DRAFT North West London Joint Health Overview and Scrutiny Committee
Notes of hybrid meeting by LB of Brent
10am-12pm on 23 September 2021

The meeting began at 10am.

PRESENT

Members of the Committee:

- Councillor Ketan Sheth (Chair) – London Borough of Brent
- Councillor Richard Eason – London Borough of Hounslow

IN ATTENDANCE REMOTELY:

- Councillor Daniel Crawford (Vice Chair) – London Borough of Ealing
- Councillor Lucy Richardson – London Borough of Hammersmith & Fulham
- Councillor Rekha Shah – London Borough of Harrow
- Councillor Marwan Elnaghi – Royal Borough of Kensington and Chelsea

Others Present:

- Rory Hegarty – Director of Communications & Engagement, NWL CCG;
- Pippa Nightingale – Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG;
- Lesley Watts – Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust
- Nicola Zoumidou – Policy Analyst, London Borough of Hounslow
- Andrew Phillips – Governance Officer, London Borough of Brent
- Hannah O'Brien – Governance Officer, London Borough of Brent
- Jacqueline Barry-Purssell – Senior Scrutiny and Policy Officer, London Borough of Brent
- Anna-Marie Rattray – Scrutiny Review Officer, London Borough of Ealing
- Artemis Kassi – Lead Scrutiny Advisor / Statutory Officer, Westminster City Council
- James Diamond – Scrutiny Officer, Royal Borough of Kensington and Chelsea
- Nahreen Maitlib – Interim Head of Policy, London Borough of Harrow
- Bathsheba Mall – Committee Co-ordinator, London Borough of Hammersmith & Fulham
- Dr Genevieve Small – Chair, Harrow CCG

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1. Apologies were received from:

- Councillor Iain Bott, Westminster City Council
- Councillor Monica Saunders, London Borough of Richmond

2. DECLARATIONS OF INTEREST

2.1. Councillor Ketan Sheth declared a personal interest that he was the Lead Governor at Central and North West London Foundation Trust (CNWL).

3. MINUTES OF THE MEETING HELD ON 4 JULY 2021

3.1. The Committee reviewed the minutes of the last meeting, and following discussion it was

It was agreed in principle, subject to ratification at the next quorate meeting:

That the minutes of the meeting held on 4 July 2021 be agreed as a correct record of proceedings.

4. MATTERS ARISING

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

5. NORTH WEST LONDON NHS ACUTE HOSPITAL STRATEGY

5.1. Toby Lambert (Director of Strategy, NWL ICS) introduced the item and gave an overview of the strategy. It was noted that the purpose of the report was to make colleagues aware of the new strategy as the move to the formal establishment of an integrated service occurred across North West London. The update also provided information on four sites in the Government's hospital building programme, those four sites being Hillingdon Hospital, St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital.

5.2. In introducing the report, he noted that:

- Though this was labelled as an acute strategy, it was purely focused on the hospital sector.
- Toby noted that the strategy focused on two narratives, one being assessing the top needs of the population and how this fed into outcomes and variations. After this the model of care could be analysed, with a particular focus on out of hospital care to look at what needed to happen within the hospital sector.
- The second narrative was highlighting that hospitals were major building blocks in local communities, which meant assessing the redevelopment of hospitals to give an opportunity to address broader health inequalities.
- Toby went through the narratives and the strategy for North West London hospitals, tying in to the overall acute strategy.
- There had been an increase in emergency work, elective work, and now a growth in demand around mental health support, in children and young people in particular. Consideration was required for allocation of resources between all of these.
- Collaboration was happening and welcomed by NHS and Local Authorities.
- There had been open and transparent discussions with citizens and patients.

