NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 29 January 2021, 10:00 a.m.
Remote meeting – MS Teams (watch it here)

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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 Pete 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. MINUTES (PAGES 1 - 14)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 27 November 2020 as a correct record.

6. COVID-19 UPDATE (PAGES 15 - 22)

This paper provides an update on the Covid-19 pandemic in North Central London.

7. POST-COVID SYNDROME PATHWAY

This paper provides further information on the Post-Covid Syndrome pathway. **(To follow)**

8. MENTAL HEALTH UPDATE

This paper provides an update in relation to Mental Health Services. **(To follow)**

9. DIGITAL INCLUSION (PAGES 23 - 46)

This paper discusses digital inclusion in response to the increasing digital approach to healthcare.

10. WORK PROGRAMME (PAGES 47 - 54)

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 (changed from 26 March 2021 due to the pre-election period)
25 June 2021 (provisional)
24 September 2021 (provisional)
26 November 2021 (provisional)
28 January 2022 (provisional)
25 March 2022 (provisional)

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Agenda Item 5

MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON FRIDAY, 27TH NOVEMBER, 2020, 10.00 AM - 12.40 PM

Present:
Councillor Pippa Connor (Chair), Councillor Edward Smith (Vice Chair), Councillor Tricia Clarke (Vice Chair) (from item 5), and Councillors Alison Cornelius, Linda Freedman, Larraine Revah, Paul Tomlinson, 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

There were no apologies for absence.

3. URGENT BUSINESS

There were no items of urgent business. The Chair noted that, due to officer availability, item 8 (Post-Covid Syndrome Service) would be taken after item 6 (Primary Care during the Covid-19 Pandemic).

4. DECLARATIONS OF INTEREST

There were no declarations of interest.

5. MINUTES

Cllr Cornelius drew attention to item 6 of the minutes, Declarations by Members, and noted that she was a ‘Council appointed Trustee’ rather than a ‘Council appointed member’ of the Eleanor Palmer Trust.

RESOLVED

That, subject to the above amendment, the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting held on 25 September 2020 were confirmed and signed as a correct record.

In terms of matters arising from the minutes, the Committee asked for clarification of whether the 85 community health beds, meant for testing care home residents to prevent Covid-19 outbreaks when they returned to care homes, were included within the 200 surge beds or whether they were a separate provision. It was also enquired

whether people with disabilities in supported living accommodation were being provided with the same access to testing as care home residents. The Chair noted that these questions would be provided with written answers.

Post meeting note: The table below showed all units capable of taking Covid 'bridging' patients (patients due to be discharged to a care home but awaiting a negative test). These were referred to nationally as 'designated' sites. The column marked 'beds' showed the capacity of the units pre-surge. The column marked 'max surge' showed the maximum capacity if all surge beds were used. Part of the surge capacity at Chase Farm had currently been implemented. All 240 beds were capable of being 'bridging beds' if required. These beds were mainly used as step-down from hospital, but not exclusively. There would be occasions when a patient was admitted directly from the community or other pathways.

Provider (NHS)	Unit	Beds	Max Surge
CLCH	Finchley Memorial Hospital	51	
CLCH	Edgware Community Hospital	20	+17
CNWL	St Pancras	51	+36
BEH	Chase Farm	33	+32
TOTAL		**155**	**85**

(This table did not show all NCL P2 block capacity. Units located in care homes or extra care sheltered units, such as Mildmay, St Anne's, and Priscilla Wakefield, were not intended as bridging beds.)

In relation to testing access for those with disabilities in supported living accommodation, it was noted that the national testing regime had provided regular testing for care home staff (weekly) and residents (monthly) in recent months. It had been announced that the national offer would provide increased testing for extra care and supported living settings shortly. In North Central London (NCL), local testing capacity had been provided to address the gaps in supported housing (and other social care settings). This had been provided by the local NHS and its use had been directed between public health and adult social care departments.

The Chair noted that the action tracker had been circulated as a late paper. It was explained that a number of the actions had been completed but that the key outstanding items were a written update on the Lower Urinary Tract Service (LUTS) Clinic and a seminar on health and social care integration hosted by Mike Cooke. The Chair added that the remaining items on the action tracker would likely be addressed later in 2021. Rob Mack, Principal Scrutiny Officer, reported that the seminar on health and social care integration had been arranged but had been cancelled due to the Covid-19 pandemic; it was noted that efforts would be made to reorganise.

6. PRIMARY CARE DURING THE COVID-19 PANDEMIC

Will Huxter, Clinical Commissioning Group (CCG) Director of Strategy, introduced the item and explained that he had oversight of ongoing programmes. He noted that Dr Katie Coleman, Islington GP and North Central London (NCL) Clinical Lead for Primary Care Network Development, and Keziah Insaidoo, Health and Care Close to Home Programme Manager, would present the item and answer questions.

Dr Katie Coleman noted that primary care had worked extremely hard during the Covid-19 pandemic to meet the needs of the local population. It was explained that there were some challenges for staff and patients and that some significant changes had been required to ensure safety. It was noted that the detail was provided in the report but that a major concern had been access to healthcare during the pandemic. Dr Katie Coleman explained that, initially, GP surgeries were not open and people were unsure how to access their GPs. There was now a digital approach to gain access to GPs and it was acknowledged that the digital approach had caused some problems for a small but significant portion of the population. It was added that it had been challenging to return to a 'business as usual' position, particularly for those with Long Term Conditions (LTCs), child immunisations, and cancer identification. It was commented that the responses of primary care were listed in the report and included creating a dedicated service to support the needs of people with Covid-19 and post-Covid syndrome. It was added that things were developing quickly which involved ongoing learning and responses to challenges.

It was noted that the Committee had been interested in assessing how services had changed for patients and their pathways, particularly in the case of diabetes as there had been some concerns that residents had not been able to access blood tests. Dr Katie Coleman noted that, at the early stage of the Covid-19 pandemic, those with LTCs were not able to access GPs. It was explained that there had been a great deal of fear for patients and staff; however, this had improved as more was learnt about the virus and about how to protect staff and patients.

In relation to those with LTCs, GPs were able to search their patient lists and actively identify those whose conditions were most poorly controlled and who were at the greatest risk of complications; this enabled GPs to stratify their populations. Therefore, someone with diabetes would be identified by a GP and would be contacted over the phone for an assessment. It was noted that this could be undertaken by a Healthcare Assistant or Pharmacist and that training for virtual support had been provided to staff. It was highlighted that a number of diabetes cases involved behavioural and lifestyle considerations, such as diet and exercise, which could be addressed virtually. After this initial assessment and identification of care needs, a patient would be offered an appointment for their annual blood tests; the GP or Pharmacist would generate and send a pre-filled form to the Phlebotomist. Afterwards, the results would be sent to the GP practice and any follow up or adjustments to medication could be made. Dr Katie Coleman explained that putting these changes in place had taken some time but that service delivery was now back to pre-Covid levels. It was acknowledged that not everything could be provided virtually but that having this option increased direct patient care; it was noted that about 50% of appointments were undertaken virtually.

