*If you require further information about this agenda please contact: please contact: Nicola Zoumidou 020 8583 3477 or email: Nicola.Zoumidou@hounslow.gov.uk*

**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC)**

A virtual meeting of the Joint Health Overview & Scrutiny Committee (JHOSC) will be held on Wednesday, 14 July 2021 at 10:00 am

*The meeting will be accessible to the public to watch live (and thereafter in a recorded form) via the Council's YouTube Channel which can be found using this link:*
https://youtu.be/1oePKjoA6gw

**MEMBERSHIP**

Councillor Ketan Sheth London Borough of Brent
Councillor Crawford London Borough of Ealing
Councillor Richardson London Borough of Hammersmith and Fulham
Councillor Shah London Borough of Harrow
Councillor Eason London Borough of Hounslow
Councillor Elnaghi Royal Borough of Kensington and Chelsea
Councillor Saunders London Borough of Richmond
Councillor Bott City of Westminster

**AGENDA**

1. Welcome & Introductions
2. Election of Chair & Vice-Chair
3. Apologies for Absence & Declarations of Interest
4. Minutes of the meeting held on 18 March 2021 ***(Pages 3 - 10)***
5. Development of the North West London Integrated Care System ***(Pages 11 - 16)***
6. North West London NHS Recovery and Covid 19 Vaccination Programme
7. Committee Work Plan 2021/2022 ***(Pages 17 - 18)***
8. Any other matters that the Chair considers urgent
9. Date of the next meeting - 23 September 2021

**DECLARING INTERESTS**

Committee members are reminded that if they have a pecuniary interest in any matter being discussed at the meeting they must declare the interest and not take part in any discussion or vote on the matter.

Niall Bolger, Chief Executive,
London Borough of Hounslow, Hounslow House, 7 Bath Road, Hounslow TW3 3EB

06 July 2021

# Joint Health Overview & Scrutiny Committee

## Draft Minutes

### Thursday 18 March 2021

**PRESENT**

**Members Present:**

| | |
|---|---|
| Councillor Mel Collins (Chair) | London Borough of Hounslow |
| Councillor Max Chauhan | Royal Borough of Kensington & Chelsea |
| Councillor Daniel Crawford | London Borough of Ealing |
| Councillor Lorraine Dean | City of Westminster |
| Councillor Marwan Elnaghi | Royal Borough of Kensington & Chelsea |
| Councillor Lucy Richardson | London Borough of Hammersmith & Fulham |
| Councillor Monica Saunders | London Borough of Richmond |
| Councillor Rekah Shah | London Borough of Harrow |
| Councillor Ketan Sheth | London Borough of Brent |

**NHS Representatives Present:**

Stephen Bloomer, Chief Financial Officer, North West London Collaboration of CCGs; Rory Hegarty, Director of Communications and Engagement, North West London Collaborative of CCGs; Pippa Nightingale, Chief Nurse Chelsea and Westminster NHS Foundation Trust and NWL Vaccine Lead; Jo Ohlson, Accountable Officer, North West London Collaboration of CCGs; Dr Mohini Parmar, Long-Term Plan Clinical Director and Chair of Ealing CCG and Lesley Watts, NWL ICS Chief Executive and Chief Executive of Chelsea and Westminster NHS Foundation Trust.

**1. WELCOME AND INTRODUCTIONS**

Councillor Marwan Elnaghi, as the representative member of the host borough, RB Kensington and Chelsea, welcomed members and officers to the meeting.

**2. APOLOGIES FOR ABSENCE**

None.

**3. DECLARATIONS OF INTEREST**

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

## 4. MINUTES OF THE PREVIOUS MEETING

**RESOLVED:**

That the minutes of the meeting held on 14 January were agreed as a correct record of proceedings.

