LONDON BOROUGH OF RICHMOND UPON THAMES

North West London Joint Health Overview and Scrutiny Committee

Meeting Date:
Wednesday, 14 September 2022

Agenda

Meeting Time:
10.00 am

Meeting Venue:
Salon - York House

Mark Maidment, Chief Executive

Members	Councillor Ketan Sheth (Chair) Councillor Daniel Crawford (Vice-Chair) Councillor Sarah Addenbrooke Councillor Nick Denys Councillor Chetna Halai Councillor Natalia Perez Councillor Angela Piddock Councillor Marina Sharma Councillor Clare Vollum
Democratic Services Officer	Nicholas Garland, nicholas.garland@richmondandwandsworth.gov.uk

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York House
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6 September 2022

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1. Apologies

To receive apologies for absence.

2. Declarations of Interest

In accordance with the Members Code of Conduct, Members are requested to declare any interests orally at the start of the meeting and again immediately before consideration of the matter. Members are reminded to specify the agenda item to which it refers and the nature of the interest.

3. Minutes (PAGES 7 - 14)

To consider the minutes of the meeting held on 9 March 2022.

4. Minutes (PAGES 15 - 26)

To consider the minutes of the meeting held on 20 July 2022.

5. Primary Care Performance and Strategy including GP access (PAGES 27 - 42)

Purpose

To receive a report on the current primary care strategy and performance in relation to North West London.

6. Emergency Department Pathways & Performance, with London Ambulance Service Performance. (PAGES 43 - 54)

To provide an overview on performance across North West London (NWL) for Emergency Department (ED) and other Urgent and Emergency Care (UEC) pathways & performance, including the London Ambulance Service (LAS)

7. Palliative Care Review

(Pages 55 - 108)

8. North West London Integrated Care System Update

(Pages 109 - 118)

9. West London changes to Hope / Horizon wards

(Pages 119 - 122)

10. NWL JHOSC Terms of reference Refresh (PAGES 123 - 128)

Purpose of the Report

To set out the draft refreshed terms of reference for the North West London Joint Health Overview Scrutiny Committee.

Recommendation

The committee is asked to review and agree the draft refreshed terms of reference for the North West London Joint Health Overview Scrutiny Committee as set out in Appendix 1.

11. Work Programme Update (PAGES 129 - 134)

Purpose of the Report

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

Recommendation

The committee to note the contents of the report and changes to the work plan outlined in Appendix 1.

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CITY OF WESTMINSTER

DRAFT MINUTES

NORTH WEST LONDON
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
MINUTES OF PROCEEDINGS

Minutes of a meeting of the **North West London Joint Health Overview & Scrutiny Committee** held on Wednesday 9 March 2022 at 10.00am at Westminster City Hall, 64 Victoria Street, London SW1E 6QP.

Members Present:

Councillor Ketan Sheth (Chair)	LB Brent
Councillor Iain Bott	Westminster City Council
Councillor Daniel Crawford	LB Ealing
Councillor Richard Eason	LB Hounslow
Councillor Nick Denys	LB Hillingdon
Councillor Lucy Richardson	LB Hammersmith and Fulham
Councillor Monica Saunders	LB Richmond upon Thames
Councillor Rekha Shah	LB Harrow

1. ATTENDANCE BY RESERVE MEMBERS

1.1 Councillor Iain Bott (City of Westminster) welcomed Committee Members, Officers and visitors to the meeting.

1.2 Councillor Iain Bott (Westminster City Council) substituted for Councillor Lorraine Dean (Westminster City Council).

2. DECLARATIONS OF INTEREST

3.1 Councillor Ketan Sheth (LB Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust (CNWL).

3.2 Richard Eason (LB Hounslow) declared that he periodically undertakes work in the voluntary sector, some of which contracting, and projects, may be related to health and social care but nothing at present.

3. MINUTES

3.1 **RESOLVED**: That the Minutes of the meeting held on 14 December 2021 be signed by the Chair as a correct record.

4. MATTERS ARISING (IF ANY)

4.1 There were no matters arising.

5. MENTAL HEALTH STRATEGY

5.1 The Committee received an update from Carolyn Regan (SRO, MHLDA Programme and Chief Executive, West London NHS Trust) on the four workstreams of the Mental Health, Learning Disabilities and Autism Programme which aims to improve access, experience and outcomes for the local population of North West London.

5.2 Councillor Lucy Richardson (LB Hammersmith and Fulham) asked for clarity on mental health teams in schools and what the service looked like. Carolyn Regan confirmed that mental health teams in schools are predominantly staffed by NHS practitioners who work closely with educational and school staff. The Committee was also updated on the dementia service where work has been commenced on the number of people accessing memory clinics and outreach being undertaken in areas to encourage people to come forward for assessments. Clarity was also provided on the closure of inpatient beds, and especially those in Westminster where the situation is being closely monitored and data would continue to be provided to Members.

5.3 Councillor Rekha Shah (LB Harrow) stated that mental health referral criteria is challenging to meet and there are too many barriers for those in crisis, or those needing help to avoid a crisis state. Carolyn Regan confirmed that work was being done in partnership with third sector colleagues to improve this. Councillor Richard Eason (LB Hounslow) noted that some Safe Spaces are not easy to access and was updated by Carolyn Regan that she had been talking to MIND regarding different locations and altering opening times to make the Spaces more accessible.

5.4 Councillor Eason asked what sustainable targeted support is available for the LGBTQ+ community where mental health is a significant health inequality and was advised that it is being picked up with the general health inequality work, especially looking at longer term funding for organisations. Councillor Nick Denys (LB Hillingdon) raised the issue of mental health assessments when the police deal with those who are suffering from poor mental health. Carolyn Regan confirmed that this is a central part of the work in mental health crisis care and it is very much a live issue where more collaboration with the police is needed.

5.5 Councillor Iain Bott (Westminster City Council) asked about the waiting time for autism diagnosis and what is being done to tackle this. Carolyn Regan confirmed that it is an issue in North West London which is being investigated. The Committee understood that there is some granular detail on waiting times and pathways to diagnosis which has been amalgamated to develop a new strategy and principles about how to reduce waiting times. Councillor Bott noted that there was an absence of a maternal and perinatal health update in the Committee papers; it was clarified that there is a plethora of data on these services across all the boroughs so a supplementary paper on this information would be sent to Members.

5.6 **RESOLVED**: That the Committee noted the update on the four workstreams of the Mental Health, Learning Disabilities and Autism Programme.

Actions Arising:

1. That data relating to the closure of inpatient beds would continue to be provided to the Committee.
2. That an update on maternal and perinatal health would be sent to the Committee Members.

6. NORTH WEST LONDON WORKFORCE - UPDATE

6.1 The Committee received an update from Charlotte Bailey (North West London Workforce) on three areas of the North West People Plan which continues to mature and contributed to regularly. The three areas discussed included: 1) grow; how the immediate workforce is growing, 2) care; how the workforce is being looked after, and 3) include; the diversity of the workforce. There were a number of Key Performance Indicators (KPIs) in the report and a snapshot of the work being undertaken in the primary and social care was provided.

6.2 Councillor Lucy Richardson (LB Hammersmith and Fulham) stated that it was great to hear about the new workforce initiatives. Councillor Richardson asked about contextualisation of the metrics when understanding the variables of the workforce date surrounding length of service. Charlotte Bailey confirmed that length of service is monitored and a lot of work is undertaken around retirements and returns to work where proactive conversations are encouraged. Councillor Richardson enquired about reducing employee inequalities and was informed that there is a workforce disability equality standard which outlines core practice and standards. Charlotte Bailey agreed to bring figures back to the Committee specifically on how standards tie in with advertising and recruitment as well as how people access jobs.

6.3 Councillor Monica Saunders (LB Richmond upon Thames) referred to the decline in GP numbers and asked whether vacancies, and predicted vacancies, tend to occur in more deprived areas and what this means for health inequalities. Charlotte Bailey confirmed that regional patterns do happen and they do tend to relate to geographies of deprivation; it was agreed that this information would be distributed to Committee Members. It was also stated that in terms of GP numbers, actions are being taken to not only increase the diversity in the types of roles, but the integration of services to support the holistic care of residents. It was stressed that it is not simply about numbers of people in posts, but the model of care and ways people work together.

6.4 Councillor Richard Eason (LB Hounslow) enquired about the involvement of trade unions and how their expertise to address challenges was being used in the People Plan. Furthermore, it was also asked what engagement and monitoring was being undertaken with the LGBTQ+ community regarding workforce and recruitment, and whether it is consistent with the population. Charlotte Bailey informed the Committee that the workforce has good

engagement with unions at both individual Trust level and at regional level. There is a partnership approach and unions are recognised as a key intelligence stream to understand themes surrounding the workforce. In terms of LGBTQ+ standards, the committee was advised that they are around Stonewall standards and the workforce has vibrant staff networks and good standards.

6.5 Councillor Ketan Sheth (LB Brent) raised the issue of addressing sickness and psychological trauma in the workforce. Charlotte Bailey confirmed that sickness and psychological trauma are not only issues stemming from COVID-19 but staff in certain specialisms face this every day so there is a lot to do in Trusts in this space to support staff. In addition to the Keeping Well service, there is the early access to psychological therapies and the number of referrals for this is going up: the Committee was pleased to note that the success rate of this service is good.

6.6 Councillor Ketan Sheth (LB Brent) asked for assurance of positive action being taken against bullying and harassment as well as headlines of feedback from values and behaviour workshop and themes in the staff survey response. Charlotte Bailey confirmed that an ethos of civility and respect is being promoted through leadership and team development; the characteristics of civility and respect were being investigated and the team, as well as individual Trusts, are drilling down into the data around bullying and harassment. The Committee noted that nearly 400 people were involved in the values and behaviour workshop and helped to co-produce an emerging values and behaviours framework through strong common and collective goals. The Committee also noted that whilst the results of the staff survey were embargoed, themes on morale and impacts of COVID-19 on capacity were expected. Charlotte Bailey agreed that an update of the results of survey would be brought to September's Committee.

6.7 **RESOLVED**: That the Committee noted:

1. Workforce performance changes specifically in absence and vacancy trends and the mitigating actions being put in place through People Plan initiatives and locally across organisations to address them; and
2. Updates against key areas of national priority in the Workforce programmes.

Actions Arising:

1. That figures on the workforce disability equality standard would be brought to the Committee.
2. That information on geographies of deprivation and GP vacancies would be distributed to Committee Members.
3. That an update of the results of the workforce survey would be brought to September's Committee.

7. INTEGRATED CARE SYSTEM (ICS) – UPDATE

7.1 The Committee received an update from Rob Heard (Chief Executive of

Integrated Care System) on the North West London Integrated Care System (ICS) which included: CEO update, COVID-19, COVID-19 vaccination, acute recovery, mental health, finance, and, the appointment of an Acute Trust Chair. The Chair (Councillor Ketan Sheth, LB Brent) congratulated Rob Heard on his appointment as Chief Executive Officer of ICS.

7.2 Rob Heard (Chief Executive of ICS) informed the Committee that the importance of the vaccine was still being disseminated and that great work has taken place in the North West Team and good progress made on the vaccine rollout. The Committee noted that there were areas of communities where this message needs to remain to be pushed to reduce health inequalities. The Committee was advised that there continues to be pressures beyond normal winter pressures in emergency departments and pressures in community services in primary care as a result of, indirectly and directly, the pandemic. The Committee noted the work undertaken to reduce pressures on the primary care system.

7.3 Rob Heard stated that part of his purpose as Chief Executive of ICS is to maintain a focus on population health, inequalities, and support the success of local borough partnerships for communities. The Committee was advised of the importance to focus on the prevention of poor public health, especially through immunisation and early diagnosis. The Committee also noted that the ICS legislation was on track to be formalised into a legal entity and replace the North West London CCG to bring together different parts of the care system; appointing a single Chair for all the acute hospitals is a good signifier of this integration.

7.4 Councillor Nick Denys (LB Hillingdon) asked how it is ensured that bureaucracy supports autonomy and flexibility of the ICS. Rob Heard acknowledged that the ICS exists to support a place-based model but it should also ensure that areas benefit from things done at scale and standardised models. Therefore, autonomy should be devolved in areas but also the ICS should support local boroughs in creating scale to allow success and optimum outcomes for residents and finances. Councillor Ketan Sheth (LB Brent) asked about the financial recovery plan and was advised that the formal long term financial position of the ICS would be examined in the year ahead. Councillor Lucy Richardson (LB Hammersmith and Fulham) enquired about historical CCG deficit and was informed that this had been mitigated.

7.5 Councillor Richard Eason (LB Hounslow) and Councillor Iain Bott (Westminster City Council) queried the large numbers of people unvaccinated and asked what the impact is likely to have on risk and volume of activity, as well as lessons learned. Councillor Ketan Sheth (LB Brent) also asked about GPs and pharmacies being brought in to help with vaccinations. Rob Heard informed the Committee that inroads into reducing the unvaccinated population were being made. Furthermore, the Committee was advised that there is no supply issue or difficulty predicted in administering vaccines but the task is getting people to come forward and take up the vaccine offer: this is being managed by hyper local vaccine campaigns from local people and places in the

communities. It is predicted that there will likely be a need for booster programmes in the year ahead, so models of provision are being looked into.

7.6 Councillor Rekha Shah (LB Harrow) stated that there have been concerns about the storage and use of data, especially from GP surgeries. Councillor Shah asked whether data cleaning is being looked at across North West London. Rob Heard confirmed that data cleaning is being investigated across North West London but could not provide an update on this process: this was agreed to be brought back to the Committee.

7.7 **RESOLVED**: That the Committee noted the update on the North West London Integrated Care System (ICS).

Actions Arising:

1. That an update would be provided to the Committee on the process of data cleaning across North West London.

8. ACUTE SERVICES – UPDATE

8.1 The Committee received an update from Professor Tim Orchard (Chair, North West London Acute Care Programme Board; Chief Executive, Imperial College Healthcare NHS Trust) and Pippa Nightingale (Chief Executive, London North West University Healthcare NHS Trust) on the North west London Acute Care Programme, including planned care recovery and development. The Chair (Councillor Ketan Sheth, LB Brent) congratulated Pippa Nightingale on her appointment as Chief Executive Officer of North West London hospitals.

8.2 Tim Orchard informed the Committee of the general situation of acute trusts across North West London and highlighted that they have done a good job of working together to provide mutual aid, including intensive care, urgent electives and a range of other things. The Committee noted that the plan for North West London is to have a collaborative of the acute trusts and appoint a single Chair across all four of the trusts.

8.3 Despite successive waves of COVID-19, the Acute Care Programme has managed to keep elective care going and, although the waiting lists are not what would be considered good, they are in a better position than other parts of the country. Focus has been on ensuring that patients with urgent clinical needs have received necessary treatment as soon as possible. At the time of the Committee, outpatient activity was at 101 percent of normal activity which should increase to 104 percent and then 110 percent; this should happen at a reasonable rate.

8.4 Work has been undertaken to move towards diagnostics operating at a satisfactory level; specifically, investigating a range of actions to frontend diagnostics into clinical pathways to identify the clinical risks. Importantly, actions need to be efficient, and consideration is being given to setting up high volume low complexity centres to improve outputs and outcomes. There are several locations to focus this programme on which has been working well but

options to develop further hubs are being examined and the intention is to work with Members to ensure it is the right way forward.

8.5 Councillor Daniel Crawford (LB Ealing) welcomed the improvements in acute services which had been outlined. Councillor Crawford asked a question on the Programme's broader strategy and how the work being undertaken in the North West area links with the capital and region as a whole, and whether lessons had been learned from other elective services. Tim Orchard confirmed that there is a well-coordinated approach where the ICS focus group meets once a month to look at performance across all five ICS in London and how to disseminate good practices across London. The Committee was informed that clinical developments has meant services can improve, especially when there is lots of buy-in. There is not complete clarity on finances but as it will be a part of the London North West Capital Programme, governance will be examined by the collaborative. In response to an additional question from Councillor Crawford on estate strategies, the Committee was informed that the issue of estates is complex and deserves its own discussion.

8.6 Councillor Ketan Sheth (LB Brent) raised the question of why Central Mid had been chosen as an orthopaedic hub and queried its accessibility. Pippa Nightingale verified that the location had been chosen due to the quality of the estate, its accessibility, the ability to expand the estate and the separation to acute pathways. For those patients who live far away, measures have been taken into consideration such as providing ample parking, ensuring good road and transport links and providing a number of choices for patients to attend other complementary sites in the community. There is a consultation planned to engage with wider communities and the conversations are happening early to ensure that the plans meet needs.

8.7 Councillor Lucy Richardson (LB Hammersmith and Fulham) asked a follow up question on the elective orthopaedic hub around service configuration and how consultation undertaken and engagement with stakeholders is carried out to make sure that the new provision is co-produced. Pippa Nightingale confirmed that previous mistakes had been learned from which is why communities are being brought in at an early stage and that they intend to work closely with the Committee to make sure that voices are being heard. Councillor Lucy Richardson also asked for a timeline for this consultative period.

8.8 Councillor Richard Eason (LB Hounslow) enquired the investment in public transport and how much the NHS plans to contribute to this to improve connectivity. Pippa Nightingale stated that communities will be listened to, to work out what will be needed and, on this basis, will work closely with Transport for London (TfL) which has not happened previously.

8.9 Councillor Ketan Sheth (LB Brent) asked about plans around the community diagnostic centre locations. It was clarified that investigations into pockets of inequality were being looked into and where the biggest impact could be made on reducing health inequalities and ensuring healthcare is accessible. It was confirmed that papers which demonstrate this work would be circulated.

8.10 **RESOLVED**: That the Committee:

1. Noted the update on the North West London Acute Care Programme; and
2. Supported the informal involvement and engagement plans of the Programme.

Actions Arising:

1. That the Committee would, at the next meeting, receive data concerning reducing health inequalities together with information on estates and finances.
2. That the ICS health inequalities programme would be formally presented at the Committee in due course.

9. OTHER BUSINESS

9.1 No other business was reported.

10. NEXT MEETING

10.1 The Chair acknowledged this was the last meeting of the municipal year and thanked all current and previous Committee colleagues, all officers from the Local Authorities and NHS staff right across North West London, as well as those others who have joined throughout the municipal year.

10.2 A vote of thanks was proposed for all the Chair's work during the municipal year; this hard work was richly appreciated and valued by colleagues as it fostered good and constructive relationships between Local Authorities and the NHS.

11. TERMINATION OF MEETING

11.1 The meeting ended at 12.00pm.

CHAIR _____ DATE _____

North West London Joint Health Overview and Scrutiny Committee
Notes of hybrid meeting by LB of Brent
10am-12pm on 20 July 2022

The meeting began at 10am.

PRESENT

Members of the Committee:

- Councillor Ketan Sheth (Chair) London Borough of Brent
- Councillor Daniel Crawford (Vice Chair) London Borough of Ealing
- Councillor Chetna Halai London Borough of Harrow
- Councillor Marina Sharma London Borough of Hounslow
- Councillor Sarah Addenbrooke London Borough of Kensington and Chelsea
- Councillor Natalia Perez London Borough of Hammersmith and Fulham
- Councillor Claire Vollum London Borough of Richmond (co-opted)

Others Present:

- George Kockelbergh - Policy Lead – Scrutiny, London Borough of Brent
- Hannah O'Brien - Governance Officer, London Borough of Brent
- Yusuf Patel – Scrutiny Support, London Borough of Hounslow
- James Diamond – Scrutiny Officer, London Borough of Kensington and Chelsea
- Anna-Marie Rattray – Scrutiny Review Officer, London Borough of Ealing (online)
- Sudheesh Bhasi – Policy Officer, London Borough of Harrow (online)
- Grace Summers - London Borough of Harrow (online)
- Bathsheba Mall – Committee Co-ordinator, London Borough of Hammersmith and Fulham (online)
- Nikki O'Halloran – Democratic Services Manager, London Borough of Hillingdon (online)
- Pippa Nightingale – CEO, London North West University Healthcare
- Damien Bruty – CDC Senior Programme Manager, NWL ICS
- Rob Hurd – Chief Executive, North West London Integrated Care System
- Tina Benson – Chief Operating Officer, The Hillingdon Hospitals (online)
- Professor Tim Orchard – CEO, Imperial College Healthcare (online)
- Dr Amrish Mehta – Clinical Director Imaging, NWL & London, Imperial College Healthcare (online)
- Joy Fashade – Head of Programme Finance, Imperial College Healthcare
- Carolyn Regan – Chief Executive, West London NHS Trust (online)
- Tony Lambert – ICS Executive Director of Strategy and Population Health (online)
- June Farquharson – Assistant Director Population Health / Inequalities, NHS North West London (online)
- Councillor Diana Collymore – London Borough of Brent (observer)
- Councillor Ahmaddi-Mogaddam – London Borough of Brent (observer)

1. ELECTION OF CHAIR AND VICE CHAIR

1.1 Councillor Ketan Sheth (London Borough of Brent) was elected as Chair.
1.2 Councillor Daniel Crawford (London Borough of Ealing) was elected as Vice Chair.

2. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.3 Apologies were received from:

- Councillor Angela Piddock, London Borough of Westminster
- Councillor Nick Denys, London Borough of Hillingdon

- Robyn Doran, COO, CNWL NHS Foundation Trust

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF THE MEETING HELD ON 4 JULY 2021

1.5 The Committee agreed to defer the minutes to the following meeting.

5. MATTERS ARISING

1.6 The Committee deferred matters arising to the following meeting.

6. ELECTIVE ORTHOPAEDIC CENTRE

1.7 Professor Tim Orchard (CEO, Imperial College Healthcare) introduced the item, which was a business proposal on behalf of all acute trusts in NWL, including Chelsea & Westminster, Hillingdon, Imperial College Healthcare, and LNW University Healthcare, for an Elective Orthopaedic Centre. The item had been brought to the previous meeting of the Committee, where the Committee had provided feedback and had been generally positive about the proposal.

1.8 In introducing the report, he highlighted the following key points:

- There were large waiting lists, with 12k patients waiting for orthopaedic care in NWL hospitals. The number of patients waiting more than 52 weeks had also increased significantly. There was a likelihood that the number of people requiring procedures would increase going forward. Waiting for surgery had a negative impact on people's ability to live their normal life, therefore finding a way for patients to have surgery as soon as possible was very important.
- The acute trusts were aware that, across the sector, there were some excellent clinical outcomes, but there were inconsistencies between hospitals with various indicators, and the aim was to provide the best care for everybody in NWL across the board.
- The proposal was to focus the 4k patients a year who had high volume, low complexity orthopaedic surgery at Central Middlesex Hospital (CMH) in a specially designed centre that did systematisation that would allow for that improved efficiency and quality of outcomes. This would open up capacity across the rest of the sector to support other specialities.
- In practice, this would mean patients would have their pre and post-surgical care locally, and their operation at CMH. It was important that the element of patient choice remained and there would be a need to still do some operations in centres with other facilities to ensure patients with more complex health needs were accommodated.
- The proposals looked to take advantage of technical and digital advances while ensuring no-one was left behind.
- The proposals presented an opportunity to build a team with skill and expertise. During the pandemic, the group of acute trusts had worked well together to provide care under very difficult circumstances, making it evident that when everyone worked together they were able to provide the best possible care.
- The acute trusts knew that fast-track surgical hubs worked well for high volume, low complexity surgery when trying to get through a backlog. Conducting a lot of operations in a very systemised way improved the quality of outcomes for patients and efficiency

of the service, meaning more patients could be treated in a quicker time frame. This model of care had been proven across the country, particularly in South West London.

- CMH was noted as a good opportunity as it was a very modern, high quality estate that could be tailored to the centre. There was no emergency department at CMH which meant there was no risk of elective orthopaedic care being disrupted by any increase in patients coming through the emergency department. In addition there was room for expansion and no requirement to displace other services to fit the centre in.
- Travel was highlighted as a key issue, and officers had reviewed the transport options and found that CMH offered the shortest median travel time both by car and public transport when looking at the whole of NWL. The issue of travel came up early during engagement activity, which included 2 virtual clinician led community events, virtual and in person focus groups and telephone interviews. The engagement found that people generally understood the need to reduce the long waiting lists and there was support for a dedicated centre for routine orthopaedic surgery, but there was concern about the end to end aspect such as getting in and out of secondary care, as well as the ease of travel into CMH.

The Chair thanked all NHS staff on behalf of the Committee. The Chair then invited questions to NHS representatives from members of the Committee, with the following issues raised.

6.3 Cllr Crawford expressed disappointment with the level of detail in the report and that some papers had been received late. He felt that the engagement conducted so far had not reached enough people and hoped for more information on the further consultation referred to in the report. Pippa Nightingale (CEO, London North West University Healthcare) apologised for the late papers and explained that the funding for the proposals was national money that NWL were trying to access. This meant officers were working to harsh timelines with NHSE as that was how money was currently distributed. The Committee were advised that they had been presented with an outline business case and not the full detailed version, which was now being worked on. She also advised the Committee that the engagement referred to within the report was not a consultation, only a pre-engagement activity to set the scope of who needed to be consulted with fully to understand the population. NHS Colleagues were asking for the Committee's support to conduct future formal consultation with the public. Once a full 12 week public consultation had been conducted, the NHS officers were then looking to return to the Committee.

6.4 Continuing to discuss engagement, the Committee asked for more engagement focused on those patients on the waiting list and, in particular, consultation with staff and those who would be moving between sites. Pippa Nightingale confirmed that was the intention, with a very detailed process for staff consultation. The fuller business case would go into the detail of each borough and their waiting lists, and boroughs would get visibility at that point. NWL knew where each patient on a waiting list was in the boroughs and the plan would be to fully engage at borough level with all affected populations across a 12 week period. The consultation process would follow the same process across all boroughs, consulting separately with boroughs and recognising where the proposals affected people more, such as those boroughs further away. As a result of the discussion, it was agreed that the full 12 week consultation would begin in the first week of September to ensure every stakeholder possible could fully engage.

6.5 The Committee asked what local modelling had been done to ensure clinical safety and what the potential risk factors were for patients. Pippa Nightingale advised that there were other places this particular model of care had proven successful, such as an orthopaedic centre in South West London, which had iterated its clinical model around improved clinical safety. This meant NWL would not be starting from scratch but learning from others. NWL had started to map governance processes, clinical

safety processes and were working on ensuring clinicians could work jointly on a single site.

