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North West London Joint Health Overview and Scrutiny Committee

Tuesday 18 July 2023 at 10.00 am
Committee Room 6 - Hillingdon Civic Centre, High Street, Uxbridge, UB8 1UW

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North West London Joint Health Overview & Scrutiny Committee

Date: **TUESDAY, 18 JULY 2023**

Time: **10.00 AM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Media are welcome to attend. This meeting may also be broadcast live.

Published: Monday, 10 July 2023
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Agenda

1 Apologies for absence and clarification of alternate members

2 Election of Chair and Vice Chair

3 Declarations of Interest

4 Minutes of the previous meeting

5 Matters Arising (if any)

6 North West London Strategy for Provision of Acute Beds

7 Standardisation of Adult & Paediatric Ophthalmology Services Across North West London - Update for JHOSC

8 Development of Musculoskeletal Services Across North West London - Update for JHOSC

9 North West London Joint Health Overview Scrutiny Committee 2023-24 Work Programme

10 North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

11 Any other urgent business

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Minutes of a meeting of the NWL Joint Health Overview and Scrutiny Committee held at Ealing Town Hall at 10.00am on 8th March 2023

Members of the Committee
Councillor Ketan Sheth (Chair)
Councillor Daniel Crawford (Vice-Chair)
Councillor Nick Denys
Councillor Chetna Halai
Councillor Lucy Knight
Councillor Natalia Perez
Councillor Angela Piddock
Councillor Marina Sharma
Councillor Claire Vollum

Others in Attendance
Chris Hilton, COO, Local and Specialist Services, West London NHS Trust
Rory Hegarty, Director of Communications and Engagement, NHS NWL
Rob Hurd, Chief Executive of NHS NWL Integrated Care Service
Pippa Nightingale, CEO London North West University Healthcare NHS Trust
Carolyn Regan, CEO, West London NHS Trust

Virtual Attendance
Roger Chinn, CMO, Chelsea and Westminster NHS Trust,
Martina Dineen, EOC Programme Manager, NHS NWL ICS
Michelle Dixon, Director of Communications, Imperial College Healthcare NHS Trust,
Dr Gareth Jarvis, Medical Director, Central and North West London NHS Foundation Trust
Richard Mountford, Deputy Director Communications, West London NHS Trust,
Clare Murdoch, CEO, Central and North West London NHS Trust,
Ann Sheridan, Managing Director, Jameson Division Central and North West London NHS Foundation Trust.

1. **Apologies for Absence**

   There were no apologies for absence.

2. **Urgent Matters**

   There were no urgent matters.

3. **Declarations of Interest**

   The Chair, Councillor Ketan Sheth (London Borough of Brent) declared that he was the Lead Governor at Central & North West London NHS Foundation Trust.

4. Matters to be Considered in Private

There were no matters to be considered in private.

5. Minutes

The minutes of the meeting of the Committee held on 7 December 2022 were confirmed as a correct record.

6. Elective Orthopaedic Centre – Summary of Consultation and Proposal

Pippa Nightingale provided the Committee with the results of the North West London Elective Orthopaedic Centre public consultation, the key themes and emerging responses, and an update on developing a 'decision-making business case' for the proposal and next steps.

The Committee discussed the report and the following points were made:

- Members asked if the proposal was aligned to the Mayor of London's Six Tests for service reconfiguration and were informed that it had gone through a number of assurance arms, of which the six tests were one, and included the clinical senate and public consultation. All of these were following similar themes but with slightly different nuances and had provided a good insight which had been helpful in highlighting where further work had needed to be done.
- Members commented that they would have like to have seen the detail of how the five key themes identified in the consultation were to be addressed. Pippa Nightingale responded that the more detailed paper would be shared with the JHOSC, when it was ready. It was a timing issue to produce that at the same time as getting the business case completed. Travel was the key theme that NHS North West London (NWL) would be addressing. There would be different elements of travel options for patients depending on their needs, including door to door collection for orthopaedic patients where that support was required. NHS NWL realised that it needed to work with the Greater London Authority (GLA) and Transport for London (TfL) to redirect some of the bus routes and better connect the outer London boroughs to the hospitals. The key message for the orthopaedic centre was that it would only require one journey, as most of the care would be provided locally. The clinical model was about meeting the best national standards to provide better outcomes and minimising disruption for the patient.
- Members asked how far NHS NWL was from producing the final business case and heard that it was 90 percent complete. The remaining work was around setting the final targets and it would not be significantly different from the draft.
- Members expressed strong reservations around how the issue of travel to the proposed orthopaedic centre was being addressed stating that from some parts of NWL a journey on public transport could require a number of transfers, which would be difficult for people with mobility issues. A detailed

travel plan that addressed these concerns and provided clarity needed to be in place. Pippa Nightingale stated that the travel plan would be included with the business case and added that patients, when travelling to the hospital for surgery, were less likely to use public transport. Mapping had shown that a third of the patients for the elective orthopaedic centre from across NWL would be entitled to door to door hospital transport, arising from an assessment of their needs. A longer piece of work needed to be done with TfL about improving accessibility to the hospital for all patients. Rob Hurd informed the Committee that as part of the contract between the Integrated Care Board and the provider collaborative there would be close monitoring which would make reference to the output of the business case including transport. He assured the Committee that their concerns concerning travel would be picked up in that monitoring process.

- Responding to a request for more information about the context for the centre, Pippa Nightingale reassured the JHOSC that the clinical model for the centre had not changed from that previously stated. Patients would continue to have choice at the point of referral from their GP, if they chose to come to the elective orthopaedic centre the model was clinical care locally by the GP and the local hospital, and one visit to the centre. Rob Hurd added that from an NHS NWL perspective, services were not considered on a hospital by hospital basis, there was an overall wating list for NWL and the additional capacity provided by the centre would significantly reduce inequality of access and waiting times. The experiences of other places that had implemented this type of service was that you needed to focus on transport, provide the door to door service, and have the care remaining local.
- Members asked whether clinicians and other staff groups were in support of the proposed service, especially if they were based elsewhere and would be travelling across NWL to the centre. Pippa Nightingale replied that work was currently being undertaken with staff groups, however a lot of the nursing and support staff posts would be filled with new recruits, staff were not just being moved. The work plans for surgeons would be changed to accommodate them moving around. There was a commitment from the clinicians to the proposal, as they saw the benefits from the same service model at the South West London Orthopaedic Centre.
- Members queried whether recruitment would be happening locally and were informed that there was a lot that could be done by the NHS to recruit local people. However as a range of posts were being recruited to, the adverts would go far and wide to attract expert staff, as well as people from the local community.
- The response rate to the consultation from Hounslow residents was seen as being quite low and members asked whether further engagement would be taking place. Pippa Nightingale said that there would be a communications campaign for residents, patients, and GPs which would consider who needed to be communicated with throughout the pathway. There would also be a branding campaign for the elective orthopaedic centre and the key area would be way finding so there was no confusion about where the hospital was and how to find the orthopaedic centre within it. The messaging about the service could also be cascaded by local authority partners through their links.
- Responding to questions about the waiting list for elective orthopaedic surgery and how the centre would assist with that, Pippa Nightingale said that there

was a two year backlog in the NHS and patients were assessed by clinical need. Orthopaedic patients were not the top priority if they had no life or death need, although they were often in pain and discomfort. Having the centre would mean a more efficient service in terms of the number of operations that could be done each day, without the pressure of supporting an Accident and Emergency Service as it was a non-urgent hospital site. The backlogs were broken down by borough and not one borough would be disadvantaged above another.

- Members asked if future funding for the centre would be impacted if the NHS returned to a payments by results model and were informed that the Integrated Care System fully supported the service. As well as providing better outcomes for patients and a more efficient service, it economically made sense.
- That for those patients who chose a local option for their orthopaedic surgery, how would it be ensured that the quality of those services was as high and how would waiting lists at those services be monitored. Pippa Nightingale stated that there were national metrics for each hospital and speciality which could identify adverse outcomes or where patients had a quicker recovery and those would continue to be monitored. Waiting lists would constantly change, the GP could see where the waiting lists were and discuss that with the patient when they were making the decision about where they wanted to be treated.
- Members queried why the quantitative survey for Harrow had the lowest number of responses at 6% compared to 28% for Hillingdon. Pippa Nightingale said that she would follow this up outside of the meeting and respond to the Committee in writing.

The Chair summarised the discussion.

Information Requests:

- To receive a response to the query regarding the disparity across North West London boroughs in the response rate to the quantitative survey.
- To share the final business case for the elective orthopaedic centre with the committee as soon as possible.
- To share the final travel plan for visitors, patients and staff with the committee when it becomes available.

Recommendations:

- To recommend that a specific travel plan is developed that addresses travel related concerns expressed in the consultation to reassure patients and stakeholders.
- To recommend that there should be monitoring of the quality of the elective orthopaedic services provided locally and at the centre located within Central Middlesex Hospital, to ensure that they are consistent and of the same standard.
- To recommend that more detail is supplied on how the NHS is implementing the consultation feedback on transport when this issue next comes back to JHOSC.

- To recommend that a communications campaign for the elective orthopaedic centre is delivered in conjunction with local government and other stakeholders.

7. North West London Integrated Care System Update

Rob Hurd introduced the report updating members on a number of current work streams being delivered across the North West London Integrated Care System.

