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

North West London Integrated Care System update

August 2021

This is the July and August update from the NW London Integrated Care System (ICS) and includes:

1. Covid-19 vaccination programme
2. Mental health update
3. Inequalities and population health
4. Resident engagement
5. Post-covid syndrome
6. Pelvic health pilot
7. Our financial challenge
8. Acute care update
9. London Ambulance Service
10. NHS 111

1. COVID-19 vaccination programme

In line with other systems, the focus of the vaccination programme is now moving away from mass vaccination centres to primary care and pharmacies. We will continue to support the programme with pop-up vaccination clinics where needed. Our mass vaccination centres are now being phased out, with the exception of CP House in Ealing, which will remain open to ensure that there is enough capacity in the borough.
Phase 3 of the vaccination programme, with a focus on booster vaccinations and then moving into the flu/winter campaign, will start in September.

2. Mental health update

2.1 Vaccination of people on the serious mental illness (SMI) register

Over 60% of people aged 16-64 years on the SMI register have received at least one COVID-19 vaccination as of the end of July. Hillingdon is performing the best at 70%. People on the SMI register were in group six for the vaccination in order to reduce inequalities in outcome (notably premature mortality and morbidity) in this group.

2.2 People with a learning disability (LD)

79% of people with LD aged 16 and over had received their first vaccine, and 72% had received the 2nd vaccine as of the 4 August 2021. People with LD were also in priority group 6.

2..3 Maternity Trauma and Loss Care (M-TLC) service launch

A new service went live on 26 July as a partnership between our mental health trusts and maternity services, led by a lead midwife and clinical psychologist. The service supports

women who experience fear of childbirth, birth trauma or loss and accepts self-referrals. The first phase of the pilot service commences out of Chelsea and Westminster, West Middlesex and Northwick Park hospital sites, before rolling out across NW London by March 2022. For more information.

2.4 Community Multi-Systems Violence Reduction Programme (London Vanguard) expression of interest

NW London CCG and partners are collaborating on an expression of interest to support young people (up to aged 25 years) affected by violence. A proposal is being developed based on existing service provision, accounting for the needs of our population and working out how best the model would be delivered. The final proposal will be submitted on 3 September 2021. Funding of ~£835k is being made available with ongoing funding to 2024 and successful ICS's will be notified by the end of September.

2.5 Autism support, advice and social prescribing service (14 years plus)

A new service for autistic people without a co-occurring learning disability was launched last month. The service which is provided by the Centre for ADHD and Autism Support is being shaped and delivered by autistic people and provides pre and post diagnostic support. Specialist training and advice will be offered to employers and providers of healthcare, social care, and education, to promote autism aware communities and reasonable adjustments for autistic people.

2.6 Autism friendly environments – mental health and paediatric inpatient settings

NW London CCG has worked with partners to develop a proposal seeking £199k spending review funding to develop sensory friendly environments within five of our mental health inpatient settings (Lakeside, Northwick Park, St Charles, Collingham Children's Centre and Lavender walk Adolescent Unit). If successful, the funding will be invested in soundproofing, silent alarms, sensory equipment, portable furnishings and staff training. An expression of interest has also been submitted seeking £73k to convert an office adjacent to the main paediatric ward at Northwick Park into a low stimulus one bedded ward and sensory area to offer a safe and quiet clinical space where autistic children and young people can receive treatment and therapy and/or relax and de-escalate.

2.7 Mental health crisis care

NW London has recently completed a procurement exercise for the NW London suicide prevention service and awarded the contract to charity Rethink Mental Illness.
Rethink has now begun to co-ordinate and deliver a programme of initiatives; establishing a NW London-wide suicide prevention network, co-producing a multi-agency suicide prevention plan, providing suicide awareness training, and delivering projects and initiatives offering direct support to service users.

2.8 Digital mental health (11-25 years)

An online mental health platform (Kooth) for children and young people between 11 and 25 years offering a single, consistent digital service across all NW London boroughs from 1

June 2021. This new service provides mental health and wellbeing support through an anonymous, self-referral digital service that enables children and young adults to 'drop in' and find fast, easy and free support at a time suited to them. A social media and local press campaign has supported the go live of the service, with additional promotional work underway with schools, universities and colleges, local authorities, mental health teams as well as primary care services, such as GPs.

2.9 Children and young people's (CYP) mentalhealth

The ICS is investing in transformation funding for the provision of additional support for children and young people in the following areas:

1. Increase early intervention through the expansion of mental health support teams in schools
2. Increase access to CYP community services through consistently delivering a minimum. 35% access rate and ensuring that a minimum of 10,923 CYP aged 0-18 years can access services, as well as ensuring that a minimum of 285 18-25 year olds can access services
3. Reduce CYP mental health presentations and lengthy waits at A&E through the development of a comprehensive crisis response across NW London that provides 1) Single point of access including through NHS111 to crisis support, advice and triage, and 2) Crisis assessment and brief response within the emergency department and in community setting
4. Improve eating disorder services through reduced waiting times and more intensive outreach and home treatment in the community.