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

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

5.3 Cllr Richardson welcomed the duality of narratives, however raised concerns that some of the strategy was top heavy, noting that a more detailed/bottom up strategy could be provided in terms of the engagement activity. He added that it was important the local NHS recognised the importance of local needs with a hyper local approach, looking at the wider social determinants of health. The Committee would welcome the Strategy having more detail from residents, including patient interaction with receptionists and patient participation group feedback. Toby Lambert noted that the engagement approach was being worked on and a lot of the focus would be on population health inequality work which fed in to the strategy. He assured councillors that the hyper local inequalities work was happening and was happy to present further details to the Committee on how that might work in practice. In relation to how the strategy would include every patient's voice, including those difficult to hear from, the Committee were advised that patient reference groups could be expanded. The ICS looked to reach all communities to take part in those groups, and outreach work during the pandemic had established closer relationships with community leaders, faith leaders, and charity and third sector groups. A new engagement approach was in the pipeline to be launched in October 2021 which would focus on health inequalities. Toby Lambert advised that more information could be provided to the Committee then.

5.4. Cllr Elnaghi asked how the ICS would address variation in patient outcomes in terms of health inequalities, highlighting the need for more data driven content in order to build on the policies to develop the strategy. He felt the ICS should be going to the users, whether that be through going to schools, young adults and the wider community as well as building capacity to use services provided by pharmacists. Pippa Nightingale (Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG) noted that policy could be formulated through co-design rather than solely resident engagement. The co-design of a clinical pathway was noted as a policy which could assist with this goal. It was acknowledged by Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) that the approach should be for all NHS leaders and local authority colleagues to address inequalities and variation in outcomes. She felt this was demonstrated through mutual aid and the approach to elective care, where the longest waiters were being offered treatment from inner NWL hospitals. It was also highlighted that North-West London ICS had committed to a very fair and equitable approach.

5.5. Lesley Watts noted that this strategy was designed for both emergency and elective care procedures. This strategy did not stand on its own but with strategies for primary care, out of hospital care and local care. It was clarified that the strategy was starting to articulate how acute units and hospitals worked together to ensure that they could respond in the most positive way, to ensure that when patients needed to be in hospital there was capacity to take them in emergency and elective care.

5.6. The Committee would like to see the different initiatives discussed included in one strategy. Lesley Watts advised that the strategy was a work in progress and all the work streams discussed would be brought together, such as how housing and transport were integrated in to it. Rory Hegarty (Director of Communications) added that the new engagement approach due to be launched in October would include outreach with community groups and increasing that through local authority networks.

5.7. Cllr Crawford noted there was good commitment around the new hospitals programme, and queried how this would affect North West London hospitals. He felt that it would be good to learn more about the strategy in advance of its publication. Lesley Watts reassured the Committee that the new hospitals programme from central government would not lead to the closure of other local hospitals as it was designed to get hospitals built. The current hospitals in NWL being built within that programme were being built on the understanding they would provide the services they currently did. It was also stressed that inequalities would not be able to be addressed unless the ICS carefully considered how and where services were provided. Lesley Watts advised that this did not mean there would be no change, but any change would be considered together with patients, staff and other leaders such as Chief Executives of local authorities. As the programme was based on a no-change programme any change would require consultation and engagement.

5.8. In response to a query, the Committee were advised that there was a piece of work reviewing how many current ICU beds would be required in the longer term. The increase in number of beds had been retained until that work was done.

5.9. In relation to the use of pharmacists in the wider community, the Committee were advised that pharmacists were trained to be able to consult and prescribe medication, but were not currently used in that way, which could be further looked in to.

5.10. Cllr Eason asked whether the strategy would take account of projected population changes in the sector and of housing growth in many areas of North-West London such as Brent. He highlighted the strategy would need to consider the location of patients as well as workforce. This also related to transport systems by both road and rail, taking into consideration transport planning for London. It was noted that this strategy could contribute to transport planning. Toby Lambert confirmed that population growth had been accounted for in the strategy, using the higher end predictions from the latest GLA housing projections. In terms of transport, it was acknowledged that transport links which were in the pipeline would be considered for future planning.

