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North West London Joint Health Overview and Scrutiny Committee

Tuesday 22 October 2024 at 10.00 am
Rooms G1 & G2, NHS North West London, Ferguson House, 15 Marylebone Road, London, NW1 5JD

This meeting will be held as an in person physical meeting with all members of the Scrutiny Committee required to attend in person.

The meeting will be open for the press and public to attend with a limited number of seats available. Alternatively, the link to follow the webcast live will be made available HERE.

Membership:

Members Councillors:	**Representing**
Ketan Sheth	London Borough of Brent
Wesson	London Borough of Ealing
Perez	London Borough of Hammersmith & Fulham
Denys	London Borough of Hillingdon
Halai	London Borough of Harrow
Knight	Royal Borough of Kensington and Chelsea
McAllister	Westminster City Council
Nagra	London Borough of Hounslow
Vollum	London Borough of Richmond - non-voting

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Strategy Lead - Scrutiny Officer

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Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

2 Declarations of Interest

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

3 Minutes of the previous meeting 1 - 14

To approve as an accurate record the minutes of the previous meeting.

4 Matters Arising (if any)

5 North West London Adult Community-based Specialist Palliative Care (CSPC) Review 15 - 62

To present the communications and engagement strategy for the public consultation on the new North West London Model of Care for Adult (18+) Community-based Specialist Palliative Care services.

6 North West London Mental Health Strategy 63 - 156

To outline the development of the Mental Health Strategy for adult residents of North West London.

7 North West London Primary Care Access 157 - 178

To present the North West London Primary Care Access Engagement Plan.

8 North West London JHOSC Recommendations Tracker 179 - 187

To present the latest 2023-24 scrutiny recommendations tracker to the North West London Joint Health Overview Scrutiny Committee (NWL JHOSC).

9 Any other business

Date of the next meeting: **5 December 2024, Westminster City Council**

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North West London Joint Health Overview and Scrutiny Committee
Notes of meeting by LB of Brent
10am-12pm on 14 March 2024

The meeting began at 10am.

PRESENT

Members of the Committee:
- Councillor Ketan Sheth (Chair) London Borough of Brent
- Councillor Natalia Perez (Vice Chair) London Borough of Hammersmith and Fulham
- Councillor Ben Wesson London Borough of Ealing
- Councillor Nick Denys London Borough of Hillingdon
- Councillor Chetna Halai London Borough of Harrow
- Councillor Marina Sharma London Borough of Hounslow
- Councillor Lucy Knight Royal Borough of Kensington and Chelsea
- Councillor Concia Albert London Borough of Westminster
- Councillor Claire Vollum London Borough of Richmond (non-voting, co-opted)

Others Present:
- Rob Hurd – Chief Executive, NHS North West London
- Rory Hegarty - Director of Communications and Engagement, NHS North West London
- Dr Genevieve Small - GP and Medical Director, Primary Care, NHS North West London
- Lynelle Hales, Lead – Access and Primary Care Strategy, NHS North West London
- Dr Vijay Tailor - GP and Primary Care Access Clinical Lead
- Kelly O'Neill - Director of Public Health, Hounslow
- Dr Tony Willis - GP and Clinical Lead for Diabetes, NHS North West London
- Hilary Tovey - Prevention and Health Living Lead, NHS North West London
- Councillor Diana Collymore – London Borough of Brent (observer)
- Councillor Mili Patel – London Borough of Brent (observer)

Support Officers:
- Chatan Popat - Policy Lead – Scrutiny, London Borough of Brent
- Hannah O'Brien – Senior Governance Officer, London Borough of Brent
- James Diamond – Scrutiny Officer, London Borough of Kensington and Chelsea
- Linda Hunting – Policy and Scrutiny Advisor, Westminster
- Nikki O'Halloran – Democratic Services Manager, Hillingdon (online)
- Sudheesh Bhasi - Policy Officer, Harrow
- Yusuf Patel - Policy and Scrutiny, Hounslow
- Anna-Marie Rattray – Overview and Scrutiny Officer, Ealing

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1 No apologies were received.

2. DECLARATIONS OF INTEREST

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

2.2 Councillor Ben Wesson declared a personal interest that he was employed by the Nursing and Midwifery Council.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The Committee RESOLVED that the minutes of the previous meeting, held on 5 December 2023, were approved as an accurate record of the discussion.

4. MATTERS ARISING

4.1 The Committee requested for further details in relation to the final paragraph in item 8 of the minutes which stated that 'there will be conversations through the engagement around the 40 staff the ICB support, the funds on the Hillingdon component of the overall 800 staff, how those staff are reconfigured'. They particularly requested clarity on what was meant by the funding component. Chatan Popat (Strategy Lead – Scrutiny) would follow this up with relevant officers and provide an update to the Committee.

5. ORDER OF BUSINESS

5.1 The Chair informed the Committee that he would be taking item 6 – Primary Care Access and Same Day Access Model first, followed by item 7, and then moving back to items 5, 8 and 9.

6. PRIMARY CARE ACCESS AND SAME DAY ACCESS MODEL

6.1 The Chair informed the Committee that he had allowed 2 public speakers and a GP to address the Committee in relation to the agenda item. He had given each speaker up to 5 minutes to make their remarks. A summary of the speakers' comments is provided below.

6.1.1 Robin Sharp, from Brent Patient Voice, addressed the Committee in relation to the Same Day Access Model. He highlighted that the new Same Day Access Model had been controversial over the past month once knowledge of the model had reached the public domain. On the face of it, the purpose of the model was to address the frustrations patients faced in being able to get appointments smoothly and as a way to avoid the Monday morning 8am rush. He recalled that this had been the major concern on the doorsteps during the May 2023 local elections and he thought it was likely the NHS had been asked to address that. He highlighted that KPMG Management Consultants had then been given a remit to run a trial with North West London (NWL) in relation to same day access. An Integrated Care Board (ICB) paper to the October 2023 Board had mentioned some pilots of the model in willing Primary Care Networks (PCNs) in the NWL area, and, in response to the proposals of the model, Brent Patient Voice had issued a strong demand for patient representatives to be involved in any radical moves affecting patients and their use of NHS services. He advised the Committee that Brent Patient Voice had received no response to those concerns. They had then received the full implementation package for the Same Day Access Model which consisted of 3 documents – a letter from the ICB Member for Primary Care instructing for Same Day Access Hubs to be in place throughout the ICB domain from 1 April which he felt had given the impression the implementation was compulsory; a 27 page document from KPMG explaining the proposals with diagrams of the model; and a good practice guide of examples of access by patients to care outside of the hospital. Robin Sharp highlighted that none of those examples related to the Same Day Access Hubs. Once Brent Patient Voice had analysed the documents, they wrote to Rob Hurd, Chief Executive of NHS North West London ICB, expressing that they felt these were radical proposals which limited the access of a large section of patients to their GPs and there was concern that the changes would be implemented without

pilots being evaluated and scrutinised in terms of their impact. In response, the ICB had written that the model would be implemented gradually.

6.1.2 Merrill Hammer, a resident of Hammersmith and Fulham, highlighted that the plans for Same Day Access Hubs had not been stopped as reported in some of the media, but delayed for 12 months with the possibility of PCNs being asked to tweak the way patients accessed primary care. She felt that there was a lack of clarity on what a hub was, in terms of whether it was a physical space or a telephone line and whether it was part of a single practice within a PCN. There were questions on where a patient would see the person who triaged them and how a hub would differ from urgent treatment centres or walk-in centres and who would staff them. Merrill Hammer expressed that triage and diagnosis were highly skilled tasks that should be undertaken by fully trained GPs, but she had heard that there would be unspecified clinicians that would make those clinical decisions and referrals, with a GP as a supervisor. She felt this was not safe. She also felt that continuity of care outlined in the plans related only to those patients with more complex needs, despite research reports by Cambridge University that continuity of care was more productive than access driven GP models. For Merrill, continuity of care meant growing familiarity of a GP or practice with a patient and their family, which was something that could only develop over time, and not something that only started when a patients' needs were already complex. In that way, she felt that continuity of care led to early diagnosis of health issues that may become complex over time if not identified early, and many GPs could give daily examples of this as patients passed through their surgery. She felt there was a need to recognise that GPs developed their skills by working with a wide range of patients with health problems ranging from the simple to the complex, allowing them to develop insights which helped them to recognise and identify that a patient presenting with one condition may also have a number of other and sometimes more serious conditions requiring treatment. For that reason, she felt it was dangerous to limit GPs to what she viewed as a binary choice between seeing simple and complex patients. From a patient point of view, she highlighted that the attendance of a home practice over a period of time allowed patients and families to develop the trust that made successful treatment more probable. Regarding the pilots of the hubs, she highlighted there had been no published reports or evaluation of their impact and no published health equalities impact assessment for this new model. The ICB had informed residents that the impact assessment would follow after implementation, which she felt was too late because it would be hard to make changes once the model was in operation. Merrill Hammer concluded with the sentiment that access to a GP was a core and important part of NHS provision.

6.1.3 Dr Vishal Valar, a local practicing GP, also addressed the Committee in relation to the Same Day Access Hub model. He advised the Committee that the Patient Participation Group within his PCN had raised concerns. The Group had queried where the care would be delivered, with most patients preferring for this to be in their own practice and not elsewhere because they would struggle to get to another place which could lead to inequality. The Group had queried who would deliver their care, with most patients preferring their own clinicians from their practice to deliver their care as they had known them for many years. The third concern had been around continuity of care, which the Group felt could be ensured if patients were able to receive same day access in their own practices and be seen by their own clinicians.

6.2 The Chair thanked the representatives for their remarks and welcomed the NHS NWL colleagues who were present to the meeting, inviting them to introduce the report. Dr Genevieve Small (GP and Medical Director, Primary Care, NHS North West London) provided some context to the Same Day Access model, highlighting that this was a fast-moving piece of work. In introducing the report, she provided the following key points:

- Dr Genevieve Small apologised on behalf of the ICB that the initial messaging to practices had not been expressed in a way that had been understandable for stakeholders and resulted in anxiety. She confirmed that the ICB would not be asking primary care to implement the model 2024-25, but to spend the year considering what was right for their practices, PCNs, patients and communities which could then be wrapped into something meaningful for the contract in the following year. This meant that nothing would change on 1 April 2024 and it had never been the intention for that to happen. The 1 April was the contract date by which the ICB would be enabling money to go into practices and PCNs to enable them to do this work.
- Dr Genevieve Small acknowledged that access was a concern for patients, which the ICB had learned through conversations with patients when undertaking local insight work. Patients had frustration at being able to see a GP in their own practice. The ICB acknowledged some of the concerns expressed from the public regarding an imposed system, and she reassured the Committee that was not what was happening. It was acknowledged that some of the language used in the initial paperwork which practices had received may have been misinterpreted, but the ICB's aim was to achieve resource out to practices for them to have time to reflect and consider the best way forward for patients to access them.
- The challenge with access to appointments in NWL was that it provided 1.4 million appointments in GP practices every month, with 67% of those face to face. Pre-covid, the level of face-to-face appointments had been approx. 80%, but NWL had recovered beyond that, because pre-covid it had been delivering 900k appointments, meaning NWL had been delivering an additional 0.5 million appointments every month post-covid. Despite that, she highlighted that NWL was not achieving the levels of access that patients wanted to maintain their health, so it was important to use the appointments that were available wisely.
- The ICB aimed to encourage practices and PCNs to look at new ways of delivering care and access. There was an awareness that the range of patient presentations could vary from very straight forward issues which may not always be clinical through to more complex care. The purpose of the Same Day Access Hubs was to bring together the skills existing within a practice to ensure the flow of patients was directed correctly. For example, if a patient attended with a sore throat, they may get quicker and more timely and relevant care if they attended a local pharmacy rather than waiting more time to be seen in their GP practice. If a patient had more evolved conditions that would need a GP or another skill within the practice then the hubs could enable that to happen. Within that, patient choice was very important and patients would have the opportunity to decide where they went to receive their care, but if they decided to be seen by their own practice then they may need to wait longer to be seen than if they chose to go to a different part of the system.
- It was highlighted that there had been no pilots of the Same Day Access Hub Model, and that those PCNs who had adopted the model were early adopters who had opted to implement the model and help guide the ICB with the work.

6.3 The Chair thanked Dr Genevieve Small for the introduction, then invited questions to NHS representatives from members of the Committee, with the following issues raised:

6.3.1 Committee members expressed disappointment with the communications that had surrounded the model. Members had heard from their GPs that they had been feeling stressed about what they believed was coming into place from 1 April onwards. The Committee advocated for engagement and co-production going forward in the next year in order to get the model right, and emphasised the importance of GPs and patients being at the heart of the service. Dr Genevieve Small responded, highlighting that the ICB would be working with practices, PCNs, Patient Participation Groups and

communities in NWL to get the model right over the course of the next year, and it had always been intended to be a localised model for individual PCNs to decide locally. Rob Hurd (Chief Executive, NHS North West London) advised that a co-production plan would be produced over the next year with an accompanying communications plan, which could be shared with the Committee. He advised it would be clear how the co-production work had taken place. Rory Hegarty (Director of Communications and Engagement, NHS North West London) added that this was not seen by the ICB as needing formal consultation, on the basis that it was not happening at scale. While it would mean a change to service delivery, the plan was to co-design this with each PCN and their patients locally, and there was no blueprint model for this. It was important that the focus was on delivering this approach locally within each patch rather than a blanket approach across all NWL, and so, because it would look different across each patch, it was not possible to do formal consultation. Instead, engagement would happen locally with all relevant stakeholders. There would also be a Patient Reference Group at NWL level to help inform the work as well as local Patient Participation Groups.

6.3.2 In relation to communication in general, Rob Hurd acknowledged that there was a need to publish the ICB work programme for the year ahead and work better at how to advance signal the projects that were underway at the right time.

6.3.3 Rob Hurd advised the Committee that there were complexities for the ICB that were national processes determining certain principles and how programmes were rolled out, but the ICB were determined to have a local, PCN-level approach with co-production at the heard of that. There was also the need to work at a reasonable pace to react to what he saw as an unacceptable situation for how patients accessed same day primary care. He felt there had been some good work from primary care leaders working in a highly complex change programme sitting between the national change process and the research by Cambridge. The ICB acknowledged its responsibilities within that, and he highlighted that there were things that could be improved straight away around how multi-disciplinary teams provided same day access which were a tweak or improvement, and not a fundamental change, providing access to clinicians in ways that enhanced and improved the current lived experience. As such, the ICB were treading the balance between allowing for continuous improvement of business as usual, and accepting improvement opportunities where possible while co-producing some of the fundamental principles involved, within the constraints of a national system.

6.3.4 The Committee raised concerns that there had been no published independent evaluation of the early adopters, as would be expected when a new system was introduced. They queried how the model could be properly evaluated in such a short period of time to understand the impact of patients not being seen by their own practice. Dr Genevieve Small highlighted that those who had already adopted the model were not pilots but early adopters, with 10 of 45 PCNs opting in. During that time, those PCNs had considered their access, the issues patients were raising and their complexities, and had then established their own individual ways of doing a change in access. All 10 PCNs started at different times and no two PCNs had taken the same approach. Her own GP in Harrow was part of the early adopter PCNs. They had learned that the early adopters had found different ways of working which had been useful, and some of that knowledge had formed part of the proposals for the 9 principles of the model. Those early adopters were being reviewed in order to understand the learning, which would be brought to the public once available. Anecdotally, one PCN in Central London had been able to demonstrate that they could give longer appointments for their more complex patients as a result of the way they had streamlined processes, and another PCN had been able to offer additional

appointments for their patients to receive care. The challenge in evaluation was that this was not a consistent model and the approach was different across each PCN so it was less possible to use evaluation as a research tool.

6.3.5 In response to queries as to why an Equality Impact Assessment on the Same Day Access Hub Model had not been conducted, Rory Hegarty explained that impact assessment would form part of the next stage of the work. The impact assessments would need to be looked at locally due to the fact each area would differ in the implementation of the model. This would happen as and when each local system decided their own local plans.

6.3.6 The Committee acknowledged that implementation would differ between PCNs, so queried how standardisation could be achieved. Dr Genevieve Small explained that the NHSE contract gave GPs a broad outline of the time GPs needed to start, finish, and be accessible to patients, which had been built on in NWL through the enhanced services model that allowed patients in the whole of NWL to access high level diabetic care and other additional services. Practices and PCNs were not prescribed how to deliver that, the ICB only set the standards of what it wanted practices to achieve, and it was up to the practices how they did that. In this way, standardisation was achieved through setting the expectations in the contract to be achieved.

6.3.7 The Committee queried what would happen to a GP practice if they opted out of the model and whether this would jeopardise funding for that practice. They heard that there was no mandate to sign a contract for 2024-25. PCNs had complete flexibility and the ICB encouraged them to be a part of the programme so they could be given the money and resource to build a better access model for their patients going forward. The funding they had already been receiving through their contract would remain completely unchanged, and would be uplifted for the delivery of additional services for patients in 2024-25. The Same Day Access Hub funding would not form part of that and the money would remain in primary care for practices opting in, so the ICB hoped that all PCNs would be happy to join them in a contract that would make that money flow forward.

6.3.8 In order to alleviate concerns, the Committee hoped for further transparency around the model, including more details on the outcomes of the early adopters and case studies to show learning and best practice. They also wanted further details on how the system would work for patients, which they believed would help to alleviate the anxiety surrounding this. ICB colleagues agreed some of those points could be taken away to provide an update at a later stage. These questions would be answered as that work began to take shape at individual PCN level. The Committee heard that, for the average patient, their first port of call would be their GP surgery, and that was not going to change, nor was there any intention of diverting or deflecting individual care from a GP practice. They were advised that the model aimed to build processes and efficiencies into access to primary care. The ICB wanted to move away from the need for patients to call at 8am or risk not being able to get an appointment on the same day. What were described as care navigators or co-ordinators within the proposals were what GP receptionists already did on a daily basis when a patient rang the surgery, as the receptionist would be doing some level of decision making about that patient. In terms of decision making on the care the patient received, that would always need to be made by a qualified clinician. It was added that, through the model, primary care teams in practices could be upskilled at care navigation, which would help with continuity of care.

6.3.9 The Committee asked how KPMG had been involved in the work. Dr Genevieve Small informed members that this had been a long-term, 2-year programme to look at improved access for patients. Over the course of that work, the ICB had worked with a range of different colleagues and clinicians, and, in the summer, because there was not enough capacity within the system to support practices and PCNs to do the work, the ICB had decided to look at opportunities from consultancies to do that work. KPMG was subsequently given the contract to support the 10 early adopter PCNs and build relationships with them. When the ICB then wanted to stretch the opportunity out to the rest of the PCNs in NWL they worked with KPMG to see if that was something they were able to support as part of their ongoing work.

6.3.10 Councillor Ben Wesson shared some reflections from an Ealing resident from Ealing Save our NHS, who had felt that the main issue with the model was around lack of continuity of care, as a GP would know the background of a patient that an employee of a hub would not. The resident had felt that the time taken to triage an urgent case would delay treatment where the patient's own GP would already know the circumstances surrounding that patient, and the resident felt that the Committee should stand against the new system which they felt did not adequately protect continuity of care. The Committee felt that the proposals fragmented the system and created barriers to patients being seen by a doctor. Dr Genevieve Small responded that continuity of care was a very important part of this work. She reassured the Committee that a patient's record would be available to the triager when a patient made contact with a practice or hub, and that triager, who would be a clinician, would make the clinical decision about where their care was best led. If the clinician decided that the patient needed continuity of care they would be directed back to their own practice, hopefully to a clinician who knew them and to a practice that had continuity of that patient's record. Because clinicians did not work full time, the ICB were encouraging practices to think about how they could implement mini-teams within their practice so that patient stories were handed through. Dr Genevieve Small highlighted that the ICB had to balance the access that NWL patients wanted against the ability NWL had to provide that access, which was difficult. She advised members that some patients did not mind who they saw and would prefer to see someone as soon as possible, compared to other patients who would want that continuity of care from their own practice or GP. All patients had different access needs and preferences. As such, she advised members that the ICB was on a journey to ensuring care was delivered in a variety of different ways in the way that fit best for patients.

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

i) That NHS NWL undertake an Equality Impact Assessment and Human Rights Impact Assessment prior to implementing any changes in the way patients access primary care.

ii) That the Committee should seek meaningful consultation with patients, communities and GPs from the ICB. Any engagement undertaken should be representative of the whole patient voice.

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

i) For the NWL JHOSC to be provided with feedback and analysis of the impact of the early adopter PCNs, including case studies that had been learned from.

ii) For the NWL JHOSC to receive full details of how patient safety and effectiveness would be measured against the proposals.

iii) For the NWL JHOSC to receive information on the outcomes of the work done by KPMG in a way that was easy to understand and that related to patient outcomes.

7. COMMISSIONING ARRANGEMETNS FOR COMMUNITY PHARMACY SERVICES AND DENTAL SERVICES

7.1 Hitesh Patel (Chief Officer, Community Pharmacy for Kensington, Chelsea and Westminster) provided a verbal update in relation to community pharmacy services, highlighting the following key points regarding the new Pharmacy First initiative:

- Pharmacy First had launched on 31 January 2024 to improve access to health services for patients in NWL.
- There were 7 clinical conditions which could be seen to by a community pharmacist by the patient either walking into the pharmacy or through a referral:
    - Sinusitis for patients aged 12+
    - Sore throat for patients 5+
    - Acute Otitis Melia, or ear infection, for patients aged between 1-17 years old
    - Insect bites for patients 1+
    - Impetigo for patients 1+
    - Shingles for patients 18+
    - Uncomplicated Urinary Tract Infections (UTIs) for women aged 16-64.
- Pharmacy First would also be able to provide prescription medicine where a patient had run out.
- The third part of the service was for minor illness consultations which would require a referral from either a GP practice, a hub, an urgent treatment centre, or NHS 111 / NHS online.
- In relation to the 7 clinical conditions that a pharmacist would now be able to treat, Hitesh Patel reassured the Committee that pharmacists would go through a very comprehensive pathway to ensure it was appropriate for the patient to have that consultation and safe for the patient to receive the treatment or recommendation that the pharmacist may give.
- One significant factor of the new service was that pharmacists would now be able to prescribe antibiotics, which was described as a game changer for patients. Under the Patient Group Direction, the pharmacist would go through a very precise clinical pathway to ensure it was appropriate to prescribe antibiotics.

7.2 Hilary Tovey (Prevention and Health Living Lead, NHS North West London) provided an update on oral health and dentistry, highlighting the following key points:

- The Integrated Care Partnership (ICP) had recently identified oral health as a very complex area requiring a cross-system approach to dentistry, and the paper outlined that approach and the action plan that had been developed.
- Hilary Tovey expressed gratitude for the leadership that had been provided from primary care and Kelly O'Neill (Director of Public Health, Hounslow) as co-chair of the steering group.
- There had been collaboration between Integrated Care Board (ICB) partners and Public Health to recognise the very severe issues with the oral health of children and young people across NWL, and she highlighted it was only through taking a cross-system approach that the issue could be tackled.
- Throughout the work, the consideration of health equity was being threaded through.

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

7.3.1 The Committee asked how the money for the dentistry contract was allocated, as it had been found in Hillingdon that it had been adhoc, inflexible, and not focused on need. They requested further information on how the ICB were managing the logistical and governance challenges of shifting the management contracts. Dr Genevieve Small (GP and Medical Director, Primary Care, NHS North West London) explained that Units of Dental Activity (UDAs) were divided across the NHS. When the new contract had come into force, which was approx. 10 years ago, dental practitioners were given a contract value and a number of UDAs to deliver over that time. Since then, dentists had been able to take advantage of opportunities to bid for additional UDAs as they became available. The Committee heard that NHS NWL only became the direct commissioners of dental services in April 2023, and so was on a journey to understand the intricacies of the dental contract and were being supported to do that by commissioning colleagues with technical expertise. NHS NWL were not taking UDAs away from practices but supporting those that wanted to add value in by encouraging dentists to build on the work they were currently doing within their own contracts or putting themselves forward for new schemes. NHS NWL were working comprehensively with dental colleagues and attended a dental oversight meeting made up of local NHS dentist practitioners, community dentists, and representatives from the London education aspect for new dentists coming forward. Collectively, that group was working to improve dental activity for all patients and ensure NWL children were given the best dental start in life.

7.3.2 The Committee asked for details on how many children had been waiting for over a year for a dental procedure and how the new commissioning model could help reduce the backlog. Hilary Tovey agreed to obtain and distribute those figures to the Committee. She felt that there were opportunities within delegated commissioning and NHS NWL had already started taking measures to try to reduce waiting times for children and young people which had been effective, particularly around the use of general anaesthetic suites for paediatric dentistry. There would be more opportunities to do that as NHS NWL looked to recommission the community dental contracts over the next few years.

7.3.3 In relation to workforce, the Committee highlighted challenges being faced by pharmacists, with many having closed, and similar challenges attracting and retaining a workforce in NHS dentistry. They asked what was being done by NHS NWL to support NHS pharmacists and dentists with workforce issues. The Committee heard that there was a NWL Workforce Strategy which included all of the different component parts of the system, however, pharmacists were independent practitioners so NHS NWL had less influence there. In terms of dentistry, one of the challenges was keeping dentists within the NHS, so NHS NWL was working with education colleagues around that. NHS NWL was still working on a timeline around workforce.

7.3.4 The Committee noted the additional £2.7m invested into 81 practices in October 2023 due to the high demand for dentistry and asked what the result of that investment had been. They heard that dentistry was in the infancy of the changes resulting from the investment so it was too early to analyse, but there would be reflections on the impact of investment at the appropriate time and NHS NWL colleagues agreed to come back to the Committee with an update on that in future.

7.3.5 The Committee asked what oral health promotions were being offered in schools to both students and parents. Hilary Tovey replied, explaining that oral health promotion

was the responsibility of local authorities, and NHS NWL worked closely with local authority partners to ensure there was consistency in the oral health promotion being offered across NWL and learning from best practice.

7.3.6 Members highlighted feedback received from residents in Harrow who had found it challenging to find NHS dentists accepting new patients and asked whether there was a list of NHS dentists currently accepting patients within each borough. They were advised that the simplest way to find an NHS dentist was the NHS Choices website which was updated often, and patients could search for their closest NHS dentist by postcode using the search tool.

7.3.7 The Committee asked what local authority partners could do in collaboration with NHS NWL to increase access to dentistry in areas of greatest need and reduce waiting times for children. Kelly O'Neill (Director of Public Health, Hounslow) highlighted that local authorities needed to work with the NHS to ensure all children saw a dentist. For preventative work, local authorities were responsible, and could do hat through funding sufficient oral health promotion in early years settings and schools. That promotion was currently variable across NWL, and currently only the most deprived areas were being targeted and this was not at the pace and scale needed. Local authorities were responsible for influencing schools through schemes such as Sugar Smart and Water Only Schools. It was felt that there was a lot within the prevention space that could be done to improve health, but the biggest impact would be if NWL could get fluoride in water. That was a Secretary of State decision and was currently being trialled in North East London. Kelly O'Neill highlighted that lobbying for fluoride in water was where councillors could have the most influence in helping to improve oral health.

7.3.8 In relation to funding for community pharmacy, Hitesh Patel highlighted that this was challenging and that community pharmacists were struggling with the national contract, which had now been devolved to the NWL ICB. There was a hope that, with the ICB now managing that contract, there would be some funding contributions to community pharmacists in future. The new contract was currently under negotiation. Currently, community pharmacists were receiving the same funding as they had received in 2016 for additional services, which amounted to a 35% reduction in funding. There was very little that could be done locally to influence the national contract, although community pharmacists were grateful to elected representatives and senior leaders for lobbying for increased funding. Dr Genevieve Small added that the ICB was looking at ways to support pharmacy colleagues, which would need to be done through funding and resource.

7.3.9 Concern was raised in relation to providing antibiotics for women aged 16-64 to treat UTIs as there had been a rise in resistance to particular anti-biotics, and if the pharmacist was not undertaking a urine test to determine infection there was concern resistance would continue to increase. The Committee were reassured that the clinical pathways in place for a prescription of antibiotics were very robust. The Antimicrobial Resistance Oversight Committee had reviewed the Patient Group Directions and the clinical pathways to ensure that antibiotics were only administered as a last resort option for any condition that the pharmacist was treating. Hitesh Patel advised there would be no difference between a pharmacist prescribing antibiotics to a nurse practitioner or GP, as the decision would go through the same rigorous pathway. In relation to undertaking urine testing to determine infection, the Committee were advised that the British Urological Society stated that testing was not needed for simple UTIs as the history of the patient was good enough to be able to determine whether someone was suffering from a UTI. If a patient had a more complicated UTI that was not considered simple the Pharmacy First scheme would not be appropriate and those patients would be referred to a practitioner.

7.4 As there were no further comments, the Chair thanked those present for their contributions and drew the item to a close.

8. **OBESITY AND PREVENTATIVE SERVICES**

8.1 Dr Tony Willis (GP and Clinical Lead for Diabetes, NHS North West London) introduced the report, highlighting the following key points:

- There was a growing obesity problem nationally and particularly for NWL. The problem was complex and would significantly impact health services and local authority services if it was not addressed.
- There had been some successes to tackle obesity locally, particularly in relation to diabetes pathways. For example, 370,000 people with non-diabetic glycemia, or pre-diabetes, had been supported with their health.
- Within the approach to tackle and prevent obesity, there was an opportunity for collaboration and co-ordination between health services and local councils to look at a set of principles that could be worked on across NWL as a joint charter of action. These principles should also look at food issues due to the clear link between deprivation, food insecurity, ultra-processed food and obesity.
- Part of the current government's Food Strategy highlighted the need to address food issues and obesity, but this had not yet happened at scale. NWL were beginning to address this, and there were some innovative practices happening in NWL such as food pantries, community kitchens and considering what could be done within local work environments to promote healthier living.
- Within this work, NHS NWL were working with specialist services around the commissioning of Wegovy, a weight loss medication.

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

8.2.1 The Committee welcomed the work outlined in the paper and commended the reference to community co-design with a culturally competent approach.

8.2.2 The Committee were pleased that this work would look to commission the weight loss drug, Wegovy, and asked whether any patients in NWL had been able to access that. They heard that NWL patients had not been able to access Wegovy yet. NHS NWL was currently working with the commissioned specialist weight loss services to get a good number of people per month into the pathway for the remainder of the year, and were developing the business case for a larger expansion into the next year.

8.2.3 The Committee noted the referral numbers for bariatrics was quite high and asked whether any modelling had been done across NWL into the impact of incorporating pharmacology into services to drive demand down there. Hilary Tovey (Prevention and Health Living Lead, NHS North West London) explained that this work was being done as part of business case modelling and there would be more understanding of the impact once those services were up and running. As well as pharmacotherapy, the services that accompanied that treatment needed investment and service change, so it was a significant undertaking, but evidence suggested that introducing pharmacotherapy could have a significant impact on the population who were significantly overweight. There had been some modelling done around the use of Wegovy and what that might look like over the next year that would form part of the business case for that substantial investment from the ICB.

8.2.4 The Committee queried how this work would address the issue of digital exclusion. Dr Tony Willis agreed that digital exclusion was something that needed to be worked on and that work was being done. He believed that what had been seen so far in the take up of digital services had been encouraging in terms of proportional representation from minority ethnic groups as well as deprived communities. He highlighted that NHS NWL had been working closely with the Patient Co-design Group around digital upskilling to increase digital literacy in NWL, and Diabetes Community Clubs were working with local groups in key areas to improve digital literacy and supporting those with no digital access to access their online records.

8.2.5 The Committee noted the information in the report detailing that 9 in every 1,000 children in NWL had a BMI of over 30, and asked how local authorities, NHS and schools could work better together to tackle childhood obesity. They heard that discussions had taken place with public health consultants locally and the work needed careful and comprehensive co-design at a NWL level. Kelly O'Neill added that there were different tiers within the pathway which would fall under different partner organisations. Tier 1 related to infrastructure, including how access to unhealthy foods could be limited, limiting unhealthy food advertising, knowing what food was available in schools, making the healthy option the easy option, and active travel. These were the responsibility of the local authority, and some of those initiatives were unpopular. Successfully tackling obesity then also required having adequate tier 2 services in the community which were supported by schools, such as through physical activity in schools. If those first two tiers were not right then this resulted in a reliance on tier 3 and 4 services. Getting tiers 1 and 2 right reduced the requirement for tiers 3 and 4 services.

8.2.6 In relation to referrals into the complications of excess weight clinic for children and young people, the Committee heard that NHS NWL was looking into why the referral numbers were so high. It was possible that NWL was making better use of that service than other areas and the high numbers was a reflection of awareness of the availability of that service and not necessarily because there was a more significant problem, but that was being analysed.

8.2.7 The Committee asked what type of training was being offered to the NHS workforce so they could give advice specifically around diet and nutrition. Dr Tony Willis explained there were a number of workstreams in relation to training for workforce. There had been webinars offered focused on lifestyle medicine and the key pillars to good health such as physical activity, diet and sleep, which had been delivered to those on the Additional Roles Reimbursement Scheme (e.g. Social Prescribers and Health Coaches), and there were plans to expand that into primary care, including for GPs and nurses. Training had also been delivered on motivational interviewing, engaging the service user in a collaborative conversation about what would work for them.

8.2.8 The Committee asked whether any work was being done to reach out to Black, Asian and Minority Ethnic women, particularly of the older population, and heard there was work being done there, looking at different personas within the co-design work.

8.3 As no further comments were raised, the Chair thanked those present for their contributions and drew the item to a close.

9. UPDATE ON COMMUNITY-BASED SPECIALIST PALLIATIVE CARE IMPROVEMENT PROGRAMME

9.1 Rob Hurd (Chief Executive, NHS NWL) introduced the report, which detailed the next steps for the community-based palliative care improvement programme. The next steps would be to conduct an options appraisal, where all options currently remained

on the table following the appraisal work done to date. The work would not be taken forward in a formal way until after the election period as there was a set of proposals that may need to be presented to the Committee after May 2024.

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

9.2.1 The Committee welcomed the news that NHS NWL was seeking to recruit a consultant for the Pembridge Centre.

9.2.2 The Committee asked for clarity on how the recommendations from the NWL JHOSC meeting in September 2024 were being taken forward in relation to design principles for partnership working and advanced care planning. Rob Hurd responded that those recommendations formed part of the evaluation criteria for each of the options on the table and were taken into account there.

9.3 The Chair thanked those present for their contributions and drew the item to a close.

10. UPDATE ON POTENTIAL CHANGE OF CONTROL AT A T MEDICS LTD

10.1 The Committee received an update on the potential change of control at AT Medics Ltd.

10.2 The Chair invited comments and questions from the Committee, with the following points raised:

- The Committee asked for assurance that the ICB would ensure any change of control would not affect service provision for patients and asked for details about the monitoring that would be done by the ICB on the standards of primary care in surgeries that might be subject to a change of control. Rob Hurd (Chief Executive, NHS NWL) explained that all existing mechanisms to monitor performance were included within the contract, which passed over in all possible scenarios and so would remain in place. This meant that existing regulatory arrangements with CQC remained in place as well as contractual arrangements for all GPs who might be subject to the change of control. The due diligence around the change of control was in progress and sought to ensure this process was not fettered and not to make a judgement on that process. He added that no surgery locations would be changing as a result of this mechanism.

10.3 As no further issues were raised, the Chair drew the item to a close and the Committee noted the update.

11. NWL JHOSC 2023-24 RECOMMENDATIONS TRACKER

11.1 The Committee noted the recommendations tracker.

12. FOR NOTING – WORK PROGRAMME 2023-24

12.1 The Committee noted the work programme.

13. ANY OTHER URGENT BUSINESS

13.1 The Committee extended thanks to the Chair for the work done throughout the year with JHOSC.

The meeting concluded at 12.22 pm.
COUNCILLOR KETAN SHETH, CHAIR

Meeting: North West London Joint Health Overview and Scrutiny Committee

Date of meeting: Tuesday 22 October, 2024

Subject: Communications and engagement strategy for the public consultation on the new North West London model of care for adult (18+) community-based specialist palliative care services

Report authors: Dr Lyndsey Williams, GP Clinical Lead NWL ICB EOLC; Robyn Doran, Director of Transformation Central and North West London NHS Foundation Trust and Brent ICP Director.

Section 1 – Summary and recommendations

Summary
As previously reported to the Committee, since late 2021, we have worked closely with local residents, families, carers, clinicians and charitable and NHS palliative care providers to develop a new model of care for adult community-based specialist palliative care services in North West London. Having engaged with our key audiences extensively on the model and completed the London Clinical Senate and NHSE assurance processes, we are now preparing to proceed to public consultation on the options for delivery of the model.

Recommendation:
Members are requested to review our communications and engagement strategy for the proposed public consultation

Section 2 - Main paper

2.1 Introduction

We began our work to review adult community-based specialist palliative care services in late 2021. Since then we have met and worked with patients, families and carers as well as our colleagues from charitable and NHS care providers to help us create a new model of care to improve the services and support available to all residents in north west London.

We know that people care deeply about their local services, whether charitable hospice or NHS, and how they support local residents, families and carers at what is the most difficult of times.

We also know that we need to improve services and make them better for patients and families so that they receive the care and support they need in an environment that supports and helps them at the end-of-life.

People have told us they want their care when dying not in a hospital in-patient ward environment but preferably at home, or in a more therapeutic and calm environment where they will receive the holistic care and support they, their families and their carers need. We heard repeatedly through our engagement how choice was so important, that everyone had different needs and that one size did not fit all. The importance of personalised care was also highlighted.

2.2 Why change is needed

We began this review with the publication of an issues paper in late 2021 that set out eight broad reasons we needed to improve these services, including:

- Our aging (and growing) population
- Reducing health inequalities and social exclusion
- Making services easier to access including for our more diverse communities
- Financial and recruitment challenges.

From late 2021 we repeatedly and consistently sought the views of local residents, clinicians and charitable and NHS palliative care providers on what was important to them about adult community-based specialist palliative care services. Key themes which arose throughout included:

- Providing the best possible care in the best location for the patient
- Providing personalised care reflecting individual needs
- Improving service integration and making navigating services easier
- Clear information and advice on accessing services and support
- The need for staff to be compassionate and culturally sensitive
- Better support for patients, carers and families through end-of-life and beyond, including improving access to bereavement support.

Also, very importantly, as we started to look at existing service provision in-depth, we found that there was significant variation in the type and level of care people received in different boroughs:

- In Hammersmith & Fulham, Ealing and Hounslow there was no hospice at home provision
- Patients in Harrow could not be treated for lymphoedema which was not caused by cancer
- Only patients in Hillingdon were able to get access to enhanced end-of-life care beds
- Patients in Harrow could only access specialist palliative care team services 5-days a week compared to the 7-days per week found in the other seven boroughs in north west London
- Consultant and nurse-led outpatient clinics are not available in Ealing or Hounslow
- 24/7 telephone advice has varying degrees of consultant supervision and is delivered by nurses of varying specialism
- Variation in the level of trained specialist psychology and bereavement practitioners.

As we moved forward we were careful to respond to each of these issues and to propose a model of care for north west London in which everyone receives the same level of high quality care regardless of their circumstances and where they live.

2.3 Developing the new model of care

We recognised from the very start of the programme to improve community-based specialist palliative care for adults in NW London that the only way we were going to succeed was if we worked closely with local residents, families and carers to develop services that truly meet their needs.

Following the beginning of our review work in 2021, we carried out extensive engagement with local residents, and in June 2022 we published an **interim engagement outcome report**, followed by a **final engagement outcome report** in March 2023.

The feedback and information received fed directly into the model of care working group who had responsibility for developing and co-designing the new model for community-based specialist palliative care in north west London. The working group consisted of north west London residents with lived experience of palliative and end-of-life care, as well as bereavement, along with clinicians and providers. Over a twelve-month period, the group met over thirty times to consider the evidence and best practice, systematically co-design the services and support the development of a new, improved model of care

The **initial version of the model of care** was published in August 2023 and we then engaged with north west London residents, health professionals and a broad range of local stakeholders to test whether the model was fit for purpose or if there had been things that we had missed or needed to strengthen.

From September 2023 to October 2023 we completed eight engagement events at both a NW London and borough level, as well as briefing councillors from each of the eight boroughs. These engagement events were attending by residents, CSPC provider leads, voluntary sector, borough programme leads and other key stakeholders. We obtained a rich amount of feedback, comments and valuable input

regarding the proposed new model of care and wider palliative care improvement which is covered in this **engagement report**.

Overall there was good support for the proposed new model of care. People liked that we want to increase the amount of support available in the community to help people stay in their own homes. They also liked the almost doubling of the number of beds to over 100 available to support local residents who either need the intensive support provided by a hospice inpatient bed or the less intense but also vital enhanced end-of-life care bed that will be available to those people who sadly are not able to stay in their own home. However, we did hear some valuable challenges and constructive suggestions on how we might improve the model of care.

This feedback was then reflected in a revised NW London model of care for community-based specialist palliative care for adults (18+), greatly strengthening the proposal.

Since then we have worked through a detailed non-financial and financial appraisal process and progressed through the London Clinical Senate, NHSE and ICB approval processes, as well as engaging with the Mayor of London's office.

2.4 The new model of care

We have listened and worked with communities to develop a model of care that responds to identified needs while reflecting good practice and best practice evidence. Our new model of care was tested with the public in 2023 and received strong local support.

The model of care recommends the common provision of adult community-based specialist palliative care services in all eight boroughs across north west London and broadly covers three areas:

1. Care at home (adult community specialist palliative care nursing teams, hospice at home and 24/7 specialist telephone advice)
2. Community specialist inpatient beds (hospice inpatient beds, enhanced end-of-life care (EoLC) beds)
3. Hospice outpatients (including lymphoedema, psychological and bereavement services), hospice day care and wellbeing services.

Figure 2 –Model of care for community based specialist palliative care

What changes will you see in how care is provided	
Care in your own home	
Service	**Key change**
Adult community specialist palliative care team	7 day service available 12 hours per day in all boroughs
Hospice at home	Care available in all boroughs 7 day service, available up to 24hrs
24.7 specialist phone advice	Consultant-led advice, available to anyone
Care in a community inpatient setting	
Service	**Key change**
Enhanced end-of-life care beds	Increase beds from 8 beds in Hillingdon to 54 across all our boroughs
Specialist hospice inpatient unit beds	57 beds are needed to meet future need. Improve access to them by increasing hours by which people can be admitted
Outpatient and wellbeing care	
Service	**Key change**
Hospice MDT outpatient clinics	Increasing specialist clinics in Ealing and Hounslow to improve consistency
Dedicated bereavement and physiological support	A consistent care pathway in all boroughs offering one-to-one counselling and group settings
Lymphoedema	Expansion of service to care for cancer and non-cancer patients

In parallel to agreeing that the elements above are key to better supporting our residents to live their best possible life as well as have the most comfortable death, we acknowledge an issue for some residents in our inner London boroughs, is that the Pembridge Palliative Care Inpatient Unit at St Charles Centre for Health and Wellbeing in North Kensington has been closed since 2018, due to challenges staffing the unit. This review is focused on the right support across all eight boroughs but will also need to provide an agreed approach to the future of the Pembridge Palliative Care Inpatient Unit.

An innovative development that directly responds to resident concerns, is the proposed introduction of enhanced end-of-life care beds in all eight boroughs in north west London that will serve patients with a moderate level of need.

Enhanced end-of-life care beds will be paid for by the NHS and supported by their local specialist palliative care team providing in-reach support and expertise. Benefits include:

- More beds closer to where people live making it easier for family and friends to visit
- Fewer people admitted to hospital at the end-of-life
- Keeping the highly specialist hospice beds for the patients with the most complex needs
- Meeting people's preferences of preferred place of death
- Improving comfort and wellbeing at the end-of-life.

There are currently eight enhanced end-of-life-care beds in Hillingdon. Based on this number and the population of each borough we are proposing the introduction of 46 additional end-of-life care beds meaning 54 in total.

2.5 Consulting on options to deliver the new model of care

Implementing the new model of care requires us to introduce new services, change existing services and make some difficult choices. We have undertaken an extensive appraisal process to explore the possible ways to deliver these changes.

An initial longlist of 54 possible options for delivery of all elements of the new model of care were assessed against key criteria determined by our steering group. This resulted in a shortlist of five possible options, which will be detailed in the main consultation document.

Further financial and non-financial appraisal of these five options has resulted in two preferred options, which scored highest in the appraisal process. We will be formally consulting on these two options.

We are pleased that in these two options, we are proposing to almost double the number of beds available to local residents and fill the gaps in service provision that has meant that some residents in some boroughs have a less equal service. We believe this is the fair and right thing to do.

We are also seeking to agree the future of the Pembridge Palliative Care Inpatient Unit in North Kensington that has been suspended for over six years and before the Covid-19 pandemic, as we have been unable to recruit the necessary specialist palliative care consultant and wider team. There is a national shortage of these highly specialist staff and despite repeated attempts to recruit we have been unable to do so. We have also worked with our partners to see if there was any way round this and have been unable to find a solution. We are sorry for this and know how upset local residents continue to be.

Whilst one of the two preferred options scored higher in the financial and non-financial appraisal, no decision has been made and we will be seeking views on both options to inform the final decision. This will be made after the consultation has closed and the feedback independently reviewed.

We acknowledge that some people would have liked us to go further and be even more ambitious. Informed by our providers and clinicians we have tried to strike the right balance between what is realistic and deliverable as well as impactful. We believe the proposals strike that right balance.

2.6 Next steps following this consultation

Once the public consultation closes, all feedback and responses received will be collated and analysed by 3ST, a charitable organisation and alliance of voluntary and community sector organisations working across north west London. This will be incorporated into a post consultation report which will be published on the north west London adult community-based specialist palliative care website.

In determining the agreed option for implementation of the new model of care for adult community-based specialist palliative care, NHS north west London will consider the outputs from the public consultation and use this to inform the final decision.

No decisions about any changes to services will be made until after a full public consultation has taken place and all of the information, including the feedback from the consultation, has been considered.

3. Communications and engagement strategy

The full communications and engagement strategy for the public consultation is attached with this paper.

In summary:

- The strategy is designed to gather feedback from local residents, stakeholders and staff, making it as easy as possible to comment through a choice of channels and reaching out effectively to ensure people are aware of the consultation and how they can contribute. It aims to ensure that inclusion in the consultation process is as broad as possible and that those individuals and groups most likely to be impacted by the service change are fully engaged and their voices are particularly clearly heard. The strategy is also designed to comply with the relevant statutory duties and guidance.

- There will be a variety of information made available to inform participants and enable them to make meaningful comments. This will be hosted on the ICB website, and include the pre-consultation business case and the core consultation information including: the main consultation document; a summary version; an easy read version; detailed background documents, including the Equalities Health Impact Assessment; the updated model of care; video updates and a white board animation that explores the patient journey.

- We will also provide support for those who may need additional help to participate, including translations, different versions of the consultation document (e.g. printed, audio, large print, Braille) and tailored support to participate if, for example, a person has a learning disability or difficulty in communicating.

- Of the nine protected characteristics identified within the Equality Act, our equality health impact assessment indicates that the proposed model of care will be positive for people whose characteristics are age, disability and religion or belief and neutral for people with the other characteristics (gender reassignment, marriage or civil partnership, pregnancy and maternity, race, sex, sexual orientation).

- Our assessment also identifies additional vulnerable groups for our work, specifically: carers; single person households, deprived populations; people living in sub-standard accommodation; homelessness; mental health and dementia. Populations with these characteristics have been identified through our engagement activities as particularly important for this work. They have therefore been included to ensure that our proposals consider the specific circumstances of people who are most likely to be impacted, and that any negative impacts are either avoided or appropriately mitigated. Our assessment indicates that the proposed model of care will be positive for carers, single person households, deprived populations, people living in sub-standard accommodation and homelessness and neutral for deprived populations and those with mental health and dementia.

- Following the equality health impact assessment, integrated impact assessment and a review by the Clinical Senate, the following groups have been identified as the high priorities for the consultation: residents of NW London; those populations who are under-represented in access to adult community-based specialist community palliative care services (including BAME residents and younger people); and people in those wards with most limited geographical access to services and longer travel times.

- In addition, other groups we are prioritising for engagement include stakeholders, and local organisations, plus networks and media who will carry information about the consultation. These include: anyone who is currently using community-based specialist palliative care services in NW London; families and carers of people who use, have used, or might use community-based specialist palliative care services; professional representative bodies (such as local medical committees; community representatives, including the voluntary and faith sector); local authorities; health and social care partners (including charitable and NHS providers of palliative care, primary care, acute hospital); community and mental health services; individuals and groups we have previously engaged with during the development of the model of care.

- The consultation questionnaire and schedule of engagement activities will be publicised through a variety of channels including existing contact lists; NHS NW London and partner social media channels, websites, newsletters and mailings; our stakeholders and partners' networks; NW London and borough end-of-life groups and contacts; community organisations, local authority channels and our borough contacts; and through advertising through social media and meta channels.

- The questionnaire will be linked to on the ICB website with both quantitative and free text questions and the opportunity to make more general comments relevant to the consultation, along with demographic and other monitoring questions to

facilitate analysis of different groups' (e.g. by area of residence, service use, demographic characteristics). Printed copies of the questionnaire, will also be made available. People will also be able to share their views with the team via email and freepost and arrange a call to feedback verbally.

- All feedback received through all the channels set out will be considered in a single analysis. We have appointed 3ST, a charitable organisation and alliance of voluntary and community sector organisations working across north west London, to carry out this analysis and produce a report. The report will be published, form an appendix to the decision-making business case (DMBC), and be formally considered by the ICB.

- There will be minimum of one public meeting in each borough. These meetings will also be open to all NW London residents but each borough specific meeting will be targeted particularly at residents and stakeholders from that borough. There will also be a number of NW London-wide events. Each event will include information on the proposals and provide opportunities to question and challenge. All comments will be considered within the consultation analysis. There will also be a programme of drop-in sessions at various locations across all eight boroughs with consultation documents available and support to consider and complete the questionnaire. A draft timetable for these events is provided with the communications and engagement strategy that accompanies this paper.

- Through a programme of community outreach, we will aim to engage individuals and groups who may be traditionally less engaged; face access issues, experience inequality or have additional needs; or who may be especially affected by the proposed service changes. This will draw heavily on local relationships maintained by NHS NW London and its partners. It will rely on working through trusted networks and intermediaries, which experience tells us is the best way to reach out.

- We will also work with the ICB Borough teams to develop an approach which identifies and seeks invitations to attend existing meetings, events and platforms.

- We will revisit the contacts we made during the development of the model of care, update them on the proposed changes and seek their views. We will also aim to reach out to the priority groups identified in the Equality Health Impact Assessment and seek in-depth conversations and interviews (where appropriate).

- The consultation is expected to begin during the week commencing 18 November 2024 and is scheduled to run for a minimum of 14 weeks (allowing two weeks for the Christmas and New Year period). The team will undertake regular review of comments and responses throughout this period and adapt plans to reflect any issues raised or identified. The team will also conduct an interim headline review during week eight covering both quantitative survey data and qualitative comments received up to that point.

North West London

Communication and engagement strategy for the public consultation on the new North West London model of care for community-based specialist palliative care services

1. Introduction

1.1. About the North West London model of care for community-based specialist palliative care services

In 2021 we began a journey to review and shape the future provision of adult (18+) community-based specialist palliative care services in North West London (NW London) with the publication of an **Issues Paper** that set out why we were looking at a service that is so important to patients, families, carers and friends at a time of their greatest need.

Our ambition is to develop services that are patient-centred and provide choice, focusing on tailoring services and treatment plans to meet the individual needs and preferences of each patient.

Since then we have focused our review programme's work on building a new model of care that will deliver equal access to high quality community-based specialist palliative care (CSPC) and end of life care and support that is coordinated, and which from diagnosis through to bereavement reflects the individual needs and preferences of NW London residents, their families, carers and those important to them. We also want to ensure that any proposed new service provision is sustainable and that we can continue to deliver the same level of high quality care in the future.

Our ambition is to develop services that are patient-centred and provide choice where it is available. There will be a focus on tailoring services and treatment plans to meet the individual needs and preferences of each patient. We recognise that healthcare should not be a one-size-fits-all approach and that people have unique health conditions, values, and goals.

1.2 Developing the new model of care

We recognised from the very start that the success of the programme would rely on working closely with local residents, families and carers. Over the past three years, we have carried out extensive engagement and made adjustments to our proposals based on feedback received. The revised model of care reflects these inputs and aims to provide high-quality, equitable services across all boroughs.

1.3 Strengthening engagement for better public involvement

Following the beginning of our review work in 2021, we carried out extensive engagement with local residents, and in June 2022 we published an **interim**

engagement outcome report, followed by a **final engagement outcome report** in March 2023.

The feedback and information received fed directly into the model of care working group who had responsibility for developing and co-designing the new model for community-based specialist palliative care in north west London.
The working group consisted of north west London residents with lived experience of palliative and end-of-life care, as well as bereavement, along with clinicians and providers. Over a twelve-month period, the group met over thirty times to consider the evidence and best practice, systematically co-design the services and support the development of a new, improved model of care

The **initial version of the model of care** was published in August 2023 and we then engaged with north west London residents, health professionals and a broad range of local stakeholders to test whether the model was fit for purpose or if there had been things that we had missed or needed to strengthen.