## 5. NORTH WEST LONDON HEALTH AND CARE PARTNERSHIP FINANCIAL STRATEGY

5.1 Stephen Bloomer briefly introduced this item. He explained the NHS were given an allocation of £3.5 billion in NWL, and they had managed to remain within that allocation. This covered routine healthcare and pressures that came with Covid-19. They had also invested around £350 million on capital, which included new buildings, maintaining assets, fire safety, IT, and medical equipment. He noted that in the second half of the year, funding would reduce, and some previous pressures would return.

5.2 On visions and priorities, Stephen Bloomer noted that a key aim was to look at addressing any inequalities surrounding funding and service provision. They had also began working to improve efficiency in all pathways and providers. An overall strategy was to focus on costs while focusing less on transactional work and looking at how to make the system more seamless. With regards to primary care, work was focused on ensuring referrals went into the correct pathways. For acute providers, the aim was to ensure people were using benchmarks. It was important to create an environment that reduced length and stay and treated patients closer to home with faster discharges. There were increased investments in mental health and work on cost and efficiency. The aim was to try and create and overall strategy that would improve costs, give greater access to patients, and reduce areas where patients may have had different access across NWL.

5.3 Councillor Daniel Crawford (LB Ealing) requested further information on the positive outcomes from the pandemic and how they may be developed. He also queried if there was a financial reason that some processes were being advanced over others. Lesley Watts responded that through pandemic, patient care had been improved by both the use of remote monitoring of patients in their own homes and the ability to hold outpatients virtually. Through this, elderly patients did not have to travel, and they were able to be more consistent in addressing pathways for patients.

5.4 Dr Mohini Parmar added that GP surgeries were able to provide care through telephone and video consultations. There were also face to face consultations for those who for example could not access digital means of communication. She noted that the workforce was being used more appropriately, and Covid-19 hubs were able to look after patients remotely. Stephen Bloomer added that they were looking and evaluating what worked best in which areas in terms of quality and on a financial basis.

5.5 In response to queries surrounding the low complexity and high-volume hubs, Lesly Watts noted it was difficult to keep elective surgery going in the pandemic and this led to centralising certain pathways, mainly surgical. High volumes of patients that required low complexity intervention were centralised in different hospitals. She noted they were learning and looking at how to protect elected pathways in the future.

5.6 Councillor Lucy Richardson (LB H&F) queried if there was more detail surrounding the allocation of the £330 million capital investment. She also asked about the gap in funding and queried the timescale for the post pandemic cost base, and how the strategy would be informed by local allocations. Finally, she questioned the engagement strategy to facilitate more local conversations and how it could be managed in different governance structures.

5.7 In response to Councillor Richardson's first question, Stephen Bloomer explained that capital was given as an ICS resource and there was a process involved that looked at the biggest areas of risk. He noted that he would circulate a breakdown of costs to the Committee. In the current year, there was work on new buildings and theatres, as well as the maintenance of existing assets and fire safety was largely on the Hillingdon site. He added that the IMT was split across all the sites and between maintaining infrastructure. The process was done across the ICS and the aim was to ensure all the large risk areas were covered as well as any key developments. Councillor Richardson commented that it would be useful to have further detail on how need was formulated. Stephen Bloomer responded that it was based on the provider rather than the areas and the capital was funded through a depreciation of assets for each of the providers, most of which, was self-funded.

5.8 Lesley Watts added that for IT, there were commitments in acute units to use the same digital systems so records could be shared for patients across different trusts. Further information on this could be provided to the Committee. In response to Councillor Richardson's second question, Lesley Watts explained that currently they did not have the financial settlement but did accept the first half of the year would likely look similar to the second half that had just passed. They were beginning to look at gaps of £200 million in the worst case during the second upcoming half. There was time to put efficiencies and schemes in place to prepare, which would involve a mixture of traditional cost improvement schemes and more transformational schemes. Teams in individual trusts were also working through their responses to this they expected to be in a good position in some weeks to outline how they would bridge those gaps. Lesley Watts noted it was important for some of the practice in place to make sure all schemes were quality checked, and it would be continued to make sure there were not any unintended consequences. Some work had begun but currently the focus was on the cost of provision rather than transactional factors.

