Minutes

NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

18 July 2023

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillor Ketan Sheth (Chair) (Brent), Councillor Natalia Perez (Vice-Chair) (Hammersmith & Fulham), Councillor Nick Denys (Hillingdon), Councillor Chetna Halai (Harrow), Councillor Lucy Knight (RB Kensington & Chelsea), Councillor Angela Piddock (Westminster), Councillor Marina Sharma (Hounslow), Councillor Claire Vollum (Richmond upon Thames) and Councillor Ben Wesson (Ealing) **Also Present**: Sarah Bellman, Assistant Director Communications and Engagement, North West London Integrated Care System (NWL ICS) Dr Bob Klaber, Director of Strategy, Imperial College Healthcare NHS Trust Joe Nguyen, SRO Musculoskeletal Services / Borough Director (Westminster), North West London Integrated Care System (NWL ICS) Rob Hurd (virtual), Chief Executive, North West London Integrated Care System (NWL ICS) **Officers Present**: Sudheesh Bhasi (Harrow), James Diamond (RB Kensington & Chelsea), Linda Hunting (Westminster), George Kockelbergh (Brent), Nikki O'Halloran (Hillingdon), Tom Pickup (Brent) and Sandra Taylor (Hillingdon)
1.	**APOLOGIES FOR ABSENCE AND CLARIFICATION OF ALTERNATE MEMBERS** *(Agenda Item 1)* There had been no apologies for absence.
2.	**ELECTION OF CHAIR AND VICE CHAIR** *(Agenda Item 2)* **RESOLVED: That:** **1. Councillor Ketan Sheth be elected as Chair of the North West London Joint Health Overview and Scrutiny Committee for the 2023/2024 municipal year;** **2. Councillor Natalia Perez be elected as the Vice Chair of the North West London Joint Health Overview and Scrutiny Committee for the 2023/2024 municipal year; and** **3. the Committee's thanks be passed to the previous Vice Chair, Dan Crawford, for his years of service to the Committee.**
3.	**DECLARATIONS OF INTEREST** *(Agenda Item 3)* Councillor Ketan Sheth declared a non-pecuniary interest in the agenda, as he was a governor at Central and North West London NHS Foundation Trust, and remained in the room during the consideration thereof.

	Councillor Ben Wesson declared a non-pecuniary interest in the agenda, as he was employed by the Nursing and Midwifery Council, and remained in the room during the consideration thereof.
4.	**MINUTES OF THE PREVIOUS MEETING** *(Agenda Item 4)* **RESOLVED: That the minutes of the meeting held on 8 March 2023 be agreed as a correct record.**
5.	**MATTERS ARISING (IF ANY)** *(Agenda Item 5)* There were no matters arising.
6.	**NORTH WEST LONDON STRATEGY FOR PROVISION OF ACUTE BEDS** *(Agenda Item 6)* Mr Rob Hurd, Chief Executive at North West London Integrated Care System (NWL ICS), apologised for not being able to attend the meeting in person. The NWL Joint Health Overview and Scrutiny Committee (JHOSC) had requested a report on the NWL ICS strategy for the provision of acute beds and the impact that the Government's decision to postpone delivery of three 'new' hospitals in NWL would have on this. It was noted that the objective had been to increase care for patients in their own homes where appropriate rather than increase the number of hospital beds to address inappropriate demand. Mr Hurd advised that the ICS needed to get maximum impact from spend so would be following evidence and adopting appropriate models of care. It was recognised that the number of beds was measurable but that it was more important to look at the bigger picture to identify what action needed to be taken to improve the situation for patients. The overall strategy was not to continue with the current acute bed situation in NWL but to respond to varying demand pressures as they arose throughout the year. System capacity remained a major challenge so the Hillingdon Hospital rebuild was a cause for celebration. Dr Bob Klaber, Director of Strategy, Imperial College Healthcare NHS Trust (ICH), advised that ICH had worked closely with the Department for Health and Social Care and the New Hospitals Programme (NHP) team. There had been some issues raised in relation to capacity as most hospitals were currently often running at capacity. It wasn't possible to talk about demand and capacity without talking about need and it was important that new hospitals were built at the right size to meet the need. To this end, the Greater London Authority (GLA) figures and predictions for future size had been used to ensure that new hospitals met future needs. These had been the same figures used by local authorities for planning (rather than using Office for National Statistics data). Dr Klaber suggested that needs had to be addressed to be able to tackle the inequalities that existed in NWL. The Government had recently made an announcement about the NHP which had been positive for Hillingdon. However, there was still lots of work to be done in relation to the rebuild of St Mary's Hospital major trauma centre as one ward had already been closed and the longer timescales made it difficult to run the hospital effectively. Charing Cross and Hammersmith had been combined as one scheme with the associated funding pushed back beyond 2030 but this was likely to be a phased rebuild which would make funding a little easier.