5.11. Cllr Sheth asked what provisions had been made around primary care and GP services to ensure that locations could be fit and proper for healthcare. Dr Genevieve Small (Chair, Harrow CCG) explained that some of the challenges seen with new housing developments were that some of the planning was completed before Covid-19 and before the health perspective on infection control. It was felt that the resources and new builds should be made appropriate for the ‘Covid age’. Dr Genevieve Small also stressed that, as well as the health services needed, it was important for new communities in emerging housing to be able to utilise existing local resources to access the wraparound support that would keep them well. It was noted that the holistic approach to care was important, and this included services such as mother

and baby groups for new families, pharmacies and primary care, and was not focused exclusively on hospitals and outpatient departments. Finally, health colleagues felt it was important to strike a balance between community and hospital provision, as well as keeping up with changing demographics.

5.12. The Chair thanked health colleagues for their responses and closed the discussion. The Committee were invited to make recommendations with the following RESOLVED:

i) For an update on the acute strategy (including links with other strategies) to come back to the Committee at its December meeting.
ii) For the committee to review the acute strategy before being finalised.
iii) To note the report.

As well as recommendations, a number of requests for information were made during the discussion, recorded as follows:

1. For NHS colleagues to provide the committee with further details of the specific engagement activity underway focused on the acute strategy and future plans.
2. For NHS colleagues to provide the committee with details of the data being used to focus activity on reducing health inequalities.
3. For NHS Colleagues to provide the committee with a copy of the draft acute strategy.

6. INTEGRATED CARE SYSTEM (ICS) UPDATE

6.1 Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) and Pippa Nightingale (Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG) introduced the item by stating that hospitals and GPs had resumed services and were very busy; including the national ambulance workload and emergency work, as reported nationally.

6.2 Pippa Nightingale spoke about the vaccination programme. There had been close to 3m vaccines given in North West London at the time of the meeting. There were now four arms to the vaccination programme. The first arm of the vaccination programme was the ‘evergreen’ offer’, with 900 people vaccinated every week for their first or second dose in NWL. The second arm was the booster campaign, offered through vaccination centres, primary care settings and community settings for over 50s. The third arm was schools vaccinations which went live on Tuesday 21 September, with an 84% uptake from children in the first schools that went live. The aim was for every school in NWL to administer the first vaccine before October half term. The fourth arm of the programme was the third vaccine for Clinically Extremely Vulnerable cohort - this was an additional vaccine rather than a booster as advised by the JCBI. The Committee were advised there were approximately 2.4m vaccinations that needed to be given over the next few months.

6.3 The Committee were provided with an update on vaccinations for those on the serious mental illness (SMI) register: over 60% of people aged 16-64 years old on the register had received at least one dose of the vaccination by the end of July. The ICS wanted

to ensure a mental health assessment was in place for patients through primary care and that they had access to the vaccine as they were a vulnerable population. Primary care were making contact with those patients where they had not come forward to be vaccinated, and where those patients were coming forward to be vaccinated the ICS were trying to ensure that it was a 'meaningful contact' in one complete offer, for both mental health patients and those with learning disabilities. The Committee were advised that learning disability schools were proactively working with the ICS on vaccinations and the parents and carers of those children were engaged in the model. For example, there had been dedicated quiet times in vaccination centres to enable those with learning disabilities to be vaccinated, with learning disability colleagues there to support that. In relation to mental health in general, Lesley Watts advised that there had been an increase in the number of patients attending emergency departments, and the ICS were working closely with mental health units, particularly in child adolescent mental health, to ensure that the demand was met.

6.4 The Chair thanked Pippa Nightingale and Lesley Watts for their introduction and invited comments and questions from the Committee, with the following raised:

6.5 The Committee queried whether it was possible to get data from other boroughs to compare their vaccination figures for people on the serious mental health illness register. Pippa Nightingale confirmed that there was borough data that could be sent to the Committee.

