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Health and Care Strategy for North West London

How NHS North West London and the eight local authority boroughs will support and improve the health and care needs of our communities, improve life expectancy, quality of life and reduce inequalities.

Produced by North West London's Integrated Care Partnership

2023

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NOTE: This is an early draft shared in the spirit of transparency for comment and feedback

Comments please to nhsnwl.nwlstrategy@nhs.net

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Part 1 – NW London ICS priorities and insight

Executive Summary

Welcome to the integrated care strategy for North West London. North West London is one of the largest, most diverse, and vibrant integrated care systems in England, with a population of over 2.1m people speaking over 100 languages.

This strategy builds on the health and well-being strategies of the eight boroughs that comprise North West London, as well as national and London ambitions. It has been prepared by North West London's integrated care partnership, that brings together the eight local authorities, the NHS, and wider partners. It lays out how we collectively aim to improve health and care across North West London to improve your health and well-being.

The population in NW London faces a number of challenges:

- While we have made great gains in health status over the last twenty years, this has largely stalled in the last 5-6 years and appears to have gone into reverse.
- While the population of NW London is generally younger than the population of England as a whole, we are still seeing the fastest growth in the oldest cohorts of the population.
- Population projections are subject to considerable uncertainty, given Covid-19, Brexit and patterns of migration, but the ONS central projection still suggests an increase of over 100,000 in the NW London population by 2040.
- People of different backgrounds – ethnicity, deprivation, people with autism and learning difficulties etc. – continue to experience unacceptable variations in their health (rates of obesity, rates of heart disease), in access to care, in their experience of care and their outcomes from care. For example, people from our more deprived populations, or from ethnic minorities, wait longer before presenting with symptoms of cancer, and then wait longer for referral for further investigation; people with autism, learning disabilities or suffering severe mental ill health die on average 10 years younger.
- While unemployment itself did not rise sharply during COVID, we saw a sharp increase in those claiming out of work benefits. The numbers have begun to fall, but remain high;
- This is exacerbated by the current cost of living crisis, as rises in prices outstrip income for most people.
- Health inequalities have existed in our communities for a long time and in many areas have been compounded over the last few years, both by the COVID-19 pandemic, national and local tragedies such as the fire at Grenfell Tower. This has put yet more pressure on our communities who

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are most in need and we must ensure our support is sufficiently targeted to provide the help they may need.

Amongst other issues, our residents have told us that:

- They are concerned about the lack of access to GPs in particular for face to face appointments;
- Services are not joined up and can be confusing to navigate. This disjointed support from can lead to a sense of disempowerment – the challenge of accessing services and the feeling of having to explain experience time and time again is exhausting so people give up'.
- Conversely, positive feedback for One Stop Shop health / inequalities events 'this event makes me feel like someone is looking after us'.
- Some communities told us they don't feel 'believed' when speaking to their GP or health professional
- Disability groups report experiencing behaviours and situations which exacerbate inequality
- Mental health stigma in some communities remains a challenge
- Some young people told us their concerns regarding mental health were not always taken seriously
- Further focus on prevention and healthy living would be a positive step. Make information about healthy eating more readily available and improve quality and variety of resources available.
- Long-term conditions. Residents want to manage their long-term conditions better but require information to support this
- Support for the NHS - amongst the frustrations, we heard many supportive comments for the NHS, understanding for workload and pressures for clinicians and saying how valuable the NHS was. Many expressed worry and concern for the NHS and those that worked in it. "You are already doing a great job."

Our health and care system is trying to respond to these challenges, but faces a number of issues itself:

- While the number of people employed within our trusts is at record levels, we do have high vacancy rates with shortages in some critical roles and many staff groups have been taking industrial action;
- Activity does not appear to have kept pace with the growth in staff and we have significant challenges in patients are treated as efficiently and effectively as possible within current resources;
- Social care remains challenged. As central government support to local authorities has reduced, almost all our boroughs cut real terms social care spending per head of population in the last decade – as our population has

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aged. While the social care workforce was increasing, it has now begun to decline, and ensuring high quality care is a constant pressure;

- Health services continue to struggle with ensuring residents can access services. While North West London generally performs better than most of the country, residents can still experience long waits for healthcare – whether for GP services, urgent or planned hospital services, mental health and community services, etc.
- There remain unacceptable variations in the delivery and quality of healthcare with some services treating more people with the same level of resources
- Services available and speed of access can also differ substantially from place to place across North West London, and between our different communities.

How the health and care system in North West London proposes to respond

Our strategic priorities are to:

1. Support health and well being for our population
2. Address unwarranted health inequalities
3. Improve access to care
4. Keep people at home wherever possible and ensure far more integrated/joined up services, particularly for our older people
5. Support babies, children, and young people will 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.

Supporting health and well-being for our population

The health and care system itself is responsible for less than half of any individual's overall health and well-being. The bigger contributors are wider social determinants of health, such as employment, education and housing, and how people behave – while smoking has fallen greatly in recent years, in remains the single biggest health risk in North West London. To really improve health and well-being, we will need to act on the wider determinants, on preventing risky behaviours, as well as improving the health and care system.

On the wider determinants, members of the ICS can have focused impact on targeted areas:

- Improving access to employment in the health and care system for our residents;
- Making NHS land available for housing, and targeted improvements in the quality of housing/ improving quality of local housing stock;
- Committing that all NHS organisations, and contractors to NHS organisations, pay at least the London living wage.

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- Increasing digital skills within deprived communities, supporting residents to better manage their health and find employment
- Supporting local businesses through more local procurement, taking into account social value.
- We will support sustainability work, promoting active travel, improving air quality and improving green spaces for deprived communities in our boroughs.

On healthy behaviours, the biggest risk factors in NW London remain tobacco use, diet, lack of exercise and high blood pressure.

- On tobacco, work with public health colleagues to improve pathways for smoking cessation in and out of hospital,
- Focus on improving diet and increasing exercise, including improving rates of breastfeeding
- Continue the rewind programme to reverse pre-diabetes where possible, in conjunction with our broader diabetes programme;
- Test how we can both better identify those of our residents at risk of high blood pressure, and better engage – through community and other routes – those at risk to help support them to manage their risks
- Work across the NHS, public health, the voluntary sector and community leaders and champions, to increase the uptake of preventative services, such as immunisation and vaccination and screening services, building on the lessons learnt from the COVID vaccination programme

Reducing inequalities in outcomes, access, and experience

We will work together with all the partners in the ICS to reduce inequalities in health and well-being through:

- Developing a shared set of services available to residents across North West London, regardless of where they live
- Ensuring that residents experience the same quality of acute care regardless of where they receive it, by identifying and reducing the causes of varied experience
- Build confidence in our communities to come forward for care and support, building on the good work over many years with diabetes, and expanding into cancer and hypertension. For example, tackling why some groups take longer to come forward when they suspect cancer, and why they attend primary care more times before they are referred for further investigation
- Using our race equality group to explore the barriers to care for Black and other ethnic minority groups;
- Bespoke programmes to support some of our most marginalised groups – for example, supporting those with special educational needs and disabilities into employment
- Improving early diagnosis of cancer at to 75% by reducing variation in screening rates, and improving willingness to present through education & outreach and standardising referrals

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- Tackling stigma in all our communities in regard to mental health issues, and providing new, less stigmatised ways of accessing care
- Focusing resource and differentiating the offer for groups with poor outcomes, for example Black women and childbirth
- Ensuring those of our population with learning disabilities and autism
- Supporting babies, children, and young people will lead happy and healthy lives, and become happy and healthy adults
- The fire at Grenfell Tower was a national tragedy. That this tragedy happened in an area where there were already high levels of inequality means that the effects were made worse for the local community, this has made the recovery more challenging. There are lessons to be learnt from Grenfell going forward, but the impacts of the tragedy will continue to have a massive bearing on the communities of North Kensington and across our boroughs.

Improving access to care

One of the greatest frustrations expressed by people across North West London is that they wait too long to access care – whether that be waiting to see their GP, access mental health services, waiting for an ambulance or other emergency care, or for planned surgery.

- For general practice and broader primary care, rationalise channels for simple urgent care (across UTCs, general practice, walk in centres, 999 and 111) and streamline access;
- For urgent care, undertake a root and branch review of our emergency care pathways, to include continuing to build up alternatives to emergency departments for simpler cases; expanding same day emergency care to reduce hospital stays for the simpler cases that at the moment require admission; continuing to streamline hospital processes to reduce length of stay and use every opportunity to accelerate discharge and virtual wards to get people home faster
- Develop and roll out Integrated neighbourhood teams that bring community, community mental health, primary care and social care services together locally to manage long term conditions, improve access to planned care and minimise the need for referrals from one team to another;
- Establish and expand a live Directory of Services that will enable onward referrals to the right part of the system for those who cannot be treated in their neighbourhood;
- Continue to expand the capacity and use of virtual wards to treat residents in their own beds under ongoing hospital supervision, rather than remain in hospital;
- For planned surgical care, institute more efficient centres to improve quality and make better use of existing resources
- Throughout, accelerate access to specialist expertise and diagnosis where required through more integrated teams, use of virtual tools, and expanding community based diagnostics

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- For mental health, continue to invest in expanding capacity, including integrating community mental health services more tightly into primary care, and developing areas where those experiencing mental health crisis can be assessed outside our hospital emergency department
- Ensure that our specialist services are readily accessible with effective and efficient pathways of care.
- Using digital technologies to expand access

Keeping people at home wherever possible

While hospitals and care homes are the safest place to be for those of residents in greatest need, for many we can provide a better service with less disruption to people's lives by bringing expertise and support to people's homes. This is particularly true for those of us who are aging, frail or experiencing multiple conditions. For many of these, a visit to hospital is not the best way to deliver care, and can result in further deterioration of their physical and/ or mental health. To do this we will:

- Systematically implement joint care planning to capture people's preferences and wishes, across every health and care setting including:
    - Identifying people who have an ongoing health or care need, with a care plan in place, to ensure they receive continuity of care.
    - Personalised care and support planning for people with long-term conditions, such as diabetes,
    - Anticipatory care planning in place to ensure care is coordinated in the event of a change in someone's condition.
    - Advance Care Planning for people in the last phase of life, supporting them to live and die well in their chosen place of care.
- Work with social care to develop a new integrated health and care approach to avoid hospital and care home admissions and support patients moving from hospital to home care;
- Pull back ambulatory care that currently flows to hospitals, with local integrated response to urgent demand within GP practices, walk-in centres, and some urgent care centres;
- Bring in local voluntary providers to operate alongside health and care providers, in particular to support residents after discharge;
- Expand the range of services and support that can be delivered in people's homes and in care homes.

Supporting babies, children, and young people

The children and young people growing up today in North West London will become the adults of the future. We will invest more in supporting them to be happy health adults, by:

- Expanding our preventative services for them, in particular tackling obesity and improve healthy weight in early childhood; ensuring an increase in rates of breastfeeding, in the uptake of immunisations to protect children protected from serious infection, and improving oral health through brushing teeth and eating healthier food

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- Expanding access to mental health support, in particular through schools, children's health hubs and by expanding ways of accessing support digitally Young people feel more confident managing negative thoughts and feelings, and moving on from them, and know when and how to access specialist mental health support.
- Developing consistent, 'right person first time' core models of care for CYP (including NHS/ LA/ VCS services) through child health and family hubs (PC), bringing in acute specialist expertise, levelling up access to community Child health services and developing a hospital service that operates as one service across NW London

Ensuring our health and care system is as productive and high quality as it can be

We all know that the resources available to providers of health and care are limited. While the NHS has continued to receive increases in funding (albeit below the long term average and growth in need of the population), funding available for social care and public health have been more constrained. While the number of health and care staff have risen, we face difficulties in recruitment and retention. We must therefore continue to innovate, improve and deliver as effective care as we can within the budget available to us while valuing and developing our people. We will:

- Continue to develop innovative and cost effective models of care, starting with cardiovascular care, cancer and children's mental health;
- Transform outpatient services to make outpatient services more convenient and reduce unnecessary appointments;
- Ensure seamless pathways from general practice to hospitals and back home again, ensuring that only those that would benefit from stays in hospital remain in hospital;
- Use digital tools to identify those residents most at risk of coming to us later with advanced disease and direct early interventions to them.
- Better manage our capacity by using digital tools that help to predict demand, support planning and add flexibility to the system, to deliver a more responsive service. Some services struggle to meet demand, while others are underutilised; the pattern of demand is dynamic, changing from week to week, day to day and hour by hour – better digital tools can track and help us to respond to this.
- Rapidly evaluate which services are delivering benefits to which residents – so professionals can direct people to the services that best meet their needs;
- Ensure that our estate is fit for purpose and that we have the right quality estate in the right places, in particular delivering on our pledges to rebuild aging hospitals such as St Mary's and Hillingdon, bringing diagnostics into the community, and addressing services where technology has moved on it no longer makes sense to deliver in the current fashion.
- Use data to understand where resources could be used more effectively

Working together with our residents and communities

The recent pandemic has reinforced for us that our health and care system can only work for our residents when our residents are fully involved in their care – and fully

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involved in designing how that care is delivered. To do so, we will work with individuals and communities to shape care. In particular, we will:

- Regularly ask 'what matters to you' as we listen, collate and share insights from all our communities across all members of the integrated care system in North West London;
- Place at least as much importance on the insights from our residents and populations as we do with qualitative data: they sit alongside population health and outcomes data in driving our strategy;
- Work with grassroots voluntary sector organisations and residents to expand our understanding of our communities, build trusted relationships and shape our health and care services;
- Co-design our future strategies with people and communities. Community engagement and co-design will happen mainly at borough and neighbourhood level, supported by system leaders, local authorities, borough based ICB staff, provider collaboratives and NHS Trusts.
- Ensure residents have a voice in all our programmes;
- Empower people to take control of their own lives and health and increase confidence in managing long-term conditions (with an initial focus on a multi-agency approach to asthma) when appropriate, with support from the health and care system.
- Do so through working through our borough based partnerships, neighbourhoods and voluntary and community sector;
- Deliver clear communication that meets the needs of our residents, communities, stakeholders and staff.

Context

National and regional context

We are developing this strategy against the background of recovery from the recent coronavirus pandemic, one of the more difficult winters the health and care system has seen, as much of our population face pressures from rising costs. Nationally, and across London, this strategy builds on a number of statements of policy, including NHS England's *Long Term Plan*; Our Vision for London, published by NHS England and the Greater London Authority; and the Mayor of London's Health Inequalities Strategy.

Our Vision for London sets our ambition for London to be the healthiest global city, and the best global city in which to receive health and care services and brings together a number of strategic themes from these documents. Alongside setting out the aim of developing more holistic support throughout a person's life and accelerating joint working at neighbourhoods, in boroughs, through integrated care systems and across London to improve health for all local populations, the Vision for London sets ten objectives:

- Reducing childhood obesity;
- Improving the emotional wellbeing of children and young Londoners;
- Improving mental health and progress towards zero suicides;
- Improving air quality;

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- Improving tobacco control and reducing smoking;
- Reducing the prevalence and impact of violence;
- Improving the health of homeless people;
- Improving services and prevention for Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STIs);
- Supporting Londoners with dementia to live well;
- Improving care and support at end of life.

These pan-London actions sit alongside, and are complementary to, the strategy and actions laid out in this North West London health and care strategy.

The London Health Inequalities Strategy focuses on five areas;

- Healthy Children: every London child has a healthy start in life
- Healthy Minds: All Londoners share a city with the best mental health in the world
- Healthy Places: All Londoners benefit from an environment and economy that promotes good mental and physical health;
- Healthy Communities: London's diverse communities are healthy and thriving;
- Healthy Living: the healthy choice is the easy choice for all Londoners.

These are picked up in North West London' strategic objectives.

Context for North West London

The North West London Integrated Care System (NW London ICS) incorporates the partnership of NHS North West London and our eight local authorities with providers of health and care, universities, and the voluntary sector within our boroughs. It is one of the biggest and most complex Integrated Care Systems nationally. We have a diverse population of over 2 million people, who come from over 200 different ethnicities. Our population is generally younger than elsewhere in England and is projected to be one of the fastest growing. Residents of North West London include some of the most well-known figures in the country, including the King and the Prime Minister.

There are also great disparities in health and care outcomes. We are home to the ward with the highest life expectancy in London and the ward with the second lowest.

The Integrated Care System brings together multiple providers including 350 GP practices, over 250 care homes, eight local authorities, 45 primary care networks, four mental health/community acute trusts, four acute trusts, universities and numerous voluntary organisations.

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It covers the area of eight London boroughs – Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster. It includes some of the strongest national academic institutions and networks, including:

- Imperial College London's White City campus, delivering a major new research facility to drive advances in life-changing medical technologies and treatments.
- Brunel University London which focuses on research in science, medicine, and social work training.
- Westminster University which offers nursing and midwifery training.

Our voluntary sector, under the banner of 3ST (Third Sector Together), is similarly diverse and dynamic.

This strategy outlines how we intend to meet four objectives:

- To improve outcomes in population health and wellbeing
- To prevent ill health and tackle inequalities
- To enhance productivity and value for money
- To support broader economic and social development.

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Challenges facing North West London and the case for change

NW London ICS is operating in a very challenging environment. The population demographics for NW London ICS are varied across the eight boroughs with significant **age distribution**, **large ethnic variation**, **income distribution** and **pockets of deprivation**. All of these are **wider health determinants** and **significant drivers of health inequalities**.

Reducing health inequalities is a matter of fairness and social justice. Health inequalities result from social inequalities. Health is closely linked to the conditions in

which people are born, grow, live, work and age and inequities in power, finances, and resources – the social determinants of health.

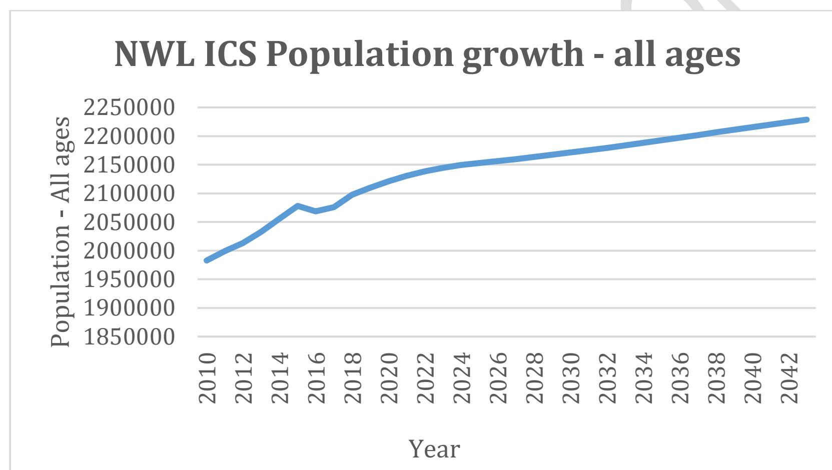
Finding effective ways to reduce the resulting health inequalities is a major challenge for the ICS.

Age distribution

The population of North West London is growing, ageing, and living with more complex conditions, increasing demands for healthcare. Meeting this rising demand, which is currently outpacing our ability to fund and our workforce's capacity, is a major challenge for the ICS.

The ageing population also means more people are living with long-term conditions. This in turn increases demand for health and social care services. Some long-term conditions, for example diabetes, cancer, and mental health problems, have disproportionate and significant impact on specific communities.

Unpaid carers play a major role in supporting our ageing population and managing complex and long-term conditions. They are estimated to save the NHS around £132 billion a year. However, the caring role can be stressful and isolating. We face a challenge to ensure every organisation within the ICS can identify people with caring responsibilities, so that we can offer support that prioritises carers' own health and wellbeing, as well as enabling them to continue their caring role for longer.



Ethnic variation

NW London ICS brings together multiple partners across the eight boroughs with differing cultures, behaviours, and priorities. We are home to people drawn from over 200 ethnicities. People's health is determined by a complex combination of genetics, socioeconomic factors, and environmental conditions. Ethnicity is one of the main social determinants of health in the UK.

There are a variety of challenges involved in working across organisations in this way. Collaborative working is vital to providing a seamless journey for service users, improving access to care and delivering the wraparound service needed to improve health outcomes. Joint working to identify shared local priorities will be key to delivery of the ICS plan. One of the lessons learned from the COVID-19 pandemic is that people need services and support to be joined up across the NHS, local authorities,

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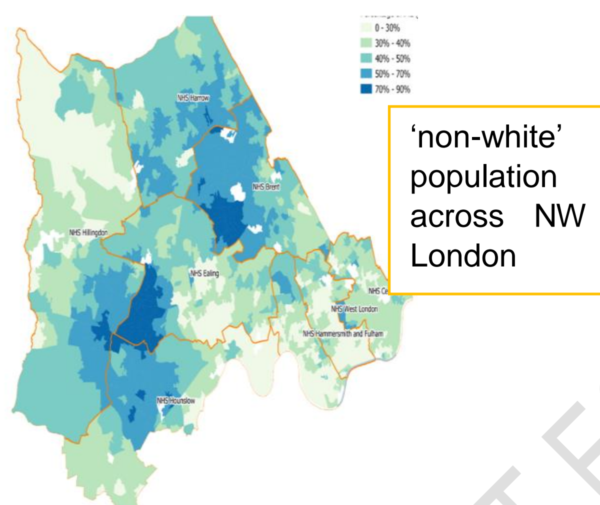
and voluntary and community organisations. Embedding this collaboration will be key to success.

Addressing health inequalities between people from different ethnic groups is a significant challenge to our ICS. Contributing factors that we need to address include unequal access to treatment, cultural and language barriers, educational attainment, and hesitancy of different groups to engage with healthcare services. As NW London communities are significantly varied in ethnicities the ICS faces the challenge of how to identify where cohorts are experiencing similar health problems, this would enable the ICS to develop a strategic approach to disease and health management for those specific groups.



Income distribution

Although NW London ICS overall as a system is less deprived than other London boroughs, and indeed nationally, there are pockets of deprivation within the boroughs and across the system. Deprivation is one of the main factors influencing overall health outcomes. The Index of Multiple Deprivation (IMD) comprises seven domains of deprivation: income, employment, health deprivation and disability, education, skills training, crime, barriers to housing and services and living environment. It shows the correlation between poor health outcomes and living the most deprived areas. North West London has high proportions of Black, Asian, and other minority ethnic (BAME) people living in more deprived areas. This results in worse health outcomes in these groups, increasing health inequalities and generating significant challenges for the ICS.

Areas of deprivation also have significantly higher numbers of overcrowded households. Overcrowding is associated with worse health outcomes, such as infectious diseases that spread a lot faster among people living in confined spaces.

Rising costs of living and an inflation rate that is at a 40-year high are having a significant impact on our population and pose even greater challenges for the ICS. Long-standing issues already visible in our boroughs, including overcrowding, deprivation, poor quality of housing and rough sleeping, will be exacerbated, widening the gap in health outcomes and worsening inequalities.

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Fuel poverty is a concern for the ICS as it can have a significant impact on health, for example infections resulting from cold, damp housing can trigger a cycle of illness even after initial treatment. The Opinions and Lifestyle Survey (OPN) shows the steps people are taking to mitigate the impact of rising costs. Examples include spending less on food and essentials which would be detrimental to overall health.

Wider health determinants

Investing in more ‘healthy’ places, for example cleaner air, access to green spaces and improving employment for residents, would have significant benefits to our population’s health outcomes.

Cuts to social care funding could mean councils have to reduce spending elsewhere to support adult social services. Areas that could get affected include education services, upkeep of estates etc. which could lead to further health inequalities. High maintenance costs of estates across NW London has generated a maintenance backlog resulting in buildings not properly maintained in time that could result in poor quality care. The ICS faces significant challenge to reduce the estates maintenance backlog due to the large amount of resources required in this climate of high inflation and cost of living crisis.

Another wider determinant for health is health risk behaviours e.g. smoking. Health risk behaviours are defined as acts that increase the risk of disease or injury which can subsequently lead to disability, death, or social problems.

Since 1990 we have been making progress by reducing the total burden of disease attributable to health risk behaviours to half, but progress has stalled in the last decade. It has stalled at approximately 15000 DALYs (Disability adjusted life year) per 100,000 population within London.

Without continuing improvement of health risk behaviours, health pressures will continue to grow creating further challenges for the ICS, compounded by the rising population numbers and life expectancy.

How we can respond

Educational attainment has an association with health as evidence shows better-educated individuals are less likely to suffer from long-term conditions, to report themselves in poor health, or to suffer from mental health conditions, such as depression or anxiety. Education provides knowledge and capabilities that contribute to mental, physical, and social wellbeing. Educational attainment is also a determinant of an individual’s future employment prospects, which in turn influences income, housing and other resources associated with health.

The COVID-19 pandemic has changed the way health and care services are delivered, triggering the rapid adoption of digital technologies. This shift has helped to manage flow into critical services, ensuring only the most appropriate referrals were made, to address backlogs in healthcare and to increase capacity in the NHS. The ICS needs to rise to the challenge of continuing to embed the latest digital technology across its organisations to improve the integration and delivery of health and care services.

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In recent years, we have responded to increased demand for services closer to people's homes by redesigning services so they can be delivered in community settings. Moving some health and care services into community settings requires an increase in the capacity and capability of staff. Retaining and improving the skillsets of the current workforce and recruiting new staff that can support this change is another key challenge for the ICS.

Retaining and recruiting a workforce with the skills and experience needed is a problem across all health and care settings. Our GP workforce is shrinking, there is an increasing trend of vacant roles particularly in acute settings, critical staff groups have been undertaking industrial action and social care staffing is a core area of concern. However, analysis of the NHS workforce in North West London shows that more people are employed within it than ever before. The workforce has increased by approximately 12%, when compared to pre-pandemic levels, but activity delivered is, on average, unchanged. Though this suggests there is scope for increased productivity in the current workforce, achieving this would be a major challenge for the ICS.

Utilisation of the established workforce of allied professionals in the community e.g. community pharmacists to help deliver vaccinations, optometrists to help treat minor eye conditions etc. would support the ICS in managing the backlog generated by the pandemic and the rising demand for care in general. However, there are a number of challenges that would arise with integrating services with workforce including resources and registration.

There are other potential solutions to these workforce issues. For example, enabling all healthcare professionals to work at the 'top end' of their scope of practice, i.e. using their graduate level skills to address health issues, while administrative and technical tasks are delegated appropriately.

Increasing the use of technology, such as blood pressure machines where professional intervention is not always necessary, could also help. Machines provide swifter results, are cheaper and remove the risk of human error. Though introducing changes to clinical practice can pose its own challenges, in terms of staff's attitudes to a new way of working.

The scale and scope of the challenges facing the NW London ICS are significant. However, there has never been a better time to develop a clear strategy for health and care that will meet the needs of our diverse population, offering everyone the best chance to remain well for longer.

What we have heard from local people to date

If we are to develop services in line with what people need, it is critical that resident insights are a key part of shaping our approach.

We are looking to build a clear picture of what our communities are telling us. We recognise that this will change over time and that it will be strengthened as we include insights from all the sources, we have access to – NHS, local government, the voluntary sector, Healthwatch and local communities. Our published monthly insight reports have started this process; we recognise they are a work in progress. We are

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working with the local voluntary sector partnership 3ST and across health and social care to develop a consistent process for analysing the insight reports and ensuring they inform our strategy at both borough and North West London level. Insight reports are shared with the ICS leadership and with each borough and ICS programme for action. In line with our involvement strategy, a Co-Design Advisory Body drawn from local residents, experts in public involvement, the NHS, local government and the voluntary sector is now being put in place to oversee this work.

We have set out below some of the key insights we have heard from local people that have fed into development of this strategy. Where points made are specific to one borough, we have referenced this.

There are some **recurring themes** across most boroughs, such as access to GP appointments, communication with patients and residents, the cost of living and mental health. There is also specific feedback from groups we have not always heard from consistently, such as children and young people, BAME communities and LGBTQ+ residents.

How we heard from local people

In line with our involvement strategy, we use a multi-method approach, building on the work borough teams, local authorities, the voluntary sector and Healthwatch are doing:

- **Community outreach:** Work with specific communities and groups and the general public. Planned and delivered at borough level and carried out by both NHS and local authority staff
- **Collaborative spaces**: Open events which anyone can attend – for example, events have been held or are planned in all boroughs with a 'What matters to you?' theme, a co-designed agenda and a primary focus on inequalities.
- **Programme-specific engagement:** For example, the public consultation on a proposed elective orthopaedic centre, the palliative care review and the Post Covid Syndrome programme.
- **Social media engagement:** Next Door, Twitter, Facebook
- **North West London-wide forums:** Residents' Forum and PPG Forum (one of each held to date)
- **Work with specific groups** such as our lay partners, local campaigners and people who regularly attend our meetings.
- **Citizens' Panel:** 3,800 people broadly reflecting our communities – used mainly for quantitative surveys.
- **Community funding:** Where funding is secured we run an expression of interest process to identify community groups to undertake work on our behalf and help reach further into our communities.

Many of the insights reflected here come from through the work of our local authorities, NHS providers, borough teams and voluntary sector. We plan to continue to build on insights from our voluntary sector, from resident surveys and other work from local authority colleagues.

