NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Dominic O'Brien, Principal Scrutiny Officer

Friday 30th September 2022, 10:00 a.m.
Westbury Room, George Meehan House, 294 High Road, Wood Green, N22 8JZ

Direct line: 020 8489 5896
E-mail:dominic.obrien@haringey.gov.uk

Councillors: Philip Cohen and Anne Hutton (Barnet Council), Larraine Revah **(Vice-Chair)** and Kemi Atolagbe (Camden Council), Kate Anolue and Andy Milne (Enfield Council), Pippa Connor **(Chair)** and John Bevan (Haringey Council), Tricia Clarke **(Vice-Chair)** and Jilani Chowdhury (Islington Council).

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of Urgent Business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under item 11 below).

4. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

6. MINUTES (PAGES 1 - 12)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting held on 15th July 2022 as a correct record.

7. NCL ICS FINANCIAL REVIEW (PAGES 13 - 32)

To provide a finance update for NCL including the overall strategic direction of travel, 2022/23 figures for the NCL ICB and for NHS Trusts that provide services to NCL patients.

8. NCL WORKFORCE REPORT (PAGES 33 - 80)

To provide an update on workforce issues in NCL.

9. NHS 111 PROCUREMENT UPDATE (PAGES 81 - 116)

To provide an update on the procurement programme for a new NHS 111 Integrated Urgent Care service to commence in October 2023.

10. WORK PROGRAMME (PAGES 117 - 124)

This paper provides an outline of the 2022-23 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

11. NEW ITEMS OF URGENT BUSINESS

12. DATES OF FUTURE MEETINGS

- 25th November 2022 (10am)
- 3rd February 2023 (10am)
- 17th March 2023 (10am)

Dominic O'Brien, Principal Scrutiny Officer
Tel – 020 8489 5896
Email: dominic.obrien@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
River Park House, 225 High Road, Wood Green, N22 8HQ

Thursday, 22 September 2022

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Agenda Item 6

MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 15th JULY 2022, 10:00AM to 1:05PM

PRESENT:

Councillors: Pippa Connor (Chair), Kate Anolue, John Bevan, Philip Cohen, Anne Hutton, Andy Milne and Larraine Revah.

1. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

2. ELECTION OF CHAIR

Councillor Pippa Connor was nominated as Chair of the Committee. There were no other nominations.

RESOLVED – That Councillor Pippa Connor be elected as Chair of the North Central London Joint Health Overview and Scrutiny Committee for the municipal year 2022-23.

3. ELECTION OF VICE-CHAIR(S)

Councillors Larraine Revah and Tricia Clarke were nominated as Vice-Chairs of the Committee. There were no other nominations.

RESOLVED – That Councillors Larraine Revah and Tricia Clarke be elected as Vice-Chairs of the North Central London Joint Health Overview and Scrutiny Committee for the municipal year 2022-23.

4. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Jilani Chowdhury (Islington), and Cllr Tricia Clarke (Islington).

5. URGENT BUSINESS

None.

6. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

Cllr Kate Anolue declared an interest by virtue of her membership of the Royal College of Midwives.

7. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

8. MINUTES

The minutes of the previous meeting of the Committee were approved.

RESOLVED – That the minutes of the meeting held on Friday 18th March 2022 be approved.

9. START WELL PROGRAMME

Anna Stewart, Programme Director for the Start Well programme, introduced the report for the item on Start Well, which was a long-term change programme focusing on children & young people's and maternity & neonatal services in a hospital context across North Central London. This covered hospital services at the North Middlesex, UCLH, Royal Free, Barnet, Chase Farm and Whittington Health as well as pathways with specialist providers such as Great Ormond Street. The project had started in November 2021 and the first phase had been looking at how services worked at the moment, how they compared to best practice and international standards, and identifying opportunities for improvement. This phase had now been completed with the Case for Change findings published.

Dr Emma Whicher, Medical Director for North Middlesex University Hospital and SRO (Senior Responsible Owner) for the Start Well programme, provided further detail to the Committee about the themes that had been identified. She said that there were good examples of outstanding care provided to children & young people and pregnant women but opportunities for improvement were found. These included:

- Health inequalities with variations in stillbirth rates between boroughs and the babies of black women twice as likely to be admitted to a neonatal unit after birth compared to those of white women.
- The sustainability of staffing was recognised as a challenge with agency staff being used to fill shifts in many instances. In neonatal services there was a

need to match care capacity with demand and the provision of community support was variable between boroughs.

- With regards to children and young people's services there had been an increase in the number of children presenting to A&E with minor/moderate health issues suggesting that these could be dealt with in alternative settings. Children and young people with long-term health conditions who lived in the most deprived areas were more likely to be admitted to hospital. Pathways for children waiting for treatment was variable between and within hospitals depending on the skills of the surgeons.

Chloe Morales Oyarce, Head of Communications and Engagement for NCL ICB, spoke about the engagement process outlining a 10-week period of consultation running from 4th July to 9th September which would seek views from staff, patients, stakeholders and the public about the Case for Change findings. The patient and public engagement process had been developed with partners including Councils and the voluntary and community sector. This would include online discussion events, interactive workshops, a questionnaire, drop-in events and specialist engagement with children and young people. A report would subsequently be published on the feedback received and this would be used to inform the next stages of the programme.

Angie Belanor, Head of Maternity & Neo-natal Commissioning for NCL ICB, reported that a piece of work was ongoing to improve midwifery workforce issues including by looking at ways of attracting staff and supporting staff health and wellbeing to improve retention and reduce sickness rates.

Anna Stewart and her colleagues then responded to questions from Committee Members:

- Asked by Cllr Connor about the questions that would be asked to residents, Anna Stewart explained that the engagement would be split into two areas. Firstly, there would be an opportunity to reflect on the findings from the Case for Change and then, secondly, asking about what mattered to the people using services. It was important to check and reflect that the work that had been done in the first phase matched with the staff and patient experience. This feedback would all be brought together in September to develop a view on what good models of care looked like. Specific factors may, for example, include individual hospital footprints and recruitment challenges.
- Cllr Cohen commented on the waiting times noting that, according to the report, 4,300 children and young people were currently waiting for treatment at NCL sites and that 330 had been waiting for over a year. Dr Emma Whicher explained that a backlog had built up during the Covid pandemic, particularly in dental and ENT procedures for children due to the strict requirements on infection control. Now that these requirements had been loosened, work was

ongoing to reduce this backlog. There was a well-established process in acute hospitals of reviewing children on waiting lists for any risk of harm. Cllr Connor commented that the waiting list numbers were shocking and suggested that a breakdown of the types of cases should be provided. **(ACTION)**

- Cllr Hutton commented that those presenting at A&E were likely to be those least engaged with health services and that the local voluntary and community sector may have a role to play in improving engagement. Cllr Revah asked about typical waiting times at A&E. Anna Stewart said that this issue had been considered as part of the programme with workshops held over the summer. She added that there was found to be a link between A&E attendance and deprivation but further exploration and engagement on this issue, including understanding on what engages people to attend, was needed in the next stages of the programme.
- Asked by Cllr Revah about the definition of age ranges for children's services and adults services, Anna Stewart said that different hospitals had different age cut-offs for transitions between services, ranging from 17 to 19. The Case for Change report acknowledged this issue and suggested that there was an opportunity for thinking more consistently on this across the NCL area.
- Cllr Revah and Cllr Anolue asked about support for new mothers to prevent isolation such as home visits, particularly in BAME communities. Cllr Milne expressed concerns about the statistic in the report that black women were twice as likely to be admitted to a neonatal unit after birth compared to those of white women. Angie Belanor said that across the country there was an emphasis on continuity of care models which improve outcomes and so it was important to ensure that this was offered in a structured way locally and that it was delivered in communities where outcomes were in particular need of improvement. Enhanced visiting was available for parents of babies that had been admitted to neo-natal units. This was also linked in with a national piece of equalities work which was looking at the experiences of staff and outcomes for patients from BAME backgrounds.
- Asked by Cllr Anolue what measures were in place to encourage recruitment into midwifery, Angie Belanor commented that national funding had recently been made available for improvements to maternity services including to support staff recruitment and retention and improve care. Support was also being provided through maternal medicine networks and a structured development programme for newly recruited staff.
- Cllr Bevan asked about measures to engage young people in the consultation process. Chloe Morales Oyarce explained that they had been using different measures with partners to do this including focus groups with children in care organised through a voluntary organisation, contact with condition-specific groups through NHS Trusts, and consultation with schools, children's centres and voluntary & community groups.

Cllr Connor suggested that details on the number of people from BAME backgrounds who were engaged over the Start Well consultation should be made available along with when their views on these topics were. **(ACTION)**

The Committee proposed recommendations based on the discussion as follows:

- **A breakdown of the types of cases of the 4,300 children & young people on the waiting list for treatment should be provided.**
- **On retention of the workforce, an understanding from staff of the key reasons that would cause them to consider leaving their job should be sought.**
- **An issue was raised about the acknowledgement in the report that the Royal Free did not have a high level of neonatal care provision and so the future of the unit was being considered. The concern expressed was that patients might not feel confident in giving birth at the Royal Free if there was no neonatal unit available should something go wrong so this issue should therefore be considered as part of the Start Well process. A similar concern was raised about the comment in the report that *"the maternity and neonatal estate at the Whittington Hospital does not meet agreed modern standards".* (ACTION)**

It was agreed that a further update on the Start Well process could brought to the JHOSC at a later date and that the timing of this would need to be agreed as part of the Panel's work planning process. **(ACTION)**

10. QUALITY MONITORING IN NCL PRIMARY CARE SERVICES

Vanessa Piper, Assistant Director of Primary Care Contracts and Commissioning for NCL, provided an overview on quality and performance monitoring of GP practices. The NCL Integrated Care Board (ICB) had responsibility for monitoring the contracts of 180 GP practices in the NCL area in line with national primary care regulations and policy guidance produced by NHS England.

Vanessa Piper explained that there were clear processes in place for any quality or performance issues that were identified and the ICB's Primary Care Contracts team and Quality team worked together to respond to any trigger indicating quality concerns or underperformance. This could include from a patient complaint, infection control issue or an adverse rating from the CQC. While CQC reports were carefully scrutinised, any ICB investigation was carried out independently from the CQC and examined a range of quality data over three or four financial years. They would also then speak to the Practice about any specific concerns or challenges that they may be facing. The ICB Primary Care Contracts team meets with the CQC and the NHS England Medical Directorate on a fortnightly basis to discuss cases and share relevant

information. Recommendations are then taken to the Primary Care Contracts Committee which meets on a bi-monthly basis and is attended by HealthWatch, local councillors and community representatives. The recommendations can include improvement action plans for individual practices or more formal contractual action.

Vanessa Piper then addressed concerns that had previously been raised by the Committee relating to reporting by the BBC Panorama programme about physician associates and the GP/patient ratio at a London GP practice. Although this practice was not in the NCL area, the ICB had started to scrutinise GP FTE workforce ratios in NCL. The current figures indicated that the ratio was too low in some practices, but it was also the case that a number of practices had not recently logged onto the National Workforce Reporting System meaning that the data was not accurate in some cases. The primary care team was therefore working with practices to improve reporting. They would also work closely with practices over the supervision and training of physician associates through the core primary care contract. In addition, the CQC looked at employment and training records through its regulatory inspections.

Vanessa Piper then responded to questions from the Committee:

- Cllr Connor referred to the concerns about the GP practice in south London that was covered by the BBC Panorama programme and asked how the monitoring practices in the NCL area would prevent a similar issue from occurring. Vanessa Piper noted that the detail of the GP practice would not be known until the CQC report was published. She added that, while ICBs had monitoring processes in place, some practices could get into a pressured position which could lead to quality and performance concerns. On top of the process described in the report there was also an annual contract review process on all primary care contracts which included questions on clinical governance and issues of protocol that practices should have in place.
- Cllr Bevan asked whether the monitoring process checked whether practices had patient participation groups established and whether these were effective. Vanessa Piper said that the ICB would survey the groups if there were any contractual changes. In addition, if there were any specific concerns triggered with a practice, the ICB would review how effectively the practice was engaging with its patient population.
- Cllr Bevan described a GP practice on Tottenham High Road which was covered in graffiti and asked whether issues such as the condition of the buildings used were included in the monitoring process. Vanessa Piper explained that an Estates Strategy was produced for the NCL area and each borough. The ICB had recently commissioned an audit of primary care estates which would consider the condition of buildings as well as issues such as infection control. There was also an NCL Estates team which looked at the condition of premises and at what additional primary care capacity was required.
- Asked by Cllr Cohen for details on the number of occasions when concerns about practices had been raised and how information about specific concerns was reported to the public, Vanessa Piper said that information was available

through the Primary Care Commissioning Committee's dashboard which included performance data, including CQC ratings, for the 180 GP practices in the NCL area. The Committee had also recently committed to provide a summary including detail of the concerns relating to a specific practice and of what action was being taken as a result. This information would be provided to the public part of the Committee's meeting and would therefore be published on the ICB's website.

- Asked by Cllr Revah how patients know where and how to complain, Vanessa Piper explained that all practices should operate a complaints procedure. Alternatively, patients could go to the NHS England complaints team or the ICB's complaints team who could ask the practice to respond to the complaint.
- Cllr Connor noted the previous comments that a number of practices had not recently logged onto the National Workforce Reporting System meaning that data on the GP FTE workforce ratio was not always accurate. She asked what assurances could be given that this would be enforced in future. Vanessa Piper suggested that further guidance on this could be provided to practices in future including clarity on the roles of the workforce and of supervision and training for staff. There was some existing guidance under the Primary Care Network directives which could be shared with practices.

The Committee then proposed recommendations based on the information that they had heard:

- **The Committee recommended that the reporting from GP practices on the GP FTE workforce ratio onto the National Workforce Reporting System should be a requirement that was enforced.**
- **While Members of the Committee welcomed the publication of concerns relating to a specific practice on the ICB website, they felt that most patients would not necessarily know where to find this information. The Committee recommended that there should be greater clarity on how this information would be communicated to patients and suggested that this could include a link to the relevant information on the website of the GP practice concerned. (ACTION)**

11. ENHANCED ACCESS TO GENERAL PRACTICE

Clare Henderson, Director of Integration in Islington at the NCL ICB, introduced the report for this item by explaining the changes that would result from the proposals on enhanced access to General Practice from October. This related to access to services outside of the core hours which were 8:00am to 6:30pm on Mondays to Fridays. At present, the enhanced access hours were offered at 'hubs' from 6:30pm to 8:00pm on Mondays to Fridays and 8:00am to 8:00pm at weekends or bank holidays. This was part of a national specification and the services were generally provided in the NCL area through GP Federations or other primary care providers. Some GP practices also offered 'extended hours' which involved longer opening hours funded through a contract.

The new proposals involved bringing these two types of services outside of the core hours into one single specification delivered through Primary Care Networks (PCNs). The timescales for implementation had been tight with the national specification released in March 2022, draft plans to be developed by PCNs by the end of July and the delivery of the new service by the beginning of October 2022. The new national specification required the additional opening hours from 6:30pm to 8:00pm on Mondays to Fridays but only from 9:00am to 5:00pm on Saturdays with no requirement for services on Sundays or Bank Holidays. There was also no longer a requirement for ring-fenced slots for NHS 111 to book into.

In the NCL area there had therefore been engagement with PCNs with a view to commissioning services on Sundays and Bank Holidays so as not to lose the 7-day access. Engagement had been based on existing patient feedback and from HealthWatch and partners in the voluntary and community sector. A survey had also been developed to support PCN engagement. However, due to the timescales, it had not been a long engagement process and the scope had been limited. An Equality Impact Assessment had been developed and, while it was expected that there would be additional capacity overall, it was also recognised that there was a high level of demand on services at present.

Clare Henderson then responded to questions from the Committee and was joined by John McGrath, a GP in Islington and interim Clinical Lead on the ICB:

- Referred to the proposals to buy provision of services in the NCL area from outside of the hours required by the national recommendations, Cllr Connor queried whether this would involve new providers and, if so, how the service provision would be monitored. Clare Henderson clarified that the new national specification required broadly the same number of appointments but in a shorter timescale within the week. Therefore, by buying the Sundays and Bank Holidays services within the NCL area, there would be no loss of capacity. The arrangements would be for PCNs to ensure the delivery of services and some would work with the same GP Federations that provided the existing services.
- Cllr Connor expressed concerns that, if new providers for enhanced access could not be found, then there could be a risk of A&E departments becoming overwhelmed as patients sought treatment there when they could not access GPs. Clare Henderson explained that from October to March the existing providers were being asked if they could provide a bridging service during this phase to ensure that urgent same day services remained available.
- Cllr Cohen asked about the approach to making a range of specialist services, such as physiotherapists or pharmacists, more widely available in order to reduce the need for patients to see their GP. Clare Henderson said that practice-based pharmacists had been well established in recent years and, while patients may not necessarily ask to see a pharmacist when ringing the practice, the triage system should direct them towards this where appropriate. There was an intention to expand this approach to other types of services including physiotherapists.

- Cllr Revah queried how patients would know that they could obtain GP appointments via the NHS 111 service. Clare Henderson clarified that patients would not need to know this as they could not simply ring NHS 111 and ask for an appointment, but the triage system would allow for a booking to be made if the described symptoms made this the most appropriate option.
- Asked by Cllr Revah about the shift towards phone or online appointments, Clare Henderson said that while these options were now more widely available, all practices would still offer face-to-face appointments if clinically needed.
- Cllr Bevan expressed doubts about the need to provide services on Sundays and Bank Holidays given the cost implications of doing so and suggested that it would be better to stick to the national specification. Cllr Cohen also asked about the cost implications. John McGrath observed that the frustration about this policy in London was that there were already services available outside of the core hours but that this was an enforced change. He welcomed the comments opposing Sunday and Bank Holiday service hours as it needed to be acknowledged that the service was in real peril due to a workforce crisis and financial difficulties. Overall, the focus of the national specification on service provision on Saturdays from 9:00am to 5:00pm prioritised continuity of care rather than same day access, which he considered to be a good thing while acknowledging the balance that needed to be struck. He also acknowledged that there were cost pressures associated with this change but did not have specific figures available. Cllr Revah requested that further information be provided to the Committee on the financial implications of the changes. **(ACTION)**
- Cllr Hutton emphasised the importance of communicating to the public about the services that were available to them, including Urgent Care Centres. John McGrath acknowledged that there was also a real challenge concerning public knowledge about the variety of services that were available and that this would need to be addressed by social care, Council and voluntary sector colleagues as well as the NHS. He added that the public may not notice the changes to enhanced access to GP practices very much at all as the aim was to ensure that services outside of core hours would continue.
- Cllr Bevan asked whether any national publicity was planned to promote public awareness of these services. John McGrath said that he was not aware of any planned national publicity but that local areas were being provided with resources/capability to do this and that NHS 111 was increasingly being recognised as an entry point to services.

Cllr Connor observed that when patients called GP practices but no appointments were available, they were not then typically signposted to the hub services and this therefore kept the pressure within the practice.

The Committee recommended that the availability of hub services, or any other appropriate services, should be more clearly communicated by GP practices at this stage. This should include wider dissemination of information about

alternative service provision to the GP practice staff that deal with patient appointments.

The Committee also recommended that, with regards to the proposed bridging service running from October to March, the number of patients likely to use this service should be carefully considered. If these figures were low then it would not necessarily represent an efficient use of resources and so patients could otherwise be treated by different services. (ACTION)

12. FERTILITY POLICY REVIEW

John McGrath introduced the report on this item, noting that this provided an update on previous reports that had been brought to the Committee on this policy review. He informed the Committee that the new policy was now expected to go live in the NCL area from 25th July 2022. The aim of the approach was to introduce a single fertility policy across the NCL area, thereby removing the postcode lottery variation that previously existed. This related to eligibility of funding for IUI treatments as well as IVF, including for same sex couples and single women, and also on extended fertility preservation issues. A Readers Panel had been involved with the development of the policy document to improve inclusivity of the language used.

Penny Mitchell, Director for Population Health Commissioning at NCL ICB, highlighted some key points around the implementation of the policy. A principle of no disbenefit was being applied to people who were already part-way through their treatment so that if the previous policy was more favourable to them then this would still be applied. A full communications engagement plan had been developed to support the implementation of the policy including with a range of core materials, easy read documents, translation information, a response feedback document, FAQs on the NCL ICB website and updates to GP practice websites. A surge of inquiries was anticipated by the team and a dedicated email address had been made available for this.

Cllr Connor welcomed the update and commented that she had been impressed by the work that had gone into this policy and how robust the engagement process had been. She noted that the Committee had not seen the leaflets but emphasised the importance of them being clear and accessible and asked for further detail about the availability of translations. Penny Mitchell clarified that text on the back of the leaflets was provided in six or seven languages to explain that full translations could be made available upon request and how to get in contact by email. This was in line with NCL ICB policy. Cllr Hutton suggested that the provision of a telephone number as well as an email address could be helpful.

Cllr Anolue highlighted the translation services provided by LanguageLine. John McGrath agreed that LanguageLine provided valuable tools in this area. He added that the review had highlighted how sensitive this issue was for some communities and that printed material was not the only or necessarily the best way of engaging. Other methods of engagement, such as through community meetings, was included

as part of the communications plan. There also needed to be a nuanced difference with this policy compared to some other areas of health policy due to the specific target demographic.

Cllr Connor suggested that a further update on the implementation of the policy and the demographic data on who had successfully accessed the services could be brought back to the Committee at a later date. Penny Mitchell commented that thought was being given to how to collect the relevant data but made the Committee aware that there were numerous challenges in doing so. Cllr Cohen suggested that it would be useful to be able to see the data broken down by Borough area. John McGrath clarified that the likely timescale to bring an update back to the Committee was approximately 18 months and this was agreed by the Committee. **(ACTION)**

13. WORK PROGRAMME

Cllr Connor summarised the work programme for the Committee noting that the next meeting on 30th September would include a detailed finance update and a workforce update. The meeting on 25th November was due to receive an update on the Estates Strategy and there was currently space for additional agenda items. No agenda items had yet been scheduled for the 3rd February 2023 and 17th March 2023 meetings. Dominic O'Brien, Scrutiny Officer, added that the previous meeting held on 18th March 2022 had included items on the Mental Health Services Review and the Community Health Services Review and that updates on these issues would need to be scheduled in the 2022/23 work programme.

Committee Members then discussed possible issues that could potentially be added to the 2022/23 work programme including:

- Ambulance waiting times and pressures across the system including A&E Departments. (Cllr Revah)
- Pediatric service review. (Cllr Revah)
- Primary care commissioning and the monitoring of private corporations operating in this area. (Cllr Revah)
- The efficacy of online GP consultations, how the disconnect between the public and the medical profession could be addressed, how the public could be reassured that outcomes would be equally as high as face-to-face consultations and how capacity can be improved in this way. (Cllr Milne)
- Health inequalities and the impact of cuts to public health budgets. (Cllr Cohen) Health inequalities could also be scrutinised as part of Mental Health Services Review and the Community Health Services Review. (Cllrs Connor/Hutton/Cohen)
- Increases in number of people being charged for services that they were previously able to access free of charge through the NHS (e.g. dentistry/ear wax syringing) (Cllr Revah)
- Update on funding for NHS dentistry for both adults and children. (Cllr Connor)

14. DATES OF FUTURE MEETINGS

- 25th November 2022 (10am)
- 3rd February 2023 (10am)
- 17th March 2023 (10am)

CHAIR:

Signed by Chair ……..

Date ……

North Central London Integrated Care System

NCL ICS Financial Review

JHOSC meeting 30th Sept 2022

16th September 2022

Agenda Item 7

Summary of main points

North Central London Integrated Care System

1. ICBs have a duty to lead collaborative working across the ICS. ICSs are local health and care and local councils to work in joined-up ways. ICBs are responsible for allocating NHS budget and commissioning services.
2. NCL is a complex health and care economy with 10 major providers with a combined income of around £5bn, two NWL providers running two boroughs' community services, five local authorities and 33 primary care networks.
3. The NCL system has been working collaboratively on financial issues for a number of years and can point to a number of successes.
4. There are arrangements in place to support financial governance in the ICS.
5. We have agreed the following top priorities for NCL's financial strategy, underpinned by principles for how we will work together.
6. The NCL NHS providers receive income from a number of sources. The system is a net importer of activity and this is clear from the size of the provider income (£5.3bn) compared to the NCL ICB budget for its population of £3.2bn.
7. NCL is a complex health economy with a variety of types and sizes of providers.
8. The strategy for the ICB is to spend a greater proportion of the budget on pro-active and preventative and out of hospital services in order to require less hospital provision.
9. There have been a number of changes to the NHS financial regime in response to the pandemic which has supported the local financial position. However, as we come out of this period we face many financial challenges.
10. In 21/22 NCL delivered a large surplus due to a number of highly unusual issues. The ICS worked together to submit a balanced plan for 22/23, however it contains a large level of financial risk.
11. In order to support sustainability with more pro-active, preventative and out of hospital care we are planning to increase investment in population health management, projects to address health inequalities, community services and mental health.
12. Next steps include the forecasting and management of 22/23, planning for 23/24 and beyond, distributing the ICS capital funding for 23/24-24/25 and the refresh of the ICS Financial Strategy.

