North West London Joint Health Overview and Scrutiny Committee
Notes of meeting by LB of Brent
10am-12pm on 14 March 2024

The meeting began at 10am.

PRESENT

Members of the Committee:
- Councillor Ketan Sheth (Chair) London Borough of Brent
- Councillor Natalia Perez (Vice Chair) London Borough of Hammersmith and Fulham
- Councillor Ben Wesson London Borough of Ealing
- Councillor Nick Denys London Borough of Hillingdon
- Councillor Chetna Halai London Borough of Harrow
- Councillor Marina Sharma London Borough of Hounslow
- Councillor Lucy Knight Royal Borough of Kensington and Chelsea
- Councillor Concia Albert London Borough of Westminster
- Councillor Claire Vollum London Borough of Richmond (non-voting, co-opted)

Others Present:
- Rob Hurd – Chief Executive, NHS North West London
- Rory Hegarty - Director of Communications and Engagement, NHS North West London
- Dr Genevieve Small - GP and Medical Director, Primary Care, NHS North West London
- Lynelle Hales, Lead – Access and Primary Care Strategy, NHS North West London
- Dr Vijay Tailor - GP and Primary Care Access Clinical Lead
- Kelly O'Neill - Director of Public Health, Hounslow
- Dr Tony Willis - GP and Clinical Lead for Diabetes, NHS North West London
- Hilary Tovey - Prevention and Health Living Lead, NHS North West London
- Councillor Diana Collymore – London Borough of Brent (observer)
- Councillor Mili Patel – London Borough of Brent (observer)

Support Officers:
- Chatan Popat - Policy Lead – Scrutiny, London Borough of Brent
- Hannah O'Brien – Senior Governance Officer, London Borough of Brent
- James Diamond – Scrutiny Officer, London Borough of Kensington and Chelsea
- Linda Hunting – Policy and Scrutiny Advisor, Westminster
- Nikki O'Halloran – Democratic Services Manager, Hillingdon (online)
- Sudheesh Bhasi - Policy Officer, Harrow
- Yusuf Patel - Policy and Scrutiny, Hounslow
- Anna-Marie Rattray – Overview and Scrutiny Officer, Ealing

1. APOLOGIES FOR ABSENCE AND DECLARATION OF ALTERNATE MEMBERS

1.1 No apologies were received.

2. DECLARATIONS OF INTEREST

2.1 Councillor Ketan Sheth declared a personal interest that he was the Lead Governor at Central and North West London NHS Foundation Trust (CNWL).

2.2 Councillor Ben Wesson declared a personal interest that he was employed by the Nursing and Midwifery Council.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The Committee RESOLVED that the minutes of the previous meeting, held on 5 December 2023, were approved as an accurate record of the discussion.

4. MATTERS ARISING

4.1 The Committee requested for further details in relation to the final paragraph in item 8 of the minutes which stated that 'there will be conversations through the engagement around the 40 staff the ICB support, the funds on the Hillingdon component of the overall 800 staff, how those staff are reconfigured'. They particularly requested clarity on what was meant by the funding component. Chatan Popat (Strategy Lead – Scrutiny) would follow this up with relevant officers and provide an update to the Committee.

5. ORDER OF BUSINESS

5.1 The Chair informed the Committee that he would be taking item 6 – Primary Care Access and Same Day Access Model first, followed by item 7, and then moving back to items 5, 8 and 9.

6. PRIMARY CARE ACCESS AND SAME DAY ACCESS MODEL

6.1 The Chair informed the Committee that he had allowed 2 public speakers and a GP to address the Committee in relation to the agenda item. He had given each speaker up to 5 minutes to make their remarks. A summary of the speakers' comments is provided below.