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Respect and good communication goes a long way

An overarching theme, reflected in everything we hear from our communities, is that what matters most to local residents is how they are treated and respected. We have been told to communicate with them in a way that supports their understanding of their health, so that they are able to understand the services and treatment on offer. They want to know how to access services, the process they will go through and what happens next.

GP Access

- Concern that lack of **face to face appointments** may mean GPs miss the wider value of the interaction with the patient to identify other issues such as mental health and connect them to wider support.
- Physical **proximity** to services and **numbers of GP and nurses** available.
- **Telephone appointments:** Worry and experience of things going wrong during phone appointments, for example lack of trust in prescription advice over the phone. Challenge for residents whose first language is not English having difficulty describing symptoms. Can be difficult to understand the automated messages and options.
- **Same gender** GP availability.
- Lack of **interpreting services** (multiple theme) spoken languages and British Sign Language (BSL) **LGBTQ+** residents often felt that those delivering care did not take account of their needs, for example in using the correct terminology
- Some young people told us their concerns regarding mental health were not always taken seriously
- **Staff communication** and **sensitivity** was criticised by some patients
- **Sensory disability** – importance of considering, for example, the needs of the deaf or visually impaired community. Nurse calling a patient name, telephone appointments or an intercom system are examples of barriers for deaf people. Video appointments can be difficult for visually impaired patients.
- Further focus on **prevention and healthy living** would be a positive step.
- Medications not always properly explained to patients and carers.

Communication

- **What should people expect** of different services, for example care at home, district nurses or palliative care? Some people said they 'felt done to' and had little say in their care.
- Communication about nature of **health screening**: what steps does it involve and what is its value? There is differing understanding in different communities and this can be due to a lack of cultural nuance. For example, several women told us they avoided Cervical Screening due to female genital mutilation (FGM), fear the screening impacts virginity or lack of assurance they would see a female practitioner
- **Services not joined up**. Disjointed support from services leading to sense of disempowerment.
- Some communities told us they **don't feel 'believed'** when speaking to their GP or health professional

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- Romanian residents told us they faced inequality due to language barriers and understanding the system.
- Positive feedback for One Stop Shop health / inequalities events 'this event makes me feel like someone is looking after us'.
- **Covid-19 vaccinations and flu jabs**, still a need for basic information regarding access, and need for booster jabs. Too many text reminders and GP appointments made without request, example of enabling access when it meets the systems need rather thank the patients. Some Afro Caribbean residents felt services only wanted to talk to them about Covid-19 and vaccinations.
- **Older residents**: Not everyone has internet access or is comfortable using mobile phones. Services need to think about how to communicate and engage with them
- **Carers** struggle to look after their own health
- **Language.** There is a need for more culturally accessible education and awareness sessions on topics such as how to prepare healthy food. This was particularly a focus among younger generations

Inequality challenges

While we know outcomes, access and experience vary by the ethnicity of our residents or their deprivation status, residents have also told us about:

Disability

- Disability groups report experiencing behaviours and situations which exacerbate inequality. These include attention to detail in regard to space, equipment to support their waiting and consultation and continuity of care given their particular multiple and often complex health issues. One example was given of a person not being able to access their diabetes check-up as they use a wheelchair and the premises isn't wheelchair accessible.
- There is a need for clear information and basic signage for people with learning disabilities (which should also support those for whom English is not their first language). Some people with disabilities said they did not feel listened to or treated with respect.

Other inequality issues

- Mental health stigma in some communities.
- 'Challenge of accessing services and the feeling of having to explain experience time and time again is exhausting so people give up'.
- Digital exclusion was raised, as was the practicality of using digital services, for example being asked to take a photograph and sending it Some residents also fed back positively on the use of technology to improve services. Cost of living; cost of travel to appointments, cost of food to support healthy eating, loss of shift work for health appointment Impact noted particularly for carers. impacting what they eat/don't eat or what they are able to do. Increased debt.
- Loneliness and isolation often raised by many groups, including carers. Some LGBTQ+ residents said they don't always feel understood or accepted in their communities leading to loneliness and isolation.
- Homeless people said they struggled to find help.

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- Housing: waiting list to get a home, wait when unwell or no longer able to manage stairs), loss of community roots when having to move due to ill health, inadequate housing.

Summary of other key issues raised

- **Public safety** - fear of knife crime, alcohol, and drug abuse
- **Healthy living.** Make information about healthy eating more readily available and improve quality and variety of resources available. Unequal access to suitable outdoor areas for exercising and growing fruit and vegetables. Concern about lack of green space for allotments due to housing demand and areas being redeveloped into flats. Participants would like to see more collaborative working, giving them opportunities to contribute to town planning and influence what is available on the high street, i.e. reducing the number of unhealthy fast-food outlets
- **Hospital discharge.** Appointment cancellations and long waiting times – impact on the family to manage the patient and situation.
- **Long-term conditions.** Residents want to manage their long-term conditions better but require information to support this
- **Sexual health services.** Young people said they found access difficult due to appointment times during working day/having to travel
- **Faith groups** - Lack of sensitivity to culture and faith are being experienced across communities and may be reflected in low referral rates for palliative care.
- **Practical challenges** – disabled parking bays, join up with the planners and Transport for London (TfL) regarding bus stops at hospitals. Street lighting around hospitals.
- **Support for the NHS -** amongst the frustrations, we heard many supportive comments for the NHS, understanding for workload and pressures for clinicians and saying how valuable the NHS was. Many expressed worry and concern for the NHS and those that worked in it. *"You are already doing a great job."*

Plan of action

Insights generated from resident involvement are shared across the system and specifically shared with boroughs, ICS programmes and the Integrated Care Board (ICB). They are reported to our Proactive Population Health Management and Inequalities Board and our Quality Committee and will be considered in depth with local community representatives at our Co-Design Advisory Body. These insights form part of our business intelligence.

The next step is to develop a consistent methodology for analysing the insights and ensuring they play an ongoing role in the development of our strategy and services. This requires co-design and is a core role of the Co-Design Advisory Body. We will also continue to publish the insight reports and our responses to them, so that local residents continue to take part in dialogue and co-design solutions to challenges.

Other immediate tasks are:

- **Widen the insights we capture** from all sources, particularly local authorities, the third sector and Healthwatch.

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- **Ensure all parts of the ICS can access the insights** as the qualitative element of our data. They are currently shared with boroughs and programme teams and published on our website. They should be accessible and familiar to all stakeholders and partners.
- Produce a **regular report** setting out how the insights are being used.
- **Map and address gaps** in our insights (for both communities and ICS programmes).
- In some cases, conduct further **targeted work with specific communities** e.g. building on insights around barriers to screening, public information campaign around general practice

Shared outcomes for all

Introduction

We know that the effective delivery of healthcare, whilst important, accounts for less than a quarter of an individual's overall health and well-being. The bulk comes from the wider determinants of health (employment, income, education, and so on) and from behaviours (smoking, health diet, and so on). It is often differences in these wider determinants, and in behaviours, that result in the differences in outcomes we see across our population. Addressing these requires all the partners in North West London's integrated care system to work together. This in turn requires us to agree shared outcomes that we will all work towards.

Purpose

This outcome framework is not an attempt to capture all outcomes that the health and care system in North West London might work towards. Nor is it intended as a performance framework for managing the health and care system – each member of North West London's Integrated Care System has their own way of managing and reporting on their performance, It is instead a statement of where partners of the North West London's Integrated Care System believe we could go further and faster by working together, and hence were we should focus our shared work. This outcomes framework looks to:

1. Identify where we can achieve better outcomes for our residents more swiftly by working together on the common priorities (whilst giving space for boroughs to focus on local priorities).
2. Bring a collective focus to tackle not just the causes of ill health, but the lifestyle and environmental factors which lead to those causes
3. Aid in structuring the planning and development of services to ensure that they are always closely linked to the outcomes they produce or the impact they have on people.

As our population differs across North West London, the specific outcomes important to people also differ. However, while acknowledging similarities and differences across and within our boroughs, most want similar good outcomes for their own health and care and for those that they care for and love. The NW London ICS' Outcomes

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Framework will set the ambitions to provide the best possible outcomes for the health and wellbeing for residents.

The approach to developing the outcomes framework

There are thousands of outcomes that are important to people. Two approaches have been taken to develop this initial view.

- To reflect the importance of wider determinants in reducing inequalities, we reviewed Professor **Marmot's** policy objectives, as set out in his seminal 2010 review, *Fair Society Healthy Lives*[1]. These are to:
    1. Give every child the best start in life
    2. Enable all children young people and adults to maximise their capabilities and have control over their lives
    3. Create fair employment and good work for all
    4. Ensure healthy standard of living for all
    5. Create and develop healthy and sustainable places and communities
    6. Strengthen the role and impact of ill health prevention
- To what is important to people across North West London, we reviewed all the borough Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategy documents to identify common themes, priorities and outcomes set by the eight boroughs. This identified the following common priorities in NW London:
    1. Reducing Inequalities
    2. Support for children and young people
    3. Long term condition prevention and management
    4. Live well, independence, old age & end of life
    5. Mental Health
    6. Healthy Places
    7. Integration

Overall, the main priority of the framework is to **reduce health inequalities**. We then came together to agree on those priorities and indicators where we could go further and faster by working together. While our boroughs and neighbourhoods will of course wish to add measures that are important locally, this offers a collective focus for North West London.

Given that reducing inequalities is a golden thread across everything that we do in North West London, the following framework sets clear **shared outcomes** for the NHS, local authorities and wider to drive forward improvement of services for communities.

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[1] 2010 Marmot Review – Fair Society, Healthy Lives

Marmot Policy Objective	Marmot Priority Objective	Common interventions that we will focus on in NW London	Shared Outcomes Indicator
A. Give every child the best start in life	1. **Reduce inequalities** in the early development of physical and emotional health and cognitive, linguistic, and social skills. 2. **Ensure high quality** maternity services, parenting programmes, childcare and early years education to meet the needs across the social gradient. 3. **Build the resilience** and well-being of young children across the social gradient.	1. Pre- and post- natal interventions that reduce adverse outcomes of pregnancy and infancy. 2. Link up maternity services with public health achieve the common aim of high-quality maternity services including improved access to mental health services and aligned risk assessment approach to support targeted post-natal follow-ups. 3. Identify and address workforce issues across maternity services and public health commissioned services (e.g. school nursing, health visiting)	Identify inequalities by review of ethnic breakdown of indicators: • Neonatal mortality and still birth rate • Smoking status at time of delivery • Vaccination uptake • Maternal mortality • Breastfeeding at six to eight weeks after birth • Patients experiencing perinatal mental illness
B. Enable all children, young people and adults to maximise	1. Reduce the social gradient in **skills** and **qualifications**. 2. Ensure that schools, families, and communities **work in partnership** to reduce the gradient in health, well-	1. System approach to build resilience in Mental Health 2. Explore Anchor institute approach to local employment	• Drug, alcohol, and substance misuse for those under 18 years of age • Increased community participation rates.

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their capabilities and have control over their lives	being and resilience of children and young people. 3. Improve the access and use of quality **lifelong learning** across the social gradient.	3. Increase in uptake of work experience/apprenticeships across the social gradient. 4. Increase in numbers accessing programmes to address skill deficits, mental health, problem drug and alcohol abuse and anti-social behaviour and offending	• Reduction in problem drug use, offending and antisocial behaviour rates • Reduction in mental health patients • Increasing public health measures of school readiness for children • Increase rates of joint communications published and reduce variation in messaging to improve patient experience
C. Create fair employment and good work for all	1. **Improve access to good jobs** and reduce long-term unemployment across the social gradient. 2. **Make it easier for people** who are disadvantaged in the labour market to obtain and keep work. 3. **Improve quality of jobs** across the social gradient.	1. As a region become an exemplar in fair employment, addressing pay gap and creating wealth. 2. Address inequalities in employment across Learning Disabilities, Mental Health and Long-Term conditions. 3. Initiatives to support disadvantaged groups into work 4. Improve staff retention through provision of decent wages and good working conditions	• Gap in the employment rate between those with a physical or mental long-term health condition and the overall employment rate • Gap in the employment rate between adults known to mental health services and the overall adult population • Adult social care vacancies (including carers) and retention rates below or equal to averages for benchmarking group of councils • Monitoring rates of staff employed who live in the North West London region • Gap of NEET (not in education, employment, or training)
D. Ensure healthy standard of living for all	1. **Establish a minimum income** for healthy living for people of all ages.	1. Acknowledging that majority of this policy objective is set at national level, as a system addressing the basic needs	• Monitoring numbers of households in temporary accommodation

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	2. **Reduce the social gradient** in the standard of living through progressive tax and other fiscal policies. 3. **Reduce the cliff edges** faced by people moving between benefits and work. 4. Ensure parity of access to health, care, and community services in an effective, timely and safe way for all.	of the local population i.e. shelter & food 2. For frequent users of health and care services, we need to explore whether living conditions are contributing to ill health and provide as much as holistic support as possible. 3. Inclusion of Housing departments as key stakeholder in wider ICS discussions 4. Strengthen use of digital enablers in delivery for health, care, and community services	• Percentage of households experiencing food insecurity and using local authority and third sector support such as food banks • % of those experiencing fuel poverty • % of those receiving the London living wage • Comparing gap in health outcomes between the homeless and non-homeless population • Increased usage of NHS and local borough online platforms and apps • Increased use of free school meals • Percentage of patients assessed as not fit for elective surgery following referrals • Time spent on triage for individual patients in hospitals • Readmission rates to hospital following planned or emergency care
E. Create and develop healthy and sustainable places and communities	1. Develop common policies to **reduce the scale and impact of climate change** and health inequalities. 2. **Improve community capital** and reduce social isolation across the social gradient.	1. Review NW London NHS contribution to climate by NHS Sustainability Unit 2. Championing environmentally good practices for employees whilst at work	• Reduced gradients in ill health associated with social isolation and adverse impacts of travel e.g., air quality levels, accidents, reports of damp in housing • Energy performance certificate ratings for NHS estates and local authority public buildings

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F. Strengthen the role and impact of ill health prevention	1. **Prioritise prevention and early detection** of those conditions most strongly related to health inequalities. 2. Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.	1. Encourage residents to come forward for screening and stay engaged with services 2. Early screening opportunities with focus on Cancer, Cardiovascular disease, Hypertension and Diabetes. Prevention needs to be built into the pathways. 3. Collate data on screening uptake by ethnicity/PCN/Practice 4. Renewed focus on dental health, smoking prevention, weight management, alcohol and substance misuse 5. Change cultural norm by asking about physical activity in consultations and interactions	• % Eligible patients with non-diabetic hyperglycaemia offered referral to NHS Diabetes Prevention Programme • Improve secondary prevention outcomes for patients with diabetes: 9 key care processes (HbA1c; BP; Cholesterol; serum creatinine; urine albumin; foot surveillance; BMI; smoking; retinal screening.) • Increase uptake of NHS Health Checks • The rate of unplanned hospitalisations per 100,000 by neighbourhood by ethnic group • Admissions for alcohol related condition and smoking prevalence with patients • Proportion of people with mental health condition receiving a physical health check • Density of fast-food outlets • Levels of overweight and obesity in CYP at Reception and Year 6 • Decayed missing or filled teeth in under 5s • Immunisation uptake by type and age group with focus on school age vaccinations

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Part 2 – NW London ICS Transformation Programmes

Proactive population health management and reducing inequalities

The aim of this programme is to improve health outcomes for all, reducing **the gap in healthy life expectancy between the most and least healthy** in our communities. We use **population health management** as a technique to reduce unacceptable variation in outcomes, access and experience, and work with partners to contribute to **wider economic and social improvement**.

Data and analysis over many years clearly demonstrates that clinical care is not the primary determinant of health outcomes – far more important are a wide range of other factors, including health behaviours, socioeconomic factors, and the built environment. The most common causes of ill health, years of life lost and premature mortality in our population are cardiovascular diseases (often linked to diabetes) and cancer. The highest risk health behaviours remain tobacco use, high body mass index (BMI) and high blood glucose. There is a significant variation in North West London in health outcomes and the determinants of those outcomes. For example:

- In Hillingdon, the life expectancy for men is 7.2 years lower in the more deprived areas compared to the least deprived
- There is significant variation between boroughs for healthy behaviours such as exercise and substance misuse, for example hospital admissions per 100,000 due to substance misuse vary between 16.9 in Hammersmith and Fulham and 64.9 in Brent.
- Around 900,000 people in NW London have at least one long-term condition, varying between 24% of the population in Hammersmith and Fulham and 43% in Hounslow
- There is a high level of overcrowded households in North West London, more than double the national average, and this is strongly correlated with non-White British ethnicity
- Kensington and Chelsea has the greatest income inequality in London
- 15.9% of children in Brent live in low income families, compared to 6.1% in Kensington and Chelsea
- There is a fivefold difference between the Income Deprivation affecting Children Index (a measure of child poverty) between Hammersmith and Fulham's richest and poorest wards

Challenges

We understand that reducing health inequalities is iterative and there are gaps in our understanding of inequalities in our communities, with a historic lack of trust and entrenched socioeconomic barriers to good health.

Talking to local residents and community groups has built our understanding of the challenges people face. People have told us about their worries related to the cost of living, including difficulties keeping warm and maintaining a healthy diet. Structural racism and lack of trust within some of our communities was a key issue highlighted during the rollout of COVID-19 vaccines, where we used a very open approach to improvement method and co-production to try to understand why people from some

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of our most vulnerable communities were less likely to come forward for a vaccine.[2] The work – combined with a strong approach to data analytics – unearthed deep rooted issues around wider issues of equity of access to, experience of and outcomes from the services we provide. Tackling these equity issues is a major focus of our mission as an integrated care system.

Actions we will be taking

This programme puts **'what matters to you'** at the heart, to ensure that we are listening to and empowering our communities. We will maximise new opportunities to respond to the challenges we face, including improved data sets, greater connections with communities that started to be built through the COVID-19 pandemic and greater opportunities to respond to wider determinants of health through system working with local authorities and other system partners.

The programme will focus on a **small number of priorities** to make a big difference over the short and medium term. It will embed a single methodology that starts with what matters to local communities, working in partnership across local authorities, public health, the NHS, Voluntary, Community and Social Enterprise (VCSE) and our local communities. Prevention and equity will be a thread through the ICS's work, with this programme providing leadership, expert support, analytical insights and supporting engagement and co-production with our population. We will take an action-focussed approach, building on initiatives that are working well and accelerating these through stories, illustrations and case studies. This will support and accelerate work at place and neighbourhood level through Borough Based Partnerships and Integrated Neighbourhood Teams, as well as influencing NHS services at scale – providing a consistent cross-system offer, with local flexibility to meet community needs.

Delivering against these priorities by taking the following actions should deliver a range of benefits to our population:

- Reduction in the **difference between estimated and recorded prevalence** of disease, particularly for more deprived communities.
- **Improvement in the quality of care**, particularly for people with long-term conditions.
- Reduction in the **variation in outcomes for different groups**, including healthy life expectancy and maternity outcomes for black women.

Solutions/transformation priorities for the programme

The programme is organised into three pillars:

1. Identify and address inequalities in access, experience and outcomes achieved by all of our existing health and care services

The work is framed around the Core20Plus5 approach to reducing inequalities, for all ages:

- Core20: Looking across all ICS programmes and clinical groups with a **health inequalities lens**, to understand (and reduce) any differential for the 20% most

[2] Imperial College Healthcare NHS Trust | Real-world data provides valuable insights into Covid-19 vaccine roll-out; For COVID-19 Vaccine Equity and More, Conversations Matter (ihi.org)

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deprived in access, experience and outcomes. This includes for people who do not attend appointments, frequent attenders to A&E and access to diagnostic services, and children and young people facing multiple disadvantage.

- Plus: **Working with our communities** to identify groups with poorer outcomes and co-produce initiatives which address the issues that most matter to them, embedding the principles of inclusion health.
- 5: Embedding specific improvement work for each of the **five clinical priority measures**:
    - For adults: continuity of care in maternity; annual health check for those with severe mental illness; a focus on chronic respiratory disease; early cancer diagnosis; and hypertension case finding. This is mainly clinically led within primary care, with the support of local authority, acute, mental health and local care partners.
    - For children: addressing overreliance on asthma medication, access to diabetes monitoring tools, increasing access to epilepsy nurses, addressing oral health and improving access to mental health support.

We will start with a specific focus on **hypertension**, given that:

- It is the largest cause of premature mortality in deprived areas (30% increase compared to other areas).
- Treatment works, with reductions in blood pressure resulting in reductions in conditions including coronary heart disease and stroke.
- There is a low recorded prevalence rate of around 11% in North West London; around 80,000 additional residents are likely to be undiagnosed.

We will improve early detection via case finding and searches within primary care, by engaging with those living in the most deprived communities and taking a 'make every contact count' approach to opportunistic blood pressure measurement. We will close the gap in blood pressure monitoring by working with primary care, public health and community pharmacies, and particularly with communities, to understand why disparities exist and to co-produce solutions. We will use the new hypertension dashboard to help us measure and monitor targets, including detecting 80% of the expected population with hypertension by 2029.

We will **build equity into the existing quality structures** across the work of our partners within the ICS – building a culture of continuous equity improvement, which leverages our current quality governance mechanisms and our quality improvement approach and resources.

A **Race Steering Group** (RSG) has also been set up with community representation. This will tackle topics such as the cost of living crisis and its impact on different communities, disparities in health outcomes between ethnic groups for cancer and disparities in senior leadership positions held between communities. The RSG will commission local reviews and bring in national support, to ensure that race is a prominent factor when addressing health inequalities.

There are already considerable resources across the ICS focused on improving health and reducing inequalities in health, with 10% of ICB core allocations and 15% of primary medical core allocations already targeted using a health inequalities and unmet need adjustment. On top of this, the ICS has **£7 million** to invest in reducing

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inequalities, which will support building the capacity required in the ICB and in Borough Based Partnerships. This will accelerate delivery of our existing duty to tackle inequalities and help to ensure the full benefits of wider public spending, including in public health teams, is realised.

2. Put in place the building blocks of a population health management approach that improves the health of our population and reduces inequalities in health across all of our work in the ICS

Population health management is an approach to deliver the most effective interventions to improve the health of our population, enabling us to achieve the inequalities ambitions set out above. We have developed a **consistent methodology for this:** the FOCUS-ON improvement methodology, as set out in the diagram below, combining co-creation with our communities with a continuous improvement approach. We want to embed this approach into core ICS business.

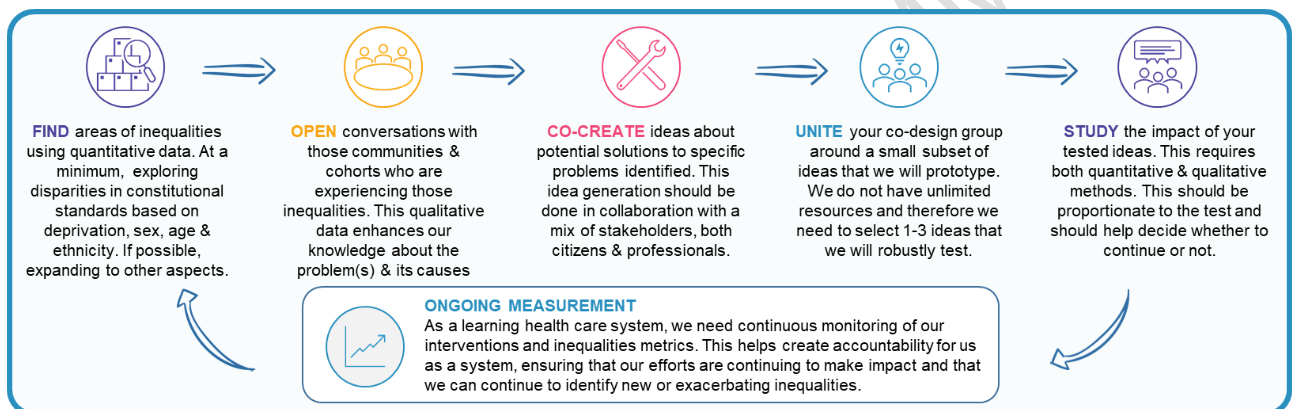

Figure XX: FOCUS-ON Improvement Methodology

This approach includes **analytical tools** so that we can focus initiatives on priority groups and measure the impact. This will build on the existing Whole Systems Integrated Care (WSIC) tools, and we will work to improve the minimum data set, including connections with LA data and data on wider determinants of health, based on NW London residents rather than patient lists. This will incorporate the latest Census data and create a single version of the truth that will allow us to better understand our population. These tools will be accessible to Borough Based Partnerships and Integrated Neighbourhood Teams (INTs).

In partnership with communications and engagement teams, we will continue to work closely with communities to understand **what matters to them**. We will build trust through listening to and empowering our communities, maximising the existing strong relationships within Borough partnerships and broadening and deepening the connections with groups who have been less heard.

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Brent Health Matters is based around:

- Community engagement / involvement: increase residents' trust in services
- Inform and support residents: Equip residents with information on services and support available
- Improve access to services available
- Build active community partners in addressing barriers in residents' own health and wellbeing
- Monitor and learn about impact through a performance framework

The programme has co-produced actions with communities, such as establishing an advice line, community grants, training, outreach, cooking programmes, mental health awareness sessions

Community health and wellbeing events have included a range of support from primary care, community services, health educators, voluntary sector, public health. They have taken health checks into the community

The clinical team support GPs and PCNs in identifying patients, with clinical information documented on EMIS community module

We will bring together this **qualitative data** from engaging with our communities with the quantitative population health data to better understand experiences, priorities and **co-produce** solutions.

We will support local teams in each borough and in our INTs to test and implement co-produced interventions, building a robust **evidence base.** We will **share good practice** through case studies, stories and illustrations to show what is possible and accelerate interventions that have shown to have the biggest impact.

We will work with academic partners to further build the evidence base in population health and will build a **health economics** function to help identify where interventions will have the biggest impact, taking into account all public funds for health and care.

We will ensure that the system has the **skills** to deliver on population health objectives and work to realign system resources to areas which are more deprived.

We will embed reporting of inequalities data within wider system governance, for example in ICB performance reports and programme governance, with all Board papers demonstrating how they reduce inequalities. We will also ensure that the VCSE is fully embedded as an effective partner in system governance, maximising the opportunities for the VCSE to support people in our communities in different ways.

3. Work together with all the partners in the ICS to improve social, environmental and healthy living factors that adversely affect health and wellbeing

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Building on the wealth of good practice at the local organisational level, we will work with our partners in Local Authorities, Provider Trusts and the VCSE to collaborate as **Anchor Institutions** to use our assets for social, economic and environmental benefits and reduce inequalities. We will focus on a range of wider determinants that affect health outcomes and will deliver an NW London Anchor strategy and plan.

We will have a specific focus on **employment**, as it is one of the biggest barriers to effective health outcomes within our communities, exacerbated by COVID-19 and the current cost of living crisis. As Anchors, we have opportunities to proactively **support people into good work and increase skills** in the most deprived communities. We will work in partnership across local communities, the NHS, local government, the voluntary sector and local business to improve retention of staff from vaccination centres, develop a new model for NHS recruitment, develop training and skills programmes, deliver a volunteering to employment pathway and increase employment of people with special educational needs and disabilities. The full detail is set out in the workforce chapter.

> Supporting people with **Special Education Needs into work**:
>
> Niaz: Enrolled on a supported internship for young people with learning disabilities and Autism at Charing Cross Hospital gaining a range of work-related experiences, training, and qualifications. He gained experience in 3 departments, was offered two jobs within the hospital, and chose to accept the role as a Band 2 Medical Lab Assistant in the Microbiology department. Niaz has been employed for 3 years, continues to make excellent progress and is a popular member of the department.
>
> Rohan: Took part in a work experience pilot at Northwick Park Hospital whilst he was at school in sixth form, spending half a day a week at the hospital for 6 months. His dream job was to work in Pharmacy and the trust were able to offer him Pharmacy work experience. He excelled in the department and then spent one year at college completing a preparation for employment course before coming back to the trust and enrolling onto their supported programme year where he concentrated on gaining further experience in Pharmacy. Rohan is now employed in Central Middlesex Pharmacy and loves his job.

We will also be focusing on the impact of the **cost of living** in year one of the strategy. This issue has particularly affected our lowest-income residents, in relation to food and fuel, leading to mental health issues, social isolation and increased attendance at A&E. We are engaging with communities and our workforce to understand what this means to them and are building on existing local authority-led initiatives to increase access to wider NHS resources and patient contacts, enhance relationships with local businesses and maximise the use of VCSE support. We are sharing best practice and learning from outside organisations such as the Greater London Authority.

We will work to increase **digital skills** within deprived communities, supporting residents to better manage their health and find employment. We will support local businesses through more **local procurement**, taking into account social value.

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We will support **sustainability** work, promoting active travel, improving air quality and improving green spaces for deprived communities in our boroughs. We will develop, in partnership with Local Authorities, an approach to improving **housing conditions**, developing our understanding and approach to keeping people healthy in their own home.

We will support **healthy behaviours** in our communities, working with public health colleagues to improve pathways for smoking cessation in and out of hospital, supporting healthy weight for all ages and improving the proactive approach to vaccination. We will focus on making every contact count – making connections to wider services when people from our more deprived communities' access services and train our staff in how to maximise these opportunities.

