North West London Joint Health Overview and Scrutiny Committee AGENDA

DATE: **Tuesday 14 December 2021**

TIME: **10.00 am**

VENUE: **Virtual Meeting - Online**

COMMITTEE MEMBERSHIP (Quorum 6)

Chair:

Councillor Ketan Sheth	-	London Borough of Brent

Members:

Councillor Iain Bott	-	City of Westminster
Councillor Daniel Crawford (VC)	-	London Borough of Ealing
Councillor Marwan Elnaghi	-	Royal Borough of Kensington and Chelsea
Councillor Lucy Richardson	-	London Borough of Hammersmith & Fulham
Councillor Rekha Shah	-	London Borough of Harrow
Councillor Richard Eason	-	London Borough of Hounslow
Councillor Nick Denys	-	London Borough of Hillingdon
Councillor Monica Saunders	-	London Borough of Richmond upon Thames

Contact: Andrew Seaman, Senior Democratic & Electoral Services Officer
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Useful Information

Meeting details:

This meeting is open to the press and public and can be viewed on www.harrow.gov.uk/virtualmeeting

Filming / recording of meetings

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Agenda publication date: 6 December 2021

1. Attendance by Reserve Members

To note the attendance at this meeting of any duly appointed Reserve Members.

2. Declarations of Interest

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Committee;
(b) all other Members present.

3. Minutes (Pages 5 - 18)

That the minutes of the meeting held on 23 September 2021 be taken as read and signed as a correct record.

4. Matters Arising (if any)

5. London Ambulance Service - Update (Pages 19 - 20)

6. Integrated Care System (ICS) - Update (Pages 21 - 28)

7. Palliative Care Review (Pages 29 - 96)

8. North West London Workforce - Update (Pages 97 - 136)

9. Any Other Business

Which cannot otherwise be dealt with.

10. Next Meeting

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DRAFT North West London Joint Health Overview and Scrutiny Committee
Notes of hybrid meeting by LB of Brent
10am-12pm on 23 September 2021

The meeting began at 10am.

PRESENT

Members of the Committee:
- Councillor Ketan Sheth (Chair) – London Borough of Brent
- Councillor Richard Eason – London Borough of Hounslow

IN ATTENDANCE REMOTELY:

- Councillor Daniel Crawford (Vice Chair) – London Borough of Ealing
- Councillor Lucy Richardson – London Borough of Hammersmith & Fulham
- Councillor Rekha Shah – London Borough of Harrow
- Councillor Marwan Elnaghi – Royal Borough of Kensington and Chelsea

Others Present:
- Rory Hegarty – Director of Communications & Engagement, NWL CCG;
- Pippa Nightingale – Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG;
- Lesley Watts – Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust
- Nicola Zoumidou – Policy Analyst, London Borough of Hounslow
- Andrew Phillips – Governance Officer, London Borough of Brent
- Hannah O'Brien – Governance Officer, London Borough of Brent
- Jacqueline Barry-Purssell – Senior Scrutiny and Policy Officer, London Borough of Brent
- Anna-Marie Rattray – Scrutiny Review Officer, London Borough of Ealing
- Artemis Kassi – Lead Scrutiny Advisor / Statutory Officer, Westminster City Council
- James Diamond – Scrutiny Officer, Royal Borough of Kensington and Chelsea
- Nahreen Maitlib – Interim Head of Policy, London Borough of Harrow
- Bathsheba Mall – Committee Co-ordinator, London Borough of Hammersmith & Fulham
- Dr Genevieve Small – Chair, Harrow CCG

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1. Apologies were received from:
- Councillor Iain Bott, Westminster City Council
- Councillor Monica Saunders, London Borough of Richmond

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 Foundation Trust (CNWL).

3. MINUTES OF THE MEETING HELD ON 4 JULY 2021

3.1. The Committee reviewed the minutes of the last meeting, and following discussion it was

It was agreed in principle, subject to ratification at the next quorate meeting:

That the minutes of the meeting held on 4 July 2021 be agreed as a correct record of proceedings.

4. MATTERS ARISING

4.1. The Committee reviewed the minutes of the last meeting, and the Chair asked whether the action items had been completed. This would be reviewed via email after the meeting.

5. NORTH WEST LONDON NHS ACUTE HOSPITAL STRATEGY

5.1. Toby Lambert (Director of Strategy, NWL ICS) introduced the item and gave an overview of the strategy. It was noted that the purpose of the report was to make colleagues aware of the new strategy as the move to the formal establishment of an integrated service occurred across North West London. The update also provided information on four sites in the Government's hospital building programme, those four sites being Hillingdon Hospital, St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital.

5.2. In introducing the report, he noted that:

- Though this was labelled as an acute strategy, it was purely focused on the hospital sector.
- Toby noted that the strategy focused on two narratives, one being assessing the top needs of the population and how this fed into outcomes and variations. After this the model of care could be analysed, with a particular focus on out of hospital care to look at what needed to happen within the hospital sector.
- The second narrative was highlighting that hospitals were major building blocks in local communities, which meant assessing the redevelopment of hospitals to give an opportunity to address broader health inequalities.
- Toby went through the narratives and the strategy for North West London hospitals, tying in to the overall acute strategy.
- There had been an increase in emergency work, elective work, and now a growth in demand around mental health support, in children and young people in particular. Consideration was required for allocation of resources between all of these.
- Collaboration was happening and welcomed by NHS and Local Authorities.
- There had been open and transparent discussions with citizens and patients.

- Lesley Watts paid tribute to her primary care colleagues, and advised that the NHS was committed to dealing with long-term issues.

The Chair thanked all NHS staff on behalf of the Committee. The Chair then invited questions to NHS representatives from Members of the Committee.

5.3 Cllr Richardson welcomed the duality of narratives, however raised concerns that some of the strategy was top heavy, noting that a more detailed/bottom up strategy could be provided in terms of the engagement activity. He added that it was important the local NHS recognised the importance of local needs with a hyper local approach, looking at the wider social determinants of health. The Committee would welcome the Strategy having more detail from residents, including patient interaction with receptionists and patient participation group feedback. Toby Lambert noted that the engagement approach was being worked on and a lot of the focus would be on population health inequality work which fed in to the strategy. He assured councillors that the hyper local inequalities work was happening and was happy to present further details to the Committee on how that might work in practice. In relation to how the strategy would include every patient's voice, including those difficult to hear from, the Committee were advised that patient reference groups could be expanded. The ICS looked to reach all communities to take part in those groups, and outreach work during the pandemic had established closer relationships with community leaders, faith leaders, and charity and third sector groups. A new engagement approach was in the pipeline to be launched in October 2021 which would focus on health inequalities. Toby Lambert advised that more information could be provided to the Committee then.

5.4. Cllr Elnaghi asked how the ICS would address variation in patient outcomes in terms of health inequalities, highlighting the need for more data driven content in order to build on the policies to develop the strategy. He felt the ICS should be going to the users, whether that be through going to schools, young adults and the wider community as well as building capacity to use services provided by pharmacists. Pippa Nightingale (Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG) noted that policy could be formulated through co-design rather than solely resident engagement. The co-design of a clinical pathway was noted as a policy which could assist with this goal. It was acknowledged by Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) that the approach should be for all NHS leaders and local authority colleagues to address inequalities and variation in outcomes. She felt this was demonstrated through mutual aid and the approach to elective care, where the longest waiters were being offered treatment from inner NWL hospitals. It was also highlighted that North-West London ICS had committed to a very fair and equitable approach.

5.5. Lesley Watts noted that this strategy was designed for both emergency and elective care procedures. This strategy did not stand on its own but with strategies for primary care, out of hospital care and local care. It was clarified that the strategy was starting to articulate how acute units and hospitals worked together to ensure that they could respond in the most positive way, to ensure that when patients needed to be in hospital there was capacity to take them in emergency and elective care.

5.6. The Committee would like to see the different initiatives discussed included in one strategy. Lesley Watts advised that the strategy was a work in progress and all the work streams discussed would be brought together, such as how housing and transport were integrated in to it. Rory Hegarty (Director of Communications) added that the new engagement approach due to be launched in October would include outreach with community groups and increasing that through local authority networks.

5.7. Cllr Crawford noted there was good commitment around the new hospitals programme, and queried how this would affect North West London hospitals. He felt that it would be good to learn more about the strategy in advance of its publication. Lesley Watts reassured the Committee that the new hospitals programme from central government would not lead to the closure of other local hospitals as it was designed to get hospitals built. The current hospitals in NWL being built within that programme were being built on the understanding they would provide the services they currently did. It was also stressed that inequalities would not be able to be addressed unless the ICS carefully considered how and where services were provided. Lesley Watts advised that this did not mean there would be no change, but any change would be considered together with patients, staff and other leaders such as Chief Executives of local authorities. As the programme was based on a no-change programme any change would require consultation and engagement.

5.8. In response to a query, the Committee were advised that there was a piece of work reviewing how many current ICU beds would be required in the longer term. The increase in number of beds had been retained until that work was done.

5.9. In relation to the use of pharmacists in the wider community, the Committee were advised that pharmacists were trained to be able to consult and prescribe medication, but were not currently used in that way, which could be further looked in to.

5.10. Cllr Eason asked whether the strategy would take account of projected population changes in the sector and of housing growth in many areas of North-West London such as Brent. He highlighted the strategy would need to consider the location of patients as well as workforce. This also related to transport systems by both road and rail, taking into consideration transport planning for London. It was noted that this strategy could contribute to transport planning. Toby Lambert confirmed that population growth had been accounted for in the strategy, using the higher end predictions from the latest GLA housing projections. In terms of transport, it was acknowledged that transport links which were in the pipeline would be considered for future planning.

5.11. Cllr Sheth asked what provisions had been made around primary care and GP services to ensure that locations could be fit and proper for healthcare. Dr Genevieve Small (Chair, Harrow CCG) explained that some of the challenges seen with new housing developments were that some of the planning was completed before Covid-19 and before the health perspective on infection control. It was felt that the resources and new builds should be made appropriate for the ‘Covid age’. Dr Genevieve Small also stressed that, as well as the health services needed, it was important for new communities in emerging housing to be able to utilise existing local resources to access the wraparound support that would keep them well. It was noted that the holistic approach to care was important, and this included services such as mother

and baby groups for new families, pharmacies and primary care, and was not focused exclusively on hospitals and outpatient departments. Finally, health colleagues felt it was important to strike a balance between community and hospital provision, as well as keeping up with changing demographics.

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

i) For an update on the acute strategy (including links with other strategies) to come back to the Committee at its December meeting.
ii) For the committee to review the acute strategy before being finalised.
iii) To note the report.

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

1. For NHS colleagues to provide the committee with further details of the specific engagement activity underway focused on the acute strategy and future plans.
2. For NHS colleagues to provide the committee with details of the data being used to focus activity on reducing health inequalities.
3. For NHS Colleagues to provide the committee with a copy of the draft acute strategy.

6. INTEGRATED CARE SYSTEM (ICS) UPDATE

6.1 Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) and Pippa Nightingale (Chief Nurse, NWL ICS; Chief Nurse Chelsea and Westminster NHS Foundation Trust and Vaccine Lead NWL CCG) introduced the item by stating that hospitals and GPs had resumed services and were very busy; including the national ambulance workload and emergency work, as reported nationally.

6.2 Pippa Nightingale spoke about the vaccination programme. There had been close to 3m vaccines given in North West London at the time of the meeting. There were now four arms to the vaccination programme. The first arm of the vaccination programme was the ‘evergreen’ offer’, with 900 people vaccinated every week for their first or second dose in NWL. The second arm was the booster campaign, offered through vaccination centres, primary care settings and community settings for over 50s. The third arm was schools vaccinations which went live on Tuesday 21 September, with an 84% uptake from children in the first schools that went live. The aim was for every school in NWL to administer the first vaccine before October half term. The fourth arm of the programme was the third vaccine for Clinically Extremely Vulnerable cohort - this was an additional vaccine rather than a booster as advised by the JCBI. The Committee were advised there were approximately 2.4m vaccinations that needed to be given over the next few months.

6.3 The Committee were provided with an update on vaccinations for those on the serious mental illness (SMI) register: over 60% of people aged 16-64 years old on the register had received at least one dose of the vaccination by the end of July. The ICS wanted

to ensure a mental health assessment was in place for patients through primary care and that they had access to the vaccine as they were a vulnerable population. Primary care were making contact with those patients where they had not come forward to be vaccinated, and where those patients were coming forward to be vaccinated the ICS were trying to ensure that it was a 'meaningful contact' in one complete offer, for both mental health patients and those with learning disabilities. The Committee were advised that learning disability schools were proactively working with the ICS on vaccinations and the parents and carers of those children were engaged in the model. For example, there had been dedicated quiet times in vaccination centres to enable those with learning disabilities to be vaccinated, with learning disability colleagues there to support that. In relation to mental health in general, Lesley Watts advised that there had been an increase in the number of patients attending emergency departments, and the ICS were working closely with mental health units, particularly in child adolescent mental health, to ensure that the demand was met.

6.4 The Chair thanked Pippa Nightingale and Lesley Watts for their introduction and invited comments and questions from the Committee, with the following raised:

6.5 The Committee queried whether it was possible to get data from other boroughs to compare their vaccination figures for people on the serious mental health illness register. Pippa Nightingale confirmed that there was borough data that could be sent to the Committee.

6.6 The Chair asked about how Afghan refugees were being supported in NWL. ICS colleagues advised that this was an important piece of work. All 946 individuals originally accommodated in NWL had now been moved out of isolation hotels and into 'bridging' accommodation in inner London Boroughs within NWL. The Committee were advised that the Department for Health and Social Care commissioned the care to Afghan Refugees and the ICS had put in place a whole layer of healthcare provision on top of that. For example, the mental health team from CNWL had done a lot of mental health first aid, assessments and emergency treatment in order to support refugees who had experienced traumatic incidents. Additionally, those who had to leave imminently without essential medications were being contacted by GPs to understand their complete healthcare needs. There was also support for pregnant people and the right maternity pathways were in place, with 96 pregnant people currently in accommodation in North-West London being supported by 12 midwives with 1:1 support. The primary care offer involved 24 hour access to 111 support, prescription writing, and health assessments, where GPs were registering individuals and families in their practices and then doing a full health assessment. The Committee were advised that the situation was becoming more stable and NWL would continue to provide that support to people joining the population.

6.7 Cllr Eason highlighted section 2.7 of the report and the work on mental health crises care and suicide prevention, asking about the scale of this work across the 8 boroughs. It was noted by the ICS that this was an important piece of work in order to minimise mental health crises which resulted in suicide. It was noted that this was initially a scoping piece of work; scoping what services already existed in each Borough and learning from different boroughs which models of care could be most effective. The ICS had also looked wider with the National Health Transformation Board to see what places outside of NWL were doing to reduce mental health crises. It was confirmed

that the ICS could report back what that model of care would look like. Lesley Watts added that it was a piece of work that was very important to the mental health offer in North-West London and there was a determination within the ICS that patients across the whole of NWL would have access to this service.

6.8 Cllr Eason noted that it was good to look at best practice nationally, and highlighted the importance of provision for those who may drop off the radar when moving locations or between boroughs.

6.9 Cllr Eason highlighted section 2.9 of the report relating to children's mental health, asking what the 35% access rate meant in terms of the other 65%. ICS colleagues highlighted that, during Covid-19, hospitals had seen that when children were presenting in crisis it was the first time they had presented and they were not previously known to mental health services, which was unusual previously. The number of children and young people presenting was increasing, and the age range was becoming younger. This had changed the way that care needed to be provided. Support in schools was being expanded and the children's mental health team had done some successful co-production with children and young people so that they could access care in other places. Where children presented in A&E they often stayed a long time in a specialist bed, so the ICS were looking for somewhere those children could be admitted for a short period of time with intensive support to get them back in to their home environment. There was not a one size fits all answer on this issue. In relation to the query regarding the 35% access rate, the Committee were advised that this was a national target for children and young people being seen, referred and treated in a timely way from when they first presented.

6.10 Cllr Richardson was interested to know more about co-production with young people and which boroughs this had been implemented in. It was clarified that many of the charity arms had supported this work which had been building momentum before Covid-19; this work was supported by Arsenal and Chelsea football clubs, who had a huge mental health and youth work provision. They had brought children from across the whole of NWL to take part in the sessions with 72 children attending over the 3 sessions. These were children who were previously known to mental health services, either through schools, online platforms or through tertiary mental health support. The Committee were advised that the sessions looked at what the mental health system should look like and was interesting, with the ICS looking to do more of this type of work. From this consultation, it was noted 24/7 online support was the preferred medium for a lot of young people accessing mental health support. Regarding online platform support offers, it was noted that there were currently three in existence. One was run by the Royal Minds Mental Health Trust, which had been commissioned for adolescents' mental health and wellbeing. There was also the Kooth interactive platform which could be accessed by children when they need support such as talking therapies and support groups. It was noted as being important to work in partnership with education to signpost these services.

6.11 Regarding the delivery of the vaccination programme, Cllr Richardson noted that Brent had very little administered by pharmacies; additionally half of the NWL boroughs were below average in terms of take-up and she queried how mistrust and misinformation around the vaccine was being addressed. Pippa Nightingale explained that, in terms of Brent's uptake in pharmacies, Brent had fewer pharmacies offering vaccinations in

the first stage of the programme, but now had 8 pharmacies offering the vaccination, so there may be a switch in the data following those additions. In terms of the low vaccine uptake in NWL, it was noted that some ONS data was outdated and did not reflect who was in the borough; however, public health messages still needed to be shared with the public and the ICS continued to do that and continued to see more people coming forward to be vaccinated. There were 46 pharmacists across NWL going live to administer vaccines over the next 2 weeks, which would address some of the public concerns about travelling to receive the vaccine. It was also hoped that the roll-out of the flu vaccine could provide meaningful conversations around receiving the Covid vaccine as well.

6.12 On the issue of vaccine hesitancy and the reasons for that, Lesley Watts noted that this data had not been recorded. The Committee queried whether this meant engagement with communities regarding the vaccine needed to be stepped up. ICS colleagues advised that health and the local authority were working together on this as it was a symptom of a much wider issue around mistrust. The Committee heard that one of the reasons integrated working had stepped up and had gone more at pace recently was to look in to these issues, as there would be multiple issues around the health of some of those populations that did not want to be vaccinated that needed to be understood. The Committee were advised that the work was started and would take time as there was no easy fix, but that the ICS needed to be consistent and determined and work hard with other partners to address these issues.

6.13 Cllr Crawford asked for more inequalities data to be provided when it became available. ICS colleagues advised that work was needed to understand how population health spoke to the JSNA in each borough. The ICS collaborated with Public Health Directors and local authority Chief Executives to ensure they had the best information available to inform the strategy for addressing inequalities.

6.14 Responding to a query relating to the involvement charter, Rory Hegarty (Director of Communications, NWL ICS) advised that the charter had been co-produced with residents and then published for consultation, which had received good feedback. The feedback was being worked through and the final document would be published in October to form part of the approach to engagement and inequality.

6.15 Cllr Eason moved on to the financial implications of the report and the underlying deficit of £453m, rising to £500m. Given the financial position of the NHS, he queried how achievable the savings programme was to close that gap. Lesley Watts answered that these were large figures which spoke to a variation across NWL that had been longstanding. There was an understanding of what it was that generated the deficit and the ICS had tried to be as transparent as possible in describing that deficit, and had provided clarity about the duties and responsibilities to drive out that variation. It was clarified that the solution to the deficit was not a one year fix, and may take a number of years to resolve. There was a need to ensure any cost inefficiencies were understood and driven out in relation to corporate costs and the provision of direct care. Lesley Watts chaired the Financial Recovery Board across the system, examining these issues for each individual provider in some detail. This was data driven to ensure that, where the ICS could see that some places were much more expensive than others to provide the same care, there was a work programme to drive out those costs. The programme was large and there were positives in terms of the

collaboration from all parts of the system to make sure money was used properly and fairly. The Committee heard that there was commitment from everyone within the system to be transparent and have an open book approach to see what was spent on what, and there was oversight from London and national bodies. The ICS were happy to bring an update on this piece of work to Committee on a regular basis.

6.16 In relation to the ambulance service and 111 pressures, the Committee was advised that North West London lead on the contracting for the London Ambulance Service (LAS) across London. Lesley Watts advised that all ambulance services, including in London, were under intense pressure currently, and there was work going on across the system on that problem. There had been a recent discussion with local authorities about the intention to treat patients in their own homes to ease that demand, through the hearing tree (seeing patients over the phone) and the seeing tree (going in to patients homes). The paramedics attending people in their homes had been upskilled to treat patients on the scene and reduce the need for conveyancing, which had made a real difference. It was added that it was important to recognise that an ambulance was not a conveyance and only for emergencies, a point which needed to be emphasised to the public and which the NHS were doing a piece of work on to communicate with the public.

6.17 The Chair thanked those present for their contributions and drew the item to a close. A number of information requests were made throughout the discussion, recorded as follows:

1. For NHS Colleagues to provide the committee with details of the Mental Health Model of Care.
2. For NHS colleagues to provide the committee with vaccination comparison data at borough level in the context of mental health and learning disability.
3. For NHS colleagues to provide the committee with further information on health inequalities (reference report that is due later in Sept).
4. For NHS colleagues to provide the committee with a copy of the Involvement Charter when it is published in October.
5. For NHS colleagues to provide the committee with an update on the financial challenges on a regular basis – and at the next NWLJHOSC meeting on 14 December.
6. For NHS colleagues to provide the committee with an update on service demand, conveyancing and response times on a regular basis as we move through the Autumn/Winter period.

7 NORTH WEST LONDON NHS DIGITAL STRATEGY

7.1. Kevin Jarrold (Chief Information Officer, Imperial College Healthcare NHS Trust) introduced the report which provided an overview of the progress being made with the development of the digital, data and technology transformation plan for the NWL ICS. The committee were informed that the document shared was a first draft on the strategy going forward.

7.2. The main points of the presentation were noted below:

- It was noted that the strategy intended to build on the lessons learned from the pandemic response, delivering an unprecedented scale and pace of digital transformation.
- The ability to share patient records was acknowledged as being important, as well as the resilience of infrastructure.
- Kevin then went through the collective approach and the seven steps which were outlined in the document, with particular emphasis on a shift from paper to electronic records and documentation.
- The Northwest London Care Information Exchange was referenced as the largest patient portal in the country, enabling the sharing of patient records with a patient so they could view it themselves and add their own information should they choose to. There were also three social services departments now able to access that to look at the Covid status of the patient and to record and save documents there.
- Complex care pathways were also referenced, ensuring that the capability was in place to support this process, as well as developing the data strategy to exploit that data to deliver benefit to both clinicians and patients.

7.3. The Chair then invited questions from members of the committee, noted below:

7.4. Cllr Elnaghi noted that the pandemic had affected digital transformation, referencing those who were digitally excluded and asking how those barriers were being handled. Kevin Jarrold responded that there were two aspects to the work; one was focussed on putting good technology in the hands of patients and clinicians, so that interactions that were previously face to face and were now digital could be a universally good experience for both the patient and the clinician. The second strand was looking at how the issue of digital inclusion could be dealt with. It was noted that there was an ambition to form a standardised approach to technology across primary care, community care and mental health care, working with providers to get the technology capability required. It was acknowledged that this was an exercise that would take time as this was dependent on the products on the market and whether they worked for each provider. It was also noted that there was the issue of how digital support could be provided to those who did not have digital equipment, which was being worked on in alignment with the population health inequalities workflow, as well as various pilot initiatives looking at how tablets could be made available to those who do not have access to them.

7.5. Cllr Richardson raised a point around patient data sharing with third parties; querying whether the deadline extension from the 23rd of June to 1st September was sufficient time to opt out, and whether there were figures for those who had elected to opt out. Kevin Jarrold assured the Committee that patient confidentiality was taken very seriously and there were annual training sessions for all staff on the importance of confidentiality. The primary focus for NWL was to ensure clinicians had the information they needed available to treat a patient, which was also important to patients. Kevin Jarrold did not have the data for how many people in Northwest London had opted out of their data being used for secondary purposes, but could gather that information. In relation to third party sharing, the Committee was informed that the NHS made use of third parties to manage and process data, but under very strict data protection controls

where the NHS still remained the data controller, and there was a rigorous framework in place that only allowed third parties to use data when authorised.

7.6. Cllr Richardson followed up on the area of data protection and the use of private companies, noting that more detail on the rigorous framework for data protection would be welcomed. Kevin Jarrold advised that the NHS was not outsourcing to third parties but using third parties to provide them with tech solutions. Through these contracts with third parties, legal obligations were placed on how patient data was handled and processed. This was explained as existing within a national framework across the NHS, which was overseen by the Information Commissioner's Office. Dr Genevieve Small (Chair, Harrow CCG) added that, as a result of the digital support that needed to be provided to patients, some of that meant using third party software, for example text messages from GPs and the ability to upload photographs, and it was about a marriage between the proper safeguards and ensuring patients were given confidence that their data protection was important.

7.7. The Committee asked about the financial framework in which the ICS could deliver what they viewed as an ambitious and challenging plan. In terms of funding, Kevin Jarrold clarified that it was a challenge to prioritise investment areas. There was a whole national approach to level up across the NHS and address the fact that some areas had been able to invest in ways that others had not. The record for Northwest London had showed it had been very proactive in securing external funding in the past. The ICS were currently going through the process of working out the costs of the strategy which was difficult to predict due to the fact the digital capacity required was not yet fully developed.