ICBs & ICSs

North Central London Integrated Care System

ICSs are local health and care and local councils to work in joined-up ways. ICBs are responsible for allocating NHS budget and commissioning services.

ICS

- North Central London is made up of five boroughs – Barnet, Camden, Enfield, Haringey and Islington, with around 1.6 million residents living here.
- North Central London Integrated Care System (NCL ICS) brings together local health and care organisations and local councils to work in joined-up ways to improve health outcomes for residents and tackle inequalities that currently exist.

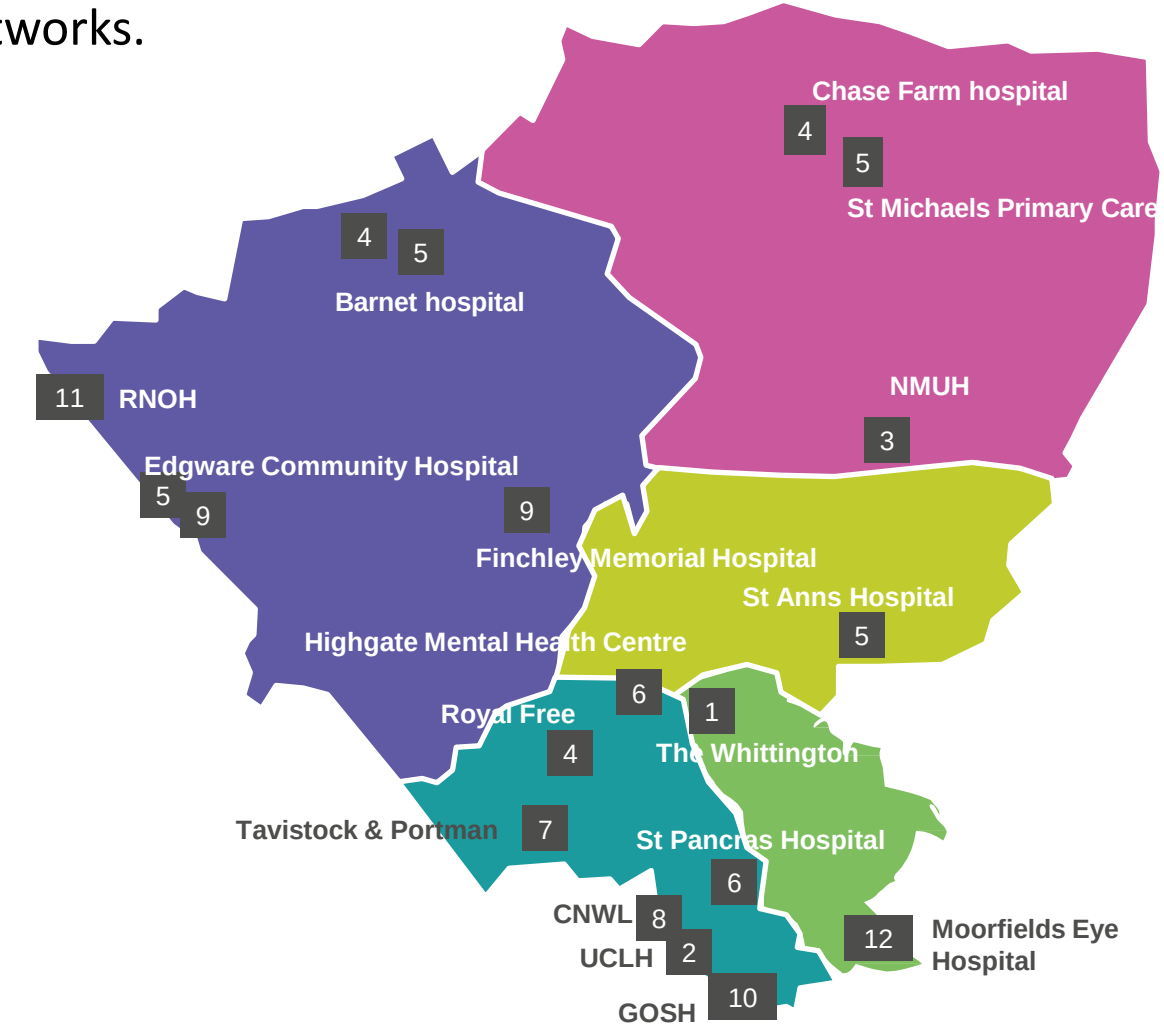
ICB

- The NHS North Central London Integrated Care Board (ICB) is responsible for allocating NHS budget and commissions services. ICBs are a key change in the Health and Care Bill, and have replaced Clinical Commissioning Groups. These changes came into effect on 1 July 2022.
- Integrated Care Boards are a statutory NHS organisations responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.
- NCL ICB will build on existing commitments, programmes and ambitions. The principles informing the work of the ICB are:
    - **Taking a population health approach:** We need to continue to develop the way we plan services to take into account the needs of people and communities, acknowledging the wider determinants of health. This will support tackling health inequalities across and within the communities we serve.
    - **Evolving how we work with communities:** Embedding co-design with partners and communities in planning and designing services, and developing systematic approaches to communications and community engagement.
    - **Continued focus on boroughs:** Partnership working within boroughs is essential to enable the integration of health and care and to ensure provision of joined up, efficient and accessible services for residents.
    - **Learning as a system:** We have learnt a lot as a system throughout both our response to COVID-19 and our efforts to recover. Capturing this learning across primary care, social care, community, mental health and hospital services will guide our next steps for both individual services and system approaches.
    - **Acting as a system to deliver a sustainable health and care system:** Providing high quality services enabled by workforce, finance strategy, estates, digital and data.

The NCL Integrated Care System

North Central London Integrated Care System

NCL is a complex health and care economy with 10 major providers with a combined income of around £5bn, two NWL providers running two boroughs' community services, five local authorities and 33 primary care networks.



NHS Providers

1. Whittington Health NHS Trust
2. University College London Hospitals NHS Foundation Trust (UCLH)
3. North Middlesex University Hospital NHS Trust (NMUH)
4. The Royal Free London NHS Foundation Trust
5. Barnet, Enfield and Haringey Mental Health NHS Trust
6. Camden and Islington NHS Foundation Trust
7. Tavistock and Portman NHS Foundation Trust
8. Central and North West London NHS Foundation Trust (CNWL)
9. Central London Community Healthcare NHS Trust (CLCH)
10. Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
11. Royal National Orthopaedic Hospital (RNOH)
12. Moorfields Eye Hospital NHS Foundation Trust

Finance System working

North Central London Integrated Care System

The NCL system has been working collaboratively on financial issues for a number of years and can point to a number of successes, including:

- Clear financial principles agreed by all Boards, including viewing every financial decision from a system (not organisation) perspective.
- Successful agreement of deployment of Covid funding throughout 2021/22 and into 2022/23.
- Agreed approach to 2022/23 contracts.
- Community services and mental health reviews have been undertaken.
- CFO group, chaired by ICS finance lead, in place fortnightly and making decisions on behalf of the system.
- System Management Board, chaired by CEO designate, meet fortnightly.
- System capital allocation process agreed 20/21 to 22/23.
- Health inequalities fund in place in 2021/22 for most deprived wards and boroughs and 2022/23.
- North London shared service set up, initially focussed on shared recruitment across NCL.
- Orthopaedic hubs established with increasing productivity, and new surgical and bed capacity open.
- Investment of funding into wider system to support elective recovery.
- UCL health alliance of all providers (including primary care) established with chair/CEO in post.

With the establishment of the ICB, the arrangements in place to support the financial governance in the ICS include:

- ICB Board and Finance Committee.
- System management Board meets monthly on system Financial Recovery.
- Continuation of ICS CFO group.
- Establishment of system financial recovery groups.
- Dedicated finance staff supporting the system financial strategy, transformation projects, planning and monitoring.

Overall financial strategy and vision

North Central London Integrated Care System

We have agreed the following top priorities for NCL's financial strategy, underpinned by principles for how we will work together.

1. We are focussed on improving the health of the population in North Central London within our available resources
2. We will address health inequalities across the sector and within our boroughs as a priority
3. We will maximise what we do locally in North Central London

The way we work

- We will focus on the benefit to the system, not on the impact to the individual organisation
- We will ensure no individual organisation loses out for doing something in the benefit of the wider system
- Strong clinical and operational engagement in everything we do
- Close working with primary care and with local authority partners
- Shared acknowledgement that system working will be required to address the challenges we face
- We will be open and transparent with each other, sharing data and financial information
- We will implement joint planning and more standardised processes across the system
- We will hold each other individually and jointly accountable for system sustainability
- We will focus on reducing the cost of service delivery, not income generation

NCL Provider Funding Profile (22/23)

North Central London Integrated Care System

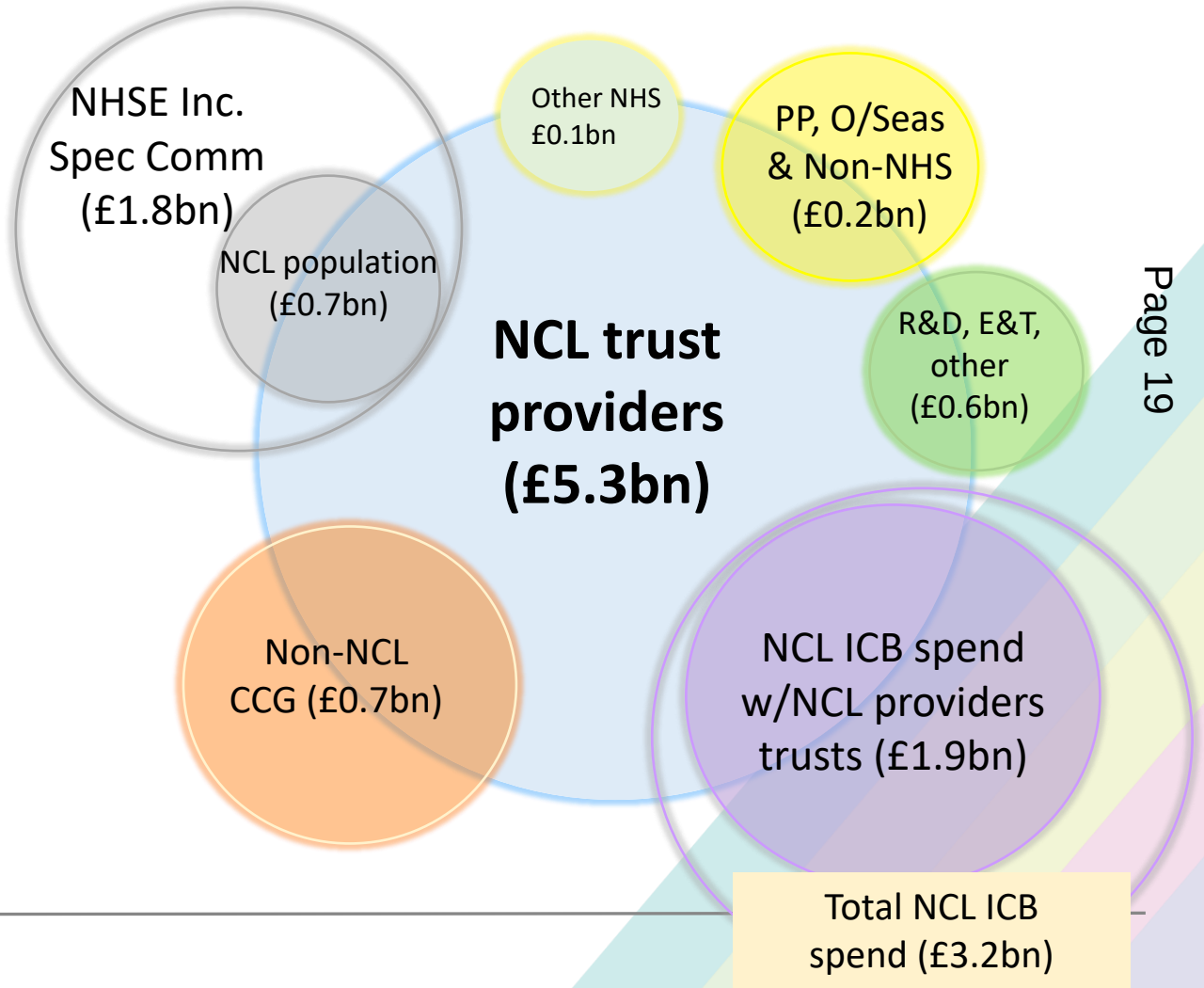
The NCL NHS providers receive income from a number of sources. The system is a net importer of activity and this is clear from the size of the provider income (£5.3bn) compared to the NCL ICB budget for its population of £3.2bn.

The total planned income for the 10 NCL trust providers is c£5.3bn.

Of this broadly c£2.6m is spent on NCL patients with c£1.9bn is received from NCL ICB (for services formerly commissioned by NCL CCG) and c£0.7bn from NHSE for Specialist services.

The balance is for treating non-NCL patients (c£1.8bn) and other patient care (c£0.3bn) and non-patient care income (c£0.6bn).

There is a more detail at a trust level on the following slide that demonstrates the extent to which trust provide local services for NCL patients and the extent to which they provide specialist services (a proportion of which is for NCL patients).



Providers in NCL ICS

North Central London Integrated Care System

NCL is a complex health economy with a variety of types and sizes of providers, including three single speciality providers and a large component of specialist services.

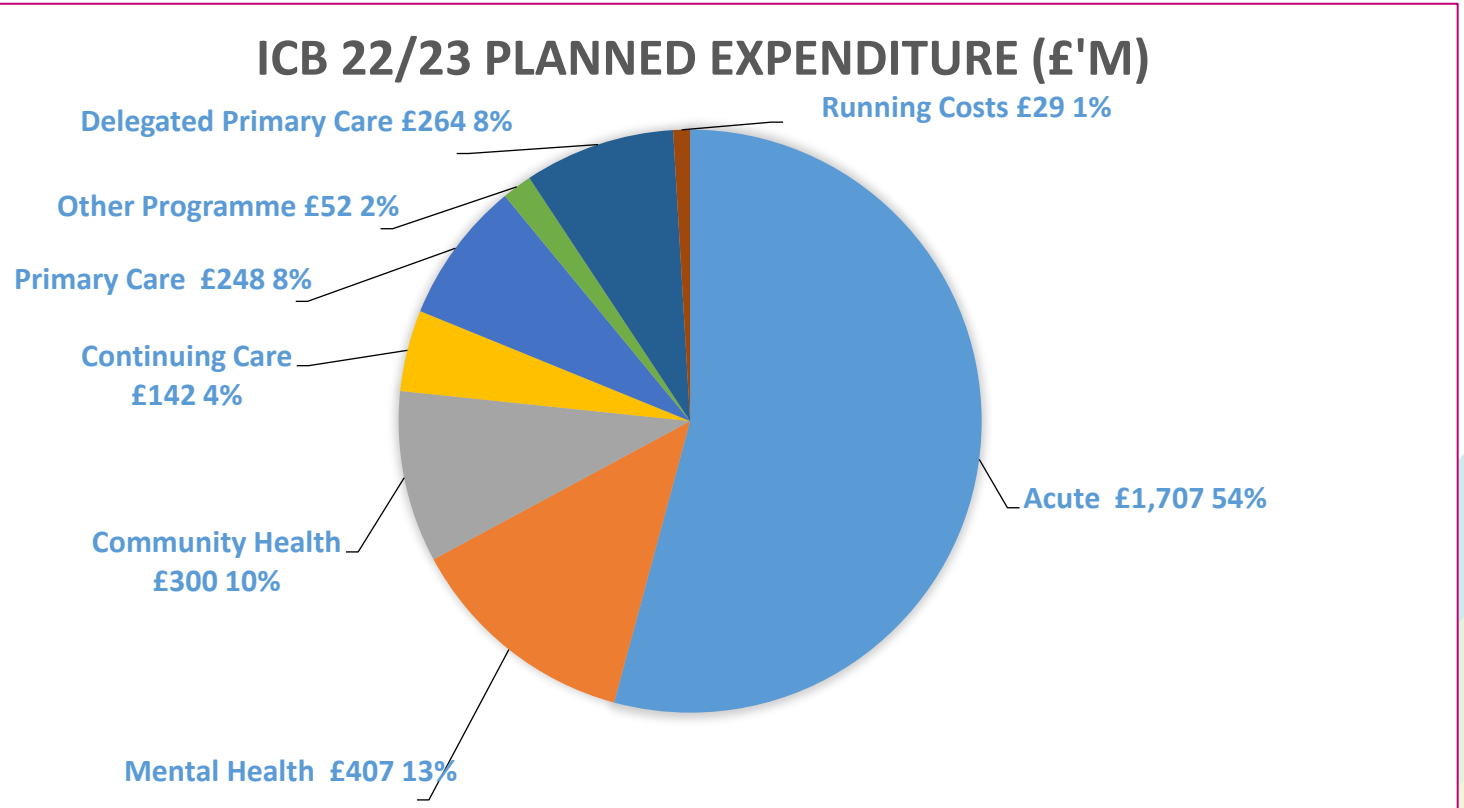
Trust	High level description of services / localities	22/23 Annual planned Income	Of which NCL ICB	Of which NHSE/Specialist services
Barnet, Enfield, & Haringey MH Trust	Local secondary and tertiary mental health services (including being lead provider for North London Forensic consortium) covering the 3 borough in the north of NCL. Also provides Enfield Community services.	£419m	£212m (51%)	£152m (36%)
Camden & Islington MH Trust	Local secondary mental health services for boroughs in south of NCL. Hosts Psychotherapy training consortium.	£190m	£126m (66%)	£0m (0%)
Great Ormond Street Hospital	Tertiary paediatric services including national specialities.	£593m	£10m (2%)	£417m (70%)
Moorfields	Secondary and tertiary ophthalmic services. Provides services in sites across London.	£280m	£26m (9%)	£32m (11%)
North Middlesex	Local Secondary acute service with some specialist services, mainly covering Enfield and Haringey populations.	£414m	£283m (68%)	£59m (14%)
Royal Free London	Local and tertiary acute services. Includes Royal Free hospital, Barnet Hospital and Chase Farm Hospital. Local services mainly covering populations in Barnet, Enfield and Camden. Has a large teaching component.	£1,289m	£553m (43%)	£377m (29%)
Royal National Orthopaedic Hospital	Local and tertiary orthopaedic services, whose main site is in Stanmore (NWL).	£179m	£30m (17%)	£71m (27%)
Tavistock & Portman	Local and tertiary psychotherapy provider. Has a large education and training function.	£65m	£15m (22%)	£18m (27%)
University College London Hospital	Local secondary and tertiary acute services. Local services cover mainly Camden and Islington populations. Has a large teaching component.	£1,452m	£367m (25%)	£551m (38%)
Whittington Health	Local secondary acute and community services provider. Local acute and community services cover mainly Haringey and Islington communities.	£391m	£294m (75%)	£20m (5%)
Total		**£5,274m**	**£1,917m (36%)**	**1,698m (32%)**

NCL ICB Spending profile

North Central London Integrated Care System

The chart shows the proportion of 22/23 £3.2bn planned expenditure on services for the NCL population.

- The strategy for the ICB is to spend a greater proportion of the budget on pro-active and preventative and out of hospital services in order to require less hospital provision.
- The chart contains planned annual costs in 22/23. The first 3 months represent NCL CCG planned spend and the last 9 months NCL ICB planned spend.
- Health partners including Local Authorities will have a greater influence on ICB planning through their direct participation in governance processes than with the CCG in the past.
- In the near future the ICB is likely to be accountable for delegated commissioning responsibilities for both specialist commissioning services and pharmacy, optometry and dentistry. This will have a material impact on the overall funding for which the ICB is responsible and will change the spending profile.



NCL ICS Recent Financial Context

North Central London Integrated Care System

There have been a number of changes to the NHS financial regime in response to the pandemic which has supported the local financial position. However, as we come out of this period we face many financial challenges.

- In recent years, pre-pandemic NCL had been able to broadly achieve its financial duties through a number of non-recurrent measures. However, going into the 20/21 planning round (before the first lockdown in March 20) it had not formulated a financially balanced plan.
- The NHS financial framework adapted significantly during the COVID-19 pandemic to enable a focus on meeting urgent operational pressures. Initially there was a financial top-up system to bring trusts back into financial balance. This then moved back to a cash limited system, but at a higher level of investment, moving away from the national tariff system to national block contract payments for providers.
- Systems received non-recurrent Covid funding to support services with the increased costs of sickness, security and preventing infection. Trusts also received non-recurrent Elective Recovery Fund funding to cover additional costs of tackling the backlog and to incentivise the increase in elective activity.
- Over the pandemic period, the NCL system used the additional non-recurrent funding to increase capacity in ITU and elective and emergency bed capacity to improve resilience. In acute providers there has been broadly a 10% increase in WTE.
- As the local system comes out of the pandemic period into a more financially constrained environment we face a challenge to reduce the cost base built up on non-recurrent funding.
- The focus now also needs to move towards getting back to a delivering efficiencies on an annual basis in the same way that we did pre-pandemic.
- The system has set up three financial recovery groups reporting into the System Management Board, covering:
    - Financial governance – organisation-level review of control, checklist and audit of processes and controllable spend.
    - Provider efficiency and benchmarking - focussed work looking for improved productivity opportunities through data review and the delivery of cost improvement plans within organisations.
    - Review of system-wide transformation programmes e.g. better use of digital, technology and efficiencies through scale/collaboration.

System Financial Challenges

North Central London Integrated Care System

NCL ICS faces a number of pre-existing and new financial challenges as it emerges from the Covid pandemic of the last two years.

Challenges in the current 22/23 financial year

- Includes a stretch to get over the line to submit a balance plan (e.g. the plan included unidentified efficiency schemes).
- Financial performance was still affected by Covid admissions/wave for first 2/3 months of financial year.
- Productivity – not an outlier in national terms, but overall not yet back to 19/20 levels, and is hard to reverse
    - Urgent Emergency Care – less admissions but longer lengths of stay, escalation beds and increased delayed discharges
    - Elective – good performance at a national level but not all Trusts yet reaching elective recovery fund national targets.
    - A&E – activity now exceeding 19/20 levels
- Excess inflation - especially utilities and Retail Price Index linked increases. There have been some funding increases but further unplanned increases in costs above the level of funding are being experienced.
- Non-NHS income- at system level, non-NHS income has not yet fully recovered to pre-pandemic levels, especially where reliance is on travel from abroad.
- Reducing costs associated with Covid and infection, prevention and control measures.
- Returning to strong pre-Covid financial discipline and control is essential but challenging to balance against elective recovery prioritisation.

Challenges for 23/24 and beyond

- NCL receives funding above the target allocation set using national needs-based “fair shares” formula. The national movement to target policy means that NCL receives lower levels of growth as a consequence and in turn a greater efficiency challenge.
- Underlying recurrent deficit position – this will need to be recovered over a number of years, requiring non-recurrent solutions to achieve financial balance each year in the intervening period.
- The delegation from NHSE of commissioning responsibilities for both Specialist Commissioning - also reflecting the distribution of specialist commissioning funding from a provider to a population basis and Pharmacy, Optometry & Dentistry services, increase financial risk and scope of responsibility (as well as providing opportunities).
- Focus on system wide transformation of services that produces both financial and non financial benefits.

NCL ICS 21/22 outturn and 22/23 plan

North Central London Integrated Care System

In 21/22 NCL delivered a large surplus due to the highly unusual circumstances. The ICS worked together to submit a balanced plan for 22/23, however it contains a large level of financial risk.

21/22 outturn - £90.1m surplus

In a highly unusual year, the NCL ICS system generated a £90m surplus due to:

- Windfall gain from national elective recovery fund scheme in Q1 of 21/22.
- Non-recurrent technical benefits.
- Underspends due to reduced elective work in covid waves during the financial year.

22/23 plan – Balanced plan

- The providers and the ICB worked together to submit a balanced plan.
- Each organisation has a significant financial stretch/level of risk in their plan including unidentified efficiency assumptions.
- Each organisations's position is supported by non-recurrent benefits.

22/23 in-year– Month 4 position

NCL ICS is reporting an aggregate £14m adverse variance at Month 4, due to a number of issues including:

- Under-delivery of efficiencies.
- Continued spend on Covid related measures in excess of plan.
- Under-performance in non-NHS income.
- Additional unplanned excess inflation pressures (with more expected to hit later in the financial year).

N.B. Unlike Local Authorities, NHS organisations cannot carry forward expenditure reserves from one year to another. NCL ICB will inherit the cumulative NCL CCG historical deficit and will have an obligation to repay it unless the ICB and the system are in balance for the first two years.