The Committee discussed the report and the following points were made:

- Members noted that the Butterworth Centre, which provided advanced dementia care, was due to temporarily close from 31 March and asked what arrangements had been put in place for the patients that were there. Rob Hurd replied that equivalent beds had been identified for those patients, alternative provision would be put in place with no overall reduction in capacity. Details of where those beds were located would be provided to the Panel in writing. The change in service provision had been driven by a set of circumstances which NHS NWL had to respond to, it had not been planned.
- Members asked if residents and patients would be involved in the formative stage of the development of a new musculoskeletal (MSK) model of care and what the timescales were for this work. Rob Hurd informed the committee that there was set of contractual arrangements in the service which were coming to an end and needed reviewing. NHS NWL was considering its procurement processes, the funding for services, the ability to build in co-production at the start, and the ability to vary contracts for different service models. Currently the focus was on stabilising the services, post September there would be the opportunity to build into new contracts the involvement and engagement for service design processes that would form part of the future service provision. The Committee requested further detail in writing on how the changes to the MSK and Ophthalmology Services would be progressed, the engagement that would be undertaken and the early input that the Committee could have.
- Members asked about what had been done to benchmark NHS performance in NWL against other areas, particularly for A&E waiting times and discharge delay and requested that the Committee regularly received comparative performance data. Rob Hurd said that NHS NWL had some of the most advanced business intelligence data in the country and that, as well as continuing to provide a performance report, he would provide comparative performance data for the Committee.
- Members asked when the workforce strategy was due to be delivered and were informed that it was a component part of the Integrated Care System Strategy. There would be an engagement process during April to June on the content prior to publication, however publication would be delayed until any serious issues of concern that might be raised were addressed. The Committee requested that the Workforce Strategy be shared with it.

The Chair summarised the discussion.

Information Requests:

- That NHS North West London provides comparisons to other London Integrated Care Systems' performance on key metrics as part of the regular performance report sent to the committee.
- To provide more information on the planning work being undertaken for the roll out of the spring 2023 Covid booster.
- To receive details on how the NHS will ensure that patients who need to be moved from the Butterworth centre will be moved seamlessly into alternative care.
- To provide the JHOSC with the details of the final North West London workforce strategy when it becomes available.

8. Inpatient Mental Health Bed Capacity across North West London

Carolyn Regan, Clare Murdoch and Chris Hilton provided the Committee with a report on current adult inpatient mental health bed capacity across the North West London Integrated Care System.

The Committee discussed the report and the following points were made:

- Members expressed serious concerns that the proposal for the changes to mental health beds in North West London were not being formally consulted on, stating that enhanced engagement was not sufficient. Chris Hilton thanked the Committee for the feedback that had been given about the decision to following an enhanced engagement approach, this had been the advice received from the London Regional Team at the start of the decision making process, however lessons would be learned. It was however important to acknowledge that the facilities in Ealing were below the quality and safety of the services that the Trust would wish to offer.
- Members stated that it was concerning that mental health beds were being lost when there was a mental health crisis and asked why had there not been advance planning to adapt these wards. Chris Hilton replied that in relation to the services in Ealing for adults in acute mental health crisis, a number of options were considered to make the facilities safe and fit for purpose and the estimated cost for refurbishment for the Wolsey wing was over £19 million pounds. Carolyn Regan added that a building from 1831 was difficult to convert for modern health services and welcomed any of the Committee members who had not yet seen the building to visit.
- Members suggested that 12,000 responses to the survey was fairly small for a major service change, when considering the population size across the three boroughs that were impacted.
- In response to the Committee's concerns on the mental health estate and lack of investment, both Carolyn Regan and Claire Murdoch said that they would be happy to bring the mental health estates strategy to the JHSOC and to work with the JHOSC on this going forward.
- Members requested reassurance that the spend on mental health services for the residents of Ealing, Hammersmith and Fulham would not be negatively impacted and received a commitment from Carolyn Regan to increased spend on mental health services and an agreement to share some of the data on that with the JHOSC.

- Committee asked for summary of impact that the service change would have on the patients and carers as a result of going from bedded provision to community based and had that patient and carer safety has been adequately considered. Chris Hilton said that they would be evaluating all of the feedback and were happy to share that and the impact assessments.
- Members asked if it would be possible to adapt part of the Gordon building so that beds could be made available for acute cases. Claire Murdoch replied that formal consultation would be launched in July on the model of care, currently the service was intensively engaging with LA colleagues and services users. There had been significant investment in mental health, and as the national director and local Chief Executive she would oppose anything that sought to take money out. With regard to beds, the service was looking at what could be done to create more beds in Westminster and also whether the ground floor of the Gordon building could be used for a mental health hub. It was clear that there were crisis pressures in the Urgent and Emergency Care Pathway, however that did not always mean that the answer was more beds.

  The Chair summarised the discussion.

Information Requests:

- To provide further information on the current spend by West London NHS Trust on mental health services across the three boroughs, the spend available per resident, and how the money was allocated so that the JHOSC can effectively scrutinise the future development of mental health services across North West London.
- To receive details on how the move towards community based mental health care will impact residents, referencing results from integrated impact assessments undertaken.
- To receive feedback from patients and carers from West London Trust's enhanced engagement when available.

Recommendations:

- To recommend that the NHS work with the JHOSC to engage on a mental health specific estate strategy by bringing this item to a future JHOSC meeting.
- To recommend that the NHS works with the JHOSC to shape the future public consultation on the Gordon Hospital.

9. North West London JHOSC Recommendations and Information Requests Tracker

The Committee noted the report.

10. North West London JHOSC Work Programme Update

The Committee noted the report.

The meeting ended at 11.55am.

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Title of report	North West London strategy for provision of acute beds
Author (name and role)	Toby Lambert, Executive Director of Strategy and Population Health

North West London Strategy for provision of acute beds

JHOSC has asked for a report detailing the North West London ICS' Strategy for the provision of acute beds across North West London. The report should also focus on the potential impact of the government's recent decision to postpose the delivery of three 'new' hospitals across the ICS on the North West London's strategy for the provision of acute beds across North West London.

Background/ context

For the purposes of this report, we have assumed that JHOSC is interested in somatic, rather than psychiatric, beds (i.e., beds primarily used for those with physical health conditions, rather than mental health conditions) and for curative care, rather than rehabilitation, long term care or palliative care. By curative care, we mean beds accommodating patients where the principal clinical intent is to do one or more of the following:

- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care); reduce severity of illness or injury, protect against exacerbation and/or complication of illness and/or injury which could threaten life or normal functions; and/ or
- perform diagnostic or therapeutic procedures.

There are live discussions on proposals for mental health care which have been covered in depth elsewhere. The ICS has commenced work on the strategy for mental health, building on 2015's Like Minded – The North West London Mental Health and Wellbeing Strategy, which will come to North West London's Integrated Care Partnership in due course.

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

There are 11 acute hospital sites in North West London, organised into four Trusts (Imperial Hospitals NHS Trust, Chelsea and Westminster NHS Foundation Trust, London North West University Hospitals NHS Trust and Hillingdon NHS Foundation Trust).

Combined, each year these sites deliver over 500,000 urgent and emergency contacts, 152,000 emergency admissions, 2.7m specialist outpatient appointments, 246,000 diagnostic imaging tests and 17,800 elective surgeries (as day cases and as inpatient cases). At present there are 3,150 such beds across North West London, broken down as follows:

Trust/Site	Borough location	Boroughs which account for 10% or more of bed use	Ave. Open Beds Jan to Jun 2023	Ave. Open Beds 2019/20
Chelsea and Westminster Hospital NHS Foundation Trust			**712**	**689**
Chelsea & Westminster Hospital	Kensington & Chelsea	West London, Hammersmith & Fulham	314	308
West Middlesex Hospital	Hounslow	Hounslow, Ealing	398	381
Imperial College Healthcare NHS Trust			**1,058**	**1,034**
Charing Cross Hospital	Hammersmith & Fulham	Hammersmith & Fulham, Ealing	421	413
Hammersmith Hospital	Hammersmith & Fulham	Hammersmith & Fulham	294	266
St Mary's Hospital	Kensington & Chelsea	Westminster, Kensington & Chelsea, Brent	343	344
Western Eye Hospital	Westminster	All North West London boroughs	0	11
London North West University Healthcare NHS Trust			**1,012**	**1,098**
Central Middlesex Hospital	Brent	Brent, Ealing	79	107
Ealing Hospital	Ealing	Ealing	267	281
Northwick Park Hospital	Brent	Brent, Harrow	666	710
The Hillingdon Hospitals NHS Foundation Trust			**367**	**422**
Hillingdon Hospital	Hillingdon	Hillingdon, Ealing	367	422*
Mount Vernon Hospital	Hillingdon		0	
Total			**3,150**	**3,242**

***Please note that the way in which bed numbers are calculated has changed since 2019/20, with rehab beds no longer included in the total. The comparable number for Hillingdon in 2019/20 is 365.**

For the purposes of the table, Queen Charlotte's and Chelsea hospital is treated as part of the Hammersmith. A standard approach to counting and classifying beds has not been in place in previous years and work is under way with Trusts to put a consistent approach in place. Consequently, the figures above do not give a like with like comparison between the two periods. The national focus for this year is for Trusts to achieve a maximum bed

occupancy of 92%. Delivery of this standard will be supported by more accurate counting of beds, which has previously over stated the number of beds that are open and available for use.

Records prior to 2019 capture acute beds by trust, rather than by site. We have indicated which borough the beds are located in, though as many residents attend or are admitted to a site outside their borough of residence this does not reflect the usage of beds by residents of each borough.

Looking forward, there are a number of trends that affect the overall number of beds required. These include:

- Population changes. Both changes in the overall number of residents in NWL, and in the demographic breakdown of that population (e.g., all other things being equal, older residents require more hospital care) affect the number of beds required.
- Managing patients in the least intensive setting appropriate for their care;
- New treatments and new technology;
- Ensuring that only those residents that require an inpatient stay receive an inpatient stay;
- Ensuring that residents requiring inpatient care are treated and discharged in a timely fashion;
- The number of people waiting for treatment.

Population change

There are many population projections available from the Office for National Statistics and the Greater London Authority. Generally, projections differ in their assumptions on birth rates, death rates and migration (both within the UK, and from/ to abroad). North West London uses the GLA's identified capacity housing-led projections for its central population forecast, as this best captures local developments.

Using this projection, and adjusting for ageing within the population as well as overall population growth, we would anticipate an increase of 15-20% in hospital activity from 2019 to 2035, or around 1% per year. This is consistent with the activity projections in the business cases for the St Mary's, Charing Cross, Hammersmith and Hillingdon hospitals.