7.8. The 'GP at hand' initiative was then moved on to, with Cllr Richardson querying the lessons learnt. Lesley Watts (Chief Executive NWL ICS; Chief Executive of Chelsea and Westminster NHS Foundation Trust) highlighted that 'GP at hand' was a national contractor for primary care services and the funding issues were now resolved on that. She noted that there were reservations but the feedback from patients had been positive. It was acknowledged that 'GP at hand' had acted as a fantastic accelerant of the way that patients were looked after, and some of the techniques the initiative used had been utilised during the Covid-19 pandemic. ICS colleagues reminded the Committee that GP at Hand had been a national conversation but felt NWL had reaped the benefits of it.

7.9. Cllr Shah asked how the NHS digital strategy could link with the digital process within health and social care, so that patients received seamless care. Kevin Jarrold answered that this was a really important part of the agenda and the handoff between health and social care was key. Through the NWL Care and Information Exchange, facilities had put in place to enable social care colleagues to access patient records where the patient had authorised this, which was up and running across three boroughs. The ICS were keen to role that out across NWL. Kevin Jarrold highlighted that there was an opportunity for improved collaboration with health and social care on digital strategy and the ICS would be happy to work closer with health and social care colleagues for better insights of when new initiatives, such as IT solutions, were being implemented.

7.10. The Chair drew the discussion to a close by asking what risks and opportunities had been identified as the planning and preparation for the digital strategy moved forward. Kevin Jarrold answered that there was fantastic opportunity to improve both the patient and clinician experience through digital capabilities, which was the driving force behind the plan. The challenges were highlighted as being around the technical capabilities and funding that was available, as well as keeping patient data secure. The committee were updated that the implementation of a single electronic patient record to be used across all four of the acute trusts was close to completion. This would mean that a clinician in any of those hospitals would be looking at the same record and able to share that record, which was a significant step forward. In the future there was an optimism that the risks identified could be mitigated and managed.

7.11. There were several requests for information raised during the discussion, recorded as follows:

1. For NHS colleagues to provide the committee with information about the data protection protocols referred to at the September meeting.
2. For NHS colleagues to provide the committee with further details of the work being undertaken to reduce digital exclusion.
3. For NHS colleagues to provide the committee with further information on the progress of the digital strategy as it moves into implementation including the prioritisation of investment.
4. For NHS colleagues to provide the committee with a finance update including costings/funding streams.

8a. JHOSC WORK PROGRAMME UPDATE

The following topics were raised as items that the Committee would like to scrutinise:

- The Estates Strategy
- Workforce
- Mental Health Strategy
- ICS Update (standing item) - Financial Challenges Update/An update on service demand, conveyancing and response times as hospitals move through the Autumn/Winter, update on Mount Vernon Cancer Service move; update on St Mark's Hospital services; update on palliative/end of life care.
- Acute Strategy

8b. WORK PROGRAMME MEETING ARRANGEMENTS 2021-22

The Chair stated that the next meeting would be hosted by LB of Harrow. It was also agreed that the meeting on 9 March 2022 would be hosted by Westminster City Council.

9. ANY OTHER URGENT BUSINESS

None.

The meeting concluded at 11.41 am.

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London Ambulance Service estates vision

In 2019, the London Ambulance Service (LAS) published an estates vision, which set out the Board's desire to transform its estate to meet future needs. The vision, which covers ambulance stations, training centres and other facilities, builds on the recommendations of the national 2018 Carter Review which highlighted the variation in the number of operational sites ambulance trusts run and scope to increase quality and reduce costs by rationalising their estate.

The vision, which we shared with stakeholders across London following its publication, detailed how we plan to modernise our estate by replacing our existing ambulance stations (of which there was 68 in 2019) with a network of circa 18 state-of-the-art Ambulance Deployment Centres (ADCs).

These ADCs, which would be supported by strategically located standby points and rest and refreshment posts for our staff and volunteers across London, would aim to have ambulance 'make ready' and light vehicle maintenance facilities, modern management, administrative, training and wellbeing facilities available to our crews at the start and end of their shift.

In understanding the benefits of this model, it is really important to understand that healthcare is not provided directly from ambulance stations. As a fully mobile service whose dispatch methodology allocates the most appropriate resources to each and every incident, the majority of incidents attended by LAS are dispatched from hospitals, strategic standby points or other locations once our clinicians have finished care and treatment of their previous patient.

This means that at the start of a shift our crews will collect their vehicle from the station and travel to various standby points or to patients directly in the area - the locations of which are dictated by modelled patient demand. Often our crews will therefore only return to the ambulance station again at the end of their shift. For example, in 2019 we attended 267,974 face-to-face incidents in North West London CCG. Of these incidents, only 81,429 (30%) were attended by at least one vehicle dispatched from an ambulance station directly.

Through developing ADCs, which are equipped with co-located facilities and access to management, wellbeing services and equipment, we believe this will help ensure we can get more ambulance crews out on the road faster and, in turn, improve the standard of care we provide to our patients across London. This model is already successfully used across other ambulance services, including West Midlands Ambulance Service and South East Coast Ambulance Service.

In June 2021, LAS shared with stakeholders in North East London and our North West London commissioners, our ambitions to take the first step towards achieving this vision through the development of our pioneer ADC in North East London. We shared how LAS was in the very early stages of realising this vision, with a desired site chosen for exploration, yet still subject to planning permission.

In developing an ADC in North East London we then planned to merge our existing stations of Romford, Ilford, Hornchurch and Becontree. Once the new station was up and running, this plan would have resulted in the subsequent permanent closure of these four ambulance stations.

The ‘Romford Group’ of ambulance stations was chosen as the first site for development as the current Romford Ambulance Station location is in a site designated for major regeneration as part of Havering Borough Council’s proposed Bridge Close Regeneration Scheme, so a new location is needed.

It is important to clarify that we have not embarked on specific plans to create an ADC in North West London, further than what has been set out in our estates vision in 2019.

With the Trust experiencing significant demand and pressures on our 111 and 999 services this year, with June, July and August being three of the top five busiest months ever, we recently announced (29 September) our decision to pause our plans on our estates vision and our first pioneer site in North East London, including the withdrawal of our planning application on the site of the proposed ADC. This means we can prioritise our resources to support our frontline operations this winter, and be there for Londoners when they need us most.

Over the winter, we will review our existing estate and our plans for how this will evolve in the future to meet patients’ needs as effectively and efficiently as possible across the capital, including North East London.

As part of this work, we will engage and, as appropriate, consult with the public and other partners on any proposed plans to move or close stations. This includes continuing to work closely with the London Ambulance Service Public and Patients Council, which provides a voice for patients, the public and carers in the design, development and delivery of LAS services, who we have been working closely with on this programme since August 2020.

We would like to provide reassurance that we will not make any changes to our services which impacts on the quality of care we provide to our patients.

More information about our estates vision and our recent announcement to pause plans can be found here: https://www.londonambulance.nhs.uk/about-us/our-plans-for-the-future/upgrading-our-ambulance-stations-modernise-estate/.

Report for:	**NW London Joint Overview and Scrutiny Committee**
Date of Meeting:	14 December 2021
Subject:	Integrated Care System (ICS) - Update
Responsible Officer:	Lesley Watts – ICS Chief Executive
Report author:	Lesley Watts – ICS Chief Executive
Enclosures:	none

Section 1 – Summary and Recommendations

This is the November/December update from the NW London Integrated Care System (ICS) and includes:

1. Covid-19 vaccination programme
2. Inequalities framework
3. Our financial challenge
4. Acute care update
5. Mount Vernon cancer services
6. Mental health
7. Senior appointments

Recommendations:

No recommendations – for information only

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

North West London Integrated Care System update

December 2021

This is the November/December update from the NW London Integrated Care System (ICS) and includes:

1. Covid-19 vaccination programme
2. Inequalities framework
3. Our financial challenge
4. Acute care update
5. Mount Vernon cancer services
6. Mental health
7. Senior appointments

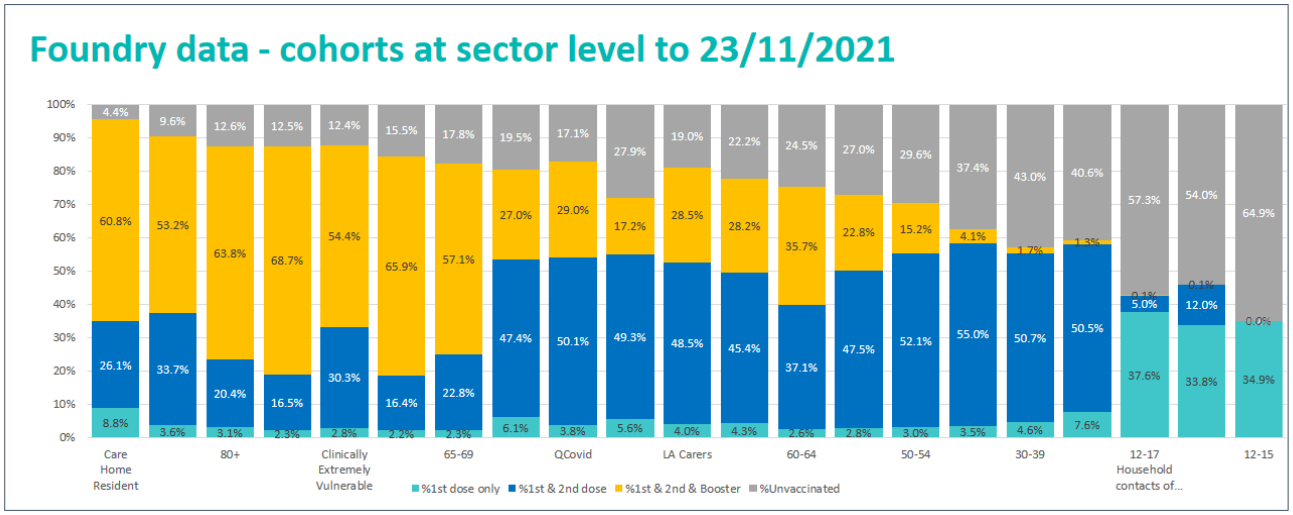
1. COVID-19 vaccination programme

At the time of writing, NW London has administered 3.5million doses of covid vaccine. That is roughly 1.6million 1st doses, 1.4million 2nd doses and nearly half a million boosters.

Following updated guidance from the JCVI, the NHS will shortly set out how staff will expand the booster programme – this will include how booster jabs will be given in priority order so that the most vulnerable people are protected first, while also increasing capacity to vaccinate millions more people in a shorter space of time.

In early November the national average for booster uptake was 54%, London was the top region at 57% and NW London was the most successful at 62.9%. Boosters are now available for anyone over 40, six months after their second dose. We are preparing should the booster be offered to more adults.

The table below shows vaccination by cohort from care home residents where we have around 96% vaccinated to 12-15 year olds where 65% remain unvaccinated.



The **12 to 15 year old** vaccination team have vaccinated over 36,000 children in an 8 week period. All schools have now had at least one visit. Phase 2 of the schools' vaccination programme is working on:

- **1. Mop-up visits:** for schools that have outstanding consents for those children still requiring vaccinations.
- **2. Schools under 20% uptake:** A big focus on schools that have under 20% uptake particularly those larger schools with 600+ pupils & over 30 schools identified in this list.

We continue to vaccinate first, second and booster doses through all sites which includes 83 pharmacies, 26 community sites and a large vaccination site. For the weekend of 26 – 28 November there will be an additional 20 pop-up events taking place (with more likely to be confirmed), including community sites, vaccine bus and existing PCN locations to drive forward the vaccine uptake.

Planning has begun for a One Year on campaign, in recognition of the first vaccination given on 8th December. The campaign will highlight the positive stories about the people who have played key roles in the vaccination programme. This will include community champions, NHS workers, volunteers and faith leaders. More details about the communications around this campaign will be available in the coming weeks.

The focus for communications and engagement in the run up to Christmas is to continue promoting first vaccines to people, where there are still large numbers yet to be vaccinated and to encourage people to come forward to get their boosters. Coronavirus vaccinations forms part of the winter communications plan.

2. Inequalities framework launch

The North West London ICS inequalities framework, which is a significant milestone in our ambition to tackle inequality across North West London, will be published in January. The framework document has been jointly produced between the NHS and local authorities in North West London and is intended to start a big conversation with our residents about how we eradicate health inequalities.

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 acknowledges 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

The plan sets out pledges and principles that will enable us to do that – but the next step is to hear from the public, especially those communities we have not always heard from and where we may need to rebuild trust.

In the weeks ahead, we will be organising events in each of our boroughs, encouraging the public to have their say on their challenges, how we might work with our communities and residents differently and how we can work together to move this agenda forward.

This is not a programme: it is a whole new way of working with our residents and is a key priority of the North West London ICS.

3. Our financial challenge

NW London finished the first half of the financial year (H1) on plan and submitted the operating plan for H2 in November. The headline performance metrics in the plan met or exceeded the national targets but did not quite achieve the NW London ambition of 100% on elective services. We are looking at additional initiatives e.g. increased usage of the independent sector and insourcing to improve the performance further.

Workforce is the largest constraining factor in planning and it reduced activity. Trusts are reporting that there is a reduction in staff available for bank work, creating greater agency pressures or gaps within services. The recruitment challenges are in acute services, primary care, community services and mental health. HR directors are looking at sector-level international recruitment and we will need to take further actions around recruitment, retention and lowering sickness and absence rates where possible.

The ICS will live within its envelope in H2 and is planning a surplus of £30m. Funding will cover the planned activity levels as well as funding the challenged Trusts (The Hillingdon Hospitals Trust - £16.5m and LAS - £14m) as these organisations cannot deliver within the initial funding allocation. Other areas being supported include winter funding (£12m), support for LA discharge schemes (£3m), increased critical care beds (£16m), supporting balance sheet challenges (£11m), revenue to capital recharges (£8m) and we are working on further invest to save and activity increasing schemes.

Despite having a favourable position in year the ICS remains challenged in its underlying deficit position i.e. the excess of recurrent cost against likely recurrent income excluding the non-recurrent pandemic support, so the focus for the Financial Recovery Board is on improving the run rate of recurrent expenditure as we leave this financial year. To achieve this we need to improve the level of recurrent Cost Improvement Plans (CIPs) in 2021/22 as Trusts are reporting an increased reliance on non-recurrent measures in year. Failure to do so will increase the CIP levels required in 2022/23. Overall the underlying deficit has reduced to £325m with improvements seen being an increase in recurrent system funding, an reduction in the underlying deficit in LAS whilst the Hillingdon position has worsened.

Month 7 results showed the system broadly delivering to plan.

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

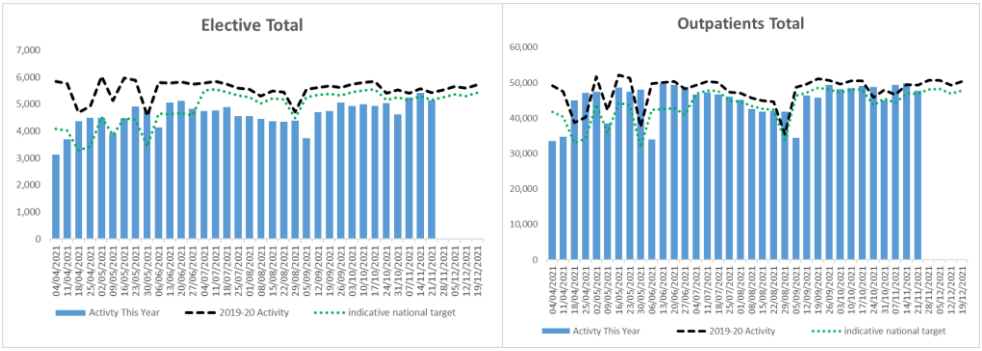
In early 2021, the four acute provider trusts came together to establish a joint acute care board and programme for North West London to guide and coordinate developments across all of our key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The effectiveness of our response to the pandemic has demonstrated that we can – and should - do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes.

Our immediate focus is on recovery from the peak of the pandemic, reducing our waiting times for planned care while continuing to prioritise by clinical need and minimising the ongoing risk of Covid-19 infection. We also want to build on new ways of working catalysed by the pandemic, drawing on evidenced best-practice and deeper collaboration, to make longer term, sustainable improvements in quality, fairness and efficiency.

Increased planned care capacity and reducing long waits

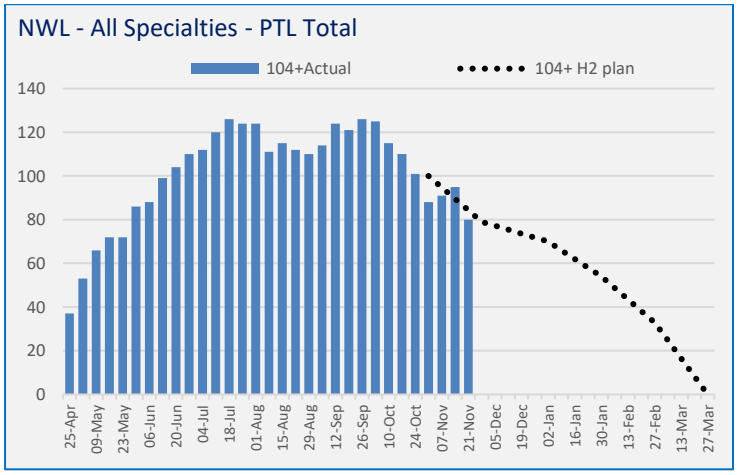
In October 2021, we averaged 92 per cent of pre pandemic planned care levels, up from 83 per cent in August 2021. Within that, our combined outpatient capacity for October 2021 was up to 101 per cent of pre pandemic activity. This is currently the highest level of planned care recovery across London. Referrals are also continuing to increase, resulting in a four per cent increase in our overall waiting list 10,000 patients since September 2021.

Graph Y – ***Current Elective and Outpatient activity versus pre-pandemic levels***



We remain on track to meet our target to have no patients waiting over 104 weeks by March 2022. We currently have 80 patients who have been waiting for 104 weeks, down from a peak of 126 patients in July 2021. We are finding it more challenging to reduce the number of patients waiting over 52 weeks and have remained at around 4,000 people through October, though down significantly from the peak of 6,802 patients in February 2021.

Graph X – ***Patients waiting over 104 weeks and reduction trajectory for the remainder of 2021/22***



Given our ambitious target for the second half of this year, to stabilise the size of our waiting list, we need to continue to increase our planned care capacity to above 100 per cent of our pre pandemic activity throughout the winter.

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 - 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. In addition to the development of planned care hubs, we are continuing to support services and hospitals with particularly long waiting times by offering care at hospitals with shorter waiting times, bringing in additional capacity from third party organisations or using the independent sector.

Diagnostics and imaging

We are making good progress on recovering diagnostics and imaging capacity to pre-pandemic levels and, for all but one imaging modality, significantly exceeding pre-pandemic levels.

Modality	Percentage of patients who have been waiting less than six weeks	Activity as a percentage of activity for the same point in 2019/20
MRI	88	113
CT	98	135
Ultrasound	97	80
Endoscopy	77	114
Echo	86	144

Two new MRI centres have been established at Ealing and West Middlesex hospitals, with five new MRI scanners in total providing significant additional capacity. This follows the replacement of two MRI scanners at St Mary's Hospital earlier this year, with a further four MRI scanners set to be replaced at London North West University Healthcare by April 2022. A wider transformation programme is in development supported by national funding of £2.3bn allocated for diagnostic services in the recent Comprehensive Spending Review. National guidance has confirmed that this funding will be allocated towards three initiatives: community diagnostic centres; digital diagnostics; and replacement of aged imaging and endoscopy equipment.

Community diagnostic centres are a national initiative to build diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. These 'one stop shops' for checks, scans and tests will be more convenient for patients and help to improve outcomes for patients with cancer and other serious conditions. We are looking to have new community diagnostic centres situated in at least two areas of north west London where there are significant clusters of deprivation – including one in the area of Hanwell, Southall and Greenford; and another in the area of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen's Park and Church Street in North Westminster. We will be engaging on these plans over the coming months as we look to develop community diagnostic centres from next year through to 2025.

Urgent and emergency care

Attendances to our A&E services, including urgent treatment centres, in October were six per cent higher than for the same period in 2019/20. Together with continuing Covid-19 infections and infection prevention and control measures, this is creating very significant pressure on our services as we head into winter.

On top of Trusts' own investment in urgent and emergency care services in response to increasing demand, additional funds have been allocated across the sector to support further improvements. These initiatives support work 'to keep care flowing', maximising our ability to care for as many patients as possible, as quickly as possible. They include extra staff and support for emergency departments and for discharge from hospital, expanding 'same day emergency care' services and additional community beds.

We have also this week launched an 'inner' north west London health inclusion service – based at St Mary's, with support also at Charing Cross, Chelsea and Westminster and in the community - to provide more tailored, integrated support for patients in our hospitals who are experiencing homelessness. At least 1,000 people experiencing homelessness who attend our hospitals could benefit from this service this winter. Once established, the service will be expanded to the rest of the sector.

5. Mount Vernon Cancer Services

Capital Funding for the replacement of Mount Vernon Cancer Centre

UCLH (University College London Hospitals NHS Foundation Trust) has submitted an Expression of Interest for funding for a new Mount Vernon Cancer Centre to the Department of Health and Social Care as part of the Government's New Hospital Programme.

Whilst UCLH do not currently manage the Mount Vernon Cancer Centre services, if funding can be agreed and the UCLH Board approves the transfer, it would be UCLH who would be

responsible for building a new cancer centre at the preferred location, Watford General Hospital. Covid recovery etc

Replacing Mount Vernon Cancer Centre services is a priority for NHS England in the East of England, who commissions the services, and is fully supported by colleagues in London and the South East whose patients also use its services.

An options appraisal exercise has confirmed that replacement on the Watford site is the preferred option, with the options to do nothing, do minimum or disperse the service rating extremely poorly in comparison. North West London ICS remains committed to ensuring high quality cancer services are in place for our residents.

More information is available here - https://mvccreview.nhs.uk/

6. Mental health – discharge and seasonal pressures

NW London has recently been allocated £2.3m to support discharge and seasonal pressures. Initiatives will focus on supporting people with mental health needs to:

- Increase the number of people who are supported to stay well at home or in the community, and preventing people's needs escalating to the point of crisis or admission;
- Reduce the number of people attending A&E or experiencing long waits where avoidable;
- Reduce the number of people who are sent out of area or experience delays to inpatient mental health admission;
- Reduce the number of people experiencing very long length of stay in psychiatric wards, and to support more people to recover at home or in the community
- Provide rapid mental health support to ambulance or police services when people dial 999 to prevent them experiencing unnecessary conveyance/ waits in ambulance services, or in police custody.

7. ICS senior appointments

The ICS has appointed Rob Hurd as Chief Executive. He is due to take up post in early January. Rob takes over from Lesley Watts, who has successfully combined her role as Chief Executive at Chelsea and Westminster NHS Foundation Trust with being interim ICS Chief Executive

Dr Genevieve Small has been appointed as interim Medical Director for the NW London ICS. She takes over from Professor Julian Redhead, who has been appointed to a national role (Julian remains Medical Director at Imperial College Healthcare NHS Trust).

The recruitment process is underway for a single chair to work across the four NW London acute trusts.

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Report for:	**NW London Joint Overview and Scrutiny Committee**
Date of Meeting:	14 December 2021
Subject:	Palliative Care Review
Responsible Officer:	n/a
Report author:	n/a
Enclosures:	Appendix A – Update for JHOSC Appendix B - Issues Paper Appendix C - Summary Issues Paper

Section 1 – Summary and Recommendations

This report sets out the focused piece of work that has commenced in North West London to improve the quality, equity and experience of community-based specialist palliative care and support residents and their family/ carers receive, as well as the sustainability of our services.

Recommendations:

No recommendations – for information only

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

NWL Community-based Specialist Palliative Care (18+) Review Programme

Update for JHOSC

25 November 2021

Summary:

NW London has commenced a focused piece of work to improve the quality, equity and experience of community-based specialist palliative care and support residents and their family/ carers receive, as well as the sustainability of our services

- Context and Scope
- Programme Approach
- Issues paper and engagement plans

Ask of this group:

- For noting and providing feedback on approach
- Continue working with us as we take next steps

Context

OUR VISION:
NWL residents and their families/ carers have equal access to high quality community-based specialist palliative and end of life care and support, that is coordinated, and which from diagnosis through to bereavement reflects their individual needs.