3. Inequalities and population health

Over recent weeks we have worked closely with colleagues from across the ICS to develop our strategic plan setting out how we will deliver the ICS objective to tackle inequalities in outcomes, experience and access. This work has been informed by engagement with local residents through our vaccine equity programme and the Covid-19 vaccination programme and is being taken forward as a joint NHS and local authority initiative. The aim is to have a published ICS document by the end of September, when we propose to publicly launch a programme to take this work forward, working with our local residents and communities.

In developing the plan, we have recognised key learnings we have identified during the Covid pandemic, and acknowledged that if we want to tackle inequalities we need to work differently, recognising opportunities in utero, in childhood, and in adulthood. Our plan will acknowledge the need to address historic racism through ongoing hyper-local engagement with independent facilitation.

We will expect all ICS workstreams to specifically work towards:

- Reducing inequality of access
- Reducing inequality of outcomes
- Reducing inequality of experience
- Enhancing economic impact of our work

We will set out a series of pledges and principles that will enable us to do that. Primary Care Networks operating at neighbourhood level will be a key delivery vehicle for population health and tackling inequalities.

We will share the draft plan for discussion in the autumn.

4. Resident engagement

Over the past month we have been working to consolidate citizen and community insight and intelligence to help shape our plans and priorities as well as well as shape our involvement approach.

The approach to involvement has been shaped by the learning from:

- Our 10-week Quality Improvement and Co-production 'Vaccine Equity Huddle' evaluation and the evaluation and the emerging 'design principles'
- Our lay partner co-produced programme on 'best practice approach to resident engagement'
- The Community Voices: Conversations for change recommendations on connecting with residents and communities to transform health and care
- The EPIC (Engage-Participate-Involve-Collaborate) programme in which we worked with over 100 residents to develop proposals for how we work with local residents as an ICS.

This approach is centered around:

- The application of 'Collaborative Spaces' as an approach which will require long term commitment and a plan that aims to build trusted relationships with citizens and communities at neighbourhood, place and across the system. The focus and investment will be targeted in areas of greatest inequality and the test bed for this approach will be the Co-production and Collaboration workstream as part of the ICS Anchor Institution Programme, which will be co-chaired with our Head of Partnerships and Engagement and Healthwatch.

- The recruitment and development support of Lay partners from diverse backgrounds and communities to be involved in the delivery of Local Services and ICP Priorities.

- Supporting the development of PCN Patient Participation Groups

- The gathering of community, patient and citizen insight and intelligence as well as the creation of a central repository of qualitative data that is accessible across the ICS in our communities.

In terms of gathering insights and intelligence, data for monthly reports is collected from over 100 community, voluntary and Healthwatch based events and outreach; insight and

feedback was also gathered through community-based Q&A sessions as well as published reports by equality groups.

The four overarching messages to the ICS from the community and voluntary Sector have been embedded in the ICS Population Health and Health Inequality Strategy.

A summary of the messages:

a. Communities do more when they decide for themselves -in particular, **having a say over the estates and neighbourhoods that they live in and shaping the services that they use**, this is the only way we will be able to manage the rising demands for health and care services.

b. Community and faith spaces are the lifeblood of local action - the starting point for all health and wellbeing programmes should be in these spaces first and foremost and that we **prioritise building a local and diverse workforce to deliver the programmes and activities**.

c. Systemic Inequalities have a negative impact on the health of our population in particular the health and wellbeing of vulnerable and excluded communities - **equipping communities that experience the greatest inequality with resources, tools and investment** so that they can decide on sustainable solutions to reducing inequalities.

d. Measure what people value - work with residents and communities to **agree a shared purpose and locally defined** individual, community and system **outcomes**

As part of the EPIC programme, we worked with residents to co-design an Involvement Charter, which sets out standards for involving local people in our work and on which we are currently seeking views. The Charter sets out five standards as follows.

Involvement charter (draft)

	Standard	Evidence
	We will make sure:	
1	You can be involved in all decisions that affect you.	The process for involving the public before decisions are taken and evidence that we have followed it.
2	You will know how your views have shaped and influenced the decisions we have taken.	Evidence of their views from the public have been taken into account in making decisions and shaping services.
3	We will co-design services with local people, working with all the communities we serve.	The process for involving local communities in shaping our services, especially those most affected.

4	We will provide you with information that is in plain language, timely, balanced , objective and in different formats when needed.	Information and material provided for the public.
5	We will be transparent in everything that we do.	A clear and transparent decision-making process.