Cllr Clarke stated that primary care had done well to recover but enquired why the Royal Free had suspended reporting on treatment waiting times. Will Huxter explained that there were national arrangements for reporting and that, due to data problems, the Royal Free had been unable to meet the national reporting standards. In these circumstances, it was agreed that the Trust ceased national reporting, although there was still local monitoring and national reporting was anticipated to resume at the end of March 2021. Cllr Clarke also noted that there were reports of increased suicide attempts and asked whether this was an issue locally. Dr Katie Coleman noted that there had been an increase in mental health issues across all age groups. Work was underway with mental health teams to ensure that there was sufficient support and funding and pathways had been changed to respond to children in crisis. It was added that there were some promising transitions underway to embed mental health care in local communities and primary care networks.

Cllr Smith enquired how GPs identified people with LTCs and whether the Clinical Commissioning Group (CCG) was monitoring whether all people with LTCs had been contacted. Dr Katie Coleman explained that all people with LTCs had codes and GP practices could undertake searches based on these codes. This database of codes was accessible to all GP practices and other providers. It was possible to monitor how GPs were achieving in the outcomes for people with LTCs using the Quality and Outcomes Framework; this was monitored annually. Some areas were also looking at enhanced services around outcomes; although this was primarily in Camden at present, this might be rolled out across NCL. In addition, there was a population health management platform used across NCL, Healthy Intent, which allowed outcomes across GPs and all providers to be monitored.

It was enquired when GPs were visiting care homes and how this workload was shared. Dr Katie Coleman explained that, at the start of the pandemic, no medical professionals were going into care homes and there were virtual ward rounds and assessments. It was noted that there had been existing plans to introduce a programme called Enhanced Health in Care Homes and this was brought forward; this meant that every care home in NCL had a dedicated clinical lead in charge of ensuring patients with concerns were identified and supported. This programme was introduced in May and then enhanced in October. It was added that the model of care for care homes was more community based with a multi-disciplinary team working in a collaborative way and reporting issues to GPs where necessary.

Cllr Das Neves stated that the most vulnerable and disadvantaged would be struggling to engage digitally and possibly even by phone; she asked how this was being monitored, whether there were clear processes, and what was being done to improve digital inclusion. Dr Katie Coleman acknowledged that the change in approach had not happened perfectly and there was always more that could be done to improve. She explained that she had raised digital inclusion as a significant risk at the NCL Digital Board recently and had been assured that this would be addressed. It was noted that there was no monitoring but that this was a known issue which needed to be addressed. It was explained that there was a project with Healthwatch that had recently begun in Haringey which tried to procure digital hardware and provide training to improve digital inclusion. Will Huxter noted that there was a plan to undertake an Equality Impact Assessment on digital inclusion which would set out what was being

measured and possible ways to mitigate issues. It was added that input from the Committee would be welcomed.

It was also noted that some residents had received varying instructions and it was enquired whether there was a clear process for the delivery of care. Dr Katie Coleman noted that each GP was an independent provider and would undertake care processes which suited them best and, as such, it was acknowledged that there would be some differences. However, the CCG endeavoured to provide GPs with recommendations about the delivery of care. For example, in terms of risk stratification, it was recommended that certain patients were contacted on a regular basis, such as those with dementia. In addition, all GPs were currently working in a more joined up way with community providers to support those at greatest risk. Dr Katie Coleman noted that GPs were also monitored at the end of each year based on their achievement against the Quality and Outcomes Framework; this meant that any issues could be examined and addressed. It was added that, if there were consistent issues, a GP would come to the attention of the regulator which would lead to additional measures and reviews.

Cllr Freedman enquired whether there was any data on the uptake of the flu vaccination. Dr Katie Coleman explained that NCL was currently on the trajectory to achieve the 75% target vaccination rate for over 65s, high risk 18-25s, and children. The Healthy Intent platform was being used to understand any areas of need and it was noted that certain parts of the community were taking up the vaccination less. It was explained that some targeted work was underway with the Voluntary and Community Sector (VCS) to raise awareness about the importance of the flu vaccine, the Covid vaccine, and the risk of contracting both diseases. It was noted that the government had procured larger numbers of flu vaccinations and there was a central supply. It was noted that not all GP practices could administer the flu vaccine but that there was more collaborative work and mutual aid which would be useful for the upcoming Covid vaccination campaign.

It was also noted that, in the report, only four of the five Healthwatch organisations had been mentioned; it was enquired why Barnet Healthwatch was not included. Dr Katie Coleman noted that all five NCL Healthwatch organisations were now working closely and one area often led on a project. It was noted that investigation could be undertaken to see why Barnet was not mentioned in this section of the report. **Post-meeting note:** Healthwatch Barnet confirmed that they were also invited to participate in the survey but were unable to do so at the time as they were going through a contract change. Healthwatch Barnet had not done specific work on this but, in general surveys, their findings replicated those from the other Healthwatch organisations, namely a mixed picture in relation to patient feedback on digital access to primary care.

Cllr Cornelius noted that some care homes struggled to obtain flu vaccinations for staff; she suggested that it would be more efficient for staff to receive vaccinations at work or for the vouchers to be sent directly to the care home. Dr Katie Coleman noted that there was a team supporting care homes to get flu vaccinations for care home residents and staff and she would have to look into this. **Post-meeting note:** Care staff did not require a voucher to get a vaccine and could obtain one from the pharmacy when they showed their care worker identification. The biggest challenge

with care staff take up of the flu vaccine this winter had been around inconsistent supplies of vaccines. However, national stock issues had been resolved and community pharmacies now had further access to vaccine stock. A range of actions had been undertaken in NCL to promote take up now that there was a good supply, including webinars and mythbusting sessions, calls to providers from their borough leads, and pop up sessions at care settings.

Cllr Revah enquired what was in place to inform people who were housebound and people with disabilities about changes to GP services. Dr Katie Coleman noted that there was a strategy for people who were housebound and they should receive the same level of care. She acknowledged that, at the start of the pandemic, there had been a lot of fear about the risk of transmission and there had been fewer home visits. However, there had been a lot of training for staff and most GPs were now undertaking home visits with PPE and additional measures. It was added that there were Rapid Response Teams in NCL for anyone who was acutely unwell but did not require hospital treatment; these were multi-disciplinary teams who were overseen by GPs and increased local capacity to respond during the pandemic. In relation to people with disabilities, Dr Katie Coleman noted that there were concerns and extensive communications campaigns had been undertaken. GPs were also expected to undertake annual learning disability health checks; these were not yet at pre-pandemic level but work was underway to address the shortfall.

Cllr Freedman noted that virtual certifications of death could be assuming that Covid-19 was a cause of death and it was enquired whether there were any face to face certifications. Dr Katie Coleman commented that certifications were initially undertaken with PPE but that processes were being developed to support certifications in nursing homes. It was explained that nursing home nurses were being trained to undertake certification of death with doctor oversight.

The Chair noted that a question had been received from a resident; it was enquired what was being done to reduce the risk of Covid-19 transmission at GP surgeries and hospitals. Dr Katie Coleman explained that robust infection prevention control procedures had been introduced which significantly reduced risks. She noted that she was a GP and could not provide the best information about hospitals but she was aware that patients with and without Covid were separated and there was regular staff testing. In GP surgeries, it was explained that there were more spaced out appointment times, waiting areas were regularly cleaned, windows were opened to increase ventilation, and Personal Protective Equipment (PPE) was worn and regularly changed.

The Chair noted that there was a framework for people with LTCs in the report which implied that people with medium or low risks would not have access to GPs. Dr Katie Coleman explained that a number of staff were qualified to deal with LTCs and the framework meant to demonstrate that those with medium or low risks could be seen by other medical professionals, not only GPs. It was highlighted that this was not a reduction in service but aimed to increase resilience.

