Notice of Meeting

North West London Joint Health Overview & Scrutiny Committee

Wednesday, 7 December 2022 at 10.00 am

Committee Room 1, Kensington Town Hall

Link to livestream broadcast:
youtube.com/kensingtonandchelsea

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Contact: Hannah Davenport
Tel: 07929 850471
E-mail: hannah.davenport@rbkc.gov.uk
Website: www.rbkc.gov.uk
Issue Date: Tuesday, 29 November 2022

Chief Executive – Maxine Holdsworth

Membership: Councillors Cllr Ketan Sheth (Chair), Cllr Daniel Crawford (Vice-Chair), Cllr Nick Denys, Cllr Chetna Halai, Cllr Lucy Knight, Cllr Natalia Perez, Cllr Angela Piddock, Cllr Marina Sharma and Cllr Claire Vollum

FILMING, BROADCASTING AND BLOGGING – *Please note that this meeting is open to the press and public and will be broadcast via the Council's website. Additionally members of the press and public may film, tweet, blog etc. from those parts of the meeting room allocated as public seating. It is important, however, that councillors can discuss and take decisions without disruption so any activity of a manifestly disruptive nature will not be permitted. Generally the public seating areas, especially those further back, are not 'in shot', however the Council cannot guarantee that any part of the room or any seat cannot or will not be filmed and as such, by entering the meeting room, you are consenting to being filmed.*

Agenda

Pages

1. Apologies for Absence

To receive apologies for absence and note any attendances by duly appointed reserve members.

2. Declarations of Interest

Any member who has a disclosable pecuniary interest in a matter to be considered at the meeting is reminded to disclose the interest to the meeting and to leave the Chamber while any discussion or vote on the matter takes place.

Members are also reminded that if they have any other significant interest in a matter to be considered at the meeting, which they feel should be declared in the public interest, such interests should be declared to the meeting. In such circumstances Members should consider whether their continued participation, in the matter relating to the interest, would be reasonable in the circumstances, particularly if the interest

may give rise to a perception of a conflict of interests, or whether they should leave the Chamber while any discussion or vote on the matter takes place.

3. Minutes of Previous Meeting 3 - 12

The minutes of the Meeting of the NWL Joint Health Overview and Scrutiny Committee held on 12 October 2022 are submitted for confirmation.

4. Elective Recovery & Cancer Care Backlog 13 - 30

Appendix A – Breast Cancer Recovery

5. Winter Planning 31 - 42

6. NWL Workforce Strategy 43 - 52

7. NWL Integrated Care System Update 53 - 76

8. Any Other Oral or Written Items which the Chair Considers Urgent

[Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;
(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and
(iii) may, with the consent of the Chair and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Note: Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985. Should any such matters arise during the course of discussion of the above items or should the Chair agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.

The next ordinary meeting of the North West London Joint Health Overview & Scrutiny Committee will take place at
10.00 am on Wednesday, 8 March 2023

NORTH WEST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on Wednesday, 12 October 2022.

PRESENT: Councillor Ketan Sheth (Chair), Councillor Daniel Crawford (Vice-Chair), Councillor Nick Denys, Councillor Lucy Knight, Councillor Natalia Perez, Councillor Marina Sharma and Councillor Clare Vollum

1. APOLOGIES

Apologies were received from the following:

- Councillor Piddock (City of Westminster)
- Councillor Halai (London Borough of Harrow)

2. DECLARATIONS OF INTEREST

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

3. DEPUTATIONS

No deputations were received.

4. MINUTES

RESOLVED that the minutes of the meeting on 9 March 2022 be approved and the Chair authorised to sign.

5. MINUTES

RESOLVED that the minutes of the meeting on 20 July 2022 be approved and the Chair authorised to sign.

6. MATTERS ARISING

The Chair requested that the Director of Communications and Engagement at North West London Integrated Care System note that information was awaited on community diagnostics and health inequalities and requested that this information be received in a timely manner.

7. PRIMARY CARE PERFORMANCE AND STRATEGY INCLUDING GP ACCESS

The Chair said that feedback he had received from residents on primary care had been positive, although there were difficulties in getting a face-to-face appointment across the whole of NW London.

Presenting officers

- Cathy Winfield, SRO Primary Care, NHS North West London
- Dr Genevieve Small, Medical Director, Primary Care
- Javina Sehgal, Director of Primary Care.

Officers presented the report and made the following points:

The new vision for integrating primary care was based The Fuller stocktake report. The vision was based on three main offers:

1. Streamlining access for people who get ill but use health services infrequently to provide them with more choice and ensure care was always available when needed
2. Proactive and personalised care from multidisciplinary teams for people with complex needs
3. Helping people stay well for longer with an ambitious and joined-up approach to prevention.

A launch workshop was held and there would be further engagement at a place based level. Additional activity would be commissioned to ensure that was sufficient winter capacity which was based on historic activity. The biggest challenge related to workforce and the paper outlined some examples of how additional GPs and securing additional roles into primary care.

In response to questions, the following additional points were made:

- Patient access to appointments was the biggest issue in primary care. Further work was needed on estates, workforce and digital technology. Primary care had to consider how to protect the capacity for bookable appointments. The Secretary of State had said that patients should be able to access an appointment within 2 weeks.
- Consideration was also needed to address the needs of those who presented on the same day. The links with the 111 service, urgent treatment centres and general practices and having a team of different practitioners working across a number of general practices.
- Telephone access would be improved which would include cloud-based telephony as some patients were unable to get through. Websites would be developed to enable patients to properly understand how they could access services. There would be additional work to help give patients confidence in the wider primary care team as they do not always need to see a GP. General practices would be expected to engage with patient groups to engage with patients on this matter. Patients would test and scrutinise websites.
- General practice had revolutionised its care pathways but was still recovering and catching up from the pandemic. There was communications work to emphasise that general practice encompassed a larger team of practitioners who worked alongside GPs. There were 350 GP practices and 45 PCNs. PCNs needed to work with partners including local authorities so that all could feel they were fully involved in the process.
- It was difficult to measure demand in the system. The best indicator was the waiting time for an appointment. The number of

appointments could be provided but would not necessarily indicate what the demand pressures were. This data could be provided to the JHOSC. Waiting time was the usual measure for demand across the NHS but this measure was under development. Anecdotal evidence from Dr Small's surgery indicated that one twentieth of a practice's patients had called on a particular Monday and there needed to be realism about what could be delivered in primary care given the level of demand. More effective metrics were being formulated on demand and response and this could be shared with the JHSOC.

- Patients would receive the same service through a virtual appointment as a face-to-face one. If it was not possible to obtain a firm diagnosis through a virtual appointment, the patient would be invited to a face-to-face appointment. Any incident where this did not happen would be looked at strongly, although there were no known incidents in NW London. Patients would be seen in the correctly modality for their condition and not at the convenience of the practice.

The Chair clarified that the JHSOC would like the following information shared:

i. Information on the current performance data, and for it to be shared monthly.
ii. To receive financial implications on the use of the Additional reimbursable roles schemes.

The following additional recommendations were agreed by the JHOSC

i. To recommend that JHOSC members are proactively consulted with and have oversight of stakeholder and public engagement activities to share with their networks.
ii. To recommend that the workforce model is appropriately balanced in order to ensure that patients are receiving equity of care across NW London.
iii. To recommend that wait times for a routine GP appointment are collected and shared with the committee.
iv. To recommend that the education and communication plan for navigating primary care systems is developed and shared when it becomes available.

8. EMERGENCY DEPARTMENT PATHWAYS & PERFORMANCE, WITH LONDON AMBULANCE SERVICE PERFORMANCE.

The JHOSC expressed its gratitude to all staff across emergency care in NW London.

Officers present:

- Rob Hodgkiss, Chief Operating Officer, Chelsea and Westminster NHS Foundation Trust
- Daniel Elkeles, Chief Executive, London Ambulance Service (LAS)
- Pippa Nightingale, CEO of London North West University Healthcare Trust,

Officers presented the report. There were 137 Trusts in the country and 3 of the top 10 Trusts by volume were in NW London. Three were around 1 million patients per year which was 20,000 per week who came through emergency care pathways in NW London.

The NW London ICS received about a quarter of the requests in London but only twenty percent of the delays and was leading on rates of discharge. There was a focus on the upcoming challenges this winter. Money had been invested in the workforce. There had been a five percent increase in the bed base which amounted to an extra 120 acute beds and additional mental health and community beds. There was also work on additional pathways to avoid attendance to an emergency department. Services as far as possible would be offered seven days a week.

Performance had been reasonable overall. Not all performance targets had been met and there was action to address this. There had been collaborative work with hospitals. LAS had responded well to events such as the Notting Hill Carnival and the funeral of Her Majesty, Queen Elizabeth. There were two inspections from the Care Quality Commission (CQC). The reports have been published and were complimentary.

The Chair asked that the appreciation of JHOSC members be passed on to all front line staff for their work. Feedback on LAS from patients was excellent.

Following questions from the JHOSC, the following additional points were made:

- It was agreed that not meeting the category 2 performance standard was not good and long waiting times should not be normalised. This would be redressed through recruitment and increasing the workforce, work to look at alternative responses to hospital including having a mental health nurse for patients with mental health needs, finding alternatives to hospital where appropriate and collaborating with hospitals. Clinicians would also be available on the telephone.
- The percentage of ambulances in Q1 by site where there had been a wait of more than 30 minutes had been published. There was a large variation between sites. The calculation was a percentage rather than time as there was much more demand in some hospitals than others in NW London. There were no really bad performers in NW London. The data was in Board reports six times a year. The Chair requested this data be shared with the committee. This could be done as it was in the public domain. Comparative response times should be looked at by ICS rather than by borough as this took account of where hospitals and ambulance stations were. The goal was to achieve a better response everywhere. Ambulance response times were more difficult in some

areas than others. Data was not broken down to place as you would get a level of granularity that did not make sense. It was much better to look at populations. Standards applied across the whole country. If three was a large wait at one hospital, then patients would be diverted to a different one which was why it needed to be a system metric. There was a collaborative rather than a silo approach. It was noted that there should be as much information to residents as possible as they still looked on performance on a borough rather than place basis.

- LAS was working with local authorities on prevention. Information was provided to children in schools. There was not a big link with social care.
- There were many unknowns for the winter, but it was known it would be difficult. There were actions implemented. More beds had been provided but this was not a long terms solution which would be to keep people well and cared for in their own home. There were many actions agreed such as primary care, acute care and discharge.
- The Winter Plan would also look at Covid and flu vaccinations, demand and capacity pressures. The plan could be shared with the JHOSC. The Chair requested that JHOSC members had the opportunity to be involved in the formulation of plans.
- There were two new education centres where training was undertaken to grow the workforce.
- Ambulances used to take patients to their nearest A&E. Patients would now be taken to the nearest appropriate available A&E. There was real time information on the capacity status of all hospitals in London and crews can obtain this information. The system wide partnership working meant that the performance in London for patient handover was good.
- The first job on an ambulance shift would be from the ambulance station. It would not then go back until the end of the shift. LAS was the only organisation with a dedicated category 1 response team which was why they could get to the patient in 7 minutes. The challenge was when you had patients waiting at hospital which impacted the response to the next patient.

Information requirements

JHOSC members requested that LAS send performance statistics to them on a regular basis. The ICS would work as a conduit to circulate the performance information to JHOSC members.

Recommendation

It was recommended that JHOSC members receive clear timescales and trajectory for when London Ambulance Service performance would improve.

9. PALLIATIVE CARE REVIEW

Presenting officers

- Jane Wheeler, Programme Director, Local Care, NHS North West London
- Dr Lyndsey Williams, clinical lead for community-based palliative care services.

There were some excellent services but there was variation across the boroughs. There were large workforce challenges. The suspension of the Pembridge Unit presented a particular difficulty. There had been four rounds of recruitment to try and obtain a consultant.

There had been a large amount of community engagement work at borough level and with different populations and communities. Actions to meet the needs of the populations were being formulated to meet need in a consistent manner across NW London. There had been 19 meetings thus far with 26-36 attendees. The co-production approach which had been highly positive.

The Chair asked that the JHOSC's thanks be given to palliative care frontline staff.

The following points are made following questions:

- It was clarified that the Pembridge Unit was suspended in 2018.
- Providers were engaging and listening to patients and providers to ensure that the service offer was right but also were encouraged to deliver as quickly as possible which was a tension. Engagement had to be done at the right pace. There were sometimes conflicting views. All documents and next stages would be published on the website. There would be some options provided on what could provide the best care model.
- There were variations in service such as access and waiting times. There was discussion how to meet unmet need. It was hoped the new model would address this. Data sets were not consistent as there was a reliance on hospice sector which were not all NHS funded had different systems and data sets. This was work in progress and there was a commitment from hospice care providers towards the work that was taking place.
- There was a commitment on education and getting the conversation and language correct. There was work to support the roll out of the London Urgent Care in NW London. Working with communities was also crucial.
- The voluntary, community & faith were keen to get involved in the ongoing dialogue and discussions.
- The Chair requested that a paper summarising emerging findings from the Borough Based Partnership's self-assessments tools by circulated.

Recommendations

i. That a paper summarising emerging findings from the Borough Based Partnership's self-assessments tools be brought to the JHOSC.

10. NORTH WEST LONDON INTEGRATED CARE SYSTEM UPDATE

The presenting officer, Rob Hurd, CEO North West London ICS/NHS North West London) presented the report.

The ICS had been operational since 1 July 2022. There would be a focus on the health inequalities framework and also engagement. There would also be a focus on the further development of place. There had been no radical change in the financial allocation methodology but there were incremental changes such as the money being invested to address inequalities. The ICS was organised around its place based partnerships and associated programmes of work.

The following points were made in response to questions:

- It was fully acknowledged that there was not currently local government representation on the ICB. There was openness to having more local government voting members than any other London ICB. There would be investigation into having local government representation on place based boards. The Chair on behalf of the JHOSC members requested that there be a prompt resolution to the matter of local government representation on the ICB governance.
- Integrated Care Partnership (ICP) meetings would be in public. There had not been any meetings to date. The ICB had recently published when its public meetings would take place over the next 18 months. They would take place every two months.

Recommendation

The JHOSC requested that it should receive information on the meeting schedule and agendas of the ICB and other meetings in order to share with relevant stakeholders.

11. WEST LONDON CHANGES TO HOPE / HORIZON WARDS

Chris Hilton, Executive Director of Local and Specialist Services, West London NHS Foundation Trust presented the report.

There was a consultation on proposed changes to the provision of mental health beds in Ealing. During the pandemic, 31 acute mental health beds had been suspended. This was partially due to staffing issues but also for infection control reasons. 18 beds were now provided in a more modern site near West Middlesex Hospital.

