MEETING
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
DATE AND TIME
FRIDAY 12TH MARCH, 2021
AT 10.00 AM
VENUE

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
1.	AGENDA AND REPORT PACK	3 - 42

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AGENDA ITEM 1

NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 12 March 2021, 10:00 a.m.
MS Teams (watch it here)

Contact: Fiona Rae / Robert Mack

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Edward Smith (Enfield Council), Pippa Connor and Lucia das Neves (Haringey Council), Tricia Clarke and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Andy Ellis, Robert Mack, and Peter Moore.

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 on 29 January 2021 as a correct record.

7. DIGITAL INCLUSION

This paper discusses digital inclusion in response to the increasing digital approach to healthcare. **(To follow)**

8. MISSING CANCER PATIENTS

This paper provides an update on possible missing cancer patients as a result of the Covid-19 pandemic. **(To follow)**

9. HEALTH INEQUALITIES

This paper provides an update in relation to health inequalities. **(To follow)**

10. WORK PROGRAMME (PAGES 13 - 24)

This paper provides an outline of the 2020-21 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

11. NEW ITEMS OF URGENT BUSINESS

To consider any items of urgent business as identified at item 3.

12. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

19 March 2021 (special meeting on Integrated Care Systems)
25 June 2021
24 September 2021
26 November 2021
28 January 2022
25 March 2022

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MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON FRIDAY, 29TH JANUARY, 2021, 10.00 AM - 1.00 PM.

PRESENT: Councillor Pippa Connor (Chair), Councillor Edward Smith (Vice Chair), Councillor Tricia Clarke (Vice Chair), and Councillors Alison Cornelius, Linda Freedman, Larraine Revah, Paul Tomlinson, Christine Hamilton, and Lucia das Neves.

1. FILMING AT MEETINGS

The Chair referred to the notice of filming at meetings and this information was noted.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Paul Fish, Royal National Orthopaedic Hospital.

3. URGENT BUSINESS

The Chair noted that a deputation had been received from NCL NHS Watch.

ORDER OF BUSINESS

The Committee agreed to receive Item 13 (Deputation on Integrated Care Systems) as the first substantive item so that local concerns could be presented to the Committee. Also, due to the availability of the presenters, this would be followed by Item 6 (Covid Update), Item 8 (Mental Health Services during the Covid-19 Pandemic), and Item 7 (Post-Covid Syndrome Pathway), before returning to the order of business as set out in the agenda.

4. DECLARATIONS OF INTEREST

Cllr Cornelius noted that, in case care homes were discussed, she would like to note a non-pecuniary interest as she was a Council appointed Trustee of the Eleanor Palmer Trust. Cllr Connor also noted that she was a member of the Royal College of Nursing and that her sister worked as a GP in Tottenham.

5. MINUTES

RESOLVED

That the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting held on 27 November 2020 be confirmed and signed as a correct record.

6. COVID-19 UPDATE

Will Huxter, Clinical Commissioning Group (GGC) Director of Strategy, and Chloe Morales Oyarce, CCG Head of Communications and Engagement, introduced the item which provided an update on the Covid-19 pandemic in North Central London (NCL). It was noted that the pressures on health and care services were significant and that, although there had been a reduction in community cases, there were still large numbers of patients in hospital and particularly in intensive care. It was noted that a number of staff had been redeployed and partnership working was in place as much as possible. It was added that regional and national communications were highlighting that regular health and care services were operating.

Cllr das Neves enquired what support was in place for staff wellbeing. Will Huxter explained that a range of psychological and other support had been put in place across North Central London (NCL) and there were regular communications to staff about the support available. It was added that the Occupational Health offer was being enhanced and that specific work was underway to establish what support would be most useful for staff.

Cllr Smith noted that a number of NHS staff were unwell or self-isolating and asked about the levels of testing and vaccination of staff; it was also asked whether there was any reluctance to be vaccinated within the care system. Will Huxter explained that staff in hospitals and clinical staff undertook regular testing and were included as a priority group for vaccinations; it was added that there were high levels of uptake in all hospital sites across NCL. It was acknowledged that there was some vaccine hesitancy in care settings and that work was underway with all five boroughs to target support, advice, and messaging. Cllr Smith also enquired whether and how the NHS was using volunteering networks. It was confirmed that there were many good examples of partnership working with volunteers. Will Huxter noted that a written update could be provided to members on vaccine hesitancy in care settings and on volunteers within the NHS.

Cllr Freedman asked about the military support that was provided in intensive care. Will Huxter explained that military support was from combat technicians who assisted the experienced intensive care staff with tasks such as turning patients. It was noted that there were about 40 combat technicians currently working in NCL.

Cllr Cornelius noted that pharmacies had used a mutual aid strategy to share vaccination but that the five boroughs within NCL had different populations and some areas had older populations. It was enquired whether this system had been perfected and, in particular, whether there would be sufficient vaccination supplies for the second round of vaccinations for care homes. Will Huxter explained that the target populations across NCL were being examined and planning was underway. It was known that different areas had different demographics which may require additional

vaccination supplies; there was regular contact with regional and national colleagues and there was confidence that there would be sufficient supplies.

Cllr Revah enquired whether the vaccine rollout was ensuring that people who were housebound and their carers were receiving the vaccine. Will Huxter noted that the housebound were on the list of people that needed to be reached and the rollout had started. It was added that additional information on the vaccine rollout for the housebound and carers could be provided in a written update.

Cllr Clarke noted that some people had received a negative lateral flow test but a later positive PCR test; she commented that £800 million had been spent on lateral flow testing so there were concerns that the tests were not reliable. Will Huxter noted that lateral flow and PCR testing were different but that test results could vary based on when a person was tested after contracting Covid-19. He explained that it was sometimes important for particular people to have a particular test and that the Committee could be provided with a written report to explain the different types of testing. It was added that spending on testing had been decided by government.

Cllr Hamilton enquired how communities with higher levels of testing and vaccine hesitancy were being contacted and whether local community volunteers were being used. Chloe Morales Oyarce explained that there was a substantial programme of community engagement on testing and vaccinations which included working with the Voluntary and Community Sector (VCS), faith groups, and other groups. This engagement work included listening to different community groups and understanding the reasons for hesitancy, providing factual information, and working with community leaders. The Committee noted that local councillors could provide a link with local communities. Chloe Morales Oyarce noted that this would be helpful; she agreed to provide information about local engagements to the Committee and encouraged councillors to provide any relevant information and feedback.