The Chair stated that the Committee should receive a report explaining the Healthy Intent initiative and a report on the NCL Digital Board work on digital inclusion, including the Equalities Impact Assessment. It was added that it would be useful for

the Committee to receive some information on the digital inclusion pilot in Haringey, even if this related to some initial findings. The Committee could then decide whether a full report would be required.

RESOLVED

1. To note the report.

2. To receive a report explaining the Healthy Intent initiative.

3. To receive a report on the North Central London (NCL) Digital Board work on digital inclusion, including the Equalities Impact Assessment.

7. SECONDARY CARE DURING THE COVID-19 PANDEMIC

Naser Turabi, Programme Director for NCL Cancer Alliance, Derralynn Hughes, Professor of Haematology at the Royal Free London and Co-Clinical Director for NCL Cancer Alliance, and Clare Stephens, Barnet GP and NCL Board and Co-Clinical Director for NCL Cancer Alliance, introduced the item.

Naser Turabi noted that this item would focus on the cancer patient pathway and experience during the Covid-19 pandemic. He explained that, at the start of the pandemic, there were concerns about the spread of the virus and the vulnerability of cancer patients and some services had paused. It was noted that protective measures had been put in place and services were now around pre-pandemic levels. In terms of patients, NCL was ensuring that the pathways were Covid safe and had returned to pre-pandemic levels of diagnosis and treatment fairly rapidly. A key concern was the drop in presentation of new cancer cases. It was explained that cancers were normally diagnosed through multiple routes, such as via GPs, routine hospital appointments, screening, and emergency presentations. Based on a comparison of previous year cancer diagnoses, it was estimated that there were 600-650 missing cancer cases. It was noted that there was a national communications campaign encouraging people to present.

Clare Stephens explained that a cancer awareness measure assessment survey was undertaken in Camden and Islington in late summer; of the 1,300 respondents, 65% admitted to delaying getting help or advice for potential cancer issues, 55% said that they did not want to overwhelm the NHS and felt that they could wait, and others had stated that they were concerned about catching the virus.

Cllr Smith noted that there were a significant number of missing cancer cases and asked whether people knew about the Covid prevention measures and whether this had helped to reduce fears. Naser Turabi noted that there was a communications campaign called ‘Help Us to Help You’ which encouraged people to present when they had seemingly minor symptoms which could be cancer symptoms, such as changes in bowel movements and skin changes. It was noted that this was a national campaign and, furthermore, NCL hospitals had been featured on Channel 4 News and in the Evening Standard. It was also noted that significant effort was being expended

by healthcare professionals and endoscopy numbers were actually higher than pre-pandemic levels.

Cllr Cornelius enquired whether there was still an issue with breast screening and endoscopy waiting times. In relation to endoscopy, it was noted that there were capacity issues as the air in the room had to be cleared between procedures. However, more appointments had been made available, including at weekends, and the service was due to be back on track by the end of next quarter. It was added that there had been significant progress and those with cancer concerns had been prioritised. Derralynn Hughes highlighted that no cancer patients were waiting for an endoscopy beyond the normal length on a 62 day pathway. In relation to breast screening, it was explained that the primary concern was that only 50% of people took up the invitation to attend screening. Although there were some concerns about capacity if additional people took up screening invitations, a working group had been established to support the breast screening service led by the Royal Free which was shared with North East London.

Cllr Freedman noted that the NHS had used some private healthcare for elective and urgent operations at the start of the pandemic and it was enquired whether this was still happening. Naser Turabi noted that some private capacity had been used initially, primarily in inner London. A new deal had been arranged nationally by NHS England whereby private hospitals could sign up to provide additional capacity but, at present, all cancer services had been returned to NHS hospitals and this was being managed within that capacity. Cllr Tomlinson enquired whether there were any issues with surgery waiting times. Naser Turabi noted that surgery waiting times were back to pre-pandemic levels.

The Chair noted that clinical harm reviews were undertaken for patients who had to wait more than 104 days for treatment; it was enquired whether these reviews were still taking place. Naser Turabi explained that clinical harm reviews were routinely carried out when a patient had waited more than 104 days for treatment and the patient pathway needed to complete before there was any analysis. It was noted that the results from the first three months of the pandemic had been analysed and Covid-19 had not been a major factor in any harm caused by delays. It was noted that some patients had chosen to wait for treatment if they were vulnerable to avoid the risk of Covid transmission. It was commented that the number of people waiting more than 104 days had decreased significantly and that there would be further analysis as further patient pathways completed.

The Chair also noted that there was anecdotal evidence that there may be more late stage cancer diagnoses as a result of people failing to present for routine testing and screening; it was enquired whether it was possible to proactively engage with any people who might have a missed cancer diagnosis. Naser Turabi explained that the figures relating to missed cancer diagnoses were estimates and there could be a fair amount of variation but he noted that targeted work would take place where possible to encourage people to seek medical attention. Derralynn Hughes added that the largest numbers of missing cancer diagnoses related to urology and prostate pathways and, as these cancers progressed fairly slowly, there may not be increased numbers of late stage cancer diagnoses. It was noted that work was underway to consider how to optimise these pathways and to understand people’s motivations for

not coming forward; it was added that more information may be presented to the Committee in future.

It was noted that there had been recent news about a new blood test pilot which aimed to detect early stage cancers; it was asked whether NCL was involved in this. Naser Turabi noted that the 'Galleri' blood test had been developed by an American company called GRAIL. It was explained that UCLH and UCL already worked with GRAIL on a large lung screening trial; the population of NCL and North East London (NEL) had access to this trial. Part of the trial involved piloting the new blood test for patients at risk of lung cancer. It was explained that the blood test would require significant further testing but that, if it worked, it would be very exciting as cancer diagnoses currently relied on biopsies. It would also be important for increasing early stage diagnoses from the current rate of about 55% to the 10 year target rate of 75%.

The Chair noted that the Committee had requested a report on the post-Covid syndrome pathway which included some elements of secondary care in the form of referrals to individual clinics. It was enquired whether there was a particular area of secondary care that would benefit from the Committee's input. Naser Turabi noted that the largest area of concern at present was missing cancers. It was commented that this involved public health and public communications issues and that local authorities would be important partners in sharing information. The Chair agreed and noted that an item on missing cancer patients would be added to the Committee's work programme.

RESOLVED

1. To note the report.

2. To receive a report on missing cancer patients.

8. POST-COVID SYNDROME SERVICE

Dr Melissa Heightman, Clinical Lead for the Covid follow up Service and NCL representative for the London Respiratory Network, introduced the item. She explained that that a clinic was started to meet patient need in May 2020 when it transpired that patients going home from the Accident & Emergency department (A&E) were having difficulties related to Covid-19; this was followed by similar reports about the long term effects of Covid-19 from the community through GPs. It was noted that University College London Hospital (UCLH) was named as the key provider for the post-Covid assessment service. It was stated that there had been over 1,000 appointments in the assessment clinic for around 800 people and that half of these people had been referred from outside NCL as there was a national shortage in this area. It was explained that the clinic had a multi-specialty team and tried to offer a 'one stop shop' for patients, covering respiratory, cardiology, neurology, and therapies assessments. It was added that clinicians tried to follow a clinical line of questioning but that there was a huge amount of information missing in this area and treatments were not guaranteed to be effective. It was highlighted that the team was working to develop an integrated care pathway for patients but that evaluation was required in

relation to how to assess someone in primary care, when to make a referral, how to investigate, and the correct forms of rehabilitation.