6.1.1 Robin Sharp, from Brent Patient Voice, addressed the Committee in relation to the Same Day Access Model. He highlighted that the new Same Day Access Model had been controversial over the past month once knowledge of the model had reached the public domain. On the face of it, the purpose of the model was to address the frustrations patients faced in being able to get appointments smoothly and as a way to avoid the Monday morning 8am rush. He recalled that this had been the major concern on the doorsteps during the May 2023 local elections and he thought it was likely the NHS had been asked to address that. He highlighted that KPMG Management Consultants had then been given a remit to run a trial with North West London (NWL) in relation to same day access. An Integrated Care Board (ICB) paper to the October 2023 Board had mentioned some pilots of the model in willing Primary Care Networks (PCNs) in the NWL area, and, in response to the proposals of the model, Brent Patient Voice had issued a strong demand for patient representatives to be involved in any radical moves affecting patients and their use of NHS services. He advised the Committee that Brent Patient Voice had received no response to those concerns. They had then received the full implementation package for the Same Day Access Model which consisted of 3 documents – a letter from the ICB Member for Primary Care instructing for Same Day Access Hubs to be in place throughout the ICB domain from 1 April which he felt had given the impression the implementation was compulsory; a 27 page document from KPMG explaining the proposals with diagrams of the model; and a good practice guide of examples of access by patients to care outside of the hospital. Robin Sharp highlighted that none of those examples related to the Same Day Access Hubs. Once Brent Patient Voice had analysed the documents, they wrote to Rob Hurd, Chief Executive of NHS North West London ICB, expressing that they felt these were radical proposals which limited the access of a large section of patients to their GPs and there was concern that the changes would be implemented without

pilots being evaluated and scrutinised in terms of their impact. In response, the ICB had written that the model would be implemented gradually.

6.1.2 Merrill Hammer, a resident of Hammersmith and Fulham, highlighted that the plans for Same Day Access Hubs had not been stopped as reported in some of the media, but delayed for 12 months with the possibility of PCNs being asked to tweak the way patients accessed primary care. She felt that there was a lack of clarity on what a hub was, in terms of whether it was a physical space or a telephone line and whether it was part of a single practice within a PCN. There were questions on where a patient would see the person who triaged them and how a hub would differ from urgent treatment centres or walk-in centres and who would staff them. Merrill Hammer expressed that triage and diagnosis were highly skilled tasks that should be undertaken by fully trained GPs, but she had heard that there would be unspecified clinicians that would make those clinical decisions and referrals, with a GP as a supervisor. She felt this was not safe. She also felt that continuity of care outlined in the plans related only to those patients with more complex needs, despite research reports by Cambridge University that continuity of care was more productive than access driven GP models. For Merrill, continuity of care meant growing familiarity of a GP or practice with a patient and their family, which was something that could only develop over time, and not something that only started when a patients' needs were already complex. In that way, she felt that continuity of care led to early diagnosis of health issues that may become complex over time if not identified early, and many GPs could give daily examples of this as patients passed through their surgery. She felt there was a need to recognise that GPs developed their skills by working with a wide range of patients with health problems ranging from the simple to the complex, allowing them to develop insights which helped them to recognise and identify that a patient presenting with one condition may also have a number of other and sometimes more serious conditions requiring treatment. For that reason, she felt it was dangerous to limit GPs to what she viewed as a binary choice between seeing simple and complex patients. From a patient point of view, she highlighted that the attendance of a home practice over a period of time allowed patients and families to develop the trust that made successful treatment more probable. Regarding the pilots of the hubs, she highlighted there had been no published reports or evaluation of their impact and no published health equalities impact assessment for this new model. The ICB had informed residents that the impact assessment would follow after implementation, which she felt was too late because it would be hard to make changes once the model was in operation. Merrill Hammer concluded with the sentiment that access to a GP was a core and important part of NHS provision.

6.1.3 Dr Vishal Valar, a local practicing GP, also addressed the Committee in relation to the Same Day Access Hub model. He advised the Committee that the Patient Participation Group within his PCN had raised concerns. The Group had queried where the care would be delivered, with most patients preferring for this to be in their own practice and not elsewhere because they would struggle to get to another place which could lead to inequality. The Group had queried who would deliver their care, with most patients preferring their own clinicians from their practice to deliver their care as they had known them for many years. The third concern had been around continuity of care, which the Group felt could be ensured if patients were able to receive same day access in their own practices and be seen by their own clinicians.

6.2 The Chair thanked the representatives for their remarks and welcomed the NHS NWL colleagues who were present to the meeting, inviting them to introduce the report. Dr Genevieve Small (GP and Medical Director, Primary Care, NHS North West London) provided some context to the Same Day Access model, highlighting that this was a fast-moving piece of work. In introducing the report, she provided the following key points:

- Dr Genevieve Small apologised on behalf of the ICB that the initial messaging to practices had not been expressed in a way that had been understandable for stakeholders and resulted in anxiety. She confirmed that the ICB would not be asking primary care to implement the model 2024-25, but to spend the year considering what was right for their practices, PCNs, patients and communities which could then be wrapped into something meaningful for the contract in the following year. This meant that nothing would change on 1 April 2024 and it had never been the intention for that to happen. The 1 April was the contract date by which the ICB would be enabling money to go into practices and PCNs to enable them to do this work.
- Dr Genevieve Small acknowledged that access was a concern for patients, which the ICB had learned through conversations with patients when undertaking local insight work. Patients had frustration at being able to see a GP in their own practice. The ICB acknowledged some of the concerns expressed from the public regarding an imposed system, and she reassured the Committee that was not what was happening. It was acknowledged that some of the language used in the initial paperwork which practices had received may have been misinterpreted, but the ICB's aim was to achieve resource out to practices for them to have time to reflect and consider the best way forward for patients to access them.
- The challenge with access to appointments in NWL was that it provided 1.4 million appointments in GP practices every month, with 67% of those face to face. Pre-covid, the level of face-to-face appointments had been approx. 80%, but NWL had recovered beyond that, because pre-covid it had been delivering 900k appointments, meaning NWL had been delivering an additional 0.5 million appointments every month post-covid. Despite that, she highlighted that NWL was not achieving the levels of access that patients wanted to maintain their health, so it was important to use the appointments that were available wisely.
- The ICB aimed to encourage practices and PCNs to look at new ways of delivering care and access. There was an awareness that the range of patient presentations could vary from very straight forward issues which may not always be clinical through to more complex care. The purpose of the Same Day Access Hubs was to bring together the skills existing within a practice to ensure the flow of patients was directed correctly. For example, if a patient attended with a sore throat, they may get quicker and more timely and relevant care if they attended a local pharmacy rather than waiting more time to be seen in their GP practice. If a patient had more evolved conditions that would need a GP or another skill within the practice then the hubs could enable that to happen. Within that, patient choice was very important and patients would have the opportunity to decide where they went to receive their care, but if they decided to be seen by their own practice then they may need to wait longer to be seen than if they chose to go to a different part of the system.
- It was highlighted that there had been no pilots of the Same Day Access Hub Model, and that those PCNs who had adopted the model were early adopters who had opted to implement the model and help guide the ICB with the work.

6.3 The Chair thanked Dr Genevieve Small for the introduction, then invited questions to NHS representatives from members of the Committee, with the following issues raised:

6.3.1 Committee members expressed disappointment with the communications that had surrounded the model. Members had heard from their GPs that they had been feeling stressed about what they believed was coming into place from 1 April onwards. The Committee advocated for engagement and co-production going forward in the next year in order to get the model right, and emphasised the importance of GPs and patients being at the heart of the service. Dr Genevieve Small responded, highlighting that the ICB would be working with practices, PCNs, Patient Participation Groups and

communities in NWL to get the model right over the course of the next year, and it had always been intended to be a localised model for individual PCNs to decide locally. Rob Hurd (Chief Executive, NHS North West London) advised that a co-production plan would be produced over the next year with an accompanying communications plan, which could be shared with the Committee. He advised it would be clear how the co-production work had taken place. Rory Hegarty (Director of Communications and Engagement, NHS North West London) added that this was not seen by the ICB as needing formal consultation, on the basis that it was not happening at scale. While it would mean a change to service delivery, the plan was to co-design this with each PCN and their patients locally, and there was no blueprint model for this. It was important that the focus was on delivering this approach locally within each patch rather than a blanket approach across all NWL, and so, because it would look different across each patch, it was not possible to do formal consultation. Instead, engagement would happen locally with all relevant stakeholders. There would also be a Patient Reference Group at NWL level to help inform the work as well as local Patient Participation Groups.

6.3.2 In relation to communication in general, Rob Hurd acknowledged that there was a need to publish the ICB work programme for the year ahead and work better at how to advance signal the projects that were underway at the right time.

6.3.3 Rob Hurd advised the Committee that there were complexities for the ICB that were national processes determining certain principles and how programmes were rolled out, but the ICB were determined to have a local, PCN-level approach with co-production at the heard of that. There was also the need to work at a reasonable pace to react to what he saw as an unacceptable situation for how patients accessed same day primary care. He felt there had been some good work from primary care leaders working in a highly complex change programme sitting between the national change process and the research by Cambridge. The ICB acknowledged its responsibilities within that, and he highlighted that there were things that could be improved straight away around how multi-disciplinary teams provided same day access which were a tweak or improvement, and not a fundamental change, providing access to clinicians in ways that enhanced and improved the current lived experience. As such, the ICB were treading the balance between allowing for continuous improvement of business as usual, and accepting improvement opportunities where possible while co-producing some of the fundamental principles involved, within the constraints of a national system.