PPHMI supporting case studies:

Community Health and Wellbeing Workers in Churchill Gardens: The team, who are residents, work with a set list of households, listening to and assisting residents in managing their health and wellbeing in a way that works for them. The team offer their services directly through visiting residents or talking to them on the phone about their health, offering support where appropriate and letting residents know about activities and services available to them.

Churchill Gardens Change4Life Neighbourhood Project: Delivering evidence based, community led initiatives to address key priorities:

- Healthy eating and cooking skills for young people
- Lack of affordable food /healthy eating options
- Increased physical activity, focusing on women only activities

For example, working in partnership with London Sports and Sports4Health to activate physical activity targeting women and young people, delivering cookery sessions for families, healthy weight management service

EARLY DRAFT DOCUMENT

Improving vaccine equity through reducing variation in the uptake of Covid-19 vaccines across our communities in north west London:

- Reflections from members of our communities around vaccine hesitancy
- Weekly coproduction and improvement huddles to bring together people and teams who are working to improve vaccine equity, engage, listen & share learning, facilitate a weekly, inclusive digital space that people can join and contribute to co-producing tests of change:
    - Starting with stories, data, and insights
    - Identifying problems, gaps, and barriers
    - Co-producing 'tests of change'
    - Finalising actions and process evaluation
- Learning around design principles for health inequalities work and evaluation of the impact

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Local care

Work within the local care programme encompasses a wide range of services:

- Those organised locally around communities where people live and work. This includes integrating general practice, community nursing and therapies, community mental health services, social care, children's services, voluntary sector and wider community assets, dentists and pharmacies.

- Those which are specialist, organised at a borough or system level. This includes specialist palliative care (including hospices), specialist children's services, and NHS community rehabilitation beds.

The programme seeks to better join up health and care support for residents. As such, the programme also focuses on the building blocks that underpin service delivery: partnerships, pathways, digital and data, and estates.

How residents want to be supported

Our residents want to receive timely and accessible care, close to where they live. This chapter sets out how we are going to achieve this by 2028. Previously we have asked residents in North West London what is important to them, which informs our approach:

My wellbeing and happiness is valued and

As soon as I am struggling, appropriate

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and

My care is seamless and joined-up across different

I feel valued and supported to stay well

I am seen as a whole person – professionals understand the impact of my housing situation, my

My life is important, I am part of my local

My wellbeing and mental health is valued equally to

Challenges

The health and care system are currently under significant pressure with longer waits to access emergency care, elective care, ambulance services, home care and community outpatient services.

In general practice, patients give very positive feedback about their experience, but the biggest challenge is being able to access primary care services. In North West London the number of GPs and practice nurses has declined by 2% and 4% respectively and we have the highest ratio of patients to GPs in London. We know that 28% of our primary care workforce are over 55 and are likely to retire over the next five years. Many of these will be senior partners leading their practice. We also know that about half of newly qualified GPs entering the profession do not wish to become partners.

Of course, the support people need does not solely come from general practice - increasingly working as part of an integrated neighbourhood team provides access to a wider set of skills. For example, community nurses in North West London are critical to keeping people well in their own homes – and every day they see close to 10,000 patients.

We also have 84 social prescribers supporting people to access services that may not be traditionally delivered by the NHS, but which are known to keep people well, for example exercise or support groups for specific conditions like diabetes. With 170,000 people living with diabetes in North West London this is a great example of work to address inequalities responding to data showing where we have individuals and communities who may not be able to access the input they need. We need to build on good work in some areas to ensure that we target support to those most at risk.

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Transformation priorities for local care services

This strategy values our residents' and patients' time. Reducing the time, they need to spend accessing and navigating services is a guiding principle. The local care programme will meet these challenges by:

- Developing a core common service offer across our eight boroughs, defining the key elements of services that will be standard across North West London.
- Implementing Integrated Neighbourhood Teams across North West London to reduce the gaps between services and give greater clarity for residents on how to get the care they need.
- Supporting borough-based partnerships to thrive as the part of our system that will best address inequalities given their closeness to the population's needs.
- Develop responses at borough/North West London-level for services that cannot be effectively delivered in every neighbourhood. For example, where small numbers of patients or very specialist staff are needed.

Delivering improved patient care also means we can get best value from the public pound. Keeping people well and avoiding the escalation of their health and care needs is better for individuals. It is also cost effective, ensuring only those with the most complex/critical needs require our most costly specialist services.

The Local and Primary Care delivery model has three 'geographical' levels of care to improve residents' health and wellbeing:

- **Neighbourhood (your community)** – local services at neighbourhood level, designed using local knowledge and understanding of the community's needs, will be delivered by Integrated Neighbourhood Teams
- **Place (your Local Authority area)** - health and care organisations working together to tackle inequalities and to better integrate with local authorities to offer joined-up services
    - Local care hubs will be developed in each borough, within a common North West London framework.
- **System (across North West London)** – reducing inconsistencies in access to and experience of care, and in population health across our eight boroughs, through the organisation of specialist services in North West London ICS.

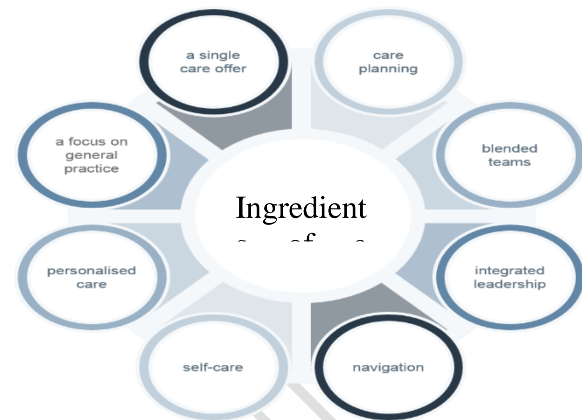
Developing a core common offer

To promote equity across North West London we will develop a core offer of services that are available to all our residents wherever they live.. This will include:

EARLY DRAFT FOR COMMENT

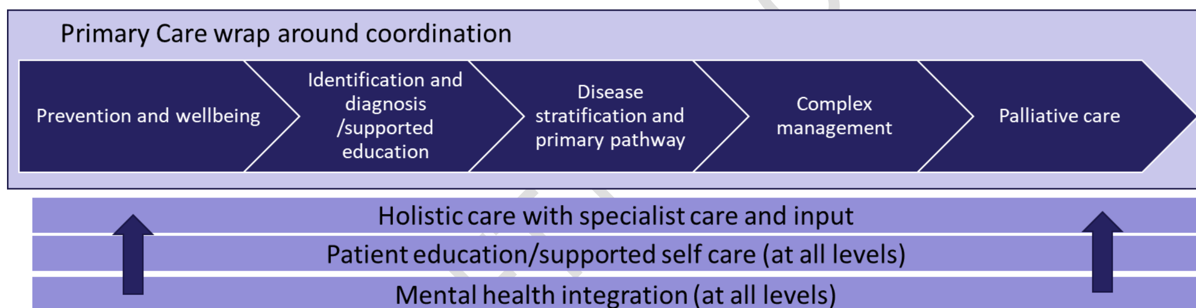
- Setting consistent minimum service and care standards across North West London, such as recent work on musculoskeletal and wound care

- Developing consistent long-term condition pathways, based on the best available evidence of what works, from prevention, digital support and self-care through to local monitoring and specialist support outreach to neighbourhood teams.



Working across the ICS to develop a new integrated health and care approach to avoid hospital and care home admissions and support patients moving from hospital to home care.

For Long Tern Conditions this will reflect the opportunity to address the 'diagnosis gap' as well as ensuring optimum treatment – as we have started with diabetes and a focus on the 9 Key Care Processes



Implementing integrated neighbourhood teams

The local care programme intends to develop Integrated Neighbourhood Teams (INTs) at neighbourhood and borough level, that wrap around communities and general practices.

They will have general practice at their heart, building on primary care networks, to bring together community services, social care and the voluntary sector to work in a geography that is meaningful to local residents and allows efficient service delivery. This new model of delivery ensures that practices, within the integrated neighbourhood team, have protected capacity to provide planned proactive care and, for patients who need it, a same day urgent response. Integrated Neighbourhood Teams will also maximise the contribution to patient care from new roles joining practice teams, such as pharmacists, physicians associates and paramedics. They will also give a bigger role to specialists who have previously provided care only in hospital settings, for example throughout patient centres. They will be run by a single management team, who will also manage 'hubs' targeted at particular groups, such as children and families, or those with particular diseases or long-term conditions.

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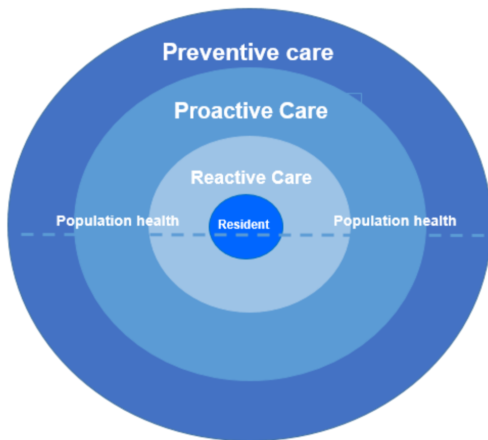
> ‘…the neighbourhood team are an extension of my eyes and ears helping me manage the patients I am most concerned about’. *GP*

The three ‘Care’ functions at a local or neighbourhood level are:



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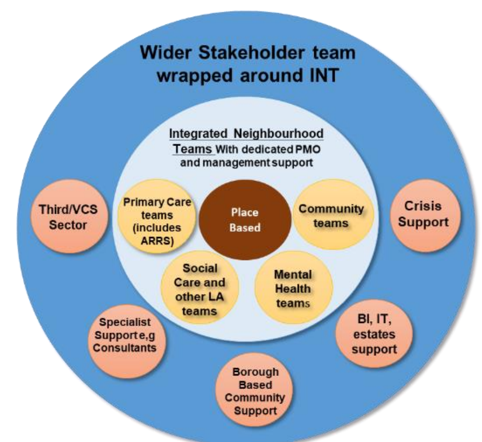
Preventative care (whole population)

By 2028, we will demonstrate a reduction in the health inequalities ‘gap’ for all North West London residents. We will do this by:



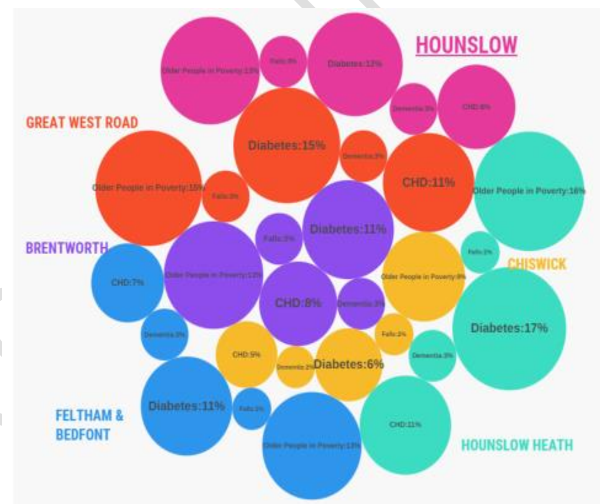
- The adoption of a population health management approach by our Integrated Neighbourhood Teams to improve health outcomes and reduce health inequalities.
- Robust data sharing across all sectors to support the identification of individuals and communities at risk of poor outcomes.
- Working across the NHS, and with public health, the voluntary sector and community leaders and champions, to increase the uptake of preventative services, such as immunisation and vaccination and screening services.
- Supporting residents with accessible information and community activities that help them to stay well and healthy.
- Working together to tackle the wider determinants of health and commission prevention approaches for those at risk of long-term conditions such as diabetes.

Proactive care (at all staged of someone’s life)

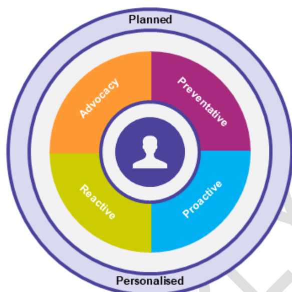
By 2028, we will:

- Identify people with undiagnosed conditions, such as cancer and hypertension, through screening and proactive case finding.
- Reduce the number of people at risk of developing a long-term condition and improving outcomes for people living with a long-term condition.
- Proactively support people with frailty and complex needs, including children and those with mental health needs
- Improve equity of access, outcomes and experience for underserved populations, e.g. homeless people.

We will do this by:



- Designing Integrated Neighbourhood Teams, in partnership with health and social care, that break down organisational silos and pull together a range of staff to work in a common geography, to improve their residents' experience of care, enhance capacity, and create fulfilling roles for our workforce. This will include staff and teams that patients may previously have had to attend hospital to see.
- Providing a proactive case finding and management model in every neighbourhood, using a population health management approach to proactively target those who may need health and care support, delivered by the multi-disciplinary team.
- Using shared data and digital tools to identify residents with complex needs who need proactive support.



- Systematically implementing joint care planning to capture people's preferences and wishes, across every health and care setting including:
  - Personalised care and support planning for people with long-term conditions, such as diabetes,
  - Anticipatory care planning in place to ensure care is coordinated in the event of a change in someone's condition.
  - Advance Care Planning for people in the last phase of life (1% of population) supporting them to live and die well in their chosen place of care.

Reactive care (providing a same day response consistently across NW London)

By 2028, we will provide an on-the-day, integrated rapid access service that supports adults and children and is integrated across primary care, community and mental health, is flexible and operates at the scale of neighbourhoods. We will do this by:

- Pulling back ambulatory care that currently flows to hospitals, with local integrated response to urgent demand within GP practices, walk-in centres, and some urgent care centres.

- Bringing in local voluntary providers to operate alongside health and care providers.
- Establishing and expanding a live Directory of Services that will enable onward referrals to the right part of the system;
- Identifying people who have an ongoing health or care need, with a care plan in place, to ensure they receive continuity of care.

There are also increasing opportunities to use digital technology to support remote monitoring of patients at home and to improve people's access to information to support their understanding of their own care. However not all of our residents have equal opportunity to access digital models of care. Therefore work on digital inclusion will be vital to ensure that no one is disadvantaged.

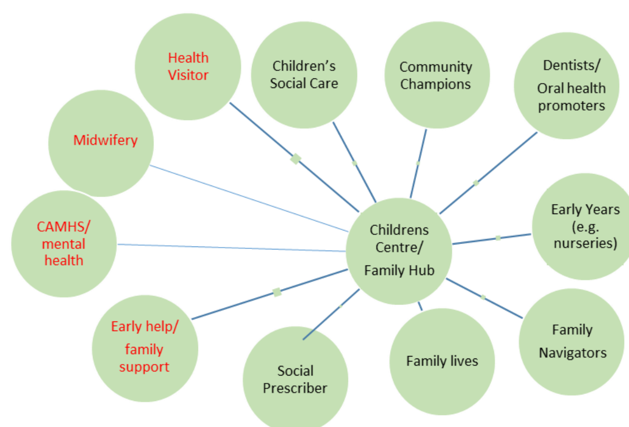
This robust and comprehensive plan will ensure that people who do not clinically require a hospital emergency response can get the right care in their own neighbourhood.

Supporting borough-based partnerships to thrive

Place Based Partnerships (PBPs) hold the key responsibility for driving the delivery of the above strategy.

By 2028, we will have Place Based Partnerships across all eight boroughs that will include local residents, local authorities (including public health and social care), primary care, community and mental health services, the voluntary sector and local hospitals.

PBPs will have a deep understanding of their population needs based on the JSNA and real time, shared population health management data. This will inform local priorities, the local design of Integrated Teams/ Local Care Networks and the location of hubs for service delivery. This will support PBPs to achieve the goals of improving health outcomes and reducing inequalities, by reaching into communities to those who are not accessing support and working on what's important to them.



Defining and developing the organisational support needed by the PBPs will be a key function for the Integrated Care Partnership. It could include the development of a single shared budget, with shared population health information critical to inform how it is best allocated.

Developing system-wide services

Whilst the ambition is to deliver as much care as appropriate, close to peoples' homes, for optimal efficiency some services must be provided once for North West London, particularly those services that are specialised or where people require admission to a bed. Not all services can be provided in every neighbourhood, therefore for specialist services or hospital admission, residents may need to travel elsewhere in

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North West London These system-wide services ensure value for money and allow funding to be prioritised for preventative care, as well as reactive and urgent care. We will therefore:

- Complete the North West London Community Specialist Palliative Care Review, developing and implementing the future North West London model of care, working closely with our residents, partners and providers.
- Develop and deliver Virtual Wards equivalent to 1,080 additional hospital beds, enabling patients to be cared for at home.
- Work with other London partners to support a common framework and digital offer for all long-term conditions (LTCs) – ensuring the whole pathway from prevention, to self-care, identification and treatment is supported.
- Continue to develop the North West London Community Collaborative; the partnership of NHS Community Trusts to drive high quality, consistent and better value services across North West London, through working as one partnership.

Community based Specialist Palliative Care
Working with each Borough Based Partnership we established the baseline of current delivery and the 'case for change' set out in our Issues paper.

- It is clear we have variation in access and experience across NW London
- We have too many people not able to die in their place of choice
- We also have too many people being admitted to hospital inappropriately
- And some feedback that services are not set up to meet the needs of all residents
- In addition with projected population growth we need to plan for future growth in demand

With a Model of Care group equally made up equally of professionals and residents we have progressed designing the future model alongside extensive engagement-with boroughs, but also across NW London with residents with particular needs: Learning Disabilities, LGBTQI. In parallel we have been able to identify and progress 'quick wins' such as standardising access to phone advice and with medication recording. We publish our papers and updates on engagement regularly and strongly benefit from partnership with our hospice colleagues.

This example of NW London work which dovetails with borough work on the whole end of life pathway indicates an approach to a 'common offer' for all NW London residents, that can also be nuanced to specific local borough needs.

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Primary care access – case studies:

Development of a Digital Access Hub in Central London

Background

- A Digital Access Hub in Central London Healthcare (GP federation) has been developed and works at significant scale by pooling resources to manage medical and administrative demands on behalf of all their local general practices.
- This approach not only extends access for all, but plays a significant role in changing patient behaviours and how they will seek to access healthcare advice in the future.
- The Central London Healthcare Digital Access Hub supports all 33 Central London borough practices and their 273,000 patients with the online consultation requests, which exceed 5,000 per month and

Overview of service model

- Through the collaborative working of the four Central London (Westminster) Primary Care Networks (PCN), the Digital Access Hub was launched in October 2020, offering the following services:
    - providing initial non-clinical and clinical triage support delivered by Care coordinators for all online consultations received with a KPI of 2 hours initial response;
    - signposting patients to self-help and self-care resources and services;
    - reviewing and closing clinical cases by the Digital Access Hub GPs;
    - booking appointments with PCN Additional Roles Reimbursement Scheme (ARRS) clinicians for Musculoskeletal health (MSK);
    - medication reviews and prescriptions; mental health support;
    - booking appointments with low acuity clinical cases to the Community Pharmacy Consultation Service;
    - closing online consultation requests.
- In just a year the Central London Healthcare Digital Access Hub has saved in excess of 6,000 GP appointments and more than 5,000 hours of practice administrative time.
- Using new PCN contract as an enabler for service transformation and integrated working.
- In addition to extending access for patients this programme if initiated at scale can further enhance productivity and value for money across the PCN landscape.

Extending Access PCN Triage Hub

Background

- Focus on delivering an integrated primary care offer by building on the opportunities that investment in ARRs roles bring and enhancing the service offer to patients across the locality.
- Using new PCN contract as an enabler for service transformation and integrated working.
- Scale is generated through pooling of additional roles across the member GP practices and also becoming more innovative in the way non clinical support staff are utilised and enhancing their role within the patient pathway.
- Working in this way enables a more appropriate streaming of clinical caseload, creating more capacity for GPs to focus on the complex and high risk and critically increasing access for patients.
- Focus on mutual support and accountability.
- PCN level contracting has been a key catalyst for transformation and service development.

Overview of service model

- Connectivity is key with a recently recruited Project Manager coordinating delivery which helps to ensure ongoing participation of the member practices
- Ensuring that ARRs resource is maximised across the PCN landscape and used as a catalyst for integrated working.
- Enhancing efficiency through the use of eHub as demonstrated through the use of the Patches Module.
- Extending access through non face to face alternatives such as the telephone appointment offer.
- In addition to extending access for patients this programme if initiated at scale can further enhance productivity and value for money across the PCN landscape.

Priorities moving forward

- Resolve some of the identified IT issues such as use of EMIS.
- Development of an IT Strategy for PCNs, supporting PCNs to deliver on the IT requirements of the programme.
- Develop a consistent strategy for recruitment to and utilisation of the ARRS roles across the PCN.
- Better manage our capacity by using digital tools that help to predict demand, support planning, and add flexibility to the system, to deliver a more responsive service.

The Connecting Care for Children Programme (CC4C)

Background

- The aim of the programme is to increase access for children and their families to specialist care in the community.
- GPs are present in every clinic working alongside the paediatrician.
- An integrated MDT approach have been established to oversee the programme, and healthcare professionals (HCP) across the MDT can be accessed by patients who receive the benefits of integrated wholistic care.
- In the main clinics take place on a face-to-face basis and this further strengthens the relationship between the HCP, the patient, and their family/carers.

Overview of Service Model

- The MDTs and clinics ensure children's and their family's needs are addressed in a wholistic and integrated way, this is demonstrated by the input of social workers who ensure that the wider needs of the child and the family are taken into consideration.
- The inter-disciplinary partnership working that is encouraged through this service ensures that a wider range of population health outcomes are achieved as well as encouraging a change in behaviour in terms of professional practice and how patients and their families engage with health and social care moving forward.
- To date the CC4C service has shown a 40% reduction in patient needs which frees up resource to manage general demand across primary care.
- Early indications suggest a positive impact in terms of improving population health and reducing inequalities

Priorities moving forward

- Secure input from all providers across patch
- Development of a common offer.
- Consider how this approach could be extended to other patient groups as well as aligning with the future development of Integrated Neighbourhood Teams
- Expanding the preventative approach in priority clinical areas.

Local Care – Grenfell:

- It has been 6 years since the terrible events on the night of June 14th 2017. The integrated care system (ICS) for North West London, a partnership of organisations including the NHS and Local Authorities who come together to plan and deliver health and care, continues to be committed to supporting the survivors, bereaved and the wider Grenfell impacted community into the future. The ICS has identified funding for a five-year-period back in 2019 and this commitment will continue.
- To date the NHS has planned for and provided healthcare services based on expected health need; that need has changed over time and services have changed accordingly. The NHS are committed to continue to review and adapt services into the future, using advice and guidance from relevant experts to inform this.
- The ICS are learning from the Grenfell Tower Fire and how to work differently with communities to aide their recovery and will share this learning more widely across health and care services. A Health Partner Forum has been formed that is able to reach into some of the seldom heard communities providing access to information through trusted routes.
- We heard from the community that services needed to be more culturally aware and have worked to improve services, such as accreditation for cultural competency training with community representation for primary care. This approach could also be applied in other areas of NWL across health and care services.
- Working with traumatised communities requires different approaches and there is significant learning from the approaches taken and the community feedback that has been received that is transferable.

Acute Care

Residents in North West London have access to a wide range of clinical expertise delivered by our hospitals, with access routinely coordinated by a patient's own General Practitioner (GP).

There are 12 acute hospital sites in North West London, organised into four Trusts (Imperial Hospitals NHS Trust, Chelsea and Westminster NHS Foundation Trust, London North West University Hospitals NHS Trust and Hillingdon NHS Foundation Trust).

Combined, each year these sites deliver over 500,000 urgent and emergency contacts, 152,000 emergency admissions, 2.7m specialist outpatient appointments, 246,000 diagnostic imaging tests and 17,800 elective surgeries (as day cases and as inpatient cases).

Although significant progress has been made in addressing the challenges in the acute hospital system following the pandemic, we know that our residents don't always have an optimal experience of care when they need it. They don't always find it easy to access timely clinical advice, whether for an urgent or non-urgent need, and waiting times for elective services remain long. Elective services describe those hospital services where a referral is made, either by a healthcare professional or yourself. Significant volumes of patients are waiting over 52 weeks to be seen; this can result in people suffering a deterioration in their health and quality of life and can place additional pressure on the primary care system. Residents don't always feel that their care is joined up; some hospital visits could be avoided, opportunities for residents to take control of their own follow-up care are not always available, and integration of specialist advice into primary care is not always consistent. This leads to variation in the quality of care and clinical outcomes experienced across our sector.

Our aim is to deliver consistently high-quality care, on a par with the best cities globally, for residents of North West London and to deliver the best hospital care in the UK by ensuring that we meet the following key objectives:

- Ensuring that residents have routine access to specialist expertise
- Significantly improving access to surgery (inpatient and day cases) to reduce waiting lists
- Ensuring that residents have convenient, effective and timely access to diagnostics
- Significantly improving urgent and emergency care to reduce delays
- Ensuring that residents experience the same quality of care regardless of where they receive it, by identifying and reducing the causes of any varied experience
- Ensure that our specialist services are readily accessible with effective and efficient pathways of care.
- Ensuring the appropriate reprovision of acute estate, starting with the four hospital sites in the national New Hospitals Programme.

We will achieve these objectives in several ways, summarised below.

Routine access to specialist expertise

Traditionally, the first non-emergency contacts a resident has with the hospital is through an outpatient appointment. The pandemic demonstrated different ways of delivering these services, whether by telephone, video call or by providing specialist advice to a GP. We will develop this further, focusing on ensuring rapid access to specialist advice and support regardless of where this is delivered. This may take the form of:

- direct GP and patient communication via email
- a virtual appointment or
- an in-person appointment which could be delivered in a community setting as well as in a hospital.

This will significantly shorten the time taken for patients to be seen, reducing waiting lists and ensuring a much quicker resolution of any condition or ongoing treatment.

North West London ICS is developing the use of digital tools to support more effective and efficient delivery of care. In dermatology we are piloting the use of digital image recognition to support the rapid identification of patients who may have skin cancer which, if successful, will release clinician time to support treatment. Across all our outpatient services we are also piloting the use of technology to automate manual administrative processes which, if successful, should improve our patient-facing services around booking and rebooking of appointments.

North West London ICS has rolled out an Advice and Guidance system for many of our hospital services, connecting GPs with specialists directly. There is scope to significantly expand this to a wider range of specialists and geographies. For some patients this may mean that a specialist can virtually 'join' an appointment with their GP (for example through a video link), or it may mean the GP and specialist work together to agree the plan to support a patient.

In other instances, routine specialist care may be delivered away from the traditional outpatient building in a hospital and make use of local care hubs.

Some services require very specialist equipment or teams, and these are likely to remain in traditional hospital settings.

We will work with patients to develop new ways of communicating and working with users. We will do this by developing effective digital tools that support reliable, accurate and timely communication, whilst ensuring that residents who are unable to use digital tools are provided with equivalent support.

Improving access to elective surgery – day cases and inpatient cases

The COVID-19 pandemic has had a significant impact upon the residents of North West London and our hospitals, with waiting times remaining significantly increased since it began.

Across North West London the four acute Trusts are working together to identify where theatres and staff can be used more effectively e.g. by reducing cancellations on the day of surgery, by using data and analytics to optimise scheduling, by reducing length of stay, and by sharing resources and expertise across sites.

As highlighted by the national Getting It Right First Time (GIRFT) programme, there are three key steps to improve quality and productivity for high volume, low complexity surgery. These are:

- separating elective and non-elective surgery
- increasing day case surgery rates
- improving the utilisation of asset such as operating theatres, x-ray equipment and other complex equipment, increasing theatre productivity and creating more efficient care pathways.
-

Separating elective and emergency work reduces the risk of cancellations and the risks of infection.

For example, we are developing a proposal for an elective orthopaedic centre, which will bring together patients and specialists from across North West London in a

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purpose-designed centre with the goal of delivering rapid access and world-class clinical outcomes.

The proposed elective orthopaedic centre is intended to be part of an improved end-to-end pathway for musculoskeletal disorders. This draws upon best practice from other parts of England where the establishment of dedicated elective orthopaedic centres has led to improved clinical outcomes and has enabled more orthopaedic activity to be undertaken throughout the year, helping to reduce waiting times for life-changing joint replacements.

Convenient, effective, and timely access to diagnostics

Timely access to appropriate diagnostic tests is key to ensuring that any treatments can happen as quickly as possible, or any problems can be excluded. Improvements can be made in several places:

- Starting in primary care, GPs will be supported with Clinical Decision Support (CDS) electronic tools that help direct referrals to the most appropriate place and ensure that results are rapidly available to both GPs and patients.
- Once referred for diagnostics, electronic systems such as Swiftqueue allow patients to organise and modify their own appointments online at their convenience. They also support electronic scheduling systems to improve the use of diagnostic equipment. Again, cross-North West London working in hospitals allows for patients to receive care as quickly as possible, ensure that there is no unnecessary duplication of tests and cuts out unnecessary travel for patients.
- We will continue to explore the use Artificial Intelligence (AI) tools to support diagnostics and ensure that specialist staff capacity is used effectively. To help achieve this, an AI strategy is being formulated and pilot initiatives rolled out.

In liaison with specialist cancer providers (see below) delivery of the Cancer Faster Diagnostic Standard (FDS) through improving care pathways will be prioritised.