New treatments

As technology advances, new treatments become available. Some treatments support shorter lengths of stay or remove the need for it entirely (for example, in the late 1980s hospitals routinely had dedicated HIV wards; the advent of antiretroviral treatments has both improved outcomes for those living with HIV and almost entirely removed the need for beds); some treatments prolong the life of those that otherwise would have died/ would not have been treatable. The rise of remote monitoring may support the expansion of efficacy of 'hospitals at home' or virtual wards, allowing residents to be treated and home and thereby reduce the need for inpatient beds. Often new treatments start with a longer length of stay that shortens over time (coronary artery disease was initially treated with open heart surgery, but can now often be treated with key hole surgery).

Least intensive setting appropriate for their care

There has been a long term shift to less intensive settings – planned treatments that originally required an overnight stay can now be performed as day cases; treatments that were carried out as day cases can now be performed in outpatient settings. Similarly, some emergency treatments that would routinely have led to an overnight stay are now performed as Same Day Emergency Care. This provides a multi-disciplinary clinical service that can give more clinical input and diagnostics than patients would ordinarily receive in Emergency Departments, substitutes for hospital stays and hence decreases the beds required.

Ensuring that only those residents that require an inpatient stay receive an inpatient stay

For many residents, inpatient hospital care is absolutely the most appropriate place for them to be. However, we know that there are a considerable number of admissions for conditions where alternatives should be available. These include admissions for ear/nose/throat infections, kidney/urinary tract infections, angina, diabetes, epilepsy and high blood pressure. These equate to approximately 16,000 admissions annually.

Design and implementation of standardised frailty pathways are underway across the sector. These will link with the virtual ward and acute front door frailty models, ensuring that where possible, frail patients can be treated in alternative settings to hospital beds. This will be aligned with improved resources for care homes, supporting them to manage patients in the home and avoid preventable ambulance conveyances to emergency departments.

Another focus is on end of life care pathways, increasing the use of Advanced Care Planning and use of the London Urgent Care Plan, which will allow services to access information about patients assessed as being in their last year of life. Emergency Departments are increasing the use of these plans, assisting with the co-ordination of patients by services across healthcare settings so that they are supported outside of hospital rather than admitted.

Likewise, a hospital at home service for children is in place across the sector, which since being implemented has been able to demonstrate a reduction in hospital admissions and emergency department attendances. It is absolutely right that many residents have an inpatient stay, however, we know that prolonged inpatient stays beyond the curative are often damaging to patients with significant impacts that can increase their length of stay in hospital and increase the challenges when returning home. This includes physical deconditioning such as loss of muscle tone, greater confusion and vulnerability with a prolonged stay in an unsuitable environment and exposure to hospital acquired infections.

Ensuring that residents are discharged in a timely fashion

Inpatient admissions, while often appropriate, can nonetheless be disruptive for individuals. Prolonged stays in particular can make it harder for residents to return home. For example, prolonged bed rest can result in a loss of muscle tone, and/or increase confusion among those already experiencing cognitive decline.

According to acute data, since April this year between 12%-14% of acute beds across NWL are taken up with residents that do not meet the criteria to reside.

The number of people waiting for treatment

Insufficient capacity leads to an increase in those waiting – in emergency departments, in the time ambulances spend waiting outside emergency departments to handover patients, and for planned care. This has been exacerbated by the rebound in care following the pandemic, and by industrial action by some of the clinical and/ or professional groups staffing our hospitals.

North West London routinely increases bed capacity during winter to meet the pressures that increased demand and clinical acuity bring. To increase ongoing resilience at particularly challenged hospital sites NHS England has released £26m capital funding for new wards in North West London, 28 beds at West Middlesex and 34 beds at Northwick Park. This will enable the sector to move towards achieving a bed occupancy of 92% during winter 2023/24.

This in turn will reduce the waits that patients experience in emergency departments, enable ambulances to offload more swiftly and get back on the road with the impact that patients will spend less time waiting for an ambulance in the community.

The majority of those waiting for planned care, however, are waiting for outpatient treatments; and of those waiting for planned inpatient treatment, the majority are for day case care. The backlog in specialties requiring significant numbers of overnight beds is being address through elective centres (e.g., the elective orthopaedic centre at Central Middlesex for hip and knee replacements).

Conclusion

In terms of number of beds required, these factors push in different directions. Population growth and aging increase the demand for beds; technology and new treatments can do either, but generally push downwards; less intensive settings, alternatives to admission and ensuring residents return home swiftly reduce the demand. The strategy addresses how we can meet the challenges, and ensure that our acute bed provision remains fit for purpose.

ICS Strategy

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

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

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

Routine access to specialist expertise

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

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

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

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

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

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

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

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

Improving access to elective surgery – day cases and inpatient cases

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

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

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

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

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

For example, we are currently developing an elective orthopaedic centre, which will bring together patients and specialists from across North West London in a purpose-designed centre with the goal of delivering rapid access and world-class clinical outcomes.

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

Convenient, effective, and timely access to diagnostics

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

- Starting in primary care, GPs will be supported with Clinical Decision Support (CDS) electronic tools that help direct referrals to the most appropriate place and ensure that results are rapidly available to both GPs and patients.
- Once referred for diagnostics, electronic systems such as Swiftqueue allow patients to organise and modify their own appointments online at their convenience. They also support electronic scheduling systems to improve the use of diagnostic equipment. Again, cross-North West London working in hospitals allows for patients to receive care

as quickly as possible, ensures that there is no unnecessary duplication of tests and cuts out unnecessary travel for patients.

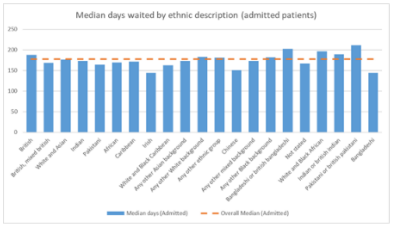
- We will continue to explore the use Artificial Intelligence (AI) tools to support diagnostics and ensure that specialist staff capacity is used effectively. To help achieve this, an AI strategy is being formulated and pilot initiatives rolled out.

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

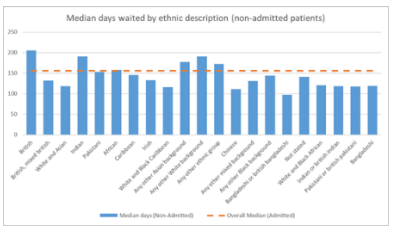
Community Diagnostics Centres (CDCs) are being established to provide additional capacity and more accessible diagnostics in Wembley, Willesden, and Ealing (all areas of high health need).

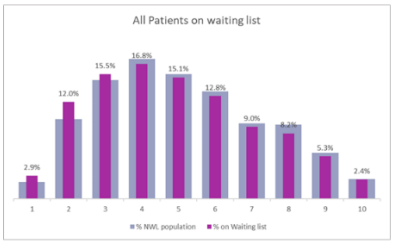
Improving quality of care and reducing variations in quality across North West London hospitals

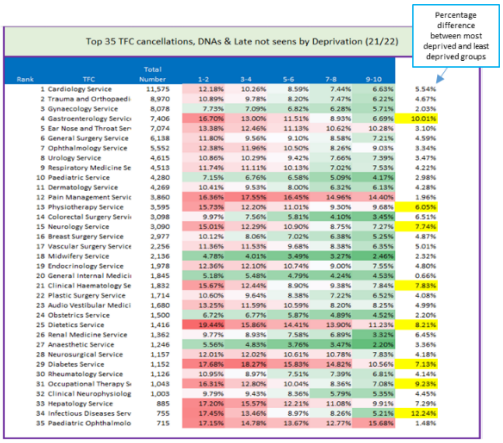
We will continue to work together to review and monitor data about access to care (including waiting times) and quality of care. Our aim is to achieve consistent standards in quality of and access to care across our population, regardless of where an individual lives or their background. An example of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



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







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

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

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

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

and technological developments and innovations to improve systems and processes within hospitals.

Always here for you in an emergency

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

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

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

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

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

Options will be available for patients not in an emergency but requiring prompt support. This could be through an urgent care centre where GPs and nurses can provide primary

care for minor illnesses and injuries or it could be through a primary care centre, bringing together GPs and expertise from district nurses, physiotherapists and pharmacists.

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

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

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

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

Ensuring the appropriate reprovision of acute estate, and the impact of the government's decision to postpone work at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital

Four of London's acute hospital sites are part of the national New Hospitals Programme – Hillingdon Hospital, St Mary's Hospital near Paddington, and both Charing Cross Hospital and the Hammersmith Hospital in Hammersmith & Fulham. We are in the process of developing and securing approval for the business cases for each of these sites. A separate PowerPoint covers the response from the trusts.

Appendix

The New Hospital Programme

- The Government launched its New Hospital Programme in 2019 with a commitment to build 40 new hospitals by 2030.
- Three schemes (covering four hospitals) in north west London were included in the original 40:
  - A full rebuild of Hillingdon Hospital (managed by The Hillingdon Hospitals NHS Foundation Trust)
  - A full rebuild of St Mary's Hospital (managed by Imperial College Healthcare NHS Trust)
  - Major refurbishment/some new build at Charing Cross and at Hammersmith hospitals (managed by Imperial College Healthcare NHS Trust) (The Trust's Western Eye Hospital is expected to be incorporated into one or more of the three redevelopment schemes)
- In May, the Government announced that it was adding eight more schemes to the programme while still committing to build only 40 by 2030. This means eight of the original schemes will be delayed beyond 2030.
  - Hillingdon remained in 'cohort 3' of the programme, with a commitment that it would proceed and be built by 2030.
  - All three of Imperial College Healthcare's hospitals were de-prioritised, with the majority of the capital funding required delayed until after 2030, though some funding to complete the business case process and to support enabling works is due to be allocated.