The Chair commented that some questions had been received from a Health Champion in Barnet. It was noted that there had been some instances where older people had been required to queue for vaccinations for several hours in the cold without access to toilets. In other cases, some people booking vaccinations online had been offered an appointment in Birmingham. The Chair enquired whether these were known issues and whether there were any mitigations in place. Will Huxter explained that it was aimed to maximise vaccination and acknowledged that some initial issues had been expected. He was not aware of any significant issues similar to those raised but noted that he would feed this information back to regional and national colleagues to see whether further action was required.

RESOLVED

To note the report.

7. POST-COVID SYNDROME PATHWAY

Dr Katie Coleman, Islington GP and North Central London (NCL) Clinical Lead for Primary Care Network Development, and Dr Melissa Heightman, Clinical Lead for the

Covid follow up Service and NCL representative for the London Respiratory Network, introduced the item which provided an update on the Post-Covid Syndrome pathway. It was explained that the second wave of the Covid-19 pandemic had been significant and would likely be followed by increased demand for the Post-Covid Syndrome service. It was highlighted that this was a new condition and understanding of the disease was developing. It was important to have a Post-Covid Syndrome pathway and this had been developed with the recognition that it was a multi-system condition and required a multi-disciplinary approach. This had resulted in the NCL Post-Covid Syndrome Integrated Service and there was equity of access across NCL.

Cllr das Neves enquired whether there was confidence in the anticipated numbers of people with Post-Covid Syndrome and the extent of the role of immunology. Dr Katie Coleman stated that there was not a lot of confidence in the numbers but these were based on national figures which estimated that about 10% of the total people who contracted Covid-19 would have Post-Covid Syndrome. Work was ongoing to better understand the demand and presentation in the community and a specific Post-Covid Syndrome code would be added to the clinical system shortly. It was also noted that the numbers of Covid-19 cases had significantly increased and it was anticipated that there would be a similar increase in the numbers of Post-Covid Syndrome cases; there were concerns about capacity in the system to deal with these additional numbers. It was highlighted that sufficient funding would be key and it was important to be able to resource community teams who could assist in patient recovery. It was noted that funding conversations were ongoing with NHS England.

It was noted that previous cases had often started as a referral to respiratory and then another referral to the Post-Covid Syndrome service. It was explained that the Post-Covid Syndrome pathway aimed to have a single point of access which would minimise multiple referrals. Dr Melissa Heightman explained that Post-Covid Syndrome was a multi-system disease and that the best approach was often to wrap specialty teams around the patient. It was noted that immunology featured in some patients and that rheumatologists, who were included in the multi-disciplinary team, had immunology expertise. It was explained that immunologists were often based in laboratories but were sometimes contacted to provide detailed information by phone.

Cllr das Neves enquired whether NCL was considering the research that was being developed in Canada and other places. Dr Melissa Heightman explained that clinical services were reliant on peer reviewed publications but that there were currently no clear therapeutic options from research. It was noted that research would be continually reviewed and that some funded research programmes in the UK were due to be announced soon. Cllr das Neves also asked what advice was provided to GPs regarding people who were unable to work due to Post-Covid Syndrome. Dr Katie Coleman explained that some upskilling and information sessions were being provided to GPs and training videos were being developed to provide rapid training resources. It was anticipated that GPs would be able to support people to ascertain their aspirations around returning to work through fitness for work notes.

Cllr Clarke was reassured that Post-Covid Syndrome was being taken seriously but expressed concerns about people who could have the condition without having been diagnosed, specifically those who were in intensive care. Dr Melissa Heightman explained that patients who had been in intensive care for a long period generally

needed significant support. It was noted that there were public health messages about Post-Covid Syndrome but there were concerns that the messaging was not strong enough to convince people to seek help from their GPs who were the gatekeepers for the Post-Covid Syndrome service. Dr Katie Coleman added that there was some consideration of whether searches could be developed within GP clinical systems to identify those who had previously contracted Covid-19 and were still experiencing symptoms. In addition, GPs were starting to contact any patients who had tested positive with Covid-19 after six weeks to see whether they had any ongoing symptoms; this was designed to increase early identification and treatment of Post-Covid Syndrome.

The Chair noted the importance of funding for the Post-Covid Syndrome service, particularly the funding of therapies teams in order to implement any treatment plans. It was also enquired whether there was equality of access and whether different ethnicities were sufficiently represented in the Post-Covid Syndrome service. Dr Melissa Heightman explained that there was an under-representation of about 20% of Black, Asian, and Minority Ethnic communities compared with the expected levels. It was also noted that there was a prevalence of Post-Covid Syndrome in people aged 35-49 and this seemed to be part of the nature of the illness. In relation to funding, it was commented that the required community services were in high demand and, as it was difficult to fund these roles, availability would depend on NHS England. The Post-Covid Syndrome service would be providing a business case to NHS England; this would set out the activities of the service and local demand and it was hoped that NHS England would agree to provide additional capacity.

The Chair noted that the Committee had previously supported requests for additional funding and would be happy to do this for the Post-Covid Syndrome service. Dr Katie Coleman noted that any support would be beneficial. Will Huxter added that highlighting the scale of the impact of Post-Covid Syndrome and the local focus on and importance of this service would be helpful. The Committee agreed to write to NHS England to support the request for funding and noted that it was essential for funding to be in place as soon as possible in order to assist the large number of people in NCL who required support and to plan for imminent increases in demand.

Cllr Cornelius noted that, throughout history, there had generally been more deaths in the second wave of a disease, which was the case for Covid-19. It was added that there were often third and fourth waves and it was enquired whether future planning had been undertaken. Dr Katie Coleman stated that this was a concern and that the vaccination programme aimed to mitigate this as much as possible; it was added that health services were aware of the risk of another wave and it would be possible to adapt quickly. Dr Melissa Heightman also noted that there were likely to be future diseases and that health services would benefit from continued preparedness.

Cllr das Neves noted that the plans for the Post-Covid Syndome service were well defined and that it would be important to provide guidance for GPs who were often the first point of contact. It was enquired whether it was possible to influence the public health message to encourage more people with symptoms of Post-Covid Syndrome to come forward. Dr Katie Coleman stated that this might require some conversations with public health colleagues. Dr Melissa Heightman explained that there had been some reluctance to increase communications until there was capacity for additional

referrals; it was noted that the Post-Covid Syndrome pathway was now defined and it should now be possible to publicise more information.

The Chair thanked Dr Katie Coleman and Dr Melissa Heightman for the update and stated that it was important for the Committee to receive these updates to ensure accurate communications between their local areas and NCL.