From September 2023 to October 2023 we completed eight engagement events at both a NW London and borough level, as well as briefing councillors from each of the eight boroughs. These engagement events were attending by residents, CSPC provider leads, voluntary sector, borough programme leads and other key stakeholders. We obtained a rich amount of feedback, comments and valuable input regarding the proposed new model of care and wider palliative care improvement which is covered in this **engagement report**.

Overall there was good support for the proposed new model of care. People liked that we want to increase the amount of support available in the community to help people stay in their own homes. They also liked the almost doubling of the number of beds to over 100 available to support local residents who either need the intensive support provided by a hospice inpatient bed or the less intense but also vital enhanced end-of-life care bed that will be available to those people who sadly are not able to stay in their own home. However, we did hear some valuable challenges and constructive suggestions on how we might improve the model of care.

This feedback was then reflected in a revised NW London model of care for community-based specialist palliative care for adults (18+), greatly strengthening the proposal.

1.4 Options for delivery of the new model of care

At the same time as revising and strengthening the proposed model of care, we also looked at how we could best deliver the new model.

We considered the widest possible set of scenarios for how the model of care could be delivered and identified 54 possible delivery options. We then applied four hurdle criteria (strategic fit, quality of care, affordability and achievability), developed by the NW London CSPC steering group, to reduce possible potential options to a manageable set of choices that we could examine in more detail.

This led to a shortlist of five implementation options:

- Option 0 – do nothing, continue with current provision (no change).

- Option 1 – some change, minimum workable solution with a focus on providing fairness of provision (minimal improvement to care in the home, Pembridge in-patient unit remains closed, 54 enhanced end-of-life care beds).
- Option 2 - some change, minimum workable solution with a focus on providing fairness of provision (minimal improvement to care in the home, Pembridge in-patient re-opens, 54 enhanced end-of-life care beds).
- Option 3 – full implementation, fully deliver model of care (substantial improvements to care in the home and other community-based specialist palliative care services, Pembridge in-patient unit remains closed, 54 enhanced end-of-life beds).
- Option 4 – full implementation, fully deliver model of care (substantial improvements to care in the home and other community-based specialist palliative care services, Pembridge in-patient unit reopens, 54 enhanced end-of-life beds).

In late November and early December 2023 we asked our local residents and stakeholders for their thoughts on these potential delivery options for the model. We undertook eleven engagement events at which we discussed the shortlisted options and attendees had the opportunity to provide feedback, ask questions and put forward their own suggestions on potential options to be considered, if they thought we had missed or not thought of something.

We obtained a rich amount of feedback, comments and valuable input regarding the proposed new model of care and wider palliative care service improvements We found that there was a broad consensus amongst attendees on the proposed five shortlisted service delivery options for the new model of care. The feedback and further detail on the process is provided in the options engagement outcome report.

Since then we have worked through a detailed non-financial and financial appraisal process and progressed through the London Clinical Senate, NHSE and ICB approval processes, as well as engaging with the Mayor of London's office.

1.5 Public consultation

We are now formally proposing that we consult on two of the shortlisted options (options 3 and 4). These options scored highest in our assessment, both individually in the non-financial and financial assessments and collectively.

We believe that 'do nothing' (options 0) and options for partial implementation of the new model of care (options 1 and 2) will not deliver the ambition we have for North West London residents. We are providing information on these options within the consultation for information and to inform feedback rather than as proposed options that we are formally consulting on.

No decisions have been or will be made on options until further engagement has taken place and NHS NW London are receptive to receiving feedback on all options that we can consider.

Further detail on our work on the options is will be detailed in Pre-Consultation Business Case that will be published when the consultation is launched.

Next steps following this consultation

Once the public consultation closes, all feedback and responses received will be collated and analysed by 3ST, a charitable organisation and alliance of voluntary and community sector organisations working across north west London,

This will be incorporated into a post-consultation report which will be published on the NHS North West London website www.nwlondonicb.nhs.uk/cspc.

In determining the agreed option for implementation of the new model of care for adult community-based specialist palliative care, NHS North West London will consider the outputs from the public consultation and use this to inform the final decision.

No decisions about any changes to services will be made until after the full public consultation has taken place and all of the information, including the feedback from the consultation, has been considered.

2. About this communications and engagement strategy

2.1. Objectives

This strategy is designed to support the public consultation process on the proposed model of care for community-based specialist palliative care services in NW London for adults (18+).

The objectives of this strategy are:

- To gather feedback from local residents, stakeholders and staff, making it as easy as possible to comment through a choice of channels and reaching out effectively to ensure people are aware of the consultation and how they can contribute
- While retaining flexibility for how people can participate and valuing all contributions, aim to secure feedback about both of our preferred consultation options – relevant to views on their respective strengths and weaknesses, how they will impact on services and service users, and issues relevant to implementation
- Secure a mix of both quantitative feedback (e.g. through a questionnaire) and qualitative feedback (e.g. through noting discussion at meetings) to develop insight into participants' views which are as rich and detailed as possible
- Where rooted in the data, indicate where there is majority agreement and where there are differences of view held by different groups
- Meeting statutory duties, ensure that inclusion in the consultation process is as broad as possible and that those individuals and groups most likely to be impacted by the service change are fully engaged and their voices are particularly clearly heard
- Capture all feedback from the consultation within a single analysis and report to enable the NHS North West London decision to be fully informed.

2.2. Governance, duties, and relevant guidance

This Strategy is designed to comply with:

- The statutory duty to involve the public and consult on proposals to develop NHS services – National Health Service Act 2006 (as amended)
    - s14Z45 (ICBs), s242 (Trusts), s244/245 (Health Scrutiny)
    - B1762 Working in Partnership with People and Communities Statutory Guidance (NHSE, July 2022) (See summary at Appendix A.)
- Equality Act 2010
    - s149 public sector equality duty
    - Other obligations including duty to reduce inequality
- The Government's four tests for NHS service change (specifically the first test: strong public and patient engagement)
- Gunning Principles for public service consultations:
    - Proposals are still at a formative stage
    - There is sufficient information to give 'intelligent consideration
    - There is adequate time for consideration and response
    - 'Conscientious consideration' must be given to the consultation responses before a decision is made.

The Mayor of London's six tests for NHS service change, specifically test six - patient and public engagement - proposals include meaningful patient and public engagement, including with marginalised groups, in line with Healthwatch[1] recommendations.

2.3. Development and responsibility for this strategy

This strategy has been developed by NHS NW London. The consultation will be delivered according to these principles:

- Through a structured process, with shared management across the system to ensure that the consultation aligns with other strategic programmes in NW London
- Working at place/borough through and with existing engagement and partnership structures
- Working in partnership with the charitable and NHS palliative care providers
- Through the wider network of NHS, local authority and community and voluntary sector groups
- Encompassing both communications and engagement – to ensure that people are able to find out about the consultation and how to participate, those likely to be particularly impacted are reached through a range of relevant channels, and comments and feedback are considered in depth

3. About the consultation

As part of our commitment to ensuring that every voice is heard, we are enhancing our approach to engagement to make it even more inclusive and meaningful for all residents in North West London. We recognise that different groups of people have different needs. To make sure we hear from a wide range of voices, we will proactively reach out to specific communities, such as older people and ethnic minority communities. This will allow us to gain deeper insights into what matters most to people with different lived experiences.

3.1 Information

There will be a variety of information made available to inform participants and enable them to make meaningful comments. This will be hosted on the ICB website, and include the pre-consultation business case, core consultation information including the main consultation document, a summary version and an easy read version. In addition, it will include:

- A summary of the case for change and current service configuration
- The consultation options
- Information about the process so far and how the model of care was developed
- How to contribute views, including a schedule of events?
- Next steps following the consultation
- How to obtain materials in accessible formats?
- Detailed background documents, including the Equalities Health Impact Assessment, the updated model of care
- A white board animation that explores the patient journey
- Video updates

We will also provide support for those who may need some additional help to participate, including translations, different versions of the consultation document (e.g. printed, audio, large print, Braille) and tailored support to participate if, for example, a person has a learning disability or difficulty in communicating.

3.2. Equalities groups and communities

The Equality Act identifies nine protected characteristics and public service providers are required to ensure that action is taken to tackle discrimination against people sharing these characteristics and, where service changes are planned, that disproportionate impacts against people sharing these characteristics are considered and mitigated where possible:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

The equality health impact assessment indicates the proposed model of care will be positive for people whose characteristics are age, disability and religion or belief and neutral for people with the other characteristics.

The assessment also identifies additional vulnerable groups for our work, specifically:

- Carers
- Single person households
- Deprived populations
- People living in sub-standard accommodation

- Homelessness
- Mental health and dementia

Populations with these characteristics have been identified through our engagement activities as particularly important for this work. They have therefore been included to ensure that our proposals consider the specific circumstances of people who are most likely to be impacted, and that any negative impacts are either avoided or appropriately mitigated.

The equality health impact assessment describes the impact on people with protected characteristics but we also indicate the proposed model of care will be positive for carers, single person households, deprived populations, people living in sub-standard accommodation and homelessness and neutral for deprived populations and those with mental health and dementia.

As we move forward through the consultation, we will continue to update the equality health impact assessment to inform any potential decision that NHS North West London makes.

3.3. Local population

The proposed model of care covers the whole of NW London so the consultation will aim to encourage responses from the local populations in each of the boroughs, working with local partners and stakeholders.

3.4. Priority groups for consultation - equalities

As required by law, the key groups for consultation are:

1. Users, or potential users, of community-based specialist palliative care services in NW London
2. Users, or potential users, sharing protected characteristics under the Equality Act (or otherwise at risk of health inequality) who may be disproportionately impacted by the proposed changes.

Following an equality health impact assessment, integrated impact assessment and a review by the Clinical Senate, the following groups have been identified as the highest priorities:

- Residents of NW London
- Those populations who are under-represented in access to adult community-based specialist community palliative care services, including BAME residents and younger people.
- People in those wards with most limited geographical access to services and have longer travel times.

3.5. Other groups for consultation – residents, service users and their families, carers and those important to them, stakeholders and staff

In addition, other groups we would prioritise for engagement include stakeholders, and local organisations, plus networks and media who will carry information about the consultation. These include:

- Anyone who is currently using community-based specialist palliative care services in NW London
- Families and carers of people who use, have used, or might use community-based specialist palliative care services
- Professional representative bodies such as local medical committees
- Community representatives, including the voluntary and faith sector
- Local authorities
- Health and social care partners including: charitable and NHS providers of palliative care, primary care, acute hospital
- Community and mental health services
- Individuals and groups we have previously engaged with during the development of the model of care.

3.6. Promotion of the consultation

The consultation questionnaire and schedule of engagement activities will be publicised through a variety of channels:

<u>Owned</u>

- Existing contact lists of service users, stakeholders and residents who have signed up to receive more information about the review of community-based specialist palliative care services and/or health services mode widely
- NHS North West London and partner social media channels (X, Instagram, Facebook and Next Door), websites, newsletters and engagement channels (e.g. mailings)
- NHS North West London and review programme key stakeholder and partner contacts
- North West London and borough end-of-life groups and contacts

<u>Borrowed</u>

- Cascade of information through community organisations/local partners/borough contacts
- Local authority channels website, social media and/or newsletters

We welcome opportunities raised by partners and stakeholders to support engagement and consultation with our residents.

<u>Bought</u>

- Advertising through social media and meta channels

3.7. Responding to the consultation

The review website and consultation documents will provide clear information on how NW London residents and stakeholders are welcome to respond, and we are committed to ensuring that it is as easy as possible to comment, through a variety of different channels which both make the process as accessible and inclusive as possible, and also actively seek the views of those priority groups set out in this strategy.

This includes actively reaching out through local groups and networks to promote the consultation and offer speakers to attend meetings.

Channels are expected to include:

- Questionnaire linked to on the ICB website with both quantitative and free text questions and the opportunity to make more general comments relevant to the consultation, along with demographic and other monitoring questions to facilitate analysis of different groups' (e.g., by area of residence, service use, demographic characteristics)
- Print copies of the questionnaire, which will be transcribed for analysis
- Correspondence by post (consultation/team mailbox), or email (consultation/team inbox)
- Shared through social media feeds
- Actively shared through the NHS NW London borough networks
- Face-to-face and online at public meetings (open access)
- Face-to-face or online meetings (focus groups and/or 1:1 depth interviews) by invitation with specific groups (e.g. staff, service users, residents, representative groups)
- Community outreach – members of the programme team attending meetings and local open forums to provide information about the consultation, promote and distribute forms and answer questions (where possible these meetings will be noted and comments included within the analysis).

Respondents will be able to use NHS North West London freepost address to respond to the consultation.

3.8. Consultation meetings and activities - report – Keeping you informed

We will provide a clear update to show how your feedback is shaping our decisions. We will share the analysis, reports, and key findings to make sure you stay informed about how your contributions are making an impact.

The consultation public meetings and events will comprise a range of activities:

- Clinician and director-led, open public meetings – deliberative methodology
- Drop-in engagement sessions – to answer questions and distribute questionnaire
- Community outreach events – attending events hosted by community organisations
- Writing to local community organisations – to promote the consultation and offer speakers
- Proactive reach out to arrange focus groups / in-depth interviews – with identified equality groups and those with whom we have previously engaged

3.9. Consultation analysis and report

All feedback received through all the channels set out will be considered in a single analysis. It will also include any formal submissions from stakeholder groups and organisations.

We have appointed 3ST, a charitable organisation and alliance of voluntary and community sector organisations working across north west London, to carry out this analysis and produce a report.

The consultation report will summarise:

- The consultation responses
- Views on the preferred option, highlighting where justified by the data differences of views between different groups
- Analysis of comments more broadly relevant to the proposals, such as views on the clinical model and issues for implementation of option(s).

The report will be published, form an appendix to the decision-making business case (DMBC), and be formally considered by the ICB.

Through this process, thematic responses which challenge the preferred option, the proposed model and/or the assumptions underpinning these will be highlighted so they can be taken into account during development of the DMBC and the final decision(s) taken by the ICB.

Any strengths identified in other options, provided as comparators, will be considered to see if they can be incorporated into the final selected option.

Appendix A: Working in Partnership with People and Communities Statutory Guidance (NHSE, July 2022)

B1762 Working in partnership with people and communities: statutory guidance NHS England (2022)

Appendix B Consultation communication and engagement plan

Consultation on the future of community-based specialist palliative care services for residents of NW London

1. Consultation activities

A range of meetings and events are being planned during the consultation period, using different formats as set out below. In order that these are as inclusive as possible, we note:

- Interpreting support/translators may be required
- Promotion must use a range of channels, including accessible formats.

1.1. Public meetings

Central to the consultation will be structured engagement meetings and events open to all – both face-to-face and online. The two main formats proposed are tried and tested in consultations across London and for this review programme. They are designed both to inform people about the proposals and gather views, and to provide a forum for broader engagement by the NHS in North West London.

1.1.1. Open public meetings

- Structured discussion to gather views and feedback using deliberative methodology.
- Including information on the proposals, opportunities to question and challenge, public discussion with notes taken and all comments considered within the consultation analysis.
- A minimum of one public meeting in each borough. These meetings will also be open to all NW London residents but each borough specific meeting will be targeted particularly at residents and stakeholders from that borough.
- A number of NW London-wide events.
- Recruitment to the events will be undertaken using existing channels and local promotion, with registration of people signing-up.

1.1.2. Drop-in engagement sessions

- Drop-in sessions at various locations across all eight boroughs with consultation documents available and support to consider and complete the questionnaire.
- NHS North West London staff available on location to answer questions and support members of the public with questionnaire.
- Sign-up not requested.

1.2. Community outreach

We recognise that North West London is home to a mixed and culturally diverse community, and we have residents with a wide range of backgrounds, needs and experiences. They are supported, represented, and brought together through a rich ecosystem of third sector providers, community groups and representative associations.

Through a programme of community outreach, we will aim to engage individuals and groups who may be traditionally less engaged; face access issues, experience inequality or have additional needs; or who may be especially affected by the proposed service changes. This will draw heavily on local relationships maintained by NHS NW London and its partners. It will rely on working through trusted networks and intermediaries, which experience tells us is the best way to reach out.

1.2.1. Community outreach events

We will work with the ICB Borough teams to develop an approach which identifies and seeks invitations to attend existing meetings and events:

- Slots incorporated into existing engagement/outreach activities/events
- Communications and engagement staff available to answer questions, encourage response and/or support completion of questionnaire
- Particular focus on targeted groups and geographic locations.

1.2.2. Writing to local community organisations

To maximise access to the consultation, we will also write to the ICB database of local community organisations:

- Provide information about how their members and users can participate.
- Offer information and provide a speaker at events.
- Provide materials on (e.g. weblinks and leaflets for distribution).

1.3. In-depth interviews

We have previously conducted a number of in-depth interviews with individuals and representative organisations during the development of the model of care.

We aim to revisit these contacts, update them on the proposed changes and seek their views.

We also aim to reach out to the priority groups identified in 3.4 and 3.5 and seek in-depth conversations and interviews.

1.4. Timing

Subject to necessary approvals, the consultation is expected to begin during the week commencing 18th November 2024 and is scheduled to run for a minimum of 14 weeks (allowing two weeks for the Christmas and New Year period).

1.6. Complaints, queries, and information requests

There will be a daily monitoring of the consultation/team inbox, social media feed and consultation responses to ensure responsive action can be taken as required. The consultation/team email will be included on all consultation materials so that people have an accessible, standard way to contact the consultation team. All communications will be directed to the central consultation/team email inbox to enable the team to respond to queries and requests efficiently.

1.7. On-going monitoring and interim headline review

This consultation and engagement strategy will be monitored on an on-going basis to ensure that activities outlined are gaining maximum reach. The team will undertake regular review and adapt plans to reflect any issues raised or identified.

The team will also conduct an interim headline review during week eight covering both quantitative survey data and qualitative comments received up to that point.

The purpose of this review will be to:

- Identify key emerging themes in the feedback in order to establish whether additional analysis or development is required for consideration of any of the options.
- Identify any groups not satisfactorily engaged or gaps in the feedback gathered, and to inform additional engagement activity required.
- Identify any issues arising that require responsive actions during the remaining consultation period.

1.8. Briefing political stakeholders

Political stakeholders will be offered:

- A briefing on the consultation before launch, so they are informed and sighted on plans before publication of the PCBC and materials.
- Opportunities for ongoing contact according to their preference (e.g. named contact person, regular update emails, attendance at events).

The key political stakeholders in scope for this part of the plan are:

- Joint Health and Overview Scrutiny Committee
- Local Authority cabinet members and officers in NW London
- Members of Parliament in NW London constituencies
- London Mayor’s Health Adviser (Dr Tom Coffey).

NB: Local authority cabinet members and officers in NW London have been engaged throughout the development of the model of care and the team will attend any appropriate scrutiny meetings, including JHOSC, during the consultation period to brief members and answer questions.

1.9. Launch plan

In order to focus attention on the consultation and promote participation, a public launch will be led by the NHS North West London Communications and Engagement Directorate. This will comprise:

- Launch of consultation website pages including launch video and event
- Widespread communication through all social media channels
- Issue of programme newsletter to all stakeholders
- Widespread communication via partner channels
- News release
- Interview offered with key clinician

1.10. Ensuring reach to seldom heard groups and those facing inequality

We will identify community and grassroots groups supporting residents with protected characteristics and/or part of the priority groups identified in the equalities impact assessment.

Targeted work is underway and will continue throughout the consultation to gather the views of people from these groups. We intend to do through partnership engagement activities with identified community groups and community representatives, undertaking one to one interviews (where appropriate) and outreach.

1.11. Response channels

We want to hear from as many people as possible - patients, families, carers, members of the public, staff, voluntary sector representatives and advocates as well as partners are all encouraged to respond to the consultation.

People can respond to the consultation in a number of ways including:

By completing the public consultation questionnaire

The online questionnaire will be available at: **www.nwlondonicb.nhs.uk/cspc**

It can also be downloaded, and a paper copy of the questionnaire completed. We have set up a FREEPOST address for postal response. The address is **FREEPOST HEALTHIER NORTH WEST LONDON** (no stamp needed).

By Post or email

People can also give feedback without using our questionnaire. They can send in their contributions in a letter or an email. We ask people responding on behalf of an organisation to state the name of their organisation in the correspondence.

Contact details for postal responses are - FREEPOST HEALTHIER NORTH WESTLONDON (no stamp needed) or email: nhsnwl.endoflife@nhs.net

By inviting members of the programme team to speak to a group or organisation

The consultation team can be contacted by email at nhsnwl.endoflife@nhs.net

By attending one of the consultation public meetings

We are holding public meetings both face to face and online. These meetings are an opportunity for interested service users and residents to find out more about the consultation proposals, ask questions and to give their views. These discussions are designed to give everyone the opportunity to participate.

Full details of all events and engagement activities will be available on the ICB website.

Interpreters can be booked on request for these public meetings by contacting nhsnwl.endoflife@nhs.net

A draft timetable of consultation events and planned activity is attached with this paper.

NHS North West London adult (18+) community based specialist palliative care

A programme of consultation events, community outreach and drop-in have been planned (subject to final confirmation).

Planned consultation events

Planned consultation events hosted by NHS North West London and borough place based partnerships.

Date	Time	Consultation event
Tuesday 3 December 2024	3.30 to 5pm	NW London online event
Tuesday10 December 2024	9.30 to 11am	NW London online event
Wednesday 11 December 2024	2.30 to 4pm	Bi-borough (Kensington & Chelsea and Westminster) online event
Tuesday 14 January 2025	10.30am to 12noon	Ealing face to face event venue tbc
Tuesday 14 January 2025	2.30 to 4pm	Harrow face to face event venue tbc
Wednesday 15 January 2025	6.30 to 8pm	Hammersmith and Fulham online event
Wednesday 29 January 2025	11am to 12.30pm	Hillingdon online event
Tuesday 4 February 2025	9.30 to 11am	Brent online event
Tuesday 4 February 2025	2.30 to 4pm	Hounslow online event
Wednesday 5 February 2025	6.30 to 8pm	NW London online event

Planned consultation activity

The NHS North West London Involvement Team have developed a grid of targeted activity covering all boroughs.

Borough	Week commencing	Session name	Meeting type	Date	Location within borough	Targeted protected characteristics

Westminster	Nov 18	Church Street Library 67 Church St, London NW8 8EU	Drop in	Nov 20 10-12	North	Open to all; area of high deprivation
	Nov 25	Community Health & Wellbeing Coffee Morning The Greenside Community Centre, 24 Lilestone St, London NW8 8SR	Public event	Nov 29 10-12	North	Open to all; area of high deprivation
	Dec 2	Grand Junction Chair Yoga Rowington Cl, London W2 5TF	Public event	tbc	North	Older residents
	Dec 9	Pimlico Library Lupus St, Pimlico, London SW1V 3AT	Drop in	Dec 11 10-12	South	Open to all
	Dec 16	Marylebone Bangladeshi Society 19 Samford St, London NW8 8ER	Public event	Dec 18 12-2	North	Open to all; Female South Asian & Middle Eastern residents
	Dec 23 Dec 30	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Jan 6	Maida Vale Library Sutherland Ave, London W9 2QT	Drop in	Jan 7 12-2	North	Open to all; area of high deprivation
	Jan 13	The Abbey Centre 34 Great Smith St, London SW1P 3BU	Drop in	Tbc	South	Open to all; area of high deprivation
	Jan 20	London Chinese Community Centre 2 Leicester Ct, London WC2H 7DW	Drop in	Jan 23 timing tbc	Central	Chinese heritage Residents
	Jan 27	Marylebone Library 9-11 New Cavendish St, London W1G 9UQ	Drop in	Jan 29 timing tbc	Central	Open to all
	Feb 3	Open Age, St Margaret's Community Centre	Public event	Tbc	South	Older residents

		1 Carey Pl, London SW1V 2RT				
	Feb 10	Victoria Library 160 Buckingham Palace Rd, London SW1W 9TR	Drop in	Feb 13 10-12	South	Open to all
	Feb 17	Paddington Library Porchester Rd, London W2 5DU	Drop in	Feb 18 2-4	North	Open to all; area of high deprivation
Kensington & Chelsea	Nov 18	Kensington Central library 12 Phillimore Walk, London W8 7RX	Drop-in	Nov 19	Central	Open to all
	Nov 25	Al-Manaar Islamic Centre 244 Acklam Rd, London W10 5YG	Public event	Nov 29	North	Open to all; faith centre
	Dec 2	Brompton library 210 Old Brompton Rd, London SW5 0BS	Drop-in	Dec 4	Central	Open to all
	Dec 9	North Kensington Library 108 Ladbroke Grove, London W11 1PZ	Drop-in	Dec 10	North	Open to all; area of high deprivation
	Dec 16	Kensal Library 20 Golborne Rd, London W10 5PF	Drop-in	Dec 17	North	Open to all
	Dec 23	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Dec 30					
	Jan 6	Holland Park Surgery 12 Phillimore Walk, London W8 7RX	Drop-In	Jan 8	North	Open to all
	Jan 13	Chelsea library Chelsea Old Town Hall, King's Rd, London SW3 5EZ	Drop-in	Nov 28	South	Open to all
	Jan 20	Portobello Medical Centre 14 Codrington Mews, London W11 2EH	Drop-in	Jan 24	North	Open to all

	Jan 27	Open Age, St Charles Centre for Health & Wellbeing Exmoor Street London W10 6DZ	Drop-in	Jan 28	North	Open to all; area of high deprivation
	Feb 3	Flashpoint Community Centre Worlds End Estate, London SW10 0HE	Public Event	Feb 5 11-1	South	Open to all; area of high deprivation
	Feb 10	Violet Melchett Community Corner 30 Flood Walk, London SW3 5RR	Drop in	Tbc	South	Open to all
	Feb 17	Notting hill Methodist Church 240 Lancaster Rd, London W11 4AH	Drop in	Tbc	North	Open to all; area of high deprivation
Hammersmith & Fulham	Nov 18	Patient Reference Group, Irish Cultural Centre W6 DT	Public event	Nov 21 10-12	Central	Open to all; for invitation contact nhsnwl.hfhcp@nhs.net
	Nov 25	Community Connect 20 Dawes Road, London, SW6 7EN	Public event	Nov 26 11-13	South	Open to all; area of high deprivation
	Dec 2	Bishop Creighton Centre, 378 Lillie Road, SW6 7PH	Public event	Dec 4 Tbc	Central	Older residents
	Dec 9	tbc	Public event	Tbc	Tbc	tbc
	Dec 16	Health and Wellbeing for All, White City Community Centre, India Way London W12 7QT	Public event	Tbc	North	Somali heritage communities
	Dec 23	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Dec 30					

	Jan 6	Nubian Life Resource Centre, Ellerslie Road, London W12 7BW	Public event	Jan 9, Tbc	North	Black heritage communities; older residents
	Jan 13	tbc	Drop in	Jan 16, Tbc	tbc	tbc
	Jan 20	W12 Together, India Way, London W12 7QT	Closed event with residents	Tbc	North	Area of high deprivation
	Jan 27	QPR Community Project, **South Africa Road, London W12 7PJ**	Public event	Jan 29 10 -12	North	Older residents
	Feb 3	Masbro Elders Project, Masbro Centre, 87 Masbro Road, London W14 OLR	Public event	Feb 5 10-13	North	Older residents
	Feb 10	Fulham Library, 598 Fulham Road London SW6 5NX	Drop in	Feb 14 10-13	South	Open to public; area of high deprivation
	Feb 17	Age UK, 105 Greyhound Road, London W6 8NJ	Public event	Feb 20, TBC	Central	Older residents
Hounslow	Nov 18	One Stop Shop, Holy Trinity Church, 6 High street, Hounslow TW31HG	Public event	November 20 10-12.30	Central	Open to public;
	Nov 25	With Heath Outreach Team,Darussalam Masjid and Culture Centre, North Hyde, UB2 5NS	Public event	November 29 10-4pm	Central	Open to residents; faith centre

	Dec 2	Health Outreach Team, vaccination pop-up, Chiswick Sainsbury's 31 Essex place, W4 5UT	Public event	December 5 10-4	North	Open to all
	Dec 9	Palliative care consultation with Hounslow respiratory group St. John's centre, 80 St. John's Road Isleworth TW7 6RN	Focused session	December 11 1.3.30	Central	Closed group
	Dec 16	Heston Library New Heston Road, Hounslow TW5 0LW	Drop in	December 17 (tbc) 10-2 (tbc)	East	Open to public
	Dec 23 Dec 30	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Jan 6	tbc	tbc	Tbc	tbc	tbc
	Jan 13	Age UK monthly session (venue tbc)	Monthly meeting	January 16 12-4	South	Open to all; older residents
	Jan 20	Tbc	Tbc	Tbc	Tbc	Tbc
	Jan 27	Tbc	tbc	tbc	tbc	Tbc
	Feb 3	Outbarn coffee morning Museum of Water and Steam, Brentford TW8 0EN	tbc	February 6 10.30-12.30	North	Open to all; carers and those with additional needs
	Feb 10	Feltham Library 210 The Centre High street Feltham TW13 4GU	Drop in	Feb 12 11:00-1.00pm	South	Open to all
	Feb 17	Tbc	Tbc	tbc	tbc	tbc

Borough	Week commencing	Session name	Meeting type Public Event / Invited Group Drop In	Date	Location within borough	Targeted protected characteristics
Brent	Nov 18					
	Nov 25	Harlesden Library; address: Craven Park Road, NW10 8SE	Drop In	tbc	South	Open to all; area of high deprivation
	Dec 2	Brent Chinese Association; location TBC	Invited Group	tbc	North	Residents of Chinese heritage
	Dec 9	WISE event; Alfric Avenue, NW10 8RA	Invited Group	tbc	South	Residents of Caribbean heritage
	Dec 16	Ealing Road Library; address : Coronet Parade, HA0 4BA	Drop In	tbc	West	Open to all; cross section of local population
	Dec 23	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Dec 30					
	Jan 6	Wembley Library (Civic Centre) address : 32 Engineers Way, HA9 8TS	Drop In	tbc	Central	Open to all; cross section of local population; area of high deprivation
	Jan 13	BIAS; people of Irish heritage; address : Ashford	Invited Group	tbc	East	Residents of Irish heritage

		Place Community Centre, 60 Ashford Place, NW2 6TU				
	Jan 20	Brent Indian Association; 116 Ealing Road, HA0 4TH	Invited Group	tbc	Central	Residents of Indian heritage
	Jan 27	Brent Carers Association; Willesden Medical Centre, 144-150 High Road, NW10 2PT	Invited Group	tbc	East	Carers and families including carers
	Feb 3	Willesden Green Library; 95 High Road, NW10 2SF	Drop In	tbc	East	Open to all; cross section of local population
	Feb 10	Residents with dementia; Memory Cafe, 60 Ashford Place, NW2 4TH	Invited Group	tbc	East	Residents with diagnosis or at risk of dementia
	Feb 17	Somali Community; Bridge Park Community Centre ?, Harrow Road, NW10 0RG	Public event	tbc	Central	Invitation to all residents of Somali heritage; area of high deprivation
Ealing	Nov 18	tbc	tbc	tbc	tbc	Tbc
	Nov 25	Jubilee Gardens Library 2 Jubilee Gardens UB1 2TJ	Drop In	tbc	West	Open to all; cross section of resident population
	Dec 2	United Anglo Caribbean Society; Uxbridge Road W7 3SU	Invited Group	tbc	West	Residents of African-Caribbean heritage

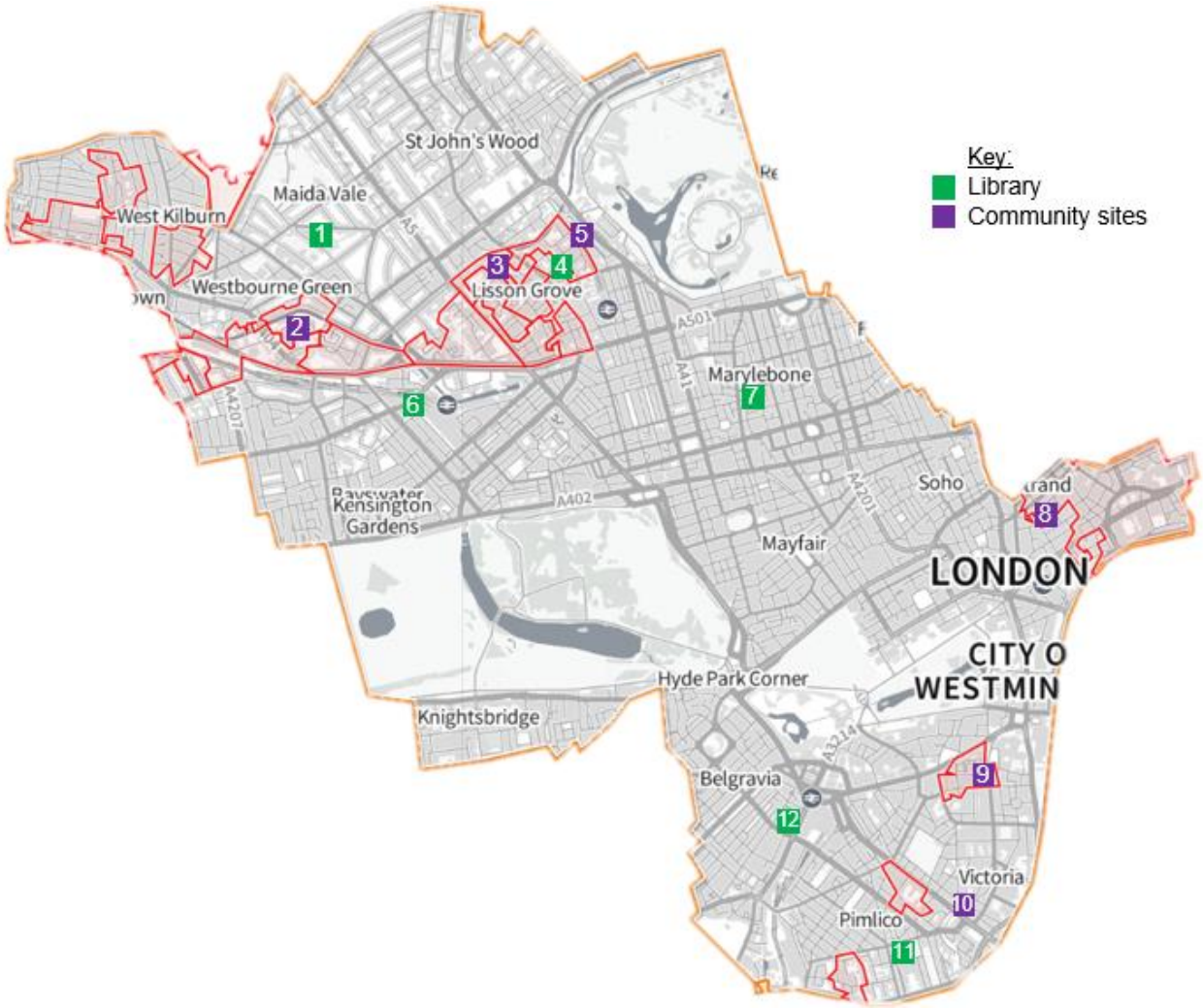
	Dec 9	Armenian Centre in Acton, Mill Hill Road, W3 8JF	Invited Group	tbc	West	Residents of Armenian heritage; area of high deprivation
	Dec 16	West Ealing Community Library; 9BT Melbourne Avenue. W13	Drop In	tbc	West	Open to all; cross section of local population
	Dec 23	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Dec 30					
	Jan 6	Northfields Leisure Centre Library Eastcote Lane, UB5 4AB	Drop In	tbc	North	Open to all; cross section of local population
	Jan 13	Northolt Library; Church Road, UB5 5AS	Invited Group	tbc	North	Residents living with disability
	Jan 20					
	Jan 27	Southall Library and Dominion Centre; 112 The Green, UB2 4BQ	Drop In	tbc	West	Open to all; cross section of local population; area of high deprivation
	Feb 3	West Ealing Community Library, Melbourne Avenue, W13 9BT:	Drop In	tbc	West	Open to all, targeting older residents and families; area of high deprivation
	Feb 10	Southall Community Alliance:1 High Street, UB1 3HA	Invited Group	tbc	West	Area of high deprivation; high index of Global Majority Residents
	Feb 17					
Harrow	Nov 18	Harrow Carers 21st November Carers Rights Day	Public event	tbc	Central	Open to all; Older residents

		- OId Lyonians 74 Pinner View, Harrow HA1 4QF				
	Nov 18	Community Touchpoint - Online CONFIRMED 21st Nov	Invited Group	tbc	Online	Community Leaders
	Nov 25	Conversation Cafe St. Peter's Church Tuesday Colbeck Road, West Harrow, HA1 4BX	Public event	tbc	West	Open to all; area of high deprivation
	Dec 2	Harrow Carers - Carer Led Peer Support Group Event	Invited group	tbc	Central	Older residents
	Dec 9	HASVO: Harrow Association of Voluntary Organisations 66 Lower Rd, South Harrow, Harrow HA2 0DH	Invited group	tbc	South	Somalian group
	Dec 16	Conversation Cafe Flash Musical Theatre Methuen Road, Edgware, HA8 6EZ **HOLD DUE TO FESTIVE AND NEW YEAR PERIOD**				**Tbc**
	Dec 23					
	Dec 30	Hillingdon Hospital, Pield Heath Rd, Uxbridge UB8 3NN		tbc		tbc
	Jan 6	HACAS Harrow African-Caribbean Association Northolt Rd, South Harrow, Harrow HA2 0LH	Public event	tbc		Black heritage communities; older residents

	Jan 13	Conversation Cafe Red Brick Cafe Wealdstone Centre, 38 – 40 High Street, HA3 7AE	Public Event	tbc	Central	Open to all; area of high deprivation
	Jan 20	Bereavement Care Engagement TBC		tbc	TBC	Area of high deprivation
	Jan 27	South Harrow Christian Fellowship Friendship Cafe - South Hill Avenue Harrow, London HA2 0NN	Public event	tbc	South	Older residents
	Feb 3	St. Lukes engagement TBC	Public event	tbc	TBC	Older residents
	Feb 10	Care Home engagement sessions (TBC)	Drop in	tbc	TBC	Open to public; area of high deprivation
	Feb 17	Age UK TBC	Public event	tbc	TBC	Older residents
Hillingdon	Nov 18					
	Nov 25	Home Instead Senior Care, 6 High Street, Ruislip HA4 6AR	Drop in	tbc	North	Older residents
	Dec 2	Volunteers Fair, Pavillion, Hillingdon, 18 Chequers Square, Uxbridge UB8 1LN	Open event	tbc	South West	All resident population
	Dec 9	Assembly for People with Disabilities and Carers Civic Centre, High Street, Uxbridge UB8 1UW	Invited group	tbc	South West	Residents experiencing disability and their carers

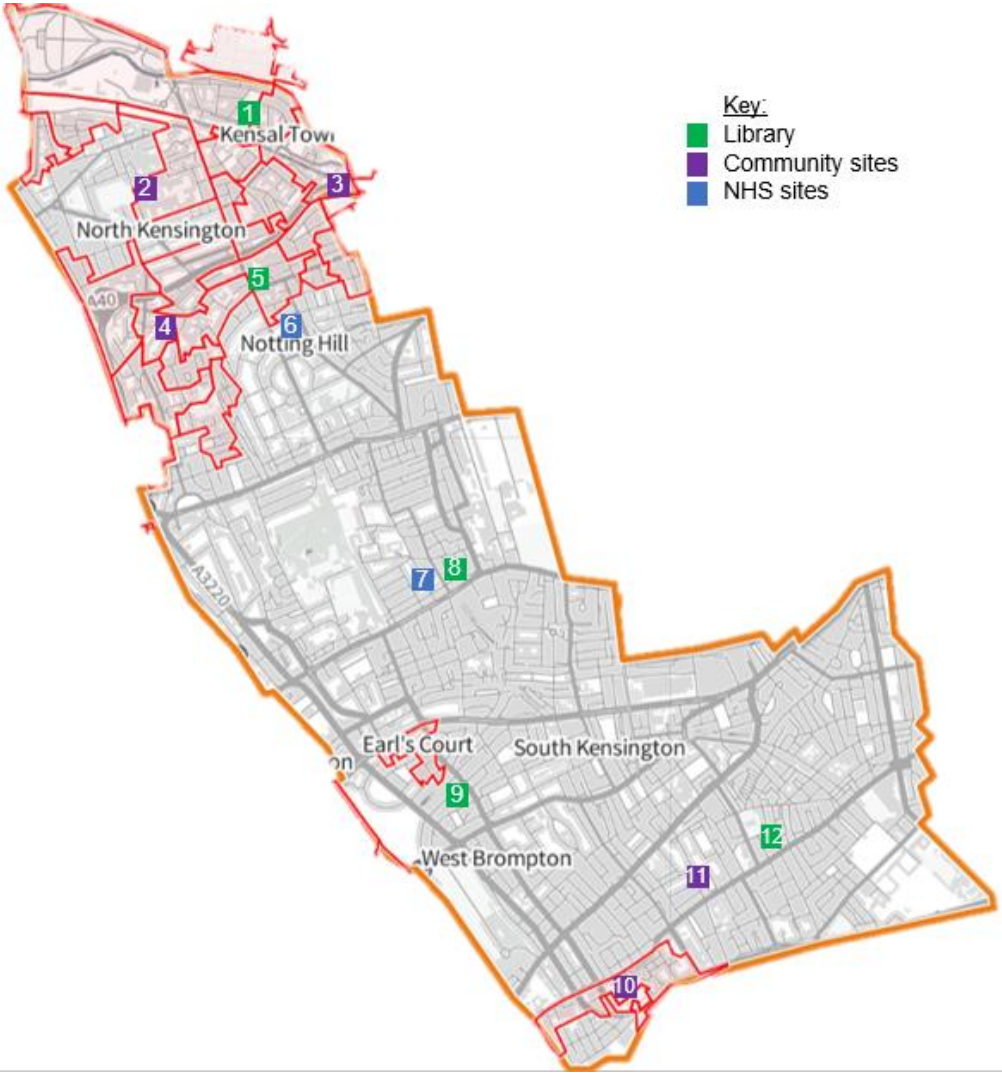
	Dec 16	Partner event with NRS Healthcare; https://www.nrshealthcare.com/ [venue to be confirmed]	Drop in	tbc	tbc	Older residents, users of support equipment
	Dec 23	HOLD DUE TO FESTIVE AND NEW YEAR PERIOD				
	Dec 30					
	Jan 6	Hillingdon Hospital, Pield Heath Rd, Uxbridge UB8 3NN	Open event	tbc	South West	All resident population
	Jan 13	Bell Farm Christian Church, South Rd, West Drayton UB7 9LW	Drop in	tbc	South West	All resident population inc. residents from refugee/asylum seeker communities
	Jan 20	Supermarket engagement [venue to be confirmed]	Open event	tbc	tbc	All resident population
	Jan 27	Heathrow Villages event	tbc	tbc	South	Cross section of local resident population
	Feb 3	Digital Access to Healthcare Workshop at Oak Farm Library, Sutton Court Road, Hillingdon UB10 9PB	Drop in	tbc	South West	Residents seeking assistance and training for digital skills; All ages
	Feb 10					
	Feb 17	Asian Women's Group , Hayes & Harlington Community Centre, Albert Rd, Hayes UB3 4HR	Invited Group with Drop In	tbc	Central	Women Residents of Asian heritage

Westminster



Locations:
1. Greenside Community Centre
2. Grand Junction
3. Marylebone Bangladeshi Society
4. Church Street Library
5. Paddington Library
6. Paddington Library
7. Marylebone Library
8. London Chinese Community Centre
9. The Abbey Centre
10. Open Age, St Margaret's
11. Pimlico Library
12. Victoria Library

Kensington & Chelsea



Hammersmith & Fulham

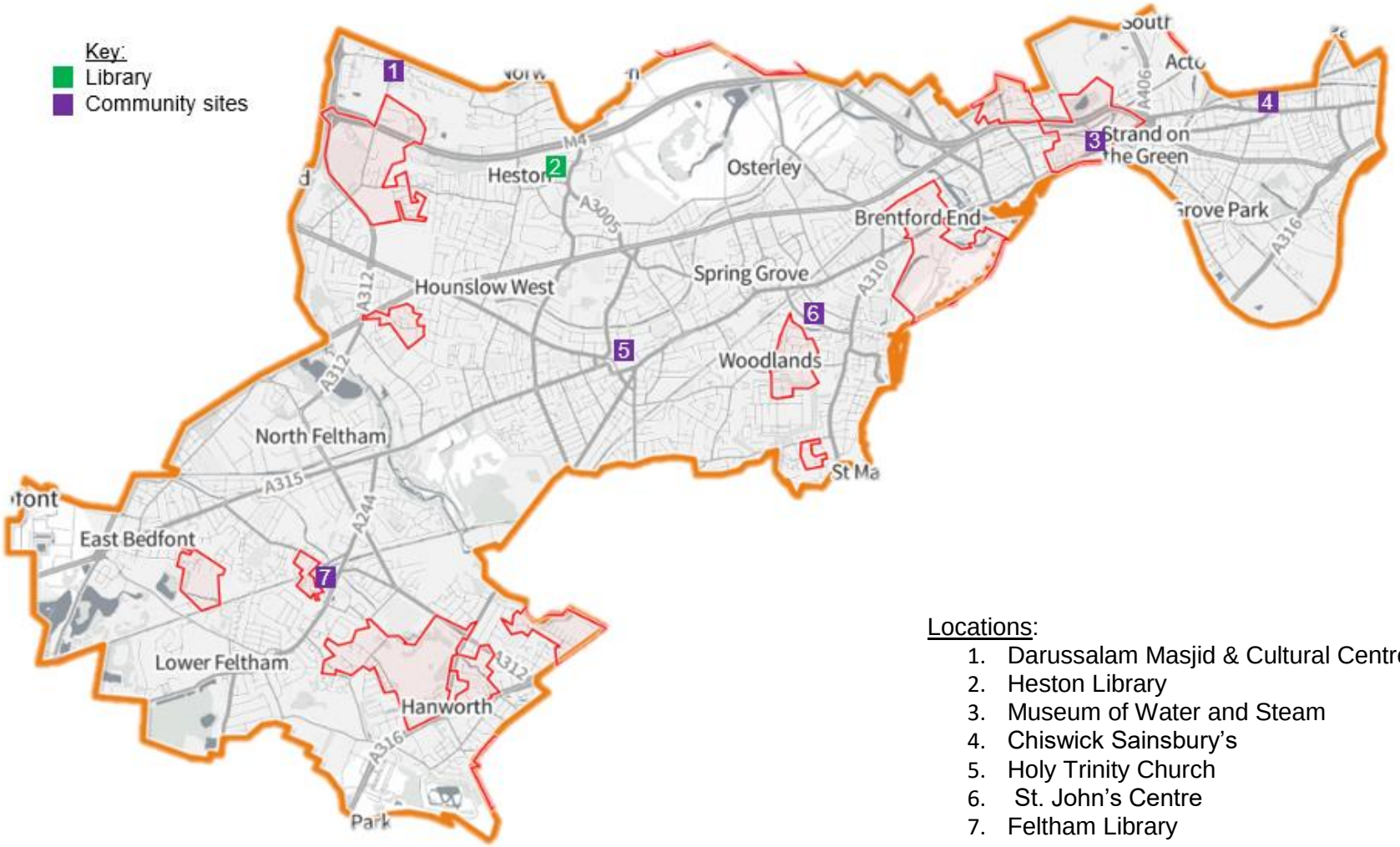
Locations:

1. Kensal Library
2. Open Age, St Charles Centre for Health and Wellbeing
3. Al-Manaar Islamic Centre
4. North Kensington Library
5. Notting Hill Methodist Church
6. Portobello Medical Centre
7. Holland Park Surgery
8. Kensington Central library
9. Brompton library
10. Flashpoint Community Centre
11. Violet Melchett Community Corner
12. Chelsea library

Locations:

1. White City Community Centre
2. TBC
3. Nubian Life Resource Centre
4. TBC
5. The Masbro Centre
6. The Irish Cultural Centre
7. Age UK Hammersmith and Fulham
8. Bishop Creighton House
9. Community Connect, 20 Dawes Road
10. Fulham Library

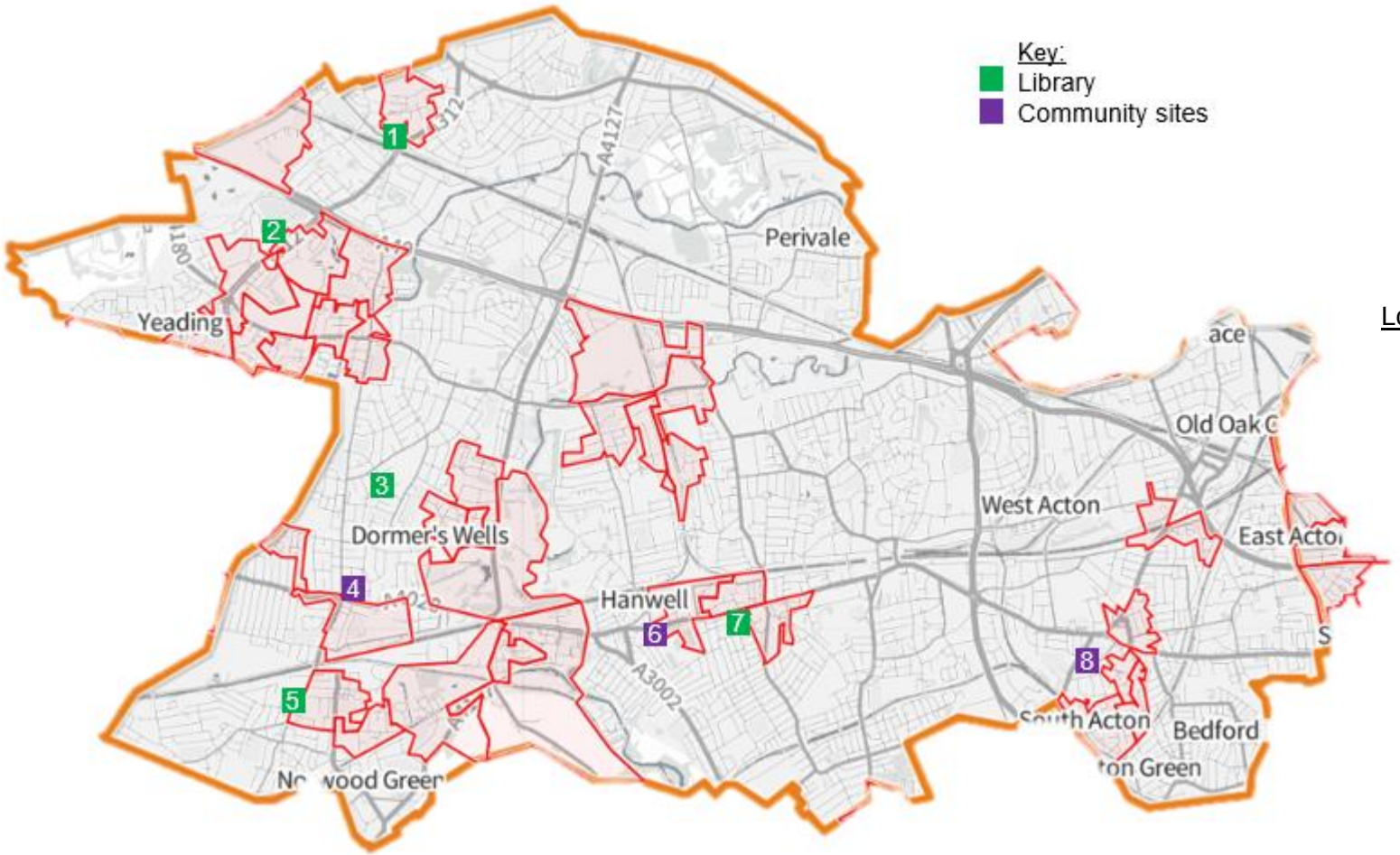
Hounslow:



Locations:

1. Darussalam Masjid & Cultural Centre
2. Heston Library
3. Museum of Water and Steam
4. Chiswick Sainsbury's
5. Holy Trinity Church
6. St. John's Centre
7. Feltham Library