6.6 NHS officers confirmed that there were several key reasons CMH had stood out as a location, following the scoping of all NWL estates. Firstly, it was highlighted that it was a state of the art and underutilised facility which would result in no displacement of other services, meaning it could be done much quicker and get through the waiting list quicker. Travel was another key reason due to the median travel times, and it was highlighted there was a need to ensure patients still had a choice – they could have an operation at an earlier date at the centre, or have their operation locally, in their local hospital, at a later date. It was highlighted that there were a number of patients choosing to go private who potentially could not afford to go private just to be seen quicker and travelling quite some time to get there, and so CMH site was a solution to input a state of the art facility as quickly as possible.

6.7 In terms of appointment allocations, the centre would not see patients by borough but as a complete NWL cohort of patients seen on a priority of need basis, following harm reviews.

6.8 In relation to funding, this needed to be further worked through in the full business case. Chief Financial Officers had worked together on the funding model, and there were examples across the country where this type of model had worked that could be learned from. The money coming from NHSE was capital money to build the estate for the 2 additional theatres needed, and the revenue money would come from the tariff of the operations NWL currently had. The focus was on considering how that money was shared to ensure no organisations were financially challenged by moving patients.

6.9 In response to the impact the proposals would have on waiting times, Professor Tim Orchard advised that, despite the fact the centre would be for the whole of NWL, waiting times would be shorter because there would be a more effective system in place. In addition, the centre would increase funding for more operations as more activity would be possible.

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

i) That the NHS considers the best strategy for the consultation to reach as many people as possible, utilising key partners across NW London.

ii) That the committee agrees to the NHS embarking on a formal public consultation that starts on the first week of September.

iii) That a clear reference is made to how the findings of the consultation will input into the business case.

iv) That the full business case is brought back to a later meeting.

v) That the NHS provide an effective communication strategy to clearly set out the pathway from primary to secondary care for patients and residents across NW London.

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

i) For the NWL JHOSC to receive details in writing about what the full business case may look like, which includes financial and resource implications and any equality impact assessment conducted.

ii) For the NWL JHOSC to receive full details in writing of the consultation due to be undertaken and engagement undertaken, and for NHS colleagues to take feedback from councillors on further engagement opportunities.

7. COMMUNITY DIAGNOSTIC CENTRES

7.1 Dr Amrish Mehta (Clinical Director Imaging, NWL & London, Imperial College Healthcare) introduced the item and ran through the slides of a powerpoint presentation. The proposals being presented to the Committee were to establish 3 new Community Diagnostic Centres (CDCs) across NWL over the next three years. The main hub would be a large facility located in the existing maternity building at Ealing Hospital, with 2 other 'Spoke' facilities at Wembley Centre for Health and Care and Willesden Centre for Health and Care. The facilities would provide a range of diagnostic tests including MRIs, CTs, X-rays and ultrasounds, as well as blood tests and cardio-respiratory tests. In presenting the item, the following key points were highlighted:

- The work was based on a national programme funded from NHSE which needed incredible pace to be delivered due to the substantial national diagnostic challenge experienced across all specialties. There was a need for increased capacity, closer to the community, which is what the programme aimed to provide.
- There were a number of aims for the CDCs, including to provide additional capacity that would be easier to access for a large population of NWL, and retention of patient choice (acute services would still be delivering diagnostic services as usual). A focus was also to improve access for those communities that traditionally experienced poorer access, driving health inequalities and poorer outcomes.
- The Committee were reassured that the governance process that officers had been through to get to the preferred choices had been thorough, taking into account a range of potential sites in excess of 60 locations, which included NHS sites, community sites, acute sites and commercial sites.
- The travel analysis had shown that, by siting facilities in key areas of deprivation, NWL could improve access in deprived communities, as well as NWL generally. Areas highlighted in red in the presentation would still retain full access to their existing sites as part of a holistic approach to diagnostics in NWL, of which the CDCs were a component. The CDCs would be fully integrated both digitally and in terms of pathways with acute sites. This would mean the referral process, appointment process and reporting process would be fully integrated and patients and clinicians would not notice a difference.
- Projections predicted 300,000 additional tests could be provided by the end of the 3rd year of the programme.
- Engagement and partnership was highlighted as important and initial engagement had taken place at a London level. The outcomes of that initial engagement had helped shape the programme within London and NWL, and would help shape how the programme would conduct its engagement with the population of NWL going forward.

The Chair thanked colleagues for their introduction and invited comments and questions from the Committee, with the following raised:

7.2 The Committee highlighted the positives; that the proposed CDCs were additional resources; that patients would still have choice; and that the impact on workforce and other diagnostic services had been considered.

7.3 The Committee queried whether Ealing Hospital was the best location for a CDC when the NHSE guidance stated CDCs should be separate from hospitals and placed in local communities. They were positive about a centre being available in Ealing to address health inequalities but had concern that it would be confused by local residents as replacing existing services. NHS colleagues advised that there had been a significant process undertaken for site evaluation, utilising Knight Frank to review public sector NHS estates as well as commercial sites across NWL. This had taken into account access points, as a key point in the Professor Richards report 2021 was around separation between elective and emergency care. The proposals for a CDC at Ealing Hospital would include a separation of existing diagnostic pathways with this additional elective route for planned diagnostics. Separate entrances would be ensured and the CDC would be treated as separate and contained, as an addition to the existing diagnostic services. It was added that the deprivation index had confirmed the need for a diagnostics hub in the Southall area, which Ealing Hospital was in the centre of. In relation to the need for separation, it was highlighted as the responsibility of NHS NWL ICS to ensure signage was appropriate so that the CDC looked and felt different to the services already existing.

7.4 Continuing to discuss appropriate locations for the CDC, members asked whether the St Charles site in Kensington and Chelsea had been considered. Damien Bruty (CDC Senior Programme Manager, NWL ICS) confirmed this site had been on the options list, but the MRI and CT equipment required for CDCs was substantial, and the estate requirements and infrastructure to house that equipment was substantial. The age and condition of the St Charles estate was considered not well conditioned towards the provision of those diagnostics equipment in particular. In response to whether the site may be reconsidered in the future, NHS colleagues advised that future potential options were subject to funding and at the current stage it was only the 3 CDC sites proposed in the paper that were being considered.

7.5 In considering the impact the new CDCs would have, the Committee were advised that some early adopter CDCs had been established on the Ealing and West Middlesex site which had been a big success and improved diagnostic turnaround. It was felt these early sites had been a contributing factor to NWL being the fastest to recover from the elective and diagnostic backlog across London. In addition, patients reported liking the service in surveys and staff reported enjoying working in these settings, which was a particular positive given staffing for these additional facilities was a key risk of the programme.

7.6 In relation to the 6 aims outlined in the paper, the Committee queried how those had been tested and arrived at. They were advised that the aims had been developed from a substantial amount of work at a national level by NHSE, which NHS NWL agreed were the right aims and signed up to them.

7.7 Key risks of the programme were around integration of care and the need to ensure integration was done in an effective way, which would require significant work from primary care and community care colleagues. Another major risk was around the national, regional and local shortage in the diagnostic workforce, and there were a number of strategies colleagues were looking at, including new models of care with non-traditional roles available to support the existing workforce. In response to whether there was a risk to A & E, the Committee heard that the additional capacity would help

to disentangle acute and elective services and free up acute services, which would improve capacity in A & E.

7.8 The Committee queried whether there was, or would be, data on comparing the new CDCs with the way diagnostics were currently running, and NHS colleagues highlighted that data was vital. The data on imaging in NWL was the cleanest data across the system and officers would be able to show members the impact on waiting times and the faster diagnosis standard. The programme had detailed 15 year projections modelled for a whole range of scenarios considering demand and capacity across the NWL system.

7.9 The Committee requested reassurance that appointments would be handled fairly and transparently across all boroughs. They were advised that patients would be able to arrange an appointment wherever they liked from a choice perspective, and NWL were testing a national pilot for direct patient booking for imaging tests. This would need to take into account appropriate timings for diagnosis as well as be supplemented with traditional points of access to ensure communities were not digitally excluded from the service.

7.10 Funding would come centrally through the CDC programme from NHSE for both the capital allocation to do enabling work (£44.3m allocated over the 3 financial years) and the revenue allocation of 36m to cover staffing and consumable costs of the service within that same time period.

7.11 The Chair thanked those present for their contributions and drew the item to a close. The Committee were invited to make recommendations with the following RESOLVED:

i) That communications and messaging are clear for local communities; to make the distinction between the new diagnostic hub and existing diagnostic facilities at Ealing Hospital and other Community Diagnostic Centres clear.

ii) That decisions made in regards to community diagnostic centres are made with consideration of new data.

iii) That NHS colleagues help to facilitate site visits to the Ealing Hospital and other Community Diagnostic Centres where appropriate.

iv) That NHS colleagues are invited to relevant borough scrutiny committees.

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

i) To receive in writing the detail of the engagement that has already taken place on this issue.

ii) To receive projections and real time data of centres impact on a number of key performance indicators, and how it will impact local A&E services.

8. **ICS UPDATE**

8.1 Rob Hurd (Chief Executive, North West London Integrated Care System) introduced the report, advising that the new NHS NWL ICS became a legal entity on 1 July 2022 as CCGs were abolished from 30 June 2022. He acknowledged how important the involvement strategy was as this new organisation formed, and highlighted the focus on working with local boroughs and authorities who had local knowledge, in order for

the NHS to change its approach to involvement in the planning, engagement and consultation process of NHS NWL. The aim was to bring more involvement to how NHS NWL did things.

8.2 In becoming an entity, a constitution was required to be published to the public domain. There were certain elements included in the document which were required by legislation but other elements were more flexible and could be amended. NHS NWL were open to working in partnership on those aspects of the constitution and were in discussions with local authorities about that. The overall responsibility for the entity was through the NWL Integrated Care Board (ICB), comprising local authorities, provider trusts and primary care colleagues.

8.3 The main points of the presentation were noted below:

- The tension that the ICS were currently experiencing was that the requirement for decisions to be made at a quick pace where NHS funding was involved could jar with the deep engagement and involvement that might be needed. There was an NHS planning process, requiring annual operating plans and responses to the situations of the day, as well as the need for a long term co-production period with communities to have a long term strategy.

- An event was planned for September 2022 for all partners to start laying out how the ICS might engage and consult to create a new strategy for the whole of NWL, whilst in parallel the NHS planning process went on.

The Chair then invited questions from members of the committee, with issues raised as outlined below:

8.4 The Chair offered thanks to NHS staff who had worked during the heatwave, and asked how services were managing in those circumstances. Rob Hurd advised that, as a health and care system, they had been dealing with challenge after challenge and felt that staff had been remarkable, with the heatwave a further example. Each organisation had a response plan to the heatwave through well-established mechanisms, which took into account the surge in Covid-19 staff sickness. Staff had also been provided with water, ice and ice lollies to try to make working as easy as possible. Hydration stations had been located outside A & E departments for ambulance staff and paramedics had based themselves in A & E departments in order to co-ordinate ambulances better. The Committee were advised that all elements of the system remained under significant pressure and there were record numbers of people turning up in emergency departments. GPs had also seen their workload increase by 30%.

8.5 Councillor Crawford took the opportunity to invite NHS colleagues to a celebration being hosted for Ealing NHS staff on 29 July 2022.

8.6 The Committee asked how the extended access from October 2022 would affect the availability of appointments and whether each primary care network would publish their own enhanced access plan. They were informed that the extended access changes from October 2022 operated within a national framework which was not designed to change or reduce access, and NHS NWL had commitment to improve access. All changes would be communicated at a primary care network (PCN) level. In relation to subcontracted services, they would operate within the same ruleset including protocols for sharing patient records.

8.7 In relation to mental health, the Committee were advised additional staff had been put into primary care through the Additional Role Reimbursement Scheme. NHS colleagues acknowledged that patients were presenting in emergency departments with mental health issues who were often waiting unsatisfactory amounts of time with complex issues. NWL were hosting a summit on the topic of mental health and were doing everything to ensure over the next period capacity was increased. The Committee noted that mental health was a topic on the work programme for later in the year where they could hear a fuller update.

8.8 The Committee queried how the governance structure would work under the new entity and what borough representation would look like. They were advised that the final design of the governance structure was still being finalised with local authorities. The Board currently comprised at least one local authority member from each of the borough based partnerships and a lead Chief Executive. Committee members expressed their disappointment that there would be only one local authority representative from each borough, highlighting a clear desire from communities for local authorities to play a key role in health. Members felt that more local authority involvement might also help the NHS financially if local authorities were aware of issues and spending more capital in the health space. They asked NHS colleagues to evolve to a model that included local authorities at a greater level.

8.9 The Committee also asked about funding going forward, and were advised that NHS NWL had an overall balanced financial position for the year's plan. Longer term there was still a large potential shortfall that needed to be worked together on.

8.10 Considering waiting lists, the Committee were informed that there was nobody waiting more than 2 years for treatment into NWL as of the month of July 2022, but the overall waiting list did continue to grow. Work was being done to ensure that any unmet need was being recognised where people may not be on waiting lists and getting into the right places for care.

8.11 The closure of Western Eye Hospital was also raised by the Committee, who queried whether there had been any tangible impact from the closure. Pippa Nightingale advised that NHS NWL were at the start of a review of ophthalmology that would be brought back to the Committee. Colleagues were aware of the need to speed up access into ophthalmology in NWL and the work would be looked at across the whole patch. Western Eye was operating with some of its services there, while the rest had been relocated to the St Mary's site and Central Middlesex site, meaning NHS NWL were still providing full capacity while improvement works were conducted on the Western Eye site. There would then be a longer term plan for where Western Eye would be in the future.

8.12 The Chair thanked those present for their contributions and drew the item to a close. The Committee were invited to make recommendations with the following RESOLVED:

i) That consideration is given to local authorities having a substantial role in the governance of the NWL ICS.

ii) That a robust plan is developed for tackling current waiting lists in NW London.

iii) That a framework is developed for monitoring performance of subcontractors in primary care.

iv) That a financially focused paper is brought back to this committee for review.

v) That an Integrated Care System's update remains a standing item on each agenda.

9. HEALTH INEQUALITIES FRAMEWORK

9.1 Carolyn Regan (Chief Executive, West London NHS Trust) introduced the update on population health and the work done to address health inequalities across NWL. The national framework for the work had been included in the agenda papers and NHS NWL were building on those. The framework focused on economic factors such as getting more local people into employment in local government, the NHS and third sector organisations and this would be a joint programme of work with councils and directors of public health very actively engaged in the work. Tony Lambert (ICS Executive Director of Strategy and Population Health) added that as NHS NWL was a new organisation they were bringing a new tone to what they did, highlighting the importance of community engagement. The engagement undertaken so far had helped to feed into the inequalities work and engagement moving forward would feed into the overall strategy of NHS NWL. The health inequalities framework acted as a draft to start that discussion with communities and stakeholders, with the aim to run that engagement over autumn to feed into the overall strategy.

The Chair thanked NHS colleagues for the introduction and invited comments and questions from the Committee, with the following issues raised:

9.3 The Committee noted that health inequalities had been discussed for a long time, and wanted to know what would be different about this particular approach. They were advised that with the creation of the Integrated Care Board (ICB) who oversaw NHS NWL, objectives had been created with a very clear strategic framework enshrined into legislation. Three of the four objectives focused on inequalities. There was also flexibility to do things locally and build on what had been done before, with more interest and willingness to act following the Covid-19 pandemic, which had shone a light on inequalities in relation to access and outcomes. The NHS were also able to collect data to identify inequalities in more detail than ever before to understand who were experiencing health inequalities, where they lived, what their characteristics were and more demographic information. In tandem, the NHS would have the ability to see if the interventions that had been put into place to manage inequalities had led to better access and outcomes.

9.4 The Committee queried how NHS colleagues would ensure they were reaching the communities experiencing health inequalities in their engagement. They were advised that this would only be achieved working in partnership with local authorities and local communities and they would need as much help as possible for that. During Covid-19, the NHS had worked very closely with local authorities, Trusts and communications and engagement teams to understand how to better reach difficult corners of the community. They had also worked closely with community groups such as faith based groups, which had been key to working out how to reach people. Rob Hurd (Chief Executive, North West London Integrated Care System) emphasised the intent of the new way of working. In addition, an involvement charter was being developed so that there was a specific approach for how NHS were engaging communities across the sector.

9.5 Regarding the piece of work encouraging people into employment, Carolyn Regan explained that there had been a prior piece of work successfully helping volunteers from vaccination centres into employment in the NHS. There was now further work being done to get local people into work in the NHS and local government, and a separate piece of work focused specifically on helping refugees get into employment

faster, working with third sector organisations. The Committee were encouraged by this work and it was agreed some information on routes to employment would be cascaded to members of the Committee so that it could be disseminated to constituents.

9.6 In relation to work done in schools about employment routes, there had been work done in primary schools recently with a new seasonal campaign, with a character known as 'Aggy the Alien' going into schools. The children and young people's programme had been worked on closely with local authorities. Links had also been established with SEND schools and some people had been offered apprenticeships as a way to get them into employment. More was in the pipeline for this topic.

9.7 The Committee queried whether there were any timelines for the work set out. NHS NWL were putting together a dashboard of metrics and indications of timelines that they could share with the Committee, but it was highlighted that some objectives would see an indication sooner while others would take longer to change.

9.8 The 'raising health observatory' had been involved in developing the framework.

9.9 It was highlighted that examples would be useful in relation to variations of residents getting covid and flu vaccinations. NHS NWL held that data that could be sent to the Committee.

9.10 The Chair thanked those present for their contributions and drew the item to a close. The Committee were invited to make recommendations with the following RESOLVED:

i) That NHS colleagues provide an annual update on health inequalities to monitor progress being made.

ii) That NHS colleagues commit to undertaking processes of benchmarking and utilising best practice in their approach to tackling health inequalities.

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

i) For the Committee to receive the impact dashboard and timescales for implementation for health inequalities framework when available.

ii) For the Committee to receive information on variance between boroughs and wards on flu / COVID vaccination uptake.

iii) For Information to be shared on pathways into NHS employment for volunteers.

10. NWL JHOSC 2022-23 WORK PROGRAMME AND MEETING ARRANGEMENTS

10.1 The Chair introduced the report, explaining that the work programme acted as a live document that would evolve as the Committee went through the year.

10.2 In considering the terms of reference, it was agreed that an updated terms of reference was needed, to be agreed offline and then brought back to Committee to formally agree.

The Committee RESOLVED:

i) To approve the work programme for 2022-23.

9. ANY OTHER URGENT BUSINESS

None.

The meeting concluded at 12.11 pm.
COUNCILLOR KETAN SHETH, CHAIR

Report to the North West London Joint Health Overview Scrutiny Committee

14 September 2022

Report Title:	Primary Care Strategy and Performance, including GP Access

Purpose

To receive a report on the current primary care strategy and performance in relation to North West London.

Background/Context:

Dr Claire Fuller's review into how to improve access for patients to primary care, *Next steps for integrating primary care: Fuller stocktake report*, has been published recently.

The review was commissioned by NHS England and NHS Improvement, with an aim to review what is working well in integrated primary care, why it is working, and how implementation of integrated primary care can be accelerated.

The report sets out a new vision for integrating primary care with improved access, experience and outcomes for communities. The vision is built around three main offers:

- to streamline access for people who get ill but use health services infrequently, providing them with more choice and ensuring care is always available when needed
- to provide proactive and personalised care from multidisciplinary teams for people with complex needs
- to help people stay well for longer with an ambitious and joined-up approach to prevention.

A launch workshop for London ICSs was held on Friday 15th July. A follow-up event is being planned for NW London to be held on Thursday 6th October with all system partners and leaders.

The focus of this workshop will be on the Fuller implementation and will also include a discussion on reducing inequalities in NW London with our system, place and individual commitment to this.

We are inviting participation and expertise from representatives from ICB, Borough based partnerships, PCNs, voluntary sector, PPG chairs, LA councillors, LMC, General Practice, wider Primary Care, System Partners, System Leaders, ICB Programme SROs and Leads etc.

Attached are summary slides that set out the direction of NW London primary care strategy development in the context of implementing the recommendations of the Fuller Report.

Primary Care Performance:

Please see the attached slides that set out the key ICS metrics for primary care and performance against them.

Extended Access

Currently, “extended” access is provided in two ways:

- PCNs deliver extended hours access under the Network Contract Direct Enhanced Service (DES - part of the core GP contracts) at 30 min/1000 population, delivered mostly by member practices; and

- ICB-commissioned extended access services locally, as GP Access Centres or Hubs, across 7 days/week, 8am-8pm cover, 30mins / 1000 population. Many of these services are currently delivered by federations and other at- scale providers, with large variation across the country.

In March 2022, NHSE/I announced a new national Enhanced Access (EA) specification would form part of the Network DES and be delivered by PCNs from 1st October 2022. The funding currently allocated to the existing two routes of delivery will fund the new specification from the same date. The stated aims were:

- aim to remove variability across the country, help improve patient understanding of the service and address inequalities. They will bring the Additional Roles Reimbursement Scheme (ARRS) workforce more consistently into the offer and support PCNs to use the EA capacity for delivering routine services.
- PCNs are able to choose to deliver the service themselves or sub-contract delivery to another provider. Commissioners will help to support any transition of arrangements and planning.
- PCNs have flexibility to use the EA capacity where it is most needed. They will be able to provide a proportion of Enhanced Access outside of EA hours, for example early morning or on a Sunday, if aligns with patient need locally and agreed with the commissioner.
- to help PCNs to have greater control and flexibility over how EA capacity can support them in caring for their patients. These changes aim to maximise the benefit of this capacity.
- ‘Network Standard Hours’ in the new national specification are mandated by NHSE as 18:30-20:00 Monday-Friday and 09:00-17:00 Saturday and PCNs must ensure they provide appointments throughout this period. PCNs can provide additional access outside of these and core hours but it is optional.

The national specification also sets out that

- Each PCN will provide 60 mins per 1,000 patients per week
- PCNs are required to engage with their local population around proposals and submit these by the end of July
- Appointments must be available a minimum of 2 weeks in advance
- Same day online booking for appointments where no triage required until as close to the timeslot as possible
- Offer a mixture of in person face-to-face and remote (telephone, video, online) appointments to full MDT

Much of the provision should be planned care appointments eg. Long term conditions management, screening, meds management, etc.

PCNs had to submit Enhanced Access plans that met the requirements of the national specification by 31st July for validation. There are 45 PCNs but many chose to collaborate in the provision of the Enhanced Access services, meaning there were 29 plans in total covering the total PCN population. Currently 28/29 are compliant, with the remaining PCN proposal receiving support to bring them into compliance.

From the plans submitted the total hours provided in the extended period pre October and from October are shown below:

- Pre-October: 2,509 hours of appointments per week are provided across NWL
- From October: 2,653 hours of appointments per week will be provided across NWL (Increase of 144 hours per week)

Also 30% of PCNs are providing enhanced access outside 'Network Standard Hours' on Sundays, Bank Holidays and Saturday evenings.

One of the required activities PCNs had to undertake in their planning was engagement with patients so feedback could shape provision. To support PCNs, NW London undertook a patient survey and shared the results with each PCN to use in addition to their own engagement activities with their PPGs, local surveys and feedback.

The NW London survey received 14,438 responses from across NWL.
These were broken down, by borough and by PCN, and shared as a starting point for engagement in June.

At the end of this document at **Appendix A** is a summary of the NW London Enhanced Access Patient Survey.

Engagement is expected to continue up to and beyond October both to communicate the new arrangements and how to access them but also to enable regular review and adaptation of provision over time.

Generally, the proportion of face to face versus other forms of consultation continues to increase in NW London, with practices providing 63% of appointments face to face in July, which is above the London average.

For the enhanced access periods we set an expectation that at least 50% of appointments should be face to face which has been confirmed through review of the plans.

Alongside the implementation of the national specification for enhanced access, our winter planning includes measures to strengthen primary care service/access resilience throughout 7 days in addition to other system actions to mitigate pressures on the urgent care system.

<u>Workforce Planning</u>

In NW London, increased recruitment of Additional Reimbursable Roles Scheme (ARRS) workforce who are designed to support the GP in delivering the care required according

to the health needs of the population they serve, by 58% in 2021-22. To further address the national and regional shortages of GPs in NW London, we are working with the London Primary Care School to encourage trainee GPs to remain in NW London via our GP SPIN Fellowships, highlighting our distinctive 'Deep End' Fellowships which support GPs who want to work in areas of high social deprivation. We are also working with our ICB partner organisations to develop portfolio fellowships, to enable us support the wider ICB, via developing GP's who have a wider understanding of the Integrated Care System in which they sit.

To enable us to fully understand the workforce capacity and enable us to target our recruitment activity and develop a NW London workforce model, we are currently working to make the workforce data more robust as part of a wider GP practice engagement programme. This programme highlights the contractual expectations of General Practice with respect to GP workforce data returns, which across NW London has been low. Since the engagement commenced, we have seen an increased submission rate from 49% to 80% in the last data harvest (August). We have also asked NHSE to supply data which is broken down into our eight place based systems (boroughs) as currently the data provided from London region is at an aggregated North West London level. It is imperative for us to analyse the data in relation to specific boroughs. The development of more robust and granular workforce data helps us to understand the recruitment and retention picture and consequently develop targeted support to the various boroughs in light of population health needs and the demographics of the workforce currently in place.

Appendix A

Summary of NWL Enhanced Access Patient Survey

Introduction

In order to support PCNs with their engagement NWL have administered an online survey from 18th May to 12th June 2022.

- 14,438 responses were received from across NWL.
- These have been broken down, by borough and by PCN and shared as a starting point for engagement.