RESOLVED

1. To note the report.

2. To write to NHS England to support the request for funding for the Post-Covid Syndrome service.

8. MENTAL HEALTH UPDATE

The Chair introduced the item which provided an update on mental health services during the Covid-19 pandemic. It was noted that the Committee had received the written report and the presenters were invited to highlight any key points. The Chair also congratulated Jinjer Kandola on her recent MBE for Services to Mental Health. Jinjer Kandola, Chief Executive for Barnet, Enfield, and Haringey (BEH) Mental Health Trust, and Andrew Wright, Director of Planning and Partnerships for BEH Mental Health Trust, introduced the report.

It was noted that there were currently more Covid-19 outbreaks in wards and among NHS staff as the new variant of the disease was more transmissible; this included up to 11% of staff unwell or self-isolating. Unlike the first wave of the disease, it was explained that there had been less of a reduction in the number of people accessing mental health services. However, it had been necessary to temporarily close some beds as a result of infection prevention control measures and there had been a need to use some out of area placements which was less desirable.

The Committee enquired whether there had been any decreases in service use for any services that had changed. Jinjer Kandola highlighted that all mental health staff had worked exceptionally hard to ensure that all NCL services continued throughout the pandemic. It was noted that there had been some service transformation during the Covid-19 pandemic and this included a single point of access for referrals, a new process for entry to A&E where patients were seen in a dedicated area by specialist staff, a new 24 hour telephone helpline with previous telephone numbers forwarded to the new number, and additional support for Black, Asian, and Minority Ethnic staff as well as other staff at higher risk. It was added that digital services were offered based on patient choice, specific work was undertaken to support those who were shielding, and all community case loads were assessed, risk rated, and prioritised accordingly. It was explained that there had been a focus on appropriate discharging and winter funding had been used to work with Mind and other organisations to ensure that people had the care they needed.

Cllr das Neves noted that future plans for health care would be managed at NCL level under the Integrated Care System (ICS) and it was enquired how it would be possible

to find a balance between consistency and tackling local issues with specialised care. Jinjer Kandola explained that residents felt that they lived in a neighbourhood rather than a borough and it was important that care was delivered in this way. It was highlighted that the long term plan aimed to ensure that there was a consistent model in all five boroughs but that local specialisation would be possible. The Chair noted that it may be appropriate to discuss this issue at the Committee's special meeting on ICS in March 2021.

Cllr Revah enquired what support was being provided to staff and others impacted, such as carers. Jinjer Kandola explained that there was an online platform to support NCL staff which had a variety of options. It was acknowledged that carers had often taken on additional responsibilities where Voluntary and Community Sector (VCS) provision had been closed or suspended during the pandemic. It was noted that there were some support packages and assessments available for carers but it was understood that there may be a need for a better ongoing support package.

The Committee noted that the Covid-19 pandemic had seen a significant mental health impact, including an increase in people attempting suicide during the pandemic. It was believed that preventative work, such as Talking Therapies, was key but that there was an inequality of access for some communities, particularly for Black people. It was added that councillors and community organisations could assist with contacting local communities. Jinjer Kandola explained that part of the mental health services transformation would be to better understand health inequalities and the first step in tackling this issue would be to identify why certain people were not accessing services. It was highlighted that this would involve a deep analysis of specific, constituent ethnic and other groups and how they accessed services. This would allow a better understanding of how care could be delivered differently to ensure access for different groups. It was added that the move towards an ICS aimed to provide consistency and retain a close relationship with local government and VCS groups who were often best placed to advise on or deliver services.

The Committee asked what beneficial changes had emanated from the Covid-19 pandemic and how mental health services were liaising with community services like Mind. The Chair noted that the Committee would like to receive an update on any situations where mental health services were working innovatively and where services were targeting any particular groups to increase uptake.

Cllr Smith noted that it was reassuring to hear that the service was delivering well despite the difficulties caused by the pandemic and that there were plans to equalise funding for services for outer London. It was enquired what the current and future spending per capita would be across the boroughs. Cllr Hamilton noted the link between mental health and homelessness and enquired what support was available for the homeless. Andrew Wright explained that work was ongoing with various providers but that this was one area where the response varied in different boroughs. It was added that this was an important priority in NCL and it was hoped that the move to a NCL-wide approach would assist in ensuring consistency. The Chair noted that it would be helpful for the Committee to receive additional information on per capita funding in different boroughs and on homelessness.

The Chair noted that individuals who required mental health services often had complex needs and were likely to come into contact with a number of other services, including local government and police services. It was explained that it was difficult for residents to know which service was relevant or would take the lead. As part of an update to the Committee, the Chair stated that it would be useful to understand how various services worked together. Jinjer Kandola stated that, as part of the longer term changes in NCL, the ICS would aim to provide integrated care, wrapping care around individuals. This would involve an assessment for individuals and a decision about who would co-ordinate their care; it was explained that care could be led by mental health, physical health, or social care depending on a person's needs. It was acknowledged that this model needed greater development and planning and that it could be useful to have a future session where the Committee and other partners could provide input.

RESOLVED

1. To note the report.

2. To receive an update on mental health services, specifically providing more information on funding for individual boroughs and homelessness.

3. To receive a response on the question of who was leading on co-ordinating all the different services in relation to mental health care, including other partners such as the Police, housing, and the Council, within individual complex cases. It was acknowledged that this model needed greater development and planning and that it could be useful to have a future session where the Committee and other partners could provide input.

4. To receive an update on any situations where mental health services were working innovatively and where services were targeting any particular groups to increase uptake.

9. DIGITAL INCLUSION

The Chair introduced the item and explained that a number of local organisations across NCL had been invited to speak to the Committee to provide an insight into their experiences in relation to digital inclusion.

Rabbi Hackenbroch, Woodside Park Synagogue (Barnet), noted that, initially, there had been a lot of excitement in setting up an online presence and allowing people to see each other. Some advantages of using a digital platform were that it was possible to deliver the usual programmes, prayers, and memorials, people who were usually unable to attend for a variety of reasons had additional opportunities, and it had been possible to achieve a more personal touch with virtual breakout rooms. Some challenges were that there was an excess of digital options, including for schooling and work, and this meant that many people did not want to spend additional time looking at screens. Also, some people struggled to use digital options for a number of reasons. It was noted that, in future, the synagogue would be running virtual options

alongside physical one to incorporate the whole community to maintain increased connections and engagement.

