already on the bank do.
- Deficit plan: Sector Trusts have a joint agreed escalation approach and response to sustainable staffing which is described in the image below:



Critical Care

NHS England requests that each sector prepares a plan to allow a 10% surge in Critical Care beds without stretching staffing ratios. NWL have achieved this as below. Surging bed numbers is expected to be the last resort once the process of expediting delayed discharges, repatriations and mutual aid within sector and region has been exhausted. Bed pressures and requirement for mutual aid will be escalated via the normal in-trust Silver, Gold and on-call structures and if necessary a sector surge call convened with operational and clinical leads from each trusts Critical Care units.

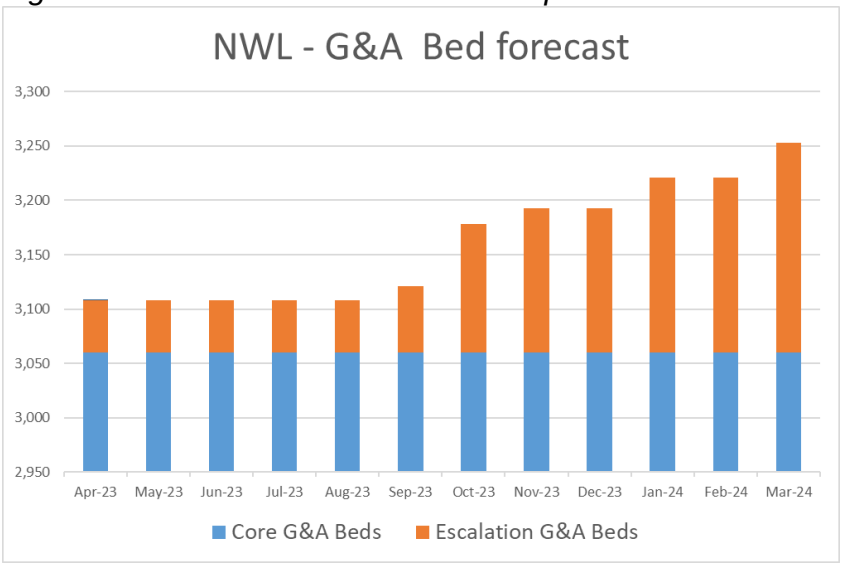
Daily bed reporting flows through the national Directory of Service (DoS) online portal and a summary of this is circulated Mon-Fri by the NWL Critical Care network. If required this can be stepped up to 7 days a week.

Figure 2. NWL Critical Care bed surge plan

General and acute (G&A) bed capacity

The main risk for G&A Beds is high demand for admitted care combined with challenge with discharge processes which cause beds to silt up and drive issues with flow across the acute hospitals. This is a major cause of high bed occupancy, with the risk that Trusts start to operate above levels considered safe. To address this, G&A bed capacity is being increased across all NWL acute sites well over and above the levels provided in Winter 2022

Figure 2 – NWL General & Acute Bed plan



This is being achieved by the construction of new wards at West Middlesex and Northwick Park Hospitals, the renovation of spaces across other sites to provide additional capacity and at times of peak pressure, increasing ward capacity by an additional one or two beds. One challenge is workforce availability which has been

addressed through early recruitment processes and by the roll out of training programmes during 2023 to upskill staff.

Avoidable admissions to hospital & delays in discharges from hospitals

This winter, NW London faces the significant challenge of managing patient flow effectively. To address this, we've invested in a comprehensive winter plan, focusing on various innovative schemes to streamline patient care and reduce unnecessary hospital admissions. Key strategies include:

1. **Virtual Wards (including PATCH for children)**: We've established 630 virtual ward beds, enabling patients to receive up to 14 days of acute clinical care at home. This approach is versatile and applicable to various conditions.
2. **Bridging Services**: These services facilitate the discharge of patients from inpatient care, allowing them to receive continued support at home whilst their longer term needs are assessed.
3. **Complex Care (Non-Bridging Better Care Fund)**: A range of borough-led schemes under the Better Care Fund enhance capacity for patients with complex care needs. Each scheme is tailored to meet specific local requirements.
4. **Discharge Hubs (Transfer of Care Hubs)**: Funded to boost workforce, these hubs ensure an integrated team approach for seamless pathway management across various patient stages.
5. **Single Point of Access/Urgent Community Response (UCR)**: This initiative provides a dedicated contact number for UCR providers, streamlining referrals from emergency services and bypassing standard referral pathways for specific patient groups.

Moreover, we have established robust monitoring and escalation management systems. The head of discharge, in collaboration with local care teams, adult social care directors, NHS Trust COOs, and transfer of care hubs, oversees system-wide discharge processes. Additionally, a sector senior responsible officer (a director of adult social care) works alongside the head of discharge as part of the 'Gold' command structure, ensuring comprehensive management of system risks and escalations.

These measures are crucial for maintaining high-quality patient care and system efficiency during the challenging winter months.

Acute respiratory infection

The NW London Respiratory workstream has developed a proactive approach to support with resilience for the increase in respiratory infections and reduce reliance on secondary care services during Winter 2023/24, across NW London working closely with primary care.

This includes identifying rising risk patients, proactive support in order to mitigate unnecessary escalations and exacerbations via the existing GP Practice review.,

proactive care planning and strengthened multi-disciplinary support for those with respiratory crises over winter, through existing pathways.

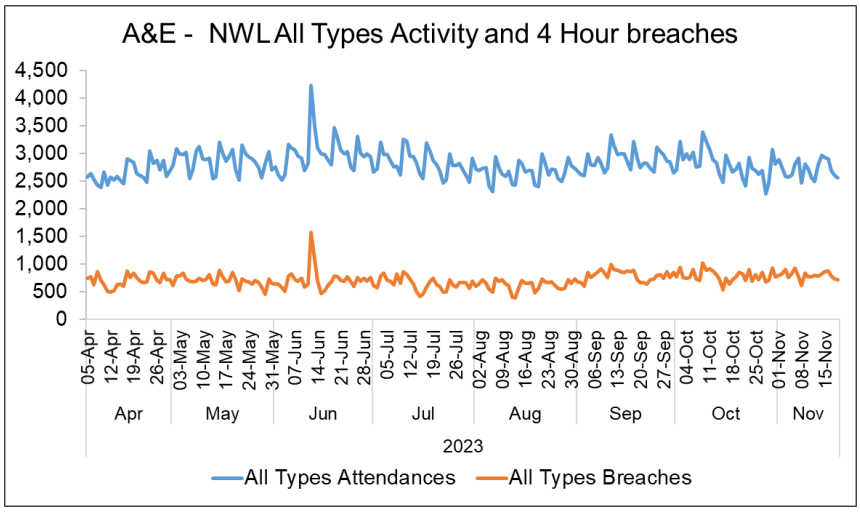
A&E waiting times

Areas of risk A&E performance this year include the acute trusts taking responsibility for all Urgent Treatment Centres (UTC) during the course of 2023, which transferred over from the previous provider with significant workforce challenges. This transfer will have major long term benefits to delivery but the immediate impact has been disruptive as models and workforce arrangements change.

UTC's are services that are co-located with Emergency Departments (ED) and with them provide a comprehensive A&E service by treating lower acuity cases. The transfer has allowed for new integrated models of care and delivery to be put in place at each site with a view to more quickly identifying the needs of patients who present at the acute front door

Other factors include the wide impact of industrial action throughout 2023, the implementation of new Patient Administration Systems at London North West and Hillingdon hospitals and the challenges with flow through the acute hospitals and onwards into acute provision.

Figure 3 – All Types A&E Activity and 4 hours breaches (ED & UTC combined)



A joint review of emergency departments across NWL was carried out from late 2022 throughout 2023 to examine clinical and operational process in each site, identify good practice and areas for improvement and to set out a sector wide workstream to improve the performance of the departments. From this process a range of separate workstreams on each key aspect of A&E operation were set up, taken forwards both by the Acute Provider Collaborative and where there was system wide working, the Integrated Care Board.

Other parallel initiatives to improve A&E performance include detailed self-assessments on site management processes that were carried out by each site over

the summers of 2022 and 2023 and missed opportunity audits that identified where there was the potential to treat patients in locations other than A&E.

Ambulance handover

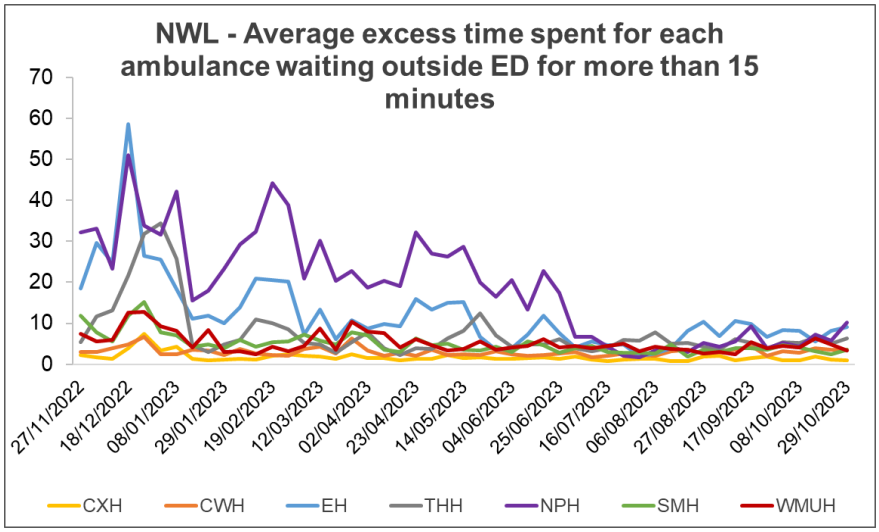
NWL has had for some years the lowest ambulance waiting times in the region and during 2023 put in measures to reduce waits further.

This has addressed the main challenges, largely focussed on the Northwick Park and Ealing sites by increased nursing staff in ED's to support more rapid handover. Since this process was implemented Northwick Park has moved from one of the most challenged sites in London to one of the least challenged.

A current risk is the volume of conveyances that ED's receive where the patient could be treated in alternative settings, which is being addressed through improving the use of alternative care pathways, including Same Day Emergency Care (SDEC) services.

Further improvements are being taken forward with the London Ambulance Service (LAS) to ensure that there is better load balancing across NWL, including a fair spread of blue light calls and that joint working between ED and LAS staff at the front doors is supported by senior officers at both organisations. This includes the implementation of a REACH (Remote Emergency Access Coordination Hub) model pilot at Northwick Park Hospital offering clinical support and advice to LAS to assist with joint decision-making on the most appropriate clinical pathway for patients.

Figure 4 – time spent by ambulances waiting outside of Emergency Departments



Ambulance Response times

Translating the reduction in handover waits to reduced ambulance response times is a key risk at present. The LAS are implementing a range of interventions to improve ambulance response times, in particular category 2, including:

- Ensuring a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans

- Increasing the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls. This will be a Phased implementation aligned to recruitment trajectory.
- Ensuring efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Noting the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services. This includes:
    - Taking learning from Industrial Action in the ambulance service, introducing the Senior Decision Maker process in order to increase referrals of patients to ACPs and to optimise ACPs through detailed data analysis to understand challenges when referring patients and maximise opportunity to refer through a process of rapid improvement.

Availability of medicines

Availability of medicines is on the NW London system risk and issue log. Escalations of risks and issues in this area would be managed through highlighting these to each organisational Chief Pharmacist and to the ICS Chief Pharmacist (Seema Buckley). The ICB Medicines and Pharmacy Team can be contacted regarding any such issues on nhsnwl.mpt@nhs.net.

Communications and Engagement

The winter communications campaign aims to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan uses data from previous winter campaigns and the Whole Systems Integrated Care Dashboard to target and support the right areas and communities.
This plan brings together the main objectives for winter from four main work streams:

- Urgent and emergency care and 111
- Vaccination (flu/Covid booster)
- Children and young people and
- Primary care.

Targeted activities (that includes taking population diversity into account) that have been undertaken so far this winter include:

- The mobilisation of 33 community groups to support local conversation on vaccination and winter services. Translated materials provided.
- Radio adverts/Spotify/social media advertising
- Google adverts, redirecting residents at the point of searching
- Work with schools, children's worksheets and information for parents
- Pharmacy information
- Council magazine articles and adverts
- Translated materials into 15 languages

This work complements London-wide and national campaigns on 111 and winter vaccination.