Organisation	21/22 Outturn £'000	22/23 plan £'000
BEH	22,629	4,869
C&I	1,017	2,124
GOSH	(4,394)	(10,620)
MEH	19,773	1,590
NMUH	19,081	1,065
RFL	7,200	(31,100)
RNOH	11,931	(1,150)
T&P	(13,374)	(3,763)
UCLH	22,464	11,516
WHIT	496	(112)
Trust Total	**86,823**	**(25,581)**
NCL ICB	3,323	25,583
System Total	**90,146**	**2**

Priority areas of investment

North Central London Integrated Care System

In order to support sustainability with more pro-active, preventative and out of hospital care we are planning to increase investment in population health management, projects to address health inequalities, community services and mental health.

NCL ICS has used the available growth in 22/23 to increase investment in Health inequalities projects, community services and primary care, as well as maintaining its investment in mental health.

Population Health issues are covered in other packs.

Community services and Mental Health services reviews are covered in the next slides.

A major project for capital investment on the St. Pancras site is also covered.

Community & Mental Health Reviews

North Central London Integrated Care System

The journey so far for community and mental health service reviews

Start of review

March 21

Agreement was reached for a strategic review of Community Health Services and a case for change was created

Mental Health

May 21

A parallel review of Mental Health Services has been conducted concurrently based on a case for change

Design co-production

May - July 21

Co-developed case for change, service offer, inequalities identification, gap analysis against Borough, through interviews, surveys and workshops with a focus on Local Authority

Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

Gap analysis

August 21

A gap analysis was conducted by Borough colleagues against the Core Offer

Core Offer

July 21

The purpose of the Core Offer is to address the inconsistency of service provision across NCL by setting out a commitment to the NCL population of the support they can expect to have access to regardless of their borough of residence

Investment principles and KLOEs for prioritisation

April – May 22

Investment priorities and KLOEs agreed at CH and MH programme Boards respectively

Provider collaboration

May 22

Areas for provider collaboration have been agreed to improve care and support financial sustainability

Provider completion of PIDs for collaborative projects

July – August 22

Benefits realisation and financial impact to be articulated for each project

Provider completion of Delivery Plans for 22/23 community investment

July – August 22

Includes project monitoring KPIs

Agree investment priorities for Y1 and profile multi-year investment plan

June 22

Programme Board agreed investment priorities based on gap analysis and correlation with investment and programme principles. NCL System Management Board (CEO level) endorsed approach

Sign off at ICB Members Board of multi-year investment plan

September 22

Following system wide discussions during June – August 2022

Borough Implementation workshops

July – September 22

Borough Implementation workshops with place based partners in each borough

Future Programme Delivery

Community Services Review

North Central London Integrated Care System

We have reviewed our community services and have identified significant variation and inequity of access, which stems from a range of historical factors.

NCL have developed a core minimum offer which is tailored to different population health cohorts. The core offer will be enhanced through coordinating functions to provide a single point of access, care coordination and case management to meet different levels of need in the most appropriate setting.

The core offer also supports a greater focus on early intervention and prevention which is a shift from the current focus on urgent care.

Investment to support the programme is expected to be realised from targeted investment in NCL community services and efficiency and productivity gains resulting from this investment. An impact assessment of the indicative benefits accrue from implementing the core offer equitably across NCL is shown opposite.

The aim of the core offer is to support more people out of hospital, ensuring that care is delivered in the right setting and at the right time, while improving quality and equity of access.

Area		NCL
Adults	Saved occupied beds from avoidable short-stay admissions (0-1 days)	3473 (24%)
	Potential savings	£1.6m
	Saved occupied beds from reducing average length of stay for longer stay admissions (2+days)	23512 (8%)
	Potential savings	£12.2m
Paeds	Saved occupied beds from reducing average length of stay for longer stay admissions (3+days)	2380 (25%)
	Potential savings	£974k
Total potential savings		**£14.8m**

Access:

- Standardised service provision
- Extended opening hours and access to OOH services – **more convenient access to services**
- Enhanced services
- **Standardised waiting times** (e.g., to first contact and follow up)
- **Simplified referrals** processes through a central point of access

Quality:

- Focus on **prevention** and **early intervention**
- **Enhanced response times** to help service users stay well - **minimise need for hospitalisation**
- Standardised and enhanced step-down services to **support timely and safe discharge of patients from hospital**
- **Enhanced older people services**

Equity and equality:

- **Consistent and standardised offer** so that all NCL residents have **equal support**
- Links and interdependencies with other agencies and support that **focus on wider determinants of health**
- Core offer will require a **resource redistribution that is aligned with need** - residents have health **equity**

Workforce:

- Support staff to **operate at the top of their license**
- **Collaborative working** with other professionals and service users
- **Improve staff satisfaction** levels
- Increased **joint working** to deliver place-based care
- Defined and **shared culture**
- **Co-location** where appropriate
- **Joint training**

Virtual Wards in the Community

North Central London Integrated Care System

NCL's vision is to implement Virtual Ward services in line with the following key design principles, which were co-designed by across the ICS via a workshop in late April. This is supported by £4.9m of investment across NCL in 2022/23:

LOOK
Patients and staff will see:

Consistent services and universal coverage:
- Standard patient referral criteria and care inputs, regardless of borough
- Every NCL patient has a virtual ward offer

Clear step-up & down interfaces
- E.g. when to refer patients to Rapid Response, when to VW, other services, etc.

Maximum clinical skills & acuity
- Maximise clinical skills
- Consistent clinical competencies, e.g. for nursing and therapies

Tech-enabled care
- Standardised use of interoperable tech
- Linked record-keeping

Clear patient communications
- Clear and simple patient information
- Routine review of patient feedback

FEEL
Patients and staff will feel:

Patients and families feel safe and well-cared, 24/7:
- Equally safe, confident and supported at home as they would in hospital, with staff who are kind to them
- Clear escalation route is available

Staff feel they are part of 'one team', a supportive partnership:
- A great and supportive place to work
- Close working relationships between people who before may just have referred via a form
- Network of people who trust each other

Services feel mutually confident in each other:
- Acute and community staff confidently release and accept patients
- Supported by clear clinical governance

SAY
Patients and staff will say:

Patients say "NCL virtual wards"…
- Are easy to access and easy to use
- Are reassuring

Staff say "NCL virtual wards"…
- Effectively provide acute level care at home
- Offer appealing clinical & care roles for staff

Referrers say "NCL virtual wards"
- Are easy to access and easy to refer to (potentially via a single point of access)
- Are helpful, can-do and positive teams who are ready to make things work!

NCL ICS says "NCL virtual wards"
- Prevent deconditioning and improve the likelihood of patient recovery
- Are less costly than an actual acute bed
- Are directly reducing acute bed occupancy
- Are 'worth' funding on a long-term basis

Mental Health Service Review

North Central London Integrated Care System

Mental health (MH) spend is broadly in line with need overall so the focus is on equity of access and gaps in the core offer across NCL Boroughs

NCL's has continued it's commitment to meeting the Mental Health Investment Standard (MHIS), a target which ensures that spending on mental health services is in line with physical health services and the ICB's headline funding allocation. In 2022/23 this means a c. £15m increase in Mental Health investment vs 2021/22 expenditure.

Initial analysis within the Mental Health Service Review confirmed that overall spend on Mental Health Services is broadly in line with need overall with the MHIS being seen a major contributory factor to this.

The broad correlation of overall need and overall investment in mental health services means that the focus for the MH service review is how we address gaps in the core offer and the equity of provision and access to services across NCL.

The affordability case for the MH core offer draws upon use of the existing MHIS funding and other non-recurrent funding such as the Service Development Fund (SDF). There is strong alignment between delivery of the MH core offer programme and existing MH Long Term Plan (LTP) targets set out by NHSE.

Financial modelling expects the MH system to work together and identify productivity and efficiency savings to partly support the core offer investment plans and provide a sustainable platform for preventative and out of hospital/inpatient care.

St. Pancras / Project Oriel

North Central London Integrated Care System

One of the NHS's largest capital schemes is being implemented within NCL.

Key facts

- The St Pancras hospital site in Camden will be entirely redeveloped.
- The site is 5 acres in size and lies to the NW of St Pancras station.
- A new building for Moorfields Eye Hospital (Oriel) (c.£400m) to replace their existing City Road site will be built on 2 acres of the site.
- The remaining 3 acres will be redeveloped with a mixture of NHS buildings (including the new HQ for Camden & Islington Mental Health Trust), office, retail and residential spaces.
- The new Moorfields Eye Hospital is expected to be ready in early 2027.
- Planning permission for the Moorfields building has been granted and the business case is currently progressing through the final stages of approval.
- The redevelopment of the remainder of the site is anticipated to be complete in 2026.

Issues and risks to manage

- It is a hugely complex combined project involving the decant and move of a number of services currently on the site across a number of different NHS bodies (including Moorfields and Camden and Islington but also Central North West London Mental Health Trust and Royal Free London Trust).
- The c£400m funding for the new Moorfields Eye Hospital (Oriel) will come from the National Hospital Programme, UCL, the Moorfields Eye Charity and the sale of the existing City Road site. Moorfields, the National Hospital Programme, the NHSE London Region and the ICB are all involved in the Oriel governance arrangements.
- The Oriel construction will start while the remaining 3 acres are still occupied so must ensure that construction does not disrupt clinical operations that will continue on the remainder of the site after they start.

Next Steps

North Central London Integrated Care System

There are a number of system financial planning next steps.

Next Steps include:

- Forecasting and year-end management of the 22/23 revenue and capital positions.
- Preparation for 23/24 – 25/26 planning – assumptions, timetables, alignment with performance and workforce plans etc.
- Receipt of 23/24-25/26 allocations (assuming there will be a longer-term planning horizon and exercise).
- Refresh of Long term capital pipeline and distribution of 23/24-24/25 ICS capital funding.
- Refresh of NCL Financial strategy to include ICB priorities including Population Health principles.

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North Central London Integrated Care System

NCL Workforce Report

JHOSC

September 2022

NCL Workforce Report for JHOSC (September 2022)

North Central London Integrated Care System

This pack has been created in response to the London **Joint Health Overview & Scrutiny Committee's (JHOSC)** request for information on the **NCL workforce** – NCL Integrated Care Board is transitioning to a new statutory organisation and we have provided the latest data, insight and commentary available across Primary and Secondary care (and Social Care information where available). We will continue to evolve our analysis and insights as we drive towards a more integrated approach to 'one workforce' across health and care within NCL.

Contents of this document:

Dentistry, optometry, pharmacy (DOP) are currently not included in existing Primary Care datasets due to this being an NHSE commissioned service however there are plans to work with partners to gather this information in the medium-term after the contracts novate to ICBs in 2023.

North Central London Integrated Care System

Setting the scene

NCL Workforce JHOSC report
September 2022

Introduction

North Central London Integrated Care System

Over the past two years, the focus on **people within health and care** has become much more front and central than any other time in the NHS's history. It is clear that our people are at the heart of our recovery and key to ensuring we can continue to deliver high quality, sustainable services for our population and beyond.

The four aims of **Integrated Care Systems** (ICSs) are:

1) to improve population health and healthcare
2) tackle inequalities in outcomes, experience and access
3) enhance productivity and value for money and
4) help the NHS support broader social and economic development.

To deliver on these commitments requires a **seismic shift in the development of effective working relationships** between health and care professionals, both spanning the levels of healthcare from primary to quaternary services and also across in the wider social care, community, voluntary and third sector provision.

With the advancement of technology, data science, Artificial Intelligence (AI) decision-making tools and treatments, even before the Covid-19 pandemic emerged, it was clear that a confluence of **social, technological and policy change drivers** would necessitate a fundamental re-consideration of how we educate, re-skill and upskill the health and care workforce.

The introduction of ICSs gives us a platform to bring together the fragmented and disparate parts of the system through a new organising principle. If done well, this is an opportunity to **truly transform the way we deliver care, looking at life courses of disease rather than just episodic and reactive care.** This will change the working practice of our current workforce (a conservative estimate of 88,000 colleagues across our five Boroughs) and redesign the skills and capability we need for our future workforce

Our approach to people

North Central London Integrated Care System

The suite of Integrated Care System Design Framework guidance published in Summer 2021 includes the development of a **People Function** to support this shift in emphasis.

Over the past five years, from the Sustainability and Transformation Partnership through to the early forming of the Integrated Care System, there has been a **Workforce Programme** within North Central London. This has achieved some very positive change for our workforce, which is set out in this pack, however over the coming months and years, this will need to develop into a People Function under the leadership of the Chief People Officer and in partnership with our wider stakeholders, partners and population.

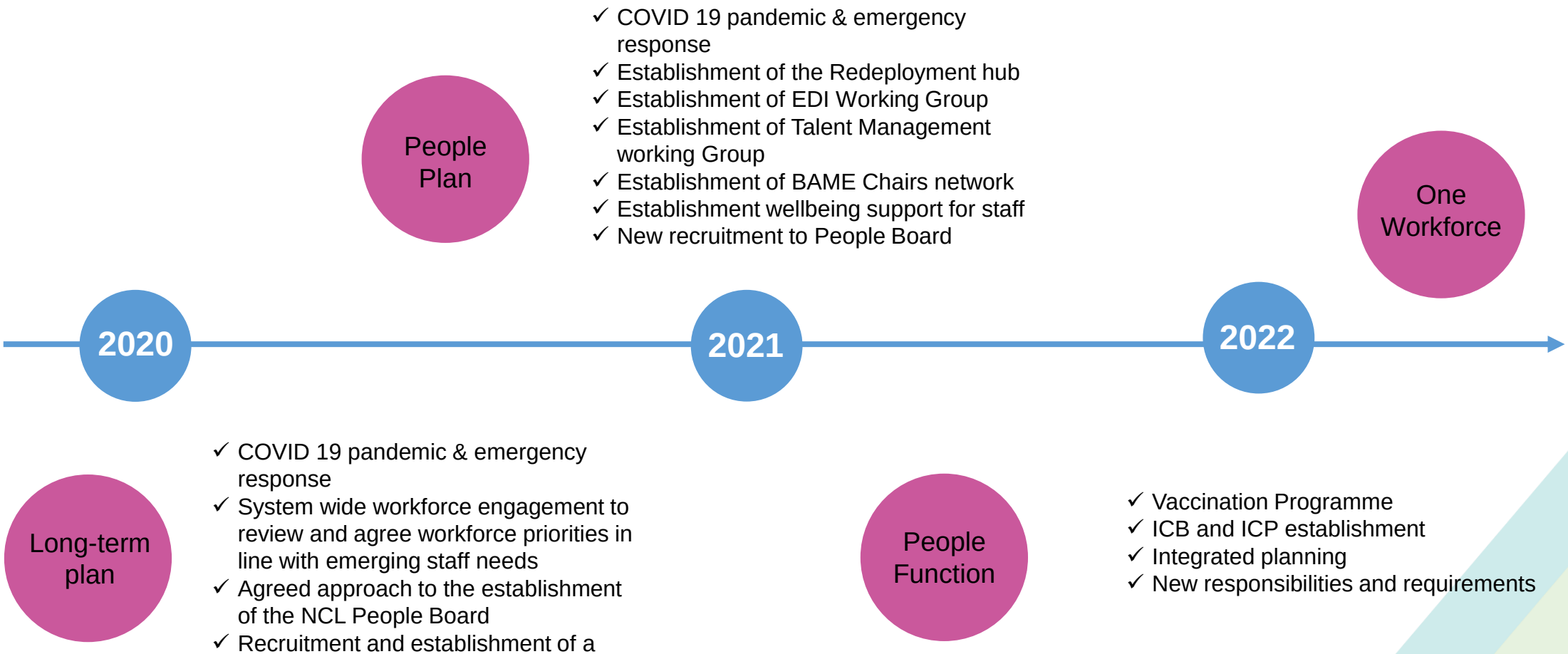
Done well, an ICS People Function will support the delivery of the four aims of the ICS and make a significant contribution, particularly in the fourth aim to support **economic and social development.** This is an area that NCL has been particularly focused on through the commitment to social determinants of health and the **Work Well** element of the Population Health Outcomes Framework.

To be successful there will need to be a balance of day-to-day understanding and support for operational pressures, performance metrics and workforce efficiencies, coupled with a strategic focus on the workforce transformation required to deliver on our **clinical and care service ambitions** such as the Fuller Review of primary care, NCL Mental Health Services Review, NCL Start Well and others.

This pack seeks to set out the journey so far and our future intentions as we establish a wider People Function over the coming months.

The NCL ICS Workforce journey, so far…

North Central London Integrated Care System



North Central London Integrated Care System

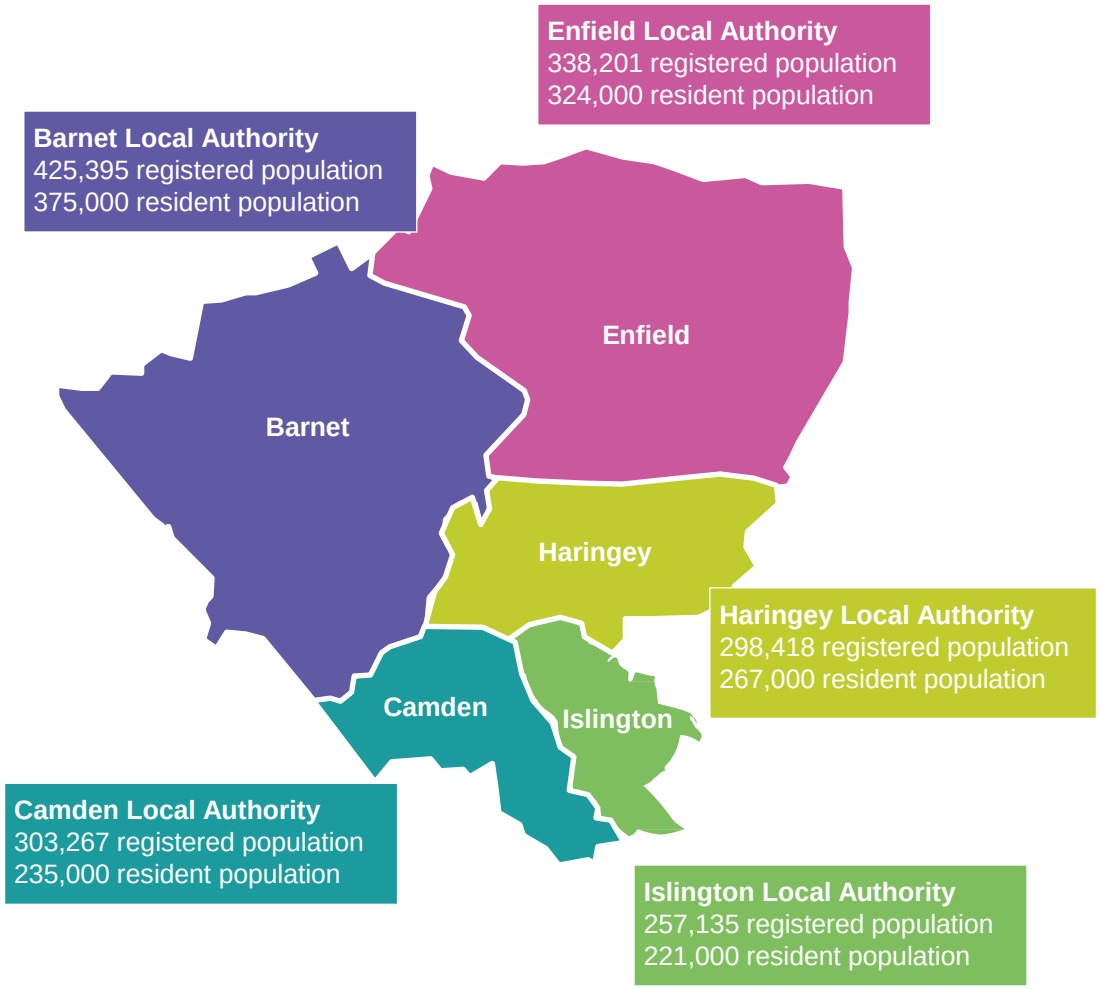
NCL Workforce Context

NCL Workforce JHOSC report

September 2022

The NCL population

North Central London Integrated Care System

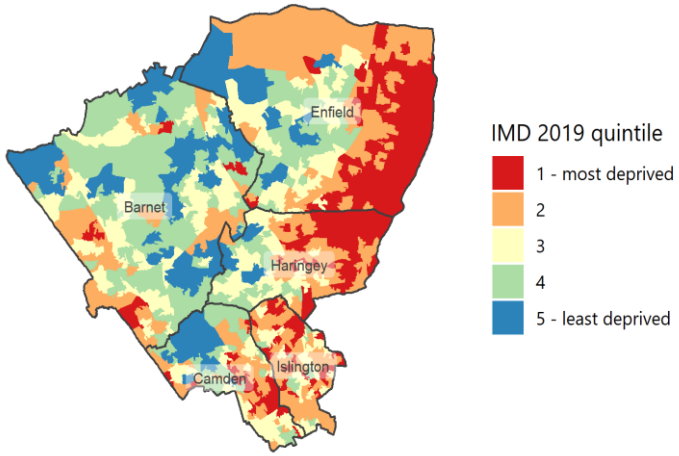


- North Central London (NCL) is made up of five boroughs: Barnet, Camden, Enfield, Haringey and Islington.
- Around 1.6 million residents live in North Central London, with a relatively young population in some boroughs compared to the London average.
- Diverse population with historic high migration – from within UK and abroad; around 25% of people do not have English as their main language.
- Significant variation in life expectancy between most affluent and most deprived areas.
- Approx. 200,000 people in NCL are living with a disability.

The NCL population

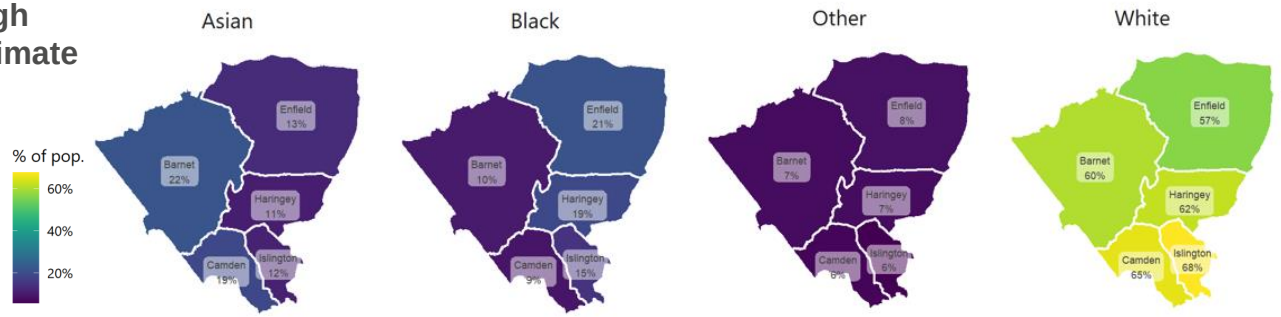
North Central London Integrated Care System

Deprivation quintile by LSOA
North Central London boroughs, IMD 2019



- Around 60% of NCL residents are White, with around 20% Asian and 20% Black. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.
- Haringey, Islington and Enfield have on average, higher rates of deprivation compared to London, although pockets of deprivation are dispersed across NCL[1].
- While not explaining all differences, the intersectionality between ethnicity and deprivation is very important. Communities that are living in the most deprived areas include Black, White Irish, Turkish, and Eastern European communities in Enfield, Haringey and Islington, the Bangladeshi community in Camden, and Gypsy, Roma and Irish Traveller communities in Barnet, Enfield and Haringey.

Ethnic groups by borough
NCL boroughs, 2018 estimate



[1] Index of Multiple Deprivation, 2019

There are **stark variations** across different communities in NCL in terms of health and care access, experience and outcomes

North Central London Integrated Care System

- Islington residents experience lower **life expectancy**, and women lower healthy life expectancy, compared to London. While Camden has one of the highest life expectancies in London, men living in the most deprived areas will live for 13 years less than those in the most affluent. For women there is a 10 year gap. In other boroughs there are gaps that are similar to the London averages (7 years for men, 5 years for women), and life expectancies are similar or higher to the London averages.
- Main **underlying causes of early death** in NCL are cardiovascular disease, cancer and respiratory diseases, with those living in the most deprived communities in NCL have a 50% higher death rate from avoidable causes of death compared to the NCL average. For cardiovascular disease, there are also clear ethnic inequalities with Black communities more likely to die prematurely from preventable (e.g. smoking cessation) or treatable (e.g. atrial fibrillation detection) causes.
- Those living with **serious mental health illnesses and learning disabilities** also experience large inequalities, as do the homeless. For example, the death rate for those with serious mental illness in Camden and Islington is three times higher than the rest of the population.
- The direct and indirect impacts of **COVID-19** have starkly highlighted these inequalities, including the inequities in access to health services and patient experience through the Covid vaccination programme - uptake is lower for some ethnicities and areas of higher deprivation.