6.3.4 The Committee raised concerns that there had been no published independent evaluation of the early adopters, as would be expected when a new system was introduced. They queried how the model could be properly evaluated in such a short period of time to understand the impact of patients not being seen by their own practice. Dr Genevieve Small highlighted that those who had already adopted the model were not pilots but early adopters, with 10 of 45 PCNs opting in. During that time, those PCNs had considered their access, the issues patients were raising and their complexities, and had then established their own individual ways of doing a change in access. All 10 PCNs started at different times and no two PCNs had taken the same approach. Her own GP in Harrow was part of the early adopter PCNs. They had learned that the early adopters had found different ways of working which had been useful, and some of that knowledge had formed part of the proposals for the 9 principles of the model. Those early adopters were being reviewed in order to understand the learning, which would be brought to the public once available. Anecdotally, one PCN in Central London had been able to demonstrate that they could give longer appointments for their more complex patients as a result of the way they had streamlined processes, and another PCN had been able to offer additional

appointments for their patients to receive care. The challenge in evaluation was that this was not a consistent model and the approach was different across each PCN so it was less possible to use evaluation as a research tool.

6.3.5 In response to queries as to why an Equality Impact Assessment on the Same Day Access Hub Model had not been conducted, Rory Hegarty explained that impact assessment would form part of the next stage of the work. The impact assessments would need to be looked at locally due to the fact each area would differ in the implementation of the model. This would happen as and when each local system decided their own local plans.

6.3.6 The Committee acknowledged that implementation would differ between PCNs, so queried how standardisation could be achieved. Dr Genevieve Small explained that the NHSE contract gave GPs a broad outline of the time GPs needed to start, finish, and be accessible to patients, which had been built on in NWL through the enhanced services model that allowed patients in the whole of NWL to access high level diabetic care and other additional services. Practices and PCNs were not prescribed how to deliver that, the ICB only set the standards of what it wanted practices to achieve, and it was up to the practices how they did that. In this way, standardisation was achieved through setting the expectations in the contract to be achieved.

6.3.7 The Committee queried what would happen to a GP practice if they opted out of the model and whether this would jeopardise funding for that practice. They heard that there was no mandate to sign a contract for 2024-25. PCNs had complete flexibility and the ICB encouraged them to be a part of the programme so they could be given the money and resource to build a better access model for their patients going forward. The funding they had already been receiving through their contract would remain completely unchanged, and would be uplifted for the delivery of additional services for patients in 2024-25. The Same Day Access Hub funding would not form part of that and the money would remain in primary care for practices opting in, so the ICB hoped that all PCNs would be happy to join them in a contract that would make that money flow forward.

6.3.8 In order to alleviate concerns, the Committee hoped for further transparency around the model, including more details on the outcomes of the early adopters and case studies to show learning and best practice. They also wanted further details on how the system would work for patients, which they believed would help to alleviate the anxiety surrounding this. ICB colleagues agreed some of those points could be taken away to provide an update at a later stage. These questions would be answered as that work began to take shape at individual PCN level. The Committee heard that, for the average patient, their first port of call would be their GP surgery, and that was not going to change, nor was there any intention of diverting or deflecting individual care from a GP practice. They were advised that the model aimed to build processes and efficiencies into access to primary care. The ICB wanted to move away from the need for patients to call at 8am or risk not being able to get an appointment on the same day. What were described as care navigators or co-ordinators within the proposals were what GP receptionists already did on a daily basis when a patient rang the surgery, as the receptionist would be doing some level of decision making about that patient. In terms of decision making on the care the patient received, that would always need to be made by a qualified clinician. It was added that, through the model, primary care teams in practices could be upskilled at care navigation, which would help with continuity of care.

6.3.9 The Committee asked how KPMG had been involved in the work. Dr Genevieve Small informed members that this had been a long-term, 2-year programme to look at improved access for patients. Over the course of that work, the ICB had worked with a range of different colleagues and clinicians, and, in the summer, because there was not enough capacity within the system to support practices and PCNs to do the work, the ICB had decided to look at opportunities from consultancies to do that work. KPMG was subsequently given the contract to support the 10 early adopter PCNs and build relationships with them. When the ICB then wanted to stretch the opportunity out to the rest of the PCNs in NWL they worked with KPMG to see if that was something they were able to support as part of their ongoing work.