6.6 The Chair asked about how Afghan refugees were being supported in NWL. ICS colleagues advised that this was an important piece of work. All 946 individuals originally accommodated in NWL had now been moved out of isolation hotels and into 'bridging' accommodation in inner London Boroughs within NWL. The Committee were advised that the Department for Health and Social Care commissioned the care to Afghan Refugees and the ICS had put in place a whole layer of healthcare provision on top of that. For example, the mental health team from CNWL had done a lot of mental health first aid, assessments and emergency treatment in order to support refugees who had experienced traumatic incidents. Additionally, those who had to leave imminently without essential medications were being contacted by GPs to understand their complete healthcare needs. There was also support for pregnant people and the right maternity pathways were in place, with 96 pregnant people currently in accommodation in North-West London being supported by 12 midwives with 1:1 support. The primary care offer involved 24 hour access to 111 support, prescription writing, and health assessments, where GPs were registering individuals and families in their practices and then doing a full health assessment. The Committee were advised that the situation was becoming more stable and NWL would continue to provide that support to people joining the population.

6.7 Cllr Eason highlighted section 2.7 of the report and the work on mental health crises care and suicide prevention, asking about the scale of this work across the 8 boroughs. It was noted by the ICS that this was an important piece of work in order to minimise mental health crises which resulted in suicide. It was noted that this was initially a scoping piece of work; scoping what services already existed in each Borough and learning from different boroughs which models of care could be most effective. The ICS had also looked wider with the National Health Transformation Board to see what places outside of NWL were doing to reduce mental health crises. It was confirmed

that the ICS could report back what that model of care would look like. Lesley Watts added that it was a piece of work that was very important to the mental health offer in North-West London and there was a determination within the ICS that patients across the whole of NWL would have access to this service.

6.8 Cllr Eason noted that it was good to look at best practice nationally, and highlighted the importance of provision for those who may drop off the radar when moving locations or between boroughs.

6.9 Cllr Eason highlighted section 2.9 of the report relating to children's mental health, asking what the 35% access rate meant in terms of the other 65%. ICS colleagues highlighted that, during Covid-19, hospitals had seen that when children were presenting in crisis it was the first time they had presented and they were not previously known to mental health services, which was unusual previously. The number of children and young people presenting was increasing, and the age range was becoming younger. This had changed the way that care needed to be provided. Support in schools was being expanded and the children's mental health team had done some successful co-production with children and young people so that they could access care in other places. Where children presented in A&E they often stayed a long time in a specialist bed, so the ICS were looking for somewhere those children could be admitted for a short period of time with intensive support to get them back in to their home environment. There was not a one size fits all answer on this issue. In relation to the query regarding the 35% access rate, the Committee were advised that this was a national target for children and young people being seen, referred and treated in a timely way from when they first presented.

6.10 Cllr Richardson was interested to know more about co-production with young people and which boroughs this had been implemented in. It was clarified that many of the charity arms had supported this work which had been building momentum before Covid-19; this work was supported by Arsenal and Chelsea football clubs, who had a huge mental health and youth work provision. They had brought children from across the whole of NWL to take part in the sessions with 72 children attending over the 3 sessions. These were children who were previously known to mental health services, either through schools, online platforms or through tertiary mental health support. The Committee were advised that the sessions looked at what the mental health system should look like and was interesting, with the ICS looking to do more of this type of work. From this consultation, it was noted 24/7 online support was the preferred medium for a lot of young people accessing mental health support. Regarding online platform support offers, it was noted that there were currently three in existence. One was run by the Royal Minds Mental Health Trust, which had been commissioned for adolescents' mental health and wellbeing. There was also the Kooth interactive platform which could be accessed by children when they need support such as talking therapies and support groups. It was noted as being important to work in partnership with education to signpost these services.

