At a meeting of the Joint Health Overview & Scrutiny Committee (JHOSC) held on Tuesday, 5 December 2023 at 10:00 am at Rooms 6:06 & 6:07 - 6th Floor, Hounslow House.

Members Present:

Councillor Ketan Sheth (Chair)
Councillor Natalia Perez (Vice-Chair)
Councillor Nick Denys
Cllr Chetna Halai
Cllr Lucy Knight
Cllr Marina Sharma
Cllr Claire Vollum
Cllr Ben Wesson
Cllr Concia Albert (online)

Others Present:

Rob Hurd – CEO, Integrated Care Board
Daniel Elkeles – CEO, London Ambulance Service
Pippa Nightingale – CEO, London North West NHS Trust (LNWT)
Nina Singh - Chief People Officer, West London NHS Trust
Mark Titcomb – Managing Director, London North West NHS Trust (LNWT)
Rory Hegarty - Lead Director of Communications & Engagement, NWL ICS (online)
Clare Murdoch – CEO, Central and North West London NHS Foundation Trust (online)

1. Apologies for Absence and clarification of alternate members

No apologies for absence were received.

2. Declarations of interest

The Chair, Councillor Ketan Sheth (Brent Council) declared a non-pecuniary interest that he was the Lead Governor a Central And North West London NHS Foundation Trust(CNWL)

Councillor Ben Wesson (Ealing Council) declared a non-pecuniary interest that he worked for The Nursing and Midwifery Council.

Councillor Marina Sharma (Hounslow Council) declared a non-pecuniary interest that she worked for a local domiciliary care provider.

Councillor Claire Vollum (Richmond Council) declared a non-pecuniary interest that she worked for Hounslow and Richmond Community Healthcare Trust.

3. Minutes of the previous meeting held on 12 September 2023

The minutes of the meeting held on 12th September 2023 were agreed as an accurate record.

4. Matters arising (if any)

There were no matters arising.

5. ICS Workforce Strategy and Programme Update

See the report at Agenda item 5, page 17

The Chair invited Clare Murdoch, SRO for Workforce in North-West London, and Nina Singh, Chief People Officer-West London, to present the report and the following points were made:

- The workforce was a top priority, other than patients, as they were the lifeblood of what we do in North-West London.
- The strategy has been widely consulted with a whole range of colleagues
- As an anchor organisation they have looked creatively at how they can employ local people from different backgrounds and create career and job opportunities, reflect our local communities and be more flexible than they have ever been. Apprenticeship routes were one example of how they would like to create a more homegrown workforce.
- They have worked together with local authority colleagues on this strategy and invited colleagues' feedback on the Health and Care Academy as they try to grow a strategy that supports an integrated approach to workforce recruitment. North-West London is uniquely vibrant and diverse and the workforce should reflect that.
- Retention was also a big focus point as well as recruitment as it was important to retain staff in the health and care sector – see the slides for more detail.
- The workforce strategy plan and action would sit in support of real transformation in patient care through the incorporation of digital strategies, assisted technologies or redesigning pathways of care to make sure they are optimising every penny and the health and care benefits and outcomes.
- The strategy would be continually reviewed and monitored and invited feedback from this Committee.
- From the two high level themes identified in developing the Workforce Strategy seven workforce priorities have been developed – see slide 2.
- Focus over the next 18 months would be on the top three priorities shown on slide 6, page 22 which have been developed in collaboration with partner organisations in North-West London including local authority and NHS colleagues and was clear on how the key priorities will be delivered at system level, through provider collaborations and by individual organisations. The focus for CPOs would be at system level.
- Nina Singh reviewed the priority 3 – Multi-Professional Education and Training Strategy and potential investment to support the training places required in North-West London.

The Committee were then invited by the Chair to ask questions and Committee Members:

Questioned how employment opportunities for refugee communities would be improved. Nina Singh confirmed that this would be a challenge and they have brought together a collection of partner organisations and were working with the Refugee Council and voluntary groups that specialise in working with the refugee community to develop a pathway particularly around the immigration and visa applications and the particular challenge that the refugee community face obtaining a DBS check which is a pre-employment requirement for NHS. This new pathway has led to the recruitment of 62 people from the refugee community of which 11 were doctors who have gone into a medical role or a medical support worker role. They also work with the Mayor's Office through the Anchor Programme.