5.9 In response to Councillor Richardson's final question, Rory Hegarty noted engagement was developing. There were more meetings with members of

the public and working with local communities. Some councils were also involved in tackling vaccine inequity and looking at inequalities. It was important to listen to communities and build relationships. The changes proposed involved developing a set of principles around service change, as well as an Involvement Charter, which could be shared with the Committee once agreed. They would also look at having public representation early on in decision making. Councillor Richardson expressed concern surrounding the enlargement of the CCG, Rory Hegarty responded that there was representation at each level of engagement and staff would continue to work in their areas and boroughs.

5.10 Councillor Ketan Sheth (LB Brent) questioned the Covid-19 allocation in NWL to deal with any extra pressures and the general state of finances for the wider trust. He also asked about the current state of deficit and surplus of the 8 CCGs and queried how they would assist in filling the financial gap. Stephen Bloomer responded that the Covid-19 allocation for the second half of the financial year was around £170 million to NWL, the first half was allocated on a retrospective basis and was just below £200 million. This did not include certain factors such as PPE, but covered costs factors including extra staff in areas like critical care. With regards to possible ongoing costs and they expected 15% loss of productivity. On the current state of the CCGs, they would balance and have their control targets and would finish on a break-even position. They were aware of some pressures going into the new municipal year and were working on alleviating them. Overall, they were in balance and expected to carry that into the next year.

5.11 Councillor Sheth further questioned the impact of reducing clinical variation on healthcare services going forward, and whether there would be a shift in resources to deal with health inequalities. Stephen Bloomer responded that CCGs had made a commitment to put further funding of around £20 million in several areas over a 4-year period, this would begin going into those areas in the next year. On clinical variation, it was important to use the right pathways to get patients to the right places. There were some issues surrounding this and work was ongoing to ensure the most appropriate placement was done in the first instance, this would create space clinically which could be reprofiled in acute units to other interventions. Stephen Bloomer further explained that they would be working towards this across the ICS as well as in primary care, to ensure everyone was working towards similar pathways. Lesley Watts added that they were determined to address the inequalities that had been exacerbated by the pandemic and asked for the Committee's support in this. Councillor Sheth further queried if there would be any shifts in resources to deal with these issues and Lesley Watts confirmed over time there would be.

5.12 Councillor Elnaghi (RBKC) questioned what support was available to staff training in changes to technology. He also queried if there were any contingency plans to address any gaps that may emerge. Lesley Watts noted there was a strategy outlining this that could be shared with the Committee. There was a need for rest, recuperation and building resilience. A key aim was to look at how to help repair from the negative impacts of Covid-19, as well as helping to build on the inspiration garnered from the training received

through the pandemic. A great deal of work went into Health and Wellbeing and that would be shared with the Committee.

5.13 Lesley Watts spoke on the White Paper on Integration and Innovation, she explained that the suggestion was that integrated care systems would be placed on a statutory basis. This would bring together the commissioning function with providers of NHS services and in partnership with local authorities. Together, they would have a duty to plan and improve health and care services for the local population. Following discussions with boroughs, place-based partnerships were formed between local organisations, mental health colleagues including the local community, primary care, and local authorities. They were also working as provider collaboratives, which included the 4 acute trusts across NWL. On regulation, the Care Quality Commission would still regulate, and they would also sit under the Department of Health and Social Care, who would look at how the systems functioned together. The aim was to work together and hold each other to account. There was a need to build up Primary Care Networks and work in local neighbourhoods as well as joining up primary community care services. Lesley Watts noted she was happy to return to the Committee to discuss those factors in further detail.

5.14 Councillor Monica Saunders (LB Richmond) noted that there were no hospital trusts in Richmond and queried how the ICS would work considering this. Lesley Watts noted that every patient required the best possible care and that it was important to ensure patient pathways were joined up. They were working with Richmond and Kingston Hospital to ensure this and hope that this could be coordinated better through the ICS.