- This service improvement programme of work is following on from the 4 CCGS palliative care review work undertaken in 2019/20 across 4 of our CCG – Brent, West London, Central London and Hammersmith & Fulham.
- We have some excellent community-based specialist palliative care services and committed partners and we want to build on this excellence and support our services to be as sustainable as possible
- We do have variation in quality and level of service across NW London and this cannot continue – this will drive our approach.
- We are committed to transparent and meaningful engagement with public, patients, families, carers and other stakeholders.
- There are some immediate challenges on workforce and sustainable funding (given impact on the charitable sector during the pandemic) that we need to address at pace

Our priorities for this programme of work are in line with the NHS triple aim:

North West London Integrated Care System

NW London's adult community-based specialist palliative care (SPC) provision

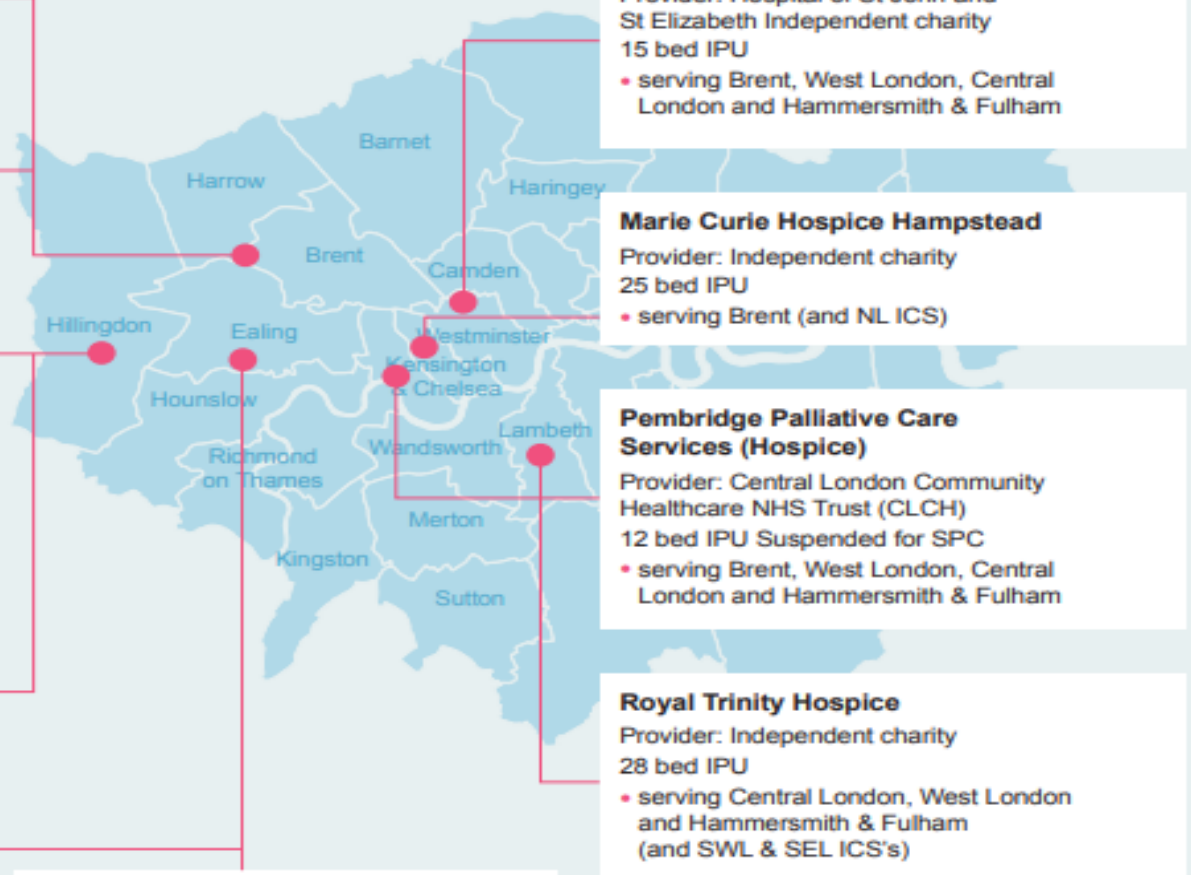
St Luke's Inpatient Unit (IPU)
Provider: Independent charity
12 bed IPU
- serving Harrow and Brent

Harrow Community SPC Nursing Team
Central London Community Healthcare NHS Trust (CLCH)
No IPU
- serving Harrow

Harlington Hospice & Michael Sobell House (MSH) inpatient unit
(Mount Vernon Hospital)
Provider: Independent charities
12 bed IPU
- serving Hillingdon

Hillingdon Community Palliative Team & Your Life Line 24 Service
Provider: Central North West London NHS Foundation Trust
No IPU
- serving Hillingdon

Meadow House Hospice
Providers: London North West University Healthcare NHS Trust (LNWH)
12 bed IPU
- serving Ealing and Hounslow



EOL Rapid Response and Unplanned Nursing Services
Provider: Marie Curie London
- serving Ealing and Hounslow

St John's Hospice
Provider: Hospital of St John and St Elizabeth Independent charity
15 bed IPU
- serving Brent, West London, Central London and Hammersmith & Fulham

Marie Curie Hospice Hampstead
Provider: Independent charity
25 bed IPU
- serving Brent (and NL ICS)

Pembridge Palliative Care Services (Hospice)
Provider: Central London Community Healthcare NHS Trust (CLCH)
12 bed IPU Suspended for SPC
- serving Brent, West London, Central London and Hammersmith & Fulham

Royal Trinity Hospice
Provider: Independent charity
28 bed IPU
- serving Central London, West London and Hammersmith & Fulham (and SWL & SEL ICS's)

Scope - What will this cover

- It will focus on community-based specialist palliative services for **adults** (18 years +) across all of NW London, as this is the part of the end of life pathway that is most fragile at this time.
- The work **will not be reviewing children's palliative and end of life care services, hospital based specialist palliative care and universal palliative care services** such as community/district nursing and primary care.
- We will however be working hard to make sure that our work links closely and integrates with hospital specialist palliative care and to all other generalist palliative and end of life care services in North West London.
- We will also be working very closely with other NWL ICS improvement programmes of work underway i.e. Enhanced health in care homes (EHCH) programme, Community District Nursing Review, Acute Discharge hubs; Cancer

Why things need to change?

- Too many people are admitted unnecessarily to hospital in their last year and last 3 months of life.
- For 2020/21 **- 49%** of our residents are dying in hospital, **5%** are dying in hospice, **14%** in care homes and only **28%** are dying at home – this is despite nationally the majority of people saying they would prefer to die at home.
- We have unwarranted variation in community-based specialist palliative care services (ie. 7 day working, access to 24/7 specialist advice, rapid response) and we have heard that they don't reach enough of our residents and diverse communities.
- Not enough of our residents are identified early as being at end of life and offered opportunity to undertake advance care planning conversations, that are then recorded on Co-ordinate My Care (CMC – the agreed London tool at present).
- Not all of the system have access to and are using CMC as much as they could be.

How we plan to do this - our objectives:

Our aim through this work is to collaboratively develop a new integrated model of care, single service specification for our services and a consistent approach to population health needs and person centred outcome measures.

- We plan to have wide reaching, robust and transparent communication and engagement with public and patients, including community, voluntary and faith groups.
- Publication of Issues Paper and other supporting documentation designed to facilitate discussions and support innovative thinking.
- Collaboratively design more responsive, sustainable and resilient services with a wider reach.
- Achieve consistency and equity in access to services across NW London and level up to good practice where possible.
- Facilitate better co-ordination of care, improve communication and integration with other services across community and acute care settings.
- Collaborative working and pathway development with other ICS programme including Cancer, Enhanced health in care homes, Continuing Health Care, community nursing and acute discharge improvement work.
- Work in partnership with health, social care and the voluntary, community and faith sectors.
- Explore development of compassionate communities with more integrated/ partnership working with Voluntary Community Sector.
- We will develop a consistent approach to person centred outcome measures, population health needs assessment, benchmarking and monitoring.
- We are working closely with our social care partners to utilise digital technology to support the development of shared care records for care homes.

Issues paper and survey published

- The programme was launched last week 18 Nov 2021 with the publication of an issues paper and a survey on the NWL ICS website
- Find out more about how to get involved here: https://www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved

North West London Integrated Care System

Issues paper

- In development - our focus at this stage is what quality, safety, equity and excellent patient experience looks like. From this we will develop new models of care and what good patient outcomes look like. It is only after that is agreed will we look at what services we need to deliver this.

- We have simply set out the **eight** broad themes we are looking at and would like to the public to feedback on :
    1. Learning from previous service improvement reviews and engagement
    2. National policy – making sure we align
    3. Changing needs of patients and population growth
    4. Health inequalities – how these act as a barrier to people receiving community-based specialist palliative care
    5. Improving the quality of care, and patient and family and carer experience – we have variation across NWL
    6. Fragmentation and the need for more joined up services - people sometimes find services these hard to access, particularly across our more diverse communities, and services do not work as well together as they could be
    7. The workforce challenge - we are having difficulty recruiting and retaining workforce
    8. The financial challenge - the increasing financial challenge the NHS is operating under and what it means for community-based specialist palliative care provision

- From this we will develop a consistent set of questions that will allow us to obtain a mixture of qualitative and quantitative feedback.
- Publication of this Issues Paper will officially launch the programme of work

Timeline: August 2021 – August 2022

Issues paper Pre-engagement (virtual)

August – October 2021

Pre-engagement with key stakeholders – internal and external

Issues paper Engagement report

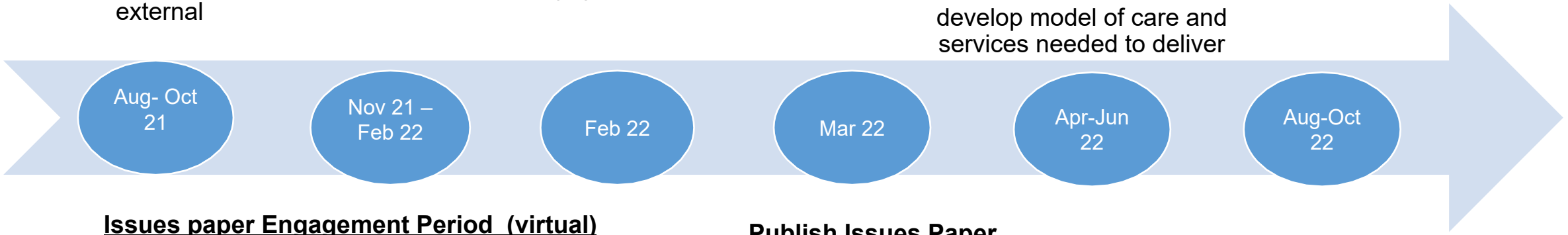
February 2022

Writing up of report based on feedback from Issues paper and engagement exercises

Development of new model of care

April – July 2022

In Partnership with patients, clinicians and stakeholders develop model of care and services needed to deliver



Issues paper Engagement Period (virtual)

Early November to early February 2022

- Patient engagement starts with publication of Issues Paper
- 3 or 4 local meetings
- 1 or 2 discussion events across the system - to go into more of the detail
- Separate meetings with faith groups and targeted groups who aren't getting access – homeless, LGBTQ+

Publish Issues Paper Engagement Report

March 2022

Publication of outcome report and next steps- testing outcomes with public and stakeholders (feedback loop)

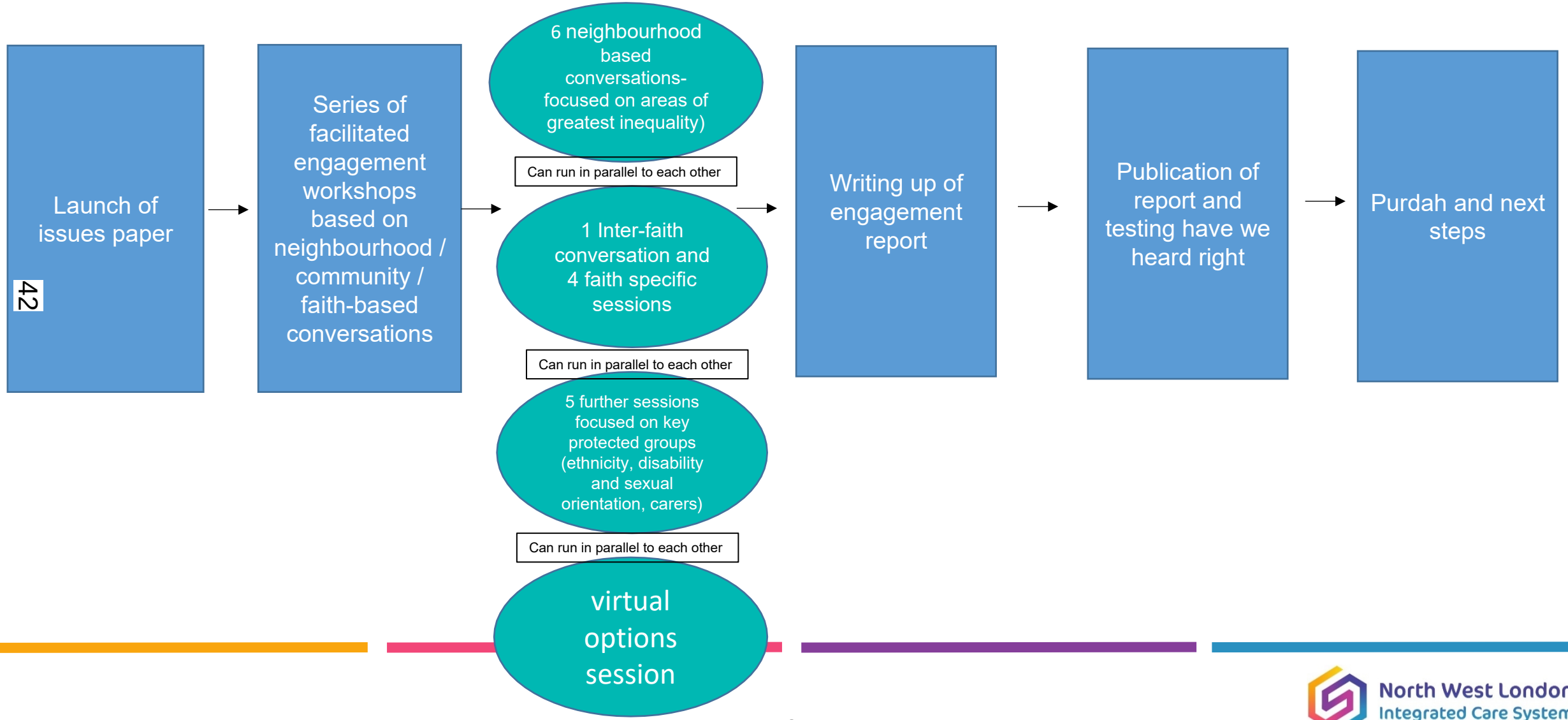
Public consultation

August – October 2022

Public consultation on changes to services if needed

North West London Integrated Care System

Diagram of overall comms & engagement strategy up until March 2022



North West London Integrated Care System

Proposed programme stakeholder workshops and early workstreams

Clinical model groups, tasks and sequence flow

WORKSHOP 1: Gap analysis using Ambitions Self Assessment tool

WORKSHOP 2: Gap analysis using Ambitions Self Assessment tool & Outcomes we want to achieve

Services Demand mapped per 200k population activity data across acute, community and hospice

Can run in parallel to each other

Services Capacity what services and staff we currently have against demand

New Service Spec & Model of Care – configuration, workforce model

Service Change Options development

WORKSHOP 3: Test Model of Care and Options

8x 'place based' workshops re local integration

Note: Finance working group tasks will be dependent on the sequencing above ie. We can't start costing up of new service spec and model until it is developed

Stakeholder Key:

Main Large stakeholder group: 40 – 50ppl
- multiple patients from across all of NWL
- wide range of clinical and operational leads (hospice and community services)
- Primary care
- LAS, NHS111, Care homes, Voluntary sector

Small sub working group –cross cut of main stakeholder group
1 or 2 patient reps / none
8 to 10 ppl max

Medium sized working group – cross cut of main stakeholder group
2 – 4 patient reps
10 – 15ppl

North West London Integrated Care System

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

Community-based specialist palliative care improvement programme

Work with us to understand how we can improve the experience for all adults who use community specialist palliative care services in North West London

November 2021

HOW TO USE THIS DOCUMENT

This paper sets out a range of challenges facing the NHS and many other partners providing community-based specialist palliative care in North West (NW) London. It sets out why we think we need to change things if we are to improve the quality, safety and equity of care provided to patients, families and carers and ensure they have excellent experience of that care.

It is not part of a public consultation process. The NHS has published it with the support of many of our local system partners (NHS and non-NHS) to encourage people to share their thoughts and consider the facts and questions we have raised, in order to support improving your local health services.

Should our discussions about the best way to make changes lead to proposals emerging for major service change, we would carry out a formal public consultation on the options available. We are not at the stage yet of knowing whether this will be needed.

We have tried to make this complex topic and associated issues in this document as easy to understand as possible, but have also made a summary document and easy read version available as well. Additionally, we have indicated where further reading or information can be found and have also collated many of these referenced documents and links on our website **wwww.nwlondonics.nhs.uk/get-involved/cspc**.

Please check the site for new updates as we will add more information as it becomes available.

CONTENTS

INTRODUCTION

Thank you for taking the time to read this document.

Death and dying is inevitable. It is widely recognised that when caring for someone in the last year of their life there is but one chance to get care right[1]. Anyone at the end of their life should be able to be with the people they want to be with, and where they want to be.

1

They, their family, loved ones and carers deserve the best quality care and support regardless of their circumstances. With a rapidly ageing society and changing patterns of illness, many more people with multiple long term palliative and health conditions will live for longer.

The need for high quality end of life care by 2040 is projected to increase dramatically. Too many people experience poor care as they approach the end of their life and with many people spending their last months, weeks in hospital and often dying there, which is not what they want. Not only is this distressing for patients and their loved ones, but this is also NHS funding that could be spent elsewhere.

Palliative and end of life care is a national priority, as well as a priority for NW London CCG and the NW London Integrated Care System (ICS). In NW London we have some excellent palliative and end of life care services (for adults (18+) with very committed partners, but we know that we need to make improvements to the care we provide in hospitals, community settings such as hospices and day centres, primary care and the patient's own home. We want to ensure all patients have equal access to accessible, consistent, high quality care across the whole of palliative and end of life care.

More also needs to be done to ensure the care provided by different organisations is more joined up. This includes looking at the IT challenge of not all services having appropriate access to clinical information held electronically by partner providers for patients under their care. We need to ensure that all patients have a personalised care plan that has been agreed with the patient and are then available to the different care sectors supporting these patients and their families.

Currently, the most fragile part of palliative and end of life care services in NW London is community-based specialist palliative care for adults (18+). The NHS and its partners are committed to making improvements in this area of service provision first before looking at other areas of palliative and end of life care.

This issues paper is designed to raise awareness of the importance of palliative and end of life care in general and also facilitate discussions to help us decide what high quality, safe, community-based specialist palliative care for adults, which also delivers excellent patient experience. We should be clear that we are not going to be reviewing children and young people's palliative and end of life care services, nor are we reviewing community nursing or acute hospital services providing generalist palliative and end of life care services.

We will be working hard to make sure that our work links closely with developments in hospital specialist palliative care, all other generalist palliative and end of life care services, and related transformation programmes in NW London.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

Some background

Approximately 600 000 people die in England each year, two-thirds of whom are aged 75 years and older. Life expectancy has risen over the past 25 years, and as such, the proportion of people aged 75 years and older has risen and is projected to continue to rise. As a result, the number of deaths in this age group is rising at an accelerated rate. The population of England is ageing, and this has important implications for the provision of palliative and end of life care, which the NHS in partnership with social care, the voluntary, charitable and community sector intends to personalise and improve in the coming years, according to policy set out in the NHS Long Term Plan.

High-quality, personalised palliative and end of life care means ensuring that all physical and psychological needs of patients and those people who are important to them are met, not just their physical needs. It also requires a compassionate approach and the ability to see each patient as an individual[2]. While high-quality clinical care is vital, it is equally important to ensure that it is well coordinated and joined up across different services and settings.

Failing to do so not only deprives our patients of the best end of life care but can leave a devastating legacy for the people important to them. Good care is focused on “What matters to me” (from the refreshed Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026).[3]

The World Health Organisation has also said that the global need for palliative care will continue to grow as a result of the ageing of populations and the rising burden of non-communicable diseases and some communicable diseases, and this is also the case in the UK.[4]

Remembering that our initial focus is community-based specialist palliative care, our aim is to deliver a high standard of clinical care with good patient, family and carer experience. We want to:

- Improve the equity of access to these services, and quality of care our residents and their families and carers receive.
- Improve the experience for our patients, families & carers by developing services that reflects what is important to them at the end of their lives, from diagnosis through to bereavement.

Everyone, should be able to be involved in decisions about their own care and develop care plans, together with those important to them and the health and care professionals responsible for their care, to support them to receive care or die in their preferred place.

[2] Marie Curie - https://www.mariecurie.org.uk/blog/what-does-it-take-to-deliver-high-quality-end-of-life-care/147878
[3] Ambitions for Palliative and End of life care: A national Framework for local action 2021 - 2026 https://learninghub.nhs.uk/Resource/2308/Item
[4] WHO - https://www.who.int/news-room/fact-sheets/detail/palliative-care

Palliative and end of life care comprises both generalist and specialist palliative care practice. By community-based specialist palliative care, we are referring to services that are not delivered within a hospital or a GP surgery, but rather in a patient's own home, a care home, a hospice and a community hospital/health centre.

Specialist palliative care professionals are experts in providing palliative and end of life care and have specific training and experience in this field of practice such, as palliative care doctors, nurse specialists and psychologists.

They usually become involved in a patient's care to support the management of more complex care problems and that go beyond the expertise and knowledge of a patient's generalist and usual care team. They also work closely alongside your GP and district nurse to offer advice on pain control and symptom management, emotional and practical support for patients and their loved ones and carers in preparing for the end of life and bereavement support after death.

Generalist palliative and end of life care is provided on a day to day basis by many health and social care professionals (such as your GP, district nurse, social workers, care home staff. It can also be provided by a patient's family and carers in their home.

What we want to do

We want to work with local residents, clinicians and partners from volunary, community and faith organisations to jointly identify and decide what high quality community-based specialist palliative care looks like, and through this develop a new model of care that is sustainable, culturally sensitive and better meets our diverse population's needs. It will also be delivered across the whole of NW London so everyone receives the same consistent high standard of care.

We will work to integrate community-based specialist palliative care provision and support for patients at end of life in their local 'place' and the role of Primary Care Networks and Borough Based Partnerships (formerly Integrated Care Partnerships) will be critical for this. This means local priorities are recognised within an overarching NW London commitment to avoid inequalities and support consistent and common offers for all NW London residents.

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

1. We want to build on the valuable learning and feedback received from previous reviews of palliative care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea and Westminster and engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.

2. Align with national policy such as the national Six Ambitions for Palliative and End of life Care[5] and the NHS triple aim of improving access, quality and sustainability, and adhere to guideline recommendations from National institute of Care and Excellence (NICE) guidelines for palliative and end of life care services as much as possible.

3. The changing demographics and needs of patients. The number of deaths within England and Wales will rise by an additional 130,000 deaths each year by 2040, and more than half of which will be people aged 85 years or older leading to increased need for palliative and end of life care.

4. We know that health inequalities act as a barrier to people receiving community-based palliative care.

5. We have variation in the quality and level of community-based specialist care that patients, families and carers receive across NW London which means that depending on where you live, some people and their families and carers do not get the support they need, and are not able to have their wishes supported at the end of their lives. We want to do all that we can to achieve this.

6. Some of our services are fragmented, not joined-up and do not work well together - not all services having access to clinical information held electronically by other providers. People sometimes find services hard to access, particularly across our more diverse communities, which cannot continue.

7. The increasing financial challenge the NHS is operating under and what it means for community specialist palliative care.

8. The difficulty we are having finding and recruiting and retaining a suitably qualified workforce and the knock on effect for service delivery.

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

We also heard that services need to be made available to more people 24 hours a day, but in particular during out of hours 5pm – 9am, be improved to be more inclusive, adaptable, offer more choice and be more coordinated. They referenced how it is important to improve access to these services so more people receive care and are supported to die in their preferred setting as much as possible. Learning also reflected the importance of not having to travel too far to access services.

The feedback did indicate that there are differing views about how we make these improvements, and create more equitable and sustainable services for all.

We also want to fully understand the role culture and religion can play in influencing the way people relate to their health. This influences how they may want to receive support, and the way they experience loss and grief. We will use this insight to develop services that meet the needs of our diverse community.

This involves a respectful and responsive approach to the health beliefs and practices, and cultural and linguistic needs of diverse population groups. However, it goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, social exclusion and socio-economic deprivation, education, geographical location, occupation and protected characteristics.

The engagement plan proposal we are introducing for this programme of work is designed around the following four principles:

- **Connecting:** by bringing together local people, frontline staff, partners and community and faith leaders as equal partners to articulate the challenge and frame solutions.
- **Strength-based:** by recognising the contribution that local community and faith groups as well as patients, families and carers in supporting improved provision of community-based specialist palliative and end of life care services.
- **Continuous and iterative:** by engaging to build and refine inclusive, sustainable and cost-effective options for future models of care.
- **Evidence-based:** by looking at evidence-based solutions that acknowledge both the interaction between health literacy and responsiveness of services to address the underlying equity of access and inequality in outcomes issues faced by people rather than reacting to individual events or individual episodes of care.

It is only when we have completed this engagement and received everyone's feedback that we will look to develop the model of care that will deliver the high quality safe and equitable care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high quality model of care and bring forward proposals. So for now we are not looking at or discussing what current community specialist palliative care services look like or what their future should be or how many beds we need in a community setting. That will come in due course when we have agreed what good quality care looks like and what the model of care we need to develop to deliver this is.

In summary, our aim to start a conversation about what we need to do to improve the quality of care our residents, families and carers receive when they need community-based specialist palliative care. From this starting position, we want to work with patients, clinicians and the wider community to develop and introduce a new model of care for community-based specialist care which is more equitable, more joined-up, sustainable, and high quality. It must also meet the clinical and individual needs of patients from diagnosis through to bereavement and also reflects the choices that people wish to make on the care they receive and where they receive it.