Asked what measures are in place to ensure recruitment is ethical when hiring overseas nurses from red list countries. Nina Singh replied that the NHS have a code of practice list. If there was a country that was on the red list they would not recruit from there and did not encourage partner organisations to recruit from there. The list changed regularly and the countries on the list varied for each different stream of nursing so recruitment would be within the NHS Code of Practice for overseas recruitment.

Asked if the recent announcement of changes to immigration rules would affect the ICS workforce strategy and programme. Clare Murdoch replied that they had not had the opportunity to properly assess the changes announced by Parliament and would need to do a detailed assessment of the impact it would have on overseas recruitment. Nina Singh added that ICS had a good connection through the NHS Employers group with the immigration department and would work with them to ensure that they can still recruit to shortage occupations. The Chair asked for the Committee to be kept updated with developments.

Noted that the workforce strategy and programme did not include mental health as a known priority when it had been noted previously there were significant gaps in specialist mental healthcare and asked what was being done to address the issue and why mental health was not highlighted as a priority in the report. Clare Murdoch replied as National Director of Mental Health for England that workforce growth in mental health was an absolutely key part of the ICS's plans and referred to the recent investment in mental health across the eight boroughs from the Mental Health Investment Standard monies which was ring fenced for investment in improvement of mental health services. She added that the slides would be reviewed to reflect that mental health was a priority for workforce development through the ring fenced investment specifically for mental health services and other eligible investment streams.

Asked about the delays in discharging mental health patients from a hospital to community settings and sought confirmation that the issue remained a major focus. Clare Murdoch replied that there was immense pressure on the UEC pathway and they have seen a creeping increase in length of stay and delayed transfers of care and noted that it was really important to work together across health and care and that enhanced discharge planning was a critical part of modern mental health services and therefore, workforce and joint working.

Asked for clarification on how productivity will be measured and reviewed and how this could be monitored going forward and asked for it to provide more qualitative data as well as quantitative data. Clare Murdoch replied that the productivity measures were being developed to ensure that the data was more qualitative and that progress/outcomes were clear to see across all work streams. Rob Hurd, Chief Executive, added that insight data would be developed working together with local authority partners through borough based partnerships on gathering the insight data and applying it to experience data alongside the quantitative data to ensure investment was made in the most optimum place to get the best outcomes for patients with a limited, constrained workforce resource.

Asked about the workforce shortage in maternity services and what was being done to recruit to the vacancies, how this impacted patient safety and the reason why nursing and midwifery were particularly affected. Pippa Nightingale updated the Committee on recent recruitment initiatives which has created a pipeline that takes North-West London to a less than 5% vacancy rate including overseas recruitment and increased student and apprenticeship recruitment. In response to measures taken to retain overseas recruits Pippa replied that the retention of overseas recruits was really positive having made a big life changing decision they come, and they stay. What needed to be improved was their career progression into more senior management roles and this was being reviewed a part of their inclusion agenda.

Nina Singh responded to a question on provision of flexible working and training to expand and diversify routes into employment from people with school age children and ICS were reviewing how this could be integrated into the workforce to enable more recruitment and retention.

Rob Hurd agreed that he would bring an update on the progress of the Race and Equalities Steering Group to a future meeting. He suggested, if the Committee wished to, he could provide an annual report to the Committee which he jointly chaired with Linda Jackson. He reviewed the work of the group so far which had produced some really good outcomes for workforce race equality standards.

The Chair asked for regular updates to the Committee on the progress of the 7 priority workstreams so they can monitor genuine tangible progress. Nina Singh said she would be happy to provide an update in 6 months time.

The Committee RESOLVED to recommend that the North West London ICS:

1. Provide an update to the Committee once they have assessed the Government's new position on immigration and how this might affect recruitment and workforce within North West London.