The Chair noted that some patients had expressed concerns that they had been referred to other specialists but had not been given access to the post-Covid syndrome service. It was enquired whether people should specifically ask for a referral. Dr Melissa Heightman noted that people should talk with their GP about their symptoms. There was increasing awareness of the service amongst GPs and there was a process to follow with screening questionnaires and initial tests. It was explained that GPs would then decide the best course of action for the patient; this could involve the post-Covid syndrome service or another course of action.

Cllr Smith enquired about the numbers of post-Covid syndrome for Black, Asian, and Minority Ethnic communities who had been disproportionally impacted by Covid-19. Dr Melissa Heightman noted that there was an excess of white, British people in the patients referred and it was not certain whether this reflected the nature of post-Covid syndrome or whether this related to health inequality. It was explained that, on average, 34% of post-Covid syndrome patients were from Black, Asian, and Minority Ethnic backgrounds. However, in one cohort of patients that had been proactively contacted after leaving A&E, 47% of people were from Black, Asian, and Minority Ethnic backgrounds.

Cllr Das Neves enquired whether the post-Covid service had sufficient capacity for demand and whether GPs were sufficiently aware that they could make referrals. Dr Melissa Heightman noted that some communications work was required but that the London pathway needed to be confirmed beforehand to ensure that there was a clear process. In relation to capacity, it was explained that there were three clinics per week and this was generally undertaken in additional to other work; there were some digital solutions but the service was waiting for funding to become available in order to be more sustainable. It was noted that treatment was currently delivered by the therapies team and there were concerns about capacity within this team. It was noted that the waiting time was currently six weeks but that information could be sent to patients as soon as their referrals were received. It was added that increased referrals were expected, as people from the second wave of transmission recovered, and there were concerns about capacity.

Cllr Smith enquired whether the scale of post-Covid syndrome was known. Dr Melissa Heightman noted that post-Covid syndrome was more prominent in community cases rather than hospital cases. The ZOE app, which was tracing data relating to community cases, suggested that 2% of people were experiencing post-Covid syndrome symptoms. It was noted that, based on referral rates, using GPs as a guide, it was anticipated that 4,000 people in NCL were experiencing post-Covid syndrome but it had been suggested that this could be 8,000. It was noted that it was challenging to design services when the extent of the issue was unknown.

Cllr Das Neves noted that some patients were referred to other services who were not aware of post-Covid syndrome; it was enquired whether sufficient information was being provided to other services to ensure satisfactory patient care. Dr Melissa Heightman stated that there was a need for communications about the developing pathways and services. It was noted that every Trust had a Covid follow up clinic for

its hospital discharge patients that should be acting as a spokesperson for the post-Covid syndrome service. However, it was acknowledged that the health service was struggling with capacity and this was a new outpatient demand; it was noted that the process for this pathway was being planned but was not yet perfected.

The Chair stated that this report had been very informative and that it would be useful for the Committee to receive further information about the communications for the post-Covid syndrome service, particularly how GP practices and clinicians in other settings were getting these communications and how they would be disseminated to the public, especially in areas where there were high levels of deprivation. It was added it would also be helpful for the Committee to receive information on funding for the therapies teams. In addition, the Chair requested an overview of the London pathway for post-Covid syndrome, even if this was in draft form, so that the Committee could consider the strategies, concerns, and risks.

RESOLVED

1. To note the report.

2. To receive a report on the post-Covid syndrome pathway in London, including information about communications and funding for the therapies teams.

9. WRITTEN RESPONSE TO DEPUTATION - TEMPORARY SERVICE CHANGES MADE IN RESPONSE TO COVID-19

The Chair stated that this item detailed the written response to the deputation made at the meeting on 25 September 2020 on temporary service changes made in response to Covid-19. It was noted that a question had been received from a member of the public about how a pan-London Joint Health Overview and Scrutiny Committee (JHOSC) would be set up. It was explained that the health scrutiny regulations required a JHOSC of all of the local authorities affected be set up to respond to proposals by NHS bodies for permanent and substantial changes to services. If and when such proposals were brought forward, action would be taken to set up an appropriate health scrutiny body to respond. Whether this was a pan-London JHOSC would depend on the nature and scope of the proposals.

It was noted that the written deputation response, which added to the verbal response provided at the meeting, was published online but would also be circulated to the people who had brought the deputation. It was added that the Committee would ensure that any proposals were scrutinised effectively.

Cllr Freedman enquired whether it was clear to local people that the changes were temporary. She noted that there had been a petition in Barnet about the temporary move of Children's Services from the Royal Free to Barnet Hospital and it was clear that the petitioners thought that the changes were permanent. Will Huxter noted that the communications on this issue explained that the changes were temporary. He added that the temporary nature of the changes to paediatrics had also been stressed at a recent scrutiny meeting in Camden. He acknowledged that these sorts of

messages did not always get through to local people but noted that any substantial permanent changes would require consultation.

RESOLVED

To note the report.

10. WORK PROGRAMME

The Chair noted that the items on General Practice and Digital GP could be removed from the work programme as there had been detailed discussion about GPs during this meeting and there would be further discussion relation to digital inclusion at future meetings. It was noted that there was a wider item on tackling inequalities through prevention and early intervention but that it might be useful to consider this specifically in relation to the disproportionate impact of Covid-19 on ethnic minorities. The Chair also stated that the Committee had requested reports on the post-Covid syndrome pathway, the Healthy Intent initiative, digital inclusion, and missing cancer patients.

Rob Mack, Principal Scrutiny Officer, explained that a seminar delivered by Mike Cooke on the integration of health and care had been organised but had to be cancelled due to the national lockdown. It was suggested that this could be reorganised to be delivered as an online seminar.

Cllr Das Neves suggested that mental health should be added to the work programme as this extremely important at present. The Chair added that Dr Katie Coleman had referred to an increased suicide risk and she believed that a piece of work was being developed to support mental health. Cllr Revah added that the mental health of carers had been significantly impacted during the Covid-19 pandemic and asked for carers to be included in any paper on mental health.

Cllr Smith suggested that health inequality and the disproportionate impact of Covid-19 on Black, Asian, and Ethnic Minority communities would require further consideration. The Chair stated that this was a very wide-reaching topic and that it might be useful to consider health inequality as part of the digital inclusion paper, particularly if digital services were not being accessed by particular communities; it was noted that it would be helpful for this paper to include what was being put in place to mitigate health inequality. The Committee commented that it would be useful to invite some organisations working with Black, Asian, and Ethnic Minority communities and faith communities as they had direct experiences and would bring a different perspective. It was added that this report would need to be underpinned by specific data.

Cllr Cornelius noted that a seminar was being delivered to Barnet councillors relating to Covid-19, housing, and mental health; it was suggested that this seminar or the research undertaken might be useful to other Councils.

Rob Mack, Principal Scrutiny Officer, noted that Camden Council had undertaken a report on the disproportionate effect of Covid on Black, Asian, and Minority Ethnic communities which could be circulated to the Committee. The Chair added that

Hackney Council had hosted a meeting with a number of high profile speakers and that it might be useful to see if they had produced a follow up report.

29 January 2021

- Post-Covid syndrome pathway, including 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.
- The mental health impact of the Covid-19 pandemic, including carers.
- 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.