6.3.10 Councillor Ben Wesson shared some reflections from an Ealing resident from Ealing Save our NHS, who had felt that the main issue with the model was around lack of continuity of care, as a GP would know the background of a patient that an employee of a hub would not. The resident had felt that the time taken to triage an urgent case would delay treatment where the patient's own GP would already know the circumstances surrounding that patient, and the resident felt that the Committee should stand against the new system which they felt did not adequately protect continuity of care. The Committee felt that the proposals fragmented the system and created barriers to patients being seen by a doctor. Dr Genevieve Small responded that continuity of care was a very important part of this work. She reassured the Committee that a patient's record would be available to the triager when a patient made contact with a practice or hub, and that triager, who would be a clinician, would make the clinical decision about where their care was best led. If the clinician decided that the patient needed continuity of care they would be directed back to their own practice, hopefully to a clinician who knew them and to a practice that had continuity of that patient's record. Because clinicians did not work full time, the ICB were encouraging practices to think about how they could implement mini-teams within their practice so that patient stories were handed through. Dr Genevieve Small highlighted that the ICB had to balance the access that NWL patients wanted against the ability NWL had to provide that access, which was difficult. She advised members that some patients did not mind who they saw and would prefer to see someone as soon as possible, compared to other patients who would want that continuity of care from their own practice or GP. All patients had different access needs and preferences. As such, she advised members that the ICB was on a journey to ensuring care was delivered in a variety of different ways in the way that fit best for patients.

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

i) That NHS NWL undertake an Equality Impact Assessment and Human Rights Impact Assessment prior to implementing any changes in the way patients access primary care.

ii) That the Committee should seek meaningful consultation with patients, communities and GPs from the ICB. Any engagement undertaken should be representative of the whole patient voice.

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

i) For the NWL JHOSC to be provided with feedback and analysis of the impact of the early adopter PCNs, including case studies that had been learned from.

ii) For the NWL JHOSC to receive full details of how patient safety and effectiveness would be measured against the proposals.

iii) For the NWL JHOSC to receive information on the outcomes of the work done by KPMG in a way that was easy to understand and that related to patient outcomes.

7. COMMISSIONING ARRANGEMETNS FOR COMMUNITY PHARMACY SERVICES AND DENTAL SERVICES

7.1 Hitesh Patel (Chief Officer, Community Pharmacy for Kensington, Chelsea and Westminster) provided a verbal update in relation to community pharmacy services, highlighting the following key points regarding the new Pharmacy First initiative:

- Pharmacy First had launched on 31 January 2024 to improve access to health services for patients in NWL.
- There were 7 clinical conditions which could be seen to by a community pharmacist by the patient either walking into the pharmacy or through a referral:
  - Sinusitis for patients aged 12+
  - Sore throat for patients 5+
  - Acute Otitis Melia, or ear infection, for patients aged between 1-17 years old
  - Insect bites for patients 1+
  - Impetigo for patients 1+
  - Shingles for patients 18+
  - Uncomplicated Urinary Tract Infections (UTIs) for women aged 16-64.
- Pharmacy First would also be able to provide prescription medicine where a patient had run out.
- The third part of the service was for minor illness consultations which would require a referral from either a GP practice, a hub, an urgent treatment centre, or NHS 111 / NHS online.
- In relation to the 7 clinical conditions that a pharmacist would now be able to treat, Hitesh Patel reassured the Committee that pharmacists would go through a very comprehensive pathway to ensure it was appropriate for the patient to have that consultation and safe for the patient to receive the treatment or recommendation that the pharmacist may give.
- One significant factor of the new service was that pharmacists would now be able to prescribe antibiotics, which was described as a game changer for patients. Under the Patient Group Direction, the pharmacist would go through a very precise clinical pathway to ensure it was appropriate to prescribe antibiotics.

7.2 Hilary Tovey (Prevention and Health Living Lead, NHS North West London) provided an update on oral health and dentistry, highlighting the following key points:

- The Integrated Care Partnership (ICP) had recently identified oral health as a very complex area requiring a cross-system approach to dentistry, and the paper outlined that approach and the action plan that had been developed.
- Hilary Tovey expressed gratitude for the leadership that had been provided from primary care and Kelly O'Neill (Director of Public Health, Hounslow) as co-chair of the steering group.
- There had been collaboration between Integrated Care Board (ICB) partners and Public Health to recognise the very severe issues with the oral health of children and young people across NWL, and she highlighted it was only through taking a cross-system approach that the issue could be tackled.
- Throughout the work, the consideration of health equity was being threaded through.