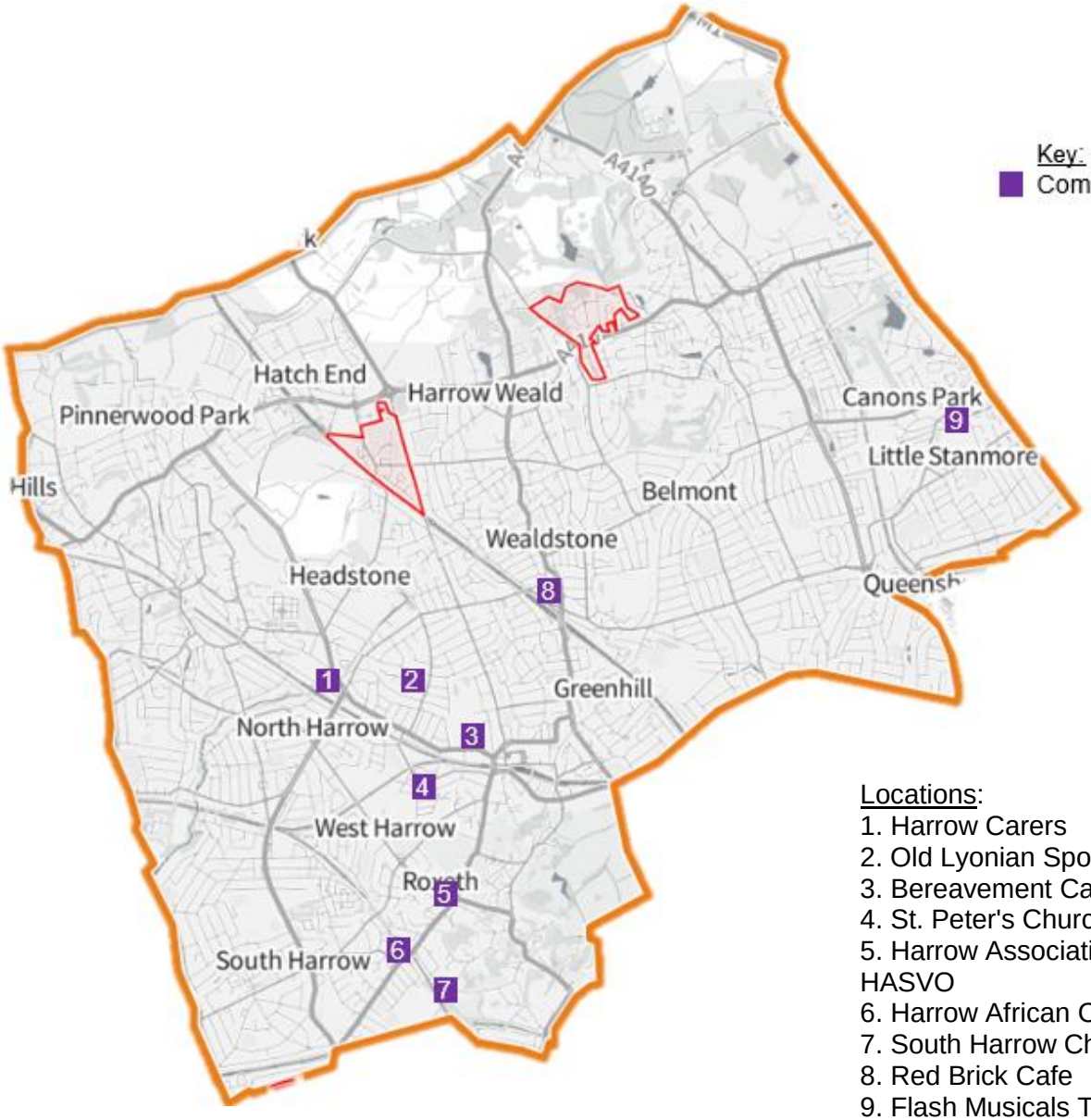
Ealing



Locations :

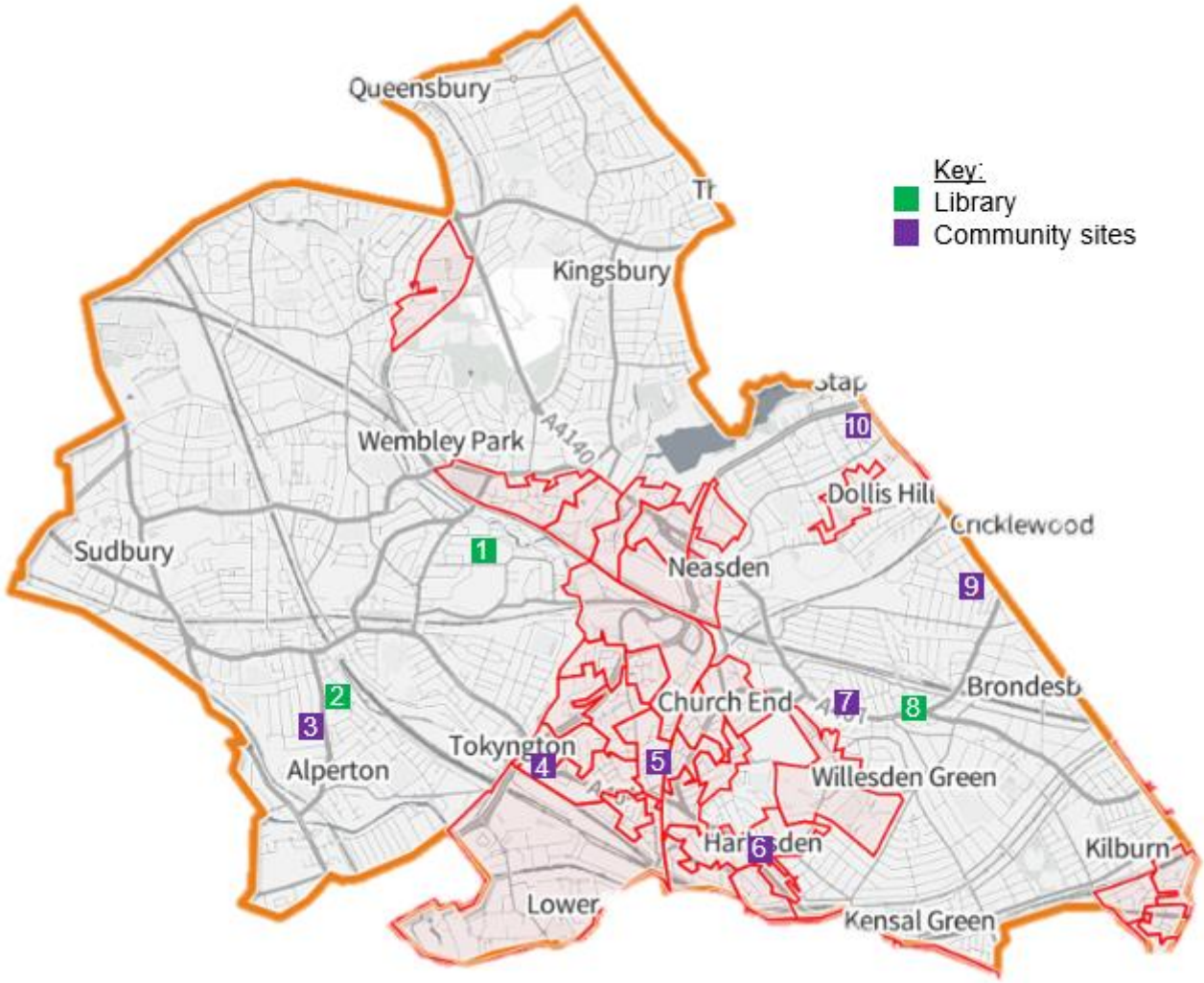
1. Northolt Leisure Centre Library
2. Northolt Library
3. Jubilee Gardens Library
4. Southall Community Alliance
5. Southall Library
6. United Anglo Caribbean Society
7. West Ealing Community Library
8. Centre for Armenian Information & Advice

Harrow



Locations:
1. Harrow Carers
2. Old Lyonian Sports and Social Club
3. Bereavement Care, The Lodge
4. St. Peter's Church
5. Harrow Association of Somali Voluntary Organisations HASVO
6. Harrow African Caribbean Association
7. South Harrow Christian Fellowship Friendship Cafe
8. Red Brick Cafe
9. Flash Musicals Theatre and Community Centre

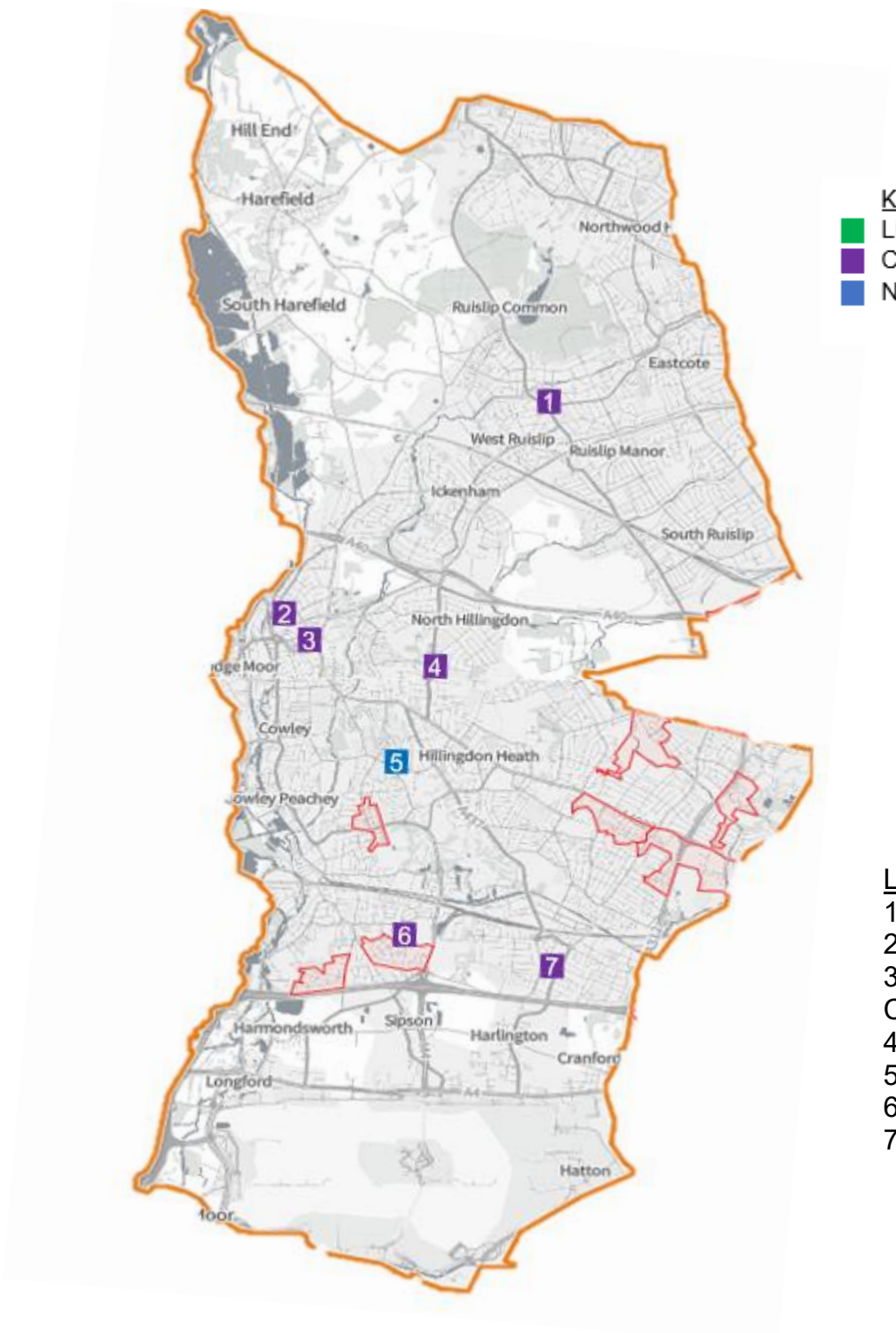
Brent



Locations:

1. Wembley Library
2. Ealing Road Library
3. Brent Indian Association
4. Bridge Park Community Centre
5. WISE Event, Alfric Avenue
6. Harlesden Library
7. Brent Carers Centre, Willesden Medical Centre
8. Willesden Green Library
9. Ashford Place Community Centre (2 events)
10. Brent Chinese Association

Hillingdon



Key:
- Library
- Community sites
- NHS sites

Locations :
1. Home Instead, Ruislip
2. The Pavillions
3. Assembly for People with Disabilities and Carers Civic Centre
4. Oak Farm Library
5. Hillingdon Hospital
6. Bell Farm Christian Church
7. Hayes & Harlington Community Centre

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Joint Health Overview & Scrutiny Committee

Tuesday 22 October 2024

10:00- 12:00

NHS North West London

Title of report	**Mental Health Strategy for adult residents of North West London**
Presenter (name and role)	Toby Lambert, Executive Director of Strategy and Population Health Katie Horrell, Acting Associate Director for Mental Health, Learning Disabilities and Autism
Author (name and role)	Katie Horrell, Acting Associate Director for Mental Health, Learning Disabilities and Autism Faiysal Patel, Head of Strategy
Accountable Executive Director/ SRO	Toby Lambert, Executive Director of Strategy and Population Health Maria O'Brien, Chief Executive – West London NHS Trust and SRO – NWL Mental Health, Learning Disabilities and Autism Programme
Purpose of the report Please tick and describe the requirement in the opposite column	**Decision/Approval** x **Assurance** **Info Only** **Advice**
The Board/ Committee is asked to:	The Joint Health Overview & Scrutiny Committee is asked to: - Endorse the strategy for publication.
Report history Committees/ meetings where this item has been considered	Name of Committee/ Board / Date of Meeting / Outcome ICS Leadership / 15 March 2024 / Endorsed Strategic Commissioning Committee / 21 March 2024 / Endorsed CNWL, WLT, CLCH Strategic Service Transformation Committee / 28 June 2024 / Endorsed ICB Executive / 05 July 2024 / Endorsed CNWL, WLT, CLCH Board in Common / 16 July 2024 / Endorsed ICB Board / 16 July 2024 / Endorsed ICP in Public / 11 September 2024 / Endorsed
Key messages	This paper outlines the development of the mental health strategy for adult residents of North West London (the strategy

	for children and young people is being developed from autumn 2024). The strategy has been developed by a working group drawing representation from local authorities and our providers, chaired by clinicians. It sets out ten ambitions (paragraph 5 below), supported by more detailed recommendations in the supporting slide pack.
Key risks and mitigations	Throughout the strategy there has been engagement with our residents along with socialisation with key partners to draw our conclusions and inform our ambitions for the future. This paper does not contain a request for confirming spend/budgets.

Describe how this work supports delivery of the NW London Integrated Care System's objectives (in particular describe the impact on inequality with reference to **equality impact assessment**)
North West London ICS is committed to providing the people who use our mental health care services with high-quality care as close to home as possible, by strengthening alternatives to admission and shifting provision to a more community-based offer in line with national priorities. A full inequalities analysis has been undertaken to support the strategy which includes demographic breakdowns and comparisons across boroughs.

What involvement and insights from residents and communities in NW London have informed this work?
The heart of our engagement process involved eight pivotal sessions that took place in various locations across each of the eight boroughs. These sessions held from late August to early October 2023, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place. These sessions were pivotal in opening a dialogue with our communities as individuals and families to help us understand the positive aspects of services as well as challenges they face in accessing and experiencing mental health services.

All Integrated Care Board papers are published, unless requested otherwise. If the paper is not suitable for publication, please confirm the reason for this below (Y= suitable, N = not suitable)		
Commercial Confidentiality	N	
Patient Confidentiality	N	
Staff Confidentiality	N	
Other Exceptional Circumstances (please describe)		

Mental Health Strategy for adult residents of North West London

1. We have been developing the mental health strategy for residents of North West London in two stages – first, for adult residents of North West London, then the strategy for children and young people will be developed over the autumn. This paper covers the strategy for adult residents.

2. The strategy has been developed by a working group comprising representatives from Local Authorities, Borough-Based Partnerships, the VCSE, Service Users, ICS Programmes and ICB Core Teams. The working group was chaired by the medical director of CNWL's Jameson division and the ICB's GP mental health lead. Together, the working group has:

    a. Reviewed and analysed data points from the Mental Health Joint Strategic Needs Assessment toolkit to demonstrate a shared understanding of need;

    b. Reviewed the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each of our boroughs;

    c. Gathered insights from our regular outreach engagement programme, drop-in sessions in each borough and online focus groups. These have encouraged our residents to share their personal experiences and stories as well as their views on further improvements;

    d. Collected views on areas of success, biggest challenges and current priorities, to inform the themes of this strategy. As we implement, we will continue to engage to ensure that services continue to support – and better support – all of our residents that use them.

3. We have conducted extensive engagement with residents in developing this strategy, with eight pivotal sessions across each of the eight boroughs. These sessions held from late August to early October 2023, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place. The engagement report is available at https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london

    A number of key themes were highlighted through engagement which included increasing residents' awareness of services and improving access to them, expanding community mental health offers, reducing waiting times for assessments, ensuring a tailored and inclusive approach to services as well better integration of services to avoid patients passing from one service to another.

4. The draft strategy has been tested with the mental health, learning disabilities and autism programme board, mental health trust chief executives, and various operational and clinical groups within our mental health trusts.

5. The strategy makes a number of recommendations which set the following ambitions for our adult mental health services:

    a. Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community.

    b. Develop an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.

c. Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness.

d. A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs.

e. Reduced variation and increased productivity in caseloads and staffing across community services.

f. Improved staff recruitment and retention.

g. Waiting times measuring in the top quartile in England.

h. Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness.

i. High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.

j. Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.

Work continues to develop the work programme and tracking against each of these areas.

6. The JHOSC will be aware that we have committed to publish the mental health strategy before making a decision on the future of mental health services in Westminster, Kensington and Chelsea (in particular the future of inpatient wards at the Gordon hospital) and in Ealing, Hammersmith and Fulham and Hounslow (in particular the future of the Hope and Horizon inpatient wards at St Bernard's Hospital).

7. The strategy has been endorsed by the North West London Integrated Care Partnership and approved by the Integrated Care Board. The NWL mental and community collaborative has agreed to take the lead on delivery of the strategy

The JHOSC is asked to:

- ***Note the strategy***

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

NHS
North West London

Strategy for meeting the mental health needs of adults in North West London

FINAL DRAFT September 2024

Overview and context

This document presents the work that has been undertaken to refresh the strategy for mental health care for adult residents of North West London. The document:

- Takes a **phased approach to refreshing the strategy**, initially focusing on adult community and inpatient mental health services. Children and Young People (CYP) will be covered in the next phase, supported by the annual refresh of the NW London CYP Mental Health Transformation Plan.
- Includes a **summary of current need** and anticipates how this need will change over the next five years.
- Reviews **current capacity** of NHS services and analyses how this could be optimised.

Engagement **with local residents** and service users was undertaken from late August to early October to hear personal experiences to understand what was working well and hear ideas on improvements.

The ICB, NHS providers, voluntary providers, local authorities and local residents have developed and discussed **key themes** of this strategy.

This document does…

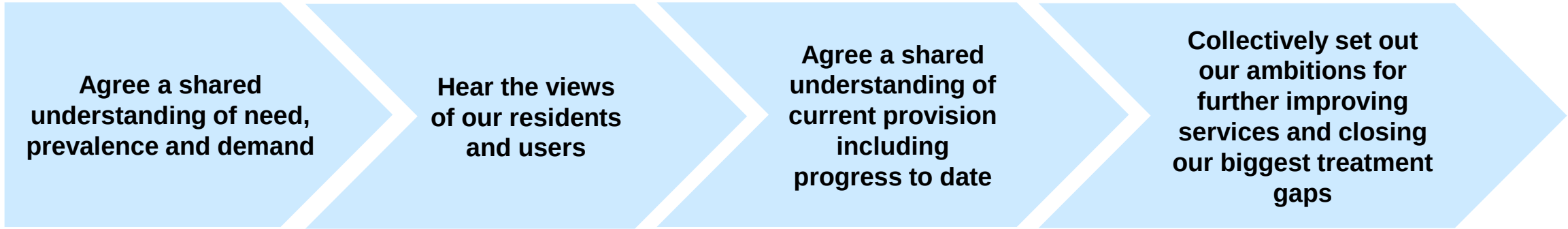
- Build upon the North West London's Integrated Care Strategy that was published in November 2023
- Build upon our boroughs' Joint Strategic Needs Assessments and complements their Joint Health and Wellbeing Strategies
- Recognise the stressors that may drive increase demand in mental health services. Each of our boroughs publishes its own health and wellbeing strategy, and this document is not intended to duplicate these – it acknowledges these existing local strategies/ plans in place for promoting resilience and wellbeing.

This document does not…

- Make recommendations as to how to improve overall wellbeing – that is the presence of our boroughs, in their health and welling services
- Recommend optimal inpatient capacity site by site. Instead, it models future demand for key services and highlights opportunities for transformation;
- Analyse workforce and finances in detail;
- Set out a detailed implementation plan: this will be developed following agreement of strategy.

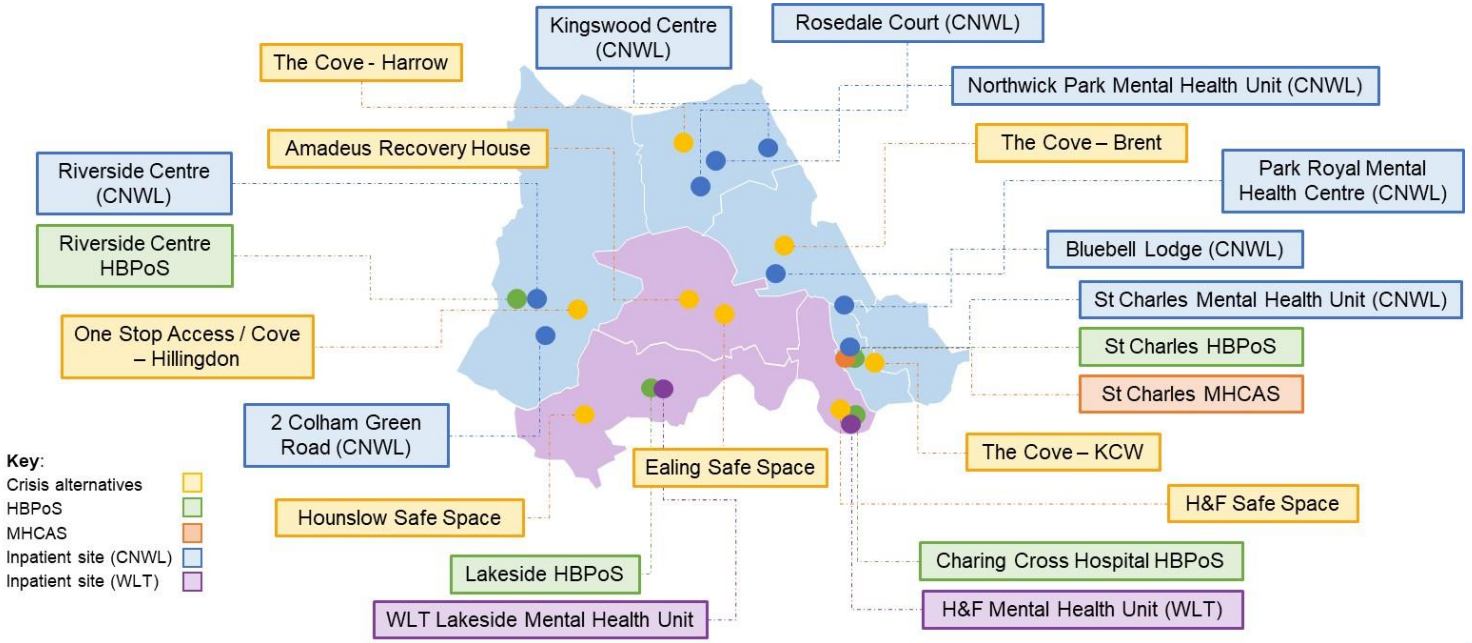
Executive summary

We have developed this strategy in four stages



- Partners from Local Authorities, Borough-Based Partnerships, the VCSE, Service Users, ICS Programmes and ICB Core Teams have worked collaboratively to develop this strategy.
- Together, we have:
  - Reviewed and analysed data points from the Mental Health Joint Strategic Needs Assessment toolkit to demonstrate a shared understanding of need;
  - Reviewed the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies developed for each of our boroughs;
  - Gathered insights from our regular outreach engagement programme, drop-in sessions in each borough and online focus groups. These have encouraged our residents to share their personal experiences and stories as well as their views on further improvements;
  - Collected views on areas of success, biggest challenges and current priorities, to inform the themes of this strategy. As we implement, we will continue to engage to ensure that services continue to support – and better support – all of our residents that use them.

Mental health services in our ICS cover eight places for our 2.1m resident population



Our residents

- North West London is one of the largest, most diverse, and vibrant integrated care systems in England, with a population of over 2.1m people speaking over 100 languages.
- 19% of adults in North West London have common mental health problems such as anxiety or depression.
- 25,955 people are registered with a severe mental illness.
- The suicide rate in males is three times higher than that for females
- Over 23,000 adults are currently in contact with community mental health services and 50,300 in contact with Talking Therapies services

Mental health provider landscape

- The total spend by the ICB on mental health services (MHIS target) in 2022/23 was £472m, representing 12% of the ICB's total allocated budget.
  - This does not include time spent by general practice supporting residents with mental health issues
  - The ICB spent £380m on block contract adult mental health in 2022/23 with the main two mental health providers
- The main mental health service providers are:
  - Central and North West London NHS Foundation Trust (CNWL)
  - West London NHS Trust (WLT)

Adult mental health services in North West London

Talking Therapies	A range of talking therapies for people who feel anxious and worried, or down and depressed
Community mental health (Mental Health Integrated Network Teams and Community Mental Health Hubs)	Community based teams made up of different professionals with a wide range of skills. They focus on supporting people's mental health, alongside their physical health and social care needs. Teams work closely with GPs, social services, the voluntary sector and other organisations to offer treatment and care in a more integrated way.
Crisis services	(i) Home treatment teams providing intensive short-term care to vulnerable patients considered for admission or discharge as an alternative to inpatient care (ii) Community based crisis alternative services are a variety of complementary and alternative crisis services to A&E and admission, offering non-clinical support to individuals experiencing a crisis or mental distress
Liaison psychiatry	Specialist services providing mental health care in a physical health setting. They specialise in the link between people's physical and mental health, and typically provide support to people who may have co-occurring physical and mental health needs
Acute mental health inpatient	For adults and older adults in need of inpatient support for severe mental health difficulties or a mental health crisis

We face significant unmet need in addressing common mental health disorders, while our residents with severe mental illness continue to be much more likely to die prematurely

1 Adults in North West London

- Our residents generally report a **high level of happiness**, with **74%** of our residents reporting a high happiness score, compared to **72% nationally** and **71%** in the **rest of London**
- There are several risk factors for people developing mental health crises - including **poverty**, **unemployment, social isolation**, **homelessness and rough sleeping**, **smoking**, **alcohol and substance misuse** and **poor overall health.** In NWL, we have a particular issue in many of these areas (e.g., unemployment in **NWL** is **4.9%,** compared to **3.5% nationally**) – these will need to be addressed through our broader work on prevention, **working closely with ICS and wider partners.**

2 Adults with common mental health disorders

- In NWL, **178,000 adults** are currently registered with **depression** – **7.8%** of our adult GP-registered population. This is in stark contrast to the rest of **London (9.5%)** and the rest of the country **(13.2%).**
- **Depression** is the **4th leading cause** of disability-adjusted life years **(DALYs)** lost in NWL, behind lower back pain, heart disease, and diabetes.
- The prevalence of **depression** (recorded) has **increased at a significant rate** over the **past 10 years** – growing **6.6% year-on-year** – a slower growth rate than the rest of the country (8.5%), but a faster growth rate than many long-term physical conditions.
- This information, when considered alongside analyses of NWL demographics, national surveys, and service usage data, suggests that NWL has a substantial level of **unmet need** for common mental health disorders, with an estimated **under-diagnosis** of c. **30%.**

3 Adults with severe mental illness (SMI)

- **1.11%** of our population is registered as having **SMI** – approximately **33,000 people**, with prevalence relatively **constant** at this level over the last five years. Recorded prevalence is highest in **K&C (1.44%)** and **Westminster (1.39%)** – approximately 50% higher than the national level (**0.95%**).
- **Premature mortality** for patients with SMI is high in **H&F** and **Hillingdon,** with a **c. 45%** and **30%** higher rate than the national value.
- There is a strong link between **long term physical health** and **mental health** - particularly apparent in **patients with SMI**.
- Patients with **SMI** are **390%** more likely to **die prematurely** (i.e. under 75) than people without SMI. Whilst this is in line with the rest of London and the rest of the country, this demonstrates the need to develop a more **holistic and proactive** in supporting these patients.

4 Adults with higher acuity mental health needs

- The number of patients with mental health diagnoses **attending emergency departments** across North West London has increased by **5%** from pre-COVID pandemic levels – with a significant proportion (~25%) of patients attending still **'unknown'** to NWL mental health services. Waiting times in emergency departments remain high, with patients waiting 8-12 hours on average. In addition, a patient with mental illness will be **twice as likely** to breach the **12 hour mark** in ED than a physical health patient.
- The NWL **suicide rate** has **decreased** steadily over the last decade – now at **7.7 deaths** per 100,000 population. Whilst this is lower than the rest of the country (**10.3 deaths**), **5 out of our 8 boroughs** have a **higher suicide rate** than the rest of London (**6.9 deaths**).
- Whilst overall inpatient **admissions** have decreased **c. 15%** since pre-COVID levels, **CMHH/MINT referrals** have increased **55%** over the same period, reflecting our investment in this area. However, demand for **CMHH/MINT** remains high and further transformation is required.

NHS North West London

Variation in access and outcomes also exists for different population groups across our boroughs

North West London (NWL) is one of the largest and most diverse population of any ICS in England with 2.1m people speaking over 100 languages. Unfortunately, **19% of adults in NWL have common mental health problems such as anxiety or depression, whilst c25,000 people are registered with a severe mental illness.** Similarly to the rest of London and England, mental illness is not evenly distributed throughout the NWL population – differences in prevalence vary by geography, gender, ethnicity and deprivation level.

Hammersmith & Fulham and Kensington & Chelsea have the highest prevalence of depression and anxiety, conditions which predominately impact younger women. Brent, Ealing and Kensington & Chelsea have the highest prevalence of severe mental illness which predominately impacts younger men. Both common and severe mental illnesses are more prevalent in ethnic minority and deprived communities. **Ethnic minority and deprived populations have higher rates of admissions, referrals and caseloads compared to the rest of the population** – suggesting a level of proportionality between prevalence and service use. In absolute terms, protected populations in Brent, Ealing and Hounslow utilise more mental health services however, ethnic minorities from inner NWL utilise more mental health services on a per population basis.

Mixed and black ethnic groups have approximately 3 times per population admissions than other ethnic groups. Black British males in Kensington and Chelsea, Hammersmith and Fulham have the highest rates of admissions though the largest gross number of admissions is from Brent. **Males have higher rates of admission than females which may reflect the severity of their mental health conditions**. Mixed, black and 'other' ethnicities have the highest per population referrals into MH services. Females have 1.5 times more referrals into mental health services than males. Mixed females in Kensington & Chelsea and Westminster have the highest referral rate per population.

Mixed and black ethnicity populations have the highest rate of caseload per population. Hammersmith & Fulham, Westminster and Hounslow have the highest caseloads per population of any borough. The Kensington & Chelsea caseload is relatively low given the prevalence of depression and anxiety in the borough. The rate of mental health caseload in NWL is consistently higher for females than males (61% vs. 39%). **The number of caseloads per admission is lower for males than for females across all ethnicities,** particularly the black population. This may indicate a higher prevalence of serious mental illness that requires admission amongst males, and/or that males in NWL are not accessing community care in accordance with their need.

The black population has highest ED attendance rates for mental health conditions, which has increased nationally and in NWL since 2019. Harrow and Kensington & Chelsea have the highest rates of ED attendances for the black population, both of which have been increasing since 2020/21. **Hillingdon has the highest number of ED attendances in NWL**, over double that of Westminster, the borough with the lowest rate of ED attendances (28.3 vs 12.6). The number of ED attendances by 18-25 years old in NWL is below that of the Rest of England average.

Considering the demographic profile of the local population allows for strategic planning of services tailored to the needs of individual communities

The demographic analysis is useful to show where populations are clustered into geographical areas and are therefore more likely to be impacted by changes in the location of services. Populations will also be impacted by changes in the quality of services, but this impact is not necessarily dependent on the physical location of the service.

Demographic composition of the catchment population

Proportion of the potentially impacted population that are of particular population groups

Area	Households deprived in at least one domain*	Poor general health	Ethnic minorities	Disabled population	Economic inactivity	Unpaid carers	Poor English proficiency	Women of child bearing age**	18-25 year olds	Single person households	Gender
Brent	60%	4%	50%	14%	21%	7%	7%	45%	12%	26%	51% female
Ealing	54%	4%	37%	13%	20%	7%	6%	44%	10%	26%	51% female
Hammersmith & Fulham	49%	4%	33%	14%	18%	6%	2%	53%	14%	36%	53% female
Harrow	51%	4%	49%	13%	17%	8%	5%	41%	9%	21%	51% female
Hillingdon	54%	4%	45%	13%	18%	7%	4%	42%	10%	24%	50% female
Hounslow	56%	4%	40%	14%	20%	7%	5%	44%	9%	25%	50% female
Kensington & Chelsea	47%	4%	39%	15%	20%	6%	2%	46%	13%	43%	53% female
Westminster	50%	5%	44%	14%	21%	7%	3%	52%	15%	42%	52% female
NWL total	**53%**	**4%**	**42%**	**14%**	**19%**	**7%**	**5%**	**45%**	**11%**	**29%**	**51% female**

*See slide X with notes

Our current services have evolved considerably over the last few years

The NHS Long Term Plan brought an enormous opportunity to build on previous progress, and direct our attention to new areas of improvement and previously under-represented groups.

Implementation of the NHS Long Term Plan in North West London saw additional investment compared to 2018/19 of:

- £39.9m in integrated models of community care for people with severe mental illness;
- £16.9m in CYP mental health care, with a strong focus on community, crisis and eating disorder services;
- £15.1m to support people with common mental health disorders;
- £10.8m in adult crisis care;
- £8.3m in perinatal mental health care; and
- £1.7m to improve the therapeutic environment of inpatient care settings

- A range of service providers, particularly from the voluntary sector, are supporting local communities to **prevent mental health problems** and support wellbeing.
- For those with common mental health problems, such as anxiety and depression, capacity of **talking therapies** has increased**.**
- Community mental health for adults and older adults is increasingly joined up with primary care and community assets and will become part of the services on offer through our **integrated neighbourhood teams** but there continue to be a number of underserved communities.
- **We have expanded mental health crisis care significantly** with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the North West London as well as expanding liaison psychiatry teams to every A&E department.
- Psychosis services are delivered well across North West London, with a positive impact on **early intervention**.
- In line with recommendations from the Royal College of Psychiatrists, best practice and national policy, we have expanded care for people with severe mental health and acute needs in the **least restrictive setting** appropriate, using admission only when there is no better alternative.

But we still need to do more – continuing the focus on prevention, shifting to community based models of care and investing in alternatives to admission

1 **Adults** in North West London	• We must **expand our reach through other organisations, sectors and industries,** to further develop the broader health, social and economic improvements of North West London. • Our local system should continue to recognise and **harness the capacity and skills of the voluntary sector,** working together to enable our residents to take better care of their mental and physical health and build confidence in people to support their mental wellbeing.
2 Adults with **common** mental health disorders	• We must continue to raise awareness of our services so that **every resident knows how to access mental health support** more widely in the community • We must reach more people and address hesitancy to access mental health services by flexing our approach, in particular by **tailoring services to differing local communities**, addressing stigma and building trust by ensuring that our workforce reflects of our residents.
3 Adults with **severe mental illness (SMI)**	• We will ensure that we provide the **highest quality, compassionate, trauma-informed and most appropriate** mental health care for adults and older adults who need it across our boroughs. • We will promote and improve professional and public knowledge of **alternative crisis services** to better direct people to the most appropriate service, preventing the need for A&E attendances and admission. • We are committed to further increasing access and **advancing health equalities for those with SMI**. • We will continue to **tailor our offer for older adults**.
4 Adults with **higher acuity** mental health needs	• We continue to implement the principle that **acute inpatient care should only be used when there is no better alternative**. There will be improved support to reduce risk of re-admission. • When hospital based care is required, it will be delivered in **a timely way, by an expert team, within a therapeutic and compassionate** environment. • We will provide **inpatient facilities** that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required.

Looking at quality, our key mental health services are considered 'good' overall by the CQC, however some services have been rated as 'requires improvement' in the *safe* domain

Both CNWL and WLT have been **rated as 'good' overall** by the CQC in their most recent inspection reports (CNWL report – published **February 2024**; WLT report – published June **2020**). Both providers were deemed to provide similarly high quality services across most of the five CQC domains, with a rating of 'good' against the 'effective', 'responsive' and 'well-led' domains. Both providers were also rated **'outstanding' against the 'caring' domain** – a testament to the staff at those providers. However, both providers were also rated as 'requires improvement' against the 'safe' domain. See below for additional information against each CQC domain.

Mental health services provided in primary care are more difficult to assess, though the most recent GP Patient Survey (2023) suggests that **NWL primary care services are generally good** and perform in line with the national average. For example, **70% of survey respondents** in NWL rated their overall experience of their GP practice as **'very good'** or 'fairly good' – in line with the national average of 71%. In general, patients also find it easier to get through to their GP practice on the phone compared to the national average – 59% of NWL respondents rated this as 'easy', versus 50% nationally.

Safe

- CNWL and WLT rated as **'requires improvement'** in this domain, with most wards deemed to be safe, clean, and well equipped.
- The CQC found that CNWL had implemented quality improvement methodologies to improve areas such as **falls** and **pressure ulcer care**, and had already resulted in in reductions in violence, aggression and restrictive interventions.
- However waiting times for patients with higher MH needs may affect patient safety. For example, waiting times in A&E remain high (see responsive domain) and waiting times for **CMHT** range from c. 30 days to 40 days and waiting times for crisis resolution teams or home treatment teams can range from less than a day to multiple weeks depending on the month and borough. **Waiting times** for these services may need to be **reduced** to improve the safety of patients referred to these services.

Effective

- CNWL and WLT rated as **'good'** in this domain, with the CQC finding that staff assessed the physical and mental health of patients on admission and **individual care plans** were developed and reviewed regularly through MDTs.
- The latest GP Patient Survey (2023) concluded that GPs in NWL generally do recognise the mental health needs of the patients they see – **79% of patients** confirmed that their mental health needs were recognised in their last GP appointment. This is broadly in line with **the national average** – **81%.** However, variation is significant across PCNs in NWL – from **65%** to **91%.**
- Recovery rates for talking therapies are just below the **50% target**, with **44-48% of patients** deemed to be **'moving to recovery'** after completing treatment.
- Both CNWL and WLT have a **lower proportion** of **30 day readmissions** for adult acute services than other London providers (5-8%, compared to 9% for London).

Caring

- CNWL and WLT rated as **'outstanding'** in this domain.
- CQC inspectors highlighted that services were patient-centred and staff wanted patients to experience the best possible outcomes and that there were many examples of staff and leaders going the extra mile.
- However, the friends and family test (FFT) results for CNWL and WLT are slightly below the England average for mental health providers.
- In the latest 12 months of FFT submissions, CNWL had an average positive response rate of **86%**, and an average negative response rate of **5%**. WLT had an average positive response rate of **82%** and an average negative response rate of **11%.** This means that generally **82-86%** of respondents would recommend these services to friends and family.
- However, the FFT response rate for both providers is relatively low – approximately **1%** in February 2024.

Responsive

- CNWL and WLT rated as **'good'** in this domain.
- The CQC did highlight major pressures on the mental health urgent care pathway, with people waiting excessive periods of time in A&E and crisis assessment services. Across NWL, approx. **30%** of MH patients wait over 12 hours to be admitted, transferred or discharged from arrival – this is twice as high as patients attending for physical health reasons.
- Waiting times for most community mental health services are quite good or in line with national targets. For example, **99%** of patients had their first **talking therapies** appointment within **6 weeks** of referral, according to most recent data (December 2023). However, waiting times between appointments can be quite high and variable – anything from **29 days** on average to **67 days** on average.

Well-led

- CNWL and WLT rated as **'good'** in this domain.
- CNWL was committed to supporting staff to 'speak up' and also had a strong reporting culture for incidents, with 98% of all incidents were reported as resulting in no or low harm, and reports were completed to a high standard.
- However, the CQC did highlight that the **escalation and oversight** of operational risk at CNWL needed to be strengthened – though work is already underway.
- WLT received similarly good feedback from the CQC, stating that leaders had the **skills, knowledge and experience** to perform their roles and that **governance processes** operated effectively and per**formance and risk** were managed well.
- Staff at WLT also engaged actively in **quality improvement** activities.
- However, it should be noted that WLT's last CQC inspection took place almost four years ago.

Sources: CQC reports for CNWL/WLT; GP Patient Survey 2023 (sample size = c. 17,000); CNWL/WLT/NWL ICB Monthly Information Returns; NHS England FFT submission Mar 2023 – Feb 2024..

Enhancing our mental health services with new digital technologies will help improve outcomes and the patient experience, whilst also improving productivity

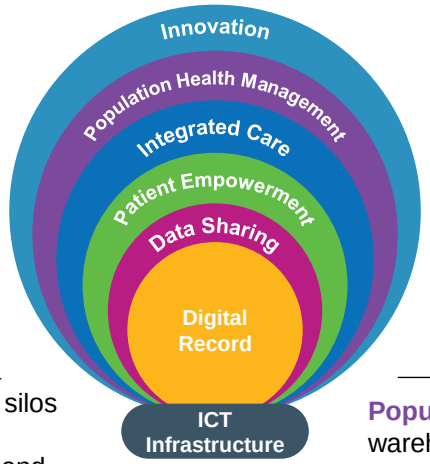
The NW London ICS Digital and Data Strategy sets out the digital and data technologies and actions that are required to enhance our mental health services. It will continue to be developed in the coming year to reflect this MH strategy and better support the recommendations that are being made.

ICT Infrastructure: Our providers have a mostly mature ICT infrastructure, with clinical systems hosted in the cloud and reasonable investment in resilience and cyber security.

Further planned work includes enhancing access in locations outside our main MH estates, better access management, and greater use of portable devices in the community.

Digital Record: Our key mental health providers have already deployed Electronic Patient Record (EPR) systems which have largely replaced paper-held records, but in many areas more work is required to optimise these systems and achieve the Digital Capabilities Framework defined by NHS England.

Data Sharing: We will continue to move beyond individual provider silos and ensure data is shared (as appropriate) between providers and between sectors – using systems such as the London Care Record and the Universal Care Plan. This will enable more effective care planning and improve handovers of care, but will require further investment.



Patient Empowerment: We will deliver a care model centred on the citizen/patient and prioritising the user experience – with patient facing systems that share care history and enable self-management of appointments. However, MH EPR systems require significant investment to deliver this functionality. We will also provide a greater range of smartphone and web-based apps to help people manage their own health and well-being.

Integrated Care: We know there is much more we can do to integrate MH services across care sectors. For example, we will continue to improve our integrated demand and capacity planning at system level – building on work completed as part of this MH strategy and including other sectors. We will also exploit shared records to better manage care that spans different settings – so that we understand people's issues as they move from primary care through to community, acute and specialist mental health services.

Population Health Management (PHM): Our MH providers are investing in internal data warehouses and BI tools to help track the outcomes and the quality and efficiency of the care they are delivering – supporting our ambitions to improve care quality, reduce inequalities and increase efficiency. Thinking about care in population health terms will help us target under-represented cohorts with specific interventions to improve outcomes for those groups. This will require a cross-sector, integrated approach to managing the mental health of our residents – as described above.

Innovation: We will develop capabilities for people who increasingly wish to interact with our mental health services using digital tools (bearing in mind the risk of digital exclusion) – both digital models of care and digital tools to navigate the mental health system. Whilst we have already implemented patient-facing tools in our CYP services such as Kooth (with some success), we will also look to implement other tools and continue to explore the wider digital mental health market and assess the suitability of new tools as appropriate, building them into our pathways.

As described in this strategy, we also know that there are productivity gains that could be made to increase the value for money of our mental health services – particularly in community services. Innovative digital tools such as e-rostering platforms and AI-assisted note taking and planning tools will help unlock these gains – reducing the administrative burden on 'caseload-carrying' staff and freeing up more time for patient care. This will require careful planning and close-working with patient-facing staff in a supportive manner.

The ICS workforce priorities and programmes support the ambitions of the Mental Health Strategy

Our ICS Workforce Strategy

ICS Workforce priorities are grouped together into two strategic intentions:

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

Transform for the future in order to respond to the NHS Long Term Workforce Plan by conducting strategic workforce planning within 'collaboratives' and 'place', informed by modelling and forecasting to support **new ways of working,** improved workforce planning, efficiency and **tracking productivity across mental health services**, in particular community teams, as well maximising the opportunities afforded by **digital and technological innovations.**

Mental Health Strategy Workforce priorities

1

Recruitment and retention:
- Reducing vacancy rates to improve quality of care
- Increasing workforce capacity through improved retention

2

Equality and diversity:
- Diversifying senior leadership and improving experience of black and minority ethnic staff;
- Diversifying the allied health and psychological professions

3

Education and joint training:
- Investment in apprenticeships
- Investment in new roles
- Increasing clinical placement capacity to capitalise on investment outlined in the NHS Long term Workforce Plan

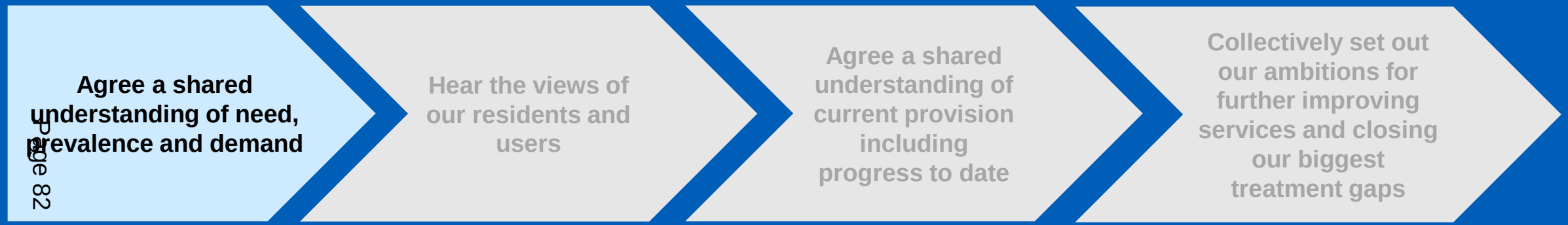
4

Workforce transformation and productivity:
- Development of new models of care and the integration of new roles (Mental Health Crisis Assessment Service and HBOS)
- Reducing reliance on the use of temporary (agency) staff

Our shared aims and ambitions for adult mental health services for the future

By 2028/29 we will have:

Ambitions	Outcomes
RAISED AWARENESS AND PROMOTING WELLBEING • Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community. • Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.	• Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes. • Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients. • Patients and staff reporting better experiences. • Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting. • All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need. • No person staying longer in a mental health bed than they need to. • Integrated solutions to housing pathways. • More people gaining and staying in meaningful employment. • Zero adult inappropriate acute inpatient stays outside of North West London.
INCREASED EQUITY AND EQUALITY OF ACCESS • Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness. • A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs. • Reduced variation and increased productivity in caseloads and staffing across community services. • Improved staff recruitment and retention. • Waiting times measuring in the top quartile in England.	
CARE IN THE RIGHT PLACE • Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness. • High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment. • Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.	Enabled by: • Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services • Allocated resource based on need. • Consistent suite of outcome measures to demonstrate the value delivered



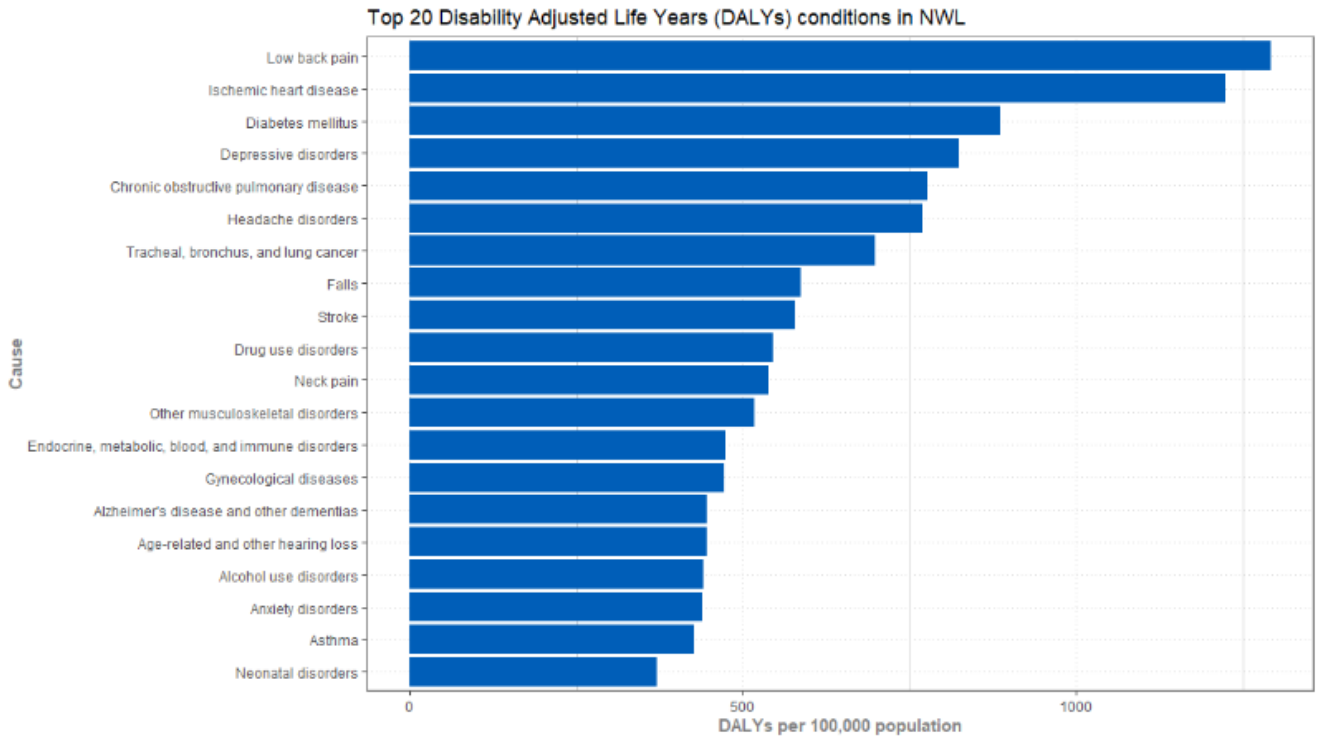
North West London Integrated Care System

NHS North West London

Depression is the 4th largest contributor to the burden of disease experienced by residents of North West London, behind lower back pain, heart disease, and diabetes

- **Depression** is the 4th leading cause of disability adjusted life years (DALYs) lost in NWL, behind lower back pain, heart disease, and diabetes.
- In NWL, depression accounts for the loss of c. **800 DALYs** per **100,000** population.
- Anxiety is responsible for the loss of a further c. **450 DALYs** per **100,000** population.
- Under-diagnosis and under recording of anxiety and depression may mean that the burden of anxiety and depression may be even higher.
- Timely, high quality and sustainable mental health services are one of the most effective interventions we can undertake to reduce the burden of disease for our residents.