James Dellow, Covent Garden Dragon Hall Trust (Camden) and SoapBox Youth Centre (Islington), explained that a key principle of youth work was to engage on platforms that young people were already using; a variety of online platforms had been used during the pandemic, including a YouTube channel, and these had been very successful. It was noted that partnership collaboration and considering new options had been incredibly valuable. Although, it was acknowledged that platforms such as Teams and Zoom were not designed for young people or for natural communication and could feel quite impersonal. It was stated that it had been challenging to work in a reactive way to the national restrictions but that it would be important to think about preparedness in the short and long term future. It was highlighted that it was important to avoid saying that virtual provision was not as good as physical provision as it reduced the value of virtual which, for some people, was a better option. It was added that providing virtual hardware and internet data had helped in reducing the digital divide but that it was also crucial to provide things such as digital skills and online safety awareness.

Nick Chanda, SACRE and Multi Faith Forum member and Revival Christian Church (Enfield), explained that he had a predominantly Black congregation and the church building had not been open since March 2020. It was explained that there had been a number of advantages in providing digital options as people still felt part of the community as they could get services at home, there was no need to travel, and people could join from all over the world. It was noted that there had been some challenges; this included a lack of digital devices or accounts to access digital platforms and the need to adapt to new digital platforms where it was difficult to connect effectively and where it was not always known who was present. It was added that it was easy for misinformation to circulate on digital platforms; this was particularly true in relation to the Covid-19 vaccination for Black, Asian, and Minority Ethnic groups and it was explained that the Church group was in a good position to provide correct information to the community.

Raj Gupta, Community Hub (Haringey), explained that providing digital options had been an amazing new experience for some charities and that, with some effort, it was possible to become digitally inclusive. It was noted that, historically, many people from Black, Asian, and Minority Ethnic communities had struggled to access online services, often due to a lack of IT skills or language issues. It was commented that remote GP consultations during the Covid-19 pandemic had been positive but that this had often required additional support from patients' families. It was suggested that, in the future, paid IT Community Champions may be needed to provide support to the community; this could be similar to social prescribing and it would be beneficial if these people came from the community and spoke additional languages.

Martin Finegan, The People's Christian Fellowship (Haringey), explained that the initial priorities had focused on maintaining contact with the congregation, delivering services, and ensuring that it was possible for people to give and support the foodbank. It was noted that a contact list and a dedicated email had been established to ensure that there was a way for the Church to communicate with the congregation and vice versa. It was explained that WhatsApp messaging had been used to share

information and prayers, Kahoot learning games had been used for family games, and a ClassDojo classroom community had been used for youth provision. In terms of challenges, it was noted that there had been some technology failures, some people did not have technology or the required technology for certain platforms, and it had been harder for some older people and people with learning difficulties to access online provision. It was added that the Church considered that digital options were a beneficial supplement but that physical provision would be its focus in the future.

Mike Wilson, Public Voice (Haringey), informed the Committee that there had been a digital support project in Haringey, funded by three hospital trusts and the NCL CCG, with the objective of helping patients access appointments remotely. This had included the provision of devices and digital support which was delivered through 50 volunteers, many of whom worked in IT and spoke community languages. It was noted that some home visits had been undertaken with Personal Protective Equipment (PPE) where required to provide support and that there were be devices in libraries and community hubs. It was added that this was a six month programme but it was hoped that, following the trial, it would be rolled out across NCL.

Anthony Doudle, SACRE officer and Head of School Improvement (Islington), noted that all schools had been surveyed in the first national lockdown in March 2020 and this had provided a picture of the digital landscape. It was established that, particularly for primary aged children, there was limited access to digital devices. It was explained that Islington had provided 3,000 new devices to ensure good access and had prioritised older children, especially those who were looked after or had a social worker. In June 2020, when schools returned, the digital survey for schools was updated and it was established that all secondary students had a device and work was underway to ensure that each family with primary school children had at least one device. It was highlighted that contacting schools, particularly mother tongue supplementary schools, had established strong communications hubs and it was notable that attendance in September 2020 was better than attendance before the pandemic. It was noted that a significant challenge had been to provide effective education in early years as this focused on creativity, language, and physical development which was difficult to deliver virtually.

The Chair thanked all of the speakers for sharing their experiences which had raised a number of aspects on digital inclusion from different communities and age groups. It was noted that these contributions would inform the Committee’s consideration of digital inclusion.

RESOLVED

To defer consideration of the report until the next meeting.

10. WORK PROGRAMME

The Chair noted that the work programme was set out in the report but that Digital Inclusion would need to be considered at the next meeting and that this may take the place of HealtheIntent.

12 March 2021
- Digital Inclusion
- Missing Cancer Patients
- Health Inequalities
- HealtheIntent

19 March 2021
- Special meeting on Integrated Care Systems

RESOLVED

To note the report.

11. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

12. DATES OF FUTURE MEETINGS

It was noted that the future North Central London Joint Health Overview and Scrutiny Committee meetings were scheduled for:

12 March 2021
19 March 2021 (special meeting to consider Integrated Care Systems)
25 June 2021
24 September 2021
26 November 2021
28 January 2022
25 March 2022

13. DEPUTATION ON INTEGRATED CARE SYSTEMS

Brenda Allen, NCL NHS Watch, explained that the deputation had been submitted in relation to the national consultation on Integrated Care Systems (ICS). It was noted that the written deputation, which had been circulated to members and published online, outlined the key issues but that NCL NHS Watch would like the Joint Health Overview and Scrutiny Committee to consider the following issues.

- There were some accountability and representation concerns, including whether there would be representation and voting rights for councillors, clinicians, members of the public, patient representatives, and private sector providers.
- Whether ICS would be responsible for present or future deficits, as some existing Trusts had a deficit, and how this would impact the ICS budget.
- How ICS responsibilities would interact with Council responsibilities for social care and public health, including how the budgets would be pooled and managed and how much input Councils would have on priorities and spending.

- The role of Health and Wellbeing Boards and Partnership Boards, specifically their ability to influence and determine local priorities and resource allocation and how they would be able to influence ICS level decisions.
- Which bodies would have oversight and scrutiny powers over ICS.
- There were concerns about the health data that would be held by ICS and held by any contractors and how data would be safeguarded.
- It was noted that there had been previous issues with health and social care integration, including eligibility, funding, and accountability, and it was not clear in the consultation document how this would be achieved effectively by ICS.
- There were also concerns about the mass transition to virtual access for GPs; this was understandable during the Covid-19 pandemic but it was considered that face-to-face provision was vital for continuity of care, diagnoses, and treatments. It was added that many cross-sections of the community, including GPs, preferred face-to-face interactions and this was not limited to older people or those who spoke English as an Additional Language.