The new Hillingdon Hospital

- The new hospital will enable the same range of services as now to be provided in state-of-the-art facilities.
- Some services, such as critical care and diagnostics, will be expanded; there will be far more single rooms; much better infection control; and a greatly improved environment and patient experience.
- Demand and capacity modelling has been developed in collaboration with partners including the North West London Integrated Care Board and Hillingdon Health and Care Partners to ensure it aligns with wider strategies and transformation plans.
- It takes account of demographic growth and occupancy targets offset against new models of care and being able to provide care more efficiently in new buildings.
- The modelling shows a need for a slight increase on the 2019 baseline of 510 beds, up to 515.
- Hillingdon Council has resolved to grant approval for the plans and it has now been referred to the Mayor of London for his approval.
- It will take around three years to build once all planning and business case approvals have been given.

The new St Mary's Hospital

- The new hospital will deliver state-of-the-art facilities for St Mary's which is the major trauma centre for the sector as well as a large provider of maternity services and a range of specialist and acute care.
- Capacity modelling has been developed in collaboration with partners, based on GLA demographic forecasts as well as new models of care, improvements in efficiency and a small amount of service expansion.
- The modelling shows a need for an increase in beds from around 600 to 840.
- The Trust submitted a first stage business case in August 2020 and, following discussions with the New Hospital Programme, updated and re-submitted the case in September 2021 based on full, upfront funding being provided by the New Hospital Programme budget.
- Following the decision to delay the main capital funding and the serious risks created by the very poor state of the facilities, the Trust is accelerating its exploration of alternative funding and design approaches that make the most of the huge potential of land that will be surplus to requirements once the hospital is on a more efficient footprint. This is supported by the New Hospital Programme
- The Trust is also looking to draw on the growing opportunities arising from the life sciences cluster it is developing with its academic, industry and community partners

Charing Cross and Hammersmith hospitals

- The Trust is continuing to work on a first-stage joint business case for Charing Cross and Hammersmith to be completed, as planned, this autumn.
- Capacity modelling has not yet been completed but the expectation is that the hospitals will have at least the same number of beds, most likely slightly more, and provide broadly the same services, including a full A&E at Charing Cross.
- As major refurbishment and expansion schemes, it was always anticipated that they would take a phased approach as capital funding becomes available. The Trust's focus is now on moving to an approved full business case as quickly as possible so that it is ready to make a start on the main building works before 2030 as and when we can secure capital funding.

NHS
North West London

Report Title:	Standardisation of Adult & Paediatric Ophthalmology services across North West London – update for JHOSC
Report Author:	Max Carter, SRO
Committee Date:	**18 July 2023**

Background

In 2022 North West London ICB reviewed community ophthalmology services across the sector. This review identified significant variations in the availability of services across the sector. Additionally, analysis of public health data demonstrated variation in rates of blindness across the sector, with several boroughs showing significant variations, potentially reflecting issues with access to eye care.

This paper summarises the proposed changes, co-designed by the ICB, GPs, Hospital Consultants, Optometrists and engagement with our NWL residents and voluntary sector specialists.

The model outlined reflects national good practice, as defined by the National Eye Care Transformation Programme.

What are the key issues with the current service?

Variation in provision across boroughs

The existing service offering across NW London is fragmented, with some boroughs having no provision of community ophthalmology services:

Boroughs with current provision	**Boroughs without current provision**
Brent – through Circle Health	Hammersmith & Fulham
Harrow – through Harrow Health CIC	West London
Ealing – through Operose*	
Hounslow – through Operose*	
Westminster – partial service	
Hillingdon – partial service	

*Operose advised in early 2023 that they would be withdrawing from the market from 30 June 2023

Within the commissioned services, there are significant variations in service offerings, with some boroughs (Ealing and Hounslow) offering a Paediatric Community Ophthalmology service not offered in other boroughs.

The services in Hillingdon and Westminster are smaller than those commissioned in other boroughs, offering only a part of the community service available in boroughs such as Brent.

This variation in service offerings adds complexity to the referral process and demonstrates an inequity of access for patients.

Service delivery and access

For the boroughs which have a commissioned community ophthalmology service, these are generally delivered by consultants in the community, following a referral from a General Practitioner. Clinics are delivered through a relatively small number of sites within each commissioned borough, with sites typically being a health centre or similar.

Referrals for common eye conditions (e.g. cataract and glaucoma)

An optometrist can identify common eye conditions during a routine eye examination, such as the standard NHS eye test (or private equivalent for residents who are not eligible for NHS tests).

Optometrists cannot refer directly to NHS hospital eye services in all boroughs. Where a referral is required, the optometrist contacts the patient's GP and requests that they make the referral. The GP will not generally make a further clinical assessment of the patient; therefore, this is primarily an administrative activity.

More recently, NHS-funded Independent Sector providers have started to allow direct referrals from optometrists for cataracts. This has significantly changed referral patterns with NWL (and nationally) by increasing the number of patients referred to private sector providers.

Optometrist decision-making criteria

Cataract

There is wide variation across NW London providers around the number of patients listed for cataract surgery following their first outpatient appointment, with the sector falling short of the national GIRFT target of 85%.

Lower conversion rates mean that patients may see a surgeon when they are either unsuitable for surgery or do not wish to have surgery at that time. Treatment options are not routinely discussed prior to referral.

Glaucoma

Patients are referred to the glaucoma pathway following a pressure test undertaken during a standard eye examination. Using a different device, the hospital will run a second pressure check on the patient's eyes. In approximately 30% of referrals, the hospital check does not reveal increased pressures, so the patient is discharged.

Optometrists are not required to undertake a second pressure check using alternative equipment. If this were to be done, a significant number of referrals could be avoided, releasing capacity in the glaucoma service for patients who require support

Minor Eye Condition Care

Many areas of the country have implemented Minor Eye Condition services, delivered by high street opticians, to provide an alternative route to accessing care for low acuity eye conditions, including dry eye.

Minor Eye Condition services are unavailable at scale across NW; consequently, patients are accessing care for low acuity conditions through their GP or other urgent care services.

Benefits of a new model of care for NWL

The developed model of care for NWL is to provide a standard community service across the sector, led by optometrists and delivered through high street optical practices to increase accessibility and visibility of the service.

The Community service will deliver the following services for adult patients:

- Cataract: shared decision-making and direct referrals
- Glaucoma: referral refinement through second pressure checks
- Community Eye Care services: support for the diagnosis and treatment of minor eye conditions through optical practices

Standardisation: a standard service model for NWL

Under the new model of care there will be a single standard in place across all NW London boroughs.

The proposed NW London model will see the contracted services delivered through high street optometrists, making better use of this expert workforce and increasing access for our residents.

The service model reflects the model for community ophthalmology recommended by the NHS National Eye Care Transformation Programme and the model of care in other parts of the city.

Consequence: Paediatric Community Ophthalmology

Existing services in Ealing and Hounslow offer community-delivered ophthalmology services for paediatric patients.

The new model of care has been initially designed for adult patients only, paediatric care will be delivered through the hospital-based service.

During the second half of 2023 a review of the paediatric ophthalmology service is proposed, bringing together a range of stakeholders, including clinicians, social care, education and patient/carer representatives.

Consequence: Stable patients with an existing glaucoma diagnosis

Some current community services provide consultant care for patients with an existing glaucoma diagnosis. The transition to an Optometrist led service means we have to change how this care is delivered.

Patients currently being managed in the community will be transferred to an alternative community provider, who will continue providing community-based consultant care.

New patients will remain under the care of the hospital eye service. The development of Community Eye Care Diagnostic Hubs will provide an alternative care route for these patients, and it is also expected that there will be further development in the optometrist community to support optometrist management of stable glaucoma.

Service delivery and access

Under the new model of care, residents will access community ophthalmology services through high-street optical practices. Having a solid high-street presence will support increased accessibility of services, with the expectation that the majority of optical practices in NWL will offer these services. Residents noted that the relationship between patient and optometrist is often long term and that they are significantly easier to see than a GP.

The variation in blindness rates across our communities raises concerns that some communities are not accessing eye care. Engagement with local residents has highlighted

that there are potential areas of misunderstanding about access to eye-care in NWL which will require a focussed approach to ongoing communications and engagement.

Optometrists will have support from Consultant Ophthalmologists within the Hospital Eye Service, accessed through education and the provision of remote advice and guidance. This will support the ongoing development of optometrists and, in the medium term, support further service improvement.

Referrals for common eye conditions and decision making

Direct referral from optometrist to the hospital

Optometrists will make direct referrals to the hospital, without requiring the GP to act as an administrator but ensuring that the GP is aware that a referral is being made.

Feedback from the hospital eye service will go to the GP and to the optometrist, supporting continued learning. Sometimes, this feedback may avoid a hospital appointment where a condition can be managed in the community.

NWL will partner with North Central London ICB to implement electronic referrals using email and the national Electronic Referral Service. Working across ICSs will support simplification of the referral model for optometrists.

Direct referrals will place NHS-provided hospital care (in particular for cataracts) on a level field with Independent Sector providers.

Cataract Shared Decision Making

When a routine eye examination identifies a cataract, optometrists will follow a shared decision-making protocol with their patients. This approach will help patients become more aware of their condition and available treatment options.

Shared decision-making will help ensure patients referred to the hospital service understand their treatment options and actively consider a surgical intervention if they are clinically suitable.

Glaucoma Second Checks

The new model of care will introduce a follow-up pressure check before a patient is referred to the hospital for a glaucoma diagnosis. The second pressure check will involve different equipment and may require patients to attend an appointment at another practice.

Adding a second pressure check in the community will improve the quality of referrals made into the hospital and will avoid many referrals.

Community Eye Care Service: minor conditions

The new service will establish a network of optical practices who can provide NHS funded care for minor eye conditions such as red eye, conjunctivitis, dry eye etc.

For our residents this provides an alternative route to care, in particular to provide an alternative to attending urgent and emergency care services.

Single Point of Access

The new model of care will establish a clinically led single point of access for referrals. The SPoA will build upon best practices (including from colleagues in NCL) and will support the provision of advice and feedback, directing patients to the most appropriate service (which may include the optometrist or GP following advice provided by a Consultant to avoid a hospital appointment).