2. Noted the invitation from Clare Murdoch as Chair of the Workforce Board to attend meetings of the Board.

3. Provide an update of progress by the Race Equality Steering Group.

4. Provide regular updates on progress of the seven priority workstreams.

6. North West London Winter Resilience and London Ambulance Performance Update

See the report at Agenda item 6, page 25

The Chair invited Rob Hurd, Chief Executive – ICB, and Daniel Elkeles, Chief Executive- LAS, to present the report and the following points were made:

The work of the London Ambulance Service cuts across how hospitals and other services are performing and responding to patient needs.

Provided an update on the workforce improvements and service delivery improvements in the LAS including:

- Recruitment of more staff both call handlers and paramedics
- The opening of 2 state of the art training facilities, one which is.based in Brentford. Committee Members were invited to visit the facilities.
- The benefits of newly introduced team working which had improved staff engagement, resulting in a 70% (6500 staff) response to the most recent staff survey.
- A new app to be introduced by Christmas which will allow staff to monitor the progress and outcomes of patients transported to hospital allowing staff to received feedback on how the patient was treated.
- Updated Members on the service performance in each category and the outreach work to train Londoners to be London Lifesavers and the new campaign to teach year 7 students in Brent, Harrow and Ealing to be London Lifesavers.
- The increase in staff and ambulances had improved performance in category 2 by 26 minutes from last November 2022
- Frail and elderly patients and mental health patients in category 3 were responded to as quickly as possible and not de-prioritised.

Committee Members were then invited by the Chair to ask questions and Committee Members:

Asked about the decision of the Metropolitan Police about right care, right person and the knock-on effect of that. Daniel Elkeles, CEO-LAS, updated Members and said that London Ambulance Service had planned very carefully with the Metropolitan Police and worked together to implement the right care, right person protocol which had resulted in between 150 and 200 extra calls a day for LAS. The transition had worked well by placing a paramedic in the Police call centre to observe and ensure the right questions were asked and then have the details and contact details of the caller transferred to the LAS call centre who would contact the patient and refer them as 999 emergency or 111 as required. Activity had increased but did not result in more ambulances sent to people who did not need them and ambulance crew have the full support of police assistance if crews require support. LAS had received the capital for 13 new dedicated mental health ambulances to transport sectioned mental health patients where Metropolitan Police carried out the responsibility but would no longer do so as this was an NHS responsibility. Clare Murdoch confirmed that she was leading nationally on the issue and monitoring the situation closely and noted that it could affect fire services, ambulance services, the acute trust social care and mental health providers. It was about doing the right thing for people using the right resources and are keen to understand what the resource implications are nationally to make sure they are properly funded. There were also cohorts that did not fit neatly into a particular path, ie, welfare checks which also needed to properly assessed. A report on right care, right person would be presented to the Committee at a future meeting.

Asked for more information on the ongoing major focus during winter, discharging patients from hospital beds and the plan for combatting that in the short term until the spring, and also the estimated risk for industrial action and the ability to meet the national targets for the delivery of urgent and emergency care over this winter and if the described mitigations fully offset the impact of industrial actions during the winter. Rob Hurd replied that they have tried to learn from last winter because a lot of the challenges the ambulance service face arise as a result of backdoor issues in hospitals and could have at any one time 650 patients in acute hospitals not meeting the criteria to reside and estimate that they can and should be making an improvement of 100 to that figure over the course of winter. This why the have introduced bridging services, invested in additional beds, invested in additional virtual ward capacity which represented approximately 500 beds and 178 extra physical beds over the winter. The discharge hub was up and running in all North West London boroughs. Rob explained that with the right measures in place and the additional £37.1 or £38.1 million industrial action funding which would be used entirely to mitigate the impact of industrial action and keep planned performance targets on track.

Asked for information on how many of the 630 virtual beds were in Hounslow and a breakdown of beds by borough if available. Rob Hurd said that he did not have the figures to hand for a breakdown by borough but would find out the information and confirmed that there were currently 330 of 500 overall virtual ward beds. This level of utilisation and growth in usage if virtual wards was one of the leading geographies in the country. Pippa Nightingale confirmed that the figures could be broken down by borough but broken down by hospital, West Middlesex was actually one of the best performing at virtual wards and have now been doing the cardiac pathways for some and the heart failure pathway for some time. It has been very well embedded and the majority of that are Hounslow patients. The figures each borough could be produced by breaking down hospital figures by Borough.