Thank you for your interest and your involvement in these important issues, we look forward to hearing from you in the coming months to help the NHS in developing a new and exciting future for community-based specialist palliative care for adults in NW London.

Pippa Nightingale,
Chief Nurse,
NW London ICS

Robyn Doran,
Borough Director for Brent
Integrated Care Partnership,
NW London ICS

WHO WE ARE

This improvment programme will be carried out by NHS NW London Clinical Commissioning Group (NW London CCG) under the leadership of the NW London Integrated Care System. (NW London ICS).

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NW London CCG comprises of the London boroughs of Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The NW London ICS consists of all NHS organisations and local authorities in NW London who have been working informally as an integrated care system (ICS), ahead of legislation to put ICSs on a statutory footing. Legislation is expected during 2021, with ICSs becoming legally recognised bodies from April 2022. The following are partners in the NW London ICS.

NW London CCG, Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust, Central London Community Healthcare NHS Trust (CLCH), Hounslow and Richmond Community Healthcare NHS Trust Imperial College Healthcare NHS Trust, Royal Brompton and Harefield Hospitals, Chelsea and Westminster NHS Foundation Trust, London North West University Healthcare NHS Trust (LNWH), West London NHS Trust, Brent Council, Harrow Council, London Borough of Hounslow, Ealing Council, Hammersmith & Fulham Council, Hillingdon Council, Royal Borough of Kensington & Chelsea, and Westminster City Council.

The purpose of the NW London ICS is to reduce inequalities, increase quality of life and achieve outcomes on a par with the best of global cities.

Our priorities are:

- To improve outcomes in population health and health care.
- To tackle inequalities in outcomes, experience and access.
- To enhance productivity and value for money.
- To help the NHS support broader economic and social development.

To find out more about NW London CCG visit **www.nwlondonccg.nhs.uk**

To find out more about NW London ICS visit **www.nwlondonics.nhs.uk**

THE SCOPE OF OUR WORK AND UNDERSTANDING WHAT WE MEAN BY PALLIATIVE CARE

The majority of issues outlined later in this paper are relevant to the whole of palliative and end of life provision for NW London.

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However, some of these issues are very pertinent and pressing for our community-based specialist palliative care provision and the focus of our improvement programme is to improve the accessibility, quality and sustainability of our community-based specialist palliative care for adults (18+). This is the most fragile part of the pathway and service provision at this time.

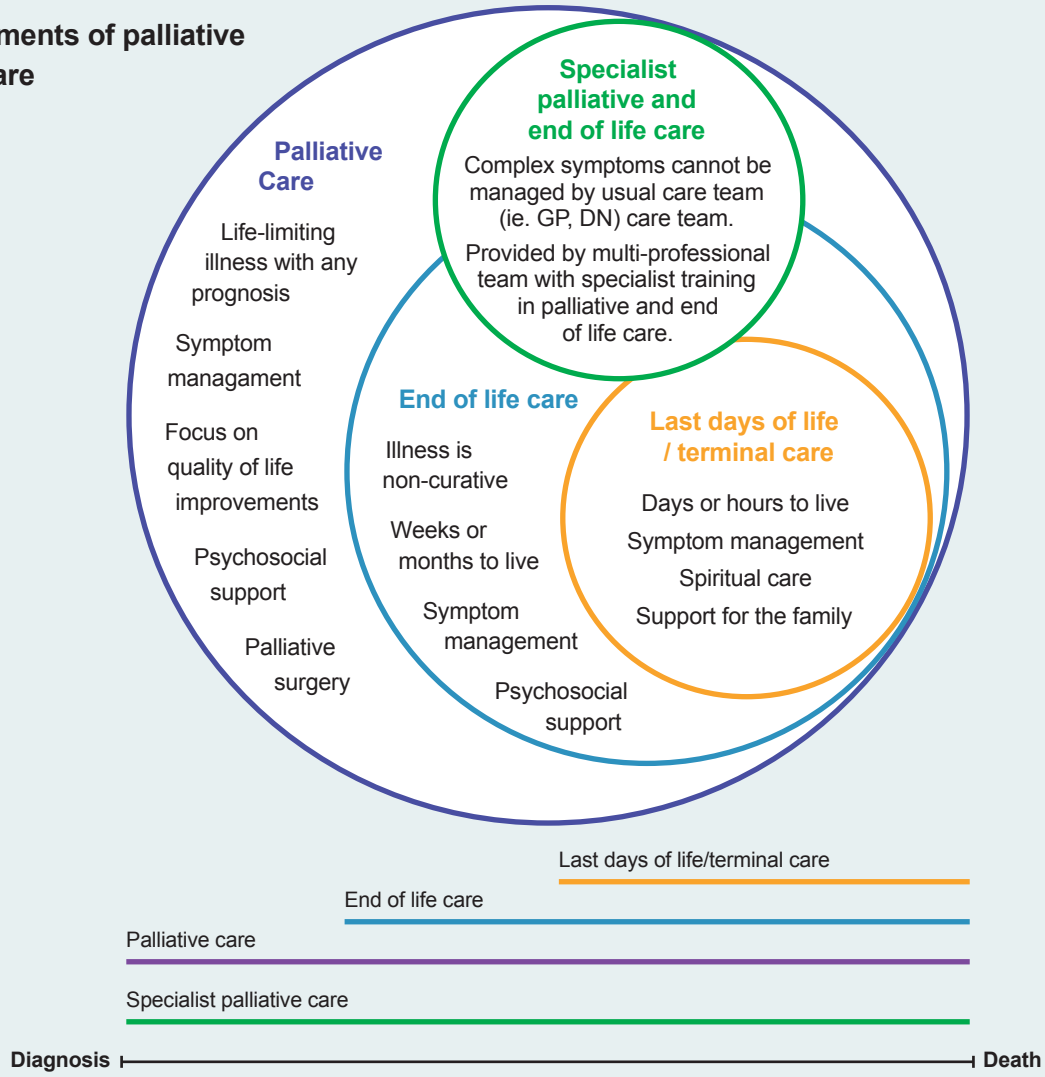
The programme does not include children and young people's palliative and end of life care services. It will also not be reviewing acute hospital specialist palliative care provision or generalist community palliative and end of life care services. We will however be working very closely with the NW London specialist palliative care hospital teams and colleagues in other areas to address any interdependencies.

Given that the majority of people with palliative and end of life care needs do not require community-based specialist palliative care input, the focus of this programme is not going to solve all of the issues in palliative and end of life care provision as a whole, in particular reducing hospital admissions in the last year of life. The aims of the programme are to have more accessible community-based specialist palliative care provision that has a wider reach for our NW London population, with the expectation that this will contribute to a reduction in hospital admissions at end of life and improve integration of care.

The above terms and services can be confusing for people. This section provides definitions of the terms, explains more about who provides this type of care and how people can access it.

3.1 Defining palliative care, specialist palliative care, end of life care, community-based specialist palliative care and who provides this care?

The different elements of palliative and end of life care



The information below has been sourced from Marie Curie[6], a resource called Homeless Palliative Care Toolkit[7], created by a partnership between Pathway, Marie Curie Palliative Care Research department (UCL), St Mungo's and Coordinate My Care and various other NHS national palliative and end of life care team resources.

Though more specific definitions can be helpful, a simple view is "palliative and end of life care" is care that optimises mental and physical well-being for people whose health is declining irreversibly and to their family, friends and carers who are supporting them in these circumstances, as well as ensuring the person is supported to die with dignity in line with their expressed preferences.

[6] https://www.mariecurie.org.uk/help/support/diagnosed/recent-diagnosis/palliative-care-end-of-life-care
[7] www.homelesspalliativecare.com

3.2 What do we mean by palliative care, including generalist and specialist palliative care?

Palliative care is a treatment, care and support approach for people of all ages with a life-limiting illness (such as cancer, organ failure (cardiac, renal, respiratory, liver disease) or a degenerative neurological disorder for which cure is no longer possible), as well as the needs of their families, friends and carers.

It is about improving the quality of life of anyone facing a life-limiting condition and those important to them, through the prevention and relief of suffering for all. Palliative care is person centred and is all-inclusive, considering physical, emotional and spiritual needs. This is called a holistic approach, because it deals with you as a "whole" person, not just your illness or symptoms. A person can receive palliative care at any stage in their life-limiting illness.

Palliative care can involve:

- Managing physical symptoms such as pain to ensure the person is as comfortable as possible.
- Emotional, spiritual and psychological support and comfort. Making sure that a person is cared for in a way that fits their beliefs.
- Social care including help with things like washing, dressing and eating and supporting the person is connected to those that are important to them.
- Support for family, friends and carers.

Palliative care is frequently misunderstood as only being required by people who are dying and need end of life care. Palliative care does include end of life care (for people who are nearing the end of life), but it is not only about this. Receiving palliative care doesn't necessarily mean that a person is likely to die soon, some people receive palliative care for years. A person can also have palliative care alongside treatments, therapies and medicines aimed at controlling their life-limiting illness, such as chemotherapy or radiotherapy.

Compassionate care and open and sensitive communication, along with personalised advance care planning are a key part of palliative care. Advance care plans support the recording of a person's personal wishes and needs should their condition deteriorate, so that these can be made available to health and social care professionals to help to preserve the person's personal choices regarding their care towards and at the end of life.

The World Health Organisation definition of palliative care can be viewed here on the World Health Organisation definition of palliative care website or in the glossary.

3.3 Where is palliative care provided?

Palliative care is provided to people living in their own home, in the community, care homes and in hospital, and is provided regardless of the person's diagnosis or which setting they are in.

3.4 Who provides palliative care?

People who face life-limiting illness require different levels of health and social care at different points in the course of their illness. Apart from care and treatment that is specific to their life limiting condition(s), they are likely to have needs that are often referred to as palliative or end of life care, especially as they approach the last year(s) and end of their lives.

A whole range of health and social care staff provide palliative care (for example - GPs, community and district nurses, care home staff, hospital teams, hospice teams, social workers, family members). The professionals involved in the palliative care team will depend on what sort and level of care and support a person and those important to them needs. The palliative care that they receive for these needs can be described as either generalist or specialist palliative care depending on the level of expertise required to support them and the professionals delivering the care.

3.5 What is generalist palliative care?

Palliative care that does not require input from professionals with specialist training and knowledge is termed "generalist or core-level" palliative care. For the purpose of this document we will use the term generalist palliative care. Generalist palliative care forms the majority of universal care and support services required by people with life-limiting conditions. All professionals and staff in health and social care have a role in the effective provision of generalist palliative and end of life care services across all care settings such as a hospital or community.

3.6 Who provides generalist palliative care?

General health and social care professionals give day-to-day palliative care to people as part of their roles. A person might see these people regularly as part of your usual care:

- GP
- district or community nurses
- hospital emergency department staff and ward teams
- care home staff
- social workers
- health care assistants
- family and friends
- religious and spiritual care professionals
- ambulance service professionals.

Generalist palliative care professionals should be involved as early as possible after a person has been diagnosed with a life-limiting illness. They will assess the person's needs and wishes, and those of your family and friends. They might also refer the person to specialist care services if needed.

3.7 What is specialist palliative care?

Throughout the course of a person's life–limiting illness, sometimes irregularly, sometimes for long periods, they may require expert assessment, advice, care and support from professionals who specialise in palliative care.

Specialist palliative care is the active, total care of patients with palliative care progressive, advanced disease and their families. Care is

provided by a multi-professional team who have undergone recognised specialist palliative care training.[8]

This care is known as specialist palliative care. It can also be called specialist level palliative care. For the purpose of this document we will use the term specialist palliative care. Specialist palliative care can help people with more complex palliative care needs that cannot be met by the person's usual generalist palliative care team (i.e. GP, district nurses or care home staff).

The focus of specialist palliative care is on quality of life in terms of a person's. physical, psychological, social and/or spiritual needs. Examples include complex physical symptoms, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions. Input from specialist palliative care professionals to the care of a person must be based on the needs of the person and not the illness they have.

3.8 Who provides specialist palliative care?

Specialist palliative care is provided by specially trained multi-professional specialist palliative care teams with professionals who will have undergone specialist training and experience in this area. These professional teams are generally based in a hospice, in the community, an NHS specialist palliative care unit or an acute hospital.

They can be made up of different healthcare professionals and co-ordinate the care of people with life-limiting illness. Specialist palliative care professionals are experts in providing palliative care and are involved in managing more complex care problems and providing joined up care. A person might see one or more specialists in the team following referral such as:

- palliative care doctors in hospital or community settings
- palliative care nurses and clinical nurse specialists (CNS)
- physiotherapists, occupational therapists and dieticians
- social workers and counsellors.

A specialist palliative care team can provide a range of support, which is likely to vary from location to location, or be offered on a continuous basis or as and when needed. This means service provision could dip in and out over time according to a client's changing needs and the progression of their illness. As specialists, they also advise other generalist palliative care professionals on palliative and end of life care.

The specialist palliative care team's support is also likely to increase as a patient approaches the end of life care stage of palliative care.

[8] Tebbit, National Council for Palliative Care, 1999

3.9 Who needs specialist palliative care?

The majority of palliative and end of life care is delivered through universal care and support services and targeted palliative and end of life care. A minority of patients who have life limiting illness and who are dying will require specialist palliative care. However, patients can move from specialist to generalist palliative care and vice versa as their needs change. This is demonstrated in the diagram of universal palliative and end of life care services below.

3.10 What do we mean by community-based specialist palliative care?

Specialist palliative care can be provided in different settings including in a person's home, in hospital, in a residential care home or nursing home, in a hospice, some out-patient clinics and day centres, and community health care centres.

Whilst we have described above the entirety of palliative and specialist palliative care, there are many patients with specific needs that can best be supported by community-based specialist palliative care services.

Universal Palliative and End of Life Care

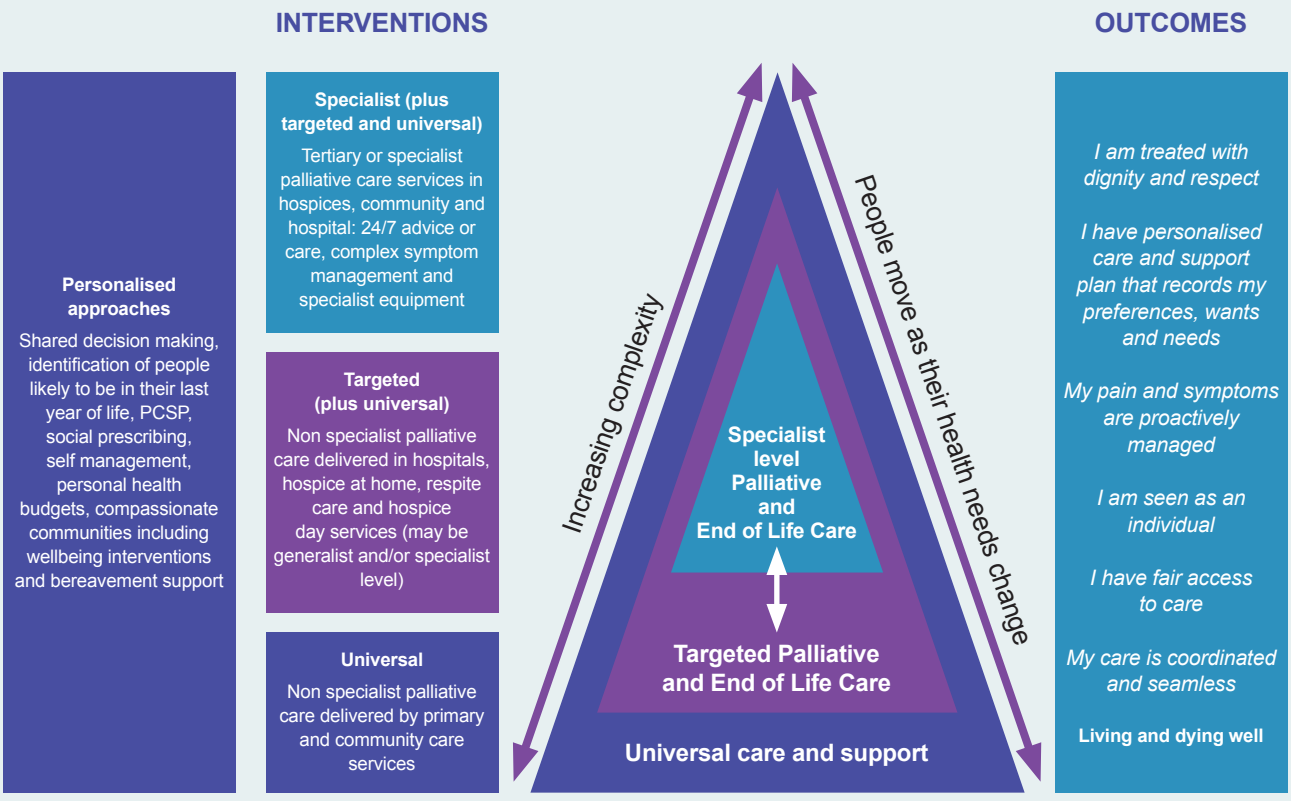


Diagram above reference: NHS National Universal model of Palliative and End of life care (PEOLC) 2021

For this document when we refer to community-based specialist palliative care services we mean those services provided in a community setting which is outside of the acute hospital or GP surgery.

Community-based specialist palliative care is care that is delivered in the patient's home, a care home, other usual place of residence, a hospice or a community health centre. It does not refer to specialist palliative care in a hospital setting.

Community-based specialist palliative care may contain, but is not limited to one or more of the following elements:

COMMUNITY-BASED SPECIALIST PALLIATIVE CARE TEAM

Specialist team consists of doctors, nurses and therapists with specialist expertise in palliative care. The nurses and therapists visit patients in their homes (home in community, care homes, usual place of residence) with input from the team's specialist doctors. Also provide 24/7 advice to patients, families and carers as needed.

DAY HOSPICE SERVICES AND OUTPATIENT DAY CARE

Provide care for patients who need more prolonged treatment or investigations than outpatients, but who do not need to stay in the hospital or hospice overnight.

SPECIALIST INPATIENT HOSPICE BED-BASED CARE UNITS

Specialist palliative care health needs identified. Person is admitted to hospice inpatient bed for symptom management overseen by a specialist consultant and/or specialist nursing team.

HOSPICE AT HOME OR BOTH

Hospice@Home is tailored to the need of the patient and can provide to provide a few hours of care through to being able to deliver twenty four hour care in the terminal phase of a patient's illness. Care is usually provided for up to two weeks.

Carers assist with all aspects of personal care from bathing and preparing meals to escorting patients to appointments for treatments such as chemotherapy or easing patients' discharge from hospital to their homes. Another important part of the service is to lessen the strain for family members who are caring for the patient.

SPECIALIST RESPITE AND SHORT BREAKS RESPITE CARE

For complex cases where case management at usual place of residence is difficult. This may be planned or urgent care and take place in the person's home or in a setting outside of the home such as a hospice or long-term care facility.

3.11 What support can community-based specialist palliative care services provide?

Community-based specialist palliative care can provide a number of services to the patients they care for including:

- **Specialist advice and support:** for example, co-ordinated support for patients with a high level of need, and the people supporting them, at their place of residence (hospice at home), or advance care planning.
- **Symptom management:** a patient's GP or hospital consultant can seek the advice and support of the community and hospital specialist teams around symptom management (e.g. pain or nausea), particularly where the symptoms are complex.
- **Day care and in-patient hospice services:** including review and assessment of physical needs, emotional and psychological support, creative and complementary therapies and advice on benefits. Support may also include short stays within the in-patient hospice unit for symptom management or respite, or to be cared for at the end of life.

3.12 How to access community-based specialist palliative care?

Anyone can refer any person with a life-limiting illness to community-based specialist palliative care services, although it is usually done by healthcare professionals. Examples of who can refer to community-based specialist palliative care:

- GPs or district nurses
- hospital doctors or nurses
- other specialist palliative care teams (ie. hospital or in community)
- patients themselves or their carers.

In general, the referral criteria for these services includes:

- The person being referred has an active life-limiting illness; a limited prognosis (likely course of the condition); and the focus of care is on quality of life.
- The person being referred has complex needs that cannot be met by those providing care (e.g. GP, hospital consultant, district nurse). These needs may be physical, psychological, social and/or spiritual. Examples include complex physical symptoms (ie. pain), difficult family and home situations, and ethical considerations.
- Family and carers who need extra support.

The person being referred to specialist community-based palliative care services should give their informed consent to the referral or if unable to do so, the referral should follow a 'best interests' decision (according to the Mental Capacity Act 2005). A referral may

be made at any point in the patient's illness pathway if the patient has needs requiring the input of a specialist.

3.13 What do we mean by approaching end of life and end of life care?

People are considered to be approaching the end of life when they are likely to die within the next 12 months. Although for people with some life limiting illnesses, this can be hard to predict and it could be years or months. This includes people with:

- Advanced, progressive, life-limiting illness.
- General frailty and co-existing conditions that mean they are expected to die within months.
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition.
- Life-threatening acute conditions caused by sudden catastrophic events.

End of life care is support for the people who are in the last year (s) and months, or days of their life. A person can receive end of life care at home, in a care home, in a hospice or in hospital. End of life care is an important part of palliative care for people who are considered to be in the last year of life, and should follow from the diagnosis of a person entering the process of dying. As this timeframe can be difficult to predict and some people might only receive end of life care in their last weeks or days of life.

End of life care aims to help people live as well and comfortably as possible until they die and to die with dignity. The individuals providing the end of life care should ask the person about their wishes and preferences for their care, and take these into account as they work with the person to plan their care (i.e. support the person to complete an advance care plan and provide care in line with this in as much as possible).

End of life care should also support the person's family, carers or other people who are important to them, and continues for as long as a person needs it. It can also involve support with practical things like making a will or getting financial support.

3.14 Who provides end of life care?

Many different health and social care professionals may be involved in your end of life care, depending on your needs. For example: hospital doctors and nurses, your GP, community nurses, hospice staff, social care staff, physiotherapists, your family and friends, and ambulance crew.

If a person is receiving end of life care at home, in a hospice or in a care home, their GP has overall responsibility for their care but will liaise with the rest of their care team which could also involve the community or hospital specialist palliative care team. Community nurses (i.e. district nurses) usually visit the person at home, and family and friends may be closely involved in providing end of life care.

CURRENT COMMUNITY-BASED SPECIALIST PALLIATIVE CARE PROVISION FOR ADULTS IN NW LONDON

NW London has eight providers of community-based specialist palliative care services, which includes seven hospice providers.

4

Between them they provide a combination of main clinical services (specialist inpatient beds, community specialist palliative care nursing, day hospice and outpatient services as outlined in the table on page 19), amongst some other services (ie, Lymphoedema well-being services, complementary therapies etc). Some of our providers only provide community-based specialist palliative care nursing services and do not have inpatient units.

Whilst three providers are 100% NHS funded (Pembridge Palliative Care Services provided by CLCH, Meadow House Hospice provided by LNWH and the Hillingdon Palliative Care Team and Your Life Line Team) the remaining five main hospice providers are funded through a combination of NHS and charitable income.

NW London's adult community-based specialist palliative care (SPC) provision (services by provider and location)

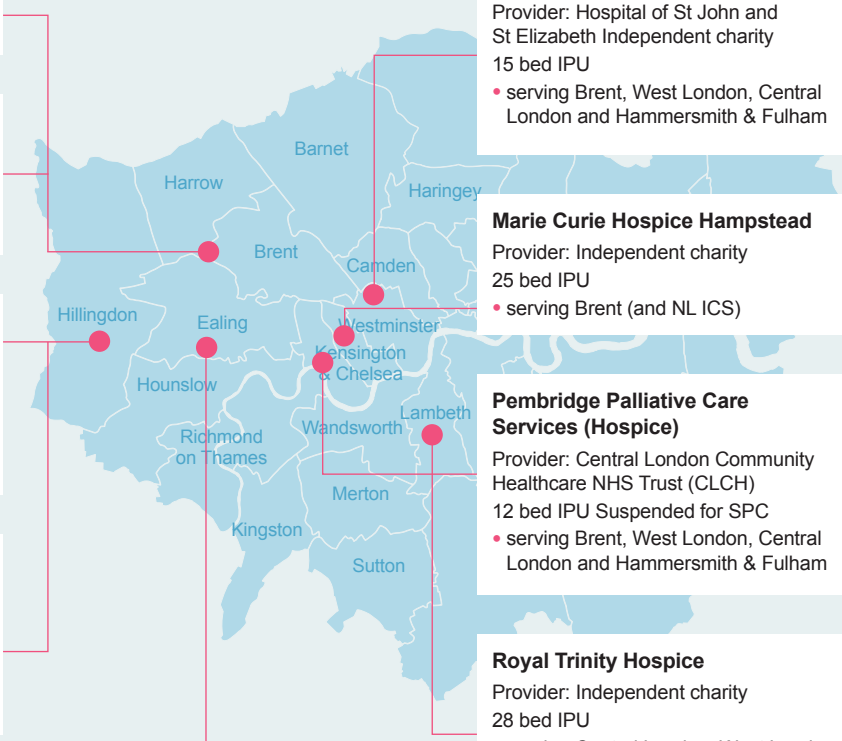
St Luke's Inpatient Unit (IPU)
Provider: Independent charity
12 bed IPU
- serving Harrow and Brent

Harrow Community SPC Nursing Team
Central London Community Healthcare NHS Trust (CLCH)
No IPU
- serving Harrow

Harlington Hospice & Michael Sobell House (MSH) inpatient unit
(Mount Vernon Hospital)
Provider: Independent charities
12 bed IPU
- serving Hillingdon

Hillingdon Community Palliative Team & Your Life Line 24 Service
Provider: Central North West London NHS Foundation Trust
No IPU
- serving Hillingdon

Meadow House Hospice
Providers: London North West University Healthcare NHS Trust (LNWH)
12 bed IPU
- serving Ealing and Hounslow



St John's Hospice
Provider: Hospital of St John and St Elizabeth Independent charity
15 bed IPU
- serving Brent, West London, Central London and Hammersmith & Fulham

Marie Curie Hospice Hampstead
Provider: Independent charity
25 bed IPU
- serving Brent (and NL ICS)

Pembridge Palliative Care Services (Hospice)
Provider: Central London Community Healthcare NHS Trust (CLCH)
12 bed IPU Suspended for SPC
- serving Brent, West London, Central London and Hammersmith & Fulham

Royal Trinity Hospice
Provider: Independent charity
28 bed IPU
- serving Central London, West London and Hammersmith & Fulham (and SWL & SEL ICS's)

EOL Rapid Response and Unplanned Nursing Services
Provider: Marie Curie London
- serving Ealing and Hounslow

BACK TO CONTENTS

WHY THINGS NEED TO CHANGE?