London Ambulance Performance

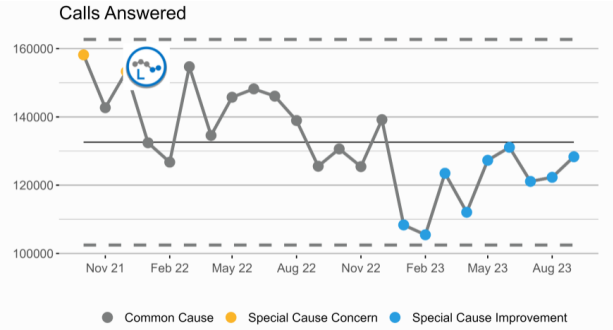
The following information has been requested for the JHOSC:

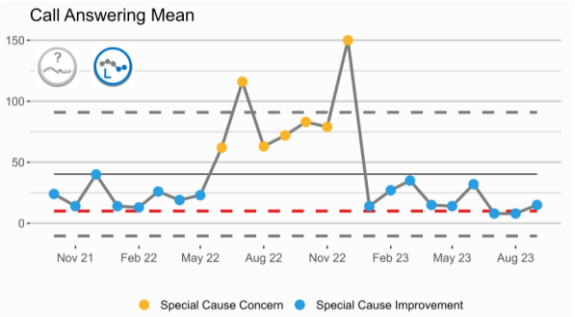
- **Performance** – Detail the internal and external targets within the LAS and set out how well the service is currently performing against these.
- **Quality** – Outline how the LAS is currently performing against the 11 clinical quality indicators compare this to the national average.
- **Apprenticeships** – Highlight how the LAS is performing against its public sector apprenticeship targets.

Performance

Call handling

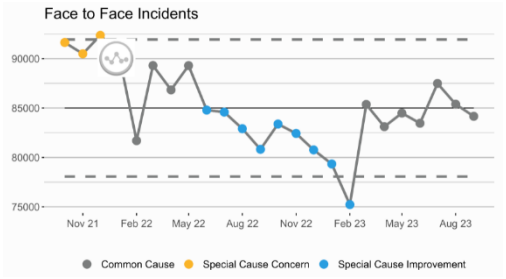
Calls volumes have increased from 122,308 in August to 128,329 in September. The call answering mean has risen from 8 seconds in August to 15 seconds in September, 5 seconds above the National Target of 10 seconds. Despite the recruitment trajectory for call handlers being achieved, LAS continue to struggle with surges in demand, impacting the call answering mean and growing sickness rates related to Covid.





Activity

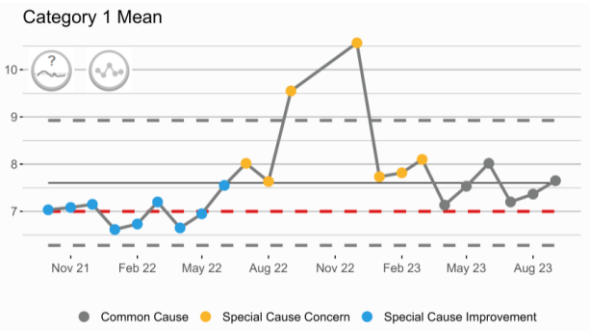
September Face to face activity is fairly stable at around c' 85,000 incidents. Continuation of the clinical validation of Category 2 calls and pre-dispatch senior clinical decision makers provide support to LAS to navigate patients to the most appropriate service. Despite this, LAS continue to struggle to consistently deliver and improve their Category 2 performance.

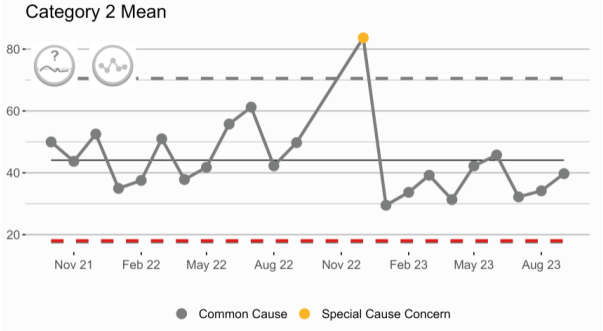


Response performance

The national target for category 1 mean is 7 minutes. The chart below shows common cause variation with a slight increase between July and September 2023. This has been in response to significantly higher number of Category 1 patients as a

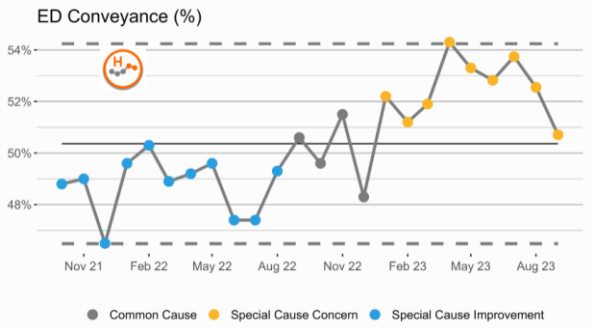
proportion of total volume. LAS continues to deliver the second best C1 performance nationally, with common case variation between 7 and 8 minutes.
The Category 2 mean national target is 18 minutes, which has not been met between June 2021 and September 2023. The chart below shows common cause variation with an increase in response time. Actions ongoing include a reduction in hospital handovers and targeted overtime.
In line with the two year National UEC Recovery Plan, LAS are reporting a Category 2 mean of 33 minutes in September, versus a plan of 31 minutes. The 45-minute handover process (see Patient outcomes below) is now implemented within all ICS areas. Fleet availability remains a key limitation in the LAS recovery plan.

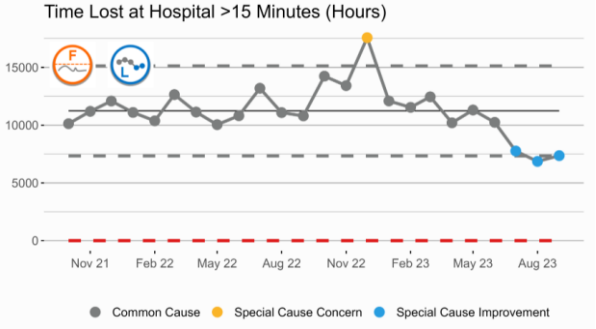




<u>Patient outcomes</u>

There is no target relating to the amount of patients that should be conveyed to ED, although ED conveyances, as a percentage of incidents continues to decrease and is currently around 50%. Whilst acuity is difficult to measure, proxy indicators (such as the percentage of blue call activity) are increasing.
Time lost at hospital over 15 minutes (delayed handovers) has improved, through the implementation of the 45-minute handover process, embedded across all ICSs.





Quality

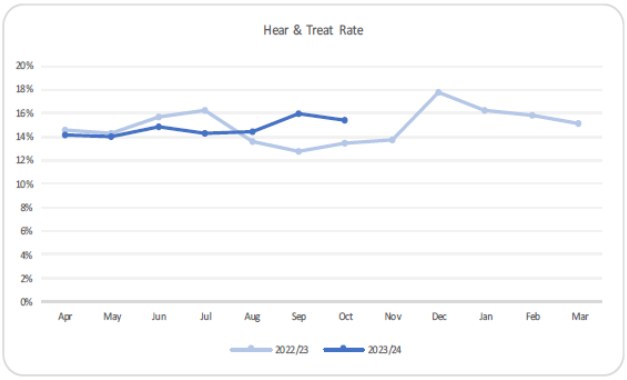
There are 11 ambulance quality indicators

1. Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene) – **not available to LAS commissioning** team
2. Service experience – **not available to LAS commissioning team**
3. Time to answer calls – **see the Performance section above**
4. Outcome from acute ST-elevation myocardial infarction (STEMI) – **see table below**

5. Outcome from cardiac arrest - return of spontaneous circulation – **see table below**
6. Outcome from cardiac arrest - survival to discharge – **see table below**
7. Outcome following stroke for ambulance patients – **see table below**

Quality indicator	National ranking	Narrative
ROSC	5th in June 2023	LAS are currently at 29.1% against a national average of 29.5% and Trust aspirational target of 31%. To note LAS, attend to more cardiac arrest calls compared to any other ambulance Trust and has the 3rd highest proportion of patients with resuscitation being commenced/continued by the service. Encouragingly, LAS ranks 2nd highest in the proportion of patients who had ROSC on arrival at hospital.
STEMI care Bundle	8th in April, May data not published, next data release Dec 2023	The STEMI Care Bundle has consistently been tracking below target at 72% (80% target). The Trust recognises this area of concern and has made improving cardiac care a standalone Quality Priority as this element is crucial in the prehospital management of ST elevation myocardial infarction (STEMI).
STEMI call to Angiography	5th in June 2023	The Trust continues to make small incremental progress against this target. LAS are currently 4 minutes under the national average of 2hrs 27 minutes
Stroke – call to Arrival at Hospital	3rd in June, 5th in May, 2nd in April 2023	the Trust has made significant improvements on this AQI. YTD mean time is 1 hour 25 minutes against a target of 1hr 50 minutes.
Stroke Bundle	8th in May 2023. No further data to published until year-end	LAS have been delivering the stroke bundle consistently at 96% YTD, inconsistent submission of information by other ambulance trust, therefore unable to draw comparisons until year-end.

8. Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate) – known as hear and treat



9. Call abandonment rate

	Month											
	Nov-22	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
EOC Contacts	181,139	186,900	139,814	135,122	156,439	142,364	160,456	165,983	154,580	155,594	162,008	163,135
Abandoned Calls (These are not included in EOC Contacts)	15,726	44,013	1,467	2,900	3,733	1,089	1,071	4,326	575	671	1,289	804

10. CT1 8 minute response time

Category 1T		Mean (hour: min:sec)
	England	**10:54**
RX9	East Midlands	15:19
RYC	East of England	12:20
R1F	Isle of Wight	11:05
RRU	London	10:30
RX6	North East	8:10
RX7	North West	10:24
RYE	South Central	10:27
RYD	South East Coast	10:02
RYF	South Western	11:33
RYA	West Midlands	9:03
RX8	Yorkshire	9:44

11. Time to treatment by an ambulance-dispatched health professional

HCP C1		Mean (min:sec)
	England	**9:46**
RX9	East Midlands	-
RYC	East of England	9:33
R1F	Isle of Wight	-
RRU	London	10:32
RX6	North East	8:59
RX7	North West	9:56
RYE	South Central	11:06
RYD	South East Coast	10:29
RYF	South Western	11:04
RYA	West Midlands	9:42
RX8	Yorkshire	8:53

IFT C1		Mean (min:sec)
	England	**9:07**
RX9	East Midlands	11:20
RYC	East of England	0:04
R1F	Isle of Wight	1:06:11
RRU	London	10:35
RX6	North East	6:41
RX7	North West	10:01
RYE	South Central	8:00
RYD	South East Coast	10:04
RYF	South Western	7:32
RYA	West Midlands	8:04
RX8	Yorkshire	7:57

C1 other than HCP / IFT		Mean (min:sec)
	England	**8:39**
RX9	East Midlands	9:11
RYC	East of England	9:21
R1F	Isle of Wight	10:06
RRU	London	7:20
RX6	North East	7:07
RX7	North West	8:16
RYE	South Central	9:00
RYD	South East Coast	8:26
RYF	South Western	10:02
RYA	West Midlands	8:27
RX8	Yorkshire	8:44

HCP Level 3		Mean (min:sec)
	England	**2:26:45**
RX9	East Midlands	6:11:43
RYC	East of England	4:31:32
R1F	Isle of Wight	1:19:04
RRU	London	1:59:31
RX6	North East	1:39:38
RX7	North West	2:42:18
RYE	South Central	1:42:23
RYD	South East Coast	2:27:42
RYF	South Western	2:46:30
RYA	West Midlands	4:32:19
RX8	Yorkshire	1:36:26

IFT Level 3		Mean (min:sec)
	England	**2:28:37**
RX9	East Midlands	6:04:09
RYC	East of England	3:34:02
R1F	Isle of Wight	2:28:20
RRU	London	1:23:12
RX6	North East	2:07:09
RX7	North West	2:53:48
RYE	South Central	1:30:14
RYD	South East Coast	2:47:03
RYF	South Western	2:50:22
RYA	West Midlands	4:00:45
RX8	Yorkshire	1:33:12

Apprenticeships

Within the service, there are 680 apprentices (LAS Strategy 2023), which is one of the largest apprenticeship programmes in the NHS. The LAS board (September 23) reported 4% growth in paramedics through the apprenticeship route, and many call handlers expressing an interest in the programme to becoming a paramedic.

London Ambulance Service evidence to North West London Joint Health Overview and Scrutiny Committee - November 2023

The committee requested an update on the following:

1. Detail the internal and external targets within the LAS and set out how well the service is currently performing against these.
2. Outline how the LAS is currently performing against the 11 clinical quality indicators, compare this to the national average.
3. Highlight how the LAS is performing against its public sector apprenticeship targets.