It was proposed to make the temporary measures that were made during the pandemic permanent as the ward was no longer fit for purpose. This would mean as a net reduction of 13 beds across the three affected boroughs. Three would be no cost saving as all of the money would be reinvested into care.

There had an engagement process, and a report would be available. It was thought that the principal impact would be on the residents of Ealing as there would be a reduction in acute beds. Out of area placements had not been needed and that remained the case. Projected population growth was accounted for in the plans. There would be further discussion at the next Health Scrutiny Committee in Ealing.

- It was believed that the principal impact would be on the residents of Ealing. There were inpatient facilities for residents of Hammersmith & Fulham. There would be a wide programme of engagement. Engagement would not only be with service users, it would also be with the wider resident population. There would be a variety of methods including face-to-face and online. There could be further conversations with Councillor Perez.
- Projected demand had been modelled across the whole of the West London Trust system (Ealing, Hammersmith & Fulham and Hounslow) and it was believed that demand could be met. There had been investment in an additional ward at Lakeside and the capacity would not be adversely affected. It was important to provide modern accommodation that was fit for purpose.
- Advice had been received about the scope of engagement required. Enhanced engagement was an appropriate approach.

.

Recommendation

A meeting be set up between Ealing and neighbouring authorities to ensure that information on this issue is shared across boroughs, and to notify members when this meeting was set up.

12. NWL JHOSC TERMS OF REFERENCE REFRESH

The Chair thanked the Ealing & Brent officers for their contribution to the new terms of reference. Officers from Hammersmith & Fulham & the Royal Borough of Kensington & Chelsea also be thanked in the minutes for their contribution.

RESOLVED that the NWL JHOSC Terms of reference be **APPROVED**.

13. WORK PROGRAMME UPDATE

Councillor Denys (London Borough of Hillingdon) offered to host a future meeting of the NWL JHOSC.

Chief Executive of the NW London Integrated Care System (ICS) gave an update on the Winter Plan. Some staff would be experiencing cost of living difficulties. Travel cost relief had been brought in as an immediate action. There was a focus on wellbeing and staff hardship support for staff. Staff who worked in primary care would be looked at. The work would take place at a place level.

The Winter Plan anticipated increased demand for healthcare services. It would also look at addressing health inequalities such as lack of access. There would be continuing analysis of the effectiveness of interventions including any impact on inequalities.

It would also look at workforce resilience. There was a keenness to work with local authorities on the social care workforce.

Communication and engagement and the importance of communicating with resident what services were available was also part of the Winer Plan.

An update on vaccinations could be provided offline.

RESOLVED that the future work programme be **NOTED**.

CHAIR

The meeting, which started at 10.01am, ended at 12:00pm.

This page is intentionally left blank

Report to the North West London Joint Health Overview Scrutiny Committee

7 December 2022

Report Title:	Elective Recovery and Cancer Care Backlog

Purpose

To receive a report on plans for elective recovery in NW London. The report also focuses on the plans to deal with the treatment backlog for cancer patients.

Detail

Background/Context:

The Covid pandemic has had a significant impact upon the residents of NW London and our hospitals. Waiting times have significantly increased during this period, with many residents anxious about delays in their care. Across NW London we are working together to reduce these waiting times by working innovatively, using new technologies and making the best use of our staff and hospitals across NW London whilst protecting those with the greatest clinical needs. Our hospitals are working together to ensure that all NW London patients are offered the earliest possible treatment, which may mean being offered care in a different location. We are achieving this by sharing information, staff and operating theatres.

During the Covid-19 pandemic, cases were clinically prioritised, focussing on urgent and cancer cases. Essential infection prevention and control measures and workforce pressures limited our capacity to undertake elective care, and in the first few months of recovery following the first wave, NW London ICS was focused on bringing back elective capacity and minimising potential for harm by focusing on patients with the most urgent clinical priority (described as Priority 2 following Royal College Guidance).

This prioritisation of patients has resulted in some patients having to wait longer. We continue to prioritise according to clinical need while also bringing down very long waits. Having eradicated nearly all two-year waits from a peak in July 2021 of 127, we are now focusing on our 78 week waiting patients and those waiting over 52 weeks.

Current Backlog:

In September 2022 (latest fully validated data), there was a total of 250,288 patients on NW London (inpatient and outpatient) waiting lists (excluding RNOH). This is an increase from the July figure of 237,660 and up significantly from the April 2021 position of 165,210. The PTL is seeing a pattern of around 5000 patients increase each month for the past year. The RNOH waiting list at the end of September 2022 stood at over 7,000 patients.

Across England in September 2022, there were 7.07m patients on waiting lists, with London accounting for 1.1m of these. Recent intelligence indicates that a significant number of patients on waiting lists nationally may be duplicate referrals; locally, we are currently undertaking work to identify these patients to ensure that waiting lists are accurate and patients are on a single clinically appropriate pathway.

Figure 1: Growth in wait list by London ICS between July and September 2022

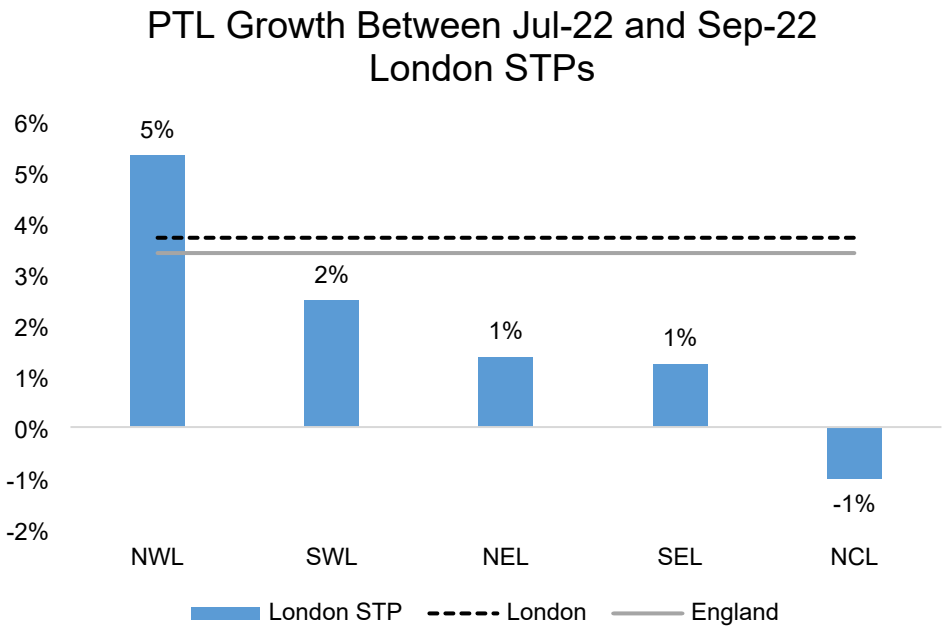
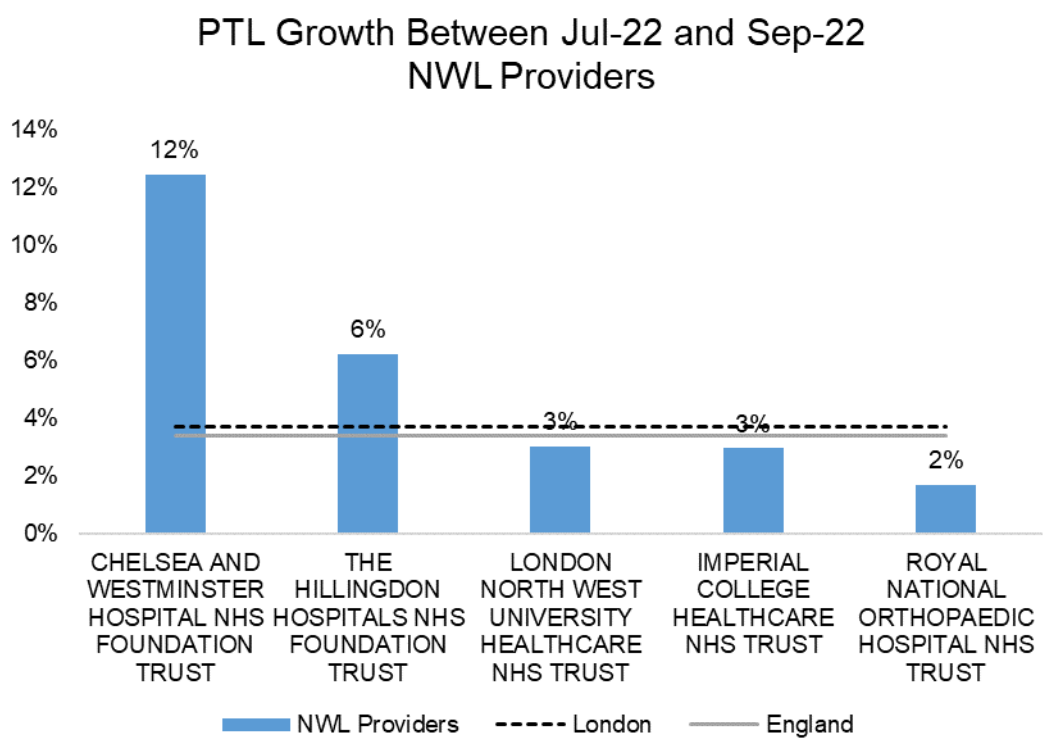


Figure 2: Growth in wait list by NW London Trusts and Royal National Orthopaedic Hospital between July and September 2022



Impact of the pandemic on recovery of services

Following the resumption of breast screening in July 2020, it became apparent that all services faced some significant challenges in their attempts to recover while continuing to screen women who became due. The challenges included:

- **Post Covid infection control measures** meant that fewer women could be screened in a day due to requirements to disinfect rooms and equipment after every consultation and to have fewer women attending clinics to reduce crowding.
- **Workforce shortages**; there is a national shortage of radiographers / mammographers which limits the extent to which additional clinic capacity can be offered.
- **Workforce health and wellbeing;** many services reported a deterioration in the physical and mental health of their clinical staff due to workload pressures; 2nd and 3rd waves of Covid have also had an impact on staffing capacity at various times setting recovery back.

The impact of pausing breast cancer screening in NWL during Covid-19 on performance metrics

Please note that cancer screening is reported at London level and we have attached a report from NHS England on breast cancer screening. Full recovery and restoration of breast screening services has been defined by NHSE as:

- **Backlog recovery:** Clear the longest waiters and Very High Risk women which ensures the reduction of the backlog and screening of the highest priority women
- **Round length restoration:** Invite 90% of women for a screen within 36 months of their last one
- **Increase screening uptake:** Ensures detection of cancers in invited women, a high uptake is important in detecting cancers in invited women

Backlog recovery:

Across London more than 100,000 clients entered a screening backlog because of this pan London service pause. At WOLBSS, there were 30,879 women in the backlog at its peak in October 2020. At NLBSS it was 36,030 women (Source: Futures NHS). There is currently a backlog of patients overdue screening at WOLBSS of 18,995 (Source: Futures NHS, October 2022).

Capacity:

WOLBSS was unable to recover its pre-Covid clinic capacity until relatively recently (July 2022). For the first 6 months of recovery (July 2020 – Jan 2021) WOLBSS was operating at 50% or less of its pre-Covid capacity. Since Jan 2021, it has slowly increased to 80% and then relatively recently recovered to 100%. This has been due in part to delays to the lifting of infection control restrictions at 3 of the 5 clinic sites (health centres not owned by Imperial NHS Trust) from which screening is delivered which has continued to limit capacity.

Round-length:

National screening guidance states that the time interval between screening and invitation (round length) should be 36 months. (High risk groups more frequently). Currently at WOLBSS, just 4% of women are screened every 36 months due to the delays in being seen. NLBSS has managed to recover more quickly; currently 90% of women are being seen within 36 months and the backlog of overdue women has been cleared.

Recovery Plan for tackling the Covid-19 backlog, recovering the round-length position and improving uptake in NW Lonon

All London services are in the process of returning to timed appointments which is expected to have a beneficial effect on uptake. The transition from open to timed invitations needs to be carefully managed and during this period of time screening capacity will be temporarily reduced which will have a corresponding impact on performance. At WOLBSS all sites will have returned to timed appointments using the SMART overbooking algorithm by the end of November. Performance should then begin to improve.

Imperial predicts that the backlog at Hounslow will be cleared by the end of December 2022, followed by St Mary's, Charing Cross and Uxbridge by March 2023 and finally Hanwell by June 2023. It also predicts that round length of 36 months will be achieved for 90% of women by April 2023. It plans to do this by:

- Using an independent organisation (funded by NHSE) to offer additional clinics at the weekends at Charing Cross
- Using bank and agency staff to cover vacancies and winter sickness.
- Using a higher appointment target for SMART clinics to recover backlogs more quickly – this is an invitation algorithm which overbooks patients based on their probability of attendance.
- Using the anticipated downtime in screening from April – July 2023 (caused by the pause of screening 3 years earlier due to Covid) to make further inroads into the backlog and/or to invite women before their 36 months due date to mitigate against the expected spike in activity from July 2023 onwards.
- Planning to over-recruit mammographers to minimise anticipated staff vacancies.
- Supporting staff health and wellbeing initiatives to improve staff retention and resilience.

The service also has plans to try to improve uptake and reduce health inequalities by contacting women who do not respond to their invitations and by using specialist health promotion staff to identify barriers to attendance and try to address them.

Delivery Plan for tackling the Covid-19 backlog of elective care in NWL

Increasing Capacity

We have a range of interventions and actions to increase capacity and these are at varying stages of progress.

North West London has rolled out an Advice & Guidance system for many of our hospital services, connecting GPs with specialists. We will develop this further, covering more services and looking at different ways of providing access to expertise. For some patients this may mean that a specialist can virtually 'join' an appointment with their GP (for example through a video link), or it may mean the GP and Specialist work together to agree the plan to support a patient. We continue to explore opportunities to make greater use of Advice & Referral pathways across a broader range of specialties.

To address our population health needs, we are looking across our system to have localised health care where possible, but centralising where necessary. We are already developing an elective orthopaedic centre, which will bring together patients and specialists from across NW London in a purpose-designed centre with the goal of delivering rapid access and world-class clinical outcomes. Bringing teams and services together in centres of expertise will ensure that we

can build upon the world class clinical and research services that we have available in NW London, ultimately ensuring that we can offer the best possible care to residents in a timely and effective manner.