Asked for information on hospital bed capacity target of 92% for winter pressures when it has been recommended that hospitals work most safely and effectively at a bed capacity of no higher than 85%. Referred to page 29, figure 2 – general and acute bed plan and asked if there was a case for increasing bed capacity and if there was enough bed capacity to meet winter pressures. Rob Hurd confirmed that there was enough beds in North West London but

were not used effectively as they should referring to discharge issues. The Trust had invested in additional acute capacity in a context where there was significant opportunity for people not being in the right setting for their needs and their care. The strategy was to ultimately improve and get patients and residents to the right care setting as opposed to open up more and more acute beds and providing care in an appropriate setting.

Referred to sufficient medicine supplies to meet winter pressures and the issues faced previously and asked if there were plans to increase medicines to ensure that there was no risk to patients. Pippa Nightingale replied that the Trust had planned their hospitals for the winter at 96% capacity and planned the additional services required such as tests on this basis including medicines that were needed. Most of the previous medicine shortages were due to supply chain issues on the back of COVID and they have risen over that and no longer have supply chain issues of any of the medications that are used. There are no shortages and they have planned for the capacity that will be delivered over winter.

Asked for further details from London Ambulance Services on meeting category 2 and 3 targets. Daniel Elkeles provided an overview of the service standards for category 2 and category 3 calls and explained the variables within and the decisions applied to patient care and transferring them to the most appropriate setting for providing that care . Pippa Nightingale promoted the need to educate the population on using emergency services and the mythical understanding that they would be treated quicker if they called an ambulance or attended an urgent care facility. Having replied to questions on a recent radio show on inappropriate use of emergency services she noted that there was a need to start re-educating the population on seeking care from pharmacists and GPs.

Asked about the communication plan and any new communications channels not used in previous plans. Rob Hurd confirmed that they do invest significant money in communication plans and try to do this in partnership with local boroughs. It needed to be hyper-local and acknowledge local variation and local communities hearing messages. Rory Hegarty provided an outline of communications which were produced working closely with local authority comms teams. A big part of the communications plan was targeted engagement with specific communities and had funded 34 community groups and grassroots groups to go out and talk to people and take some of the messaging to people that they wouldn't necessarily always reach but are known to the community groups who are trusted sources of information for them. Also in the plan are social media campaigns which are done every year and are mostly targeted advertising to promote specific messages in key areas on particular issues in the local area. This year they have included Spotify advertising and also Google advertising targeted to searches made by the user.

Asked London Ambulance Service if they expected category three calls to reduce or since the last published figures or would they go up. Daniel Elkeles provided an update on expected category 3 demand and how calls would be managed with the appropriate response from car teams, eBike responders or if required, an ambulance. Category 3 calls were from the frail and elderly. As they go into the winter, they expect an increase in emergency calls to both 111 and 999.

The Committee RESOLVED to recommend that the North West London ICS and LAS:

1. Provide a briefing paper on the impact of right care, right person focussing on the impact on partners and the changes taking place in the Spring.

Increase collaboration with Local Authority Comms Teams to reach wider audiences.

7. North West London Elective Orthopaedic Centre update

See the report at Agenda item 7, page 43

The Chair invited Mark Titcomb, LNWH Managing Director-EOC, CMH & Ealing, and Pippa Nightingale, CEO-London North West NHS Trust, to present the report and the following points were made:

- The Elective Orthopaedic Centre opened as scheduled and treated its first patient on 4th December 2023.
- There would be around 46 patients treated at the EOC for the first week and just under 200 going through in December 2023 in total.
- Once the EOC has reached full capability at the end of February 2024/Beginning of March 2024 when the additional 2 theatres are ready the EOC will be seeing between 400 – 500 patients a month which will take the total patients treated to 5000 – 6000 each year and was very much on track in terms of this progress.
- In consultation with local residents and public a transport working group was formed to design a transport service for patients based at Central Middlesex Hospital available 7 days a week and also 4 patient pathway navigators to assist patients, their family and carers with transport requirements.
- When the EOC has reached full capability at the beginning of March 2024 it will be carrying out routine hip, knees and some upper limb work which will free up capacity within the home trusts for more complex orthopaedic work other elective surgeries which will help reduce the long waiting lists.