1. The Service's performance against targets

Despite ongoing pressure on our services this year, throughout 2023, our Category 1 response time (for our most seriously ill patients) across London has consistently been second best in the country (of 10 ambulance trusts) and significantly below the England average for ambulance trusts. Our Category 3 response rate has also regularly been among the best performing trusts nationally and within the two-hour standard. However, we recognise that we have more to do to bring our response time down further for our Category 2 incidents. We have implemented a number of initiatives to improve our Category 2 response time and make sure we are getting to people who need us as quickly as possible. This includes our work as an early adopter of NHS England's Category 2 segmentation pilot, which sees our clinicians assessing appropriate calls to check whether these patients need to be prioritised for an ambulance or whether they could be treated more quickly elsewhere. This has ensured that those who are most in need receive the fastest response.

In September 2023 we launched our new five-year strategy, which sets out the vision for our sustainable future with commitments to our patients, our people and the capital. As the capital's emergency and urgent care responders, this is a vision that reflects our dedication to serving the diverse and dynamic communities of London with the highest standards of care. After extensive engagement with our colleagues, patients and partners, the blueprint details how we will make the Service an even better organisation over the coming years.

In this strategy, we have given ourselves three missions to focus on:

- Our care – delivering outstanding emergency and urgent care whenever and wherever needed.
- Our organisation – being an increasingly inclusive, well-led and highly skilled organisation people are proud to work for
- Our London – using our unique pan-London position to contribute to improving the health of the capital

To achieve these three missions we have set ourselves 50 commitments to deliver over the next five years.

- Watch our five-minute animation about our strategy.
- Read our summary of the missions, priorities and commitments.

- Read our Easy Read version of our strategy document.

Table 1- London Ambulance Service response time by incident category 2023

Month	CAT1			CAT2			CAT3		
	LAS mean (0:07:00 target)	National ranking	England average	LAS mean (0:18:00 target)	National ranking	England average	LAS mean (2:00:00 target)	National ranking	England average
January	00:07:44	2	00:08:30	00:29:30	7	00:32:06	00:53:17	1	01:26:09
February	00:07:50	2	00:08:30	00:33:40	8	00:32:20	01:07:52	3	01:42:39
March	00:08:06	2	00:08:49	00:39:11	8	00:39:33	01:16:40	3	02:13:40
April	00:07:09	2	00:08:07	00:31:19	7	00:28:35	00:57:15	2	01:30:55
May	00:07:33	2	00:08:17	00:42:11	11	00:32:24	01:22:31	2	01:46:08
June	00:08:01	2	00:08:41	00:45:43	11	00:36:49	01:25:18	2	02:05:40
July	00:07:12	2	00:08:21	00:32:13	6	00:31:50	01:01:48	2	01:50:09
August	00:07:23	2	00:08:17	00:34:11	8	00:31:30	01:14:43	2	01:45:27
September	00:07:39	2	00:08:31	00:39:43	8	00:37:38	01:21:35	2	02:15:59
October	00:07:22	2	00:08:40	00:37:59	6	00:41:40	01:18:09	1	02:31:05

Source: NHS England

Table 2- North West London response time by incident category 2023

Month	CAT1	CAT2	CAT3
January	00:07:36	00:28:13	00:51:49
February	00:07:30	00:33:38	01:06:17
March	00:07:56	00:39:32	01:16:02
April	00:06:58	00:31:29	00:56:06
May	00:07:13	00:40:38	01:22:04
June	00:07:44	00:45:14	01:21:55
July	00:07:03	00:30:06	00:57:22
August	00:06:58	00:32:39	01:12:02
September	00:07:30	00:40:24	01:20:47
October	00:07:05	00:39:36	01:19:13

Source: London Ambulance Service

2. The Service's performance against 11 clinical quality indicators

We detail performance against the national clinical quality indicators in our comprehensive Integrated Performance Report, which is regularly published online as part of our Trust Board meeting papers. The latest data on our performance surrounding national ambulance quality indicators is published online by NHS England.

We have provided a summary of our actions on key quality indicators surrounding our response to cardiac arrests, heart attacks and stroke patients below:

- Outcomes from cardiac arrests and return of spontaneous circulation (ROSC): We maintain the largest cardiac arrest research registry in the UK and are world leaders in cardiac arrest research and auditing. Cardiac arrest survival rates have increased since the period surrounding the COVID-19 pandemic but are yet to return to pre-pandemic levels. In September, we attended 946 cardiac arrest patients. To further enhance cardiac arrest survival rates in London:
    - We are working to improve the speed at which we are answering emergency calls and our call handlers begin to deliver resuscitation instructions.
    - We are organising life-saving resuscitation and defibrillator training for communities, organisations and schools across the capital through our London Lifesavers campaign so that more people can respond effectively when someone is in cardiac arrest
    - We continue to deliver our clinical core skills refresher programmes to ensure our clinical staff receive regular update training in resuscitation skills.

- Outcomes from heart attacks - acute ST-elevation myocardial infarction (STEMI): We were the first ambulance service in the UK to introduce direct admission to specialist Heart Attack Centres for patients suffering with STEMI. In September 2023, we attended 244 STEMI patients.

- Outcomes for stroke patients: 99% of stroke patients attended by the Service are transferred to an appropriate receiving centre with specialist Hyper Acute Stroke Unit facilities. We are trialling new systems to provide our clinicians with access to remote video consultations from stroke consultants while they are on scene, supporting our crews to further improve diagnosis and initiate appropriate treatment earlier. In September, we attended 1,266 suspected stroke patients.

3. The Service's performance against its public sector apprenticeship targets:

The apprenticeship public sector target has now ended but we continue collecting and reporting data on our apprenticeship figures annually. We currently have 664 apprentices in training at the Service, and our programme continues to go from strength to strength.

We have a complete apprenticeship career pathway for frontline ambulance services. Individuals require no clinical experience or qualifications to join and can progress to become a fully qualified paramedic in just over four years. We have a number of apprenticeships available at the Service:

- In April 2023, we launched our new Level 3 Ambulance Support Worker Apprenticeship. This programme is for all new recruits to our entry-level Assistant Ambulance Practitioner (AAP) role. We currently have 163 apprentices on this programme.
- We continue to offer our Level 4 Associate Ambulance Practitioner Apprenticeship to Trainee Emergency Medical Technicians, allowing AAPs to progress into becoming Emergency Medical Technicians. We currently have 138 apprentices on this programme.
- We continue to offer our Paramedic Degree Apprenticeship (delivered in partnership with the University of Cumbria), which allows Emergency Medical Technicians to progress into becoming qualified Paramedics. We currently have 338 apprentices on this programme.

The first cohort of our Paramedic Degree Apprenticeship graduated in July. We have had 80 apprentices graduate through this programme so far, many of whom achieved First Class Honours.

In July 2023, the Service was again named in the Department for Education's Top 100 apprenticeship employer listing. We are now the only NHS trust to be featured in this list every year since it was launched in 2020.

In October 2023, we won the Mayor of London's Apprenticeship Employer of the Year award for the second successive year. Our Emergency Medical Technician Benjamin Lees – who is in his final year of the Paramedic Degree Apprenticeship programme – was also awarded the Mayor's Good Work Award in recognition of his exceptional professional progression in the workplace.

We have recently secured funding from the Mayor of London as part of the Jobs and Skills for London programme to support the delivery of a new programme to recruit more diverse Londoners to our frontline roles. The Our LAS Inclusive Response Programme will provide support and training to help these individuals successfully gain an apprenticeship and start a career at the Service.

As part of our new five-year strategy, we will work to continue to be the largest provider of NHS apprenticeships and broaden the range of apprenticeships to include non-clinical roles.

Report to the North West London Joint Health Overview Scrutiny Committee

5 December 2023

Report Title:	North West London Elective Orthopaedic Centre
Report Author:	Mark Titcomb, LNWH Managing Director EOC, CMH & Ealing
Committee Date:	**5 December 2023**
Report Deadline:	**23 November 2023**

Purpose

To provide an update on the report reviewed in March 2023 on the results of the NWL Elective Orthopaedic Centre consultation, the decision-making business case and progress made on delivery.

Detail

Background and context

Our response to the Covid-19 pandemic demonstrated what can be achieved when we work more collaboratively, joining up our care and making the best possible use of our combined expertise and resources.

One of the ways we were able to maintain more planned care during the later phases of the pandemic was by establishing 'fast track surgical hubs'. These were facilities within our hospitals that focused on specific, routine operations, separated as far as possible from urgent and emergency care. This meant that operations were less likely to be put on hold when there was pressure on our emergency services.

As we emerged from the pandemic with long waiting lists and many other challenges, we wanted to draw on best practice and go further with our improvements. We proposed bringing together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence, completely separated from emergency care. Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency.

Clinicians and managers from across the four north west London acute trusts worked with GPs and other colleagues, as well as with patients and lay partners, to develop a detailed proposal for an 'elective orthopaedic centre.'

The process involved a detailed assessment of all the NHS acute hospital sites in north west London (excluding the specialist Western Eye and Queen Charlotte's and Chelsea hospitals), as well as the possibility of using non-NHS sites. A single elective

orthopaedic centre at Central Middlesex Hospital was found to be the best option because:

- It is a modern and high-quality estate which, with some limited expansion and remodelling, offers a 42-bed facility tailored to systematised surgery.
- It is one of only two hospitals in north west London that does not provide emergency care, and so is much less impacted by urgent and emergency care pressures.
- None of the existing services need to be moved as there is plenty of room for expansion.

An Outline Business Case was approved by the London North West University Healthcare NHS Trust (LNWH) board in May 2022, subject to advice and assurance which was provided in a Pre-Consultation Business Case published in August and approved by the North West London Integrated Care board (NWL ICB) on the 27 September 2022.

Following this, and in partnership with the NWL ICB, we then invited patients and the public to share their views on our proposal for improving inpatient orthopaedic surgery in a formal consultation running from 19 October 2022 to 20 January 2023. An evaluation of the feedback – from around 2,000 individuals and organisations – was produced by independent research agency, Verve Communications.

The feedback emphasised the need for additional transport support, for care – between hospitals and with community services – to be fully joined-up and to avoid leaving anyone behind with new ways of working, particularly in terms of expanding digital options. We therefore built upon our initial proposal, committing to a door-to-door transport offer, patient navigators and ensuring in-person alternatives to all digital services.

We next reviewed all the feedback to develop recommendations on next steps within a 'decision making business case' which was approved by NHS North West London Board on 21 March 2023. The proposal also reflected feedback and guidance from the London Clinical Senate, the North West London Joint Health Overview and Scrutiny Committee (provided 8 March 2023) and the Mayor of London (who commissioned the Nuffield Trust to assess the proposal against his six tests for major NHS service change).

The Decision Making Business Case was endorsed by the NWL ICB in March 2023. On the 18 April 2023 the NWL Acute Provider Collaborative's Board in Common endorsed the Full Business Case.

<u>Overview and phased opening (from Monday 4 December 2023)</u>

The EOC programme remains on track to open as planned, using three dedicated orthopaedic theatres at Central Middlesex Hospital (CMH).

The first patients are now booked and undergoing their pre-operative assessments. The

initial EOC operating period, from December 2023 to end of February 2024 allows the remaining estate construction activities to be completed ahead of the move to full EOC capability (five orthopaedic operating theatres) from the end of February 2024 onwards.

This initial operating period will also be helpful in proving the pathways, gaining familiarity for those surgeons new to CMH, and resolving any early teething issues. It will also allow some early patient feedback and to make any improvements or adjustments if they are needed.

Implementation Plan

The EOC full business case (FBC) approved in April 2023, detailed the implementation and mobilisation plan with a timeline for an EOC 'go-live' for end of November 2023.

The approach adopted used four assurance gateways between April 2023 and go-live. These gateways served as checkpoints, with each one being comprising a RAG rated review process that drew on subject matter expertise that then reported through to the EOC partnership board.

Detailed implementation was undertaken within four workstreams: Corporate, Clinical Design (including digital), Workforce and Estates; this provided a clear critical path which was reviewed and updated as the project progressed.

A schematic of the gateway approach with associated dates is shown in Appendix 1 on page 8.

Corporate governance and communications

A full governance structure has been established with the monthly EOC partnership board reporting to the Northwest London Acute Provider Collaborative Executive Management Board.

Management of any immediate significant barriers and risks during implementation is undertaken via the Partnership Board and through a weekly EOC task and finish group. A programme risk register was developed in the early stages of the EOC and is maintained using qualitative measures to calculate the overall level of risk according to their impact and probability. Partners review this register monthly and it is used to manage and control programme risks.

The EOC benefits realisation plan is kept under regular review and includes Key Performance Indicators covering: productivity, cost effectiveness, clinical outcomes, patient access, transport, patient satisfaction and workforce. It also describes how clinical activity and equity will be monitored by the EOC and the wider NWL APC to ensure parity of access for all residents.

Clinical and digital design

This workstream covers every aspect of patients' clinical pathway from initial referral until after discharge from hospital and any local post-operative care. It includes the design of an EOC electronic patient tracking process that builds on the IT system (Cerner Electronic Patient Record) that is now shared across the four partner trusts. A schematic of the pre-surgery patient pathway is shown in Appendix 2 on page 9.