Community Diagnostics Centres (CDCs) are being established to provide additional capacity and more accessible diagnostics in Wembley, Willesden, and Ealing (all areas of high health need).

Improving quality of care and reducing variations in quality across North West London hospitals

We will continue to work together to review and monitor data about access to care (including waiting times) and quality of care. Our aim is to achieve consistent standards in quality of and access to care across our population, regardless of where an individual lives or their background. An example of how we are doing this is set out

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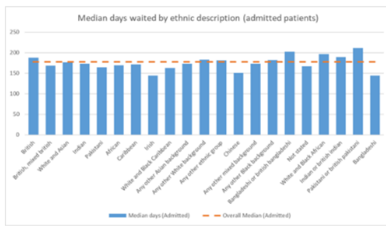
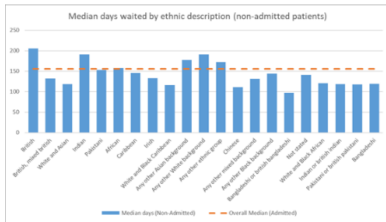
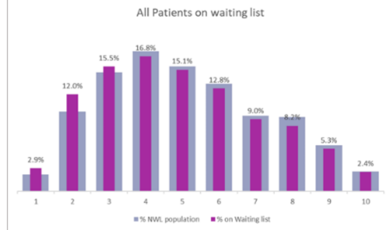
below.



Data shows that there is no significant difference in waiting times for elective care across different ethnic groups. There is slight disproportionality in the percentage of patients on the waiting list in North West London from deprivation deciles 1-3 compared with the total population accounted for by this group of patients…





Top 35 TFC cancellations, DNAs & Late not seens by Deprivation (21/22)

Rank	TFC	Total Number	1-2	3-4	5-6	7-8	9-10	Percentage difference between most deprived and least deprived groups
1	Cardiology Service	11,575	12.18%	10.26%	8.59%	7.44%	6.63%	5.54%
2	Trauma and Orthopaedi	8,970	10.89%	9.78%	8.20%	7.47%	6.22%	4.67%
3	Gynaecology Service	8,078	7.73%	7.09%	6.82%	6.28%	5.71%	2.03%
4	Gastroenterology Servic	7,406	16.70%	13.00%	11.51%	8.93%	6.69%	10.01%
5	Ear Nose and Throat Ser	7,074	13.38%	12.46%	11.13%	10.62%	10.28%	3.10%
6	General Surgery Service	6,138	11.80%	9.56%	9.10%	8.58%	7.21%	4.59%
7	Ophthalmology Service	5,552	12.38%	11.96%	10.50%	8.26%	9.03%	3.34%
8	Urology Service	4,615	10.86%	10.29%	9.42%	7.66%	7.39%	3.47%
9	Respiratory Medicine Se	4,513	11.74%	11.11%	10.13%	7.02%	7.53%	4.22%
10	Paediatric Service	4,280	7.15%	6.76%	6.58%	5.09%	4.17%	2.98%
11	Dermatology Service	4,269	10.41%	9.53%	8.00%	6.32%	6.13%	4.28%
12	Pain Management Servic	3,860	16.36%	17.55%	16.45%	14.96%	14.40%	1.96%
13	Physiotherapy Service	3,595	15.73%	12.20%	11.01%	9.30%	9.68%	6.05%
14	Colorectal Surgery Servi	3,098	9.97%	7.56%	5.81%	4.10%	3.45%	6.51%
15	Neurology Service	3,090	15.01%	12.29%	10.90%	8.75%	7.27%	7.74%
16	Breast Surgery Service	2,977	10.12%	8.06%	7.02%	6.38%	5.25%	4.87%
17	Vascular Surgery Service	2,256	11.36%	11.53%	9.68%	8.38%	6.35%	5.01%
18	Midwifery Service	2,136	4.78%	4.01%	3.49%	3.27%	2.46%	2.32%
19	Endocrinology Service	1,978	12.36%	12.10%	10.74%	9.00%	7.55%	4.80%
20	General Internal Medici	1,845	5.18%	5.48%	4.79%	4.24%	4.53%	0.66%
21	Clinical Haematology Se	1,832	15.67%	12.44%	8.90%	9.38%	7.84%	7.83%
22	Plastic Surgery Service	1,714	10.60%	9.64%	8.38%	7.22%	6.52%	4.08%
23	Audio Vestibular Medici	1,680	13.25%	11.59%	10.59%	8.20%	8.25%	4.99%
24	Obstetrics Service	1,500	6.72%	6.77%	5.87%	4.89%	4.52%	2.20%
25	Dietetics Service	1,416	19.44%	15.86%	14.41%	13.90%	11.23%	8.21%
26	Renal Medicine Service	1,362	9.77%	8.93%	7.58%	6.89%	3.32%	6.45%
27	Anaesthetic Service	1,246	5.56%	4.83%	3.76%	3.47%	2.20%	3.36%
28	Neurosurgical Service	1,157	12.01%	12.02%	10.61%	10.78%	7.83%	4.18%
29	Diabetes Service	1,152	17.68%	18.27%	15.83%	14.82%	10.56%	7.13%
30	Rheumatology Service	1,126	10.95%	8.97%	7.51%	7.39%	6.81%	4.14%
31	Occupational Therapy S	1,043	16.31%	12.80%	10.04%	8.36%	7.08%	9.23%
32	Clinical Neurophysiolog	1,003	9.79%	9.43%	8.36%	5.79%	5.35%	4.45%
33	Hepatology Service	885	17.20%	15.57%	12.21%	11.08%	9.91%	7.29%
34	Infectious Diseases Serv	755	17.45%	13.46%	8.97%	8.26%	5.21%	12.24%
35	Paediatric Ophthalmolo	715	17.15%	14.78%	13.67%	12.77%	15.68%	1.48%

…However, we have identified variation in attendance at appointments between different ethnicity and deprivation groups, and we are now seeking to develop interventions that will better support our population to access elective services.

Today, we can view a single waiting list for North West London and ensure that patients are offered equitable treatment, including offering earlier appointments at other hospitals, where this is clinically appropriate.

We have established clinical networks and communities of professionals to share information and best practice across North West London, and to develop new, more collaborative ways of delivering care. We will continue to work with our local universities and researchers to build upon North West London's esteemed position in research and development.

Across our acute system, we will have a consistent and standardised approach to our digital infrastructure to allow for seamless end-to-end care for our patients and sharing of information. All our hospitals will have a common electronic patient record by the end of 2023 providing a solid building block for this. We will look at ways of harnessing digital and technological developments and innovations to improve systems and processes within hospitals.

Specialist services

We will prioritise the collaborative transformation of a small number of specialist services and their associated pathways. These transformations will look to develop the overall quality of the service (in terms of effectiveness, patient-centeredness, safety, efficiency and equity) by working with clinicians from across the system.

We will focus on those pathways with the greatest need for transformation, whether it is due to demand (specialist tertiary referrals) or to links with other key clinical pathways (for example where specialist services have a measurable impact upon urgent and emergency care pathways).

Ensuring the appropriate reprovision of acute estate

We will ensure that our estate is fit for purpose and that we have the right quality estate in the right places, in particular delivering on our pledges to rebuild aging hospitals. Four of London's acute hospital sites are part of the national New Hospitals Programme – Hillingdon Hospital, St Mary's Hospital near Paddington, and both

Charing Cross Hospital and the Hammersmith Hospital in Hammersmith & Fulham. We are in the process of developing and securing approval for the business cases for each of these sites. We will also bring diagnostics into the community, and addressing services where technology has moved on it no longer makes sense to deliver in the current fashion.

Always here for you in an emergency

The current urgent and emergency care system is clearly under pressure with very long waits for patients in primary care, at urgent care centres and in A&E departments.

Some reasons for this are:

- delays in discharging people from hospital beds who need social care and ongoing support
- internal hospital systems which add to delays e.g. not discharging people until later in the day, difficulties in patients receiving their drugs to take home, not planning for discharge early enough
- blockages in A&E due to the above which then lead to delays in ambulances offloading patients
- people with severe mental health problems being cared for in an A&E department rather than a dedicated mental health facility
- delays in ambulance staff being able to contact other services who could look after people at home rather than taking them to hospital
- large numbers of people attending urgent care centres and A&Es due to difficulty accessing a GP appointment
- lack of sufficient support for older and frail people to be cared for in their own home/care home rather than taken to hospital
- a plethora of choices for different types of services. This can be confusing to people who need care but lack the information or time to identify the best place to go.

We are currently seeking to invest resources to address these challenges, but we also need to undertake a holistic review to ensure we are making the best use of facilities and staff, and supporting systems to better respond to urgent and emergency care needs. Services will have sufficient capacity to meet with demand, along with a commitment to efficient working and high clinical standards to reduce the time that patients spend on each stage of their urgent care journey.

Urgent and emergency care services must work closely with other services, such as primary care, mental health care, community healthcare and social care, to ensure that urgent care is delivered in the most appropriate way possible.

This could be through A& E, for patients who need specialist services or inpatient care. For patients who require more extensive investigation and treatment but not necessarily admission to hospital, same day emergency care departments are able to carry out a range of diagnostics, bring in specialist support and, if required, review patients at the same time for multiple conditions. North West London ICS are extending these services, allowing them to treat more people, take on different conditions and open for longer hours, taking pressure from hospital emergency departments.

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Options will be available for patients not in an emergency but requiring prompt support. This could be through an urgent care centre where GPs and nurses can provide primary care for minor illnesses and injuries or it could be through a primary care centre, bringing together GPs and expertise from district nurses, physiotherapists and pharmacists.

We are working closely with the London Ambulance Service (LAS) to ensure that 999 calls are answered quickly and that patients who require an ambulance receive one promptly. North West London ICS will work with the LAS to ensure that options are available to people who require care but don't need to be taken to A&E.

The 111 service provides advice to people over the phone, making appointments in primary care and booking patients into an urgent treatment centre. 111 can also make referrals to other services such as community nursing.

Patients with mental health conditions will receive prompt assistance from specialist services. Dedicated service models are being developed for babies, children and young people, older people, and those on end of life care pathways.

North West London ICS is committed to learning from the best examples of care, nationally and internationally. It will work with all urgent emergency care (UEC) providers to achieve a consistent and high level of service so patients, wherever they are, will be met with the care that they need.

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Mental health, learning disabilities and autism

The Mental Health, Learning Disabilities and Autism (MHLDA) programme brings together multi-disciplinary stakeholders and lived experience and expertise to improve access to services, patient experience and outcomes for every resident of North West London, affected by mental health, learning disabilities and autism.

Mental health disorders are the fourth largest driver of years lost to disability and death in North West London[3], and therefore present one of our biggest opportunities to improve the health and wellbeing of our residents.

Our areas of focus for North West London are informed by what our patients, families and carers tell us is important to them – greater access, more local care and treatment and prompt response in crisis – as well as the NHS Long Term Plan, locally defined priorities and our continued learning from COVID-19.

The MHLDA programme is made up of four workstreams:

1. Community Mental Health
2. Crisis Care
3. Children and Young People's Mental Health
4. Learning Disabilities and Autism.

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[3] PHE's burden of disease study – fourth driver of DALYs in NWL for seven boroughs (number 3 for H&F)

Challenges

In recent years, more and more people are aware of, and are seeking help and support for, their mental health needs. Demand and complexity are increasing, both exacerbated by the COVID-19 pandemic and the resulting, wider consequences to society. This is demonstrated by a greater number of people presenting at A&E in mental health crisis, who are not previously known to services.

Transformation priorities

Across all its workstreams, the mental health, learning disabilities and autism programme will:

- Deliver an equitable core offer to all residents of North West London.
- Co-produce interventions and delivery models to meet the differing needs and attitudes of our residents, with a particular focus on groups and communities that have historically been underserved.
- Build on existing community assets.

Community mental health

With over 80,000 contacts each year, community mental health focuses on three areas, using psychological (and other) therapies to alleviate anxiety and depression; to support treatment and recovery for people with serious mental illness; and complex emotional needs in the community. Also, to improve the care provided to people with dementia, whether they are in a hospital or their own home.

Community mental health in North West London is now more focused on treatment and recovery. It is becoming more joined up with primary care and community assets and will become part of the services on offer through our integrated neighbourhood teams. This enables people to receive more holistic, individualised care – joining up physical health, social and mental health interventions closer to their homes that address underlying issues and problem.

For those with common mental health problems, such as anxiety and depression, we have improved access to talking therapies. Whilst capacity has expanded rapidly in recent years, people's access to care remains relatively low compared with prevalence. We will reach more people by flexing the approach, particularly tailoring the service to differing local communities. We must also expand our reach through other organisations, sectors and industries, to further develop the broader health, social and economic improvements of North West London.

Community teams will cover more days and longer times and provide more local care and treatment. This will be achieved by a local system, including the voluntary sector, that works together to enable residents in North West London to take better care of their mental and physical health, and building confidence in people to support their mental wellbeing.

There is also a renewed North West London-wide commitment from our partners to improving dementia diagnosis rates and post diagnostic support, as well as reducing variation in service user and carer experience between boroughs.

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Crisis care

We estimate that over 35,000 people present in crisis each year. Mental health crisis care has significantly expanded with 24/7 community teams, a range of crisis alternatives to A&E and admission available across the ICS and the expansion of liaison psychiatry teams that meet Core 24 standards in every A&E department in North West London.

There is a growing need to further promote and improve public knowledge of alternative crisis services to better direct people to the most appropriate service and prevent the need for A&E attendances and admission. Added to this, we will continue to improve the existing 24/7 open access urgent mental health helplines, including capacity of telephony systems and follow-up care in the crisis pathway, connecting these services to NHS 111.

Taking forward actions from the Crisis Care Concordat and developing our estate and physical spaces to provide dedicated mental health assessment will also ensure that mental health crisis is treated with the same urgency as a physical health emergency. Focusing on improving the quality of treatment and care when in crisis will enable people to be treated with dignity and respect, with a trauma informed approach in a therapeutic environment.

Children and young people

Children and young people's mental health services have continued to expand and diversify over the last four years. This has resulted in over 17,400 children and young people accessing mental health care and support in the last year. However, the severity and complexity of issues and needs has also increased. Despite, relative success in increasing access, there is also a large proportion (approx. 55%) of children and young people with needs that do not seek and/or access the help and support that would benefit them, their families and carers.

Within North West London, access to services will continue to expand and join-up, with an emphasis on delivering preventative and early support and interventions, digitally where appropriate. Systemic issues and symptoms will be detected earlier, and with a "no wrong door" approach, children and young people will have a wider range of their needs supported so that they are able to thrive. Further development of multi-disciplinary forums and structures, such as Child Health Hubs will enable holistic care.

Early support and building resilience will be a priority and there will be more resource and focus on education settings. Mental Health Support Teams (MHSTs) already operate in over 40% of schools within North West London, there is both scope and appetite to offer a comparable level of support to all schools. We will also consider an appropriate offer for those that do not attend school, to ensure that their needs are also met.

Learning disabilities and autism

Patients, families and carers, as well as fellow professionals, sometimes struggle to navigate services that deliver care and support for those with learning disabilities and autistic people. Waiting times are variable throughout North West London, particularly

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within diagnostic pathways. This is, in part, caused by historical complex commissioning arrangements which is compounded by workforce shortages, as well an increase in prevalence rates of autism in schools between 2010 and 2019[4]. It is estimated that autism affects 1-2% of the population[5].

North West London will address this by developing a common, scalable, resilient core offer that gives more equitable access, support and outcomes, including swifter access to diagnosis. For patients, families and carers that continue to wait, clear and constructive communication will be consistent throughout, ensuring more proactive, timely support for challenges and issues as they arise. An enhanced offer through the voluntary, community and social enterprise sector and peer led organisations will mean that an additional, diverse range of needs will be met, and residents will be better equipped to thrive in the community.

Actions

Taking our priorities forward rests on ensuring multi-year workforce plans, which include developing and diversifying the types of roles across our providers. We are committed to establishing sustainable partnerships and building capacity with the voluntary, community and social enterprise sector and independent providers, increasing our reach and improving provision, particularly for diverse and underserved communities and groups.

The workstreams vary in scope, covering different service areas and population groups with some overlap and interdependencies. There are agreed objectives and metrics in place which we will continue to evolve, largely focused upon increasing awareness and access to improve outcomes and quality of life by delivering quality care with dignity in the least restrictive settings.

Establishing appropriate systems and frameworks that enable Provider Collaboratives to design, commission and deliver a wide range of pathways and services is key to driving the transformation and improvement of all mental health, learning disabilities and autism services across North West London.

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Mental health, learning disabilities and autism – case studies:

Community Mental Health Transformation: Pathways for people with a diagnosis of 'personality disorder' (Complex Emotional Needs, CEN) in Westminster

One of the key areas that was fed back when carrying out engagement events to support community mental health transformation from both service users, carers and the GP workforce was that service users with CEN were falling

[4] McConkey R. (2020). *The rise in the numbers of pupils identified by schools with autism spectrum* ... g, 35:

... -june-

Community Mental Health Transformation: Advancing equality and joint delivery of provision with the third sector and local authority

The aim of transformation work is to expand the therapeutic offer to those with serious mental health needs and reduce inequalities in mental health with more provision by the VCSE. To ensure a collaborative approach West London NHS Trust leads worked with the local grants programme that already exist within the local authority boroughs. This included providing culturally appropriate therapeutic support and holistic approaches to those residents who have experienced trauma, providing services to support the health and mental wellbeing of those residents who identify as LGBT+ and working with ethnic groups across the Trust area.

The services have supported over 600 people collectively direct/indirect across the six organisations commissioned. This includes medication management, prevention of escalating crisis, supporting access for marginalised groups into mental health treatment and raising awareness, wellbeing groups, therapeutic sessions, signposting and peer support, significant work has also been delivered on supporting women and families.

Individual Placement and Support: evidence-based model of supported employment

Individual Placement and Support (IPS) has been thoroughly trialled and has outperformed all other tested forms of support for job seekers with serious and enduring mental health needs. The implementation of IPS has been a key element of the NHS Long Term Plan and preceding strategies for national mental health improvement. IPS in NW London is expanding and continuing to embed into the community mental health transformation model. This service provides valuable support and job outcomes for service users such as Shaden, who is now working as a Software Professional and has shared her recovery story:

"My Care Co-ordinator referred me to the Employment Specialist who is part of the service / team. Knowing she was based with my care team really reassured me. I was already applying for jobs and getting interviews. The hurdle was passing the interview. We had regular mock interview sessions where I could practice how to best answer potential questions. With support from my Employment Specialist, I felt positive that I would get a job.

I am now working full-time for a well-known international software company. I have regular meetings with my Employment Specialist where we discuss how I am getting on at work and the challenges my role brings. Having in-work support means that I can pick up the phone, email her or text her whenever I need support. During my days off, we meet at a local coffee shop and talk more about work. It's really helpful to go through the difficulties and positives that work brings. My ES is very encouraging, listens to me, discusses options with me and respects my decisions."

Part 3 – clinical networks

Maternity

Our vision for the future of maternal and neonatal care provision in North West London is to provide equity of access, experience and outcome to all people using our services. We will deliver co-produced and co-delivered services using our multi-disciplinary expertise to provide holistic and preventative care that extends from pre-conception to the early years. These services will be delivered close to home and designed to maximise the health and wellbeing of mothers, babies, and growing families.

The maternity programme plays a fundamental role in achieving the NW London ICS's overall objectives. Maternity and related services have the potential to improve both the health of people using them now and, through their children, the health of wider society for generations to come. Growing evidence shows that to maximise health gain and reduce inequalities in the population, the focus of effort must be on the health of families before conception, during pregnancy and in the first three years of children's lives.

The ICB Maternity programme team is organised in three pillars for delivery of high quality, safe services tailored to the needs of the population we serve: **insight, infrastructure, and improvement**.

Since 2015 maternity services in North West London have been working collaboratively to configure services for the needs of our population with a focus on equity and equality. We have been sharing outcomes data to target areas for improvement, collaborating on innovation to meet national requirements and engaging with our stakeholders to understand what matters to them. In this way we have delivered innovative services that are nationally recognised.

Challenges

Workforce

Retaining staff is as important to us as recruitment. Relationships between staff and patients can be lost if there is a high turnover of staff.

Staffing shortages impose heavier demands on the workforce resulting in staff reporting that work is emotionally exhausting and that they often feel burnt out because of work. This in turn adversely affects the continuity and quality of care delivered to our residents and patients.

This challenge will be addressed in North West London through:

- an ongoing recruitment and retention drive
- improving efficiencies with better use of digital technologies
- investing in and working with local partners and communities to adopt 'anchor institution' practices
- tackle demand across North West London by joining up capacity and resources across the patch to improve productivity and efficiencies. Suggested initiatives include: North West London Birth Centre, North West London Home Birth model and North West London Surgical Hub.

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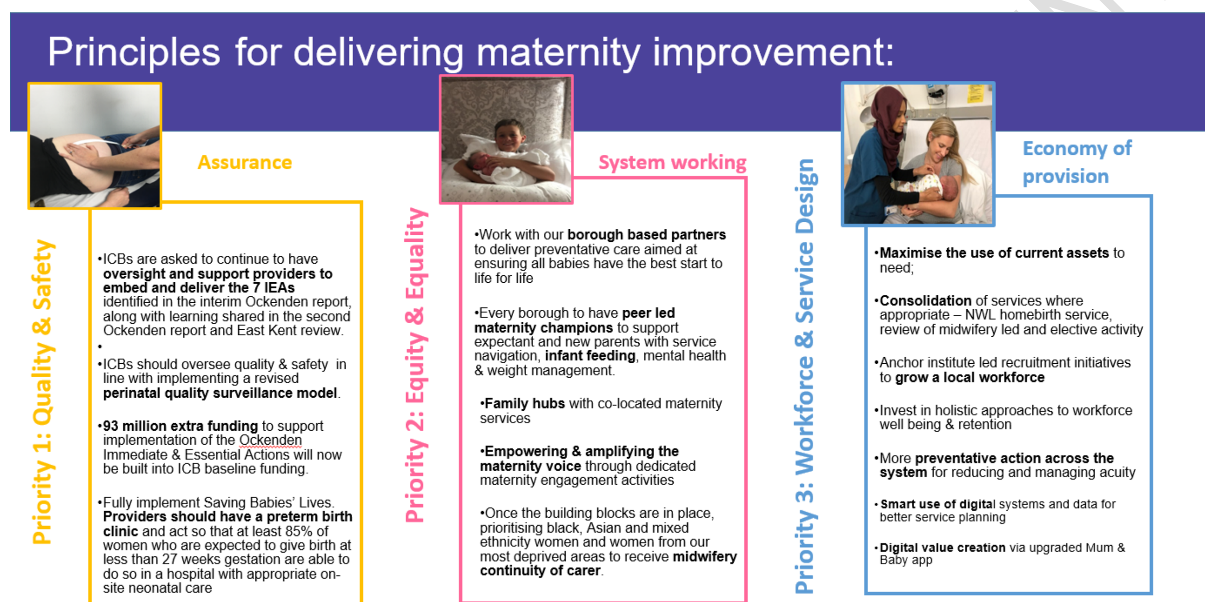
Inequalities

There is a disproportionately high number of still births, neonatal deaths, and poor outcomes among expectant and new mothers from black, Asian, and mixed ethnicity groups. This challenge will be addressed in North West London through midwifery services targeted towards deprived and ethnic minority population groups, as set out in the NW London maternity equity and equality action plan and strategy.

Transformation priorities for the maternity programme

We have developed three interlinked principles for delivering maternity improvement: **assurance, systems working and economies of provision.**



Assurance

The ICB maternity programme is responsible for assuring the **quality and safety** of maternity and neonatal services in North West London. We do this by supporting our providers to deliver on national recommendations. We have implemented a revised perinatal quality surveillance model that facilitates clear lines of escalation from ward to board, championed by staff at every level of the system, ensuring that concerns raised are acknowledged and acted upon. Extra funding is being invested into maternity services to increase staffing levels and develop better multi-disciplinary training. Our North West London maternity dashboard uses data intelligently to monitor variation in outcomes, enabling early alert and intervention where and when required. **For example**: *reducing stillbirth, pre-term birth, intrapartum brain injury, maternal death, and readmissions, increasing infant feeding.*

Systems working

Systems working is how we grow stronger and more effective. As the ICS evolves, we can **develop stronger links with our community partners and stakeholders**. Working with primary care networks, our borough-based partners and VCSE we can identify local need and increase preventative measures that support the best start in life. We will explore/focus on:

- **Empowering and amplifying the maternity voice** through dedicated maternity engagement activities to learn how we can improve the experience of using our services and together co-produce improvements.
- Introducing **peer led maternity champions in every borough** to support expectant and new parents with service navigation, **infant feeding**, mental health & weight management.
- Co-locating maternity services with borough **family hubs.**
- Ensuring the building blocks are in place to prioritise black, Asian and mixed ethnicity women and women from our most deprived areas to receive **midwifery continuity of carer**.
- Acute collaborative services working together with primary care partners and local authorities to **develop effective pathways** for our population.

Economies of provision

- The people who work in our services are key to the **quality of care** that we deliver. North West London maternity programme is working with the anchor institutions to develop innovative projects to get local people into work.
- We invest in holistic approaches to workforce wellbeing and retention.
- We are developing our capabilities for **the smart use of digital systems and data** for better service planning.
- We are continuing to create **Digital Value** via the upgraded Mum & Baby app.
- Consolidation of services where appropriate is under review as we **co-produce the design of services to meet changing need and demand**.
- By focussing on more **preventative action across the system** we aim to reduce and manage acuity.

Enablers

We will work with the following partner programmes to deliver specific areas of improvement:

- **Children and Young People (CYP)** – focusing on the first 1000 days from conception, including the neonatal interface
- **Acute** – focusing on chronic conditions in early pregnancy; the interface between acute and chronic medical care and maternity services; and ensuring prevention, efficiency and effectiveness in the care of pregnant people requiring acute and chronic care.
- **Mental Health** – focusing on expanding the perinatal mental health service provision
- **Population health & inequalities** – focusing on development of the maternity and neonatal equity and equalities strategy which is supported by the North West London race steering group; a vaccination programme for delivery of flu, COVID-19 and pertussis vaccinations in pregnancy; and workforce development enabling local population balance.
- **Digital & data** – focusing on a North West London developed and owned (income generating) maternity app; developing a maternity digital strategy, in line with the ICS priorities and population and service need; harmonisation of maternity IT systems and digital tools; improving our application and analysis of big data to target interventions to reduce acuity; and increasing our analytics

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capability to support workforce analysis and enable resource being targeted in the most impactful way.

- **Workforce** – focusing on developing a workforce fit for the future, improving staff wellbeing and job satisfaction.
- **Local care** – focusing on the interface with GPs in the provision of care to women and babies, preconception to postnatal; provision of over the counter medicine for pregnancy, standardisation of medicine policy (eg Vitamin D) and provision of prescriptions for pregnant population; pre-conception counselling; diabetes prevention support programme for mothers at high risk of Type 2 following episode of gestational diabetes and Type 1 Continuous Glucose Monitoring (CGM); and implementation of personalised care plans in maternity, social prescribing and motivational interviewing.
- **Safeguarding** – Focusing on supporting and caring for families with complex social needs and identification, treatment and prevention of Female Genital Mutilation (FGM).

Our plans going forward

What we do:	Why it matters:
Holistic care from pre-conception to early years for all the family: • maternity care embedded within family hubs and part of neighbourhood teams in all boroughs. Maternity champions. • Working alongside public health to maximise use of existing resources • ensure equitable access with effective signposting	Having the best possible start in life is critical to the health of our future population. System level investment in pre-conception, maternity and neonatal care will deliver health benefits for generations to come. Delivering timely preventative care, close to home reduces complexity and acuity, improving outcomes and increasing efficiency. For example reducing late booking to maternity services, improving infant feeding, increasing provision and consistency of smoking cessation support and improving perinatal mental health.
Developing a standardised assurance approach	Understanding what's going well, what the challenges and issues are, helps us to collaboratively support all our maternity services to provide excellent, high quality and safe family centred maternal and new-born care.
System level sharing learning from risk	Open multi-disciplinary meetings explore themes arising from serious or untoward incidents to learn and share together how to improve safety and quality in maternity and neonatal services.
Service and workforce review and co-design	Creating economies of provision by maximising our use of assets across the system. Our workforce is fit for the future.
Addressing inequalities in access, experience and	Reduce variation so that all birthing people and their families have the same quality of access,

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outcomes – data driven to target resource	experience and outcome across North West London.
Better alignment with Integrated Care System inequalities and population health	Work with our borough-based partners to reduce, actively challenge and remove the causes that lead to black, Asian and mixed ethnicity people having poorer outcomes than others. Develop a workforce that mirrors our population better.
Integrated Care System centralised and sustainable support to enable the programme to deliver at pace	The national spotlight on maternity demands rapid transformation, our Integrated Care System is committed to investing in the infrastructure to support our services to deliver the changes required.
Digital strategy fit for the future	Using technologies to share and learn from data. Enabling information sharing, interaction and personalised care. Digital tools can improve confidence and trust during times of change and uncertainty.