6.11 Regarding the delivery of the vaccination programme, Cllr Richardson noted that Brent had very little administered by pharmacies; additionally half of the NWL boroughs were below average in terms of take-up and she queried how mistrust and misinformation around the vaccine was being addressed. Pippa Nightingale explained that, in terms of Brent's uptake in pharmacies, Brent had fewer pharmacies offering vaccinations in

the first stage of the programme, but now had 8 pharmacies offering the vaccination, so there may be a switch in the data following those additions. In terms of the low vaccine uptake in NWL, it was noted that some ONS data was outdated and did not reflect who was in the borough; however, public health messages still needed to be shared with the public and the ICS continued to do that and continued to see more people coming forward to be vaccinated. There were 46 pharmacists across NWL going live to administer vaccines over the next 2 weeks, which would address some of the public concerns about travelling to receive the vaccine. It was also hoped that the roll-out of the flu vaccine could provide meaningful conversations around receiving the Covid vaccine as well.

6.12 On the issue of vaccine hesitancy and the reasons for that, Lesley Watts noted that this data had not been recorded. The Committee queried whether this meant engagement with communities regarding the vaccine needed to be stepped up. ICS colleagues advised that health and the local authority were working together on this as it was a symptom of a much wider issue around mistrust. The Committee heard that one of the reasons integrated working had stepped up and had gone more at pace recently was to look in to these issues, as there would be multiple issues around the health of some of those populations that did not want to be vaccinated that needed to be understood. The Committee were advised that the work was started and would take time as there was no easy fix, but that the ICS needed to be consistent and determined and work hard with other partners to address these issues.

6.13 Cllr Crawford asked for more inequalities data to be provided when it became available. ICS colleagues advised that work was needed to understand how population health spoke to the JSNA in each borough. The ICS collaborated with Public Health Directors and local authority Chief Executives to ensure they had the best information available to inform the strategy for addressing inequalities.

6.14 Responding to a query relating to the involvement charter, Rory Hegarty (Director of Communications, NWL ICS) advised that the charter had been co-produced with residents and then published for consultation, which had received good feedback. The feedback was being worked through and the final document would be published in October to form part of the approach to engagement and inequality.

6.15 Cllr Eason moved on to the financial implications of the report and the underlying deficit of £453m, rising to £500m. Given the financial position of the NHS, he queried how achievable the savings programme was to close that gap. Lesley Watts answered that these were large figures which spoke to a variation across NWL that had been longstanding. There was an understanding of what it was that generated the deficit and the ICS had tried to be as transparent as possible in describing that deficit, and had provided clarity about the duties and responsibilities to drive out that variation. It was clarified that the solution to the deficit was not a one year fix, and may take a number of years to resolve. There was a need to ensure any cost inefficiencies were understood and driven out in relation to corporate costs and the provision of direct care. Lesley Watts chaired the Financial Recovery Board across the system, examining these issues for each individual provider in some detail. This was data driven to ensure that, where the ICS could see that some places were much more expensive than others to provide the same care, there was a work programme to drive out those costs. The programme was large and there were positives in terms of the

collaboration from all parts of the system to make sure money was used properly and fairly. The Committee heard that there was commitment from everyone within the system to be transparent and have an open book approach to see what was spent on what, and there was oversight from London and national bodies. The ICS were happy to bring an update on this piece of work to Committee on a regular basis.

6.16 In relation to the ambulance service and 111 pressures, the Committee was advised that North West London lead on the contracting for the London Ambulance Service (LAS) across London. Lesley Watts advised that all ambulance services, including in London, were under intense pressure currently, and there was work going on across the system on that problem. There had been a recent discussion with local authorities about the intention to treat patients in their own homes to ease that demand, through the hearing tree (seeing patients over the phone) and the seeing tree (going in to patients homes). The paramedics attending people in their homes had been upskilled to treat patients on the scene and reduce the need for conveyancing, which had made a real difference. It was added that it was important to recognise that an ambulance was not a conveyance and only for emergencies, a point which needed to be emphasised to the public and which the NHS were doing a piece of work on to communicate with the public.