26 March 2021

- Missing cancer patients.
- Healthy Intent (information report).
- Health Inequalities, specifically looking at the impact of Covid-19 on Black, Asian, and Minority Ethnic communities in more depth and with more data.

RESOLVED

To note the report, subject to the above amendments.

11. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

12. DATES OF FUTURE MEETINGS

It was noted that the dates of future meetings were:

29 January 2021
26 March 2021

CHAIR:

Signed by Chair ……..

Date ……

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in health and care

NHS

Covid-19 update

JHOSC meeting 29 January 2021

Summary

- In January, the pressures on the health and care system in north central London have continued unabated, with covid-19 cases at their highest, and significant demand for hospital services.
- North Middlesex and Whittington Health have a very high proportion of Covid positive patients, while UCLH and Royal Free have greatly expanded their intensive care capacity
- On 8 January Sadiq Khan, the Mayor of London, declared a major incident in London underpinning the importance of working together across NCL to support health and care services
- This paper provides an update on the current situation in NCL including:
  - System pressures
  - Staffing and workforce
  - Hospital services
  - Communicating to local people
  - Covid-19 Vaccination programme

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NHS

System pressures

We have responded to this demand/challenges in the following ways:

- Acute and community providers have been working with huge flexibility to increase capacity for critical care beds, high dependency and acute units, and step-down facilities
- We have also seen exceptional support from the specialist providers in our system:
  - the Royal National Orthopaedic Hospital opening 64 beds to take covid-19 improving patients and 10 intensive care beds to relieve pressures on acute providers, and have two theatres running for cancer and other urgent surgeries
  - Over 250 Moorfields staff redeployed to provide care in other parts of our patch
  - Great Ormond Street Hospital has redeployed over 75 nurses, allied health professionals and doctors to support services across the system.
- We have increased our adult critical care bed capacity from 152 to 283 as of 11 January and are looking to increase further to 300.
- We have increased our general and acute hospital inpatient beds by 409, an increase of 19%.
- We are working to open an additional 36 community beds to help step-down Covid-19 patients
- We have secured support from the military with staffing in intensive care and logistic

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NHS

Staffing and workforce

- Staffing continues to be challenging as we have a larger than usual number of staff off sick, self-isolating or shielding, and we have opened additional beds
- We are very grateful to everyone working in our health and care system in NCL for their ongoing hard work and resilience in the face of continued challenges.
- We are particularly grateful to the NHS and social care staff who have cancelled annual leave, even over the festive period, and worked extra shifts to continue to meet patients' care needs.
- As a system, we have strong mutual aid arrangements in place to ensure the right staff are working in the right place at the right time. We have established a workforce hub to make best use of all the offers of help that we have received from doctors, pharmacists, therapists, retired workforce, and other paid and voluntary staff.
- We are using the NCL Volunteering Network to help match volunteers to roles which help to deliver priority programmes, such as the vaccination roll out.

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Health and care services

- We have been working hard to keep elective (planned) services running for as long as possible, but have had to take the difficult decision to stand down all but the most urgent elective care. All patients who are affected by this will be contacted directly by the relevant NHS trust.
- We are continuing to work closely together across the health and care system, including hospitals, community health services and adult social care. All providers are collaborating to ensure that while there are huge pressures on all parts of the NHS and social care, local people can continue to have confidence that high-quality care is there when they need it.
- Equally, if local people need urgent or emergency care, the NHS remains open for Covid and non-Covid patients.
- **We would be grateful for your support in communicating to local people and communities that if they have appointments scheduled and have not been advised of any changes, they should still attend.**

Communicating to local people

We would be grateful for your support in communicating to local people and communities that

- If residents have appointments scheduled and have not been advised of any changes, then please still attend, or let us know if you cannot attend.
- If residents need urgent or emergency care, the NHS remains open for Covid and non-Covid patients.
- London Ambulance Service is very busy, and please only call 999 or use A&E for emergencies.
- We continue to encourage people to contact their GP or NHS 111 for urgent care advice
- Residents should continue to observe simple clear public health advice to stay at home, wash hands regularly, and where they must go outside, maintain social distancing.

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NHS

Covid Vaccination Programme

- Our programme to vaccinate as many vulnerable people as quickly as possible against covid-19 continues, following the national guidance on prioritisation determined by the Joint Committee on Vaccination and Immunisation (JCVI).
- We have already vaccinated more than 60,000 individuals in the highest priority groups, including care home residents and staff, people over 80, and health and care workforce.
- We have already visited nearly 60 care homes across north central London, and continue to undertake visits daily to protect this vulnerable, and the staff who care for them.
- Primary care colleagues are working to ensure priority groups are invited to take up the offer of vaccination as soon as possible, and our roll-out of new vaccination sites continues, with a significant number of additional facilities coming on stream across the whole of NCL from w/c 11 January.
- Residents will be contacted by the NHS to come forward for a vaccine as soon as possible, and do not need to contact their GP practice or other NHS provider to make this happen.

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NHS

Programme delivery in NCL

Local vaccine services – smaller scale sites provided by GPs and pharmacies within local communities.

16 primary care network sites now live. pharmacies to come online in January.

Hospital hubs – located within local hospitals will be clinics run by hospital staff administering vaccines primarily to inpatients, outpatients, NHS and care staff.

Eight hospital sites live – with "buddying" arrangements to allow access for care staff and community and mental health providers.

Vaccination centres – large scale sites convenient for transport networks that support high volumes in a fixed location for an extended period.

Large vaccination centres proposed in each borough to go live through January

Roving models – comprising vehicles that can deploy vaccinators, vaccine and supplies on an outreach basis, for those housebound or in care settings.

Roving models live delivering in care homes, joint work between the primary care networks and community providers and local authorities.

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NHS

Digital Inclusion:

JHOSC meeting 29 Jan

Summary

The NHS and North London Partners had already been moving towards a more digital approach to healthcare prior to the Covid-19 pandemic. The demands of the pandemic and the requirement to reduce all face-to-face contact to reduce the spread of the virus, has led to an acceleration of this digital approach. More care is being delivered across primary, secondary and specialist care in a non-face-to-face way, through either telephone, video or virtual consultation. We recognise that there is a risk that particular communities and populations could be excluded from these changes, and have therefore committed to an equalities impact assessment. We would welcome the advice of the JHOSC on our approach to this.

This paper includes:

- Information about NLPs health equalities impact assessment commissioned for digital inclusion
- NCL's digital approach
- Defining and understanding digital inclusion/exclusion
- Insight from community engagement
- Considerations for JHOSC

Commissioned health equality impact assessment

Background

- North Central London (NCL) has commissioned an initial desk top equalities review of the impact of moving services and appointments away from face to face to digital options.

- The purpose of this equalities impact assessment is to better understand the impact of the move to a more digital approach to delivering healthcare, including a review of the potential impact, both positive and negative, on groups with protected characteristics and social inclusion groups.

- This will help inform an action plan that will set out the approach in NCL and how this way of delivering care may be adjusted to better meet the needs of the local population, increasing access (and recognising for different groups access will have different implications such as knowledge, equipment ongoing costs, environment) and reducing the impact on health inequalities.