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Babies, children, and young people

Children in different parts of NW London do not get an equal start in life. Childhood is a critical time to get things right for families. Needs and risks change as we grow from babies, into infants, children, and young people. Rarely can changes be made in children's health services without considering the impact on education, social development, and families. Inequalities in childhood shape our long-term health outcomes, and our later independence in society. Having a supportive family, and a good educational are some of the biggest protective factors for health outcomes.

NW London Integrated Care Partnerships can now bring together key players within our health, education, and care systems with responsibilities across prevention, early years, education and children's social services. The NW London ICS programme for babies, children and young people (BCYP) will tackle childhood inequalities in a systematic way, and will challenge the status quo where necessary to co-produce improved services and deliver better health outcome for children and families.

Our principles

Our strategy for babies, children, and young people (BCYP) is underpinned by these key principles:

- **Listen with humility** to children and their families; involve them in decisions about themselves.
- Use local, multi-agency **qualitative and quantitative evidence** to coproduce service improvements with families.
- Enable families to have better access to **advice, preventative care, and early help**, particularly in the first 1,000 days from conception.

- Consider the **childhood and family health inequalities**, holistic needs of the child, their physical, emotional, and mental health, and the wider determinants of health by working with agencies across health, social care and voluntary sector. (Detailed child mental health plans are in the chapter on Mental Health, Learning disabilities, and Autism).
- Balance the focus on reactive care with the proactive care to **prevent later development of ill health in adulthood.**
- Deliver care in the **most appropriate setting**; locally where possible, centralised where necessary, and making best use of the health and care estate.
- Improve **equity of access, experience and outcomes across all ages**, places, protected characteristics and other vulnerable groups.
- **Integrate our publicly funded resources** in North West London to the benefit of all children.

Our theory of change

Pyramid of care for improving health outcomes for babies, children, and young people

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We will deliver this through:

1. **Implementing new 'models of care'**, for example: changing the way integrated neighbourhood teams of GPs, social workers, and community paediatric teams work with residents to identify and reach out to families at risk of missing out on preventative care; acute paediatric hospitals working together to ensure children receive consistent standards of care
2. **Establishing 'system enablers'**, for example: regularly listening to the ideas, concerns, and experiences of parents with new babies, infants, adolescents, and young adults through a range of age-appropriate engagement activities;

using the diversity of communities and number of health and care children's services to create more attractive opportunities for professional recruitment, development, and retention; changing some of the contract arrangements for child health services to incentivise more preventative care for families at risk of poor health outcomes.

3. **Coordinating 'programmes of work'** across NW London ICS, for example: reducing waiting times for children with special educational needs and disability (SEND) to access assessments and care improving access to remote monitoring equipment for children with diabetes; work with schools and families to ensure all children with asthma know what to do if they have an asthma attack, and how to reduce their risks; improve the oral health advice and access to dental care for children at risk of tooth decay, thereby reducing the number of children who need tooth extraction in hospital; supporting paediatric hospitals and community health services to increase their capacity to treat common childhood diseases, so that children and families get better care locally.

To support all segments of the population in a proactive way, NW London ICS will use the 'Whole System Integrated Care' (WSIC) dataset to share intelligence between health, education, and social care to proactively identify and prioritise care for children and families who have the highest level of need, and highest risk of health inequality.

Pyramid of care – key objectives

- Fewer children sent outside NW London for specialist hospital care or multi-agency placements – Regular review of BCYP referred to services outside NW London used to identify **opportunities to invest in improving local services**, for example: specialist foster-care; specialist cardiac and respiratory care.
- Reduced inequality of access to care when local services are stretched. NW London hospitals to work together as a **centre of excellence in managing common diseases of childhood**, embedding best practice within all NW London communities and involving all NW London ICS providers, led by the **West London Children's Healthcare Alliance**.
- To improve the efficiency and impact of reactive care, NW London ICS will coordinate an **approach to urgent and emergency care for BCYP that goes beyond immediate care** to consider opportunities for relapse prevention; self-management; and high-quality care in the home, GP practice, and urgent care settings.
- BCYP 'provider alliances' will be established, enabling provider collaboratives and Borough Based Partnerships to **level-up children's services in each borough** and **plan for future workforce skill mix and capacity** to the be on par with the best global cities.
- Quantify and optimise the use of **digital platforms, local resources, community assets**, and neighbourhood expertise to ensure BCYP receive care within NW London ICS, at home or close to home whenever possible; and increase the opportunities for NW London children and families to participate in clinical research.
- Co-locating services and coordinating appointments to **reduce travel and time away from school** for children, and reducing the number of in-person appointments needed to deliver clinically appropriate care

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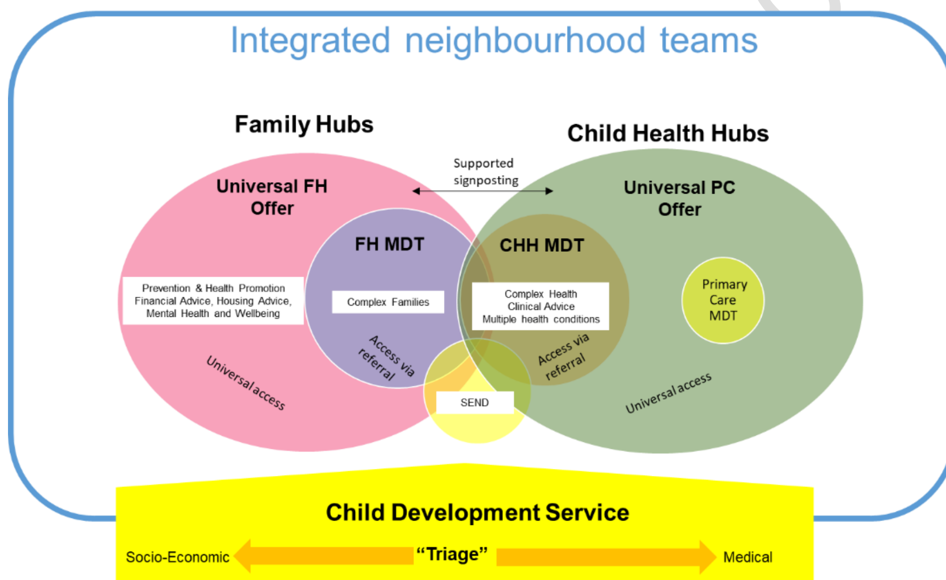
- **Multi-disciplinary teams including schools** to support early intervention, holistic care of long-term conditions and complex needs; including dedicated focus on reducing health inequalities in mental health, SEND, asthma, diabetes, and epilepsy
- Improve the work of integrated neighbourhood teams to **tackle health inequality for children growing up in the poorest areas,** or in households with the lowest income.
    - **Extend the NW London ICS roll-out of 'Family Hubs'** to all eight boroughs, so that multiagency support is optimal for pre-school children; with dedicated workstreams to tackle inequality in outcomes around oral health, SEND and healthy weight
    - **Extend the NW London ICS roll-out of 'Child Health Hubs'** to all 45 Primary Care Networks, so that all BCYP registered with a GP practice have improved-access to specialist child health resources, earlier intervention and holistic care; with dedicated workstreams to cover areas of focus such as asthma, mental health, immunisations and complex health
- Helping **families to be more active**, supporting physical activity to benefit children's physical development, such as strengthening bones.



Priorities based on Need and Equity Across Population Segments

NW London will develop integrated care for children and young people that moves beyond pathways and takes a whole population 'segmentation' approach. A child will fit into more than one segment at a time and move dynamically between segments.

Generally healthy child

Healthy Child: Children growing up in NW London are more likely to be overweight, less likely to be immunised, more likely to need hospital admission for extraction of decayed teeth, less likely to exercise and more likely to have mental health needs than children growing up in the healthiest parts of England. Our children and young people tell us that their emotional wellbeing is a key priority and school readiness can impact on and

improve a child's life chances. Therefore, the following are priority areas of focus for generally healthy children North West London:

Oral health: Tooth decay is the number one cause of admission to hospital for 5–9-year-olds (dental extractions and treatment); 23% of 5-year-olds have experience of dental decay and there are strong links with ethnicity and levels of deprivation experienced at home;

Mental health and emotional wellbeing: BCYP from lower income households are more likely to have unmet mental health treatment requests compared with the highest.

Supporting a healthy weight: While tackling the social determinants of poor health is key, investments in prevention and early intervention services have been shown to be effective in improving many health outcomes in the short term.

Social development: School readiness (physical skills, listening and speaking skills, and literacy skills) starts in the first 1,000 days from conception. With the support of parents and caregivers, young children acquire the social and emotional skills, knowledge and attitudes necessary for success in school and life. By reducing the variation in outcomes between boroughs and increasing the number of children that are school ready at age five, we will have a strong impact on future educational attainment and life chances.

Childhood Immunisations: NW London childhood immunisation rates are lower than the UK average. More children are vulnerable to life-changing and life-threatening infections as a result. We intend to catch-up after the drop in vaccination during the CoviD lockdown, and then increase immunisation rates with targeted work to increase uptake and support informed decisions by families who are hesitant. Learning from our experience during the CoViD-19 pandemic, we will continue to offer vaccination in a diverse range of locations in the community. These will include GP surgeries, schools and community venues. NW London ICS will explore ways to use local community resources to promote vaccination uptake, particularly among seldom-heard communities, or among groups where there are commonly differences in uptake associated with ethnicity, socioeconomic status or religious belief.

Vulnerable child with social needs

Child with Social Needs: People living in more deprived circumstances have less timely access to health and care support than their peers. Experiencing trauma and adversity in childhood negatively impacts long-term physical and mental health outcomes. Knife crime related to gang activity in NW London continues to be a risk and concern for children and young people. This is why, as a system, we aim to ensure every contact makes a positive impact for the children and young people, whether it be a trusted professional or via a peer-to-peer contact.

The following are priority areas of NW London ICS focus for vulnerable children with social needs:

Looked After Children: Tackling the significant variation in health outcomes for this group.

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Safeguarding Children: Addressing the significant harm babies, children and young people continue to suffer through abuse and maltreatment.

Child with single long - term condition

Child with a single long-term health condition: Children in NW London with long-term conditions have told us it is difficult to navigate the health, education, and care system. Parents carry enormous pressure. As children grow, their care transitions to adult services. This occurs at a vulnerable time of their lives. Experience of transition is often poor. Health education can help maximise self-care and independence.

The following are priority areas of focus for children with a single long-term condition:

Asthma is significantly more common in black and minority ethnic groups. For children requiring admission to hospital, there is a widening difference between the least and most deprived population deciles. Environmental factors such as air pollution, access to second-hand smoke and poor-quality housing all contribute to poorer outcomes for children and young people.

Diabetes Type 1 diabetes is affecting rising numbers of children and young people in the UK. Poor management of the condition in childhood can have severe long-term health implications. CYP with Type 1 Diabetes from minority ethnic backgrounds and those in more deprived areas have consistently poorer blood glucose control.

Epilepsy: Optimal management of epilepsy improves health outcomes and can also help to minimise other impacts on social, educational and employment activity. Poor management of epilepsy can be life-threatening and may lead to children and young people requiring unplanned emergency care. Epilepsy is the most common cause of treatable death in children and young people with a learning disability aged 4-18. 27% of CYP aged 0-24 diagnosed with epilepsy are in the most deprived quintile, compared with 17% in the least deprived quintile. Epilepsy affects an estimated 112,000 CYP in the UK.

Child with complex health needs

Child with Complex Health Needs: Advances in paediatric care mean that more children with complex medical problems (for example, heart disease or neurodevelopmental problems) are surviving their early years. Given the susceptibility of these children to poor health outcomes, these advances in medical care have important knock-on implications for the design and delivery of community healthcare, and the forecasting of the 'special school' places and health workforce needed in schools. Importantly, their medical needs must also be understood and addressed within the context of the child and family's life circumstances. There is growing recognition that many other factors contribute to a child's complex health needs for example, family problems, fragmentation of health, education, and care provision, psychological difficulties or social issues. Supporting children with complex health needs is a priority area of focus for NW London ICS. This includes supporting their social development and maximising their independence and decision-making as they grow older.

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When a child or young person has **Special Educational Needs and Disabilities** (SEND), we will meet the statutory requirements as a minimum. We will spread best practice across NW London ICS. NW London ICS BCYP programme will work to co-produce a framework for speech and language therapy to improve equality of access, experience, and outcome.

Acutely mild-to-moderately unwell child

Child who is acutely mild-to-moderately unwell: If the most deprived children in North West London went to A&E at the same rate as the least deprived, there would be 55,000 fewer A&E visits per year in North West London. Pre-CoViD-19 data for England showed A&E attendances for the most deprived infants and pre-schoolers were over 50% higher than the least deprived. For the most deprived teenagers they were nearly 70% higher. The health can care system can be confusing to navigate. Parents know they can get care quickly and reliably from A&E any time of the day or night. As a result, for many parents have relied on paediatric emergency departments as a trusted setting to get rapid advice, even if their child has a non-urgent condition. It is a challenge to help parents trust and use other suitable sources of clinical review due to their fears and beliefs that it may take more time than they have or may be less thorough. Our 0-19 services can share knowledge with parents about minor illness management, particularly to follow-up after a child attends A&E.

Specialist Pathways: Children need to have equal access to high quality surgical expertise and efficient pathways that limit time waiting for care and spent in hospital wherever they live in NW London.

Acutely severely unwell child

Child who is acutely severely unwell: For trauma, oncology, infection or allergy, variation in care and outcomes across NW London ICS needs to be addressed. Improvements in the quality of care will draw on the specialist and academic expertise in NW London ICS to level-up outcomes for all BCYP and families. This could be done by local application of innovation and research, with a focus on treatment and management of infection, using centres of excellence sector-wide and delivering a coordinated paediatric intensive care unit (PICU) offer. Whenever clinically appropriate, children from NW London should be cared for within our boroughs.

Our approach within North West London ICS

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NWL ICS Programme Boards

Delivery programmes

Local care including primary care

Mental health and care for people with learning disabilities and autism

Acute care
- Urgent and emergency
- Elective (high volume/ low complexity, outpatients and diagnostics)
- Critical care
- Specialist (low volume/ high complexity care, including maternity)

Enabler programmes

Workforce

Research and innovation

Digital

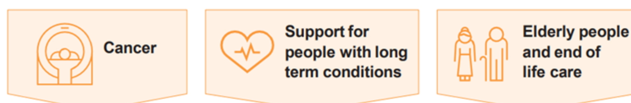
Data

Finance and estates

Improving population health and reducing inequalities in health

Babies, children, and young people

There are also a number of clinical networks focused on specific groups of people/ patients, these include:



With the establishment of NW London ICB in July 2022, NHS England set a **constitutional duty on the ICB** to achieve a demonstrable progress on improving the health of children and young people (https://www.england.nhs.uk/wp-content/uploads/2022/06/9-nhs-north-west-london-icb-constitution-010722.pdf Para 0.2a). To deliver this new duty, the existing NW London ICS child health arrangements need additional support. The BCYP programme will require support for analytics, age-appropriate engagement, project coproduction (with ICB programmes, Borough Based Partnerships, and residents), and health economics expertise (to shift the balance of resources towards more targeted prevention activity).

Coordinating Programmes of work across NW London ICS

The ICS has major programmes of work that impact babies, children, and young people. NW London will organise these to be coordinated and mutually effective, via an **'enabler' Babies, Children, and Young People Programme Board**. The BCYP programme will ensure that babies, children and young people are integral to the all-age programmes and delivery areas:

- NW London **mental health, learning disability, and autism:** there will be nuanced, non-medicalised consideration of support for improved emotional wellbeing, physical wellbeing, and mental illness.
- NW London **Local Care community provider forum:** to ensure statutory duties for Looked After Children's healthcare assessments are met and aligned to work by West London Alliance of Local Authorities to reduce placements outside NW London.
- NW London **primary care** programme: support the systematic roll-out of Child Health Hubs as part of the response to the Fuller Review.
- NW London **population health and inequality programme** to align Core20plus5 for children with Core20plus5 for adults and have a single plan for narrowing the gap in life-expectancy.
- NW London **maternity** programme to consider the needs of pregnant people with other children in the home, tackling in utero health inequalities (including

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neonatal and infant mortality), and developing consistent core service models for health visiting.

- NW London **urgent care** programme to develop alternative models for providing families with timely, trusted out-of-hours advice, and aligning developments of remote monitoring, Same Day Emergency Care, and home assessment and treatment to be on a par with that of adult services.
- NW London **elective acute care** programme to improve the use of beds, so children in our boroughs spend less time in hospital, and NW London hospital beds are available when needed, with fewer occasions when children have to be sent outside the area for care.
- NW London **specialist and critical care** to support the development of cardiac, respiratory, and sexual abuse examination services for children to reduce the reliance on services outside NW London.

In addition, the NW London ICS BCYP programme will work with other NW London ICS programme teams and with Borough Based Partnerships to establish a strong multi-agency workplan:

- NW London will **amplify the voices of 490,000 children under 18** across NW London ICS by pooling the insights from engagement with families and children at neighbourhood, borough, and provider level. We will also ensure a robust link to the NW London race steering group, to ensure intersectional identity issues across generations are adequately reflected.
- Young people will provide **reverse mentoring** support to strategic leaders; providing inspiration from a young person's perspective and challenging the unconscious bias of adults making decisions on behalf of children.
- NW London will dedicate time and resources to **age-appropriate co-production** to work with our communities on making sense of health and care data, agreeing local priorities for service improvement, co-producing locally tailored models of care, making best use of digital platforms and smart technology, and evaluating the impact of service changes.
- Patient and **public-facing materials** (including digital resources, and 'hot topic' social media campaigns) will be co-designed with families and coordinated across NW London to achieve consistent messaging.
- **Strong participation** with community representatives, voluntary sector organisations, public health and Local Authority teams will support a focus on the wider determinants of health, and delivery of preventative care.
- NW London ICB **anchor institution** work will support local work experience, apprenticeship, and recruitment opportunities integrated with employment readiness work in schools and colleges.
- A detailed **workforce** strategy will support greater opportunities for staff, through rotation and critical mass, creating centres of excellence that provide non-financial incentives to increase retention of existing staff and support local recruitment.
- High quality BCYP **data** systems will support better coordination and efficiency of clinical and professional activity. Address current gaps in critical child health data (such as healthy weight, and immunisation status) by developing links to the national Child Health Information System (CHIS) and dental health systems. Data content will be transparent about inclusion or exclusion of certain age-

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bands; population health systems will encourage pro-active case-finding, inequality analysis, and impact tracking.

- Oversight of **multi-agency packages of complex care for children** will ensure the best health and care outcomes, timely reviews, and care in the least restrictive settings.

Aligning BCYP work streams with ICS core purposes

NHS England's four core purposes of Integrated Care

Systems:
a) improve outcomes in population health and healthcare;
b) tackle inequalities in outcomes, experience and access;
c) enhance productivity and value for money; and
d) help the NHS support broader social and economic development.

Top 20 proposed work streams for child health	a	b	c	d
NHS-LA linked data & qualitative analysis for BCYP	Very high	Very high	High	Medium
Coordinated hospital care	High	High	Very high	Medium
Integrated neighbourhood teams (CHH & FH)	High	High	Very high	Medium
Special Educational Needs & Disabilities (statutory)	High	High	High	High
Complex care packages	Medium	High	Very high	Medium
BCYP core community offer	High	Very high	Very high	Low
Looked After Children (statutory)	High	Medium	High	Medium
Healthy weight	High	High	High	Medium
Supported care at home (PATCH)	Medium	High	Very high	Medium
Unscheduled care (SDEC)	Medium	High	Very high	Medium
Oral health	High	High	High	Low
Emotional wellbeing, social development	High	Very high	Medium	High
Asthma (implement care bundle)	High	High	High	Medium
Mental illness (in physical care settings)	High	High	High	Medium
Inclusion health groups of children	Medium	Very high	Medium	Low
Specialist care outside NWL	Medium	Medium	Very high	Medium
Diabetes	High	High	Medium	Medium
Epilepsy	High	High	Medium	Low
Preventable child death	Medium	Very high	Low	Low
Palliative & end-of-life care for babies and children	Medium	High	Medium	Low

We will have succeeded when:

- More children receive preventative care (health, education, and social development), with access to digital and face-to-face support.
- More families feel confident managing long-term conditions.
- Children spend less time in hospital.
- Families get better access to timely advice and are less reliant on emergency care.

- More children and young people participate in research programmes, and recognise improvement are driven by local evidence and insights.
- Fewer young people have to travel outside NW London to access specialist hospital care.

More families and young people experience care that is driven by high quality data and evidence.

Cancer

Cancer accounts for 3,134 deaths/ year (2020/21) in North West London and is the leading cause of death in the over 40s in every borough[6] (Table 1). Over 62,000 people are living with or beyond cancer in North West London. Improving cancer outcomes is a key strategic aim for North West London ICS, and the national priority for cancer is to increase survival by focusing on early diagnosis, with the ambition to ensure 75% of patients are diagnosed at stage 1/2.

Table 1: cancer deaths by age group as a percentage of all deaths (all boroughs) NWL 2021

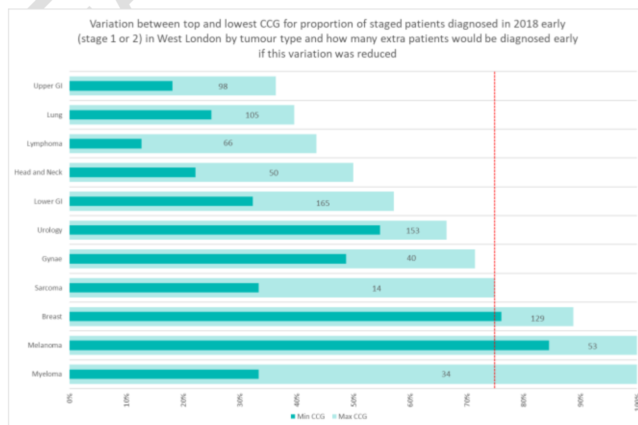
Cause of Death 2020/21	0-24	25-39	40-59	60-74	75+	Total
NWL as a whole	0%	24%	37%	37%	22%	27%

As at 2018, the early diagnosis rate across NW London stood at 55%. This average masks variation in terms of both early diagnosis rates by borough[7] (figure 1) and by tumour type by borough (figure 2). Tthe National Cancer Patient Survey shows the inequitable experience across the cancer pathway for some groups, specifically those from our most deprived communities, those who identify as Black or Asian[8] or as LGBTQI+.

Figure 1: early diagnosis rates as a percentage of those staged by

	% stage 1/2
Brent	50%
Ealing	52%
Hammersmith and Fulham	55%
Hillingdon	56%
West London	56%
Central London (Westminster)	57%
Harrow	58%
Hounslow	59%
Average	55%

Figure 2: Variation in early diagnosis by tumour type showing disparity between top performing and bottom performing borough and number of people impacted across NWL/



Our approach to improving early diagnosis is to tackle variation in screening, time to diagnosis, and treatment by deploying both universal interventions and targeted interventions focused on those least likely to be diagnosed early. We will harness emergent innovations that ensure more people get diagnosed earlier and codesign approaches with

...is on 16 December 2022]

[7] National Staging Data 2018
[8] Terminology from NCPES survey

people from groups who are less likely to be diagnosed early (Figure 3).

Seven work programmes have been identified to ensure we achieve this:

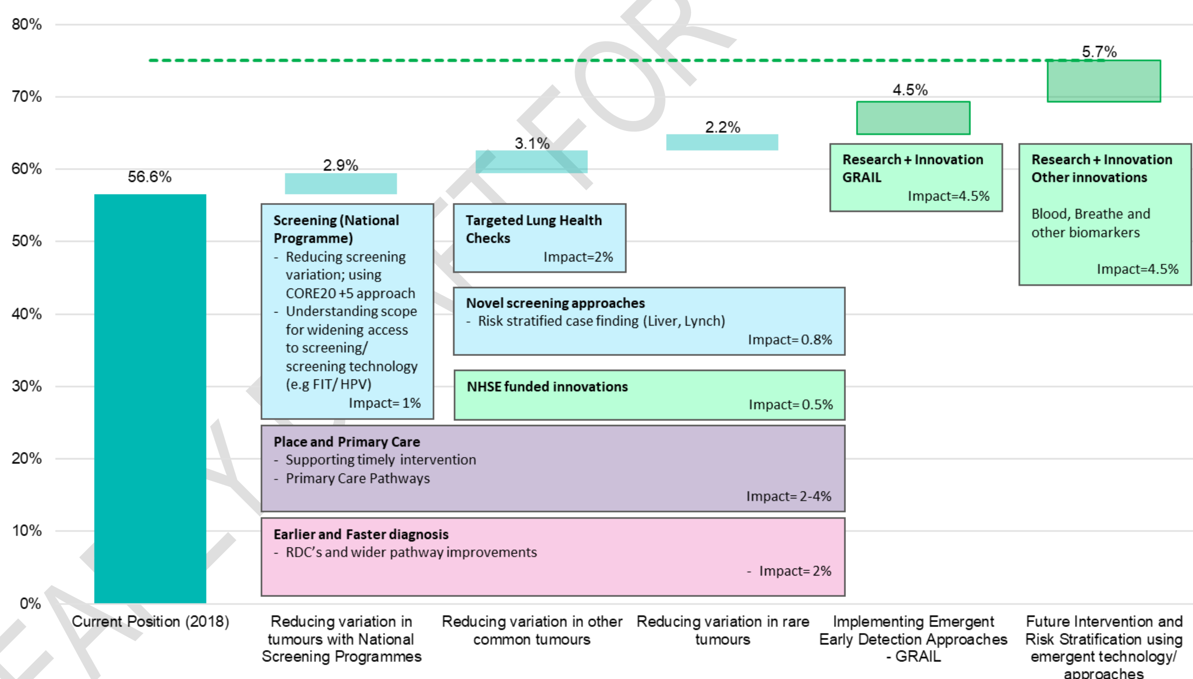
Cross-cutting programmes

1. Eliminating variation and inequalities
2. Ensuring services recover from the impact of COVID-19
3. Optimising care through innovation and improvement

Specific programmes

4. Use of novel screening approaches and reducing variation in screening programmes
5. Working with Communities and primary care to reduce local variation in early diagnosis
6. Diagnosing people earlier and faster and improving survival
7. Implementing evidence-based personalised care

Figure 3: Impact of improving early diagnosis by intervention



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Programme Ambition	Key challenges	Stakeholders
- Screening: **Reduced variation in uptake of the National Screening Programme (NSP) through use of real time data to highlight variation and actionable insights to deliver targeted improvements.** - **Roll out targeted lung health checks by 2027 using an inequalities first approach.** - **Continue to pioneer national and local novel screening methods for at risk populations.**	- Cervical screening: significant adverse variation in uptake associated with high deprivation, age under 30 and ethnicities of Chinese, 'Other' White, Pakistani and Black people. - Bowel screening - adverse variation between the lowest and highest deprivation rate and screening rates. - Breast screening: services still recovering from COVID-19 backlog. - Targeted lung health checks - at risk population located in most deprived wards in North West London.	- NSP, Screening hubs (bowel and breast) - Primary care and North West London primary care teams (cervical) - WSIC team - Place based engagement teams to support understanding of barriers and codesign
Place and Primary Care: - **We will improve population awareness and confidence in seeking support for concerning symptoms and will deliver focused interventions to reduce variation around the cancer detection rate [9]within primary care.** - **We will improve the standard and quality of referrals around TWW, and FIT testing compliance.**	- Some groups less likely to seek help in less than 3 months after onset of symptoms (NCPES 2021). - Some groups less likely to be referred after 2 visits to their GP. - Faecal Immunochemical Test (FIT) testing currently at 70% across North West London.	- Place engagement teams to support understanding of barriers and codesign of improvements. - Primary care networks and North West London primary care teams to highlight variation of detection rate. - GP practices with lowest and highest detection rate to enhance actionable insights.
Faster diagnosis	- Variation in Faster[10] diagnosis standard by Trust and Tumour group	- Acute Provider Collaborative - Pathway groups

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	- Increase in TWW referrals (16% up)	
Treatment variation	Ensuring that access to treatment is local where possible and, where specialist, easy to access and resilient.	- Acute Provider Collaborative

Key risks and challenges

Key risks	**Management and mitigation**
Early diagnosis improvements may be impacted by delayed presentation following COVID19, or failure to address variation. This could worsen cancer inequalities.	The delivery programmes in this strategy aim to minimise the continuing impact of the pandemic, while accelerating recovery. We will: • Focus on addressing variation, and share areas of variation with our stakeholders. • Work closely with Trusts to monitor referrals and capacity and support when needed. • Optimise pathways such as 'straight to test' to ensure rapid diagnostic pathways. • Focus on recovery of the national screening programmes.
Significant workforce shortages in a range of cancer specialist roles (e.g nurses, oncologists, radiologists, AHP) could affect the capacity and stability of some cancer services across North and South West London.	We will take a proactive role managing and mitigating workforce risks, including: • Working with Health Education England and NW London ICS to develop an effective approach to supporting the training and development of specialist staff across RM Partners (Cancer Alliance for West London). • Understanding where role variation exists and developing plans to enable staff to work at the 'top of their licence' (for example in straight to test pathways). • Identify those specialities where we expect demand to increase the most and work with our partners to develop proactive recruitment and retention strategies.
The impacts of rising demand for cancer services, alongside increasing urgent and emergency care and the wider demands of elective recovery, could mean we	We will support our partners to manage and maximise cancer capacity by: • Supporting the elective programme in modelling demand, capacity and workforce requirements • Sharing performance data and forecasts to enable system-wide decisions.