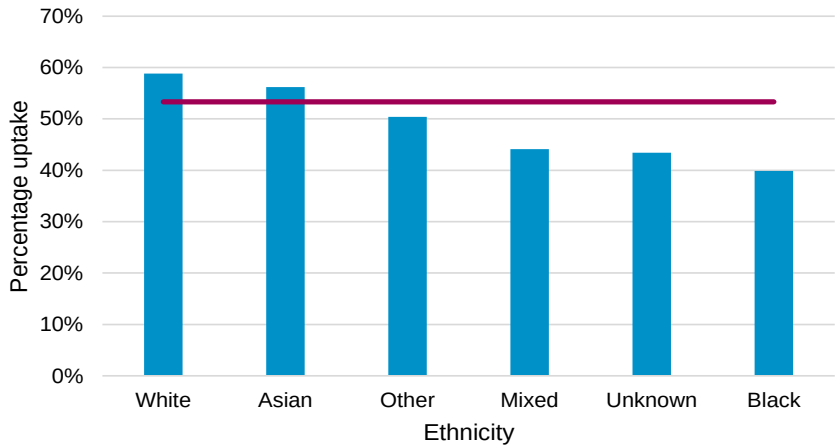
Life expectancy and inequality and healthy life expectancy

	England	London	Barnet	Camden	Enfield	Haringey	Islington
Life expectancy at birth: Male	80	81	83	83	81	81	80
Life expectancy at birth: Female	83	85	86	87	85	85	83
Healthy life expectancy at birth - Male	63	64	64	64	64	65	63
Healthy life expectancy at birth - Female	64	64	65	67	64	66	62

Significantly BETTER than London average | Significantly WORSE than London average

Public Health England, Overarching indicators, Life expectancy (2017-2019) and healthy life expectancy (2016-2018)

Uptake of Covid-19 vaccination, NCL



GP records, Individuals' registered ethnicity by their GP, Snapshot of records 14th August, 2021

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life. We have identified **five strategic aims** to deliver our ambition and achieve our purpose.

North Central London Integrated Care System

Start well

By working collaboratively with schools and communities, our children and young people will have:

- tools to manage their own health
- access to high quality specialist care
- safe and supported transitions to adult services.

Live well

Our residents will have early support for health issues including:

- equitable access to high quality 24/7 emergency mental and physical health
- world-class planned and specialist care services
- true parity of esteem between physical and mental health.

Age well

Our residents will:

- be supported to manage their long term conditions and maintain independence in their community
- receive seamless care between organisations
- experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can.

Work well

Our workforce will:

- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels.

Enablers

We will provide key enablers for success, including:

- digital technologies to connect our health and care providers with our residents and each other
- a fit for purpose estate in each locality
- being a financially balanced health economy driving value for money for the taxpayer.

Supporting data on next 3 slides

Under development

Start Well

North Central London Integrated Care System

- Around 50,000 children and young people in NCL were living in **poverty**, substantively impacting their life chances and their future health and wellbeing.
- The pandemic is likely to have **widened the gap** between children in poverty and others, and with the exception of childhood immunisations and asthma admissions, all of the Start Well indicators are likely to have deteriorated.
- Enfield and Camden had poorer outcomes for **GCSE** attainment, and Enfield for school readiness too.
- Nearly a quarter of children in London are **obese** by the time they leave primary school. Enfield has a significantly higher percentage at 27%.
- Hospital admissions for **self harm** among young people are higher in Barnet and Islington, and there is increasing evidence that Covid-19 has had a detrimental impact on young people's mental health.
- With the exception of Barnet, boroughs have a lower uptake of **childhood immunisations** compared to London and England, with MMR uptake in all boroughs far below the herd immunity for measles (95%). Haringey has low uptake for children in care.

Start Well indicators

	England Average	London Average	Barnet	Camden	Enfield	Haringey	Islington
Education							
School readiness (children having good development at end of reception)	72%	74%	74%	73%	70%	75%	71%
Educational attainment (5 or more GCSEs)	58%	61%	69%	57%	58%	60%	61%
Health and wellbeing							
Asthma admissions (per 100,000 population, age 0-9)	192	191	120	83	134	143	137
Obesity (at year 6)	21%	24%	21%	22%	27%	23%	25%
Hospital admissions as a result of self-harm (per 100,000 population, age 10-24)	440	190	250	200	180	200	220
Wider determinants							
Children in relative low-income families (under 16)	19%	18%	14%	15%	18%	19%	18%
Immunisations							
MMR vaccine coverage (age 2)	91%	84%	83%	80%	79%	81%	81%
Children in care immunisations	88%	80%	93%	79%	86%	77%	96%

Fingertips, 2018-2020

Significantly BETTER than London average | Significantly WORSE than London average

Live Well

North Central London Integrated Care System

- Around one in five NCL residents have a common **mental health illness**, with the highest prevalence in Islington and Haringey. Most boroughs have a high prevalence of serious mental health illness too. The Covid-19 pandemic has had an adverse impact on some people's mental health, so mental health needs in NCL are predicted to increase.
- **Smoking, alcohol and obesity** are major risk factors for early death. Smoking rates are high in Enfield, Haringey and Islington, and alcohol admissions high in Islington. While overweight/obesity levels are lower or no different than the London average, in Barnet and Enfield, nearly 60% are overweight/obese.
- Across NCL there are about 88,000 people living with **diabetes**, 33,000 with heart disease and 21,000 with serious respiratory disease (COPD). Nearly 6,000 new cancers are diagnosed each year. Unadjusted for age, Enfield has higher prevalence of long term conditions and a higher incidence of cancer. Barnet has a higher prevalence of chronic kidney disease and heart disease.
- The **wider determinants of health** are critical for health and wellbeing too. Islington, Haringey and Enfield have higher rates of unemployment. Air pollution levels are high in Camden, Haringey and Islington. Homelessness rates are highest in Haringey and Barnet.

Live Well indicators

	England Average	London Average	Barnet	Camden	Enfield	Haringey	Islington
Mental Health							
Depression and common mental disorders (16+)	17%	19%	16%	19%	19%	22%	23%
Severe mental illness	0.9%	1.1%	1.0%	1.4%	1.3%	1.3%	1.4%
Lifestyle risk factors							
Overweight/obese (18+)	63%	56%	58%	48%	58%	50%	49%
Smoking (15+)	17%	16%	14%	15%	22%	21%	18%
Alcohol-related hospital admissions (per 100,000 population)	640	600	380	620	410	580	820
Wider determinants							
Unemployment (claiming out of work benefits, 16-64 years)	6.5%	7.6%	6.5%	7.7%	9.2%	9.5%	9.6%
Air pollution (µg/m3)	9.0%	11%	11%	12%	11%	12%	12%
Homelessness (household owed a duty, rate per 1,000)	12%	15%	16%	10%	15%	26%	11%
Long term conditions							
Diabetes (17+)	7.1%	6.8%	6.6%	4.0%	10%	6.5%	4.8%
Chronic kidney disease (18+)	4.0%	2.4%	3.3%	1.9%	3.3%	2.0%	1.7%
Cancer (new cases per 100,000 population)	530	350	360	300	400	340	320
Hypertension	14%	11%	12%	9.5%	16%	11%	8.8%
Coronary heart disease	3.1%	1.9%	2.4%	1.4%	2.8%	1.6%	1.4%

Fingertips 2018-2020

Significantly BETTER than London average | Significantly WORSE than London average

Age Well

North Central London Integrated Care System

- Every borough in North London has a higher percentage of **older people living in poverty** compared to the England average, equating to about 51,000 older adults.
- NHS **screening programmes** prevent early death. Improvements in uptake could be made across all boroughs, but Camden, Islington and Haringey have a particularly low uptake of bowel cancer screening, and Islington for aortic aneurysm too.
- Proportionately more older people **live alone** in Barnet, which may mean they are more likely to be socially isolated.
- **Fuel poverty** is highest in Haringey and Enfield, making it difficult for older people to keep warm and well in colder months.
- **Levels of dementia** are higher than the London average in most NCL boroughs, with around one in twenty older people diagnosed.
- Moderate or severe **frailty prevalence** is highest in Islington and Camden, with Islington also having higher rates of alcohol admissions among older people.

Age Well indicators

	England Average	London Average	Barnet	Camden	Enfield	Haringey	Islington
Healthy lifestyle							
Health-related quality of life (65+, 0 to1 score)	0.74	0.73	0.74	0.75	0.73	0.73	0.69
Abdominal aortic aneurysm screening	76%	63%	74%	65%	75%	63%	59%
Bowel cancer screening	64%	56%	56%	52%	57%	54%	53%
Lifestyle risk factors							
Alcohol-related conditions admissions (65+, per 100,000 population)	1050	1040	970	1080	1120	1120	1450
Wider determinants							
Older people in poverty (60+, IDAOPI)	14%	NA*	16%	23%	21%	30%	34%
Fuel poverty (65+)	10%	11%	12%	12%	13%	14%	11%
Older people living alone (65+)	12%	10%	11%	10%	10%	7.8%	8.1%
Ageing							
Dementia (65+)	4.0%	4.2%	4.6%	4.9%	5.3%	3.7%	4.8%
Moderate or severe frailty (eFI classification)^	NA	NA	25%	29%	22%	23%	31%

Fingertips, 2018-2020, Significantly BETTER than London average | Significantly WORSE than London average

GP records, individuals registered with GP on eFI frailty classification, Snapshot of records 14th August, 2021

*London average not available, values compared to England average

We are using the **Population Health Outcomes Framework** to guide the development of the NCL Population Health Strategy

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Start well

Every child has the best start in life and no child left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduction in the number of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Reduction in early death from cancer, cardiovascular disease and respiratory disease

- Reducing prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in good jobs

- Support people to stay in jobs, including mental health and musculoskeletal services
- Anchor institutions to employ local people including those with mental health illness, physical disability, and learning disabilities, and to buy locally including by using social value-based commissioning and contracting

Parity of esteem between mental and physical health

- Reducing racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reducing deaths by suicide

Age well

Older people live healthy and independent lives as long as possible

- Ensure that people get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Improved outcomes for older people with long-term conditions, including dementia

Older people are connected and thriving in their local communities

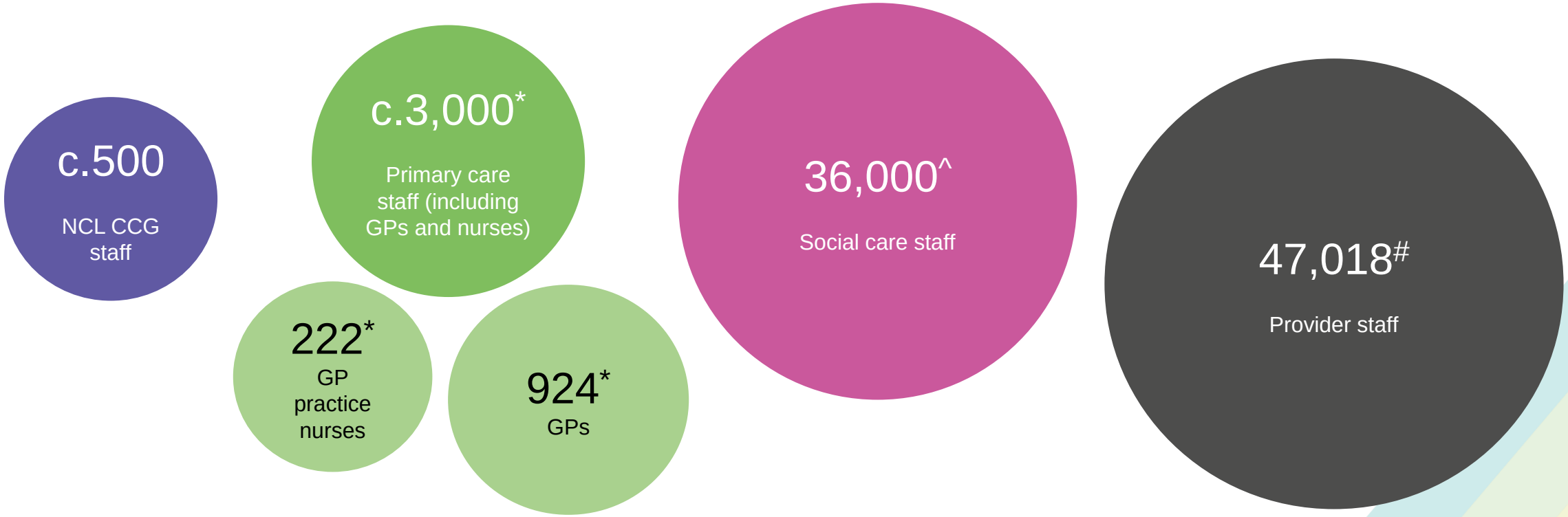
- Older people have fulfilling and meaningful social life
- Older people are informed well and can easily access support for managing financial hardship

8

The NCL health and care workforce

North Central London Integrated Care System

There are more than **85,000 people** working across health and care in NCL.



** Full time equivalent, Data source: HEE March 2022*
^ March 2021 social care data
 # Data Source: HEE March 2022

We need to work differently along pathways and across organisations in NCL

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We believe for one part of the system to succeed all parts need to. This is driving new ways of planning and delivering across organisations.

Clinical and care leadership is evolving: with shared responsibilities for outcomes across pathways. If we succeed we will harness the world leading translational medicine we have in our specialist trusts and have a greater impact for the health of our population.

Proactive care: Across NCL, multidisciplinary teams (made up of social services, acute, primary care, mental health and VCSE) are coming together to manage patients with multiple long term conditions proactively, using population health tools to understand elements of care that would best support them.

Single elective waiting list across organisations: Working with providers, we have effectively started to manage a single waiting list across NCL. Putting in place demand management initiatives to match capacity and reduce waiting times. There is also active mutual aid to treat those in need, quicker.

Taking a pathway approach to recovery: We need to challenge the inverse care law and invest outside of the normal large acute sites to drive improvements in outcomes. We have invested across pathways from diagnosis and point of referral through to support in the community.

And integrate the findings and recommendations from the Fuller report:

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Key national recommendations

- Encourage all **international medical graduates** (40% of GP registrars) to settle in England as an NHS GP on a permanent basis.
- Look at the **GP Performers List** to increase capacity e.g. enabling appropriately qualified clinicians to contribute more easily as part of the primary care workforce
- **Simplify guidance and address common misunderstandings regarding ARRS**. Consider further flexibilities that could support recruitment in the short term and consider how ARRS will operate after March 2024.
- **Provide clarity that PCN staff in post will continue as part of the core PCN cost base beyond 2023/24**. **Improve the supervision**, development and career progression of individuals in ARRS roles to retain them and maximise their skills within neighbourhood teams
- **National workforce strategy should include primary care** and support ICSs to deliver successful neighbourhood and place-based teams. It should build on HEE's Strategic Framework 15 and **must inform national estates plans** to ensure adequate space for training, development and service provision
- **Roll out NHS Staff Survey across primary care**, building on current pilots in general practice to provide parity across the NHS family.
- **Ensure a consistent leadership development offer accessible to primary care staff** that is comparable to other NHS family providers and promotes multi-professional leadership. This should include access to leadership development programmes that promote integrated working across systems

Support local systems to shape their workforce

- **Work with system partners to promote education, apprenticeships and new local employment opportunities**
- **Roll out electronic staff record or similar throughout primary care** to inform demand and capacity planning, enable team-based job planning and rostering and inform future national workforce & estates strategies)
- **Work with systems to identify measures to better support local recruitment and training** of key community healthcare teams to work alongside primary care in integrated neighbourhood teams e.g. community nursing

Extending the agenda beyond headcount

- **Create a more consistent and comprehensive training, supervision and development offer across primary care** (including medical and non-medical staff), and retention strategies across early, mid and late career.
- **Systems will want to work with primary and community care training hubs** to ensure 'the offer' they provide is broad enough to help integrated neighbourhood teams flourish.

Invest in local leadership to drive change

- **PCN clinical directors are essential to the leadership of integrated neighbourhood teams** - more focus is needed on the development and support of clinical directors, including local provision of sufficient protected time to lead integrated neighbourhood teams
- **Enable senior GPs to serve as the 'consultant in general practice'**
- **Secure specialist input from secondary care required in neighbourhood teams** as part of job planning for consultants
- **Supporting community partners to embed relevant teams as integral part of PCN**

North Central London Integrated Care System

Workforce is a key enabler to delivering our ambitions and outcomes.

The **NCL ICS People Strategy** is currently under development and will be aligned to the NCL Population Health Improvement Strategy and will include:

- New ways of working across the NCL ICS
- Enabling the Population Health outcomes framework (and supporting definition of the Work Well outcomes)
- Integration of the Fuller Report recommendations
- One Workforce strategy (integrating primary, secondary and social care)
- The NCL response to our four strategic aims

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NCL Workforce Challenges

NCL Workforce JHOSC report
September 2022

National and local drivers

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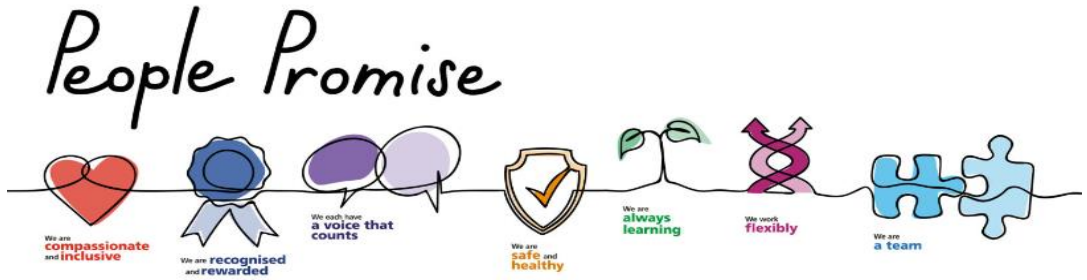

ICS 10 Outcome-based People Functions

1. Supporting the health and wellbeing of all staff
2. Growing the workforce for the future and enabling adequate supply
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Valuing and supporting leadership at all levels, and lifelong learning
5. Leading workforce transformation and new ways of working
6. Educating, training and developing people, and managing talent
7. Driving and supporting broader social and economic development
8. Transforming people services and supporting the people profession
9. Leading coordinated workforce planning using analysis and intelligence
10. Supporting system design and development

The **Future of NHS HR and OD** sets out a vision for the people profession for 2030, to support delivery of future-focused people services in support of services, staff and patients.

The **NHS People Plan** sets out actions at all levels to help deliver more people, working differently, in a compassionate and inclusive culture. The four pillars help frame the 10 people functions of an ICS.

Strategies and plans for **other parts of the one workforce** need to be part of delivering the 10 ICS people functions. These strategies and actions need to be increasingly seen as an integrated whole.

Additional specific strategies/plans :

- Long term plan targets e.g. mental health workforce and CYP
- Government's Manifesto to recruit 50,000 more nurses and 6,000 more GPs in England by 2024/25.
- NHS target to fund 26,000 additional new roles to ease the pressure on general practice
- elective recovery plan, which pledges to recruit 10,000 international nurses
- Interim NHS People Plan: a) the future allied health professions and psychological professions workforce; b) the future dental workforce; c) the future healthcare science workforce; d) the future medical workforce; e) the future pharmacy workforce
- Carers for social care – NHS & LAs resources to support the care sector

Local NCL needs

- NCL Workforce priorities
- Community and mental health review recommendations

Our NCL Workforce vision and mission

North Central London Integrated Care System

NCL ICS strategic aims are Start Well, Live Well, Age Well and **Work Well**.

Our North Central London ICS vision for “Work Well” strategic aim and workforce is for our community to receive high quality health and care services delivered **by a representative and diverse workforce, where people are supported to achieve their full potential in an inclusive and compassionate environment free from racism or other discrimination.**

Our mission is to support NCL health and social care organisations to:

- be excellent employers, developing and supporting the wellbeing of existing staff and attracting new people to live and work in North London
- plan workforce and its development needs to deliver new care models in new settings, including in integrated care systems
- be socially responsible organisations, using our influence and decision making to best serve the interests of our communities and to reduce inequalities

The local NCL health and care system is a complex environment

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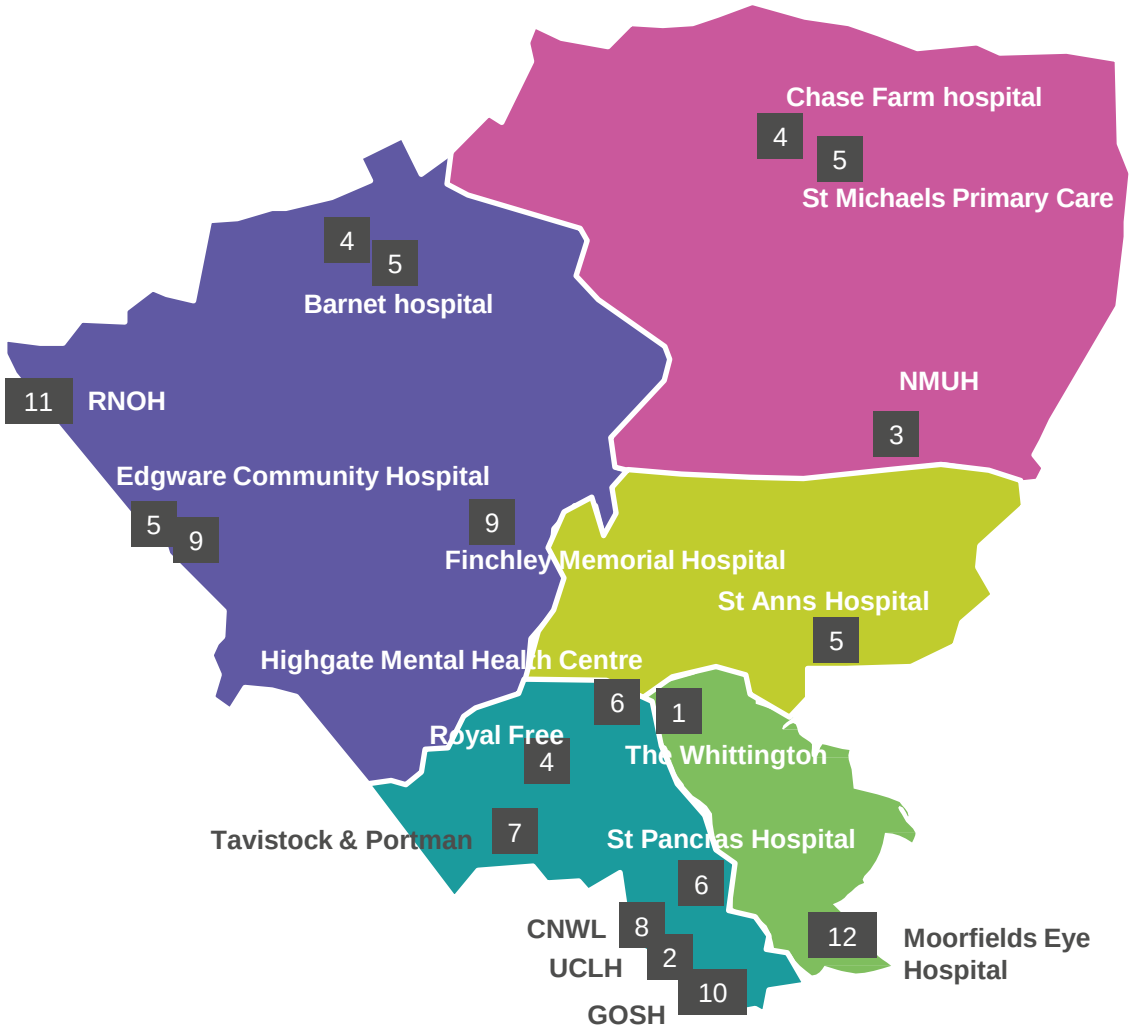

- NCL has the highest number of specialist trusts in London
    1. Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
    2. Royal National Orthopaedic Hospital (RNOH)
    3. Moorfields Eye Hospital NHS Foundation Trust

- There are 182 GP practices within NCL
- There is a high level of geographic and demographic variation across our workforce

Our current NCL Workforce challenges

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- Decrease in **workforce capacity** due to sickness and COVID fatigue/burnout affecting workforce resilience
- **Workforce availability** to deliver the backlog recovery programme as well as priorities of business as usual continues to be an issue
- Multiple service priorities are **competing** for the same workforce
- Ongoing concerns about **workforce availability** particularly medical, nursing and midwifery, AHPs, diagnostic and a depleted mental health workforce
- **Staff burnout and resilience** is a risk, with the wellbeing support being mitigation.
- There is a risk that a focus on system recovery limits the time of key stakeholders including clinicians to engage in **wider workforce development**.
- Planned **service enhancements** may be limited by workforce.
- Uptake of **bank shifts** and the impact of **enhanced pay rates** coming to an end.
- **Transition to the new ICS** is likely to impact some roles and responsibilities within the legacy structures.