The pathway is designed to ensure the patient only needs to attend the EOC at Central Middlesex Hospital on their day of surgery, exactly as described in the public consultation. Any other pre-surgery visits, such as pre-operative diagnostic tests or 'joint school,' are either undertaken locally at their 'home' trust, or virtually, where appropriate.

Workforce

The EOC staffing establishment includes existing LNWH clinical and admin staff who are already based at Central Middlesex Hospital, as well as new posts that are being recruited.

A full recruitment campaign was launched earlier this year and LNWH, as the employing organisation, continue to recruit for a variety of roles at the EOC. In total approximately 140 new staff are required to support the centre at full capacity. Recruitment has progressed well, with sufficient staff in place to safely open the EOC from 4 December 2023.

However, recruitment needs to continue over the winter to ensure full staffing will be in place for the two additional theatres that will bring the EOC to full capability in March 2024. Two 'hotspot' areas of more challenging recruitment are anaesthetists and theatre scrub nurses, so mitigation plans and extra focus is being prioritised in these areas.

Surgeons performing operations at the EOC will come from all four partner trusts. All other staff based at the EOC will be employed by LNWH and this includes ward medical cover and anaesthetic cover. An operating theatre rota has been developed to provide sufficient sessions for surgeons from all partner trusts.

Estates and construction

Following approval of the full business case, the start of construction was initially delayed until August 2023 due to contractual and legal issues that required resolving. These resulted in a 12-week delay to the planned start date of construction for the two additional EOC operating theatres, with a new completion date of the end February 2024. The intention is to operate the EOC at full five theatre capability from Monday 4 March 2024.

Transport

A key area of interest raised within the public consultation (which ran from October 2022 to January 2023) was around travel times to Central Middlesex Hospital, journey complexity and costs.

Following considered public engagement on the issue, we have agreed a transport solution that is ready to implement when the EOC opens on the 4 December.

A public transport working group was established in July. The group was tasked with reviewing current work & KPIs, and transport offered by partner trusts. The working group then helped design and cost an appropriate enhanced support solution for complex, lengthy or costly journeys.

The working group consisted of one councillor and nine resident representatives from across north west London. There was also representation from TfL and Healthwatch. The group met in July, August, September and October. This included a site visit to Central Middlesex Hospital.

We are grateful to our transport working group for sharing their concerns and insights, and constructively challenging our initial proposals, to help us arrive at this transport solution.

We have arrived at a three-step approach that provides patients with a service that is above the standard non-emergency patient transport service. It comprises:

- providing detailed travel information and advice to patients through a variety of formats and channels.
- a dedicated EOC patient transport navigator team, with advisors able to guide and signpost patients, families and friends via telephone, SMS, MS Teams, and face to face. This service will be available seven days per week, with proposed operating hours of 7.30am to 7.30pm (adjusted at weekends) with EOC ward staff taking out-of-hours enquiries.
- the provision of free patient transport services where they are required for those with costly, complex or lengthy journeys. This includes support for early morning transfer to and late departures from the EOC where these would cause difficulty.

Where transport is provided, ambulance and car ambulance will be the default vehicles, and these will be ringfenced to the EOC. This means the provision of patient transport services for the centre will not be impacted by surges in demand across other areas of the Trust.

When taking patients to the EOC our transport provider will ensure patients reach the theatre admissions waiting area and are left comfortable. Likewise, on the return journey from hospital, they will assist patients into their home as necessary, and will ensure that patients are safe, secure and comfortable in their home before leaving.

For those arriving by car there is adequate parking capacity at Central Middlesex Hospital to accommodate the additional patients coming to the NWL EOC. The site has 514 spaces with 10% marked as disabled. There will be a signposted NWL EOC access point, located adjacent to the NWL EOC theatre admissions.

For those travelling by public transport there are Overground and Underground stations within two kilometres of Central Middlesex Hospital and onward transfer to the EOC can be facilitated. Regular buses run from the stations to Central Middlesex Hospital, each with a journey time of around seven minutes.

A live digital information board with bus updates will be installed inside the main entrance/foyer. There is also a covered walkway from the main entrance to the bus stops.

This transport solution meets the requirements set out in the Decision Making Business Case and the Full Business Case. Modelling of indicative patient numbers shows the solution fits within the EOC financial allocation for transport.

The plan will be reviewed throughout the phased opening of the EOC and adjusted if required. Further reviews will be undertaken at six-monthly intervals.

Post-operative care

Patients who have their surgery at the EOC will receive follow-up therapy under the care of their 'home' trust and in keeping with current processes at their home trust.

The onward referral processes for therapy, social care and equipment following treatment at the EOC has been discussed and agreed with therapy leads from each of the four north west London partner trusts.

There is a single referral form that will be used for all musculoskeletal outpatient physiotherapy referrals across the sector. This will ensure that information is provided back to the home trusts in a timely and standardised manner.

All therapy partners have agreed to acknowledge receipt and triage of these referrals within one working day. Equipment needs identified for a patient's discharge will be ordered by the therapists from the EOC but issued from the community equipment providers local to each patient.

Referrals for community therapy and social care packages will be made via the local processes currently in place for each of the home trusts. All patients will be provided with contact details for both the elective orthopaedic centre therapy team and the local team who will be continuing their care on discharge.

Finance

The financial expectation from the EOC is a recurrent delivery and improvement in annual North West London Acute Provider Collaborative financial standing of £4m by treating 5,800 patients through the newly developed centre.

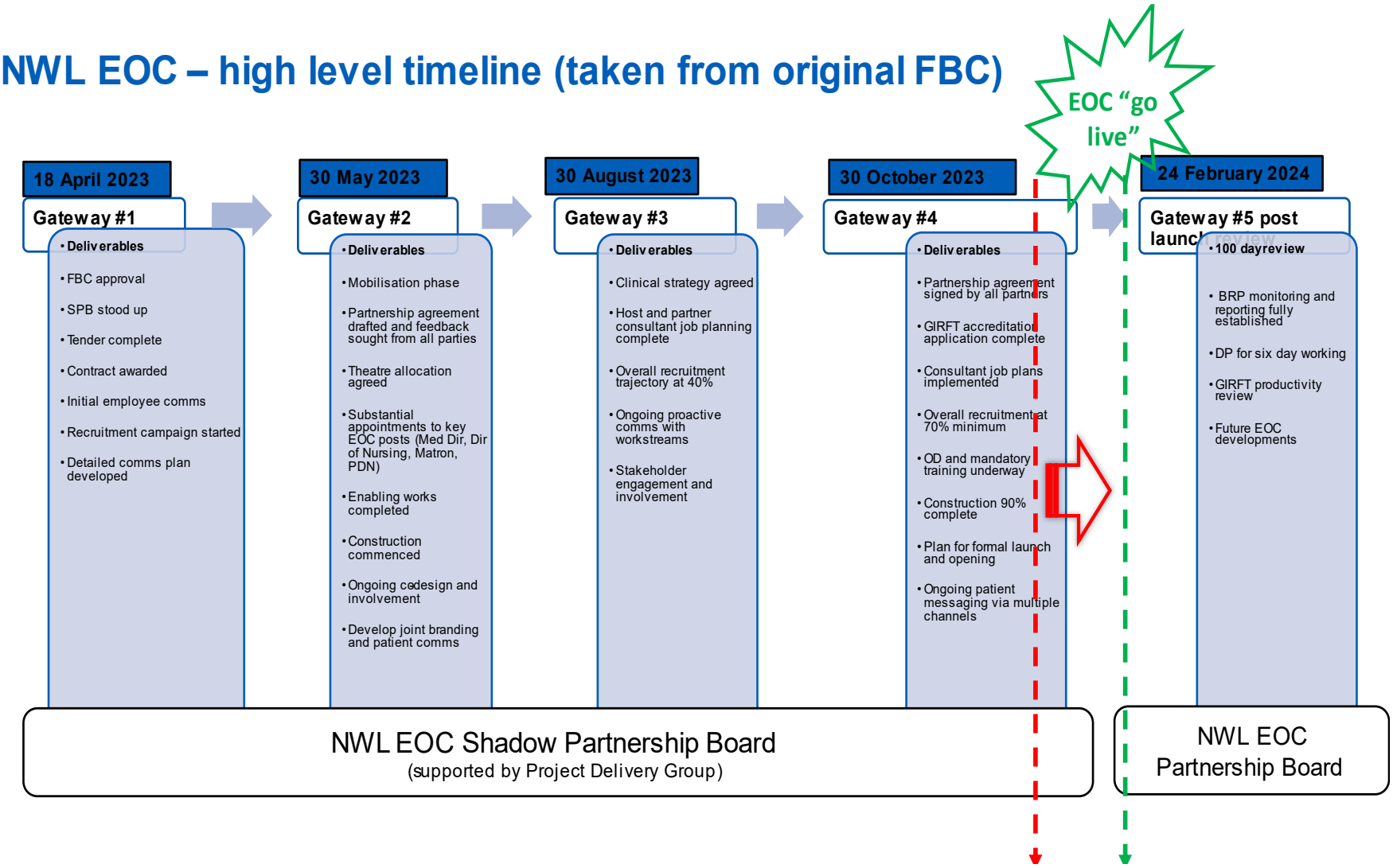
These financial expectations are planned from April 2024. They are based on increased theatre productivity, reduced length of patient stays, and from the release of key clinical capacity on the referring hospital sites, so that these organisations can use these facilities to create new surgical capacity to assist with patient waiting list recovery.

Referring trusts are actively working through backfill plans to support the utilisation of the created capacity on their sites. This will provide a further benefit, which whilst not valued in the scope of the original business case, is however a critical benefit.

Engagement and Equality

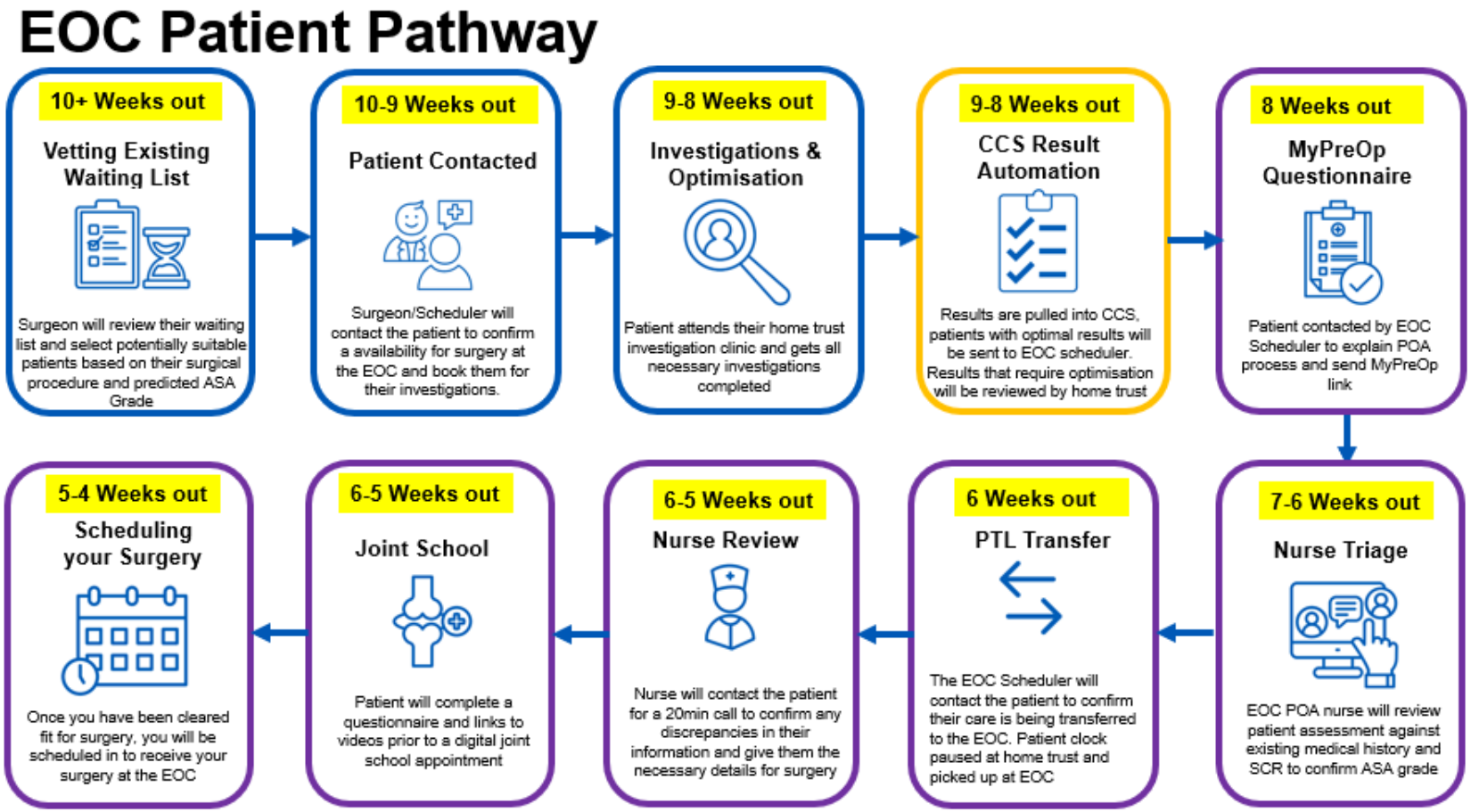
Ongoing public engagement is central to the success of the EOC. We will seek engagement with patients throughout the phased opening of the centre. Our patient experience team will collate early insights and feedback on transport and accessibility, information, signage and overall patient experience. This will help ensure the care provided at the EOC is equitable and will highlight any issues that need to be resolved in good time and before we reach full theatre utilisation in March 2024.