There are eight broad reasons why things need to change for in NW London Community-based Specialist Palliative Care provision.

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In the following section we list the reasons why things need to change and want to hear your views on these issues and any others that may be important to you:

5.1 Learning from previous service improvement reviews and engagement

Residents across NW London have previously taken the opportunity to tell the NHS what they want from services and our intention is to build on this work as we had some very valuable learning.

This future transformation work will build on this previous review of adult community-based palliative care and end of life services improvement work that commenced in Brent in 2018, as well the Independent Strategic Review of palliative care services[9] delivered by Penny Hansford in the London Boroughs of Hammersmith and Fulham, Kensington and Chelseas, and Westminster in 2019, and the subsequent engagement carried out in 2020.

The new programme of work will be expanding NW London wide, to include the other four London boroughs (Harrow, Hounslow, Ealing and Hillingdon) and community-based specialist palliative care providers not involved previously in the review and engagement work.

A summary of the feedback received is below and the full report can be found at www.nwlondonics.nhs.uk/get-involved/cspc:

- There was strong agreement from all that palliative care services are important to support people to die with dignity.
- More needed to be done to communicate and raise awareness of palliative care services so that residents could more easily access them,

health professionals were more comfortable to talk about death and dying and that it enabled earlier care planning.

- Residents wanted to be reassured there was enough capacity to care for people who needed support from community-based specialist palliative care services.
- Residents want to know more about the evidence the CCG was using.
- There was agreement that palliative care needed to reach more people, especially Black, Asian and Minority Ethnic (BAME) communities, but that we also needed to do more to take into account peoples cultural and religious needs.
- People wanted to know more about the problems in recruiting and retaining staff.
- Residents wanted to understand any funding issues and how that might impact service delivery.

[9] https://www.centrallondonccg.nhs.uk/media/95631/2-PJH4-Independent-review-palliative-care_Report.pdf

- There was concern about the impact that any change in services would have for travel and transport, with many elderly people not owning their own car and relying on public transport.
- Whilst many were happy with the care they had received, there was general acceptance that things needed to change if we were to improve access for all.
- Residents wanted easily understandable information and for their views and opinions to be taken into account.
- Strong local desire to maintain inpatient services at Pembridge and opposition to the suggestion it would close.

This work was paused in early 2020 as a result of the Covid-19 pandemic.

In 2019, Hillingdon CCG spoke to local residents about their experiences of palliative and end of life care which highlighted:

- The diverse nature of their communities and their needs.
- The importance for the care giver (the health professional) to be sensitive and aware of the needs of the patient, which may include their cultural and faith aspirations).
- The importance for patients and their families to be aware and involved in their care, so that their voices are heard and their wishes are respected.
- More needed to be done to ensure that everyone knew about the care is fully benefiting from the support that is already in place.

This previous engagement work has provided us with very valuable learning which we will bring forward into this system wide review. However, the new programme gives us the opportunity to make sure:

- The previous work came to the correct conclusions that are applicable across NW London as a whole,

Or

- develop new proposals as to the future of our adult community-based specialist palliative care.

Your views

The publication of the Issues Paper gives you the opportunity to have your say on community-based specialist palliative care services but do you have a view on the outcome of the previous engagement work carried out?

5.2 National context

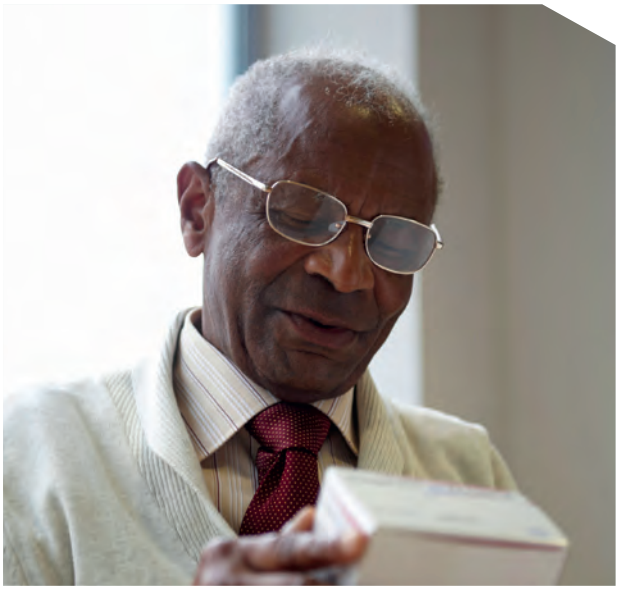
The Long Term plan and the recently refreshed Ambitions for palliative and end of life care: A national framework for local action 2021 to 2026 are the most current national directives guiding both palliative and end of life care.

These along with The National Institute for Health and Care Excellence (NICE) guidelines and standards, national palliative and end of life commissioning resources, and other relevant key documentation will form the basis on which the adult community-based specialist palliative care improvement work is progressed.

The NHS Long Term Plan[10] defines the 'must dos' so the NHS can be fit for the future based on the experiences of patients and staff. The plan commits to provision of more personalised palliative and end of life care and specifically asks commissioners to consider end of life care in the following areas:

- Increasing the offer of personal health budgets (section 1.41).
- Increase personalised care and support planning (section 1.42).

The Ambitions for palliative and end of life care framework was co-produced by a partnership of 27 national organisations, including health and social care bodies across the statutory and voluntary sectors. It provides a national framework for us to base local delivery of palliative and end of life care and consists of six ambitions, that describe what good looks like in palliative and end of life care for people of all ages, including their carers and others who are affected.



The six ambitions are:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

The Ambitions framework emphasises the contribution of specialist palliative care services as an integral part of the overall care in meeting a person's changing needs as their illness progresses. As well as the needs of families, carers and those important to the person, and other professionals who have the main responsibility for their care.

[10] https://www.longtermplan.nhs.uk

The National Audit of Care at the End of Life report for England and Wales 2019/2020 makes a number of recommendations on the future delivery of palliative care and end of life care relevant to this review:

- Put in place systems and processes to support people approaching the end of life to receive care that is personalised to their needs and preferences.
- Review capability and capacity across all care settings, to provide appropriate care at the end of life, and to support people important to the dying person through to bereavement, with the aim of better meeting people's needs and preferences.
- Ensure systems and processes for anticipatory prescribing for patients transferring from hospital to home or care home to die are aligned across the health and social care system.
- Require and support health and care staff to gain competence and confidence in communicating effectively and sensitively with the dying person and people important to them in the last days and hours of life.

In addition, there is an extensive library of research and papers on what good palliative care looks like and the issues that act as a barrier preventing people accessing palliative care on the NW London ICS website at www.nwlondonics.nhs.uk/get-involved/ics

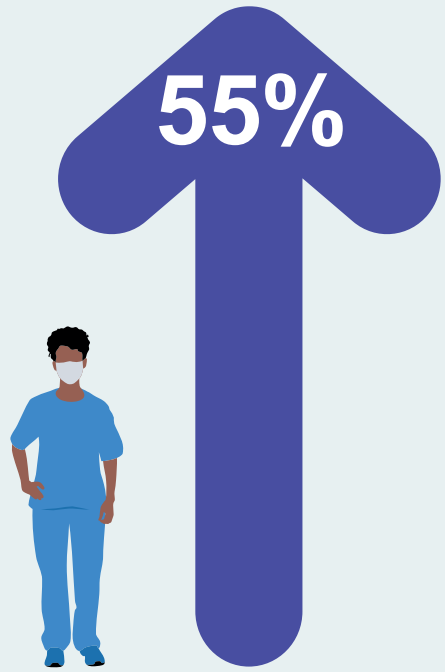
Learning from the Covid-19 pandemic
We also need to learn from the challenges and long-standing health inequalities that have been highlighted, and opportunities which have arisen from the Covid-19 pandemic to improve palliative and end of life care. We need to ensure that positive innovations and solutions can be sustained and continuous improvement takes place.

Your views
What is your view on the information provided and do you have anything you would like us to consider as we discuss the importance of community-based specialist palliative care?

5.3 Changing needs of patients and population growth

In the UK we have a rapidly ageing population with multiple morbidities and life-limiting illnesses. The health needs of people across the country including NW London are changing and the demands on our health services are increasing. Improvements in care and treatments mean that more people are living longer with more chronic illness. The NHS in the short and long-term will need to look after more people with greater needs.

In 2019 the UK population was 66.65m people with 530,000 deaths that year. That is 0.8% of the population. National population estimates show that the number of deaths within the UK will rise by an additional 130,000 deaths



The number of people receiving palliative care services is set to

increase by 55%

over the next ten years.

each year by 2040 and more than half of these deaths will be in people aged 85 years or older.

In 2017 it was estimated that these changing disease patterns and demographics would mean at least a half a million people in England and Wales would need palliative or end of life care every year by 2040, with cancer and dementia the main drivers of increased need. In mid-2018, there were 1.6 million people aged 85 years and over. By mid-2043, this is projected to nearly double to 3.0 million[11].

NW London population growth rate by borough and age

By 2023 it is expected that the over 65's population across NW London will be 30,3990, a 14.8% increase on 2017 figures. Five of the eight boroughs will see an increase of more than 15%, with the most significant change being in Brent

NW London deaths

The average number of deaths per year in NW London between 2015-2020 was 11,565. The actual number of deaths in NW London in 2019/2020 was 11,960 for all deaths. 27.81 % of these deaths were due to cancer and 72.19% non-cancer related. Of all the 11,960 deaths in 2019/202:

- 52.69% deaths took place in hospital
- 24.45% at home
- 14.53% at care homes
- 4.87% at hospice
- 3.56% in other locations.

In 2019/2020, NW London statistics for deaths showed that:

- A similar proportion of deaths in hospitals took place in comparison to the whole of London which is only lower by 1.59%,
- 8.01% more deaths took place in hospital for London than the England national average of 44.68%.
- Death at patient's home, NW London was almost on a par with London at 24.45% and England national average at 24.13%.
- Care home deaths, NW London was 7.26% lower than the national England average of 22.60%.

[11] ONS - https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2018based

The tables below show that the over 65's population will grow at a much higher rate than younger age groups.

	2018		2019		2020		2021		2022		2023	
	Under 65	65+	Under 65	65+	Under 65	65+	Under 65	65+	Under 65	65+	Under 65	65+
Brent	0.28%	3.27%	0.72%	2.29%	1.05%	2.60%	1.31%	2.94%	1.23%	2.63%	1.03%	3.18%
Ealing	-0.59%	2.85%	0.68%	2.48%	1.56%	2.48%	1.94%	2.44%	1.79%	2.45%	1.62%	2.17%
Hammersmith and Fulham	0.78%	2.68%	0.66%	2.08%	2.30%	2.08%	2.17%	2.18%	1.89%	2.20%	1.67%	2.97%
Harrow	0.16%	2.04%	0.72%	1.73%	0.51%	1.99%	0.57%	2.27%	0.51%	1.97%	0.40%	1.86%
Hillingdon	0.54%	1.36%	0.97%	1.38%	0.66%	1.49%	1.11%	1.86%	0.96%	1.88%	0.78%	2.17%
Hounslow	0.27%	2.63%	0.99%	2.19%	1.28%	2.22%	1.75%	2.32%	1.54%	2.57%	1.38%	2.55%
Kensington and Chelsea	-0.38%	2.55%	0.26%	2.12%	-0.18%	2.05%	-0.31%	1.73%	-0.42%	1.84%	-0.60%	2.14%
Westminster	3.37%	4.02%	0.67%	2.73%	0.16%	2.60%	-0.28%	2.52%		2.13%		2.30%

Borough	2023 Predicted Poulation Over 65's	% Increase on 2017'
Brent	7,028	18.1%
Ealing	6,879	16.2%
Hammersmith and Fulham	2,911	15.1%
Harrow	4,777	12.5%
Hillingdon	4,241	10.6%
Hounslow	4,887	15.4%
Kensington and Chelsea	3,126	13.1%
Westminster	5,255	17.4%
North West London	39,114	14.8%

- In hospice deaths, NW London is 0.86% below the average for London of 6.13%.

The way we have organised our hospitals, community-based services and primary care in the past will not meet the needs of the future. The demands on our system's health services are greater now than ever. The way in which we deliver our community-based specialist palliative care services needs to change in order to meet changing demands, and to improve the quality and safety of services and the experience that patients and their families and carers receive

According to a research study published in the open access journal BMC Medicine in 2017[12], population and mortality trends in England and Wales suggest that 25 percent more people will die each year by 2040, but with at least 42 percent more people needing palliative care due to a sharp increase in the number of people dying from chronic illness, particularly cancer and dementia .

The study concludes that we must prepare for the projected growth in dementia and cancer if we are to provide appropriate care to people dying in the future, and therefore current models

[12] How many people will need palliative care in 2040? Past trends, future projections and implications for services. Etkind et al. BMC Medicine May 2017 https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-017-0860-2

of palliative care must adapt in accordance to these projected changes, with more attention being given to the needs of people and those close to them when facing progressive illness, particularly those dying from chronic and complex illnesses, and age related syndromes such as frailty and dementia[12].

Your views

Our population is getting older and we will see increasing demand for community-based specialist palliative care. Do you have a view on this and what needs to be done?

5.4 Health inequalities

In 2020, The Marmot Review - 10 years on[13], was published and follows the original findings from Marmot's review into health inequalities[14]. The original report highlighted that across England, people who live within some of the poorest areas will die, on average, seven times earlier than those who are from the richest neighbourhoods. It went on to say that people who live in the poorest neighbourhoods not only die sooner but also spend more of their lives living with a disability or complex health condition.

There is also a lot of evidence that people with protected characteristic and certain populations such as the homeless, Lesbian, Gay, Bisexual, Transgender, Queer & Questioning (LGBTQ), BAME and people with learning disabilities are not well served by community-based specialist palliative care services and are not accessing the care they need, may not always be receiving care that meets their needs.

We still have significant health inequality across England, and, unfortunately high levels of deprivation across NW London. Some key health inequalities challenges that NW London are facing:

- Of our eight boroughs, Brent and Hammersmith & Fulham are amongst the most deprived local authorities in the country.
- Westminster has the highest overall number of people sleeping rough, many of which, will have mental health needs and will be less likely to access primary care services.
- Westminster and Hillingdon boroughs have the highest police use of Section 136 of the Mental Health Act which gives them the power to detain someone if they think they have a mental illness and you need care or control.
- 29% of children in Westminster are from low income families, versus 13.9% in Harrow.
- 78.9% of people are in employment in Harrow, compared to 64.4% in Westminster.
- Rates of emergency hospital admissions for self-harm are twice as high in Hounslow as they are in Harrow.

[13] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[14] https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives
[15] NW London Inequalities analysis.pdf

- 17.1% of people in Hillingdon smoke, versus 9.2% of people in Ealing.

- Hounslow has significantly lower life expectancy for both men and women compared to the London average.

- Although Kensington and Chelsea have among the highest life expectancies in the country, there are very large inequalities within parts of these boroughs.

- Hillingdon, Harrow, Ealing and Hounslow boroughs most frequently record higher rates per thousand for the most common long term conditions. Kensington and Chelsea and Hammersmith & Fulham boroughs have high recorded rates per thousand for correlated long term conditions, anxiety and depression.

- We know that our BAME communities are often disproportionately affected by Covid-19. At around the peak of first wave of the pandemic, compared to White Londoners, Black Londoners had around two and a half to three times the risk of dying with Covid-19 (within 28 days of diagnosis) and people of Asian ethnicity had up to twice the risk.

Nationally, those in the most deprived decile have almost twice the mortality rate of those in the least deprived. During Covid-19 Wave 1, this inequality became even wider.

The mortality in NW London in Wave 1 of Covid-19 was greater than the national average. There were a much greater proportion of deaths in the community and fewer in care homes[15].

Marie Curie identified 45 literature reviews describing unmet needs and disparities in palliative and end of life care for BAME groups.

These reviews found BAME people had:

- poorer access to care

- disparities and unmet needs when in receipt of care.

Most people would like to be with their loved one at the end of their life. This can be harder if their loved one is further away from where they live due to distance and travel costs and this can be doubly challenging for people who are on low income.

It also recognised the importance of understanding social inequities such as deprivation, differences in access to care in general, social exclusion and racism, when analysing unmet needs and disparities[16].

Your views

We have large health disparities in NW London and we know that some in our community do not always get good access to care. Are there other issues we should consider and what is your view on possible solutions?

[16] Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK, Demographic profile and the current state of palliative and end of life care provision. https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2013/palliative-and-end-of-life-care-for-black-asian-and-minority-ethnic-groups-in-the-uk.pdf

5.5 Improving the quality of care, and patient and family and carer experience

Patients, carers and families in NW London, depending on where they live, currently receive a different level of service and care when accessing our community-based specialist palliative care services. We also accept that some of these services are not in line with best practice. For instance, NICE end of life out of hours care quality statement 4, states that all adults approaching the end of life, and their carers supporting them should have access to specialist support 24 hours a day, seven days a week, but one of our eight boroughs currently does not have a seven day community-based specialist palliative care nursing service in place.

We also know that only seven of our eight boroughs provide 24/7 specialist palliative care telephone advice, with one of the providers not offering this out of hours (after 5pm). There is also variation in the offer of well-being and bereavement support services across the providers.

The type of care and support on offer also varies between the providers. For example, lymphoedema and hospice@home services are not commissioned across all of the providers meaning that patients have unequal access to services depending on where they live.

Whilst emergency admissions for patients in their last year of life journey are sometimes necessary. In NW London we often see people being admitted to hospital when they either don't need or don't want to be there as there is a lack of alternative provision and support available in the community that would prevent that admission.

This is especially true for people towards the end of their life and this is not considered to be good end of life care. We know from existing surveys that most people would prefer to die at home if this is possible to achieve. Yet national studies show that people in their last year of life experience an average of 2.28 hospital admissions and spend 30.1 bed days in hospital.

This is more likely to be avoided if patients are identified earlier as approaching their end of life and have adequate and appropriate care, is timely and that high quality advance care planning has taken place to support their wishes and preferences being communicated across the system and being upheld as much as possible.

The percentage of deaths with 3 or more emergency admissions in the last 3 months of life is national key performance measure of end of life care services. It can indicate issues with identification of end of life, planning and availability of services outside of hospital, coordination and information sharing.

Between April 2020 and Mach 2021, there were 6213 patients in NW London who had admissions to hospital in the last year of life, of which 709 (11%) of these patients had three or more admissions in their last 90 days of life. This totals to 91,876 bed days used, with an

average length of stay being 14.79 days for these patients in their last 90 days of life.

As a result, more of our patients are dying in hospital which is not what the majority of patients and families want. Providing care in hospital is often much more expensive than providing good quality services in the community or in the patient's own home.

We need to question whether the services and the way in which we are delivering them for the residents of NW London are good enough or if we need to change the way we do things if we are to deliver services that are equitable, high quality, safe and meets the needs of our diverse communities.

The CQC report, A Different Ending[17] indicates that because commissioners and providers do not fully understand or consider all the specific needs of the different groups in their populations, people in certain groups in society experience poorer quality care at the end of their lives.

We know in NW London that even where we have high quality care and services they do not always reach wide enough to support all our diverse communities who are not accessing the care that is available and that the services that are available do not always fit their preferences and needs. Improving the delivery of community-based specialist palliative care services will not reduce all end of life care hospital admissions and deaths, but will definitely help to reduce some unnecessary hospital admissions and support more people from our diverse communities to die in their preferred place.

More must be done to ensure that everyone who lives in NW London has equal access to high quality, accessible community-based specialist palliative and end of life care, that is consistently better for all. The needs of people of all ages who are living with dying, death and bereavement together with their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.

Your views
What is your view on how we can improve the quality, safety and equity of the services we provide as well as improved patient experience? What does good look like to you?

5.6 Fragmentation and the need for more joined up services

NICE Quality standard 13, statement 3 www.nice.org.uk/guidance/qs13/chapter/Quality-statement-3-Coordinated-care says that "Adults approaching the end of their life rshould eceive care that is coordinated between health and social care practitioners within and across different services and organisations."

The rationale being that adults approaching the end of their life are likely to receive planned and emergency care from a range of services and in a number of settings. Coordination of these services is necessary to ensure that there is a

[17] https://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf

shared understanding of the person's holistic needs and that the person receives end of life care that meets their specific needs and personal preferences. Coordination also leads to care being provided more quickly, as it is needed.

Improved information sharing across organisations will help to ensure that adults approaching the end of their life do not have to repeatedly provide information that can be shared between services. Coordination will help to ensure that people are not over-burdened with appointments and home visits. Appointments can be reviewed and optimised if possible, for example, coordinating appointments to avoid multiple visits.

In NW London we have multiple providers of community-based specialist palliative care. Community-based specialist palliative care nursing teams for some boroughs are also provided by separate providers to those providing bedded inpatient hospice care.

During our previous engagement on palliative and end of life care in 2019/20, we heard from our residents and clinicians that the existing fragmentation of services makes it difficult for patients, families and clinicians to navigate services, particularly out of hours when seeking expert and timely advice in the event of a crisis.

We also know our services do not always work well enough together to support the needs of our patients who can be asked multiple times for the same information by people involved in their care. Patients are bounced between services and care settings without services seeming to talk to each other. There is also the additional IT challenge of not all services having appropriate access to clinical information held electronically by partner providers for patients under their care. We aim to work collaboratively to address these issues.

Patients need integrated services that work across organisational boundaries to support the best care for them and their families. If we are to improve the quality of care patients receive in the place they want to receive their care, we need a more joined up approach between services so they all have a joint understanding of the clinical needs of the patient and importantly what their wishes are.

Personalised care, built around individualised quality advance care planning recorded on London's shared urgent digital care plan platform (currently Coordinate My Care), must be central to any improvements to the model of care for our services.

There are also likely to be missed opportunities for hospices and other providers to realise economies of scale through shared resources and collaborative working. In some instances, NW London is not the main commissioner, further complicating the landscape.

Your views
Our services are more fragmented than they should be. What is your view on this and what we should do to make them more joined up?

5.7 The workforce challenge

Nationally the safe and effective delivery of quality 24/7 palliative care in all settings is currently difficult to achieve consistently as a result of a national shortage of key palliative medical staff including specialist palliative care (SPC) consultants and specialist palliative care clinical nurse specialists (CNS) leading to gaps in the provision of specialist palliative care.

This is also true in NW London where we have a number of key vacancies across the patch for acute and specialist palliative care provision. Despite ongoing efforts by providers they have had trouble recruiting and retaining these key staff into permanent positions and this means services are not as sustainable and robust as they should be.

To cover this gap we employ lots of temporary doctors and nurses which is expensive and makes the service fragile should they leave at short notice, which does happen. One of our challenges is to build a model of care and services which has more permanent staff who are motivated to stay in NW London. This will lead to a more resilient service that is able to meet the needs of our patients, families and carers.

We need to explore ways to make better use of the expertise we currently have to deliver care, which could include consideration of new roles like social prescribers and GPs with specialist interest in community specialist palliative care.

Your views
What is your view of the workforce challenges we face and what do you think possible solutions are?

5.8 The financial challenge

Nationally, NHS spending has not been cut. It has risen slightly above inflation every year since 2010. But the costs of providing care are rising much more quickly than that, due to innovative but costly new technologies and rapidly increasing demand from a rising and ageing population. This has been further accelerated by the Covid- 19 pandemic and there are increasing conflicting demands on the money that we have.

The NHS in North West London the NHS has an underlying deficit of £453 million in 2021/2022. We are spending more money than we have and our challenge is continuing to deliver high quality care for local residents whilst trying to balance the books. Our focus is efficiency and better resource management whilst supporting the need to move resources within NW London ICS to help reduce inequality of service and access, and improve the quality of our services.

The amount that is being spent across NW London on community-based specialist palliative care in 2021/2022 is around £18

million. Whilst the amount we spend is not likely to fall, we cannot be sure we will be able to get an increase in funding as we move forward. We must take this into account when developing services if we are to develop equitable and sustainable services for the future. We also need to take into account that if we delivered everything that everyone wanted our services would not be affordable.

Most NHS care takes place outside hospital, with community-based services being more convenient for patients. However, most of the NHS funding is currently spent in hospitals, with emergency admissions for patients in last year of life having a significant financial burden.