5.15 Councillor Saunders further queried what investment in mental health would look like following Covid-19. Stephen Bloomer responded that they were pushing mental health forward, there was additional funding which would involve work in provider teams as collaborative and primary care teams. There was an acceptance that there would be a greater need for mental health services after Covid-19, and there would be a separate national fund of around £1.5 billion, of which NWL would have access to. Dr Mohini Parmar added that mental health services, for patients who did not require acute responses, were largely conducted online because of lockdown measures. She added that the best delivery of mental health provision happened at borough level, and noted it was important to have mental health throughout integrated services. Dr Mohini Parmar finally added that FPs would have additional mental health workers in the coming year and were working with mental health providers in Primary Care Networks.

5.16 Pippa Nightingale provided a brief update on vaccinations. She noted 735,000 people had been vaccinated with their first dose in NWL, and they had achieved over 80% in all age groups above 60. As all boroughs were very different, they had devised 8 individual borough plans to deliver vaccines to the different populations in a tailored way. Some vaccination methods were mobile, for example, pop up clinics for local communities. There were also roaming models to go into communities that needed to be vaccinated.

5.17 Councillor Mel Collins (LB Hounslow) questioned how many people had received their second dose. He also requested further information on working with communities that may have been wary of the vaccine. Pippa Nightingale responded that 19% of the 735,000 had received their second dose, as they had only begun 2 weeks prior. The whole of April would be focused on administering second doses of the vaccine. She noted it was important to not have a blanket approach, there were diverse communities in the boroughs and a variety of approaches were required. There had been some hesitancy at the start from some religious groups, but this was decreasing. They were taking different approaches to communication and they had been working alongside religious leaders.

5.18 Councillor Crawford requested further information on the process behind selecting vaccination sites. Pippa Nightingale responded that decisions were made early regarding vaccination site requirements through a criterion set by NHS England. The criteria involved a lease contract for at least 9 months, but many venues could only commit to 3 or 4 months. The criteria also ruled out many buildings due to factors such as space for social distancing, one-way systems, car parking and travel costs. Local pharmacists all began using pop-up models, which meant people would travel less.

5.19 Councillor Richardson spoke of the hesitancy surrounding vaccinations in Hammersmith & Fulham and queried what strategy was in place to deal with this. Pippa Nightingale responded that there were 3 areas, Central, West and H&G where hesitancy and refusal was significant. There was a plan for the 3 boroughs that had been piloted in Central over the past week, which linked local authority staff with primary care staff. This also involved conversations with people that were hesitant about the vaccine, and there was an increase in vaccine take up in the borough as a result. This would now be rolled out across all 3 boroughs. Individuals that were hesitant would receive a phone call to discuss any queries or issues. It was clear that several people were concerned about the effects on their long-term conditions. Councillor Richardson queried how the data on this would be captured. Pippa Nightingale responded that these boroughs had complex populations, with many residents residing outside the borough. Through the phone calls, they were able to document whether those residents were currently living in the borough and that data would be available to each borough.

5.20 Councillor Saunders outlined some concerns surrounding the lack of locations available to book the second vaccinations and noted that some people were receiving duplicate notification letters. She also highlighted issues surrounding lack of liaison with high dependency wards. Pippa Nightingale explained that booking second appointments had been challenging but encouraged people to look for more sites closer to the date as they would have the opportunity to change their appointments. She noted there had not been problems in NWL with communications of notification letters. Communications in wards had not been ideal, though communication for patients in intensive care had been good, this was due to family liaison teams. Patents in high dependency or acute wards did not have access to these teams. It was important to have a different approach to communication and in future, ensure liaison teams covered high dependency wards also.