Insofar at St Mary's Hospital was concerned, concern was expressed about the impact that no action would have on inner London. Dr Klaber noted that if the hospital was not rebuilt, it increased the risk of catastrophic failure. A 24 bed ward had already been temporarily closed so funding needed to be brought forward from 2030. It was anticipated that there would be slippage on other schemes that had been included in the Programme so St Mary's just needed to continue to work in partnership and be ready to take advantage of any opportunity that arose from this.

Dr Klaber noted that ICH undertook more research than other Trusts but needed to take a new approach to funding. As such, consideration was being given to the possibility of securing part of the funding for the project from the Government and raising the remainder from land sales. Previously, consideration had only been given to full public funding but there was now a willingness and openness to working through alternative ways of funding the project to get the best outcome for local residents. It would be important to not just focus on the exciting things that were going to happen (but which were still a few years away from realisation) and instead look at changing the models of care to improve the service.

Same Day Emergency Care (SDEC) had been developed as care that had previously taken three days could now be done at home with remote monitoring. This type of good work had started to happen now at scale. However, it was noted that multi morbidity was also starting to become more of an issue. As individuals now had more complicated health issues than they had had fifteen years ago, it was critical that this was dealt with urgently. Resources such as community mental health services and technology could be used to reach out in a helpful way.

Mr Hurd advised that vertical and horizontal integration was needed and that Hillingdon Health and Care Partners had been leading the way on this by bringing partners together and working jointly with the local authority. Work needed to be undertaken across the acute sector and should not be to the detriment of any of the partners. The ICS model looked to procure pathways and standardise services to secure the best deals. It was agreed that further information on vertical and horizontal integration would be provided at a future meeting.

Concern was expressed in relation to acute beds regularly being at 100% capacity rather than at the 92% target and it was queried how the ICS planned to reduce the total beds used and free up capacity without exacerbating health inequalities. Mr Hurd advised that 92% bed occupancy was a target and that there would be variation throughout the year. The ICS strategy was not to increase the number of beds but to increase space in alternative appropriate care settings to create a sustainable position to achieve the 92% target during the winter peak period.

To increase ongoing resilience at particularly challenged hospital sites, NHS England had released £26m of capital funding for new wards in NWL. Mr Hurd advised that some of this winter pressures funding had been used in February to provide extra bed capacity at Northwick Park Hospital to be used when necessary. Dr Klaber advised that partners were working together like never before and that the work was better done up front. As such, the commitment was to deliver care as close to home as possible.

Mr Hurd stated that a pilot in relation to London Ambulance Service waiting times had been initiated which had improved turn around times. He reiterated that increasing the number of beds would not be the answer to the increased demand and that new

	models of care were needed. Good progress had been made over the last year in relation the use of bed stock and it was anticipated that this would continue to improve. Mr Hurd advised that he would provide regular updates to Harrow. In terms of delayed discharge, Mr Hurd advised that Hillingdon had made good progress as a result of effective partnership working and the development of bridging services such as Discharge to Assess. Local work continued across NWL to understand the causes of delays to patient discharge so that a forensic approach to addressing these could be taken. Dr Klaber noted that it was all about relationships with local communities and that the NHS was not typically very good at this - the NHS would often talk about patient flow, discharge, etc, when it was residents that were at the heart of the matter. Concern was expressed about the risk assessments in relation proposals such as undertaking planned treatments, that would previously have included an overnight stay, as day cases. Dr Klaber advised that each case would be determined on its own merits and in consultation with the patient and their family. Concern was expressed that there had been some issues at Hammersmith Hospital which had not yet been resolved and which could result in a reduction in capacity. Dr Klaber advised that relationships were critical in dealing with big population-based issues and that Member insights were appreciated as they helped the NHS to work smarter. The situation was challenging as the hospital was still delivering high quality care but could not continue as it was. Over the next few years, NWL ICS was going to need to work closely with the voluntary sector, local authorities and other partners to achieve improvement to service delivery. It would also be important to get the Hillingdon Hospital redevelopment completed. **RESOLVED: That:** **1. further information on vertical and horizontal integration be provided at a future meeting;** **2. Mr Hurd provide regular updates to Harrow in relation to the achievement of the 92% bed capacity target at Northwick Park Hospital;** **3. the Committee be provided with an update on the progress of the implementation of the NWL ICS strategy for the provision of acute beds; and** **4. the discussion be noted.**
7.	**STANDARDISATION OF ADULT & PAEDIATRIC OPHTHALMOLOGY SERVICES ACROSS NORTH WEST LONDON - UPDATE FOR JHOSC** *(Agenda Item 7)* Mr Rob Hurd, Chief Executive at North West London Integrated Care System (NWL ICS), advised that the current practice for the provision of adult and paediatric ophthalmology services across NWL was currently confusing so needed to be standardised to make it easier for local residents and communities to navigate. The service also needed to be aligned with the new procurement process that had been put in place. A programme of engagement had already been put in place but the Committee's feedback on monitoring and engagement would be welcomed. It was noted that paediatric ophthalmology would move immediately into acute hospitals which would provide patients with choice as to which hospital they preferred. During the procurement process, there would be a need to push the standardisation of services and new models of care.