If we are not able to invest additional resources into community-based specialist palliative care services, we will need to review how we spend the money across all elements of the services we have, to ensure the services we provide both meets the clinical and individual needs of patients and reflect the choices that they wish to make. Increasing palliative and end of life care interventions in primary, social and community care settings are potentially cost-saving or cost-effective[18].

A Sue Ryder report from March 2021, states that currently 245,000 people in England are expected to receive palliative care in the coming year and this is expected to increase to 379,000 people per year by 2030. The current national funding model for charitable hospices mean they only receive around one third of the money required to fund their end of life services from the government.

The running costs of the palliative care sector are estimated to be £947 million a year between now and 2030. If government funding remains the same, the hospice sector will be required to fundraise £597 million every year in order to keep hospices open.

Historically, the provision of specialist palliative care services by the independent sector has been partially funded by the NHS (with a share ranging between less than a fifth to two fifths of total expenditure) with the rest of the funds raised from donations, fundraising activities, charity shops etc. Information gathered from Hospice UK (the national hospice membership charity) showed that, even before the start of the COVID-19 outbreak, around 90% of surveyed hospices reported a lack of resources to meet increasing demand for services, and one fifth were thought to be at risk of imminent closure due to extreme financial difficulties[19].

Financial pressure on the charitable hospice sector was already increasing in 2019/20 due to rising demand for services before the Covid-19 pandemic significantly impacted charitable income for NW London hospice providers with almost all fundraising activities coming to a halt.

[18] Public Health England: Cost-effective commissioning of end of life care Understanding the health economics of palliative and end of life care https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/612377/health-economics-palliative-end-of-life-care.pdf

[19] It is time to end the hospice funding crisis - https://www.sueryder.org/news/hospice-funding-crisis

In NW London, hospices have taken steps to reduce their expenditure, but this still does not provide sufficient protection from further economic downturns resulting from subsequent Covid-19 waves or from a wider recession. This leaves our charitable hospice sector vulnerable and fragile, and work needs to be done to ensure we have robust and sustainable services for the future.

There is also considerable variation in NW London's community-based specialist palliative care contracts including:

- The amount of activity they have to deliver and workforce capacity to deliver this.
- Some are block contracts where we pay an agreed amount for the service they provide and some are paid based on the amount of activity they deliver.
- Some hospices are commissioned by different NHS boroughs and other ICS's to provide different service models from one site.
- There is no consistent service specification between the CCG and all providers who are providing these similar services.
- The amount we pay per day for an in-patient bed varies across providers.
- There is limited incentive for cross organisational collaboration and efficiencies.

This inconsistency creates a fragmented and inequitable service offer for NW London residents, and is not the most cost-effective or innovative way of using the current funds available for this provision. In the landscape of constrained resources and increasing demands for these community-based specialist palliative care services, all system partners need to

come together to creatively develop new ways of working to support more effective use of our existing resources.

Your views

The NHS is under pressure and we cannot spend more money than we have. What do you think that means for community-based specialist palliative care and what are the possible solutions?

WHAT WE NEED TO DO NEXT?

We now need the input of patients and carers along with the wider clinical staff across the GP community, mental health services and hospitals, the community, voluntary and faith sectors, in generating ideas to help us to improve the quality, safety and equity of care provided to patients, families and carers with excellent experience of that care.

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We want to know what you feel good care looks like and from that, working with our partners and taking into account all the issues raised in Section 5 will develop a model of care that will enable us to deliver that excellent care. It is only when this has been done will we look at what services we need to deliver the care and access whether we have the resources to deliver it, including workforce and finance.

Our aim through this work is to develop a new integrated model of care, single service specification for our services and a consistent approach to population health needs and person centred outcome measures.

- We plan to have wide reaching, robust and transparent communication and engagement with public and patients, including community, voluntary and faith groups.
- Publication of this Issues Paper and other supporting documentation is designed to facilitate discussions and support innovative thinking.
- Co-develop and implement with partners, a new integrated model of care for community-based specialist palliative care and a single service specification for our services that better meets our population needs.
- Collaboratively design more responsive, sustainable and resilient services with a wider reach.
- Achieve consistency and equity in access to services across NW London and level up to good practice where possible.
- Facilitate better co-ordination of care, improve communication and integration with other services across community and acute care settings.
- Collaborative working and pathway development with other ICS programmes including cancer, enhanced health in care homes, continuing health care, community nursing and acute discharge improvement work.
- Work in partnership with health, social care and the voluntary, community and faith sectors.
- Explore development of compassionate communities with more integrated/ partnership working with Vvoluntary and community sector.
- We will develop a consistent approach to person centred outcome measures, population health needs assessment, benchmarking and monitoring.
- We are working closely with our care home partners to utilise digital technology to support the development of shared care records for improved communication of patient wishes and well-being. We also aim to develop innovative ways using digital technology to facilitate improved education via specialist palliative care colleagues for our generalist palliative care workforce

Your views

What is your view on our proposed approachas set out above? Are there other issues that we should consider? What is your view of the possible solutions?

6.1 The timeline

NOVEMBER 2021 – FEBRUARY 2022

Patient engagement period – starts with publication of this issues document

JANUARY 2022 – FEBRUARY 2022

Writing up of report based on feedback from Issues paper and engagement exercises

MARCH 2022

Publication of outcome report and next steps – testing outcomes with public and stakeholders (feedback loop)

6.2 Get involved

We want your help in exploring what the issues are and coming up with possible solutions.

Over the coming months we will have lots of ways that you can get involved and opportunities to give your views.

The easiest way to keep up to date is to sign up to Community-based Specialist Palliative Care News, the e-newsletter that we will use to keep people up-to- date. To sign up to receive the e-newsletter click here.

We have also developed a dedicated section on the NW London ICS website www.nwlondonics.nhs.uk/getinvolved/cspc which contains all the most recent information and the documents and links we have highlighted through-out this document.

The website will also host links to surveys and registration for events once these become available.

Community and voluntary sector organisations will be running events for service providers and also holding focus groups for service users and carers.

If you would like to get involved in these activities, then please contact us.

Should we come to the conclusion that we need to develop proposals for services changes, we would need to consider whether we would need to go out for further engagement or consultation.

To respond to the questions raised in this Issues Paper, or to share any questions or concerns you have, go to www.nwlondonics.nhs.uk/getinvolved/cspc

Email us: **nhsnwlccg.endoflife@nhs.net**

If you or someone you know wants this Issues Paper translated or in another accessible format, please contact us via the details on the back cover.

GLOSSARY OF TERMS

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Advance care planning (ACP)
Advance care planning (ACP) is the term used to describe the conversation between people, their families and carers and those looking after them about their future health and care wishes and priorities. It is a way for a person to think ahead, to describe what's important to them and have this recorded to ensure other people know their wishes to help that person to live well right to the end of their life.

Advance Care planning is a key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing

Community-based specialist palliative care
By community specialist palliative care, we are referring to settings where this care is delivered that are not within a hospital or a GP surgery, but rather in a patient's own home, a care home, a hospice and a community hospital or centre.

Compassionate care
Care that is person centred (care that is focused on the needs and preferences of the individual) and involves the person delivering the care demonstrating characteristics such as empathy, sensitivity, kindness and warmth towards their patient[21].

Generalist palliative care
Generalist palliative and end of life care is provided on a day to day basis by many health and social care professionals (ie. GP, District Nurse, Social workers, care home staff. It can also be provided by a patient's family and carers in their home.

Health inequalities
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing[22].

Life limiting illness
A life-limiting illness is an illness that can't be cured and that a person is likely to die from. You may also hear the terms 'terminal', 'progressive' (gets worse over time) or 'advanced' (is at a serious stage) to describe these illnesses. Examples of life-limiting illnesses include advanced cancer, motor neuron disease (MND) and dementia[23].

Model of care
A "Model of Care" broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place[24].

[21] https://jcompassionatehc.biomedcentral.com/articles/10.1186/s40639-015-0015-2
[22] Definition of Health Inequalities, NHS England https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities
[23] Marie Curie - https://www.mariecurie.org.uk/help/support/diagnosed/recent-diagnosis/palliative-care-end-of-life-care?msclkid=f18fe3a5a903141b6eef82d67ac30640
[24] Government of Western Australia, Department of Health (2012) http://www.agedcare.health.wa.gov.au/home/moc.cfm

Palliative care
The World Health Organisation (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

Palliative care is for individuals of all ages with a life limiting (non-curable) illness aiming to improve the quality of life of patients, their families and their caregivers as it:

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten or postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- Uses a team approach to address the needs of patients and their families.
- Enhances quality of life and may also positively influence the course of illness.
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to better understand and manage clinical complications.

Personalised care
Personalised care is about giving people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life. It accepts a one-size-fits-all health and care system cannot meet the complex needs and expectations of the individual. Personalised care is based on 'what matters' to people and their individual strengths and needs.

Personalised health budget
A personal health budget is an amount of money to support your health and wellbeing needs, which is planned and agreed between you (or someone who represents you), and your local NHS team. It is not new money, but it may mean spending money differently so that you can get the care that you need.

Psychosocial
The term psychosocial refers to the psychological and social factors that influence mental health. Social influences such as peer pressure, parental support, cultural and religious background, socioeconomic status, and interpersonal relationships all help to shape personality and influence psychological makeup.

Psychological
Psychological means mental or emotional rather than physical

Quality of life

In healthcare, most researchers and clinicians agree that quality of life (QOL) is related to symptoms, functioning, psychological and social wellbeing, and probably to a lesser extent to meaning and fulfilment. However, during end-of-life care spirituality and existential issues become more prominent, as well as family members' perception of quality of care[25].

Spiritual care

Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires[26].

Universal Care and Targeted care

Universal care is open to all of general public and free to access.

Targeted care is commissioned provision that is group/diagnosis/age-related[27].

[25] Kaasa S, Loge JH. Quality of life in palliative care: principles and practice. Palliat Med. 2003 Jan;17(1):11-20. doi: 10.1191/0269216303pm662ra. PMID: 12597461.

[26] NHS Education for Scotland, 2009

[27] https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Statement-of-resources_S7.pdf

Community-based specialist palliative care review
North West London Clinical Commissioning Group
Ferguson House
15 Marylebone Road
London
NW1 5JD

Email: nhsnwlccg.endoflife@nhs.net
Web: www.nwlondonics.nhs.uk/get-involved/cspc

Community-based specialist palliative care improvement programme

Work with us to understand how we can improve the experience for all adults who use community-based specialist palliative care services in North West London

North West London Integrated Care System

November 2021

Summary Issues Paper

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

Anyone at the end of their life should be able to be where they want to be, with the people they want to be with. They (and their family, loved ones and carers) deserve the best quality care and support, regardless of their circumstances. With a rapidly ageing society and changing patterns of illness, many more people with multiple long-term health conditions will live for longer. As a result, the need for high-quality palliative and end-of-life care is expected to increase dramatically by 2040.

Too many people experience poor care as they approach the end of their life, with many people spending their last months and weeks in hospital, often dying there, which is not what they want. Not only is this distressing for the patient and their loved ones, but this is also NHS funding that could be spent elsewhere.

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

More also needs to be done to make sure the care provided by different organisations is more joined up. This includes making sure all patients have a personalised care plan that has been agreed with them, and that the plan is available to the different care sectors supporting them and their family.

Currently, the most fragile part of the palliative and end-of-life care services in North West London is the community-based specialist palliative care for adults. In North West London we have eight community-based specialist palliative care providers providing services. These include seven hospices with inpatient units, as well as separate community specialist palliative care nursing services.

The providers deliver a wide range of services including specialist inpatient and community-based specialist palliative care nursing, day hospices and outpatient services, as well as some additional specialist services including lymphedema, well-being services and complementary therapies. Some of our providers only provide community-based specialist palliative care nursing services and do not have hospice inpatient units.

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

- Royal Trinity Hospice is based in South London. It provides services to parts of Hammersmith & Fulham, Westminster and Kensington & Chelsea.
- St John's Hospice is based in Westminster. It provides services to Brent, Hammersmith & Fulham, Westminster and Kensington & Chelsea.
- Marie Curie Hospice is based in Hampstead and provides services to Brent. Marie Curie's London Nursing Service provides end-of-life rapid response and nursing services to Ealing and Hounslow.
- St Luke's Hospice is based in Harrow. It provides services to Harrow and Brent (North).
- Harlington Hospice is based in Hillingdon. It also provides the Michael Sobell House Inpatient Unit at Mount Vernon Hospital in Hillingdon. Both services serve Hillingdon.
- Meadow House Hospice is based at Ealing Hospital, and is run by London North West University Hospital Trust. It provides services to Ealing and Hounslow.
- Pembridge Palliative Care Service is in North Kensington. It provides services to Hammersmith & Fulham, Westminster, Brent (South) and Kensington & Chelsea (please note, the inpatient bed part of this service is currently suspended). Harrow Community Specialist Palliative Care Team is also provided by Central London Community Healthcare NHS Trust, and provides services in Harrow only.
- The Hillingdon Community Palliative Care Team and Your Life Line Service are provided by Central and North West London NHS Foundation Trust. These services are provided in Hillingdon.

The NHS and its partners are committed to making improvements in community-based specialist palliative care for adults before looking at other areas of palliative and end-of-life care.

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

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

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

However, we will be working hard to make sure that our work links closely and joins up with hospital specialist palliative care and all other generalist palliative and

end-of-life care services in North West London. We will also work with a number of NW London ICS's other service-improvement initiatives that are already looking to reduce differences in and improve the quality of non-specialist (generalist) palliative and end-of-life care services. This includes the NW London Community District Nursing Review and NW London Enhanced Health in Care Homes programme.

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

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

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

What we want to do

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

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

1. To build on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.
2. To bring services in line with national policy such as the national Six Ambitions for Palliative and End of Life Care and the NHS triple aim of

improving access, quality and sustainability, and to make sure providers follow the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services, as far as possible.

3. To meet patients' changing needs arising from changes in the population. By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.
4. To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.
5. To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care that patients, families and carers across North West London receive. This means that depending on where a patient lives, they and their family and carers may not get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.
6. To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.
7. To cope with the increasing financial challenge the NHS is facing and the effect this has on community-based specialist palliative care.
8. To reduce the difficulty we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.

What people have said before

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

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

The feedback showed that people have different views on how we should make these improvements.

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

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

When we have completed our research and received everyone's feedback, we will look to develop the model of care that will deliver the high-quality safe and fair care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high-quality model of care and make sure it can be maintained in the long term, and to bring forward proposals that set this out.

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

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

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

We have published an issues paper which provides more detail. You can read it at www.nwlics.nhs.uk/cspc

Get involved

We want your help in finding out what the issues are and coming up with possible solutions. Over the coming months we will have lots of ways that you can get involved and opportunities to give your views.

To find out how to get involved visit www.nwlics.nhs.uk/cspc or email nhsnwlccg.endoflife@nhs.net

Timeline

November 2021 – February 2022
Patient engagement period starts

January- February 2022
Writing up a report based on feedback from the issues paper and engagement exercises

March 2022
Publication of outcome report and next steps – testing outcomes with public and stakeholders (feedback loop)

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Report for:	**NW London Joint Overview and Scrutiny Committee**
Date of Meeting:	14th December 2021
Subject:	NW London Workforce Update
Responsible Officer:	Claire Murdoch, CEO CNWL and SRO for Workforce
Report author:	Charlotte Bailey, CPO NW London ICS Lindsey Waddell, AD of Workforce NW London ICS
Enclosures:	Appendix A - NWL ICS Workforce Update

Section 1 – Summary and Recommendations

This report provides an update on progress with NW London Workforce programmes. Recent successes and performance changes are highlighted as is progress with NWL People Plan programmes and development of the ICP People Function.

Recommendations:
No decisions are required; the paper is for noting.

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Working together for better health and care

Workforce Update
JHOSC

The JHOSC are asked to:

- Note recent successes
- Note the performance changes specifically in absence and turnover trends and the mitigating actions being put in place through People Plan initiatives and locally across organisations to address them
- Note People Plan 6 key areas and specific achievements and progress
- Support the collaborative approach for creation of the ICS values and behaviours framework as it develops
- Note the 10 people functions for the ICS and progress made in transitioning to an ICS people function
- Support the development and resourcing of a workforce programme for primary care and social care

Charlotte Bailey | 14 December 2021

Contents

1. Current workforce performance and trends (Core KPIs)
2. People Plan Progress: quarterly achievements against milestones
3. People Plan: what's next and longer term objectives
4. Transition to the ICS people function: progress update

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Current Workforce Performance and Trends

A NWL dashboard of workforce KPIs is being matured. We collect data where it is comparable across organisations. This is core workforce data to help us understand key system trends.

Performance: Core Workforce KPIs

Section	Metric	Metric Status	Trend	NWL Target Range	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Core Workforce KPIs	Trust Post Establishment (WTE)	Watch		n/a	50,320	50,365	50,538	50,869	51,489								
	Trust Staff Inpost (WTE)	Watch		n/a	45,162	45,145	45,176	45,066	45,596								
	Trust Staff Inpost (headcount)	Watch		n/a	49,815	49,847	49,838	49,606	50,118								
	Vacancies (WTE)	Watch		n/a	5,158	5,220	5,363	5,803	5,893								
	Vacancy Rate (%)	**Driver**	→	8-12%	10.3%	10.4%	10.6%	11.4%	11.4%								
	In-month Sickness Rate (%)	**Driver**	↑	3.3-4.4%	3.5%	3.5%	3.9%	4.2%	4.3%								
	Rolling 12-Month Sickness Rate (%)	**Driver**	↓	3.3%-4.4%	4.1%	4.1%	3.8%	3.9%	3.8%								
	Voluntary Turnover Rate (%)	**Driver**	↑	10 - 18.4%	11.7%	11.7%	12.1%	12.3%	12.4%								
	Core Skills Compliance Rate (%)	**Driver**	↑	85%-92%	88.7%	88.7%	90.6%	90.2%	91.9%								

North West London Integrated Care System

Performance Trends

- Our total Provider workforce was 56,513.42 WTE at the end of Q2

- Overall staffing WTE planned changes between H1 out-turn (end of Q2) and H2 out-turn (end of Q4) of an additional **1,009 WTE**, split as;

- Increase of 1,046 WTE substantive staff
  - International nursing and midwifery recruitment
  - Pipeline and planned recruitment activities
  - IAPT, CAMHS and Perinatal Service expansions
  - Elective recovery and Elective Care Unit (colorectal services)
  - Critical Care provision
  - ED Mental Health Assessment Unit
- Increase of 99 WTE bank staff
  - Support for additional planned H2 activity
- Decrease of 135 agency staff
  - Cessation of agency staffing as a result of substantive recruitment.

Acute, Ambulance, Community and Mental Health Organisations	Establishment	Baseline	Actual	Actual	Plan	Plan	Establishment
	2020/2021	Staff in post outturn	As at the end of June 2021	As at the end of September 2021	As at the end of December 2021	As at the end of March 2022	2021/2022
	Year End (31st March 2021)	Year End (31st March 2021)	Q1	Q2	Q3	Q4	Whole Year
Workforce (WTE)	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	**55425.37**	**50438.40**	**50250.87**	**50307.70**	**50801.79**	**51353.62**	**57565.19**
Bank		5547.48	5215.64	4685.14	4747.97	4783.75	
Agency		1785.50	1413.02	1520.58	1429.42	1385.49	
Total Provider Workforce (WTE)	**55425.37**	**57771.38**	**56879.53**	**56513.42**	**56979.18**	**57522.86**	**57565.19**
Substantive by staff group							
Registered nursing, midwifery and health visiting staff	16489.19	14269.66	14262.14	14185.71	14460.21	14625.07	16888.67
Allied health professionals	3546.24	3228.72	3209.96	3188.41	3201.45	3231.92	3598.59
Other scientific, therapeutic and technical staff	2560.46	2406.45	2348.20	2385.09	2381.16	2474.73	2870.72
Health Care scientists	909.82	753.46	737.43	732.87	709.10	709.41	884.72
Qualified ambulance service staff	2589.19	2609.09	2591.09	2571.20	2659.20	2734.20	2796.39
Support to nursing staff	6522.17	6051.05	5981.27	5911.19	6001.40	6009.32	6744.47
Support to allied health professionals	653.09	576.60	579.96	595.41	592.15	597.07	650.21
Support to STT & HCS Staff	1205.30	1125.33	1150.87	1159.44	1151.70	1151.74	1234.53
Support to Ambulance Staff	1655.23	1555.91	1616.45	1667.26	1678.26	1730.26	1855.23
Total non-medical - Clinical staff substantive	**36130.69**	**32576.26**	**32477.37**	**32396.58**	**32834.61**	**33263.70**	**37523.53**
Consultants (including Directors of Public Health)	2385.83	2273.93	2267.41	2292.26	2314.22	2316.50	2545.68
Career/Staff grades	422.29	341.80	345.85	346.65	350.16	350.53	429.46
Trainee grades	3375.25	3291.31	3186.06	3286.52	3297.40	3301.41	3448.49
Total medical and Dental Staff substantive	**6183.37**	**5907.04**	**5799.32**	**5925.43**	**5961.77**	**5968.43**	**6423.63**
NHS Infrastructure support	13095.29	11927.38	11945.46	11957.98	11977.56	12093.64	13591.47
Any Others	16.02	27.72	28.72	27.72	27.86	27.86	26.57
Total non-medical - non-clinical staff substantive	**13111.31**	**11955.10**	**11974.18**	**11985.70**	**12005.42**	**12121.50**	**13618.04**

North West London Integrated Care System

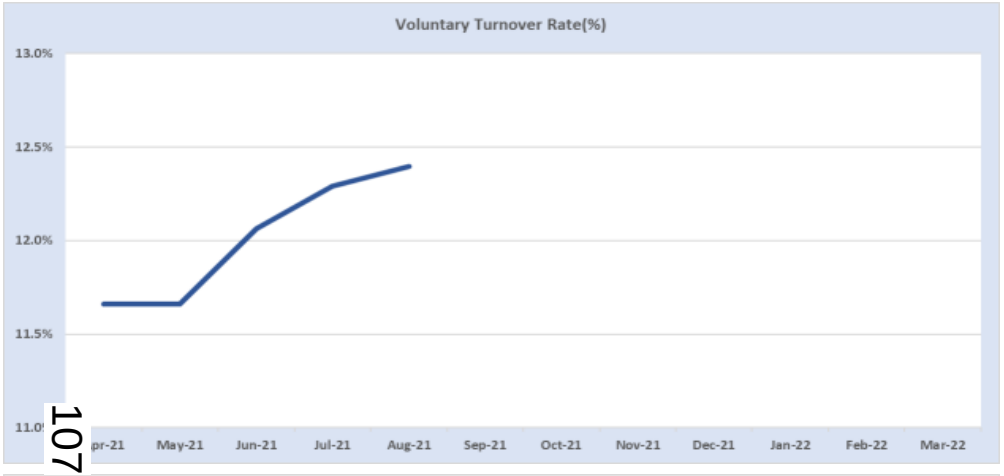
Performance Trends

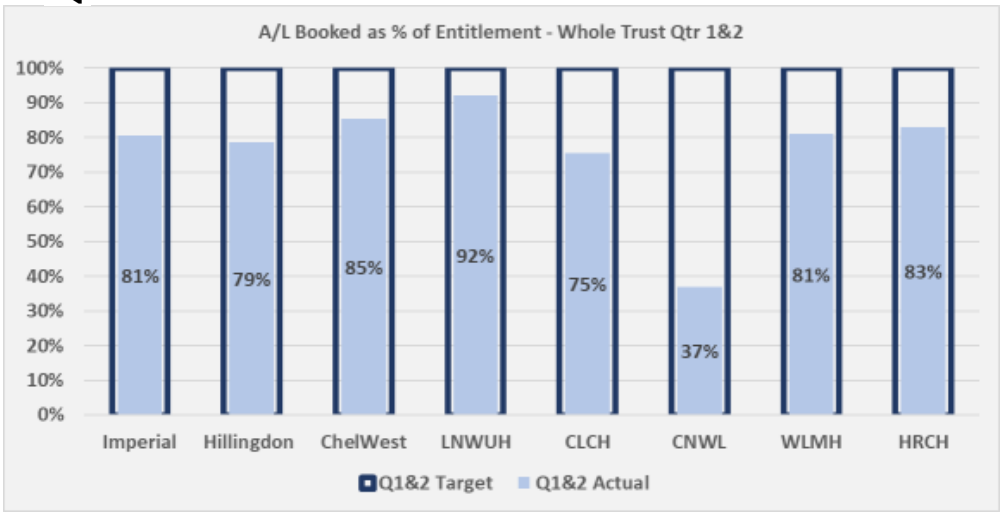
- At the end of August 2021 there were a total of 5,893 WTE vacancies across NWL Trust, a vacancy rate of 11.4%; no change from the previous month.
- Voluntary turnover has seen a small but steady increase since the position in April 2021 with a rate of 12.4% at the end of August 2021. This is an area of concern and CPOs are undertaking a deep dive in mid-November to understand patterns and trends and develop mitigating action.
- All trusts have model employer targets (diversity within staffing); currently the work is being conducted at an organisational level. We are setting up a group with organisational leads:
  - to review organisational trajectories, plans and progress
  - look at trends across organisations and best practice that can be shared
  - collectively agree an overall ICS-wide target with organisational trajectories, which will drive collective action towards the reduced timescale to achieve the national goals
- Core skills compliance remains good with an increasing trend reported since the end of May 2021; current compliance is 91.9%.
- Sickness absence has increased month on month since June 2021 with 4.4% reported during the month of August 2021. Despite the monthly rise in sickness absence, the rolling 12-month position is holding steady due to lower levels recorded at various times over the past year. CPO are monitoring trends, developing winter plans and ensuring staff are taking leave.
- The most common reasons for sickness absence from work are on slide 8.
- The joint NWL Keeping Well Service has had 1,948 referrals since June 2020 and of those receiving an IAPT intervention, 62% have recovered – higher than the 50% norm. September referrals were 147.
- Where the presenting problem is known, the majority of referrals have cited depression (38%) or Generalised Anxiety Disorder (31%). PTSD (5%). (*More information is in Appendix 1)*