Results

1. When would be best for you to access GP services outside of usual opening hours? (Usual opening hours are 8am – 6.30pm Monday to Friday)	No.	%
Depends when I need help	5634	39%
Saturday	3112	22%
Sunday	602	4%
Weekday evenings	3991	28%
Weekday Mornings	1024	7%
Blank/Don't Know	75	1%

2. How would you prefer to access GP services outside of the usual opening hours?	No.	%
I'm happy with any of these	5813	40%
In person face-to-face	7627	53%
Telephone	649	4%
Video Call	291	2%
Blank/Don't know	58	0%

3. How far would you be willing to travel for a face-to-face appointment outside of usual opening hours?	No.	%
I would be happy to travel 0-1 miles to another local practice (or NHS hub)	1931	13%
I would be happy to travel a bit further 1-2 miles to another practice (or NHS hub)	647	4%
I would be happy with any of these options	4441	31%
I would want to go to my local practice the one I am registered with	7311	51%

Blank/Don't know	108	1%

4. Which practice staff would it be helpful for you to be able access outside of usual practice opening hours?	No.	%
Any health professional appropriate to your needs	7718	53%
GP (doctor) only	3780	26%
GP (doctor) or nurse only	2841	20%
Blank/Don't know	99	1%
5. How would you like to book your appointment in the evening or at the weekend?	**No.**	**%**
Book in yourself through GP online services	4491	31%
Calling 111	252	2%
Calling 111 Book in yourself through GP online services	10	0%
Calling the GP Practice	6986	48%
Calling the GP practice Book in yourself through GP online services	1912	13%
Calling the GP practice Calling 111	138	1%
Calling the GP practice Calling 111 Book in yourself through GP online services	452	3%
Blank/Don't Know	145	1%

Further Considerations

- This survey should be the starting point of engagement and PCNs will be required to demonstrate how the development of their model has been informed by patient engagement.
- The survey results are informative but PCNs must keep in mind that these results will be skewed towards patients that can read and write in English along with those that have access to devices that access the internet and further engagement and the design of the model should take this into account.
- When considering responses to Q1, PCNs should ensure they consider the large cohort of patients that have selected ‘Depends when I need help’ as these patients are likely to welcome a 7-day access model which is currently available and in-line with the NWL principles.

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

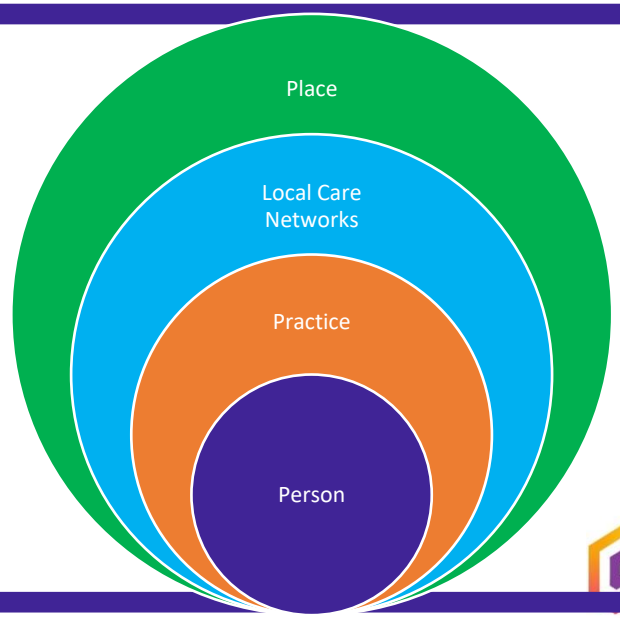
NHS
North West London

Primary Care – Developing NW London Strategy

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

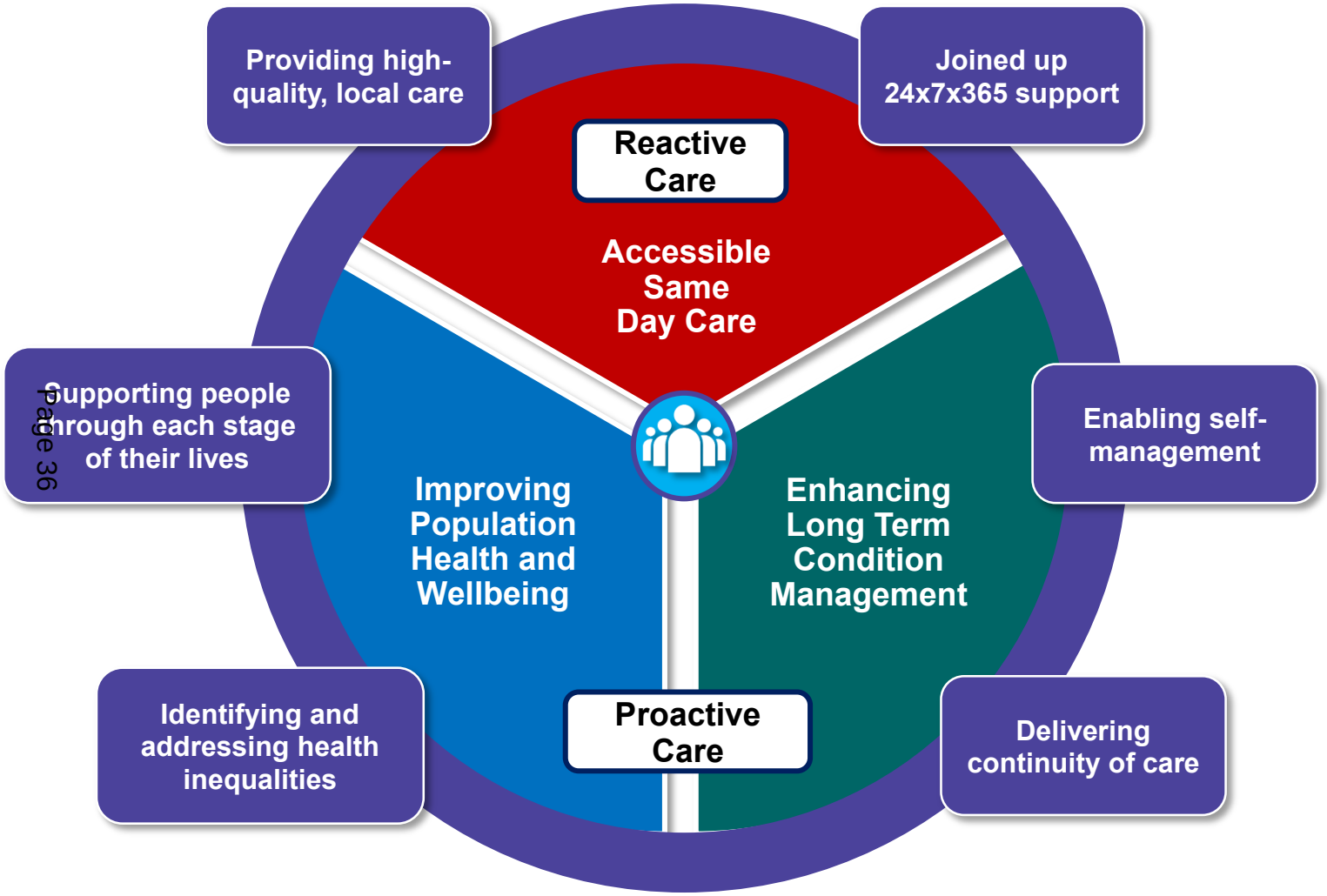
High Quality consistent care delivered in neighbourhoods ensuring equality of outcomes for our residents and our people which make us proud to live and work in NW London

Focused on the needs of the person
Maximising population health interventions
High quality consistent access and care
Meaningful achievement of inequality agenda
Good quality (top decile) outcomes
Delivery appropriate to the type of care required
- continuity when it matters
- convenient when required
Well trained workforce with broad skill mix
Proud neighbourhood teams with sense of belonging
Delivered at a scale that makes sense



North West London Integrated Care System

Primary Care 2022 to 2025
"From reactive to proactive care"



Partnering across:

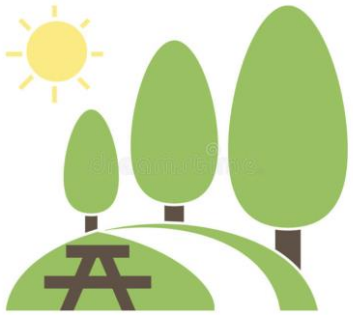
- ✓ GP Practices
- ✓ Primary Care Networks
- ✓ Pharmacies
- ✓ Dental Services
- ✓ Voluntary & Community Sector
- ✓ London Ambulance Service & 111
- ✓ Acute, Community & Mental Health Providers
- ✓ Adult & Children's Social Services
- ✓ Public Health
- ✓ Care Homes
- ✓ Hospices
- ✓ Housing
- ✓ Schools
- ✓ Police
- ✓ …

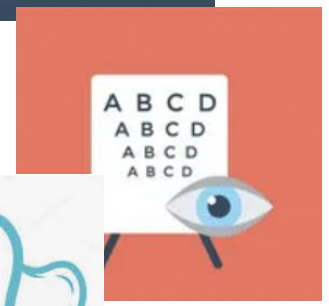
Enabled by:

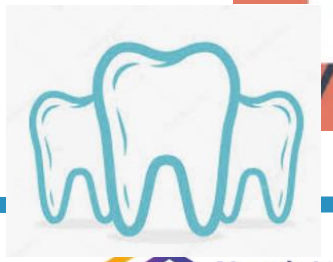
- ✓ Workforce transformation
- ✓ Education and training including hubs
- ✓ Research and innovation
- ✓ Population Health Management
- ✓ Estates & IT
- ✓ Enhanced Access
- ✓ Enhanced Services
- ✓ Digitisation

North West London Integrated Care System

Local Care Networks: agnostic of provider –







North West London Integrated Care System

Predominantly proactive care

Team based care

Continuity when important

Long term conditions blended provision

Clarity of access / one record with exacerbations & anticipatory care

Bringing Fuller to life throughout population cohorts

Clarity of provision after co-design with communities

Recognise unwarranted variation

Driven by data and strategy

Predominantly Reactive care

Episodic care

Digitally open

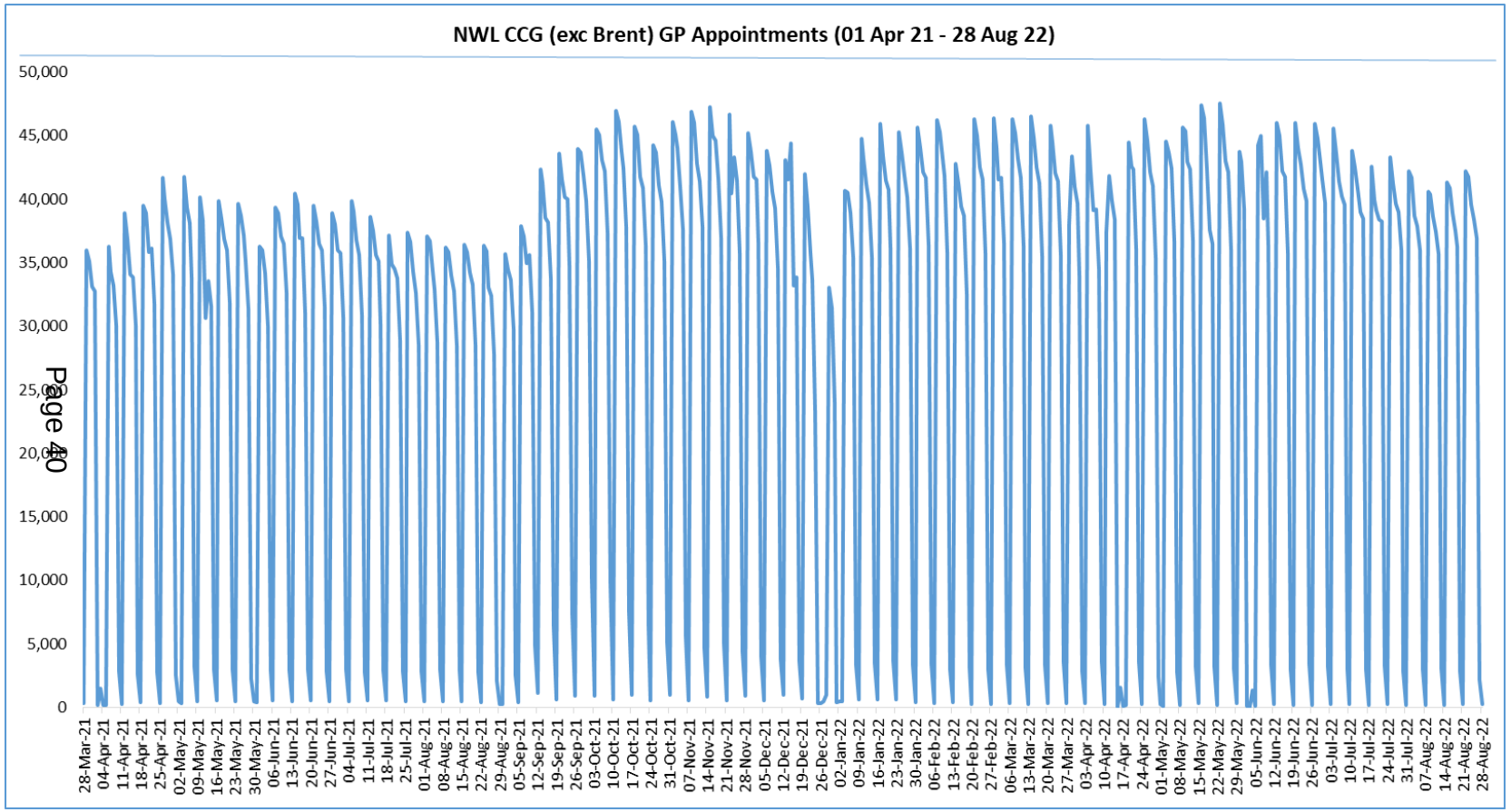
Preventative model – primary & secondary requiring interventions with innovation and through communities

Access relevant to the need

North West London Integrated Care System

Primary Care – Key ICS Metrics

GP appointments available in NW London continue to be above the April 2021 baseline with an additional 21.9% appointments in August 2022.



Month	Finished/Completed GP Appointments (Brent excluded)	NWL Finished/Completed GP Appointments	Estimated NWL GP Appts (inc DNAs)	% Difference
Apr-21	724,405		905,506	Baseline Month
May-21	709,304		886,630	97.9%
Jun-21	814,162		1,017,703	112.4%
Jul-21	780,690		975,863	107.8%
Aug-21	719,477		899,346	99.3%
Sep-21	862,558		1,078,198	119.1%
Oct-21	921,886	1,080,313	1,152,358	127.3%
Nov-21	963,168	1,124,325	1,203,960	133.0%
Dec-21	795,330	937,705	994,163	109.8%
Jan-22	837,587	984,454	1,046,984	115.6%
Feb-22	842,937	988,119	1,053,671	116.4%
Mar-22	973,346	1,142,415	1,216,683	134.4%
Apr-22	782,463	935,277	978,079	108.0%
May-22	905,772	1,073,586	1,132,215	125.0%
Jun-22	856,858	1,015,675	1,071,073	118.3%
Jul-22	868,541	1,026,797	1,085,676	119.9%
Aug-22	794,696	938,283	993,370	109.7%
Aug-22 Forecast	879,842	1,038,813	1,099,803	121.5%

The *Estimated NWL GP Appointments* includes 25% uplift has applied to *Finished/Completed GP Appointments (Brent excluded)* to account for Brent GP Appointments and DNAs.

Using April 2021 Total GP Appointments as Baseline we have calculated the % difference.

August includes appointments up to the 28th.

The August forecast is a straight line forecast based on the 28 days of data available.

Data excludes Brent
Data Source: S1/EMIS

North West London Integrated Care System

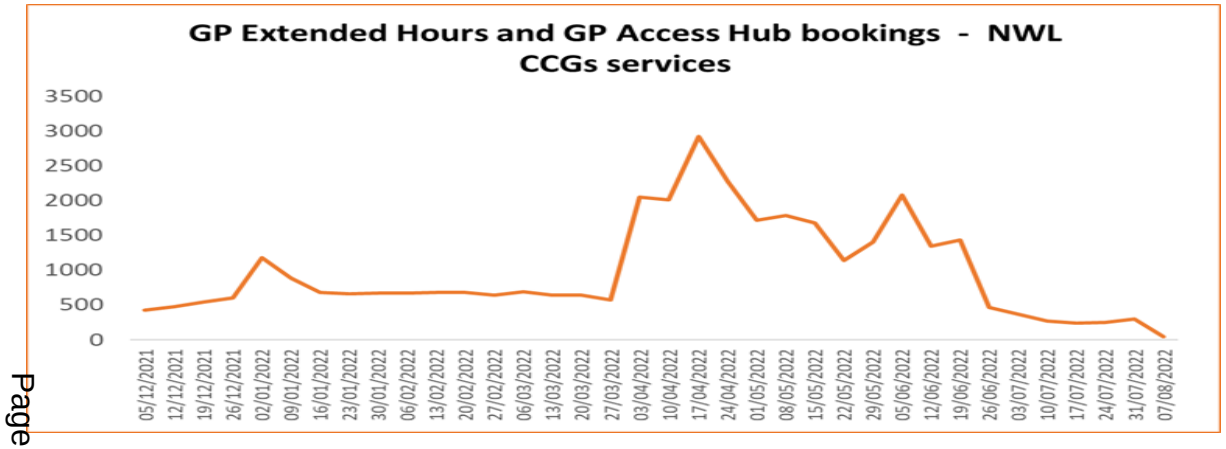
Face to Face GP appointments available in NW London continue to increase in line with the national trend. 63% of appointments in July were face to face, the highest in London.

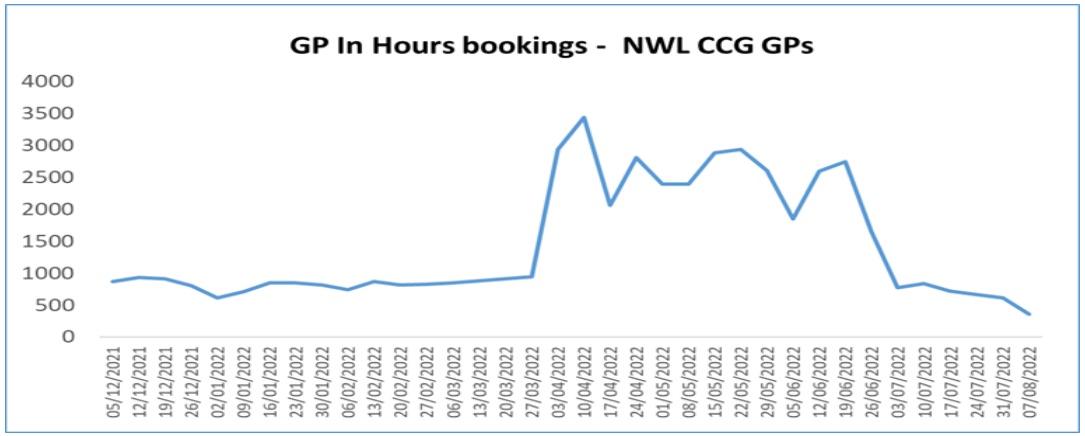
No. of GP Appointments by Borough ('000s)

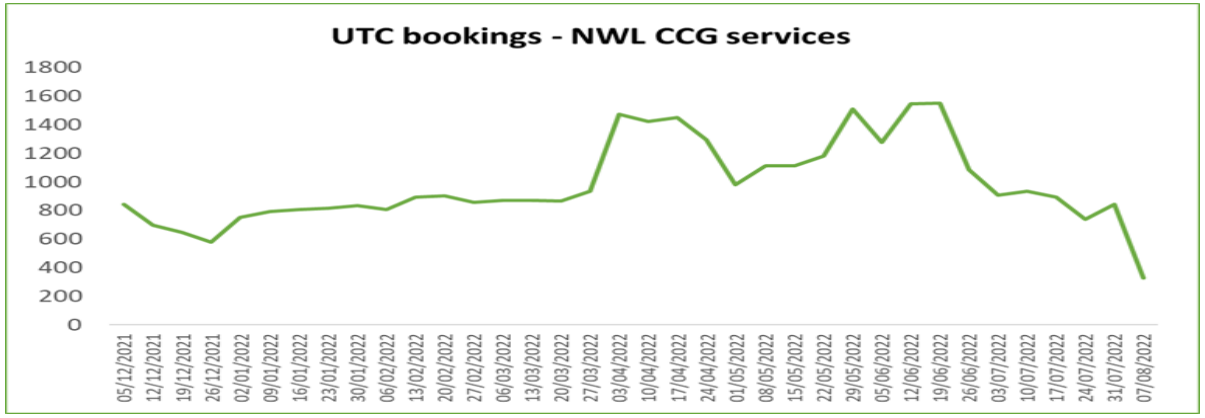
Borough	Virtual / Telephone		Face-to-Face		Total
	#	% of Total	#	% of Total	
Brent*	271	42%	367	58%	**637.70**
Central London	79	22%	279	78%	**358.05**
Ealing	261	35%	490	65%	**750.86**
H&F	112	28%	290	72%	**402.64**
Harrow	139	41%	203	59%	**342.09**
Hillingdon	198	41%	288	59%	**485.75**
Hounslow	176	34%	349	66%	**525.76**
West London	282	51%	266	49%	**548.45**
NWL Total	**1,518**	**37%**	**2,533**	**63%**	**4,051.30**

Data Source: S1/EMIS
*Brent estimated

111 Bookings in NW London reduced in July for GP In Hours and UTC. However 111 Bookings into GP Extended Hours and GP Access Hubs increased slightly, dipping again during August.







111 Bookings report as of 29/05/2022.

North West London Integrated Care System

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Report to the North West London Joint Health Overview Scrutiny Committee

14 September 2022

Report Title:	Emergency Department Pathways & Performance, with London Ambulance Service Performance.
Report Author:	Daniel Heard

Purpose

To provide an overview on performance across North West London (NWL) for Emergency Department (ED) and other Urgent and Emergency Care (UEC) pathways & performance, including the London Ambulance Service (LAS)

Background/Context:

The urgent and emergency care system in NW London is under pressure. Since 2020 demand for UEC services has been highly volatile with low attendance during covid surge periods/national lockdowns and extremely high attendance outside of these times. Demand this summer has matched levels normally seen during winter. 111 services have also seen unprecedented levels of activity.

We are preparing for a winter of further increasing demand and are working in partnership across the system to configure services and pathways in the most effective way possible.

In NW London, as for all areas in England, our approach is in line with the national strategies for UEC, starting with the UEC 10 Point Plan published in 2021. Implementation within NW London includes the following areas:

<u>Supporting 999 and 111</u>

NW London receive the highest number of LAS conveyances in London. Despite having amongst the lowest waits in the region, we have focussed on further reducing handover times to support transferring patients into hospital care quicker and freeing up ambulances to return to the community and attend other emergency calls.

Our trusts work closely with LAS to balancing the conveyance load across the NW London ED sites by prioritising ambulances to less pressured sites.

The Northwick Park site has high volumes as expected given their location. We have been focussing on overall hospital flow and have introduced Hospital Liaison Officers (HLO's) to provide a better interface between the ED and LAS crews, together with a review of site operational efficiency.

The role of Alternative Care Pathways for ambulance services, avoiding conveyance to ED's is also being accelerated. For 111, the main focus has been on a Single Virtual Call Centre, in effect a London wide call handling service that will enable more operational resilience for the 111 services operating in the capital.

<u>Primary care and community health services to help manage UEC demand</u>

Integration across healthcare settings is a particular priority. IT integration to allow direct referring to primary care services is in place and more effective joint working between 111, other UEC services and community services such as Urgent

Community Response has been taken forward. Primary Care has supported ED departments through GP led front door services, with an increasing focus now on seamless access to GP slots by acute referrers.

Use of Urgent Treatment Centres (UTC)

A standard specification for UTC services across NW London has been developed, underpinning a procurement process for those UTC's currently delivered by private sector providers that will put new contract arrangements in place for early 2023. The sector has worked intensively with the main UTC providers to support their resilience, for example integrating triage processes with the onsite ED, and improve front door pathways and redirection processes.

Support for Children and Young People

A higher than usual level of demand for UEC services has been seen within this cohort. NW London has invested in an innovative hospital at home service (PATCH) that is now delivered consistently across all boroughs.

Initiatives to better meet demand for urgent same day care for this group will be a main area in the Fuller Report implementation described below.

Using communications

NW London invested significantly into a communications and engagement approach for the public during winter 2021. A plan for winter 22/23, developed in partnership with local authority and Trust colleagues, is now in place which builds on areas of success in Winter 21/22 and supports key system objectives. Community outreach, social media and online activity as well as more traditional approaches will be used.

Improving in-hospital flow and discharge

The way in which patients are treated following registration at ED is changing rapidly, with the development of Same Day Emergency Care services (SDEC) and the implementation of new operational metrics through the Clinical Review of Standards (CRS).

SDEC services are well developed at NW London's seven acute sites, offering a multidisciplinary (MDT) service to patients who don't require admission but need more time and specialist input than ED can offer. This has taken significant pressure from ED and also reduces the level of short term admissions.

The CRS metrics are replacing the four hours wait in ED standard by improved metrics that better pinpoint operational issues and are less susceptible to being managed by operational practice that doesn't improve real performance.

Alongside this NW London are running a comprehensive self-assessment and peer review process on operational practice in ED and admitted care. The first stage of which will conclude in September and lead into an implementation process that will bring NW London to the top end of recommended practice.

Adult and children's mental health needs

Demand for mental health (MH) services have accelerated across the board during the COVID period and are one of the principle drivers behind long waits in ED.

The sector ran a MH/UEC summit in June, including Local Authority representation, that identified a major action list to improve joint working between acute and mental providers, improve operational and clinical processes and understand capacity and system issues. A joint work programme to address those actions has been agreed.

NWL's UEC programme goes well beyond the areas set out in the 10 Point Plan and anticipates new national strategies currently in development.

<u>High intensity users</u>

Work is underway to support high intensity users who make frequent use of UEC services without necessarily needing the services that they offer. An established service at Charing Cross Hospital has set the bar for working with this patient cohort for some years, with the development of a service for Chelsea & Westminster Hospital underway and a new, ambitious, pilot service in St Mary's Hospital now live. The pilot builds on the Charing Cross model and is integrated across primary and secondary care, voluntary and community services, as well as using data from WSIC dashboard.

Alongside this borough level services are being established or consolidated, providing MDT support for these patients before they reach hospital. The goal is to provide consistent pathways and care across NW London.

<u>Older people</u>

Pathways for frailty, older people, those requiring End of Life Care and those with long term conditions are also under review for UEC, focusing on how improved integration and operational practices will enable patients to get the right intervention more quickly in the right place.

ED Pathways:

The initial point of access at the acute front door is via the UTC reception and streaming nurse, after which patients will be directed to the UTC treatment service, to ED or SDEC. Patients who don't require acute or UTC services can be redirected to primary care.