The Committee were then invited by the Chair to ask questions and Committee Members:

Asked if they saw any challenges between now and March 2024 that would need to be looked at again and asked Mark to elaborate on the mechanisms that have been established for ongoing monitoring of the new Orthopaedic Centre, specifically producing intended improvements, productivity, quality which is quantitative and qualitative and efficiency that led to the Centre being developed. Mark Titcomb said that the challenges between now and March 2024 are continually keeping a really close eye on the programme to make sure that it is kept on track. A key focus was on making sure they have the right workforce and the right people. They currently have between 86-90 of 140 people based at Central Middlesex Hospital. Ongoing monitoring was a key part and as part of the planning and as part of the business case which was quite a comprehensive benefit realisation plan and outcomes that are expected for patients both in terms of qualitative ones are around patient experience, around the level of engagement and around the way that they are clinically cared for within the hospital and within the EOC and also the quantitative ones about productivity particularly around areas such as length of stay, ie, within the hospital. They will continue monitor all metrics and matrix's. The report refers to the Patient Engagement Committee for example that currently exists at Central Middlesex Hospital they will make sure that that absolutely includes the EOC patients as well so they have got that real time feedback from patients and from residents. Pippa Nightingale said that this was a huge challenge for productivity and for surgeons to adapt to a different way of working that will see them increase the number of surgeries performed without the distractions of emergency surgery.

Asked if by February/March/April they will have a full workforce in place. Pippa Nightingale said that February/March was when Hillingdon Hospital comes on board as well as having an additional 2 new theatres which will also be finished which will complete the picture. The workforce recruitment should also be completed by then using a bespoke model that attracted new people to North West London.

Asked what specific systems were there in place to engage patients in terms of this initial experience with more specific information as to how that is captured also for patients who may not have English as a first language, what systems were there in place to capture their feedback. Pippa Nightingale said that they have done a few things, first of all the normal collection of patient experience that happens for all patients and then it can be broken down by specialty and will be able to see which patients had their care at the elective orthopaedic centre. What their friends and families score is, that's only a small little touch base. What will be done for the first few patients is really getting some detailed feedback face to face. Pippa and Mark reviewed the monitoring measures and that the performance was reported monthly to the Partnership Board with the first report at the end of January 2024.

Asked when the first report to understand the changes to different levels of care that are being introduced and overall clinical outcomes for patients be considered? Has a timeframe for this being worked out. Mark Titcomb confirmed that a monthly Partnership Board which comprises all four acute partners for the Elective Orthopaedic Centre that has been sitting every month will begin to look at the initial data from December when it meets at the end of January and every month thereafter and it will effectively have a dashboard of both clinical quantitative and qualitative patient experience results to look at, so from the end of January onwards that will be looked at, of course within that on a weekly basis and indeed on a daily basis the medical director and Mark will check on a regular basis but the formal reporting will begin at the end of January through the partnership board.

Rob Hurd noted that in the context everything, this was a fantastic example of implementing good practice to getting the balance between scaling something for the benefit of patients with the important work of involving residents on the travel. I think if we can't do it in orthopaedics good luck to us in everything else is what I would say. This is a lesson for the future of orthopaedics. You can measure things, we have things with patient related outcome measures. There's something called a national joint registry and you can look up online what patients are actually saying and how individual hips and knee joints and how effective they are. There is a wealth of information so commend the team for that. I think the wider point is the best use of resources for best outcomes for patients that meets the workforce required is a lesson for many other services that will be going on a journey in the coming years.