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[9] The % of total new cancers treated at GP practice level via the Two week wait pathway/ all new cancers treated at that GP practice
[10] Faster Diagnosis Standard- % of urgent cancer referrals informed of whether they have cancer within 28 days

don’t have enough cancer capacity across North West and South West London.	• Supporting Trusts to manage capacity risks together through mutual aid. • Plan and implement additional diagnostic capacity. • Continued focus on optimising cancer pathways.
Changes to commissioning and specialist commissioning arrangements expected in 2023, could destabilise specialist cancer services. Overall system cost pressures from 2023 could risk the adoption of innovative approaches and treatments.	• We will take a lead, with delegated resource to support North West and South West London, to understand and plan for the implications of the devolution of specialist cancer service commissioning, to assure service, quality and financial resilience and performance. • We will work with London region, the Pathfinder programme and our tertiary providers to agree the best approach to devolution of the £168m specialist commissioning cancer budget (excluding drugs).

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Part 4 – NW London ICS Enabling Programmes

Communications, resident involvement and community insight

Our strategy for North West London will not succeed if it is not well communicated and shaped by the healthcare needs and insights of local people.

Insights and feedback from our residents and communities have helped us develop our strategy. This includes our approach to working with our residents and communities.

Over the last three years, we worked with a group of over 200 residents to co-design a best practice approach to involving local people in our work. We have spoken with over 300 community groups, held events in each of our eight boroughs and worked with the voluntary sector and Healthwatch to develop a clear picture of people's hopes and concerns for healthcare services. We are now publishing monthly insight reports setting out what our communities are telling us – and what we will do about it. These insight reports will be further developed in the months ahead to ensure that they are capturing feedback from as many sources as possible.

The views and experiences of local people will continue be a key factor in our future decision-making and feedback from residents will be considered alongside other data, such as healthcare outcomes and performance, in developing our plans.

This chapter sets out how we will communicate with our residents, how insights from residents have informed our strategy to date and how we will continue to involve local people in co-designing the health and care services of the future.

Context

The size and diverse nature of our population necessitates a multi-faceted approach to how we work with local people. Most, if not all, of this work will need to be delivered at borough and provider level, by a partnership of NHS and local authorities, working with Healthwatch and grassroots organisations with good links into local communities. We will offer a mix of meetings and events that are open to all and targeted engagement with specific communities and groups. Outreach programmes will be devised at borough level, taking account of population health data, JSNAs and other insights from providers, primary care networks and local authorities. We need to deepen our reach into communities that we have not always successfully engaged in the past, recognising that only a minority of our residents will want to attend our meetings.

The diversity of our population is reflected in over 200 languages spoken and a range of specific communication needs among sections of our population, including people with disabilities, people with learning difficulties and autism, children and young people, travellers, and users of mental health services. We also need to recognise the important role that family carers, parents and agencies such as schools and employers can play in delivering and responding to healthcare messages. It is important that we work with our partners to fully understand our populations, including meeting their specific needs.

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We recognise that only 10% of a person's wellbeing relates to access to healthcare; wider determinants of health include income, housing, employment, environment, and education. The only way to address these challenges is through an ongoing partnership between health, local government and our residents. This work is underway through our Proactive Population Health Management and Reducing Inequalities programme and will be developed further through co-design with residents and populations.

While there needs to be a substantial focus on outreach and reaching more of our communities more consistently, we also recognise the value of resident voices sitting on workstreams and decision-making bodies. We will recruit and work with lay partners to ensure that there is public representation on key workstreams at both North West London and borough level.

We recognise that there are a number of residents and patients who already take an active role in engaging with the NHS and local government. GP practices have patient participation groups (PPGs), provider Trusts have various patient and service user groups and, in some cases, lay partners and there are a range of condition-specific and campaigning groups in North West London. We will work with existing groups while seeking to broaden our reach into our populations.

The NHS can learn from others working with local communities – e.g. the voluntary sector and local authorities – as well as from communities themselves. We must work together: the NHS, local councils, the voluntary sector, Healthwatch, non-executive directors and governors, local people – to co-design the future of healthcare services in North West London. Every member of staff and everyone in North West London has a potential role to play.

We recognise that the unique pressures created by the Covid-19pandemic have delayed the development and implementation of our new approach to working with people and communities, but we also recognise that public support and confidence in our services can only be improved by working with our residents as partners.

Lastly, we need to recognise that we are not starting from scratch. While our approach is new, the principle and requirement of working with residents is not. It is important that we build on existing relationships that are held at borough and provider level and that we work with primary care networks to ensure that they involve residents and patients effectively at neighbourhood level.

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Issues and challenges

f	Why this is a problem for residents/ communities/ patients	What success would look like for residents/ patients
The NHS has often focused on asking the public for their views on specific proposals, rather than asking open questions	The concerns of patients about wider healthcare issues are not addressed when the debate is framed narrowly around specific service change proposals and there is limited	Ask residents more open questions like 'what matters to you?' Hold open meetings which anyone can attend and where agendas are co-set with residents. Where

	opportunity for unprompted feedback	there are specific proposals, work with the public as part of a wider ongoing dialogue.
Residents have suggested that their feedback sometimes goes in to a 'black hole' and they are unclear that is has been heard or used	There is no point in talking to residents and communities and recording their views if we are not clear about what we will do with the insights. Residents will not want to give up their time if they do not feel their feedback has any impact.	Insights from our communities are central to development of ICS/ICP strategy. They are treated as qualitative data, in the same way as population health or performance data, and used to inform the shaping of future strategies and services.
Public engagement during the COVID-19 pandemic taught us that some communities feel alienated from the NHS and public services in general; there are significant issues of trust to address.	If residents do not trust public bodies and public information, this is likely to exacerbate unhealthy behaviours and health inequalities.	The ICS is in ongoing dialogue with the population, including an outreach programme to ensure that we are talking to and hearing from all our communities. There is a commitment across all ICS partners to significantly reduce health inequalities.
North West London has one of the largest ICS footprints in the country with eight quite different boroughs: maintaining consistent and effective communication and consistent resident involvement across the sector presents a significant challenge	Residents should have the same opportunity to engage wherever they live and whatever their background. If communication is not clear, consistent and joined up across the system, residents and staff will not get the information they need.	An involvement and communications strategy developed and assured at North West London level in line with national requirements is delivered at place by a partnership of the NHS and local authority, allowing for specific local nuance and variation.
Resident insights may increasingly inform our strategy, but it is also important to directly involve local people in our programmes so that the resident voice is always heard.	Without direct resident involvement, the voice of residents in developing and co-designing solutions may be lost.	Residents can become 'lay partners' and are supported to sit as resident voices on ICS and borough-based programmes.
Extensive engagement with the public is taking place across health and care. We need to find a way to bring all of the insights together in a	Without a shared analysis, the insights and feedback we receive from the public are unlikely to drive our strategy or shape future	• A published monthly report setting out what we are hearing from our communities in each borough

meaningful way so that there is a shared analysis of what our communities are telling us and how their insights will be used.	services to meet the needs of our population.	across health, local government, the voluntary sector, Healthwatch and elsewhere. • A co-designed system for analysing insights and shaping responses at a system level. • All insights to be shared with the relevant borough or programme and with the integrated care partnership leadership.
There are substantial health inequalities across our communities, and it is important that we hear from all our residents, including those usually furthest from decision-making.	If we do not better understand the lives of those residents with the highest health and care needs, we will be unable to work with communities to develop services and plans that better address their needs. If we do not have trusted relationships with all our communities, we will not be able to influence health behaviours.	A joint NHS-local authority outreach programme in each borough, working with the voluntary sector, Healthwatch and our local communities, to better understand the lives of the people we serve.

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Principles

- **Insights** from our residents and populations are **qualitative data**: they sit alongside population health and outcomes data in driving our strategy.
- The ICB and its constituent bodies will work in partnership with local government to reach and gather insights from all our populations. This strategy sets an overall framework for action, but we recognise that a **hyper-local approach** is the best way to work with our residents. Detailed planning and delivery of public engagement will take place at borough and neighbourhood level.
- We will **co-design** our future strategies with people and communities. Community engagement and co-design will happen mainly at borough and neighbourhood level, supported by system leaders, local authorities, the voluntary sector, borough based ICB staff, provider collaboratives and NHS Trusts.
- Residents will have a voice in our programmes.

- We will work closely with Healthwatch and the voluntary sector as key partners in reaching and working with residents, so we can get a clear picture of what our communities are saying.
- Meetings of the ICB Board will take place in public and residents are very welcome to attend. We will consider the best ways of ensuring the resident voice is heard in these meetings, in the context of the wider involvement strategy and other statutory meetings, such as Trust boards, that also take place in public.
- People should be empowered to take control of their own lives and health when appropriate, with support from the health and care system.
- We will meet the standards set out in the North West London Involvement Charter, which was co-designed with residents.
- We are committed to clear communication that meets the needs of our residents, communities, stakeholders and staff.
- Our approach will evolve over the next three years, based on insights from our populations and what is seen to be working.

What we will do

We want to empower local people to take control of their own health and co-design the healthcare agenda. We will work with our populations to reduce inequalities in outcomes, access, and quality of care, through active co-production.

Our approach has been co-designed with over 200 local residents, built on through ‘vaccine equity’ workshops with residents in 2021 and via ongoing dialogue with over 300 community groups across North West London. Some of this work is already underway, some of it is new.

- Working in partnership across the NHS and local councils and with our voluntary sector, community groups, resident associations, faith groups, schools, patient groups and more to reach out into the community and hear their views, in the first year (up until July 2023), we will work with the Proactive Population Health Management and Reducing Inequalities programme, Healthwatch and local people to develop clear **public health related metrics** for public involvement work, including short term proxy measures (e.g. take up of screening for diabetes or cervical cancer, impact of winter campaign on health behaviours and subsequent system pressures) and longer term public health targets. **These targets are to be agreed separately.**
- Align our community engagement to the national ***Core20Plus5***[11] approach to reducing health inequalities, agreeing parameters with our Proactive Population Health Management and Reducing Inequalities Board.

[11] The Core20Plus5 national approach to reducing health inequalities will inform our approach. The ‘core 20’ is the most deprived 20% of the national population identified by the Index of Multiple Deprivation. The ‘Plus’ is population groups the ICS identifies as experiencing worse than average outcomes who are not identified in the core 20, with a number of specific ‘inclusion groups’ named in the guidance for us to take

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- Support development of ICS strategy and population health and care inequalities strategy by ensuring public involvement in ICS/ICP decision-making.
- Work with and through local authorities to develop a coordinated programme of **outreach and community research** in our population in each borough, using population health and outcomes data, as well as existing grassroots community knowledge, to target specific communities as appropriate
- Hold quarterly '**collaborative spaces**' in each borough: open community conversations where health and care professionals come together with the public and stakeholders to discuss healthcare issues. The agenda for these meetings will be co-designed with residents; it is important to recognise that issues raised unprompted by local people can provide important insights. (These conversations may be combined with existing arrangements at borough level where appropriate.)
- Work with ICB Business Intelligence teams, who compile public and population health data, to ensure that all **insight** from public engagement with residents and all patient experience feedback is stored in our whole systems integrated care database to inform strategy.
- Publish monthly **insight reports** setting out what we are hearing from our residents, pulling on insight from all partners in the ICS;
- Put in place our **Lay Partner programme**, recruiting residents from our communities to support NW London programmes in shaping their plans. Ensure that residents are represented and supported to participate equally on key ICS and borough-based workstreams so that there are always resident/patient voices in the room. Build on the success of the Imperial lay partner programme by sharing learning across the system[12].
- A **Co-Design Advisory Body** will be developed from community-based stakeholders and residents with expertise in public and community involvement.
- Establish a **North West London Resident Forum**, bringing together lay partners, patient participation groups and others with an interest in North West London-wide 'collaborative spaces'. This group will discuss specific North West London-wide healthcare issues. We will ensure that the group represents different communities, age groups and characteristics.
- Put in place and support specific **resident reference groups** where ICS/ICB programmes require deliberative input – for example, our Post Covid Syndrome patient group.
- Work with public health directors to deliver **integrated public health campaigns** on agreed topics.

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account of. The 5 sets out five areas of clinical focus: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

[12] Imperial College Healthcare NHS Trust has a strategic lay forum made up of lay partners, which oversees the Trust's involvement strategy. Lay partners often support key workstreams, ensuring the Trust's plans and initiatives are shaped by the needs and preferences of patients and communities.

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- Specifically **target** and work with groups with specific needs, including people with long-term conditions, BAME communities, people with disabilities, including people with learning difficulties and autism, traveller communities, children and young people, older people, mental health service users, LGBT communities, family carers and others. This work will be carried out at borough level, based on local health data and insights.
- Ensure **NHS service change programmes,** and key ICS and borough-based workstreams, carry out appropriate public involvement or consultation. This work can be led at Trust, provider collaborative or ICS level as appropriate.
- Work with grassroots voluntary sector organisations and residents to **build trusted relationships** with our communities, tested with a 'before' and 'after' survey via our Citizens' Panel.

- Draw on local expertise in involvement and communities, setting up a dedicated advisory group to support and develop our approach to working with people and communities across North West London.
- Ensure that our duties under **equalities** legislation are met and exceeded by putting in place ICB oversight of equalities impact assessments, conducting appropriate gap analyses of which communities and groups we talk to and publishing an annual equalities report.
- Recognise **digital exclusion** by ensuring a good mix of in-person and online engagement with people and communities.
- Use our 3,800-strong, demographically representative **Citizens' Panel** to deliver surveys and focus group research across the ICS and to disseminate healthcare information.
- Develop and maintain a strong focus on hearing from **people who are furthest from decision-making** by working with grassroots community organisations, charities, churches, employers, schools, patient groups, MPs and councillors, Healthwatch and residents' associations to maximise our reach in to local populations.
- Support and work with **existing resident and patient groups**, such as patient participation groups and patient and lay groups based in provider trusts.
- **Meetings of the Integrated Care Board** and other decision-making meetings will take place in public and the public will have the right to ask questions at these meetings.
- Ensure clear **staff communication** across the ICS and ICB, so that the work delivered at place and North West London level is well communicated, understood and joined up.
- Support and enable staff across North West London to work with residents and communities.
- **Coordinate social media** activity across the sector, between the different parts of the ICS, especially on public health campaigns, service change programmes and promoting public events and involvement opportunities. We will use a multi-channel approach, including film and infographics, to get information across.
- Continue to work proactively and reactively with the **media** so that we can communicate important messages to local people and other stakeholders.

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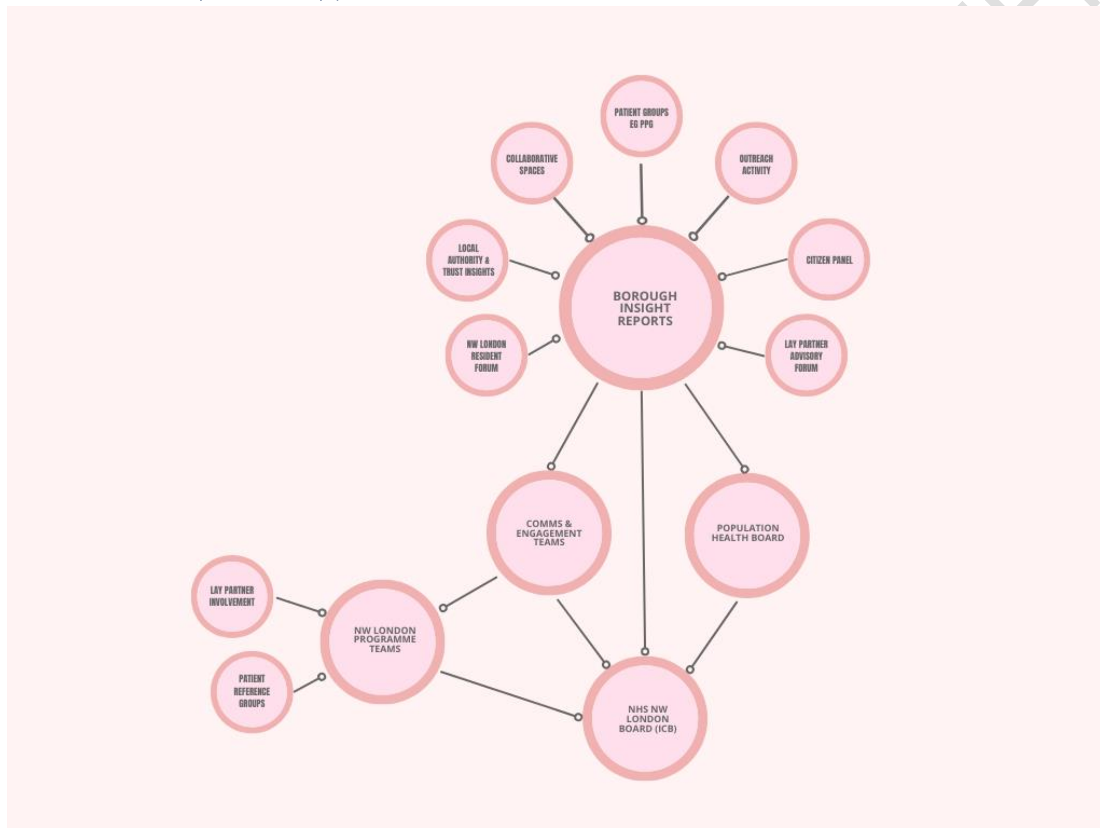
- Develop our single **website** housing ICB and ICS content, linking to all partner organisations' websites.

This approach will be assured and underpinned via the North West London **Involvement Charter.**

Working in partnership is key to success

We know we are stronger when we work collectively together: the NHS, local authorities, the voluntary sector, Healthwatch and local people. Our approach has been developed on the understanding that all of these partners and individuals can play their part in generating the communications and insights that will drive improvements to healthcare in North West London.

Visual summary of our approach



Summary of routes to resident involvement

Involvement methods and routes	Explanation
Involvement Charter	The co-designed Involvement Charter underpins the ICS's new engagement framework.
Community outreach	Targeted involvement of groups we have not successfully involved in the past, based on health and insight data and usually planned at borough level.

Collaborative spaces (quarterly in each borough)	Open community conversations where health and care professionals meet with the public and stakeholders to discuss healthcare issues. These work differently in different areas (e.g. Harrow has a Citizens Forum) but the key principle is that they are open to all and the agenda is co-designed with attendees.
Borough-based stakeholder and residents' meetings	Each borough-based partnership is responsible for organising its own resident, public and stakeholder involvement forums, in partnership with local councils, NHS provider trusts, Healthwatch and the voluntary sector as appropriate.
Resident voices and lay partners	Resident voices and lay partners are invited to participate in our health and social care programmes and projects that require the lay/patient perspective. We will work with others to offer training to lay partners, who can then act as resident voices on programmes and workstreams.
Citizens Panel (CP)	The CP is a demographically representative group of 3,800 residents. It provides NHS information, supports surveys and focus group research across the ICS, to a membership of nearly 4,000 local residents.
The Patient Participation Groups' Forum (PPGs)	All North West London PPGs are invited to attend this forum to share intelligence, challenge and develop consistency. The intention is that this will be a self-organised, user-led forum.
NHS North West London Residents' Forum	The North West London Residents' Forum is open to the public to attend and will discuss specific North West London wide issues. This forum does not have any set dates, but organised when required.
North West London Co-design advisory body (DAB)	This body consists of a diverse range of stakeholders and lay partners. The aim of DAB will be to assess the effectiveness of the North West London Involvement strategy and the Involvement charter against our practical engagement and involvement plans present and future.

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Data and digital

North West London's successful track record of implementing technology includes the development of a leading population health database (Whole Systems Integrated Care); and the largest personal health record in the country, with more than 400,000 patient accounts (the North West London Care Information Exchange).

Continuing to invest in and improve our data and digital capabilities will give us the best chance of meeting our four strategic objectives. For example:

- We can use digital tools to identify those residents most at risk of coming to us later with advanced disease and direct early interventions to them. WSIC can support this but needs ongoing investment to keep it up to date.
- We can improve our residents' experience of care by offering patients digital and virtual options to access care and support, where appropriate, and by sharing data between healthcare professionals and teams to reduce the need for patients to repeat their information at each appointment.

- We can enhance quality of care by:

    - Delivering swifter access to specialist opinion through schemes like digital advice and guidance, using tools such as clinical decision support to enhance the quality and speed of clinical decision-making and reducing the scope for error, by giving professionals access to shared digital care records.
    - We can better manage our capacity byUsing digital tools that help to predict demand, support planning and add flexibility to the system, to deliver a more responsive service. Some services struggle to meet demand, while others are underutilised; the pattern of demand is dynamic, changing from week to week, day to day and hour by hour – better digital tools can track and help us to respond to this.
    - Rapidly evaluating which services are delivering benefits to which residents – so professionals can direct people to the services that best meet their needs

- We can support our staff to deliver the best, by:
    - Improving our digital infrastructure. We need to keep investing in computers and networks, and improving our back-office processes, to help our teams to deliver care as efficiently and effectively as possible.
    - Continuing to protect data, prioritising security, and confidentiality.
    - Deploying tools that reduce error, such as artificial intelligence on radiology scans, and support clinicians to make decisions.

- We can implement innovative technology proven elsewhere and test new ideas across North West London, by:
    - Continuing to invest in innovation activity.

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- Opening data at scale via a world-leading Secure Data Environment for Research and Innovation.

Programmes already underway will address many of these needs – the single Cerner system in Acute, the clinical systems in other care settings, the London Care Record, the Care Information Exchange, Whole Systems Integrated Care. We need to finish deploying them and transform our services and processes to exploit their potential.

ICS priorities data and digital

Stakeholder feedback identified high priority digital and data objectives:

- Support operational management with innovative tools to track activity and capacity, enabling providers to understand patient demand, plan and track improvements.
- Data consistency and analytics support for integrated care and population health management: a single source of truth (WSIC); and Business Intelligence resources to turn data into intelligence.
- Enhanced support for multi-disciplinary teams working across integrated care pathways: sharing information about patients/service users between care settings.
- Patient empowerment and communication: make information about health and care accessible to citizens in a consistent way, while addressing the issue of digital exclusion.
- Shared Electronic Patient Records (EPRs): complete the migration from paper records to digital and improve the flow of information to support integrated care pathways.
- Infrastructure resilience and standardisation: staff need access to high quality hardware and systems that are well designed, regularly refreshed, and work reliably in any location.

Workforce programme

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. This is separated into two strategic programmes which align to local, regional and national requirements:

Under 'Great Places to Work' we aim to be an exemplar partnership:

- for quality health and wellbeing support reaching all staff,
- developing organisational cultures that foster physical and psychological safety, and
- ensuring our organisations reflects and champions the diversity of our workforce.

Under 'Transform for the Future', we will:

- conduct strategic workforce planning, informed by modelling and forecasting,

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- deliver initiatives to grow the current workforce base and ensure the capability of the registered and non-registered workforce is maximised
- create a culture of collaboration with social care and primary care for multi-disciplinary initiatives where appropriate.

We will adopt an integrated approach across our NHS Trusts, primary care, social care and voluntary sector organisations, working closely with finance and performance teams to ensure workforce plans are realistic, triangulated, and aligned to our digital and estates strategy. We will work with primary care and social care to develop the infrastructure that wraps around to staff.

To meet growing demand for services, we will adopt a collaborative approach to working with all health and care partners. This will enable us to think and act differently, creating a joint workforce strategy that achieves local ambitions.

Context

Our ICS is made up of 4 Acute Provider Trusts, 2 Mental Health and Community Trusts, 1 Community Trust, 347 primary care practices, and over 1000 care providers. Within each type of organisation, we have different types of roles, providing different types of services to our population, with different baseline of data available. The below describes the context for each part of our sector, with our Provider Trusts clustered together as the North West London Provider Trusts.

The North West London Provider Trust workforce shows an ageing workforce (with 30.8% aged over 50), a diverse workforce (with 55.2% Black, Asian and minority ethnic staff), and a predominately female workforce (with women making up 73.5%). We have an increasing trend in our rolling 12-month sickness rate, currently 4.9%, and in our voluntary turnover rate, currently at 14.6%.

Across the North West London Provider Trusts, there are currently more than 52,000 whole time equivalent staff (WTE) in post with the following composition:

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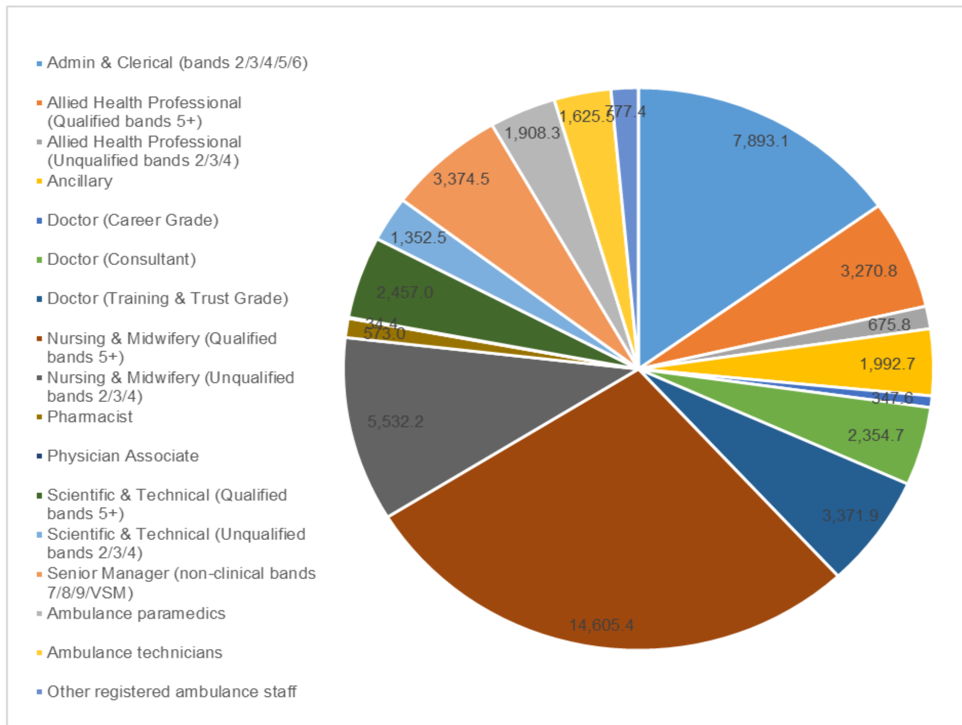
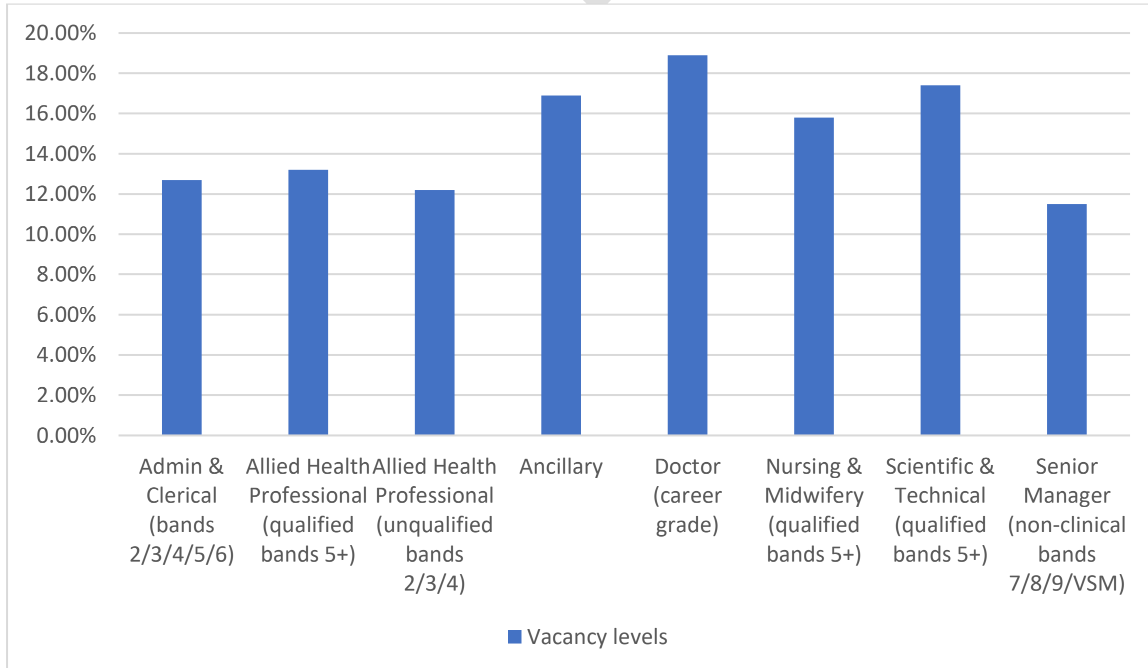
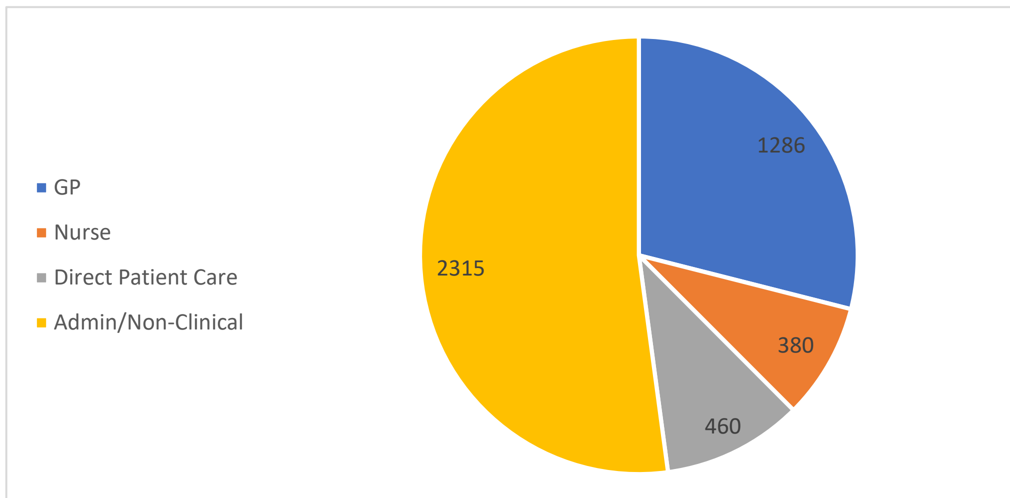


We therefore have a 11.7% vacancy rate and our strategic ambitions and plan will need to address this challenge. The highest vacancy levels (above 10%) are in the following roles:



There are also significant challenges with an ageing workforce in primary care, , with 30.6% of GPs and 39.1% of GP nurses aged over 55. North West London also has on average 44 GP WTE per 100,000 patients, the lowest proportion across London. We're seeing an increasing trend of fewer GPs becoming salaried or partners. There is an ongoing decline in the numbers of our nursing workforce, currently at 380 WTE.