Members queried how the proposed changes would help in the short and long term. Dr Bob Klaber, Director of Strategy, Imperial College Healthcare NHS Trust (ICH), advised that the reopening of the Western Eye Hospital (WEH) had been very helpful and important in giving the staff a real boost. The WEH emergency service had been responsive to urgent issues but there were vertical integration issues in that it was not possible to have paediatric ophthalmologists at every hospital. As such, this needed to be linked across to specialist expertise and then back across to the paediatricians.

With regard to ensuring quality of care at the patient's first point of contact, Mr Hurd stated that standardisation of care was important. Clear and measurable pathway milestones needed to be put in place and expectations needed to be managed by providing criteria about what would be done and the standardisation of onward referrals, etc. As this standardised approach was currently not in place, there appeared to be a lack of clarity between GPs and ophthalmologists.

Ms Sarah Bellman, Deputy Director of Communications and Engagement at NWL ICS, advised that the survey questions had asked which NWL borough the respondent lived in and had listed all eight boroughs (i.e., there had been no 'Other' option available). As there were some respondents that had not responded to that particular question, they were classed as 'Other'. There were some boroughs that had not been identified by respondents as their place of residence.

Fourteen face-to-face engagement events had been held covering every NWL borough and there had been 101 respondents to the online survey. As no respondents had identified themselves as being from Hammersmith and Fulham, further work had been undertaken in that area. Analysis of the borough and its demographics had been undertaken so that targeted work could then take place. Ms Bellman advised that she would share this work with the Committee and noted that there was always more that could be done.

Ms Bellman stated that there would be different phases of engagement which would respond to the service design that was happening and feed into the procurement process. Consideration was now being given to where more in depth engagement needed to take place.

Mr Rob Hurd noted that artificial intelligence (AI) was a huge area and that standardisation would be helpful for a research and innovation programme. Much could be learnt from AI and algorithms.

It was noted that a lot of work had been undertaken in the community and it was therefore queried what best practice could be replicated in NWL. Mr Hurd advised that best practice had been built into the model so that it was Right First Time (RFT). It was important to improve locally based on national and international experience. The new RFT model had been informed by work undertaken elsewhere and would be monitored through standardised pathways and measurements as part of the contract management process through the acute programme of care.

Members queried the NWL performance against national benchmarks and requested more information in relation to health inequalities. Mr Hurd confirmed that NWL had been benchmarked nationally and that he would provide the Committee with baseline data on the current performance. He was unsure how far the data could be broken down in terms of London and regions but would provide whatever he had. Currently, performance was not at a good standard so, although the model would form part of the

	answer to address health inequalities, the ICS would need to reach out to communities. In terms of exactly how bad the situation was, Mr Hurd advised that he would need a quantified assessment of adult and paediatric ophthalmology services. Ms Bellman noted that people were unaware of what support was available to them, especially given the cost of living pressures, so the availability of support needed to be promoted to those that could access it. In terms of next steps, the analysis had been undertaken and the team now needed to explore things further. A lot of preparatory work was underway and consideration needed to be given to what further engagement work was needed. Ms Bellman asked the Committee to let her know if there were any issues that they thought ought to be included in their discussions. Without the local authorities' communication teams, it would not have been possible to reach into the community as far as they had. **RESOLVED: That:** **1. Ms Bellman share the results of the targeted work that had been undertaken in Hammersmith and Fulham;** **2. Mr Hurd provide the Committee with baseline data on the current performance in NWL (broken down to NWL and London level if possible); and** **3. the discussion be noted.**
8.	**DEVELOPMENT OF MUSCULOSKELETAL SERVICES ACROSS NORTH WEST LONDON - UPDATE FOR JHOSC** *(Agenda Item 8)* Mr Joe Nguyen, SRO Musculoskeletal Services at North West London Integrated Care System (NWL ICS), advised that he had been working across the eight NWL boroughs to look at standardising musculoskeletal (MSK) services. Working over such a large area was deemed by some to be ambitious but the project was only in year one of a five-year programme. During this initial year, work had been undertaken to understand the variations in delivery and to look at the inequalities agenda. It was noted that around 30% of residents had MSK issues which resulted in the second highest levels of absence from work. Mr Nguyen advised that an MSK group made up of patients and clinicians had been running for about eight years. MSK services tended to be a bit of a checklist so consideration needed to be given to looking at what mattered to people with a personalisation agenda. Everyone had their own goals in relation to their condition and this needed to be addressed. Acute interventions also needed to be addressed, there needed to be alignment between spend and prevalence and support needed to be provided to help people return to work. Residents did not currently feel that they were being understood and waiting times varied significantly across the eight boroughs. The key changes that were being proposed were a common offer, a single point of access and staff development. As part of the engagement activity, Mr Nguyen was reaching into the community to establish why people were not accessing services. It was anticipated that, by 2025, 9.1m people would have a long term condition and that 3/10 of those aged 45+ would be MSK related. As such, Members queried whether the proposed changes would be future proof. Mr Hurd recognised that this was a fundamental demographic timebomb so needed to be links between an elective orthopaedic centre and a standardised approach to MSK. As there was not an infinite pot of money or unlimited staff, future proofed change would need to be achieved