At a specialty level, we are working with clinical colleagues to review data, trends and growth factors, to develop action plans including learning from successful interventions within the sector and the wider London region. We also continue to identify opportunities for mutual aid, including through collaborative working with colleagues across the London region, and utilisation of independent sector where available, e.g. transfer of ENT patients in >40ww cohort from Hillingdon to Healthshare.

We are planning for mass clinics/joint drives/'super' sessions in selected specialties e.g. hernia week across NW London. These initiatives aim to address long waits in particular, mitigate the clinical risks associated with long waiting times and reduce the likelihood of the NW London system continuing to see waits of over 78 weeks beyond the end of March 2023.

Prioritising treatment

The prioritisation of patients has resulted in some patients having to wait longer as we continue to prioritise according to clinical need while also bringing down very long waits.

Having eradicated nearly all two-year waits from a peak in July 2021 of 127, we are now focusing on our 78 week waiting patients and those waiting over 52 weeks. As noted above, initiatives are currently being rolled out in specialties with the highest volumes of long waiters, aimed at ensuring these patients are treated as soon as possible. Waiting list validation and review processes are in place to ensure that patients on waiting lists still require treatment and are prioritised correctly in line with clinical need.

Transforming the way we provide elective care

We are developing new ways of working that enable access to expertise, with services delivered through new models of care which make the best use of the skills available across the NHS in NW London. This will move routine specialist care away from the traditional outpatient building and make use of local care hubs, telemedicine and, at its most basic, embrace the convenience of a telephone (or video) conversation. Services may be delivered by different staff, doctors, nurses and other healthcare professionals, who will all have access to the same support, advice and expertise.

We are working with our London networks to review where we may have procedure room opportunities and initiatives to reduce follow-ups (e.g. Patient Initiated Follow Up PIFU).

Cancer:

Percentage of patients first seen within 2 weeks of referral from GP (commissioner level -operational standard 93%)

	% seen in 2 weeks		
	NWL	London	National
Jul-22	89.0%	85.9%	77.8%
Aug-22	87.8%	86.1%	75.6%
Sep-22	87.3%	85.2%	72.6%

Through RM Partners, the Cancer Alliance for West London the following activities have been undertaken:

- Audit of current pathways including demand and capacity across all 4 secondary care trusts and the key tumour sites (breast, prostate, colorectal) to understand the bottlenecks and process changes that can support improved access to capacity

- RMP funded waiting list initiatives for short term capacity, most notable through Q3 for patients to be reviewed with their symptoms who have been waiting the longest on an open urgent query cancer pathway. Impact seen in cancer backlog from August at 890 to end of November 530 and under trajectory at a year to date position. The sustainability of the backlog position will result in increasing the number of people that have their first treatment for cancer within 62 days from point of referral. The key drivers for the current number of patients who are not treated within 62 days are the delays in accessing diagnostics. This is partly due to the balance between the multiple demands on the same diagnostic service for cancer and routine patients and the increase in 2ww referrals across the system following the COVID 19 pandemic. .

- RMP are currently running 7 pilots across all NW London acute trusts to improve efficiency of radiology utilisation. These include breast, gynae, head and neck pathways and if patients require imaging based on their referral or if an alternative investigation would be more appropriate. These are anticipated to be evaluated in Q1 2023/24 to help shape pathway development in the future.

- Strategic workforce development has been funded to increase capability in clinical workforce to undertake diagnostic investigations. Specifically in

urology, the development of a diagnostic nursing role to undertake cystoscopy and prostate biopsy, and up-skilling of consultants to undertake gynaecology USS to streamline and facilitate a one stop endometrial cancer service.

- Full review of clinical pathways to optimise resource and estate for diagnostics to take place in the most appropriate location (e.g. prostate biopsy to be undertaken under a local anaesthetic in a minor ops space and wide scale use of TNE outside of endoscopy estate)

- RMP are running the National research programmes into the diagnostic use of CCE (at 1 acute trust) and cytosponge (at 1 acute trust) to understand potential opportunities to deliver alternative investigations outside of OGD and maximise endoscopy use. The research projects will run until end of March 2023.

- RMP are supporting the implementation of the 'Low FIT' guidance to streamline patients with the highest need into colonoscopy earlier

- Through the ICB system and with RMP support mutual aid and networked capacity solutions have been implemented to ensure equity of provision across NWL and that all patients are seen with a similar wait time regardless of point of referral.

- There is weekly elective care board oversight and reporting where diagnostic waiting lists and backlog are reviewed and system level blocks and escalations are discussed.

- There in an on-going wider piece of work to secure direct to investigation pathways for GP access for appropriate concerning symptoms, including their transition to community diagnostic centres once they have been established.

- RMP are delivering a pilot into primary care advice and guidance for breast pain to support community management and appropriate onward on referral. The outcome of which will be shared widely across the system once evaluated.

- RMP deliver regular primary care education events and information to all sector GPs to support with recognition of symptoms and appropriate referral management.

How this addresses health inequalities

- All projects are influenced by RMP data which has incorporated deprivation, stage of diagnosis, age and other protected characteristics.

- NWL communications team and RMP have developed tailored messaging by borough to support addressing local variation in presenting to healthcare providers with symptoms and to support up-take of screening, including the augmentation of National Public Health advertising.

- Investment has been made by RMP into a digital access and interactive platform for the team to access a comprehensive understanding of population at ward level to support development and delivery of key interventions.

- RMP team have undertaken significant training in understanding racial inequality to support comprehensive project delivery.

- Across the ICB there is the utilisation of performance and other metrics to ensure equity of access, diagnosis and treatment across the sector.
- Mature process of mutual aid is established to reduce the inequalities in timely access to diagnostics.

- Improved weekly communication across the sector where there are pinch points in specific pathways or trusts.
- Aligned RMP alliance and NWL Acute Trust view on priority tumour pathways and shared commitment to resolving these together.

- RMP have established an ITR process to reduce variation in access to treatment following a diagnosis of cancer. This process has recently been set up and is in early stages of development. As a system NWL has agreed to focus on head and neck and gynaecology pathways as priority pathways in the first instance.

- RMP offer training and education for all clinical and primary care practice staff to support our LGBTQ+ communities through their cancer experience.

- Future plans to further develop stakeholder engagement and co-production with local communities.

***Screening recovery is a London-wide responsibility and the subject of a separate paper which has been prepared for the JHOSC by NHS England.**

NHSE London has formed a Health Inequalities Advisory Group and a Strategic Delivery plan and agreed priority focus areas, which include:

1. Recognising and supporting best practice by building knowledge and innovation through the coordination of a regional BS HI Community of Practice so that specialist screening staff can respond with interventions that can have the greatest impact
2. Working to improve availability of core BS data against protected characteristics and under-served populations
3. Working with established entities such as the COVID Legacy and Equity Partnership to engage with local communities who are working to raise awareness, including the provision of individual support and advice through the screening pathway.
4. Increase awareness (Cultural competence and health promotion) by commissioning and overseeing the roll-out of a BS social media campaign and health promotion model that promotes education for the public and health care staff, to make informed personal choices about whether to be screened.

- The workstream will also be tracking the impact of existing improvement initiatives by breast screening providers, Cancer Alliances, local authority and primary care to support joined-up planning and delivery to under-served groups.

We are in the initial stages of planning for a London-wide social marketing campaign for breast screening and are working with Imperial College to support the rollout of campaign targeted at under-served communities

Next Steps:

We continue to target the eradication of 78 week waits for treatment by the end of March 2023, 65 week waits by March 2024 and 52 week waits by March 2025, in line with the ambitions set out in the NHS delivery plan for tackling the Covid-19 backlog of elective care. Our elective recovery work is reported and monitored locally via our Elective Care Board.

Appendix 1: Breast Screening Recovery Programme Update

Purpose

To provide an overview on recovery performance across North West London (NWL) for breast screening in NW London.

Background/Context:

Breast screening is a method of detecting breast cancer at a very early stage. Screening saves about 1 life from breast cancer for every 200 women who are screened. This adds up to about 1,300 lives saved from breast cancer each year in the UK

The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50 and up to their 71st birthday. Because the Programme is a rolling one which invites women by date of birth and last screening result (if previously screened), not every woman receives an invitation as soon as she turns 50. But she will receive her first invitation before her 53rd birthday. Once women reach, 70, which is the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointments.

How breast screening works?

The first step involves an x-ray of each breast - a mammogram. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor. If the mammogram identifies any abnormalities, the woman will be invited for further investigation (e.g. ultrasound and biopsy)

Breast Screening Services in NWL

Breast screening services in seven out of the eight boroughs that make up NWL ICB are delivered by Imperial NHS Trust and known as the West of London Breast Screening Service (WOLBSS). The Brent population access the North London Breast Screening Service (NLBSS), delivered by the Royal Free NHS Trust (though patients are able to access neighbouring services if more convenient).

WOLBSS runs screening clinics in 5 sites:

- St Mary's Hospital
- Charing Cross Hospital
- Heart of Hounslow Centre for Health
- Hanwell Medical Centre
- Uxbridge Health Centre

Impact of Covid-19 on breast screening services

As a result of the COVID-19 pandemic all routine breast screening was paused as of 23 March 2020 except for high risk screening which continued to be offered as per national guidance. Services recommenced routine screening in July 2020 with

reduced clinic capacity. Due to concerns around COVID-19 a significant number of clients chose to defer screening and assessment appointments.

Following the pause in screening and the resulting backlog, a decision was made nationally that the methodology for inviting women should change. In order to be able to invite more women more quickly, it was decided that all services should use open invitations, whereby women are informed that they are due to be screened and asked to contact the administrative Hub to book an appointment. This is in contrast to the former methodology of timed appointments whereby women who were due to be screened were sent a timed appointment at their nearest screening centre with the option of changing the appointment by contacting the Hub.

This change in methodology had an anticipated detrimental effect on uptake across London which was already the lowest in the country and below the acceptable standard of 70%. In January 2020, the average uptake in London was 63.2%; as of April 2022, it was 51.5%. There is considerable variation within London.

Some boroughs in NWL have traditionally had some of the lowest cancer screening uptake in London, namely Hammersmith and Fulham, Kensington and Chelsea and Westminster. These boroughs have seen a significant deterioration in their coverage* and uptake** rates since Covid-19 and the subsequent introduction of open invitations (see appendix 1 and 2).

**Coverage is defined as the percentage of women in the population who are eligible for screening at a particular point in time, who have had a screening test with a recorded result within the last three years.*

***Uptake is the percentage of women invited for screening in the year, who were screened adequately within six months of invitation. Refers only to women who have received a routine invite to screening, it does not include short term recalls or GP and self-referrals.*

Impact of the pandemic on recovery of services

Following the resumption of breast screening in July 2020, it became apparent that all services faced some significant challenges in their attempts to recover while continuing to screen women who became due. The challenges included:

- **Post Covid infection control measures** meant that fewer women could be screened in a day due to requirements to disinfect rooms and equipment after every consultation and to have fewer women attending clinics to reduce crowding.
- **Workforce shortages**; there is a national shortage of radiographers / mammographers which limits the extent to which additional clinic capacity can be offered.
- **Workforce health and wellbeing;** many services reported a deterioration in the physical and mental health of their clinical staff due to workload pressures; 2nd and 3rd waves of Covid have also had an impact on staffing capacity at various times setting recovery back.

The impact of pausing breast cancer screening in NWL during Covid-19 on performance metrics

Full recovery and restoration of breast screening services has been defined by National as:

- **Backlog recovery:** Clear the longest waiters and Very High Risk women which ensures the reduction of the backlog and screening of the highest priority women
- **Round length restoration:** Invite 90% of women for a screen within 36 months of their last one
- **Increase screening uptake:** Ensures detection of cancers in invited women, a high uptake is important in detecting cancers in invited women

Backlog recovery:

Across London more than 100,000 clients entered a screening backlog because of this pan London service pause. At WOLBSS, there were 30,879 women in the backlog at its peak in October 2020. At NLBSS it was 36,030 women (Source: Futures NHS). There is currently a backlog of patients overdue screening at WOLBSS of 18,995 (Source: Futures NHS, October 2022).

Capacity:

WOLBSS was unable to recover its pre-Covid clinic capacity until relatively recently (July 2022). For the first 6 months of recovery (July 2020 – Jan 2021) WOLBSS was operating at 50% or less of its pre-Covid capacity. Since Jan 2021, it has slowly increased to 80% and then relatively recently recovered to 100%. This has been due in part to delays to the lifting of infection control restrictions at 3 of the 5 clinic sites (health centres not owned by Imperial NHS Trust) from which screening is delivered which has continued to limit capacity.

Round-length:

National screening guidance states that the time interval between screening and invitation (round length) should be 36 months. (High risk groups more frequently). Currently at WOLBSS, just 4% of women are screened every 36 months due to the delays in being seen. NLBSS has managed to recover more quickly; currently 90% of women are being seen within 36 months and the backlog of overdue women has been cleared.

Recovery Plan for tackling the Covid-19 backlog, recovering the round-length position and improving uptake in NWL

All London services are in the process of returning to timed appointments which is expected to have a beneficial effect on uptake. The transition from open to timed invitations needs to be carefully managed and during this period of time screening capacity will be temporarily reduced which will have a corresponding impact on performance. At WOLBSS all sites will have returned to timed appointments using

the SMART overbooking algorithm by the end of November. Performance should then begin to improve.

Imperial predicts that the backlog at Hounslow will be cleared by the end of December 2022, followed by St Mary's, Charing Cross and Uxbridge by March 2023 and finally Hanwell by June 2023. It also predicts that round length of 36 months will be achieved for 90% of women by April 2023. It plans to do this by:

- Using an independent organisation (funded by NHSE) to offer additional clinics at the weekends at Charing Cross
- Using bank and agency staff to cover vacancies and winter sickness.
- Using a higher appointment target for SMART clinics to recover backlogs more quickly – this is an invitation algorithm which overbooks patients based on their probability of attendance.
- Using the anticipated downtime in screening from April – July 2023 (caused by the pause of screening 3 years earlier due to Covid) to make further inroads into the backlog and/or to invite women before their 36 months due date to mitigate against the expected spike in activity from July 2023 onwards.
- Planning to over-recruit mammographers to minimise anticipated staff vacancies.
- Supporting staff health and wellbeing initiatives to improve staff retention and resilience.

The service also has plans to try to improve uptake and reduce health inequalities by contacting women who do not respond to their invitations and by using specialist health promotion staff to identify barriers to attendance and try to address them.

