SUPPLEMENTARY AGENDA

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

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 2)

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

7. DIGITAL INCLUSION (PAGES 3 - 32)

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

8. MISSING CANCER PATIENTS (PAGES 33 - 42)

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

9. HEALTH INEQUALITIES (PAGES 43 - 74)

This paper provides an update in relation to health inequalities.

Fiona Rae, Principal Committee Co-ordinator
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John Jones
Monitoring Officer (Interim)
River Park House, 225 High Road, Wood Green, N22 8HQ

Monday, 08 March 2021

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. The takeover makes Operose /Centene Corp. the biggest single 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. The last declared profits of A T Medics Ltd from their 49 contracts across London was £35m 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 allowed provided the current contract holders ask permission in advance and provide assurances that the contract will operate as before. 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 member, was 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. 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.

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 on matters concerning 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. Are there other APMS contracts in North Central London held by other companies. What is the remaining term of those contracts. 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, 8 March 2021

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in health and care

NHS

Digital Inclusion:

JHOSC meeting 12 March 2021

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 in NCL

Innovative digital projects to improve patient care and experience in NCL

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The aims of Digital priority projects for 2020/21

Online and video consultation

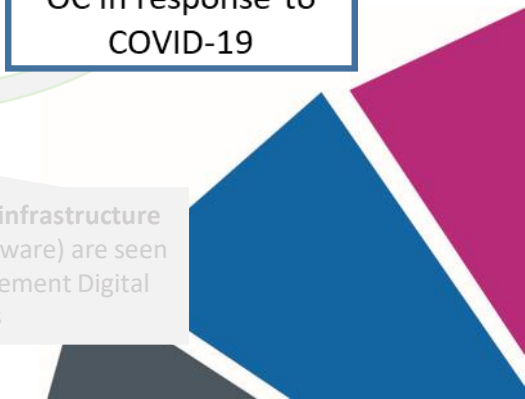
The use of online and video consultation is **embedded** and **normalised** across NCL by both patients and GPs.