5.21 Councillor Elnaghi requested some information of the strategy surrounding pop-ups. Pippa Nightingale explained that there were several styles, some were single roaming models that were going directly into homes to vaccinate. There were also some pop-ups going into GP practices to vaccinate a small number of patients and pop-ups in religious buildings. The pop-ups all ran in a similar fashion, with professional standards, and involved temporary clinics that were shut down at the end of the day

5.22 Councillor Chauhan queried if there was a roaming service available. Pippa Nightingale confirmed that there were VaciTaxis, as well as support from local transport teams in taking people to vaccination sites.

5.23 Councillor Sheth requested more detail on work surrounding care homes and homelessness. Pippa Nightingale responded that 91% of residents had been vaccinated in care homes, it was an ongoing programme as care homes would receive new residents. On homelessness, GPs were out vaccinating and using that opportunity to carry out health checks. They were working with and supported by charities.

5.24 The Committee thanked all officers for their attendance and time. Councillor Collins noted any additional questions could be sent to officers.

**ACTIONS:**

- Stephen Bloomer to provide a breakdown of costs and spending to the Committee.
- Lesley Watts to provide further information on work and spending surrounding IT.
- Rory Hegarty to share Involvement Charter with the Committee once available.

## 6. WORK PLANNING PROGRAMME

6.1 Councillor Collins noted there were several issues that could be put forward to the work programme. The Committee agreed to decide on a date for a future work planning meeting.

**ACTONS:**

- To decide a date for a future work planning meeting.

## 7. ANY OTHER BUSINESS

7.1. Councillor Collins spoke of the importance of Hillingdon's membership to the committee. The Committee agreed that Councillor Collins would write to Hillingdon in the new municipal year.

7.2. Councillor Crawford thanked Councillor Collins on behalf of the Committee for his leadership as Chair of the Committee.

**ACTONS:**

- JHOSC to write a letter to Hillingdon in the new municipal year.

Meeting started: 2pm
Meeting ended: 4.43pm

Contact officer: Yasmin Jama
Governance Administrator, RB Kensington and Chelsea

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

# NW London ICS update

**Joint Health Overview and Scrutiny Committee, 14 July 2021**

This update from the ICS focuses on the issues requested by JHOSC, elective recovery, the vaccination programme and development of the ICS.

## Context

The NW London ICS will play a critical role in aligning action between partners to achieve our vision: **to improve life expectancy and quality of life, reduce inequalities and achieve health outcomes on a par with the best global cities.**

As a starting point, it is worth noting again that everyone across our health and care system has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme, while continuing to provide essential services. We want to put on record our thanks and appreciation for their remarkable response to an unprecedented public health challenge.

As this paper makes clear, we still face major operational challenges: tackling backlogs; meeting deferred demand; new care needs; tackling longstanding health inequalities; and enabling respite and recovery for staff who have been at the frontline of our response.

## 1. Service recovery

The pandemic has had a significant impact on services, creating a lengthy backlog of unmet need. As Covid-19 cases were prioritised and essential infection prevention and control measures and workforce pressures further limited our capacity, we now have around 4,500 patients who have been waiting over 52 weeks for elective care. This compares to a figure of just 26 patients waiting for a year or more prior to the pandemic. The figure peaked at 7,000 and we have been working since then to reduce it. We do not expect the backlog to be cleared until March 2022.

We are committed to equity of access across North West London. This means that patients in greatest need will be prioritised, potentially including being treated in a different North West London hospital to the one they were referred to. Our view is that it should not matter where in North West London you live; treatment should be offered in priority order of patient need. This approach is likely to make waiting times equal across the system and will mean a shorter wait for those in most urgent need. It follows that patients with less urgent needs may wait longer – though we recognise all of these patients have had longer waits than we would have wanted.

In order to maximise the number of procedures we carry out, we are carrying out a number of measures.

- Our acute trusts are working together to ensure a fair and equitable approach, with those most in need of treatment prioritised. We have continued to provide planned operations and other treatment for patients who we know need treatment within two weeks.

- We will bring together routine clinical operations into 'fast track surgical hubs' in order to improve quality and efficiency.