Staff in Post is rising across Primary, Secondary and Social care

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- **NCL's primary care workforce has increased 3.4 over the last 12 months (August 2022)**
  - There has been an increase in Direct Patient Care and Admin/Non-Clinical staff, while GP numbers have remained reasonably static over the past few years, while the number of nurses has decreased.
  - 18% of GPs, 31% of admin staff and 42% of nurses are **over 55** in NCL

- As at July 2022, the **NCL provider workforce is 12% higher** than in April 2019, with increases seen across all staff groups and at most providers. We are collating further information to understand the drivers of these increases;
  - Since March 2022, there has been a reduction in substantive staff (-608 WTE) but an increase in bank and agency staff (+231 WTE)
  - Compared to the Operating Plan submitted in June, NCL is 1.3% below plan (appendix)
  - 46% of NCL's provider workforce is **Black, Asian and Minority Ethnic**. There are significant differences in the proportions of staff from Black, Asian and Ethnic Minority backgrounds by band: for example, 57% of Band 5 staff compared to 27% of Band 8 staff.

- There are currently (August 2022) **36,000 NCL social care staff in local authorities and the independent sector**, growing at 6% v. the London average of 3%
  - There are fewer staff on zero hours contacts (36%) than the London average (42%)

NCL **Provider** Workforce Profile

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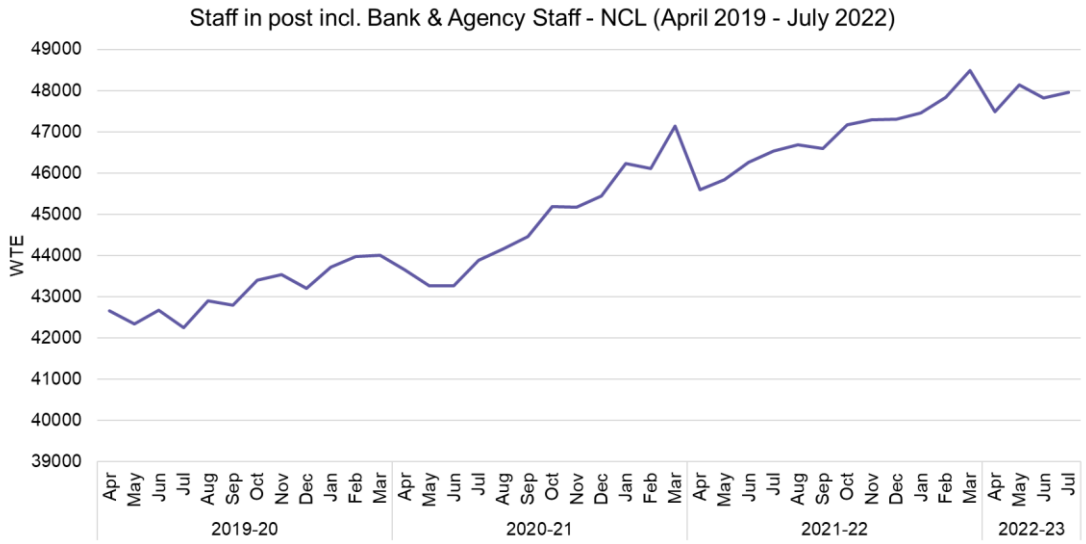

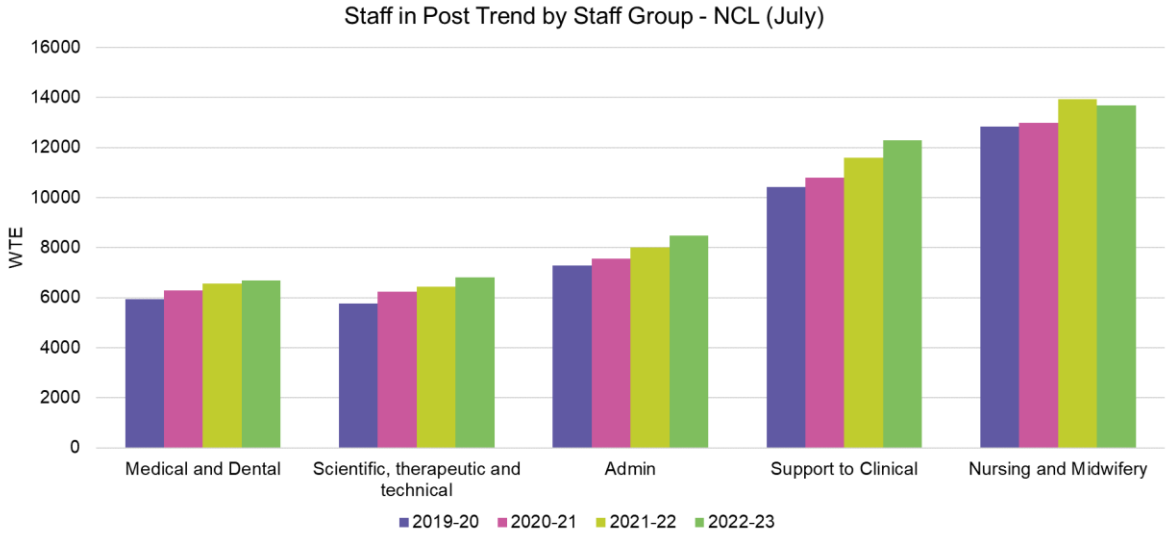

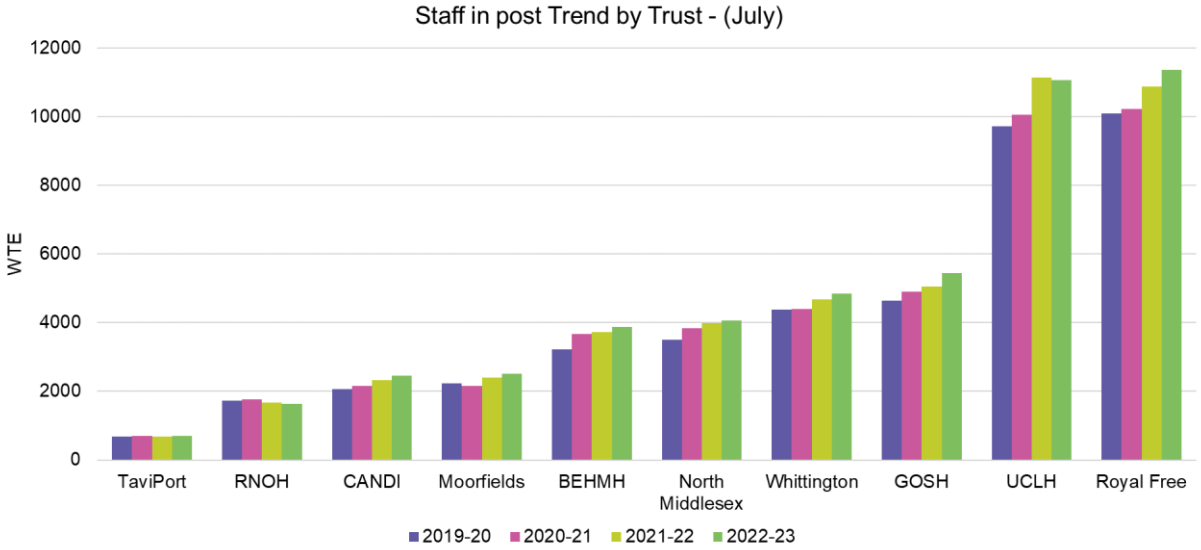

	Total WTE	Substantive Staff	Bank & Agency
As at July 2022	47,950	42,219	5731
Total WTE Growth (Apr 2019 - Jul 2022)	5,288	4,892	396
	12.4%	13.1%	7.4%
Total WTE Growth (March-July 2022)	-377	-608	231
	-0.8%	-1.4%	4.2%

Nursing and Midwifery saw a decrease of 1.8% in the last 12 months. All other staff groups saw a growth in workforce.

To note: We are looking to build on the drivers for workforce changes incl. Vaccination Staff in future versions.

Source: Finance Trust Returns
As of July 2022

NCL **Vacancy** Rate – By Staff Group

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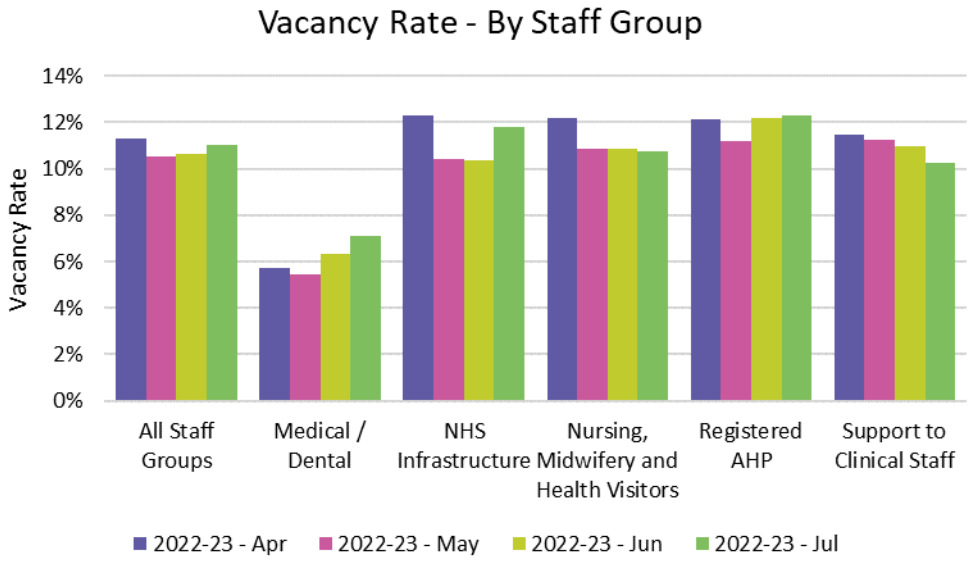
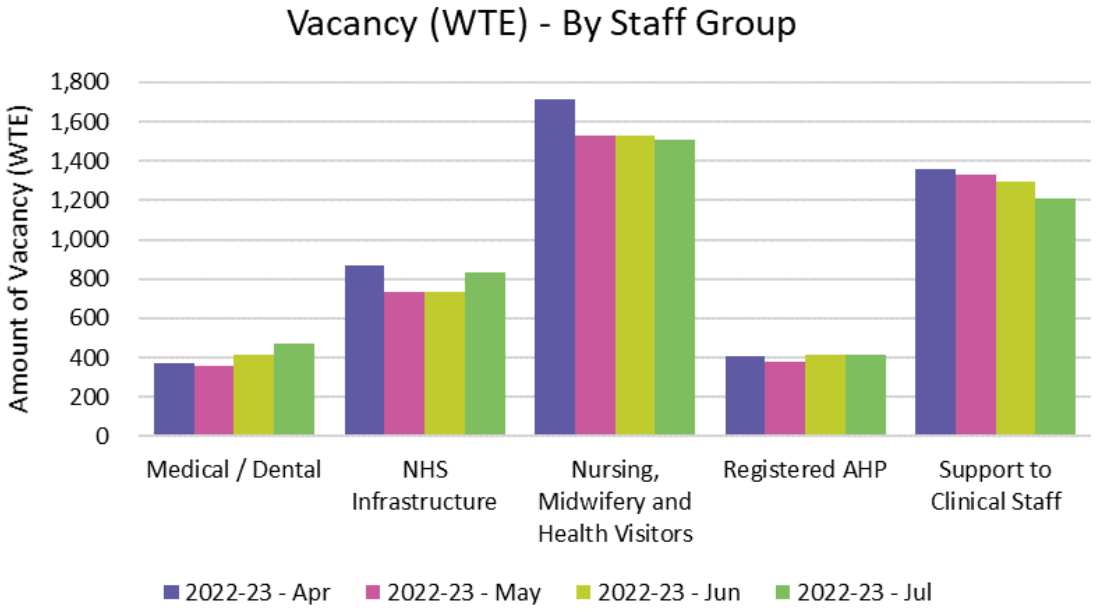
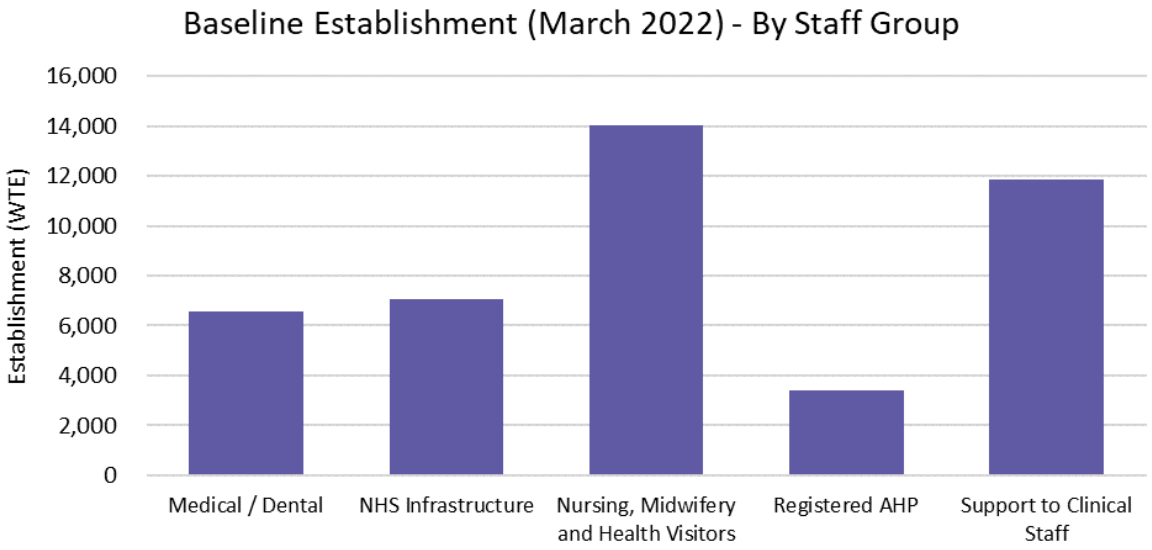






The Medical / Dental vacancy rate is significantly lower than all other staff groups.

Nursing (1508 WTE) and Support to Clinical (1213 WTE) have the largest amount of vacancy in July.

No vacancy data available for Tavistock and Portman
The Baseline Establishment (March 2022) from the June Operating Planning submissions was used as an estimate of monthly Establishment.
Vacancy is the difference between Establishment and Substantive (WTE).
Vacancy Rate is calculated as: Vacancy / Establishment.

Source: Financial Returns, Operating Planning Submissions
As of July 2022

Recruitment and Retention are an ongoing challenge for NCL

North Central London Integrated Care System

Recruitment

- Specific **recruitment challenges** in Children and Young People (CYP) and mental health.
- Challenges recruiting trained staff across London in various roles e.g., **oncology and A&E Consultants and middle grade doctors**
- Recruitment pipelines and **reliance on bank and agency** staff
- COVID 19 has **reduced the migratory flow** in and out of London, which has had a negative impact on our ability to recruit staff.

Retention

- The challenges of the cost of living, particularly in London, is making it difficult for nurses at the start of their career, to be able to afford to live and work here, which is leading to a **retention problem**
- The long-term impact of COVID-19 on our staff- staff choosing to leave the NHS **due to their experiences in responding to the pandemic.**
- There are challenges to releasing staff for the health and wellbeing support they need.

Secondary and Social care are fairing well v. peers across **vacancy** and **turnover** challenges

North Central London Integrated Care System

Vacancies

- **NCL's provider workforce** vacancy rate is currently 11%, with 5,179 vacancies. Nursing, Midwifery and Health Visitors, and Support to Clinical Staff are the staff groups with the highest numbers of vacancies.
- **Social care** vacancy rate – 6.2% v London average 8.9%

Turnover and Leavers

- **NCL's provider turnover** rate is currently 17%, and is now increasing following a reduction over the past two years. Turnover rates a highest for both the oldest (65+) and youngest (under 35) staff groups, but are increasing across all age groups.
  - Limited 'reason for leaving' data shows an increase in nurses leaving due to pay/reward, and an increase in medical/dental retirements (appendix)
- **Social care turnover** – 28.3% v. London average 32%

Sickness Absence

- Recent sickness trends have been impacted by Covid, but are generally between 4-5%. There has been an increase in the proportion of sickness absence due to mental health conditions.

To note - Primary care data has not been routinely collected but this is currently under development

Primary care challenges

North Central London Integrated Care System

Distribution of primary care workforce within NCL is a challenge: eg south sector have more GPs per head than northern boroughs, particularly Enfield and Haringey (with their areas of greatest deprivation).

General Practice Nursing	• Our **GPN rates continue to be one of the lowest in the country** at 13 per 100,000 compared to a national average of 27 per 100,000. *Challenges are also felt by our neighbours in NWL at 14 per 100,100 and NEL at 15 per 100,000.* • Camden has the **3rd lowest GPN** to patient ration in London • Our GPN numbers continue to decrease with an **11% decrease in FTE GPNs** over the last 5 years • Ageing workforce: **19% of GPs and 43% of nurses over 55** • ***Current mitigation*** *through Training Hub GPN Strategy but instability of funding for posts*
Workforce Data Quality & Funding	• Data is collected monthly for practices and quarterly for PCNs via National Workforce Reporting System and used to measure performance and to allocate funding for workforce. • There are important caveats to note re the data on Operating Plan metrics given that: • **43% of our practices have not logged on (and therefore not updated) in the last 3 months.** For our PCNs this is 37% with 5 PCNs never having submitted any workforce data • ***Current mitigation*** *through targeted work underway with PCNs and Practices to improve recording with support from boroughs*
ARRS & Other Direct Patient Care Workforce support & retention	• In NCL we have had the highest % increase nationally of Direct Patient Care roles employed by practices together with our high performance in ARRS recruitment – both of which together make this a priority area • The implementation of the Fuller Review will enable the multi-professional teams to be further embedded into primary care to support patients in a more holistic way • ***Current mitigation*** *through Training Hub workforce development but further development needed*
Burn out and Change Fatigue	• Model of care has evolved and continues to evolve at a rate never seen before in General Practice • Further significant change to come under Fuller and the development of Integrated Neighbourhood Teams • In addition to this General Practice are seeing more patients (**NCL 23% increase in booked appointment between Feb 2020 and Feb 2022** with recent data showing 80% of NCL boroughs exceeding pre pandemic levels)

Secondary care challenges

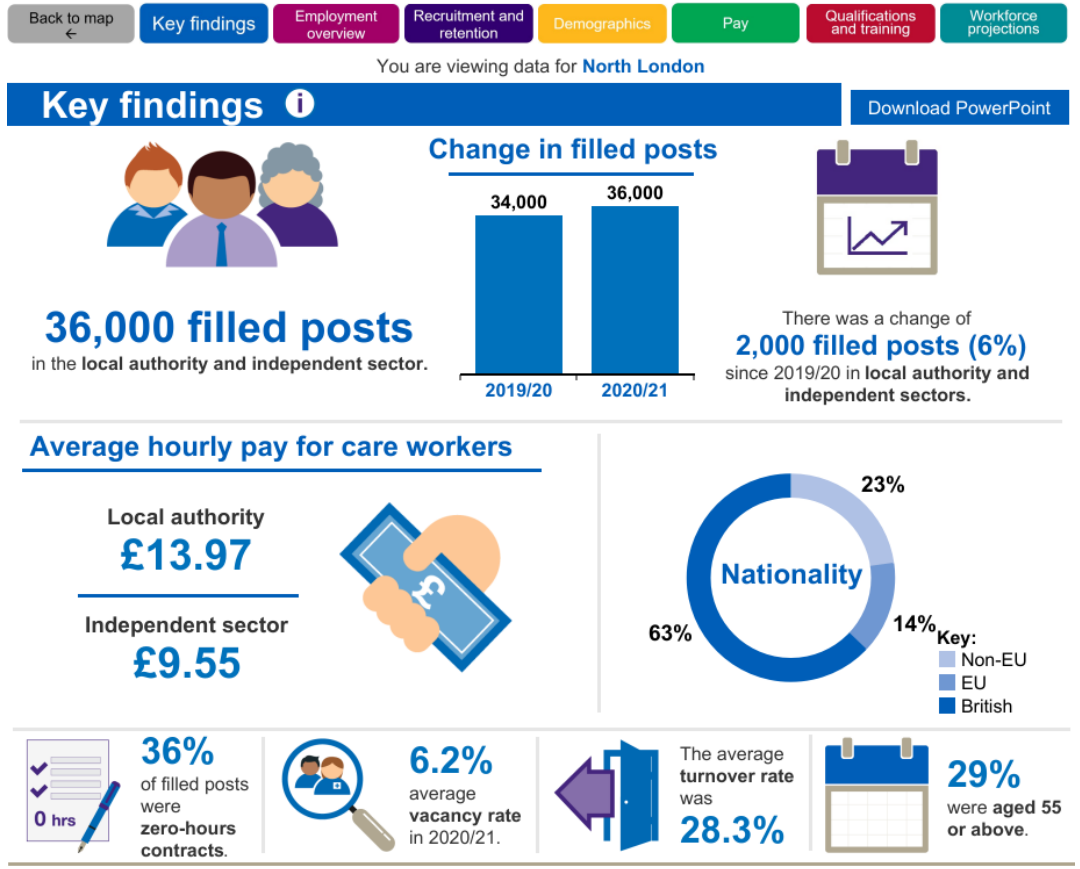
North Central London Integrated Care System

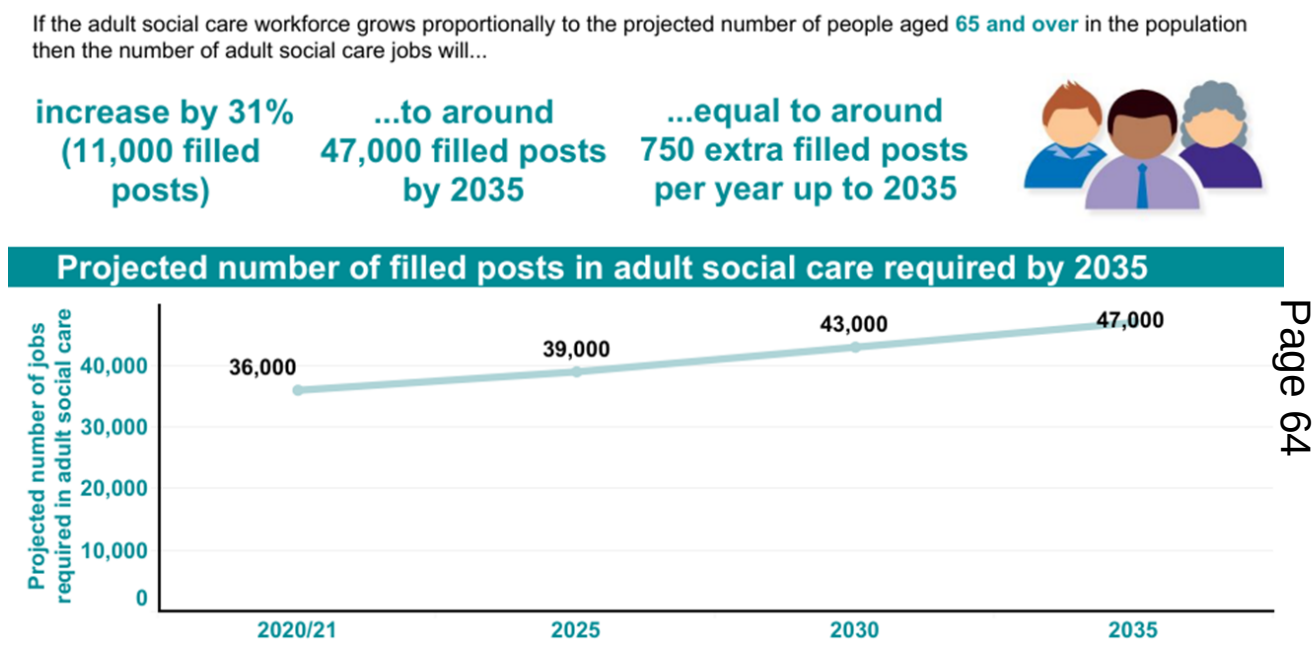
Secondary care workforce is currently experiencing: **high vacancy rates, increasing turnover rates, increase in nurses leaving due to pay, increase in medical & dental staff retiring, high levels of staff sickness/absence due to successive covid waves and increasing staff sickness due to mental health conditions.**

Demand	• **A&E attendances** remain higher than 2019 (>10%) impacting all NCL sites, but concentrated in the north of the sector. • Ambulance conveyances remain approx. 20% lower than 2019 however the acuity (level of sickness) of patients is higher and increased length of stay and challenges in discharging patient, has led to ambulances having longer stays outside hospitals before they can hand over patients • NHS111 call volumes stable • **Covid+ admissions continue to decrease** and forecasts predict a continuing decline in both new admissions and beds occupied by Covid+ patients • The **mental health system** remains challenged with the numbers of patients in **out of area placements** continuing to increase
Performance	• 4hr performance is **improving** although still below target and remains challenging • **Ambulance handover delays** – 15/30/60 min performance remains a challenge but is improving with a reduction in the total time lost due to delays over last two months. • Elective recovery steady and have been achieving the performance required to remain on target to meet the 104 week wait requirements • Overall, it remains a challenge across the sector, however performance is slowly moving in the right direction. • The challenge of winter and any potential industrial action could have an impact on this progress and mitigation plans are in development
Capacity and Infection Control	• Bed occupancy – **consistently high in NCL** with high length of stay, which creates very little capacity for new patients being admitted • Number of escalation beds (additional beds opened) steady so not increasing but not able to decrease yet • High numbers of patients awaiting a discharge home due to challenges with social care capacity • Minimal acute beds closed due to Infection Control • Reduction in beds occupied by Covid+ patients however expecting another wave in winter • Staff absences due to Covid have stabilised and sickness levels have improved