- 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



Online Consultation in NCL

Overview of the digital tools available

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

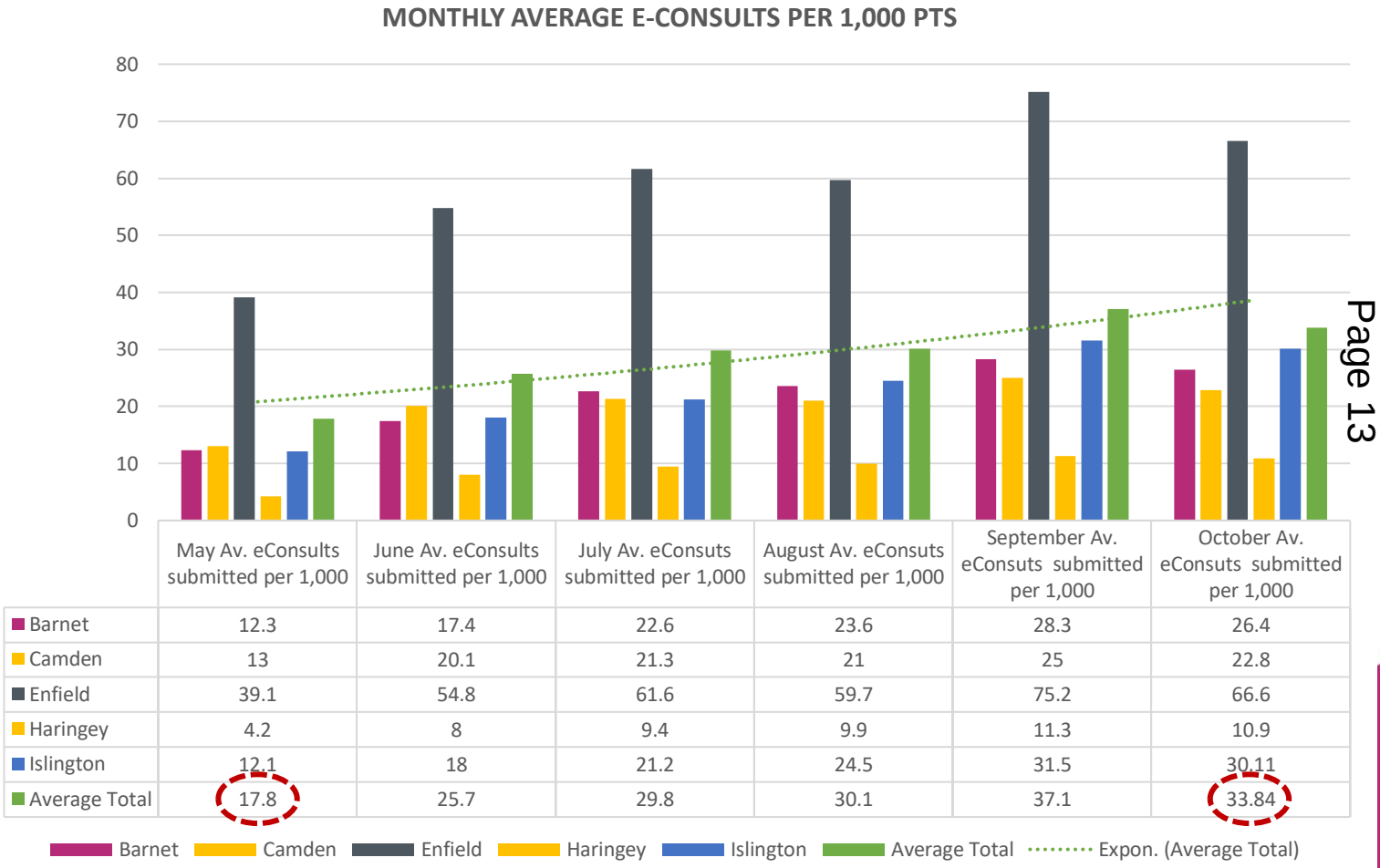
NHS

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

Feedback from JHOSC meeting 29/1

Benefits

- Digital methods create additional opportunities for people to access services, stay in touch and feel part of the community
- Lots of young people already using digital platforms and for some is a better option
- Digital support delivered through volunteers (Haringey) had been very successful
- New devices have been made available to some (example given in Islington schools) helping to foster good relationships and encourage attendance

Challenges

- Variety of digital options and use during Covid mean people want to have a choice
- Access to hardware/devices, digital skills and online safety awareness can be a hindrance
- Some platforms Teams/Zoom are impersonal
- Not always easy to know who is present via virtual consultations
- Easy to circulate misinformation via digital platforms/channels
- Using digital can be challenging for those whose first language isn't English and may require support from families
- Digital channels also challenging for people with learning disabilities
- Technology sometimes fails!

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

NHS
North Central London
Clinical Commissioning Group

Digital inclusion for Haringey patients

Haringey's response to digitally excluded patients

NHS
North Central London
Clinical Commissioning Group

Responding to Covid-19 has significantly changed the way patients access health and care services.

- Fewer patient facing appointments with more video consultations in primary, community and secondary care.
- General practice has adopted a model of total triage supported by new investment in IT.
- This brings significant potential advantages in improved access for patients, but also great concern that some patients are digitally isolated from care, with no access to appropriate devices / connectivity.