5. Post Covid syndrome

Work on Post-Covid |Syndrome (sometimes called Long Covid) is ongoing and pathways have been defined. GPs have had guidance on what they need to do for patients presenting with symptoms and when/how to refer them onwards. For those discharged from hospital after severe Covid, general post-discharge clinics will identify those patients with probable post Covid syndrome and pass them to Post Covid Assessment Clinics where required.

Post Covid Assessment Clinics are provided across five locations in NW London, to make the service as accessible as possible for patients. The clinics meet regularly to ensure that they provide a consistent model of care across the sector. Where patients have had the necessary investigations and then need treatment, they are passed on to multidisciplinary teams covering each NW London borough.

Both the clinics and the community teams are closely monitoring the data, showing who is accessing their services, what their needs are and how long they are having to wait for assessments.

Material is being co-developed with a user group of experts by experience in order to support self-management of the condition. This includes written material, a website and recorded webinars. Patient groups have been set up with people who have been diagnosed with post-Covid syndrome and on the pathway or who are self-diagnosed. There are currently 12 members who attend the user group and to date, there have been three meetings. The patient group is an important step in providing the insight needed to design the support and communications tools under development and has provided valuable insight. Some of the key findings from the last meeting were:

- The group accept that post Covid syndrome is new to the NHS but pointed to a distinct lack of information Those referred are either still waiting or unsure with the service, due to there being sparse information.
- There seems to be a difficulty with referrals to the assessment centres. Members felt GPs are unsure about the diagnosis or how to refer and post COVID referral seems to be the last option
- In terms of symptoms, every member spoke about brain fog, lack of energy and/or an exacerbation of their previous long term condition. Those with children and/or working had further anxieties with their mental health and well-being. All members, were relieved to hear each experiences and stories.

Work has begun to build the platform for a webpage that will host post Covid information and resources for people to help them manage their post-Covid conditions. This will include information on post Covid syndrome, FAQs, case studies and links to local support services. The patient group will be used as a useful resource to test the information we provide and enhance the support offered. We will be carrying out a schedule of planned activity in conjunction with our local authority partners in September, when the materials are ready to go live.

Another element of self-management will be the introduction of an app which gives patients guidance on how to manage their symptoms and also provides a platform for patients to give updates to the professionals treating them.

6. Pelvic Health Service Pilot

A national pilot study is underway to improve the care of women's pelvic health during pregnancy and after. NW London ICS is one of the 14 regions across the England chosen to participate in the pilot.

As part of the pilot, we will review the support, education and services available for women and staff providing care to these women. This will include elements of pelvic floor education as well as how to direct people with changes to their pelvic floor and genital tract as a consequence of pregnancy and childbirth to help.

To kick off the project in NW London a survey will be widely distributed throughout August/September to capture women's experiences and an understanding of whether those that need help and support are getting it. The survey will be also supported by a series of webinars.

The outcomes will help to shape the development of services in each of the four NW London Trusts.

7. Our financial challenge

It is well known that NW London faces a significant financial deficit. We have carried out an analysing of the drivers of this deficit and we have a plan to move back to a position where we operate within our financial allocation. This includes addressing the shortfall in our national financial allocation and areas where we currently overspend or pay too much for services. Our plan also commits us to spending less money on non-clinical services and to running all our services more efficiently, so that we can protect frontline services as we tackle our underlying deficit. Working as a single system across NW London, with reduced duplication and resources targeted to where they are needed most, can only support this. During the financial year 2020/21, the way in which NHS organisations were funded changed. We are now funded at system (ICS) level and resources are allocated as appropriate across the local system. Non-recurrent additional funding to tackle the Covid-19

pandemic was included in budgets for the last financial year, NW London was able to manage within its allocated budget.

For 2021/22, the national team has confirmed that we will move back to previously published allocations for each ICS. This reduces our available funding by 16%. We have an underlying financial deficit of £453m, which rises to £502m when allowing for winter. This deficit breaks down broadly as £100m in commissioning, £97m in regional services (London Ambulance Service) and £256m in our providers.

A further reduction of £107m (5%) is expected in the second half of this financial year. In 2022/23, a reduction in the Elective Recovery Fund and a further reduction of £120m is expected. We have set up a Financial Recovery Board to address the challenge of continuing to deliver services within our reduced budget.