NCL Social Care Workforce (2020/2021)

North Central London Integrated Care System





Key Risks:

- Very high turnover rate of 28%
- Ageing workforce: 29% over 55
- Low independent sector average pay v other sectors
- Requirement to increase workforce in line with ageing NCL population

*21/22 data due to be released mid-October. Data and infographics from [My ICS area (skillsforcare.org.uk)]

Social Care challenges (including wider context beyond workforce)

North Central London Integrated Care System

Recruitment challenges	• 46% of providers report **applications for new roles are much lower** (25%) or a little lower (21%) than pre-covid • Over 50% of providers are using values-based recruitment approaches • 47% of providers said staff **mental health and wellbeing had worsened** since covid • **Competitor sectors**, such as retail, have more flexibility to increase wages • Risks from COVID as a condition of **deployment**, particularly for homecare

Hospital discharge demand	• Significant increased demand from hospital discharge leading to:
	  • Up to 500% increase in requests for **24 hour care**
	  • 30%+ increase in demand for **double up packages** of care
	  • 100% in **care home placements** over £1,000 pw
	  • Providers tell us that the processes around hospital discharge and over-prescribing of care are heightening capacity issues

Other factors	• Increase in **care homes** that are focused on self funders • Social care managing increased activity due to covid (heightened responsibility around discharge; reviews; safeguarding etc) • **Cost of living crisis** • **Reduced discharge** funding

North Central London Integrated Care System

NCL Workforce Initiatives

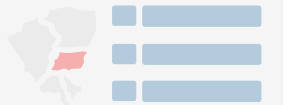
NCL Workforce JHOSC report
September 2022

Current NCL workforce programme priorities

North Central London Integrated Care System

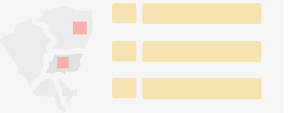
Responsibility level of People Plan actions

STP/ICS



Borough

Neighbourhood



Organisation

Our identified NCL Workforce high impact priorities are aligned with the London and People Plan priorities

NCL priorities	London priorities	People Plan Priorities
RETENTION	Caring for and celebrating our people	Looking after our people
Equality & inclusion & diversity	Training and development for critical care	Belonging in the NHS
Staff wellbeing & tailored programmes		
Talent management, progression and career pathways		
RECRUITMENT	Attracting people into the NHS	Growing for the future
Local workforce recruitment routes into health and care employment	Sustaining and growing nursing	
SYSTEM CHANGE	Enhancing medical education	New ways of working and delivering care
Working with & across sectors & NCL People Board	Ensuring productive working across London	Supporting our NHS people for the long term
Workforce planning and modelling based on population		

Responding to new challenges and opportunities

2021/22 achievements and successes: Workforce Programme

North Central London Integrated Care System

1. **Building collaborative approach to equality, diversity and inclusion across NCL with a focus on supporting improved recruitment practices and reducing bullying and harassment**

2. **Developing inclusive and diverse leadership capacity in NCL through involving more staff from all levels, backgrounds and professions in the working groups and People Board**

3. **Building strong foundations from which to develop the People Function through facilitating collaboration and setting up an effective infrastructure and baselines for workforce development across NCL**

4. **Strengthened system working, wider workforce engagement and priorities co-design through strong programme management support, convening diverse stakeholder groups and supporting innovation**

5. **System reach into primary care through building strong partnerships with the Training Hubs**

6. **40 new Registered Nurses and over 100 potential new recruits on the pathway, with an established system infrastructure to support recruitment, retention and development of nurses**

7. **Strengthened Workforce Analytics Function supporting data-driven interventions**

2021/22 achievements and successes: Nursing Workforce Programme

North Central London Integrated Care System

11,583 WTE Nurses in NCL

Established **NCL HCSW education network**

Delivered system Nursing event

55 HCSW have met NMC requirements through the Local International Nurse Transitions project

2790 views so far
- Series of **'Walking in my Shoes'** online resources published for AHPs, Midwives, Nurses and Clinicians

Exceeded target for **International recruitment** by **16.9%**

83 Trainee Nursing Associates candidates invited to apply and sit the entrance exam

Established **NCL Nursing Workforce Winter Planning Group** with CYP Leads

6 Completed IPC Fellowship and **2 promoted**

Established **PNA Implementation Group** and created **tools and guidance** to support PNA roles across the system

Established **Programme Team** to work with project leads and **collaborate with the system and partners** on Programme delivery

Workforce Awards 2021/2022

North Central London Integrated Care System

London HCSW Awards September 2021

- North Middlesex University Hospital NHS Trust - Innovation in recruitment
- Mercy Okougha, Whittington Health NHS Trust - Career framework and development
- Diana Oliveria, Royal National Orthopaedic Hospital NHS Trust - HCSW of the year

Nursing Times Awards 2021

- Clinical Research Nursing Award – ROAM (research opportunities at Moorfields) - Managing Long-term Conditions Award
- Paediatric specialist automated Red Cell Exchange Service (led by Albin Bendiola) NMUH NHS Trust

Student Nursing Times Awards 2021

- Student Midwife of the Year Nicolette Porter - Middlesex University
- Student Nurse of the Year: Children Demie Risby – Great Ormond Street Hospital
- Most Inspirational Student Nurse of the Year Sian Chinnoyelum Chinwuba – Middlesex University

RCM Award Winner 2021

- NMC Excellence in Perinatal Mental Health Award Case Holding Women with Perinatal Mental Health Collaboratively (Magnolia Midwives Team)

Health Hero Awards 2021

- Mebrak Ghebrehiwet, BEH Eating Disorders Service – Health Hero

We are currently developing our strategy, governance and portfolio of work across the ICS

North Central London Integrated Care System

- The Population Health Improvement strategy is guiding our portfolio development
- NCL People strategy in development for December
- There is strong oversight on Workforce via the Provider Alliance and People Board
- We are collaborating with and learning from other ICSs
- **Supporting information for sample initiatives on the next slides**

Summary and next steps

North Central London Integrated Care System

- The NCL ICS Workforce Programme is **undergoing transition** as we move to establishing an ICS People Function and meet the national requirements*
- Our focus will be on the development of our ICS **People Strategy** (required by December 2022) and the associated **5-year implementation plan** (required by March).
- A key plank of this is the development of the **Work Well** strategic aim and supporting portfolio as part of the Population Health Improvement Strategy and Outcomes Framework
- Workforce is a key priority in all our ambitions for **delivering a transformed health and care system.** Delivery of the commitments set out in our transformation programmes such as Mental Health Services Review, Fuller, Community Services and implementation of People at the Heart of Care – adult social care reform remains our focus.
- Despite this ambition, workforce is also a significant challenge due to the current position of a **lack of staff nationally and our current context with cost of living driving people out of London, potential industrial action and a difficult winter.** However we are committed to ensuring we are relentlessly focussed on the delivery of improved population health and high quality care services for our population.

* Building strong integrated care systems everywhere – guidance on the ICS People Function - https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf

North Central London Integrated Care System

Appendices – Case studies

Example initiative: Insights from Primary Care workforce

North Central London Integrated Care System

EXAMPLE successful workforce schemes

- **GP Fellowship Scheme** (national scheme with local implementation, 100% offer to newly qualifying GPs with high uptake rates)
- **Mentoring Scheme** (both national scheme but local schemes extended to cover broader workforce)
- **ARRS budgets** – NCL has the 2nd highest utilisation per list size in London and significantly higher than national average
- **Wellbeing pilot** delivering a 20% increase in Primary Care support referrals to 'Keeping Well NCL'
- **TNA programme** covering recruitment into health & social care – on track to exceed 22/23 target, flagship for London

EXAMPLE Initiatives with challenges

- **GP Nursing Fellowships –** take up very low as only open to newly qualified – GPN roles tend not to be 1st destination & would benefit from being extended as an offer to any career stage transitioning into General practice
- **Expansion of Clinical Placements** – Programme aspirations remain but implementation has proven to be more time intensive
- **Nursing funding** – GPN initiatives could have slowed the rate of decline in GPN workforce but remains in decline
- **Sustainability of impact** – short project funding impact longer term impact
- **ARRS retention & partnership recruitment** of ARRS roles to reduce professional isolation. Some areas of good practice but needs further expansion
- **Retention** – Success of schemes has been difficult to measure

Example initiative: London Living Wage

North Central London Integrated Care System

London Living Wage is currently set at £11.05 per hour.

Recently launched by London Recovery Board plan “Building a Fairer City” is about tackling structural inequalities in light of covid and makes range of recommendations for statutory and non-statutory organisations to come together with practical action to address – of which LLW one plus tie closely to Anchor aspirations.

The aim is to Make London a Living Wage City: “Wealth inequality, especially among the most disadvantaged Londoners is now pernicious. It is imperative that as employers we step up our commitment to pay the London Living Wage to every staff member, whether they are on permanent or temporary contracts. We should also encourage our partner businesses, including supply chains, to do the same.”

Helping to address:

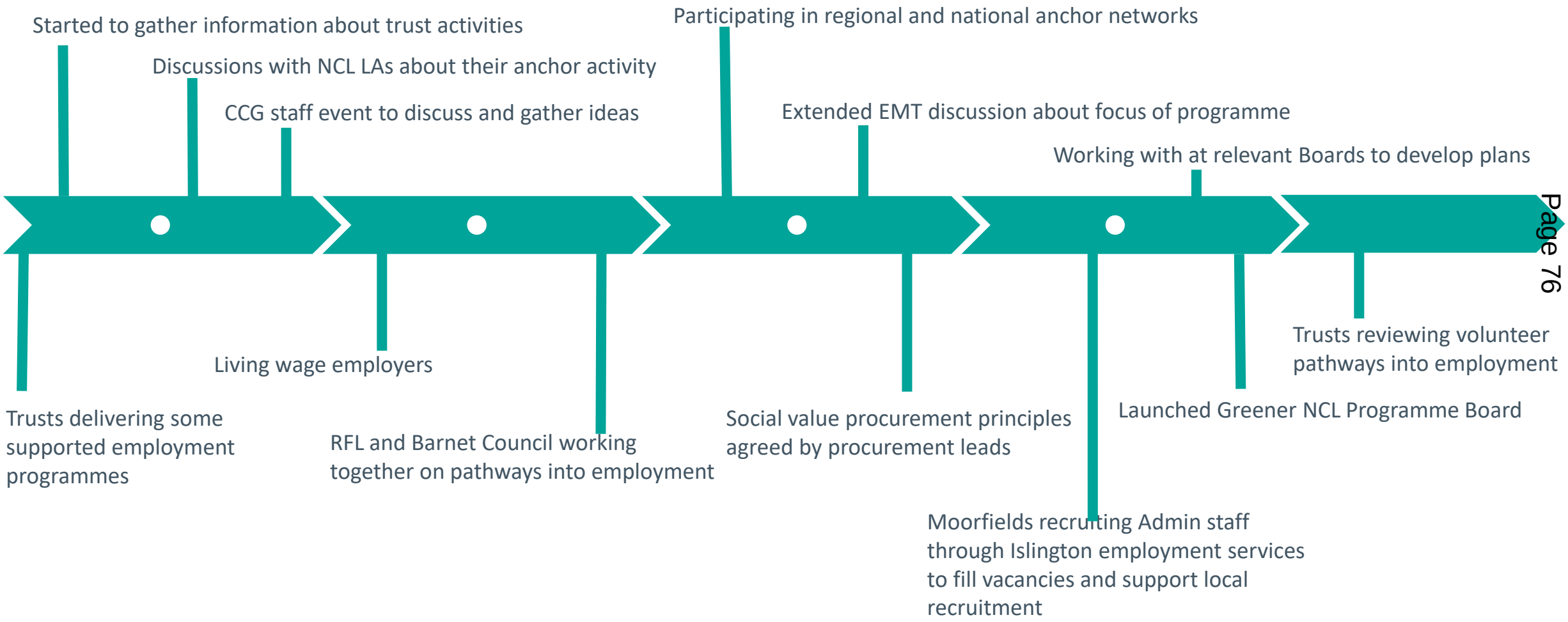
- In work poverty; the cost of living crisis has created more urgency
- Inequality; supporting our aims to address health inequalities for our population
- Workforce challenges such as recruitment and retention

The Living Wage Foundation runs an accreditation scheme for employers who commit to paying all their directly employed staff the Living Wage, as well as having a plan in place to move all regular third-party staff to the Living Wage.

Example initiative: London Living Wage timeline

North Central London Integrated Care System

On behalf of the NCL ICS, the Communities Team has been working on…



Example initiative: Work in NCL – Training Hubs - Primary Care Anchor Networks

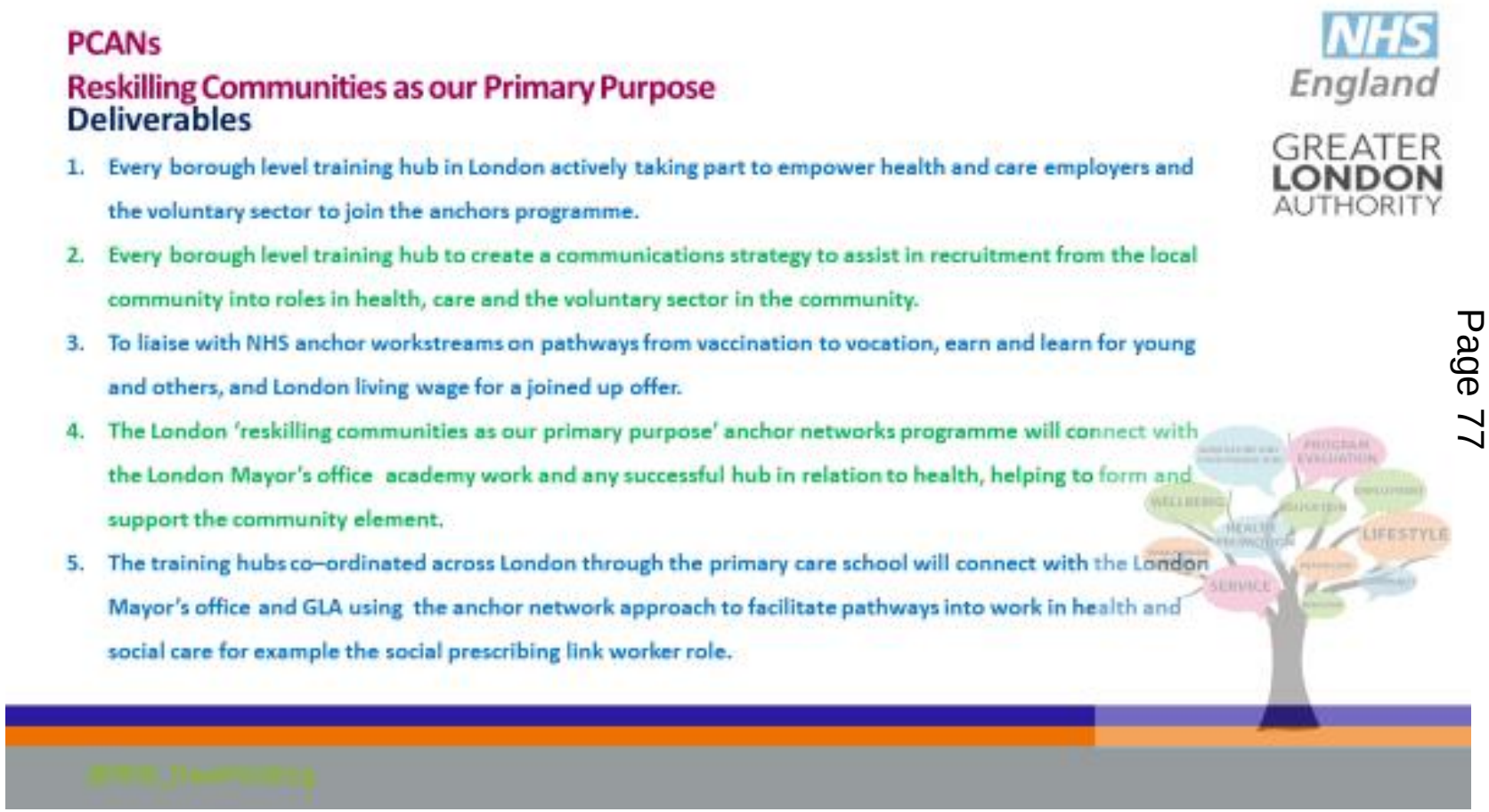
North Central London Integrated Care System

Training Hubs supporting LLW through Primary Care Anchor Networks (PCANs)

- Training Hubs are receiving complementary HEE funding to enable a Project Manager to drive PCAN agenda

- Work has already begun through, Practice Manager Leads, to promote LLW alongside other HR best practice identified through NHS People Plan priorities

- PCAN work is looking to align with Mayoral Health & Social Care Academies to further support engagement and promotion of LLW

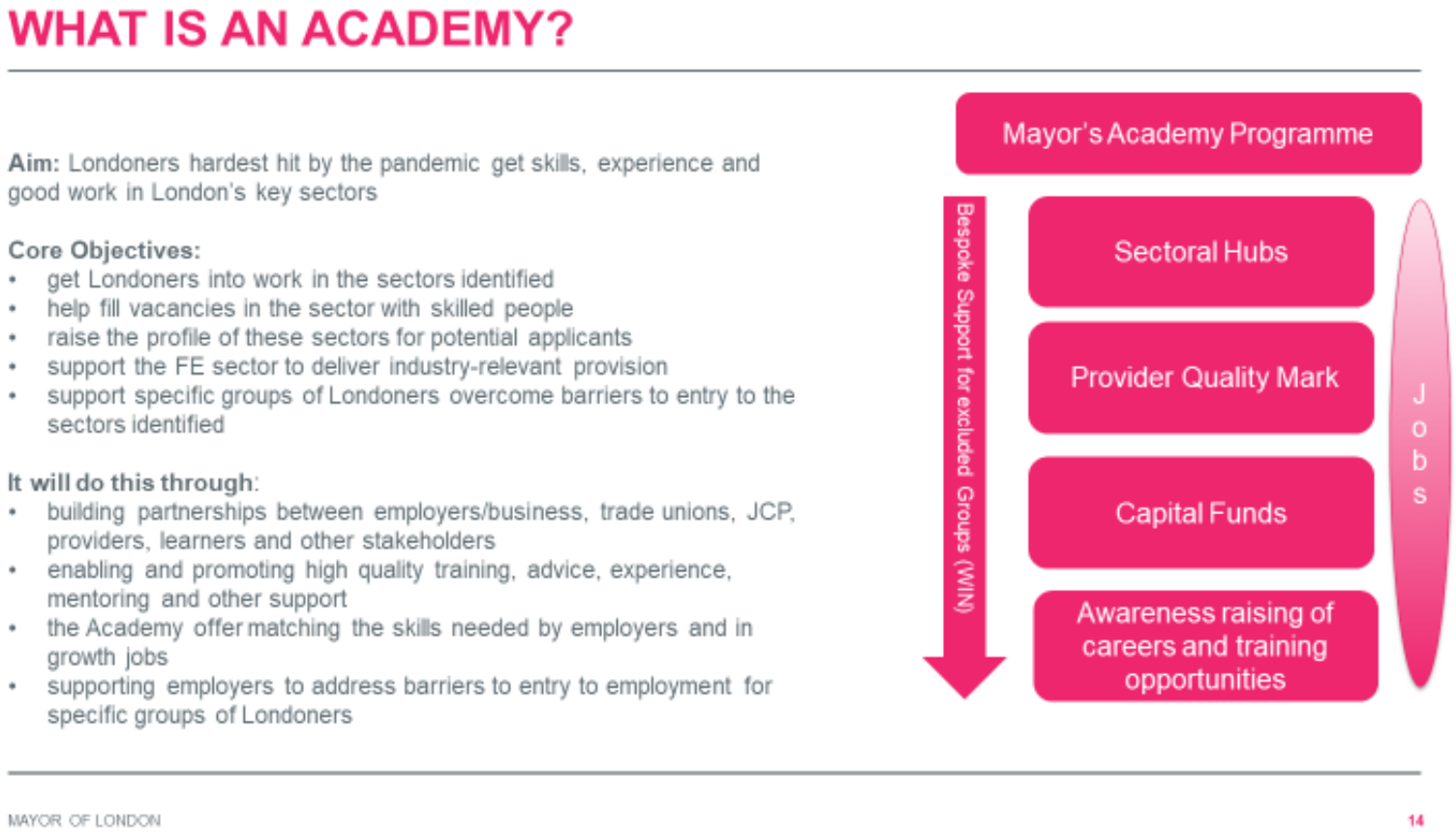


Example initiative: Work in NCL – Mayoral Academies (Health & Social Care)

North Central London Integrated Care System

Mayoral Academies to support LLW

- NCL is mobilising a GLA funded Health Academy (scaling up from Islington's Health & Care Academy)
- We're also bidding for a Social Care Academy
- Both are aiming to mobilise in Q3 2022-23 and have promotion of LLW as a requirement for any roles they focus on



North Central London Integrated Care System

NCL Workforce Report

JHOSC

September 2022

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Agenda Item 9

North Central London
Integrated Care Board

NHS 111 (Integrated Urgent Care) Update for JHOSC

August 2022

Section 1: Introduction & Background

1.1 Introduction

The Joint Health Overview Scrutiny Committee (JHOSC) is a key stakeholder in respect of local health services. In April 2022, the NCL Clinical Commissioning Group (CCG), now known as the NCL Integrated Care Board (ICB) informed the JHOSC of the ICB plans to undertake a procurement exercise to deliver a new NHS111 Integrated Urgent Care (IUC) Service to commence on 4 October 2023.

This report provides the JHOSC with a further update of the procurement programme including:

- Update on the procurement progress and critical milestones;
- Update on the communications & engagement activities undertaken and feedback received;
- Update on national strategic drivers which include:
  - The implementation of the London Region NHS111 'single virtual contact centre' model (SVCC)
  - The NCL NHS111 and London Ambulance Service (LAS) integration pilot; and
  - Primary Care changes & its impact on NHS111 IUC.

1.2 Overview of Current Contract

The NHS111 Integrated Urgent Care (IUC) Service is a nationally mandated single point of access service supporting 24hr access to all urgent health and social care services 365 days a year. The North Central London NHS111 IUC service is currently provided by London Central and West Unscheduled Care Collaborative (LCW) and comprises the area covered by the London Boroughs of Barnet, Camden, Enfield, Haringey and Islington. The contract was awarded against a local specification but since 2018 a number of changes have been made to the service model to meet increasing demand and ensure alignment with national requirements, with the National IUC Service Specifications being published in 2018 and 2021.

The existing contract expired in September 2021 but was extended to September 2023 to enable time for the design, planning, procurement and mobilisation of a new service to commence on 04 October 2023.

NCL IUC Service currently consists of the following elements:

- NHS111 Telephone and Online Support on a 24/7 basis, 365 days a year
- Urgent GP face-to-face services from 5 NCL sites during the out-of-hours period, including home visits
- A 24/7 Clinical Assessment Service (CAS) made up of of GP and Nursing staff

Key service changes and enhancements include:

- Direct booking (heralded) into various healthcare settings including GPs, Extended Access Hubs, Urgent Treatment Centres and Emergency Departments.
- The implementation of the CAS, remote working for Health Advisors/Clinicians and the introduction of a Senior Advisor Role
- Introduced 24hr ED/Ambulance validation by a clinician. This ensures that only those patients that need it are sent to the Emergency Department or sent an ambulance.
- Implementation of the regional NHS111 'single virtual contact centre' model (SVCC); and
- The NCL NHS111 and London Ambulance Service (LAS) integration pilot.

1.3 National Context

A key principle of the NHS Long Term Plan is that England has in place a 24/7 Integrated Urgent Care Service, accessible via NHS111 telephony or online.

NHS111 services have continued to grow and develop since being established. The Covid pandemic changed the UEC paradigm. The national 'Think 111 First' programme was launched, which advises people thinking of attending an emergency department with non-life threatening conditions to call NHS111 in the first instance. NHS 111 IUC services have had to manage significant increases in activity and number of patients through 'hear and treat' pathways and changes being made to the service operational arrangements.

The National IUC Service Specification and the IUC Commissioning Framework were published in 2021. These documents set out the requirements for the NHS111 IUC service which included call handling to be delivered on a regional footprint at scale which would bring providers to work together. See section 4.1 which gives more detail of this change.