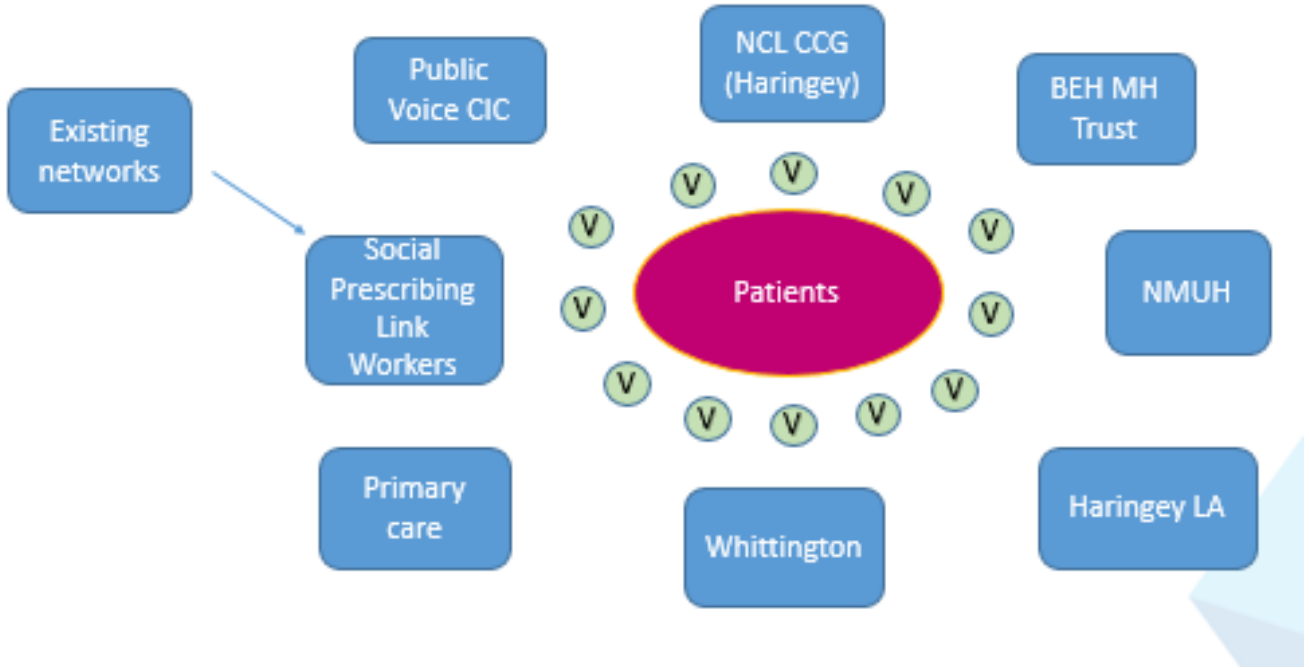
The project aims to improve access for patients; by mobilising a team of volunteers to provide tailored technical support on how to access GP and hospital appointment systems, i.e. eConsult and Attend Anywhere.

The level of support will be determined by level of need. In some instances devices will be loaned along with support on using the device and navigating the internet and health and care services, remotely or in person.

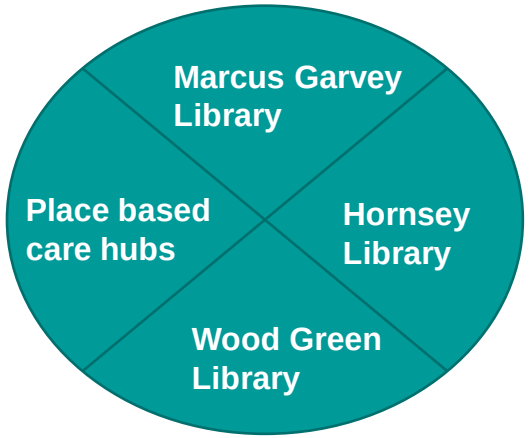
Key stakeholders and partners

North Central London Clinical Commissioning Group

The CCG, primary care, Whittington Health, NMUH, Barnet, Enfield and Haringey Mental Health Trust, Haringey Council and Public Voice are committed to a collaborative and integrated approach to support this service offer.



Community based hubs



Patient cohort identification criteria

North Central London
Clinical Commissioning Group

Criteria group 1: people at risk of social exclusion: These patients will experience barriers to / have limited method to access and would benefit via a loaned phone or appointments via community hub (library). For example people with complex needs, including mobility needs, who experience barriers getting to and from appointments with potential associated financial burdens. It is anticipated this group will be identified from hospital trust providers (North Middlesex, Whittington or BEH). It is vital this groups is supported effectively.

Criteria group 2: people who can access care in more productive ways: Patients who are IT literate enough to use e-Consult, NHS related Apps, online booking systems, video consultations etc., but require low level support (remote).

Sub-set group: People in care homes (staff, residents and family and friends)

Supporting and enabling criteria group 2 will free up space in the primary care system to allow GPs and clinicians to offer longer appointments and better care for patients who need it most. This also applies to criteria group 1 who may find it easier / prefer to have face to face GP / hospital appointments (i.e. where remote consultation is less important and where it is clinically appropriate).