Analysis of the deficit

We have analysed the underlying deficit (excluding LAS, for which NW London is responsible for only 20%) and drawn the following initial conclusions:

- Funding is based on raw GP list size and we have analysed this against ONS and GLA population data. It does not currently include ongoing Covid costs, which we expect to be an important factor. Even allowing for NW London currently being 1% over its target funding, we are 1.3% under-funded as a system by population. Our population has grown by 3.3%; we are funded at 1% for this. In income terms, this creates a shortfall of £70m.
- In 2019/20, NW London spent 60% more than the London average, having planned for 15%. All areas apart from running costs were more than the rest of the capital. The biggest gap between acute and actual spending was on acute care and this would have been higher if we did not have risk share arrangements in place.
- When removing the £36m of additional Covid funding, the CCG spends £64m more than it can afford.
- The unit costs of some of the healthcare we provide are higher than we would expect: the quantum of this cost is between £300-463m.
- Our acute provider collaborative has identified £230m of excess costs. A work programme is underway to look at nine specialities where there is consistency across providers and this cover £96m of the over-cost. However, it is important to recognise that the analysis may over-state the financial opportunity as there will be financial attribution issues. For this reason, the data will not be used on its own but we will also draw on national Model Hospital data.
- Our out of hospital collaborative, primary care and mental health are also looking for opportunities to improve productivity and efficiency. We will of course continue to meet the Mental Health Investment Standard and to invest in primary and community care: this exercise is about ensuring we get value for money and deliver services as efficiently as we can.

Financial recovery plan

Our Financial Recovery Board is developing a financial recovery plan, which will be brought to future meetings of the statutory NHS bodies (CCG and Trusts) and shared with Health and Wellbeing Boards and scrutiny committees.
Our immediate actions include the following.

- Continue to evaluate Covid costs and work with the national team on funding. Locally, work with our borough (ICP) teams on GP lists and population data to inform these discussions.
- Our Local Care workstream is pulling together a standard definition for the expected specifications for community services
- We are looking at all contracts to ensure a more standard offer and no duplication across NW London.
- Our provider collaboratives are looking at over-costs and targeting variances, including the £96m identified by the acute provider collaborative.
- Working with the London and national teams to agree a resilient specification with benchmarked cost for the London Ambulance Service.

8. Acute care update (Chelsea and Westminster Hospital, The Hillingdon Hospitals, Imperial College Healthcare and London North West University Healthcare)

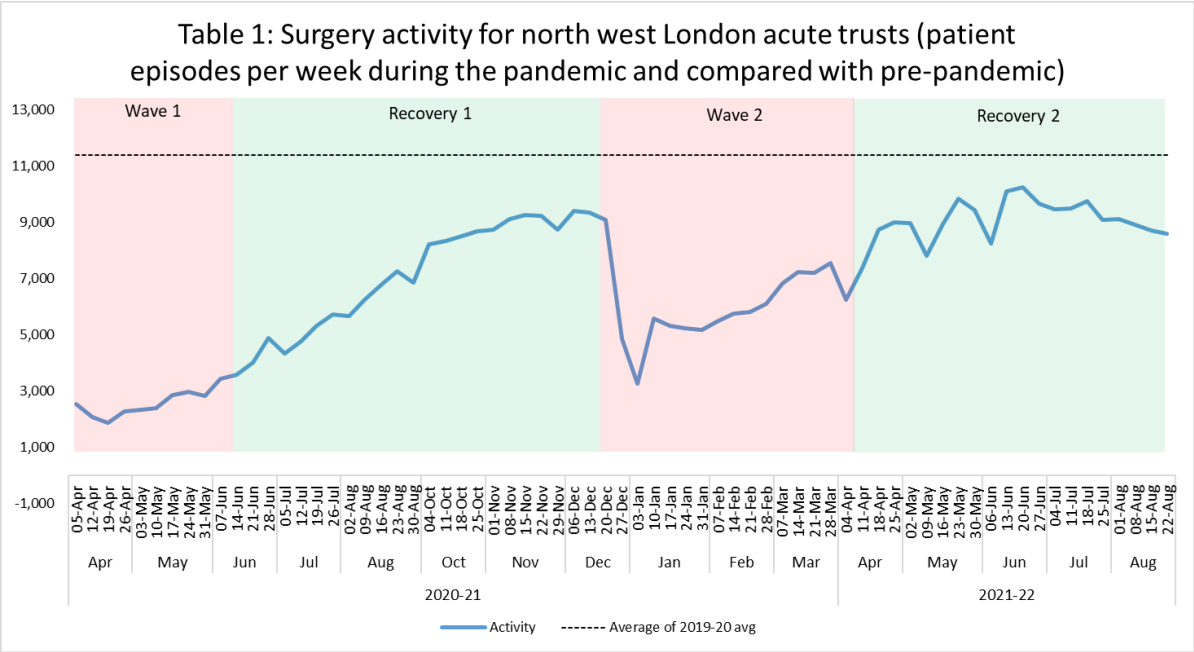
1 Overview

We are continuing to recover our services following the peak of the Covid-19 pandemic. As reported previously, we are continuing to offer acute patients who have been waiting a long time for treatment the option of being treated in another NW London hospital. We are looking to ensure that cases are prioritised fairly across NW London, recognising that a significant backlog developed due to the pandemic. We are working as quickly and efficiently as we can to tackle the backlog cross all services. Infection prevention and control guidance remaining in place on NHS premises and we continue both face to face and digital appointments as appropriate for patients.