Section 2: IUC Procurement Progress

2.1 Procurement Process and Key Milestones

The re-procurement for the NCL NHS111 IUC Programme is overseen by a multi-disciplinary Procurement Steering Group and includes representation from primary care, ED's, LMC, NHSE and Patient & Public. This committee has 2 Sub-Groups (Clinical Sub-Group and Engagement & Communications Sub-Group).

The Engagement and Communications Sub-Group which is made up of patient & public champions from across NCL boroughs have supported and advised the programme on the patient and public engagement activities for the procurement. This group is also chaired by one of the Patient Champions.

The Clinical Sub-Group is made up of clinical and quality leads and also includes patient & public champions. This group has focused on developing the clinical model taking into account local need and the requirements set out in the National IUC Service Specification.

The re-procurement programme is split into 3 phases which are; 1. Planning & preparation; 2. Procurement; and 3 Mobilisation. Each phase follows an assurance process to assure NHS England & Improvement (NHSE&I) that the various stages of the procurement have been robustly constructed according to defined good practice and this has been built into the timeline.

There has been significant progress made with the procurement programme since the last correspondence to the JHOSC. The key activities achieved to date are summarized in the table below:

Project Resources, governance structure & TORs for the steering group and its sub-groups are in place and these groups have been meeting regularly since November 2021
A Procurement Task and Finish Group established in March 2022 and this group has supported the programme in taking forward the development of the Procurement Strategy and the Invitation To Tender preparations.
A service options appraisal was undertaken by the Clinical Sub-Group which included patient champions. Three broad future service model options were considered and these details are explained in section 2.2.
Market Event - An early Prior Information Notice (PIN) was published on 22 March 2022 notifying the market of NCL's plan for procurement. The Market Event was successfully delivered on 10th May 2022 and a market event questionnaire was subsequently published and the feedback has been collated.
Communications & Engagement Plan - A comprehensive communications and engagement plan was developed with the Patient & Engagement Sub-Group and this ensured that our integrated care system partners, wider stakeholders, residents, service users, GPs and primary care colleagues were made aware of the CCG plan to re-procure the service. Engagement activities commenced in March and to date the team have engaged with a variety of groups across NCL. This is explained further in the report at section 3.
Equality Impact Assessment (EQIA) – An initial EQIA was completed and approved by the NCL Equalities Lead and endorsed by the Governing Body on 30 June as a working document. Since then a full EQIA has been undertaken and a number of actions have been identified. The EQIA will be reviewed throughout the programme.

A summary of the actions taken include strengthening the new service around training for staff to deal with particular groups, assurance around the interpretation and translation offer and highlights further work that is recommended for the regional teams to consider that is outside the scope of this procurement, for example feedback received on the call menu and collecting patient information on all protective characteristics.
Business Case developed and signed-off – The business case for the procurement of the new NHS111 IUC service starting from October 2023 was approved by the NCL CCG Governing Body on 30 June. The business case focused on three core elements; the provision of front-end Call Handling, Clinical Assessment Service (CAS) and a GP Out-of-Hours service (GP OOH) which ensured that an effective, resilient and best value for money service can be delivered. Each core element have been considered against national and regional strategic drivers, published service specifications, existing system-wide partnership arrangements and interdependencies, and the financial position of the Integrated Care System(ICS).

The table below shows the remaining procurement timeline and critical milestones:

Key Milestones	Date
ITT Documents Sign-off by	w/e 23 Sep 22
Invitation to Tender (ITT) to Submission	End Sep – Nov 22
Shortlisted bidder Presentations/Interview	End Jan-23
Submit Award Report to approval	01-Feb – 28 Feb 23
Contract Award Report Approval	01-Mar -10 April 23
Inform bidders of outcome and observe standstill period	11-Apr - 21 Apr 23
Contract award and discussion	24-Apr - 28 Apr 23
Mobilisation	01-May – 3 Oct 23
Contract start	04-Oct-23

The planning phase of the procurement is almost completed and the procurement phase due to commence from September with the ICB is now aiming to publish the ITT during the week ending Friday 23rd September 2022.

2.2 Clinical Model

The Clinical Sub-Group identified and considered three broad future service model options:-

1. Maintain current service provision
2. Maintain current service provision with local clinical enhancements
3. Deliver the full National Service specification

Following extensive public, patient and clinical engagement ‘Option 2’ was identified as the preferred service model that would provide the greatest improvement in patient experience and additional benefit to the local system by continuing to meet the fundamental elements of the national service specification whilst also increasing the rate of ‘consultant and complete’. This option was endorsed by the NCL CCG Governing Body in April 2022 as the preferred option for implementation.

Over the past months, significant work has been underway to develop the NCL service specification with input from all members of the procurement programme. The draft has where possible taken into account the feedback that has been received from the communications & engagement exercise. Once the service specification is approved, this will form part of the suite of documents to be published when the procurement is launched.

Section 3: Communications and Engagement

3.1 Engagement Events and Feedback Themes

Since March 2022, the ICB NHS111 IUC Procurement Project team have engaged extensively with NCL residents, service users, its' integrated care system partners, wider stakeholders, GPs and primary care colleagues on its plans to re-procure the NHS 111 IUC service. This has been overseen by the Engagement & Communications Sub-Group.

The Sub-Group and our supporting team have attended a number of voluntary & community group meetings and staff network meetings as well as arranging targeted focus groups for specific user groups which were identified in research and the initial EQIA as experiencing challenges accessing the service. These have included:

- People with learning disabilities;
- People who are profoundly deaf:
- People with visual impairment;
- People with mental health needs; and
- People whose first language is not English.

The following is a summary of the key themes that emerged during the discussions about the experience of service users and the outcomes of the specific focus groups can be seen at Appendix 2:

- Some people are still unsure when to use 111 and 999
- Most users who received a booked appointments found it helpful but felt that this was not being offered all the time
- Most people thought that the call menu is too complicated and can be confusing
- It was important to people that call backs occur in the stated time frame and the 111 service is appropriately connecting people to the right setting for further treatment
- Many people thought there was a need for a simpler mental health pathway when contacting 111 and mental health clinicians in the clinical assessment service
- Language barrier if English is not your first language makes contacting the service less accessible
- More consideration is needed when designing the service around people with learning disabilities, dementia, neurodiversity, autistic, auditory processing issues, and mental health issues
- Some people expressed concerns around digital applications such as 111 Online, video consulting which are not accessible for those that are not digitally literate or can't afford a computer or internet
- People referred to the OOH GP service found this was conveniently located for them
- Most people are not aware about the GP OOH service
- Some people felt the service is risk averse especially in the case of children as they will send to A&E
- People wanted a high quality service; there were some concerns expressed about the training and experience of the call handlers and a strong feeling that they needed on-going training and support when dealing with particular groups
- Some people felt improved communication between the 111 service and GP practices is needed to ensure that patients get ongoing support where necessary
- Residents wanted to be able to speak to a local healthcare professional as quickly and as early as possible once they called NHS111 as opposed to be being dealt with by a regional provider

- The new service needs to be able to make good links with the local health system if it is to be effective for local residents.

3.2 Survey Evaluation

An NCL NHS111 IUC survey was developed with the Patient & Resident Champions to understand the NCL residents' experiences of using the service; to find out about the barriers that may prevent people from easily accessing the IUC service; and why people may choose to attend emergency departments rather than contacting NHS 111. The survey ran from 12 May to the 19 June 2022 and was promoted through various channels. Full details of the survey can be seen at Appendix 1.

In summary, the themes that have come out of the survey largely mirror those were identified from the engagement sessions above.

3.3 Communications & Engagement Next Steps

The feedback from the Communications & Engagement exercise has been factored into the development of the service specification where appropriate. In addition to this, the ICB programme team will be developing an action plan to capture & address the feedback from communication & engagement exercise. This will be developed with the Patient & Engagement Champions and taken forward as part of the procurement process.

Section 4: Strategic Drivers

4.1 Implementation of the Single Virtual Contact Centre (SVCC)

The IUC Commissioning Framework (released in 2021) set out the case for call handling at scale via a Single Virtual Contact Centre model (SVCC). To address the national requirement and given the scale and complexity of this transformation, regular discussion between London ICS NHS111 leads and the Regional team have been taking place since November 2021 to ensure a smooth and seamless implementation.

The SVCC was fully launched on 19 April. This model integrates all calls to NHS111 through a regional platform, which effectively directs any caller in London to the first available service across the region where a local call handling provider is unable to respond within the regionally agreed threshold. Following assessment and if the caller requires CAS input, the call will be transferred to the patients respective ICB IUC provider for CAS triage, onward referral and resolution. The intention is to provide patients with the right care first time with parity of NHS service provision regardless of which provider deals with the caller when they first access the service.

A number of local pathway exclusions to this process are in place. For NCL the exclusions include patients under the age of 1 and over 75. This means approximately 70% of NCL calls fall within the SVCC model. An initial SVCC impact analysis has shown a stabilisation of performance across London and has highlighted a reduction of calls being abandoned each day. A regional deep dive and evaluation of the SVCC model will be undertaken and this will also be shared with the Patient Engagement Sub-Group once this is available.

The ICB continues to closely monitor the impact of regional and national direction of travel closely and recognises that the programme will need to be flexible and align its work accordingly with the procurement programme.

4.2 NCL 111 and London Ambulance Service (LAS) integration Pilot

In addition to the above implementation, In April 2022, the ICB approved a one year pilot to re-route Category 3 and 4 ambulance dispositions from the current 111 IUC provider to LAS. This work aligns to the London 999 & NHS111 programme strategic vision for integration and this approach has brought NCL in line with the rest of London resulting in LAS delivering Pan-London NHS111 Category 3 & 4 validation, supporting the service to better manage ambulance dispatch.

A recent analysis of the pilot has shown approximately 100 fewer conveyances per week for NCL and is seen as an integral part of the system-wide improvement plan to reduce hospital handover waiting times. A six month review will be undertaken to consider the benefits of the pilot on reducing ambulance conveyances and hospital handover waiting times as well as value for money.

4.3 Primary Care Changes

There are changes being made to Primary Care. From October 2022 the GP Extended Access Service transfers to Primary Care Networks (PCNs) with an associated change in contractual requirement. This change includes the removal of both the Sunday provision and the need to ring-fence NHS111 specific appointments.

Currently ICB internal discussions are underway and a number of options are being explored. Furthermore, in May 2022, The Fuller Stocktake Report was released and this sets out the next steps for integrating Primary Care and outlines a new vision that re-orientates the health and care system

to a local population health approach through building neighbourhood teams, streamlining access and helping people to stay healthy.

Over the next 6 months NHSE will review the role of NHS111 as an enabler for delivering integrated urgent care pathways. The ICB will then consider the outcome of the review, which may result in national or regional mandated changes to the NHS111 operating model

Section 5: Recommendations

The JHOSC is asked to note and where appropriate comment on the following:

- The update on the procurement progress and the timelines as given above;
- The communications & engagement activities undertaken and feedback received including next steps;
- The update on the recent national strategic drivers which include:
    - The NHS111 ‘single virtual contact centre’ model (SVCC);
    - The NCL NHS111 and London Ambulance Service (LAS) integration pilot; and Primary Care changes.

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Service Specification and Clinical Model Outline

North Central London Integrated Urgent Care Board (NCL ICB) will go out to tender for NCL's NHS 111 Integrated Urgent Care Service during week ending 23 September 2022. The service specification along with the procurement suite of documents were presented at the various NCL ICB Governance forums and approval was received on 6 September 2022 to progress with the procurement launch.

The next stage of the process is undergo an assurance process with NHS England (London Region) prior to launching the tender publication.

These key service/clinical model principles set out below have been developed to align with the fundamentals of the national service specification. The service specification was developed with input by a range of programme members and subject matter experts including GPs, Local Medical Committee members, Patient Champions, NHS England London Regional colleagues and wider stakeholder feedback following the engagement activities undertaken as part of this programme. More detail about the programme progress and engagement to date can be found in the longer update paper.

The JHOSC are asked:
To note the extensive engagement undertaken to support the development of the service specification;
To note the key service model principles in the table below: and
To note this model aims to provide the greatest improvement in patient experience and additional benefit to the local system by continuing to meet the fundamental elements of the national service specification whilst also increasing the rate of 'consultant and complete'.

The service specification focuses on three core elements:-

- The provision of front-end Call Handling 24/7, 365 days a year;
- 24/7 Clinical Assessment Service (To CAS) including GP and Nursing staff; and
- Urgent GP Out-of-Hours service (GP OOH) including home visits

The following table reflects the NCL NHS111 IUC key service model principles:-

• The 111 front-end call handling response will form part of the London's 111 Regional Call Management Single Virtual Contact Centre (SVCC) model. This model ensures calls are dealt with quickly across a regional footprint. It will improve service resilience and performance whilst maintaining NHS111 growth in call volumes. • Aiming to reduce the number of unnecessary separate patient contacts ensuring the patients call is dealt with on the initial call (consult and complete model), where clinically appropriate.

- Supporting patients to look after their own health, including through signposting wellbeing and self-care opportunities across NCL e.g. local pharmacies.

- Aiming to enhance the clinical capacity within the Clinical Advisory Service (CAS) particularly during the in-hours period and look to the provider for innovations where it can bring workforce efficiencies ensuring capacity is maximised with the appropriate skill mix, staff retention and sharing resources that bring economies of scale where appropriate.

- Aiming to reduce the number of emergency department (ED) attendances by encouraging patients to contact NHS111 first and continued emergency department clinical validation and downgrading of dispositions where appropriate to ensure most appropriate pathway for healthcare need.

- Increasing the level of direct booking opportunities to emergency departments, urgent treatment centres (UTC) and other primary care and community settings, in particular GP in-hours (NHSE ambition is 70% of 111 ED and UTC referrals are heralded and booked).

- Improving collaborative working and integration across the NHS 111 and wider urgent and emergency care system and providers, primary, community and mental health services to deliver a more streamlined pathway.

- Continuing to work closely with the regional programme on the added feature for the Mental Health pathway which is to include the *2 option to enable rapid and effective streaming to Mental Health and Crisis services.

- Building upon digital remote tools such as remote consultations when they become available via regional discussions.

- Supporting ambulance conveyances through the continued clinical validation of category 3 and 4 calls either through a partnership arrangement with London Ambulance or via the new NHS 111 provider.

- Exploring the late evening and overnight Primary Care Centres (PCC) provision within GP Out of Hours/Extended Access in order to ensure value for money and sustainability of service.

- Meeting the NCL population health needs when accessing the service, promote wellbeing and reduce inequalities, to deliver the maximum positive impact within the resources available.

- Providing a seamless and consistent experience, reducing inappropriate delays and unnecessary demand flow on the most pressured parts of the urgent and emergency care

system by enabling access to alternative care pathways, electronic referrals and bookings, and access to pertinent patient information

- Supporting the regional/national direction of travel to reduce whole scale London NHS system costs through greater economies of scale, integration of clinical services and workforce efficiencies and reduced transactional complexity across separate contracting and commissioning organisations.

- Supporting to develop a more resilient NCL and London urgent and emergency care system and maximise the benefits of national and regional clinical, digital and interoperability initiatives rapidly through greater service integration, scale and interoperability.

- Proactively seeking the views of the diverse communities in NCL and build relationships with people and communities who are seldom heard, vulnerable or experience barriers to accessing services or health inequalities.

- Supporting the new ICS model of providing joined-up health and care for residents through closer collaboration between local NHS organisations, councils and other groups, such as charities and community groups to provide care that is tailored to individual needs and helping people to live healthier lives for longer.

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North Central London
Integrated Care Board

NHS 111 Integrated Urgent Care resident experience survey

Vee Scott and Robyn Sandler
Communications and Engagement Team

Date of publication August 2022

Introduction

The North Central London Integrated Care Board is undertaking a procurement exercise to award a new contract for the NHS 111 Integrated Urgent Care (IUC) service starting in October 2023.

Planning for this has started with the aim that the future service will be developed based on the latest national guidance and the identified needs of our local population.

As part of the engagement process, between 12 May 2022 and 19 June 2022, we ran a survey to understand our residents' experiences of using the NHS 111 Integrated Urgent Care service. We also want to find out about the barriers that may prevent people from easily accessing the IUC service and why people may choose to attend emergency departments rather than contacting NHS 111.

The survey feedback will be taken into consideration when the new service is developed to ensure improvements are made if needed.

How was the survey promoted?

- Online version hosted on our public and GP websites
- Shared with our key stakeholder database, which included Healthwatches, Voluntary Community Sector (VCS) groups, local authorities and local patient/membership groups.
- Distributed to the North Central London Residents Panel – a group of nearly 1,000 local residents with an interest in health and care services
- Promoted via CCG public channels, notably social media, newsletters (to the wider NCL system and also our residents newsletter), news articles on our public-facing website and our intranet (recognising that our staff may wish to share their views).
- Shared with local general practice teams (both GPs and via Practice Managers and PPG Groups) across our boroughs via NCL CCG GP website and newsletter.

Survey findings

1: How many times have you used the NHS 111 service in the past year?

Option	Total	Percent
Once	59	52.21%
2-5 times	50	44.25%
6-10 times	4	3.54%
More than 11 times	0	0.00%
Not Answered	0	0.00%

2: Did you do this online or via the telephone?

Option	Total	Percent
Online	10	8.85%
Telephone	90	79.65%
Both	13	11.50%
Not Answered	0	0.00%

3: If you contacted the service by telephone did you think the call menu was easy to use?

There were 101 responses to this part of the question.

Option	Total	Percent
Very easy	36	31.86%
Somewhat easy	57	50.44%
Not at all easy	8	7.08%
Not Answered	12	10.62%

If you found the call menu difficult to use, please let us know why

There were 24 responses to this part of the question. The key theme was the messages were too long and complicated, particularly when you are unwell. It made the process too long to get through to the call handler and some people got confused about which option to select as it went through the information fast. A lot of comments about the amount of generic Covid information that was included, which delayed them getting through. Some felt it made them feel as though they didn't want you to call.

Example quotes:

'It's a lengthy confused menu aimed to dissuade callers from continuing their calls. It keeps repeating the same Covid info over and over. It takes no notice of the needs of patients who have disabilities, neurodevelopmental conditions, hearing/auditory processing issues... for whom making calls is already difficult and having to spend much longer than necessary makes it very painful.'

'Confusing - repeated message. Very long time to get through. And message spoken too fast to be able to take down what one should do instead www: etc.'

4: Do you have any comments to make about the call menu that you heard?

There were 37 responses to this part of the question. The theme was the same as in the response to question three in terms of it being too lengthy, fast in message delivery and difficult to navigate, particularly when unwell and worried. However for those people that found the call menu relatively easy to use they repeated that they found it straightforward to use.

Example quotes:

'perhaps a lot of info to take in when you are ill/panicked/stressed'

'We have had 2.5 years of Covid. Why do you need to repeat the same info at every step. It's confusing and irritating.'

'Pretty easy to follow'

5: If your call was not answered quickly would you have?

There were 97 responses to this part of the question.

Option	Total	Percent
Held on until the call was answered	55	48.67%
Abandoned the call	8	7.08%
Gone to A&E	10	8.85%
Tried to contact your GP	3	2.65%
Tried to call 111 at a different time	5	4.42%
Visited a walk-in centre or urgent treatment centre	13	11.50%

Visited a pharmacy	3	2.65%
Not Answered	16	14.16%

Other
There were 20 responses to this part of the question. The key theme was that it would depend on the nature of the problem and the level of urgency. Most said they would hold on or call back later, but, in some cases if urgent and too long a wait, they would abandon the call and choose another option, such as go to UTC or A&E.

Example quotes:

'No point contacting your GP do not respond - tell you go to A&E!
You should review Barnet A&E they do a wonderful job but the demand has outstripped the size of the department. Maybe spend a day in A&E following the patient journey. It's terrible till you see the nurses.'

'I think that there was no other option available but to hold on.'

'Daft question. Would depend on how long you are talking about and the degree of concern about the issue for you were ringing 111.'

6: From your experience of the 111 service, please tick the boxes that seem closest to your views

The staff were helpful	Total	Percent
Strongly agree	48	42.48%
Agree	33	29.20%
Neither agree nor disagree	13	11.50%
Disagree	5	4.42%
Strongly disagree	3	2.65%
Don't know/can't say	2	1.77%
Not Answered	9	7.96%

The questions asked were relevant	Total	Percent
Strongly agree	27	23.89%
Agree	39	34.51%
Neither agree nor disagree	16	14.16%
Disagree	10	8.85%
Strongly disagree	7	6.19%
Don't know/can't say	2	1.77%
Not Answered	12	10.62%

The service dealt with my problem quickly	Total	Percent
Strongly agree	38	33.63%
Agree	28	24.78%
Neither agree nor disagree	13	11.50%
Disagree	9	7.96%
Strongly disagree	11	9.73%
Don't know/can't say	3	2.65%

Not Answered	11	9.73%

The service helped me to make contact with the right health service	Total	Percent
Strongly agree	41	36.28%
Agree	28	24.78%
Neither agree nor disagree	12	10.62%
Disagree	7	6.19%
Strongly disagree	9	7.96%
Don't know/can't say	3	2.65%
Not Answered	13	11.50%

Do you have any other comments about these statements?
There were 47 responses to this part of the question. The majority of comments in response to this question were unfortunately quite negative. Many of the respondents said that they were asked a lot of questions and that many seemed irrelevant. People reported being given incorrect or unhelpful advice, being sent to the wrong place and not receiving timely call backs. One person raised the issue of poor mental health service provision, which has also cropped up in focus group work. There were also some reported positive experiences with people finding the call handlers polite and getting a good service.

Example quotes:

‘I phoned up during the night in a mental health crisis. The call handler was obliged to ask me lots of irrelevant questions - had I been abroad recently, might I have malaria? I actually hung up the phone at one point and he called me back. He was kind but I repeatedly asked to speak to a mental health worker. He contacted the BEH Crisis team and told me they would phone me. Six hours later they had not phoned. A nurse from 111 phoned me and was able to cancel the request for Crisis Team and make a same day GP appointment for me. I later discovered that 111 in this area does not have mental health workers. I think that is absolutely disgraceful.’

‘Despite severe asthma and promises of a call back: either this still didn't happen after over 6 hours of waiting instead of the "within the hour" I was promised or when I did eventually get a call back, it'd be from someone not qualified to issue a prescription, or the GP in question (after waiting for days for that call back) would simply interrogate me as if I were lying - I have had asthma for 40 years.
NHS 111 is an absolute joke and a dehumanising, not-fit-for purpose service.’

‘I find it good to maintain 111 service as I have experienced it myself, the service is good once those recording is finished to listen on the beginning of my call .everything were done for me. I can say on my personal experience I love 111 minus recording on the beginning of the call.’

‘I recommend 111 to all my friends on the basis of my experiences.’

7: If the service advised you that you needed to speak to a clinician (e.g. GP or Nurse) were you given a timeframe for a call back?

There were 113 responses to this part of the question.

Option	Total	Percent
Yes	63	55.75%
No	14	12.39%
Don’t remember	16	14.16%
Not applicable	20	17.70%
Not Answered	0	0.00%

8: If you were told to expect a call back how satisfied were you that that the clinician called within the timeframe given to you?

There were 113 responses to this part of the question.

Option	Total	Percent
Very satisfied	43	38.05%
Fairly satisfied	27	23.89%
Neither satisfied nor dissatisfied	7	6.19%
Fairly dissatisfied	5	4.42%
Very dissatisfied	7	6.19%
Not applicable	24	21.24%
Not Answered	0	0.00%

9: At the end of the phone call, where, if anywhere, did 111 advise you to attend?

There were 113 responses to this part of the question.

Option	Total	Percent
Accident and Emergency (A&E)	27	23.89%
Urgent treatment/walk-in centre	9	7.96%
Out of hours GP	6	5.31%
Own GP practice	13	11.50%
Given self-care advice	4	3.54%
Pharmacy	5	4.42%
Other (Please state)	30	26.55%
Not applicable	19	16.81%
Not Answered	0	0.00%

If you selected "Other", please state where you were signposted to

There were 33 responses to this part of the question. A variety of locations and actions were identified: 12 were sent ambulances or told to call one; GP home visit, GP call back and OOH GP; OOH dentist; OPAU; X Ray clinic; Moorfields; Ambulatory Care; A&E; Prescription sent to pharmacy; Put in touch with MH Crisis Team.

10: Was an appointment booked for you?

There were 113 responses to this part of the question.

Option	Total	Percent
Yes	35	30.97%
No	40	35.40%
Don’t remember	8	7.08%
Not applicable	30	26.55%
Not Answered	0	0.00%

11: Did this resolve your problem?

There were 113 responses to this part of the question.