Groups of patients and the type of support required

North Central London
Clinical Commissioning Group

Group 1

Patients that are IT literate and have devices but have limited to zero knowledge on how to remotely access GP or NHS Trust appointments (likely remote)

Group 2

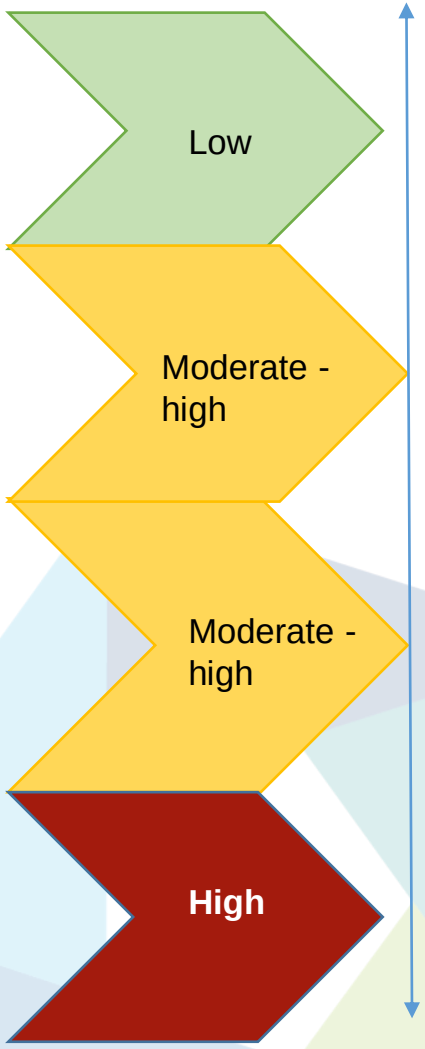
Patients with connectivity / access to tech but limited skills / confidence / awareness and require ‘how to’ support using internet / email (remote / in person)

Group 3

Patients with no access to tech / lack experience / awareness but prefer to have appointment at a community-hub provided with support (remote or in person)

Group 4

Patients with no access to tech and lack experience / awareness loaned a smart phone and provided with more intensive support (remote or in person)



Other identified groups to support with digitalisation

North Central London
Clinical Commissioning Group

- **Care home staff**: volunteers can offer training on using digital devices by remote access / training videos.
- **Patient Participation Groups**: to support, empower and encourage PPGs to use digital devices to access virtual meetings and strengthen the development of PPGs.
- **Reception teams**: to offer training on the platform used at the GP practice, so they are also able to support patients to use video consultations (VCs) as the majority of patients unable to use / access their VCs will express queries and concerns to reception staff.
- **GP pilot sites**: Morris House, Bounds Green and West Green Surgery

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The impact of Covid-19 on cancer in NCL