Top 20 health conditions, ranked by disability adjusted life years (DALYs) lost
North West London, 2019



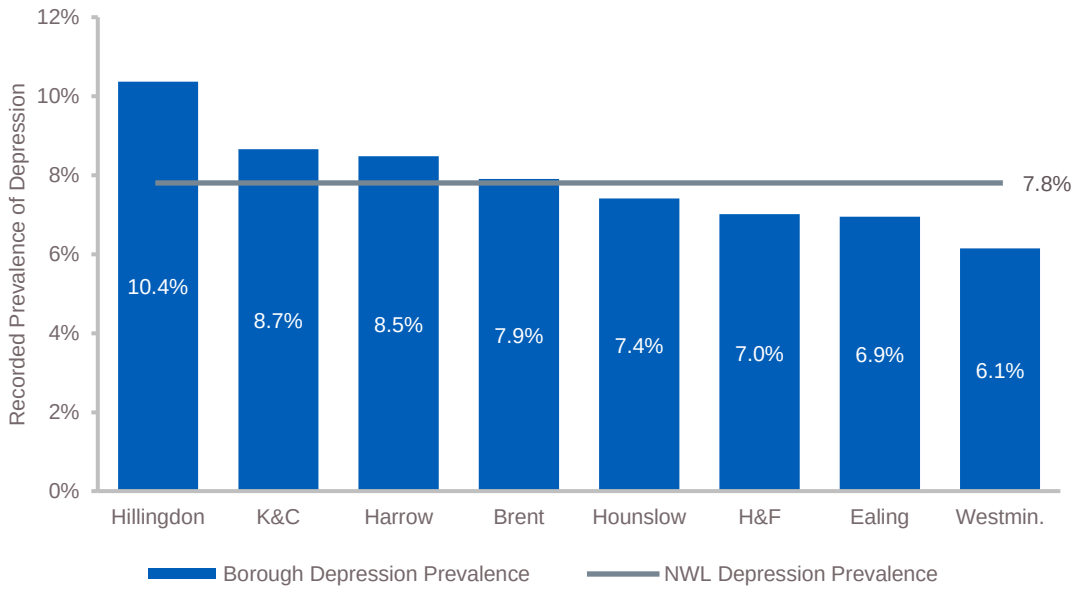
Sources: Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease, 2019

NHS North West London

Recorded prevalence of depression has increased significantly across North West London, though still well below national levels, suggesting potential under-diagnosis

Depression: Recorded Prevalence

As a proportion of registered population, 18+ [FY23]

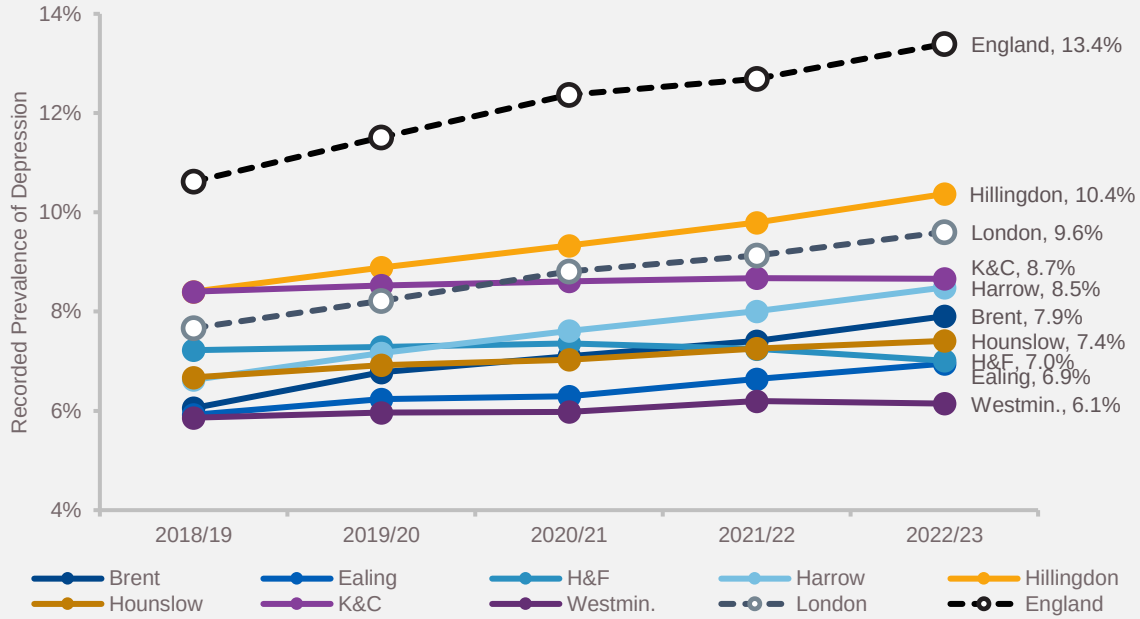


- **Though Hammersmith & Fulham and Westminster both have lower prevalence than the rest of North West London, they also have the two highest suicide rates** – adding weight to the hypothesis that there may be unmet need in the system that needs to be addressed (see analysis on suicide rates at the end of this section).
- Of our 8 boroughs, Hillingdon has the highest recorded prevalence for depression.

Sources: NHS Digital, Quality and Outcomes Framework (QOF) – 2022/23 – recorded depression prevalence.

Depression: Recorded Prevalence

As a proportion of registered population, 18+: Trend over time

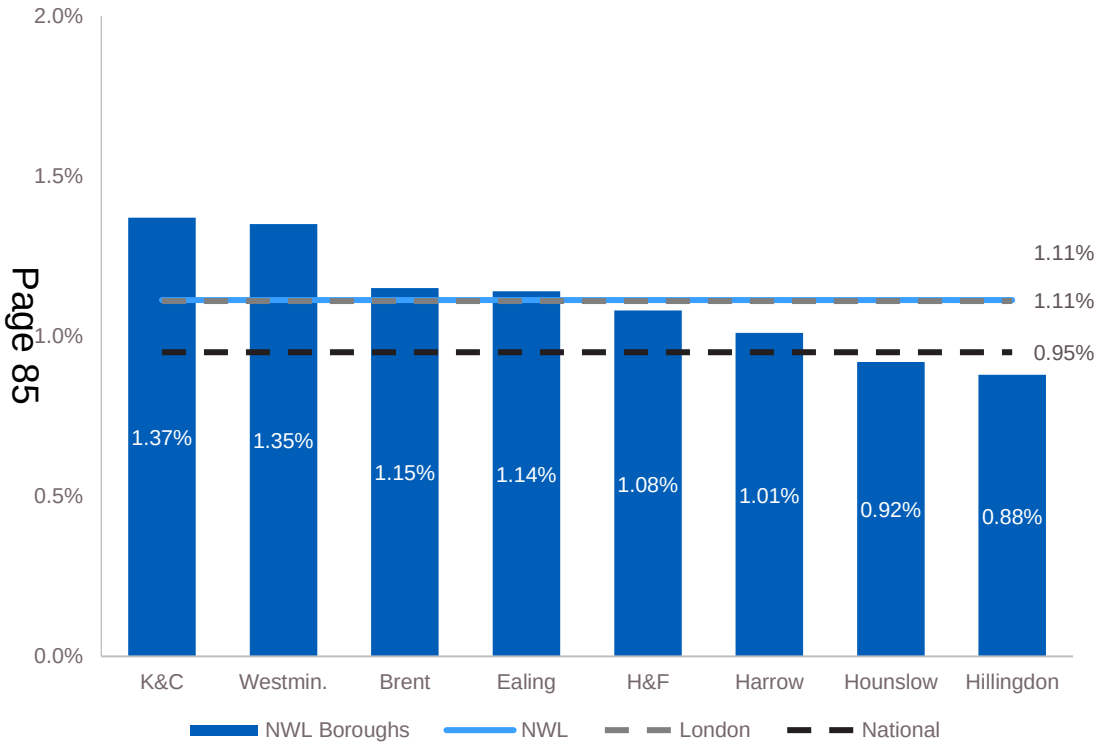


- Recorded depression prevalence in Hammersmith and Fulham has reduced over the period
- K&C and Westminster's recorded depression prevalence has remained flat over the period.
- Most other boroughs have experienced an increase in recorded prevalence in line with the rest of London and the country.
- NWL's (and London)'s recorded prevalence is far below the England average, suggesting either lower actual prevalence or significant under diagnosis. This in turn may reflect hesitancy amongst our residents to seek help, and/ or less effective support for our communities.

Kensington and Chelsea and Westminster see higher recorded prevalence of severe mental illness; everywhere residents with severe mental illness are much more likely to die prematurely

Recorded prevalence of severe mental illness
Percentage of registered population aged 18 and over [2021/22]

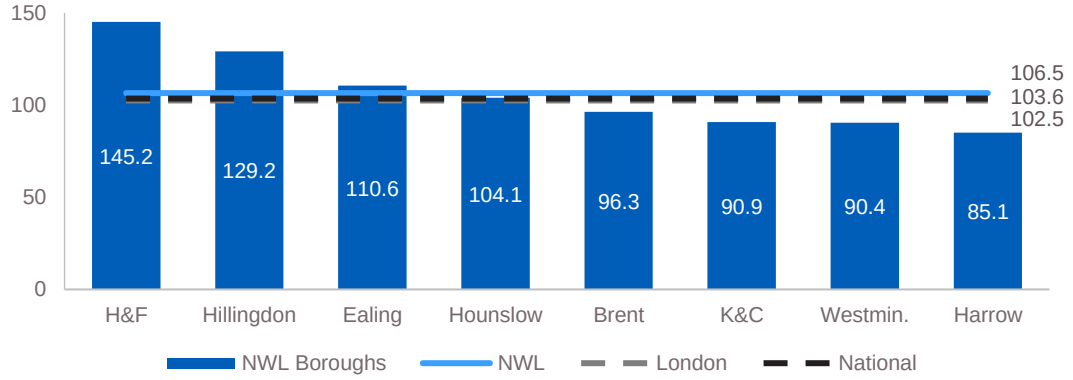
Source: Quality and Outcomes Framework, NHS England, 2021/22



***Note:** SMI for these particular indicators have been defined by Public Health England as having a referral to secondary mental health services in the five years preceding death. It is not directly comparable to the definition of SMI under the NHS QOF.

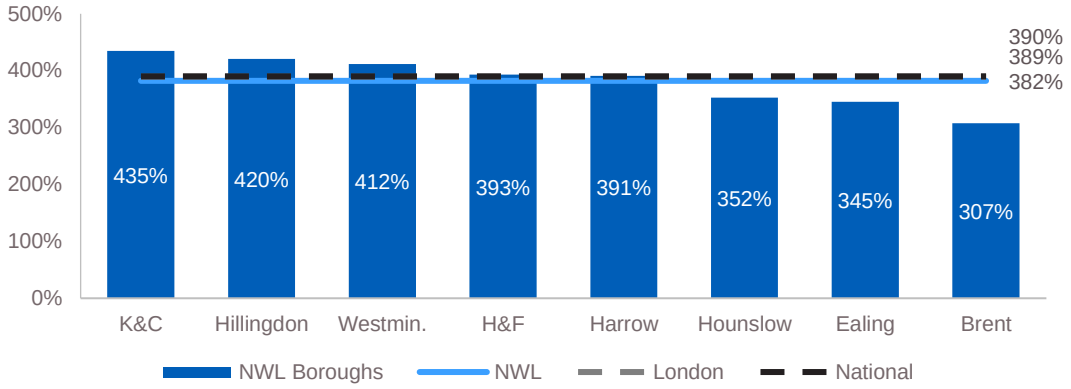
Premature mortality (before age of 75) in adults with SMI*
Directly standardised rate, per 100,000 population [2018-20]

Source: PHE, NHS MHSDS, ONS, 2018-2020



Excess mortality in under 75s with SMI*
Excess risk – i.e. x% higher/lower risk of premature death (before age 75) than adults without SMI* (%) [2018-20]

Source: PHE, NHS MHSDS, ONS, 2018-2020

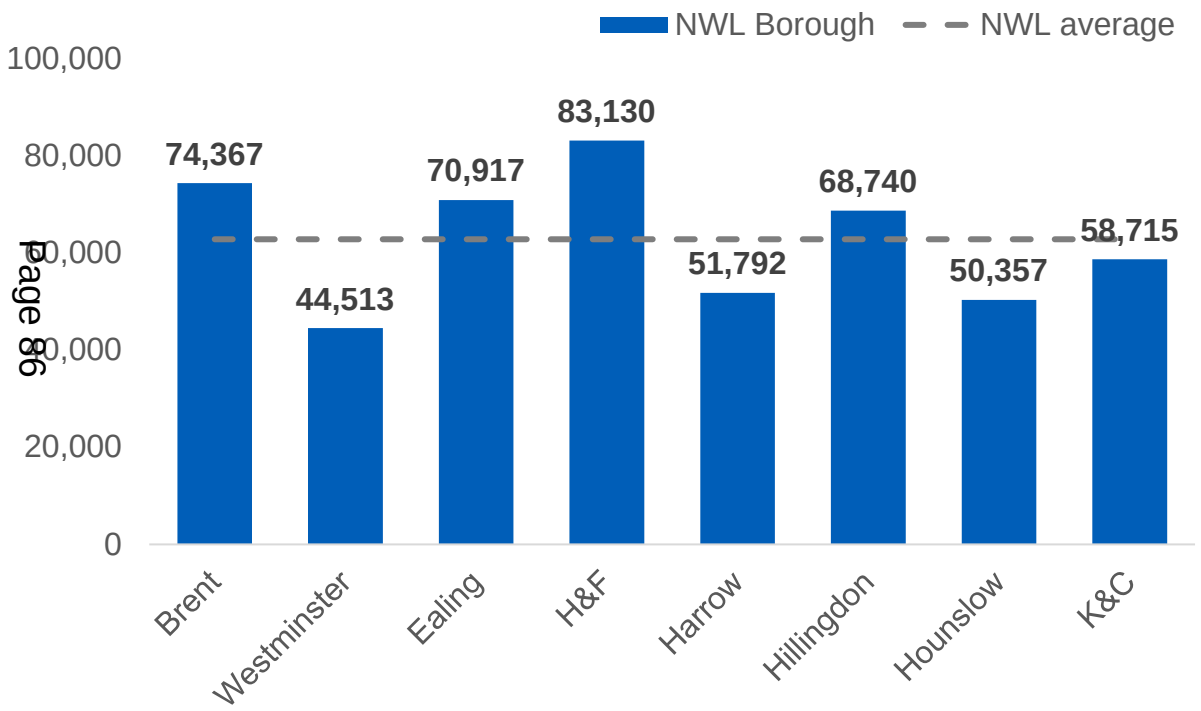


North West London

Hammersmith and Fulham has the highest prevalence of anxiety and depression in 18-65 year olds throughout NWL

Prevalence of anxiety and depression by borough in NWL

Total number of 18+ years old with anxiety and/or depression by borough



Gender	# of people with anxiety	# of people depression
Female	166,138	146,070
Male	97,067	93,256

Age	# of people with anxiety	# of people depression
18-64	223,498	206,146
65+	36,491	33,180

Ethnicity	# of people with anxiety	# of people depression
Asian / Asian British	52,477	48,110
Black / Black British	21,379	21,903
Mixed	10,185	9,925
Other ethnic groups	30,119	29,876
Unknown	2,873	2,496
White	146,172	127,016

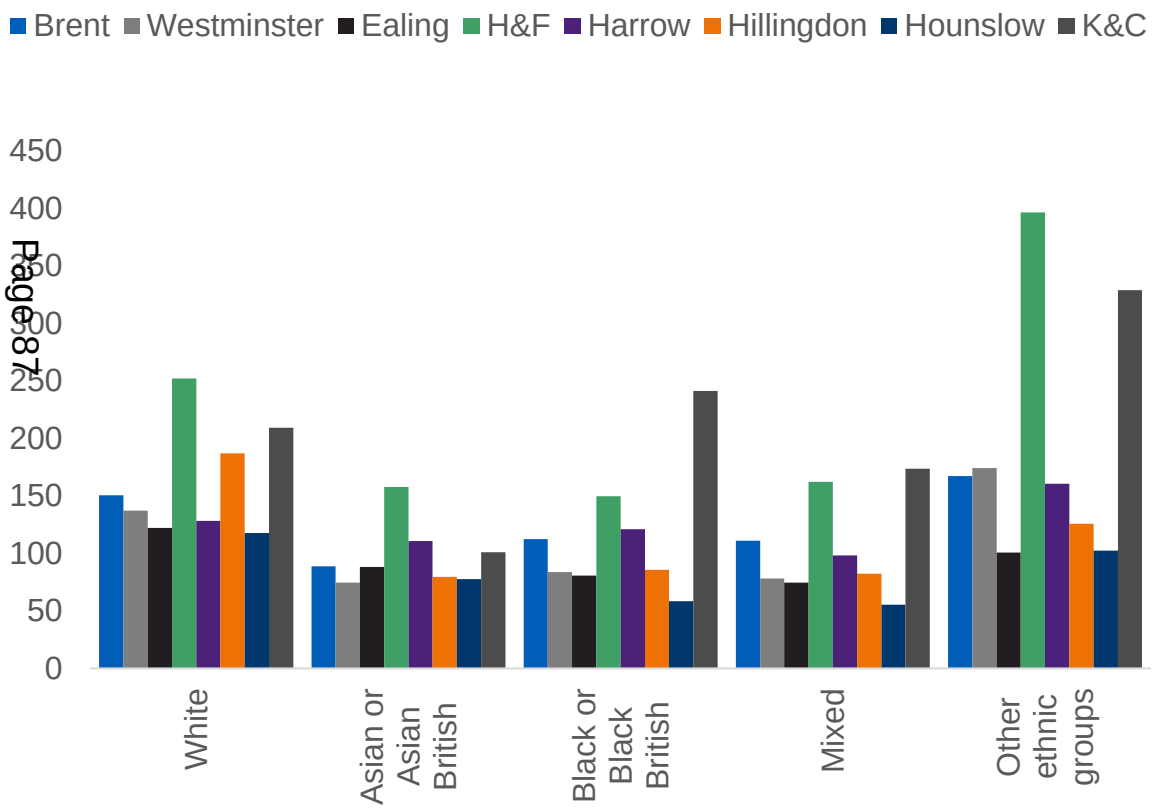
Deprivation Quintile	# of people with anxiety	# of people depression
1 (Most deprived)	39,045	39,866
2	85,347	81,694
3	71,267	63,243
4	46,053	38,043
5 (Least Deprived)	21,004	16,031

Source: Quality Outcomes Framework 2022/23, CF analysis

The highest prevalence of anxiety and depression is seen in the other ethnic groups living in Hammersmith & Fulham, and Kensington & Chelsea

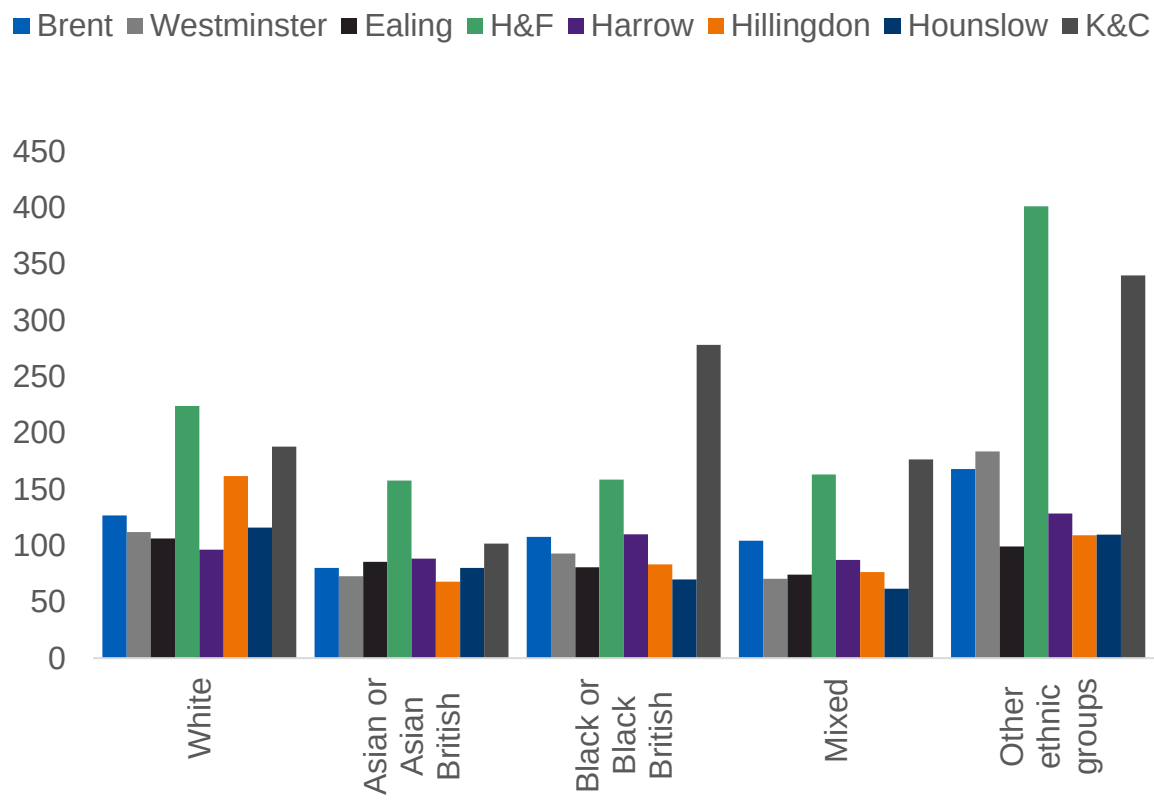
Prevalence of anxiety by ethnicity in NWL

Prevalence of anxiety in the catchment population by ethnicity per 1,000



Prevalence of depression by ethnicity in NWL

Prevalence of depression in the catchment population by ethnicity per 1,000

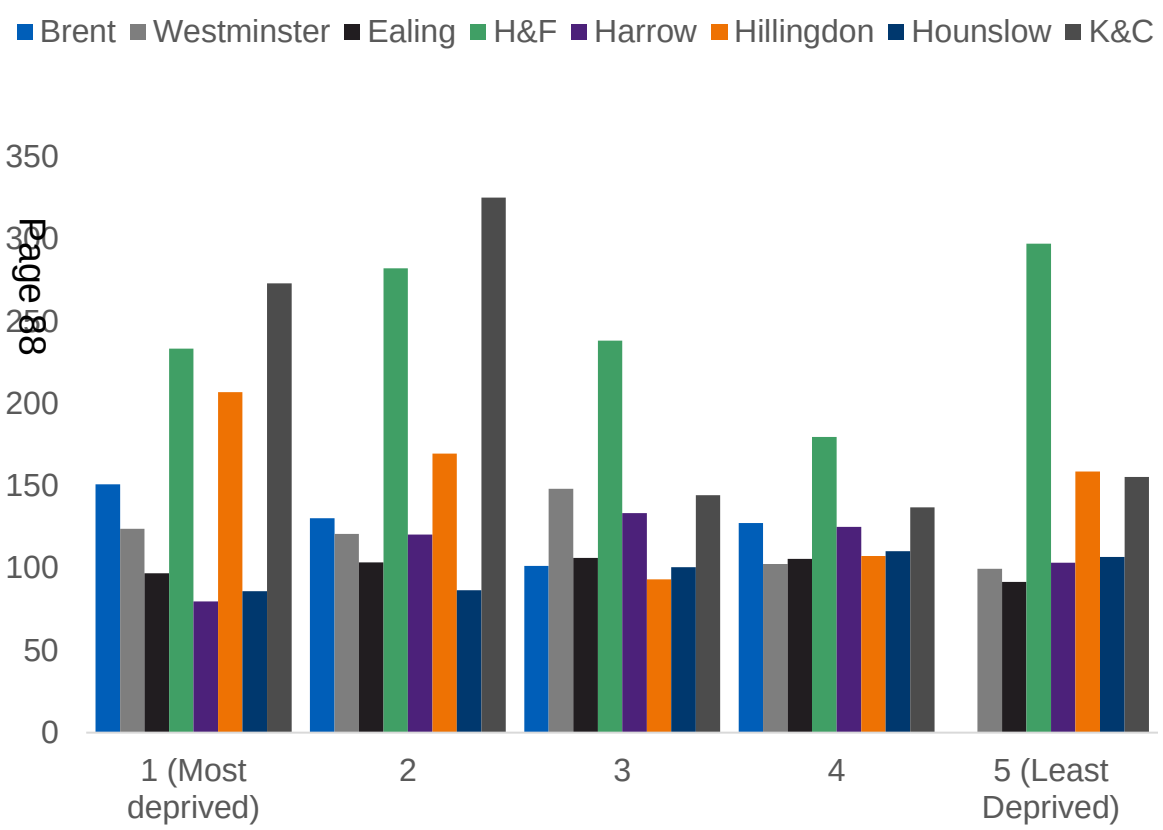


Source: Quality Outcomes Framework 2022/23, CF analysis

People living in the first and second most deprived quintile in Kensington & Chelsea have the highest rate of anxiety and depression

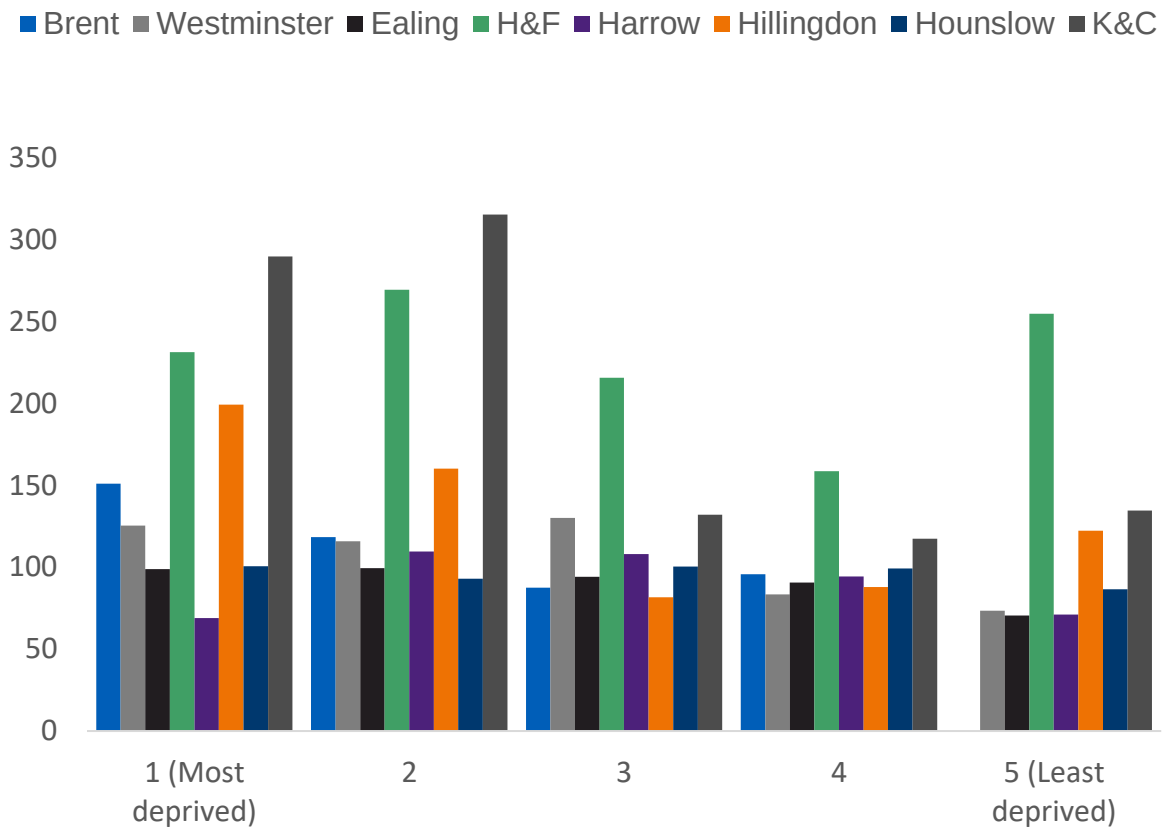
Prevalence of anxiety by deprivation in NWL

Prevalence of anxiety in the catchment population by IMD quintile per 1,000



Prevalence of depression by deprivation in NWL

Prevalence of depression in the catchment population by IMD quintile per 1,000

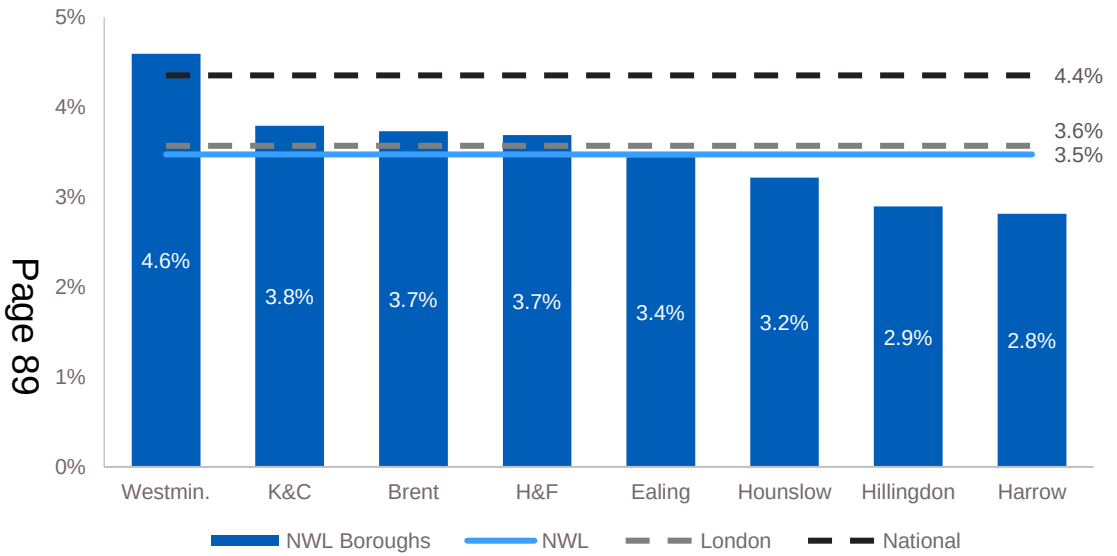


Source: Quality Outcomes Framework 2022/23, CF analysis

Approximately 60,000 NWL residents are economically inactive due to long-term illness – with c.17,000-33,000 inactive due to mental illness

Economically inactive due to being long-term sick or disabled (NWL)
No. of inactive residents (16+) as a proportion of total resident population (16+)

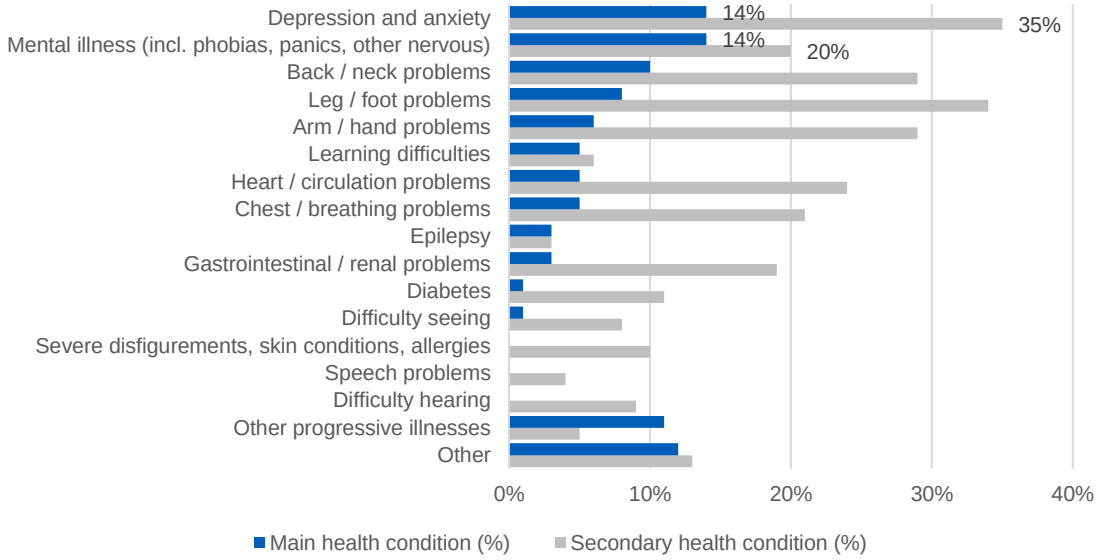
Source: ONS Census Data, 2021



- There are **60,000** people in NWL who are economically inactive due to being long-term sick or disabled – this equates to **3.5%** of our resident population.
- This accounts for approximately **10%** of our **total** economically inactive population – **610,000.**
- Most people are economically inactive for **other reasons**, e.g., retirement, students, or needing to look after the home or family (in that order).
- Our rate of economic activity due to health reasons is **lower than the London** rate of inactivity (**3.6%)** and the **national** rate (**4.4%**).
- However, **variation between boroughs** suggests room for improvement in Westminster, Kensington & Chelsea, Brent, and Hammersmith and Fulham.

Reason for sickness or disability-related economic inactivity (UK)
Percentage of respondents identifying their main or secondary health condition(s)

Source: ONS Labour force survey dataset, 2019



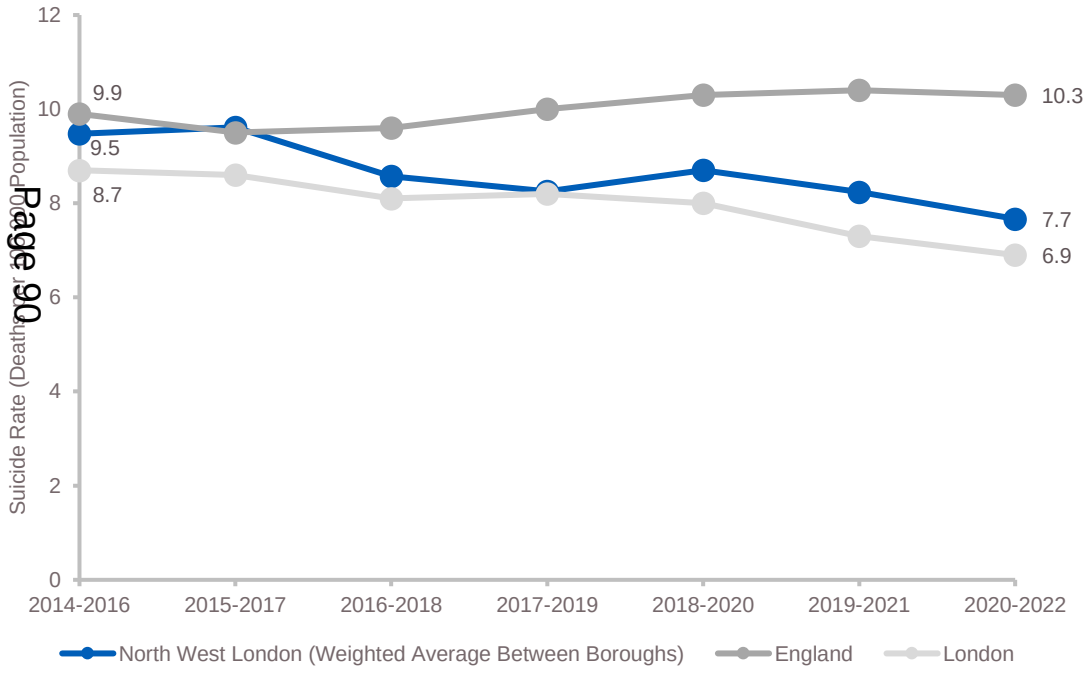
- Of the long-term sickness or disability related economically inactive people surveyed by the ONS nationally, **14% were inactive** due to depression and anxiety as their main reason, and another **14% were inactive** due to other mental illnesses, such as SMI, phobias, and other nervous disorders.
- Respondents were also asked to list any secondary health conditions that were driving their inactivity, and a total of **55% of respondents** listed depression, anxiety or other mental illnesses as the cause.
- If we apply these **proportions to NWL**, we can infer that **17,000** to **33,000** residents are inactive due to mental illness as the primary or secondary reason respectively.

Note: This analysis has limitations related to variation in prevalence across the UK and further work is required to derive a more robust estimate, given NWL has a lower prevalence of common mental illness.

NHS North West London

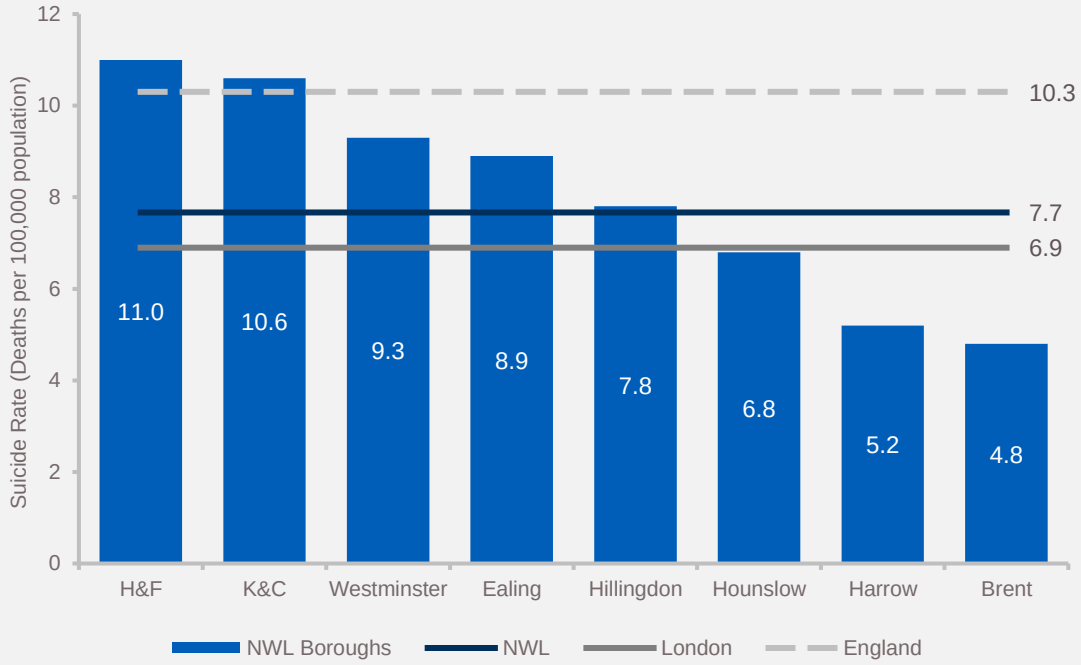
While North West London's (and London's) suicide rates appear to be falling and are lower than England's, there is still significant variation within North West London

NWL Suicide Rates vs **London** and **England** [2014-2022]



- Suicide rates in NWL and the rest of London have gone down over the last 10 years, in contrast to the slight increase in suicide rates across England.
- However, throughout this period, suicide rates in NWL have remained higher than the rest of London, implying a level of unmet need in MH services that should be investigated further.

NWL Suicide Rates by Borough [2020-2022]



Sources: ONS, 2020-22.

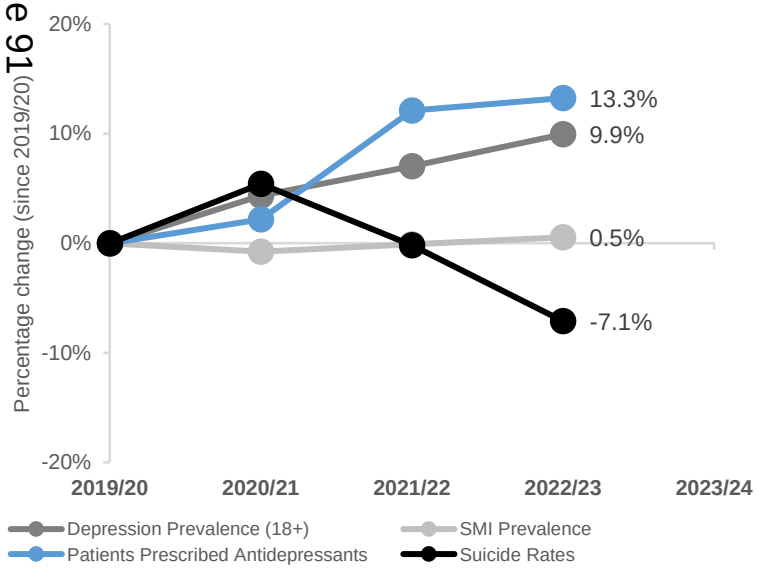
Note: Registering a death as a suicide can take a long time, often taking multiple years. This means that there is a significant delay between the actual suicide rate and what is reported by the ONS (and shown here). And reported figures may not yet reflect the full effect of the COVID-19 pandemic on suicides.

The ONS publishes suicide statistics on a rolling 3-year basis for this reason.

North West London has experienced a significant increase in recorded prevalence and demand for community services, and a decrease in inpatient admissions

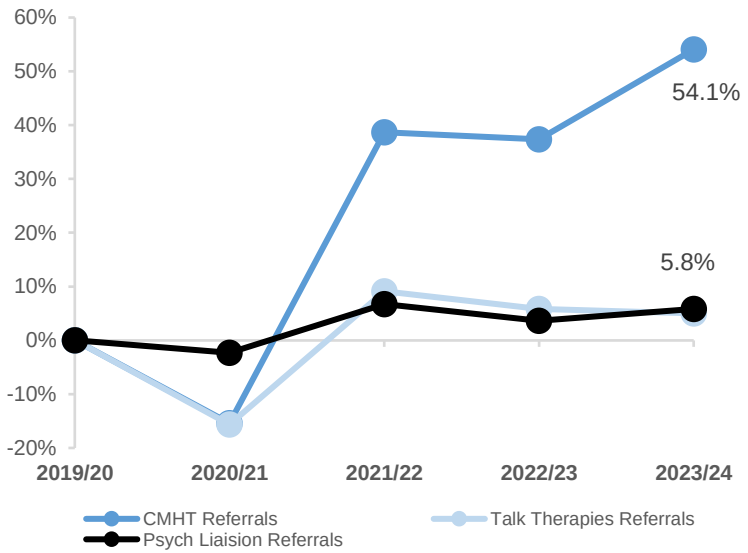
Need: key trends

- The recorded **prevalence of depression** has increased **9.9%** over the past 4 years – roughly in line with our rate of antidepressant prescribing. This may reflect improved case finding, rising actual prevalence, or both
- The recorded prevalence of **severe mental illness** has remained approximately flat over the period.
- Whilst our **suicide rate** has decreased by **7%**, our suicide rate remains higher than the rest of London (see Appendix 1).



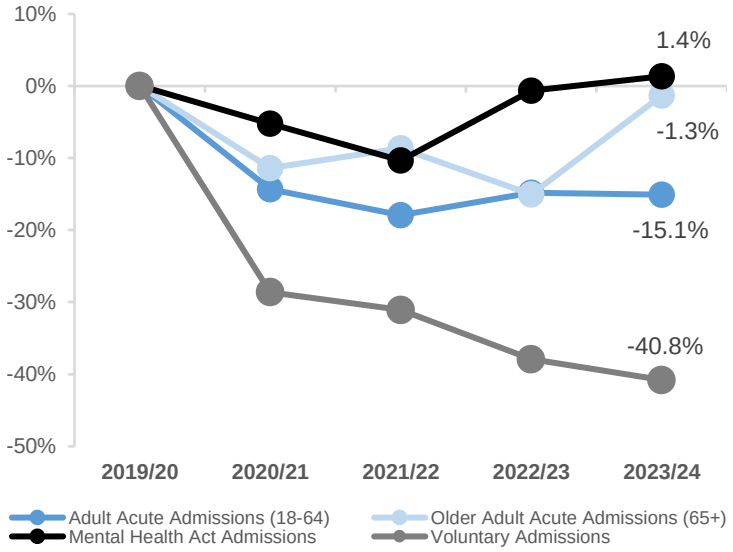
Community service demand: key trends

- **CMHH / MINT** referrals have **significantly increased - 54%** over the period, supported by increased investment in MH community services.
- **Talking Therapy** referrals have increased by **6%** over the same period, though **true caseloads** have increased at a greater rate.
- **Psychiatry Liaison** referrals in our hospitals have also increased. This may reflect increased provision of liaison psychiatry, or unmet need to be addressed (i.e. through providing appropriate care to patients before they need to attend ED / hospital for a MH crisis).



Inpatient service demand: key trends

- Reflecting our focus on improving access to community mental health services and providing care in the least restrictive setting appropriate, **voluntary admissions** have decreased significantly by **40%.**
- Admissions made under the **MH Act** have increased slightly over the past 2 years
- Overall acute admissions for **working age adults** have **reduced by 15%** over the past 4 years.
- Admissions for **older adults** have also decreased, though at a lower rate.

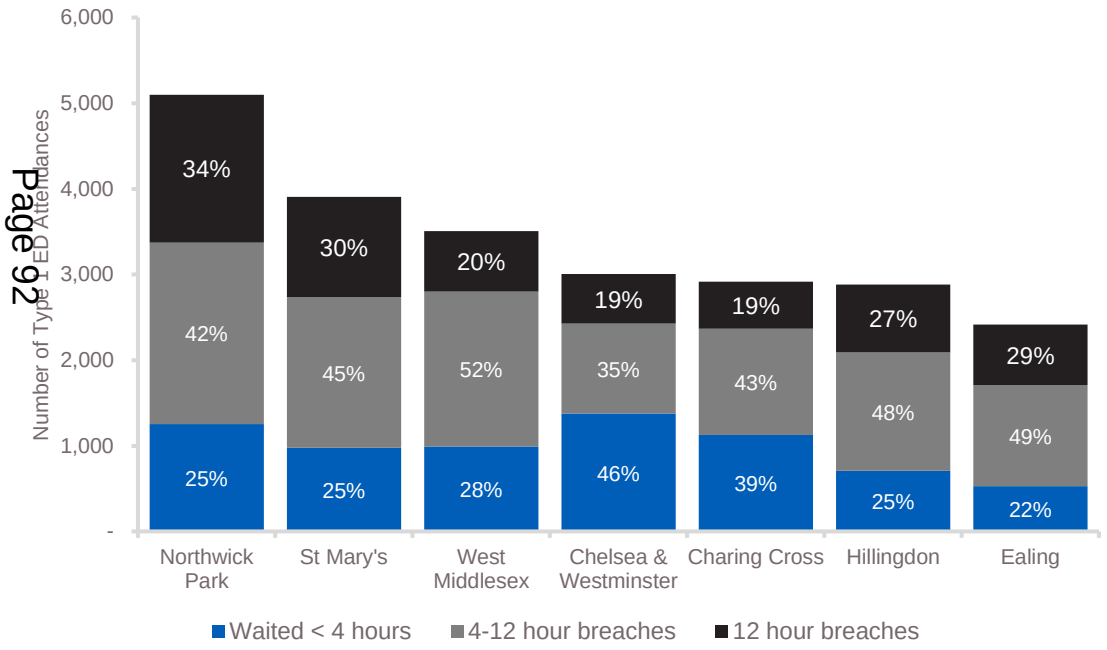


Sources: NHS Digital, QOF Data; ONS; NHS BSA, Medicines Used in Mental Health; CNWL and WLT EPRs.

Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

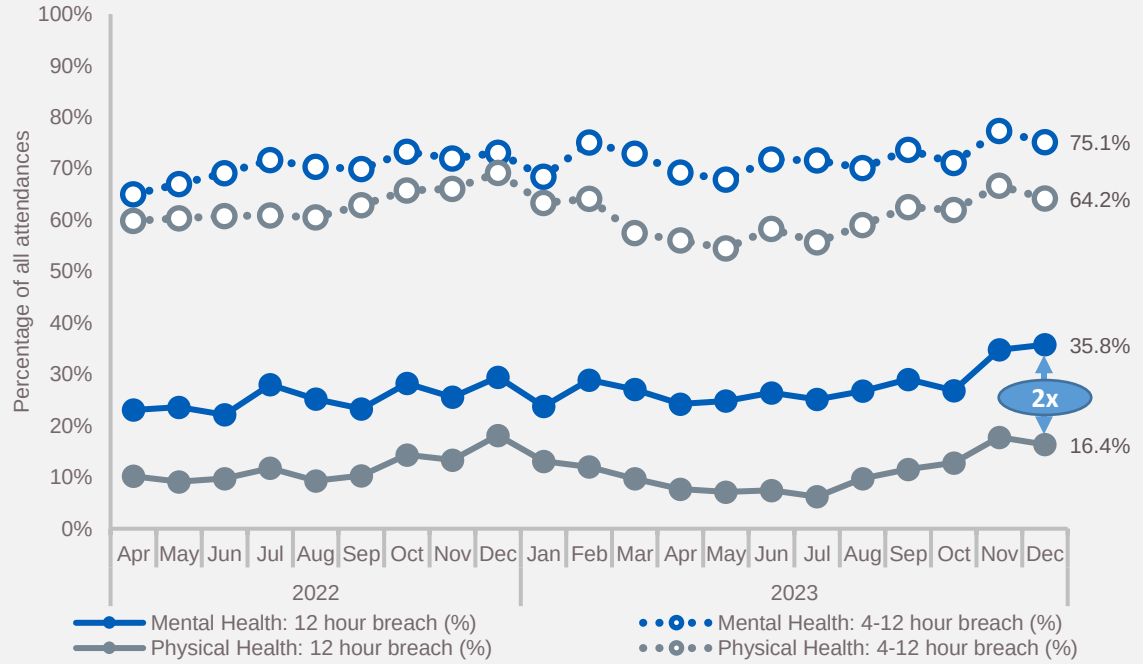
Patients attending ED with a MH diagnosis

Split by waiting time bracket [Jan – Dec 2023]



Mental Health breaches compared to Physical Health breaches

Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

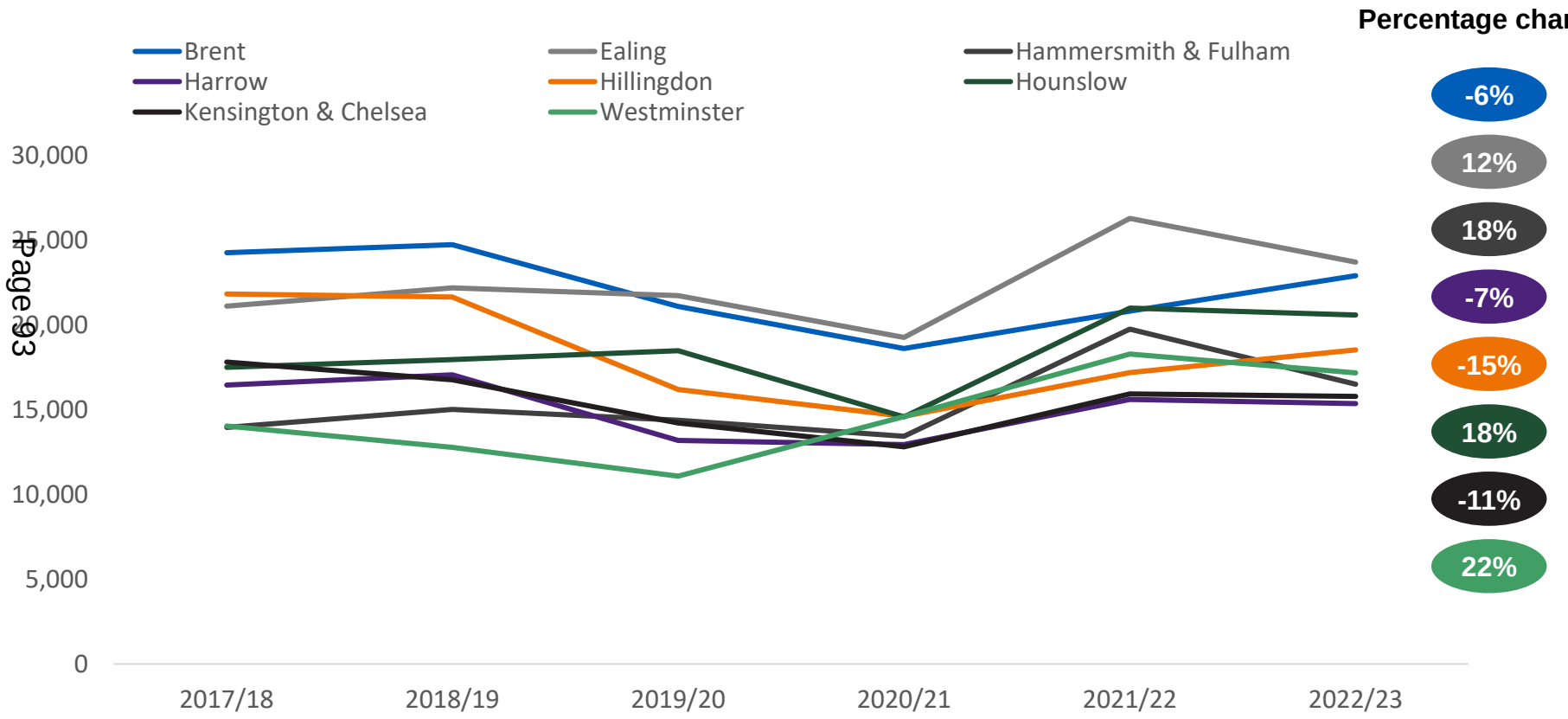


Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
Note: ECDS data is currently part of a thorough data quality improvement programme.