6.17 The Chair thanked those present for their contributions and drew the item to a close. A number of information requests were made throughout the discussion, recorded as follows:

1. For NHS Colleagues to provide the committee with details of the Mental Health Model of Care.
2. For NHS colleagues to provide the committee with vaccination comparison data at borough level in the context of mental health and learning disability.
3. For NHS colleagues to provide the committee with further information on health inequalities (reference report that is due later in Sept).
4. For NHS colleagues to provide the committee with a copy of the Involvement Charter when it is published in October.
5. For NHS colleagues to provide the committee with an update on the financial challenges on a regular basis – and at the next NWLJHOSC meeting on 14 December.
6. For NHS colleagues to provide the committee with an update on service demand, conveyancing and response times on a regular basis as we move through the Autumn/Winter period.

7 NORTH WEST LONDON NHS DIGITAL STRATEGY

7.1. Kevin Jarrold (Chief Information Officer, Imperial College Healthcare NHS Trust) introduced the report which provided an overview of the progress being made with the development of the digital, data and technology transformation plan for the NWL ICS. The committee were informed that the document shared was a first draft on the strategy going forward.

7.2. The main points of the presentation were noted below:

- It was noted that the strategy intended to build on the lessons learned from the pandemic response, delivering an unprecedented scale and pace of digital transformation.
- The ability to share patient records was acknowledged as being important, as well as the resilience of infrastructure.
- Kevin then went through the collective approach and the seven steps which were outlined in the document, with particular emphasis on a shift from paper to electronic records and documentation.
- The Northwest London Care Information Exchange was referenced as the largest patient portal in the country, enabling the sharing of patient records with a patient so they could view it themselves and add their own information should they choose to. There were also three social services departments now able to access that to look at the Covid status of the patient and to record and save documents there.
- Complex care pathways were also referenced, ensuring that the capability was in place to support this process, as well as developing the data strategy to exploit that data to deliver benefit to both clinicians and patients.

7.3. The Chair then invited questions from members of the committee, noted below:

7.4. Cllr Elnaghi noted that the pandemic had affected digital transformation, referencing those who were digitally excluded and asking how those barriers were being handled. Kevin Jarrold responded that there were two aspects to the work; one was focussed on putting good technology in the hands of patients and clinicians, so that interactions that were previously face to face and were now digital could be a universally good experience for both the patient and the clinician. The second strand was looking at how the issue of digital inclusion could be dealt with. It was noted that there was an ambition to form a standardised approach to technology across primary care, community care and mental health care, working with providers to get the technology capability required. It was acknowledged that this was an exercise that would take time as this was dependent on the products on the market and whether they worked for each provider. It was also noted that there was the issue of how digital support could be provided to those who did not have digital equipment, which was being worked on in alignment with the population health inequalities workflow, as well as various pilot initiatives looking at how tablets could be made available to those who do not have access to them.

7.5. Cllr Richardson raised a point around patient data sharing with third parties; querying whether the deadline extension from the 23rd of June to 1st September was sufficient time to opt out, and whether there were figures for those who had elected to opt out. Kevin Jarrold assured the Committee that patient confidentiality was taken very seriously and there were annual training sessions for all staff on the importance of confidentiality. The primary focus for NWL was to ensure clinicians had the information they needed available to treat a patient, which was also important to patients. Kevin Jarrold did not have the data for how many people in Northwest London had opted out of their data being used for secondary purposes, but could gather that information. In relation to third party sharing, the Committee was informed that the NHS made use of third parties to manage and process data, but under very strict data protection controls

where the NHS still remained the data controller, and there was a rigorous framework in place that only allowed third parties to use data when authorised.