Appendix 1



The red line shows the current programme position and indicating that Gateway 4 has now been passed:

Appendix 2


EOC Patient Pathway
10+ Weeks out
Vetting Existing Waiting List
Surgeon will review their waiting list and select potentially suitable patients based on their surgical procedure and predicted ASA Grade
10-9 Weeks out
Patient Contacted
Surgeon/Scheduler will contact the patient to confirm a availability for surgery at the EOC and book them for their investigations.
9-8 Weeks out
Investigations & Optimisation
Patient attends their home trust investigation clinic and gets all necessary investigations completed
9-8 Weeks out
CCS Result Automation
Results are pulled into CCS, patients with optimal results will be sent to EOC scheduler. Results that require optimisation will be reviewed by home trust
8 Weeks out
MyPreOp Questionnaire
Patient contacted by EOC Scheduler to explain POA process and send MyPreOp link
7-6 Weeks out
Nurse Triage
EOC POA nurse will review patient assessment against existing medical history and SCR to confirm ASA grade
6 Weeks out
PTL Transfer
The EOC Scheduler will contact the patient to confirm their care is being transferred to the EOC. Patient clock paused at home trust and picked up at EOC
6-5 Weeks out
Nurse Review
Nurse will contact the patient for a 20min call to confirm any discrepancies in their information and give them the necessary details for surgery
6-5 Weeks out
Joint School
Patient will complete a questionnaire and links to videos prior to a digital joint school appointment
5-4 Weeks out
Scheduling your Surgery
Once you have been cleared fit for surgery, you will be scheduled in to receive your surgery at the EOC

Request for Report to the North West London Joint Health Overview Scrutiny Committee

5th December 2023

Report Title:	ICS Update
Report Author:	Rory Hegarty / Rob Hurd
Committee Date:	**5th December 2023**
Report Deadline:	**27th November 2023**

Purpose

To provide report updating members on a number of current work streams being delivered across North West London Integrated Care System. Items included have been requested and agreed between Chair of JOHSC and NHS NWL ICB Chief Executive.

Areas covered in this report

- Palliative Care
- Estate Strategy
- Acute mental health services consultation (City of Westminster and RBKC)
- Workforce Strategy
- NHS NWL ICB Organisational Design Programme (including fit for purpose ICB and running cost savings).

Workforce strategy update

See separate slide deck.

Update on adult (18+) community-based specialist palliative care

North West London residents are currently being asked to provide feedback on potential service options for delivery of the new model of care for adult (18+) community-based specialist palliative care.

The proposed new model of care has been co-designed over the last year by a working group of NW London residents, along with clinicians, NHS providers and charitable hospices with the ultimate goal of making sure there is improved access to high quality services.

Details of the potential service delivery options have been published and a number of webinars are being held at both a borough and NW London level. People also have the opportunity to input via a very simple survey and direct by email. Further information can be found at www.nwlondonicb.nhs.net/cspc

Estates Strategy

We have analysed and reviewed NHS estate (including primary care) comprehensively over the past 18 months. We are working with the boroughs and place based partnerships to review risks and opportunities in each borough. We

are currently aligning those requirements against our overall ICS strategy (as published- including high level vision for our estate) to develop the process of involvement and engagement on the implementation plan to deliver the strategy. We want to ensure that we deliver healthcare from right-sized places, integrated with our technology and digital offering. We have a varied estate and we will be targeting reducing the inequalities in the way we deliver our services across North West London.

NW London's revised overarching Estates Strategy and next steps to develop the delivery plan was endorsed at the ICB's Strategic Commissioning Committee (SCC) this month. The newly formed Estates Programme Board, chaired by SRO Steve Bloomer (CFO) met on 22nd November to confirm next steps and commence implementation. The Terms of Reference for this Programme Board are clear that the development of the plan and all and any associated planned changes will require appropriate involvement of communities and stakeholders that are affected.

The strategy commits to:

- developing and improving integrated neighbourhood teams hub plans to support the transformation and delivery of services. These will be aligned to changing population demographics and demand projections;
- improving the integration of services, fitness-for-purpose and utilisation of our existing estate across all health and care partners;
- reducing void and unused bookable space costs to the ICB (currently costing circa £9m p/a);
- proactively respond to large-scale planning applications for new developments to ensure health requirements continue to be met;
- improving alignment with local authority's Infrastructure Delivery Plans (IDPs);
- enabling other ICB delivery programmes;
- introducing 'smarter' ways of working across our practices and estates; and
- driving greener, net-zero carbon ambitions.

Next steps will include scoping and prioritisation of projects with boroughs and local authorities that are required in order to meet our strategic ambitions, the development of an agreed programme architecture and associated governance requirements, and project delivery plans. A quarterly Estates Programme Board will be held with key ICS stakeholders to monitor ongoing progress and delivery.

Work is underway with local authorities and NHS stakeholders to inform the eight Infrastructure Delivery Plans, ensuring alignment to our overarching strategic ICS priorities and population needs. ICB Estates continue to work with partners and local authorities to review available and expiring s106 (a developer contribution) and CIL (Community Infrastructure Levy) funding. So far, significant sums are in the process of being secured and allocated to estates activity. The ICB is working with local authorities, borough teams/Trusts and NHS property companies to review further opportunities to bid for CIL funding to support estates projects, and submit collective asks.

Expressions of Interests for FY 24/25 London Improvement Grant (LIG) funding closed on November 2023, which offers funding for Primary Care to improve the condition of premises on an annual basis. The ICB will now work with NHSE to review and prioritise bids against the NHS's Cost Premises Directions and our overarching Estates Strategy.

A new governance process, led by the ICB Estates team, has been introduced for changing occupancy (e.g. vacating existing demised space or requesting new space) at NHS PS and CHP sites. This will support with documenting occupancy, improving the pace of change and managing costs. We kindly ask that you continue to liaise with the ICB Estates team to support the implementation of this new process.

A new Community Diagnostics Centre (CDC) project Willesden Centre for Health is now complete. This new facility forms part of a wider hub and spoke model being delivered across Wembley (due for delivery in early 2024) and Ealing. Refurbishment works at Belmont Health Centre will complete this month. This project will improve the fitness-for-purpose of the premises, support the integration of practices and, like the CDC, help to reduce void costs.

Consultation on acute mental health services

Public consultation is underway on the future shape of acute mental health services in Westminster and Kensington and Chelsea. Events have been arranged in both boroughs and there will also be an event for Brent residents, given a small number use the services at the Gordon Hospital which may permanently close under the preferred option.

Consultation is expected to end on 30 January 2024. A separate JHOSC made up of the two local authorities is scrutinising this consultation.

Reduction in ICS running costs and its impact on staffing levels and office facilities

NHS North West London (the ICB) is undertaking a period of organisational redesign. This follows a national decision to reduce the running costs of all ICBs by 30% and the need to ensure that the ICB as a relatively new body has the capacity, capability and culture to carry out its statutory functions on behalf of the ICS.

A period of staff and stakeholder engagement on the proposed changes is underway and the feedback from this will inform development of formal proposals for staff consultation in the new year.

To ensure that the organisational design programme delivers the required transformation we have established five key projects to focus on different areas of the organisational design:

- Organisational design: fit for purpose ICB (includes staff restructure)

- HR: managing the change process
- Workforce development
- Running cost efficiency
- Organisational effectiveness: enabling staff through slick processes.

While our operating model including the role of our borough, programme and corporate teams has been agreed, we are keen to establish by talking to staff and partners whether our proposals will deliver our agreed model.

Proposals are subject to change during the engagement phase and subsequent consultation process. Our current thinking on future structure can be summarised as follows.

- The residents of NW London deserve the best health and care services. To make this happen, we need the right capabilities, capacity and culture to deliver on our statutory responsibilities, working with provider collaboratives and local authorities to transform and integrate healthcare for our communities.
- The ICB's role is to integrate, coordinate and transform services to improve population health and reduce inequalities across the whole NW London area. Our work is planned and commissioned at NW London level.
- Our main focus is on NW London-wide programmes to enable system transformation and integration. Place-based teams will deliver these NW London programmes through partnerships with local authorities and providers at borough level.
- Corporate services such as finance, HR, IT, strategy, communications and governance will support programme and borough teams, enabling them to focus on implementing the ICS strategy.
- Where we have stopped/ slowed an activity or shifted it elsewhere, staffing in that area is likely to be reduced. Overall, this means a move towards more ‘once for NW London’ activity, with borough-based partnerships supported by programme and corporate teams.
- A strong clinical voice is important: clinical leadership will be delivered through our Medical and Nursing directorates, with expert clinical support provided to all our programmes.

To minimise the impact on staff, we have looked to reduce costs not associated with staff numbers. One significant cost is estates. Current office occupancy averages 21% across all our sites.

- In some cases we are unfortunately bound by lengthy leases e.g. Marylebone Rd (MBR) to 2033.
- Our preferred option is to give up most borough sites and offer space for borough based staff in existing ICB locations at Sudbury, Heart of Hounslow and MBR under a hub and spoke model. This option also proposes subletting two floors in MBR.
- We recognise that the ICB not having an office base in each borough is not ideal for place-based working. We hope to be able to put in place hot desking arrangements with local authorities.

• Potential cost saving for estates are in excess of £2 million in year 2024/25 whilst still retaining dedicated place based presence in Brent, Hounslow and Central London. • Through this engagement phase we will work with partners and staff to consider all options, and remain open to developing other solutions. We will be discussing our proposals with local authorities and NHS provider trusts during the engagement period and we will consider all feedback before developing final proposals.	
Member Request:	**Cllr Ketan Sheth, Committee Chair, 2023**

Adult (18+) community-based specialist palliative care - summary of service improvements by NW London borough

The following pages identifies the services gaps in provision of adult (18+) community-based specialist palliative and how the proposed model of care that is being recommended will lead to changes to service provision in each of the eight boroughs in North West London.

Brent

Summary of service improvements for Brent residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Brent residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Brent residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community specialist in-patient beds

- Brent residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available for residents in all boroughs of NW London. They are currently only available in Hillingdon.
- Brent residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Brent residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Brent residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Brent residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Brent residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Brent residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Brent residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Ealing

Summary of service improvements for Ealing residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Ealing residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Ealing residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Ealing residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Ealing residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Ealing residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Ealing residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Ealing residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of a common core offer lymphoedema support and expanded out-patient clinics to include medical and nurse led clinics
- Ealing residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Ealing residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Ealing residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Hammersmith and Fulham

Summary of service improvements for Hammersmith & Fulham residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Hammersmith & Fulham residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours for the team will increase to 8am - 8pm from current 9am to 5pm. Hammersmith & Fulham residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- Hammersmith & Fulham residents will have access for the first time a Hospice at Home service. This service currently does not exist.
- This service supports up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community specialist in-patient bed care

- Hammersmith & Fulham residents will have access to an increased number of beds in the community, which includes dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Hammersmith & Fulham residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Hammersmith & Fulham residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospices/ specialist palliative care providers.
- This existing service will be expanded to support Hammersmith & Fulham residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Hammersmith & Fulham residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Hammersmith & Fulham residents will have improved access to bereavement and psychological support services with a common core

offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Hammersmith & Fulham residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Hammersmith & Fulham residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Harrow

Summary of service improvements for Harrow residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Harrow residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. The service will also be expanded to operate 7-days a week as opposed to the current 5 days a week (Monday to Friday). Harrow residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Harrow residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Harrow residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Harrow residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Harrow residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Harrow residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support, as well as expanded to support non-cancer lymphoedema diagnoses which is currently a gap in provision for Harrow.
- Harrow residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Harrow residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Harrow residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Hillingdon