- Hospital clinicians are reviewing each of their patients to support prioritisation and ensure the treatment is still needed. For new referrals, we're putting in place processes to enable GPs to get advice and guidance quickly and easily from specialist colleagues in the acute trusts when needed.

- We had to quickly move as many outpatient consultations as possible to telephone or video during the pandemic to minimise the risk of Covid-19 infections. They have not always worked smoothly but we are continuing to build in improvements to our processes and ways of working and to find better ways of identifying and supporting patients who have difficulty in accessing care in this way. We would like to maintain high quality, virtual outpatient appointments for a significant proportion of our patients.

- To empower patients to manage their own long or short term conditions, we have enabled 'patient initiated follow-ups' in line with national guidance on outpatients, meaning patients can get follow-up appointments when they need them and reducing appointments that are not needed.

- The NHS 111 First service was introduced in December, enabling patients who need to attend A&E or an urgent treatment centre to be given a timed slot to attend. We have also expanded our 'same day emergency care' services. We want to raise awareness and understanding of these services, particularly to make it really clear to everyone in our local communities what to do if they need urgent or emergency care.

- In common with other areas of the country, reduced theatre capacity and patients delaying their treatment during Covid has created a significant backlog in cancer care. Patients are being offered treatment in order of need regardless of where in North West London they live.

- Demand for mental health services has risen significantly, with particularly high prevalence among children and young people. This includes increased unplanned attendances at hospitals by young people in urgent need of mental healthcare and a significant rise in eating disorders. Fewer beds are available nationally than previously for Child and Adolescent Mental Health Services (CAHMS) and this is a challenge we are trying to work through, including introducing measures to improve productivity while keeping service users safe. We will invest an additional £14.4m in mental health services in 2021/22, taking the total budget to £417m and ensuring we meet the Mental Health Investment Standard. We recognise that a joint approach between CAHMS and social care is needed to address this rising challenge.

- Primary care services are not currently meeting the national target for over 60% of appointments being face to face, though patients are seen on a face to face basis when necessary. Primary care estate varies, meaning it is easier for some practices to achieve this target than others in the light of infection control measures.

- A key ongoing challenge that we are tackling is unwarranted variation of provision and access in primary and community care services. To address this, clinicians across these services have developed clear, evidence-based specifications on how services should be delivered and the aim is to put these in place consistently across NW London.

- A good example is diabetes care, where significant variation in funding across boroughs has resulted in uneven service delivery and outcomes. For example, Brent, Harrow, Hillingdon have been less well-resourced in this area historically in spite of high need. We are working to address this through a service specification that will reduce variation, drive up equality of access and provision, address health inequalities and support a consistent offer across NW London. This offer will be integrated across all parts of the system, so patients get a seamless service. Delivery is currently focused on supporting the primary care component, with further work planned to integrate other parts of the system (e.g. community health and hospitals) to ensure a joined up, effective and sustainable approach.

  By moving resources to where they are needed most, we are able to provide more consistent services across North West London. Core offers are being developed for hospital discharge, care homes, long term conditions, Post Covid Syndrome, community nursing, urgent community response and community rehab beds. System-wide reviews are being carried out on community rehab beds, end of life care, walk in and urgent treatment centres and neurological rehabilitation.

## 2. Covid-19 update and vaccination programme

Rates of Covid-19 are rising rapidly again in North West London. The vast majority of new cases are the so-called Delta variant, which now appears to be the dominant strain of Covid-19. This strain is highly transmissible: it appears to be the most infectious strain of Covid-19 to date. The latest modelling from Imperial College suggests there is a risk that the new variant could lead to a third wave of hospitalisations and deaths. Proposals for 'opening up' on 21 June 2021 were postponed by the government for a minimum of four weeks, with the aim of vaccinating as many people as possible during this period, including second doses for those who have not yet had them.

The Delta strain appears to be affecting younger people initially, as was the case with previous variants, but with more young people now being admitted to hospital. Younger people also appear more susceptible to Post Covid Syndrome. Hospital admission rates remain relatively low for people who have had both doses of any of the available vaccines, but we have had some hospitalisations in North West London for a small number of patients who are double-vaccinated.