A number of initiatives are underway in NW London to improve ED pathways:

<u>Supporting patients to access the best service for their needs</u>

We are working to address those patients who don't require acute services but are presenting to hospital sites as this delays care for patients who do require emergency services. However, the process of redirecting back to primary care once patients have made the journey to hospital is complex. Increasing redirection away is supported by direct referral into a specific GP slot in the community, early intervention by a GP or nurse prior to UTC registration and support with GP registration where required. Patient champions are in place at most sites – these are non-clinical staff who can spend more time with patients to understand their reason for presenting, support access to primary care services

and if appropriate support access to non-clinical services. This is supported by ongoing communications and engagement work across the region.

Integration

The long term vision for front door pathways is full digital and operational integration across acute and primary care services, with the UTC at the centre absorbing pressure from ED and working fluidly with primary care. The NW London specification for UTC services has integration at its core and the current procurement process is expected to introduce a new way of working across UEC services.

Same day emergency care (SDEC)

The increasing role of SDEC is vital to support ED pathways by receiving patients who don't require overnight admission but require more investigation, treatment and time, potentially from a range of clinicians than ED can offer. The main focus at present is on extending the clinical pathways and delivery of SDEC, improving referral processes and access and bringing data and reporting up to standard. Direct pathways to SDEC from the LAS and Primary Care are being established along with ensuring that more people are streamed straight to SDEC from the front door. NW London has well established clinical pathways built on previous ambulatory care pathways, has developed new pathways across other medical and surgical area, is moving forward on SDEC pathways for children and will look at the principle of SDEC for frail, older patients.

Alongside SDEC, consideration will take place of role of access to specialty services from the front door and Hot Clinics, one stop, rapid access specialty clinics that can be referred to directly by primary care clinicians. Interaction between primary and secondary care clinicians is increasing through 'advice and guidance' processes that support out-patients services but which can also have an impact on UEC.

Hospital flow

The efficiency of hospital flow is vital for front door pathways to work effectively. Discharge pathways are categorised into Pathway Zero (limited support required for to discharge to Pathways 1-3 (increasing levels of support required for discharge). The latter pathways are supported by the development of Integrated Discharge Teams for each acute site, allied with the ongoing development of more care in the community, including specialist pathways such as Neuro-Rehab and step down provision.

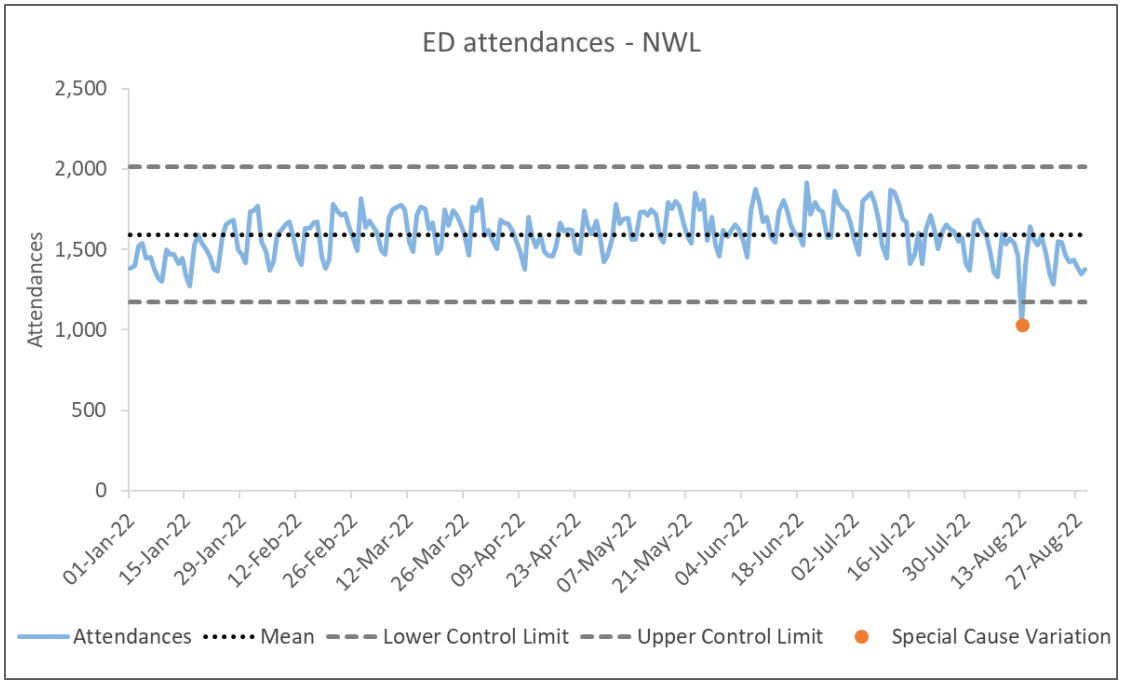
Assessment of Criteria to Reside takes place within weekly discharge performance monitoring to identify the proportion of patients fit for discharge. Over winter the processes for discharge will be supported by increased medical, therapy and pharmacy support, including focussing on more seven day delivery with the goal of achieving discharge rates for Pathway Zero patients that are more consistent with weekend rates.

Re-admissions

Re-admission to hospital rates are monitored alongside discharge performance. Volatility of activity, demand and pathways during COVID has significantly distorted readmissions data as the overall admissions profile changed enormously. It is now expected that the admissions profile will normalise, though the introduction of SDEC services and other pathways also distorts current activity when compared with previous trends. With this factors in mind, understanding readmission rates to validate the effectiveness of the new discharge processes is a priority.

ED Performance:

Demand for all UEC services, including ED, has increased steadily since the Autumn Omicron surge. Although the graph below shows a reduction from late July onwards, activity remains higher than normal for this time of year.



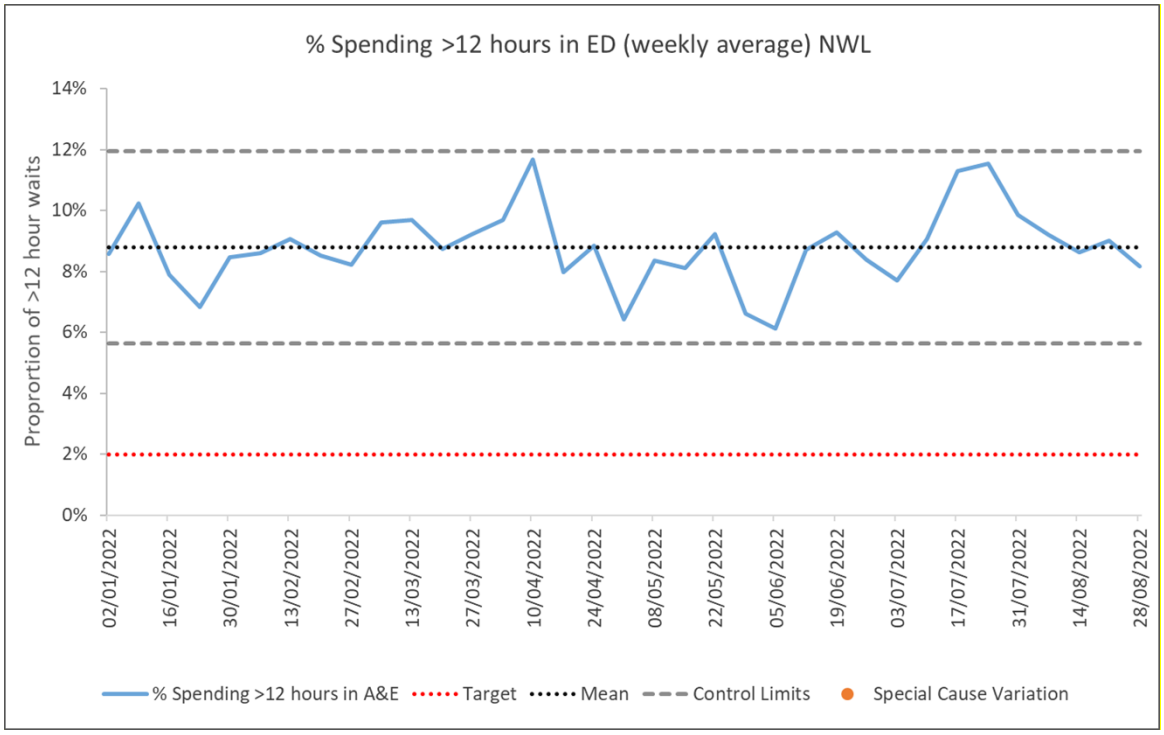
In line with the national direction, NW London has moved to reporting and assessing performance against the CRS metrics, which assess performance against:

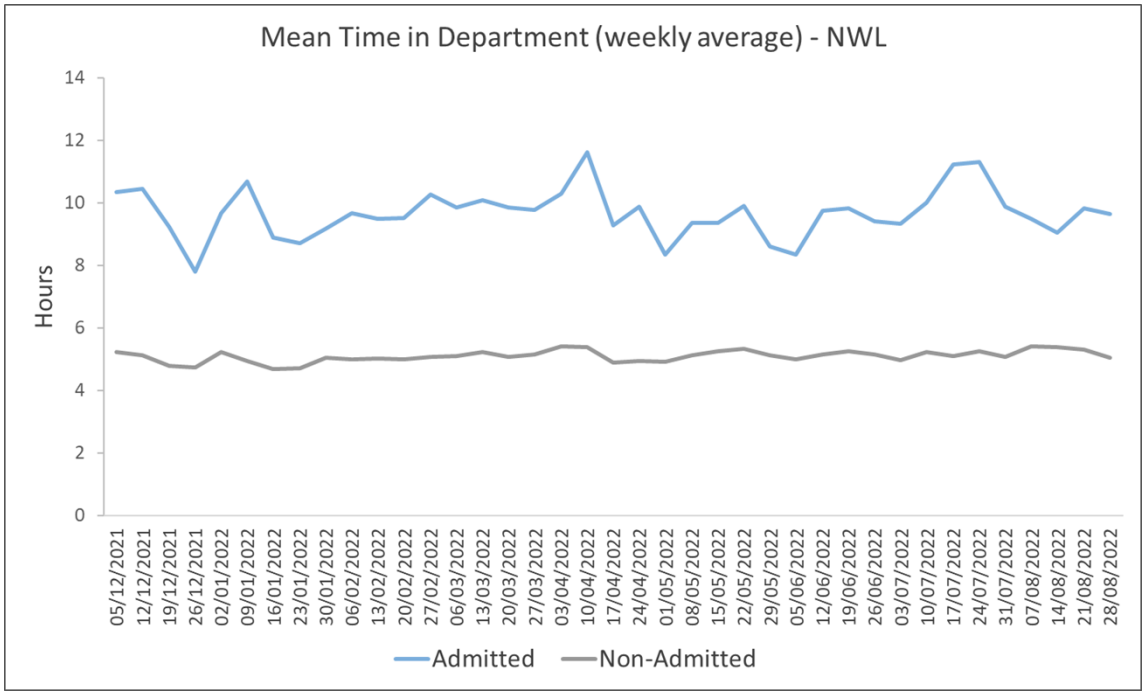
- No more than 2% of patients to be wait 12 hours or more in department
- 95% of Clinical Assessments to be done within 15 minutes of presentation to department
- Discharge from department to take place within 1 hour of a decision that the Patient is 'Clinically ready to Proceed' (CrTP)

Alongside this the sector is monitoring Trust performance against mean time in department for patients and that are admitted and also those that are not admitted. The move to the new standards is supported by the introduction of a new Emergency Care Data Set (ECDS) that also provides much richer data on the patient attendance and journey. These standards and metrics replace reporting against the 4 hour waits in department standard, which was not a reliable indicator of performance or operational efficiency.

Performance against the 12 hours standard is a particular challenge given the higher levels of demand.

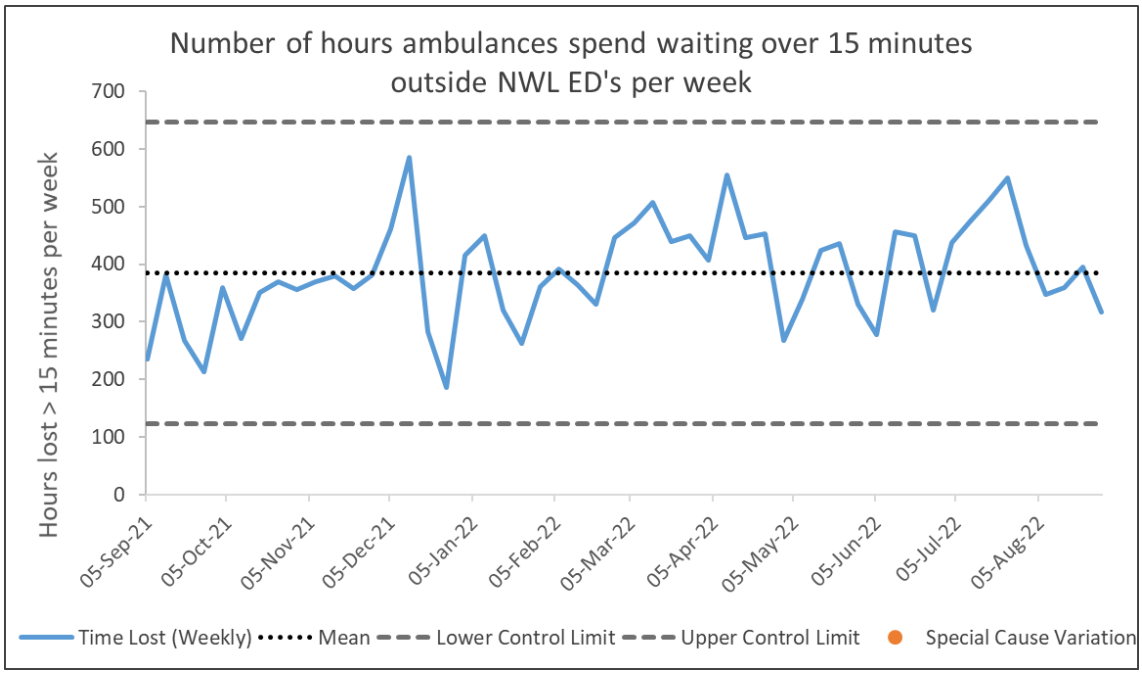
NW London performance is significantly above target, however prior to August, performance improvement was being delivered. Benchmarking against national and regional performance isn't fully available given that processes for the new standards are bedding in, however indications are that NW London performance is better or consistent with other systems. Long waits within ED are currently a widespread issue.





Performance challenges exist for both admitted and non-admitted pathways; increases in presentations by patients in crisis with mental health conditions; and ambulance handovers. Actions to address these challenges are highlighted earlier in this paper.

The key metric for ambulance handovers is the number of hours that ambulances are waiting in total outside of department on a daily basis, moving away from reporting breaches against the 15, 30 and 60 minutes waits targets. Despite the high number of conveyances that NW London receives, it's performance is less challenged than other sectors though there is still concern about the degree of waits outside ED's.



Operational performance is being better understood through the implementation of a Self-Assessment and Peer Review process. This is based on two key national documents that set out best clinical and operational best practice for ED's and admitted care. They assess internal working practices but also how sites integrate with non-acute services and the deployment of innovative as well as good, standard practice. Staffing levels, including recruitment, retention and training practices are incorporated within this assessment process. The findings will be reviewed at sector level in September, with system wide actions rolled out to address gaps and issues from that point.

London Ambulance Service Performance:

See separate paper.

Next Steps:

There are areas of work identified in this paper which the Committee may wish to return to in future meetings, specifically the progress of the UTC procurement and our post-winter performance evaluation.

London Ambulance Service
NHS Trust

London Ambulance Service report to the North West London Joint Health Overview and Scrutiny Committee

Request for update on the following:

- *Detail the internal and external targets within the LAS and set out how well the service is currently performing against these.*
- *Outline how the LAS is currently performing against the 11 clinical quality indicators, compare this to the national average.*
- *Reference the CQC report of 2020, outline the plans for moving the service from 'good' to 'outstanding'.*
- *Highlight how the LAS is performing against its public sector apprenticeship targets.*

The Service's performance against targets

Despite ongoing pressure on our services this year, throughout 2022, our Category 1 response rate (for our most seriously ill patients) across London has regularly been the best in the country (of 10 ambulance trusts) and within the 7 minute nationally set standard (mean). Our Category 3 response rate has also regularly been among the best performing trusts nationally and within the two hour standard. However, we recognise that we have to do more to bring our response time down further for our Category 2 incidents, and have a number of measures in place to try and reduce this. We have seen sustained demand on our 999 and 111 services this year, with the volume of calls received and answered at our emergency operations centres growing across most months.

London Ambulance Service response time by incident category 2022:

Month	CAT1			CAT2			CAT3		
	LAS mean (0:07:00 target)	National ranking	England average	LAS mean (0:18:00 target)	National ranking	England average	LAS mean (2 hour target)	National ranking	England average
January	0:06:37	1	0:08:31	0:34:56	7	0:38:04	1:35:45	5	1:56:52
February	0:06:44	2	0:08:51	0:37:31	9	0:42:07	1:48:20	4	2:16:13
March	0:07:13	2	0:09:35	0:50:57	5	1:01:05	2:08:36	3	3:28:12
April	0:06:40	1	0:09:02	0:37:49	4	0:51:22	1:31:53	2	2:38:41
May	0:07:00	2	0:08:36	0:41:45	8	0:39:58	1:46:16	4	2:09:32
June	0:07:33	1	0:09:06	0:55:44	8	0:51:38	2:08:52	2	2:53:54
July	0:08:03	1	0:09:35	1:01:10	8	0:59:07	2:08:20	2	3:17:06

Source: NHS England

North West London – London Ambulance Service response times by incident category 2022:

Month	CAT1	CAT2	CAT3
January	0:06:08	0:33:33	1:37:27
February	0:06:19	0:39:00	1:49:12
March	0:06:49	0:46:21	1:58:09
April	0:06:13	0:33:39	1:22:28
May	0:06:33	0:40:43	1:44:04
June	0:07:26	1:00:01	2:14:53
July	0:07:38	0:59:52	2:11:23

The Service's performance against the 11 clinical quality indicators

We detail performance against the national clinical quality indicators in our comprehensive Integrated Performance Report, which is regularly published online as part of our Trust Board meeting papers.

Our latest Integrated Performance Report is included in our Trust Board meeting papers from May 2022, covering performance against key standards for the 12 months to March 2022.

How the Service plans to move from 'good' to 'outstanding' in its next Care Quality Commission report

In 2020/21, we set 10 quality priorities for the financial year. These priorities were identified as a result of our previous Care Quality Commission inspection, as well as feedback from our stakeholders and internal sources of quality intelligence. Those priorities are:

1. Implementation of the Patient Safety Incident Response Framework as a pioneer in the new process for ambulance trusts across the country
2. Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services such as our Clinical Assessment Service, Clinical Hub and Emergency Clinical Advisory Service
3. Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment, which is protected by policy
4. The Trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation

5. Strengthen our focus on patient and communities engagement and involvement
6. Continued delivery of the clinical strategy
7. Integrating the 999 and 111/ Integrated Urgent Care Clinical Assessment Service systems to provide seamless care for patients regardless of access point
8. Implementing the station/service quality accreditation programme
9. Development of the Trust's Culture Diversity and Inclusion Strategy
10. Continue to invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.

Although we were faced with unprecedented demand as a result of the pandemic, we focussed our efforts and remained committed to delivering on these priorities as we believed they remained fundamental to delivering good quality care. We have made significant progress against all 10 priorities.

Information on how the Service is progressing against each of these is available in our latest Annual Quality Accounts report.

For 2022/23 we developed three quality priorities on which we have focussed our improvement efforts:

- Patient care
- Patient, family and carer experience
- Staff engagement and support.

To shape these priorities around the needs of our patients and staff and volunteers, we undertook engagement sessions with members of the London Ambulance Service Public and Patients Council (which provides a voice for patients in the design, development and delivery of services), operational staff and managers, and held an open survey for our staff. Our progress against these priorities is being monitored and reported on a monthly basis throughout the year to ensure we deliver meaningful improvement on each objective. A full report will be included in the annual Quality Account for 2022/23.

The Service's performance against its public sector apprenticeship targets

Public sector employers had a target to employ at least 2.3% of our staff as new apprentices during the period of 1 April 2021 to 31 March 2022.

At the London Ambulance Service:

- As of 31 March 2022, the percentage of new apprenticeship starts at the Service as a proportion of the total number of new starters was 8%
- We currently have 732 apprentices working at the London Ambulance Service

- 10% of our total members of staff are apprentices.

The Service has an additional 274 people working as Assistant Ambulance Practitioners, a role which also provides on-the-job training. We created this new role during the pandemic, meaning people with no clinical experience could quickly be trained to work on the frontline. Recruits complete a 12-week training programme which includes studying for a level 3 diploma and a blue light driving course before working alongside paramedics on ambulances.

In July 2022, the Service was again named the top NHS employer for apprenticeships in the country in the Department for Education's Top 100 Apprenticeship Employers 2022. The Service is one of only three NHS trusts in the UK to make the rankings. In the list of the top 100, LAS is ranked 25th.

Our apprenticeships training programme received a rating of 'good' from Ofsted following its first inspection in March this year. The full report is available in our May Trust Board meeting papers.

Our approach to apprenticeships forms a crucial part of our ambitious drive to recruit 1,600 new people to the Service this year. The Service's ongoing efforts to significantly boost recruitment and training of our operational workforce is being undertaken to meet increased levels of patient demand across the capital.

We are training our apprentices at state-of-the-art new sites such as our Dockside Education Centre in Newham and Brentside Education Centre, which help us to deliver the highest quality education with the latest technologies. Colleagues completing training for roles such as Assistant Ambulance Practitioner are supported in their training by tools such as our 'simbulances', which recreate the inside of an ambulance to aid learning. Our 'simbulances' are the only ones of their kind in use by an ambulance trust in the country. Simulation rooms in our education centres also provide immersive, virtual training for students, projecting video and sound to fully immerse learners.

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

Community-based specialist palliative care improvement programme

North West London Joint Health Overview Scrutiny Committee

14 September 2022

www.nwlondonics.nhs.uk/get-involved/cspc

Contents

1 Introduction

Working together with residents and the eight local councils in North West London (NW London) it is going to be critical to ensure we best meet the needs of those who require community-based specialist palliative care (CSPC).

The North West London Integrated Care System (NW London ICS) is acutely aware that the ambiguity on the Pembridge Palliative Care Centre inpatient unit is problematic and we need to ensure we reach a clear and sustainable future for services in NW London, whilst developing a new model of care that delivers a safe and clinically high standard service that meets the needs of patients and at the same time and addresses inequalities across NW London.

We are undertaking a NW London exercise so we can learn from good practice across our eight boroughs and meet the ICS objectives around equality of access, experience and outcomes, however within that the specific concerns and needs in each borough are important.

We welcome the chance for a discussion today on these issues. When we come to mutual decisions we need to know they are backed up by robust engagement and that we have worked through the pros and cons transparently.

Key points for NW London

Key points

- A North West London wide steering group has been established that consists of NHS providers, hospices, local authority and resident representatives. Our Issues Paper published in November 2021 sets out the key reasons why we are looking at community-based specialist palliative care and helps us have a conversation on what future care could look like.
- There are some things that we have found that needed to be addressed immediately. We found not all boroughs had the same level of in and out of hours' access to end of life care and anticipatory medication. The gap was closed by commissioning an equivalent service which meant that during the pandemic all NW London residents have equal access to these medications 24 hours a day.
- An interim engagement outcome report was published on Thursday 9 June 2022 which contained all the feedback given following discussions with local residents and those who have first-hand experience of palliative and end of life care received in NW London. A number of borough specific engagement events have continued after publication, and a final paper will summarise all engagement activity.
- The outcome report was sent to stakeholders across NW London including council and NHS leadership, MPs and Healthwatch. We also used our established channels to communicate with other stakeholders and North West London residents. A short video was produced to accompany the launch and a newsletter that has been distributed widely.
- All the public feedback received is currently being used by our CSPC model of care working group, which is responsible for designing, planning and recommending the 'must haves' and options for the future model of care for adult community-based specialist palliative care to the steering group.

- Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. The group has been asked to:
    - agree a common specification / common core offer for community-based specialist palliative care.
    - develop a new model of care to deliver the specification / common core offer.
    - map out how this can be implemented in each borough.
- The work will draw on the national service specification for adult palliative and end of life care, the previous NW London 4 CCGS palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.
- The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing in view of their local context and population needs.
- We will work with the Health & Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.
- Moving forward, our expectation is that there will be wide ranging resident and stakeholder involvement throughout this process. If significant service change is proposed, we would undertake a formal consultation.
- The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate.
- Along with a number of unsuccessful attempts to recruit consultants, we have sought to work across the system to 'network' consultants in hospitals and hospices to support reopening Pembridge beds, but have not been able to develop a clinically supported model to do that – this challenge is underpinned by a national workforce shortage.
- In April 2020, the inpatient beds at Pembridge were temporarily re-designated for the for rehabilitation of Covid positive patients. We were able to staff the service – which was not consultant led- because we had national guidance to pause many other services. It is unlikely that Pembridge will be required to fulfil this function again due to the knock on impact on those other services.
- We do recognise that local residents are disappointed with the need to suspend this inpatient service and confirm that a decision on the future of the unit will only take place following the completion of the community-based specialist palliative care review that the North West London Integrated Care System is leading and is currently underway.

- We confirm that qualitative factors such as local accessibility and stakeholder views will be an important consideration alongside quantitative factors such as capacity and referrals when making any decisions regarding future provision of community-based specialist palliative care service in NW London including the future of the Pembridge in-patient beds.

We share with all North West London Councils and residents a focus on palliative care because of the importance of getting care and service provision right

> ""We have seen what a difference specialist palliative care services can make to a patient and their families and carers as they come to the end of their life but unfortunately we have seen what can happen if the care and support is not there and the damaging legacy for those left behind. That is why it's important that we work together to develop services that are clinically to a high standard but also meet what patients and family's need."
>
> **Dr Lyndsey Williams,**
> **NW London GP Clinical Lead for End of Life and Care Homes**

It is widely recognised that when caring for someone in the last year of their life, we have only one chance to get it right.