Summary of service improvements for Hillingdon residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Hillingdon residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Hillingdon residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Hillingdon residents currently have access to dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. This service will be improved through a common core offer that will be available to all boroughs of NW London.
- Hillingdon residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Hillingdon residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.
- This existing service will be expanded to support Hillingdon residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and Well-being services

- Hillingdon residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Hillingdon residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Hillingdon residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Hillingdon residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Hounslow

Summary of service improvements for Hounslow residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Hounslow residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team
This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Hounslow residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Hounslow residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Hounslow residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Hounslow residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Hounslow residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Hounslow residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of lymphoedema support and expanded out-patient clinics to include medical and nurse led clinics
- Hounslow residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Hounslow residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Hounslow residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Kensington & Chelsea

Summary of service improvements for Kensington & Chelsea residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Kensington & Chelsea residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Kensington and Chelsea residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community in-patient bed care

- Kensington and Chelsea residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Kensington and Chelsea residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Kensington and Chelsea residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.
- This existing service will be expanded to support Westminster residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Kensington and Chelsea residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Kensington & Chelsea residents will have improved access to bereavement and psychological support services with a common core

offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Kensington & Chelsea residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Kensington & Chelsea residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Westminster

Summary of service improvements for Westminster residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Westminster residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Westminster residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community specialist in-patient bed care

- Westminster residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available across all boroughs of NW London. They are currently only available in Hillingdon.
- Westminster residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Westminster residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.
- This existing service will be expanded to support Westminster residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Westminster residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Westminster residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Westminster residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Westminster residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Report to the North West London Joint Health Overview Scrutiny Committee – 05 December 2023

North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

No. of Appendices:	**2** Appendix 1: 2022/23 North West London JHOSC Recommendations and Information Requests Tracker Appendix 2: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Chatan Popat, Strategy Lead - Scrutiny Strategy and Partnerships, Communities and Regeneration Brent Council chatan.popat@brent.gov.uk 02089375068

1.0 Purpose of the Report

1.1 To present the latest 2022/23 and 2023/24 scrutiny recommendations tracker to the North West London Joint Health Overview Scrutiny Committee (NWL JHOSC).

2.0 Recommendation(s)

2.1 That:

The committee note the latest 2022/23 and 2023/24 scrutiny recommendations tracker municipal year in Appendix 1 and 2.

3.0 Detail

3.1 The North West London JHOSC, according to its Terms of Reference can make recommendations to the North West London Integrated Care System and its Integrated Care Board, NHS England, or any other appropriate outside body in relation to the plans for meeting the health needs of the population.

3.2 The North West London JHOSC may not make executive decisions. Recommendations made by the committee therefore require consideration from the relevant NHS body. When the North West London JHOSC makes recommendations to NHS bodies, the relevant decision maker shall be

notified in writing, providing them with a copy of the committee's recommendations and a request for response.

3.3 The 2022/23 and 2023/24 North West London JHOSC Recommendations and Information Requests Tracker (attached in Appendix 1) provides a summary of scrutiny recommendations made during the previous municipal year. This tracks decisions made by NHS colleagues and gives the committee oversight over implementation progress. It also includes information requests, as captured in the minutes of its committee meetings.

3.4 Updates to the tracker from the previous meeting are highlighted within the table.

Appendix 1: 2022/23 North West London JHOSC Recommendations and Information Requests Tracker

Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
20 July 2022	Elective Orthopaedic Centre at Central Middlesex Hospital	Information Request	To receive details in writing about what the full business case may look like.	Pre-consultation business case shared separately as a PDF.	
		Information Request	To receive details in writing of the consultation & engagement.	A paper was brought to the December JHOSC meeting for members to review.	
		Recommendation	That the NHS considers the best strategy for the consultation to reach as many people as possible, utilising key partners across NW London.	Complete. Consultation closed on the 21st Jan. Further information going to JHOSC w/c 30 Jan and discussion expected at March meeting. Final decision expected at ICB Board of 21 March. Consultation plan been to JHOSC	
		Recommendation	That the committee agrees to the NHS embarking on a full consultation that starts on the first week of September.	Consultation began in October after being delayed by one month	
		Recommendation	That a clear reference is made to how the findings of the consultation will input into the business case.	Complete. This is covered in the decision making business case that is going to JHOSC.	
		Recommendation	That the full business case is brought back to a later meeting.	Agreed. Expected March meeting.	
		Recommendation	That the NHS provide an effective communication strategy to clearly set out the pathway from primary to secondary care for patients and residents across NW London.	Part addressed by the communication strategy within the winter plan and also picked up within the 'we are general practice campaign' discussions. The NHS runs frequent national and local campaigns on these issues.	
	Community Diagnostic Centres	Information Request	To receive in writing the detail of the engagement that has already taken place on this issue.	PowerPoint shared separately.	
		Information Request	To receive projections and real time data of centres impact on a number of key performance indicators, and how it will impact local A&E services.	The document above covers both information requests.	
		Recommendation	That communications and messaging are clear for local communities; to make the distinction between the new diagnostic	LNWUHT are apparently in contact with Cllr Crawford on the programme	

			hub and existing diagnostic facilities at Ealing Hospital and other Community Diagnostic Centres clear.		
		Recommendation	That decisions made in regard to community diagnostic centres are made with consideration of new data.	Complete. Public engagement is planned as part of the process of developing the centres and we are happy to work with councillors on this.	
		Recommendation	That NHS colleagues help to facilitate site visits to the Ealing Hospital and other Community Diagnostic Centres where appropriate.	LNWUHT are apparently in contact with Cllr Crawford on the programme and site visits for local OSCs. Brent officer discussed site visit in early 2023.	
		Recommendation	That NHS colleagues are invited to relevant borough scrutiny committees	Agreed.	
	North West London Integrated Care System Update	Recommendation	That consideration is given to local authorities having a substantial role in the governance of the NWL ICS.	Confirmed constitution has been amended to increase LA partner voting members from one to three.	
		Recommendation	That a robust plan is developed for tackling current waiting lists in NW London.	Complete and covered in the performance reports shared by Rory.	
		Recommendation	That a framework is developed for monitoring performance of subcontractors in primary care.	In progress.	
		Recommendation	That a financially focused paper is brought back to this committee for review	Financial focused paper brought to October meeting.	
		Recommendation	That an Integrated Care System's update remains a standing item on each agenda.	This has been actioned.	
	North West London Health Inequalities Framework	Information Request	The committee has requested to receive the impact dashboard and timescales for implementation for health inequalities framework when available.	Word document shared separately.	
		Information Request	The committee has requested information on variance between boroughs and wards on flu / COVID vaccination uptake.	PowerPoint sent separately.	
		Information Request	Information to be shared on pathways into NHS employment for volunteers.	PowerPoint sent separately.	

		Recommendation	That NHS colleagues provide an annual update on health inequalities to monitor progress being made.	Agreed. The inequalities framework is overseen by a steering group chaired jointly by an LA CEO (Niall Bolger) and Trust CEO (Carolyn Regan). They will be producing regular updates on progress.	
		Recommendation	That NHS colleagues commit to undertaking processes of benchmarking and utilising best practice in their approach to tackling health inequalities.	Agreed and already happening as part of inequalities programme.	
12 October 2022	Primary Care Strategy and Performance	Information Request	To receive information on the current primary care performance data, and for it to be shared monthly.	PowerPoint sent separately.	
		Information Request	To receive financial implications on the use of the Additional reimbursable roles schemes.	There is an acknowledged issue with our ARRS claims, which the Primary Care contracts team are working hard to address, equally there is an issue with the ARRS data on the NWRS system, this is because they allocate ARRS roles under the Patient Facing designation, consequently in part due to the low GP submissions, something we are addressing and the way the NWRS collates the roles, the NWRS data does not reflect the actual numbers. At the end of Q2 it has for NWL approx. **157 FTE** ARRS roles. In fact we have **697.17 FTE** as at the end of Q2. To mitigate the issue with robust workforce data for the ARRS roles, until we can rectify the above issues, the Primary Care workforce team does an internal scoping of the roles each quarter, this is cross referenced against the NWRS and the claims data . This was initiated so we have accurate ARRS data and involves direct contact with the NWL PCN's to collate the information. This is to date the most robust ARRS data we hold. The roles per borough are as below: - FTE/ Borough - 99.33: Brent	

				- 54.60: Central - 93.10: Ealing - 99.17: Hammersmith and Fulham - 76.93: Harrow - 95.90: Hillingdon - 103.35: Hounslow - 74.81 West London 697.19: Total	
		Recommendation	To recommend that JHOSC members are proactively consulted with and have oversight of stakeholder and public engagement activities to share with their networks.	Community insight reports are published monthly on the ICB website https://www.nwlondonics.nhs.uk/download_file/2981/182	
		Recommendation	To recommend that the workforce model is appropriately balanced in order to ensure that patients are receiving equity of care across NW London.	Being covered in the NWL workforce paper at the December 7, 2022, JHOSC meeting.	
		Recommendation	To recommend that wait times for a routine GP appointment are collected and shared with the committee.	This will be published from 24/11 and can be found here: Appointments in General Practice, October 2022 - NDRS (digital.nhs.uk)	
		Recommendation	To recommend that the education and communication plan for navigating primary care systems is developed and shared when it becomes available.	Is being developed and will be available early next year.	
	Accident and Emergency Pathways and Performance, including London Ambulance Service performance	Information Request	For the committee to receive performance data from the trust board reports, and to receive data on a bi-monthly basis. The NWL ICS will take ownership for providing the data.	We will share monthly performance reports which will include LAS information.	
		Recommendation	To receive clear timescales and trajectory for when London Ambulance Service performance will improve.	**(From Daniel Elkeles)** **Demand and performance update** Between September and November, London Ambulance Service has seen demand grow across our 111 and 999 services. We have been at REAP (Resource Escalation Action Plan) level 4 since escalating to this level on 22 September.	

				We have also been working hard to prepare for challenges to come by bringing together three strands of action to help us meet demand across the winter: 1. The first of these is to recruit more staff. After recruiting 1,074 new starters since 1 April this year as part of our biggest ever recruitment drive, we have already been able to increase the number of ambulances on the road by up to 20 to 30 a day. We are continuing our focus on recruiting and training more call handlers and dispatch staff for our emergency operations centres. 2. The second set of actions relates to setting up more alternative care pathways to give our staff and volunteers further options to ensure patients receive the care they need. This is based on the success of schemes such as our six mental health response cars (where we team our paramedics with registered mental health nurses), which are now running across the capital. 3. Lastly, we are recruiting many more clinicians to our emergency operations centres to ensure patients waiting for an ambulance are kept as safe as possible and our sickest patients are prioritised. As the Service is an early adopter of NHS England's Category 2 segmentation pilot, our clinicians are in particular assessing these calls to ensure patients who are most in need receive the fastest response. This approach will not delay our response for patients who still require an ambulance. Instead, our expanded clinical team will be able to better direct people in need to the right care services for them. We are also continuing to work with our partners at integrated care systems and hospital trusts to address delays in patient handovers to emergency departments. As you will be aware, we have been working incredibly hard to move to a new Computer Aided Dispatch (CAD) system, known as Cleric. Our new CAD is being used by staff in our emergency operations centres to assess and prioritise 999	

				calls and to dispatch ambulance crews when they are needed. We are working with other trusts to help our transition to this new system and have set up processes to monitor patient safety and performance. The introduction of the new CAD has meant we have recently been putting the data we generate and record under a renewed level of forensic focus. This new level of scrutiny has revealed some anomalies that might be making some parts of our response time data unreliable and not reflective of our actual response times. This is not an issue with the new software but a general reporting issue and it is clear we need to look into our processes. As an open and honest organisation with a commitment to the highest quality patient care, at the Service we know that we have to take action to make sure we are recording data properly and are doing everything we can to reduce our response times. It is imperative that our patients and the communities we serve can also see a full and accurate picture of performance. To do this as quickly, fairly and transparently as possible, we have commissioned an independent review, in partnership with NHS England and our commissioners, which will be carried out by an expert external organisation that regularly works with the NHS. Independence and transparency are important to this process so that we can check we are doing the right things and can all have full confidence in our approach as we move forward. In the meantime, we have to continue delivering for patients by doing everything we can to improve our response times as we head towards winter. That will mean a renewed focus on Category 1 as well as Category 2 calls, getting the most effective mix of clinicians on the road, ensuring we have the vehicles available, and improving our processes for dispatch.	