through better working. Mr Nguyen advised that they had been working with the Primary Care Networks and other teams as they needed to set goals and develop a holistic model.

Members queried how better joined working could be encouraged between Hammersmith & Fulham and Bretford whilst also improving access. Mr Nguyen advised that the diagnostic offer was being reviewed as part of this process and it was important that clinics improved too. The timeliness of diagnostics was very important and would also be included.

It was queried how the service model would impact on service provision as, even though the Royal Borough of Kensington and Chelsea (RBKC) had been leading the way, residents were still having to wait 6-8 months for an appointment. Mr Nguyen noted that there had been lots of issues in RBKC in relation to waiting time discrepancies. Consideration was being given to complaints that had been received about the service as part of the process so Mr Nguyen would be happy to speak to Members about specific issues that they were aware of.

Members asked how the new service would improve the situation for the whole of NWL in the next 6-12 months. Mr Nguyen advised that five contracts would be expiring in the next few months which would provide a commissioning opportunity for the new service model to be introduced and get rid of some of the current variation in service provision. Mr Hurd advised that he would provide the Committee with baseline access information and detail of how it was proposed the situation be moved forward from there. It was agreed that this needed to be linked to access times for diagnostics.

Mr Nguyen stated that part of the work that was being undertaken was to develop partnerships with others and gain community support but that this was still being scoped out. He would find out if anticipatory pathways were being included for those that had functional disabilities.

Members queried what the report meant with regard to "de-transactionalising" when it stated "opportunity for productivity through 'de-transactionalising' MSK care in primary & community on on-ward referrals to acute care". Mr Nguyen advised that there were different ways to access MSK services and that effort was being made to streamline the pathway and have a single point of access. Mr Hurd advised that the phrase meant that there was a danger that all effort would be focussed on reducing waiting lists rather than focussing on clinical solutions and treatment.

It was recognised that language was a barrier to some people accessing services. Mr Nguyen advised that, during this first year of the five year journey, they were reaching out to these groups and would also be looking at lifestyle factors. Phase two of the project would include engagement work and consideration needed to be given to how this would work best for patients.

Ms Sarah Bellman, Deputy Director of Communications and Engagement at NWL ICS, advised that the engagement and implementation undertaken to date had not been representative of the entire population at this stage and that phase one had been built on elective orthopaedic, asking patients what they thought about MSK issues. Phase two would look at the detail and what needed to be explored further. The next stage would see the ICB going out to talk to those people who were not currently using the services about the community services that were available. Similarly to diabetes where a lot of work was undertaken to ensure lifestyle advice was relevant to different groups, a broader approach would be needed for MSK.

	RESOLVED: That: 1. **Mr Hurd provide the Committee with baseline access and diagnostics information and detail of how it was proposed the situation be moved forward from there;** 2. **Mr Nguyen establish whether anticipatory pathways were being included for those with functional disabilities; and** 3. **the discussion be noted.**
9.	**NORTH WEST LONDON JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE 2023-24 WORK PROGRAMME** *(Agenda Item 9)* The Chair noted that some Members of the Committee had already contacted him with suggestions for inclusion on the Committee's Work Programme. As this was a live document, Members were welcome to request additional items offline. **RESOLVED: That the 2023-24 Work Programme be noted.**
10.	**NORTH WEST LONDON JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE RECOMMENDATIONS TRACKER** *(Agenda Item 10)* Consideration was given to the Recommendations Tracker report. **RESOLVED: That the report be noted.**
11.	**ANY OTHER URGENT BUSINESS** *(Agenda Item 11)* The Chair noted that this would be Mr George Kockelbergh's last meeting as the primary scrutiny advisor for the North West London Joint Health Overview and Scrutiny Committee (NWL JHOSC). On behalf of the JHOSC, he thanked Mr Kockelbergh for the incredible support that he had provided him as well as the support he had provided local authority and NHS colleagues and wished him well in his new role. **RESOLVED: That the vote of thanks to Mr George Kockelbergh be noted.**
	The meeting, which commenced at 10.00 am, closed at 12.00 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.