Objectives of the equalities impact assessment

- Provide assurance to the NCL system and stakeholders about the move to a more digital approach to delivering health and care across the NHS and the safeguards that need to be in place
- Conduct a review of existing research into the impact of increased use of digital healthcare, and identify possible impacts on groups with protected characteristics (including socio-economic deprivation, carers, asylum seekers and homeless people)
- Identify which (if any) of the protected characteristics groups are more likely to be affected by the move towards a more digital approach
- Map this analysis onto the population information in NCL, and underlying population need, so that there is clarity about the geographical areas and population groups who need to be the focus of digital inclusion strategies
- Inform an NCL digital inclusion plan across all stakeholders, and include practical guidance about the rollout of digital approaches across all care settings and populations
- Consider the impact on safeguarding for vulnerable people

Scope and outputs

- Analysis of the concept of ‘digital exclusion’ and how this may apply to healthcare provision
- Undertake a review of existing research, engagement tools and analysis relating to non face-to-face healthcare delivery, and the impact on access, health inequalities and patient experience
- Identify if any protected characteristics groups in NCL (including socio-economic deprivation and carers) are more likely to be affected by the move to digital provision
- Map this analysis onto known demographic information in NCL, so that there is clarity about the geographical areas and population groups who need to be the focus of digital inclusion strategies
- Understand the digital baseline and differing levels of digital poverty across NCL
- Inform a digital inclusion plan with recommendations for maximising positive impacts and ways to mitigate or minimise any adverse effects
- Identify ways we can work with in partnership with local councils and voluntary and community sector to ensure local communities have digital access across NCL and utilise our resources to share training, equipment, best practice and where/how digital improves access.
- Set out how the core constituent public sector health organisations can fulfil the Public Sector Equality Duty (PSED)

NCL’s digital approach and current landscape

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Digital programmes in NCL

Innovative digital projects to improve patient care and experience in NCL

NHS

Enabling and empowering GPs and primary care **clinicians** and **improving access** to healthcare, **health outcomes** and **patients' experiences** through accelerator projects funded by NHSE/I and NHSX.

The aims of Digital priority projects for 2020/21

Online and video consultation	Improving text messaging, website design	Remote monitoring in care homes	Digitalising social prescribing	GP Connect and patient pathways	NHS App beacon site
The use of online and video consultation is **embedded** and **normalised** across NCL by both patients and GPs.	GP surgery websites are clear and easy for patients to **understand** and find the information they need. Text message campaigns are **coordinated** and **effective**.	Care Homes are **enabled** and **supported** in using digital technology to support patient care and speed up communications with primary care providers.	There is a **single Directory of Services** across NCL for social prescribing schemes, with GPs and Link Workers **confident** in the data provided.	GPs, 111 and UEC services have **access** to the same information and can share patient data safely and **securely**.	For patients in NCL to use the NHS App as the **front door** into the NHS's digital services.

The Digital Board

The Board is comprised of **commissioners, clinical leads, GPIT experts and SME/PMO experts**. Working together, the Board agree **how to prioritise and approve funding** to meet the needs and digital aspirations of the five boroughs in north central London.

Dependency on **core IT and infrastructure projects** (WiFi, internet, hardware) are seen as the **key enablers** to implement Digital First initiatives

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Digital First in NCL

Innovative digital projects to improve patient care and experience in NCL

NHS

Enabling and empowering GPs and primary care **clinicians** and **improving access** to healthcare, **health outcomes** and **patients' experiences** through accelerator projects funded by NHSE/I and NHSX.

The aims of Digital priority projects for 2020/21

Online and video consultation

The use of online and video consultation is **embedded** and **normalised** across NCL by both patients and GPs.

- The **NHS Long Term Plan** set out that every patient will have the right to digital-first primary care by **2023/2024**
- The **'Journey to a New Health and Care System'** published in April 2020 states '**virtual by default**' as one of its key expectations for ICSs in the next 12-15 months

In response to the **COVID-19 pandemic**, **NHSE advised** the **rapid implementation of online consultation** to support the **total triage** model in app GP practices.
The current provider framework (DPS) lists **34 potential providers** for online consultation.

The Digital First Board
The Board is comprised of **commissioners, clinical leads, GPIT experts and SME/PMO experts**. The Board evolves and changes depending on the projects that that come within the Digital First portfolio. Working together, the Board agree **how to prioritise and approve the funding** to meet the needs and digital aspirations of the five boroughs in north central London.

Dependency on **core IT and infrastructure projects** (WiFi, internet, hardware) are seen as the **key enablers** to implement Digital First initiatives

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Online Consultation in NCL

Overview of the digital tools available

NHS

Patient communication

Messaging	Consultations
• 2-way messaging • Batch messaging • Scheduled messaging • Photo attachments	• Messaging • Phone • Video

Online services

Online review questionnaires	Self -management	Prescriptions management
• Long Term conditions • Health and lifestyle	• Self-management help • Signposting local services • Travel advice	• Acute • Repeat

ICT integration and access

Interoperability	Access routes
• Patient record systems • NHS app	• NHS app • Practice website

Workload management

Workload management	eHubs
• Reduced phone traffic • Reduced work for practice staff • Reduced repeat prescriptions management	• Virtual eHubs for practices/primary care networks to process eConsults • Out of hours eHubs

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Current uptake of eConsult in NCL