Option	Total	Percent
Yes	67	59.29%

No	30	26.55%
Don't remember	1	0.88%
Not applicable	15	13.27%
Not Answered	0	0.00%

If your answer is no why not?
There were 35 responses to this part of the question. Clear themes were difficult to identify on this question as there was a lot of variation. However some people reported not receiving a timely call back, if at all, and ending up waiting a long time before giving up and taking their own course of action. There did seem to be some communication issues between services. Some people were advised to contact their GP, which some criticised, as difficult to get a GP appointment. Some instances where people didn't like the advice they were given and didn't follow it. A variety of ambulance issues, in one case an ambulance was booked, it didn't turn up and the ambulance service had no record of the booking. Some people answered no to this question but actually it was because they needed further treatment, so this one 111 instance did not resolve their problem. Finally there were two criticisms, one in respect of how an individual with a mental health crisis was supported and one wider criticism of how the NHS generally treats someone with a disability.

Example quotes:

'My deciding to attend A&E and UTC resolved issue; not clinician's call back'

'mental health crisis for member of family left with them alone for several hours not receiving a call back in the end had to get police before ambulance called and taken to a and e'

'Waste of time. I am a Carer and needed medical advice concerning my 100 year old lady. I got nowhere with 111. I called an Ambulance and explained my 111 experience to the wonderful crew. They said they hear this all the time, and in future, don't waste my time, just call 999.'

'NHS 111 advised that a time slot had been given to us to attend the A&E dept. When we arrived the A&E staff had no idea what I was talking about because they had no booked time slots. Therefore I would have been better off taking an elderly 92 year old with a head injury to my nearest A&E instead of waiting 6 hours for an X-Ray in an appalling A&E.'

12: If you contacted NHS111 online how easy was it for you to get the help you needed?

There were 45 responses to this part of the question.

Option	Total	Percent
Very easy	11	9.73%
Fairly easy	15	13.27%
Not very easy	9	7.96%
Not at all easy	10	8.85%
Not Answered	68	60.18%

13: How satisfied were you with the advice given to you?

There were 42 responses to this part of the question.

Option	Total	Percent
Very satisfied	13	11.50%
Fairly satisfied	12	10.62%
Neither satisfied nor dissatisfied	6	5.31%
Fairly dissatisfied	5	4.42%

Very dissatisfied	6	5.31%
Not Answered	71	62.83%

14: How important is it to you that 111 can provide you with the right advice and treatment in one call/contact without the need to direct you to another service?
There were 113 responses to this part of the question.

Option	Total	Percent
Very important	88	77.88%
Somewhat important	17	15.04%
Don't know/can't say	4	3.54%
Not important	4	3.54%
Not Answered	0	0.00%

15: Would you prefer to be offered the choice of a face-to-face appointment or a video consultation to resolve your health problem?
There were 113 responses to this part of the question.

Option	Total	Percent
Face-to-face	56	49.56%
Video consultation	7	6.19%
Either	50	44.25%
Not Answered	0	0.00%

16: Out-of-hours GP services run from 6.30pm to 8am on weekdays and all day at weekends and on bank holidays. If you have been advised to attend an out-of-hours GP by NHS 111 has the location been convenient to travel to?
There were 113 responses to this part of the question.

Option	Total	Percent
Yes	29	25.66%
No	7	6.19%
I was not sent to an out-of-hours GP	77	68.14%
Not Answered	0	0.00%

17: At busy times if appointments are limited would you be willing to travel to be seen more promptly?
There were 113 responses to this part of the question.

Option	Total	Percent
Yes	54	47.79%
No	17	15.04%
Unsure	42	37.17%
Not Answered	0	0.00%

18: If you were advised to attend a GP out-of-hours appointment, how satisfied were you with the service?

There were 113 responses to this part of the question.

Option	Total	Percent
Very satisfied	15	13.27%
Fairly satisfied	8	7.08%
Neither satisfied nor dissatisfied	4	3.54%
Fairly dissatisfied	1	0.88%
Very dissatisfied	1	0.88%
I was not sent to the GP out-of-hours service	84	74.34%
Not Answered	0	0.00%

Do you have any other comments about the out of hours GP service?

There were 21 responses to this part of the question. There were some very positive experiences reported for those who had been referred. Criticism lay in not being aware of the service, not being offered an appointment and a general comment about the ability to get a GP appointment at all. Also mentioned were prescriptions and only being able to get an emergency supply of medication and potential distance to travel when you are unwell, although some people reported being willing to travel to be seen.

'I was very satisfied, as I was away from home, but returning home that evening, and the GP (in Essex) was able to see me, diagnose the issue, and send a prescription to a late night pharmacy in London for me to pick up when I got back. Excellent service.'

'It was wonderful! Such a surprise to see someone late at night.'

'Never been offered it, sent to A&E instead, would have preferred GP appt, he could have prescribed the meds I needed'

19: How well do you think the NHS 111 service (online or phone) is adapted to any special needs you may have, for example providing help in your language, British Sign Language and so on?

There were 61 responses to this part of the question. Those people who were hard of hearing found using the service more difficult due to the complex call menu and also couldn't always hear the call handler. People with a range of disabilities and chronic conditions also found it hard to use. Language difficulties were also cited for consideration. For people with dementia remembering the call options etc. is challenging. An interesting issue raised was whether people with mobility issues could gain access to transport to get them to an appointment. One example, which has also been raised in other question responses, was being referred by 111 to a service who then didn't think they should have been sent there. This cropped up here with Moorfields, but has also been mentioned for A&E and the ambulance service.

Example quotes:

'I have an auditory processing problems which can make it incredibly hard to make out what someone is saying - particularly if there is a background noise as is the case with NHS 111 operators - I also have severe asthma and many other health issues which make it very difficult to sustain a phone conversation. Having to repeat the same info over and over - particularly when my asthma has flared up and I have a chest infection - is near impossible. Yet no provision or even understanding because the NHS doesn't understand disabilities and needs.'

‘Not very- I am a carer for an elderly lady who is very hard of hearing. she cannot always hear the service handlers. They need to speak slowly and clearly’

‘I think it is improving - maybe the staff have been trained and work as a team; they don't seem to be afraid to get advice so they must all be working together - either the management is good and there is no bullying or there is good leadership’

20: Is there anything else you’d like to share with us?

There were 67 responses to this part of the question. There was a mixture of positive and negative comments, with many reporting a good service that they value. Comments mainly focused on the complication of getting through to a clinician and then how their call was handled. Training and communication were raised in terms of better communication between services and training for call handlers, some of whom came across as not knowledgeable in local services and their location. Mental health problems were also cited as an issue with people suggesting the need for better qualified staff to handle this type of illness. Some comments as to more investment being needed and better staff numbers with appropriate training, more awareness raising of what the service is and what it can offer, and the ability to book actual appointments to relieve the pressure on other services, such as A&E.

Example quotes:

‘Access to 111 and a quick response to the call ie answering the call quickly, especially important now that it’s more difficult to get through to your GP on the phone.
Only issue is that 111 would have sent me to ED/UTC rather than the WIC that has X-Ray facilities.
Would have been great if a pre-bookable appointment could have been made by 111.
Travelling to a call centre for Out of Hours is ok if it’s easy to travel to the Centre, but NCL is a large borough and transport links are not good if for example you have to travel East to West (vice-versa) or even into other NCL boroughs where the Centre is not on a convenient train line. Preference would be to keep services local and within borough.’

‘I have been happy with the service I have received, both times for recurrent cystitis which has occurred over a bank holiday or weekend. A prescription for antibiotics was sent through to a local pharmacy.’

‘As I was unable to see a doctor prior to my 111 call I was in a terrible state. The doctor who rang me back could access my results and supply me with antibiotic which actually worked, the previous antibiotics had not been correct leaving me awake most of the night not knowing where to turn. This problem had been ongoing for about six months and I was extremely grateful to the lovely doctor who not only supplied me with the right antibiotics but gave me advice as to how to help my problem. I am very happy with my experience with the NHS 111 service.’

‘I would not advise anyone to phone 111 about mental health. I had to wait 6 hours for a call from Crisis Team that never came. If I had wanted to speak to Crisis Team I would have phoned them myself. Please put in specification for new 111 contract that they need to have mh nurses as well as general nurses. How was this ever allowed to happen?’

Which of the following best describes you?

Option	Total	Percent
Female	73	64.60%
Male	34	30.09%
Non-binary	3	2.65%
Prefer to self-describe	0	0.00%
Prefer not to say	3	2.65%
Not Answered	0	0.00%

What is your ethnic group?

White background - White

Option	Total	Percent
English, Welsh, Scottish, Northern Irish or British	74	65.49%
Irish	4	3.54%
Gypsy or Irish Traveller	0	0.00%
Roma	0	0.00%
Any other White background	10	8.85%
Not Answered	25	22.12%

Mixed or multiple ethnic groups - Mixed or Multiple ethnic groups

Option	Total	Percent
White and Black Caribbean	2	1.77%
White and Black African	0	0.00%
White and Asian	2	1.77%
Any other Mixed or Multiple ethnic Background	1	0.88%
Not Answered	108	95.58%

Asian or Asian British - Asian or Asian British

Option	Total	Percent
Indian	8	7.08%
Pakistani	0	0.00%
Bangladeshi	0	0.00%
Chinese	1	0.88%
Any other Asian background	4	3.54%
Not Answered	100	88.50%

Black, Black British, Caribbean or African - Black, Black British, Caribbean or African

Option	Total	Percent
Caribbean	4	3.54%
African	1	0.88%
Any other Black, Black British, Caribbean or African background	0	0.00%
Not Answered	108	95.58%

Any other ethnic group - Other ethnic group

Option	Total	Percent
Arab	0	0.00%
Any other ethnic group	4	3.54%
Not Answered	109	96.46%

How old are you?

Option	Total	Percent
Under 16	0	0.00%
16 to 17	0	0.00%
18 to 24	0	0.00%
25 to 34	6	5.31%
35 to 44	10	8.85%
45 to 54	15	13.27%
55 to 64	21	18.58%
65 to 74	39	34.51%
75 to 84	16	14.16%
85 or over	5	4.42%
Not Answered	1	0.88%

Are you a deaf person who uses sign language?

Option	Total	Percent
Yes	2	1.77%
No	107	94.69%
Not Answered	4	3.54%

Do you have any long-term physical or mental health conditions, disabilities or illnesses?

Option	Total	Percent
Yes	54	47.79%
No	53	46.90%
Don’t know/Can’t say	1	0.88%
I would prefer not to say	3	2.65%

Not Answered	2	1.77%

Which borough is your GP practice in?

Option	Total	Percent
Barnet	36	31.86%
Camden	12	10.62%
Enfield	46	40.71%
Haringey	13	11.50%
Islington	5	4.42%
Not Answered	1	0.88%

When you use NHS 111, do you need translation services?

Option	Total	Percent
Yes	0	0.00%
No	111	98.23%
Not Answered	2	1.77%

When you use NHS 111, do you need access to BSL interpreters?

Option	Total	Percent
Yes	0	0.00%
No	112	99.12%
Not Answered	1	0.88%

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Patient experiences of NHS 111

Focus group findings by Healthwatch Enfield

July 2022

Contents

Introduction

Healthwatch Enfield were approached by North Central London Integrated Care Board (NCL ICB) to undertake a series of focus groups with local people from specific communities to identify and discuss people's experiences of using NHS 111, with a focus on using the service as a local resident with additional access needs such as disabilities or English as a second language.

Methodology

NCL ICB carried out an online survey seeking views from the wider public on people's experiences of using the NHS 111 service. To ensure that harder to reach groups were included in the findings, Healthwatch Enfield planned and carried out four focus groups with four specific community groups based in Enfield. These included:

- Enfield Clubhouse Mental Health Support Group – 7 participants.
- One to One Learning Disability Group – 7 participants.
- Visually Impaired Enfield Residents supported by Healthwatch Enfield – 2 participants.
- Speakers of English as a Second Language (ESOL) supported by Edmonton Community Partnership – 4 participants.

The small focus groups were led by Healthwatch Enfield staff and volunteers, using intimate conversations in a safe space to gather detailed information of people's understanding and experiences of accessing and using the NHS 111 service.

A series of questions, aligned to the online survey were used as a framework for conversations, with participants encouraged to expand on their experiences, provide more detail and share issues that may not be covered by the questions. These topics covered included:

- People's use of the NHS 111 service, and whether it was online or via telephone.

- Awareness of the online option.
- Telephone call menu ease of use.
- Alternatives to NHS 111 if not satisfied with it.
- Staff helpfulness.
- Appropriateness of the questions asked by the service.
- Referrals to other services and whether they were the right ones.
- Outcomes of the contact with the service.

Key findings

Access

Of the people we spoke to, more than half had used or tried to use the NHS 111 service. People with learning disabilities were most likely to have used it, followed by people with mental health needs. People with English as a second language were least likely to have used the service. Key issues faced included:

- **Awareness:** There was a general lack of awareness of the service or parts of the service.
    - Several of those who were aware of the service were not always sure what it was for or how it differed or related to other health services. This was particularly the case for non-English speakers.
    - Many of those who were aware of NHS 111, know it as a telephone service and most were unaware of the online service. People with visual impairments and those with learning disabilities expressed that they were the least likely to use the online service, either because it was inaccessible due to their lack of sight, difficulties using online services, or they preferred to speak to a person to discuss health issues, rather than use an online service.
    - At least two people from the mental health support group expressed that they would probably prefer to use the online service if they were aware of it, with others preferring to use the telephone service.
    - The group with learning disabilities felt that an entirely online service would be detrimental to people's health as it wouldn't be as accessible.
    - Participants from the mental health support group were not aware that NHS 111 could book appointments for them.
- **Health service inaccessibility:** Several people from different groups expressed frustration with trying to access primary care services like GPs.
    - One person with visual impairment discussed the difficulty of having to see locum GPS on a regular basis, and how this caused a lack of consistency in their treatment, and the need to frequently repeat information.
    - At least one person stated that they had to use the NHS 111 service frequently due to a range of ongoing conditions. They often had to call 111 in the evenings and were frequently given hospital appointments or referred to A&E, which was further to travel, but usually easier than getting a GP appointment.

"I am aware that its online but cannot use the service this way. I prefer to use my phone. It is easier for me. I do not have a support worker or anything to help me with things like accessing services…"

Service usability

- **Call Menu:** Non-English speakers and those with learning difficulties found the service hardest to use.
    - Non-English speakers discussed their difficulties with understanding the questions being asked by the service, in particular how they either simply couldn't understand the questions, with expressing embarrassment about their lack of English so they don't even try to access the services (as well as other health services).
    - At least one person expressed that people on the phone can become impatient when talking to them, if they are struggling to understand, and this can put them off using the service again.
    - The group with learning difficulties felt that the call menu was 'too long' and 'annoying' and many felt that it often led them round in circles. The group also expressed that the menu sometime caused anxiety, especially in a medical emergency.
    - One participant with LD discussed their negative experience of using the service, where they spent a number of hours holding to speak to someone, only to be cut off and ending up going straight to their GP instead.
    - People in the mental health support group also felt that the menu was generally too long-winded and off putting, potentially discouraging repeat use of the service.

"It would not be practical for me to use NHS 111 online. I am not aware of any provisions for visual impairments available for me to access at my GP or at hospital appts. When I have an appt I have to arrange in advance for a support worker to come with me to guide me physically around buildings and to read signs or instructions. I cannot do this alone. There are often problems with poor, out of date or inadequate signage in GPs and hospitals."

- **Language and culture:** Non-English speakers again expressed the difficulties they have in being understood, both by the NHS 111 service and health services in general, including their GPs). They felt there were no options for translation and interpreting services to help them out, and there were very few local community organisations to help them out. This generally made using NHS 111 impossible.

  - Non-English speakers also expressed they were far more likely to go straight to A&E than try to access other services as it was more convenient geographically, although they often had to wait longer as the hospital needs to find someone who can translate.
  - The issue of people looking down on non-English speakers came up several times, with sometimes even people that speak their language being seen as judgemental because they can't speak English.
  - In one case, someone described a time when their father had paid people to help them fill in forms, register for GPs etc, but that the people had stolen money. They stated that this happens all the time to lots of people.
  - Participants with learning disabilities felt that they often had more health issues than others, and they were not always able to read or fully understand forms and questions, so easy read version or forms with pictures would be helpful.
  - A small number of participants expressed that accents of staff of the NHS 111 service could be difficult to understand, which can make using the service more difficult.
  - Several participants expressed that the people from their communities were often unlikely to access services like NHS 111 because they didn't have awareness or didn't understand how the NHS works, and what services are accessible to them. Sometimes this was more of a cultural issues with a resistance to accessing health services either due to a mistrust of authority, or because their communities relied on other methods of managing their health, for example going to community leaders or elders for advice instead.
- **Staff**: Many participants expressed that the helpfulness of the staff at NHS 111 could be hit and miss. Some members of the learning disability group stated that staff were generally very understanding, but this experience was not shared by the whole group, with several haven't different experiences of less understanding staff.
  - Members of the mental health support group felt that staff on NHS 111 (and other NHS areas) were not always helpful. One participant stated "I try to be polite."

"I have used the NHS 111 service in the past and would use it again in the future. I would say the service they provide is OK and I know that everyone these days are stressed."

- **Referrals and call backs:** Only a small number of people had been referred on to other services by NHS 111.
  - When people had been referred (usually to GPs, A&E or urgent care) people generally felt the referral pas appropriate. One member of mental health support group expressed that they had definitely been referred to the right service,

however another felt that their issue had not been dealt with properly, after being referred to a dentist.
    - Members of the same group also expressed that usually the issue had been dealt with at the time over the phone, so there had been no need for a call back.
- **Alternatives and complaints**: Most participants said they would either try to go their GP, or straight to A&E if they didn't find the service satisfactory.
    - Members of the learning disability group said they might also ask a family member for help, or possibly their support worker or someone from the Citizen's Advice Bureau (CAB).
    - One of participants with visual impairment stated they Often had to spend a long time on the phone to their GP to get appointments.
    - Members of the mental health support group also stated they were most likely to go to their GP if they weren't satisfied with 111 service, but felt that this was often a 'post code lottery' of access. There were also strong feelings that GPs were now using Covid as an excuse for poor access.
    - Several participants of the mental health support group stated they would not always be comfortable making complaints about the service.

"My dad paid people to help us, fill out application forms, register with GPs et, but they were not always good people as they stole our money. It cost us a lot of money and we did not get proper support. This was happening all the time, to lots of people we know."

Actions/Recommendations

Based on the conversations held during the focus groups, most of the feedback we received coalesced around the three themes of awareness, accessibility, and useability. Specifically, the following areas appear to be ripe for further investigation and/or action, and would be relevant to the upcoming NHS 111 procurement process:

- **Language:** The availability and use of interpreting services appear to be a particular block to people using the service. This is especially true for non-English speakers and those with learning difficulties. If translation services are available, they need to be advertised more widely, including through the service itself. If not available, then further investigation is needed into how this section of the community can best be provided for. Consideration also needs to be given for people who are deaf or hearing impaired, especially British Sign Language users, who may need to rely on other people to use the service, if they are not able to use the online service.
- **Awareness**: Awareness generally of NHS 111 appears to be low. Those who were aware of the service were often not aware of what the service can offer (for example booking appointments), and most were not aware that the service was also available online. Further communication/marketing needs to take place to improve awareness amongst particular communities and sections of the society

- **Service user support and staff training:** The helpfulness and effectiveness offered by staff on NHS 111 appears to be patchy, with a variety of mixed experiences. People with learning difficulties and non-English speakers seemed to have the least positive experiences. As a result we recommend the following:
    - **Training:** Additional training could be provided to NHS 111 staff, potentially supported by or provided directly by voluntary sector/community groups with lived experience to help staff with understanding and patience when handling calls from people with additional needs.
    - **Support:** The NHS should investigate the possibility of offering direct support services to particular groups with additional needs. This could be additional funding to support local community groups, but ideally specialist, trained call handlers to support people – accessible either through the call menu or possibly a new number.
- **Usability:** The call menu on NHS 111 is long, unwieldy and can put people off using the service with the potential impact of increasing pressure on other NHS services. A more refined menu, with fewer questions, and clearer pathways and potential outcomes would be preferable.

Engagement in service development and delivery

In general, all of the focus groups appreciated the opportunity to feed into this process. It was felt that more frequent, honest and genuine collaboration and co-production between local health organisations, professionals, and residents is vital to move forward and improve services. Regular community conversations about services like NHS 111 should be widely advertised and accessible. This reflects a common theme raised by local people with us over the past few months. This approach can go a long way to improve delivery of key underutilised services like NHS 111, as well as the knowledge, understanding and usage by all sectors of the community, especially amongst more marginalised communities. This in turn, may help to reduce pressure on other essential services like GPs and A&E, and improve the health and wellbeing of all residents in our local community.

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NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**
REPORT TITLE Work Programme 2022-2023	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 30 September 2022

SUMMARY OF REPORT

This paper reports on the 2022-23 work programme of the North Central London Joint Health Overview & Scrutiny Committee and also requests confirmation of the reports for the next meeting.

Local Government Act 1972 – Access to Information

No documents that require listing have been used in the preparation of this report.

Contact Officer:
Dominic O'Brien
Principal Scrutiny Support Officer, Haringey Council
Tel: 020 8489 5896
E-mail: dominic.obrien@haringey.gov.uk

RECOMMENDATIONS

The North Central London Joint Health Overview & Scrutiny Committee is asked to:

a) Note the work plan for 2022-23 and consider any updates that may be necessary;

b) Confirm the agenda items for the next meeting which is currently scheduled to take place on 25th November 2022.

1. Purpose of Report

1.1 This paper outlines the areas that the Committee has chosen to focus on for 2022-23. The Committee is asked to note the list of topics that have been identified as a potential agenda items for the year and consider any amendments that may be required

1.2 This next meeting of the JHOSC is scheduled to take place on 25th November 2022 and the Committee is also asked to confirm the items for this. The items currently scheduled to be on the agenda for this are as follows:

- Estates Strategy update

1.3 Full details of the JHOSC's work programme for 2022/23 are listed in **Appendix A**.

2. Terms of Reference

2.1 In considering suitable topics for the JHOSC, the Committee should have regard to its Terms of Reference:

- "To engage with relevant NHS bodies on strategic area wide issues in respect of the co-ordination, commissioning and provision of NHS health services across the whole of the area of Barnet, Camden, Enfield, Haringey and Islington;

- To respond, where appropriate, to any proposals for change to specialised NHS services that are commissioned on a cross borough basis and where there are comparatively small numbers of patients in each of the participating boroughs;

- To respond to any formal consultations on proposals for substantial developments or variations in health services across affecting the areas of Barnet, Camden, Enfield, Haringey and Islington and to decide whether to use the power of referral to the Secretary of State for Health on behalf of Councils who have formally agreed to delegate this power to it when responding to formal consultations involving all the five boroughs participating in the JHOSC;

- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- The joint committee will seek to promote joint working where it may provide more effective use of health scrutiny and NHS resources and will endeavour to avoid duplicating the work of individual HOSCs. As part of this, the joint committee may establish sub and working groups as appropriate to consider issues of mutual concern provided that this does not duplicate work by individual HOSCs; and

- The joint committee will aim to work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people."

3. Appendices

Appendix A –2022/23 NCL JHOSC Work Programme

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Appendix A – 2022/23 NCL JHOSC work programme

15 July 2022

Item	Purpose	Lead Organisation
Start Well programme	• For the Committee to receive an overview of Start Well, a strategic programme for children and young people's services.	NCL partners
Update on Fertility Services Review	• For the Committee to scrutinise the final version of the Fertility Services Review.	NCL partners
Enhanced Access to General Practice	• An update on upcoming national changes to 'enhanced access' to general practice (the additional provision of appointments outside of core hours).	NCL partners

30 September 2022

Item	Purpose	Lead Organisation
Finance Update	• For a detailed finance update to include latest figures from each Hospital Trust in NCL, the overall strategic direction of travel and responses to the Committee's supplementary questions published in the March 2022 agenda papers.	NCL partners
Workforce Update	• An update on workforce issues in NCL.	NCL partners

25 November 2022

Item	Purpose	Lead Organisation
Estates Strategy Update	To receive an update on the Estates Strategy including finance issues. This follows on from the discussion on the Estates Strategy at the meeting held on 28th Jan 2022.	NCL partners
TBC		

3 February 2023

Item	Purpose	Lead Organisation
TBC		

17 March 2023

Item	Purpose	Lead Organisation
TBC		

Possible items for inclusion in future meetings

- Ambulance waiting times and pressures across the system including A&E Departments.
- Pediatric service review.
- Primary care commissioning and the monitoring of private corporations operating in this area.
- The efficacy of online GP consultations, how the disconnect between the public and the medical profession could be addressed, how the public could be reassured that outcomes would be equally as high as face-to-face consultations and how capacity can be improved in this way.
- Health inequalities and the impact of cuts to public health budgets. Health inequalities could also be scrutinised as part of Mental Health Services Review and the Community Health Services Review.
- Increases in number of people being charged for services that they were previously able to access free of charge through the NHS (e.g. dentistry/ear wax syringing)
- Update on funding for NHS dentistry for both adults and children.

2022/23 Meeting Dates and Venues

- 15 July 2022 - Camden
- 30 September 2022 - Haringey

- 25 November 2022 - TBC
- 3 February 2023 – TBC
- 17 March 2023 - TBC

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