2 Returning to pre-pandemic capacity and improving care pathways

2.1 Planned surgery

We are learning much during the pandemic and working hard to apply that learning rapidly. While we treated more patients with Covid-19 in the second wave of infections, we also managed safely to maintain more planned care. In wave one, planned surgery activity dropped to as low as 15 per cent of pre-pandemic levels while we maintained 50 – 60 per cent of our pre-pandemic activity levels throughout the vast majority of the second wave.



In August 2021, we averaged 83 per cent of pre-pandemic planned care activity levels. We achieved 87 per cent in June and took the decision to reduce activity slightly through July and August in order to help ensure our staff had an opportunity to rest and recuperate. In addition, our hospitals are under pressure from unplanned admissions. This includes continuing admissions due to Covid-19, albeit at a much lower and steadier level than during the second wave of infections. A national target has been set for planned care recovery which, if we meet, gives us access to additional central income through the elective recovery fund (ERF). The national target was up to 85 per cent for the first quarter of 2021/22, which we met. The target was increased to 95 per cent from July and we are working to meet that level from September.

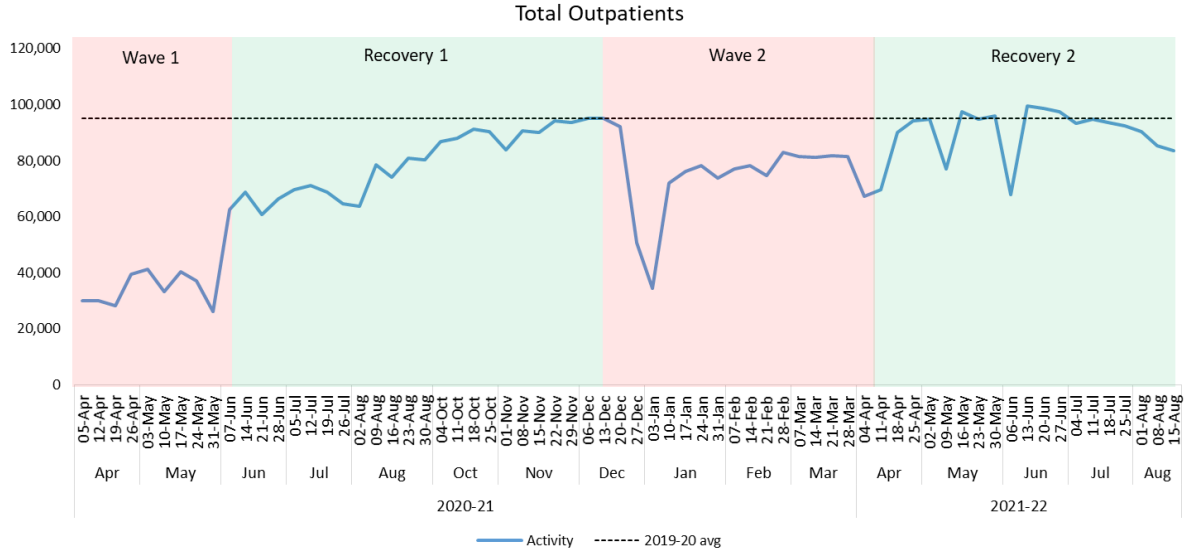
To help us boost capacity, we are maximising the use of our existing facilities, using national benchmarks and best practice (supported by the national Getting It Right First Time (GIRFT) programme) to help us understand where we should focus our improvements. Our clinical and operational leaders meet regularly through joint 'speciality huddles' and sector wide clinical reference groups to review data visualisations to aid analysis and agree actions.

The GIRFT approach also underpins the further development of our fast track surgical hubs -14 surgical facilities across our hospitals dedicated to one or more types of routine operation where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of that procedure systematically. The hubs focus on six clinical specialties characterised by 'high volume, low complexity' procedures.

For a small number of services with particular capacity challenges, we have brought in an external specialist organisation to provide additional capacity within our own facilities or contracted with an independent sector hospital to provide surgery or treatment for our patients.

2.2 Outpatient care

Table 2: Outpatient care activity for north west London acute trusts (appointments per week during the pandemic and compared with pre-pandemic)



During the second wave of Covid-19 infections, we managed to maintain outpatient activity at around 80 per cent of pre-pandemic levels. In August, we averaged 97 per cent of previous levels, continuing to exceed the national target which was 85 per cent for the first quarter of 2020/21, increased to 95 per cent from July.