Further detail is in appendix 1

North West London Integrated Care System

Underlying reasons for performance that requires improvement

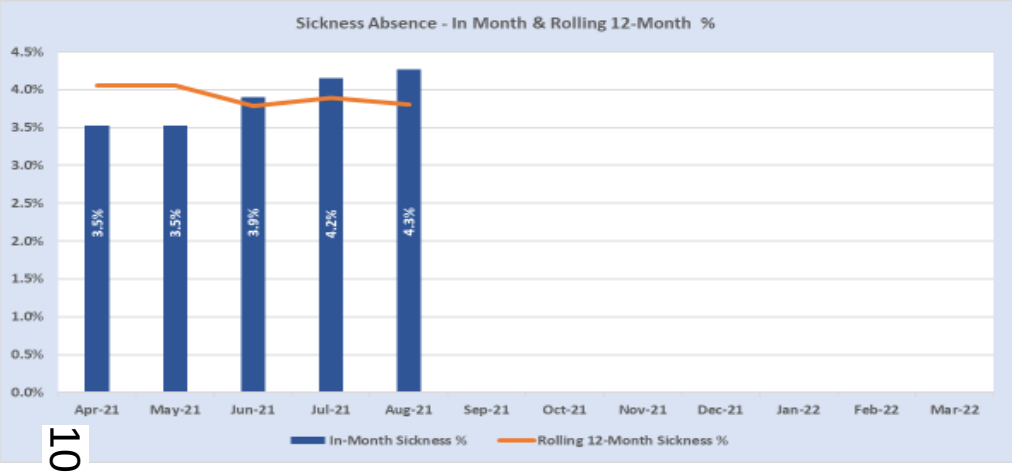


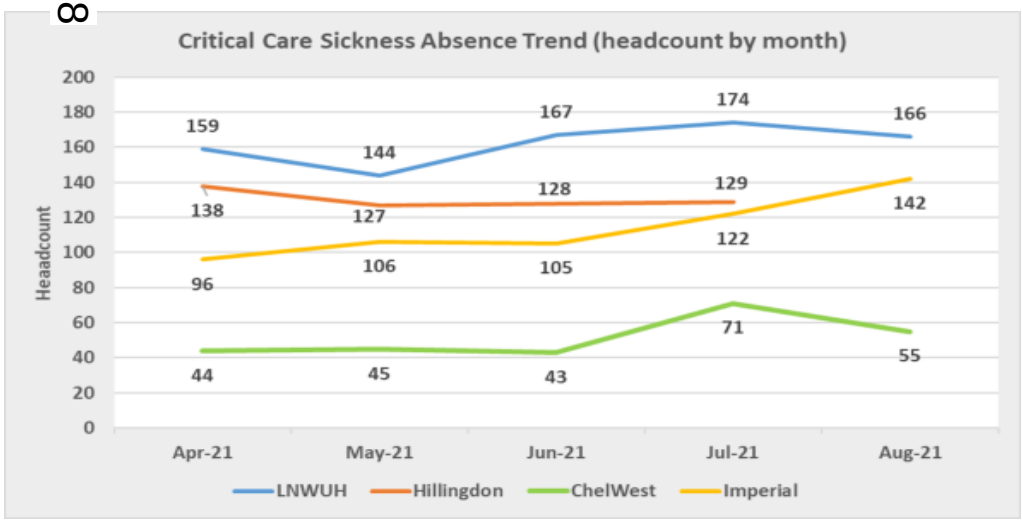


- Small but steady increase in voluntary turnover seen month on month since May 2021.
- We are currently working with Trusts to understand the main drivers to this rise but anecdotal evidence is pointing to an increasing number of clinical staff re-thinking their area of work following the pressures and stresses of the past 18 months; Covid-19 response, elective recovery and increased A&E attendances and admissions.
- Evidence is also emerging that turnover amongst the Allied Health Professional staffing group, which already has an established high turnover rate, is also increasing. Of particular concern are Occupational Therapists where there is a national shortage of staff.
- Well-being support for staff is a key enabler in reducing turnover and monitoring of annual leave uptake across the Trusts is ongoing to ensure all staff have the opportunity to rest.

North West London Integrated Care System

Underlying reasons for performance that requires improvement





- Increasing trend in sickness absence seen each month since May 2021. Driving factors;
  - i) increased levels of Covid related absence
  - ii) increased levels of cough/cold/flu type illness
  - iii) increased levels of gastrointestinal type illness

- Increasing numbers of staff absent through self-referred sickness such as gastrointestinal illness along with coughs colds & flu and headache/migraine are strong indicators of increased fatigue and stress within the workforce.

- A deep-dive into sickness absence within Critical Care services across the sector also showed increased levels of sickness absence since May 2021 correlating to the reasons stated above as well as increased levels of anxiety/stress/depression/other psychiatric illness and headache/migraine.

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People Plan: Quarterly Achievements against milestones

The NWL People Plan was refreshed in June 2021 and the short term priorities and flagship work projects as a system were agreed via the People Board, ICS Exec and ICS Partnership; the longer term strategic workforce pieces can still be developed and modified by system partners, it is not fixed. The priorities in the NWL People Plan have been aligned with the national people plan and the current ICS plans.

Current achievements

- **Awards and recognition**: Keeping Well Programme: positive practice recognition in Mental Health award and finalists for BMJ and the HSJ Value awards
- **Bids and funding**: the money we have drawn in by working together is over £2m
- **Growing OH**: national recognition of the NWL programme with an award of funding of £500k to continue and share learning
- **Leadership Ladder Programme**: is one of first to take regional positive action with placements starting 18th October
- **Compassionate Leadership Programme**: first cohort completed the programme in October and is taking learning into their workplace
- **Mass vaccination and retention programme**: NWL is recognised for the success of the mass vaccination programme and is successfully implementing retention plans moving volunteers and programme staff into vacancies across health and social care roles
- **Collaborative Bank:** the medical bank is active and has already supported efficiencies in the region of £219,850 through supporting trusts to access each others staff via the portal

NWL People Plan Progress Update: we are 'on track' against the milestones set against current projects

NB: Highlight reports for each pillar can be found in Appendix 2

	On track
	Delays, recoverable
	Delayed, mitigation plans in train

Pillar	Focus / Purpose	Quarterly achievements	RAG	Flagship Project
CARE **Nina Singh**	To develop a core HWB offer and add value by working together to deliver services	• **Staff Mental Health Hub** – delivering rapid access to IAPT and supported by £470,000 funding • **Keeping Well academy** – providing self-service online resources to staff supported by £338,000 funding • **ICS HWB Framework** – funding allocated to Trusts supporting local HWB initiatives for critical care staff (total £748,000) • **Occupational Health shared service –** supported by £500,000 Growing OH funding; Prototype Business Case complete		Delivery of the medium-term framework 10-point plan
LEAD **Charlotte Bailey**	To support the development of our leaders and managers in core skills	• **Compassionate Leaders** – Cohort 1 complete and next cohorts in planning • **Organisation Development** – ICS Values and Behaviours workshops developed and borough level analysis to shape local OD plans • **Leadership Ladder programme** – Implementation underway which supports BAME staff into senior roles • **Delivery of new ICS Graduate scheme** – updating model to support an ICS approach		ICS & System OD plans, Values and Behaviours supporting ICS creation Delivery of the Graduate Schemes
INCLUDE **Lou[illegible]** **Joh[illegible]n**	To improve our WRES targets and meet our model hospital targets	• **Inclusive Recruitment** – best practice recruitment and selection toolkit developed • **National MWRES** – review completed and best practice case will inform NWL plans • **Scrutiny Panel** – established to act as a 'critical friend' to the programme board		Leadership Ladder Develop NWL-wide target to meet WRES model employers goal
GROW **Sue Smith**	To address workforce gaps in priority and hard to recruit roles	• **Vaccination to Vocation** – retention programme underway moving people into permanent health and care roles (161 staff into permanent jobs) • **NWL Academy** – a true partnership approach ensured a strong bid for GLA funding for £250k over2-years; outcome pending • **Map educational and apprenticeship pathways –** to support employment into the NHS from our local populations in NWL		Development of the NWL recruitment and retention strategy
TRANSFORM **Kevin Croft**	To develop new ways of working that are more effective, efficient and support	• **Acute Care** – workforce transformation programme to support the recovery and sustainability of elective care, critical care, and urgent and emergency care • **Primary Care** – workforce programme to support the PCN recruitment function and expansion of GP/GPN Fellowships • **Mental Health** – workforce transformation programme to support expansion and redesign • **Medical Staffing** – improvement programme		Elective care recovery and protection of elective care through winter
ENABLE **Claire Gore**	To simplify workforce processes and support sustainability and improvement by working together	• **Collaborative Bank implementation**– Medical collaborative bank launched and nursing bank near completion with potential savings identified • **Workforce information and analytics** – development of the Workforce intelligence Service Model agreed with monthly reporting underway • **Simplifying HR processes and systems** – baselining activities underway to identify further opportunities for consolidation		Nurse Collaborative Bank to be launched Core HR Admin consolidation to streamline common processes

We are planning to develop more on education and training to support the workforce of the future and will be creating a new pillar – Learn

Primary Care Workforce Update

This is our current baseline and we are conscious of the need to finalise and implement the longer-term strategy that will make a difference in outcomes

Context: Primary Care workforce is under pressure on service provision and a redesign is a fundamental key enabler for improvement. A key driver for change includes the PCN Enhanced Service (DES) where roles such as the Additional Reimbursable Roles Scheme (ARRS) were introduced to support delivery of additional activity outlined in the primary care contract and NWL ICS development; this has prompted further debate on Local Care and place-based workforce activity.

ARRS Activity:

- Intention to recruit 90 ARRS through 2021/22; a review is underway to analyse the impact of the roles and the support provided to them

Risks and Challenges:

- **Recruitment:** a 'tight' job market and low pre-registration placements mean challenges to achieve desired targets
- **MH Practitioner ARRS**: difficult to recruit but engagement activities indicate increased applications with interviews underway
- **Paramedics:** difficult to recruit - working with LAS to recruit band 6 rotational posts; a peer support pilot with 8 paramedics is underway

Next Steps for the transformation plan:

- Analysis of the recruitment intent to assess where additional support may be required for recruitment of the ARRS roles
- Exploring recruitment events with ICS partners and rotational development posts
- PCN workforce plans analysis to ensure ARRS funding has been fully allocated for 2020-21

GP & GPN Activity:

- Analysis of latest data December 2020 – June 2021 shows an increase in GPs by 1.02% and a decrease of GPNs by 11%; if left, GPN numbers will decline by >40% in the next 5-years *

NWL Workforce Data	Sum of TOTAL_GP_FTE	Sum of TOTAL_GP_EXR_FTE	Sum of TOTAL_NURSES_FTE
NWL December 2020	1,263	1,125	400
NWL June 2021	1,276	1,126	357

- Detailed analysis is underway and preliminary data indicates NWL vacancies is consistent with other London systems but flagged a amber
- Mitigation includes: support to newly qualified GP's and GPN's via the NHSE Fellowship initiative; GP mentorship scheme with 13 mentoring agreements in place; using patient satisfaction reports to triangulate impact on service delivery against the GP and GPN numbers per head of population

Risks and Challenges: funding for support roles is 'at risk' for key support roles (i.e. SPIN Director role reduced to two session per week; GP Clinical Mentorship Lead role is currently vacant and out to advert

Next steps for the transformation plan:

- Ensure the GP and GPN SPIN Fellowship and mentoring scheme are continued and supported by NWL
- Scope the NWL training practice information in light of the Under Doctored Area data to identify priority areas
- Develop clear data to support the impact of a reduced GP and GPN workforce in light of service delivery
- Develop a network of Clinical supervisors to support the NWL GP and GPN workforce

*NB: Accurate and consistent data capture and reporting remains an issue in Primary Care; plans to address this are part of the ICS Workforce Dashboard development

North West London Integrated Care System

A summary of next steps for Primary Care workforce plans

Workforce Data Develop core workforce data standards across the NWL ICS to ensure Primary Care Workforce data is comparable to partner organisations and incorporated into workforce planning	**Workforce Planning** Support NWL PCN's to explore workforce in light of their population needs, including GP and GPN needs over the next 2-5 years. available ARRS funding to maximise allocation of ARRS roles	**ARRS** Work with PCN's to utilise all their ARRS allocations based on their population health needs ensuring full utilisation of funding by year end	**ICS Integration** Ensure Primary Care is fully embedded in the ICS development and the NWL People Function
Work with the NWL Business Intelligence Team to scope all available data • In collaboration with the NWL ICS Workforce Intelligence Network ensure that the primary care data is comparable to the wider ICS partners looking at commonalities and variations in programme delivery	Build the workforce discussion into all NWL Primary Care work streams moving forward to ensure the workforce training and development discussion is part of all programmes including: • Primary Care summit's • SOM's • Capacity and Demand Activity • PCN Development	Analysis of roles intended for recruitment to build in support resources including collaboration with ICS partner organisations looking at potential: • Joint development roles in integrated teams • Wider ICS recruitment activity • Development of supervision support networks to embed these new roles in primary care	Ensure NWL Primary Care Teams have access to the resources and support available within the wider ICS system including: • ICS recruitment events • Joint working to develop the NWL Anchor Institute perspective • Development of ICS wide pre-registration placement and curriculum development

North West London Integrated Care System

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People Plan what's next and longer term objectives

We are developing a high-level plan on a page and there are detailed plans emerging with milestones and timescales. Our plan is divided into:

- Operational (immediate – less than one year and what we need to do to address here and now workforce priorities)
- Tactical (medium term – what people need in the coming year, conducted within the annual budget process, smaller scale priorities)
- Strategic (longer term – 2-5 years and what is required to delivery against longer term business strategies; integrated and focused on workforce planning)

We are working to understand the critical roles and services where we have high vacancy or turnover rates (i.e. hard to recruit/ hard to retain) and develop workforce transformation plans against these. This will form part of the tactical and strategic plans.

We continue to integrate plans across health organisations and primary care and have a longer-term approach for incorporating Social Care into those plans

People Plan on a Page: next steps and future initiatives

As we implement our plans we will meet with our partners to align approaches with Social Care and Local Authorities; a Social Care representative is being invited to become a member of the NWL People Board

Pillar	**Operational** (immediate – less than one year and what we need to do to address here and now workforce priorities)	**Tactical** (medium term – what people need in the coming year, conducted within the annual budget process, smaller scale priorities)	**Strategic** (longer term – 2-5 years and what is required to delivery against longer term business strategies; integrated and focused on workforce planning)
CARE **Nina Singh**	• Organisational plans developed for the Delivery of the 10 point plan • All organisations implement Pulse Survey	• Delivery of the 10 point plan across ICS • Development of long-term strategic ICS HWB framework • Integration of Primary Care into plans	• Integration of social care into plans
LEAD **Charlotte Bailey**	• ICS values and behaviours framework developed • Compassionate leadership approach roll out	• ICS wide deployment of 2022 Graduate Management Trainee Scheme agreed and in place • Management development programme in place supporting ICS talent management approach	• Enhances leadership development programme integrated into ICS-wide succession planning process
INCLUSIVE **Louise Johnson**	• Develop a NWL-wide target to meet WRES Model employers goal trajectories • Implement of the NWL Inclusive Recruitment Guide	• 'Insight' programme to support the development of BAME NEDS, incorporating learning from organisations	• Tbc
GROW **Sue Smith**	• Vaccination to vocation programme complete • Hard to recruit roles identified with plans to address requirements	• ICS-wide apprenticeship provision in place • Map educational and apprenticeship pathways that support entry to post graduate level employment into the NHS from the NWL population	• Place-based NHS recruitment model addressing underrepresented groups in NWL and opportunities for development / career progression
TRANSFORM **Kevin Croft**	• Recruitment against ARRS roles • Maximise workforce agility for winter plans • Joint strategies for increasing staff mobility and enhanced use of MOU to enable a more flexible workforce	• ARRS roles development against longer term Primary Care workforce strategy • Integration of workforce agenda with Primary Care, including transformation, training and education • Creation and development of workforce plans for Elective Care, UEC and Critical Care	• Long term acute group model and local care transformation • Collaborative recruitment strategies and vacancy reduction plans, including new routes into the professions
ENABLE **Claire Gore**	• Implement nursing collaborative bank across Acute Trusts • Baseline core HR Administration functions to develop Level 2 end to end processes	• E-rostering adopted across all Acute Trusts • Expansion of collaborative bank to all organisations and professional groups	• Tbc
LEARN **Tbc**	• Establish the pillar priorities and resource to deliver • Alignment of competency frameworks – national and local to inform required initiatives and plans for upskilling staff	• CPD programmes and technology enhanced learning resources • ICS Management development programme supporting new and existing managers	• Tbc

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Transition to the ICS people function – progress update

We have developed a plan to meet the requirements outlined in the People Function ICS Guidance.

A HRD working session will be scheduled for early December to work through the requirements and assess the readiness and capability of the People Function.

ICS People Function 4 preparatory actions are underway and to be completed by the end of March 2021/22 to support delivery of 10 people functions

No.	Action	Notes	Progress
1.	Agree the formal ICB and ICP governance and accountability arrangements for people and workforce in the ICS, including appointed SROs.	Roles are identified and due to be appointed to. Governance arrangements are being developed.	
2.	Agree how and where specific people functions are delivered within the ICS (for example, ICB, provider collaborative, place-based partnership).	Plans for each people function/pillar are in development which will determine where delivery will take place.	
3.	Review and refresh the current ICS People Board (or establish where not already in place) in line with wider ICS governance and accountabilities and with clear reporting arrangements into the ICS Board.	People Board refreshed in line with NWL People Plan and ICS governance arrangements agreed.	
4.	Assess the ICS's readiness, capacity and capability to deliver the people function (for example, using resources already available such as the System Development Progression Tool), including identifying gaps and initiating a plan for developing the necessary infrastructure across the totality of the ICS.	Some milestones underway. Additional milestones and plan to be agreed in line with overall ICS readiness programme plan.	

North West London Integrated Care System

Preparing to transition to the ICS People Function

Note: additional information is provided in Appendix 3

ICS People Functions	Our Current NWL People Plan is aligned to the ICS People Function						
	Care	Include	Lead	Transform	Grow	Enable	Learn
Supporting the health and wellbeing of staff	✓						
Growing the workforce for the future and enabling adequate workforce supply					✓		
Supporting inclusion and belonging for all, and creating a great experience for staff		✓					
Valuing and supporting leadership at all levels, and lifelong learning			✓				✓
Leading workforce transformation and new ways of working				✓			
Educating, training and developing people, and managing talent				✓	✓		✓
Driving and supporting broader social and economic development					✓		
Transforming people services and supporting the people profession						✓	
Leading coordinated workforce planning using analysis and intelligence				✓			
Supporting system design and development			✓				

Current state of readiness

- People Plan programmes have been mapped to the 10 outcomes and we continue to make progress with implementation
- Full and detailed project plans are in place to complete:
  - Process for deliver of people functions
  - Delivery arrangements
  - Governance and accountability (see appendix)
  - How and where specific people functions will be delivered within the ICS
  - Refresh the People Board
  - Readiness assessments
  - ICS culture plans

Progress reporting

- Monitored through HRD and People Board meetings and reporting quarterly to Partnership Board

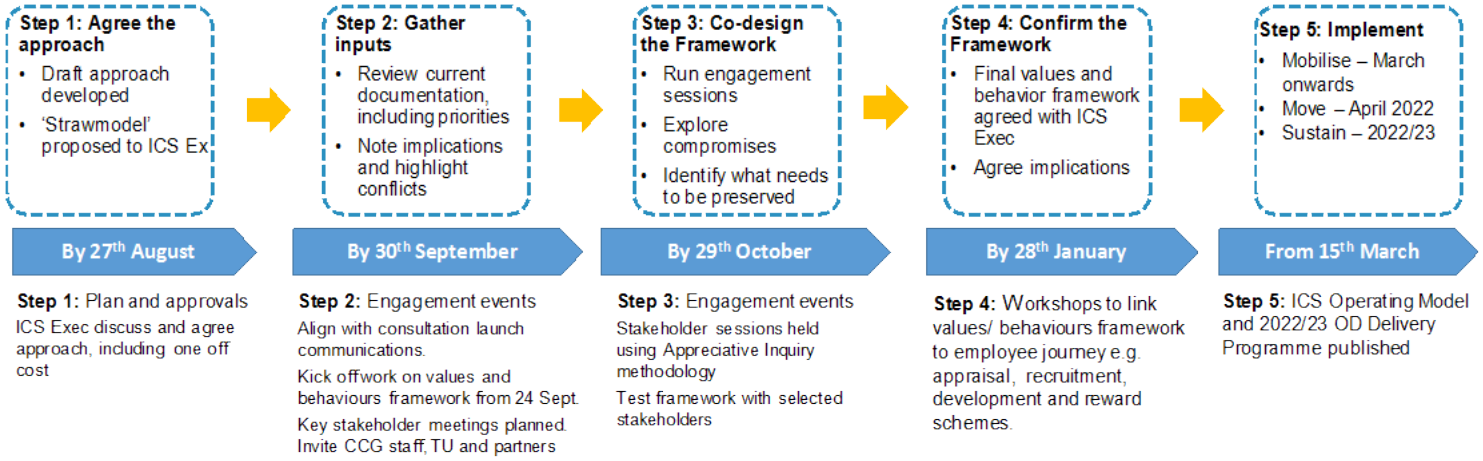
ICS Organisation Development

- Values and behaviours framework development plans are in train (see next slide)

North West London Integrated Care System

Developing the ICS Workforce Update

- A series of workshops are in development to co-design the framework engaging both employees and partners
- An 'appreciative enquiry' approach will ensure preservation of what works well now and what might/should/will work well in the new ICS
- Aim for approx. 200 participants in 8 workshops commencing end October to end December
- Additional feedback forums will be introduced to widen participation and engagement during and after this period
- A dedicated workshop for ICS Execs and Partnership Board members is planned following completion of the workshops



Why we are taking this approach

- Engaging across a wide set of stakeholders to co-create a framework that describes shared ways of working and behaviours will ensure that all parts of the ICS, at system, borough and employee levels know what is expected of them and each other and will have contributed to shaping how this will be delivered
- Substantial engagement and involvement will help move people along the change curve from 'awareness' to 'commitment' and build trust over time. This cannot be achieved from introducing a new governance structure and statute alone
- We are taking action to address the risk of 'new acronyms but old ways of working' to ensure staff deliver to their full potential and, as an ICS, we continue to build our reputation based on how we act on what we are committed to delivering
- Once developed, the framework will be hardwired into ICS structure, systems and processes to support all staff with leaders acting as visible role models

North West London Integrated Care System

Next steps and support required from ICS Partnership

- ICS Partnership Board is asked to
  - Note recent successes
  - Note the performance changes specifically in absence and turnover trends and the mitigating actions being put in place through People Plan initiatives and locally across organisations to address them
  - Note People Plan 6 key areas and specific achievements and progress
  - Proactively support the collaborative approach for creation of the ICS values and behaviours framework as it develops
  - Note the 10 people functions for the ICS and progress made in transitioning to an ICS people function
  - Support the development and resourcing of a workforce programme for primary care and social care

Appendices

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Appendix 1: NWL People Performance

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Workforce Summary

Target Performance:

Currently all 8 Trusts have their own workforce KPI targets and work has commenced with the sector HRDs to look at setting and agreeing sector-wide targets for core workforce KPIs

Current Month's Achievement:

- Trusts overall vacancy rate at 11.4%; no change from the previous month
- Establishment up by 620 WTE and staff by 530 WTE; TUPE transfer into CLCH
- Core skills overall compliance remains good at 91.9%

Plans to Mitigate Performance:

- Voluntary turnover has seen a small but steady increase since the position in April 2021 with a rate of 12.4% at the end of August 2021.

See workforce slide 2 for drivers and mitigations

- Sickness absence has increased month on month since June 2021 with 4.4% reported during the month of August 2021.