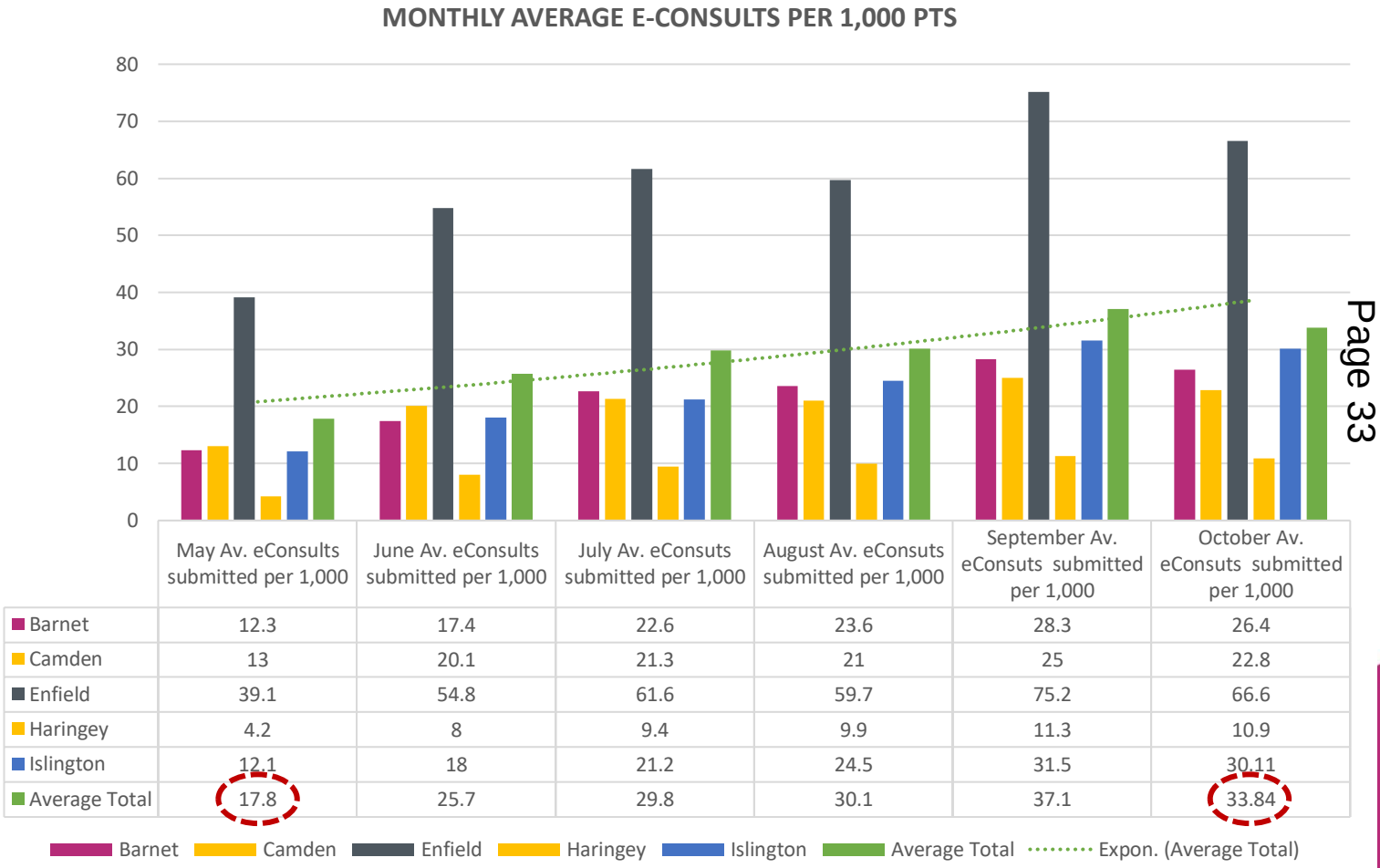
NHS

99% of Practices are using an online consultation provider (166 eConsult, 2 DoctorLink, 6 Dr IQ, 6 Footfall and 1 EMIS Eston)

NCL has the 2nd highest utilisation across London and **Enfield was the first** borough to adopt online consultation

Utilisation has nearly doubled (over the last 6 months)

October saw high levels of patient satisfaction with **63%** of patients **likely or extremely likely to recommend online consultation** for care and advice



	May Av. eConsults submitted per 1,000	June Av. eConsults submitted per 1,000	July Av. eConsuts submitted per 1,000	August Av. eConsuts submitted per 1,000	September Av. eConsuts submitted per 1,000	October Av. eConsuts submitted per 1,000
Barnet	12.3	17.4	22.6	23.6	28.3	26.4
Camden	13	20.1	21.3	21	25	22.8
Enfield	39.1	54.8	61.6	59.7	75.2	66.6
Haringey	4.2	8	9.4	9.9	11.3	10.9
Islington	12.1	18	21.2	24.5	31.5	30.11
Average Total	17.8	25.7	29.8	30.1	37.1	33.84

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Additional utilisation figures

October 2020

NHS

~41X more *since May (36)*

55% increase *since May (3337)*

Borough	Visits	Unique visitors	Self-help visits	Local service visits	eConsults submitted	eConsults diverted
Barnet	38767	24165	1511	166	12339	1314
Camden	22697	15608	874	220	6878	757
Enfield	61439	34512	3838	775	20932	1861
Haringey	12265	8012	337	73	3488	372
Islington	22676	14821	968	235	8154	866
Grand Total	**157844**	**97118**	**7528**	**1469**	**51791**	**5170**

123% increase *since May (3383)*

105% increase *since May (25271)*

Top 10 utilised templates	Barnet	Camden	Enfield	Haringey	Islington	Grand Total
Administrative help	3060	1633	6649	921	1823	**14806**
General advice	3149	1933	5059	927	2397	**13465**
Rash, spots and skin problems	852	400	1100	265	532	3149
My child is generally unwell	366	141	608	80	167	1362
Earache	302	137	528	92	208	1267
Contraception	234	243	311	69	248	1105
Back pain	261	99	521	76	139	1096
Cold or flu	238	116	441	52	165	1012
Depression	199	166	366	52	180	963
Cystitis in women	190	159	328	53	177	907
Anxiety	181	144	241	53	137	756

LTC reviews	Submitted	Diverted
Asthma review	126	6
Blood pressure review	137	4
Contraceptive pill review	208	1
COPD review	10	0
Diabetes review	49	2
Hypertension review	8	0
Medication review	210	0
Thyroid review	37	1
Grand Total	**785**	**14**

Defining and understanding digital inclusion/exclusion

Digital Exclusion and Digital Inclusion defined**

Digital exclusion occurs when people and groups in society are unable to exploit the benefits from technologies including the internet or devices. At an individual level, digital exclusion is a combination of a number of contributing factors reflecting an individuals' access to, use and engagement with digital technology.

The gap between those who are excluded and those who are able benefit from technology is known as the **digital divide.**

Digital inclusion is an approach for overcoming the barriers to opportunity, access, knowledge and skills for using technology (Gann 2018).

Quantification of digital exclusion and inclusion would require an agreed criteria for NCL. We know from local work that there are differences in local definitions. [see next slide]

Health inequalities and disadvantaged groups – factors likely to contribute to digital exclusion:

- Different income groups or socioeconomic classes
- Different ethnic and racial groups
- People living with disabilities and others
- People who live in different geographic areas, like urban and rural areas
- Different levels of deprivation
- People with differing sexuality and sexual behaviours
- Homeless people and the rest of the population.
- Asylum seekers and migrant workers

** Digital technology and health inequalities: a scoping review; NHS Wales (source)

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Comparison of criteria used – examples of variations

NHS

Criteria for discussion	NHS Digital Digital Inclusion Guide for Health and Social Care (June 2019)	Islington Islington Digital Inclusion Resource Pack: Support and Signposting for Local Organisations (Nov 2020)	THT Update and proposal to the THT board: community engagement and co-production on digital access to health and care services (July 2020); with input from VCSE, Digital Accelerator and GP Care Group
Older age groups	• older people	• Older people	• Some groups of older people
Lower income groups	• people in lower income groups	• People in lower income groups and/or who are unemployed	
Unemployed	• people without a job		
No recourse to public funds			• People with No Recourse to Public Funds (NRPF)
Fewer education qualifications / left school before 16	• people with fewer educational qualifications excluded left school before 16	• People who left school before the age of 16	
Homeless	• homeless people	• Homeless people	• People who are homeless or in insecure housing
Insecure housing			
Social housing	• people in social housing		
Living in rural areas	• people living in rural areas		
Women fleeing domestic abuse			• Women fleeing domestic abuse
People without confidential or secure home environments			• People without confidential or secure home environments
Disabilities	• people with disabilities	• People with a disability and/or who are chronically ill	• People with additional barriers (e.g. speech impairments, people who are blind)
Chronically ill			
Complex and multiple needs			• People with very complex and multiple needs • People who can access online services but are experiencing challenges with online access include people who have new diagnoses, and more complex conditions which require multiple investigations.
First language not English	• people whose first language is not English	• Migrants and refugees and/or people for whom English is a second language	
Migrants and refugees			
Gypsy, Roma and Traveller communities		• Gypsy, Roma and Traveller communities	
People without digital devices, or without data and wifi - often those on low or no income, and those who are covered within the other groups outlined here.			• People without digital devices, or without data and Wi-Fi - often those on low or no income, and those who are covered within the other groups outlined here.

Resource and links from external sources

This toolkit serves as a how-to guide on strategies that can be used when tackling digital exclusion in our communities.