NHS England is leading a 'vaccination sprint' in London, with the aim of getting all over 18s vaccinated at least once and everyone over 40 having had their second vaccine. To meet the targets we have been set, North West London would need to vaccinate 200,000 people a week – in most weeks, we deliver just over 20,000 vaccines, so the new target is placing

unprecedented demands on clinical staff and vaccination centres. Vaccine hesitancy remains an issue with some communities and residents and the challenge of getting people to take up the vaccination offer – including going back for second vaccines – cannot be under-estimated.

We are diverting resources to vaccination centres to support this demand and three mass vaccination events took place on Saturday 19 June at Chelsea Football Club, Bridge Park Community Leisure Centre in Brent and the Dominion Centre in Ealing. Mass vaccination events have been taking place across the capital, following our event in May at Twickenham, where 11,000 people were vaccinated in a single day. As the vaccine becomes available to younger people, we are targeting both new cohorts and patients awaiting their second dose. Waiting times between doses are being reduced.

We recognise that this serious situation means the NHS needs to be prepared for a potential third wave and that this could further impact our ability to recover elective care services. The next four weeks will be critical in striving to avoid this.

## 3. NW London ICS development

North West London was formally designated as an ICS from April 2021, and ICSs are expected to become statutory bodies from April 2022, pending national legislation. In reality, we have been working as an ICS across all parts of the local NHS and our eight local authorities for some time, and this partnership working was strengthened as we worked together in response to the Covid-19 pandemic.

The White Paper setting out proposed legislation days the NHS and local authorities will be given a duty to collaborate. Statutory ICSs will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners and an ICS body. The NHS body will be responsible for the day to day running of the NHS, while the health and care partnership will bring together systems to support integration and develop a plan to address the area's public health and social care needs.The executive summary of the paper states:

*"The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources."*

The ICS is in effect a continuation of existing working arrangements in North West London, though these will be put on a statutory footing. There is no proposed change to services and no requirement for public consultation on what is a national legislative change. However, we will work with local stakeholders and organisations to explain the new working arrangements and how people can get involved.

The ICS has three functions: strategic planning, delivery and assurance.

### 3.1 Strategic planning

Our strategic planning function will considers population health, quality of care, how services should best be designed to meet the needs of our residents and how resources including money should be allocated across the system.

Healthy life expectancy in NW London varies significantly by neighbourhood, borough, gender, race and age. Our most disadvantaged populations are often those with the greatest inequality of health outcome.

As we have rolled out the Covid vaccination programme, we have started to evidence that health inequalities can be tackled by working with our most disadvantaged communities in a spirit of co-design and co-operation. We have used our Whole Systems Integrated Care (WSIC) dashboard to track vaccinations and have then been able to target engagement and information at communities and areas where take-up appeared to be low.

Our ten-week programme of 'vaccine equity huddles' co-designed solutions and approaches to vaccine resistance, reaching deeper into our communities, working with those communities, other local residents, faith leaders, local councillors and health and care staff. The discussions with local communities led to us exploring some of the wider inequalities and challenges, such as historic racism, social exclusion and the role of the NHS and local councils as significant local employers. The huddles combined quantitative data with qualitative discussion. The success of this approach was such that we are adopting it as a future model for public engagement, creating open 'collaborative spaces' at both ICS and borough level. While there is a long way to go, the vaccine equity huddles have pointed to a different way of working with local residents and communities which can help address inequalities.

We aim to reduce the gap in healthy life expectancy between our top and lowest boroughs by 2025. Reducing the difference between the highest and lowest boroughs within three years is achievable if there is a concerted effort to work with our communities to tackle the practical and socioeconomic factors that can be barriers to improving health access, health outcomes and patient experience.