The Committee asked about the desired role for patients and other local representatives in ICS Boards. Brenda Allen, NCL NHS Watch, explained that a number of concerns related to the erosion of local involvement. It was noted that some reduced involvement during the Covid-19 pandemic was understandable but that it would be important to ensure that this was not embedded for the future. It was stated that better health decisions were made when patient and councillor experience was included in the decision making process to design and deliver accessible healthcare. It was added that the inclusion of councillors, in particular, as voting members of the ICS Board would be essential for accountability and democracy.

The Chair thanked NCL NHS Watch for the deputation and noted that the voice of the community would be key to the Committee's discussions on ICS.

CHAIR: Cllr Pippa Connor

Signed by Chair ………………………………..

Date …………………………………

Agenda Item 10

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	London Boroughs of Barnet, Camden, Enfield, Haringey and Islington
REPORT TITLE Work Programme 2020-2021	
REPORT OF Committee Chair, North Central London Joint Health Overview & Scrutiny Committee	
FOR SUBMISSION TO NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**DATE** 12 March 2021

SUMMARY OF REPORT

This paper provides an update on the 2020-21 work programme of the North Central London Joint Health Overview & Scrutiny Committee. It also invites proposals for agenda items for the meetings in 2021/22 and especially provisional items for the first meeting, which will be on 25 June 2021.

Local Government Act 1972 – Access to Information

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

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RECOMMENDATIONS

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

a) Note the work plan for 2020-21;
b) Consider proposals for agenda items for meetings in 2021/22;
c) Agree provisional items for the first meeting of the Committee of 2021/22, which will be on 25 June 2021.

1. Purpose of Report

1.1 This paper outlines the areas that the Committee has chosen to focus on for 2020-21. The Committee is asked to note the list of topics that have been considered during the current year as well as matters that have been identified as potential agenda items but not yet considered. These are listed in **Appendix A**.

1.2 The next meeting of the JHOSC is scheduled to take place on 19 March and will be the final meeting of 2020/21. The after this will be the first of the 2021/22 year take place on 25 June. The Committee is asked to consider agenda items for future meetings and, in particular, the meeting on 25 June. These can be topics previously identified or new ones.

1.3 Meetings are likely to need to continue to be virtual for the foreseeable future. If and when this changes during the current year, arrangements will have to be made to identify suitable venues for meetings.

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 – 2020/21 NCL JHOSC Work Programme
Appendix B – NCL JHOSC Action Tracker

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Appendix A – 2020/21 NCL JHOSC work programme

27 November 2020

Item	Purpose	Lead Organisation
Secondary Care – Patient Pathway	Underlying access to secondary care, disparities between groups, rates of access/referral. Deep dive around cancer (multi-faceted).	NCL partners
Primary Care – Patient Pathways;	What is known about access to care, primary care numbers, diabetes case study, dentistry.	NCL partners
Long Covid	What are the arrangements and plans for future.	NCL partners
Outline response to deputation on changes to services during Covid-19 pandemic	To respond to the deputation regarding emergency changes to NHS services in response to the Covid-19 pandemic and set out the potential process and timeline should permanent changes be made.	NCL partners

29 January 2021

Item	Purpose	Lead Organisation
Post-Covid syndrome pathway	To include communications, the financing for the therapies teams and a section about which communities were presenting with post-Covid syndrome given concerns about the disproportionate amount of white British people presenting.	NCL Partners/UCLH
Mental health services during the Covid pandemic	The mental health impact of the Covid-19 pandemic, including carers.	NCL partners/BEH MHT
Digital Inclusion	Digital inclusion, including the NCL Board report and Equality Impact Assessment, specific reference to Black, Asian, and Minority Ethnic communities, faith communities, and specific data.	NCL partners

12 March 2021

Item	Purpose	Lead Organisation
Missing cancer patients	To consider the issue of the drop in the number of patients presenting with cancer since the start of the Covid 19 pandemic and how this might be addressed.	NCL partners
Health inequalities	Health Inequalities, specifically looking at the impact of Covid-19 on Black, Asian, and Minority Ethnic communities in more depth and with more data.	NCL partners
Digital Inclusion	To consider further the issue of digital inclusion in view of the increasing use of digital technology in healthcare, particularly for communication.	NCL partners

19 March 2021

Item	Purpose	Lead Organisation
Integrated Care Systems	To consider the implications of the further development of Integrated Care Systems	NCL partners
AT Medics	To respond to concerns relating to the procurement of GP services from AT Medics	NCL partners

To be arranged

Finance	A report to respond to address funding and finance issues.	NCL partners
Screening and Immunisation	NCL partners to confirm focus and scope.	NCL partners
Children and Young People – integrating care for children and young people	A report on work across NCL through the paediatric integrated network with examples of how this is improving care for children and young people	NCL partners

Temporary changes to Paediatric services	An update to respond to concerns around the closure of Paediatric Services at the Royal Free and UCH.	NCL partners
Continued Emergency and/or Recovery Planning	Updating on plans for emergency planning and recovery planning	NCL partners
Estates Strategy Update	Update on progress with the Estates Strategy for NCL	NCL partners

2021/22 Meeting Dates

- 25 June 2021
- 24 September 2021
- 26 November 2021
- 28 January 2022
- 25 March 2022

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Appendix B – NCL JHOSC Action Tracker

Meeting	Item	Action	Action by	Progress
29-Jan-21	Covid-19 Update	The JHOSC asked a number of questions in relation to Covid-19 testing and vaccination. The Chair also asked a question in relation to vaccination on behalf of a resident. It was agreed that a written update could be provided.	Chloe Morales Oyarce/ Will Huxter	Complete – a written response was circulated to JHOSC members and (where relevant) residents. The public information was also published on the Council's website alongside the meeting information.
29-Jan-21	Post-Covid Syndrome Pathway	It was agreed that the Chair would write to NHS England to support the request for funding for the Post-Covid Syndrome service.	JHOSC Chair	Complete – the letter was sent to NHS England in February 2021.
29-Jan-21	Mental Health Update	The JHOSC asked to receive an update on mental health services, including: • More information on funding for individual boroughs and homelessness. • A response on the question of who was leading on co-ordinating all the different services in relation to mental health care, including other partners such as the Police, housing, and the Council, within individual complex cases. It was acknowledged that this model needed greater development and planning and that it could be useful to have a future session where the Committee and other partners could provide input. • An update on any situations where mental health services were working innovatively and where services were	Chloe Morales Oyarce/ Will Huxter	Complete – a written response was circulated to JHOSC members. The public information was also published on the Council's website alongside the meeting information.