Total mental health referrals have increased by 2% across NWL between 2017/18 and 2022/23

Mental Health referrals in NWL

MH referrals, 2017/18-2022/23



Percentage change

Brent	-6%
Ealing	12%
Hammersmith & Fulham	18%
Harrow	-7%
Hillingdon	-15%
Hounslow	18%
Kensington & Chelsea	-11%
Westminster	22%

- Whilst mental health admissions have decreased compared to pre-pandemic levels, the total referrals across NWL have increased by 2%.
- Referrals have increased by 22% in Westminster and 18% in Hammersmith & Fulham but have decreased by 15% in Hillingdon and 11 % in Kensington & Chelsea
- This increase in referrals is likely to be an impact of the pandemic
- However, the differing trend to total admissions suggests more service users are being cared for in the community

Source: CNWL activity data (provided by Real World Health), CF analysis

Mixed, black and other ethnic populations have the highest rate of referrals in the catchment area per 1000 population, with females typically having higher rates

Mental health referrals by ethnic groups by gender by borough per 1,000 population

MH referrals, 2022/23

	Brent		Ealing		Hammersmith and Fulham		Harrow		Hillingdon		Hounslow		Kensington and Chelsea		Westminster	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Asian or Asian British	24	27	31	37	38	41	19	26	16	24	35	49	27	42	37	50
Black or Black British	45	62	41	46	62	71	47	74	41	58	45	57	85	123	72	83
Mixed	58	69	62	78	75	105	59	109	32	77	65	87	141	187	119	164
Other Ethnic Groups	73	121	43	73	48	85	56	101	49	89	43	82	61	114	50	89
White	51	58	54	60	84	103	44	60	33	52	68	81	90	97	68	66
Total	34	42	37	46	43	52	27	37	26	44	43	58	45	62	48	58

- The mixed ethnicity population in Kensington and Chelsea and Westminster have the highest rate of mental health referrals in NWL, with females having higher rates than males
- The Asian population has the lowest mental health referral rates across all ethnicities in NWL

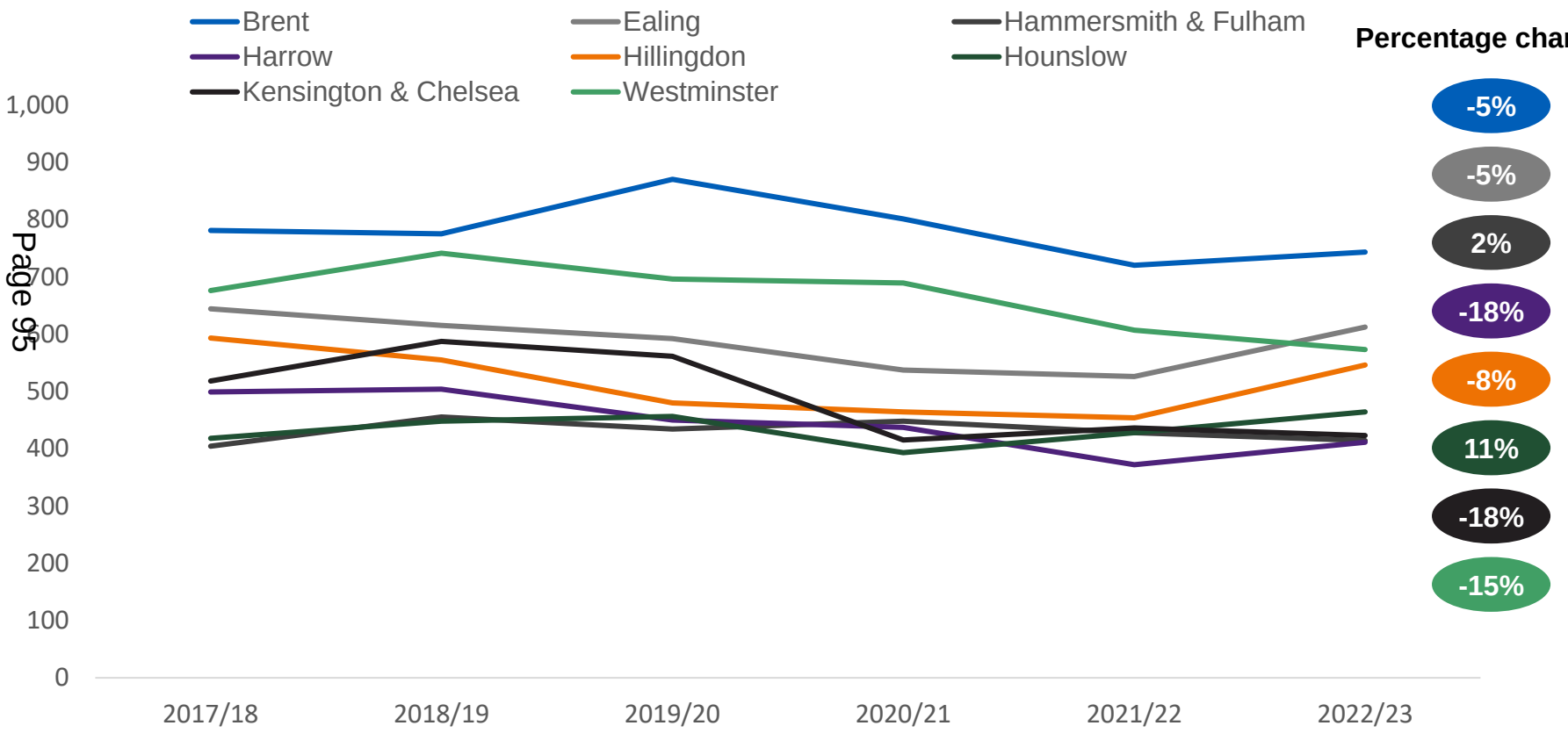
Note this analysis excludes patients where ethnicity is not stated

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

Total mental health admissions have declined by 7% compared to 2017/18 levels across the catchment population

Mental Health admissions in NWL

MH admissions, all ages and ward types, 2017/18-2022/23



Percentage change

-5%
-5%
2%
-18%
-8%
11%
-18%
-15%

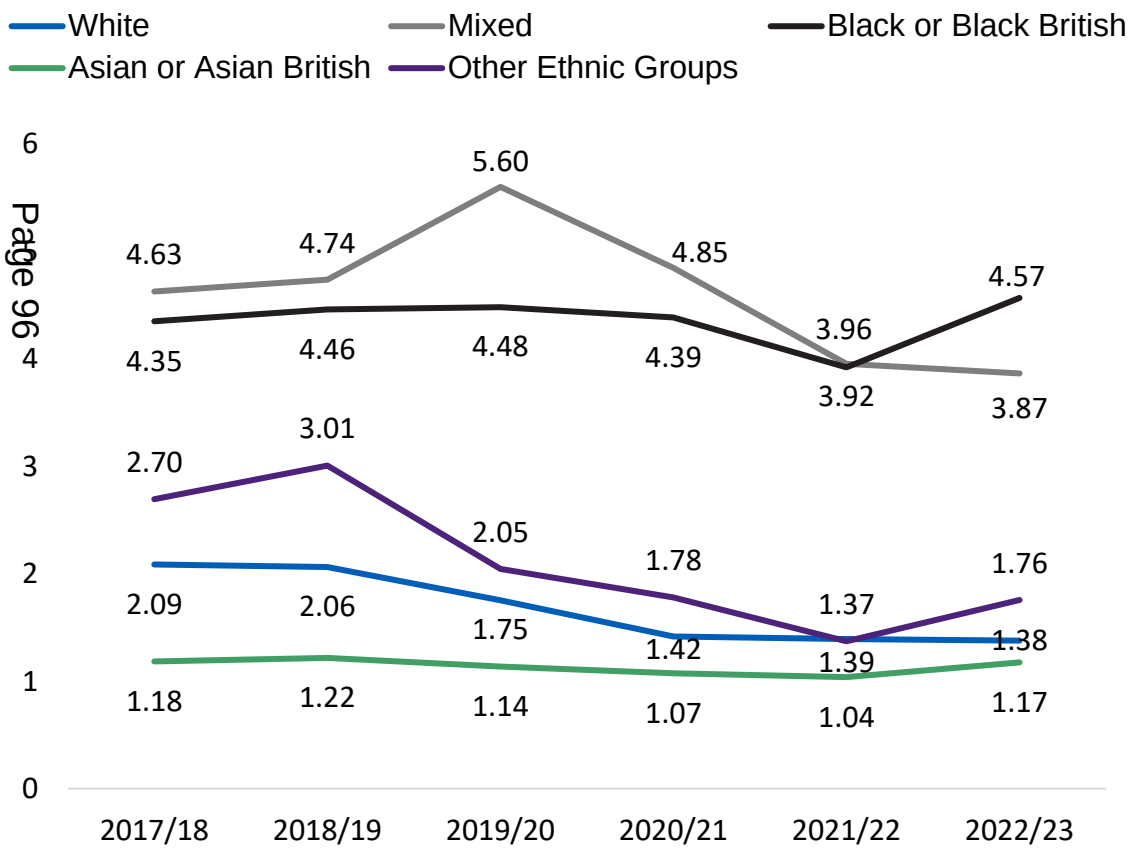
- The mental health admissions for the general NWL population has declined by 7% since pre-pandemic levels
- The decline is most pronounced in Harrow and Kensington & Chelsea (-18%) in 2022/23 compared to 2017/2018
- Hounslow has seen the greatest increase in mental health admissions (11%)

Source: CNWL activity data (provided by Real World Health), CF analysis

The mixed and black ethnic groups have the highest proportion of admissions per 1,000 population; the white population had the proportion of highest total admissions

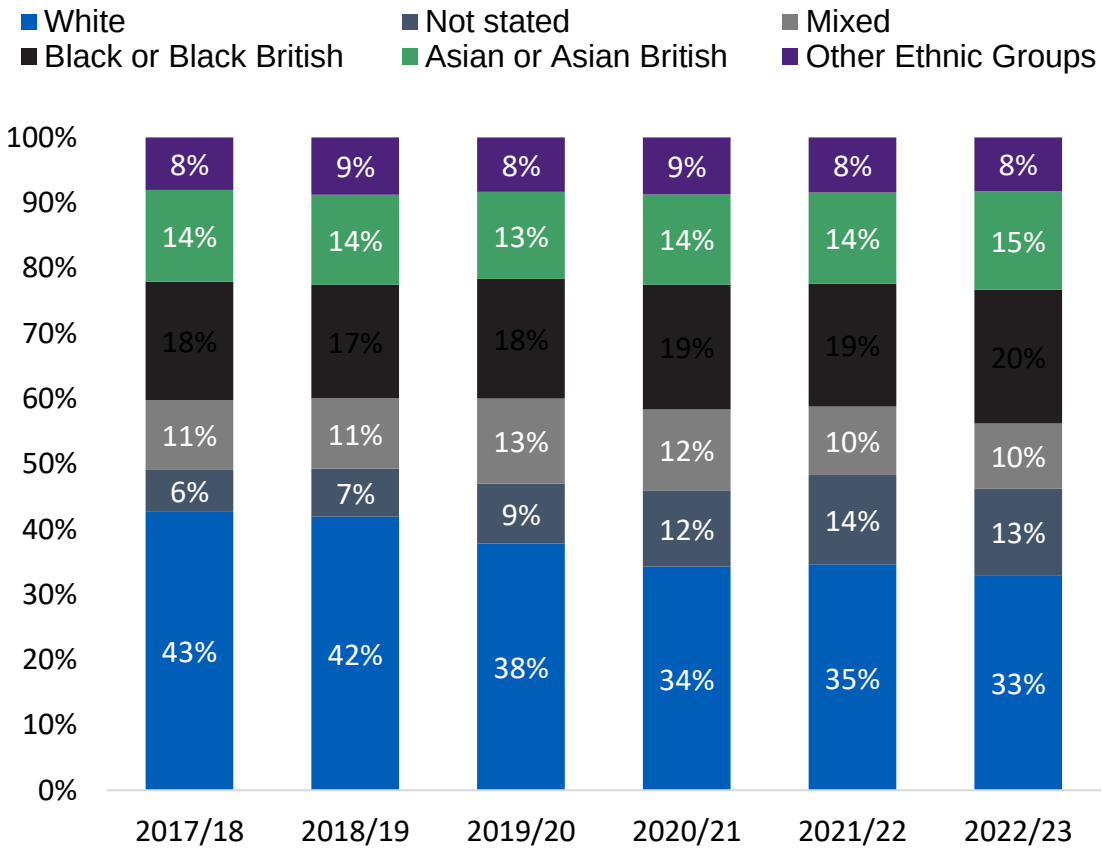
Mental health admissions by ethnic groups per 1,000 population

MH admissions in NWL by ethnic group, 2017/18-2022/23



Proportion of mental health admissions by ethnic groups

Proportion of MH admissions by ethnic group, 2017/18-2022/23



Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

Mixed and black ethnicity populations have the highest rate of admission in NWL per 1000 population, with males typically having higher rates than females

Mental health admissions by ethnic groups by gender by borough per 1,000 population

MH admissions, 2022/23

	Brent		Ealing		Hammersmith and Fulham		Harrow		Hillingdon		Hounslow		Kensington and Chelsea		Westminster	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Asian or Asian British	1.4	0.5	1.5	1.2	1.7	1.6	0.8	0.8	1.3	0.7	1.7	1.2	1.5	0.9	1.9	1.9
Black or Black British	5.3	3.6	2.8	3.0	8.2	4.0	6.5	4.1	5.4	3.8	4.5	2.8	10.5	2.5	7.0	5.9
Mixed	4.6	1.7	3.6	1.9	4.0	4.3	3.1	4.4	1.7	3.3	1.5	1.5	6.6	8.2	6.8	7.2
Other Ethnic Groups	1.4	1.3	1.2	1.3	1.5	1.1	1.3	1.0	1.6	1.5	1.4	1.3	1.4	1.5	1.0	0.7
White	2.6	2.4	1.3	1.1	2.5	1.3	1.7	2.0	1.9	1.8	2.6	1.9	4.4	2.6	3.0	2.0
Total	2.3	1.6	1.6	1.5	2.5	1.7	1.5	1.3	1.8	1.4	1.8	1.4	2.8	2.0	2.8	2.3

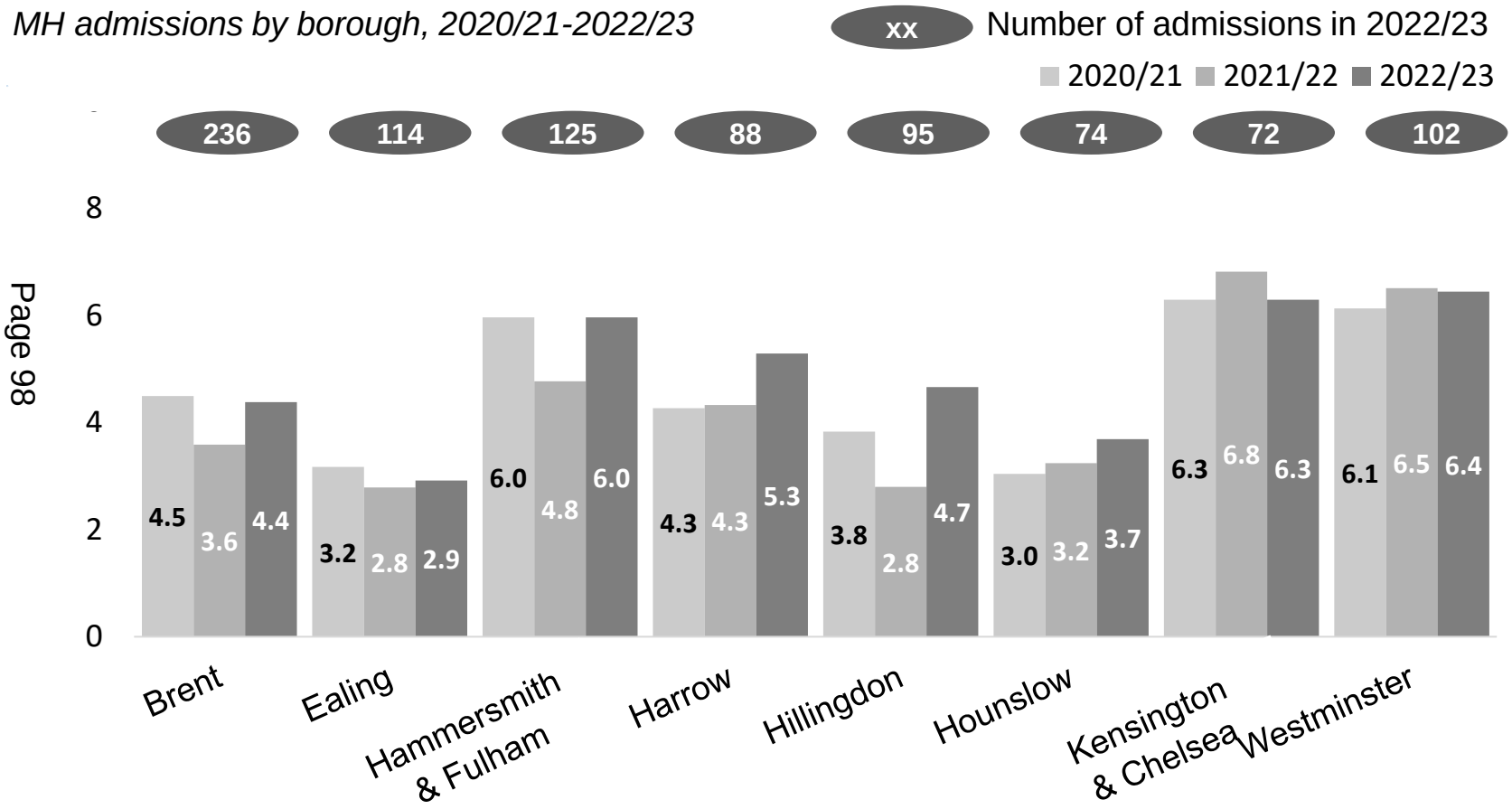
- The black male population living in Kensington and Chelsea have the highest rate of mental health admission in NWL, with 10.5 admissions per 1,000 population
- This rate is significantly higher than that of the black female population living in the same area (2.5 admissions per 1,000 population)

Note this analysis excludes patients where ethnicity is not stated

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis

The mental health admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23

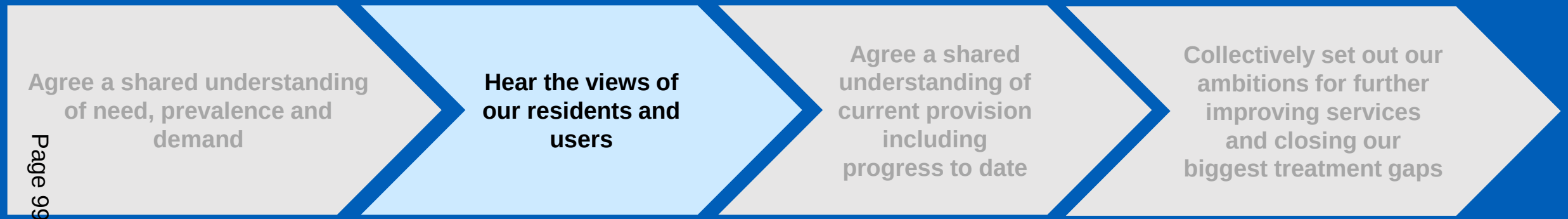
Mental health admissions per 1,000 population with Black ethnicity



Note: Admissions where the ethnicity was unknown have been excluded

- There is variation in the trend of mental health admission rates in NWL boroughs within the Black population, with half of NWL boroughs seeing an increase in rates since 2020/21
- The admission rate within the Black population in Westminster was 2.2 times higher than that of Ealing in 2022/23
- Kensington & Chelsea and Westminster had the highest admission rates within the Black population in 2022/23
- Brent had the highest absolute number of mental health admissions within the Black population in 2022/23

Source: CNWL activity data (provided by Real World Health), ONS demographic data, CF analysis


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

Insights from our local residents: Key themes

The heart of our engagement process involved eight pivotal sessions that took place in various locations across each of the eight boroughs. These sessions held from late August to early October, brought together a diverse range of residents and service users to share their experiences. Two online sessions (lunchtime and evening) open to all residents also took place.

These sessions were pivotal in opening a dialogue with our communities as individuals and families to help us understand the positive aspects of services as well as challenges they face in accessing and experiencing mental health services.

A number of **key themes** were highlighted through the engagement sessions.

- **Access**
- **Community mental health offers**
- **Waiting times**
- **System integration**
- **Approach of services**
- **Awareness of services**

Insights from our local residents: What we heard

Access

"They offer good touchpoints throughout the week and help build people's networks."

"A need for more accessible mental health support for inpatients in hospitals and post-hospitalisation community support."

"More contacts throughout the week would be good. Hestia and other charity organisations are stepping in where people have nowhere else to turn to."

Community mental health offers

Waiting times

"The IAPT programme is generally effective but requires additional resources."

"The wait to see a psychologist or for someone to see a therapist or for talking therapies is way too long. By the point they end up seeing someone, they are now much worse off than when they first ever saw a GP"

"Concerns about long waiting lists for assessments, especially when patients are at their breaking points.

System integration

"There is no accountability. It's passed from one person to another, and I am the one who has to deal with it all."

"Need for a social systems approach"

"Empowerment, mutual respect, kindness, solidarity, care, and love as essential for improving health and well-being"

Approach of services

"Wish services were better advertised because there are people that need it that don't know about it."

"Suggestions to utilise platforms like TikTok for mental health education, specifically highlighting the need for awareness regarding women's hormones and mental health."

Awareness of services

"Include community organisations in trauma-informed care"

NHS North West London

Insights from our local residents: Recommendations

There were several core recommendations arising from the themes gathered through our engagement to support the development of the mental health strategy.

1) Improve access and reduce waiting times

- Develop strategies to improve access and significantly reduce waiting times for mental health services.
- Support ‘waiting well’, with clear communication on the stages of the mental health pathway and provision.

2) Improve community outreach, connection and communication

- Increase in awareness campaigns about the community mental health support services that are available.
- Promote services through accessible channels such as local libraries, social media, community partners and influencers, to reach diverse audiences.
- Simplify the process for seeking help and connecting to services, particularly at points of transition.

3) Foster community resilience

- Provide training for grass roots community organisations and families in how individuals and families can support themselves.
- Support these groups with resources and facilities for effective advocacy and support.

4) Prioritise cultural competence

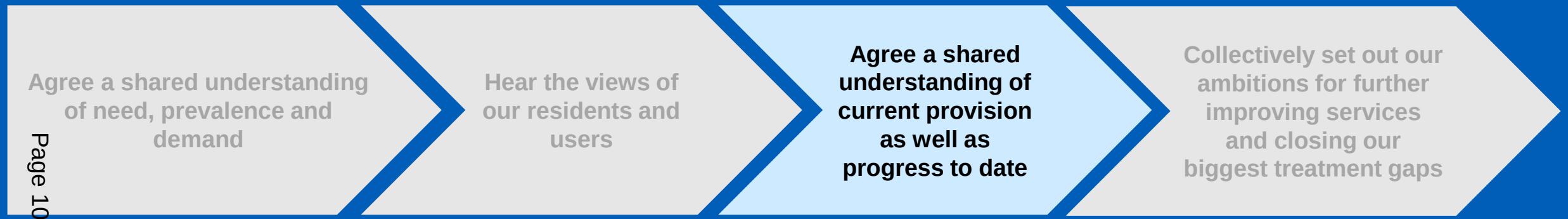
- Ensure cultural competence and awareness in mental health services to serve diverse populations.
- Provide training for healthcare professionals on cultural backgrounds, religion, and inequalities, to enhance patient care.

5) Focus on the impact of the wider determinants of health

- Recognise the strong link between housing and employment challenges and mental health problems.
- Invest in housing support programs to alleviate overcrowding and other housing related crises.
- Consider the wider determinants of health’s impact upon residents’ mental health.

6) Strengthen a trauma-informed workforce

- Expand the adoption of trauma-informed care and ensure that the voluntary community sector workforce is trained in these approaches.
- Foster collaboration between mental health services and community organisations to provide comprehensive support.



NHS
North West London

We have focused our work on the following service areas

1 **Adults** in North West London	• Prevention of mental health problems and promoting wellbeing – understanding local plans in place to promote wellbeing and support early intervention to prevent the need for greater intervention
2 Adults with **common** mental health disorders	• Access to Talking Therapies for Anxiety and Depression – understanding current need as well as unmet need against referrals to identify how capacity can address waiting lists and enable reliable recovery and improvement. • Community Care – highlighting the opportunities through Integrated Network Teams.
3 Adults with **severe mental illness (SMI)**	• Community Care – Outlining the need for greater consistency and productivity improvements to ensure services can meet the needs and demand of adults and older adults with serious mental illness. • Early Intervention in Psychosis – services have expanded and there is sufficient capacity to provide early intervention within two weeks however more could be done to optimise service delivery.
4 Adults with **higher acuity** mental health needs	• Care for people in crisis – expansion of community services has enabled a local alternative offer to A&E and admission however more needs to be done to tackle long waits in A&E. • Inpatient care for adults and older adults – modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities

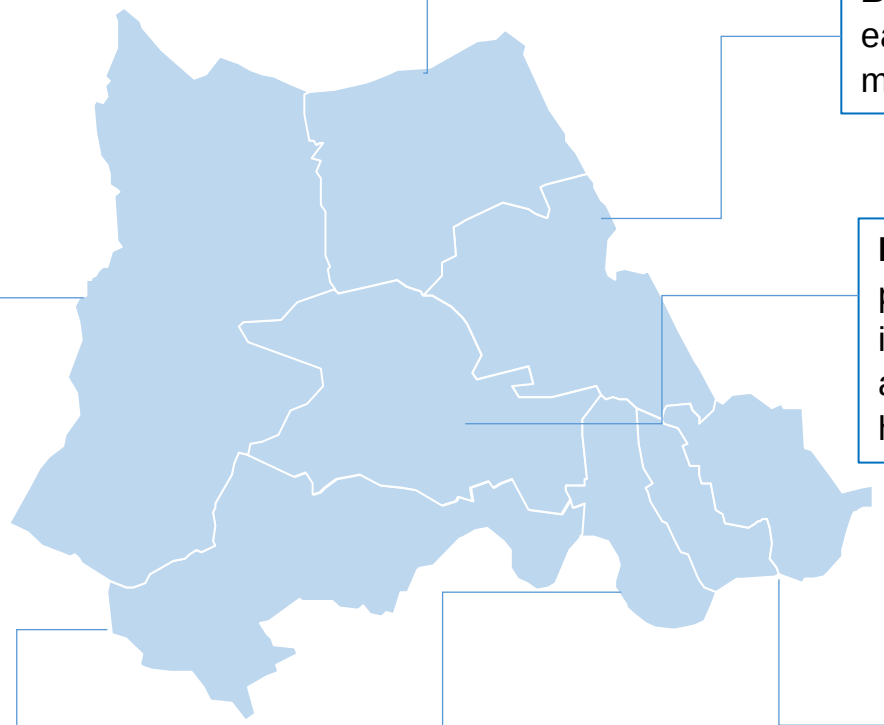
Prevention of mental health problems

A review of local Joint Strategic Needs Assessments and local priorities highlights commitment to preventing mental ill health and promoting wellbeing

Harrow: Reducing health inequalities through **embedding CORE20Plus5** focus and increasing community capacity for action and strengthening our preventative approach

Hillingdon: Proactive care and mental health with a particular focus on the health needs in the south of the borough

Hounslow: Reduce health inequalities in the population so that fewer residents miss life opportunities due to avoidable long-term health conditions. Achieved through prevention and early detection of illness to reduce people developing long term conditions.



Brent: Increasing access to mental health support earlier for communities and reducing variation in mental health care for the local Brent communities

Ealing: Prevention and Wellbeing for the whole population: including reducing stigma and social isolation; identifying mental health needs earlier; addressing the links between physical and mental health; suicide prevention.

Bi-borough: Prevention and early intervention, evidence suggests an increase in demand for mental health services. Focusing on prevention as well as early intervention, also addressing the increasing demand by service planning for the future.

Hammersmith & Fulham: Effective prevention planning with focus on socio-economic determinants and environmental surroundings as part of the broad range of factors which affect resident's mental health.

North West London Integrated Care System

NHS North West London

Several actions are already in place to support the prevention of mental illness, however we recognise that there is still more work to be done

1 Adults in North West London

- In the context of this strategy, prevention is defined holistically as **primary, secondary and tertiary prevention*** - recognising that different prevention measures are required for different types of residents and mental health patients.
- Though this MH strategy is focused on adults, we know that evidence suggests that **prevention of mental illness needs to at an early age** – 50% of all mental illnesses present before children turn 14, and 75% present before the age of 24 (WHO[1]). This will need to be addressed in detail in the next phase of this work (refreshing our children and young people's mental health strategy).
- We know the recorded prevalence of **common mental health disorders** is increasing, so as a system we need to better understand the **wider determinants of mental health** (i.e. housing, education, finance, relationships etc.) and develop **joint interventions** (working with our local authority partners and VCSE organisations) to address these issues before a person's mental health deteriorates and requires a formal diagnosis.

2 Adults with common mental health disorders

- This could include interventions such as **relationship counselling**, **housing interventions**, **financial advice, employment support** and **workplace wellbeing support.** NWL-reported data shows **significant room for improvement for assessments completed**: employment (33% of patients with employment assessments completed); finance status (32% completed); accommodation (9% completed); carer status (32% completed)[2].
- The difficulty of implementing this should not be underestimated and will require **proactive approaches to intervention** and **population health approaches** to managing the overall mental health of our residents. **Primary care has a significant role** in delivering some of these interventions and helping residents navigate the system – however we should recognise the impact of this on a sector that continues to be under significant pressure.
- This will also require ensuring our relevant patient-facing staff across the system have **appropriate training** to support people's mental health.

3 Adults with severe mental illness (SMI)

- The **prevalence of SMI is relatively stable** in NWL, and so prevention for this cohort will focus on **preventing the deterioration** of these patients' **overall health.** For example, we know that people with SMI are **3-4 times more likely** to die **before the age of 75** than people without SMI.
- The NHS Long Term Plan outlined the importance of annual physical healthchecks for patients with SMI, and in the most recent published data (for the 12 months preceding March 2024), NWL had a **80% completion rate** for **full physical health checks**, which is higher than the England average and London average. However, there is still room for improvement in this area.
- In addition, we also need to **tackle smoking, alcohol and substance misuse** in this cohort – with only 39%, 3% and 2% of patients with smoking, alcohol and substance misuse (respectively) receiving relevant interventions. Improving in this area will close multi-disciplinary working and coordinated treatment plans.

4 Adults with higher acuity mental health needs

- We have invested significantly to help **prevent the deterioration** of patients with higher acuity mental health needs, for example, investing heavily 24/7 community crisis and home treatment teams and **crisis alternative services** (such as our mental health crisis assessment service – MHCAS, our Coves and our Safe Spaces).
- These services were put in place (in part) to prevent unnecessary A&E attendances (that can often result in MH patients waiting over 24 hours for a transfer to another service) and provide a more suitable safe space for patients in crisis.
- Ultimately, these crisis alternatives should prevent further deterioration of these patients and prevent suicide attempts. However, further work is required to understand the **effectiveness** of these crisis alternatives, with a **full evaluation** underway.

***Primary prevention:** preventing illness from developing in the first place; **secondary prevention:** detecting and treating illness at an early stage; **tertiary prevention:** managing illness to slow or stop its progression and limit the extent to which the illness is disabling. **Sources:** 1 - Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, Kessler et al.; 2 – NWL whole systems integrated care dashboard (WSIC)

Access to Talking Therapies for Anxiety and Depression

North West London Integrated Care System

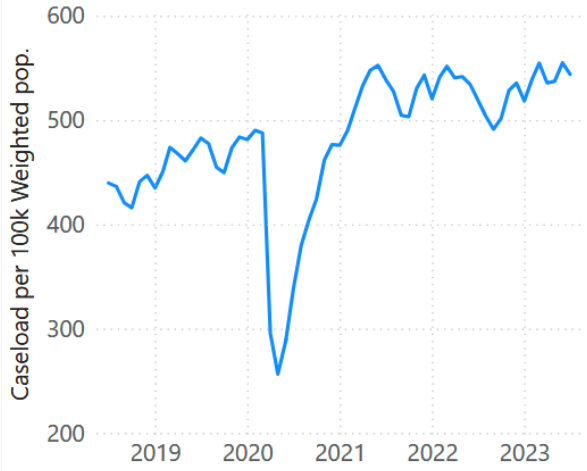
NHS North West London

While North West London meets access targets for Talking Therapies, waits for first contacts indicate significant unmet need

- The proportion of the adult (18+) population in-treatment at any one time has increased and now stands at c.544 per 100k weighted population (+24% on 5yrs ago). We define 'In-treatment' as those service users with at least one contact in the past 60 days*
- About one fifth of the caseload are waiting for first contact, an indicator of unmet demand. For Brent, about two fifths of the caseload are waiting for first contact
- Overall, access (using discharged service users as a proxy) is about 20% higher than the 23/24 access target, with only Ealing falling short (by 4%)

IAPT In-Treatment Caseload per 100k Weighted Population, Per Month

01/07/2018 - 30/06/2023



Talking Therapies Treatment Met & Unmet Need

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Av. Caseload	Av. In-Treatment Caseload	Av. Waiting List (Caseload Waiting for First Contact)	Discharged in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
IAPT - Brent	3,008	1,656	1,034	11,610	9,422	2,188	236,907	5%
IAPT - Ealing	2,637	1,990	307	9,597	9,987	-390	243,031	4%
IAPT - H&F	2,113	1,480	471	8,416	6,861	1,555	139,004	6%
IAPT - Harr	1,223	995	117	7,654	5,980	1,674	181,646	4%
IAPT - Hill	1,900	1,592	153	9,125	7,072	2,053	221,491	4%
IAPT - Hounslow	2,068	1,417	518	9,199	6,812	2,387	194,848	5%
IAPT - K&C	1,843	1,320	310	9,717	8,740	977	120,664	8%
IAPT - Westm	2,439	1,471	483	8,525	7,158	1,367	210,025	4%
Total	**17,221**	**11,919**	**3,391**	**73,843**	**62,032**	**11,811**	**1,547,616**	**5%**

* This reduces caseload across North West London by 31% on average (low 16% (Hillingdon) to high 45% (Brent)

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

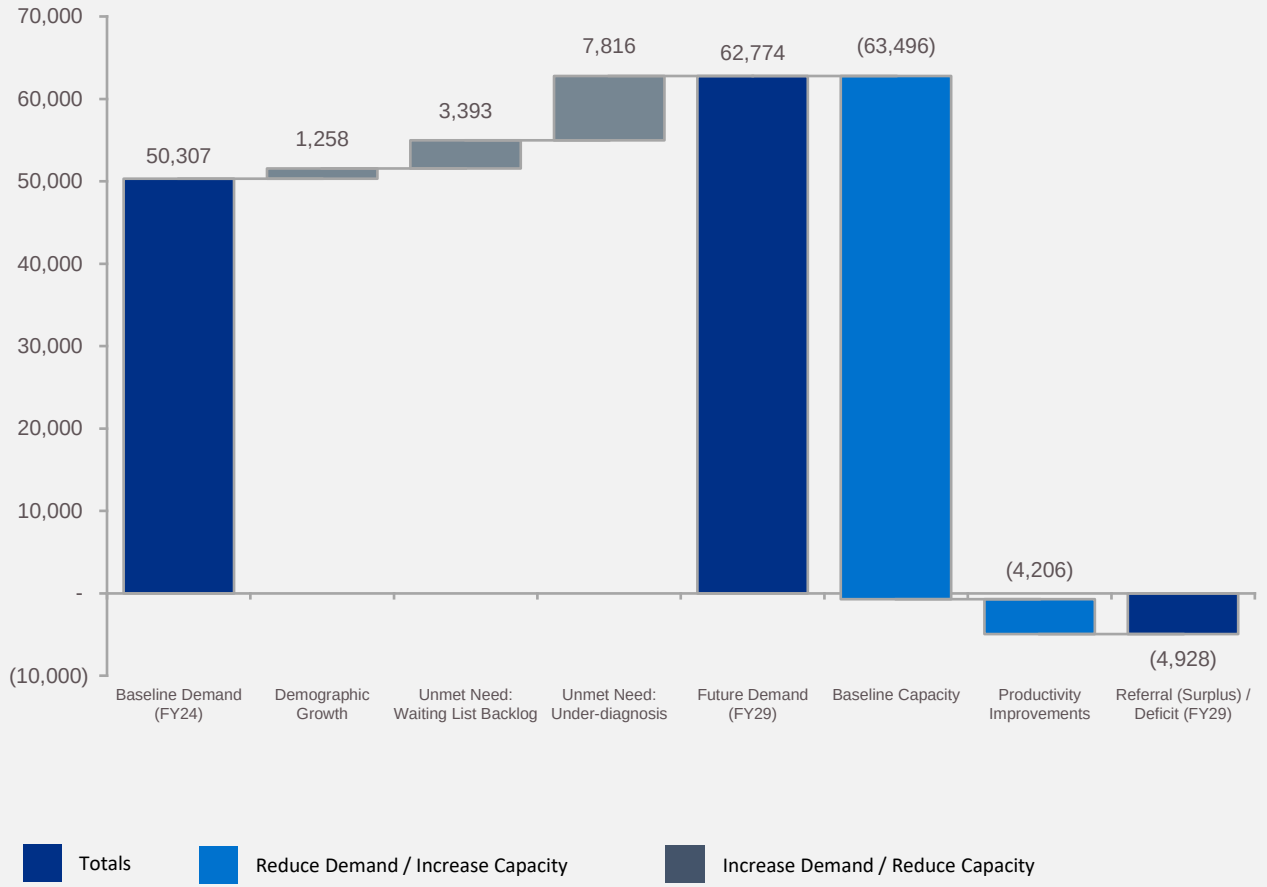
Modelling demonstrates that we can service our Talking Therapies waiting lists and address some unmet need by FY29

Talking Therapies Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 7k referrals** to a **surplus of 8k referrals**, depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we have plenty of capacity to service a significant level of unmet need.
- Ongoing work will continue to refine inputs and assumptions.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**50k**	**50k**	**50k**
Demographic Growth	1k	1k	1k
Unmet Need: Waiting List Backlog	3k	3k	3k
Unmet Need: Under-diagnosis	15k	8k	9k
Future Demand [FY29 'Do Nothing']	**71k**	**63k**	**60k**
Current Capacity [FY24]	(63k)	(63k)	(63k)
Productivity Improvements	-	(4k)	4k
Referral (Surplus) / Deficit [FY29 'Do Something']	**7k**	**(5k)**	**(8k)**

Talking Therapies Referrals: 'Central' Case Modelling Scenario



Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

North West London Integrated Care System

North West London

Work is underway to increase access to talking therapies – only 1.11% of people estimated to have anxiety or depression receive talking therapies, with variation across North West London

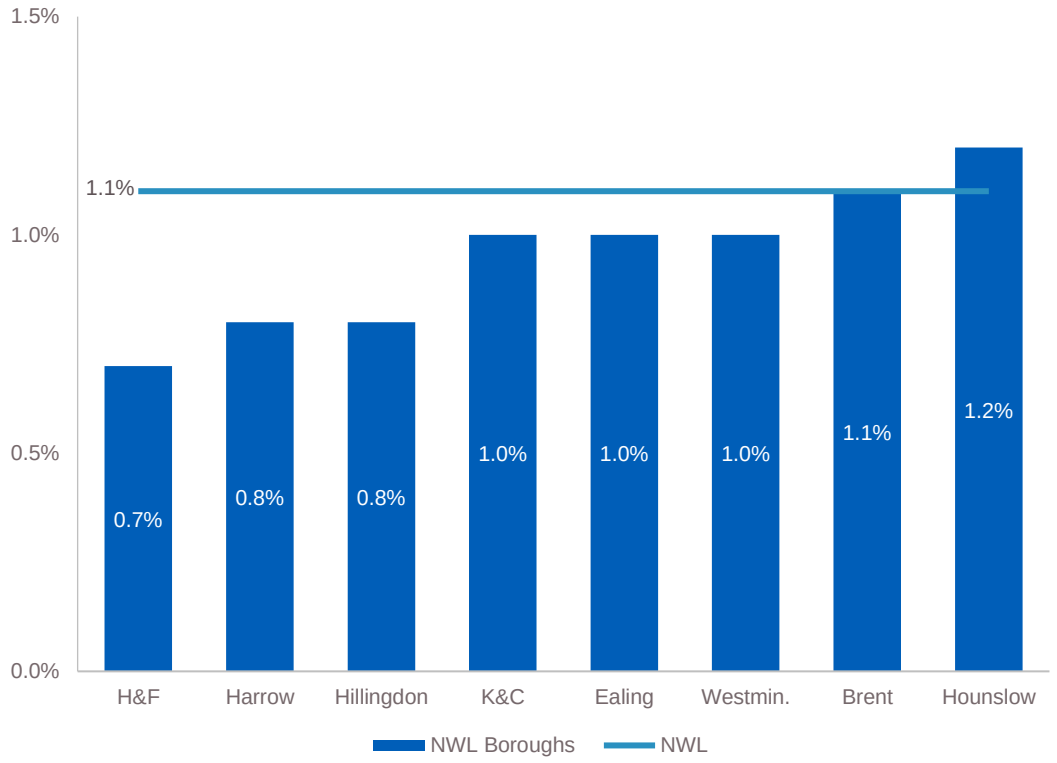
.

North West London has continued to improve access to talking therapies for those with common mental health problems, such as anxiety and depression. Whilst capacity has expanded rapidly in recent years, people's access to care remains relatively low compared with prevalence and nationally, the attrition rate of 45% between one and two contacts.

- We will reach more people by flexing the approach e.g. accessibility, group work, particularly tailoring the service to differing local communities and ensuring that the workforce is reflective of the local population.
- We must also expand our reach through other organisations, sectors and industries, to further develop the broader health, social and economic improvements of NW London.
- We will ensure closer alignment with community mental health and primary care to reduce the attrition so that more people to get to the right service first time, enabling reliable recovery and improvement.

Access to Talking Therapies: People entering Talking Therapies as a percentage of those estimated to have anxiety / depression

Source: NWL local data, August 2023



North West London Integrated Care System

NHS North West London

Community care

Community Mental Health Care in North West London is now more focused on treatment and recovery

- Community mental health is increasingly joined up with primary care and community assets and will become part of the services on offer through our Integrated Neighbourhood Teams, which are central to development community based models of care.

- This enables people to receive more holistic, person centered care based on individual need – joining up physical health, social and mental health interventions closer to their homes that address underlying issues and problem.

10 principles for Community Mental Health Transformation

1. A local delivery model. All resource will be **'place based'** positioned in the Hubs and MINT Locality Teams.
2. There will be a 24/7 **referral route.**
3. Community Hubs and MINT Locality Teams **aligned to Primary Care Networks** (PCNs) with shared care protocols and records where necessary.
4. Regular Community Hub/MINT Locality Team and PCN **catch ups.**
5. Less focus on caseloads and more on responsive and **timely easy to access** support offers, including a therapeutic menu and **voluntary sector led provision**.
6. Daily **senior triage meetings**.
7. **DIALOG+** to be used to inform every assessment with a stepped care model reducing repeat assessments and multiple referrals.
8. Every person to have a named worker with **individualised care**.
9. Delivery of intervention based care meeting clinical and social needs which make use of existing **community assets and individual strengths**, not generic care coordination.
10. Every member of staff dedicated to **empowering their service user** to maintain good physical health and working to enhance mental health equalities.

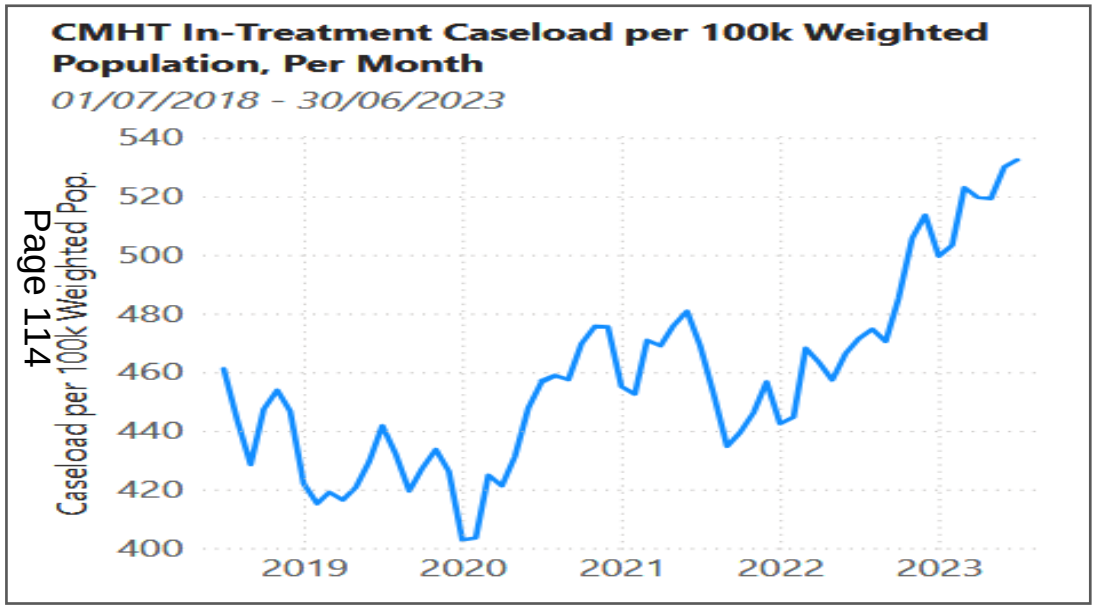
Opportunities for community mental health in INTs:

- Information sharing between mental health services, primary care teams, community services and VCSE providers.
- Strong promotion of good mental health and wellbeing with a focus on the most at-risk populations.
- Consider the role of INTs in the commissioning of VCSE led mental health services in the community.
- Making the right connections with housing services, to prevent homelessness and address need arising from housing issues.
- Address a holisitic approach to care through addressing physical and mental health needs through integrated complex care.

NHS North West London

Capacity in community mental health teams has expanded to enable greater access

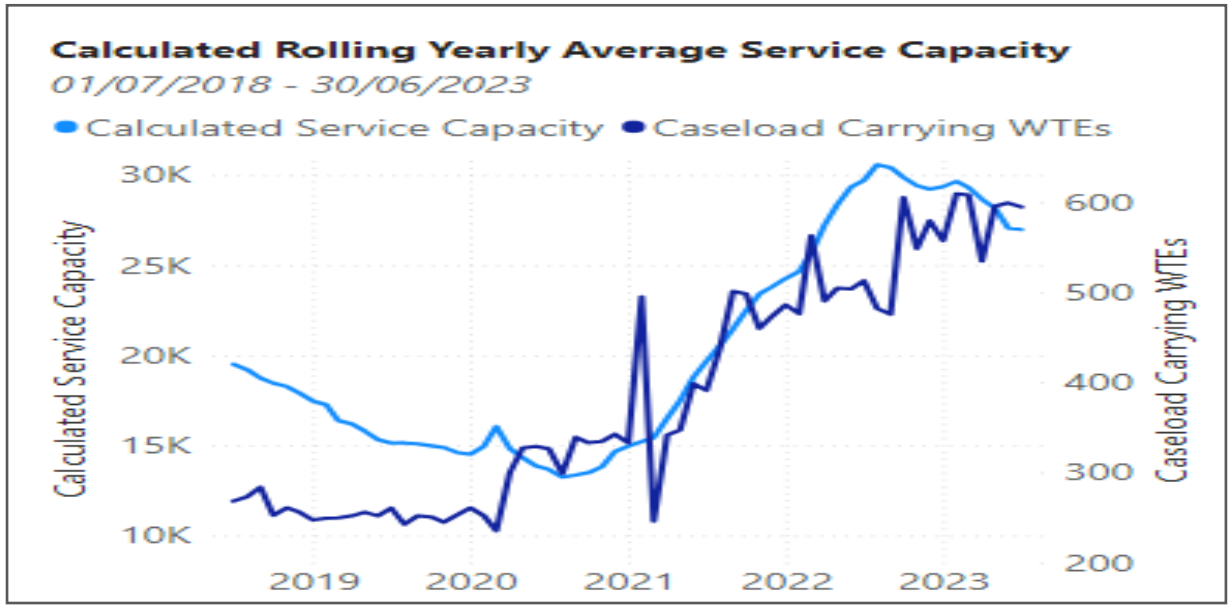
The proportion of adults 18+ [1] in community mental health treatment at any one time has increased by ~16% on 5 years ago



In-treatment caseload is determined by excluding service users on caseload without at least one contact in the past 60 days; this reduces the caseload by -50%. This varies greatly between CMHH (-36%) & MINT (-65%[2]).

CMHH/MINT teams will have services users on their caseloads that do not require high contact intensity, e.g. a 6 monthly medication review. Of 11,219 excluded service users 4,569 were waiting for first contact, a measure of unmet need

Caseload carrying WTEs has increased by ~150% – we have calculated what this should mean for our capacity



We have calculated service capacity as the number of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician and average case length (at discharge) – see details on next page

Capacity has generally moved in line with the caseload carrying WTE increase in recent years

North West London Integrated Care System

(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT
(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness

NHS North West London

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

There is variation in access to community teams between boroughs, while just under one third of service users are awaiting first contact

- Service users with 2+ contacts is lower than planned access with Westminster as the exception in surpassing its access goal.
- Further work has taken place to understand workforce differences between teams to inform service improvements and productivity.

CMHT Treatment Met & Unmet Need

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Av. Caseload	Av. In-Treatment Caseload	Av. Waiting List (Caseload Waiting for First Contact)	SUs With At Least 2 Contacts in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
CMHT - Brent	2,503	1,770	476	3,506	4,235	-729	236,907	1.48%
CMHT - Harr	2,182	1,342	460	2,635	2,842	-207	181,646	1.45%
CMHT - Hill	2,562	1,349	519	2,469	3,581	-1112	221,491	1.11%
CMHT - K&C	1,700	1,217	252	2,388	2,767	-379	120,664	1.98%
CMHT - Westm	2,621	1,736	403	3,390	2,370	1020	210,025	1.61%
MINT - Ealing	4,313	1,710	933	3,419	4,751	-1332	243,031	1.41%
MINT - H&F	3,178	1,053	739	2,034	2,525	-491	139,004	1.46%
MINT - Hounslow	3,668	1,185	787	2,766	3,361	-595	194,848	1.42%
Total	**22,565**	**11,346**	**4,569**	**22,607**	**26,433**	**-3826**	**1,547,616**	**1.46%**

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

(1) AWA and OA services are merged for comparison as the cut off age differs between CNWL and WLT
(2) WLT's MINT teams operate across two EPR systems, which does affect contact capture completeness

North West London Integrated Care System

NHS North West London

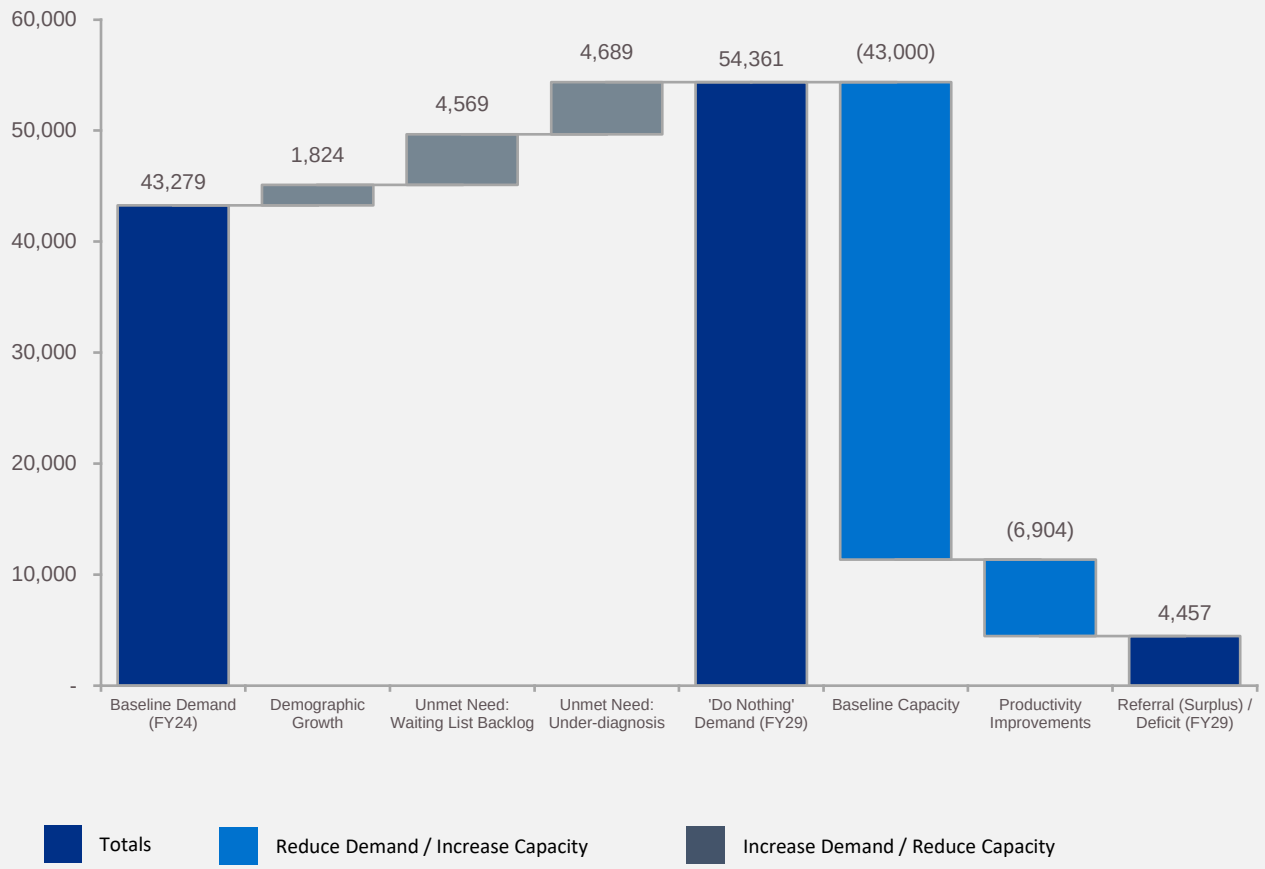
Unless significantly higher productivity improvements can be made in community mental health teams, there could be a significant capacity gap in FY29

CMHH / MINT Referrals:

- The modelling demonstrates that in **FY29, NWL's** referral surplus / deficit could range from a **deficit of 12k referrals** to a **deficit of 3k referrals** depending primarily on the level of unmet need in the system that we can service, and the productivity improvements that we can unlock.
- The **'central case' scenario** (which is the most realistic of the three scenarios) concludes that we need to make higher productivity improvements to meet the currently estimated level of unmet need in the system.
- Work continues to refine inputs and assumptions, particularly around the existing CMHH / MINT capacity.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**43k**	**43k**	**43k**
Demographic Growth	2k	2k	1k
Unmet Need: Waiting List Backlog	5k	5k	5k
Unmet Need: Under-diagnosis	5k	5k	4k
Future Demand [FY29 'Do Nothing']	**55k**	**54k**	**53k**
Current Capacity Estimate* [FY24]	(43k)	(43k)	(43k)
Productivity Improvements	-	(7k)	(7k)
Referral (Surplus) / Deficit [FY29 'Do Something']	**12k**	**5k**	**3k**

CMHH / MINT Referrals: 'Central' Case Modelling Scenario



CMHH – Community Mental Health Hubs (CNWL)
MINT – Mental Health Integrated Network Teams (WLT)
***NOTE:** Further work is required to refine this capacity estimate.
Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

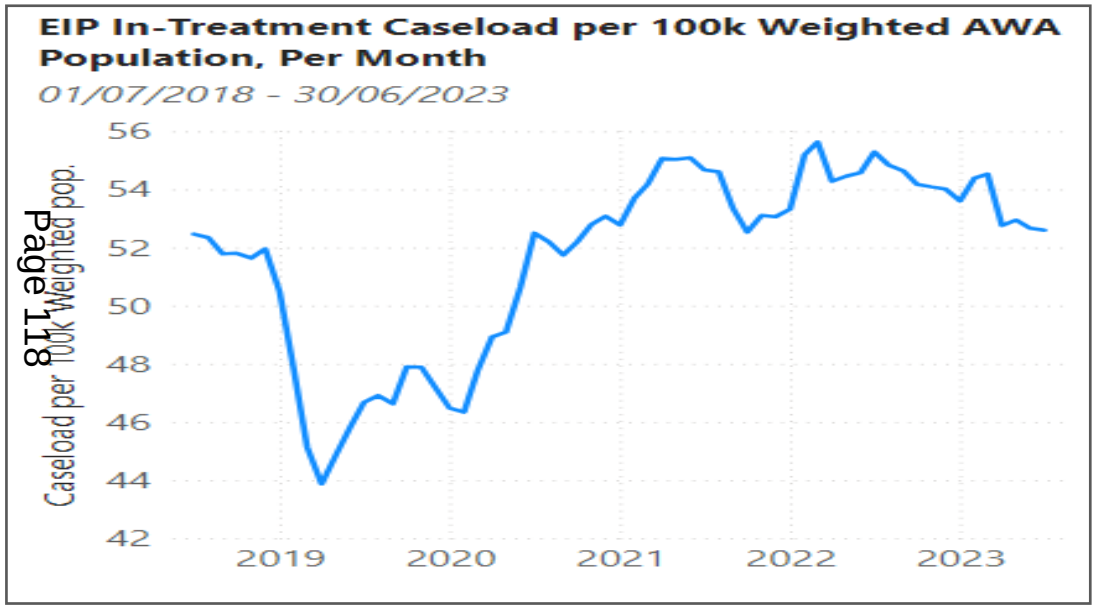
Early Intervention in Psychosis

North West London Integrated Care System

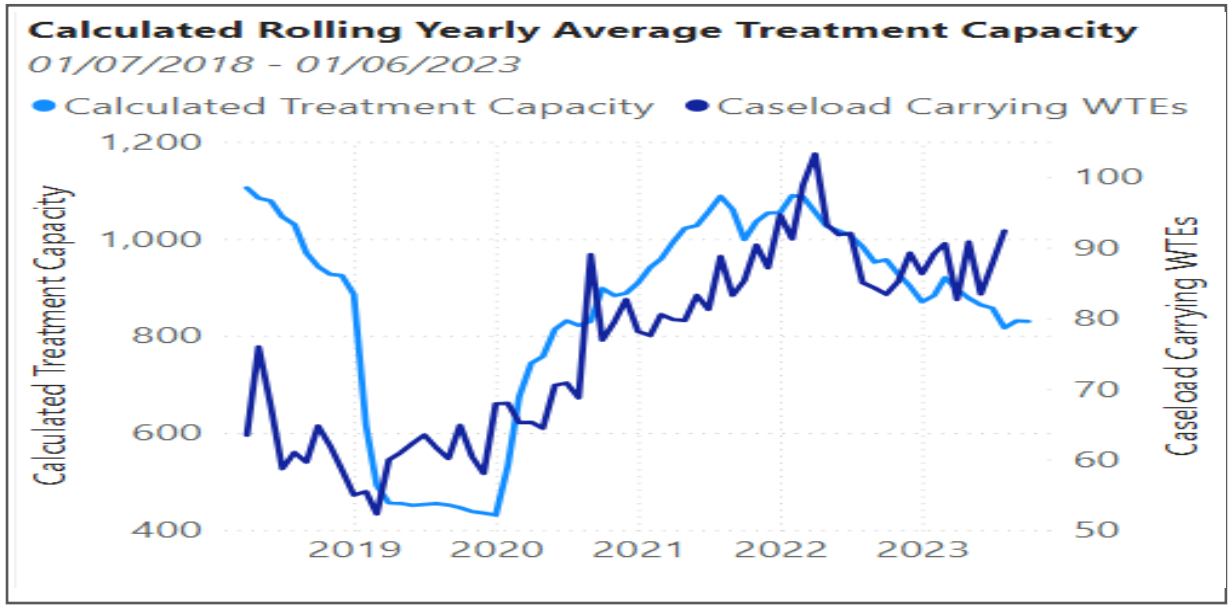
NHS North West London

Capacity in early intervention services has expanded to enable greater access

The proportion of the adult working age (AWA) population in-treatment for EIP is largely back to pre-Covid levels



Caseload carrying WTEs for EIP has increased by ~30%



In-treatment has been determined by excluding Service Users (SUs) on caseload without at least one contact in the past 60 days, EIP will have a cohort at any one time not engaged with the service

Very few SUs are waiting for first contact, our first indicator of unmet demand.