Engagement

A public engagement programme has been undertaken across NWL, including:

- Online engagement webinars
- Face-to-face engagement events in each borough – dedicated and combined with existing events
- Face-to-face engagement at key stakeholder meetings
- Patient surveys – online and face to face through all contacts

To support hearing from a range of ophthalmology service users, including users of primary eye care optician services, a broad approach to engagement was taken. The patient survey was accessible to all NW London residents and was actively promoted through NHS, Local Authority and VCS channels, across all 8 boroughs. The survey was available in digital and traditional formats, with accessible versions available online (increased contrast, adjustable font size and screenreader compatible) and an easy-read version of the paper survey. The survey was available and actively promoted through all regular outreach events during the period, to support reaching more of the population.

The NW London Next Door channel was used to promote the survey, reaching nearly 98,000 residents and with the survey being opened by 5199 residents. This was one of the top five posts on this channel in May.

Online engagement workshops were run at various times of the day (8am, 12.30pm and 6.30pm) to support online engagement with residents who have work or other caring commitments. Each Borough also hosted a face to face meeting, and additional meetings were supported with local community organisations or local Councillors, for example Action on Disability in North Kensington.

Ongoing Engagement

Procurement

Patient representatives have been recruited to support the procurement programme.

Ongoing Service Evaluation and Engagement

There will be a continuous process of engagement as the new service is implemented. Patient and resident feedback will be actively sought through a range of routes, to ensure that the new service and ongoing ophthalmology communications are working effectively and engaging with all parts of our communities.

Procurement Timeline

Next Steps

Service Development and Future Technologies

There will be further developments of the community service, building upon the skills (and equipment) available within our high street optical practices. These developments are likely to include:

- Monitoring of stable glaucoma in the community
- Independent prescribing within optical practices

Paediatric Services

An ongoing review and re-design of paediatric ophthalmology services shall be initiated during this year. The purpose of this review will be to ensure that we have consistent pathways across all 8 boroughs and to determine whether there are alternative models of delivering the service which may improve access and engagement for children and their carers. A co-design approach will be taken engaging with all key stakeholders, including carers, health colleagues and local authority colleagues.

Appendix A: Summary Analysis of Ophthalmology Engagement Survey

Ophthalmology Engagement Analysis

Ophthalmolgy engagement analysi

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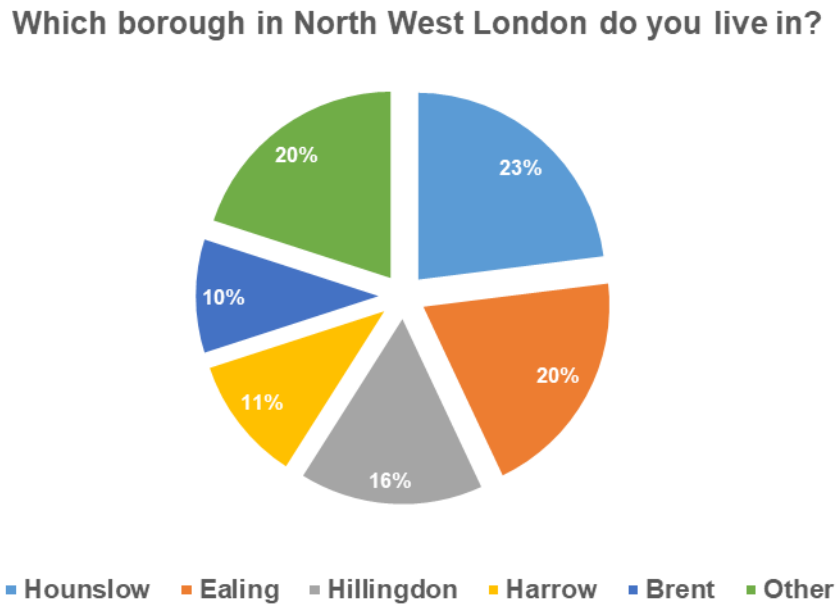
Ophthalmology Engagement Analysis for NWL Overview and Scrutiny Committee Chairs

1.0) Background – Engagement completed on NWL ophthalmology pathway changes

NWL Integrated Care board (NWLICB) is completing work to commission a single specification for community eye care across the 8 boroughs within NWL. As part of this work engagement was undertaken with the residents of NWL on the current community eye services. This was part of the engagement exercises undertaken regarding the new pathway which also included online and face to face sessions with NWL residents to get their views on the new services being proposed.

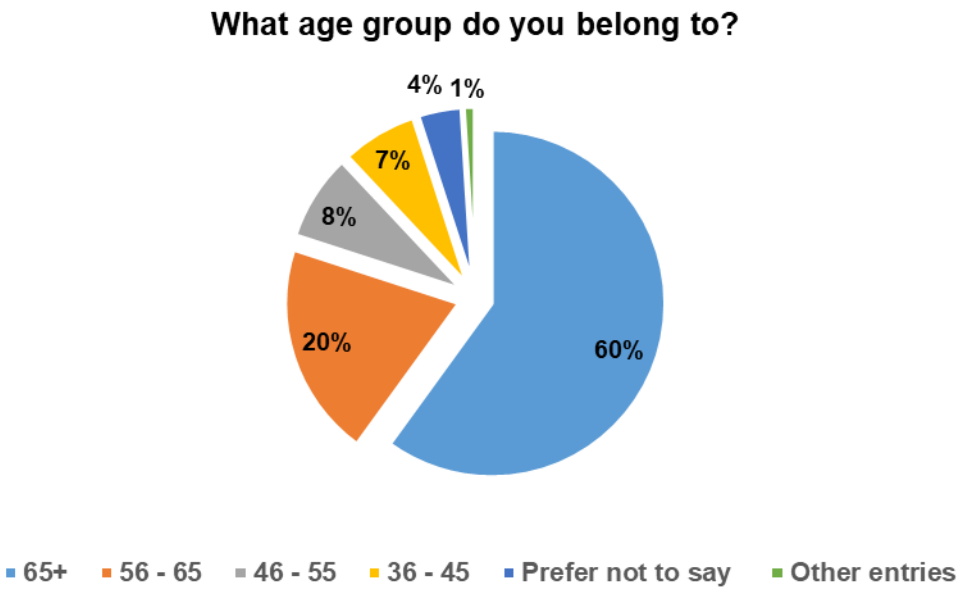
2.0) Ophthalmology survey analysis

The survey was shared with the NWL Citizens panel and the Next Door digital platform. Within the Next Door platform, work on ophthalmology generated the fourth highest level of interest within May. The survey was also shared via NWL ICB engagement leads to borough specific local community organisations as well as local residents with a particular interest in health care. The survey was shared over a period of 7 weeks with a total of 101 responses received. The split of respondents by NWL borough is detailed in the diagram below.

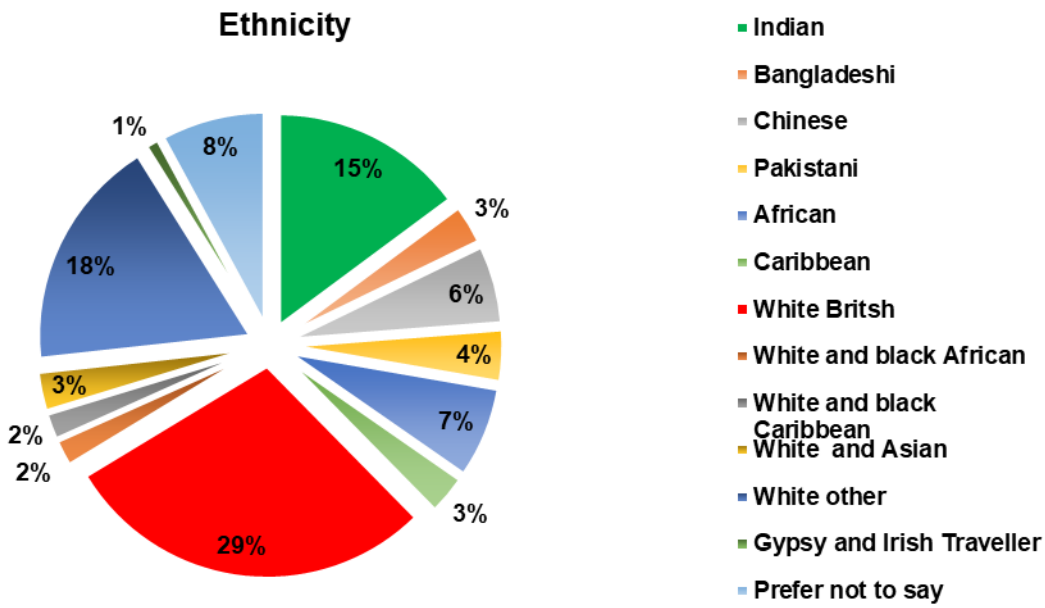


2.1) Demographics

The majority of patients responding to the survey were aged over 65 years (60%) with 20% of respondents aged between 56-64



The responses received for the survey were in line with the ethnicities that make up the communities within NWL with a wide range of ethnicities responding to the survey.