		targeting any particular groups to increase uptake		
29-Jan-21	Mental Health Update	To receive an update on mental health services.	Chloe Morales Oyarce/ Will Huxter	Officers advised that it would be useful to provide an update around September 2021.
27-Nov-20	Secondary Care during the Covid-19 Pandemic	To provide a report on Missing Cancer Patients to the Committee in March 2021.	Chloe Morales Oyarce/ Will Huxter	Complete – a report will be provided to the JHOSC on 12 March 2021.
25-Sep-20	Deputation – Temporary Services Changes made in response to the Covid-19 Pandemic	A formal commitment was made to commission an Equality Impact Assessment around digital access to GPs and other health care settings. NHS partners would be looking to learn and reach out how to mitigate the risk.	Rob Hurd	The Equalities Impact Assessment is being commissioned in November and North London Partners will update the Committee on progress.
25-Sep-20	Deputation – Temporary Services Changes made in response to the Covid-19 Pandemic	In terms of the abolition of Public Health England and replaced by the National institute for Health Protection and the lack of consultation, this would be taken away and comments would be provided to members at a later date.	Rob Hurd	
25-Sep-20	All future reports	For future reports, Committee members requested that officers provide at the front of the report a summary, no more than one side of A4 of the main issues and outcomes.	Report authors	Ongoing.
4-Sep-20	Orthopaedic Services Capacity	To receive a report on the issue of capacity in 12-18 months (Sept 2021-March 2022).	Anna Stewart	
4-Sep-20	Orthopaedic Services Review	To receive an update on how the Programme Team had managed to deliver on the performance metrics which tracked achievements and performance. The Committee also requested that when the	Will Huxter and Anna Stewart	

		update report came back that it also included views from Care Co-ordinators as well as the Patient Representatives.		
Jul-20	LUTS Clinic	To receive a written update on what was happening with regard to the LUTS clinic, a matter on which the Committee had received a number of deputations from concerned patients over the past few years.	Frances O'Callaghan, Richard Dale	Frances O'Callaghan said she would liaise with the relevant officer (Richard Dale) about providing a written update on the topic.
Jan-20	Health and Care Integration	Informal private seminar to be set up, hosted by Mike Cooke with invites to HASC members from across NCL. To discuss what outcomes we want to achieve.	Mike Cooke, Henry Langford	Complete – the JHOSC will be having a special meeting on Integrated Care Systems with Mike Cooke on 19 March 2021.
Sep-19	Deputation – Patient Transport	Pan London JHOSC meeting to be arranged with representatives from NHS England, Department for Health and Kings Fund on patient experience of transport.	Policy Officer	Officers continue to work alongside the Chair to arrange a Pan London JHOSC meeting on patient transport. Awaiting confirmation from NHS colleagues. A successful Pan London JHOSC meeting was held on 16 January 2020 discussing the Mayor's '6 Tests' framework for major hospital service reconfigurations.
Sep-19	Deputation – Proposed Merger North Central London CCGs	The Committee requested further information about the amalgamation of the CCGs from the North London Partners in Health and Care. It was suggested that the Committee hold a special meeting to consider the information when it became available	Policy Officer	Where possible, items for consideration by JHOSC are incorporated into the work programme and planned schedule of meetings for 2019/20. Having met with the Chair, it was agreed a specific response to the comments made by JHOSC would be included in the Health and Care Integration item at the January 2020 meeting. The committee can choose to allocate further time to the issue during the work programme item.

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BARNET LONDON BOROUGH | ENFIELD Council | Camden | Haringey LONDON | ISLINGTON

SUPPLEMENTARY AGENDA II

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 12 March 2021, 10:00 a.m.
MS Teams (watch it here)

Contact: Fiona Rae / Robert Mack

Direct line: 020 8489 3541 / 020 8489 2921
E-mail: fiona.rae@haringey.gov.uk / rob.mack@haringey.gov.uk

Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Edward Smith (Enfield Council), Pippa Connor and Lucia das Neves (Haringey Council), Tricia Clarke, and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Andy Ellis, Robert Mack, and Peter Moore.

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

AGENDA

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 10)

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

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Tel – 020 8489 3541
Email: fiona.rae@haringey.gov.uk

John Jones
Monitoring Officer (Interim)
River Park House, 225 High Road, Wood Green, N22 8HQ

Thursday, 11 March 2021

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Deputation to JHOSC, North Central London, 12 March 2021

Background

NCL CCG have given their agreement to a change in control of the 8 APMS contracts in North Central London which have hitherto been held by the company AT Medics Ltd, allowing them to pass over the contracts to Operose, a wholly owned subsidiary of Centene Corporation, a vast American insurance company which makes its money from providing medical cover for Medicare, Medicaid and the Affordable Care Act (Obamacare). Centene has a litany of violations of its responsibilities and has been heavily fined by the US regulators. A T Medics held 49 contracts across London, including the 8 NCL practices. This makes Operose /Centene the biggest provider of GP services in England.

There has been strong public objection to this change both through the local press, through all Executive lead members on Health and Social Care in the five boroughs, and through motions in local political parties. There would undoubtedly have been street demonstrations had it not been for lockdown. It is inconceivable that the CCG would have selected a subsidiary of Centene Corp in open competition. Its track record in the USA would have ruled it out. Centene used a less objectionable locally based company, AT Medics Ltd as a Trojan horse, buying them up and with that their contracts with the NHS. Profits after tax for A T Medics Ltd for the years 2016 -2020 from their 49 contracts across London was £28.4m and it is rumoured that the six GPs who were the directors of A T Medics Ltd received £140m for the sale of their company.

What NCL CCG did and did not do

NCL CCG claims that their hands were tied. Transfer of NHS contracts between companies is prohibited unless allowed by the commissioner if they are satisfied with assurances that the contract will operate as before and that the current contract holders ask permission in advance. If this process is not followed, the commissioner may re-procure the contract. A T Medics Ltd gave the assurance that as they would remain directors of the company control would remain unchanged in practice. This was recorded in the minutes of the primary Care Commissioning Committee (PCCC) of 17 December 2020 and the minutes were confirmed as correct at their next meeting on 18 February 2021. But A T Medics directors all informed Companies House on 10 February that they had resigned as directors of A T Medics. They were replaced by people who were employees of Centene and Operose. In an emailed letter on 20 February from 19 health campaigning organisations the CCG was informed of that situation but during the following week they took the decision anyway to agree the transfer. So they had the opportunity legally to put a stop to this Trojan horse manoeuvre but did not do so.