7.3 The Chair thanked colleagues for their introduction and invited comments and questions from the Committee, with the following raised:

7.3.1 The Committee asked how the money for the dentistry contract was allocated, as it had been found in Hillingdon that it had been adhoc, inflexible, and not focused on need. They requested further information on how the ICB were managing the logistical and governance challenges of shifting the management contracts. Dr Genevieve Small (GP and Medical Director, Primary Care, NHS North West London) explained that Units of Dental Activity (UDAs) were divided across the NHS. When the new contract had come into force, which was approx. 10 years ago, dental practitioners were given a contract value and a number of UDAs to deliver over that time. Since then, dentists had been able to take advantage of opportunities to bid for additional UDAs as they became available. The Committee heard that NHS NWL only became the direct commissioners of dental services in April 2023, and so was on a journey to understand the intricacies of the dental contract and were being supported to do that by commissioning colleagues with technical expertise. NHS NWL were not taking UDAs away from practices but supporting those that wanted to add value in by encouraging dentists to build on the work they were currently doing within their own contracts or putting themselves forward for new schemes. NHS NWL were working comprehensively with dental colleagues and attended a dental oversight meeting made up of local NHS dentist practitioners, community dentists, and representatives from the London education aspect for new dentists coming forward. Collectively, that group was working to improve dental activity for all patients and ensure NWL children were given the best dental start in life.

7.3.2 The Committee asked for details on how many children had been waiting for over a year for a dental procedure and how the new commissioning model could help reduce the backlog. Hilary Tovey agreed to obtain and distribute those figures to the Committee. She felt that there were opportunities within delegated commissioning and NHS NWL had already started taking measures to try to reduce waiting times for children and young people which had been effective, particularly around the use of general anaesthetic suites for paediatric dentistry. There would be more opportunities to do that as NHS NWL looked to recommission the community dental contracts over the next few years.

7.3.3 In relation to workforce, the Committee highlighted challenges being faced by pharmacists, with many having closed, and similar challenges attracting and retaining a workforce in NHS dentistry. They asked what was being done by NHS NWL to support NHS pharmacists and dentists with workforce issues. The Committee heard that there was a NWL Workforce Strategy which included all of the different component parts of the system, however, pharmacists were independent practitioners so NHS NWL had less influence there. In terms of dentistry, one of the challenges was keeping dentists within the NHS, so NHS NWL was working with education colleagues around that. NHS NWL was still working on a timeline around workforce.

7.3.4 The Committee noted the additional £2.7m invested into 81 practices in October 2023 due to the high demand for dentistry and asked what the result of that investment had been. They heard that dentistry was in the infancy of the changes resulting from the investment so it was too early to analyse, but there would be reflections on the impact of investment at the appropriate time and NHS NWL colleagues agreed to come back to the Committee with an update on that in future.

7.3.5 The Committee asked what oral health promotions were being offered in schools to both students and parents. Hilary Tovey replied, explaining that oral health promotion

was the responsibility of local authorities, and NHS NWL worked closely with local authority partners to ensure there was consistency in the oral health promotion being offered across NWL and learning from best practice.

7.3.6 Members highlighted feedback received from residents in Harrow who had found it challenging to find NHS dentists accepting new patients and asked whether there was a list of NHS dentists currently accepting patients within each borough. They were advised that the simplest way to find an NHS dentist was the NHS Choices website which was updated often, and patients could search for their closest NHS dentist by postcode using the search tool.

7.3.7 The Committee asked what local authority partners could do in collaboration with NHS NWL to increase access to dentistry in areas of greatest need and reduce waiting times for children. Kelly O'Neill (Director of Public Health, Hounslow) highlighted that local authorities needed to work with the NHS to ensure all children saw a dentist. For preventative work, local authorities were responsible, and could do hat through funding sufficient oral health promotion in early years settings and schools. That promotion was currently variable across NWL, and currently only the most deprived areas were being targeted and this was not at the pace and scale needed. Local authorities were responsible for influencing schools through schemes such as Sugar Smart and Water Only Schools. It was felt that there was a lot within the prevention space that could be done to improve health, but the biggest impact would be if NWL could get fluoride in water. That was a Secretary of State decision and was currently being trialled in North East London. Kelly O'Neill highlighted that lobbying for fluoride in water was where councillors could have the most influence in helping to improve oral health.