Pan-London priorities to improve breast screening uptake & reducing inequalities

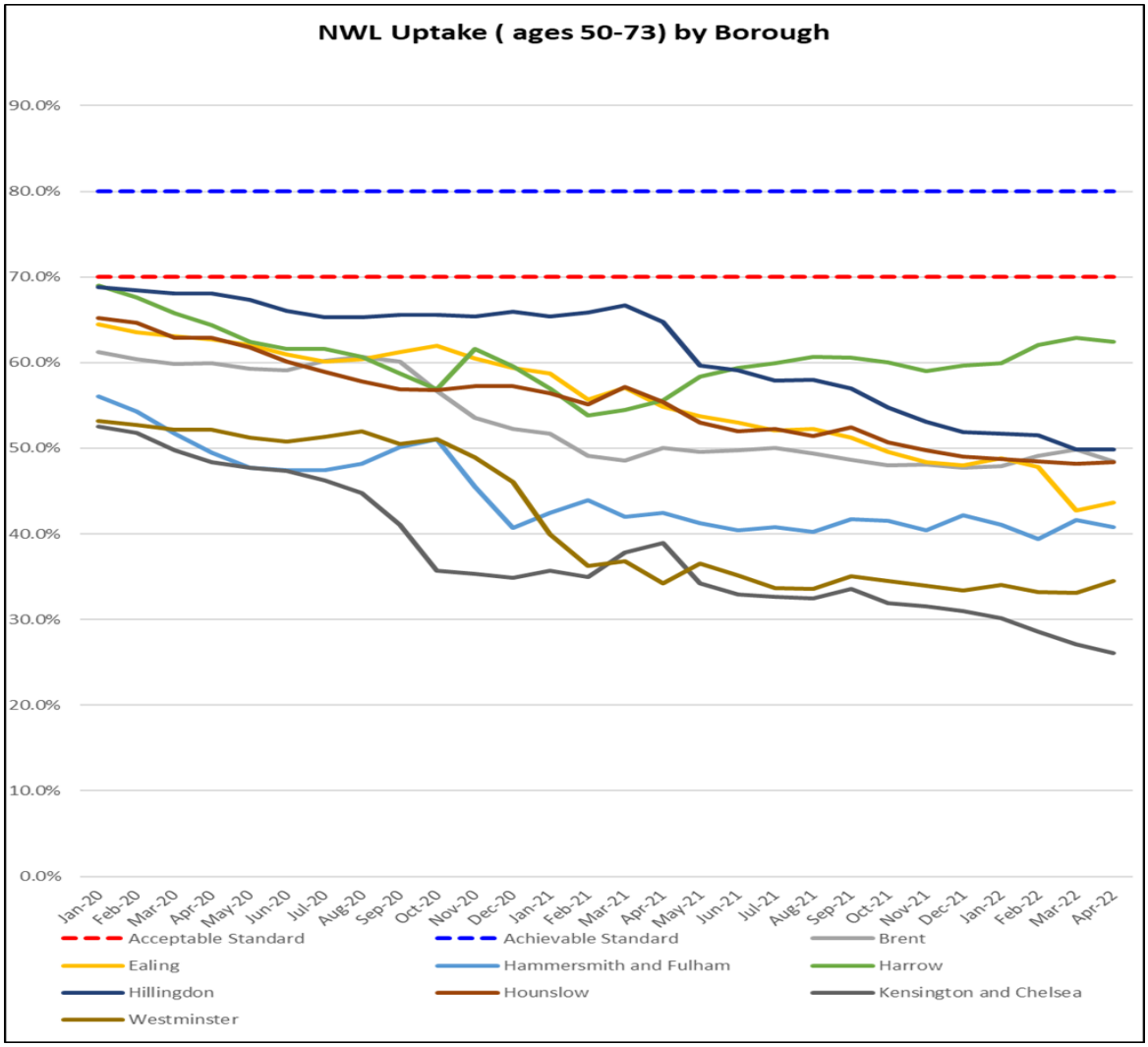
NHSE London has formed a Health Inequalities Advisory Group and a Strategic Delivery plan and agreed priority focus areas, which include:

1. Recognising and supporting best practice by building knowledge and innovation through the coordination of a regional BS HI Community of Practice so that specialist screening staff can respond with interventions that can have the greatest impact
2. Working to improve availability of core BS data against protected characteristics and under-served populations
3. Working with established entities such as the COVID Legacy and Equity Partnership to engage with local communities who are working to raise awareness, including the provision of individual support and advice through the screening pathway.
4. Increase awareness (Cultural competence and health promotion) by commissioning and overseeing the roll-out of a BS social media campaign and health promotion model that promotes education for the public and

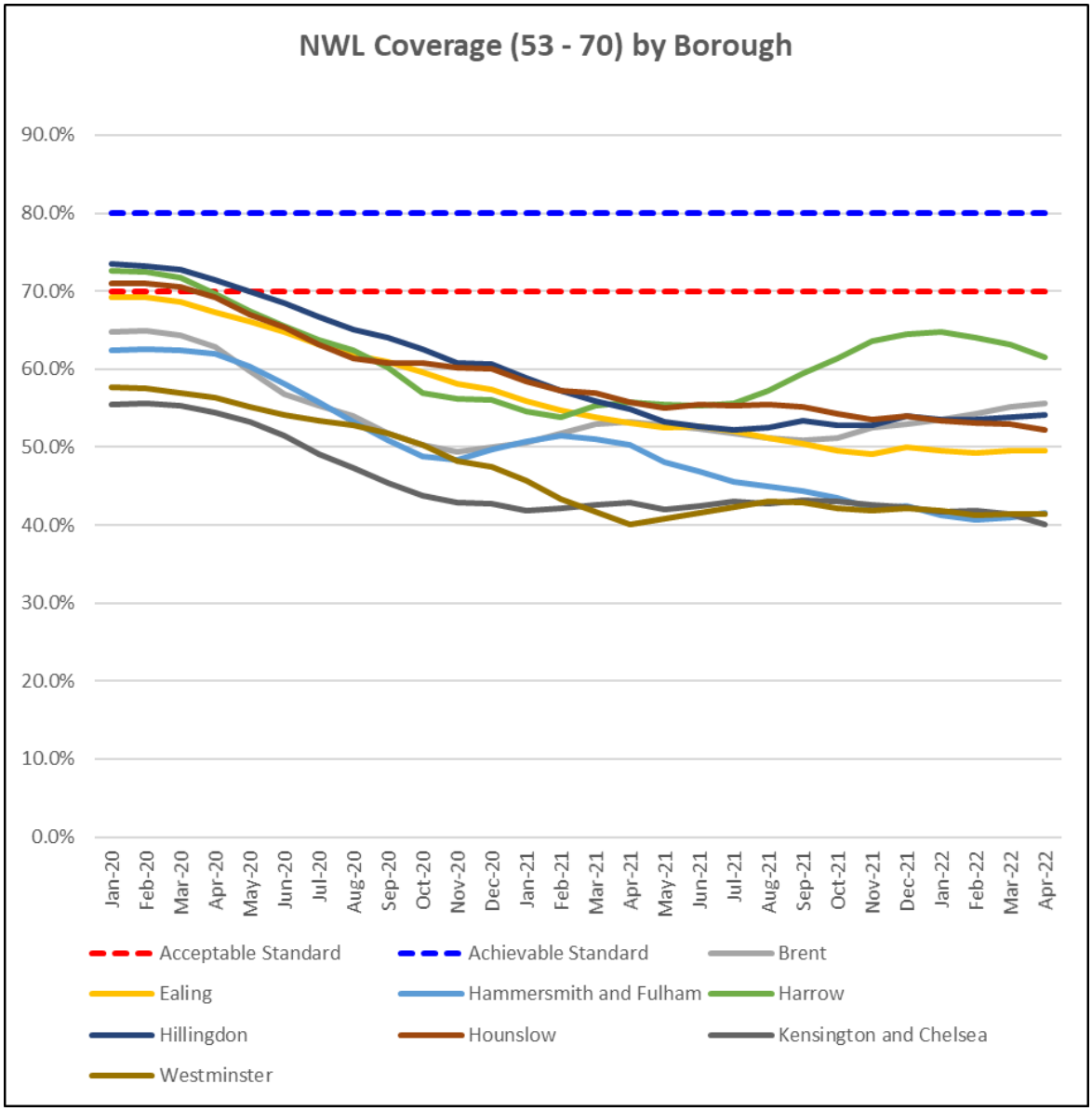
health care staff, to make informed personal choices about whether to be screened.

- The workstream will also be tracking the impact of existing improvement initiatives by breast screening providers, Cancer Alliances, local authority and primary care to support joined-up planning and delivery to under-served groups.
- We are in the initial stages of planning for a London-wide social marketing campaign for breast screening and are working with Imperial College to support the rollout of campaign targeted at under-served communities.

Appendix 1 – Breast Screening Uptake in NWL (Jan 2020 – April 2022)



Appendix 2 – Breast Screening Coverage in NWL (Jan 2020 – April 2022)


NWL Coverage (53 - 70) by Borough
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
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
Acceptable Standard
Achievable Standard
Brent
Ealing
Hammersmith and Fulham
Harrow
Hillingdon
Hounslow
Kensington and Chelsea
Westminster

This page is intentionally left blank

NHS
North West London

Winter plan 2022/23

Purpose of report

The purpose of this paper is to update JHOSC members on the NWL ICS winter planning programme.

Executive summary and key messages

Winter is traditionally the period of highest demand for health services. The winter planning process aims to increase capacity and operational resilience by funding and mobilising a range of initiatives across health and social care to tackle winter pressure.

The Urgent and Emergency Care (UEC) system in North-West London (NWL) is under pressure. Since 2020, demand for UEC services has been highly volatile with low attendance during covid surge periods/national lockdowns and extremely high attendance outside of these times. Demand in summer matched levels normally seen during winter. 111 services have also seen unprecedented levels of activity.

NW London, like other parts of the country is now experiencing a winter of continuous demand and is working in partnership across the integrated care system (ICS) to configure services and pathways in the most effective way possible.

The ICS has identified £15.5m of additional funding for winter. National funding has been substantially 'topped up' from ICB budgets. This is an increase from £12.52m last year.

1. Context

As we enter the 22/23 winter period, we are approaching a period of significant challenge for the health and care system in London. While health and social care are used to challenging winters, the current modelling and wider context suggests that we are facing a significantly more difficult winter than usual. This is due to a range of factors which include the cost of living crisis and rising energy prices which have a significant impact on illness, particularly for vulnerable residents and those on low incomes.

In NW London, the eight Local Authorities (LAs) are experiencing increasing demand for poverty-related support for which they are developing plans. Additionally, we anticipate a difficult flu season, the potential for additional waves of Covid-19 and a rise in other respiratory illnesses. Workforce challenges are evident across the system, with some

critical disciplines such as social care, primary care and nursing particularly stretched. Demand for mental health services is increasing, as are attendances at A&E as compared to 2019/20. Delays in discharging patients from a hospital bed to a community setting remains a significant pressure.

1.1. In planning for a busy winter there is also an imperative to ensure we continue to provide timely treatment for cancer and urgent planned care patients, whilst reducing very long waits for other elective treatment.

2. National guidance

2.1. NHS England published its guidance for increasing capacity and operational resilience in urgent and emergency care ahead of winter in August 2022.

2.2. The guidance recognises that a lack of capacity across the NHS has an impact on all areas of the system and that, for hospitals, the root cause of the challenges seen at the front door, is often related to a lack of flow and delays with discharge. In view of this, NHS England has identified the following core objectives and key actions for operational resilience this winter:

- Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
- Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.
- Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

2.3. Delivery of the core objectives will be measured at Integrated Care System (ICS) level through six metrics that NHS England has identified as key to the provision of safe and effective urgent and emergency care. These include:

- 111 call abandonment;
- Mean 999 call answering times;

- Category 2 ambulance response times;
- Average hours lost to ambulance handover delays per day;
- Adult general and acute bed occupancy; and
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

2.4. Each ICS was required to submit their plan to meet the core objectives, with corresponding performance trajectories for the six key metrics, at the end of September 2022. The expectation is that these trajectories will be delivered alongside existing Elective Recovery Plan requirements to eliminate waits of over 18 months and to reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.

3. Winter funding and schemes

3.1 The ICS has identified £15.5m of additional funding for winter, an increase from £12.5m last year. This includes a contribution from NHS England of £9m. NHS North West London has contributed an addition £5.56m and is the only ICB in London to contribute additional funds.

3.2 This is non recurrent funding and must be used to address the significant system pressures anticipated ahead of winter, until the end March 2023. Only schemes which are proven to deliver in the short term will be funded in order to ensure maximum care this winter. Proposals to use this funding were assessed using the following principles, which were agreed by the relevant programme SROs and programme directors across the ICS:

I. There must be good evidence that the scheme will create capacity in acute hospitals to maximise elective activity and reduce ambulance handover delays;
II. Schemes that support best use of existing capacity should be considered alongside proposals for additional beds and upstream community schemes to reduce demand; and
III. Schemes must be deliverable at pace and benefit this winter.
IV. Impact of virtual wards to be considered in prioritisation.

3.3 The initiatives span:

- actual physical additional beds (which are easiest to measure but hardest to staff)
- schemes that ensure best usage of the capacity we already have (increasing throughput/ reducing/length of stay)
- schemes that seek to reduce demand.

This additional funding sits alongside existing transformation work and investment which support managing flow year round.

NWL Winter Funding			22/23 (£'000)	
NHSE/I Winter allocation			£	9,319
Additional ICB contributions :				
ICB funding	£	2,860		
Subsequently identified local care Funding	£	2,700	£	5,560
Regional MH Winter Funding			£	568
UCR Implementation Support			£	96
Total NWL 22/23 Winter Funding pot (excl. Primary care)			**£**	**15,543**
21/22 (Last year's winter funding excl. Primary care)				12,524.69
Increase funding over last year (£)			*£*	*3,018*
Increase funding over last year %				*24%*

Allocation of funds

	£'000										
Prioritised proposals (£'000)	**C&W**	**ICHT**	**LNW**	**THH**	**Total Acute**	**Mental Health**	**Community**	**Primary Care**	**ICB Comms**	**UCR Implementation Support**	**Total**
Physical Beds	£1,554		£2,195	£1,619	£5,368	£1,827	£1,013				£8,208
Discharge/Flow initiatives		£834	£337		£1,171	£325	£1,300				£2,796
SDEC/Frailty Unit				£161	£161						£161
Other non bedded provision						£568	£2,800	£750			£4,118
Winter communications								£0	£165	£96	£261
Total	**£1,554**	**£834**	**£2,532**	**£1,780**	**£6,700**	**£2,720**	**£5,113**	**£750**	**£165**	**£96**	**£15,543**
Beds	*28*		*68*	*24*			*43*				*163*
NWL BAU Beds capacity	*2800*										
% increase	*5.8%*										

4. Risks and actions taken to mitigate them

4.1 Workforce

HR directors have jointly led a process of monitoring capacity, risk and introducing mitigations, supported by a fully established ‘Gold’ process to allow rapid decision making across NWL. The ‘Grow’ programme have been identifying priorities for reducing hard to fill vacancies and where collaborative working would be most beneficial. Substantial work has taken place to identify alternative staffing models that could add value to our winter preparedness.