We are continuing to provide around 25 per cent of our outpatient consultations via telephone or video. We had to move quickly to virtual appointments at the start of the pandemic and, while we need to continue to improve the user experience and our own processes, the vast majority of patients and clinicians welcome the new approach and want it to continue.

A further significant development for outpatient services will be the implementation of a common and consistent approach to how our hospital clinicians work with GPs to provide specialist advice and guidance earlier in a patient's care pathway. This will help determine whether and how a patient should be referred for hospital care or whether their condition is
better managed in the community or at home. The approach is being supported by investment in a sector-wide digital platform for GPs and hospital clinicians, to be integrated with core patient administration and referral systems so that a referral can be progressed automatically if required. The system is already being used by The Hillingdon Hospitals and London North West University Healthcare and will be rolled out to Chelsea and Westminster and Imperial College Healthcare this autumn.

2.3 Cancer care

Urgent cancer referrals (on the 'two-week' pathway) have increased since March 2021 and are now above the average for 2019/20. We have still managed to improve performance against the national 'faster diagnosis' standard, with 73 per cent of patients being informed whether they have cancer or not within 28 days of urgent referral as of July 2021, equivalent to an additional 400 patients month.

The significant increase in referrals is having an impact throughout the cancer care pathway. Overall, as of July 2021, cancer first treatments are up 8 per cent against of the baseline of 2019/20. Total cancer surgical treatments (excluding skin and breast) are up 16 per cent against the 2019/20 baseline, with an additional 139 surgeries compared with the 2019/20 average. This increase in demand is creating capacity and operational pressures and longer waits for cancer care than planned. Performance against the 62-day wait (between an urgent referral and the start of treatment) standard is stable at 78 per cent. Together with RMP Cancer Alliance and wider partners across the integrated care system, we are working through how we can best achieve greater, sustainable improvement.

The increase in referrals is a positive development following a fall-off in patients presenting with cancer concerns during the pandemic. There continues to be a major sector-wide focus to help increase awareness amongst local communities, GPs and other partners of the importance of investigating cancer symptoms as soon as possible. The overall 'gap' (between actual and expected cancer diagnoses and 'first treatments') for patients resident in north west London has significantly reduced since March 2021 - from a starting deficit of 471 patients to a deficit of 233 patients in July 2021.

2.4 Diagnostics and imaging

Activity for all but one imaging modalities is now above 2019/20 levels. The exception is non-obstetric ultrasound which is running at 60 per cent of 2019/20 activity levels though referrals have also reduced due to the introduction of more detailed referral guidance. We are addressing some specific capacity challenges in the same way as for planned surgery, by offering care in our hospitals where there is more capacity and making use of independent sector capacity.

Greater collaboration and coordination is enabling a major upgrade and expansion of imaging equipment, funded by a national programme, to deliver greater benefits to our local population. Following replacement of two MRI scanners at St Mary's Hospital in February 2021, a further two new scanners are now being installed at Ealing and West Middlesex hospitals. A wider transformation programme is in development.

3 Minimising clinical harm and engaging with patients

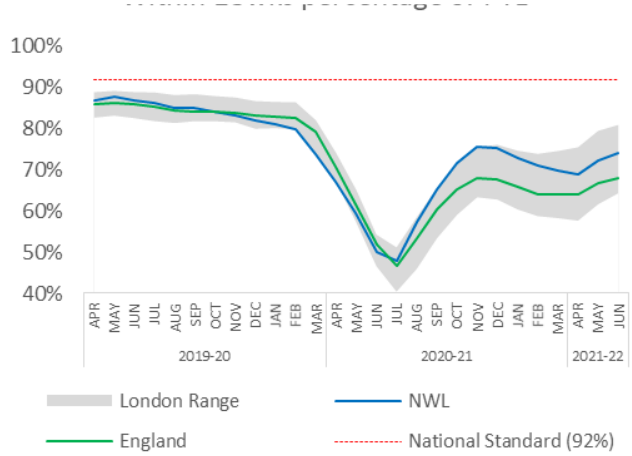
Our clinicians continue to prioritise all patients according to clinical need and regularly review patients waiting for treatment for potential clinical harm. They aim to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify appropriate remedial action. We are following principles established by the medical royal colleges which have been adapted for local use by the clinical leaders across north west London who make up the clinical reference groups for the different specialties.

We are beginning to roll out a pilot to improve communications and engagement for patients who have been waiting a long time for outpatient care and planned surgery, beginning in ear, nose and throat services at Imperial College Healthcare. It includes a letter and materials apologising to patients for the delay, providing information and

advice about their care and asking them to confirm their details and whether they still need their appointment. Initial results have been positive, with the vast majority of patients who respond saying they feel more reassured and some letting us know that they no longer need care or rearranging their appointment or changing their details, helping us to make best use of our resources.