7.3.8 In relation to funding for community pharmacy, Hitesh Patel highlighted that this was challenging and that community pharmacists were struggling with the national contract, which had now been devolved to the NWL ICB. There was a hope that, with the ICB now managing that contract, there would be some funding contributions to community pharmacists in future. The new contract was currently under negotiation. Currently, community pharmacists were receiving the same funding as they had received in 2016 for additional services, which amounted to a 35% reduction in funding. There was very little that could be done locally to influence the national contract, although community pharmacists were grateful to elected representatives and senior leaders for lobbying for increased funding. Dr Genevieve Small added that the ICB was looking at ways to support pharmacy colleagues, which would need to be done through funding and resource.

7.3.9 Concern was raised in relation to providing antibiotics for women aged 16-64 to treat UTIs as there had been a rise in resistance to particular anti-biotics, and if the pharmacist was not undertaking a urine test to determine infection there was concern resistance would continue to increase. The Committee were reassured that the clinical pathways in place for a prescription of antibiotics were very robust. The Antimicrobial Resistance Oversight Committee had reviewed the Patient Group Directions and the clinical pathways to ensure that antibiotics were only administered as a last resort option for any condition that the pharmacist was treating. Hitesh Patel advised there would be no difference between a pharmacist prescribing antibiotics to a nurse practitioner or GP, as the decision would go through the same rigorous pathway. In relation to undertaking urine testing to determine infection, the Committee were advised that the British Urological Society stated that testing was not needed for simple UTIs as the history of the patient was good enough to be able to determine whether someone was suffering from a UTI. If a patient had a more complicated UTI that was not considered simple the Pharmacy First scheme would not be appropriate and those patients would be referred to a practitioner.

7.4 As there were no further comments, the Chair thanked those present for their contributions and drew the item to a close.

8. OBESITY AND PREVENTATIVE SERVICES

8.1 Dr Tony Willis (GP and Clinical Lead for Diabetes, NHS North West London) introduced the report, highlighting the following key points:

- There was a growing obesity problem nationally and particularly for NWL. The problem was complex and would significantly impact health services and local authority services if it was not addressed.
- There had been some successes to tackle obesity locally, particularly in relation to diabetes pathways. For example, 370,000 people with non-diabetic glycemia, or pre-diabetes, had been supported with their health.
- Within the approach to tackle and prevent obesity, there was an opportunity for collaboration and co-ordination between health services and local councils to look at a set of principles that could be worked on across NWL as a joint charter of action. These principles should also look at food issues due to the clear link between deprivation, food insecurity, ultra-processed food and obesity.
- Part of the current government's Food Strategy highlighted the need to address food issues and obesity, but this had not yet happened at scale. NWL were beginning to address this, and there were some innovative practices happening in NWL such as food pantries, community kitchens and considering what could be done within local work environments to promote healthier living.
- Within this work, NHS NWL were working with specialist services around the commissioning of Wegovy, a weight loss medication.

8.2 The Chair then invited questions from members of the committee, with issues raised as outlined below:

8.2.1 The Committee welcomed the work outlined in the paper and commended the reference to community co-design with a culturally competent approach.

8.2.2 The Committee were pleased that this work would look to commission the weight loss drug, Wegovy, and asked whether any patients in NWL had been able to access that. They heard that NWL patients had not been able to access Wegovy yet. NHS NWL was currently working with the commissioned specialist weight loss services to get a good number of people per month into the pathway for the remainder of the year, and were developing the business case for a larger expansion into the next year.

8.2.3 The Committee noted the referral numbers for bariatrics was quite high and asked whether any modelling had been done across NWL into the impact of incorporating pharmacology into services to drive demand down there. Hilary Tovey (Prevention and Health Living Lead, NHS North West London) explained that this work was being done as part of business case modelling and there would be more understanding of the impact once those services were up and running. As well as pharmacotherapy, the services that accompanied that treatment needed investment and service change, so it was a significant undertaking, but evidence suggested that introducing pharmacotherapy could have a significant impact on the population who were significantly overweight. There had been some modelling done around the use of Wegovy and what that might look like over the next year that would form part of the business case for that substantial investment from the ICB.

8.2.4 The Committee queried how this work would address the issue of digital exclusion. Dr Tony Willis agreed that digital exclusion was something that needed to be worked on and that work was being done. He believed that what had been seen so far in the take up of digital services had been encouraging in terms of proportional representation from minority ethnic groups as well as deprived communities. He highlighted that NHS NWL had been working closely with the Patient Co-design Group around digital upskilling to increase digital literacy in NWL, and Diabetes Community Clubs were working with local groups in key areas to improve digital literacy and supporting those with no digital access to access their online records.