Moreover, although they claim that the issue was fully discussed by all members of the PCCC on 17 December, no mention was made there of Centene. The information that they

were involved was confined to Part 2 of the meeting which was not made available to the public and from which all non-voting members, including the community members, were excluded. The CCG clearly knew it had something to hide.

Had they taken the decision to re-procure the contracts, It is likely that A T Medics / Operose/ Centene would have kept their service in place to allow that to happen, and they may have been contractually obliged to do that. Even if they had not done so, the GP Federations could have been asked to supervise the service being delivered by the current salaried GPs working in the practices, new salaried doctors or locums. We have heard that the Islington Federation would have been willing to do that.

We are sure that NCL CCG was put under a lot of pressure by NHSE to waive through this change of control, making the most of the current emergency to make changes they wanted to make anyway, as discussed in our deputation to you in September 2020. We believe this is not unconnected to the desire to have a free trade deal with the USA and to demonstrate that US health interests would be welcome in the UK.

Strategic issues raised by this matter

1. The CCG had the choice of serving the interests of the public of North Central London in the decision, or following instructions from NHS England. How will they seek to restore the broken trust of leading members of the local authority, with whom forthcoming legislation requires them to work in partnership, and how will they restore the trust of the wider public
2. What lessons have they learned about the need for transparency from the decision to confine discussion of the presence of Cetene in this matters to the closed Part 2 of a public meeting. Will they acknowledge that recent public statements and letters from the CCG have falsely claimed that there was full discussion by the PCCC. Will they guarantee not to use the Part 2 device in future for matters of public interest, reserving it for matters where confidentiality for individual people is required.
3. Will the CCG write to members of the public covered by these 8 practices, explaining what has happened and also that they have a choice about which practice they wish to use, and further explain how they should go about transferring elsewhere. This letter should contain messages in languages other than English showing how the user of that language can find out more. The same information should be available on the CCGs website.
4. What is the remaining term of all APMS contracts and what are the arrangements for rolling over or re-commissioning them. Are there other APMS contracts in North Central London held by other companies. What contingency planning has the CCG undertaken about how to respond if Centene / Operose make a similar takeover bid for those companies. How will the CCG respond in future if an existing PMS / GMS practice fails. Will they create a new APMS contract.

   Prof Sue Richards, on behalf of NCL NHS-Watch, 9 March 2021

Haringey and Islington KONPs Deputation on GP Access to NCL JHOSC,

12 March 21 SUMMARY

Haringey and Islington KONP are extremely concerned that the "temporary Covid GP Access policy" is becoming a permanent policy in NCL and risks damaging health outcomes for vulnerable sectors of the population ie the elderly, the disabled, those with MH issues, people with Learning Difficulties and Autism, the BAME community and Migrants .

We believe there are 3 Issues for the JHOSC to consider:

- The clinical need for, and the right to face-to-face access to a GP /clinician
- That the policy of "digital first" is detrimental to the long term health and wellbeing of NCL residents, most particularly to vulnerable groups with protected characteristics, as defined by the Equality Act (2010)
- Problems of equity with GP access systems, now and in the future

(Details of our concerns on the attached document)

HKONP and IKONP have the following questions for the JHOSC:

- 1/ Can JHOSC seek assurances from NCL CCGs that face-to-face GP appointments will be reintroduced as the norm post lockdown?
- 2/ Will the CCG acknowledge patients' right to face-to-face appointments for both primary and secondary care post lockdown, and publicise this at every GP surgery and on their website?
- 3/ when will the results of the Health Impact assessment be available and will it cover all protected groups and include the elderly, disabled people, people with MH issues, people with LD and Autism, the BAME community, migrants and victims of domestic abuse?
- 4/ what action is the CCG taking to avoid any potential discrimination resulting from this policy on the above groups?
- 5/ How will NCL CCGs make sure that isolated, vulnerable people/elders who are digitally excluded will not disproportionately suffer if they cannot contact their GP by telephone in a timely manner?
- 6/ how will CCGs deal with problems of access to GPs now, and in using e-Consult?
- 7/ How will Haringey CCG address the privacy concerns raised by the use of Public Voice volunteers and/or public libraries as access points in Haringey?
- 8/ CCG to give more details Initiative on digital access from Whittington etc.
- 9/ What are the numbers of face to face appointments available now in NCL ?

Rod Wells, Haringey KONP; Frances Bradley, Islington KONP

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- Problems of equity with GP access systems, now and in the future

KONP believe that this policy is not just a temporary Covid response but part of a permanent NHSE policy known as "digital first" under the NHS Long Term Plan. HKONP have twice raised concerns about this policy with NCL CCG since Nov 2020,

We now ask JHOSC to ensure NCL CCGs provide answers to each of the questions 1-7 set out at the end of this document.

Clinical Need for Face-to-Face Examination

We at KONP believe people have a "right "to face-to-face treatment, as the NHS constitution clearly states, i.e.

"You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences." (1)

If face-to-face appointments are reserved largely for the elderly or the digitally illiterate, this will compromise safe healthcare for large numbers of other patients. CCGs know that good clinicians often gather diagnostic clues from a patient's movements, skin tone, and speech patterns etc., which are not visible on a computer screen or via a phone. In addition, people of all ages whether vulnerable or not - particularly non-native English speakers – can find the digital interface makes it more difficult to speak openly to medical personnel. This all means that some important diagnostic clues are likely to be missed during online and telephone consultations.

Patient-GP rapport which is more easily established by face-to-face consultation and helps patients speak in confidence on sensitive subjects, for example, concerning mental health issues. Also importantly, a good doctor-patient rapport encourages treatment compliance.

The BMA has warned that doctors "[feel] that a greater use of … technology....could potentially be detrimental to some patients who require face to face appointments." (In September 2020, (2)

And furthermore, recent research published in the BMJ “reveals that increased continuity of care by doctors is associated with lower mortality rates” because at traditional face-to-face appointments, doctors can observe changes in their patients over time. BMJ ref........ (3).

.So KONP believe that this policy is a switch from a genuine widening of choice for clinicians and patients, to “digital first “will have long term costs for health outcomes and the wellbeing for patients of NCL

Health Inequalities Impact on vulnerable populations of “ digital first “access

This is an issue for significant minority groups, such as people with mental health issues, LD, the BAME community and migrants.

Although digital access to a GP undoubtedly suits some people - those with simple medical conditions who need a straightforward fix for an easily diagnosable problem and who are comfortable with using digital technology, we believe that for others this prioritising digital will reduce access.