Anyone at the end of their life should be able to live and be cared for where they want to be and be with the people they want to be with. They (and their family, loved ones and carers) deserve the best quality care and support, regardless of their circumstances. We live in a rapidly ageing society, where people are living longer but are more likely to live with multiple complex long term conditions. As a result, the need for high-quality palliative and end-of-life care is expected to increase dramatically by 2040.

> "We need to remember how scattered families can be and how people in theory would often like to think of dying at home, and so would their families. But the reality and the lack of properly seamless care means that it becomes an impossibility or can lead to a very, very negative death. The repercussions upon individuals of experiencing negative death of somebody they care about go on to have psychological and other repercussions throughout their lives."
>
> **Quote from member of the public attending the engagement event on 13 December 2021**

Too many people experience poor care as they approach the end of their life, with many people spending their last months and weeks in hospital, often dying there, which may not be what they want. Not only can this be distressing for the patient and their loved ones, but it also adds more pressure on acute hospitals.

Palliative and end-of-life care is a national priority, as well as a priority for health and social care partners across North West London. In North West London we have some excellent palliative and end-of-life care services for adults (aged 18 and over), provided by very committed partner organisations, but we know that we need to improve the care we provide in hospitals, community settings (such as hospices and day centres), primary-care settings and patients' own homes. We want to make sure all patients have equal access to accessible, consistent, high-quality care across all palliative and end-of-life care services.

More also needs to be done to make sure the care provided by different organisations is more joined up. This includes looking at the IT challenge of not all services having appropriate access to clinical information held electronically by partner providers for patients under their care; and making sure all patients have a personalised care plan that has been agreed with them, and that the plan is available to the different care sectors supporting them and their family.

2 Our focus on community-based specialist palliative care

We are focused on community based specialist care for adults at this stage because of the fragility of those services.

In North West London we have eight community-based specialist palliative care providers delivering services. These include seven hospices with inpatient units, as well as separate community specialist palliative care teams and nursing services provided by community NHS trusts.

The providers deliver a wide range of services across them (including inpatient and community-based specialist palliative care nursing, day hospice, hospice@home, , outpatient services, well-being services and bereavement services, 24/7 specialist advice, rapid response and overnight nursing services) as well as some additional services (including lymphedema and complementary therapies).

Three providers – Central London Community Healthcare NHS Trust, London North West University Healthcare NHS Trust and Central and North West London NHS Foundation Trust – receive all their funding from the NHS. The other five providers are charitable hospices and receive their funding from a combination of NHS and charitable income.

Provider	**Hospice / Community SPC team/ service**	**The NW London boroughs where they provide services**
Royal Trinity Hospice (based in South London)	Royal Trinity Hospice	West London Central London Hammersmith & Fulham
St. John's and Elizabeth's hospital (based in Westminster)	St. John's hospice	West London Central London Hammersmith & Fulham Brent
Marie Curie London	Rapid response and planned variable nursing services	Ealing and Hounslow
Marie Curie London	Marie Curie Hampstead Hospice	Brent
St. Luke's Hospice (based in Harrow)	St. Luke's Hospice – Kenton	Brent and Harrow * North Brent residents receive support from St Luke's Hospice Community Specialist Palliative Care Team. South Brent residents receive support from the Pembridge Palliative Care service's Community Specialist Palliative Care team*
London North West NHS Trust	Meadow House Hospice at Ealing Hospital site	Ealing Hounslow
Harlington Hospice (based in Hillngdon)	Harlington Hospice and Michael Sobell Inpatient Unit at Mount Vernon Hospital	Hillingdon
Central and North West London NHS Trust	Hillingdon Community Specialist Palliative Care Team	Hillingdon

Central and North West London NHS Trust	Your Life line 24 Service	Hillingdon
Central London Community Healthcare NHS Trust (CLCHT)	Pembridge Palliative Care Centre – St Charles Centre for Health and Wellbeing, Kensington & Chelsea *Inpatient unit is currently suspended but all other services in operation*	West London Central London Hammersmith & Fulham Brent
Central London Community Healthcare NHS Trust (CLCHT)	Harrow Community Specialist Palliative Care team	Harrow

The NHS and its partners are committed to making improvements in community-based specialist palliative care for adults within this review process, but will continue to seek to improve other areas of palliative and end-of-life care where possible in parallel.

Beyond this review there are opportunities for improvement across the wider palliative care landscape

We also want to raise awareness of the importance of palliative and end-of-life care in general, and discuss what we want to see in the future from high-quality, safe, community-based specialist palliative care for adults, which also delivers an excellent patient experience. We want to:

- Make sure everyone receives the care they need, when they need it, regardless personal characteristics such as their gender, ethnicity, social standing or where they live (this is known as equity of access), and improve the quality of care our residents and their families and carers receive.
- Improve the experience for our patients, and their families and carers, by developing services that reflect what is important to them at the end of their lives, from diagnosis through to death.

We are not reviewing children's and young people's palliative and end-of-life care services, community nursing which provides generalist palliative and end-of-life care services, or acute hospital services which provide specialist palliative care services.

However, we will be working hard to make sure that our work links closely and joins up with hospital specialist palliative care and all other generalist palliative and end-of-life care services in North West London. We will also work with a number of NW London ICS's other service-improvement initiatives that are already looking to reduce differences in and improve the quality of non-specialist (generalist) palliative and end-of-life care services. This includes the NW London Community Nursing Review and NW London Enhanced Health in Care Homes programme.

Difference between generalist and specialist palliative care

Palliative and end-of-life care can be generalist or specialist. By community-based specialist palliative care services, we mean care and support services that are not provided in an acute hospital, GP surgery or by district nurses or community matrons. Instead, they are provided in a patient's own home, a care home, a hospice, a community hospital or health centre by specially trained multi-disciplinary teams.

Specialist palliative care professionals, such as palliative care doctors, nurse specialists, therapists and psychologists, are experts in providing palliative and end-of-life care and have specific training and experience. They usually become involved in a patient's care to help manage more complex care problems that go beyond the expertise and knowledge of a patient's generalist and usual care team (for example, their GP and district nurses). They work closely with the patient's GP and district nurse to offer advice on controlling pain and managing symptoms, provide emotional and practical support for patients, their loved ones and carers in preparing for the end of their life and, after the patient dies, offer bereavement support to their loved ones.

Generalist palliative and end-of-life care is provided on a day-to-day basis by many health and social care professionals, such as GPs, district nurses, social workers and care home staff. A patient's family and carers can also provide generalist palliative and end-of-life care in the patient's home.

We are starting by ensuring a shared view of the different issues that we are trying to solve

There are eight broad reasons why we need to improve the way we deliver our community-based specialist services to ensure everyone receives the same level of high-quality care, regardless of their circumstances.

1. To build on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.
2. To bring services in line with national policy such as the national Six Ambitions for Palliative and End of Life Care and the NHS triple aim of improving access, quality and sustainability, and to make sure providers our aligned to the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services.
3. To meet patients' changing needs arising from changes in the population. By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.
4. To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.
5. To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care that patients, families and carers across North West London receive. This means that depending on where a patient

life, they and their family and carers may not get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.

6. To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.
7. To cope with the increasing financial challenge, the NHS is facing and the effect this has on community-based specialist palliative care.
8. To reduce the difficulty, we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.

3 Pembridge Palliative Care Service

A number of borough's have a particular interest in the future of Pembridge Palliative Care Service provided by CLCH

When Pembridge inpatient unit was suspended in 2019 we committed to completion of the review prior to any decisions were made on the future of this unit. It is regrettable that the period of time where we have focused on Covid response and recovery has impacted on the timeline for completing this work. Whilst acknowledging the local frustrations on the lack of clarity for the future, we remain committed to do this review properly so there is a clear process and transparency on next steps.

Pembridge Palliative Care services during Covid pandemic waves one and two

As part of a system response to support Covid-19 patients the Pembridge inpatient beds were designated to support the rehabilitation and care of Covid positive patients.

- During the first wave the inpatient unit was opened on 20 April 2020 and closed again on 30 July 2020.
- During the second wave the inpatient unit was opened on 16 November 2020 and closed on 26 March 2021.

Other service elements of the Pembridge Palliative Care Services were operating as follows:

- The community specialist palliative care team continued to offer a 7 day a week service running 8.30am to 5pm Monday to Friday, 9am to 5pm Saturday, Sunday and Bank holidays. The community team were prioritising patients with uncontrolled complex symptoms that have not responded to previous treatments, and actively dying patients with no previous plan of care in place.
- 24/7 advice line including specialist palliative care consultant support.
- Day hospice and patient attendances to the hospice were suspended. Patients known to the service were receiving telephone advice and support from the clinical team.
- The social work and bereavement team suspended visiting and outpatient sessions, but continued to operate, receiving new referrals and providing telephone advice and support.
- The Pembridge teams moved to video conferencing services where possible to further support patient care.

Pembridge Palliative Care service now

The Pembridge Palliative Care Services inpatient unit remains suspended, but the following other services elements continue to be provided:

- Community specialist palliative care nursing team, seven days a week visiting service 8.30am - 5pm Monday to Friday, 9-5 weekends (Saturday and Sunday) and Bank Holidays.
- 24/7 advice line including palliative care consultant support.

- Rehabilitation team support -visiting and virtual from Occupational Therapist (OT), Physiotherapist (PT) and Rehabilitation Assistant five days a week (Monday – Friday).
- Social work and bereavement support, five days' week (Monday –Friday);
- Day Hospice Services Monday – Friday during Covid as many of these services as possible were offered virtually.

NW London ICS End of Life programme team monitors the number of patients who would have been eligible for inpatient care at Pembridge and instead are supported in a different unit. During 21/22 (extrapolated from nine month's data) this was 25 patients. Largely, these patients receive care at St John's Hospice which is part of the St John and St Elizabeth's Hospital and located in St Johns Wood, with a much smaller number at Royal Trinity Hospice. Further work needs to be undertaken to understand if the service closure has resulted in a fall in the number of patients accessing inpatient beds, as well as the impact of Covid-19 across all hospices as a whole.

Over the recent Covid outbreaks our NW London hospices and other community specialist palliative care services have shown considerable flexibility and joint working to provide system support, such as flexing criteria to support discharges. We have consistently had spare bed capacity in NW London hospices (with the exception of a short period during the recent Omicron variant where staff sickness impacted across health and social care services).

In July 2021 prior to relaunching this North West London wide review of community – based specialist palliative care, a number of palliative medicine consultant vacancies arose across three of our palliative care providers, including Pembridge Palliative Care Service, St John's Hospice and Imperial College Healthcare NHS Trust (ICHT). We undertook project work with these providers to review the service requirements for their consultants and how these might be met through new models of consultant service delivery for specialist palliative medicine within community, hospice and hospital domains to ensure a more resilient and sustainable workforce collaboratively. As part of this work we looked to identify if there was, two years on any other potential solutions to the Pembridge consultant workforce challenge to support safe running of the inpatient unit.

Through this work we engaged with a number of NHS Trusts and hospices, both inside and outside of North West London on their consultant models. We learnt that flexibility, rotation between care domains, career progression, being part of clinical network and organizational culture are all important in attracting and retaining consultants. It was also noted that across London and nationally there are palliative care consultant workforce vacancies and shortages, with many organisation struggling to fill and retain these posts.

Despite substantial input from all partners on this work, at that time we could not identify any collaborative solutions that did not destabilise one service to stabilise another. The outcome was that each organisations proceeds to recruit independently to the posts, as the solution would need more dynamic transformation work to address the palliative care workforce challenge, which is not just synonymous to these three organisations. This issue would therefore best be addressed within the North West London wide Community-based specialist palliative care review programme and development of a new model of care, including palliative care workforce.

We reiterate that no decision has been taken on the long-term role of Pembridge and as part of this review the important function that is inpatient palliative care will be addressed. We also recognise the impact this has on individuals and families of those who need to use alternative services elsewhere.

4 Building on feedback previous done

We must build on feedback previously given – valuing people's time and views, by showing progress where ever possible

When we talked to people about community-based specialist palliative care services previously, we heard what a crucial role the services play. The feedback confirmed that people really value their local specialist services and people with experience of these services are very positive about the care they have received.

We have also heard that services need to be made available to more people 24 hours a day, particularly that out-of-hours services (those provided between 5pm and 9am) need improving to make them more inclusive and adaptable, and to offer more choice and be more co-ordinated. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice or in hospital. It is also important that people don't have to travel too far to access service.

> Mum wanted to die at home and was told that there were drugs that would be needed and they'd arrange for these to be prescribed. I then got a call from the palliative care team the next day to tell me they'd sent the prescription to mums nominated chemist. When I got there, I was told one item wasn't in stock and they'd order it. When I got outside I realised it was the pain relief which is what I needed the most and I had to run around trying to get it."
>
> **Example from a bereaved resident on the challenges of integrated care**

The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it. We also want to fully understand the role culture and religion can play in influencing the way people relate to their health, the support they want to receive and the way they experience loss and grief. We will then use this insight to develop services that can take this into account.

5 Next steps

We cannot resolve the current situation and issues unless we work in partnership with residents and other stakeholders –we welcome North West London Council's support to do this

We want to work with local residents, clinicians and partners from volunteer, community and faith organisations to jointly identify and decide what high-quality community-based specialist palliative care looks like. We will then develop a new model of care for our community-based specialist palliative care provision that broadly defines the way that services are delivered, in a way that can be maintained, is culturally sensitive and better meets our diverse population's needs. The new model of care must be affordable and financially sustainable in the short and long term and will be delivered across the whole of North West London to make sure that everyone receives the same consistent high standard of care.

This involves a respectful and responsive approach to the health beliefs and practices, and cultural and linguistic needs, of diverse population groups. However, it goes beyond just race or ethnicity and can also refer to characteristics that are protected by the Equality Act, such as a person's age, gender, sexual orientation, disability and religion, and also social exclusion and socio-economic deprivation (deprivation caused by factors such as being unemployed or on a low income, or living in a deprived area), education and geographical location. (For more information, visit www.equalityhumanrights.com/en/equality-act)

When we have completed our research and received everyone's feedback, we will look to develop the model of care that will deliver the high-quality safe and fair care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high-quality model of care, that is not only affordable, but sustainable in in the long term, and to bring forward proposals that set this out.

So, for now, we are not looking at or discussing what current community-based specialist palliative care services look like or what their future should be, or how many beds we need in a community setting. That will come in due course when we have agreed what good-quality care looks like and the model of care we need to develop in order to provide it.

In summary, we are having a conversation about what we need to do to improve the quality of care our residents and their families and carers receive when they need community-based specialist palliative care.

From this starting position, we want to work with patients, clinicians and the wider community to develop and introduce a new model of care which is fairer, more joined up, high quality and can be maintained in the long term. It must also meet the clinical and individual needs of patients from diagnosis through to the end of their life, and reflect the choices that people want to make on the care they receive and where they receive it.

6 Insight report

We understand it is really frustrating for people to provide feedback, not see any action, and then be asked again for their views

We have received a tremendous amount of feedback which we are responding to and have taken to date. There are also some areas we are currently developing and implementing or propose to do in partnership, to address the issues raised to support improved care and support for patients, families and carers in the last phase of life. We also detail feedback received where we do not feel able to take action, with the reason for that given.

Our aim is to continue to work collaboratively with our public, patients, clinicians and other system partners to build on this work as it is a key part of the next phase of this programme when we look to explore the model of care and service design options to meet our NW London population's community-based specialist palliative care service's needs.

Feedback	Action taken
• Align GPs more closely with individual care homes and develop enhanced care service for care home residents. • This needs to include the development of personalised care plans to support their care needs and expressed wishes and involve relevant health professionals and the families and carers in these care planning conversations in as much as possible.	• As part of the PCN Direct Enhanced Service (DES) all care homes in NW London have a named GP and where possible are aligned to a single PCN. We are currently working on developing a NW London wide common core standard that will provide enhanced support to care homes and cover the provision of Multi-Disciplinary Team (MDT) working and personalised care and support planning. This includes advance care planning and use of Coordinate my Care/Urgent Care Plan.
• Increased access to end of life and anticipatory medication in the community. Community Pharmacists should be included in the engagement and review process to understand the issue of availability and timely access to end of life medication for patients, families / carers and clinicians in the community.	• Not all boroughs had the same level of in and out of hours' access to end of life care and anticipatory medication. The gap in West London, Central London and Hammersmith & Fulham boroughs was closed by commissioning an equivalent service meaning that during the pandemic all NW London residents have equal access to these medications 24 hours a day. The NW London Medicines Management Team have recently reviewed the service contracts and are putting plans in place to ensure ongoing 24-hour access to end of

	life and anticipatory medications in the community. • NW London has implemented the Pan-London Symptom Control Medicines Authorisation and Administration (MAAR) Chart, developed by the End of Life Care Clinical Network . This MAAR chart supports safe administration of complex injectable regimens.
Feedback	**Action being take**
• Include clinicians in public engagement meetings and patients in programme working groups for the purpose of transparency and trust.	• During the previous review of palliative care that took place in Brent, Hammersmith & Fulham, Kensington & Chelsea's and Westminster in 2020, we had a clinical reference group who worked on development of the new model of care and options. We did not have any public and patient representation on this group. For this programme we have developed a model of care working group that will have public, clinical and operational lead representatives.
• Access to 24/7 end of life care advice and support for patients, families, carers and clinicians, which includes a single point of access and co-ordination service. This is of particular importance during the out of hours period between 5pm and 8am when the patient may be experiencing a lot of pain and the family and carer may not be able to contact the usual care team or know which services to contact for support.	• All of the hospices that provide services in NW London now provide 24/7 nurse led advice lines that have 24/7 palliative care consultant support. • A further gap was identified for the Harrow Community Specialist Palliative Care team who did not have seven day working and visiting available. We have secured funding to support the development of this service and work is underway to mobilise this as soon as possible.
Feedback	**Action we propose to take**
• Having hospice inpatient services locally is very important, particularly for residents where the spouse, carer and family of the patient requiring hospice inpatient care is elderly or has family and work commitments and are negatively impacted by increased travelling time. Consideration should be given to re-opening the Pembridge inpatient service as part of the service review.	• This programme will be reviewing the role specialist palliative care inpatient beds play in community-based specialist palliative care provision so that we understand the level of need and capacity required across NW London using data to support this work. Discussions about the level of need and sites will happen at a later stage in the review once the new model of care has been developed.
• Not enough support available or consistent offer of bereavement	• Bereavement care and support really came to the fore as a gap

support (pre and post death) available to patients, families and carers. Could this reviewed as part of the latest programme of work to understand current provision and what more could be done to improve this offer.	nationally, regionally and locally during the Covid-pandemic. Through the community-based specialist palliative care review programme we will be scoping current provision and gaps for NW London which will then be considered as part of the new model of care development work.
Feedback	**Reason why we are not able to take action at this stage**
• We have heard from local residents and stakeholders that they would like the NHS to reopen the Pembridge Palliative Care Unit in-patient beds.	• The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. • It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate. • In April 2020, the inpatient beds at Pembridge were temporarily re-designated for the for rehabilitation of Covid positive patients. We were able to staff the service – which was not consultant led- because we had national guidance to pause many other services. It is unlikely that Pembridge will be required to fulfil this function again due to the knock on impact on those other services. • We do recognise that local residents are disappointed with the need to suspend this inpatient service and confirm that a decision on the future of the unit will only take place following the completion of the

	community-based specialist palliative care review that the North West London Integrated Care System is leading and is currently underway. • We confirm that qualitative factors such as local accessibility and stakeholder views will be an important consideration alongside quantitative factors such as capacity and referrals when making any decisions regarding future provision of community-based specialist palliative care service in NW London including the future of the Pembridge in-patient beds.

Moving forward, we will continue to update the Insight Report and the actions we have taken as a result. You can find the most up to date Insight Report here.

7 Demographics of Community-based Specialist Palliative Care services users for NW London

Overview of the data

From the outset it is important to articulate transparently that palliative and end of life data availability and reliability are a challenge. The data we have comes from multiple sources and there is no national data set. There is also a wide variation in what data our providers collect and how they do this, so we do not have an overarching view of the provider data. This is particularly true for patient/service user demographic data. We do however have some elements of data, alongside the feedback from our residents and our different communities, that can help inform our new model of care. One of the priorities of the Community-based specialist palliative care (CSPC) review programme work is to ensure a common data set, that includes demographics, across all our providers. A longer term goal of the last phase of life programme is also to have all the data joined up and in one place.

The CSPC review programme is currently developing our future model of care, looking at current service activity data across all care domains, the data available on numbers of deaths in NW London and any demographic information related to these deaths, as well as the workforce we currently have in our community specialist teams. This will involve review of any other demographic data available about the NW London population. In conjunction with a review of the literature around capacity and ultimately the agreed new model of care and single common offer/ service specification, this work will allow us to articulate what our future services capacity needs to be and see where our resource needs are greatest across NW London.

NHS North West London and this programme is committed to promoting equality and diversity amongst all our staff, stakeholders and patients - fulfilling our obligations under the Equality Act 2010 and the associated guidance from the Equalities and Human Rights Commission. We aim to commission healthcare services that are equitable to everyone regardless of:

- Age
- Disability
- Gender-reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race, ethnicity or national origin
- Religion or belief
- Gender
- Sexual orientation
- Domestic circumstances
- Trade union membership (or non-membership)
- Socio-economic or employment status

We will be fully transparent with this work and share our outputs and recommendations with relevant stakeholders to support decision making.

Mortality data and demographics

We have utilised the mortality data from 2021 to give an indication of where residents who have died by setting of care and the current demographic data that is also available around this.

Figure 1 shows a breakdown of all deaths in North West London by setting. Clearly the majority of people died at hospital, whilst a secondarily large number died at home.

Figure 1: Number of deaths and place of death for 2021 for NW London - split by borough

	Deaths					
Commissioner	Care Home	Home	Hospice	Hospital	Other	Total
Brent	209	622	117	1,141	66	**2,155**
Ealing	300	702	132	1,251	72	**2,457**
Hammersmith and Fulham	119	357	41	496	52	**1,065**
Harrow	197	569	89	921	40	**1,816**
Hillingdon	423	591	110	1,028	58	**2,210**
Hounslow	153	503	69	941	103	**1,769**
West London	107	398	44	606	55	**1,210**
Central London	94	217	64	426	101	**902**
NWL	**1,602**	**3,959**	**666**	**6,810**	**547**	**13,584**

Figure 2: Percentage of deaths in NW London by place of death

	Percentage of Total Deaths				
	Care Home	Home	Hospice	Hospital	Other Places
Brent	10%	29%	5%	53%	3%
Ealing	12%	29%	5%	51%	3%
Hammersmith and Fulham	11%	34%	4%	47%	5%
Harrow	11%	31%	5%	51%	2%
Hillingdon	19%	27%	5%	47%	3%
Hounslow	9%	28%	4%	53%	6%
West London	9%	33%	4%	50%	5%
Central London	10%	24%	7%	47%	11%
NWL	**12%**	**29%**	**5%**	**50%**	**4%**

Figure 3: Health Borough Comparison - Deaths in NW London boroughs by age, gender, deprivation decile, cancer vs non cancer, top 10 causes of death and top 10 countries of birth

Note: A decile is a dimension which places the deprivation scores of individual areas into one of ten groups of equal frequency. The deprivation decile 1 represents the most deprived and deprivation decile 10 represents the least deprived.

Health Borough Comparison

dod_Year: 2021 — <-- Select the filters to change the table below

Place of Death: (All) — Cells highlighted red are greater than the NWL percentages

	Brent	Central London	Ealing	Hammersmith and Fulham	Harrow	Hillingdon	Hounslow	West London	NWL
Age									
<65	23.4%	19.1%	22.1%	24.5%	15.9%	16.8%	21.9%	18.0%	20.2%
65-74	16.6%	16.7%	16.7%	17.4%	15.1%	17.6%	19.2%	16.2%	17.0%
75-84	25.5%	26.4%	28.6%	27.3%	28.0%	27.1%	27.1%	30.4%	27.5%
85+	34.6%	37.8%	32.6%	30.8%	41.0%	38.5%	31.8%	35.4%	35.3%
Gender									
Female	44.6%	47.8%	45.3%	46.7%	49.9%	49.3%	47.3%	44.9%	46.9%
Male	55.4%	52.2%	54.7%	53.3%	50.1%	50.7%	52.7%	55.1%	53.1%
Deprivation									
1	8.6%	19.3%	4.4%	7.5%	0.1%	0.1%	1.0%	15.5%	5.6%
2	14.5%	13.4%	14.8%	13.3%	2.0%	2.7%	10.2%	21.4%	10.9%
3	16.4%	17.5%	19.6%	25.3%	5.5%	21.5%	18.9%	13.5%	17.2%
4	22.5%	11.1%	13.7%	13.8%	6.6%	12.4%	19.0%	10.6%	14.2%
5	15.9%	11.1%	14.9%	13.5%	15.6%	9.2%	19.9%	7.7%	13.9%
6	13.5%	14.6%	14.7%	11.3%	16.4%	12.0%	17.6%	13.2%	14.3%
7	5.3%	9.6%	7.8%	7.8%	19.6%	10.2%	9.7%	11.2%	10.0%
8	2.2%	3.1%	3.6%	4.3%	13.3%	10.2%	3.2%	6.4%	6.0%
9	0.7%	0.2%	6.4%	3.2%	10.2%	13.9%	0.6%	0.6%	5.3%
10	0.2%	0.0%	0.0%	0.0%	10.7%	7.7%	0.0%	0.0%	2.7%
Cancer vs Non-Cancer									
Cancer	23.4%	28.0%	23.0%	23.1%	22.7%	24.7%	21.9%	25.6%	23.7%
Non-Cancer	76.6%	72.0%	77.0%	76.9%	77.3%	75.3%	78.1%	74.4%	76.3%
Top 10 ICD 10 Codes									
Emergency use of U07.1	41.0%	41.2%	36.5%	35.3%	36.2%	37.2%	40.8%	38.1%	38.2%
Chronic ischaemic heart disease,	15.2%	9.7%	10.7%	9.6%	15.2%	8.7%	7.9%	8.7%	11.0%
Unspecified dementia	9.1%	12.4%	11.6%	11.3%	11.2%	11.7%	11.1%	9.0%	10.9%
Malignant neoplasm: Bronchus or	7.1%	11.6%	8.3%	12.0%	8.2%	10.8%	9.7%	12.5%	9.5%
Acute myocardial infarction, unsp	8.7%	6.6%	8.3%	6.6%	9.5%	7.8%	8.5%	8.8%	8.3%
Stroke, not specified as haemorrh	5.2%	4.7%	4.1%	6.4%	5.7%	5.7%	7.1%	5.9%	5.5%
Malignant neoplasm: Breast, unsp	3.5%	5.0%	5.1%	5.4%	4.0%	5.1%	3.2%	5.7%	4.5%
Atherosclerotic heart disease	2.3%	1.9%	5.6%	7.6%	2.5%	5.3%	6.1%	4.1%	4.5%
Pneumonia, unspecified	4.4%	2.8%	5.3%	2.9%	4.6%	2.8%	2.7%	3.1%	3.8%
Alzheimer disease, unspecified	3.5%	4.1%	4.5%	2.9%	2.8%	5.1%	2.8%	4.1%	3.8%
Top 10 Countries of Birth									
England	37.4%	76.6%	51.3%	66.9%	57.3%	76.8%	64.0%	73.7%	61.0%
India	20.3%	3.6%	18.6%	5.4%	16.3%	7.9%	16.8%	3.2%	13.3%
Ireland	13.7%	8.0%	9.2%	13.9%	6.8%	5.6%	4.8%	8.8%	8.4%
Kenya	6.3%	1.4%	3.5%	0.6%	7.9%	1.7%	3.5%	0.6%	3.7%
Jamacia	12.3%	1.0%	2.7%	3.7%	2.2%	0.6%	0.7%	3.2%	3.3%
Pakistan	3.2%	1.0%	3.8%	1.0%	1.6%	1.4%	3.8%	1.3%	2.4%
Scotland	1.1%	4.4%	2.4%	4.0%	1.5%	1.9%	2.0%	4.7%	2.3%
Poland	2.0%	1.3%	4.8%	2.4%	1.1%	0.9%	1.9%	1.6%	2.1%
Sri Lanka	2.7%	0.4%	2.2%	0.6%	4.0%	1.0%	1.1%	0.7%	1.8%
Wales	1.1%	2.2%	1.5%	1.7%	1.3%	2.2%	1.4%	2.1%	1.6%

Figure 2 (above) shows deaths by borough and NW London average split by age, gender, deprivation decile, cancer vs non-cancer, top ten causes of death and top ten countries of origin. We do not have within our data set the ability to split the death data by ethnicity. Where highlighted red this indicates that the proportion is above the NWL average.