Note - targets and RAG rating still to be developed

Indicator	Target	(April)	(May)	(June)	(July)	(August)
Establishment Post WTE	-	50,320.2	50,365.4	50,538.2	50,869	51,489
Staff InPost WTE	-	45,161.9	45,145.4	45,175.6	45,066	45,596
Vacant WTE	-	5,158.3	5,220.0	5,362.6	5,803	5,893
Staff InPost Headcount	-	49,815	49,847	49,838	49,606	50,118
Vacancy Rate %	8% - 12%	10.3%	10.4%	10.6%	11.4%	11.4%
In-Month 2021 Sickness %	3.3% - 4.4%	3.5%	3.5%	3.9%	4.2%	4.3%
Rolling 12-Month Sickness %	3.3% - 4.4%	4.1%	4.1%	3.8%	3.9%	3.8%
Voluntary Turnover Rate %	10% - 18.4%	11.7%	11.7%	12.1%	12.3%	12.4%
Core Skills Compliance %	85% - 92%	88.7%	88.7%	90.6%	90.2%	91.9%

Data Source:
ICS Dashboard

North West London Integrated Care System

Workforce Sickness Absence

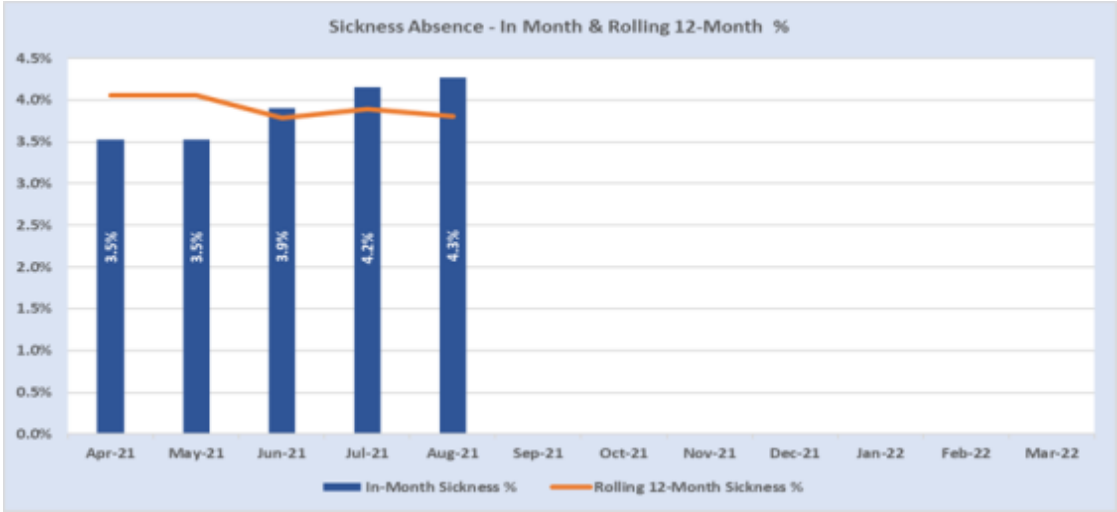
- Increasing trend in sickness absence seen each month since May 2021. Driving factors;

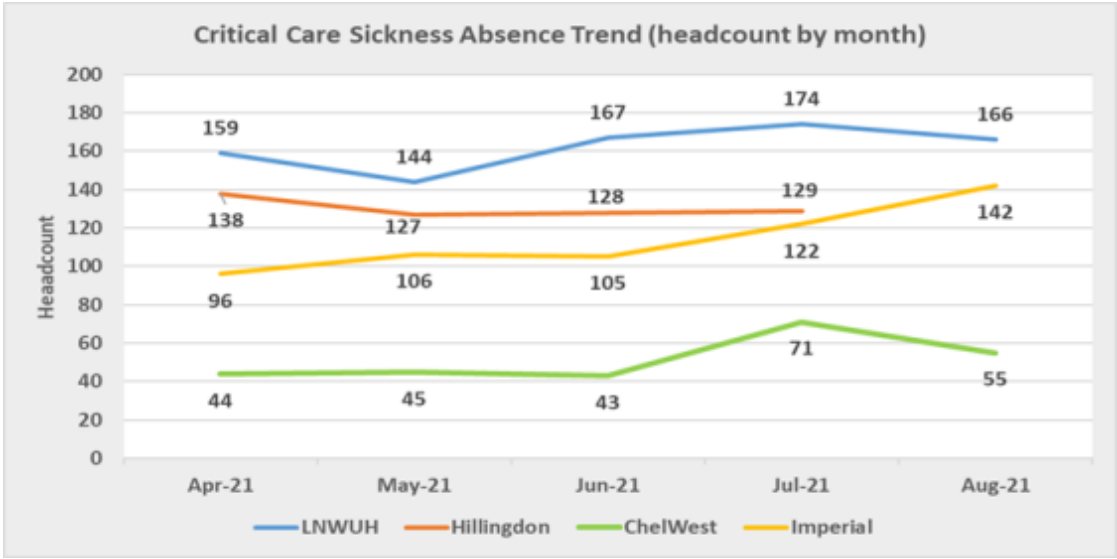
  i) increased levels of Covid related absence
  ii) increased levels of cough/cold/flu type illness
  iii) increased levels of gastrointestinal type illness

- Increasing numbers of staff absent through self-referred sickness such as gastrointestinal illness along with coughs colds & flu and headache/migraine are strong indicators of increased fatigue and stress within the workforce

- A deep-dive into sickness absence within Critical Care services across the sector also showed increased levels of sickness absence since May 2021 correlating to the reasons stated above as well as increased levels of anxiety/stress/depression/other psychiatric illness and headache/migraine

- Trend analysis of long and short term sickness absence is underway to ascertain the make up of sickness episodes, reasons for absence and hot-spot areas for focus



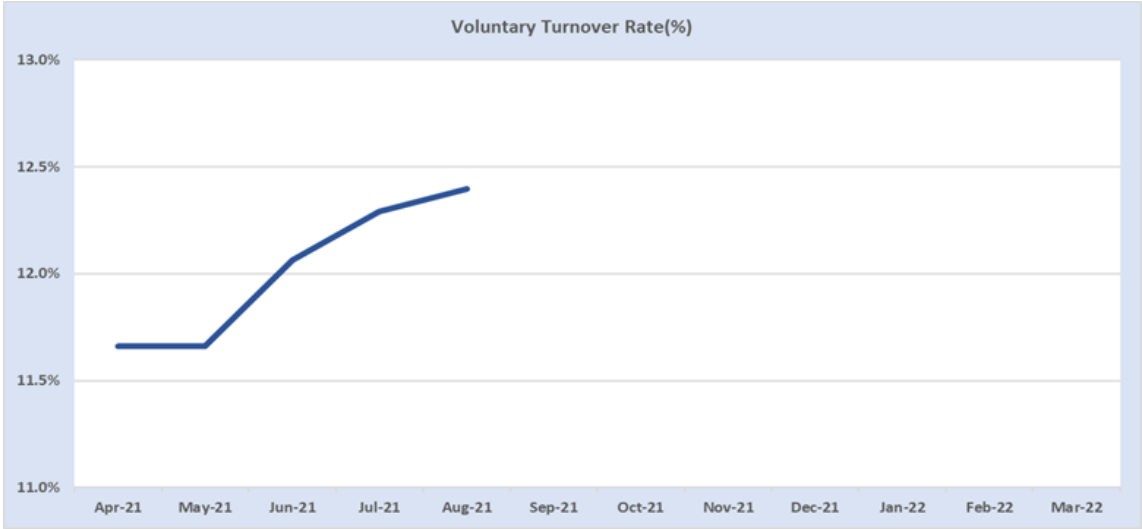


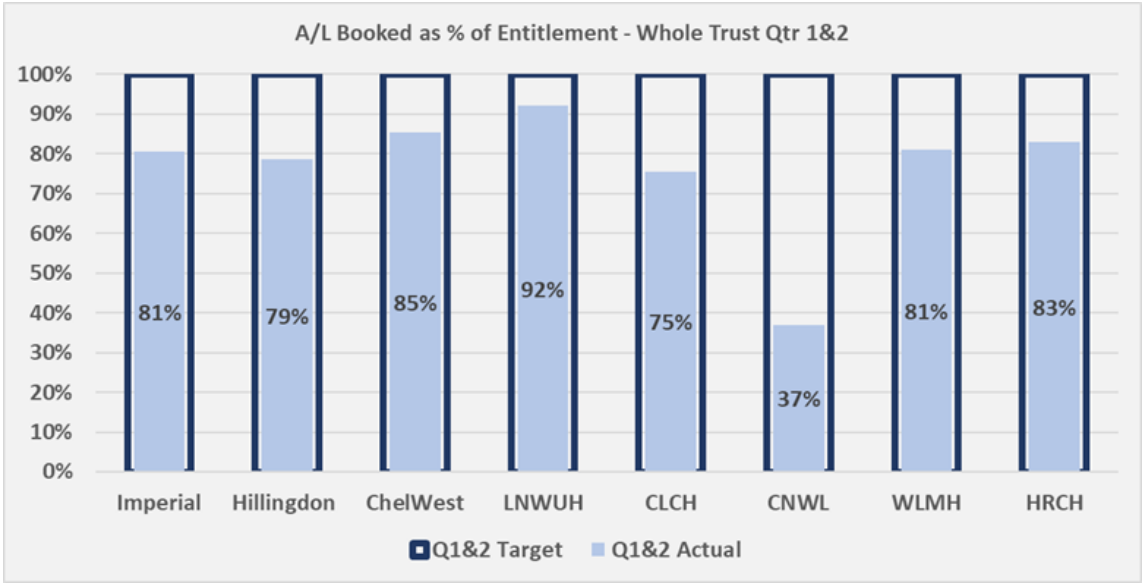
Data Source:
Workforce Dashboard

North West London Integrated Care System

Workforce Voluntary Turnover

- Small but steady increase in voluntary turnover seen month on month since May 2021.
- We are currently working with Trusts to understand the main drivers to this rise but anecdotal evidence is pointing to an increasing number of clinical staff re-thinking their area of work following the pressures and stresses of the past 18 months; Covid-19 response, elective recovery and increased A&E attendances and admissions
- Evidence is also emerging that turnover amongst the Allied Health Professional staffing group, which already has an established high turnover rate, is also increasing. Of particular concern are Occupational Therapists where there is a national shortage of staff
- Well-being support for staff is a key enabler in reducing turnover and monitoring of annual leave uptake across the Trusts is ongoing to ensure all staff have the opportunity to rest





Data Source:
Workforce Dashboard

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Appendix 2: NWL People Plan Highlight Reports

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CARE: We have a healthy and engaged workforce

Focus	Area	RAG	Area	RAG
Outcome: Access to psychological support for individual and team wellbeing **Legacy:** A workforce that feels that NWL employers understand their needs **Impact:** A workforce that has increased resilience and loyalty to NWL employers	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Staff Mental Health Hub** - £470,000 funding is supporting psychological support for ITU/Critical Care staff and staff supporting Covid-19 response
- **Outreach to Primary and Social Care via the Keeping Well academy -** £338,000 funding to curate a digital library of research and guidance, including strategies to maintain and support staff wellbeing and training resources within the system
- **ICS Health and Wellbeing Framework In-reach with NHS Trusts** - £748,000 allocations to each Trust based on a weighted framework that enables development of infrastructures where needed; allocations will also be used to implement the ICS H&WB Framework for 2021-22 and develop a 3 year H&WB Strategy for 2022-25
- **Occupational Health shared service - £500,000 Growing OH** funding secured to support the creation of NWL OH services

What comes next

- Establish committed actions from Trusts within the medium-term framework to consider:
  - Implementation of 'pulse checks'
  - Mental health first aider training
  - Team check-ins
  - Multi-disciplinary learning events
  - Dedicated support sessions for staff in high impact areas
  - Wellbeing Guardians
- Review national H&W framework longer term strategy to inform/align mid- to longer term plans

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LEAD: We care and staff report positive experiences

Focus	Area	RAG	Area	RAG
Outcome: Improved career opportunities and increased job satisfaction **Legacy:** A compassionate, kind and inclusive culture **Impact:** A workforce that is the best they can be to deliver health and care services	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Compassionate Leaders** – Cohort 1 is completing (started 18th May) with further cohorts in development and utilising HWB funding of £740,000 (see Care update)
- **Organisation Development** – agreement to develop ICS Values and Behaviours framework supporting transition to the ICS and new ways of working; established ICS OD leads network and held early planning meetings to support ICP Directors in developing local plans
- **Leadership Ladder programme** – programme ready for implementation supporting BAME staff in senior roles; offers development secondments/placements across Band 8a-c roles (Linked with Include)

What comes next

- Compassionate Leaders: confirm plans for the next programme for Cohorts 2 & 3
- Run Values and Behaviours workshops and co-design the framework and develop additional engagement plans to 'hardwire' behaviours into ways of working
- Work with ICP Directors to develop OP plans supporting establishment of place-based teams
- Leadership Ladder programme go-live 18th October (with Include)
- Establish the ICS Graduate Scheme working with local Universities and supporting local talent into roles within NWL and link with the national GMTS scheme to develop a NWL rotation.

INCLUDE: We are inclusive and succeed because of our differences

Focus	Area	RAG	Area	RAG
Outcome: Embedded diverse and inclusive workforce **Legacy:** Positive action on EDI in design, delivery and review of processes & policies **Impact:** Inequalities are identified and addressed	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Leadership Ladder programme** – programme ready for implementation:
  - 12 associates matched to 12 placements
  - Online learning platform developed and available to associates
  - Information packs have been shared with host and substantive managers
  - Associates have met with host managers
  - Preparation for induction, on-boarding and objective setting is underway
  - Secondment agreements are being signed
- **Inclusive Recruitment** – develop a best practice SOP for recruitment to ensure people processes are as inclusive as possible enabling organisations to review their processes against the best practice recruitment and selection toolkit
- **National MWRES –** review completed and best practice case studies used to inform NWL plans
- **Scrutiny Panel** – established to act as a 'critical friend' to the programme board

What comes next

- Leadership Ladder:
  - First 6mth placements start 18th October
  - Evaluation process underway to identify what worked well and what can be modified for future cohorts
  - Mentors to be agreed across all seven participating organisations
- Plan and complete rollout of the Inclusive Recruitment Toolkit and work with workforce leads to support implementation of local plans
- BAME NED development - scope a NW London version of the Insight programme to allow potential NEDS the opportunity to shadow boards, receive induction, attend board and sub-committee meetings and to receive mentoring and support from a non-executive director "buddy".

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GROW: We have the capacity to deliver great care

Focus	Area	RAG	Area	RAG
Outcome: A workforce that is resilient and agile **Legacy:** Creation of intelligence driven, locally led dynamic workforce planning **Impact:** Attraction of the best talent by working collaboratively including with universities and colleges and pan-London groups	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Appointment of Grow senior programme manager –** ensuring plans are developed and delivered
- **Vaccination to Vocation**– retention programme in place and moving staff into permanent health and care roles across ICS; 40% of all staff from Vaccination hubs to be placed in roles
- **NWL Academy** – a partnership approach ensured a strong bid for GLA funding supporting the NWL health academy was submitted for £250k over 2-years

What comes next

- Ongoing retention of vaccination staff including those stood down from Phase 3 vaccination programme
- NWL Academy – (pending successful bid) detailed plans to be developed and appointment of the Academy co-ordinator
- Apprenticeship approach for NWL developed and agreed across Trusts
- Staff Retention project – bid to secure funding for a 1-year programme designing and implementing retention strategies across NWL – diagnostic phase in Q4
- Establish governance to ensure partnership working is aligned across initiatives

TRANSFORM: We have the skills to deliver 21st century care

Focus	Area	RAG	Area	RAG
Outcome: A workforce equipped with skills and structures to deliver new clinical models **Legacy:** An agile workforce using new technologies to deliver outstanding care **Impact:** New roles and new ways of working supporting new models of care	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Acute trust redeployment**: plans confirmed
- **Workforce principles**: adoption of Elective Recovery workforce principles - NWL and London
- **Skills Passport**: Increased uptake of skills passport to support critical care surge
- **Clinical engagement group**: set up for medium/longer term approach to critical care sustainability/expansion
- **Digital Passport**: agreement to continue the use of the inter-organisational portability agreement pending digital passport set up
- **Managing spend**: Agreed approach to contain temporary medical spend
- **Programme Launch**: kick off meeting for the Acute and Medical Staffing Transformation Programme

What comes next

- Confirm resourcing for the Acute and Medical Staffing Transformation Programme
- Skill mix & new workforce models for winter and longer term expansion
- Coordinated approach across acute trusts to the management of bank/agency pay rates and staff incentives
- Joint strategies for increasing the mobility of staff across organisations and locations, including the utilisation of the digital passport
- Collaborative recruitment strategies and vacancy reduction plans
- Review of training capacity across NWL to facilitate CESR Programmes
- Review of job planning guidance/tariffs across NWL
- Engage key stakeholders to understand the medical workforce structures and staffing across NWL trusts

ENABLE: We support organisations to make the transition to operate as part of a single system

Focus	Area	RAG	Area	RAG
Outcome: Processes and systems are simplified and consistent across the sector **Legacy:** A workforce that is equipped to work flexibly across the ICS **Impact:** Organisations operate as part of a single system	**Are we on track to deliver?**		**Resources in place**	
	Risks		**Governance in place**	

What has been achieved so far

- **Simplifying HR processes and systems** – Medical collaborative bank launched and nursing bank near completion with potential savings identified
- **Workforce information and analytics** – development of the Workforce intelligence Service Model agreed with monthly reporting underway
- **Core HR Admin consolidation and collaboration** – baselining activities are underway to identify further opportunities for consolidation including SIPS, Process Automation and BOT pilots

What comes next

- Launch nursing collaborative bank at end November
- Continue planned approach to mature workforce information and analytics
- Confirm additional HR consolidation opportunities, identifying quick wins and options to take forward, developing high level Business Case

Appendix 3: ICS People Function Development

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North West London Integrated Care System

Workforce Governance will be reviewed following readiness of ICS People Function

Current Governance Structure

Care Partnership

ICS Exex. Deep Dives

CEO's

Quarterly National Returns against ICS People Plan

Regional Returns

NWL People Board
Claire Murdoch Chair

Education Board ensuring ongoing workforce development

HRD Programme management oversight

Inclusion Board and independent scrutiny of workforce inequalities

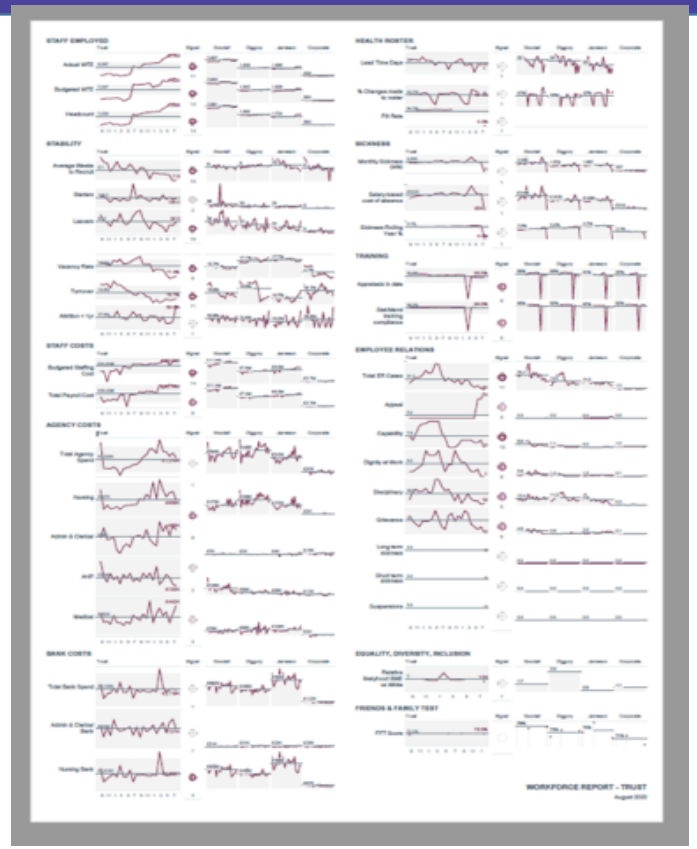
HRD Sponsors

Leadership of the collaborative workstreams (20%)

Trusts

Collective work we all do but in our individual trusts (80%)

Workforce element of SOM



Evolving maturity of the NWL Workforce Dashboard which will improve creation of insights

North West London Integrated Care System

Using the System Development Tool, it outlines key design features which should be in place:

People delivery infrastructure

Phase	ID	Feature	Assessment
Preliminary	1.1	The ICS has established a Workforce Improvement Programme Board, and programme leadership, and associated resources have been identified and mobilised	
	1.2	The ICS has established arrangements to account for progress and performance in respect of the workforce improvement programme and response to the NHS People Plan to the ICS Board, to place partnerships and to the statutory boards of ICS partners, as appropriate	
	1.3	The ICS has a clear understanding of the key workforce challenges that prevail across and within the ICS	
	1.4	A system-wide workforce development work programme has been defined and key priorities and timelines identified. This work programme is under way	
Foundation	2.1	The ICS has strong local people and workforce leadership, with Board level accountability for people across the breadth of the system. People and workforce are prioritised within ICS strategic plans	
	2.2	A system-wide ICS People Plan has been developed and is being delivered by the ICS. This Plan describes how the ICS will deliver the people priorities set out in the NHS People Plan and annual planning guidance, as well as its own local people priorities	
	2.3	An ICS People Board has been established to oversee the implementation of the ICS People Plan and other local people priorities. The ICS People Board has appropriate powers vested in it that enable it to carry out the functions assigned to it and it includes appropriate clinical, professional and staff representation. The People Board reports directly to the ICS Board	
	2.4	The ICS has assessed its current maturity to deliver a full people function against the themes in the system workforce improvement model (SWIM), and has plans with key milestones to develop its capacity and capability to deliver this, as part of wider ICS development plans	
Advanced	3.1	The ICS's People Plan continues to be one of the ICS's principal areas of collective activity. This Plan continues to command the full attention of the ICS Board and is supported by appropriate levels of leadership and resource	
	3.2	The ICS NHS Board continues to provide oversight of the ICS's People Plan. The Plan has been periodically refreshed in light of progress made, as well as emerging local and national people priorities	
	3.3	The ICS regularly reviews its progress against the themes in the system workforce improvement model (SWIM) to identify areas for further development in order to deliver local people priorities and a mature people function	
	3.4	The ICS has established processes to undertake medium to long-term planning of the system's 'one workforce' in an integrated way across workforce, finance and activity – factoring in future workforce demand, changes in skills and ways of working, service transformation and care delivery requirements	

North West London Integrated Care System

Using the System Development Tool, it outlines key design features which should be in place:

Talent management and development

Phase	ID	Feature	Assessment
Preliminary	1.1	There are clear approaches to talent management which include annual career conversations, unbiased recruitment process and identification of talent pools. This is underpinned by consistently understood definitions of potential, talent and readiness criteria	
	1.2	Recruitment and onboarding processes are inclusive and values based, aligned to organisational objectives	
	1.3	Inclusive talent management is recognised as a strategic priority which is reflected in ICS people plans and with collective accountability embedded within the ICS	
	1.4	Organisations routinely collect talent data and have initiated the development of cross-boundary talent data sharing principles. This includes collecting and measuring data around diversity and associated benefits	
Foundation	2.1	Organisations have a clear transparent inclusive talent management strategy which is incorporated into People Plans and linked to strategic priorities and objectives. This strategy describes the benefits and value of diversity	
	2.2	The system has a clear approach to using data to identify and mitigate issues relating to talent management	
	2.3	The ICS actively engages with talent by shaping apprenticeships, development intiaitves, mentioring schemes and career transition conversations to support individuals' ability to maximise their potential and the ICS to deliver its objectives	
	2.4	There are named organisational Board members responsible for inclusive talent management, with priorities written into strategic/delivery plans, job descriptions and objectives and explicitly role modelled	
Advanced	3.1	The ICS has an inclusive talent management strategy, linked to strategic priorities and objectives. This strategy is understood by all and delivery of it is seen as everybody's responsibility	
	3.2	Data and lived experience are actively used to close the gap on inequalities and address retention issues	
	3.3	Talent information is used to design ICS-wide interventions and support mobility through ICS-wide succession planning and engaging staff in talent development opportunities	
	3.4	Collective decision making takes into account national perspectives and encompasses organisational, ICS, regional and national landscapes	

10 outcomes-based functions

1. **Supporting the health and wellbeing of all staff:** people working and learning in the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate care to patients.
2. **Growing the workforce for the future and enabling adequate workforce supply:** the system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the ICS is representative of the local communities served.
3. **Supporting inclusion and belonging for all, and creating a great experience for staff:** people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS are representative of the diverse population they serve.
4. **Valuing and supporting leadership at all levels, and lifelong learning:** leaders at every level live the behaviours and values set out in the People Promise, and make strides so that this is the experience of work for all of their 'one workforce'.
5. **Leading workforce transformation and new ways of working:** service redesign is enabled through new ways of working, which make the most of staff skills, use of technology and wider innovation – to both meet population health needs and drive efficiency and value for money.
6. **Educating, training and developing people, and managing talent:** education and training plans and opportunities are aligned and fit for the needs of staff, patients and citizens, including to enable new ways of working and support meaningful and personalised career journeys.
7. **Driving and supporting broader social and economic development:** leaders ensure that their organisations leverage their role as anchor institutions and networks to create a vibrant local labour market, promote local social and economic growth in the wider community, support all ICS partners to 'level up', address wider health determinants and inequalities at the heart of poor health.
8. **Transforming people services and supporting the people profession:** high-quality people services are delivered by a highly skilled people profession to meet the future needs of the 'one workforce', enabled by technology infrastructure and digital tools.
9. **Leading coordinated workforce planning using analysis and intelligence:** integrated and dynamic workforce, activity and finance planning meets current and future population, service and workforce needs, across programme, pathway and place.
10. **Supporting system design and development:** the system uses organisational and cultural system design and development principles to support the establishment and development of the integrated care board (ICB), and the integrated care partnership (ICP). The organisational development approach creates a system-wide culture that: is driven by purpose; enables people, places and the system to fulfil their potential; is connected to the people served by the system and those delivering services; harnesses the best of behavioural, relational and structural approaches; and nurtures collaboration

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