8.2.5 The Committee noted the information in the report detailing that 9 in every 1,000 children in NWL had a BMI of over 30, and asked how local authorities, NHS and schools could work better together to tackle childhood obesity. They heard that discussions had taken place with public health consultants locally and the work needed careful and comprehensive co-design at a NWL level. Kelly O'Neill added that there were different tiers within the pathway which would fall under different partner organisations. Tier 1 related to infrastructure, including how access to unhealthy foods could be limited, limiting unhealthy food advertising, knowing what food was available in schools, making the healthy option the easy option, and active travel. These were the responsibility of the local authority, and some of those initiatives were unpopular. Successfully tackling obesity then also required having adequate tier 2 services in the community which were supported by schools, such as through physical activity in schools. If those first two tiers were not right then this resulted in a reliance on tier 3 and 4 services. Getting tiers 1 and 2 right reduced the requirement for tiers 3 and 4 services.

8.2.6 In relation to referrals into the complications of excess weight clinic for children and young people, the Committee heard that NHS NWL was looking into why the referral numbers were so high. It was possible that NWL was making better use of that service than other areas and the high numbers was a reflection of awareness of the availability of that service and not necessarily because there was a more significant problem, but that was being analysed.

8.2.7 The Committee asked what type of training was being offered to the NHS workforce so they could give advice specifically around diet and nutrition. Dr Tony Willis explained there were a number of workstreams in relation to training for workforce. There had been webinars offered focused on lifestyle medicine and the key pillars to good health such as physical activity, diet and sleep, which had been delivered to those on the Additional Roles Reimbursement Scheme (e.g. Social Prescribers and Health Coaches), and there were plans to expand that into primary care, including for GPs and nurses. Training had also been delivered on motivational interviewing, engaging the service user in a collaborative conversation about what would work for them.

8.2.8 The Committee asked whether any work was being done to reach out to Black, Asian and Minority Ethnic women, particularly of the older population, and heard there was work being done there, looking at different personas within the co-design work.

8.3 As no further comments were raised, the Chair thanked those present for their contributions and drew the item to a close.

9. UPDATE ON COMMUNITY-BASED SPECIALIST PALLIATIVE CARE IMPROVEMENT PROGRAMME

9.1 Rob Hurd (Chief Executive, NHS NWL) introduced the report, which detailed the next steps for the community-based palliative care improvement programme. The next steps would be to conduct an options appraisal, where all options currently remained

on the table following the appraisal work done to date. The work would not be taken forward in a formal way until after the election period as there was a set of proposals that may need to be presented to the Committee after May 2024.

9.2 The Chair thanked NHS colleagues for the introduction and invited comments and questions from the Committee, with the following issues raised:

9.2.1 The Committee welcomed the news that NHS NWL was seeking to recruit a consultant for the Pembridge Centre.

9.2.2 The Committee asked for clarity on how the recommendations from the NWL JHOSC meeting in September 2024 were being taken forward in relation to design principles for partnership working and advanced care planning. Rob Hurd responded that those recommendations formed part of the evaluation criteria for each of the options on the table and were taken into account there.

9.3 The Chair thanked those present for their contributions and drew the item to a close.

10. UPDATE ON POTENTIAL CHANGE OF CONTROL AT A T MEDICS LTD

10.1 The Committee received an update on the potential change of control at AT Medics Ltd.

10.2 The Chair invited comments and questions from the Committee, with the following points raised:

- The Committee asked for assurance that the ICB would ensure any change of control would not affect service provision for patients and asked for details about the monitoring that would be done by the ICB on the standards of primary care in surgeries that might be subject to a change of control. Rob Hurd (Chief Executive, NHS NWL) explained that all existing mechanisms to monitor performance were included within the contract, which passed over in all possible scenarios and so would remain in place. This meant that existing regulatory arrangements with CQC remained in place as well as contractual arrangements for all GPs who might be subject to the change of control. The due diligence around the change of control was in progress and sought to ensure this process was not fettered and not to make a judgement on that process. He added that no surgery locations would be changing as a result of this mechanism.

10.3 As no further issues were raised, the Chair drew the item to a close and the Committee noted the update.

11. NWL JHOSC 2023-24 RECOMMENDATIONS TRACKER

11.1 The Committee noted the recommendations tracker.

12. FOR NOTING – WORK PROGRAMME 2023-24

12.1 The Committee noted the work programme.

13. ANY OTHER URGENT BUSINESS

13.1 The Committee extended thanks to the Chair for the work done throughout the year with JHOSC.

The meeting concluded at 12.22 pm.
COUNCILLOR KETAN SHETH, CHAIR