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates; Weighted population – See Appendix 1; 23/24 Access Goal – NWL provided MH trajectories

North West London Integrated Care System

NHS North West London

North West London appears to have sufficient capacity to support early intervention in psychosis

- We have calculated treatment capacity as the no. of cases a team appear to be able to complete in a year. This is a function of the clinical workforce size, each team's average caseload per clinician & average case length (at discharge).
- Capacity has generally moved in line with the caseload carrying WTE increase in recent years. The pandemic did reduce capacity by elongating case length. Case length increase is also the prime driver of capacity decline since Feb-22. This is not, however, necessarily a concern if EIP is adhering to its evidence-based model of intense support for up to 3 years. However, only WLT EIP services seem to be adopting 3 year model when we review team discharge profiles.
- Brent and Hammersmith & Fulham place lower caseload demands on staff, which reduces treatment capacity.

Calculated Service Treatment Capacity and Estimated Service Deficit

Latest 12-Months (01/07/2022 - 30/06/2023)

Service	Caseload Carrying WTEs (A)	In-Treatment Caseload per Caseload Carrying WTE (B)	Av. Case Length (C)	Annual Treatment Capacity (A*B*365)/C	Treatment Capacity per 100k Weighted AWA Pop.	Treatment Capacity Deficit per 100k Weighted AWA Pop.	Treatment Capacity per 100k AWA Pop.	Treatment Capacity Deficit per 100k AWA Pop.
Early Intervention - Brent	16	9	459	117	39		59	
Early Intervention - Hill /Harr	15	13	390	178	60		54	
Early Intervention - KCW	17	12	495	156	33		56	
EIP - Ealing	15	14	404	195	51		96	
EIP - H&F	10	10	400	93	39		77	
EIP - Hounslow	13	14	414	157	65		95	
Total	**87**	**12**	**429**	**886**	**46**		**68**	

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

Sources: Activity Data – EPR System Feeds; WTEs – NWL Trial Balance Data; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1

Optimising the delivery model would increase capacity by 24%

- If we look at the efficacy of services as measured by step down success (a recovery pathway) and avoidance of A&E crisis presentations. Then replicating Ealing's results would appear to raise standards, it currently has a high step-down success rate of 81% and a crisis presentation rate lower than most at 2%.
- If we, for illustration purposes, align all services to Ealing's operating model metrics then the treatment capacity would increase by 213 (24%) across North West London per the table below.

Optimising Treatment Capacity

Latest 12-Months (01/07/2023 - 30/06/2023)

Service	Caseload Carrying WTEs	In-Treatment Caseload per Caseload Carrying WTE	Av. Case Length	Annual Treatment Capacity	Annual Optimised Treatment Capacity	Optimised Capacity Per 100k Weighted AWA Pop.	Optimised Treatment Capacity Deficit Per 100k Weighted AWA Pop.	Optimised Capacity Per 100k AWA Pop.	Optimised Treatment Capacity Deficit Per 100k AWA Pop.
Early Intervention - Brent	16	9	459	117	200	66		100	
Early Intervention - Hill	15	13	390	178	191	65		58	
Early Intervention - KCW	17	12	495	156	219	47		79	
EIP - Ealing	15	14	404	195	195	51		96	
EIP - H&F	10	10	400	93	128	54		106	
EIP - Hounslow	13	14	414	157	165	68		100	
Total	**87**	**12**	**429**	**886**	**1099**	**57**		**85**	

Note: EIP accepts referrals from SUs aged 14 years +; Determining 14-65 pop. is not straightforward, AWA pop. used as a proxy.

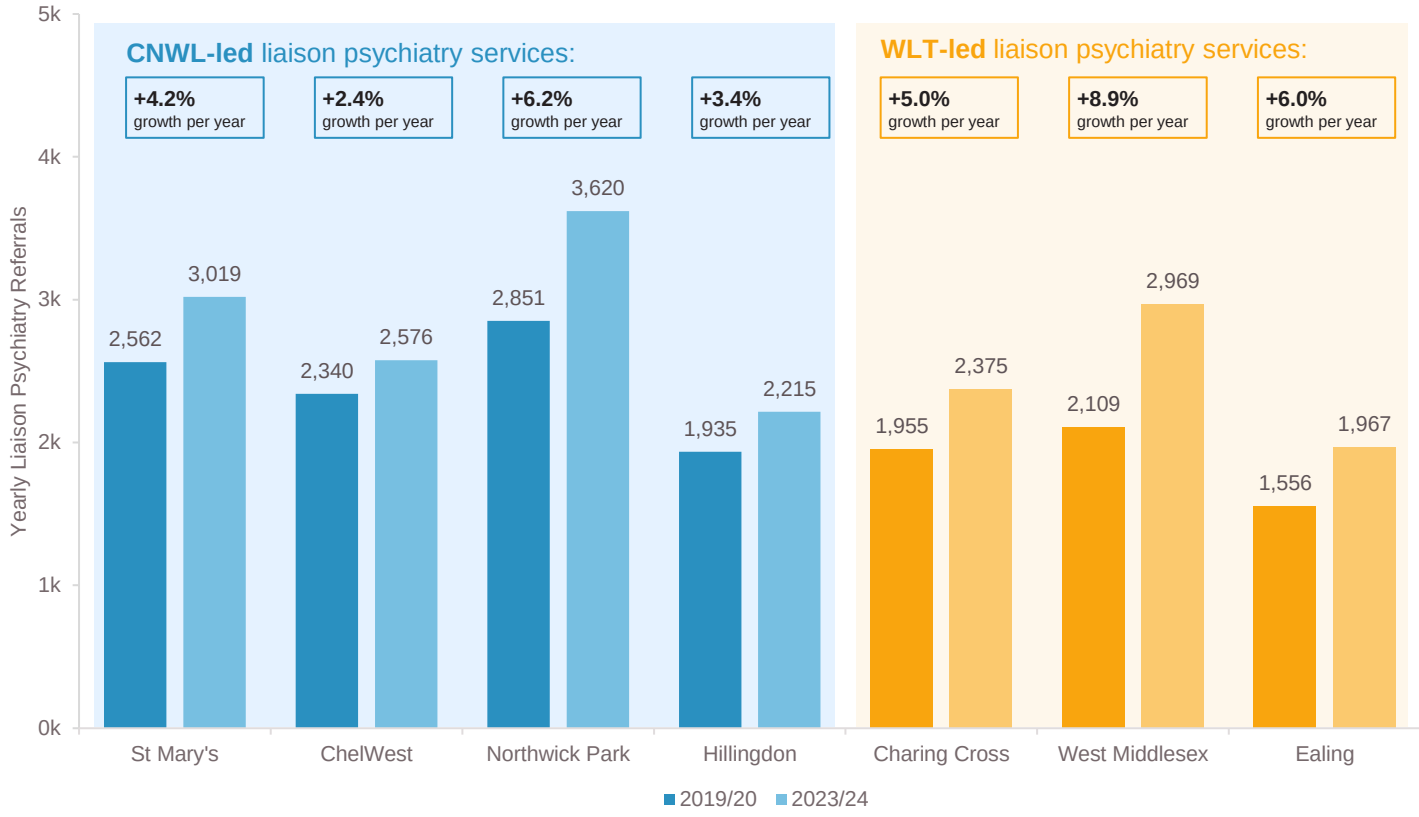
Sources: Activity Data – EPR System Feeds; Absolute population – ONS mid-2020 population estimates, Weighted population – See Appendix 1

Care for people in crisis

Demand for mental health crises in A&E departments has also grown significantly over the last 5 years – at 5.2% per year

- There are now **51 patients** attending NWL A&E departments **every day** for a mental health crisis – this is up 25% from 2019/20 (41 patients per day), equivalent to 5.2% growth per year.
- This figure is derived purely from A&E referrals to liaison psychiatry teams. There are likely to be even more patients who are attending A&E departments for a physical health condition, but also have an underlying mental health condition.
- As shown previously, the **recorded prevalence** of depression and SMI has grown by **6.6% per year**, and therefore liaison psychiatry demand tracks broadly in line with overall mental health prevalence – as expected.
- **25% of overall liaison psychiatry demand** is associated with patients **registered outside of NWL**, foreign nationals, or patients with unknown GP registration status. This varies significantly by site – **40%** of patients attending **Chelsea & Westminster Hospital** for a mental health crisis are considered to be non-NWL patients.
- Growth in mental health demand in Type 1 A&E departments is significantly higher than physical health demand (**1.6% per year**).

Growth in liaison psychiatry referrals by A&E department: 2019/20 – 2023/24 [4 years]



Source: CNWL and WLT internal liaison psychiatry referral data, Type 1 A&E departments only (2019/20 – 2023/24)

North West London Integrated Care System

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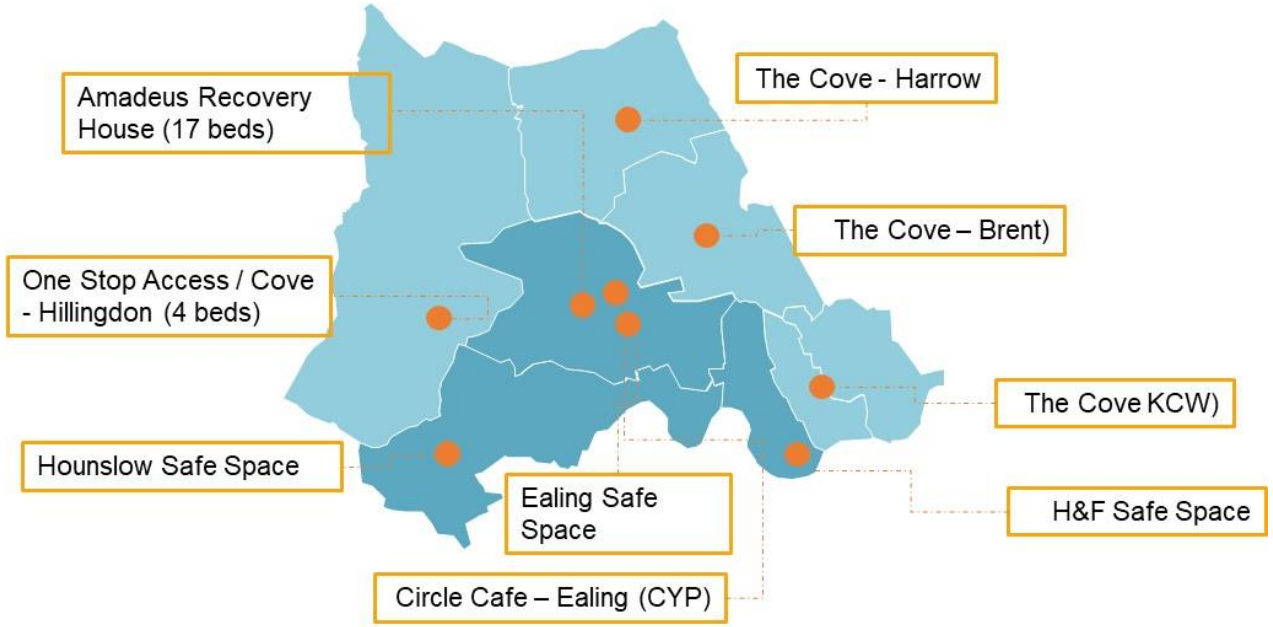
Mental Health Crisis Care has continued the shift to community based models of care and investing in alternatives to admission

- For those experience mental health crisis, our aim 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.
- Mental health crisis care has significantly expanded with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the ICS. The expansion of liaison psychiatry teams means that every A&E department in NW London has a team in place that meets Core 24 standards.
- There is a growing need to further promote and improve professional and public knowledge of alternative crisis services to better direct people to the most appropriate service and prevent the need for A&E attendances and admission. Added to this, we continue to improve the existing 24/7 open access urgent mental health helplines.



North West London Integrated Care System

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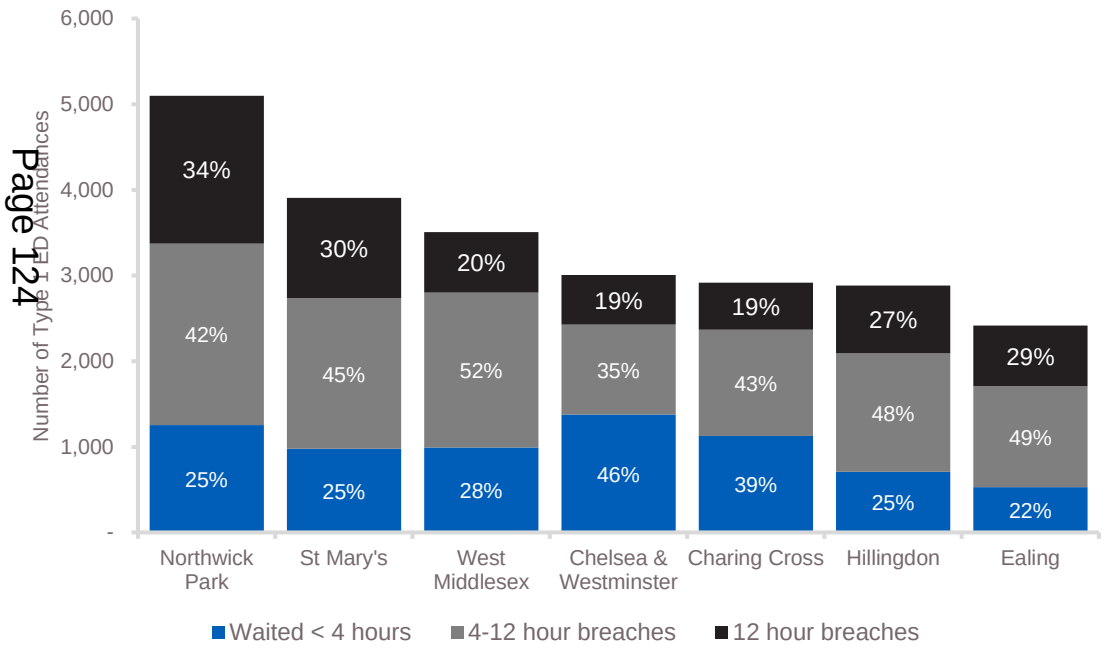
Residents attending A&E departments with a mental health diagnosis are twice as likely to wait more than 12 hours compared to those without such a diagnosis

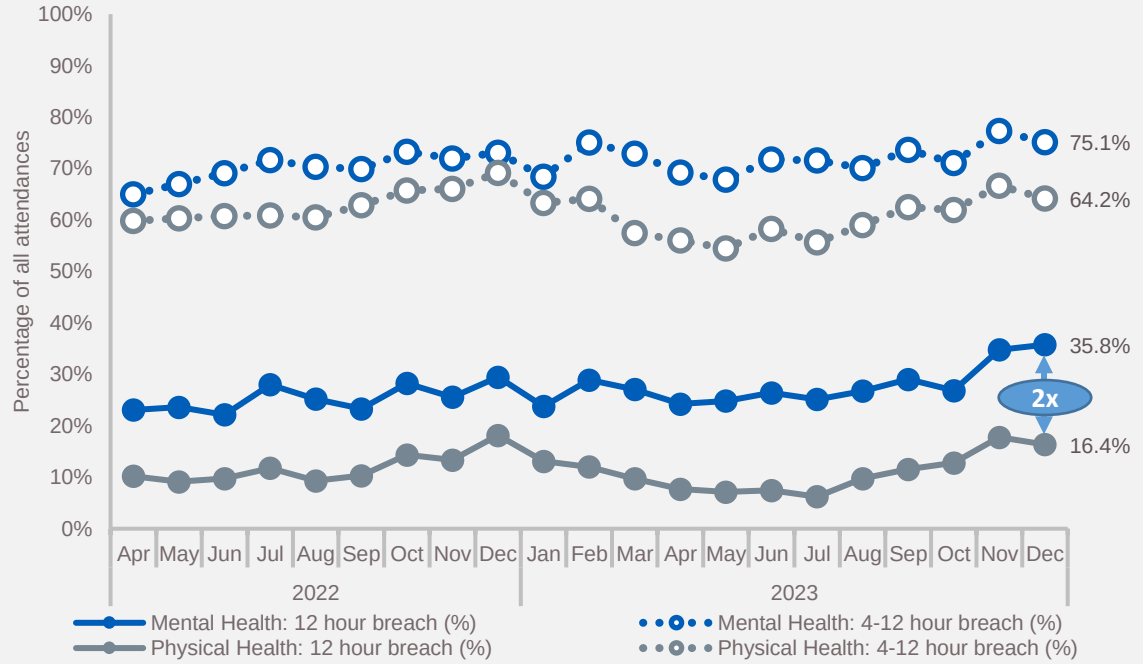
Patients attending ED with a MH diagnosis

Split by waiting time bracket [Jan – Dec 2023]



Mental Health breaches compared to Physical Health breaches

Split by 4-12 hour breaches and 12 hour breaches [Jan – Dec 2023]

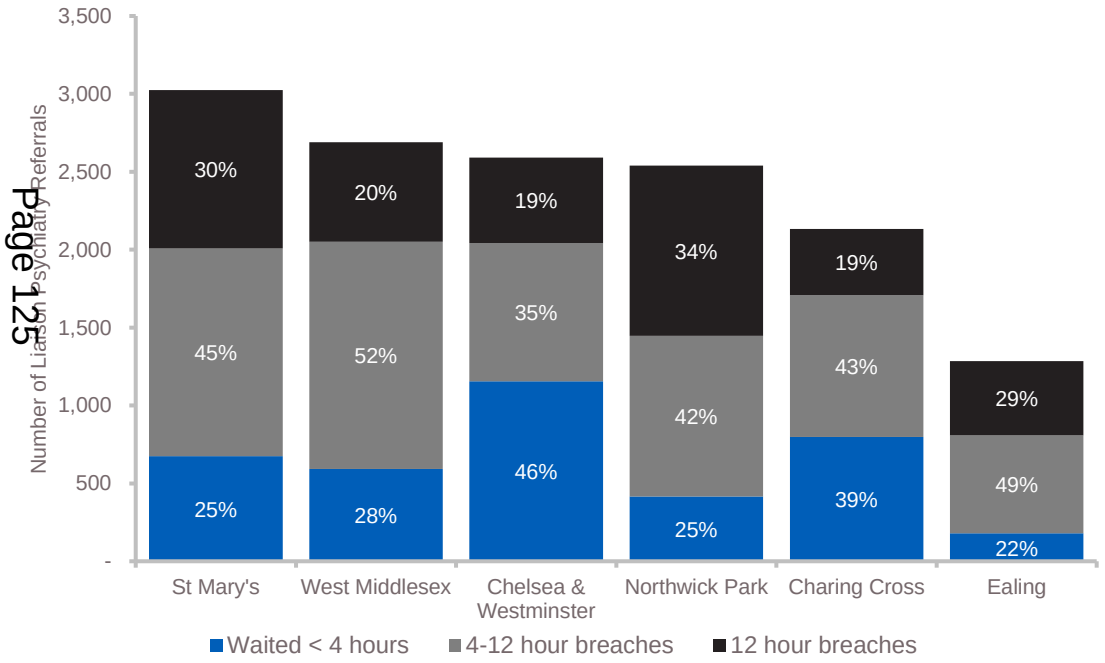


Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] used to quantify daily MH ED attendances using custom NWL logic (through use of primary and secondary diagnoses and other logic.
Note: ECDS data is currently part of a thorough data quality improvement programme.

Patients being referred to Liaison Psychiatry wait on average 8-12 hours in ED, with those breaching 12 hours spending c. 24 hrs in ED

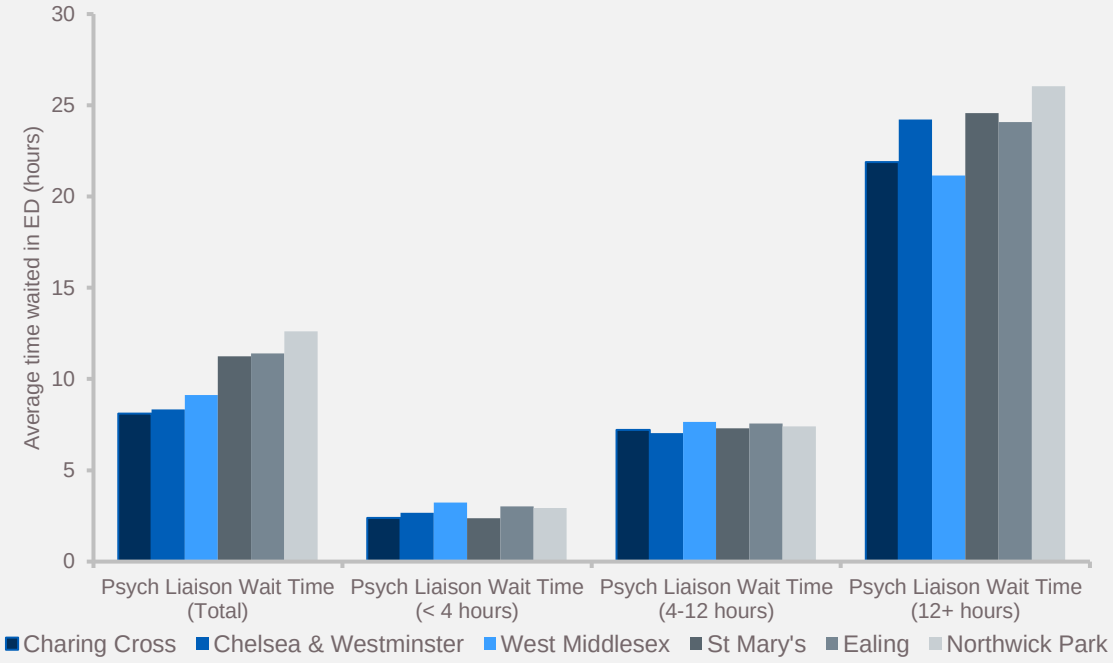
Patients referred to Liaison Psychiatry

Split by waiting time bracket [Jan – Dec 2023]



Waiting times for patients referred to Liaison Psychiatry

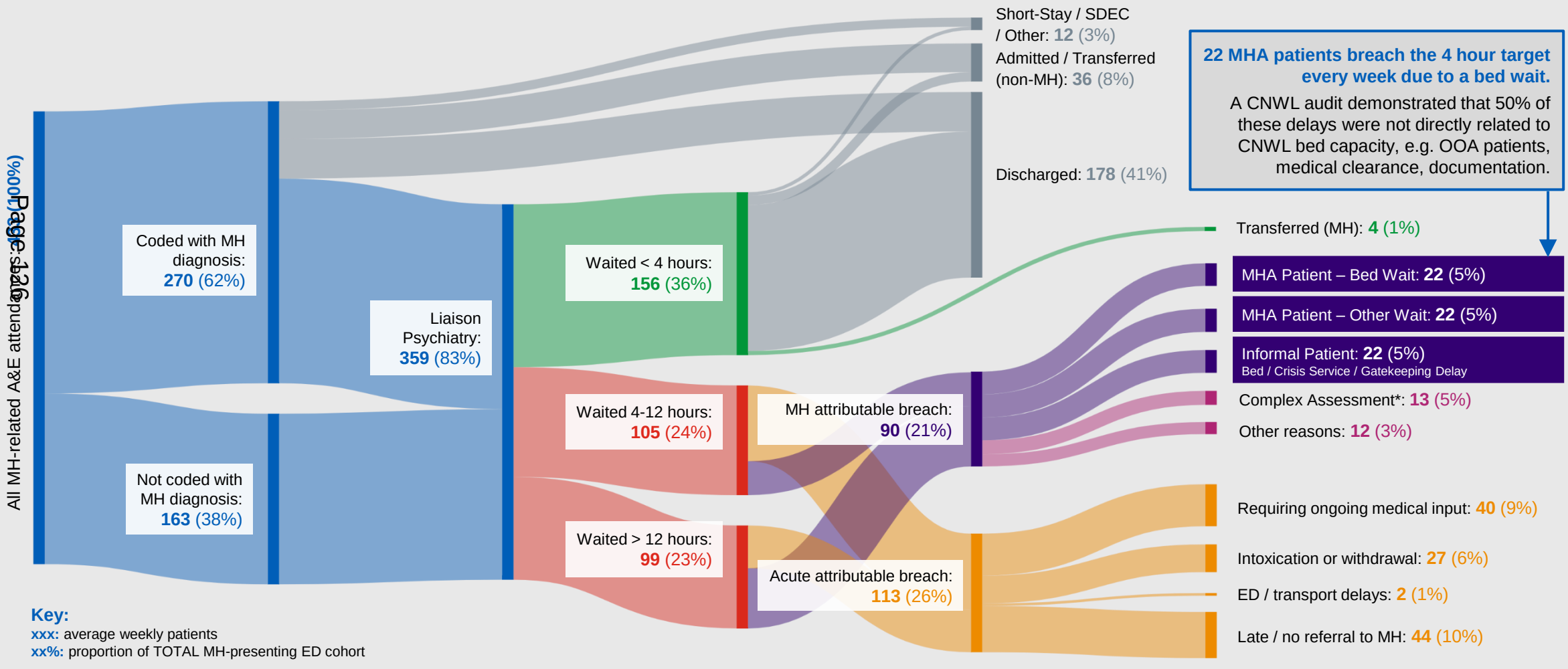
Split by waiting time bracket [Jan – Dec 2023]



Source: NWL ECDS Data [Jan 2023 – Dec 31st 2023] filtered by patients referred to Liaison Psychiatry.
Note: ECDS data is currently part of a thorough data quality improvement programme.

On average, over 98 mental health patients are required to wait over 12 hours in our A&E departments every week with 22 waiting over 4 hours due to a lack of mental health beds

- **433** patients attend our A&E departments every week with an urgent mental health need.
- **359** of these patients are referred to our Liaison Psychiatry teams, with **156** of these patients waiting less than 4 hrs, **105** patients waiting between 4 and 12 hrs, and **99** patients waiting over 12 hrs.

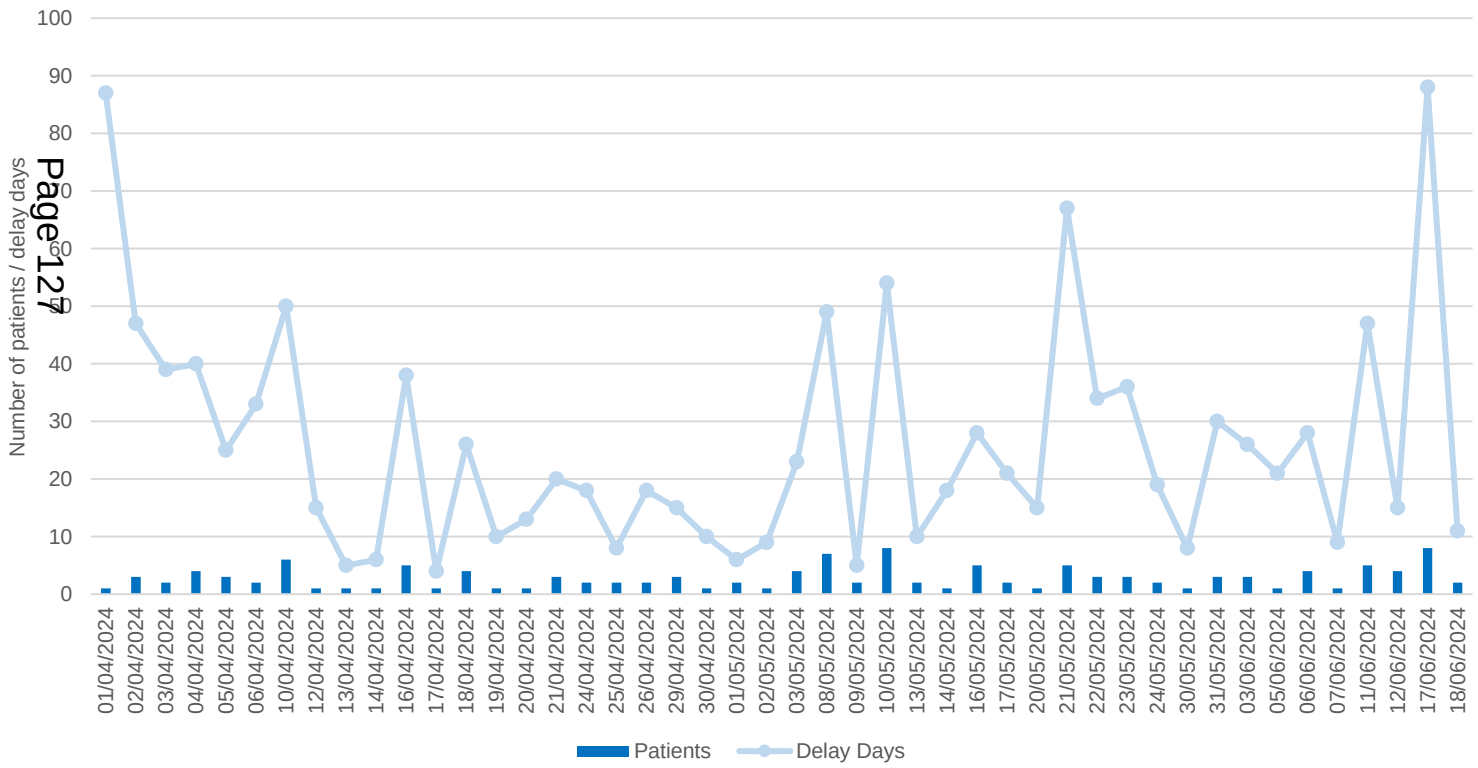


Sources: ***NWL ECDS Data (June 1st 2023 – May 31st 2024)*** used to quantify daily MH ED attendances and Liaison Psychiatry referrals using national logic. Breach reasons analysis derived from ***manual reporting collated by CNWL (June 5th 2023 – June 4th 2024)***. Note: ECDS data is currently part of a thorough data quality improvement programme. Where available, manual reporting takes precedence in quantifying total liaison psychiatry referrals, 4-12hr breaches and 12hr breaches.
*Complex assessments include items such as multiple reviews, interpreters required, appropriate adult required, medical queries, etc.

Across all NWL acute hospital wards, 129 patients were identified with discharge delays attributed to transfer to a mental health bed

Number of mental health patients admitted to an acute ward (physical health and the number of delay days

Snapshot [01 Apr- 18 Jun 2024]

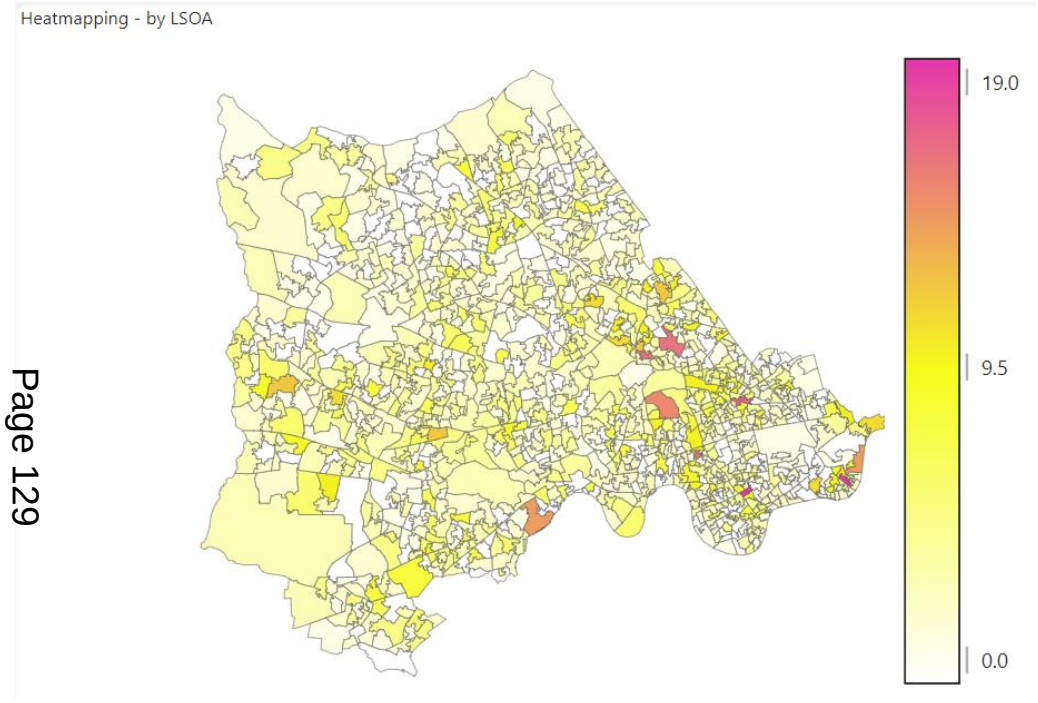


- A snapshot (01 April 2024 to 18 June 2024) of mental health patients in acute physical health beds awaiting admission to a mental health bed highlights that 129 discharge delays were attributed to waits for mental health beds.
- Approximately 26 patients (20%) were from a borough outside NW London but these were not generally the patients waiting the longest.
- Overall, the 129 patients were delayed for **1,204** days overall, which equates to approximately **15 beds** of **acute hospital capacity per day** over that period (0.5% of NWL's acute bed base).
- Each patient was delayed for an average of **9.3 days.**
- **Further work** is being completed to understand how many of these patients still required some level of acute care (e.g. intravenous fluids) that cannot be provided in acute mental health wards.

Source: NWL PM scorecard, 01 April 2024 to 18 June 2024

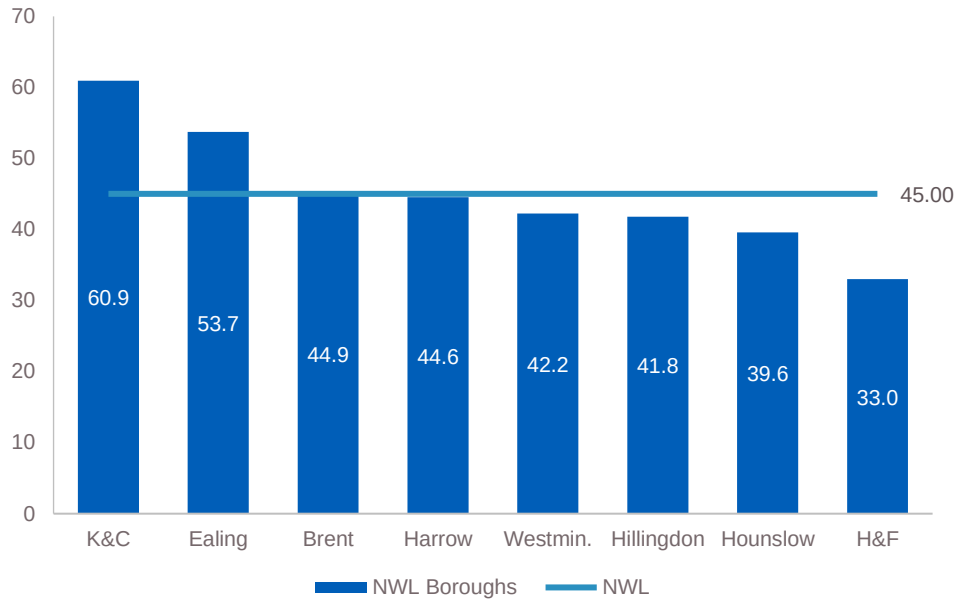
Acute/ inpatient care

There is variation in admissions and inpatient lengths of stay across our boroughs



Occupied bed days in acute mental health services
Per 100,000 population

Source: NWL local data, August 2023



- 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 increased access to integrated services in the community, 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 principles laid out in the Mental Health Capacity Act 2005 that mental health care should be in the least restrictive setting and acute inpatient care should only be used where there is no better alternative.

Modelling demonstrates that demand growth for inpatient services can be addressed through several transformation opportunities

MH Inpatient Services: Central Case Modelling Summary

Service	Current Demand [FY24 Outturn]	Demographic Growth [5 yrs]	Unmet Need Estimate [p.a.]	Future Demand [FY29 – 'Do Nothing']	Capacity [Current + Plan]	Transformation opportunities [p.a.]	(Surplus) / Deficit [FY29 – 'Do Something']
Adult Acute	**330** beds	**11 beds**	**8** beds for OOA patients **4** beds to better service ED long waits	**353** beds	**(343)** current **(8)** future	**(20)** [-6% admissions] **(20)** [-6% Av LoS] **+35** [adjustment to hit target occupancy of 90%]	**(2)** bed surplus
Older Adult Acute	**86** beds	**6 beds**	-	**93** beds	**(102)** current	**(12)** [-13% admissions] **(23)** [-28% Av LoS] **+6** [adjustment to hit target occupancy of 90%]	**(37)** bed surplus
Rehab	**144** beds	**6 beds**	-	**151** beds	**(144)** current	**(10)** [-6% Av LoS] **+16** [adjustment to hit target occupancy of 90%]	**13** bed deficit
PICU	**48** beds	**1 bed**	-	**49** beds	**(54)** current	**(0.3)** [-1% Av LoS] **+5** [adjustment to hit target occupancy of 90%]	**1** bed deficit
LTC / CC	**17** beds	**3 beds**	-	**20** beds	**(37)** current	**(9)** [-1% Av LoS] **+5** [adjustment to hit target occupancy of 90%]	**(25)** bed surplus

PICU: Psychiatric Intensive Care Unit; **LTC / CC:** Long-Term Complex / Continuing Care; **AvLoS:** Average Length of Stay.
Note: Demographic growth for each service differs due to the varying age profile and borough breakdown of demand for those service.

Adult Acute: Our ‘Central’ scenario demonstrates we can manage future demand through realising several transformation opportunities

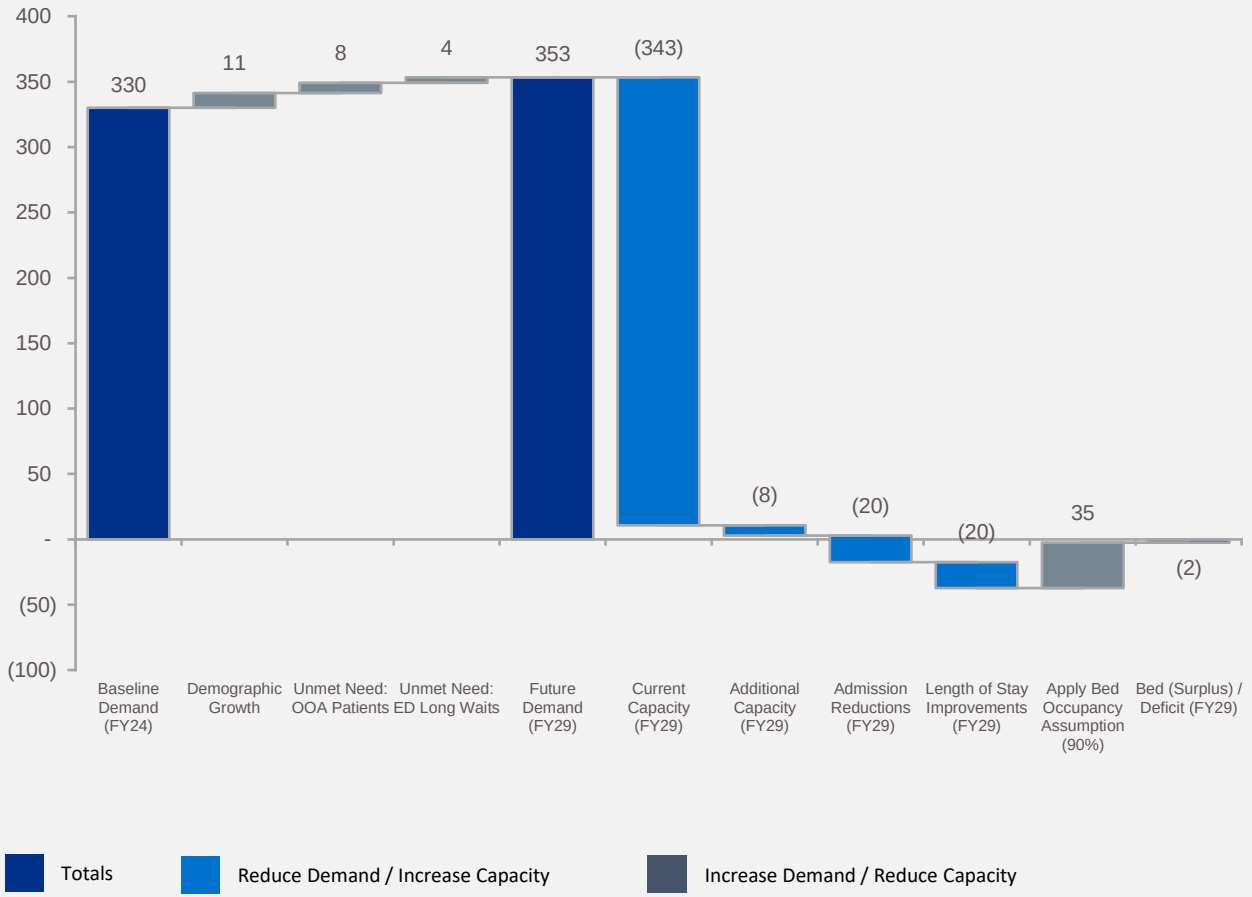
Adult (18-64) Acute Beds:

- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 50 beds** to a **surplus of 38 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for patients in crisis.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we currently have sufficient adult acute MH beds, assuming that we can appropriately transform our services.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**330**	**330**	**330**
Demographic Growth [FY24-FY29]	11	11	2
Unmet Need: OOA Patients [FY29]	8	8	8
Unmet Need: ED Long Waits [FY29]	4	4	4
Future Demand [FY29 ‘Do Nothing’]	**353**	**353**	**343**
Current Capacity [FY24]	(343)	(343)	(343)
Additional Capacity [FY24-FY29]**	(8)	(8)	(8)
Admission reductions [FY29]	-	(20)	(36)
Length of stay improvement [FY29]	-	(20)	(18)
Apply bed occupancy assumption	39	35	15
Bed (Surplus) / Deficit [FY29 ‘Do Something’]	**50**	**(2)**	**(38)**

Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].
*Further **Relates to a 16 bed ward being built at Park Royal, though 8 beds are currently temporarily being provided at Kingswood.

Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



Older Adult Acute: Our ‘Central’ scenario demonstrates we could have a bed surplus through achieving transformation opportunities

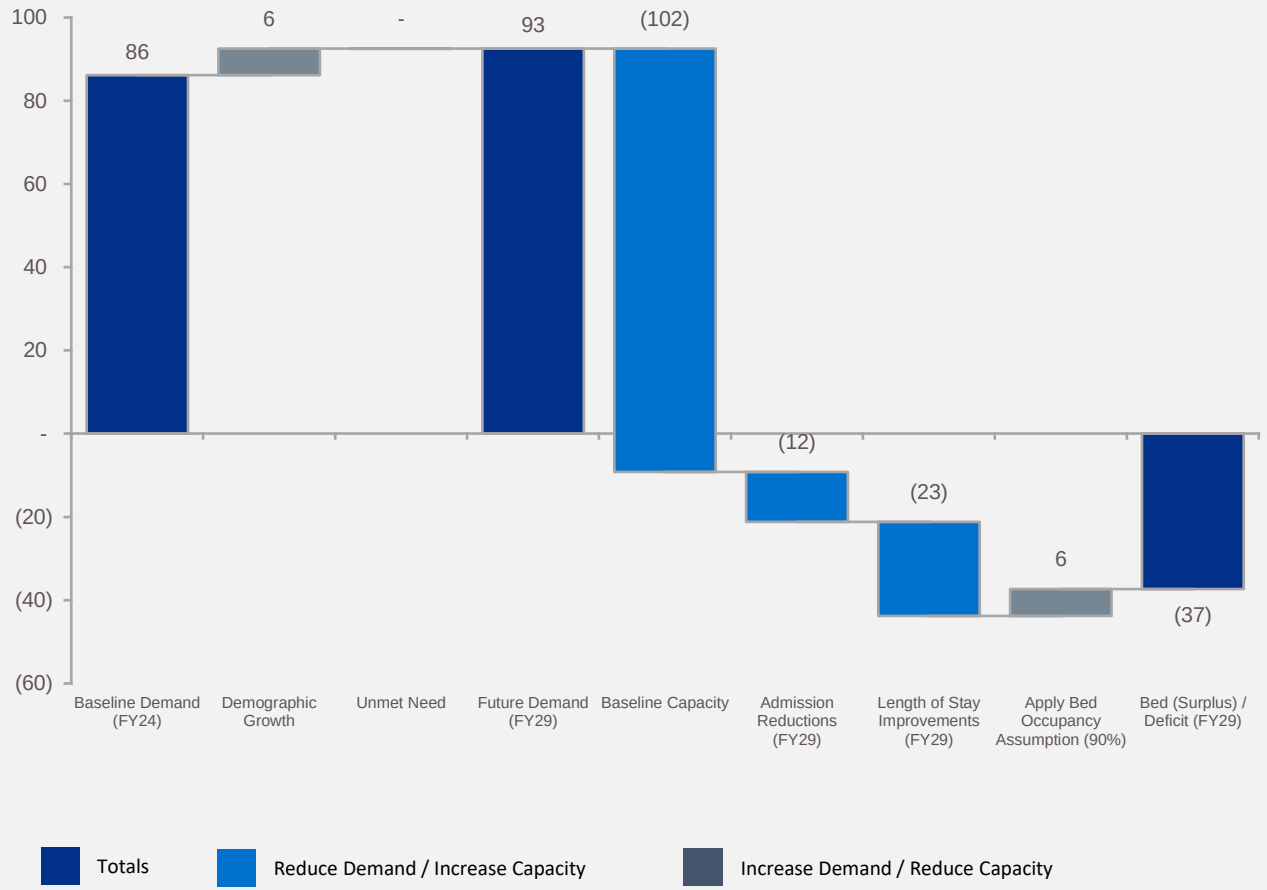
Older Adult (65+) Acute Beds:

- The modelling demonstrates that in **FY29, NWL’s** bed surplus / deficit could range from a **deficit of 1 bed** to a **surplus of 46 beds**, depending primarily on our ability to transform our services through reducing length of stay, reducing bed occupancy, and reducing admissions through providing alternative, more suitable settings for older adults.
- The **‘central case’ scenario** (which is the most realistic of the three scenarios) concludes that we will have plenty of beds for older adult acute patients, assuming we can transform our services appropriately.

Scenarios	Worst	Central	Best
Current Demand [FY24 outturn]	**86**	**86**	**86**
Demographic Growth [FY24-FY29]	6	6	10
Unmet Need	-	-	-
Future Demand [FY29 ‘Do Nothing’]	**93**	**93**	**97**
Current Capacity [FY24]	(102)	(102)	(102)
Admission reductions [FY29]	-	(12)	(22)
Length of stay reductions [FY29]	-	(23)	(21)
Apply bed occupancy assumption	10	6	3
Bed (Surplus) / Deficit [FY29 ‘Do Something’]	**1**	**(37)**	**(46)**

Sources: CNWL / WLT demand data and available beds data [Jan 2023 – Dec 2023].