The social care workforce in North West London records an increasing turnover rate, currenbtly at 30.5%, resulting in a greater number of vacancies. Again there is an ageing workforce as 30% of the social care workforce profile are aged over 55.

The inconsistencies and inequalities of pay, terms, and conditions across health and care organisations is impacting the organisations and sectors people choose to work in. This is leading to greater competition with private non-health organisations for our staff, particularly at entry-level.

Given the expected growth in the overall population, and specifically in the number of people aged 65 and over, our workforce will need to grow to meet demand. It will also need to transform delivering new skill mixes, new roles, greater mobility of workforce, multi-disciplinary working models and portfolio careers to address the pending challenges.

Challenges

Our workforce have gone through, and continue to go through, one of the most extraordinary times in their career and are facing considerable and increasing demands. The culture of working in health and care is being negatively impacted as people are overstretched and exhausted at work, while managing their own personal responses to COVID-19 and the cost of living crisis. Staff in critical professions have been taking industrial action. This has resulted in decreased staff engagement, higher attrition, and higher sickness rates.

Our strategy will address the greatest challenges, which include:

- The health and wellbeing of our workforce, particularly during a cost of living crisis. We will focus on dealing with high sickness rates and burnout amongst our staff, as well as issues around financial wellbeing.
- The culture and environment within our ICS. Our staff need good and consistent approaches to leadership, high quality lifelong learning opportunities and an employer able to meet the differing wants and expectations of a multi-generational workforce.

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- Diversity of staff at all grades. We need to tackle the discrimination staff continue to face from patients and colleagues and ensure diversity at all staff groups, particularly at senior level, strengthens decision-making.
- Workforce shortages, particularly in critical and hard to recruit roles, that create a deficit of experiences staff and clinical leadership. We need to tackle a range of issues here given expected rises in demand including:
    - Voluntary turnover
    - Hotspots in hard to recruit roles
    - Fewer people opting to complete health and care qulifications
    - Organisations increasingly recruiting from the same pool of staff
    - No clear talent management and succession planning
    - Challenges in GP and GP Nurse (GPN) recruitment
    - A dependency on agency to fill our gaps.
- Workforce productivity and transformation. Data indicates that we employ more staff than ever, but we are delivering less activity. Some services are overwhelmed by demand and others are underutilised. We will need to transform our workforce to deliver care for residents while achieving an acceptable workload, utilising approaches such as safe staffing/caseload levels.
- Staff numbers falling and vacancies rising in social care. We will need to tackle wage constraints linked to social care funding, unclear career paths and competiton from private sector employers.

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Our solutions

Aspiration 1: A great place to work

Our aim is to improve retention rates, focusing on the key issues leading to high turnover and vacancy rates, and to address recruitment challenges. To achieve this, we will:

- Develop the employer value proposition in organisations across North West London. This includes a focus on staff health and wellbeing, development opportunities for staff, and creating new ways of working and service delivery, enabled by digital technologies and improved working conditions.
- We will look at pay, terms and conditions in a broader sense across health and social care, ensuring this is equitable where possible as part of workforce planning and transformation, influencing discussions at a national level. We will ensure we pay the London Living Wage, reviewing contracts at renewal points to ensure we influence this in contracted organisations, and influencing private providers of health and social care services, developing our role as an anchor institution.
- Create flexible and fluid career pathways across North West London ICS organisations, building development opportunities up, down and across all organisations within our system to ensure our staff are deployed against our most critical priorities and we provide growth opportunities.
- Create a strong culture, reflective of the differing wants of the different generations within our organisations. We will embed our ICS values and

behaviours as an employer and a partnership, building strong, inclusive and collective leadership, committed to purpose and high-quality performance.

- Address racism and inclusive practice and by promoting diversity across the organisations, especially ethnic diversity at senior and Board level which data is suggesting is a big issue, bring greater diversity of thought and decision-making. We will meet the Workforce Race Equality Standard (WRES) Model Employer Goals by 2025 and North West London ICS will be in the upper quartile of WRES results in London. This ensures employees from Black, Asian and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment whilst in the workplace.
- Develop the wellbeing of our staff, providing world-class health and wellbeing offers through the continued development of the North West London Keeping Well Service. Given the influence physical and digital environments have on our staff's health and wellbeing, we will ensure health and wellbeing is embedded into our estates, digital and I&T strategies.
- Develop and support system organisational development, working in partnership across health and care organisations. We will support our organisations and system to align its strategy and enhance our people's ability to achieve our shared goals.

Aspiration 2: Transform our workforce to meet future needs

Workforce transformation is critical to deliver the North West London strategy and to respond to changing service models. The increasing demand for, and on, health and care services, combined with increasing financial constraints, means the effectiveness of the existing workforce needs to be maximised and we need to utilise new ways of working, including the development of new roles, and developing our people in new skills.

Our vision is drive and enable workforce transformation and redesign, based on integrated workforce planning and development to meet health and care system needs of our service users and population now and in future. To achieve this, we will:

- Ensure the workforce agenda is embedded within all service redesign and transformation, including the upskilling, training and development of the workforce designated to support the programmes of work
- Conduct transformative workforce redesign planning at North West London level to support new models of care and to fill hard to recruit roles.
- Develop a workforce planning function with a shared dataset across North West London, which will provide the evidence base for directing investment into transformation activity. We will also conduct a review of staff redeployment across North West London.
- Work with primary care and social care to assist in developing integrated workforce plans at ICP level, developing this across health and social care will deliver new ways of working, meeting our population's health and wellbeing needs and wrap care and support around the person. This will support the development of joint roles.

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- Ensure effective education and training programmes for our existing and future workforce are in place to deliver future models of care, new roles, and new apprenticeships through a North West London health and care skills academy. We will affiliate with local educational institutions to build apprenticeship programmes to increase the participation of young people from diverse backgrounds in health and care careers. This will support our local population into good work, specifically for our under-represented communities.
- Develop our role as anchor institutions, working with our local populations and communities to develop innovative routes into employment, such as earn and learn models and collaborative recruitment, and offer opportunities for good work. We will develop alternative employment models to better support people to work for our organisations, bring in new and different talent, and reaching out to non-traditional and under-represented groups which will support and address health inequalities. This includes strengthening our partnerships across the ICS, including the voluntary sector and Local Authorities, to develop pathways for volunteering into employment and supporting our SEND populations.
- Strengthen our practice development infrastructure to ensure our workforce are supported to thrive at every level of practice and at every stage of their careers.
- Build a robust recruitment pipeline, working with Health Education England (HEE), training and education partners, and our local population, including effective and equitable utilisation of the education and training tariff to support placement growth.
- Better enable the portability and mobility of our staff across organisations to support development of our staff and meet service and population needs.

Our success:

We will develop clear and realistic targets that enable us to measure what matters to deliver our ambitions. We will know we are succeeding as we will see:

- Improved staff retention rates
- A healthier pipeline of local people coming into health and care roles with clear career pathways available to them
- Improved supply and quality of pre-qualifying student placements
- Greater numbers of apprentices
- Lower nurse, GP, AHP and other vacancies
- Reduced sickness rates
- Effective e-rostering systems supporting staffing and mobility
- Improved CQC 'Well Led' ratings across our system
- Increased diversity of staff with protected characteristics, particularly ethnic diversity at senior level
- Positive NHS Staff Survey feedback with more staff recommending North West London is a place to work
- Improved support to our North West London Boards to enable informed decisions across and on behalf of the NW London system using consistent data and reporting across our system

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NW London ICS Workforce in practice – case studies:

North West London Health and Care Skills Academy: 14 employers across NW London and 6 training and education providers are engaged to support our local population into training, education, and employment opportunities. There is a particular focus on supporting under-represented Londoners into employment and apprenticeships across our health and care organisations.

Since launching in Q4 of 2021/22 and by Q3 of 2022/23, 1,968 people from NW London have participated in training and education, and 1433 have entered employment, apprenticeships, or paid work placements with our NHS employers. The Academy has expanded to also support our population now into employment with NW London care organisations.

New models of recruitment: Trialling different models of recruitment across our sector

- Mass recruitment day across our NHS organisations to recruit Health Care Support Workers
- North West London Health and Care Career Festivals
- Working with the West London Alliance and job brokerages to mass recruit our local population into roles to support the vaccination programme. Subsequently, we have retained 35% of the vaccination workforce into other roles across our health and care organisations
- Supporting our refugee communities into employment

North West London Health and Care Career Festival: Events have been run across NW London so that our local population can find out more about a career in health and social care. Our most recent careers festival took place in January 2023 and attendees had an opportunity to meet and speak with a variety of different training and education partners, NHS organisations and social care organisations.

The event gave an opportunity to show the different ways to start a career, from volunteering, to starting an apprenticeship, to completing further studies and completing on the job training. There were a number of speakers taking about their own experiences, how they started their careers and what is involved in their day-to-day jobs.

Estates

NW London is the largest of the London ICBs and has over 800 pieces of estate (including but not limited to over 300 GP practices across 45 Primary Care Networks, and over 500 pharmacy or optometrist practices), includes four acute hospital trusts

across at least twelve sites (with an additional four trusts outside of NW London who own estates in NW London boroughs).

NW London ICS contributes to 20% of London's GLA projected growth, particularly across Brent and Ealing which together account for 70% of that growth (HUDU 2023).

In addition to this, our transformational estates ambition is further complicated by the fact that leases and buildings are often (co)owned and managed by a mix of service providers including NHS Property Services and CHP/LIFTCo, have a range of in-flight leases (including long-term Private Finance Initiatives (PFIs)), and fall under multiple and often complex landlord/tenant structures.

Further to this, the ICB have identified a number of legacy issues requiring urgent address under the NW London ICB Estates programme, including:

- A history of multiple disjointed local organisation-focused strategies, in the absence of an overarching ICB strategy, which do not collectively address the changing needs of our ICS (i.e. vast projected population growth, new service requirements and rapidly increasing patient list sizes).
- Poor quality estate which has been badly maintained and no longer fit-for-purpose.
- Significant void and avoidable overpayment by the ICB for its estates, especially on facilities management and for sessional and unused bookable space.
- Incorrectly sized facilities and service delivery from the wrong locations, and
- No overarching plan on how 'core', 'flex' and 'tail' estate will be strategically managed long-term across the NW London ICS.

To address the above issues, the new Estates strategy and programme will encompass a variety of projects and ongoing initiatives, such as:

- **'Right Size Right Price' (RSRP)**: this approach will assess all space across NW London estates and encourage boroughs to work together to utilise space more collaboratively. Leases will be practically and proactively reviewed, helping to inform decision-making and business case proposals, whilst highlighting circumstances where it may be more appropriate to surrender leases or close single GP practices in favour of introducing more transformational solutions (e.g. multi-service Primary Care 'hubs') to meet demand and better serve communities.
- **Proactive management of void, sessional and unused bookable space**: A joined up void, sessional and unused bookable space management programme will be progressed in collaboration with other NHS property companies and other key stakeholders. This will inform a range of related projects designed to mitigate unnecessary costs to the ICB, reduce and release vacant space, offer efficiencies that can be reinvested back into more viable estate initiatives, and ensure a more appropriate deployment of services to meet patient needs. Whilst the programme will not directly address the number of LIFT building leases coming to an end over the next 10 years, it will consider this and apply a holistic approach during planning and business case approval processes.
- NW London 'Big Ticket' projects (e.g. NW London HQ Estate, Alexandra Avenue, Heart of Hounslow, Parkview, St Charles Hospital, St Mary's and South Westminster Centre): These schemes offer significant space e.g. from void and unused bookable space, provide opportunities for urban expansion, and offer potential financial savings that can be reinvested across estates and the NHS. This

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includes supporting National Programmes (e.g. the introduction of Community Diagnostic Centre (CDC) suites across Ealing and Brent boroughs).

- **Digitisation of records:** the programme will support Technology teams with ongoing digitisation of documentation and records to free up additional space across NW London ICS estate which can be re-allocated to in-demand services and other clinical activity.
- **Business-as-usual (BAU) Schemes:** the ICB has already identified a minimum of 40 BAU schemes in need of address (including small general refurbishments, ongoing maintenance, mergers and the introduction of additional services at sites). The programme will implement a system for governance and resource allocation to prioritise, oversee and support local BAU schemes across the ICS. This ensures estates remain compliant and fit-for-purpose, improves alignment with technological and digital offerings and estates principles, and allows services to continue supporting their respective populations.

In addition, the NW London ICB Estates Programme will:

- exercise a rolling review dedicated to ensuring building improvement
- explore opportunities to downsize our estate in light of an anticipated increase in GPs moving into retirement
- proactively engage with planning committees for large development schemes aimed at addressing population growth (e.g. the Oak and Park Royal Development Corporation (OPDC) which is expected to create approximately 12,500 new homes across three NW London boroughs by 2040) to explore opportunities for new health and social care, such as new health centres.
- lead on business transformation and the introduction of 'smarter estates' ways of working principles
- continue to support the Government's 'One Public Estate' programme to ensure opportunities for joint working and shared use of land or property is maximised with other public sector and local authority bodies to boost economic growth, unlock regeneration, release surplus, under-used land for development, reduce running costs, and create more integrated, transformative services for our communities. This includes exploring opportunities for releasing brownfield estate back to local authorities to support housing needs, or exploit this for NHS staff housing
- support NHS property companies with their commitments to providing affordable housing for key workers, including ensuring these are wider considerations are factored into business case proposals and improving occupancy levels where opportunities arise
- assess possibilities where it would be cost-effective and appropriate to purchase and take over ownership of managing sites as part of 'hand back' schemes, and
- work collaboratively with other NHS bodies (such as LEDU and HUDU) and Local Authority planning departments from the earliest stages of planning to exploit opportunities for securing joint funding and shared services.

Whilst the reprovision of the acute hospital sites - four of London's acute hospital sites are part of the national New Hospital's Programme – Hillingdon Hospital, St Mary's Hospital near Paddington, and both Charing Cross Hospital and the Hammersmith Hospital in Hammersmith & Fulham is being carried forward by the acute hospitals rather than by the ICB Estates Programme, we will work closely with DHSC and NHSE throughout planning and delivery phases to exploit opportunities to modernise and

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transform estates, improve space utilisation and support ongoing service provision for these sites.

We remain fully aligned with our Local Authority partners in their ambition to deliver exemplary social care across our eight boroughs. Where possible, we will ensure close integration between local authority provided care and spaces, and those services provided. We anticipate increased development of partnership working in strategically placed community hubs.

Issues and challenges

The Estates team have identified several legacy issues and challenges requiring urgent attention under this programme including:

- **A history of organisation-focused estates strategies:** the absence of an overarching, NW London ICS-wide strategy in favour of multiple local borough or organisation-led strategies has meant borough activity is often disjointed and misaligned. Opportunities for joint ventures (e.g. under One Public Estate), new buildings or the establishment of integrated community 'hubs' have sometimes been overlooked or underutilised. This means additional work, investment, resource and time has been required to revisit these schemes in search for more sustainable opportunities against tighter deadlines and budgets. This has further meant that the pace of transformation has fallen out of sync with population growth.
- **Poor quality estate is badly maintained or no longer fit-for-purpose:** this is typical across Primary Care estate, which is often delivered from non-compliant and ageing converted residences or poorly maintained purpose built premises. Estates have not been appropriately invested in due to their long-term need nor has there been any real prioritised investment or project roadmap that has been strategically aligned to lease statuses, building condition, fitness-for-purpose, and compliance with internal and external requirements.
- **Overpayment by the ICB for its estates**: there are significant amounts of underutilised or inappropriately used space that is not service-driven across NW London boroughs and trusts, which the ICB continues to fund. Incurred costs could be mitigated or covered by other funding sources, allowing for ICB investment into other interventions across the ICS in order to meet strategic ambitions and service provision requirements.
- **Wrongly sized facilities in the wrong locations**: there are multiple ICS estates with inadequate facilities for their respective list sizes with space that are not sustainable or compliant with NHS-built requirements. There is also over-provision of space for some services and estates which are fully occupied by with the wrong service offerings.

Legacy of organisation-focused estates strategies:

Following the introduction of the NW London ICS, there has not yet been a comprehensive, mutually-agreed, overarching strategy for addressing and modernising long-term estate needs across the eight boroughs and its Trusts. NW London has historically had a number of separate borough, Trust, CCG and Local Authority strategies, resulting in opportunities for multi-function estate or innovative schemes being overlooked or inefficiently used (e.g. Willesden Centre for Health & Care, see below.). Furthermore, these strategies have not always been aligned with

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other organisational roadmaps and ambitions, such as Technology, Digital and Sustainability.

The ICB Estates Team will work collaboratively with boroughs and Trust to develop and roll out a well-informed, collectively agreed strategy that will underpin this programme of work, to ensure that services are delivered effectively and consistently across the ICS and in line with the national steer.

Wrong size facilities in the wrong locations

The ICB Estates Programme will ensure that estates are service-led and designed to support the current and existing health and social needs of patients, as well as the addressing environment considerations and projections in population growth, inequalities and deprivation.

This has not always been the case across NW London. At Willesden Centre for Health and Care, an ongoing scheme of work is now coming to a close which introduces a CLCH ward, a dental provision and a new Community Diagnostic Centre (CDC) to fill void space. However, the premise initially failed as a Primary Care Hub due to poor public transport accessibility and infrastructure and limited car parking facilities. Whilst there is no void space and no financial burden for the ICB, at Parkview in White City, there remains a significant proportion of underused sessional space which could be better utilised by relevant services.

There are additional scenarios where NW London estate requires expansion in order to meet demand. At St Mary's Hospital, additional capacity is required to make space on site for a single site neurosurgical service co-located with the major trauma centre, and across Primary Care, GPs are frequently faced with scenarios where increasing patient lists are outgrowing the size for which the practice was built. Willesden Green Surgery based in Cricklewood is a long-standing family run practice catering for a fast increasing patient list of over 9000 patients, many of which are from a large deprived refugee community who require Arabic translation and live in the vicinity of the next door mosque. The surgery is well past its critical capacity, operating out of just three clinical rooms, and having exhausted the use of all available space, including corridors. Weekend clinics have had to be set up and cuts in other available services have had to occur to accommodate demand. The surgery's only non-clinical space is a 2/3m kitchen, which serves as their admin team room, practice manager room, staff room and meeting room. The practice's list size continues to grow by 200 patients per month and is further exacerbated by the fact they are located in the Cricklewood regeneration area with 2000 new homes due to be built within half a mile of the practice. Primary care services in the Cricklewood area continue to struggle, especially since the walk-in centre 200m away was shut down in 2020 and the next closest practice received an 'inadequate' CQC rating. Closure of this practice without a viable solution or failure to act would unfairly impact not only the displaced patients but any neighbouring Primary Care practices that do not have the capacity, experience or facilities to support patients' needs.

Going forward, it is essential that estates decisions are prioritised accordingly from the centre with consideration to the above factors. The 'RSRP' approach will proactively assess all space across estates and encourage boroughs and practices to work

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together to utilise space more collectively and creatively. Leases will be reviewed more proactively and practically, helping to inform decision-making and business case proposals. Improved facilities management (including maintenance and service charges) will further inform decision-making around estates, especially as these tend to be notoriously high in NHS Property Services (NHS PS) premises.

ICB projects will ensure that estates are utilised more effectively to agreed standards including improved clinical utilisation rates (of up to 85% or over), extended operating hours and weekend hours, increased virtual consultations, reductions in unused void and bookable space, prioritisation of clinical rooms for face-to-face appointments, active management of flexible sessional space, and reconfiguration of non-clinical space where most urgent needs are to create clinical capacity (e.g. reduction in records stored on-site, ensuring appropriate relocation for non-clinical activity).

Poor quality estate

NW London estate varies considerably in terms of condition. Following recent surveys, 44% of estate was rated either Category C ('*operational but requires major repair or replacement in the short-medium term*') or Category D ('*inoperable or displays a serious risk of major failure or breakdown*'). Across Primary Care alone, only 34% of estate is highlighted as being 'core' ('*will remain in operation delivering primary care services for at least 10 years*').

Primary care estate in particular consists of either poorly maintained purpose-built premises or converted residential houses. Often, refurbishment costs far outweigh any potential return on investment and would not be fit for modern health and social care needs. Furthermore, investment in existing estate without a holistic view of the bigger picture could hinder future plans to exploit opportunities to deliver primary care and other services at scale or under more community-friendly models. It is more beneficial for all parties to explore joint solution opportunities with neighbouring practices or opportunities to develop community Primary Care Hubs which offer improved integration of spaces (e.g. single reception, single back-office spaces, engagement with local providers) and with multiple services to a greater population of patients. This includes demonstrating effective use in the new facility (e.g. virtual consultations, non-clinical/back office functions).

The programme will consider where we have fabric or structural building risks (e.g. the current issues being seen with hospitals which historically were built using reinforced autoclaved aerated concrete (RAAC)) and seek opportunities across our overall estate that enable tactical solutions to reduce system risk and cost.

The programme will also address significant challenges around capacity and managing timely delivery of effective medical services (including mental health and community-based services). These challenges have historically been exacerbated by poor quality building fabric and ageing building systems (e.g. out of service building plant, systems, telephony and technology).

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Sustainability

The Estates programme will work with key stakeholders to create and embed sustainable models of care that reduce health inequalities, ensuring that operations and estates are as efficient, sustainable and resilient as they can be.

Projects and initiatives will commit as far as possible to reducing carbon and peak energy demand by investing in energy efficient and low carbon solutions to support the NHS' net zero carbon responsibilities, and that all practice have green travel plans/initiatives. This includes ensuring alignment with the wider ICS Green Plan and introducing opportunities for operating more sustainably. This includes:

- reviewing the way buildings are assessed
- ensuring procurement requirements include provisions that suppliers use sustainable materials from sustainable sources, helping to avoid repeated investment later down the line (e.g. RAAC)
- running schemes that utilise local employment or offer apprenticeships
- introducing green travel options, including bike rakes at sites and building or maintaining premises which are easily accessible and close to public transport links
- introducing EV charging points or other sustainable measures and renewable technologies to support other NHS initiatives (such as fleet electrification), and
- considering clinical commissioning intentions and service delivery changes to create more sustainable solutions (e.g. the reduction in face to outpatients to reduce the clinical space required, reduce carbon emissions and business travel via virtual means and via community-based diagnostics).

The programme will ensure provisions are in place around 'green lease' agreements and provide guidance to the ICS community (including landlords and tenants) around the operation and implementation of energy efficient technologies and retrofits, as part of the lease management framework piece.

The ICB Estates Programme Team will work with partners to continue exploring opportunities for available funding sources available to the ICS and its stakeholders to support our commitment to becoming net zero carbon and cover the costs of renewable technologies and becoming energy efficiency, including UK government grants (e.g. the Boiler Upgrade Scheme), The Mayor of London's Energy Efficiency Fund, and Community Solar Accelerator grants.

Actions we will be taking

Next steps for the NW London ICB Estates Programme include:

- Implementing the ICS wide Estates Strategy for NW London to underpin and inform decision-making around and utilisation of estates, helping to reduce (and eventually avoid) doubling up of or lack of service provision.
- Conducting a thorough assessment of our estate in line with 'core, flex and tail' prioritisation guidance, lease management reviews and the 'RSRP' approach. This will highlight opportunities to release ageing estates and surplus land, move to multi-service 'hub' or community-based models (as part of the Out of Hospital strategy), and either break, renegotiate or surrender leases which are no longer cost-effective or appropriate to the ICS' ambitions.

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- Working in tandem with other programmes, boroughs, internal/external stakeholders and ICBs to develop and agree a programme of relevant projects designed to future-proof service provisions and improve long-term fitness-for-purpose of our estates.
- Ensuring estate decisions are informed by proven initiatives and the overarching direction of travel, e.g. Mental Health services continuing to move under the Community model and appropriately repurposing any mental health estate that is no longer required.
- Proactively build an ICS-wide picture of void, sessional and unused bookable space management in collaboration with NHS property service companies. This will underpin programme activity and identify where efficiencies can be made by the ICB, whilst mitigating vacant space and ensuring the more appropriate deployment of services.
- Continuing to support the broader NHS initiatives including the rebuild/refurbish and operational delivery of the four hospitals being introduced under the New Hospitals Programme and as part of the Community Diagnostic Centre (CDC) roll-out programme.
- Continuing regular engagement with local authorities and national partners to maximise mutual opportunities to improve our services to our populations.

Research and Innovation

Summary of what the programme is about and aims to achieve

Our ICS needs to become a learning system that applies best evidence to make sure we are doing the right things, avoiding the pressure to defend the status quo or expend effort implementing ineffectual and unevidenced initiatives. Doing this relies on a much more systematic use of research and innovation as a fundamental feature of how our ICS does its work. To enable this, we will focus R&I efforts on a small number or priority missions

North West London is in a highly enviable position of being home to internationally renowned health services and academic institutions, and it is the home of many small, medium, and large innovators in life sciences and data science. This gives us an incredibly strong platform to use the public sector investment in research and innovation (for example through the NIHR) to make a visible and meaningful impact in addressing the health needs of our local population. It also gives us a prized location from which to connect with academia and the life sciences industry so that both sectors make a stronger contribution to improve the NHS.

In this chapter we look at the issues and opportunities in NW London, and explore how research and innovation support is a necessary condition for our ICS to deliver our objectives; we unpack what we mean by the terms research and innovation, and describe some of the barriers to action we face and the changes we are making to address them; and we look at specific examples of existing innovation and show how

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they can add up to a coherent and deliberate portfolio of projects which will help us address one of a small number of major missions for health improvement.

Our definition of Research and Innovation

Across the ICS we have different concepts that apply to research and innovation. For some people the terms infer only early-stage science or clinical trials, for others it is a much broader set of activities that flows through to adoption and spread and the processes of continual improvement. This is reinforced by institutional and funding separations that create a false dichotomy: universities and NIHR-infrastructure focus on research; operational people do not. To recast some of these concepts we have set out a simple illustration to define the range of activities and actors. The world is not as neat as our diagrams, but we find the model in Figure 1 useful to delineate roles across the domains of 'invention', 'innovation & implementation science', and 'improvement'. This reflects the different organisations and skills involved in different stages, the autonomy of the stakeholders, and the relatively discrete funding of different activity types.

We think about 'Innovation' as the application of an idea, technology, or object that is new to accepted standards of care and has the potential to offer substantial positive impact on health-related outcomes. These often disrupt current service delivery models. Central to successful innovation is that these ideas and technologies be useful, useable, and used and that they must enable changes to practice in ways that can be adopted, adapted, and scaled. Likewise, innovation requires disruption to be proactively managed by creating the conditions for use, both enabling the new model and challenging the status quo. To those ends, our ways of working must catalyse access to new innovations, creating disruption by inculcating a sense of new possibilities, and stabilizing the transition by providing practical transformation support.