4.2 Critical care bed capacity

Trusts have presented their plans on increasing Critical Care capacity with escalation processes in place to decide when additional beds are opened. In the event of higher than predicted demand, our Adult Critical Care Transfer (ACCTS) is in place if decompression is required. There is continuous work with local services to ensure flow is maintained.

4.3 General & Acute bed capacity

NW London is ahead of trajectory for implementing additional acute beds and on trajectory for other areas, including non-acute beds. Extensive monitoring and reporting mechanisms are in place to facilitate decision-making. This is complemented by initiatives in place across the whole patient journey to ensure hospital beds are protected for those who need them.

4.4 Avoidable admissions to hospital

In addition to opening additional bed capacity, the winter planning focus for NW London continues to be ambulance handover, maximising the use of Same Day Emergency Care (SDEC) pathways and optimising discharge arrangements. Our plans incorporate the latest infection, prevention and control guidelines and we have made preparations should we see admissions for COVID, influenza and seasonal infections increase.

All our acute sites have well developed (Same Day Emergency Care (SDEC) services, offering multidisciplinary (MDT) care to patients who don't require admission but need more time and specialist input than the emergency department can offer. The focus for winter is on extending the clinical pathways SDEC can provide. This includes establishing direct pathways from the LAS and primary care, along with ensuring that more people are streamed straight to SDEC from the front door.

Alongside SDEC, access to specialty services will be augmented with the expansion of hot clinics. These are one stop, rapid access specialty clinics that can be referred to directly by primary care clinicians and by inpatient teams to facilitate discharge.

A number of Voluntary and Community Sector (VCS) schemes are being implemented to support both prevention of admission and safe hospital discharge. We have invested in additional district nursing capacity to support people in care homes. We have collaborated with primary care and vaccination colleagues to launch a number of campaigns for the early detection, prevention and management of potential admissions to secondary care. NW London has rolled out a number of dashboards and data tools to support primary care to use data to identify and target individuals and populations through evidence-based interventions.

All places within NW London have opted to implement winter resilience schemes that increase capacity within primary care at scale. Each place has one scheme for provision of additional appointments with some borough specialising the offer for Paediatric or High Intensity Users appointments.

Borough teams are working with their primary care networks (PCNs) to mobilise their winter schemes, which includes determining scale of provision i.e. PCN or place level, mode of appointments and location of service. Seven schemes are due to go live this

month with approximately 2,800 additional appointments planned for November 2022. It is anticipated that these additional appointments will offer sufficient redirection capacity for 111 and UTCs. The Extended Enhanced Access provision will also support winter pressures and is operational across NWL.

For patients with Long-term Conditions (LTCs), we have a complete Primary Care Quality and Outcomes Framework (QOF) as we go into winter, for checks and disease finding to support increasing prevalence of condition identification.

Alternatives to A&E attendance/admission for people in mental health crisis are available in every NW London-borough. We continue to advance place-based integration of secondary care mental health and PCN-level services with 24/7 support. Liaison psychiatry teams are operating in all NW London's acute hospitals with additional capacity over winter at pressured sites.

We are in the process of implementing a high intensity user dashboard across NW London, at acute and practice level as a method of cohort identification using risk stratification tools. We continue to embed MDT and case management models bringing together medical, psychiatry and external partners. Nominated PCN-led schemes are underway to deliver proactive personalised care, provided by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators.

4.5 Delays in discharge from hospital

Efficient hospital flow is vital for urgent and emergency care pathways to work effectively. Over winter, discharge processes will be supported by increased medical, therapy and pharmacy support, including focussing on more seven day delivery, with the goal of achieving discharge rates for pathway zero patients (where limited or no out-of-hospital support is required) that are more consistent with weekday rates.

We have implemented a wide range of schemes based on last year's successful initiatives, including additional medical staffing, enhanced integration with virtual wards to support with hospital flow and facilitate early discharge, additional pharmacy and therapy support and bolstering front door arrangements.

Schemes to support hospital flow and discharge have been developed in tandem with out of hospital services. We are in the process of creating a discharge dashboard which will increase data quality and help to identify blockages in hospital flow and discharge more accurately.

4.6 A&E waiting times

Improvement plans are developed to build on the FOCUSED and Patient FIRST audits that ran across August and September 2022. These desktop processes are being supplemented by an on-site, clinically led peer review of emergency department (ED) services across NW London. The outcomes will be service specific and sector wide improvements to increase performance and clinical outcomes. They will be set out at an urgent and emergency care quality summit in December.

The results of 'missed opportunity' audits conducted at ED sites across NW London up to October will be reviewed on a sector wide basis and take account of opportunities to direct patients to alternative locations. Actions to ensure that discharge resources in the

community remain in place are being taken at sector level and are aligned with winter funding initiatives.

Actions continue to be taken on a daily basis to support LAS conveyances across NWL, and specifically in response to challenges at local sites. We continue to collaborate with LAS to understand the acuity of patients conveyed and alternative ways of managing low acuity.

4.7 Ambulance handover times

A range of winter funded schemes are introduced in order to improve ambulance handover times. There is a continuous effort to promote alternative care pathways: Urgent Community Response (UCR), Same Day Emergency Care (SDEC), Frailty virtual ward.

4.8 Acute Respiratory Infection

The NW London Autumn Covid plan outlined several surge scenarios with corresponding modelling, undertaken to ensure that capacity and infrastructure can meet likely demand on local systems. The Autumn plan has scope to deliver an extra 180,000 vaccinations per week if required and this should cover most scenarios e.g. new variants, opening up of new cohorts etc.

We have established Respiratory hubs open in all 8 areas to support Chronic Obstructive Pulmonary Disease (COPD) and asthma diagnosis complemented by obesity initiatives. Diagnostic hubs model links to MDT for consultant specialist advice & guidance. Current focus is on building COPD and Community Acquired Pneumonia (CAP) virtual ward.

5. Communications and engagement

The purpose of this year's winter communication campaign is to support local residents with decisions about their health and the services they use, by providing information and redirecting people at the point of need. The plan will build on success of the 2021 campaign and use data from the Whole Systems Integrated Care Dashboard to target and support the right areas and communities. Our plan brings together the main objectives for winter from four main work streams - Urgent and emergency care; Vaccination (flu/*Covid booster); Children and young people; Primary care.

The three focusses on the campaign will be:

1. **Vaccinations** (flu and Covid boosters)
2. **Where to go** (GP, 111 online, 111, Pharmacy, UTC, A&E)
3. **Self-care** (general winter messages stay warm, active, connected)

Delivering the winter comms campaign will support to address unnecessary attendances to A&E and UTC, increased usage of 111 online, provide support information for parents, build confidence in GP and increase vaccination uptake.
The communications and engagement approach has been developed in partnership with colleagues across NHS and local authority organisations in NW London.

Communications

- Online resource portal for NHS and local authority colleagues to use our materials and messages.
- Public information leaflet, covering key messages, translated into a range of key local languages
- Flyer digital distribution
- Easy read document providing support for registering with GP practice.
- GP and community videos and translations
- Poster (pharmacy/GP practice)
- Community radio activity
- Pharmacy bags
- Aggie the Alien campaign to primary schools
- Parents winter guide
- Newsletter text for community groups to share
- Expressions of Interest to community groups to have local support for our outreach activity.
- Information on GP screens
- Communications pack for practice managers: Website messages, answer phone message, text messages.
- Carers guide
- Staff promotion
- Community webinars
- Whatsapp messages – videos MP4s (animation)
- Social media (twitter, Instagram, Facebook, Nextdoor, Citizen's panel)
- Google adverts
- Dedicated website page
- Advertisement in council publications

Engagement

- Ongoing outreach activity across all protected characteristics and boroughs.
- Events involving pharmacists, providing basic health checks, and access to VCSE and LA support in one place.
- NW London citizen panel is well established and can be used to test sentiment and experience.
- Expression of Interest process to allocate funding to community groups supporting us reaching further into the community.

Activity to date

The NW London ICS winter website page contains key messages and information for the public.

Detailed information regarding outreach activity and the feedback heard from the public can be viewed in our monthly insight reports online.

Activity	*Winter messages supported	Date started/ planned for	Reach
Beat radio	Vaccinations	October 26	Brent community
Children's information leaflet available on Systemone for GPs to share – supported by social media campaign	Support for parents this winter	October	*Stats to add after paid for promotion*
Council magazine content	111, vaccinations	September/October - Content sent to all eight magazines (planning underway for December mag paid for adverts)	~700,000 homes
English leaflet and posters sent to all GP practices	*All	Arrived from 27/28 September	350 practices sent flu posters and winter leaflets
Football clubs	Over 50s men vaccinations	Free space in QPR and Fulham match programmes in November	25,000 people in target audience
Google adverts	Emergency services, 111 and vaccinations	Started 22 September -	Update 25 Oct - Searches for urgent and emergency care have directed 38,000 people to click on 111 online with 100,000 impressions. 18,000 clicks and 200,000 imp for Covid and flu vaccine searches
Information leaflet available to all staff for	*All	September	20,000 printed copies being used in initial outreach – additional targeted activity to

the public – in 12 languages			Bangladeshi and Pakistani communities based on vaccine uptake data
Information on GP screens	*All	September	350 practice receptions
London Fire Brigade	Vaccinations	Mid October – leaflets taken out with LFB outreach	3,000 leaflets provided
Media broadcast	Vaccine ITV national – WCHC GP appointment promotion – SOS visit Pimlico National PA	28 Sept 21 Sept	
Paid for social media	*All	Started mid-October. (Have your elderly loved ones been vaccinated? – supporting over 80s uptake)	– Reach 6790 people.
Pharmacy bags	*All	1 Nov – 4 weeks	300,000+ bags have gone to all 300 NW London pharmacies
Pharmacy digital adverts	Vaccinations	Booked by NHS London for October – in pharmacies areas with deprivation decile	30 pharmacies
Procurement of grass roots organisations to support engagement	*All	Launch additional engagement activity from November	22 communication organisations initially provided with funding
Schools activity sheet	Services, 111 pharmacy, A&E	Launched 17 October – ahead of half term	564 primary schools All school aged children upto the age of 10
Social media (Facebook, Twitter, Instagram, Nextdoor, Whatsapp)	*All Current focus on Flu and covid-19 booster	Ongoing plan throughout the winter (spaced to allow time for separate messages)	Nextdoor post opened by 20,000 people generating questions and discussion.

			Weekly posts on all social channels, translations shared through community whats app groups
Webinars and scoping of community radio	Vaccinations (FAQ and pregnancy)	November/December	
Website updates	*All	1 September - ongoing	3000 visits to winter information in last 7 days – 18,000 in the last month
Weekend and evening appointments GP pack and posters	Evening and weekend appointments	Shared with GP practices 23 September – ongoing rollout through October	Stats to add November

This page is intentionally left blank

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

NHS
North West London

JHOSC: Workforce Strategy

The JHOSC are asked to note:

- The update on the development of the workforce strategy

Agenda Item 6.

Claire Murdoch: 7th December 2022

Building our workforce strategy is a collaborative undertaking

We are coming together with partners from across the system to shape and create our long-term workforce strategy that will transform how we do things and make NWL a great place to work

Reflect on what we have achieved so far and the impact we've had so that we can build on the things that make the biggest difference

Understand the strategic priorities across the system and share best practice to prioritise what we need to change and transform

Work together to jointly shape how we move forward and with a powerful vision for our workforce that we can all commit to

Agree our priority areas that will deliver our vision and agree the plans and resources required to deliver it

This will create a diverse, talented and sustainable workforce where individuals can reach their true potential and where collaboration is the norm

North West London Integrated Care System

NHS North West London

Workforce is important

- National challenge of supply and demand
- Increasing numbers of people leaving the NHS (first-year leavers, turnover, retirement numbers all increasing)
- Returning to 2019 levels of productivity requires different thinking in the workforce
- Increased need for workforce efficiency through technology, new roles and partnership working
- Strategic and operational workforce planning and delivery is more important than ever to plan for future deficits and new service models
- Opportunities for the wider heath and social care workforce to address challenges together
- Workforce was identified as the biggest challenge at the ICP meeting (17/10/22)

Our workforce has gone through and continues to go through one of the most extraordinary times in their career and are facing considerable demands:

- Continuing to manage Covid and winter pressures
- Staff fatigue and personal responses to Covid
- Managing backlogs and waiting times
- Increased demands for some services
- Staffing and supporting growing vaccination requirements through 2023
- Maintaining BAU productivity
- Delivering against the ICS ambitions
- Changes and transformations in the NHS
- Increased demands for strong leadership and management

Workforce shortages are our biggest challenge and increasing the workforce supply is our priority focus

- We're working against a backdrop of fewer people doing HSC qualifications and joining Health & Social Care as a career; the number of staff leaving is increasing.
- The main reasons staff give us for leaving are lack of flexibility, career development and pay
- People want flexibility, development and career progression, diversity in career experience, health & wellbeing and fitness at work, security and stability
- The cost of living is also impacting the sectors in which people want to work in
- Our workforce strategy will to take into account the challenges and opportunities from the different aspirations of our different generations in the workplace. This ranges from freedom and flexibility preferences of GenY, to a better work-life balance for GenX and greater security and stability from GenZ
- Technological advancements mean more people are looking to work flexibly and remotely
- More staff are also looking for portfolio careers
- Long-term workforce planning is critical to our success

Snapshot of our current position:

NW London Provider Trusts:

- 30.8% aged over 50
- 55.2% of BAME staff
- 73.5% female
- 52,146.8WTE in post
- 11.7% vacancy rate
- Highest percentage vacancies in Nursing & Midwifery, Career Grade Doctors & Scientific and Technical

Primary Care:

- 30.6% of GPs and 39.1% of GP Nurses aged over 55
- 44 GP WTE per 100,000 patients
- c.1286 GP WTE
- c.380 GP Nurse WTE

Social care (21/22 data):

- 30% aged over 55
- 40,000 filled posts
- 6,800 vacancies
- 30.5% turnover rate

Our strategy will therefore need to support our workforce to grow, whilst also transforming with new skill mixes, new roles, multi-disciplinary working models, and portfolio careers to address these challenges.