7.6. Cllr Richardson followed up on the area of data protection and the use of private companies, noting that more detail on the rigorous framework for data protection would be welcomed. Kevin Jarrold advised that the NHS was not outsourcing to third parties but using third parties to provide them with tech solutions. Through these contracts with third parties, legal obligations were placed on how patient data was handled and processed. This was explained as existing within a national framework across the NHS, which was overseen by the Information Commissioner's Office. Dr Genevieve Small (Chair, Harrow CCG) added that, as a result of the digital support that needed to be provided to patients, some of that meant using third party software, for example text messages from GPs and the ability to upload photographs, and it was about a marriage between the proper safeguards and ensuring patients were given confidence that their data protection was important.

7.7. The Committee asked about the financial framework in which the ICS could deliver what they viewed as an ambitious and challenging plan. In terms of funding, Kevin Jarrold clarified that it was a challenge to prioritise investment areas. There was a whole national approach to level up across the NHS and address the fact that some areas had been able to invest in ways that others had not. The record for Northwest London had showed it had been very proactive in securing external funding in the past. The ICS were currently going through the process of working out the costs of the strategy which was difficult to predict due to the fact the digital capacity required was not yet fully developed.

7.8. The 'GP at hand' initiative was then moved on to, with Cllr Richardson querying the lessons learnt. Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) highlighted that 'GP at hand' was a national contractor for primary care services and the funding issues were now resolved on that. She noted that there were reservations but the feedback from patients had been positive. It was acknowledged that 'GP at hand' had acted as a fantastic accelerant of the way that patients were looked after, and some of the techniques the initiative used had been utilised during the Covid-19 pandemic. ICS colleagues reminded the Committee that GP at Hand had been a national conversation but felt NWL had reaped the benefits of it.

7.9. Cllr Shah asked how the NHS digital strategy could link with the digital process within health and social care, so that patients received seamless care. Kevin Jarrold answered that this was a really important part of the agenda and the handoff between health and social care was key. Through the NWL Care and Information Exchange, facilities had put in place to enable social care colleagues to access patient records where the patient had authorised this, which was up and running across three boroughs. The ICS were keen to role that out across NWL. Kevin Jarrold highlighted that there was an opportunity for improved collaboration with health and social care on digital strategy and the ICS would be happy to work closer with health and social care colleagues for better insights of when new initiatives, such as IT solutions, were being implemented.

7.10. The Chair drew the discussion to a close by asking what risks and opportunities had been identified as the planning and preparation for the digital strategy moved forward. Kevin Jarrold answered that there was fantastic opportunity to improve both the patient and clinician experience through digital capabilities, which was the driving force behind the plan. The challenges were highlighted as being around the technical capabilities and funding that was available, as well as keeping patient data secure. The committee were updated that the implementation of a single electronic patient record to be used across all four of the acute trusts was close to completion. This would mean that a clinician in any of those hospitals would be looking at the same record and able to share that record, which was a significant step forward. In the future there was an optimism that the risks identified could be mitigated and managed.

7.11. There were several requests for information raised during the discussion, recorded as follows:

1. For NHS colleagues to provide the committee with information about the data protection protocols referred to at the September meeting.
2. For NHS colleagues to provide the committee with further details of the work being undertaken to reduce digital exclusion.
3. For NHS colleagues to provide the committee with further information on the progress of the digital strategy as it moves into implementation including the prioritisation of investment.
4. For NHS colleagues to provide the committee with a finance update including costings/funding streams.

8a. JHOSC WORK PROGRAMME UPDATE

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

- The Estates Strategy
- Workforce
- Mental Health Strategy
- ICS Update (standing item) - Financial Challenges Update/An update on service demand, conveyancing and response times as hospitals move through the Autumn/Winter, update on Mount Vernon Cancer Service move; update on St Mark's Hospital services; update on palliative/end of life care.
- Acute Strategy

8b. WORK PROGRAMME MEETING ARRANGEMENTS 2021-22

The Chair stated that the next meeting would be hosted by LB of Harrow. It was also agreed that the meeting on 9 March 2022 would be hosted by Westminster City Council.

9. ANY OTHER URGENT BUSINESS

None.

The meeting concluded at 11.41 am.