‘Playbook’ or ‘Toolkit’ from Leeds and Croydon Councils collaboration with Age UK and Tech Resort.
https://digitalinclusionkit.org/

The Covid-19 lockdown has exposed how vulnerable some of us are. Without internet access and basic digital skills, millions of people across the UK have struggled to access vital local services. As the first lockdown began, the Ministry of Housing, Communities and Local Government asked council digital teams to submit proposals for tackling the pandemic.

Croydon Council and Leeds City Council applied separately with partners to create a “playbook” or “toolkit”, collecting together the best digital inclusion tips we’ve used in the past. MHCLG invited us to work together, and digitalinclusionkit.org is the result!

Our two councils were joined by Age UK Croydon and TechResort, and we’ve been working collaboratively for the last few months. We all share our digital know how with others, and have learned so much as a result.

Equity of access guidance from UCL Partners.

In July London academic health science networks hosted a webinar on virtual consultations and equity of access. Key reflections – need for shared learning and centralised resources.

‘digital exclusion is its own inequality’. Facing this together means that we can implement the best adaptations and solutions driven by patient need, focused on equity and targeting division.

https://uclpartners.com/blog-post/how-to-make-virtual-consultations-accessible-to-all/

Link to the full webinar from July.
https://youtu.be/aCZ2UlwSV-I

Insight from community engagement

What our most recent engagement has told us

- Understanding digital inclusion or exclusion to services does not necessarily always mean people do not have digital access. i.e.
  - Does a person have the privacy or physical space in their home to access digital services?
- IT literacy does still impact our local communities
- Accessibility to services and to book GP appointments was an issue pre-lockdown and this has been exacerbated by the pandemic. These include:
  - You need to be registered with a GP to book online or access online appointments
  - If you don't speak English as a first language booking online or over the phone can be challenging
  - If you are hard of sight or hearing booking online or over the phone can be challenging
- Safeguarding; for those at risk of abuse – online provides some real challenges, including lack of privacy.
- There is confusion around how to access appointments and a lack of understanding about what is available. This ties into a wider issue around how people are supported to make appointments (with a focus in primary care) and where they can find reliable information about services.
- As part of this work we also need to recognise some of the positives moving to digital has brought e.g.:
  - Improve patient experience for family planning services with speedier referral to abortion (less trauma for women).
  - Improved patient experience and speedier referral to first appointment for Moorfields eye hospital services.

Current community work

Islington: Community Research and Support Programme

The focus is on digital exclusion working with Islington BAME, older residents and residents in social inclusion groups.

The project is being delivered through a consortia led by Healthwatch Islington, and three other local charities and in partnership with voluntary organisations across Islington, primary care networks and a local mosque. The project covers:

- the Somali community in Islington.
- BAME residents
- a range of Islington residents, including those over 65 years

The key areas the project are researching are:

- Working with those who are digitally literate and those with less knowledge to understand the different barriers
- Researching impact of digital accessibility and barriers
- Alongside a general understanding of residents use to and access to internet and digital equipment
- Ways in which people access the internet and access online services and support
- Types of technology that people use

The projects all offer support, which includes:

- Provision of equipment,
- Provision of training and support

Islington Council and Healthwatch have also undertaken a research project pre-pandemic on digital inclusion and the support people need – this has informed the development of the above work.

Current community work (continued)

Haringey digital inclusion project

- Haringey's primary care team is leading on a digital inclusion project in collaboration with primary care, Whittington Health, NMUH, Barnet, Enfield and Haringey Mental Health Trust, Haringey Council and Public Voice. The project involves providing support to enable and empower local residents to access health services digitally by providing training, building confidence and in some cases loaning devices (such as mobile phones).

- They are also looking at setting up community based hubs, such as in libraries, where residents can access online consultations privately. Digital access and inclusion was also a recurring feedback theme at a public meeting in November 2020.

- Feedback relating to digital inclusion include themes such as:
  - Some concerns around privacy and confidentiality
  - Lack of confidence in using new technology, support should be provided when introducing new technology
  - Concerns that move to digital could increase health inequalities particularly for older people

- Healthwatch Haringey's Lessons from Lockdown report, from August 2020 includes residents' feelings around digital access and inclusion.

- Healthwatch Haringey have also been commissioned to support primary care networks in Haringey with their communications and engagement. This involves supporting practices developing Patient Participation Groups to ensure a more diverse group of patients can feed back into service development. This includes supporting them to use digital platforms to involve patients.

Current community work (continued)

Islington: Community Wellbeing Projects and Good Neighbours Scheme:

A series of estate based community projects that are commissioned in partnership and delivered through Help on Your Doorstep. The projects work with the local community including employing local people, to understand needs, skills and developing a range of sustainable solutions together. This includes wellbeing interventions and activities.
Since the start of the pandemic and as we moved into 'recovery' the project has adapted instantly to move online and address the specific challenges covid-19 has brought
such as supporting people to access online support and services which tackle social isolation. The services range from wellbeing activities such as local exercise groups & coffee mornings, to befriending support via whatsapp groups & 1:1 telephone & online, to managing basic needs such as accessing pension support and benefits online, shopping and other council / health services.

Across NCL boroughs:

All community development projects and local VCS support delivered in the NCL boroughs through the pandemic have included elements of digital inclusion. Including, offering advice and support to local residents as they move services online or to telephone. There have been a range of learnings through the VCS – as they support local residents, particularly those who are most vulnerable or are within the social inclusion groups, through multiple lockdowns – coming up with innovative ways of working to support the needs of their clients.

Considerations for JHOSC

Considerations for JHOSC

We would be grateful for the Committee's comments or suggestions on the following areas:

- The scope and objectives of the equalities health impact assessment
- Solutions or themes that might be included in an action plan
- Any known examples of good practice around digital inclusion
- Ongoing concerns raised by residents around digital exclusion

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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 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** 29 January 2021

SUMMARY OF REPORT

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

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 the remainder of 2020-21;
b) Agree the bringing forward of the next meeting of the Committee to 19 March 2021;

c) Approve the dates for Committee meetings in 2021/22.

1. Purpose of Report

1.1 This paper outlines the areas that the Committee has chosen to focus on for the remainder of 2020-21, as determined by the last meeting. The Committee is asked to note the list of topics highlighted in Appendix A and consider any amendments that it may like to make.

1.2 The next meeting of the JHOSC is scheduled to take place on 26 March. This date now falls within the pre-election period for the London Mayoral elections. It is therefore proposed that the date be brought forward one week to 19 March.

1.3 The following provisional dates are proposed for meetings of the JHOSC in 2021/22:

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

1.4 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 need to be made to identify suitable venues for any remaining 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

26 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
Healthy Intent	To report on the development of North Central London's Population Health Management system.	NCL partners

To be arranged

Tackling inequalities through prevention and early intervention	A report covering NCL's focus on prevention and early interventions to improve the health and wellbeing of residents, including wider determinants of health and preventable health issues.	NCL partners
Integration of health and care	Updating on actions and following up from previous items in March and June. Including update and NCL CCG	NCL partners
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

NCL JHOSC Action Tracker

Meeting	Item	Action	Action by	Progress
27-Nov-20	Primary Care during the Covid-19 Pandemic	To provide a briefing paper on Healthy Intent for the Committee; this would allow the Committee to decide whether a full report was required.	Chloe Morales Oyarce/ Will Huxter	Complete – a briefing paper was provided to the Committee on 21 January 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	
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	Will Huxter and Anna Stewart	

		Committee also requested that when the 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	A date has been set with invites distributed to JHOSC members. Individual HASC members also to be invited.
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.