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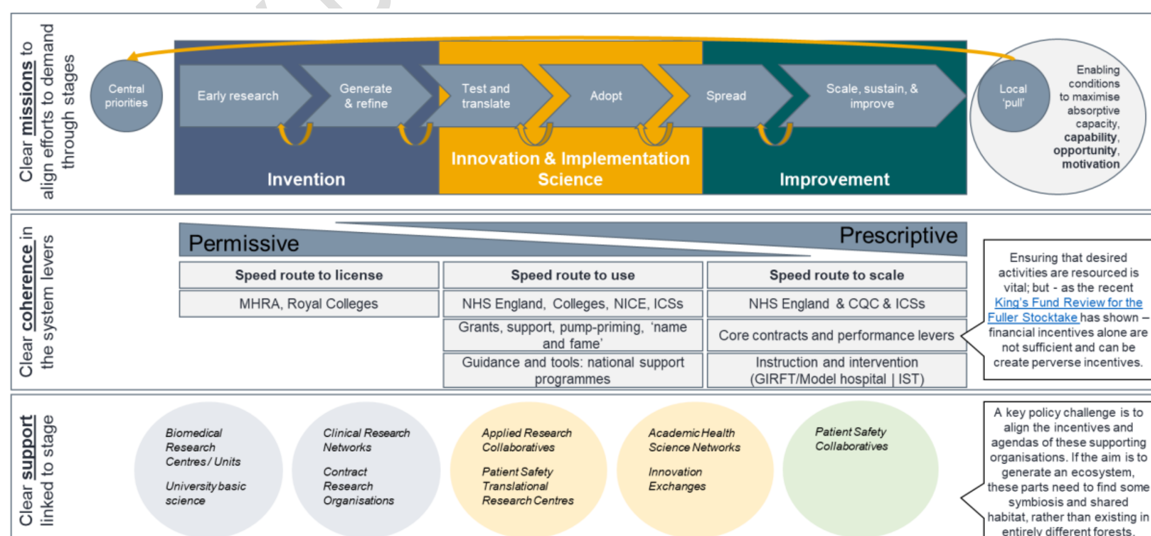
Figure 1 – Our conceptual model of the ecosystem in which innovation happens



Current issues

The four aims of the ICS are to:

A - Improve outcomes in population health and health care

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

C - Enhance productivity and value for money

D - Support broader economic and social development

Delivering these aims depends upon a transition away from current practices to more coordinated pathways and services that make more effective use of resources. That means changing the balance of activities across the local health and care system. Our aim is to make it easier for people to stay well and help themselves; for people with health service needs to get the right access at the right time (managing chronic conditions and preventing acute need where possible); and for people who have acute need to access services promptly and recover quickly in appropriate settings. And to make this the case fairly across all parts of the population, levelling up for all, not just providing excellence for the fortunate few. These sorts of changes would help us make the most of the talents in the workforce, and make jobs do-able, supporting staff to focus on the things they can do rather than being overwhelmed by 'failure demand' that is created and exacerbated by our current ways of working.

Whether primarily funded through National Institute of Healthcare Research (NIHR) or NHS England, much of the research and innovation infrastructure has, for understandable historical reasons, emerged and developed to serve the funder rather than the needs of the population. This has two major consequences: the great work that is happening through R&I infrastructure is less well known (and less well applied) than it should be; and the ICS has relatively fewer mechanisms to orchestrate the R&I activities in the sector than it needs. As a result, ICS teams tasked with developing new service models find it difficult to understand and avail themselves of the capabilities of teams funded through the sector's research infrastructure.

Our ICS will not be able to impact these things by doing more of the same. Changes of the sort we require depend upon being able to generate deep insights about what is happening and why and to use those insights to: invent new interventions, testing and translating them into real-world practice; innovate and implement ideas, adapting and adopting at scale practices that are shown to work; and establish methods of improvement to help spread good practice everywhere.

Whilst health care systems globally struggle to implement innovation at pace and scale, the pandemic showed that health systems can innovate at pace when there is a clear mission and aligned support to make change happen. But across the globe places are at risk of reverting to old habits and failing to learn the lessons of the recent past: demand signals remain insufficiently clear to properly align the activities and agencies supporting invention, innovation, and improvement; and we are often not fully using the levers at our disposal (at all tiers of the system) to create the conditions for innovation and implementation. This means that the benefits of innovation are not realised – for residents, health economies, innovators and the wider economy – and

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inequalities of access, experience, and outcomes persist. We recognise the same challenges in NW London, but recent experience of change, and new opportunities from system reform, mean we have the chance to do better.

Actions

We recognise that the status quo will not deliver the ICSs objectives and so in order to change, we have committed to the following actions:

We will unite around an analysis of population need.

We will make significant changes to the way we signal our priorities, **setting out a smaller number of themes with much larger scope and ambition**. The priorities should act as to focus effort and we should use systems engineering approaches[i] (systems thinking) to understand what is really happening in those areas and why. From this we should establish portfolios of projects to explore, test and adopt what innovations can address the issues faced. A subgroup of the Research and Innovation Board used a pragmatic process (see appendix) to identify three major priority missions for the research and innovation work to focus on.

- We will maximise the experience and outcomes for residents with chronic disease, and improve VfM, by preventing, diagnosing, treating a person's needs. *In the first instance we will focus on cardiovascular disease, with a view to adopting generalisable working practices in other areas.*
- We will take action to minimise the harm suffered by patients being in the wrong care setting, with the aim of seeing people in the right place at the right time every time. *We will start first exploring acute pathways and discharges of people who are medically fit.*
- We will take action to ensure that children and young adults have the best start in life, with a particular focus on promoting positive mental health and enabling an appropriate range of support to enable early and effective intervention.

We will address split incentives caused by different funding sources .

We will review the major levers available within the ICS to support and incentivise research and innovation on these themes, looking in detail at opportunities to:

- **Use procurement mechanisms to support co-development of technologies** and the adoption of proven innovations (e.g., enabling and building on the existing requirements of the MedTech Funding Mandate). This should begin with a specific area of focus around digital, and learn from recent case studies like the successful development and deployment of technology in the Heart Failure pathway[ii]
- **Resource Clinical Effectiveness Group infrastructure** to provide practical support in primary care to increase the ability to absorb new ways of working. This must develop to operate across the primary-acute boundaries. This should start first with a focus on CVD and it should use grant funding (e.g., the InHIP funding secured by ICHP) to augment sector investment
- **Use the formal contracting and oversight mechanisms** (e.g., the System Oversight Meetings) to emphasise the importance of progress in these themes, and to include research and innovation activities as the core business of an ICS and its borough based partnership

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- **Use the formal NHS planning round** to establish this as a foundation for the year ahead – the ICB should commit to determine the R&I objectives within each ICS programme including resourcing and required impact measures for agreement in March 2023.

We will ensure research and innovation is seen as part of the 'day job' of delivery and have research and innovation at their core.

- We will task colleagues in research and innovation teams to map current work against these missions and share them with the nominated ICS programme leads; and make visible the ways in which these work areas can access / draw from funded work going on (for example BRC work on the Core20+5 agenda). Further, we will proactively look to (re)shape work plans where possible, for instance: working with ICHP on the use of AHSN funding for 2023/24 so that it maps explicitly to these priority themes; and exploring the opportunity of the RRDN redesignation to build a platform of clinical trials support related to these agendas.
- We will do more to use the deep analytical capabilities of the local universities and school of public health to create a shared description of need and explain its drivers. This is currently left to the ICS BI team and individual programmes, and they do not have easy access to additional people and skills. This is despite major thematic overlaps (e.g., the ARC theme on multimorbidity or child population health[iii], or the BRC and AHSN themes relating to the Core20+5 agenda[iv])
- We will do more to build capability and capacity in primary care by including more roles within the infrastructure grants of the BRC, CRN (now designated as RRDNs[v]), ARC, and AHSN. This can help attract and retain clinicians wanting portfolio careers and their involvement would help to connect the research, innovation, and clinical delivery agendas. Lack of capacity here makes it difficult to do that, whereas in other parts of London we see Clinical Effectiveness Group models achieving this tripartite aim.
- We will do more to use the opportunity of the new medical school at Brunel to rethink what the sector needs from its medical education, and to reimagine what the sector can offer (e.g., by way of different types of educative experience and projects/fellowships to students of medical schools in the sector).
- We will do more to orient our discretionary grants (e.g., the AHSN funding) towards a small number of major ICS programmes that support transformation in provider organisations
- We will more deliberately and systematically consider the range of levers that make innovation happen, including creating the time and support to engage; and establishing pragmatic but aligned commissioning, regulatory (e.g., area prescribing committee decisions), and contractual expectations that ensure resources are put behind stated intent.

Moving from ambition to action

As the chapter on Population Health and Inequalities sets out, cardiovascular disease is the main cause of ill health for our population and a major driver of health inequalities. Addressing it is central to improving outcomes, and delivering the Core20+5 agenda. And research and innovation over decades continues to show that this is amenable to change: improvements in blood pressure control drive better

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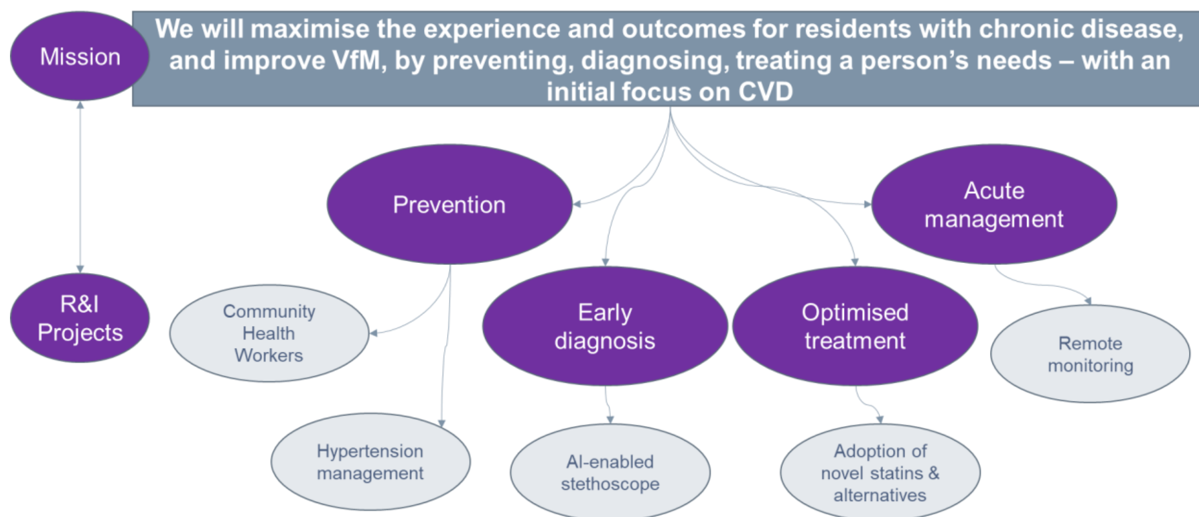
outcomes and avoid adverse events: every 10mmHg reduction in blood pressure results in 17% reduction in coronary heart disease, 27% reduction in stroke, and 13% reduction in all-cause mortality. Interventions exist to lower blood pressure, from smoking cessation and exercise to the use of high intensity statins and novel drugs such as Inclisiran. Around 470,000 people in NW London are thought to have hypertension, but only 275,000 people have a recorded diagnosis leaving circa 195,000 people undiagnosed. Of those people with a diagnosis, fewer than half (120,000 people) have had a blood pressure measurement recorded in the last year.

As the case studies in the appendix illustrate, lots of research and innovation work is already happening in NW London and we are, in places, seeing that be adopted into new practice. A missions-based approach will help us to be more deliberate and purposeful in managing the coordination and cross-fertilisation of these sorts of initiatives. This starts to give an indication of how we will build a portfolio of work to tackle the CVD mission and we will do the same for the other missions.

Figure 2 – An illustration of what a Long Term Conditions 'mission' would focus on in the first stage



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Embedding sustainability

In 1987, the United Nations Brundtland Commission defined sustainability as "meeting the needs of the present without compromising the ability of future generations to meet their own needs."[13]

Sustainable development requires an integrated approach that takes into consideration environmental concerns along with economic and social development.

[13] United Nations

Building a more sustainable economy will help reduce the greenhouse gas emissions that cause climate change. Sustainable development and climate action are linked, and both are vital to the present and future wellbeing of humanity.

Climate change has now been recognised by most governments, businesses and organisations from all sectors as a global issue that needs to be addressed with urgency to limit global warming and its associated threats to people, society and the planet.

In 2019, the UK government was the first government to enshrine a net zero target by 2050 in law, where net zero means that carbon emissions must be eliminated first where possible or removed to achieve carbon neutrality.

The NHS position on sustainability and the climate emergency

The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.

In 2020, NHS England published its "Delivering a Net Zero National Health Service" report which sets targets of:

- net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 for greenhouse gases (GHG) emissions we control directly (scope 1&2), and
- net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 for the emissions we can influence (scope 3).

These are ambitious targets that require immediate action and support from senior leaders. NHS England's emissions represent around 4% of Britain's emissions.

Trusts and ICBs have produced their respective green plans aligned with NHS England net zero targets. NHS North West London ICB's green plan was published in April 2022.

This means sustainability is now a strategic factor that needs to be integrated in all decision-making processes.

Why?

Embedding sustainability in our strategy ensures a **long-term vision and a more holistic approach**, to avoid revisiting decisions taken now in the future. It can:

- Provide cost relief through reductions in energy and utility costs achieved by deploying energy efficient solutions (e.g. LED lighting).
- Ensure we remain within or ahead of legislation relating to carbon emissions, energy efficiency, net zero targets. (e.g. Energy Performance Certificate rating of buildings legislation)
- Support organisations in adapting to climate change, making sure they can remain operational in all circumstances, as extreme weather events increase in frequency and strength.
- Send a clear message to all organisations seeking to do business with NHS NW London about our journey to net zero and our expectations that they match our

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ambitions. This in turn encourages other organisations to take action to address their own impact on climate change.

- Decarbonisation road maps are being developed by NHS England that NHS NW London will need to implement.

Sustainability can also become a **key enabler to deliver on NHS NW London's priorities,** as climate change disproportionally affects the most vulnerable.

How?

- Make sustainability a key criterion in all decisions, review decision-making processes and develop guidance.
- Reflect sustainability and net zero in all major strategies: estates, procurement, patient care, medicines, research and innovation, workforce, data and digital.
- Make best use of enablers: train and empower workforce to create change from within (e.g. scholarship for primary care, move away from high carbon products such as inhalers and anaesthetic gases), ensure research and innovation programmes embed sustainability, continue to use digitalisation as a tool to reduce carbon emissions (e.g. virtual clinics), be better at using data to identify challenges and track and monitor progress.
- Behaviour change and leadership: change on the scale required to address our impact on climate change cannot happen without the full support of the leadership team. Sustainability needs to become a standard Board item.
- Bring in sustainability upstream: most emissions come from procurement and supply chain: tighten procurement rules to reduce imported emissions from products and services.
- Climate risk register: develop a climate risk register for NHS NW London and each delivery and enabling programme.
- Collaborate with anchor institutions: there many areas where collaboration with other organisations within the region can deliver better and faster, e.g. estates, transport, waste.

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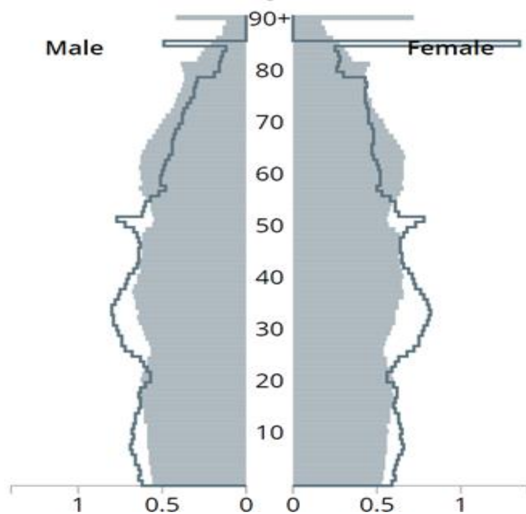
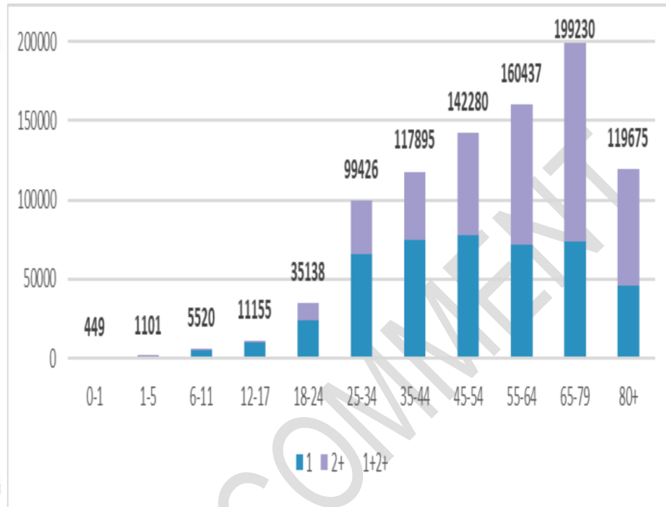
Annex A – age distribution supporting information

Age distribution 1998 v 2028 age group

Number of people with long-term conditions per





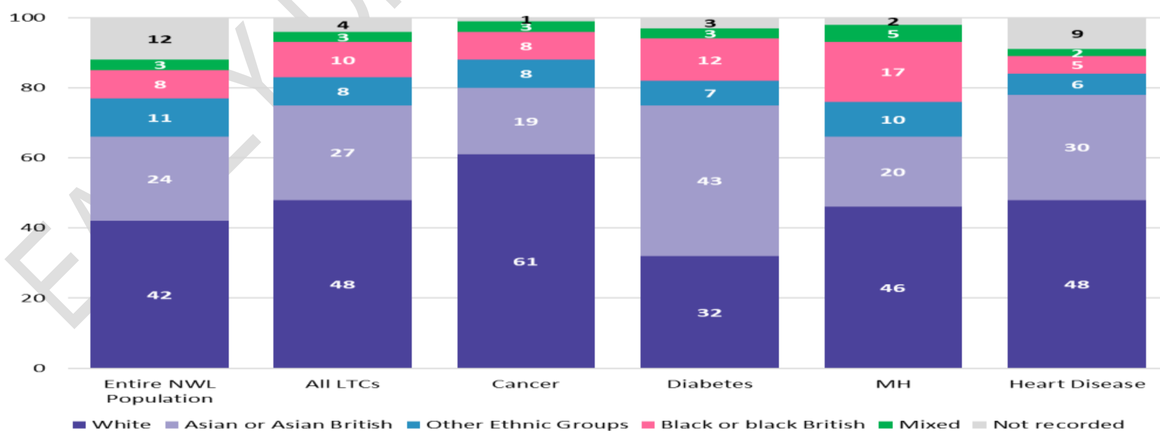
Percentage of population in age band.
Outline grey line shows 1998.

Source: WSIC, NHSE

Source: PHE

Annex B – ethnic variation supporting information

% of people with long-term conditions by ethnic group



Annex C – income distribution supporting information

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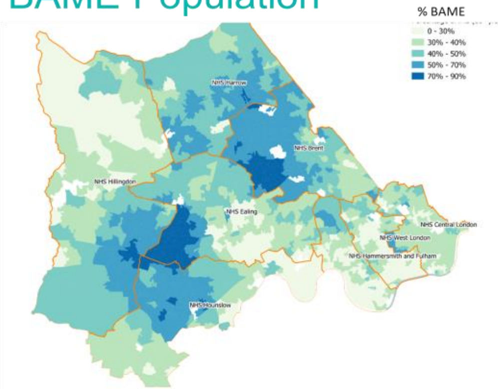
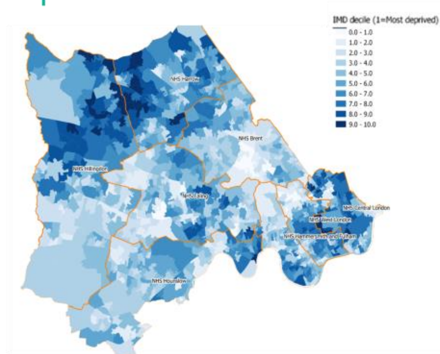
BAME Population

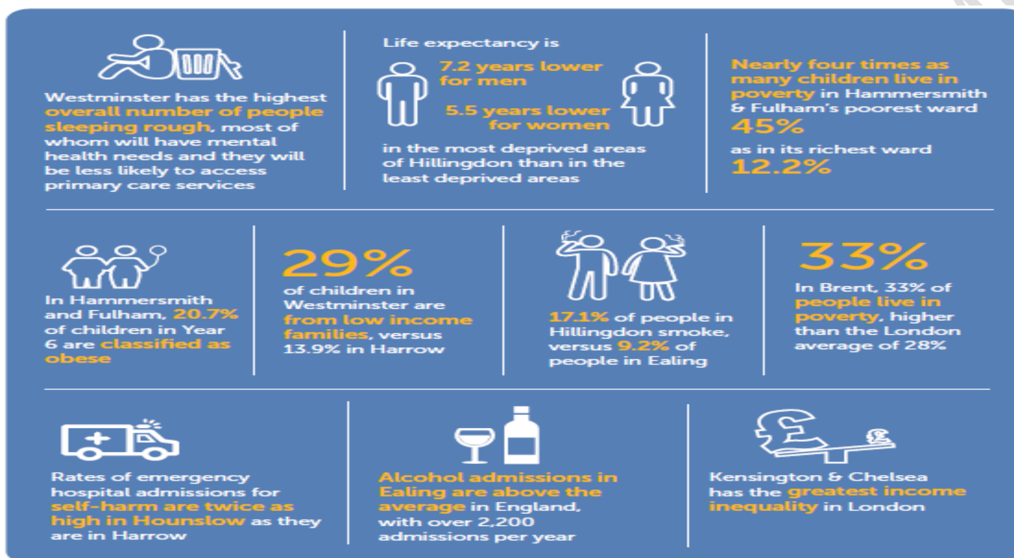


Deprivation



Source: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Variations in outcomes across the 8 Boroughs



Source: PHE, OHID

Income inequality in 2017/18-2019/20

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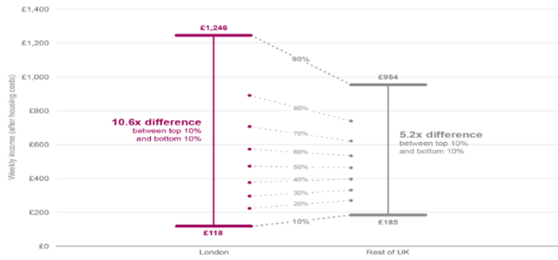
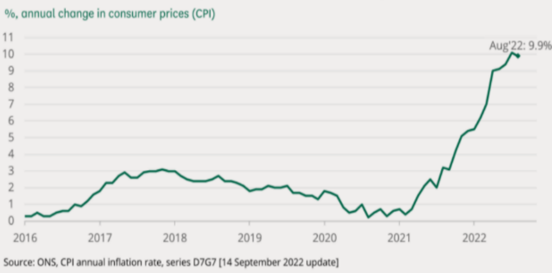
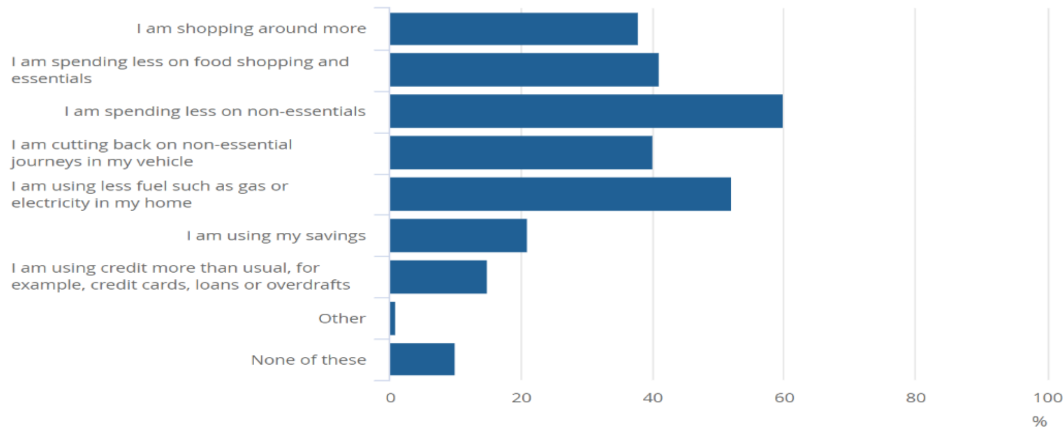
Difference in weekly income (after housing costs) between top 10% and bottom 10%



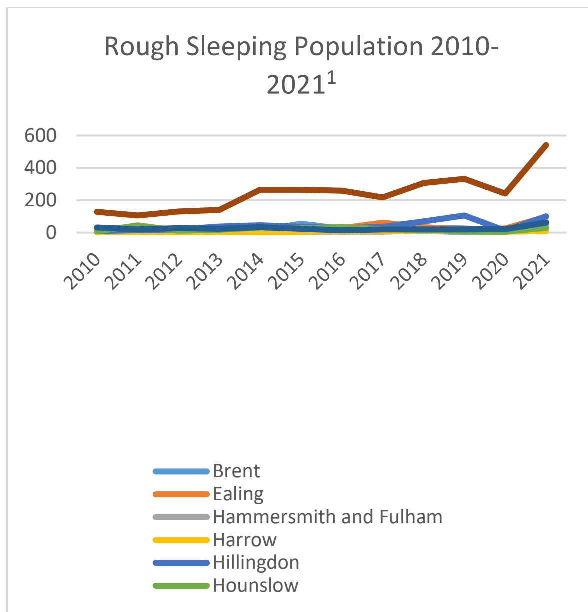
Source: HBAI microdata, DWP



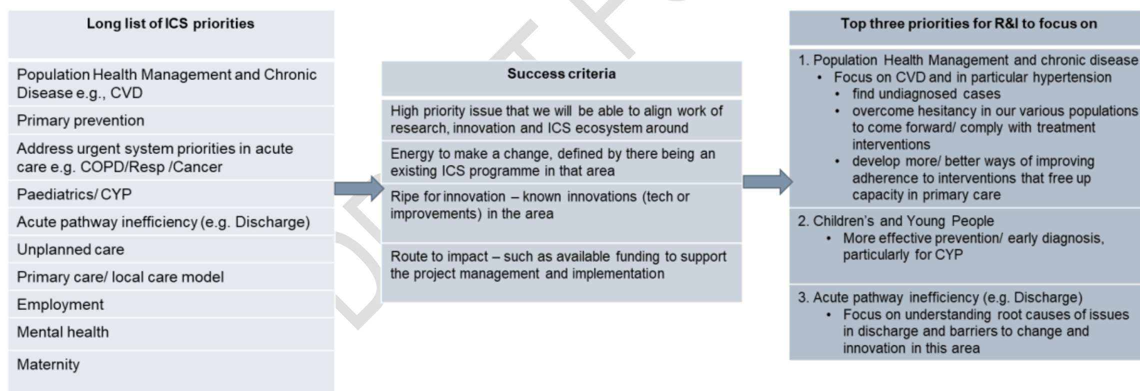
Which of the following are you doing because your cost of living has increased?



Source: Office for National Statistics – Opinions and Lifestyle Survey: Public opinions and social trends, Great Britain: Household finances, 25 May to 5 June 2022



Annex D - A high-level summary of the process to select priorities to support the Research and Innovation chapter



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[i] At NASA, "systems engineering" is defined as a methodical, multi-disciplinary approach for the design, realization, technical management, operations, and retirement of a system. A "system" is the combination of elements that function together to produce the capability required to meet a need. The elements include all hardware, software, equipment, facilities, personnel, processes, and procedures needed for this purpose; that is, all things required to produce system-level results. The results include system-level qualities, properties, characteristics, functions, behaviour, and performance. The value added by the system as a whole, beyond that contributed independently by the parts, is primarily created by the relationship among the parts; that is, how they are interconnected. It is a way of looking at the "big picture" when making technical decisions. It is a way of achieving stakeholder functional, physical, and operational performance requirements in the intended use environment over the planned

life of the system within cost, schedule, and other constraints. It is a methodology that supports the containment of the life cycle cost of a system. In other words, systems engineering is a logical way of thinking. 2.0 Fundamentals of Systems Engineering | NASA

[ii] This Heart Failure Pathway Improvement Project won this year's HSJ Award for Digitising Patient Care Award. It is an end-to-end pathway redesign for heart failure in north west London, drawing support from clinical and operational teams, the ICB, and ICHP. Working with multiple industry collaborators, more than 100 interventions were combined to deliver substantial improvements including. These include: data systems integration between primary, community and secondary care; increased community HF diagnosis, reduced unplanned hospital costs, greater convenience for patients and the first remote monitoring app for HF medicine optimisation in the UK. HSJ award judges said this work displayed an impressive approach to design and the scale and transferability was evident. HSJ Awards 2022: Digitising Patient Care Award | HSJ Awards | Health Service Journal

[iii] The Applied Research Collaboration for NW London has research themes for Child Population Health, Multi-morbidity and mental health, digital health, innovation and evaluation; and cross-cutting themes on information and intelligence, patient engagement and involvement, collaborative learning and capacity building. Research (nihr.ac.uk)

[iv] Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

[v] From April 2024, the current NIHR Clinical Research Network will be changing to become the NIHR Research Delivery Network. The NIHR Research Delivery Network (RDN) will continue to support the effective and efficient initiation and delivery of funded research across the health and care system in England for the benefit of patients, the health and care system and the economy, with a name that better reflects the scope and purpose of the network to support: Clinical Research Network | NIHR

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