This will require an ICS financial strategy that directly tackles inequalities, for example by targeting resources to tackle diabetes at those boroughs and communities that have the highest prevalence and risk or by deciding where interventions should be targeted to provide the greatest benefit. ICPs will adapt and deliver the strategy at borough level, including developing specific local priorities to meet their residents' needs. It is important to recognise that the ICS brings together eight very different boroughs which have had very different outcomes and different levels of financing. The ICS will mean that resources are directed where they are needed most.

### 3.2 Delivery

The delivery arms of the ICS are borough-based integrated care partnerships, provider collaboratives and primary care networks.

Place or borough-based integrated care partnerships (ICPs) have already established leadership arrangements, with a lead ICP Director in each ICP/Borough, co-ordinating a senior Leadership Team, comprising as a minimum a quartet, with directors from the local authority, community and mental health trusts, and lead GP. This group drives delivery at a place level, and ensures agreement of local priorities to improve health & wellbeing. All ICPs link and 'report' to their Borough Health & Wellbeing Board.

We have two emerging provider collaboratives, covering acute care and mental health and community services. Provider collaboratives work together to improve health and care outcomes, reducing health inequalities and unwarranted variation for residents. They share and coordinate resources, leadership and best practice, working through delivery partners and primary care networks to deliver ICS priorities, also providing mutual aid and support.

General practices are organised in 47 primary care networks (PCNs), working with local partners such as social care, pharmacists and other NHS services to deliver care at 'neighbourhood' level across our eight boroughs.

### 3.3 Assurance

The ICS has an independent Chair, Penny Dash and an interim Chief Executive, Lesley Watts (also chief executive of Chelsea and Westminster NHS Foundation Trust). We have established an ICS Partnership Board, a Clinical Quality Committee and a Clinical Advisory Committee. ICS leaders (NHS and local authority) meet on a monthly basis.

Statutory authority remains with statutory bodies – Trust boards, local authorities and the CCG governing body – until ICSs become statutory bodies. The ICS Partnership Board therefore reports to the relevant statutory bodies. The ICS will operate in shadow form until October and subject to proposed legislation, is expected to become a statutory body in April 2022.

Oversight of quality, finance, performance and workforce will in future take place at a system level. System oversight reporting and monitoring is already in place for each provider organisation.

We expect senior appointments to the NW London ICS to be confirmed in the autumn. Our current working model will be further developed following the publication of the ICS Design Framework by NHS England on 16 June 2021. All partners will work together to design a governance structure that will assure the success of the ICS and maximise opportunities for residents and stakeholders to work with us to deliver on our vision.

# Draft North West London Joint Health Overview and Scrutiny Work Plan 2021-2022

**14 July 2021**

| Agenda Item | NHS Organisations | Host Borough |
|---|---|---|
| 1. North West London NHS Covid 19 Recovery and Vaccination Programme | North West London Clinical Commissioning Group | London Borough of Hounslow |
| 2. Development of the Integrated Care System in North West London | North West London Integrated Care System<br><br>North West London Clinical Commissioning Group | London Borough of Hounslow |

**23 September 2021**

| Agenda Item | NHS Organisations | Host Borough |
|---|---|---|
| 1. North West London NHS Acute Strategy | North West London Clinical Commissioning Group<br><br>North West London Integrated Care System | TBC |
| 2. North West London NHS Digital Strategy | North West London Clinical Commissioning Group | TBC |

**14 December 2021**

| Agenda Item | NHS Organisations | Host Borough |
|---|---|---|
| 1. North West London NHS Estates Strategy | North West London Clinical Commissioning Group<br><br>North West London Integrated Care System | TBC |
| 2. North West London NHS Workforce | North West London Clinical Commissioning Group<br><br>North West London Integrated Care System | |



**9 March 2022**

| Agenda Item | NHS Organisations | Host Borough |
|---|---|---|
| 1. Implementation of the Integrated Care System in North West London | North West London Integrated Care System<br><br>North West London Clinical Commissioning Group | London Borough of Brent |