From the workshops to date, themes have been drawn out

1. Developing a NW London employer value proposition
2. Creating a strong climate and culture
3. Developing the health and wellbeing of our staff
4. Undertaking effective workforce planning to support transformation and new models of care
5. Working with Primary Care and Social Care to develop integrated plans
6. Education and training programmes in place to deliver the requirements of the future
7. Developing our role as an anchor institution including the development of innovative routes into employment

Our strategic aim is to:

- **Be a great place to work**

  &

- **Transform our workforce to meet future needs**

We will adopt an integrated approach to workforce across all health and care partners to deliver our ambitions, ensuring these are aligned with finance & performance

We will build on our achievements and the work that is already underway including:

Establishment of NW London Health and Care Academy

Refugee recruitment programmes, including a successful bid for 200 refugees to attend a Stepping into Work Programme

Mass HCSW recruitment event focusing on transferable skills

Successful bids for skills boot camps for AHP bridging programme and peer support workers

Introduction of new roles:
Critical Care Support Workers
Therapy Assistants
ARRS roles
Anaesthetic Associates
Apprentice Nurse Associates

Refugee recruitment programmes, including a successful bid for 200 refugees to attend a Stepping into Work Programme

Establishment of NW London Workforce Information Network

Establishment of Acute nursing collaborative bank – over 200 shifts booked since Feb 2022

Development of Keeping Well service across health and care sector. C.400 contacts per month

314 people retained from vax workforce (32.8% - over target of 25% by Mar 2023)

Over the next 12 months, we will:

- Continue developing the NW London Health and Care Academy, supporting our population to access training and education to support them to move into health and care roles
- Work with clinical teams to transform the workforce in support of new models of care and clinical strategy

Our 2 workforce priorities will be delivered through our People Plan pillars – NB: DRAFT proposed priorities

1. Transform for the future

TRANSFORM
- Agree system-wide frameworks for analysing workforce data and the use of BI to support integrated workforce planning
- Enable strategic planning, delivery and oversight of national workforce growth commitments across sectors

GROW
- Explore and implement alternative recruitment approaches
- Collaborate with ICS partners to create education (e.g. via Academy), employment and apprenticeship opportunities to widen participation in health and care for local communities

ENABLE
- Provide high quality people services consistently in the system, particularly where the infrastructure is lacking
- Created automated HR processes that support our staff to join, progress and stay in NWL health and care roles

2. Great place to work

CARE
- Ensure accountability for delivering the HWB agenda across the ICS, supporting employing organisations to deliver priorities
- Strengthen staff wellbeing, engagement and experience to build workforce resilience across the system

LEAD
- Embed leadership standards in recruitment, performance, development and behaviour supported by tailored development for the leaders of today and the future
- Develop education leaders to work as MDTs across disciplines

INCLUDE
- Establish a diverse workforce supported by a sense of belonging, inclusion and partnership
- Embed inclusive recruitment and career promotion approaches that prevent bullying, harassment, violence and discrimination

EDUCATION
- Establish a culture where learning and CPD for clinical and non-clinical staff across the system is encouraged and barriers are actively identified and removed
- Maintain oversight of education funding and outcomes

Next steps…

- A chapter for the ICS strategy is in development. We will use the strategy for our clinical models of care to inform the workforce strategy.
- A robust workforce strategy to underpin the new models of care and workforce themes will be developed alongside the ICS strategy.
- Finalise our priorities and build on current plans to deliver them

This page is intentionally left blank

North West London Integrated Care System	**North West London Joint Health Overview Scrutiny Committee** 7 December 2022
	Report from the North West London Integrated Care System

NW London ICS update report

No. of Appendices:	1
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Sarah Bellman, Assistant Director, sarah.bellman@nhs.net

1.0 Purpose of the Report

1.1 To provide a report updating members on current work streams being delivered across the North West London Integrated Care System.

1.2 Areas covered in this paper are:

- Governance arrangements
- Hillingdon Hospital Rebuild
- Progress on the relocation of Mount Vernon Cancer Centre
- St Mark's Hospital relocation to Central Middlesex Hospital
- Gordon Hospital
- LNWH Sickle cell service
- GP hubs
- Covid and flu vaccination rollout
- Procurement update
- Elective orthopaedic centre consultation

2.0 Recommendation(s)

2.1 To note the report

3.0 Detail

3.1 Governance arrangements:

Agreed changes:

a. Constitution to be amended to increase Local Authority Partner voting members from one to three. Revised Constitution to be agreed by ICB and then sent to NHS England for approval prior to publication **Action**: ICB Governance team
b. Local Authority Partner Member person specification to be amended to widen from "CEO or as the Elected Leader of a Local Authority" to CEO or local authority leaders or elected member of a local authority (amended version attached)

Communication/Other forums of communication

It would be very helpful if Local Authority leaders/members could provide feedback on the suggested approaches described in our note below (please note these are in addition to a wider range of officers meetings and engagements including an LA CEO and NHS CEO dialogue/meetings that take place every two weeks.

a. Quarterly NHS Chairs and LA Leaders (or members) Forum
b. 6 weekly LA Leaders (or members) & LA CEOs with NHS Leadership
c. Advice on how to best work with local authorities on involvement in place based partnerships and wider ICB Programmes of work.
d. Outside of the formal meetings as above, we agreed it would be helpful to continue the dialogue in a more informal manner and you offered to invite Penny to join some of your meetings across the eight LAs. Should we liaise with Bernie/Peter's office on that?
e. We would also like to be able to discuss other specific local issues directly where appropriate e.g. the development of Brunel or the future development of the White city campus. We will liaise directly with individual offices on those issues.

3.2 Hillingdon Hospital rebuild:

The Outline Business Case for the New Hillingdon Hospital was approved by the Trust Board in June 2022. Around the same time in May 2022, the trust submitted a planning application. It is a hybrid planning application, including a full planning application for the new build and an outline planning application for the residual site. The trust continues to undertake extensive engagement on the plans with public, stakeholders and staff.

Following engagement over the summer with the London Borough of Hillingdon, it was agreed to set up a dedicated planning committee for the New Hillingdon Hospital application. This committee is anticipated to take place in January 2023.

The New Hospital Programme (NHP) will submit its Business Case to HM Treasury in, we anticipate, December 2022. From there, it is expected that a clear timetable for progression of each NHP cohort scheme (the New Hillingdon Hospital scheme is in cohort 3) will be provided.

3.3 Progress on the relocation of Mount Vernon Cancer Centre:

The Cancer Centre is currently run by East and North Hertfordshire NHS Trust. An Expression of Interest has been made to the New Hospital Programme for capital funding to re-locate the Mount Vernon Cancer Centre to Watford.

There is a proposal for the management of the cancer centre to transfer from East and North Hertfordshire NHS Trust to University College London Hospitals NHS Foundation Trust.

Related to this, a new chemotherapy unit has been incorporated in the design of the new Hillingdon Hospital.

3.4 St Mark's Hospital relocation to Central Middlesex Hospital:

In autumn 2020, LNWH transferred the main hub of St. Mark's services to Central Middlesex Hospital site as part of the trust's emergency response to the Covid-19 pandemic. The move supported the winter plan, helped alleviate in-patient capacity pressures at Northwick Park, and made available 50 non-elective beds for Northwick Park's emergency department. It also ensured that highly vulnerable patients were treated in a site that does not provide emergency care, protecting them from the risk of infection.

The transfer revealed sustainable, long-term advantages over the pre-Covid-19 situation. In particular, the non-emergency nature of the site protects patients from disruption to their planned care. The highly specialist nature of the service mitigates against travel issues, as does the fact that the CMH site is geographically central, with good public transport links, and is not far from Northwick Park Hospital, where the main hospital hub was originally based.

In addition, the trust continues to provide St Mark's services (complex cancer surgeries, therapeutic endoscopy, inpatient emergency gastroenterology and bowel cancer screening) at Northwick Park, while St Mark's gastroenterology, endoscopy and radiology services are also delivered at the Ealing hospital site.

Based on the benefits identified from the temporary move, and noting that key services would remain on LNWH's other sites, the trust engaged with Brent and Harrow Councils as well as with other key stakeholders, and came to a decision that the main hospital hub would remain permanently located on the Central Middlesex site in Park Royal. St Mark's services will continue to operate at both Ealing and Northwick Park Hospitals.

A successful staff consultation has now taken place for those employees affected by the changes, and St Mark's has written to patients to explain them fully. Major capital investment in five more St Mark's endoscopy suites is now in progress.

3.5 Gordon Hospital:

The formal consultation on the Gordon wards is planned for 2023. This provides time to engage and jointly develop the strategy for the management of mental health demand in Westminster. CNWL will use this time to continue engagement with local communities and work alongside the local authority to contribute to the Mental Health Strategy for Westminster, so that mental health pathways are effective and services meet the needs of local residents.

The Trust is working with the Performance Team at the ICS and with ICB colleagues to produce key metrics which evidence the direction of travel from treatment in acute inpatient beds to treatment in an enhanced community setting.

CNWL recognises that there is significant demand in the system but evidence from the last year suggests that creating alternative assessment and treatment spaces in the community produces better outcomes for service users compared to an increase in the number of acute inpatient beds.

The enhanced community offer includes a range of services providing intensive support to service users, including Crisis Houses offering 24-hour intensive support in the community, Step-Down houses which enable safe, timely discharge from hospital and enhanced Home Treatment providing face to face medical and nursing care up to twice a day in a service user's home.

The Trust has already launched new initiatives including 15 beds in Crisis Houses in KCW, Brent and Hillingdon and 40 beds in Step-Down Houses across the CNWL London boroughs. New initiatives are planned over the winter, including the Mental Health Crisis and Assessment units at St Charles and St Mary's Hospitals. These new services need time to embed and demonstrate effectiveness. They will be evaluated using 'breach' and 'admission' data and feedback from patients and partners. The plan to launch the formal consultation in 2023 will provide time to show if the new developments have met their objectives.

3.6 LNWH Sickle cell service:

Over the last year, London North West University Healthcare Trust (LNWH) has been working on a wide range of improvements to its sickle cell service. Close work with Imperial College Healthcare has led to the appointment of a joint clinical director for haematology, offering collaborative clinical leadership.

LNWH also reviewed all its sickle cell policies and processes and introduced ring-fenced beds for patients with sickle cell disease on its specialist haematology ward, where they are cared for by specialist nursing staff. A new emergency department pathway for patients presenting in crisis includes immediate notification of senior haematology and anaesthetics clinicians, analgesia within 30 mins and admission to a specialist ward. Joint MDTs, handover and escalation protocols between LNWH and ICHT support early discussion about and transfer of critically ill patients. At Central Middlesex Hospital, the trust has restarted the ambulatory pain management pathway and is exploring options to expand both capacity and hours of operation. Following a site visit and discussion with employees, patients, and other service users, NHS England noted many improvements in the LNWH service. The final visit report concluded that "changes to the patient pathway have enhanced the quality of care patients receive" and that there was a "robust pathway within the ED for [SCD] patients".

The trust recognises the need for longer-term work that builds on this progress, and is now developing a range of additional improvements, including:

- Annual reviews and individualised care plans for all patients
- Passporting to bypass emergency departments
- Open access to day care services

- MDT sickle cell clinics
- A single point of admission at Hammersmith for high risk patients in crisis

In October, LNWH hosted a public engagement event, supported by representatives of the Sickle Cell Society and the Haemoglobinopathy Coordinating Centre. A significant number of patients and their families attended to share their experiences and views on the service. There was much valuable discussion and a clear commitment to co-production in design of future services and employee induction and training. LNWH will continue to work closely with patients and service users as it develop its improvement plan.

3.7 GP hubs:

Over recent years, NW London has commissioned evening and weekend appointments from providers in each of the eight boroughs to deliver Extended Access Hubs to cover 18:30-20:00 Monday-Friday and 08:00-20:00 Saturdays, Sundays and Bank Holidays. These arrangements came to an end at the end of September due to a national contract change.

From 1st October 2022, evening and weekend GP and Primary Care appointments have begun to be delivered through an 'Enhanced Access' service that is commissioned from groups of GP Practices (Primary Care Networks) through the nationally mandated Network Contract DES. Across NW London, there are a total of 29 PCN Groupings that are delivering this service as some of the 45 PCNs are choosing to collaborate in groupings. The contract requires appointments to be offered during 'Network Standard Hours' which are 18:30-20:00 Monday-Friday and 09:00-17:00 on Saturdays. Each PCN has gone through a process to engage with their local population to support them in determining where appointments should be offered and which staff roles they would like to see and services have been designed taking this into account.

Recognising the potential for a reduction in provision on Sundays and Bank Holidays, NW London has, with the support of NHS England, commissioned an 'Extended Enhanced Access' service to ensure all eight boroughs have provision from 17:00-20:00 on Saturdays and a minimum of 6 hours on Sundays and Bank Holidays in line with existing utilisation for Winter 2022/23. These services are set-up to receive re-directions from 111 and Urgent Care Centres to support with system resilience.

Data from the new services is beginning to be collected and will be reviewed to understand the levels of utilisation across the system and help inform future commissioning decisions.

3.8 Flu and covid vaccination rollout:

COVID: The Autumn campaign is now in its third month of delivery with over 355,000 booster vaccinations administered across all eligible cohorts. However, uptake for the 50-64 age group remains stubbornly low with London averages for this cohort ranging from 24% for 50-54s to 40% in 60-64s age group. NHS London have requested systems to review how local demand might be stimulated through additional mechanisms including use of enhanced communications and engagement and other delivery methods such as use of shopping centres to capture large public footfall etc.

FLU: Delivery of the flu seasonal campaign continues with a fortnightly NW London operational meeting providing governance, oversight and scrutiny to the programme and offers a system-wide platform for highlighting issues and challenges as and when they arise. Data up to 20/11/22 shows NW London as administering over 406,981 flu vaccinations to all eligible cohorts which is the highest number in London and is equivalent performance to this time last year but with some overall signs that uptake is now starting to slow down. The NW London flu programme lead will continue to provide direction and challenge where necessary over the coming months and will work with individual borough teams if required to achieve both regional and national targets.

3.9 Procurement update:

In Harrow a series of community services are currently being provided through a contract with Harrow Health. This contract has been in place for ten years and is now coming to an end.

During the tenure of this contract Harrow CCG became part of NHS NW London. This means that as part of the re-procurement of these services a full review is being undertaken to ensure the future provision aligns with the same services being provided across NW London.

A key priority for the review (and provision of future services) is to ensure that the access, equability and provision in Harrow is in line with the rest of NW London. The review will focus on understanding of data and information on local health inequalities and their impact on service delivery and transformation.

Feedback and engagement with current service users will be built into the review process and procurement.

The services that are provided within this contract are listed in the table below.