4 Tackling long waits and making waiting fairer

Table 3 Percentage of patients who have been waiting 18 weeks or less from referral to treatment



In line with expectations, our combined waiting list increased during the first quarter of 2021/22 though our sector has the lowest per capita list in London. As of June 2021, an overall total of 179,753 patients were waiting for planned care, equivalent to 85 patients per 1,000 population. As of June 2021, 74 per cent of patients had waited 18 weeks or less from referral to treatment, still under the pre-pandemic national standard of 92 per cent but significantly up on a low of less than 50 per cent in July 2020. As a sector, we are also above the average for England.

Like the rest of the NHS, though, a significant number of patients on our list have been waiting for a long time. Alongside ensuring we treat patients with urgent clinical needs within the safest timescales, we have also put a special focus on treating those with the longest waits.

We have reduced the number of patients waiting 52 weeks or more from a peak of 6,802 in February 2021 to 3,883 as of June 2021. Currently, 2 per cent of patients on our list are waiting more than 52 weeks, compared to 4 per cent for the whole of London and 6 per cent across England. We have reduced the number of patients waiting more than 104 weeks from a peak of 126 on 17July 2021 to 112 patients at the end of August. Almost all of these patients now either have a booked date for their treatment or have chosen to postpone their treatment further for personal reasons. We are committed to having no one waiting over 104 weeks by the end of 2021/22.

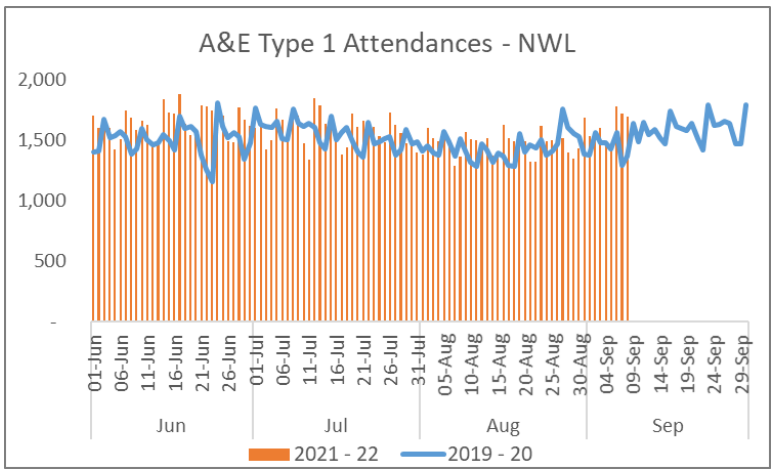
Closer collaboration has been one of the key ways in which we have been able to tackle our longer waits and it is also driving a strategic development to make waiting

times fairer overall. We have been creating a single view of waits across our hospitals to understand where a service in a hospital that has good capacity might be able to support the same service in another hospital that has long waits. In recent months, we have been able to offer faster care for patients waiting for gynaecological surgery, cataract surgery and endoscopy.

Longer term, we want to create a common and consistent approach to managing waiting lists across specialties and hospitals as effectively as possible. We're working towards common definitions and processes and beginning to explore digital systems to help provide up to date information and booking support to hospital clinicians and GPs, as well as to patients.

5 Urgent and emergency care

Urgent and emergency attendances continue to be significantly higher than expected for this point in the year. We have a major focus on Trust and sector-wide plans and improvements to help manage demand as we head into the winter. This includes: an expansion of 'same day emergency care'; optimising our 'front door' pathways, including encouraging the use of NHS111 First, to avoid waits in A&E and urgent treatment centres; and closer working to reduce delays in discharging patient who are medically fit to leave hospital.