For NW London death rates amongst the deciles 3 and 4 are generally higher, but there are boroughs for example Brent and Central London where there is higher level of deaths amongst the most deprived residents compared to other boroughs like Hillingdon where the highest level of deaths is at decile 9. In terms of age, for NW London the highest rate of death is amongst the over 85s whereas for some boroughs,

Brent, Ealing, Hammersmith & Fulham and Hounslow there are a higher proportion of deaths in the under 65s. NW London's average shows a higher proportion of men dying than women. Interestingly for NW London roughly two-thirds (76.3) of deaths are non-cancer related, with Central London borough having a higher rate of cancer deaths than the rest of the boroughs and NW London average.

The bottom of Figure 2 and Figure 3 (below) shows the top 20 countries of birth for those that died in NW London in 2021. This has limitations as there is significant ethnic diversity amongst those born in the UK, however, it does give a level of insight, for example a significant proportion of deaths were amongst the Indian community and also fairly high amongst the Irish and Jamaican community.

Figure 4: top 20 countries of birth

NW London population demographics and health inequalities at a glance[1]

Health inequality is a major problem for North West London People in less well-off areas are more likely to have a disability and/or be living with a long term condition. People from a Black, Asian or other ethnic minority background are more likely to live in less affluent areas, as are people who are less well educated or working in lower paid jobs. People from these populations can find it harder to access healthcare, receive a high quality service and get a good health outcome. They have fewer opportunities for better paid jobs. The Covid-19 pandemic has both increased health inequality in North West London and shone a spotlight on it.

[1] NW_London_ICS_-_Addressing_Inequalities_across_NW_London_July_2022.pdf (nwlondonics.nhs.uk)

North West London has a diverse population of over 2.4 million people across eight London boroughs, comprised of over 173 wards and served by over 470 councillors. We have over 360 GP practices arranged into 46 Primary Care Networks, and 12 hospitals, including two major mental health providers. North West London benefits from a diverse population. More than 50% of the population in some of our boroughs come from a black, asian and other minority ethnic (BAME) background.

Below is an Illustration of some of the key challenges NW London faces

Long term conditions

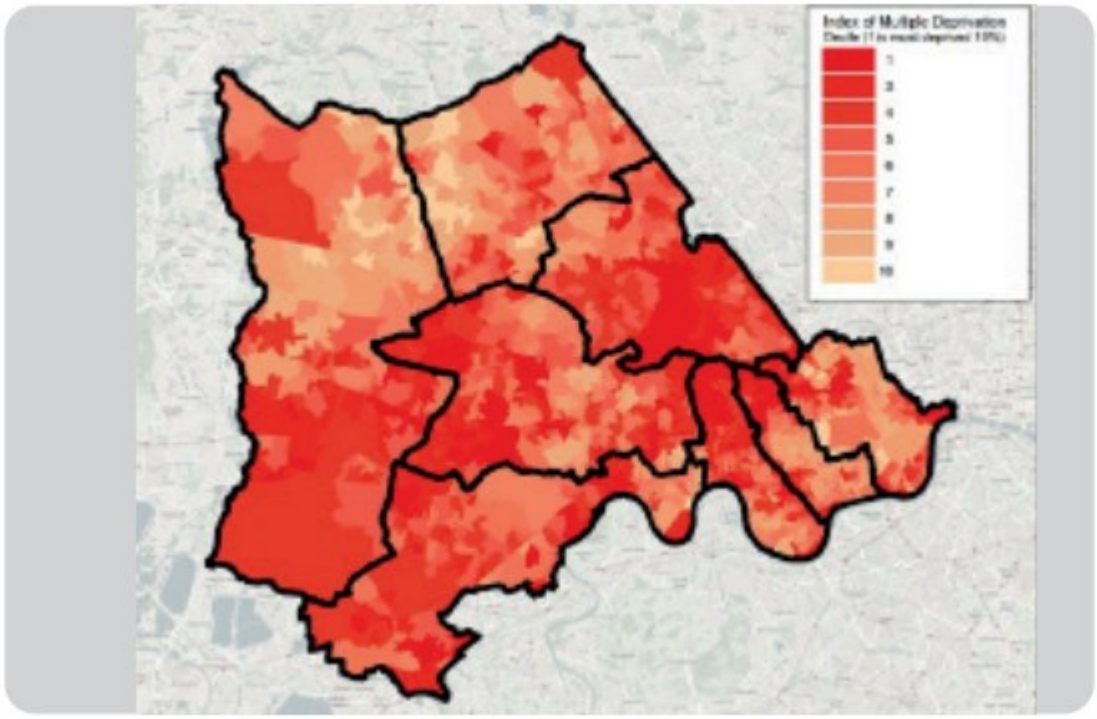
21% One in five (21%) of our population is classed as having complex health needs.

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

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

Hypertension | Diabetes | Obesity | Anxiety and Depression | Sickle Cell

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



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

Figure 5. Unique patient activity for Community-based specialist palliative care services by provider for 2021

	St Luke's Hospice	Marie Curie London	Harlington Hospice including MSH	Royal Trinity Hospice	St John's Hospice	Meadow House Hospice (LNWH)	Pembridge (CLCH)	Harrow CSPC Team (CLCH)	Hillingdon CSPC Team and Your life Line service (CNWL)
Hospice inpatient unit	206	15	181	91	162	307	N/A	N/A	N/A for either service
Community SPC Team	584	N/A	N/A	754	455	1805	1062	499	1,486
Day hospice services (social activities)	0	N/A	N/A	N/A	60	N/A	19	N/A	N/A
Outpatients (Specialist appointments)	29	19	319	N/A (covid)	397	190	N/A	N/A	N/A
Bereavement	49	14	N/A	73	165	156	49	N/A	N/A – separate service
Psychological Support	0	N/A	273	144	279	N/A	N/A	N/A	117
Hopsice@home	230	514	154	N/A	126	N/A	N/A	N/A	N/A
24/7 SPC advice line	1229	N/A	147	169	TBC	Data not available	TBC	N/A	N/A for Hillingdon Community SPC team. Your life line (YLL) 24/7 service has 24/7 advice line offer visits overnight (not daytime) to known patients only – data TBC
Rapid response	108	796	N/A	N/A	N/A	N/A - Marie Curie London provide Rapid Respons e	N/A	N/A	801

Please note for above activity data the way in which the data has been captured is slightly different provider to provider, and the providers have different service configurations and offers so a direct comparison is not advised

The below information is a snapshot example of the patient/service user demographics data that we receive from one of our providers, Royal Trinity Hospice, for services commissioned across three of our boroughs – Central London, Hammersmith & Fulham and West London. As mentioned above we currently do not have this data from all our providers and are work aims to ensure we receive this data consistently and in more detail going forward.

EXAMPLE - ROYAL TRINITY HOSPICE Quarter 4 Report for 2021-2022: Patient information for Central London, Hammersmith & Fulham and West London

Central London Borough - Patient information – Jan – March 2022

Ethnicity

	Q4 All Services		YTD All Services	
	No	%	No	%
Asian/Asian British - Indian	1	1%	1	1%
Asian/Asian British - Pakistani	1	1%	1	1%
Asian/Asian British - Bangladeshi	1	1%	3	2%
Asian/Asian British - Chinese	0	0%	0	0%
Asian/Asian British - Other background	3	4%	4	2%
Black/African/Caribbean/Black - Other background	2	3%	12	7%
Mixed/Multiple - White and Black African	0	0%	0	0%
Mixed/Multiple - White and Asian	0	0%	0	0%
Mixed/Multiple - Other background	1	1%	2	1%
Other ethnic group - Arab	1	1%	3	2%
Other ethnic group - Other background	3	4%	6	3%
White - English/Welsh/Scottish	39	49%	88	49%
White - Irish	1	1%	5	3%
White - Other background	15	19%	28	16%
Not given	11	14%	27	15%

Age

	Q4 All Services		YTD All Services	
	No	%	No	%
19-24	0	0%	0	0%
25-64	14	18%	31	17%
65-74	16	20%	29	16%
75-84	26	33%	46	26%
85+	23	29%	74	41%

Gender

	Q4 All Services		YTD All Services	
	No	%	No	%
Male	33	42%	86	48%
Female	46	58%	94	52%

Diagnosis

	Q4 All Services		YTD All Services	
	No	%	No	%
Cancer	45	57%	99	55%
Non-cancer	34	43%	81	45%

Hammersmith & Fulham Borough Patient information: January – March 2022

Ethnicity

	Q4 All Services		YTD All Services	
	No	%	No	%
Asian/Asian British - Indian	0	0%	0	0%
Asian/Asian British - Pakistani	1	1%	1	0%
Asian/Asian British - Bangladeshi	0	0%	0	0%
Asian/Asian British - Chinese	1	1%	1	0%
Asian/Asian British - Other background	0	0%	8	3%
Black/African/Caribbean/Black - Other background	7	7%	17	7%
Mixed/Multiple - White and Black African	1	1%	1	0%
Mixed/Multiple - White and Asian	0	0%	0	0%
Mixed/Multiple - Other background	2	2%	3	1%
Other ethnic group - Arab	0	0%	2	1%
Other ethnic group - Other background	1	1%	4	2%
White - English/Welsh/Scottish	54	51%	129	52%
White - Irish	8	8%	19	8%
White - Other background	18	17%	33	13%
Not given	13	12%	31	12%

Age

	Q4 All Services		YTD All Services	
	No	%	No	%
19-24	0	0%	0	0%
25-64	27	25%	42	17%
65-74	14	13%	41	16%
75-84	28	26%	78	31%
85+	37	35%	89	36%

Gender

	Q4 All Services		YTD All Services	
	No	%	No	%
Male	45	42%	101	40%
Female	61	58%	149	60%

Diagnosis

	Q4 All Services		YTD All Services	
	No	%	No	%
Cancer	66	62%	163	65%
Non-cancer	40	38%	87	35%

West London Borough - patient information January – March 2022

Ethnicity

	Q4 All Services		YTD All Services	
	No	%	No	%
Asian/Asian British - Indian	3	3%	6	2%
Asian/Asian British - Pakistani	0	0%	1	0%
Asian/Asian British - Bangladeshi	1	1%	1	0%
Asian/Asian British - Chinese	0	0%	1	0%
Asian/Asian British - Other background	3	3%	11	4%
Black/African/Caribbean/Black - Other background	3	3%	6	2%
Mixed/Multiple - White and Black African	1	1%	2	1%
Mixed/Multiple - White and Asian	0	0%	0	0%
Mixed/Multiple - Other background	2	2%	10	4%
Other ethnic group - Arab	1	1%	2	1%
Other ethnic group - Other background	4	4%	14	5%
White - English/Welsh/Scottish	54	51%	130	47%
White - Irish	0	0%	5	2%
White - Other background	15	14%	46	17%
Not given	18	17%	40	15%

Age

	Q4 All Services		YTD All Services	
	No	%	No	%
19-24	0	0%	1	0%
25-64	8	8%	29	11%
65-74	14	13%	32	12%
75-84	27	26%	75	27%
85+	56	53%	138	50%

Gender

	Q4 All Services		YTD All Services	
	No	%	No	%
Male	44	42%	125	45%
Female	61	58%	150	55%

Diagnosis

	Q4 All Services		YTD All Services	
	No	%	No	%
Cancer	54	51%	150	55%
Non-cancer	51	49%	125	45%

8 Engagement

We have arranged a number of events and webinars, attended external meetings and arranged numerous one on one interviews with local residents and representatives of the voluntary, community and faith sectors. This engagement will continue throughout the length of the review.

The table below detail the engagement activity that has taken place.

Event	Boroughs	Date
Hounslow Integrated Care Patient & Public Engagement (ICPPE) Committee	Hounslow	07 December 2021
Public involvement event	NW London wide	13 December 2021
NW London Joint Health and Overview Scrutiny Committee	NW London wide	14 December 2021
Older people's Engagement at the Pavilions Shopping Centre in Uxbridge	Hillingdon	28 January 2022
BME Health Forum Director interview	Hammersmith & Fulham, Kensington & Chelsea and Westminster	08 February 2022
SOBUS Community Lead interview	Hammersmith & Fulham	10 February 2022
BME Stakeholder Event	Kensington & Chelsea and Westminster	22 February 2022
North Kensington Health Partners	Kensington & Chelsea	03 March 2022
RBKC Adult Social Care and Health Select Committee	Royal Borough of Kensington and Chelsea	03 March 2022
Trustee, Kosher Dementia UK	NW London wide	04 March 2022

Public involvement event with a focus on ethnic minorities	Hounslow and Ealing	10 March 2022
Public involvement event with a focus on ethnic minorities	Westminster, Kensington & Chelsea, Hammersmith & Fulham	15 March 2022
Hounslow and Ealing Integrated Care Partnership Engagement Event	Hounslow and Ealing	17 March 2022
Public involvement event with a focus on ethnic minorities	Brent, Harrow and Hillingdon	17 March 2022
Public involvement event feeding back what we have heard so far and actions we have taken as a result	NW London wide	18 March 2022
Hammersmith and Fulham Integrated Care Partnership end of life meeting 08 March & 03 May 2022	Hammersmith & Fulham	08 March and 03 May 2022
Hammersmith and Fulham Integrated Care Partnership Event	Hammersmith & Fulham	11 May 2022
Harrow Palliative Care and End of Life Webinar	Harrow	11 May 2022
Come and help us shape the end-of-life care in Brent	Brent	15 June 2022
Spectra CEO interview	NW London wide	21 June 2022
Brent Community and Wellbeing Scrutiny Committee	Brent	05 July 2022
Come and help us shape end-of-life care in Kensington and Chelsea and Westminster	Kensington & Chelsea and Westminster	12 July 2022
Hammersmith & Fulham Health and Adult Social Care Policy and Accountability Committee	Hammersmith & Fulham	20 July 2022

A conversation with a carer of someone living with dementia 22 July 2022	NW London	22 July 2022
Dementia Group for Hounslow	Hounslow	25 July 2022

We have committed to transparent and meaningful engagement at every stage of the work

We also linked in with experts both locally and nationally in certain areas including learning disabilities and homelessness. Their advice led us to carry out two literature reviews for people living with homelessness and people living with a disability which have been published and used as evidence in the review.

We received a large amount of feedback which we are responding to and some actions have already been addressed as a result. There are also areas we are currently developing and implementing, or propose to do so, in order to address the issues raised. Some local residents have been kind enough to share their stories so we could use them as case studies to illustrate the good experiences and the challenges that people face when using community-based specialist palliative care services, so that we can learn from their experiences.

In addition to these meetings, we developed a number of online surveys through which local residents and health and social care professionals could give their views. Open-ended questions were also included to give respondents the opportunity to express their opinions in their own words. We also received a number of written submissions which were responded to.

It is our expectation that engagement with local residents will continue as we move forward. All boroughs have had the opportunity to be involved in a webinar or complete a survey.

All the public feedback received is being used by our model of care working group, which is responsible for co-designing the future model of care for adult community-based specialist palliative care.

Membership of this group consists of local residents who bring lived carer and patient experience, clinicians and other palliative and end of life care stakeholders. The group is being asked to:

- agree a common specification / common core offer for community-based specialist palliative care
- develop a new model of care to deliver the specification / common core offer which also facilitates tailoring in response to local need
- support the development of a long list of options for delivery of the new model of care

The work draws on the national service specification for adult palliative and end of life care, the previous NW London 4 CCGs palliative care review programme work and

qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We also are utilising activity trend data obtained from service providers and will undertake further work looking at the structure of our services workforce.

The expected output is a set of core service standards, requirements, service line definitions demonstrating what we believe good community-based specialist palliative care looks like and co-designed principles required to successfully design and deliver the model of care across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

We understand and share local residents' feedback that having good community-based specialist palliative care services is really important. In some cases, the feedback that has been provided has led us to make changes to services where possible and have plans to do some more of this via this review programme. This is detailed in an insight report where we also detail areas where we are not able to make changes.

We would like to reiterate our commitment to work collaboratively with our public, patients, clinicians and other system partners as we move forward to develop the future model of community-based specialist palliative care for adults, which includes consideration of current services and where the locations we need our services in

1.1 Key findings from the feedback received

As laid out in the Issues Paper, there are eight broad reasons why we need to improve the way we deliver our community-based specialist services to make sure everyone receives the same level of high-quality care, regardless of their circumstances.

We have carried out an analysis of all the feedback received through the webinars, surveys, one to one conversations, meetings attended and literature reviews and grouped the feedback received against the eight broad reasons.

1. **To review the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.**

In the previous review of community-based palliative care provision in in 2019 and 2020 we talked to people about community-based specialist palliative care services and heard what a crucial role the services play. The feedback confirmed that people value their local specialist services and would like to receive them as close to home as possible, and people with experience of these services are very positive about the care they have received. Local residents and stakeholders said they would like the NHS to reopen the Pembridge Palliative Care Unit in-patient beds

following their temporary closure in October 2018 due to a lack of specialist care consultant cover and being unable to recruit due to the national shortage of trained personnel (see Section 1.2 Insight report and actions taken for further details).

We also heard that services need to be made available to more people 24 hours a day, availability of care needs to be improved during the out-of-hours periods (between 5pm and 9am) particularly, services need to be more inclusive and adaptable, offer more choice and more be more joined up. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice, or in hospital. It is also important that people don't have to travel too far to access services.

The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it.

See the Palliative care services Independent review - full report Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster.

See the Palliative Care Services Public Engagement Report July 2020 In the boroughs of Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster.

In January 2020, Hillingdon Commissioning Group (HCCG) performed a review of End of Life Services looking at the views of general practitioners (GPs) and the lesbian, gay, bisexual, and transgender community (LGBT).

See the Review carried out on End of Life Services in Hillingdon in January 2020.

2. **To bring services in line with national policy. Such as**
    a. **the national Six Ambitions for Palliative and End of Life Car**
    b. **the NHS triple aim of improving access, quality and sustainability**
    c. **Ensure providers follow the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services.**

- We will utilise the learning and gaps in improvements taken from the borough and ICS level self-assessments against the six national ambitions for palliative and end of life care.
- Future community-based specialist palliative care services will need to align with national standards and guidelines.
- This includes adhering to the national service specification for community-based specialist palliative care.

3. **To meet patients' changing needs arising from changes in the population. By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.**

- We will need to take into account aging population with likely increased demand on community-based specialist palliative care.
- The number of people living with dementia is increasing which brings increased complexity of care needs.
- The number of elderly people living on their own is increasing with no one to care for them. Often they can live away from their family leading to social isolation.
- This includes support for the family and carer supporting them.

4. **To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.**

- Review should look at ways of tackling the widening Health Inequalities for people who require palliative and end of life care and support service.
- Attention should be given to isolated people, those with family outside the country or in different regions, elderly couples that are physically or mentally unable to care for each other, the large number of disabled people that require specialist care and those who experience homelessness.

5. **To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care services that patients, families and carers across North West London receive. This means that depending on where a patient lives, they and their family and carers may always be able to get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.**

- Implement a 24/7 telemedicine co-ordination, advice and support service for care home staff to better support their residents at end of life.
- To improve co-ordination and navigation of care and support available, implement a single point of access (preferably a single telephone line) for patients, family, carers and clinicians to contact to obtain information about what palliative and end of life care services are available, how to access them, support with getting medication and equipment etc.
- To build flexibility into the service model that supports a person and their family to change their mind about place of care and place of death even if it is at the last minute. This could be where a person has always said they wanted to die at home but change their mind as they and the family are scared or believe it is too hard on the family who initially thought they could cope. Instead they want to go to a hospice or a hospital.
- Align GPs more closely with individual care homes and develop enhanced care services.
- Pembridge in-patient service should be reopened.
- A review of the number of hospice inpatient beds should take place.
- The number of and quality of care plans need to be improved. Patients and families need to be given access. More needs to be done to ensure health professional access the care plan routinely when seeing patients.
- There needs to be improved record keeping around preferences, treatment etc. and more needs to be done to make sure they are automatically accessed by the people providing care.

- The need to identify that someone is dying and recognise this earlier was identified as an important point that feeds directly into the patient and families choices about appropriate treatment etc.
- We need to make sure that there are wrap around care to provide support to the patient if they are to stay at home.
- Care needs to be holistic, and include clinical and non-clinical support e.g. Home adaptations, advice and support on what to do when a patient passes away.
- There is a lack of bereavement support across NW London for families and carer. A review of current provision is needed to understand what type of support is needed and how it could be delivered.
- We need to ensure we consider the impact of caring for someone who is dying on family and carers. Concerns were raised about impact on:
    - unpaid carers and those who are older
    - Those who have their own health issues and are struggling
    - Are trying to hold down employment or have kids and are busy and what that means for them trying to undertake a caring role.
- The way someone dies can have a big impact on the person caring for them and we need to ensure that support for relatives and carers continues after the person has died.
- Palliative and end of life care needs to be patient centred and the importance of family/carers/those of importance to the person being involved in decision making and kept informed.
- We need to think about how we design more integrated services, between the patient and family, the community, social care and clinical services.
- Care and support needs to be available 24/7 365 days a year (including pain relief). out-of-hours service (OOH), consider including an OOH service to impatient services to enable carers and patient seek help when needed.
- Lack of clarity for carers/family around medication. Medication for EoLC patients should be thoroughly explained to carers/family members so they are able to identify which medications are missing and act quickly.
- Family members and carers should be kept informed at every point during a patient's care pathway.
- Professionalism, Confidentiality and Compassion - Clinicians visiting family homes to see EoLC patients should be briefed fully on the patient's condition/situation and maintain the highest level of confidentiality when they are communicating with other clinicians in the presence of the patient and other family members.

6. To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.

- More needs to be done to create culturally competent services that take into account cultural and faith beliefs.
- We need services that are able to care for people from ethnic minorities who may not speak or have difficulty speaking and understanding English.
- Participants identified a need for existing care and support services to do more in reach into different communities in a culturally sensitive way.
- More needs to be done to promote community-based specialist palliative care, encouraging people to think, talk and plan about end of life care.
- The importance of having local services was stressed with reference to the cost, time and difficulty of using public transport.

- Need to design services that take into account people cultural and faith needs.
- Creating seamless service provision with services properly integrated with other ancillary services like 111 would make them easier to access and improve patient experience of care.

7. To cope with the increasing financial challenge, the NHS is facing and the effect this has on community-based specialist palliative care.

- Consider a proper financial settlement for hospices as their financial situation has been exacerbated by Covid.
- Local residents wanted to know more factual information on finance, demography and the help available locally.
- Look at ways of clawing back some funding from the NHS service providers when patients with intensive clinical needs decide to die at home.

8. To reduce the difficulty, we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.

- A comprehensive workforce plan is needed to address the workforce challenges mentioned in the report.
- More needs to be done to educate and train all workforce to identify need. This should be NHS, Local Authority (social care) and voluntary groups so they can capture and signpost potential need.
- Need to build extra capacity and extra staff to meet growing demand.

The full interim engagement outcome report is available here.

9. Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

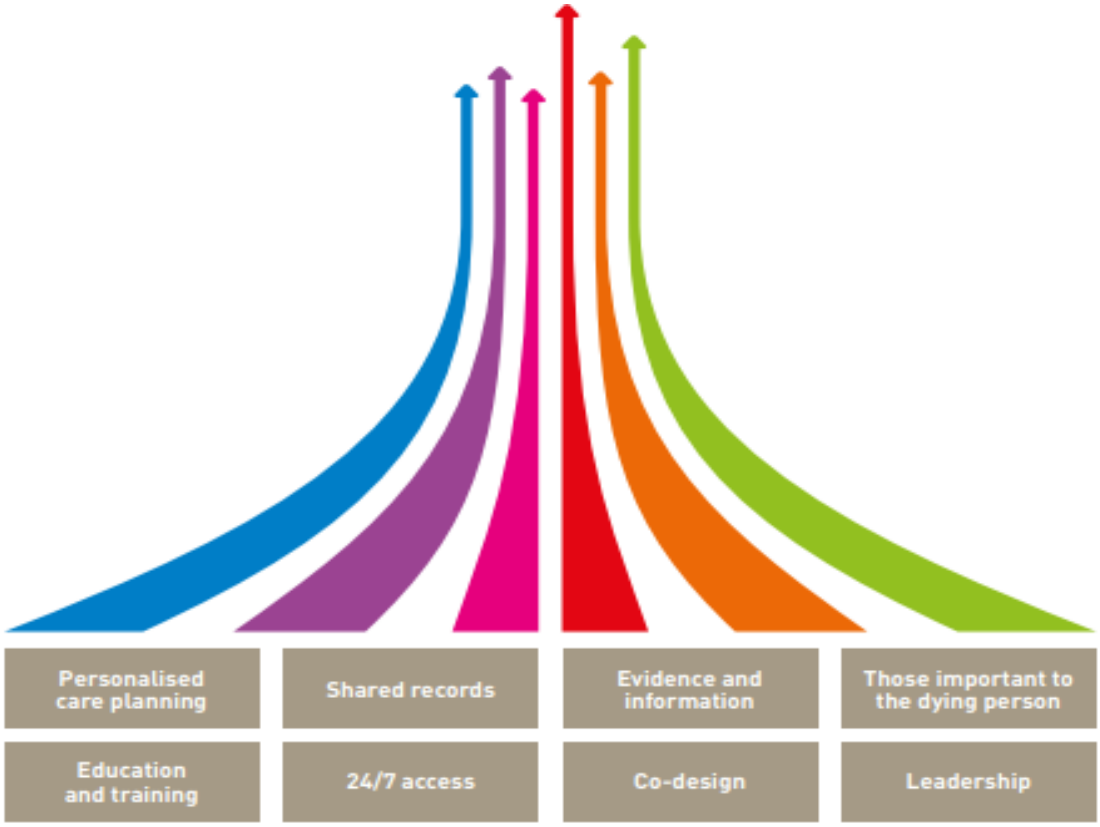
In 2015 The National Palliative and End of Life Care Partnership published the **Ambitions for Palliative and End of Life Care: A national framework for local action (2015-2020)** to improve palliative and end of life care (PEoLC), building on the 2008 Strategy for End of Life Care and other strategies and reports.

It describes what is needed to realise that ambitions, and calls for local health and social care leaders to use these foundations and building blocks to collaboratively build the accessible, responsive, effective, and personal care needed, via a process that is open, transparent and effective.

A refresh of the Ambitions Framework (2021-2026) was published in May 2021, with a reminder that more must be done, building on the learning from COVID-19 pandemic to focus more efforts on personalised palliative and end of life care, to improve support for people of all ages including those bereaved, and to drive down health inequalities.

Each ambition includes a statement to describe the ambition in practice, primarily from the point of view of a person nearing the end of life. Each statement should also be read as our ambition for carers, families, those important to the dying person, and where appropriate for people who have been bereaved.

The eight foundations that underpin the ambitions and are required to bring about this improvement. Different individuals and organisations can lay these foundations, either on their own or collectively.



Foundations for the ambitions

To support delivery of the six ambitions, the NHS England & NHS Improvement Palliative and End of Life Care Team worked alongside stakeholders to further develop the Ambitions for Palliative and End of Life Care self-assessment tool as a national resource.

This tool provides a self-assessment framework and process to support localities/ boroughs to

- Support a more coordinated response for localities to determine their current level of delivery of services against the Ambitions for Palliative and End of Life Care - A National Framework for local action (2021-2026).
- To understand where there are strengths and opportunities for improvement and growth that need prioritising within future strategy for palliative and end of life care.

In order for this self-assessment process to become a meaningful and useful exercise, localities are encouraged to be as honest as possible, with cross-organisational collaboration to complete the tool and achieve the improvements being vital. Localities are strongly encouraged to ensure health and social care are equal partners in this assessment process.

All eight Borough Based Partnerships (BBP) completed the self-assessment tool and came together in two workshops facilitated by the NW London last phase of life programme to facilitate its completion. Participants included representatives of local councils and residents.

All BBP's have now completed the self-assessment tool. The rich discussions that took place in each BBP breakouts, and feedback from multiple workshop stakeholders, that completing the self-assessment tools with multiple stakeholders locally for each BBP was really beneficial:

- To ensure the information on the tool is as accurate as possible for each BBP and ultimately for completion of the NW London self-assessment.
- To raise the profile of PEoLC locally and regionally.
- To identify the relevant PEoLC stakeholders and building place-based links.
- To start the basis for driving PEoLC improvement work forward at place and within other programme areas.

An analysis has now taken place and a NW London level and this will be used to inform the new CSPC model of care (MOC) in development by the CSPC MOC working group. In addition:

- Key gaps/ areas of improvement identified for other parts of the end of life pathway will be shared with other NW London programme areas.
- BBP self-assessments will be shared with BBP and borough directors with an ask to support any local PEoLC improvements using the findings to inform this work.
- NW London Last phase of life programme will host a 3rd workshop later in the year for all PEoLC stakeholders across the system to share the outcome of the NW London self-assessment, learning and areas of good practice identified.

We would like to thank partners and local residents for taking part in the workshops and contributing to their success.

10 The model of care working group

The model of care working group was set up by the NW London ICS to develop a framework and action plan to ensure that high quality community based specialist palliative care is delivered equitably and sustainably across NW London, and that all residents are able to access the service if it is needed.

Membership of the group which meets on a weekly basis consists of local residents, clinicians and other palliative and end of life care stakeholders. Patient/carer members contribute and provide feedback on the group's work, which reflects the voice of patients, carers and their families.

This is not a plan to replace work that is already going on. It is a plan to build on the on-going commitments in NW London for community specialist palliative care and recognising where there are gaps and opportunities.

The work draws on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.

Objectives

- agree a common specification / common core offer for community-based specialist palliative care
- develop a new model of care to deliver the specification / common core offer which also facilitates tailoring in response to local need
- support the development of a long list of options for delivery of the new model of care

The expected output is a set of core service standards, requirements, service line definitions demonstrating what we believe good community-based specialist palliative care looks like and co-designed principles required to successfully design and deliver the model of care across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is necessary.

Who are the members of the model of care working group?

Key palliative and end of life stakeholders including 12 patient and carer representatives:

- NW London NHS community specialist palliative care (SPC) providers

- NW London Hospice SPC providers
- Twelve patients and carer representatives
- Primary Care
- Acute SPC
- Discharge teams
- NW London are homes lead
- Local authority and social care
- London Ambulance Service
- Community nursing
- Continuing health care (CHC)

We also invite additional topic related stakeholders when needed.

Model of Care – what do we mean?

There are many, many definitions of what constitutes a 'Model of Care'. We have set out below what we think the scope of this stage of work is:

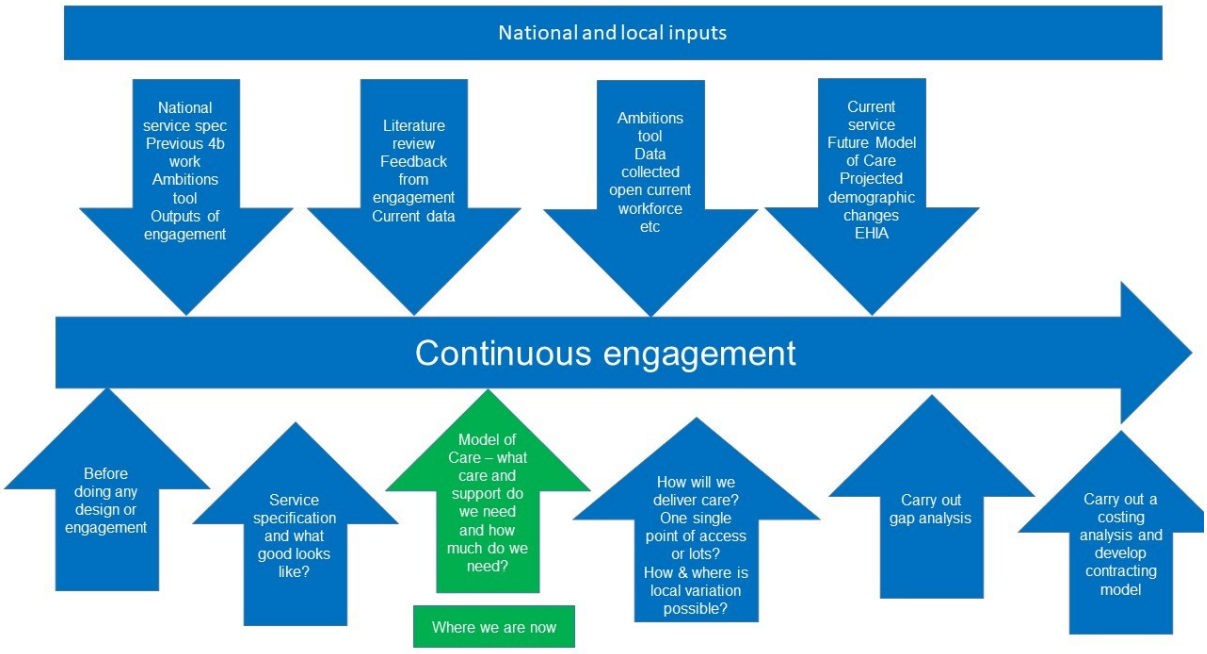
Defining what the core elements of delivery are	Yes	This is the kind of detail within the national service specification and the starting point
Defining how much of these key elements we need	Yes	This isn't covered in the national spec but is critical to be able to ensure common approach across NW London how much" could include hours, staffing, capacity etc.
Defining how services should be delivered	Partially	For example, we may want to define elements such as access (including geographical availability) but not how services are integrated at place.
Who delivers elements	No	But substantial change not anticipated
How much costs	No	Not at this stage

The work will draw on the national specification for adult palliative and end of life care, the previous NW London palliative care review programme work, qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement and further data obtained through the programme's data working group.

11 Timeline

We are taking a flexible approach to the timeline to make sure that we can carry out good conversations with local residents and our partners within the Integrated Care System.

The diagram below shows the national and local inputs into the development of the model of care and immediate next steps.



It is anticipated that the model of care working group will complete its work in Autumn 2022. We will then move into a development phase where we will carry out a gap analysis, costing exercise and develop the costing model. This will be accompanied by the commencement of an assurance process with NHS England/NHS Improvement and the London Clinical Senate.

12 Conclusion

- We are undertaking a wide range of engagement and events to understand the improvements residents and health care professionals want in terms of community-based specialist palliative care.
- We have reviewed the feedback and published an interim engagement outcome report that is being used by the model of care working group which is responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.
- The inpatient unit at the Pembridge remains closed, however, we are currently providing alternative provision through neighbouring local hospices.
- We recognise that services need to be accessible locally and will review inpatient provision as a key part of the review, but cannot pre-empt what this means at present.

We welcome further feedback and suggestions from Brent Council. Please let us know by emailing nhsnwlccg.endoflife@nhs.net

Appendix 1 – Detail on the Palliative care services improvement programme in the London Boroughs of Brent, Hammersmith & Fulham, Kensington and Chelsea and Westminster. Note this review has been superseded by the current NW London wide process and as such the outcomes will feed in to that process but the options are not recommendations that we are actively progressing

In November 2018 Central London CCG, on behalf of West London CCG and Hammersmith & Fulham CCG, commissioned Penny Hansford, former Director of Nursing at St Christopher's Hospice, South East London; to independently review provision of community-based specialist palliative care services in the three boroughs following suspension of the in-patient unit at The Pembridge Hospice following that failure to recruit a consultant registered on the specialist register for palliative care which is required to cover inpatient care.

This event, combined with commissioner's desire to ensure palliative care services are fit for the future, meant the tri-borough CCGs decided to review the current provision of specialist palliative care. The independent review of palliative care services published with the aim of developing recommendations for an improved commissioning model that would deliver high quality services for patients, families and carers across the three boroughs.

A 'Call for Evidence' was launched on 14 December 2018 and a clinical steering group was created, with representatives from GPs, acute trusts, community trusts and hospice providers, all with an interest in specialist palliative care, with the final review published in June 2019.

The report provided a comprehensive assessment of the current local service provision, a review of best practice and made a number of recommendations for commissioners to consider for the future model of service.

Findings and future options

The review of services offered to patients identified the following three overarching challenges to be addressed:

- inequity of specialist palliative care services in the three boroughs
- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services; and
- inequity of funding arrangements for the services from the CCGs.

The review put forwards three options in order to address these challenges whilst providing a sustainable local system, which ensures all patients receive care in their preferred place at the right time:

Option one (recommended option)

Tender a new community service with one lead provider for the specialist palliative care services, to provide an 8am-8pm co-ordination/case management centre. Out-patient, rehabilitation and well-being services should be easily accessible to patients and be located within the boroughs

Option two

Tender a new service and rationalise and reduce the number of specialist providers to two, with the same service specification and contracts and

Option three

Tender the services based on one community service per borough with the same service specification with one co-ordination centre/case management centre per borough.

Read the review in full here.

In Autumn 2019, the three CCGs were joined by Brent CCG as a commissioner of services at the Pembridge Hospice in holding a number of workshops to understand the experience of the end to end pathway.

Workshops were on held on ‘Access’, ‘Care’ and ‘Bereavement / aftercare’ with the purpose of having some in-depth conversations on the whole end to end pathway and use the information to feed into future potential scenarios for service delivery.

After listening to feedback from the public and stakeholders following the public workshops, we launched our ‘potential scenarios’ to the public for discussion and feedback and work in partnership with the public to design future potential options for service delivery.

This led to the development of four scenarios that set out how we might organise palliative care services in the future and in February 2020 we asked the public for their feedback on them.

Scenario 1—Services remain the same.

This scenario would keep all palliative care services as they are including the re-opening of the inpatient unit at the Pembridge, subject to the appointment of a palliative care consultant. In-patient, day and community care services would continue as they are.

Scenario 2- Some improvements to day and community services with in-patient services remaining the same.

This scenario would keep in-patient services as they are now, including the re-opening of the inpatient unit at the Pembridge subject to the appointment of a palliative care consultant.

Community services would also be standardised to 5 days’ week. This scenario would also lead to some improvements in the co-ordination of out of hours’ advice.

Scenario 3—A re-design of all elements of palliative care services.

This scenario would see in-patient services delivered from four rather than five sites but without reducing the number of beds that the NHS funds.

This would enable CCGs to fund enhanced community services 7 days a week, with 24/7 admissions for patients. It would also provide an out of-hours nurse visiting service and Hospice@Home available to all.

Scenario 4—A re-design of all elements of palliative care services including access to a new nurse-led inpatient service.

This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds. CCGs would then fund enhanced community services.

Patients who do not have complex medical needs, but whose preference is to die in a hospice environment could receive nurse-led care at a bed in North Kensington provided by the Pembridge Palliative Care.

There followed a period of further engagement on the options with the public and a wide range of stakeholders which brought forward a number of themes and feedback on the scenarios.

- Dying in dignity and agreement on the importance of palliative care and local services
- Communication and awareness of death and dying, palliative care and the need to plan for it
- Capacity of service provision now and in the future
- Review process – residents wanted more information on the evidence being used to inform the process
- A strong desire to keep inpatient services at Pembridge and opposition to closure
- Agreement on the need to improve access to services
- Better and more clear engagement
- More information on the staffing issues
- More information on the finance issues
- To consider the impact of travel and transport when making decisions
- Recognition that there was a need for change

In summary we heard throughout the engagement period, that specialist palliative and end of life care services play a crucial role for people. The feedback confirmed that people really value their local specialist services and people with experience of these services are very positive about the care they have received.

We also heard that we could improve and that these services could be available to more people, be more inclusive, adaptable and offer more choice. The feed-back indicates however that there are differing views about how we make these improvements, and create a more equitable service for all.

View the full public engagement report

The decision was then taken to pause the programme of work due to the current coronavirus outbreak and the subsequent decision by the NW London ICS to look at community-based specialist palliative care services across the eight boroughs in NW London.

Appendix 2 - borough plans and initiatives

All boroughs are in different places along the road when it comes to developing their approach and priorities. For some, completing the Ambitions Framework has jump-started their work and others are further forward. However, all eight boroughs have now appointed clinical leads and have either established or will shortly be setting up borough based groups to move this important matter forward.

Brent

Brent Integrated Care Partnership has appointed Dr Lyndsey Williams as clinical lead for palliative and end of life care. Dr Williams also acts as the overall North West London lead.

Brent has established a robust bi-monthly engagement meeting (End of Life Stakeholders Group) that enable closer working/building relationship with a wide array of stakeholders such as Local Authority, patient representative, community and voluntary sector, hospices, Central London Community Healthcare Trust (CLCH) and others representatives. This is a non-formal or non- decision making group, but provides opportunity to identify, discuss, and escalate issues via a more appropriate route.

Brent alongside their local partner CLCH organised a meeting in July involving various charity organisations/patient representatives with the aim to build relationship, understand their values and roles in order to help support residents better in the community.

A local ‘Resource pack for anyone giving support to someone at their end of life in the community’ document developed by Dr Williams and Elcy Nwokeji. We hope it will serve as an exemplar for the NW London Integrated Care Partnerships. This document provides useful information on palliative care, what to do when someone is dying, how to support patients and their families well within the community and directory of key contacts (i.e. faith groups, specialist palliative team and community voluntary sector). This document is awaiting sign-off.

Brent has established contact with various faith groups/leaders while developing the resource pack – the next plan is to invite/set up a task and finish group that will enable further discussion on spiritual and religious aspects. This will ensure patients’ spiritual or faith/religious needs are met when they’re in their end of life.

Another addition is how the end of life care programme can work closer with other community services, working with CLCH who provide majority of our community services specifically supporting our frail population, anticipatory care and care home population (so our most vulnerable).

We are also supporting the implementation of the new London Urgent Care Plan to ensure all those identified as in their last phase of life, and those important to them, have the opportunity to discuss a care plan that is shared on the Urgent Care Plan to the NW London health and care community. Trouble shooting access and use from primary care through 1:1 and drop-in sessions.

We worked closely with the Brent Carers Centre and local hospices in the Carers Support Services Showcase Event held in June 2022 which was very productive with good feedback received.

Brent End of Life team joined the Brent Health Matters on a radio session (Beat Health Hour) on 30 May 2022 to raise awareness of palliative care and end of life. Local residents were informed about the ongoing NW London community-based specialist palliative care review.

Central London and West London (Bi-borough response)

The Bi-Borough have appointed Dr Amit Patel as the local clinical lead and have completed the Ambitions Framework.

We are planning to develop and implement a local Palliative and End of Life Care delivery plan for the next 12-18mths with input from key stakeholders including the Royal Borough of Kensington and Chelsea and Westminster City Council.

There are plans to hold ongoing local engagement sessions (commencing September/October), to enable us to develop local priorities, share updates and gather feedback on priorities. This will also allow us to feed in the bi-borough perspective into the North West London review.

The frequency of local engagement will be confirmed after the first session with stakeholders.

Ealing

Ealing Place Based Partnership has appointed Dr Ann Down from the Argyle Surgery in Ealing as the local clinical lead and following completion of the Ambitions Framework revived the Ealing borough palliative and end of life steering group. Membership consists of NHS and hospice providers, local authority, voluntary and community sector and local residents.

We have held two meetings so far and have been working hard to identify what the local priorities are. Some of which are:

- Driving forward training, promoting usage and increasing records of:
    - Urgent Care Plans
    - Advance Care Plans
- Gaining shared access of records across multiple providers

Moving forward our intention is to contribute proactively to the North West London review currently underway and have a stated objective of working closer together, sharing ideas and joint problem solving.

Hammersmith and Fulham

In Hammersmith and Fulham as part of the Health and Care Partnership (HCP), we have made a commitment that coproduction is at the heart of everything we do and have set up an End of life and Integration of palliative care service group that meets on a monthly basis. Representatives include NHS, Acute providers, community providers, district nursing teams, community response and enablement

team, hospice providers, local authority, voluntary sector, Lay partners and Hammersmith and Fulham save our NHS (HAFSON). This group sits under the Hammersmith and Fulham Frailty health and care partnership campaign.

Our aim is to work with the residents and communities from the very start, to understand what matters to them, to redesign services in a way that works for them, and to work with them to make changes. In order to ensure an effective engagement; the Hammersmith and Fulham team worked closely with the lay partners and members of HAFSON to develop & implement the engagement strategy. We worked together:

- To design the engagement material, agree the narrative for a rich conversation,
- looked at ways to promote our events via voluntary sector organisations, tapping into their network to ensure we reach out to all the cohorts and everyone intending to share their feedback has a platform to do so e.g. via online surveys, written feedback via email or post to the NWL ICS team and virtual engagement events.
- To facilitate the conversation at the public engagement event
- Locally, it was agreed to extend the scope of the engagement to include the breadth of "out of hospital" Palliative Care Services within H&F (generalist and Specialist Palliative Care together).
-

Full engagement report from H&F local public engagement event can be found at: H&F Local Engagement Report

All the feedback collated on Specialist Palliative care has been reported to the NWL ICS Programme team to support the NWL wide review of CSPC services. It will be used by the model of care working group responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care. Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. H&F Lay partners and members from HAFSON are active members of this working group.

Overall engagement feedback including General Palliative care has been reported to the "End of Life & Integration of palliative care service subgroup. This working group will utilise the engagement feedback to identify areas for improvement and agree priorities for delivery on a borough level. Jo Dang[Choji-Davou], North Locality Lead-District Nursing Teams H&F, CLCH and Sharon Douglas, Locality Lead H&F, CLCH are leading this piece work at HCP level and are supported by Dr Jia Jia Billins, H&F Borough Clinical Lead.

Some of the key considerations emerging from recent feedback review includes:

Improve integration between NHS service & Council Service

Consider ways to create and improve integration / connection between social workers and the healthcare staff visiting the same patient. The group considered arranging information/ discussion sessions with representation from social care and healthcare staff outlining their services. Plan is to consider some scenarios of unnecessary admissions from both sides to understand why they do what they do? Is this because of lack of information, knowledge, confidence or are there any tools/ equipment/ pathways/ guidance that can be arranged to deliver the care in certain

situations etc.? Is there anything we can do jointly that can improve outcomes for the EOL patients and make services better for the staff? This will help create awareness and understanding of each other's service and it will also be an opportunity to tease out areas where we can create bridges i.e. create opportunity for sharing information and provide coordinated care for patients.

Develop a Directory of Service

Hammersmith and Fulham has agreed to develop an infographic hybrid model showing current services provided by the NHS, Social care and voluntary care sector organisations. This is already taking shape based on all the information we have collated so far and we are working with the partners to complete this.

Harrow

In Harrow we have established a Harrow Palliative Care Group made up of NHS North West London, Harrow Council, all providers and voluntary and community organisations. We have an ambitious programme that is already producing tangible results including:

- We are carrying out a further gap an analysis of the whole palliative and end-of-life pathway, which will be supported by an independent Population Needs Assessment, commissioned by St Luke's Hospice
- We are finalising an integrated training package for health and care staff and carers which aims to provide joint training to groups of service users and staff
- We are looking at how we can make the death certification process more efficient for families and carers of the deceased
- We are supporting the North West London community-based specialist palliative care review
- We are developing a new strategy for improving palliative and end-of-life care in the borough.

Hillingdon

In Hillingdon, as part of the Hillingdon Health and Care Partners (HHCP), we have established an End of Life Transformation Steering Group which reports to the End of Life Board and meets fortnightly. Membership of the group includes all partners: CNWL, H4ALL, Hillingdon Hospital, Hillingdon Council, ICS. We have appointed Dr. Vanessa Sivam as the EoL Clinical Lead for Hillingdon.

Hillingdon is working towards a new Model of Care for End of Life as part of six new Models of Care, building health and care around the population of Hillingdon. The new "End of life care" model of care will be developed first and includes a new vision and strategy, business model and five-year roadmap. The Ambitions work has been a good start to this work. As part of the new integrated model of care, a Coordination Hub will be implemented later this year, in time to help alleviate winter pressures.

In terms of the work completed to date:

- A TOR was developed and signed off by all partners for the EOL Transformation Steering Group.
- The EoL Strategy and Case for Change have been endorsed by HHCP Delivery Board.

- Patient and carer feedback on existing services is being sought through an online survey developed with HHCP Engagement Leads. The survey is live on the Healthwatch Hillingdon website until the end of September.
- Workshops have taken place on the new model of care design principles and measures, outcomes, and service mapping.
- Next steps are the development of the implementation plan.

Report to the North West London Joint Health Overview Scrutiny Committee

14 September 2022

Report Title:	North West London Integrated Care System Update
Report Author:	Rob Hurd

1. **Financial Outlook:**

Full financial overview can be found in July Board paper – overview below:

Publications :: North West London ICS (nwlondonics.nhs.uk)

1.1 Funding arrangements:

In NW London budgets are set at NW London level, (with the exception of primary care) a set of financial principles are used for resource allocation:

- In everything we do we will aim to put the patient first and we believe that the best way to achieve this in strategic planning is to be clear and transparent in resource allocation and allocate the maximum level of resource to the system and hold low levels of system contingency.

- Resource allocation will continue to build on those aims introduced in 21/22 being:
    - New funding to target health inequalities within NWL based on population data;
    - Agreed increase in primary care investment;
    - We will achieve through Service Development Funding ensuring that the funding achieves the national aim and reduces inequalities locally;
    - We will aim to limit the efficiency requirements within NWL to an achievable level and work collectively to support organisations in distress;
    - We will have a joined up approach to planning winter led by the Urgent Care Board with all members of the ICS; and
    - Funding of new developments and support to be agreed by NWL CFOs.

- In 22/23 we will aim to increase the influence of place in financial planning by involving Boroughs through the Local Care Board in the design and funding of non-acute services. This will build on the delegated authority within Boroughs for Primary Care and Better Care Fund.

- In 22/23 we will see the return of contracting and activity based contracts. NWL will aim to work within an environment that minimises the transactions within NWL and across London.

- We will incentivise productivity, flow and invest to save proposals.