There are some complexities to this procurement in Harrow. In other boroughs across NW London some similar service contracts have also come to an end.

This means that some of the services in the list will be reviewed as part of a wider NW London re-procurement and not solely in Harrow. This includes community ophthalmology, community MSK and ADHD services. More information about these three NW London wide service re-procurements will be provided at a later date.

Service name	**What is provided**	**Review**
Community Ophthalmology	Clinics for acute and chronic eye conditions including: glaucoma allergies and inflammation.	NW London wide
Community musculoskeletal (MSK) services	Clinics to help with joint and back problems	NW London wide
Community Physiotherapy	Physiotherapy services GPs can book into directly	Harrow

Community Neurology	Headache clinic	Harrow
Community Gastroenterology	Clinics for stomach and bowel check-ups	Harrow
Community Out-patients paediatrics	Children's clinics	Harrow
Community ENT	Ear, nose and throat clinics	Harrow
ADHD	Clinics to support for patients with ADHD	NW London wide

Next steps: A service user survey will be shared with Harrow residents early January 2023. This will be accompanied by a series of feedback workshops to ensure people have an opportunity to share their views on the current service and how they would like to see the future services run.

Alongside this engagement, clinical leads will review the performance, access and outcomes from the current service to feed into the objectives of the tendering process.

3.10 Elective Orthopaedic Consultation:

We are now carrying out a formal 14-week public consultation programme to inform a decision on whether the proposal should be progressed and how it could be improved.

The consultation is running between Wednesday 19 October 2022 and Friday 20 January 2023.

There are a range of ways to take part:

- Find out more – using information on our website nwl-acute-provider-collaborative@nhs.uk
- Complete a questionnaire – via our online survey on our website or a hard copy to be returned using the Freepost address below
- Write to us – at FREEPOST: HEALTHIER NORTH WEST LONDON or email nhsnwl.eoc@nhs.net
- Give us a call – on 020 3311 7733
- Come to one of our events – we are holding community meetings and drop-in sessions in each borough as well as sector-wide online events.

Planned programme of public consultation events in each north west London borough:

Events in Brent	**Community meeting** Monday 31 October 2022, 17.30 - 19.30 Brent Civic Centre **Community drop-in sessions** • Thursday 1 December 2022 , 16.00 – 19.00, Chalkhill Community Centre

	• Monday 16 January 2023, 09.00 – 13.00, Central Middlesex Hospital (opposite main reception)
Events in Ealing	**Community meeting** Monday 31 October 2022, 14.00 – 16.00 Victoria Room, Ealing Town Hall **Community drop-in sessions** • Monday 14 November 2022, 11.00 – 15.00, Ealing Central Library • Friday 20 January 2023, 09.00 – 13.00, Ealing Hospital (outside WH Smith)
Events in Hammersmith & Fulham	**Community meeting** Wednesday 16 November 2022, 16.30 – 18.30 Irish Cultural Centre, 5 Black's Rd, London W6 9DT **Community drop-in sessions** • Wednesday 9 November 2022, 10.00 – 14.00, Shepherd's Bush Library • Monday 16 January 2023, 09.00 – 13.00, Charing Cross Hospital
Events in Harrow	**Community meeting** Tuesday 1 November 2022, 14.00 - 16.00 Harrow Civic Centre **Community drop-in sessions** • Thursday 17 November 2022, 10.00 – 15.00, Old Lyonians Sports Centre • Wednesday 18 January 2023, 09.00 – 13.00, Northwick Park Hospital (outside former 'Adam's Apple' shop, adjacent to main reception)
Events in Hillingdon	**Community meeting** Thursday 10 November 2022, 13.30 – 15.30 Hayes and Harlington Community Centre **Community drop-in sessions** • Monday 21 November 2022, 10.00 – 14.00, Uxbridge Library • Thursday 19 January 2023, 11.00 – 14.00, Hillingdon Hospital (Education Centre)
Events in Hounslow	**Community meeting** Friday 4 November 2022, 16.30 – 18.00 West Middlesex University Hospital, Education Centre **Community drop-in sessions** • Thursday 10 November 2022, 11.00 – 15.00, Hounslow Library • Wednesday 18 January 2023, 11.00 – 14.00, West Middlesex Hospital, Education Centre

Events in Kensington and Chelsea	**Community meeting** Monday 31 October 2022, 10.30 – 12.30 Chelsea & Westminster Hospital, Medi Cinema, 3rd floor **Community drop-in sessions** • Wednesday 9 November 2022, 11.00 – 14.00, Chelsea Football Club, Chelsea Foundation Space • Tuesday 17 January 2023, 10.00 – 13.00, Chelsea and Westminster Hospital
Events in Westminster	**Community meeting** Friday 4 November 2022, 13.30 – 15.00 Trevelyan Hall, St Matthew's Conference Centre, SW1P 2BU **Community drop-in sessions** • Friday 11 November 2022, 10.00 – 14.00, Maida Vale Library • Wednesday 18 January 2023, 09.00 – 12.30, St Mary's Hospital
Online public meetings	**Anyone with an interest in these services is welcome to join:** • Tuesday 15 November 2022, 19.00 – 20.30 • Thursday 12 January 2023, 19.00 – 20.30

We are currently planning for up to ten focus group sessions involving targeted groups who are assessed as being under-represented during the consultation, run by independent qualitative researchers/facilitators. Based on the assessment of the reach of the consultation programme so far, we are looking at a mix of geographic and specialist groups – the format would remain flexible in order to reach target groups e.g. through virtual meetings, in-clinic or at existing community group meetings. We could also offer telephone interviews for people with accessibility issues.

Next steps after the consultation:

After the North West London Acute Provider Collaborative has considered everyone's views on the proposal, they will produce a consultation outcome report. This will be used in the development of a 'decision-making business case'. NHS North West London will then consider the decision-making business case and its recommendations in early 2023 in order to decide whether to implement the proposal, update the proposal or find an alternative solution.

The consultation outcome report will be shared with the Committee for its consideration. We would like to formalise the Committee's continuing involvement in the consultation process and plan the steps for its response to the decision-making business case as soon as possible.

We have prioritised the development of this proposal in order to tackle the backlog in our waiting lists and improve the quality of orthopaedic care as quickly as possible.

After consulting with a wide range of people likely to be affected by the proposed changes, we would like to take a decision on whether or not to proceed to implementation by early 2023. If the decision is to proceed, a period for contracting

and construction would follow, with the elective orthopaedic centre able to open by autumn 2023.

A more detailed overview of the consultation and activity is included as an appendix.

Appendix

Improving planned orthopaedic inpatient surgery in north west London

1. Introduction

This report to the North West London Joint Health Oversight and Scrutiny Committee sets out the proposal from the four acute NHS trusts in north west London to bring together most of their routine, inpatient orthopaedic surgery - primarily hip and knee replacements - completely separated from emergency care services.

The response to the Covid-19 pandemic showed what can be achieved when our four trusts work more collaboratively, joining up our care and making the best possible use of our combined expertise and resources.

One of the ways we were able to maintain more planned care during the later phases of the pandemic was by establishing ‘fast track surgical hubs’. These were facilities within our hospitals that focused on specific, routine operations, separated as far as possible from urgent and emergency care. This meant that operations were less likely to be put on hold when there was pressure on our emergency services.

As we come out of the pandemic with long waiting lists and many other challenges, we want to draw on best practice and go further with our improvements. We want to bring together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence, completely separated from emergency care.

Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency.

Clinicians and managers from across the four acute trusts have worked with GPs and other colleagues, as well as with patients and lay partners, to develop a detailed proposal for an 'elective orthopaedic centre' – orthopaedic services have some of the longest waiting times in north west London. We are sharing this proposal with as many patients, local residents and staff as possible, to hear their views and ideas so that we can continue to improve health and healthcare with – and for – our local communities.

This report is based on the contents of the full consultation booklet and pre-consultation business case which can be read by visiting the online consultation area at nwl-acute-provider-collaborative.nhs.uk/eoc

2. What is planned inpatient orthopaedic surgery?

Orthopaedic surgery treats damage to bones, joints, ligaments, tendons, muscles and nerves (the musculoskeletal system). Patients may be referred to an orthopaedic surgeon for a long-term condition that has developed over many years, such as osteoarthritis.

Hip and knee replacements are the most common type of orthopaedic surgery offered in the NHS. However, other types of surgery of the hips, knees, shoulders, elbows, feet, ankles and hands are also types of orthopaedic surgery.

Planned surgery is when patients have their operation booked in advance. It is generally arranged after a referral to hospital by a GP or community service followed by an assessment by hospital specialists in an outpatient clinic. It is sometimes called 'elective' or 'non-emergency' care.

Inpatient care describes when a patient stays in hospital while receiving medical care or treatment.

3. Our ambition

As previously reported to the Committee, we want to bring together much of the routine, inpatient orthopaedic surgery for the population of north west London in a purpose-designed centre of excellence at Central Middlesex Hospital, Park Royal, completely separated from emergency care services.

This means that:

- Patients will have faster and fairer access to surgery and would be much less likely to have their operation postponed due to emergency care pressures.
- Care would be of a consistently high quality, benefitting from latest best practice and research, provided by clinical teams that are highly skilled in their procedures.
- The centre would be extremely efficient, enabling more patients to be treated at a lower cost per operation.
- Patients will have better outcomes, experience and follow-up.

In addition, capacity created in other north west London hospitals by bringing together routine surgery in the elective orthopaedic centre would be able to be used for surgical patients who have more complex needs and for other specialties.

4. Why are we suggesting changes to orthopaedic surgery?

4.1 We need to reduce our waiting times

The Covid-19 pandemic has had a big impact on waiting times for planned care across the entire NHS, particularly for orthopaedic care, which accounts for more than a quarter of all surgery nationally.

In August 2022, more than 15,000 people were waiting for orthopaedic care in north-west London hospitals. Just under 3,700 of these people had had their initial assessment and were waiting for an operation. The proportion of people waiting more than 52 weeks for orthopaedic care has increased by more than a quarter during the pandemic.

Even though procedures like hip or knee replacements are not usually considered to be time critical, waiting for treatment can badly affect your quality of life and many conditions can worsen over time, making treatment and recovery harder.

4.2 We need all our care to be consistently of the highest quality

Performance against national indicators for clinical outcomes and patient experience in northwest London is amongst the best, for some measures in some trusts. But there is much room for improvement in all trusts and a lot of unnecessary variance between trusts. But there is much room for improvement in all trusts and a lot of unnecessary variance between trusts. North west London hospitals are in the bottom half for many quality measures when ranked against all NHS trusts in England.

Hospitals in north west London also perform relatively poorly in terms of cancellation rates for orthopaedic operations. This is related to the impact of urgent and emergency care pressure at hospitals that provide planned, urgent, and emergency care. And there is also wide variation across our trusts in terms of how well our operating theatres are used, including how much unnecessary ‘down time’ there is between operations.

4.3 We need to make our care more patient focused

Though we generally get positive feedback from patients that our staff are caring, kind and helpful, they are much less positive about their experience of navigating the healthcare system. Patients have reported frustration with long waiting times between their initial assessment and surgery or while attending their appointments, having to chase up their follow-up appointments or feeling worried due to re-scheduling or cancellations.

Elderly or disabled patients often say travel to appointments is a problem. Patients also highlight communication problems, such as lack of coordination between GPs and hospital services or confusing information. Patients say they want more control over their care and they want us to organise our care system so that it is as clear, consistent and straight forward as possible.

4.4 We need to help improve health and reduce health inequalities

Musculoskeletal (MSK) disorders are the third leading contributor to the burden of disease in Greater London. MSK conditions are one of the most common long-term health conditions for the most deprived 20 per cent of the population. While many of

the ways to prevent and limit the impact of MSK disorders sit outside the control of acute hospitals and even the wider NHS, improving orthopaedic surgery would particularly help older patients and patients from more deprived backgrounds.

4.5 We need to be prepared for the future

If we do nothing, our waiting lists will continue to grow faster than our capacity to provide care. By 2030 we expect the number of people waiting for orthopaedic surgery in north west London will increase by almost a fifth if we continue as we are now.

We also want to make sure we make the most of digital and other technological advances, without leaving anyone behind.

And it's really important that we continue to attract and retain great staff who love their jobs, and to continue to build their skills and expertise.

5. How would services change?

5.1 Current orthopaedic surgery

All or some elements of planned orthopaedic surgical care are currently provided in nine hospitals in north west London. There are many differences between the hospitals. Some have A&E departments and intensive care units and special types of operating theatres and so are suitable for more complex types of surgery and for operations on patients with more complex needs. These hospitals are also more affected by urgent and emergency care pressures. Other hospitals have more dedicated day-case surgery facilities, suitable for less complex surgery.

Currently, where you go if you need orthopaedic surgery depends to a large degree on where you live and whether you have any preferences. But the complexity of your needs and the surgery you require also have an impact. For example, if you have a number of other health problems which means you are at more risk from surgery, you will need to have your operation at a hospital with more intensive after-care services.

Current provision of planned orthopaedic surgical care in north west London:

5.2 Our proposal

The proposed elective orthopaedic centre would bring together most 'routine' orthopaedic inpatient surgery for patients who are otherwise generally well – an example of what is known as 'low complexity, high volume' surgery. There are around 4,000 operations of this type in north west London each year. Evidence built over many years shows that when this type of surgery is done frequently, in a systematic way, there is an improvement in both quality and efficiency.

Outpatient care (including pre-operative assessment and post-operative rehabilitation and follow up) would continue to be provided as and where it is now. And day case and complex surgery would continue in the hospitals where they are provided currently.

If a patient can have their operation at the elective orthopaedic centre, their end-to-end care would remain under the surgical team based at their 'home' orthopaedic hospital. Their 'home' surgical team would travel with them to undertake the surgery, supported by the centre's permanent clinical support team and an electronic patient record system that is shared by all the hospitals in north west London. This would help provide joined up care and make sure that expertise continues to be developed across the surgical teams in north west London.

Proposed provision of planned orthopaedic surgical care in north west London:

We calculate around 4,000 inpatient operations per year could be provided at an elective orthopaedic centre at Central Middlesex Hospital following a systematised 'high volume, low complexity' approach. This would enable the centre to provide routine surgery for all patients with low complexity needs who currently have these operations in north west London hospitals (see table).