Clearly not all patients, or their medical conditions, fit into simple categories. For example, elders - who as a group have the greatest health needs - are much less likely to be able to use digital technology to access their GP. Unequal access is already recognised as a prime cause of health inequality across different population groups.

KONP therefore asks that qualitative research be undertaken to determine if “digital first” creates a barrier to timely access to healthcare for patients. Bear in mind that late presentation and diagnosis tends to mean greater medical intervention is needed, and lead to worse health outcomes.

A lack of access of high-tech coincides with higher rates of poverty across all age groups. This is exacerbated within BAME communities where English is not the mother tongue, as well as in more insular or distinct groups, such as the Hasidic Jewish community, where the majority of households do not have a TV, smartphone or Internet at home (Jewish Post, 6/10/20).

KONP press the CCG to describe what action they are taking to assist the above groups to access primary care so that treatment is “appropriate ...and reflects their preferences”

Addressing digital exclusion- sources of support for digital access

Many people in the protected groups have relatives or friends who can help and support them to access their GP via digital technology. But it is not safe to assume that everyone is happy to speak openly about their health concerns in front of others, or that family or friends are necessarily benign.

For people who don’t have someone to help them navigate the internet, charities and local libraries (when they are open) are expected to provide access and to help people master the necessary technology. And we are aware of Public Voices project in training elders in digital technology –see later

Designing a system of access which depends on charity/PV to enable certain people to access health care goes against the NHS founding principle of appropriate care for all individuals at the point of need.

Discrimination/Health Impact Assessment of "digital first"

KONP do not believe the health inequalities of these protected groups have been addressed fully by the CCG**.**

We welcome the CCG doing a Health Impact Assessment for the elderly and people with LD but assessment must cover all protected/vulnerable groups.

Furthermore, NCL CCGs must be able to demonstrate that their policy of "digital first" will not discriminate against any group which has limited access to/facility with, the necessary technology, or people who are not fluent in English. Again this refers to the protected groups identified in the Equality Act (2010).

How will the detrimental effects will be addressed as they arise, because the health of vulnerable people is at stake here?

Because of existing social inequality KONP need written assurance that differential access to health care particularly across vulnerable groups will be closely monitored to ascertain any detrimental effects on long-term health outcomes and trends in death rates.

Monitoring is therefore necessary to ascertain that everyone who needs health care is indeed able to access their GP in the way that suits their capacities and their needs, as well as respects their privacy.

When and how will NCL CCGs publicise their findings?

Joint Initiative with Whittington Health North Middx and Barnet and Enfield and Haringey MHT on Digital Access

This pilot is "to understand how we can better support patients to access NHS services digitally and to help inform future commissioning approaches."(Rachel Lissauer CCG 14/1/21)

KONP therefore asks what analysis will be done of the needs of different vulnerable groups for face-to-face appointments and how will these needs be addressed? Have these Hospital Trusts contacted local authority/voluntary organisations which support the different groups for advice?

KONP suggest that in-depth monitoring of the "digital first" pilot study must demonstrate that sufficient time is allocated for face-to-face GP appointments. People who are ill must not be forced to wait a long time for an appointment, and potentially suffer worse health outcomes as a result.

When will a report into this be available?

Access to GPs Now: face-to-face/ telephone/e-Consult

We understand that in January 2021 the level of face-to-face access was 20/40% in Haringey. One HKONP member found themselves 14th in a phone queue and waited 48 minutes for an answer. This raises the question, what is the current availability of a) face-to-face and b) telephone appointments per head of population across NCL boroughs?

The problem of waiting a long time to get through to a GP/practice nurse will be prohibitively expensive for poorer people who tend to use a pay-as-you-go phone. How many patients cannot afford the time or money to wait this long on the phone?

How will CCGs enable these people to have *equitable* access to GP appointments?

Use of Public Voice volunteers in Haringey

We acknowledge the work the CCG is doing in Haringey via Public Voice to help people to gain digital access to primary care This input makes it appear that the "digital first" policy is to be permanent. Though

We have concerns with PVs project

- how this is being publicised? How will the CCG know they have adequately supported everyone in Haringey who needs assistance?
- Privacy - the presence of a 'volunteer' for what should be a private interaction may feel intrusive and insensitive.
- Issuing mobile phones and laptops in public libraries raises the question of privacy and confidentiality and whether people can successfully connect with GPs

A report on the efficiency and effectiveness of Public Voice project in reaching digitally excluded groups is needed. When will this be available?

Using e-consult

This system of access seems problematic .To be entitled to book online appointments is a big hurdle and one member of HKONP - with a good level of computer literacy - reports being unable to navigate e-consult, which indicates the programme's poor design is a barrier to access.

At least a dedicated helpline is needed to offer support and, if that fails, patients must be allowed to contact the GP surgery directly. We understand from the CCGs engagement, only 14% of Haringey residents said they would use e-consult.

. What will be done to ensure e-consult is not overly complex and the lack of support addressed, if patients are to rely on e-Consult?

HKONP and IKONP have the following questions for the JHOSC:

1/ Can JHOSC seek assurances from NCL CCGs that face-to-face GP appointments will be reintroduced as the norm post lockdown?

2/ Will the CCG acknowledge patients' right to face-to-face appointments for both primary and secondary care post lockdown, and publicise this at every GP surgery and on their website?

3/ when will the results of the Health Impact assessment be available and will it cover all protected groups and include the elderly, disabled people, people with MH issues, people with LD and Autism, the BAME community, migrants and victims of domestic abuse?

4/ what action is the CCG taking to avoid any potential discrimination resulting from this policy on the above groups?

5/ How will NCL CCGs make sure that isolated, vulnerable people/elders who are digitally excluded will not disproportionately suffer if they cannot contact their GP by telephone in a timely manner?

6/ how will CCGs deal with problems of access to GPs now, and in using e-Consult?

7/ How will Haringey CCG address the privacy concerns raised by the use of Public Voice volunteers and/or public libraries as access points in Haringey?

8/ CCG to give more details Initiative on digital access from Whittington etc.

9/ What are the numbers of face to face appointments available now in NCL ?

Rod Wells, HKONP; Frances Bradley, Islington KONP

References

1/ NHS Constitution -“Access to health services” https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-rights-and-the-nhs-pledges-to-you

2/ BMA https://www.bma.org.uk/bma-media-centre/evidence-on-digital-appointments-needs-scrutiny-says-bma-as-government-instructs-more-to-use-the-technology-in-the-nhs

3 BMJ https://bmjopen.bmj.com/content/8/6/e021161

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