	Community based specialised palliative care improvement programme	Recommendation	To bring a paper summarising emerging findings from the Borough Based Partnership's self-assessments tools to the committee	Rory Hegarty has spoken with Jane Wheeler who confirmed this will be addressed at a future JHOSC meeting. This will be address within a paper to the committee on the 12 September. Update: Status now green.	
	North West London Integrated Care System Update	Information Request	To receive information on the meeting schedule and agendas of the ICB and other meetings in order to share with relevant stakeholders	Rory to send as part of the regular fortnightly update including a key meetings grid.	
		Recommendation	For the JHOSC to be aligned with the ICB in agenda forward planning.	Fortnightly update from Rory should address this.	
	West London Changes to Hope and Horizon wards	Recommendation	To recommend that a meeting is set up between Ealing and neighbouring authorities to ensure that information on this issue is shared across boroughs, and to notify members when this meeting is set up.	Meeting took place 7 December 2022 at Royal Borough of Kensington & Chelsea	
7 December 2022	Elective Recovery and Cancer Care Backlog	Information Request	To receive the data validation figures on waiting lists numbers, that the NWL system has sight of to be shared with the JHOSC.	Monthly performance report is now being shared with JHOSC. Update: Status now green.	
		Information Request	To receive details of best practice in terms of Breast Screening uptake broken down by place for the NWL system.	Sanjeet sending what they have for NWL wide but don't have breakdown via borough currently but this is being worked on this year. Liz forwarded on 20/01/22	
		Information Request	To receive data and information on best practice in elective recovery in regard to North West London.	Elective recovery / elective care is now included in the performance reports.	
		Recommendation	To recommend that JHOSC members and community leaders are utilised to feedback and share messaging on Breast Screening and elective recovery with our communities.	Rory supplied JHOSC with Sanjeet's (Programme Director – Breast Screening Recovery Programme) contact details on 7th Dec - (sanjeet.johal@nhs.net) for any screening questions councillors might have. Sanjeet confirmed they are keen to share messages, key campaigns and pilot projects.	
	Winter Planning	Information Request	To receive information on how additional winter funding will be used at a borough	Sarah Bellman has shared the winter materials during 7th Dec JHOSC.	

			level, and what the impact of this funding will be for our residents.		
		Information Request	To receive more information on the collaboration between the ICS and Local Authorities on winter planning.	Sarah Bellman has shared the winter plan covering this item. Liz to also share winter plan paper.	
		Recommendation	To recommend that JHOSC members and community leaders are utilised as a way of communicating messages to our communities and for the NWL ICS to review the opportunities to tackle inequalities together.	Agreed: Sent winter messaging, performance report and involving chair and vice chair in discussions about 'we are general practice campaign'.	
		Recommendation	To recommend that information on winter planning is distributed more widely than local authority communications teams.	Complete: Sarah sent to JHOSC already and shared with leaders/CEO's. Noted the recommendation for the future.	
	North West London Workforce Strategy	Information Request	To receive information on how NHS NWL is tackling racism towards its staff as part of its workforce strategy.	**How NWL is tackling racism towards its staff as part of its workforce strategy:** As part of the Great Places to Work portfolio, the Include (Workforce Inequalities) pillar has adopted a multi-dimensional approach to tackling racism across NWL ICS, which recognises disparity between white and Ethnic Minority staff in their experiences and senior-level representation. This is a data-driven approach, which draws on insights from the Workforce Race Equality Standard (WRES) to shape system-wide interventions and seeks to address inequality through targeted interventions focused on organisational culture, leadership and structural processes. A current priority is reducing bias in the recruitment and selection process. To address this, we have rolled out the De-Bias Recruitment Toolkit across the system, which is designed for recruiting managers and presents a set of measures to improve the fairness and diversity at each stage of the recruitment process. The embedding of these inclusive recruitment practices is intended to increase diversity of representation at senior levels.	

				The ICS has also taken action to reduce the disparity between Ethnic Minority and white staff entering into formal disciplinary processes, by supporting system partners to adopt a just and restorative culture, focused on rebuilding relationships and learning from mistakes, in place of punitive action. At a senior level, this cultural change programme is complemented by the Building Leadership for Inclusion Initiative, soon to be delivered with the ICB Board, which will work with the Board members supporting them to undertake their role as inclusive leaders, in recognition of their individual and collective influence over organisational culture and structures. This programme has a particular focus on systemic racism and social justice. The Include (Workforce Inequalities) Programme has taken steps to ensure accountability for anti-racist actions at a local and system level, by establishing London's first independent Inclusion Scrutiny Panel, which acts as a critical friend to the Staff Inclusion/Workforce Inequalities Programme Board. We are also fostering 'Safe spaces' across the system, through the establishment of Freedom to Speak up Guardians across Primary Care, and there has been dedicated work to empower staff networks and amplify staff voice to ensure it is captured and incorporated into system-wide decision making. Finally, the Include/Workforce Inequalities pillar also assures progression across the system against WRES action plans to ensure sustained improvements to address workforce inequalities throughout Trusts, Primary Care and the ICB. Work is underway to align actions with Local Authorities as well.	
		Recommendation	To recommend that tackling racism towards NHS staff to be included and highlighted as an explicit part of the NHS NWL workforce strategy.	Bashir Arif has provided the paragraph above in response to the request from the JHOSC meeting for additional information relating to tackling racism. We include the points	

				he has made within our strategy as part of our NWL People Plan. Please also note that organisations have their own policies that set out how racism is managed, whether it is from service users or visitors abusing staff through to incidents between employees. In summary, it is not tolerated and processes are in place to ensure full investigation and follow up action is implemented.	
	North West London Integrated Care System Update	Information Request	To receive information on the proposed lengths of contracts as set out in the procurement update on 3.9 of the update report.	These contracts are part of an overall single with different specifications for the services listed below – all of which ends of the 30 Sept 2023 except ADHD which is currently not commissioned with Harrow Health CIC. There are ongoing discussions with the ICB and Harrow Health CIC regarding the future commissioning of ADHD services, but no decision has been made yet.	
		Recommendation	To recommend that the committee is consulted with on plans for the upcoming primary care campaign. With a focus group of JHOSC members explored as one of the methods of delivering this consultation piece.	The campaign has now launched which was done in partnership with the chair of the JHOSC. Update: status now green.	
8 March 2023	Elective Orthopaedic Centre – Summary of Consultation and Proposal	Recommendation	To recommend that a specific travel plan is developed that addresses travel related concerns expressed in the consultation to reassure patients and stakeholders.	We commissioned a detailed review of travel by public transport, helping to inform a three-step travel support solution, including the provision of free travel for patients unable to travel to or from the elective orthopaedic centre for their surgery independently or via an existing patient transport scheme and who would encounter a long, complex and/or costly journey by public transport. Our approach incorporated into the DMBC is to create a three-step travel offer for elective orthopaedic centre patients: **Step 1: Information – all patients** Provide all patients with the latest information on the range of options for travel to and from Central Middlesex. The information will be provided proactively, fully accessible and available in whatever languages and formats are required.	

				Step 2: Facilitation – all patients Provide all patients with practical support – via a team available by telephone or online – to help understand and book the different travel options and, wherever possible, to access additional support. **Step 3: Patient transport – eligible patients** For patients who are unable to travel to or from the elective orthopaedic centre for their surgery independently or via an existing patient transport scheme – and who would encounter a long, complex and/or or costly journey by public transport, we would provide transport – a car ambulance or taxi – free of charge. We will continue to collaborate with patients, community groups and local stakeholders to develop this approach. We currently anticipate that we would extend a transport offer to around a third of elective orthopaedic centre patients, including a small number of patients who currently have a complex journey to their local hospital and may not currently be eligible for support. While Central Middlesex is the most centrally located hospital in north west London but, wherever we place the centre, some patients will face longer journeys. We think the benefits of a single centre of excellence outweigh the inevitable downside of longer travel times for some patients. And we also believe we can significantly minimise the impact on affected patients. The transport solution is detailed in Chapter 4, section 4.3.1 of the DMBC.	
		Recommendation	To recommend that there should be monitoring of the quality of the elective orthopaedic services provided locally and at the centre located within Central Middlesex Hospital, to ensure that they are consistent and of the same standard.	The DMBC sets out how patient access/waiting times will be monitored for the EOC and across the NWL acute provider collaborative. This approach will be expanded across quality, workforce, and patient experience at the NWL EOC partnership and through NWL APC clinical quality and equality governance. In the DMBC, we have developed a more detailed framework for monitoring achievement of the anticipated benefits of the proposal across the four acute providers and the wider ICB. It includes a revised and expanded set of key performance indicators (KPIs) with clearly designated owners and validated	

				trajectories. This includes benefits under the following seven KPI themes: • Clinical outcomes and experience • Patient access • Productivity (Getting it Right First Time – GIRFT) • Cost-effectiveness • Transport • Patient satisfaction • Workforce There will also be detailed monitoring of benefits to ensure that local and national best practice benchmarks are achieved and feedback on cost-effectiveness, transport and patient experience. This will be undertaken through a gateway approach, with the programme required to pass through successfully each gateway before proceeding to the next. These KPIs will be reviewed by the Elective Orthopaedic Centre Management Board on a monthly basis within the governance model and through each gateway. The expected benefits realisation plan is detailed in Chapter 5, section 5.5 and Appendix C of the DMBC. Further detail on the design will be included in the Full Business Case (FBC) with continued development throughout the implementation period.	
		Recommendation	To recommend that more detail is supplied on how the NHS is implementing the consultation feedback on transport when this issue next comes back to JHOSC.	The transport solution has been designed to provide information and facilitation to all patients attending the elective orthopaedic centre for their operations, with transport being made available at no charge for any patients facing a long, complex, or costly journey to the elective orthopaedic centre. Our implementation of the solution will be fully developed through the implementation phase in readiness for go live in November 2023. We have already identified the patients and stakeholders that are likely to be affected by this transport solution and have consequently incorporated them into our co-design approach. Following the approval of the FBC, patients and key stakeholders will be further involved in the development of the transport solution, including the patient portal, scheduling, tracking system, communication and governance. We will undertake pilot testing of the transport solution to ensure that it meets the requirements of patients, providers	

				and other stakeholders while operating as intended. This will include collecting qualitative feedback from patients on their experience, reviewing patient attendance data, and uptake of the proposed solution. 4 The elective orthopaedic centre team including the care navigator roles will be aware of the travel support available to patients and the associated resources so that they feel confident about how to support patients to navigate their pathways. The development of travel information, facilitation and travel solution will be monitored through implementation and feature in the gateway assurance framework. The transport solution will be improved continuously through quality improvement initiatives based on feedback from stakeholders including JHOSC, emerging technology solutions, and as the elective orthopaedic centre is fully embedded in north west London's health and care system. The implementation approach is detailed in Chapter 5, section 5.8 of the DMBC and will expand on this through the development of a full business case and implementation plan, subject to approval of the DMBC by the NWL ICB on 21 March 2023.	
		Recommendation	To recommend that a communications campaign for the elective orthopaedic centre is delivered in conjunction with local government and other stakeholders.	Continued engagement and involvement with patients and carers, public, staff and local authorities is central to implementing the new model of care to better inform development of the elective orthopaedic centre and better allow continued improvement. We have built up a significant volume of insight over the past 18 months about what patients and local communities in north west London want and need from inpatient orthopaedic care and wider MSK services. This has been established through the public and patient involvement activities that informed the development of the initial proposal for an elective orthopaedic centre and even more so through the formal public consultation on the proposal and the IIA. We are committed to continuing to build and respond to this insight, to inform both the continued development and implementation of the elective	

				orthopaedic centre and supporting inpatient services and the related plans to improve community-based MSK services. It begins with ensuring we communicate proactively and openly with all of our audiences to raise awareness and understanding of what our services offer and what they involve, now and as they change. This will be an integrated approach across the APC hospitals and with community services. Patient information, including patient letters, will have a consistent approach in terms of content, terms, tone and branding, helping patients to experience our care as a joined-up pathway even as they move between their home orthopaedic hospital and the elective orthopaedic centre. We will also ensure that information about travel support options, follow-up care and help with queries or concerns as well as feedback prompts are widely publicised and consistent. 5 We then see the diverse contacts and relationships we have made through the engagement and consultation work to date as being central to continued engagement and involvement on inpatient orthopaedic services and wider MSK care. We propose doing that in the following ways: • Inviting the 200 plus people who took part in the consultation and who gave us permission to keep them informed – as well as the community organisations who supported us with particularly in reaching individuals not generally engaged with our services – to take part in involvement activities through a regular email update about the project (and wider MSK service improvements). • Continuing to include lay partner roles in the governance structure for implementation (including oversight of ongoing involvement plans and patient and community feedback and experience indicators). • Developing an iterative plan, employing a variety of methods, for expanding our understanding of patient and community needs and views to inform the further development and implementation of the elective orthopaedic centre and related care pathways. The iterative plan (plus the insights and responses to those insights) to be overseen as part of the main	

				project governance for implementation and for onward, continuous improvement: a) ad hoc co-design workshops for specific elements of implementation, for example, transport options b) patient panels – for feedback via email, for example, on patient information c) surveys d) focus groups e) continuing to triangulate existing sources of patient feedback and insight. The communications and engagement plan is detailed in Chapter 5, section 5.4 of the DMBC.	
		Information Request	To receive a response to the query regarding the disparity across North West London boroughs in the response rate to the quantitative survey.	The NHS took an identical approach in each of our eight boroughs to holding engagement events and promoting the survey. There is no obvious reason why the response rate in some boroughs was higher than others; the only explanation more residents chose to respond in certain boroughs	
		Information Request	To share the final travel plan for visitors, patients and staff with the committee when it becomes available.	**Response from LNWH NHS Trust** The travel plan for the Elective Orthopaedic Centre (EOC) is currently being co-designed with patients and remains on track with published timeline for the end of October 23. Following the approval of the Full Business Case in April 2023, we held a public engagement webinar on Tuesday 20 June. At this webinar we asked for members of the public to volunteer to be members of our transport working group. The working group meetings are underway (first meeting 5 July 2023) and includes both patients, councillors, residents and other stakeholders. We expect to share the output of the transport working group with the EOC partnership board in late summer.	
	North West London Integrated Care System Update	Information Request	That NHS North West London provides comparisons to other London Integrated Care Systems' performance on key metrics as part of the regular performance report sent to the committee.	The performance report focuses on delivering improvements against the agreed ICS/programme ambitions. These ambitions are based on national/regional benchmarks, plans and standards. In the performance report, we provide London and regional averages to all available metrics on the borough scorecard. Programmes also include specific benchmarks in the detailed report.	