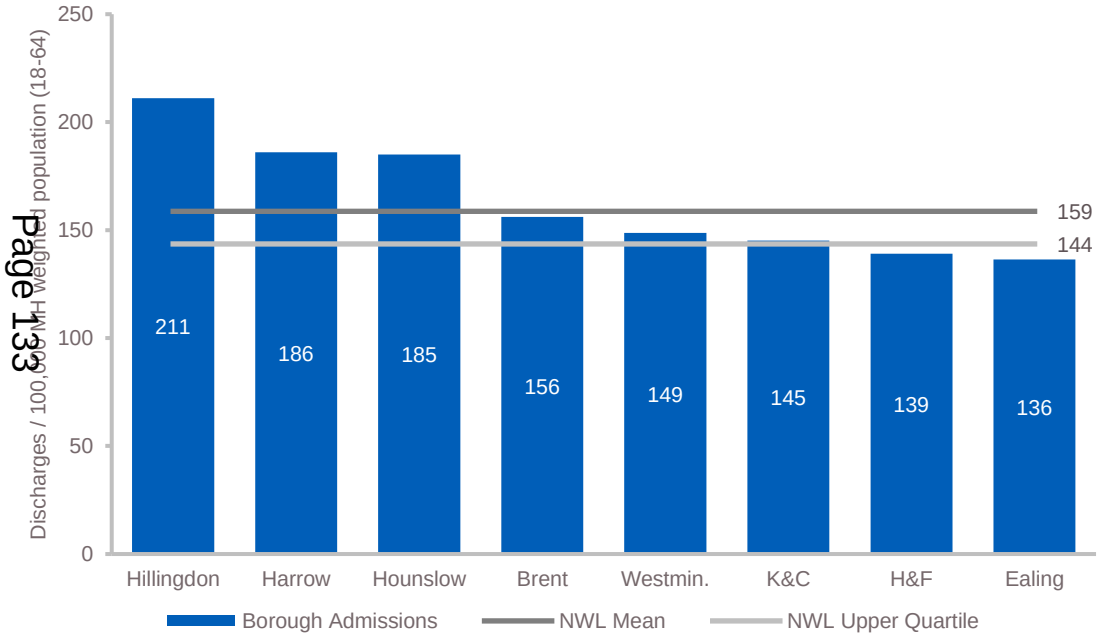
Older Adult (18-64) Acute Beds: ‘Central’ Case Modelling Scenario



Acute Admissions: Benchmarking within North West London shows some room for improvement in preventing admissions (e.g. by aligning care models)

Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark

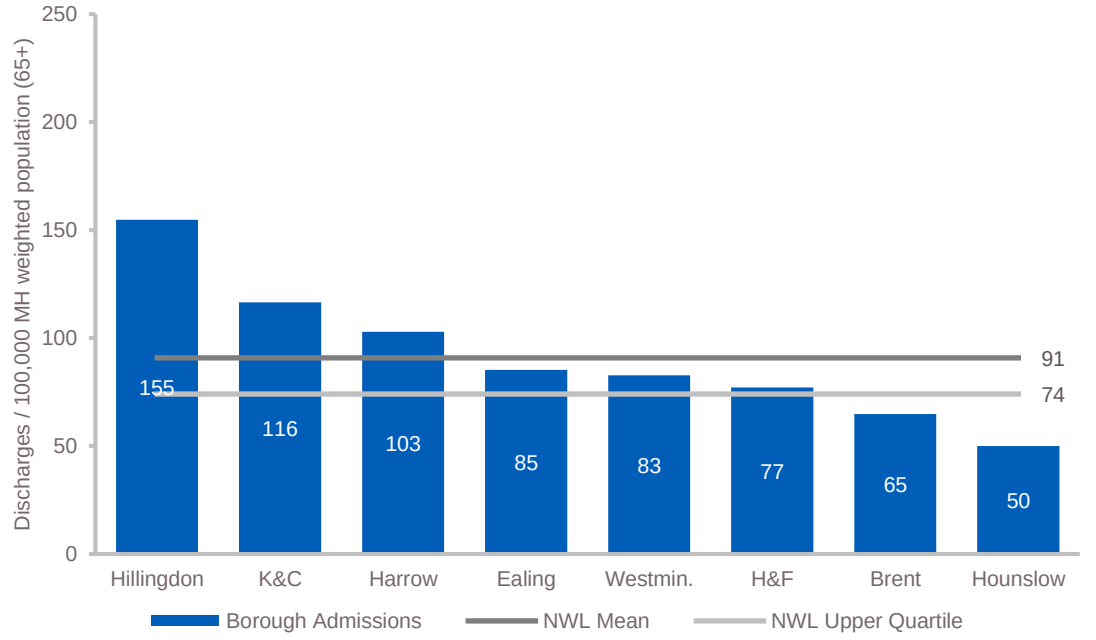


Reducing unwarranted variation:

- Internal benchmarking estimates an improvement opportunity of **6% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **11%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, and/or providing alternative services such as the Mental Health Crisis Assessment Service (MHCAS).

Older Adult Acute Admissions

per 100,000 MH weighted population (18-64): Jan – Dec 2023 benchmark



Reducing unwarranted variation:

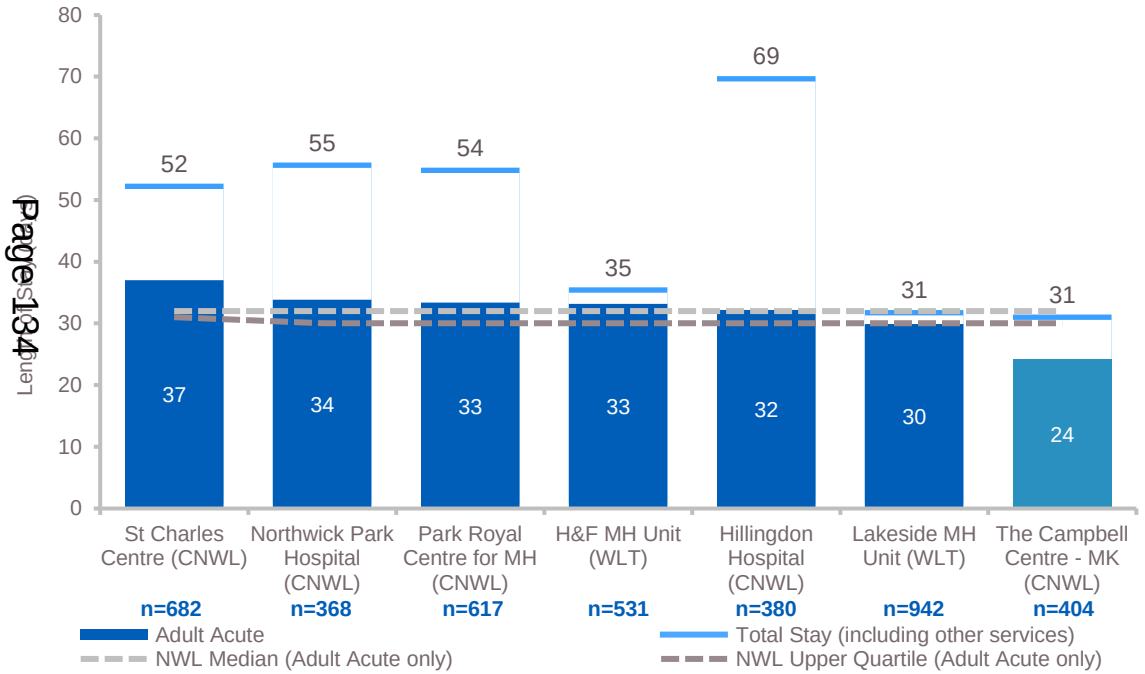
- Internal benchmarking estimates an improvement opportunity of **13% fewer admissions** across NWL, if all boroughs are able to achieve the NWL mean level of admissions – i.e. Hillingdon, Harrow and Hounslow are able to prevent unnecessary admissions.
- Boroughs achieving the NWL upper quartile would result in **23%** fewer admissions.
- This could be achieved by aligning care models, focusing on prevention, etc.

Sources: CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

Average Length of Stay for Acute Services: Benchmarking within North West London indicates some room for improvement in reducing average length of stay

Adult Acute:

Average length of stay by NWL (+ Milton Keynes) site [Jan – Dec 2023]

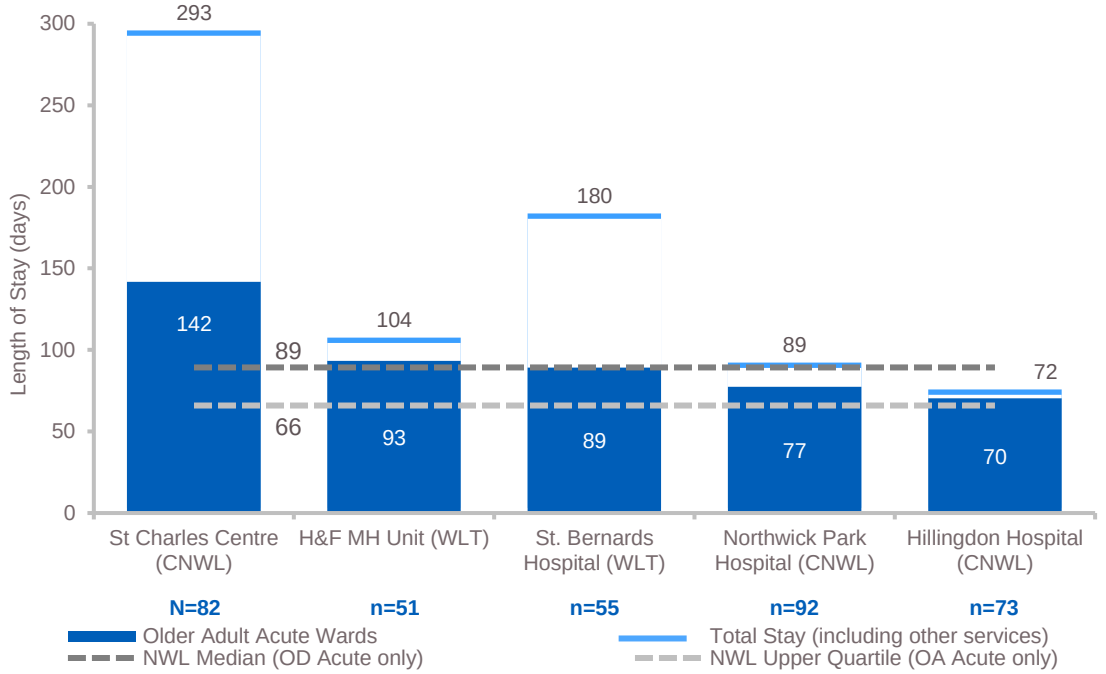


Reducing unwarranted variation:

- Benchmarking estimates an improvement opportunity of **3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **32 bed days** (from an Av. LoS of 33.1).
- Benchmarking estimates an improvement opportunity of **7% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **31 bed days.**
- Av. LoS could be reduced by 16% if each site were able to achieve the NWL upper decile performance (27.6 bed days).

Older Adult Acute:

Average length of stay by NWL site [Jan – Dec 2023]



Reducing unwarranted variation:

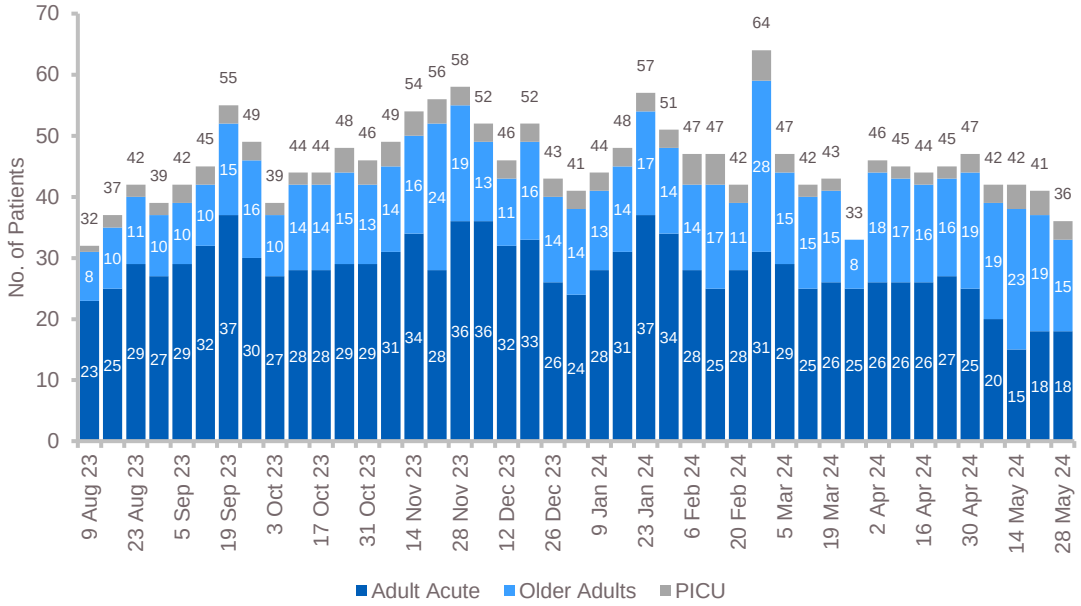
- Benchmarking estimates an improvement opportunity of 1**3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **89 bed days** (from an Av. LoS of 91.6).
- Benchmarking estimates an improvement opportunity of **20% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **77 bed days.**

Sources: CNWL / WLT patient-level activity data [Jan 2023 – Dec 2023]. Av. LoS excludes leave.

At any time over the past 10 months there were c. 43 patients that were clinically ready for discharge from a mental health bed

Patients Clinically Ready for Discharge (CRFD)

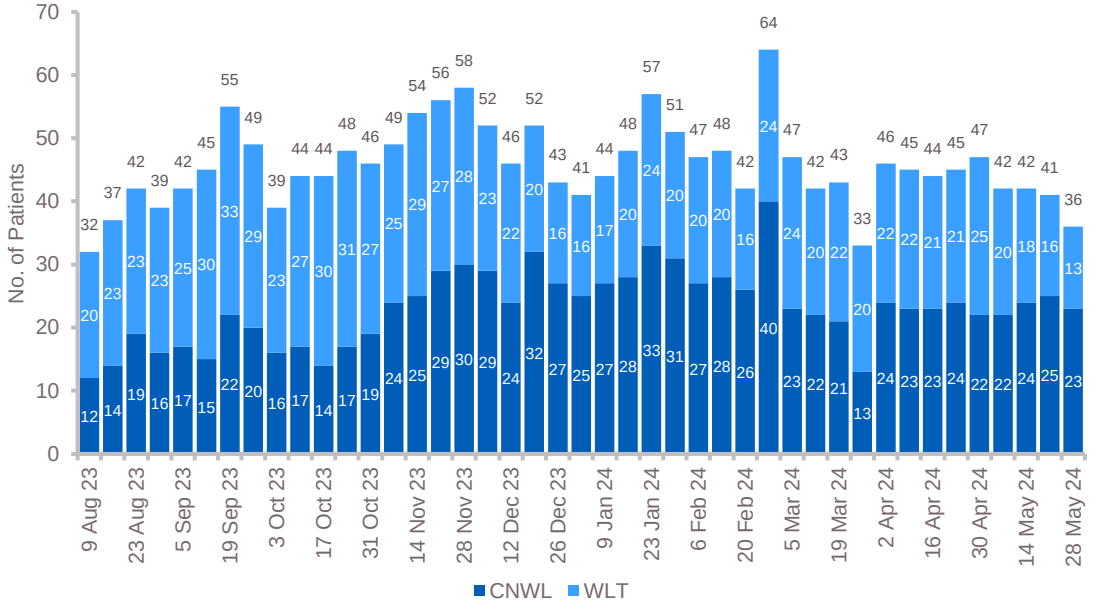
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]



- On any given day, there has been 32 – 64 patients that are clinically ready for discharge (CRFD) over the period August 2023 to May 2024.
- This is driven primarily by patients in Adult Acute beds and Older Adult Acute beds (approximately in line with our overall bed base).

Patients Clinically Ready for Discharge (CRFD)

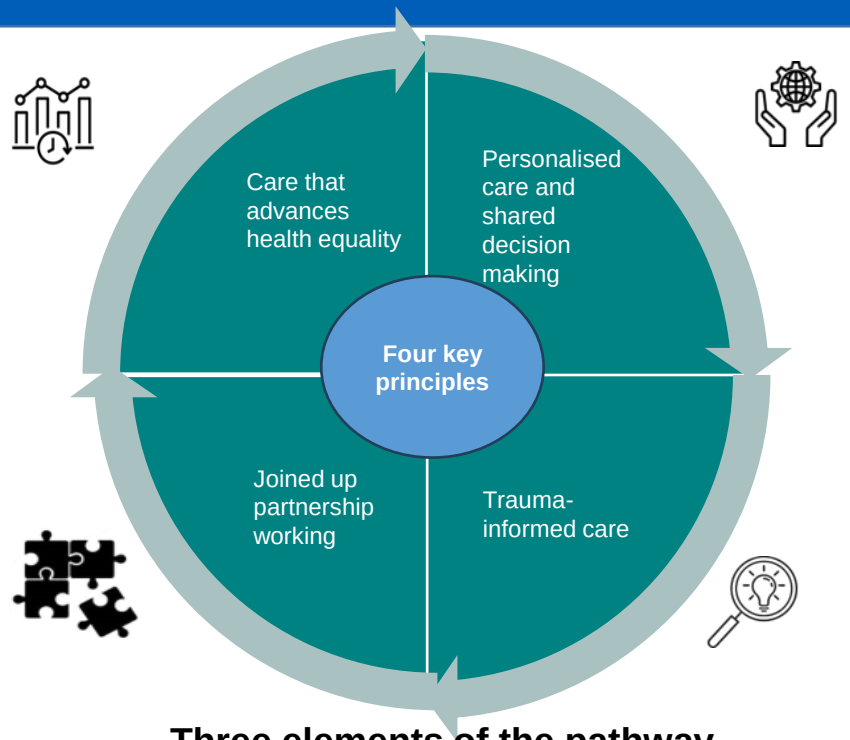
Split by service / bed type: Manual weekly audits [Aug 2023 – May 2024]



- The chart above shows a steady increase in CRFD over the winter period, with approximately 45-55 CRFD patients, though this has started to decrease in recent weeks.
- This implies that average length of stay (and therefore our overall requirement for MH beds) could be reduced substantially by carefully diagnosing and resolving delays in discharge – for example through working with our ICS housing partners.

Sources: NWL CRFD Dataset (manually submitted weekly since Aug 2023)

As part of the Quality Transformation Programme, NWL is developing a plan to localise and realign mental health, learning disability and autism inpatient services



Three elements of the pathway

Purposeful admissions

Therapeutic inpatient care

Proactive discharge planning an effective post discharge support

Two key enablers

A fully multidisciplinary, skilled and supported workforce

Continuous improvement of the inpatient pathway. Using data, co-production and quality improvement methodology

Purposeful admissions

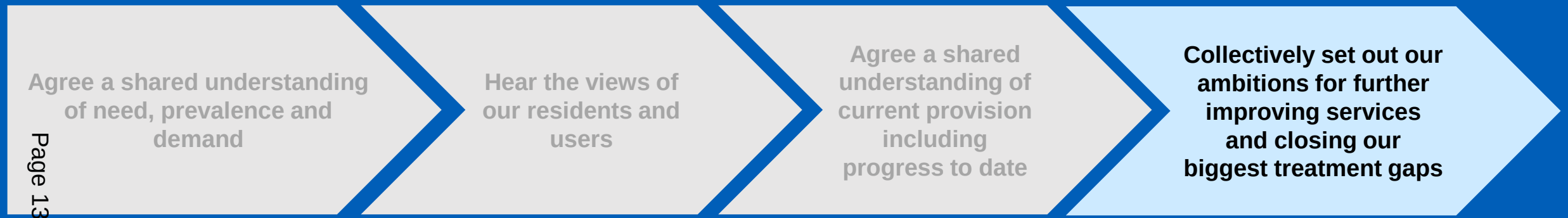
People are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available bed for the persons needs and there is a clearly stated purpose for the admission.

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chose carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

Proactive discharge planning an effective post discharge support

Discharge is planned with the person and chosen carer/s from the start of their inpatient stay, so they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an in-patient setting, with all planned post-discharge support provided promptly on leaving hospital.


Agree a shared understanding of need, prevalence and demand
Hear the views of our residents and users
Agree a shared understanding of current provision including progress to date
Collectively set out our ambitions for further improving services and closing our biggest treatment gaps

We have four key themes

We will work together in trusted partnership to build a supportive community environment that harnesses a broad range of roles, providers and sectors to enable care and support, recognising and advocating for the skills, expertise and benefit of the whole community. We will improve access to education, training, employment and broader health settings and interventions to promote good mental wellbeing for all.

Organisations and services that support residents' mental health, in both statutory and VCSE sector, will be equipped to meet the diverse health and social needs of the local population in a culturally effective manner. There will be a clear emphasis on prevention, early intervention, maximising independence and embedding strengths based approaches to both community and individual interventions.

For people (including carers) in crisis or requiring an urgent response, they will be able to access a multi-agency response that supports a holistic psycho, social and welfare approach to preventing, supporting and managing the crisis.

Care will be delivered in the least restrictive setting, but when hospital based care is required, it will be delivered in a timely way, by an expert team, within a therapeutic and compassionate environment.

Detailed recommendations (1)

1) **Prioritise equity and equality of access** to services, using local data to drive co-produced service developments that meet the needs of specific communities; ensuring locally tailored and culturally appropriate solutions to improve access for these groups.

2) **Raise awareness** across North West London so that **every resident knows how to access mental health support** both in crisis and more widely in the community, also aiming to reduce stigma in all communities and prevent suicides.

3) Ensure **local community mental health offers are provided more widely** in each borough where people can access help with social issues and gain meaningful employment, with a view to seeking help earlier to prevent mental health problems and crisis.

4) Provide **signposting to mental health support in each local authority housing department** in North West London and ensure close liaison between mental health and housing services by having named link staff with expertise in this area.

5) Support further **integration between primary care and mental health services** to facilitate better joined up working so that care can be delivered in the right setting, at the right time, to respond to the needs of patients.

6) **Reduce waiting times** for therapeutic interventions within our community services to be better than the London average, and where waiting is necessary, **support patients and carers to 'wait well'** with up to date information on waiting times, self help information and community resources that can provide additional engagement and support.

Detailed recommendations (2)

7) Ensure equitable access and **consistent provision in North West London of crisis alternative services to A&E and admission**, and raise awareness so that all residents know where and how to access these in times of crisis.

8) Ensure **appropriately adjusted mental health services that use trauma informed approaches** are available for different groups, such as young adults and neuro-diverse adults, informed by local and national analysis.

9) **Review the quality of our inpatient services** to ensure we are providing timely care, by an expert team in a therapeutic and compassionate environment.

10) **Continue to push productivity, in particular:**

a) **Optimising inpatient lengths of stay** so that no patient stays in hospital longer than they need to, by improving early discharge planning with system partners and post discharge support in order to reduce re-admission to hospital.

b) **Reducing unwarranted variation** in caseloads and staffing so that patients receive person-centred and timely care from community mental health teams.

11) **Improve staff retention** and continue our good track record with growing our own. Review the impact of service change on staff, with a view to supporting culture change and managing workloads so that staff vacancies and turnover does not reduce the effectiveness of service developments.

12) **Invest in and support the Voluntary, Community and Social Enterprise Sector (VCSE)** to enable locally tailored and visible, community support services; building capacity in providers to plan and develop their services for patients.

Our shared aims and ambitions for adult mental health services for the future

By 2028/29 we will have:

Ambitions	Outcomes
RAISED AWARENESS AND PROMOTING WELLBEING • Raised awareness across North West London so that every resident knows how to access mental health support both in crisis and more widely in the community. • Developed an assets-based approach to promoting mental health, wellbeing and independent living, partnering with and investing in local community organisations.	• Services responsive to population health needs and flexibly delivering changes with no unwarranted variation in outcomes. • Locally tailored and visible, community support services; built capacity in providers to plan and develop their services for patients. • Patients and staff reporting better experiences. • Optimal community and inpatient capacity to respond to growth in need whilst delivering our transformation goals and increasing care in a community setting. • All people known to mental health services with a crisis management plan that supports them to use crisis alternatives to A&E for de-escalating their needs, where there is no physical health need. • No person staying longer in a mental health bed than they need to. • Integrated solutions to housing pathways. • More people gaining and staying in meaningful employment. • Zero adult inappropriate acute inpatient stays outside of North West London.
INCREASED EQUITY AND EQUALITY OF ACCESS • Increased equity and equality of service access to reflect different needs of our local and diverse communities, with greater targeted support to those with severe mental illness. • A consistent core offer for community and crisis care for adults, with a focus on severe mental illness, that also enables flexibility for local and diverse needs. • Reduced variation and increased productivity in caseloads and staffing across community services. • Improved staff recruitment and retention. • Waiting times measuring in the top quartile in England.	
CARE IN THE RIGHT PLACE • Integrated care between primary care and mental health teams to enable more person-centred care and a greater focus on adults with severe mental illness. • High quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment. • Worked together with our Local Authority partners to develop solutions to the housing and employment pathway challenges.	Enabled by: • Increased funding into mental health, benchmarked with other areas nationally, in line with the medium-term financial plan, alongside increased productivity of services • Allocated resource based on need. • Consistent suite of outcome measures to demonstrate the value delivered

Proposed phasing

	Ambition	Year 1	Year 2	Year 3	Year 4	Year 5
RAISED AWARENESS AND PROMOTING WELLBEING	Every resident knows how to access mental health support both in crisis and more widely in the community	• Agree local demographic data and local insights to understand barriers to access • Identify target groups with lower access	• Develop outreach models	• Implement outreach models for target groups with barriers to access/ lower levels of access		
	An assets-based approach to promoting mental health, wellbeing and independent living	• Review community mental health support offer • Develop common support offer	• Review delivery partner capacity	• Build capacity in VCSE to enable greater testing/ delivery of models		
INCREASED EQUITY AND EQUALITY	Increased equity and equality of service access to reflect different needs of our local and diverse communities, with targeted support for SMI	• Identify target groups with largest variation • Identify actions to reduce variation	• Take forward actions to reduce variation in outcomes and experience			
	A consistent core offer for community and crisis care for adults, with focus on SMI, that also enables flexibility for local and diverse needs	• Review current offer(s) • Develop common community and crisis offer	• Move towards common offers using productivity improvements and/ or resource			
	Reduced variation and increased productivity in caseloads and staffing across community services	• Single approach to monitoring, baselining and evaluation to identify areas for action	• Embed QI approach, with initial focus on older adults	• Agree further set of initiatives, with continued shared learning		
	Improved staff recruitment and retention	• Recruitment to the top five hard to fill vacancies (MH nurses)				
	Waiting times measuring in the top quartile in England	• Develop standard approach to waiting well information across all services	• Identify services that have the longest waits or greatest need, along with indicative opportunities	• Take forward opportunities, better informed by population health management		
CARE IN THE RIGHT PLACE	Integrated care between primary care and mental health teams, with focus on SMI		• Consider further opportunities of Mental Health ARRS in primary care	• Mapped to the further development of Integrated Neighbourhood Teams		
	High quality inpatient facilities	• Review inpatient facilities in line with developing plan	• Implement as per Inpatient Quality Transformation Plan			
	Develop solutions to the housing and employment pathway challenges	• Expansion in employment advisors in Talking Therapies	• Identify opportunities with LA on housing pathway	• Take forward opportunities, better informed by population health management		

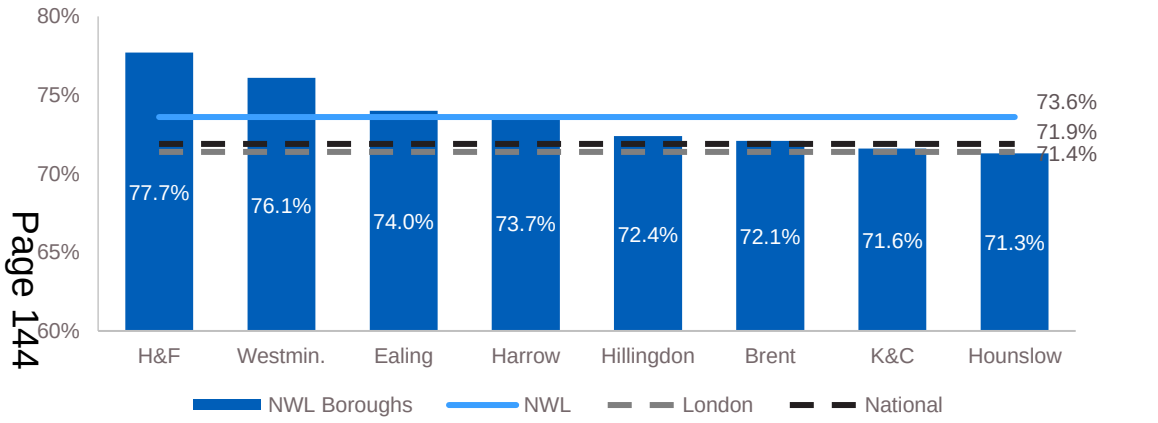
Appendix 1 – supporting information for needs assessment

NHS
North West London

~75% of people in North West London self report high happiness/ satisfaction this drops to below 30% for those with a high anxiety score

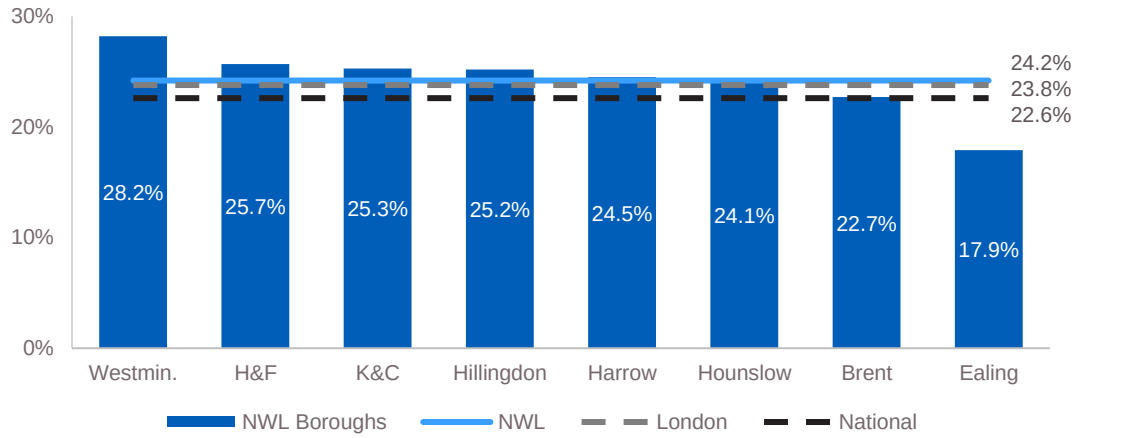
Self-reported happiness
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21



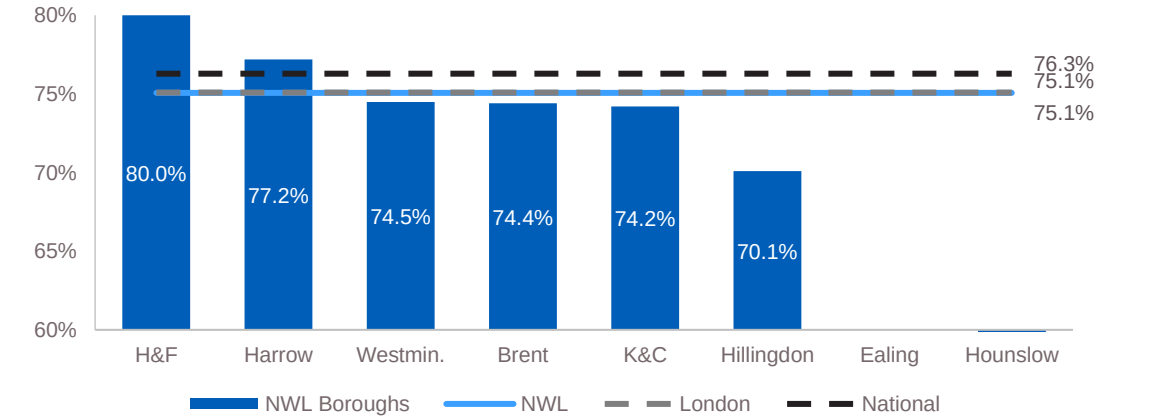
Self-reported anxiety
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21



Self-reported satisfaction
Percentage of respondents with a high score [2020/21]

Source: Public health profiles, OHID, 2020/21

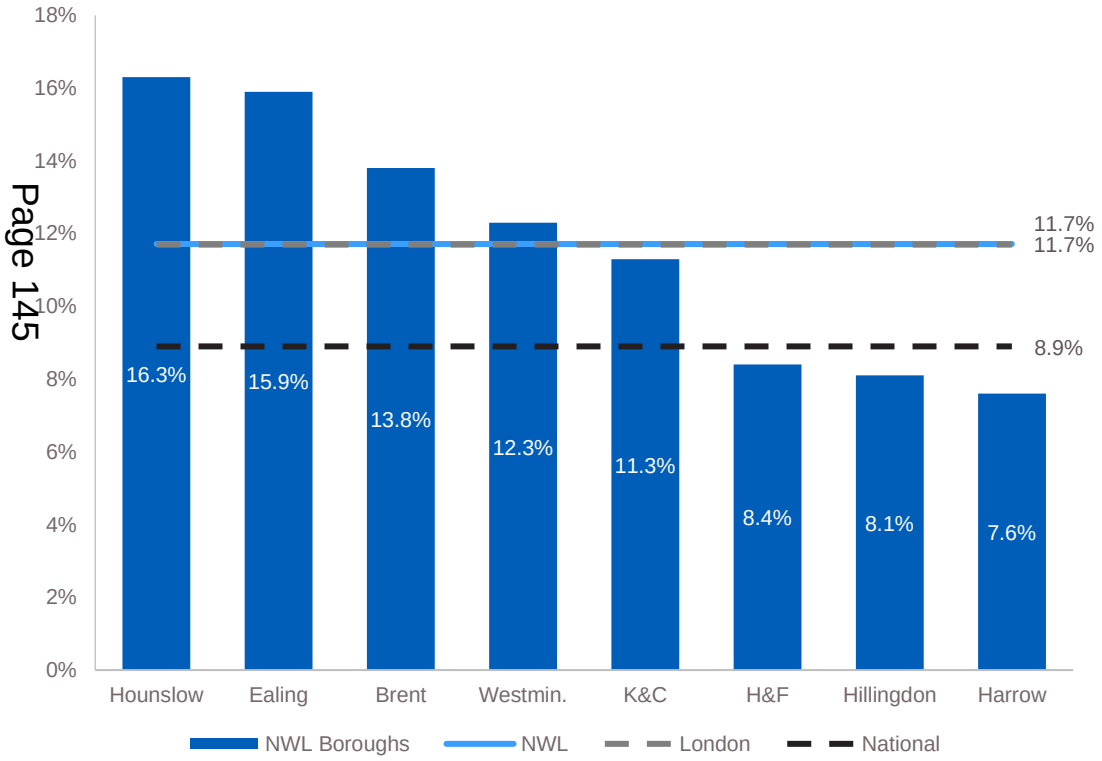


NHS North West London

Smoking rates are higher amongst adults with a long term mental health condition – and vary across Boroughs

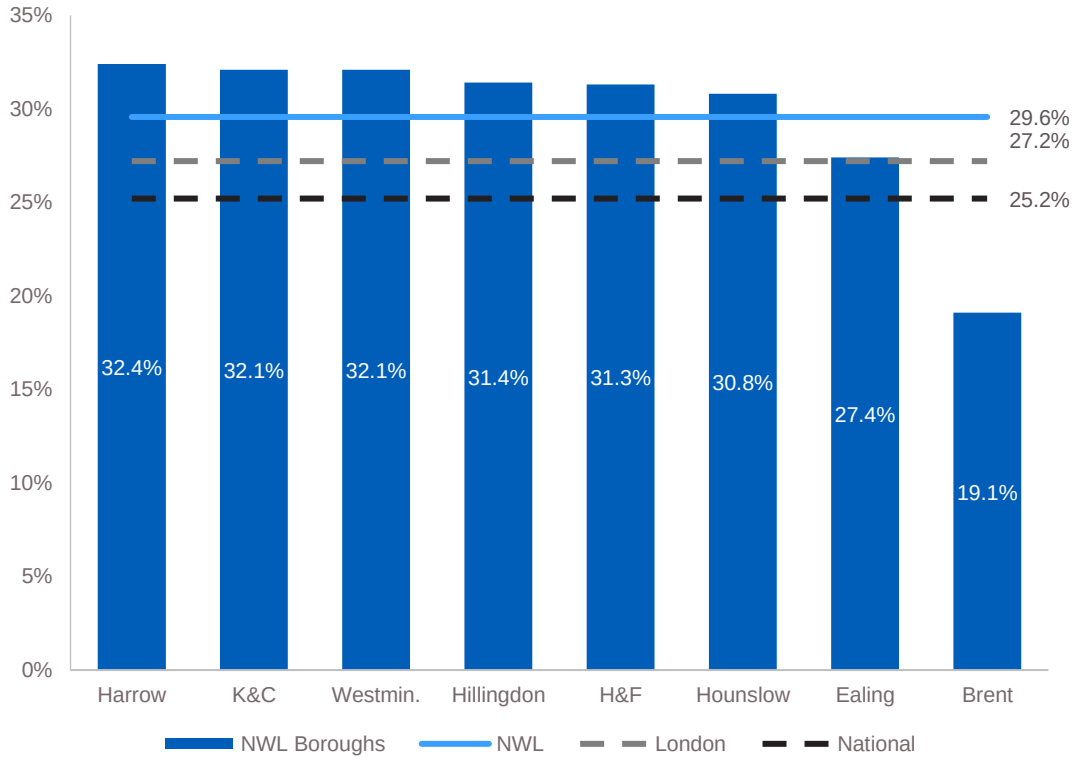
Smoking prevalence in adults (18+)
Current smokers as a percentage of adult population [2022]

Source: Public Health England, 2022



Smoking prevalence in adults with a long-term MH condition:
Current smokers as a percentage of population with MH conditions [2021/22]

Source: Public Health England, 2021/22

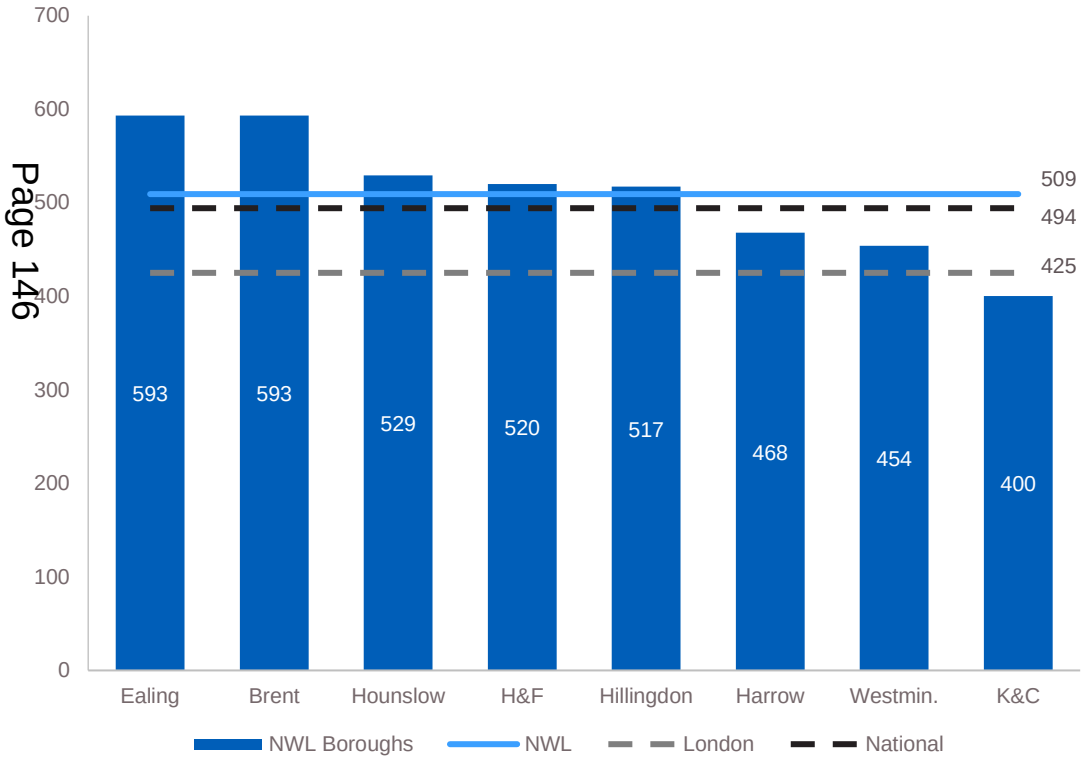


North West London

Alcohol misuse is a risk factor for poor mental health, with variable levels of prevalence and variable success rates

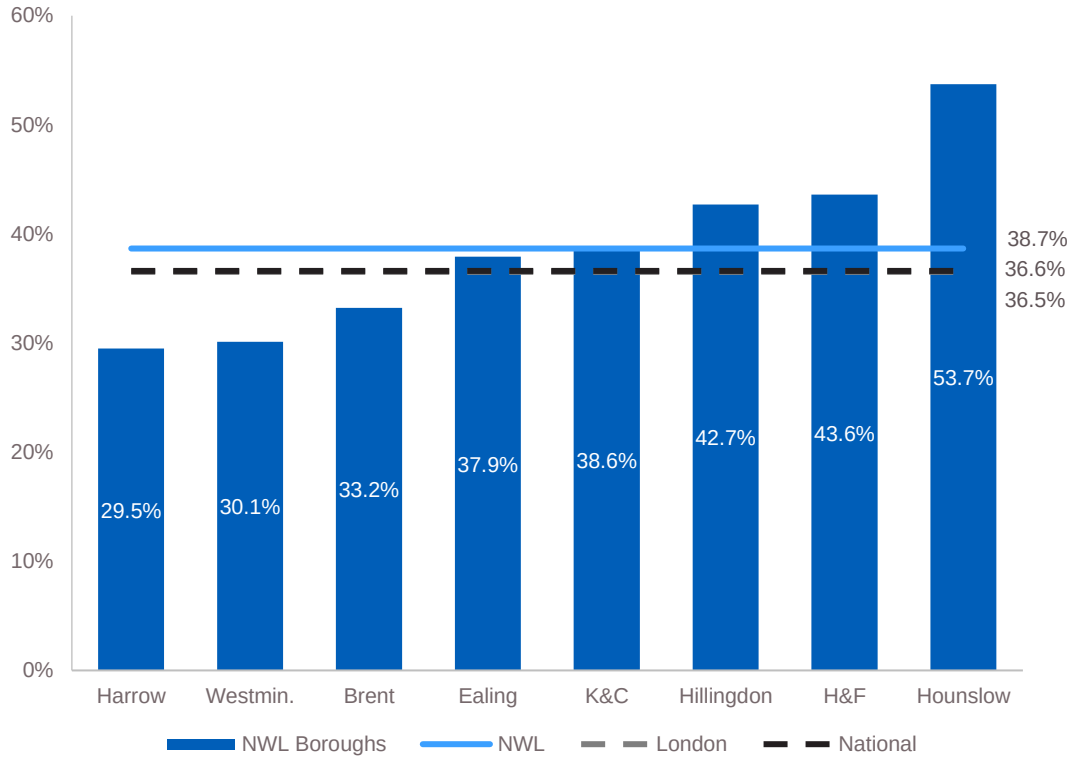
Admission episodes for alcohol-related conditions: Number of episodes (primary diagnosis) per 100,000 standardised population [2021/22]

Source: Public Health England, 2021/22



Successful completion of structured alcohol treatment: Percentage of alcohol users that left treatment successfully [2021]

Source: Public Health England, 2021/22

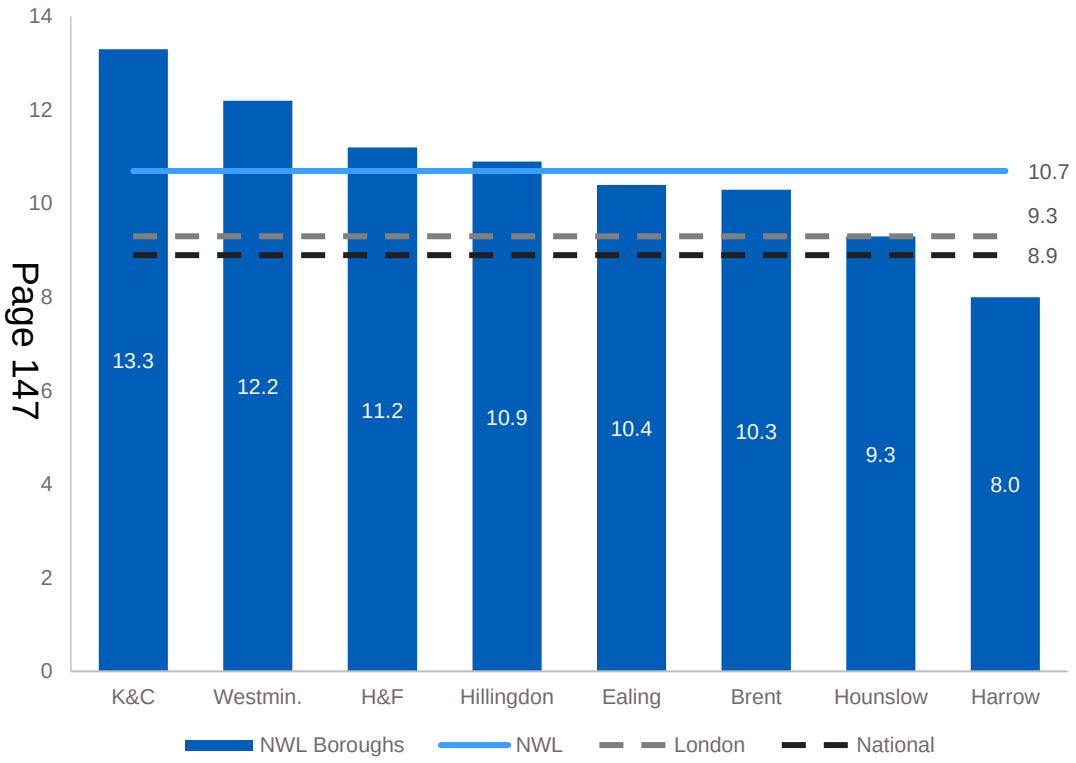


NHS North West London

Drug misuse is also a risk factor for poor mental health, with variable levels of prevalence and variable success rates

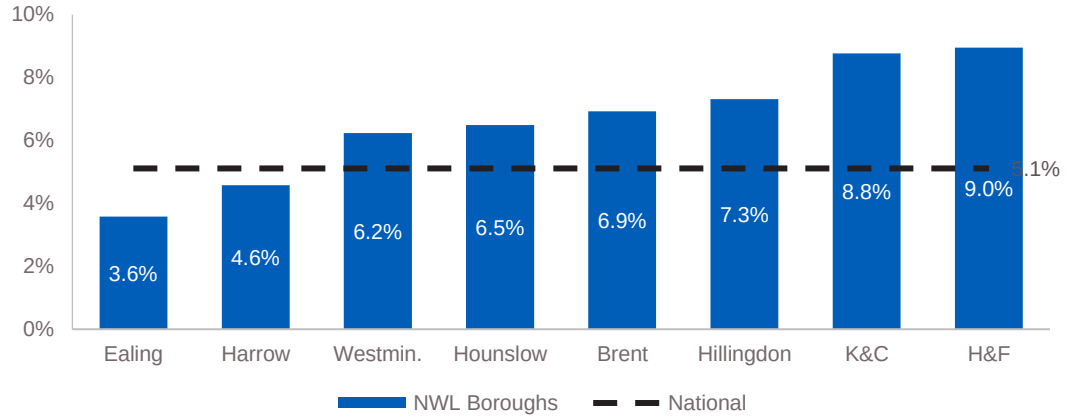
Estimated prevalence of opiate and/or crack cocaine use
Crude rate per 1,000 population aged 15-64 [2016/17]

Source: Public Health England, 2016/17



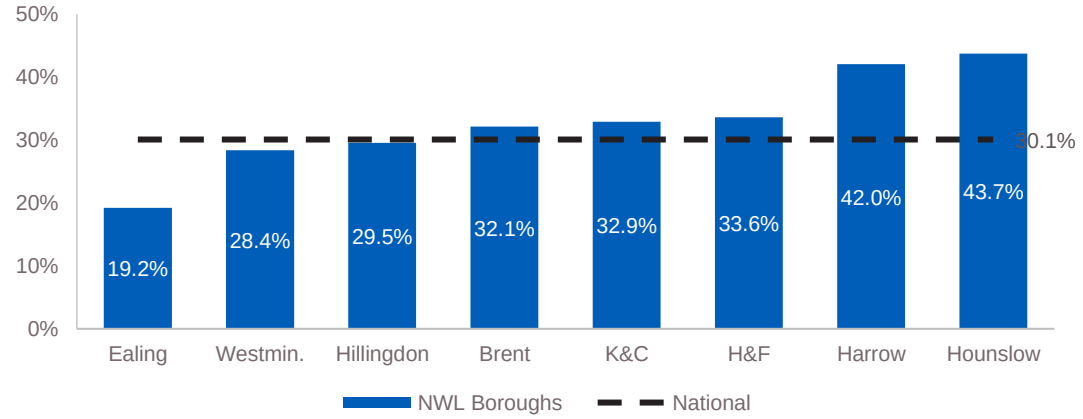
Successful completion of opiate treatment:
Percentage of treatment plans completed [August 2022 – July 2023]

Source: National Drug Treatment Monitoring System (NDTMS), 2023



Successful completion of non-opiate treatment
Percentage of treatment plans completed [August 2022 – July 2023]

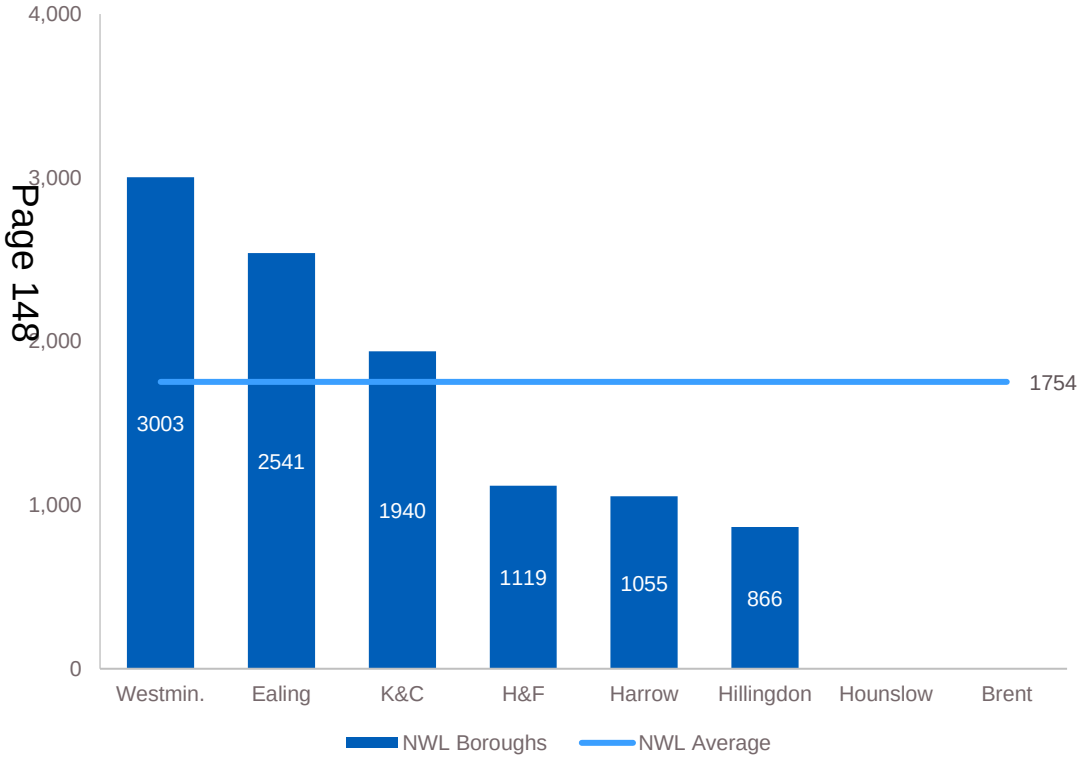
Source: National Drug Treatment Monitoring System (NDTMS), 2023



Housing is a challenge for c. 1/3 of people with more severe mental health conditions

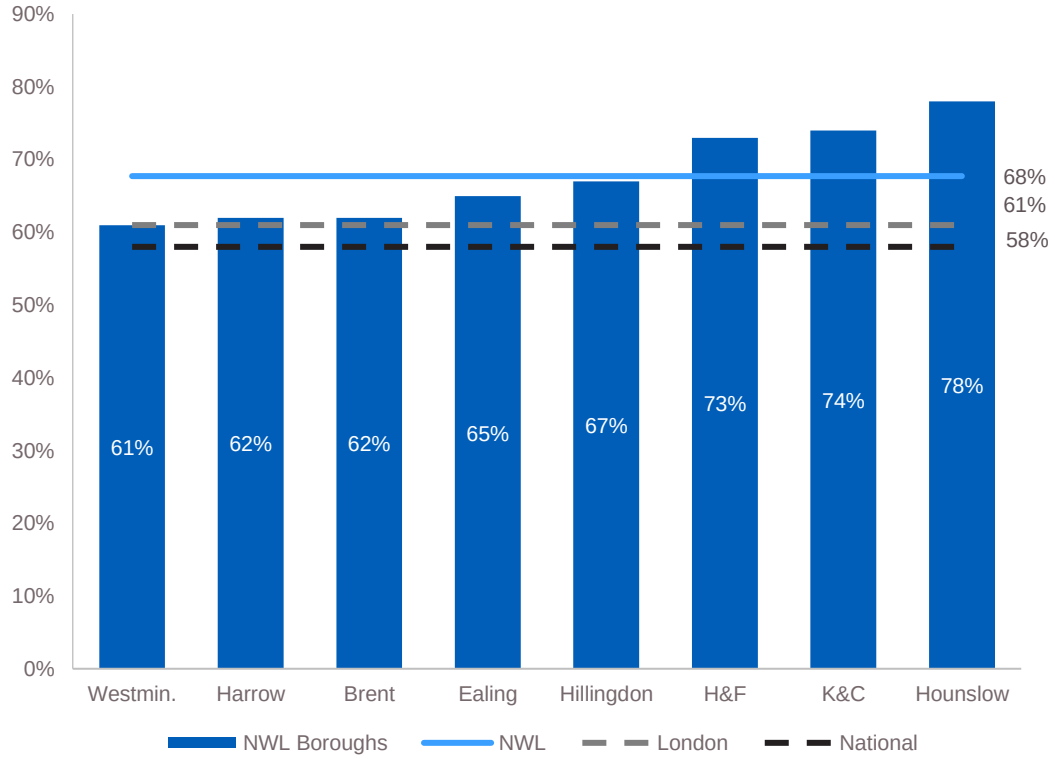
Homelessness: households in temporary accommodation
Total number of households [2023 Q1]