Offered congratulations on the first procedure yesterday (4th December) Appreciate there is still a long way to go but also wanted to pay tribute particularly for the work that you've done around transport. We often talk about co-production within the NHS and I think this a is really good example of including patients on that journey and the report mentions about reviewing the situation on an ongoing basis and it would just be helpful to have the details of those reviews in due course. Mark Titcomb added that within that transport group they developed a real rapport with that group and wanted to build on that. So rather than just saying that the transport piece is done, they want to effectively move that into the patient experience/patient feedback and how is transport looking.

Asked for clarification on what criteria are considered for defining journey times as costly, complex or lengthy making patients eligible for the free transport services and confirm that this would be delivered through ambulance services and not contracts with taxi companies. Mark Titcomb replied that what they have got is effectively at Central Middlesex for the Elective Orthopaedic Centre. They have a dedicated effectively ring fenced transport facility. There is no emergency care at Central Middlesex which is a huge advantage so there is no risk of that transport being taken off for a higher priority and have made sure that they have sufficient of that. It is ambulances or car ambulances for patients so that they can get them in early in the morning when they need to and can get them home in the evening or indeed at weekends and are expecting to discharge throughout the whole of the weekends. In terms of the first point around long, complex and costly, they have got established criteria on that.

Effectively they are trying to be as open and as helpful as possible not just for patients but for their carers as well. They can't extend that all the way to family and friends as you'll recognise but they are being really open and transparent around that.

Checked if the plan put in action included the Healthcare Travel Costs Scheme to provide financial support to those who qualify for benefits and within the guidelines of the scheme it said one of the specifications was to have a referral for specialist care which presumably would be what the appointment would be categorised as. Mark Titcomb confirmed that they do include the healthcare travel scheme.

The Committee RESOLVED to recommend that the Elective Orthopaedic Centre

1. Report to this Committee on the success against metrics and targets identified for the Orthopaedic Centre and also get feedback from staff and patients. It would be interesting to get some reports from staff and patients after March on - how they feel things have been going and what could be improved and what the NHS system can learn going forward.

2. Report to this Committee on the operation of the dedicated transport provision.

8. ICS Updates (Palliative Care, Estates Strategy, Consultation on Acute Mental Services & ICS Running Costs Reduction)

See the report at Agenda item 8, page 52

The Chair invited Rob Hurd, Chief Executive-Integrated Care Board, to present the report and the following points were made:

This was a mop-up report on various ongoing themes in the background that the Committee requested.

Rob Hurd provided an overview of the work of the NHS North West London I Integrated Care Board Organisation and Design Programme which referred to the core staff that are employed and funded under National Health Service running cost allowance which is being reduced in order to reinvest £12m in frontline services. That is going to lead to a significant staff reduction of the order of 100 staff out of the 900 that are currently employed. 3 years ago it was 1100 people so on a continued trajectory to reduce the overhead management costs in order for that money to be reinvested in frontline care.

The Committee were then invited by the Chair to ask questions and Committee Members:

Asked about provision of palliative care. In September there was mention of providers working together closely on workforce issues for expanding our palliative care offer and asked to be provided more details on the specific progress or developments that have occurred in this regard. Pippa Nightingale replied that palliative care was a really hard to recruit to role and that was because NHS was not offering the right model of care and also because this model of care is not largely the NHS. Most hospices were run by Charities and therefore for a nurse to go and work in it they would lose their pension status because they were not working within the NHS and why this issue was bigger than just beds. This would need to be about having the right clinical model, therefore the right workforce model and how do we attract people to work in this because Pippa believed, when you listened to nurses they really want to work in this area but they are almost stopped from that because of having to leave the NHS to do it. We need to create NHS pathways so that we can provide good palliative care and therefore use NHS staff to be able to deliver that care as well as the voluntary sector that are

huge in this area and our hospices that have great expertise as well but they are almost competing with us at the moment so it is a bit of a wipe the mat clean, what does the right clinical model look like, therefore the workforce model needs to be layered on top of that and then what we understand it would be much easier to recruit to them because right now it is virtually impossible to recruit to a specialist palliative care nurse as all providers were competing with each other to do that. It was also not just about beds but about really understanding the needs of our population and supporting patients to die well in a comfortable setting of their choice. Rob Hurd provided reasons why it was not possible to make use of Pembridge in Westminster.