		Information Request	To provide more information on the planning work being undertaken for the roll out of the Spring 2023 Covid booster.	NWL Strategic Slides have been attached separately for the committee.	
		Information Request	To receive details on how the NHS will ensure that patients who need to be moved from the Butterworth centre will be moved seamlessly into alternative care.	A letter to the Lead Members of Westminster and RBKC councils have been received, which outlines that all residents have been safely transferred to alternative accommodation	
		Information Request	To provide the JHOSC with the details of the final North West London workforce strategy when it becomes available.	The Workforce strategy will be a section of the wider ICS Strategy. We are currently discussing and agreeing the key workforce programme priorities to ensure these align with the national long term workforce planned that was published at the end of June. This is a work in progress until September and we hope to share/update post September.	
	Inpatient Mental Health Bed Capacity across North West London	Recommendation	To recommend that the NHS work with the JHOSC to engage on a mental health specific estate strategy by bringing this item to a future JHOSC meeting.	The scope of the mental health strategy is still being agreed and we will share when done.	
		Recommendation	To recommend that the NHS works with the JHOSC to shape the future public consultation on the Gordon Hospital.	Plans for consultation in September now being discussed – will be ICB led, with CNWL support, and are happy to be advised by JHOSC on scrutiny arrangements.	
		Information Request	To provide further information on the current spend by West London NHS Trust on mental health services across the three boroughs, the spend available per resident, and how the money was allocated so that the JHOSC can effectively scrutinise the future development of mental health services across North West London.	In 2020/21, a strategic review of need, current provision and investment was undertaken to support future planning of adult and children and young people's community mental health services over the remaining period of the NHS Long Term Plan. The wider aims of this review were to tackle inequalities, reduce inequity within and across boroughs, and ensure that future resource allocation is based on mental health need, with a consistent offer across North West London. Specifically to address the requirement that mental health services be better aligned to the needs of the population, to: (1) Improve outcomes in population health and healthcare; (2) Tackle inequalities in outcomes, experience and access; (3) Enhance productivity and value for money; and (4) Help the NHS support broader social and economic development.	

				The review was based in investment made by the then eight CCGs in 2019/20 and showed that overall investment had been higher in inner boroughs on total investment, and on a per head of population (weighted by need); but a simple inner/outer borough narrative on investment masked service-level variation. Variation existed both in terms of £ per person, as well as proportional split of funding across services (NB: the review did not account for any local authority funding). The review highlighted that an isolated view on investment did not take account of service provision, workforce or outcomes, and in particular need. To fully understand this picture would require more detailed analysis at a team level and that wide scale reapportionment based on a simple funding gap formula was not advocated. Further to this, the levers of a single ICS, enabled by a maturing provider collaborative offered routes to address this level of investment variability, also factoring in workforce, outcomes and service models. Looking ahead to 2023/24, and since the establishment of a North West London ICB, investment into mental health services is not formally reported on a borough (or previous 8 CCG) footprint however, this will be provided following finalised agreement. Work is underway to detail how the recurrent £30.35m Is invested at a borough and service level. This will be in line with North West London's financial strategy, which specifically, for mental health services means that the investment will: • Improve access and target investment to those communities with highest need; • Improve activity reporting, to understand the cost base and improve efficiency; • Reduce the cost of, and reliance on, treating patients outside North West London; and • Reduce service duplication by working as a system.	

		Information Request	To receive details on how the move towards community based mental health care will impact residents, referencing results from integrated impact assessments undertaken.	Work is underway to refine North West London's mental health strategy, in particular, continuing the shift to community based models of care and investing in alternatives to admission. Our aim across North West London ICS is, and always will be, to ensure that we provide the highest quality, compassionate, trauma-informed and most appropriate mental health care for people who need it across our boroughs. This includes inpatient facilities that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required. We follow the principle that mental health care should be in the least restrictive setting and acute inpatient care should always be an absolute last resort. In order to achieve this vision, North West London ICS maintains a focus on the following principles: 1) Continuing the shift to community based models of care and investing in alternatives to admission; 2) Ensuring a person-centred therapeutic environment and experience when an admission is needed, to enable reducing length of stay to the national average, and positive outcomes e.g. no readmissions; 3) Eliminating adult acute inappropriate out of area placements; and 4) Ensuring high quality estate. In early 2019, North West London ICS embarked on a journey to significantly transform community mental health services in order to respond to local needs and deliver the requirements of the NHS Long Term Plan. As an early implementer site, North West London ICS launched a new model of community mental health care which enabled more people to receive personalised care in the community, closer to home. Significant investment has been made over the past four years to support the transformation of community mental health services across North West London. This transformation complements North West London's dedication to improving	

				the record sharing and communication channels between primary and secondary mental health care. As part of this journey, North West London ICS has also re-designed its crisis services to ensure appropriate community-based crisis care (clinical and non-clinical alternatives), and reduce preventable admissions to inpatient services. Significant investment has been made over the past four years to expand crisis teams to provide 24/7 assessments within the community, and a range of community based and Voluntary, Community and Social Enterprise provided crisis alternatives to attendance at Accident & Emergency (A&E) Departments and admission to inpatient care were developed, providing non-clinical alternatives	
		Information Request	To receive feedback from patients and carers from West London NHS Trust's enhanced engagement when available.	Ealing adult mental health beds (westlondon.nhs.uk)	

Appendix 2: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker

Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
18 July 2023	Acute beds	Information Request	For the JHOSC to receive ongoing updates regarding extra capital funding for acute beds in relation to winter pressures	Slides around this have been shared with wider council colleagues, as suggested by the JHOSC in July. We should have some more clarity on next steps later in September.	
		Information Request	For the JHOSC to receive more detail on horizontal and vertical working between community and acute settings and how this is working in practice across North West London. With a view to reviewing this working at a future meeting of the JHOSC.	Response is to follow.	
		Information Request	For the JHOSC to receive updates on the work undertaken by Acute Trust and the ICS to progress the work at delayed hospitals in the New Hospitals Programme.	**Imperial College Healthcare redevelopment update - August 2023** Following the concerns we raised about the delays announced for our schemes (at St Mary's, Charing Cross and Hammersmith hospitals), we hosted a visit at St Mary's in July from Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care. We were able to show the minister the very damaging impact of our failing estate on patients and staff and set out the many benefits of our redevelopment plans, including for the local and national economy. We had a good discussion about the work we have underway to explore the feasibility of potential partnership opportunities that could accelerate the St Mary's redevelopment, leveraging the value of the land that will be surplus to requirements once we have a new hospital on a less sprawling footprint. We are due to meet Lord Markham again in early autumn to update him on the outcome of this work. We have also had significant engagement with the New Hospital Programme team and we are currently working through a process with them to test our capacity and cost	

				modelling for all three of our schemes. We are still hoping to complete a first stage business case for Charing Cross and Hammersmith this autumn and, depending on the outcome of the St Mary's partnership feasibility work, to secure first stage business case approval for St Mary's by the end of the year. While there is still much to be clarified in terms of further process and decision making, progressing our business cases has to be a priority whatever route we take. Meanwhile, our estates team is working hard to delay any further major buildings failures for as long as possible. You may have seen the extensive scaffolding in place at Charing Cross and, more recently, St Mary's. Works include an extensive weather-proofing programme for our oldest buildings at St Mary's, roof repairs at Charing Cross and essential inpatient ward refurbishments across our sites to ensure we are able to maintain infection prevention and control standards. We are keen to continue to share our thinking and plans as they evolve. We also want to engage more broadly with our patients and local communities as soon as we have a little more clarity on next steps.	
	Ophthalmology	Information Request	For the JHOSC to receive more details on the ongoing engagement work related to the standardisation of ophthalmology services.	Engagement so far has been through a series of online and face to face sessions, supported by surveys. As part of the new community service the selected provider will be expected to work with the Integrated Care Board in undertaking focussed patient engagement, looking at experiences of using the service and opportunities to improve the service to better meet the needs of all of our communities. As we further develop the standardisation, the intention is to work with patient representatives to co-design pathways in partnership with primary and secondary care clinical	

				stakeholders. These co-design workshops will be supported by targeted community engagement activities where co-designed pathways will be introduced and feedback from our communities gathered to support further improvements. These activities will commence later this year and continue for the duration of this contract (i.e. 3 years)	
		Information Request	For the JHOSC to receive more information on how the standardisation of ophthalmology services will address health inequalities in North West London.	Standardisation of our ophthalmology service will support the drive to address health inequalities in NW London by: • Ensuring that there is a standard service offering available to all NW London residents – in particular this includes ensuring that all NW London residents have access to a community ophthalmology service • Ensuring that residents are able to access primary eye care through the large number of optical practices available across NW London, which will make it more convenient for patients to access care The ICS will work in partnership with all of the key stakeholders in our communities, bringing them together with colleagues from primary and secondary care and public health to understand how we can better support communities in accessing eye care.	
		Information Request	For the JHOSC to receive baseline data on performance in ophthalmology services in order to measure performance in North West London against national and London standards. With a breakdown by paediatric and adult ophthalmology service performance.	Data will be provided for future JHOSC meetings showing performance of North West London ophthalmology benchmarked locally and regionally. This reporting will commence when the community ophthalmology service is in place and will cover the complete pathway from initial optician appointment through to secondary care access and outcome.	

	Musculoskeletal (MSK)	Recommendation	To ensure that diagnostic capacity across North West London is properly linked to musculoskeletal services to best benefit residents across North West London.	Recommendation has been taken to Diagnostic colleagues and will feedback to the JHOSC in due course.	
		Information Request	For the JHOSC to receive baseline access wait times for musculoskeletal services and details on how the new service standards will improve waiting times for treatment.	This is currently being collating this as part of the Community wait times work. This detail isn't available for all boroughs yet but it will be shared with JHOSC once ready.	
12 Sep 2023	Review of Palliative Care	Recommendation	For JHOSC to receive design principles around partnership working to enable patients and families to hold partners to account, following the implementation of the new model.	TBC	TBC
		Recommendation	Bring a report on advanced care planning for palliative and end of life care to come to a future JHOSC meeting.	Waiting for response / confirmation of the suggested meeting date.	
		Information Request	To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.	Separate paper supplied on 27/11/23 to Chatan	
	North West London Mental Health Strategy	Recommendation	Provide a report to a future JHOSC meeting on the engagement with Directors of Adult Social Care at each borough around coordinated activity on mental health within the region.	We are seeking clarification on this point outside of the meeting.	
		Recommendation	Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.	We are currently working through the Children and Young People Mental Health Steering Group to refresh our Children and Young People Mental Health transformation plan and also intend to focus the strategy work on Children and Young People in the new year. Could this could be added to a JHOSC meeting in March?	
		Information Request	To receive the details of the alternative provision to accident and emergency located across the boroughs.	An interactive map can be found here	
			To receive further details around on the engagement plans when available.	Yes, we can do this, the interim engagement report from the strategy work should be on our website next week.	

		Information Request	To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.	As we further develop the mental health strategy, this will include a strengthened focus on inequalities.	
	Proposals on the future of The Gordon Hospital	Information Request	To provide the following: • The commentary and output of the pre-consultation workshops. • Completed and upcoming events with service users and carers. • Service users' experience of Gordon Hospital. • A more detailed consultation plan. • Historical reports of Gordon Hospital service users over the last 5years. • Historical demographic data of Gordon Hospital service users.	This information is published on the ICB website. Acute mental health consultation :: North West London ICS (nwlondonicb.nhs.uk)	