1.2 2022/23 month 3 (June) full year forecast

1. The ICS has an efficiency target of £192m in 2022/23
2. Organisations have collectively identified plans totalling £162.69m (85.2% of the target) over 555 schemes
3. The full year forecast stands at £161.23m, a +£21.09m improvement since last month, but -16% below the overall target
4. £119.38m of the full year forecast is for recurrent savings (74%)
5. Identified plans have increased by+£19.1m since last month (from £144.58m)
6. £99.47m of forecast is aligned to medium or low confidence rating
7. £61.76m of the forecast is aligned to a high confidence rating (or a closed scheme)
8. £110.25m of the forecast is associated with schemes still in the initiation or planning phase, or with no phase recorded.

1.3 Financial projections and position month 3 (June):

The year to date system position against the plan is a deficit of £18.7m, all within the providers. The variation against the plan is driven by £10.7m for elective recovery fund (ERF) clawback and the remaining is due to expenditure control particularly on higher level of temporary staff usage and underperforming against their efficiency plan by £9.3m.

The CCG (June) reported a breakeven position after adjusting the numbers in line with national guidance as the CCG move to ICB. The pre-adjusted position would have been £11.1m surplus which includes the clawback on ERF £13.3m (£10.7m in sector and £2.6m out of sector), offset against £2.2m overspend driving by phasing issues and non-recurrent allocations not yet received.

The system unadjusted position would be £7.6m deficit and forecast to breakeven.

The year to date under delivery of ERF was as expected, however activity is planned to pick up from quarter two.

In quarter one there was an increase in Covid cases for both patients and staff leading to extra pressure on the services with higher level of temporary staff usage.

The remaining overspend is due to phasing issues on the efficiency plan at Imperial where it is in equal twelfth with the actual delivery of the schemes back ended. This also applies to Chelsea and Westminster and Central London Community Health where their efficiency plan is phased relatively equal during the course of the year.

The phasing also impacts the variance between pay and non-pay with any unidentified efficiency currently within non-pay.

	Year to date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	1,334.4	1,334.2	(0.3)	5,346.0	5,363.4	17.4
Pay Expenditure	(857.6)	(861.6)	(4.0)	(3,424.8)	(3,415.7)	9.1
Non-pay Expenditure	(462.8)	(477.9)	(15.2)	(1,847.0)	(1,877.1)	(30.1)
Non-operating items / Other Spend	(22.5)	(21.7)	0.8	(79.8)	(76.2)	3.6
Total Provider Position	**(8.4)**	**(27.1)**	**(18.7)**	**(5.6)**	**(5.6)**	**(0.0)**
CCG Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total System Position	**(8.4)**	**(27.1)**	**(18.7)**	**(5.6)**	**(5.6)**	**(0.0)**

1.4 Capital position

The year to-date underspend of £7.8m but is expected to recover in the forecast. This is in line with previous years' trend with capital spend being under at the beginning of the financial year but to recover by yearend. In the June planning submission the ICS has over committed the CRL by £5m however it is expecting some slippage during the course of the financial year with the overall spend back to £219m.

Organisations	Year to date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
WLHT	3,309	2,288	1,021	22,205	22,205	0
ICHT	12,075	10,007	2,068	71,916	71,916	0
CWFT	2,616	3,269	(653)	32,331	32,331	0
THH	3,489	2,576	913	23,227	23,227	0
LNW	4,948	3,463	1,485	30,523	30,523	0
CLCH	945	987	(42)	10,147	10,147	0
CNWL	1,470	1,742	(272)	16,654	16,654	0
LAS	5,831	2,512	3,319	17,199	17,199	0
Total	34,683	26,844	7,839	224,202	224,202	0

2. Gordon Hospital

The JOHSC requested an update on the future of the Gordon Hospital. No decisions have been made on this and the process and timetable for involvement engagement and any public consultation will be provided to the next meeting in December.

During the pandemic, it was not possible to consult on the alternative services that had to be put in place that led to the closure of beds at the Gordon Hospital to best care for residents - CNWL provided a range of new service models during this period to respond to patient and resident needs.

In the context of the potential options for the Gordon Hospital beds, the ICB is working with CNWL to analyse and understand better how we should best provide for the mental health needs of our residents over the short, medium and long term.

3. Plans for Local Authority Representation on ICS

- Integrated care systems bring together the NHS and local authorities in an area to focus on improving the health of the local population. All NHS organisations and local authorities in North West London have already been working as an integrated system, ahead of legislation that establishes Integrated Care Boards from 1 July 2022.
- We have engaged with colleagues in local authorities about our journey to becoming an ICB since late 2021 and each Partnership Board since November 2021 has discussed and agreed proposals for the membership of the ICB (Harrow LA CEO was a member of the Partnership Board). The leaders Cllr Graham Henson and Cllr Tim Mitchell participated in monthly NWL London ICS Chairs meetings, where the transition to becoming an ICB was discussed.

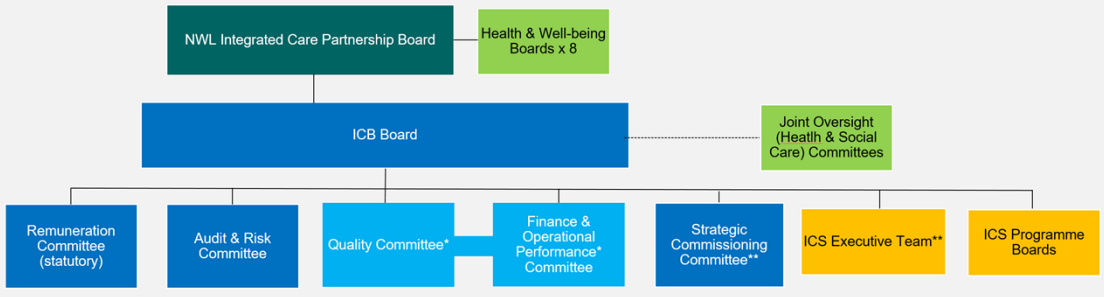
3.1 Statutory Integrated Care Board (ICB) Local Authority Partner Member

The NHS NW London ICB is the statutory body that has overall responsibility for NHS functions. When ICBs were legally established on 1st July 2022, clinical commissioning groups (CCGs) were abolished and current NW London CCG staff moved into the employment of the ICB.

The accompanying presentation provides on update on ICB Board membership, Integrated Care Partnership and Local Authority representation/involvement in the ICS.

Our aim is to create an ICB which is inclusive and also clear in terms of responsibilities and accountabilities in order to deliver the ICS's objectives.

ICB Governance Structure – 01 July 2022



* Quality and Finance & Performance Committees will share a chair and a core common membership and meet on the same day, so to ensure quality and finance matters remain informed by all factors. When necessary, the committees will 'meet in common' to consider issues that fall into both ambits.
** Primary Care Commissioning will be conducted at a borough based level as part of the Executive function as far as possible, with NWL-wide strategy and decisions taken at the Strategic Commissioning Committee. Meetings will be held in public as appropriate.

All partners, including Local Authorities have been asked to nominate their representative to the Integrated Care Partnership, and the first meeting of this Committee will be held on 27th September 2022.

4. Vaccinations

4.1 Covid-19

- Final JCVI confirmed that 1-9 cohorts will be offered a COVID-19 booster vaccine this autumn.
- Prioritising vaccinations of care homes and housebound people will begin from w/c 5th of September, PCN groupings and other commissioned COVID-19 vaccination sites should start vaccinating residents and staff and arrange visits to housebound patients.
- Working to maximise opportunities to co-promote and co-administer vaccinations where possible and clinically advised (eg COVID-19, flu and pneumococcal), especially where this improves patient experience and uptake, but this should not unduly delay administration of either jab.
- The National Boking System (NBS) should be open soon to enable those aged 75 years and over and self-declaring health and social care workers to book their COVID-19 vaccination appointment from w/c 12 September. NBS will extend to people aged 65 and over and allow self-declaring pregnant women, carers, household contacts of immunosuppressed people and those at increased risk of COVID-19.
- It is expected that all providers supporting frontline health and social care workers to take up the offer of a COVID-19 and flu vaccination. Providers have the flexibility to determine the timing of vaccination and health and social care workers will continue to be able to self-declare on the NBS.
- Eligible 5 to 17-year-olds (at risk) will receive their COVID-19 vaccine at assured GP-led vaccination sites, community pharmacies and other vaccination centres.
- In line with the JCVI recommendation, the NHS will deploy a single type of vaccine (bivalent vaccines) – the mRNA bivalent Omicron BA.1/Original ‘wild-type’ vaccines for adult booster doses. Site-level allocations for the first four weeks are to be confirmed, and then sites will be able to order vaccines from 23rd August in readiness for delivery w/c 5th September. Ordering deadlines continue to be in line with corresponding fixed delivery day routines.
- Regional teams have advised that a brief assurance exercise must be completed for all existing Hospital Hub, Vaccination Centre, PCN and Community Pharmacy sites** continuing into Phase 5 of the Covid Vaccination programme by Friday 19th August. This will enable sites to order and receive vaccine stock in time for the go-live date.

- It is expected that all sites to be vaccinating at full operational capacity from 19 September.
- The flu programme will begin as usual from 1 September with sites vaccinating when locally procured vaccine allows.

4.2 Polio

Since type 2 polio virus was found in sewage samples taken from north London, all children aged 1-9 need to have a dose of polio vaccine now. For some children this may be an extra dose of polio vaccine, on top of their routine vaccinations. In other children it may just bring them up to date.

Existing Covid vaccination sites have been approved to offer the vaccination to 5-9 year-olds. These sites are CP House (Ealing), 145 King Street (Hammersmith & Fulham) and Brent Civic Centre. GPs are also vaccinating children in their surgeries (1-4 year-olds need to be vaccinated at their GP surgery. 5-9 year olds can be vaccinated at the surgery, a community pharmacy or a vaccination centre.)

We are working with local schools and other organisations that work with young people and parents to get the message out to parents.

Parents will be contacted directly and offered an appointment; they do not need to contact the NHS.

5. Launch of NW London Inequalities framework

The ICS published its inequalities framework on Tuesday 12 July. This is very much a joint initiative between the NHS and the 8 local authorities. The starting point is a framework report setting out the startling inequalities challenges our eight boroughs face and putting the ambition to address them at the heart of ICS strategy. In the coming months, community conversations will be set up in each borough to discuss these issues with residents, who will be asked to help shape the future of healthcare in North West London.

Press release - Inequalities framework

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

NHS
North West London

ICS update

Current position regarding Local Authority representation in the ICS

Rob Hurd
Chief Executive
NW London ICS
14 September 2022

Integrated Care Partnership membership

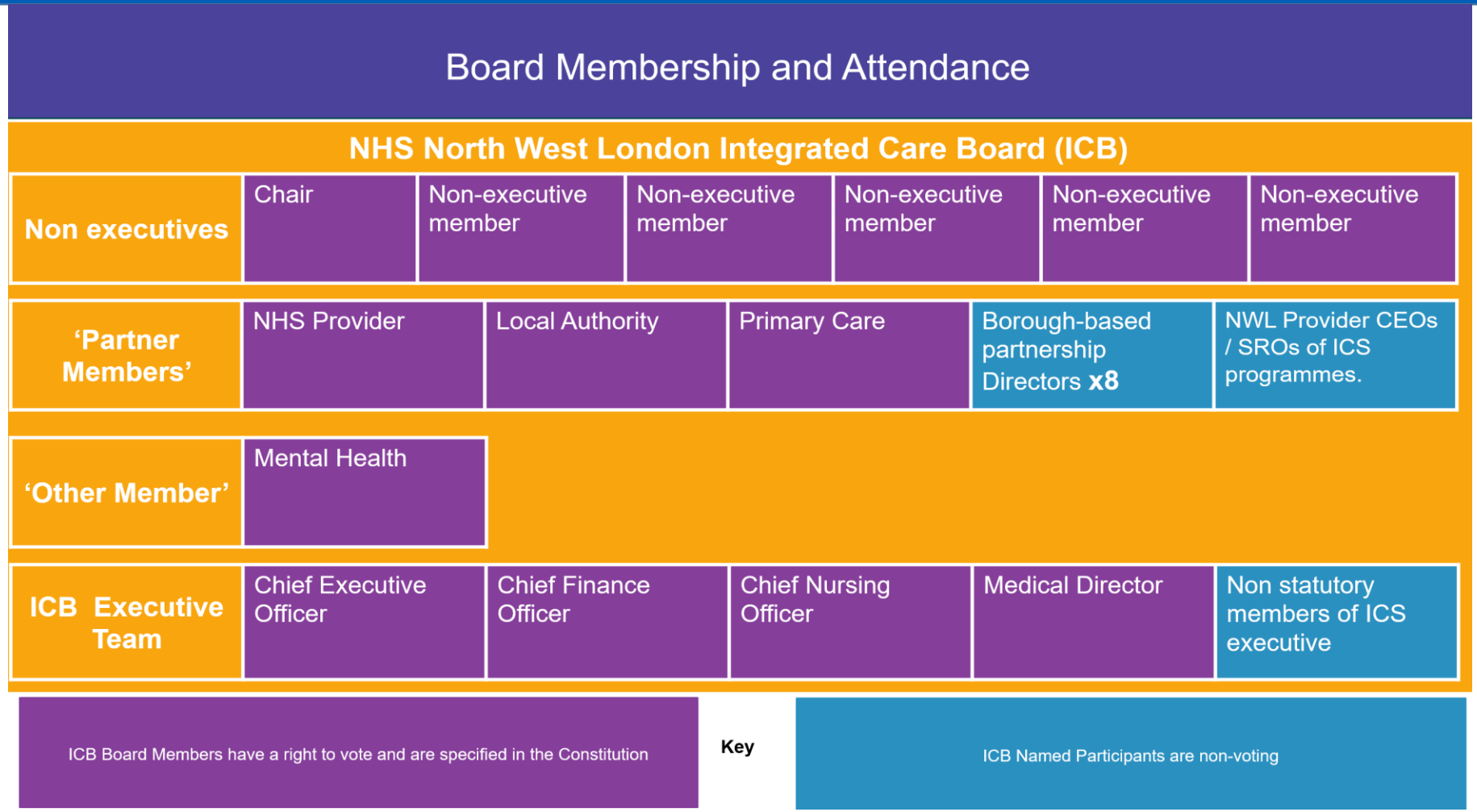
Purpose of ICP: statutory committee to bring together local authorities, NHS, key stakeholders to co-produce the NWL health and care strategy, and to align purpose, ambitions and plans for the NW London integrated care system. The ICP will be co-chaired by LA leader and chair of ICB.

Membership: ICPs can determine membership above the statutory minimum prescribed by Legislation; x1 member appointed by each of the local authorities responsible for social care within the ICS area and x1 member appointed by the Integrated Care Board. The proposed membership to be presented to the first ICP meeting on 27th September 2022 includes:

- **Local authorities**: x1 member appointed by each LA, up to 8 members appointed by DPH, up to 8 members appointed by directors of adult social services and up to 8 members appointed by directors of children's services.
- **Integrated Care Board**: 2 members appointed by each Borough Based Partnerships, one of which must represent the resident voice for the borough covered by that partnership. Further 5 members appointed from executive of the Integrated Care Board.
- **Statutory NHS Providers**: 1 member appointed by each of the NHS providers + 1 member appointed by each of the of the NHS providers accorded named participant status for the Integrated Care Board
- **Primary Care**: 1 member appointed by primary care providers (likely to be same as the primary care member of the ICB)
- **Academic partners**: 1 member from each; AHSC (Imperial College Academic Health Science Centre), AHSN (Imperial College Health Partners), Imperial College London
- **Major employers**: 2 members appointed by the Chair(s) of the ICP to represent major employers in NWL
- **Third sector**: 2 members appointed by third sector and **Healthwatch**: 1 member appointed by each Healthwatch Committee relevant to the ICS area

The ICP may wish to consider additional members i.e. Collaboratives (Royal Marsden Partners), Primary Care members working in each of the 8 borough based partnership, LMC.

Integrated Care Board membership



The Integrated Care board membership is in line with legislative requirements and the NW London ICB Constitution to fit the context of NW London healthcare system and needs of our population (*s7.9 of Constitution)*

Proposed variations in Local Authority ICB membership

Our continued aim is to develop effective engagement between the ICB and Local Authority colleagues and ensure it is inclusive and clear in terms of responsibilities and accountabilities in order to deliver the objectives of the ICS. We remain in the process of updating the ICB constitution with the involvement of LA partners, including process for setting ICB agendas.

Proposed variation: increase to *two Local Authority members, to be voting member of the NWL ICB Board*, to be nominated by Local Authorities. (We will continue with a lead LA CEO in our ICS leadership team and on the ICB and would consider one of the voting members could be this LA lead CEO).

LA engagement and involvement: LA colleagues are members of each Borough Based Partnership (BBP) and are engaged in the development/appraising of innovative options of providing services, to respond to increase in demand across health & care, decreased workforce and cost of living crisis. Examples of forums beyond place where LA and NHS colleagues work together are:

- Hounslow LA CEO is joint chair of the ICS Population Health and Inequality Board
- Weekly ICS leadership group includes lead LA CEO and LA and Leaders meet with NHS leadership team once every 6 weeks
- DASS group meets with NHS on local Care issues fortnightly
- public health colleagues are included in particular work streams as system representatives, i.e. Specialist Palliative Care review
- Local Authority colleagues are members of Local Care Board
- BBP workshops – to continuously learn from and develop the 8 Borough Based executive leadership teams as these were originally set up in October 2020 with a lead NHS Director accountable for integrated delivery and to be the single point of contact for the NHS working alongside Local Authorities. LAs were involved with the selection of the BBP leads in each of their Boroughs.

  It is possible for a Local Authority executive to be put forward to be the BBP lead on the Board.

West London NHS Trust

Ealing Adult Acute Mental Health Beds

Enhanced Engagement Approach Oct-Dec 2022

West London NHS Trust

August 2022

1. Context and purpose

In the early stages of the Covid-19 pandemic (March 2020), the Trust suspended the use of the 31 inpatient beds and HBPOS in the Wolsey Wing on a temporary basis. This was done to ensure safe staffing levels and rigorous infection and control measures for patients and staff across the three boroughs.

The Trust has diverted the resources made available through suspension to open an 18-bed inpatient ward (Robin ward) in Lakeside Mental Health Unit which better meets modern standards of care dignity and privacy; and provide dedicated staffing for the Hounslow HBPOS.

In addition, the Trust has also opened nine additional mental health beds in supported living settings across the three boroughs. Known as step-down beds, these provide rehabilitation and reablement care following discharge from the hospital and before people move back to their own communities. This remains the current position.

2. The case for change

The physical environment in the Wolsey Wing, built in 1829 before the NHS was founded is not fit for delivering modern health care. The Care Quality Commission (CQC) have been critical in their inspections over the years and commented that despite the very best efforts of staff, the two wards based in the Wolsey Wing did not promote privacy, dignity and recovery and struggled to meet the equality, accessibility and quality standards that are essential for safe and effective clinical care. WLT is committed to providing inpatient care in a modern environment, conducive to recovery, so that people can return as soon as possible to their local communities and stay well, supported by a range of easily accessible services.

3. Progress

In December 2021, the Trust began work on a business case to develop a permanent solution for the wards and future provision of adult acute inpatient mental health care. Through earlier phases of the project, we have clarified the scope and set up of the work required, mapped impacts and stakeholders with outcome modelling, collated qualitative and quantitative insights, carried out early engagement with service users, carers and wider communities, as well as staff, commissioners, the local authority, and NHSEI. This led to development of case for change, development, scoring, shortlisting and selection of possible options (that incorporated the early feedback received) and provided greater clarity on the specific groups to further engage in moving towards a decision on the future of the wards.

We are now progressing to the fourth and penultimate phase, the purpose of which is to carry out wider engagement to inform final decision-making. During this engagement phase, we will broaden our engagement to build on earlier engagement findings, and inform the outcomes including mitigation measures that ensure equality of access for people in Ealing.

4. The preferred option

The preferred option would mean services continue to be provided from Robin ward and Hope and Horizon wards are permanently closed. Reinvestments would continue into Robin ward, HBPoS service, SPA service and step-down pathways, as is currently the case.

The Trust would continue to offer adult inpatient mental health care from 226 beds across its three boroughs with 55 beds in Ealing, 89 beds in Hounslow and 82 beds in Hammersmith and Fulham. This would represent a reduction of 13 adult acute mental health beds overall.

he funding would remain ringfenced acute, crisis and community-based services across the Trust's catchment population. The Trust is committed to invest any additional funds from Mental Health Investment Standards in developing additional local solutions, based on feedback received in this proposal development process. It remains a priority that patients are not admitted to inappropriate out of area placements for adult inpatient mental health care, as seen in recent years.

5. Our proposed approach for enhanced engagement

During this wider engagement we will be seeking feedback on the proposal, to identify any areas we have not already considered. We will also be testing the solutions that are being developed to mitigate perceived impacts on different communities, and looking into any additional solutions that have not yet come forward.

We will use a blend of communication and engagement activities that are tailored to the audience we are aiming to reach. The engagement methods we propose to use in the phase are:

- Webinars and online events
- Focus groups and 121 interviews
- Survey
- Briefings
- Attending existing meetings
- Writing to service users
- Posters and documents on hospital sites
- Non digital channels (postal address)
- Existing networks and contacts

Key findings from the early EHIA and travel analysis have identified several groups most likely to be impacted (but not disproportionately affected) by proposal. In this engagement phase, we will continue to seek to engage with these groups to ensure that we fully understand and include their perspectives.

This phase of engagement is currently expected to run for 10-12 weeks, following a decision from the WLT board to approve this approach, and will be informed by discussions at Ealing OSC.

6. Rationale for a wider engagement approach

To date, stakeholder engagement has supported developing options for change and options appraisal criteria. Service user and voluntary sector representatives were also involved in the shortlisting of options into a single preferred option. Those most affected by any changes to the service have been involved to understand experiences of the service at Hope and Horizon and the change since moving services temporarily, due to COVID.

Feedback from our early engagement phase has showed **strong support for the need to change and agreement that Hope and Horizon wards are not fit for purpose**. There has been broad understanding of the case for change. Therefore, the Trust believes **a period of wider, enhanced, engagement is most appropriate for the scale of change**. This approach satisfies legal duties and obligations, further details of which can be found in the Trust's Enhanced Engagement Plan.

This enhanced engagement period will focus on understanding, from the wider community; the **impacts of implementing the single preferred option**, **testing the mitigations** that the Trust are considering putting in place and if there are **any further considerations** within the preferred option that need to be explored.

7. Next steps and moving towards a decision

Following completion of the enhanced engagement phase, a post engagement report will be produced in January 2023, that summarises the activities and findings from the phase and how any feedback will be taken forward in the final phase of the project which will focus on decision making and implementation. The final outcomes are intended to be presented for decision making to Ealing Scrutiny Committee in February 2023.

Report to the North West London Joint Health Overview Scrutiny Committee – 14 September 2022

North West London Joint Health Overview Scrutiny Committee Terms of Reference Refresh

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

1.0 Purpose of the Report

1.1 To set out the draft refreshed terms of reference for the North West London Joint Health Overview Scrutiny Committee.

2.0 Recommendation(s)

2.1 The committee is asked to review and agree the draft refreshed terms of reference for the North West London Joint Health Overview Scrutiny Committee as set out in Appendix 1.

3.0 Detail

3.1 In the context of changes to the North West London health sector landscape, the committee's terms of reference have been refreshed pending approval from the committee.

3.2 The Health and Care Act 2022 led to the creation of Integrated Care Systems (ICS) in local areas, which are now fully implemented. This includes replacing Clinical Commissioning Groups with the North West London Integrated Care System (i.e. the Integrated Care Board) and the establishment of the Integrated Care Partnership. In North West London, the ICS includes eight local authority areas, which are all represented as voting members of the North West London JHOSC.

3.3 Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

3.4 Integrated Care Boards are statutory NHS organisations that are responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care Systems area.

3.5 Once the committee agrees and approves the content of the draft refreshed terms of reference as set out in Appendix 1 of this report, they will be incorporated into the Constitutions of

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NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TERMS OF REFERENCE 2022

Membership

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

Terms of Reference

1. To scrutinise the plans for meeting the health needs of the population and arranging for the provision of health services in North West London; in particular the implementation plans and actions by the North West Integrated Care System and their Integrated Care Board, focusing on aspects affecting the whole of North West London. Taking a wider view than might normally be taken by individual local authorities

2. To review and scrutinise decisions made, or actions taken by North West London Integrated Care System, their Integrated Care Board and/or other NHS service providers, in relation to the plans for meeting the health needs of the population and arranging for the provision of health services in North West London, where appropriate.

3. To make recommendations to North West London Integrated Care System and its Integrated Care Board, NHS England, or any other appropriate outside body in relation to the plans for meeting the health needs of the population and arranging for the provision of health services in North West London; and to monitor the outcomes of these recommendations where appropriate.

4. To require the provision of information from, and attendance before the committee by, any such person or organisation under a statutory duty to comply with the scrutiny function of health services in North West London. Individual local authority members of the North West London Joint Health Overview and Scrutiny Committee will continue their own scrutiny of health services in, or affecting, their individual areas (including those under the for North West London).

5. Participation in the Joint Health Overview and Scrutiny Committee will not preclude any scrutiny or right of response by individual boroughs. In particular, and for the sake of clarity, this joint committee is not appointed for and nor does it have delegated to it any of the functions or powers of the local authorities, either individually or jointly, under Section 23 of the local authority

(Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Duration

The Joint Health Overview and Scrutiny Committee will continue until all participating authorities decide otherwise and does not preclude individual authorities from leaving the Committee if they choose to do so. The Committee will keep under review whether it has fulfilled its remit and recommendations of the Committee will be reported to a Full Council meeting of each participating authority, at the earliest opportunity.

Report to the North West London Joint Health Overview Scrutiny Committee – 14 September 2022

Scrutiny Committee Work Programme Update

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

1.0 Purpose of the Report

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

2.0 Recommendation(s)

2.1 The committee to note the contents of the report and changes to the work plan outlined in Appendix 1.

3.0 Detail

3.1 The work programme sets out the items which the North West London Joint Health Overview Scrutiny Committee will consider during the municipal year.

3.2 The work programme of a scrutiny committee is intended to be a flexible, living document that can adapt and change according to the needs of a committee. The changes set out are reflective of this.

3.3 The work programme has been updated to reflect that the London Borough of Richmond upon Thames are hosting the 14 September meeting of the North West London Joint Health Overview Scrutiny Committee.

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

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

20 July 2022

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

14 September 2022

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

7 December 2022

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

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

8 March 2023

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

TBC		Ealing