Requested confirmation that ICB will be engaging with the Council's estates team to ensure that there is an alignment on projects and residents needs.
Rob Hurd replied yes absolutely. Part of what ICB are trying to do in the estate strategy is make this beyond an NHS only in a health strategy. All models are on the table. One has to acknowledge however, within that, that we face some constraints in how we are funded and the models of estates that we are able to enter into in the NHS without headquarters approval around some of those models. As PFI and other initiatives have shown over the years we need to tread carefully in all of those models but the basic concept of working together on making better use of having options for the future configuration.

Asked Rob Hurd if considering the cuts that are required, if there was a possibility of surrendering the 10 year lease for the ICB offices in Marylebone Road. Robin replied that they were doing everything they could to get out of the lease/subcontract. Every £1 spent on office and underutilized facilities was a £1 that could be better spent in other ways. It is in the papers that a £2m reduction in our office costs across our 8 different boroughs was part of this and very much see the Marylebone Road as an expensive underuitlized facility. He has been showing people around regularly to get that office paid for my somebody else until we can break the lease as soon as possible.

Noted that the plans for the 30% reduction in expenditure for the ICS had not been shared in any detail with local authorities. There was a perception that there would be variation in terms of the impact on local teams across North West London with up to a 40% reduction for some borough based partnerships. The balance between centralisation and localisation of staff would be key in terms of how the borough based partnerships and place based working is applied and understanding what the centralized functions will be would be key in understanding what the remaining borough based partnership function will be. They asked Rob Hurd to comment and he said that this week ICB were launching an engagement document with partners which will be coming out to borough based partnerships and local authorities. Within the overall timetable, we are now entering an engagement phase prior to next year a consultation phase. Next year being a transition year for implementation in full for April 2025 of these changes so we are still at an early stage of these proposals. Second point, borough-based partnerships were a fundamental component of our operating model. We think there will always be a London and we think there will always be a London Borough but there won't necessarily always be a North West London sub-regional unit of which he was currently the accountable officer so the fidelity of upholding the borough based partnership model out of where we came from with clinical commissioning groups into a future model of borough based partnership he assured Committee was at the heart of what this was trying to do.

Questioned the need to for reorganisation so soon after the last time and the impact this would have on the current structure which was working well. Rob replied that the idea would be to hold on to that which is working and improve that which is not working effectively looking to build on the good work in that and making the HQ better at supporting that place based partnership to succeed. As I say there will be some conversations through the engagement

around whether the 40 staff the ICB support, the funds in the Hillingdon component of our overall 800 staff, how those staff are reconfigured so that we have a broader resource out of our 800 focused around supporting that so is a different model of support we need to work through. It is frustrating that it is another change, it has been driven by circumstances beyond control in terms of a requirement to do this over this time scale.

The Committee RESOLVED to recommend to the North West London Integrated Care System:

1. To bring a report to the Committee when there are more detailed plans of the redesign and the consultation because how they impact all of us will be very important.
2. Requested context for and feedback on borough based partnerships,
    a. how it was, how it is now, what is working well, what can we do better
    b. Seek reviews from patients and staff to get their feeback.
    c. Also seek reviews and get feedback on palliative care and the further work you are going to do on people's chosen place of death that would be really interesting for this committee to know and how we can develop it. Also a brief update on developing the NHS pathways for the NHS staff to give them the opportunity to work in a range of palliative care provision. It would be good to see how this has been developing and see how this committee can support you further.
3. Recommended that the Committee supports the borough based partnership and place based working. It has been something that has worked rather effectively as we have reflected in this meeting and should be formally noted.

9. London Joint Health Overview Scrutiny Committee Recommendations Tracker

See the report at Agenda item 9, page 73

RESOLVED

To note the report

10. Any other urgent business

There was no urgent business

11. Date of next meeting - 14 March 2024

The date of the next meeting was confirmed as 14th March 2024

The meeting finished at11 58am. The minute taker at this meeting was Joti Patel