3.0) Survey responses

The responses received were in general positive with

- Majority of respondents finding the location of community services convenient (74%) including some comments regarding high street locations / community services in a place with good transport links being particularly preferable
- Majority of respondents stating the community service helped with the management of their health needs (61%)

- Majority of respondents said the service they received was very good or good (61%)

The table below gives a high level summary of the responses received for each question within the survey

Some of the survey questions	Brief feedback
Q1. Which type of community eye health services do you use or have used?	An assortment of services that people use. There does appear to be a well-defined knowledge and information about the range of eye services that people use.
Q1b). Are you a long term Glaucoma follow up patient?	23% indicated yes
Q1c). Please let us know if you are responding for a patient accessing the paediatric service?	Only 4% responded on behalf of a child
Q2. Are you being monitored for raised eye pressures or for monitoring of glaucoma treatment (drops)?	A number of participants indicted that they were being monitored for raised eye pressure
Q3. Are you also under the care with another ophthalmology service e.g.hospital?	23% indicated yes – it appears that the majority attend Moorfields
Q4. How do you find booking your community eye health service appointments?	Ease of booking mixed: 43% said very easy or easy and 32% said very difficult or difficult. However, on reading the comments. It is not so much the difficulty of booking it is the long waits between appointments
Q5. How do you get to your appointments?	22% walk, 23% bus, 20% car
Q6. Do you find the location of the community eye health service convenient	A huge number of 74% indicated that they find the location service convenient. With some indicating a preference of closer to home.
8. How would you rate the community eye health service you receive?	61% indicated that they rated their community eye service as either very good or good, whereas 20% indicated as very poor or poor
Q9. Has the community eye health service helped you manage your health needs?	61% indicated yes against 39%. The comments connected to this question were essentially positive

Some areas for improvement were also flagged which we will build into the delivery of the newly procured service. These included

- 32% of respondents found it difficult or very difficult to book appointments for the service. We will work with provider for the procured service to support approaches that may appointment booking easier for residents.
- Waiting times for services were also mentioned. As the procured service will be provided across a number of optometry practices within each borough, this will support a large capacity being available for the service. This should help to reduce waiting times for an appointment. We have also included key performance indicators within the service specification that will support patients being seen within 4 weeks for routine conditions.
- Comments relating to location where it was felt this could be improved included consideration of sites where long travel distances were undertaken and the modes of transport required (example given of travel from Ealing to Brent Cross which required a car in particular for patients unable to use public transport). The procured service will be provided by high street optometrists to help improve access with sites being available within the high street.
- Location comments also included Mobility requirements therefore where possible to have services provided from sites that are on the ground floor.
- 20% of respondents felt the services received were poor or very poor. One comment mentioned that the services were not convenient especially for older people.
- With regards to approaches that could improve their experience:
    - One comment flagged that hard copy letters should still be sent as communication about the services as they had problems accessing the digital letters sent to their phone.
    - Communication post the GP referral was also mentioned to keep patients aware of the service they have been referred to.

- One comment related to information being shared with patients regarding which services they could self-refer to, which required GP referral and how to get a GP appointment.

4.0) Online and face to face engagement sessions

A total of 14 online and face to face engagement sessions (3 online, 11 face to face) with 49 attendees, were held across the different NWL boroughs.

The sessions provided detailed information on the reasons why the service model for ophthalmology required some change and the proposed new model. These included:

- The rates of sight loss registrations being higher in 5 NWL boroughs (Harrow, Brent, Ealing, Hillingdon and Hammersmith and Fulham) than the London average
- Variations in rates of blindness in particular for three boroughs (Brent, Harrow and Hillingdon) compared with the remaining boroughs within NWL
- New model would be optometry led, increasing access to services through the provision of these from high street optometry practices

Feedback on the new model of care was supportive with participants seeing the value in supporting the early diagnosis of complex conditions that impact eye health and vision. It was also welcomed that there would be an improved link for opticians to the specialist to be able to support patient with preliminary and ongoing eye care

Comments were raised highlighting some potential areas which included:

- Where ongoing communication will be required, for example around charges for optician services and access to information on the different parts of the eye care pathway.
- Suggestions were also made on how to engage with harder to reach populations e.g. with the use of a mobile outreach van.
- Some queries were also raised including how would patients not currently suitable for treatment would be monitored so they could be identified when treatment is required.

Section 5 below details some of the frequently asked questions from these sessions.

5.0) Community Ophthalmology engagement frequently asked questions

Frequently asked questions from the ophthalmology engagement sessions have been detailed below. These have / will also be shared on the NWL ICB website.

Q1. Keretonisis is a particularly serious complaint that impacts teenagers and young adults. It's a complaint that is frequently missed by Opticians. I am concerned that this new model relies on opticians who might miss it. If not picked up early enough it can have very a very serious impact on sight.
A1. The new model supports better working relationships between the local optician and the hospital ophthalmologist or other eye specialist. Opticians will be able to raise queries and receive training to support their diagnostic skills.

Q2. The services delivered in local opticians, will it be local independents, or high street / brand names?
A2. The tendering will be open to both and we would expect this to encourage earlier access to the optician and with more opticians on the high street better access to services.

Q3. **I am concerned about what you pay for and what is free, I have visited the optician and they are always trying to sell you other stuff. I would worry about going as I might have to pay even when I just want the eye test. If I go to my GP it is free?**
A3. The eye test at your local high street optician (optometrist) is free for those that fall within certain criteria including, children under 16, those in full time education between 16-18, adults over 60, adults diagnosed with diabetes or glaucoma. For the full list of criteria please see Free NHS eye tests and optical vouchers - NHS (www.nhs.uk)
Within the planned new service Opticians will be able to do more to help you, including managing some common lower complex eye conditions that don't require hospital management as well prescribing for certain conditions.

Q4. **Will the GP or Optician be able to refer me to the hospital?**
A4. The planned new service will support opticians providing services within the new service model to refer patients directly to the hospital. Hospital Ophthalmologists will be able to support the local optician with advice and guidance so more things can be tackled locally before having to go on to hospital.

Q5. If I have healthy eyes but think I have a problem will I have to pay for the eye test?
A5. If you need a prescription or treatment, then you will have to pay for this under the same guidelines as the GP. The eye test is free for those that fall within certain criteria Free NHS eye tests and optical vouchers - NHS (www.nhs.uk) but a prescription or over the counter medication would need to be paid for unless there are exemptions.

Q6. When a patient accesses the services how or do the results get back to the GP?
A6. Currently patient results are shared with the patient GP post management within the hospital services. The specification for the new service will requires electronic links for patient information to be shared by the hospital specialist both with the GP and the referring optician.

Q7. If the new service identifies a patient is not suitable for onward referral to hospital for a chronic condition. How will the patient be monitored so it can be identified when they need onward referral?
A7. Patients referred to the new service for a chronic condition will receive routine monitoring from their regular optician. Should their regular optician identify at a later date that onward referral is required they will be referred by their regular option to the new service or to their GP depending on the condition that requires management.

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North West London

Report Title:	Development of Musculoskeletal Services across North West London – update for JHOSC
Report Author:	Joe Nguyen, Borough Director (Westminster), NHS North West London Integrated Care Board
Committee Date:	**18 July 2023**

Purpose

To receive a report on the development of musculoskeletal services (MSK) across North West London, and the potential for a new MSK model of care.

Detail

Background/Context

The UK faces challenges from an ageing population and growing prevalence of Musculoskeletal (MSK) conditions that impact healthcare and society as a whole. There has also been considerable national focus on MSK in recent years because it presents great opportunities for large-scale change in order to improve quality and outcomes.

Analysis of the MSK pathway across NWL has highlighted a significant opportunity for a new model of care to address existing inefficiencies, optimise existing resource, tackle inequality and differential access to services and focus on the right care, particularly for those with the biggest modifiable risk factors. This will improve the quality of care, patient outcomes and value for money.

The key headlines are:

- MSK conditions affect a large proportion of our population – and disproportionately affects our residents who live in deprived areas – 13% of NWL residents have chronic MSK issues which contributes to 2nd highest number of work absence
- Further need to focus and tailor and personalise our MSK service offer for our residents in most deprived areas and with chronic and multiple co-morbidities
- MSK disorders contributes to the top 3 burden of disease for NWL – one of the highest areas of acute spend and wait times (e.g. rheumatology & pain wait times)
- Our current community spend does not correlate to our prevalence/needs and secondary care outcomes
- Opportunity for productivity through ‘de-transactionalising’ MSK care in primary & community and on-ward referrals to acute care

- Opportunity to support residents to optimise their conditions for employment and further contributions to economic activity

Current service provision

There are services, triage and referral elements as well as services across the current MSK Pathway which have changed very little over the past years, with inequity in access and outcomes across several boroughs. Patient outcomes and user experience are inconsistent across all MSK services. In some boroughs patients sometimes have several referrals as they are "bounce" between teams, with long waits and growing demand. Whilst other boroughs offer a holistic triage approach with greater variety and choice of services which allows for short waits and lower referral rates into secondary care. Currently Kensington and Chelsea and Westminster are the only boroughs to commission fully integrated community MSK pathways, including orthopaedic, physiotherapy, pain and rheumatology services. All other boroughs offer a limited combination of MSK services.

What our residents and patients are telling us about their experiences of the eight MSK community services across the patch:

- At times not feeling understood, listened to and/or trusted by clincians
- Wait time are long in some of our boroughs
- Lack of coordination between community and acute provision of MSK related care – and system of 'referrals'
- Online appointments are not as effective – and not providing the what matters to the patient/resident
- Follow-ups are not always consistent and timely
- Challenging for non-English speakers to necessarily understand advice on exercise and nutrition
- Lack of support for patients who are waiting for surgery and procedure
- More access from MSK clinicians to diagnostic tests would be helpful

Vision for MSK services in North West London

With the formation of the NW London Integrated Care Board, substantial opportunity has arisen to redesign and integrate consistent MSK pathways across the eight Borough, fully realising local aims and ambitions and eliminate inequality in service provision across NWL. These changes will further be enabled and supported by the system working in a more cohesive and integrated fashion.

The future state model of care has been co-designed with local residents and clinicians – and aligns to national MSK best practice. The guiding principles and components are as follows:

- Tailor MSK service and offer to different communities – and better understanding and working with local communities to 'in-reach' to residents who live in areas deprivation
- Providing a holistic equitable, continuum of care for patients with MSK presentations and ensuring they are seen at the right time in the right place with the right information.

- Recognition that overall fitness and physical health play key roles in the successful management of any degenerative condition in both the rate of deterioration and the success of any operative treatment.
- Providing support to patients to manage their fitness and physical health concerns ensuring messages around optimisation of long-term conditions are given at the same time as any discussion around management of MSK conditions
- To provide as many diagnostic and treatment options for patients in their communities, increasing skill mix in the local health professionals by working collaboratively with secondary care colleagues.
- Join with our secondary care colleagues to work together to identify complex patients at an early stage in their pathway.
- Work towards the elimination of unwarranted clinical variation and quality in referrals to secondary care by local peer review and creation of teaching opportunities and sharing of skills.
- Deliver “operation ready” patients to secondary colleagues

Changes to MSK Services

The integrated model seeks to remove the current emphasis on “medical care” and to focus instead on a more holistic approach with equality, self-referral, education and self-management being an integral part of the new model. The aim of this new approach is also to ensure optimisation, fitness and activity as key components of pre-operative pathways.