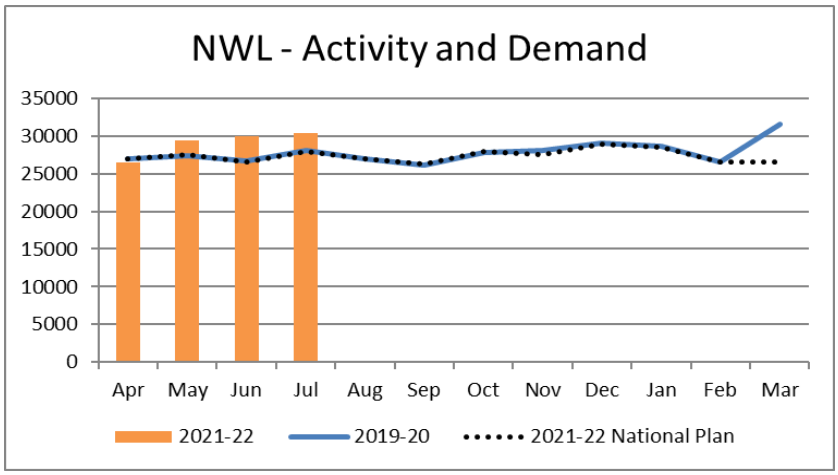
6 Specialist care

While not formally part of the acute care programme, the four acute providers are also working collaboratively, along with NHS England, to improve the quality of specialist care services. So far, the vascular care teams from Imperial College Healthcare and London North West University Healthcare have come together to provide complex surgery for abdominal aortic aneurysms in one centre at St Mary's Hospital in line with research demonstrating best practice and outcomes. This service change was completed in July 2021, with engagement and input from our local authorities and wider stakeholders. The two clinical teams are continuing to work together in order to explore further improvements.

Clinical leaders for a number of other specialist services in the four acute providers, including complex colorectal cancer, pouch surgery, head and neck cancer and

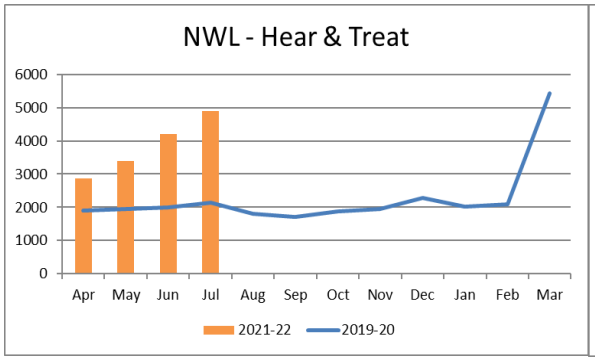
clinical haematology, are also coming together to explore opportunities to improve quality through greater collaboration and, potentially, some service consolidation.

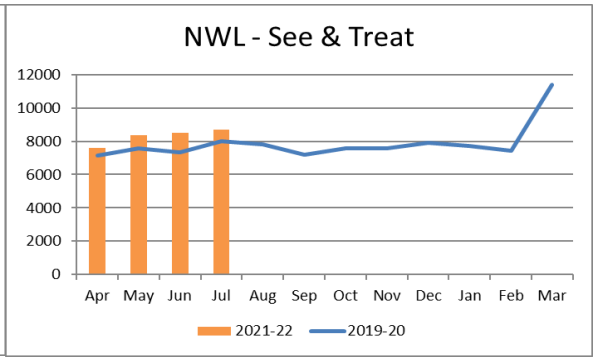
9. London Ambulance service



At month 4 (July 2021), total incident activity has risen above 2019/20 levels adding pressure to LAS services.

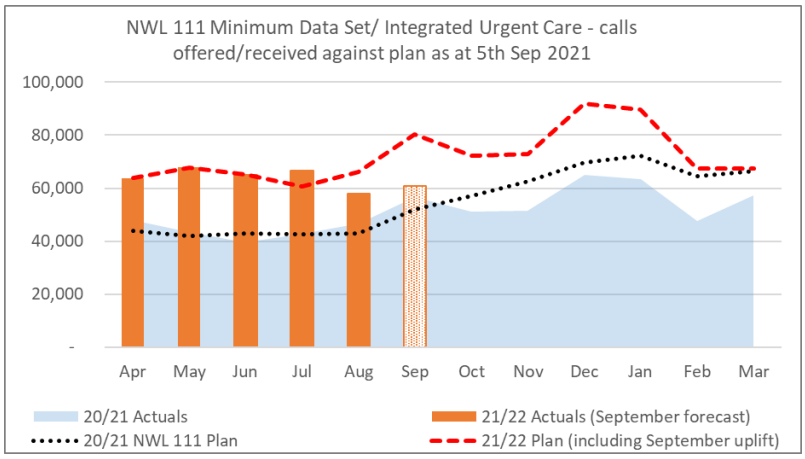
London continues to have low rates of conveyance to hospital relative to other parts of the country. This has been achieved through a significant increase in interventions where more cases are closed without conveyance to hospital. allowing ambulance crews to be diverted to more serious, high priority incidents.





10. NHS 111

NHS 111 has also seen increased levels of demand. Demand connected with lower acuity health conditions has been a factor, in line with a resurgence of patient demand for all healthcare services, particularly primary care.


NWL 111 Minimum Data Set/ Integrated Urgent Care - calls offered/received against plan as at 5th Sep 2021
100,000
80,000
60,000
40,000
20,000
-
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
20/21 Actuals
21/22 Actuals (September forecast)
20/21 NWL 111 Plan
21/22 Plan (including September uplift)