Low complexity inpatient orthopaedic operations in north west London hospitals by borough of patients (2019):

Borough	Number of operations
Brent	687
Ealing	714
Hammersmith and Fulham	333
Harrow	430
Hillingdon	665
Hounslow	381
Kensington and Chelsea	235
Westminster	244
Boroughs outside of north west London	532
Total	**4,221**

The elective orthopaedic centre would offer only low complexity, planned inpatient surgery. Complex inpatient surgery would be out of scope, as would joint revisions (for when a hip or knee replacement needs to be repaired or replaced again) and spinal surgery. Spinal surgery in north west London is provided through a separate centralised service run by Imperial College Healthcare's neurosurgical service made up of neurosurgeons as well as orthopaedic surgeons. Children's orthopaedic surgery is also out of scope.

Day case surgery has been excluded currently on the basis that there is greater benefit from shorter travel distances on the day of surgery. Day case surgery and some complex surgery provided by London North West University Healthcare would continue at Central Middlesex Hospital as that is also one of their 'home' orthopaedic hospitals.

Key case study
South west London elective orthopaedic centre

Since 2004, planned orthopaedic surgery across south west London has been consolidated at SWLEOC (South West Elective Orthopaedic Centre), a centre of excellence for orthopaedic surgery. SWLEOC is a partnership between four acute trusts and is the largest hip and knee replacement centre in the UK, providing elective orthopaedic surgery services for 1.5 million people across the region with around 5,200 procedures a year. The facility is located on the Epsom Hospital site but is self-contained with 71 beds and a high dependency unit. The Care Quality Commission has rated

6. How was Central Middlesex Hospital selected as the proposed location and what would it mean for patients?

We assessed all of the NHS acute hospital sites in north west London (excluding the specialist Western Eye and Queen Charlotte's and Chelsea hospitals), as well as the possibility of using non-NHS sites.

A single elective orthopaedic centre at Central Middlesex Hospital was found to be the best option as:

- It is a modern and high-quality estate which, with some limited expansion and remodelling, could offer a 41-bed facility tailored to systematised surgery
- It is one of only two hospitals in north west London that does not provide urgent and emergency care, so is much less impacted by urgent and emergency care pressures
- None of the existing services would need to be moved as there is plenty of room for expansion.

We undertook detailed analysis of the average time to travel to each of our hospitals from all parts of north west London.

We found that Central Middlesex Hospital has:

- The shortest median (midpoint) travel time by car at 22 minutes
- The second shortest median (midpoint) travel time by public transport at 45 minutes.

We estimate it would cost around £9.4 million to expand capacity and make the building changes at Central Middlesex Hospital. This includes the cost of building two additional laminar flow operating theatres, creating a larger recovery unit and remodelling some parts of the existing estate.

7. Benefits and challenges

7.1 Care and quality benefits

The development of an elective orthopaedic centre for north west London would help clinical teams to provide orthopaedic surgical care:

- that consistently meets national best practice standards by having greater specialisation in specific operations
- that is more efficient by taking a more systematised approach, drawing on national best practice
- that separates planned orthopaedic surgery from urgent and emergency services, in line with guidance and policy from NHS England, Royal College of Surgeons and the National Clinical Advisory Team
- that makes best use of the facilities and skills of the four acute trusts that supports surgical skills training and new role development as well as better and more flexible ways of working
- that supports continuous improvement and innovation.

7.2 Patient experience benefits

As well as improved quality of care, the proposed changes in planned orthopaedic inpatient surgery would:

- support faster and fairer access for patients who need orthopaedic surgery across northwest London
- prevent conditions from getting worse when waiting a long time for surgery
- mean fewer postponed operations due to urgent and emergency care pressures
- help care to be more joined up across the whole of the musculoskeletal care pathway
- support more focus on care before and after surgery to help reduce the risks of surgery and enable faster recovery.

7.3 Staff benefits

While the development of an elective orthopaedic centre would require change for many staff working in this specialty, it would:

- support the development of both planned and urgent and emergency surgical skills across all the north west London teams
- allow greater specialisation in skills for staff based permanently in the centre
- support more focus on research, education and innovation
- facilitate the development of new roles and ways of working.

7.4 Challenges

We know that with any change there may be some disadvantages for some people. We think the key challenges for this proposal would be:

- some patients would have to travel further to get to and from Central Middlesex Hospital to have their operation
- some visitors would also have to travel further
- some staff would have to work in a different hospital to the one they work in now and may need to work on different sites on different days
- people with additional needs (such as those with a learning disability or dementia) could find it confusing to have their inpatient surgery in a different, possibly unfamiliar, hospital.

We are developing plans to minimise these challenges, looking at how other centres have developed solutions. For example, the South West London Elective Orthopaedic Centre, established in 2004, has a contract in place with a local taxi firm to provide transport for patients who would otherwise struggle to get there and back home. We are also very keen to get your ideas through the consultation events and survey.

We also heard concerns in our earlier discussions with patients and local communities that a greater use of digital services and apps could leave some patients behind. We are exploring potential dedicated roles for digital coaches and care co-ordinators as part of the further detailed planning for the proposed elective orthopaedic centre.

8. How the proposals could affect different communities in north west London

When the NHS proposes changes to services, we need to make sure we take into account the needs of everyone who uses or will use these services in future.

As part of our work in developing the proposal we have carried out an equalities and health impact assessment (EHIA) and a travel analysis and we have compiled feedback to date from patients and local communities. This includes the outcome of conversations with just over 70 people this summer about bone and joint care in north west London and some early feedback on the possibility of a dedicated centre for planned orthopaedic surgery.

<u>What some community members told us so far</u>
People understand the need to reduce waiting times and support work to enable this to happen as quickly as possible, even if it means travelling further to be seen faster.

- A dedicated centre for routine orthopaedic surgery was seen as a good idea, particularly as a way of maximising staff time and developing clinical expertise.
- Our patients generally praised acute care and most of the concerns raised were in relation to pathways into hospital care. We have shared these insights widely with lead clinicians and partners within the north west London healthcare system to inform how the implementation of issues, as well as informing improvement and transformation projects, such as a project to improve and standardise the provision of community musculoskeletal services.
- Some concerns were raised about ease of travel into Central Middlesex Hospital, particularly for those with further to travel. We are exploring how we can improve accessibility to the site.

We now want to have conversations with as many people as possible who may be affected by the proposed change. We would like to hear from a diverse mix of the population who would be served by the proposed elective orthopaedic centre, particularly those identified as being most at risk of barriers to access or poorer health outcomes,and including those belonging to disadvantaged groups or sharing one or more protected characteristic.

- People in the 45+ age group who are already on our waiting lists and their families/carers – this group makes up most of the target population for the elective orthopaedic centre. Our involvement activities indicate that we need to focus on increasing participation from people most likely to be suitable for routine surgery.
- People with more complex health care needs - who may face specific challenges in accessing orthopaedic services and navigating the healthcare system, such as:
    - people who are disabled or who have hearing impairments, learning disabilities or autism
    - people with a mix of health needs, such as hypertension and diabetes
    - people with mental health related issues.
- Black, Asian and other minoritised groups – people from minoritised ethnic groups (particularly those for whom English is their second language) are more likely to report poorer outcomes. The Covid-19 pandemic has further highlighted structural disadvantages faced by these groups. We need to make sure our plans for the elective orthopaedic centre do not deepen these inequalities.
- LGBTQIA+ groups – high incidences of prejudice experienced by people identifying as LGBTQIA+, including negative attitudes from healthcare professionals, may prevent individuals from accessing treatment.
- Groups likely to incur longer travel times – while Central Middlesex Hospital site has the shortest average travel time by car and the second shortest average travel time by public transport, there is variation in travel times for residents across the boroughs. We need to ensure we understand views on accessibility from across the sector.
- Residents living in the most deprived areas – deprivation can be a barrier in access to healthcare and our EHIA indicates that over a half of the north west London population are more deprived than the national average, with a particular concentration of high deprivation in the middle of the geographical region.

9. How would our staff be affected by this proposal?

As we move forward with public consultation, we will also be stepping up engagement with staff and partners to develop the detail of care pathways, staffing models and training and support plans for the proposed elective orthopaedic centre.

Based on what we know works well in other centres, we envision a staffing model where some staff – such as ward, theatre and administrative staff – would be based permanently at Central Middlesex Hospital. Then other staff – primarily surgeons –

would move with ‘their’ patients from their ‘home’ orthopaedic care to the elective orthopaedic centre to undertake the surgery.

If the proposal is taken forward, we would undertake a formal consultation with the staff who are affected. Other types of planned orthopaedic care will continue at all hospitals that currently provide planned orthopaedic care and so we would continue to need orthopaedic staff in these hospitals.

10. Public consultation

The four acute NHS trusts in north west London – Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust – work in partnership as the North West London Acute Provider Collaborative.

We have gathered some ideas and views from patients and community groups that have helped inform this proposal for an elective orthopaedic centre. We are now carrying out a formal 14-week public consultation programme to inform a decision on whether the proposal should be progressed and how it could be improved.

We want to get the views of as many patients, residents, staff and partners as possible to inform our plans during our public consultation – running between Wednesday 19 October 2022 and Friday 20 January 2023.

We would like to hear views on:

- Whether we have developed the best possible solution to the current challenges in providing planned orthopaedic surgery in north west London
- Are we doing all we can to ensure that services are of the best quality
- Are we doing the right things to ensure everyone who needs care can access it in a timely way
- Whether there are more things we could do to make services responsive and tailor them for those with specific needs

We are particularly seeking views on the challenges to our proposals – we want to minimise them, looking at how other areas have developed solutions, and are keen to get more ideas. We are also interested to receive alternative proposals to the solution we have laid out.

All feedback will be evaluated by Verve Communications, an independent company who have been engaged to receive and evaluate feedback regardless of how it is submitted.

There are a range of ways to take part:

- Find out more – using information on our website nwl-acute-provider-collaborative@nhs.uk
- Complete a questionnaire – via our online survey on our website or a hard copy to be returned using the Freepost address below
- Write to us – at FREEPOST: HEALTHIER NORTH WEST LONDON or email nhsnwl.eoc@nhs.net

- Give us a call – on 020 3311 7733
- Come to one of our events – we are holding community meetings and drop-in sessions in each borough as well as sector-wide online events.

Planned programme of public consultation events in each north west London borough:

Events in Brent	**Community meeting** Monday 31 October 2022, 17.30 - 19.30 Brent Civic Centre **Community drop-in sessions** • Thursday 1 December 2022 , 16.00 – 19.00, Chalkhill Community Centre • Monday 16 January 2023, 09.00 – 13.00, Central Middlesex Hospital (opposite main reception)
Events in Ealing	**Community meeting** Monday 31 October 2022, 14.00 – 16.00 Victoria Room, Ealing Town Hall **Community drop-in sessions** • Monday 14 November 2022, 11.00 – 15.00, Ealing Central Library • Friday 20 January 2023, 09.00 – 13.00, Ealing Hospital (outside WH Smith)
Events in Hammersmith & Fulham	**Community meeting** Wednesday 16 November 2022, 16.30 – 18.30 Irish Cultural Centre, 5 Black's Rd, London W6 9DT **Community drop-in sessions** • Wednesday 9 November 2022, 10.00 – 14.00, Shepherd's Bush Library • Monday 16 January 2023, 09.00 – 13.00, Charing Cross Hospital
Events in Harrow	**Community meeting** Tuesday 1 November 2022, 14.00 - 16.00 Harrow Civic Centre **Community drop-in sessions** • Thursday 17 November 2022, 10.00 – 15.00, Old Lyonians Sports Centre • Wednesday 18 January 2023, 09.00 – 13.00, Northwick Park Hospital (outside former 'Adam's Apple' shop, adjacent to main reception)
Events in Hillingdon	**Community meeting** Thursday 10 November 2022, 13.30 – 15.30 Hayes and Harlington Community Centre **Community drop-in sessions** • Monday 21 November 2022, 10.00 – 14.00, Uxbridge Library

	• Thursday 19 January 2023, 11.00 – 14.00, Hillingdon Hospital (Education Centre)
Events in Hounslow	**Community meeting** Friday 4 November 2022, 16.30 – 18.00 West Middlesex University Hospital, Education Centre **Community drop-in sessions** • Thursday 10 November 2022, 11.00 – 15.00, Hounslow Library • Wednesday 18 January 2023, 11.00 – 14.00, West Middlesex Hospital, Education Centre
Events in Kensington and Chelsea	**Community meeting** Monday 31 October 2022, 10.30 – 12.30 Chelsea & Westminster Hospital, Medi Cinema, 3rd floor **Community drop-in sessions** • Wednesday 9 November 2022, 11.00 – 14.00, Chelsea Football Club, Chelsea Foundation Space • Tuesday 17 January 2023, 10.00 – 13.00, Chelsea and Westminster Hospital
Events in Westminster	**Community meeting** Friday 4 November 2022, 13.30 – 15.00 Trevelyan Hall, St Matthew's Conference Centre, SW1P 2BU **Community drop-in sessions** • Friday 11 November 2022, 10.00 – 14.00, Maida Vale Library • Wednesday 18 January 2023, 09.00 – 12.30, St Mary's Hospital
Online public meetings	**Anyone with an interest in these services is welcome to join:** • Tuesday 15 November 2022, 19.00 – 20.30 • Thursday 12 January 2023, 19.00 – 20.30

We are planning for up to ten focus group sessions involving targeted groups who are assessed as being under-represented during the consultation, run by independent qualitative researchers/facilitators. Based on the assessment of the reach of the consultation programme so far, we are looking at a mix of geographic and specialist groups – the format would remain flexible in order to reach target groups e.g. through virtual meetings, in-clinic or at existing community group meetings. We could also offer telephone interviews for people with accessibility issues.

12. Next steps after the consultation

The Integrated Care Board in North West London is called NHS North West London. It is the statutory NHS organisation responsible for developing a plan that meets the health needs of the local population, managing the NHS budget and arranging for the provision of health services in north west London. They – and NHS England

London – have given the go ahead for this consultation following a review of a 'pre-consultation business case' developed by the North West London Acute Provider Collaborative.

After the North West London Acute Provider Collaborative has considered everyone's views on the proposal, they will produce a consultation outcome report. This will be used in the development of a 'decision-making business case'. NHS North West London will then consider the decision-making business case and its recommendations in early 2023 in order to decide whether to implement the proposal, update the proposal or find an alternative solution.

The consultation outcome report will be shared with the Committee for its consideration. We would like to formalise the Committee's continuing involvement in the consultation process and plan the steps for its response to the decision-making business case as soon as possible.

13. What are the timescales?

We have prioritised the development of this proposal in order to tackle the backlog in our waiting lists and improve the quality of orthopaedic care as quickly as possible.

After consulting with a wide range of people likely to be affected by the proposed changes, we would like to take a decision on whether or not to proceed to implementation by early 2023. If the decision is to proceed, a period for contracting and construction would follow, with the elective orthopaedic centre able to open by autumn 2023.

This page is intentionally left blank