Source: Gov.uk, 2023 Q1



Adults receiving secondary MH services who live in stable and appropriate accommodation: Proportion of adults [2020/21]

Source: Public Health England, 2020/21

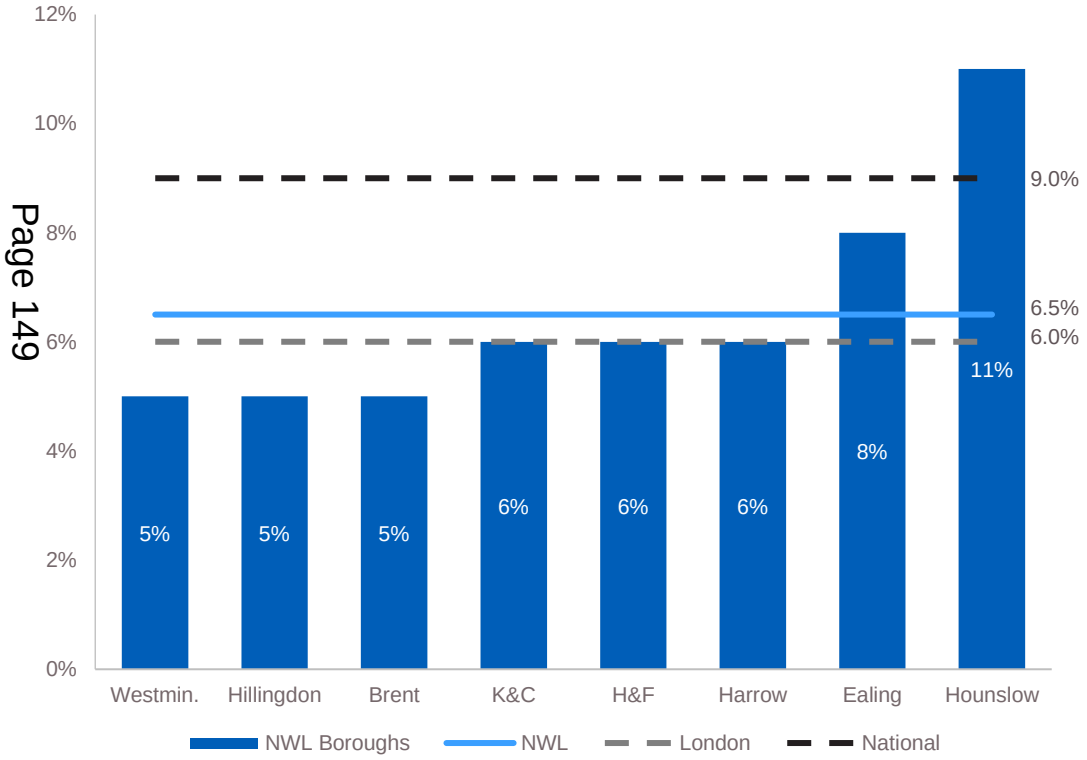


NHS North West London

Less than 3% of people in contact with secondary mental health services are in paid employment – versus over 60% with a physical/mental long term condition

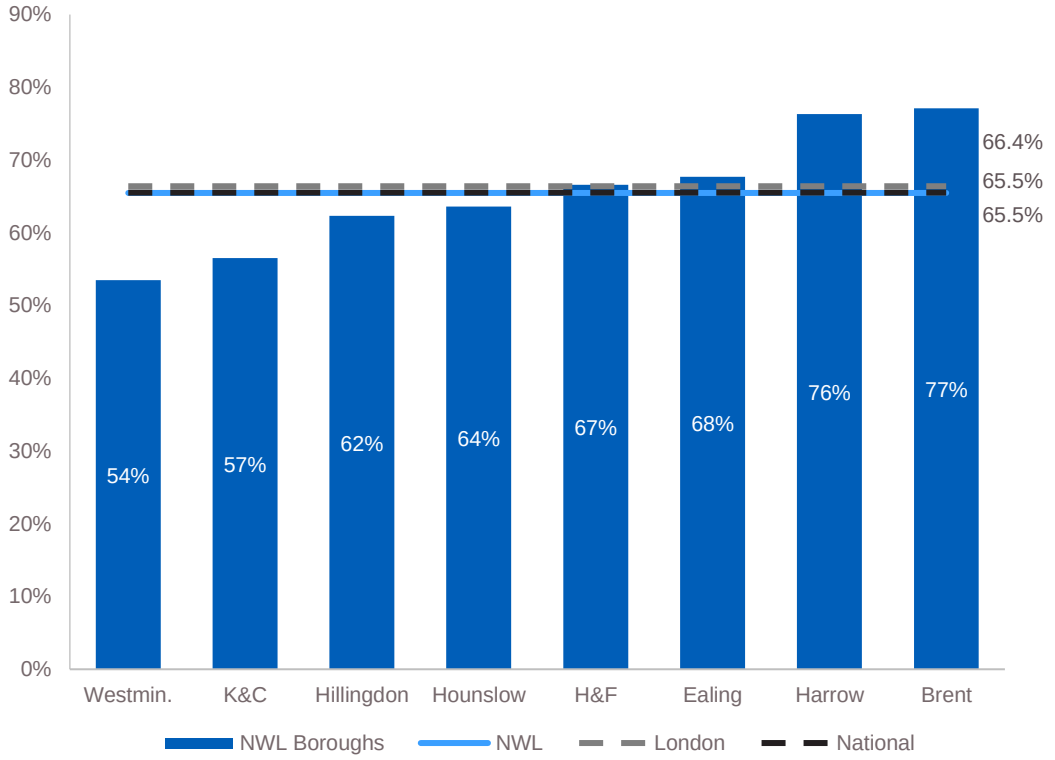
People receiving secondary MH services who are in paid employment: Proportion of people [2021/22]

Source: Public Health England, 2021/22



People with physical / mental LTC who are in paid employment: Proportion of people [2021/22]

Source: Public Health England, 2021/22

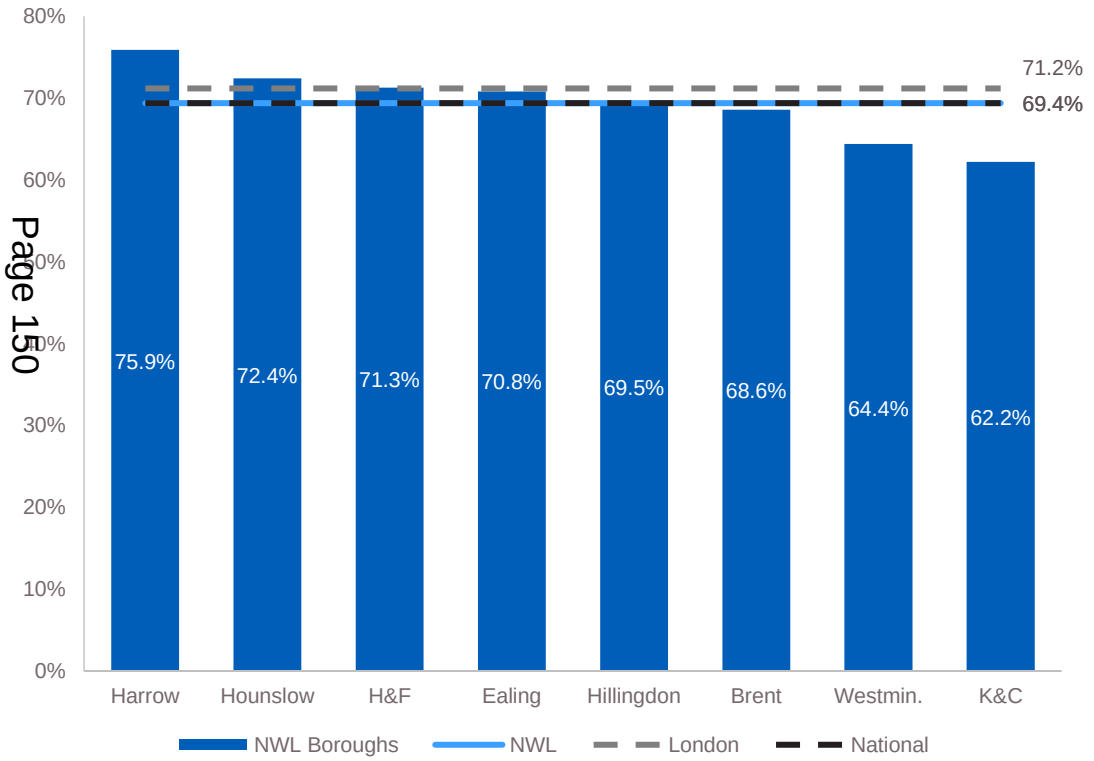


NHS North West London

People helped into employment are less likely to need support from community mental health services and have further inpatient admissions

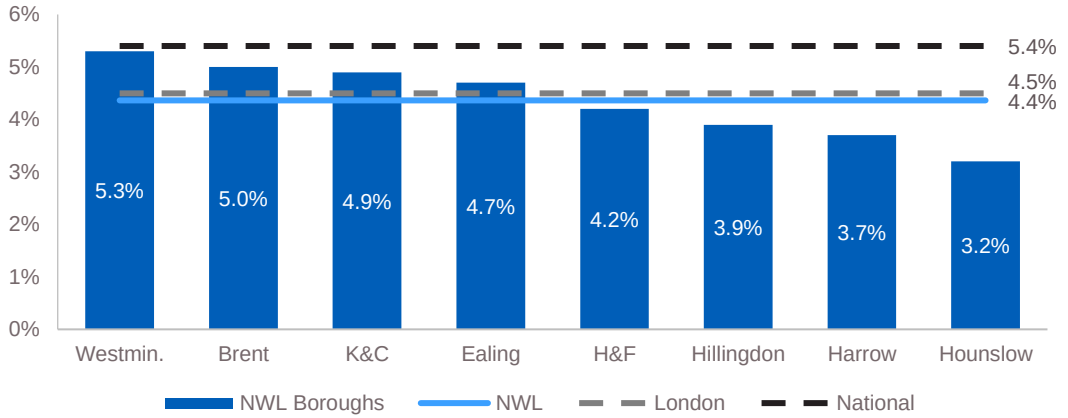
Gap in employment rate for those who receive secondary MH services: Percentage point difference with overall rate [2021/22]

Source: Public Health England, 2021/22



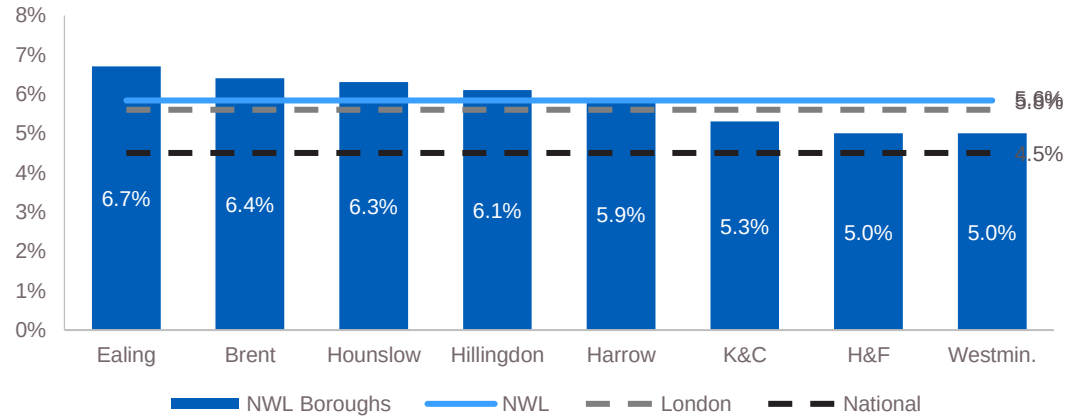
Employment and support allowance claimants: Proportion of population [2018]

Source: Public Health England, 2018



Unemployment rate: Percentage of over 16 population who are unemployed

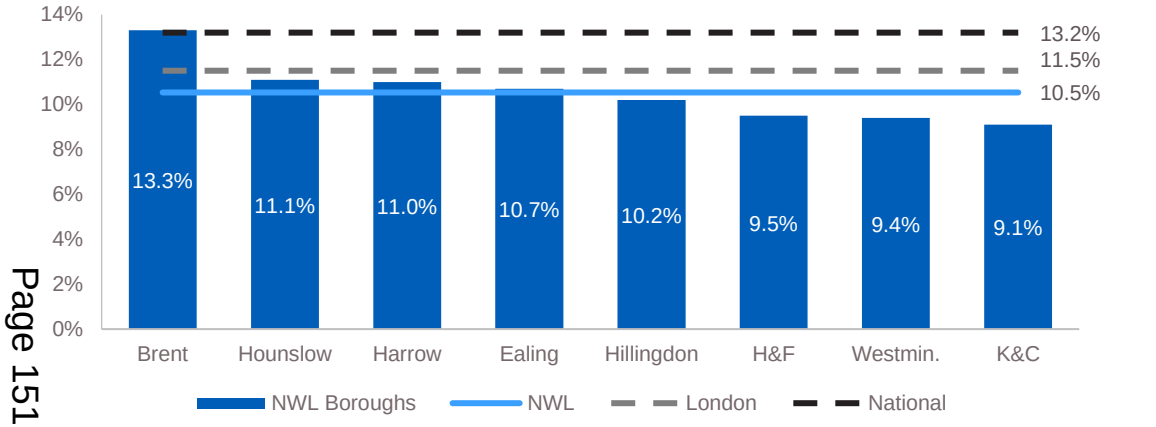
Source: NOMIS – Labour Force Survey, 2021-22



Other risk factors related to mental health problems

Fuel poverty (households with low income, poor energy efficiency, energy prices): Proportion of households in fuel poverty [2020]

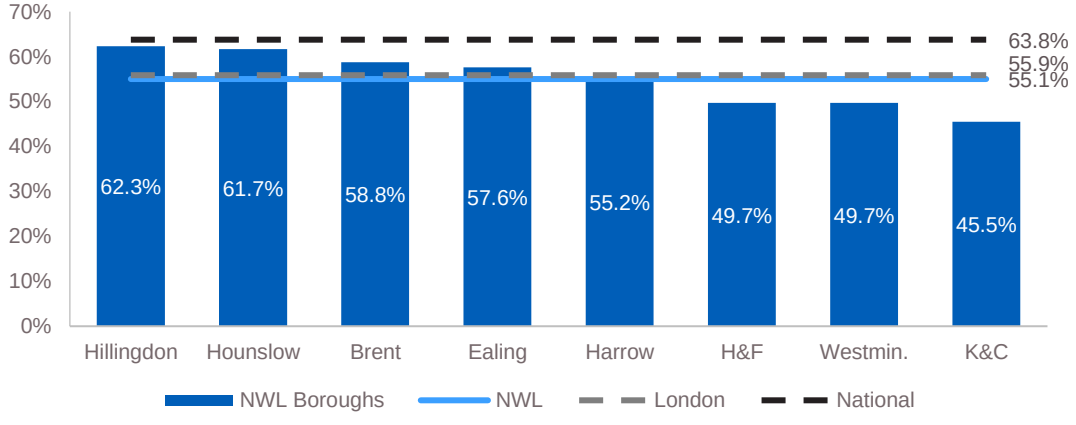
Source: Gov.uk, 2020



Percentage of population classified as overweight or obese

Percentage of over 18 population [2021/22]

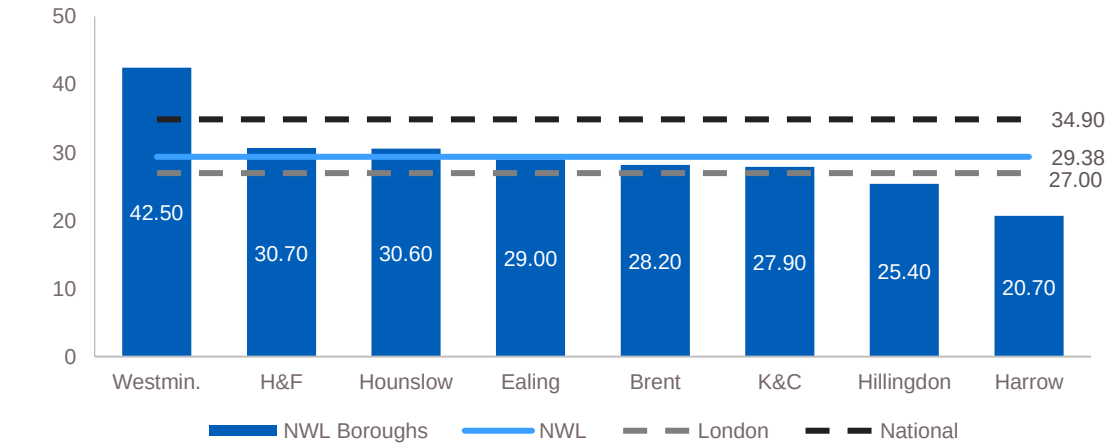
Source: Public Health Outcomes Framework, 2021/22



Violent crime rate:

Violent offences per 1,000 population [2021/22]

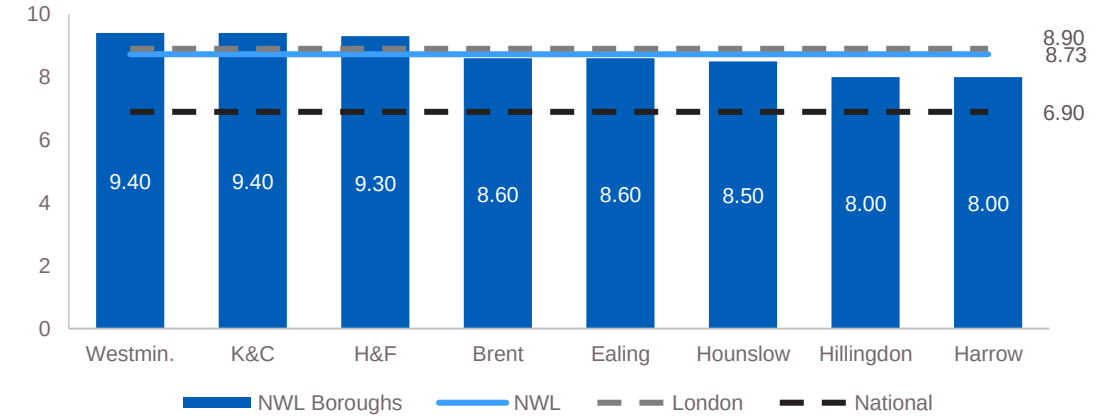
Source: Public Health Outcomes Framework, 2021/22



Air pollution:

Mean fine particulate matter in micrograms per m3

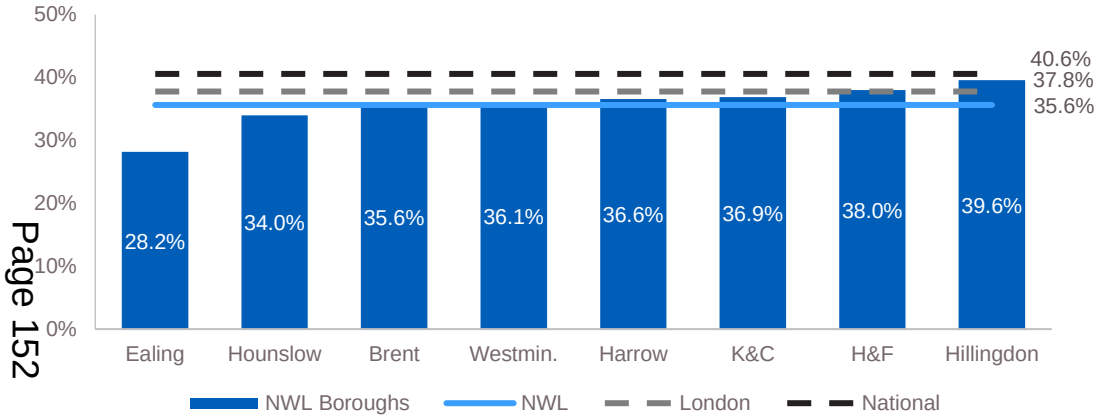
Source: Public health profiles, 2020



Social interaction and physical activity are vital to good mental health

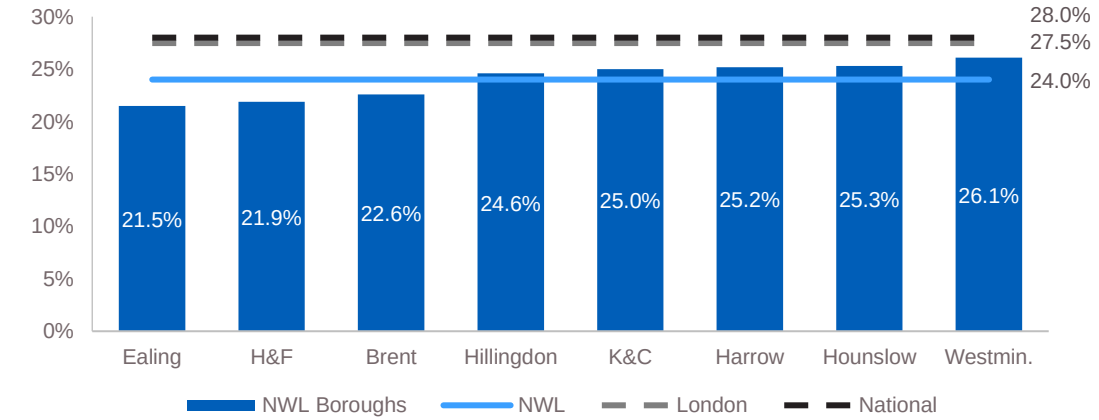
Social isolation (adult social care): Proportion of adult social care users who have as much social contact as they would like [2021/22]

Source: Public Health Outcomes Framework, 2021/22



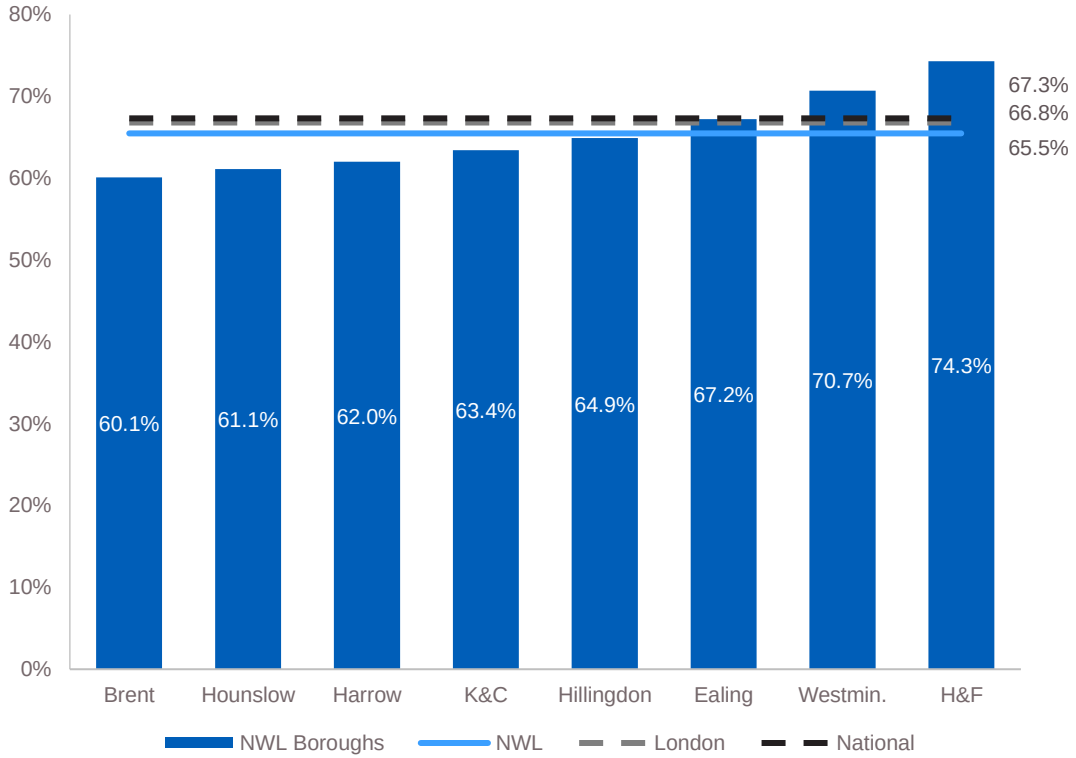
Social isolation (adult carers): Proportion of adult carers who have as much social contact as they would like [2021/22]

Source: Public Health Outcomes Framework, 2021/22



Physical activity: Percentage of adults who are physically active [2021/22]

Source: Public Health Outcomes Framework, 2021/22

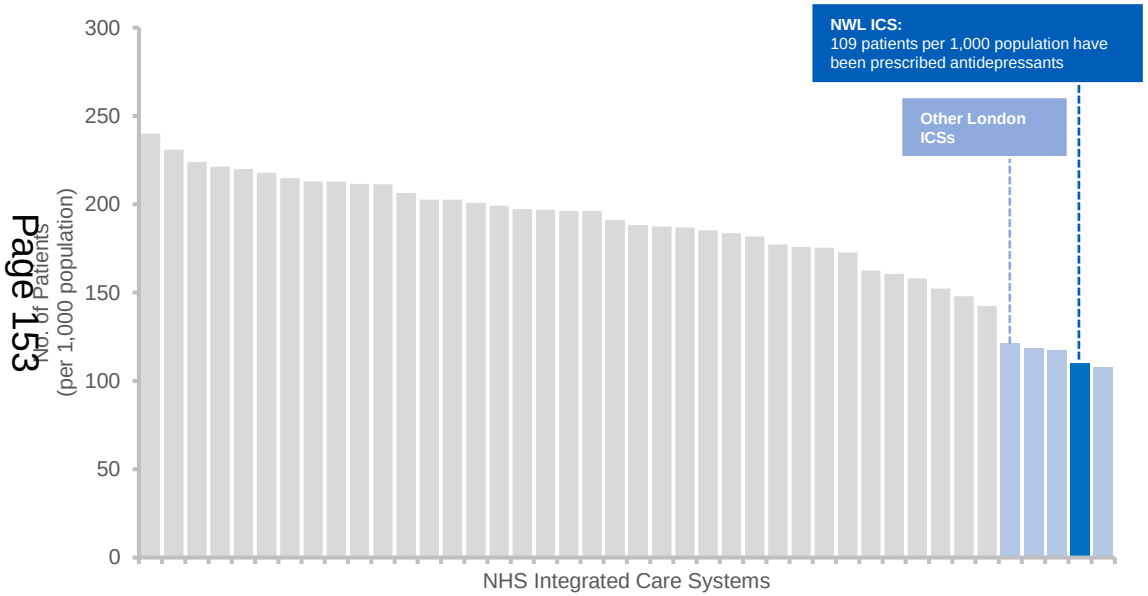


NHS North West London

North West London has one of the lowest levels of antidepressant prescribing in the country, though this has grown 14% since the pandemic

No. of patients prescribed antidepressants

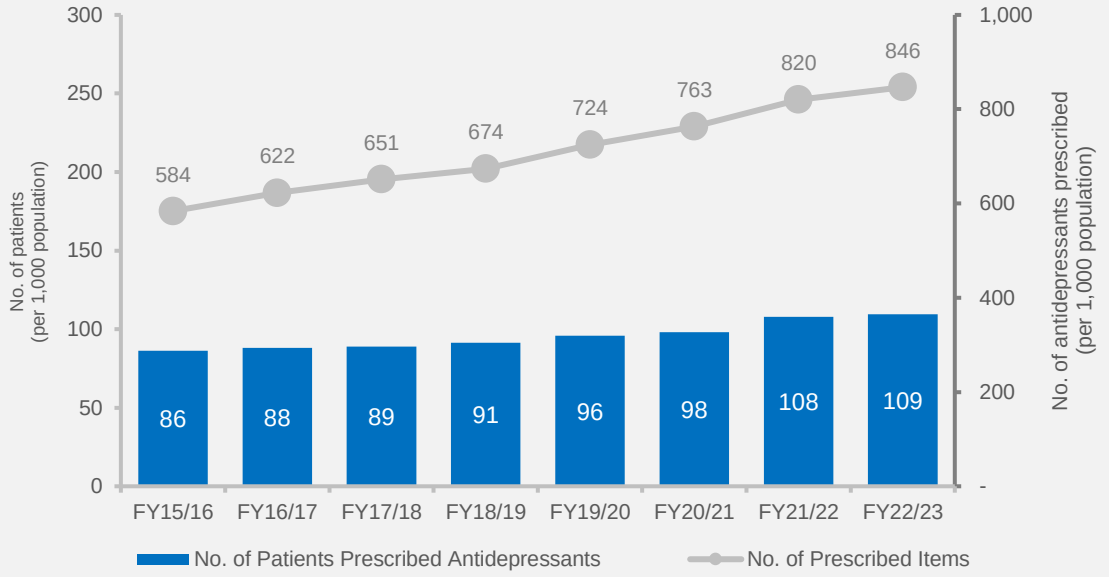
per 1,000 population: FY22/23



- **North West London ICB** has the **2nd lowest** level of antidepressant prescribing.
- **This is in line with other London ICBs**, which together have significantly lower levels of antidepressant prescribing than other England ICBs.
- **The national median is 190 patients per 1,000 population** being prescribed antidepressants – **72% higher than NWL.**
- North East and North Cumbria (NENC) ICB has the highest rate of antidepressant prescribing, with 240 patients per 1,000 population being prescribed antidepressants.

No. of patients and no. of antidepressants prescribed

per 1,000 population: FY16 – FY23



- North West London ICB's level of antidepressant prescribing has **grown 3% year-on-year** over the **past 8 years,** with **total growth of 27%.**
- The level of antidepressant prescribing has **grown 14% since the COVID-19 pandemic.**
- The no. of antidepressants prescribed has grown at a higher rate – **4.8% year-on-year**, with **total growth of 45%,** suggesting patients with depression are taking more antidepressants than previous levels.

Source: NHS BSA Medicines Used in Mental Health Dataset (2015/16 – 2022/23)

Appendix 2 – workforce priorities

NHS
North West London

Mental Health Strategy: Workforce priorities 2024-2026

WF priority	Initiative	Outcomes
Recruitment and retention	• Recruitment to the top five hard to fill, high impact roles that are a core driver for temporary staffing usage: 1. Mental Heath nurses 2. Psychiatrists 3. Occupational therapists 4. Psychologists; and 5. Social workers	Meet the collective target: • Vacancy rate of 10% or below
	• Increase retention of current staff by making our organisations better places to work through the implementation of the exemplar initiatives within the People Promise themes	• Voluntary Turnover Rate at 12% or below
	• Recruit refugees, care leavers, volunteers (including service users) into employment each year through Care leavers, refugee and volunteers schemes	• Agreed number each year each year
Equality and diversity	• Diversify senior leadership and improving experience of black and minority ethnic staff	• Achieve ICS model employer goal of 50% by 2025
	• Agree collective and organisational action to implement the medium term interventions that will embed equality, equity, social and racial justice within our organisations	• Sustained improvement against all 9 indicators of the Workforce Race Equality Standard and the Annual Staff Survey
	• Diversify routes into employment to provide a more inclusive pipeline of staff into roles into our allied health, psychological professions and support the new NWL graduate scheme	• Demographic workforce data

Mental Health Strategy: Workforce priorities 2024-2026

WF priority	Initiative	Outcomes
Education and training	• Ensure that the development of a multi professional Education strategy at ICS level reflects the needs of the mental health workforce	• Education Strategy with Mental health delivery Plan
	• Allocate places to NW London Graduate Leadership scheme with rotations across all organisations	• Annual cohort of graduates agreed
	• Expand number of apprenticeships and use this route to widen access and diversify entry into professional registered roles	• Increase by apprenticeship from xx to yy
	• Review clinical placement capacity to support expansion of apprenticeships and student training numbers	• Additional capacity identified in each provider
	• Deliver the Oliver McGowan Mandatory Training via the training academies across all organisations as well as continuing a focus on cultural competency and trauma informed practices	• 30% of staff completing the training each year
Workforce transformation and productivity	• Promote, monitor and track new role development focusing on RNDAs, Psychology CAP roles, advance practice and scope feasibility of physician associate roles	• Track increase in number from 2023 baseline
	• Workforce transformation to redesign new ways of working required to support community based models of care through Integrated Neighbourhood Teams	• tba
	• Support teams and services to make productivity improvements, ensuring skill sets such as QI are developed to support this	• tba
	• Ensure that all the rules for providers on agency expenditure, collectively known as the 'agency rules' are enforced and put in measures to reduce reliance on the use of agency staff	• Comply with a ceiling for total system agency expenditure

Report to the North West London Joint Health Overview Scrutiny Committee

22 October 2024

Report Title:	General Practice Access for North West London
Report Author:	Siobhan Herron, Dr Vijay Tailor and Javina Sehgal
Committee Date:	**22 October 2024**

Purpose

To provide an update on the General Practice Access plans, following on from the last NWL JHOSC meeting held in March 2024 where the Same Day Access (SDA) model was discussed.

Detail

Background/Context:

The Access programme was set up in 2023 with the intention of

- improving access for patients – as this is the single most pressing and talked about issue at all ICB events
- in the face of ever-increasing demand, helping to reduce the pressure on general practice by supporting General Practice to reconfigure their services to better manage demand and to create more time and space to support patients needing continuity

The plans to commission a same day access model across NWL from April 2024 were not well-received and, shortly after the last JHOSC meeting, the ICB agreed to pause and re-set the programme.

Current status:

The purpose of this presentation is to update the JHOSC as to the revised plans to improve access into general practice. The refreshed plans aim to ensure a bottom-up approach, grounded on how patients experience and navigate access and what they say is working well/ what is not working well.

To achieve this, the ICB is proposing to have two elements to the Access programme:

1. Engagement

Recognising that a one-size-fits-all approach does not work, we want to ensure that future plans are based on a shared understanding of what patients want at a local level.

Each area has, therefore, be asked to do a thorough engagement exercise to understand patients', staff, wider communities' and Healthwatch's views of access into their Practice/PCN. There will be a number of components to the engagement programme to try and ensure we get a wide range of feedback from as many sources as possible.

The final approvals were given for this work on 13 September and the slides provided outline the components of the contract.

Key points to note are that:

- The survey will give us data on how patients feel access is working now in each PCN. It is the first stage of the process and co-design at local level will follow
- The survey will be triangulated with what the ICB has heard and continues to hear from community outreach work and used to encourage discussions at PCN level
- The LMC was a significant contributor to the survey questions and we made a number of changes based on their input

- We accept that the timescales are tight. Additional funding to improve access to primary care is available for a limited period and PCNs and the LMC tell us they are keen to access this funding
- The ICB will pull together an over-arching report for NW London from the engagement exercise, including patient, staff and stakeholder views of access.

2. Part 2 – developing modern general practice

A business case has been submitted to the ICB to gain approval for enabling each PCN area to make a case for funding to the ICB, to support plans they might have for improving access. The plans will need to be based on what the engagement process has highlighted about patients' experiences, as well as any other data the PCN has available to support their plans. The plans will also need to:

- demonstrate a return on investment
- take into account local limitations to services and resources
- take learning from what they might have tried and tested before
- consider the constrained timeframes available for implementation

Those areas that have previously implemented same day models may look to build on and develop these further or decide to focus on something different. Each area will, however, be expected to incrementally trial and test their plans, to involve patients in developing and shaping their plans, to continuously evolve and improve what they are doing and work to organically improve patient satisfaction with access.

As part of setting up any new ways of working, the Practices/PCNs will also need to determine how they work together, which patients their plans impact, how those patients can get involved, plus how they work with their partner organisations, such as 111, to ensure clarity, minimise duplication and promote easy-to-understand pathways. Lastly, all areas would be expected to assess the effectiveness of what they are doing on improving access and report to the ICB.

The business case proposal is still going through due process to get sign off by the ICB. A template will be drawn up to enable submission and early applications will be accepted where areas already have services up and running and data to support their plans readily available.

NW London Access Engagement

North West London Integrated Care System

NHS North West London

Aims for the Access Programme

NW London ICB launched an Access programme in 2023 to improve access into Primary Care.

The overarching intentions for the programme are to:

- improve access for patients (the demand for access is ever-increasing and the single most pressing and talked about issue at all ICB events)
- help reduce the pressure on general practice by supporting General Practice to reconfigure their services to better manage demand and to create more time and space to support patients needing continuity

Background – original plan

The programme was based on three stages and used external consultancy support:

- Research and analysis:
  - review local, national and international good practice
  - Analysis of current demand and capacity within the NW London system
- Early adoption:
  - Work with a cohort of early adopters to support them redesigning low complexity, same day access at scale, building upon the principles of the Fuller stocktake
- Roll out:
  - Use the learning from stages 1 and 2 to produce a single enhanced access service specification and commission a consistent model across NWL from April 2024
  - Support PCNs with preparation and designing plans in readiness to deliver against a service specification

Background – agreements made

- As you know, our plans to roll out same day access were not well received and we encountered significant media interest, anxiety and upset

- It was agreed that the revised implementation plan would:

1. Remove Access from the ES Single offer contract with PCNs for 2024/25
2. Work collaboratively with the LMC and stakeholders to develop a specification for inclusion in the ES Single Offer for 2025/26
3. Change the approach for 2024-2025 to allow for greater focus on quality improvement and supporting PCNs to co-produce their access models with their member practices and patients

The aims for Access in 2024/25 are to…

Implement an approach:

1. that begins with getting a true and shared understanding of access within each PCN

2. lays the foundations for –

   — improving access across the domains of high quality care - safety, effectiveness, patient centredness, timeliness, efficiency and equity

   — embedding a focus on continuous quality improvement, change management and value for money

   — agreeing access plans for 2025/26

Getting a shared understanding of access

CONTRACT

We have set up a contract with the PCNs (providing 50p per weighted patient) to:

- Send out patient survey on access to all patients of 14 years+ (core survey, with up to 2 additional local questions included)
- Send out a survey to all staff members of the PCN and member practices (survey to be provided later)
- Host and facilitate a minimum of 2 local events to discuss the survey results and other local issues on the subject of improving access into general practice
- Manage the engagement process to ensure richness of feedback/ wide and representative demographic base
- Comprehensive completion of the post-event template (provided later)

Reach of the engagement exercise

SURVEY

- The patient survey is the start of a wider process
- It will be sent to all patients aged 14 years +, where contact details are provided
- PCNs will need to ensure distribution via a range of methods (text, website, NHS App and in person (via paper copy) and display posters
- A response rate of 5% of each PCN's eligible population is anticipated
- 111 will also direct willing patients to the survey
- UTCs will display posters with QR codes and provide paper copies
- A staff survey will also be conducted to gain value insights from an alternative perspective

EVENTS

- In recognition that a large percentage of the population will not engage via a survey, the PCNs are each asked to also host at least 2 events (virtual and f2f)
- They should invite their patients, PPGs and promote the sessions with local community groups
- They should aim to jointly plan events with the support of patients and community groups

OUTREACH

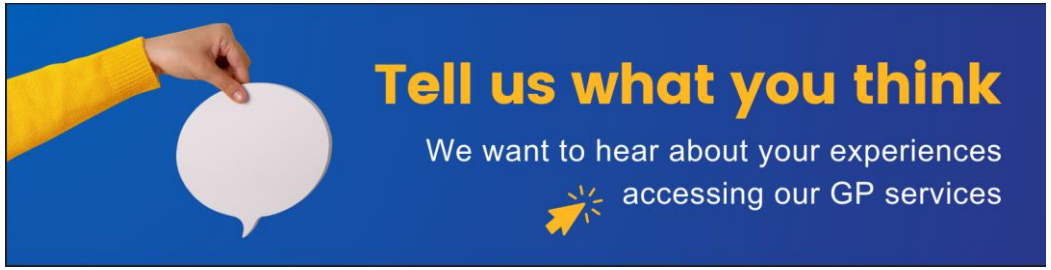
- The ICB Involvement team will seek the experiences of the 20-60 community groups we engage with monthly
- The team will share the feed back received so it can be built into the final report

Timeline of events/discussions relating to engagement

ICB Board Meeting	16/07
Access meeting with LMC	22/07
Letters to LMC to thank for support on survey	22/08 and 03/09
Webinar to reintroduce Access	07/08
Task & Finish Group meeting re: patient survey, with follow up by email	01/08
Webinar on Engagement	21/08
Task & Finish Group re: staff survey	05/09
Follow up Task and Finish Group re: staff survey	11/09
Approval to progress engagement	13/09
Residents and Campaigners meeting	18/09
NWL PPG Forum	25/09
Contract launch and survey link mailout to PCNs	09/10
Survey launch	14/10
Reminder to boroughs	15/10

Anticipated Engagement Timelines

Milestone	Anticipated Timeline	Status
Contract and survey dissemination	w/c 07/10/24	Contract, survey links, survey pdfs sent on 09/10/24
Survey live period	14/10/24 - 27/10/24	The survey has gone live
Survey analysis	28/10/24 to 11/11/24	
Focus groups held	12/11/24 - 29/11/24	
Reporting of focus group findings	By 06/12/24	
Staff survey	Between 28/10/24 – 29/11/24	
Final detailed report compiled	09/12/24 – 17/01/25	



We have developed posters and web banners for PCNs to use and we will also display them in the UTCs

Bang The Table

- Bang the Table's mission is "to improve the quality of public debate and level of community involvement in public life"
- Bang the Table's online platforms provide a range of methods to engage online including surveys
- The ICB will be using it to provide and collate the survey responses and generate the reports
- The software includes AI functionality to interpret the free text responses

Next Steps

Next Steps

PCNs:

- Run the patient survey for the agreed period, maximising uptake
- Set the dates for the patient events, advertise them and let the ICB know them
- Liaise with and invite local PPG and community groups to attend
- Plan the events and submit a template re: findings

ICB:

- Finalise, upload and distribute the staff survey questions
- ICB to host discussions on access as part of its usual outreach programme
- Advertise the PCN events
- Analyse the survey responses and provide an initial report to each PCN
- Analyse the findings from the events and compile an over-arching report on Access
- Share findings with JHSOC and others in January 2025

Appendix – patient survey questions

Patient Survey Questions (1/5)

❑ Please select the name of your surgery from the drop-down menu below.

Contacting my practice

❑ I am satisfied with how easy it is to contact my surgery during opening hours (08:00-18:30, Mon-Fri).

(*Strongly agree – Agree – Neither agree nor disagree – Disagree – Strongly disagree*)

❑ Please provide further details about your experience contacting the surgery.
(*free text*)

Booking an appointment:

❑ I can book a same day / next day appointment for urgent matters/care.

(*Strongly agree – Agree – Neither agree or disagree – Disagree – Strongly disagree*)

❑ I can book an appointment in advance; 1-2 weeks for non-urgent matters/care.

(*Strongly Agree – Agree – Neither agree or disagree – Disagree – Strongly disagree*)

❑ Please provide further details about your responses (*free text*).

Patient Survey Questions (2/5)

My on-going care needs:

- ❑ It is important to me to see the same GP or surgery staff member, and I am willing to wait for an appointment with them. … *(tick all that apply*)
  - On every occasion
  - When I need an appointment for ongoing, long term medical problems
  - When I have a new medical problem
  - It depends on the medical condition I have
  - I do not mind which professional I see, as long as they have access to my medical records, and I am seen at a time convenient to me
  - Other reason. Please explain (*free text*)

Working together:

- ❑ Some GP surgeries collaborate with their neighbouring GP surgeries to offer a broader range of services and appointments at different locations, or remotely (e.g. by phone). How do you feel about this?
  - If I benefit from more appointments and services, this will be a positive move
  - I think this is generally positive but I have some concerns
  - I think this is a bad idea.
  - Please tell us why you chose that option (*free text*)

Patient Survey Questions (3/5)

- You have used the online consultation service (e.g., PATCHS, eConsult, or other) offered by your practice, how satisfied were you with it? (If you have not used the online service then go Q11)
  (*Very satisfied, Satisfied, Neutral, Dissatisfied, Very dissatisfied)*

- Please provide further details (*free text*). Then go to question 12

- If you have not used the online consultation service, can you tell us why? (tick all that apply)
  - I was not aware my GP surgery was offering it
  - I do not know how to use it but would if training was provided
  - I don't have access to digital technology
  - I don't want to use an online tool and would prefer to speak to someone instead
  - Other reason. Please explain (*free text*)

Patient Survey Questions (4/5)

- I use the NHS app to… (tick as many options as needed) *If you have never used the NHS app go to question 13*
  - Order repeat prescriptions
  - See test results
  - Make appointments, if available
  - Contact my GP surgery online for medical advice
  - See hospital appointments and correspondence
  - View my medical record
  - Other. Please explain (free text)

- If you have not used the NHS App, can you tell us why?
  - I don't know about i.
  - I don't know how to use it
  - I have tried but found it difficult to install or register
  - I don't have access to digital technology
  - I don't want to use any online methods and would prefer to speak to someone instead whenever possible
  - Other. Please explain (free text)

Patient Survey Questions (5/5)

Contacting your surgery:

❑ I have contacted my surgery in the last year because I have needed to… (please tick all options that apply)

- Get test results
- Ask the surgery to write me a letter or fill out a form (e.g. for work, education, benefits)
- Check details about a hospital appointment or operation date
- Request an on-the-day appointment
- Make a routine appointment within 1-2 weeks
- Make an appointment for screening and health promotion
- Change my appointment time
- Make an appointment for a blood test or other investigation
- Request repeat medication
- The hospital asked me to contact the GP for a prescription or another matter (e.g. request a blood test or investigation).
- Other. Please explain (*free text*)

Improvement

❑ What changes, if any, would you like to recommend to improve your experience when contacting your GP Surgery? (free text)

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Report to the North West London Joint Health Overview Scrutiny Committee – 22 October 2024

North West London Joint Health Overview Scrutiny Committee Recommendations Tracker

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

1.0 Purpose of the Report

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

2.0 Recommendation(s)

2.1 That:

The committee note the latest scrutiny recommendations tracker for the 2023/24 municipal year in Appendix 1.

3.0 Detail

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

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

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

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

Appendix 1: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker

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

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

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

	Musculoskeletal (MSK)	Recommendation	To ensure that diagnostic capacity across North West London is properly linked to musculoskeletal services to best benefit residents across North West London.	Recommendation has been taken to Diagnostic colleagues and will feedback to the JHOSC in due course.	
		Information Request	For the JHOSC to receive baseline access wait times for musculoskeletal services and details on how the new service standards will improve waiting times for treatment.	This is currently being collating this as part of the Community wait times work. This detail isn't available for all boroughs yet but it will be shared with JHOSC once ready.	
		Recommendation	Bring a report on Urgent Care Plan to a future JHOSC meeting.	Recommendation request has been reworded for clarity	
		Information Request	To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.	Separate paper supplied on 27/11/23 to Chatan	
		Recommendation	Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.	We are currently working through the Children and Young People Mental Health Steering Group to refresh our Children and Young People Mental Health transformation plan and also intend to focus the strategy work on Children and Young People in 2024. Suggest that this is timetabled for later on in the year, following agreeing the scope of the CYPMH part of the strategy.	
		Information Request	To receive the details of the alternative provision to accident and emergency located across the boroughs.	An interactive map can be found here	
			To receive further details around on the engagement plans when available.	Everything is on the website, including the engagement report: https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london	
		Information Request	To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.	As we further develop the mental health strategy, this will include a strengthened focus on inequalities. The strategy is being presented at the October 22nd 2024 JHOSC.	
	Proposals on the future of The Gordon Hospital	Information Request	To provide the following: • The commentary and output of the pre-consultation workshops. • Completed and upcoming events with service users and carers.	This information is published on the ICB website. Acute mental health consultation: North West London ICS (nwlondonicb.nhs.uk)	

			• Service users' experience of Gordon Hospital. • A more detailed consultation plan. • Historical reports of Gordon Hospital service users over the last 5years. • Historical demographic data of Gordon Hospital service users.		
05 Dec 2023	ICS Workforce Strategy and Programme Update	Recommendation	Provide an update to the Committee once NHS have assessed the Government's new position on immigration and how this might affect recruitment and workforce within North West London.	The main impact will be on social care rather than health care professionals. From March 2024, care workers and senior care workers will not be able to bring dependents and only CQC-registered providers in England will be able to sponsor Health and Care Visa applicants. Ahead of this, 53 Senior Carers completed pre-employment compliance through NW London International Recruitment Team. The first Cohort of Senior Carers landed in UK, induction completed with employers supported by NWL Health & Social Care Skills Academy.	
		Recommendation	Provide an update of progress by the Race Equality Steering Group.	The Race Equality Steering Group is Co-Chaired by Rob Hurd and Linda Jackson. The Steering Group commissioned an Independent Report into Barriers to Leadership. The Report and strategic recommendations will be published as a Call for Action.	
		Information Request	Provide regular updates on progress of the seven priority workstreams.	Progress is reported monthly to the Strategic Chief People Officers Meeting and bi-monthly to the ICS People Board. There has been good progress on the pipeline for acute roles following two International Recruitment events, offers made to; 67 Registered Nurses, 40 Registered Midwives, 2 Sonographers, 2 ODP, 26 Radiographers, 5 physiotherapists, 2 ODPs There has also been a strong response to the launch of the ICS Graduate Scheme for future leaders. An undergraduate scheme is also in development.	

				A Spring EDI Summit is being planned to agree sustained medium term interventions that will embed equality, equity, social and racial justice Work also continues to deliver new ways of working to support new models of care.	
	NWL Elective Orthopaedic Centre	Recommendation	Report to the Committee on the success against metrics and targets identified for the Orthopaedic Centre and also get feedback from staff and patients. It would be interesting to get some reports from staff and patients after March on - how they feel things have been going and what could be improved and what the NHS system can learn going forward.	In January 2024 the EOC operated on 140 patients. Of these 64 were admitted to the EOC ward, with an average length of stay of 2.8 days. Unfortunately, 14 lists (35 patients) were cancelled in January due to the Junior Doctors' industrial action. The Friends and Family Test has reported 100% satisfaction with the service. A selection of patients were contacted for further feedback. Generally, the feedback was positive with all patients highly satisfied with their experience and very likely to recommend the EOC to others. Areas of suggested improvement were around the early morning theatre admission process and clearer signage about where to wait. The EOC's current operating capacity of three theatres will increase to five theatres (full capacity) in March 2024 at which point reporting against metrics and targets can be better undertaken.	
		Recommendation	Report to the Committee on the operation of the dedicated transport provision.	In January 2024 there were 12 EOC patients that used the free patient transport service. Three journeys were from the patients' homes to the hospital, and nine journeys were from the hospital to patients' homes. The earliest arrival at the hospital was 7.30am and the latest departure was 6pm. Eleven journeys were by ambulance and one was by car ambulance. Except for two occasions where the patient wasn't ready, journeys were able to commence on time or earlier than scheduled. Journeys were made to/from Brent, Ealing, Hounslow, Harrow and Hammersmith & Fulham.	
	ICS Updates:	Recommendation	To bring a report to the Committee once there are more detailed plans available on the redesign and consultation.	There is no impact on services, so our focus will be on how we work with partners and our organisational effectiveness.	

	ICS Running Costs Reduction				
14 March 2024	Primary Care Access And Same Day Access Model	Recommendation	That NWL NHS undertake an Equality Impact Assessment and Human Rights Impact Assessment prior to implementing any changes in the way patients access primary care.	Same day access proposals are not currently being implemented. Any significant change at a practice or PCN level would be subject an EHIA at that level.	
		Recommendation	That the Committee should seek meaningful consultation with patients, communities and GPs. Any engagement undertaken should be representative of the whole patient voice.	PCNs are leading a process of engagement and co-design at local level.	
		Information Request	For the NWL JHOSC to be provided with feedback and analysis of the impact of the early adopter PCNs, including case studies that have been learned from.	Awaiting response	
		Information Request	For the NWL JHOSC to receive full details of how patient safety and effectiveness would be measured against the proposals.	The proposals previously discussed are not currently being pursued.	
		Information Request	For the NWL JHOSC to receive information on the outcomes of the work done by KPMG in a way that was easy to understand and that related to patient outcomes.	Awaiting response	

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