Aim and Core Principals of the revised model of care:

- The core principle of this service, defined in the service specification, is to reduce the unwarranted variation in service provision and access to MSK services across North West London.
- To ensure that all people registered with a GP Practice in North West London have equal access to standardised, high quality, clinically effective community MSK services, whilst reducing inequalities in outcomes and experience for the population of North West London, and to introduce First Contact Practitioners (FCP) into MSK services across NWL.
- Personalised care; Education and self-management; Addressing health inequalities; Evidence based practice; Self-referral; Population health approach and a focus on prevention will form the basis of the MSK Service provision across all Boroughs.

Alignment with EOC and CDC’s

The proposed MSK services will work in tandem with Primary Care Networks to form the ‘front-door’ for referrals into the new Elective Orthopaedic Centre and will be utilising the services of the new Community Diagnostic Centres in North West London when appropriate when that comes online.

Next Steps:

The proposed next steps for the development of MSK services across North West London include:

- Sign-off of NW London MSK service specification by ICB
- Finalise our procurement for expiring MSK service provision (5 boroughs) – with go-live of new services in April 2024 and continued service development until March 2025
- Work with our existing MSK service providers to re-develop offer to NW London MSK service specification
- On-going - continue our co-design and development with residents and staff – and launching our MSK co-production, addressing health equity and movement group – working with communities, 3rd sector, NHS and other public sector partners

Report to the North West London Joint Health Overview Scrutiny Committee – 5 July 2023

North West London Joint Health Overview Scrutiny Committee Work Programme 2023/24

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

1.0 Purpose of the Report

1.1 To present the North West London Joint Health Overview Scrutiny Committee's (NWL JHOSC) 2023/24 Work Programme to the committee.

2.0 Recommendation(s)

2.1 That:

The committee note and confirm the committee's draft work programme outlined in Appendix 1.

3.0 Detail

3.1 The North West London Joint Health and Overview Scrutiny Committee's work programme outlines the decisions and health policy areas the committee plans to review during the municipal year, according to its Terms of Reference. The committee's principal role is: 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

3.2 The NWL JHOSC undertakes 4 formal committee meetings each municipal year. Though there is scope for other scrutiny activities to take place throughout the year, at the chair's discretion.

3.3 The NWL JHOSC is formed of Councillors from the 8 Boroughs of North West London: Brent, Ealing Harrow, Hammersmith & Fulham, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster. The committee also

has a non-voting representative from the London Borough of Richmond upon Thames.

3.4 The committee held its annual work programming meeting on 6 June.. During this meeting the committee undertook a process of prioritising items for inclusion in its work programme based on a set of criteria. Prioritisation is considered best practice by the Centre for Governance and Scrutiny (CfGS) and is an effective tool for a scrutiny committee to develop a coherent work plan for the year[1], which ensures that the work of the NWL JHOSC is effective.

3.5 The committee's updated work programme for the 2023/24 municipal year is detailed in Appendix 1.

3.6 There is a possibility that the committee's work programme may change during the municipal year. This is so that the committee can work flexibly to review emerging items as they arise. It is imagined that the work programme will evolve over the municipal year, according to the committee's needs. At times it may also be necessary to move items from a particular committee date for practical reasons, in these cases the work programme will be updated and a new version will be presented at the next formal NWL JHOSC meeting.

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

Appendix 1 – Draft North West London Joint Health Overview and Scrutiny Committee Work Programme 2023/24

The North West London Joint Health Overview and Scrutiny Committee's work programme is designed to be flexible and adaptable to the needs of the committee, it is therefore likely that items may change over the municipal year.

Depending on the timing of the Consultation on the Future of the Gordon Hospital, the Chair may arrange a special meeting of the North West London Joint Health Overview and Scrutiny Committee before the consultation begins.

18 July 2023

Agenda Item	NHS Organisations	Host Borough
North West London Strategy for provision of acute beds	North West London Integrated Care System Imperial College Healthcare NHS Trust London North West University Healthcare NHS Trust The Hillingdon Hospitals NHS Foundation Trust	Hillingdon

Standardisation of Adult & Paediatric Ophthalmology services across North West London	North West London Integrated Care System	Hillingdon
Development of Musculoskeletal Services across North West London	North West London Integrated Care System	Hillingdon

12 September 2023

Agenda Item	NHS Organisations	Host Borough

North West London Mental Health Strategy	North West London Integrated Care System West London NHS Trust Central and North West London NHS Foundation Trust	Royal Borough of Kensington & Chelsea
Consultation Proposals on the Future of the Gordon Hospital	North West London Integrated Care System Central and North West London NHS Foundation Trust	Royal Borough of Kensington & Chelsea
Proposals for Consultation on the North West London wide review of Palliative Care	North West London Integrated Care System	Royal Borough of Kensington & Chelsea

5 December 2023

Agenda Item	NHS Organisations	Host Borough
North West London Estate Strategy and Mental Health Estate Strategy	North West London Integrated Care System	Hounslow
Winter Resilience programme and London Ambulance Service Performance	North West London Integrated Care System London Ambulance Service	Hounslow

Workforce Strategy Update	North West London Integrated Care System	Hounslow
Update on the Elective Orthopaedic Centre for North West London	North West London Integrated Care System London North West University Healthcare NHS Trust	

14 March 2024

Agenda Item	NHS Organisations	Host Borough

Obesity and Preventative Services	North West London Integrated Care System	Westminster
North West London Commissioning Arrangements for Community Pharmacy and Dental Services	North West London Integrated Care System	Westminster
Primary Care Access – following changes to GP Contracts	TBC	Westminster

Report to the North West London Joint Health Overview Scrutiny Committee – 18 July 2023

North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

No. of Appendices:	**2** Appendix 1: 2022/23 North West London JHOSC Recommendations and Information Requests Tracker Appendix 2: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	George Kockelbergh, Strategy Lead – Scrutiny, Strategy and Partnerships, Communities and Regeneration Brent Council George.Kockelbergh@brent.gov.uk 0208 937 5477

1.0 Purpose of the Report

1.1 To present the previous year's municipal year's scrutiny recommendations tracker to the North West London Joint Health Overview Scrutiny Committee (NWL JHOSC), and to set out a blank scrutiny recommendations tracker to be used by the committee during the 2023/24 municipal year.

2.0 Recommendation(s)

2.1 That:

The previous recommendations, suggestions, and information requests of the committee in the 2022/23 municipal year be noted in Appendix 1.

The committee note the blank recommendations tracker for use in the 2023/24 municipal year in Appendix 2.

3.0 Detail

3.1 The North West London JHOSC Recommendations and Information Requests Tracker tabled at the 18 July 2023 meeting relates to the 2022/23 municipal year.

3.2 The North West London JHOSC, according to its Terms of Reference can make recommendations to the North West London Integrated Care System

and its Integrated Care Board, NHS England, or any other appropriate outside body in relation to the plans for meeting the health needs of the population.

3.3 The North West London JHOSC may not make executive decisions. Recommendations made by the committee therefore require consideration from the relevant NHS body. When the North West London JHOSC makes recommendations to NHS bodies, the relevant decision maker shall be notified in writing, providing them with a copy of the committee's recommendations and a request for response.

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

3.5 The 2023/24 scrutiny recommendations tracker set out in Appendix 2 is currently blank and will be populated as the municipal year progresses.

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

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

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

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

				ARRS data we hold. The roles per borough are as below: - FTE/ Borough - 99.33: Brent - 54.60: Central - 93.10: Ealing - 99.17: Hammersmith and Fulham - 76.93: Harrow - 95.90: Hillingdon - 103.35: Hounslow - 74.81 West London 697.19: Total	
		Recommendation	To recommend that JHOSC members are proactively consulted with and have oversight of stakeholder and public engagement activities to share with their networks.	Community insight reports are published monthly on the ICB website https://www.nwlondonics.nhs.uk/download_file/2981/182	
		Recommendation	To recommend that the workforce model is appropriately balanced in order to ensure that patients are receiving equity of care across NW London.	Being covered in the NWL workforce paper at the December 7, 2022, JHOSC meeting.	
		Recommendation	To recommend that wait times for a routine GP appointment are collected and shared with the committee.	This will be published from 24/11 and can be found here: Appointments in General Practice, October 2022 - NDRS (digital.nhs.uk)	
		Recommendation	To recommend that the education and communication plan for navigating primary care systems is developed and shared when it becomes available.	Is being developed and will be available early next year.	
	Accident and Emergency Pathways and Performance, including London	Information Request	For the committee to receive performance data from the trust board reports, and to receive data on a bi-monthly basis. The NWL ICS will take ownership for providing the data.	We will share monthly performance reports which will include LAS information.	
		Recommendation	To receive clear timescales and trajectory for when London Ambulance Service performance will improve.	**(From Daniel Elkeles)** **Demand and performance update**	

	Ambulance Service performance			Between September and November, London Ambulance Service has seen demand grow across our 111 and 999 services. We have been at REAP (Resource Escalation Action Plan) level 4 since escalating to this level on 22 September. We have also been working hard to prepare for challenges to come by bringing together three strands of action to help us meet demand across the winter: 1. The first of these is to recruit more staff. After recruiting 1,074 new starters since 1 April this year as part of our biggest ever recruitment drive, we have already been able to increase the number of ambulances on the road by up to 20 to 30 a day. We are continuing our focus on recruiting and training more call handlers and dispatch staff for our emergency operations centres. 2. The second set of actions relates to setting up more alternative care pathways to give our staff and volunteers further options to ensure patients receive the care they need. This is based on the success of schemes such as our six mental health response cars (where we team our paramedics with registered mental health nurses), which are now running across the capital. 3. Lastly, we are recruiting many more clinicians to our emergency operations centres to ensure patients waiting for an ambulance are kept as safe as possible and our sickest patients are prioritised. As the Service is an early adopter of NHS England's Category 2 segmentation pilot, our clinicians are in particular assessing these calls to ensure patients who are most in need receive the fastest response. This approach will not delay our response for patients who still require an ambulance. Instead, our expanded clinical team will be able to better direct people in need to the right care services for them. We are also continuing to work with our partners at integrated care systems and hospital trusts to address delays in patient handovers to emergency departments.	

				As you will be aware, we have been working incredibly hard to move to a new Computer Aided Dispatch (CAD) system, known as Cleric. Our new CAD is being used by staff in our emergency operations centres to assess and prioritise 999 calls and to dispatch ambulance crews when they are needed. We are working with other trusts to help our transition to this new system and have set up processes to monitor patient safety and performance. The introduction of the new CAD has meant we have recently been putting the data we generate and record under a renewed level of forensic focus. This new level of scrutiny has revealed some anomalies that might be making some parts of our response time data unreliable and not reflective of our actual response times. This is not an issue with the new software but a general reporting issue and it is clear we need to look into our processes. As an open and honest organisation with a commitment to the highest quality patient care, at the Service we know that we have to take action to make sure we are recording data properly and are doing everything we can to reduce our response times. It is imperative that our patients and the communities we serve can also see a full and accurate picture of performance. To do this as quickly, fairly and transparently as possible, we have commissioned an independent review, in partnership with NHS England and our commissioners, which will be carried out by an expert external organisation that regularly works with the NHS. Independence and transparency are important to this process so that we can check we are doing the right things and can all have full confidence in our approach as we move forward. In the meantime, we have to continue delivering for patients by doing everything we can to improve our response times as we	

				head towards winter. That will mean a renewed focus on Category 1 as well as Category 2 calls, getting the most effective mix of clinicians on the road, ensuring we have the vehicles available, and improving our processes for dispatch.	
	Community based specialised palliative care improvement programme	Recommendation	To bring a paper summarising emerging findings from the Borough Based Partnership's self-assessments tools to the committee	Rory Hegarty has spoken with Jane Wheeler who confirmed this will be addressed at a future JHOSC meeting.	
	North West London Integrated Care System Update	Information Request	To receive information on the meeting schedule and agendas of the ICB and other meetings in order to share with relevant stakeholders	Rory to send as part of the regular fortnightly update including a key meetings grid.	
		Recommendation	For the JHOSC to be aligned with the ICB in agenda forward planning.	Fortnightly update from Rory should address this.	
	West London Changes to Hope and Horizon wards	Recommendation	To recommend that a meeting is set up between Ealing and neighbouring authorities to ensure that information on this issue is shared across boroughs, and to notify members when this meeting is set up.	Meeting took place 7 December 2022 at Royal Borough of Kensington & Chelsea	
7 December 2022	Elective Recovery and Cancer Care Backlog	Information Request	To receive the data validation figures on waiting lists numbers, that the NWL system has sight of to be shared with the JHOSC.	Monthly performance report is now being shared with JHOSC.	
		Information Request	To receive details of best practice in terms of Breast Screening uptake broken down by place for the NWL system.	Sanjeet sending what they have for NWL wide but don't have breakdown via borough currently but this is being worked on this year. Liz forwarded on 20/01/22	
		Information Request	To receive data and information on best practice in elective recovery in regard to North West London.	Elective recovery / elective care is included in the performance report.	
		Recommendation	To recommend that JHOSC members and community leaders are utilised to	Rory supplied JHOSC with Sanjeet's (Programme Director – Breast Screening Recovery Programme) contact details on 7th	

			feedback and share messaging on Breast Screening and elective recovery with our communities.	Dec - (sanjeet.johal@nhs.net**)** for any screening questions councillors might have. Sanjeet confirmed they are keen to share messages, key campaigns and pilot projects.	
	Winter Planning	Information Request	To receive information on how additional winter funding will be used at a borough level, and what the impact of this funding will be for our residents.	Sarah Bellman has shared the winter materials during 7th Dec JHOSC.	
		Information Request	To receive more information on the collaboration between the ICS and Local Authorities on winter planning.	Sarah Bellman has shared the winter plan covering this item. Liz to also share winter plan paper.	
		Recommendation	To recommend that JHOSC members and community leaders are utilised as a way of communicating messages to our communities and for the NWL ICS to review the opportunities to tackle inequalities together.	Agreed: Sent winter messaging, performance report and involving chair and vice chair in discussions about 'we are general practice campaign'.	
		Recommendation	To recommend that information on winter planning is distributed more widely than local authority communications teams.	Complete: Sarah sent to JHOSC already and shared with leaders/CEO's. Noted the recommendation for the future.	
	North West London Workforce Strategy	Information Request	To receive information on how NHS NWL is tackling racism towards its staff as part of its workforce strategy.	**How NWL is tackling racism towards its staff as part of its workforce strategy:** As part of the Great Places to Work portfolio, the Include (Workforce Inequalities) pillar has adopted a multi-dimensional approach to tackling racism across NWL ICS, which recognises disparity between white and Ethnic Minority staff in their experiences and senior-level representation. This is a data-driven approach, which draws on insights from the Workforce Race Equality Standard (WRES) to shape system-wide interventions and seeks to address inequality through targeted interventions focused on organisational culture, leadership and structural processes. A current priority is reducing bias in the recruitment and selection process. To address this, we have rolled out the De-Bias Recruitment Toolkit across the system, which is designed for recruiting managers and presents a set of measures to	

				improve the fairness and diversity at each stage of the recruitment process. The embedding of these inclusive recruitment practices is intended to increase diversity of representation at senior levels. The ICS has also taken action to reduce the disparity between Ethnic Minority and white staff entering into formal disciplinary processes, by supporting system partners to adopt a just and restorative culture, focused on rebuilding relationships and learning from mistakes, in place of punitive action. At a senior level, this cultural change programme is complemented by the Building Leadership for Inclusion Initiative, soon to be delivered with the ICB Board, which will work with the Board members supporting them to undertake their role as inclusive leaders, in recognition of their individual and collective influence over organisational culture and structures. This programme has a particular focus on systemic racism and social justice. The Include (Workforce Inequalities) Programme has taken steps to ensure accountability for anti-racist actions at a local and system level, by establishing London's first independent Inclusion Scrutiny Panel, which acts as a critical friend to the Staff Inclusion/Workforce Inequalities Programme Board. We are also fostering 'Safe spaces' across the system, through the establishment of Freedom to Speak up Guardians across Primary Care, and there has been dedicated work to empower staff networks and amplify staff voice to ensure it is captured and incorporated into system-wide decision making. Finally, the Include/Workforce Inequalities pillar also assures progression across the system against WRES action plans to ensure sustained improvements to address workforce inequalities throughout Trusts, Primary Care and the ICB. Work is underway to align actions with Local Authorities as well.	

		Recommendation	To recommend that tackling racism towards NHS staff to be included and highlighted as an explicit part of the NHS NWL workforce strategy.	Bashir Arif has provided the paragraph above in response to the request from the JHOSC meeting for additional information relating to tackling racism. We include the points he has made within our strategy as part of our NWL People Plan. Please also note that organisations have their own policies that set out how racism is managed, whether it is from service users or visitors abusing staff through to incidents between employees. In summary, it is not tolerated and processes are in place to ensure full investigation and follow up action is implemented.	
	North West London Integrated Care System Update	Information Request	To receive information on the proposed lengths of contracts as set out in the procurement update on 3.9 of the update report.	These contracts are part of an overall single with different specifications for the services listed below – all of which ends of the 30 Sept 2023 except ADHD which is currently not commissioned with Harrow Health CIC. There are ongoing discussions with the ICB and Harrow Health CIC regarding the future commissioning of ADHD services, but no decision has been made yet.	
		Recommendation	To recommend that the committee is consulted with on plans for the upcoming primary care campaign. With a focus group of JHOSC members explored as one of the methods of delivering this consultation piece.	In progress. Campaign hasn't started yet. Involving chair and vice chair in discussions about 'we are general practice campaign'. This campaign will focus on how primary care has changed, explaining some of the challenges and new roles and helping residents get the best from primary care. We also propose to run a deliberative inquiry on the future of primary care in NW London.	
8 March 2023	Elective Orthopaedic Centre – Summary of Consultation and Proposal	Recommendation	To recommend that a specific travel plan is developed that addresses travel related concerns expressed in the consultation to reassure patients and stakeholders.	We commissioned a detailed review of travel by public transport, helping to inform a three-step travel support solution, including the provision of free travel for patients unable to travel to or from the elective orthopaedic centre for their surgery independently or via an existing patient transport scheme and who would encounter a long, complex and/or costly journey by public transport. Our approach incorporated into the DMBC is to create a three-step travel offer for elective orthopaedic centre patients: **Step 1: Information – all patients**	

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

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

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

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

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

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

				productivity and value for money; and (4) Help the NHS support broader social and economic development. The review was based in investment made by the then eight CCGs in 2019/20 and showed that overall investment had been higher in inner boroughs on total investment, and on a per head of population (weighted by need); but a simple inner/outer borough narrative on investment masked service-level variation. Variation existed both in terms of £ per person, as well as proportional split of funding across services (NB: the review did not account for any local authority funding). The review highlighted that an isolated view on investment did not take account of service provision, workforce or outcomes, and in particular need. To fully understand this picture would require more detailed analysis at a team level and that wide scale reapportionment based on a simple funding gap formula was not advocated. Further to this, the levers of a single ICS, enabled by a maturing provider collaborative offered routes to address this level of investment variability, also factoring in workforce, outcomes and service models. Looking ahead to 2023/24, and since the establishment of a North West London ICB, investment into mental health services is not formally reported on a borough (or previous 8 CCG) footprint however, this will be provided following finalised agreement. Work is underway to detail how the recurrent £30.35m Is invested at a borough and service level. This will be in line with North West London's financial strategy, which specifically, for mental health services means that the investment will: • Improve access and target investment to those communities with highest need; • Improve activity reporting, to understand the cost base and improve efficiency;	

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

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

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

Meeting Date	Item	Recommendation / Information Request	Detail	Response