JHOSC meeting 12 March 2021

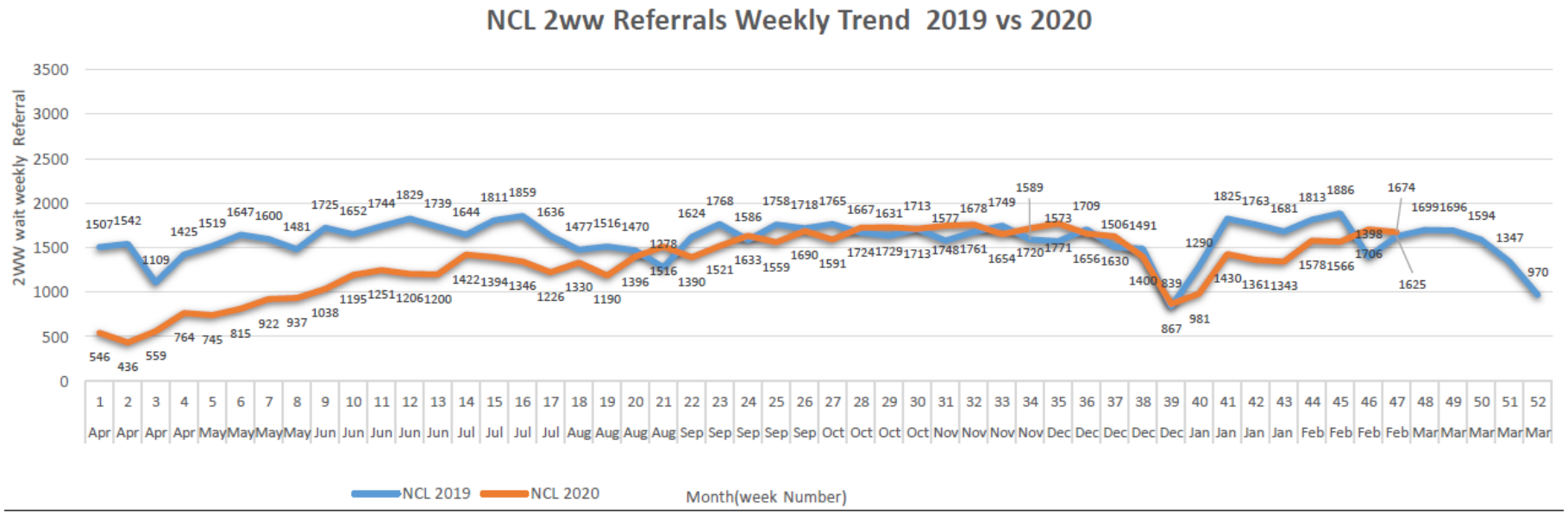
Summary

This paper covers the impact that Covid-19 has had on cancer referrals and the levels of local people diagnosed with cancer since the start of the pandemic. Using modelling based on data from previous years we have estimated the number of people with possible cancer symptoms who have not yet presented to health and care services, and how we are responding as a system.

The paper includes:

Cancer pathways – impact of Covid-19

- There was another dip in GP suspected cancer referrals (“Two week waits”) during the latest Covid surge – January 2021 was 32% down year on year - normally we would expect 30% of cancer diagnoses through this route
- No variation in recovery by age, sex or socioeconomic status

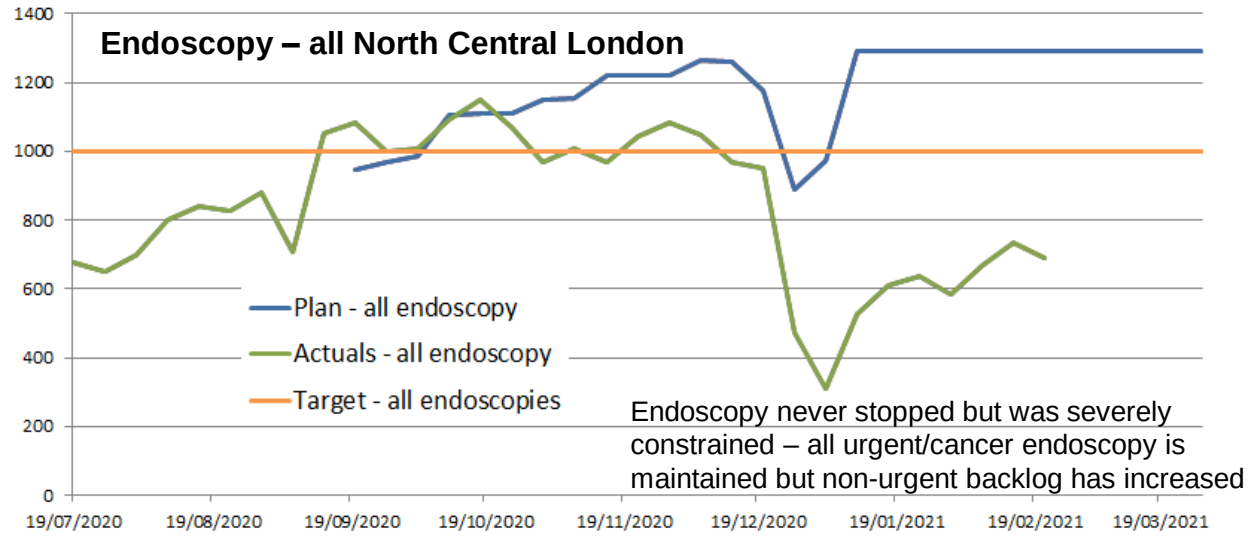


- A further 30% of cancer diagnoses come from routine outpatient appointments – but routine referrals are still below pre-pandemic levels
- There is a piece of work underway across NCL to understand whether the shortfall in routine GP referrals, which fell by ~ by a 70% reduction at the start of Covid-19 - is indicative of patients coming to harm. This is particularly pertinent to cancer due to the proportion of cancer diagnosis identified via a routine referral.
- There is anecdotal evidence that we are seeing a greater proportion of later stage cancers.

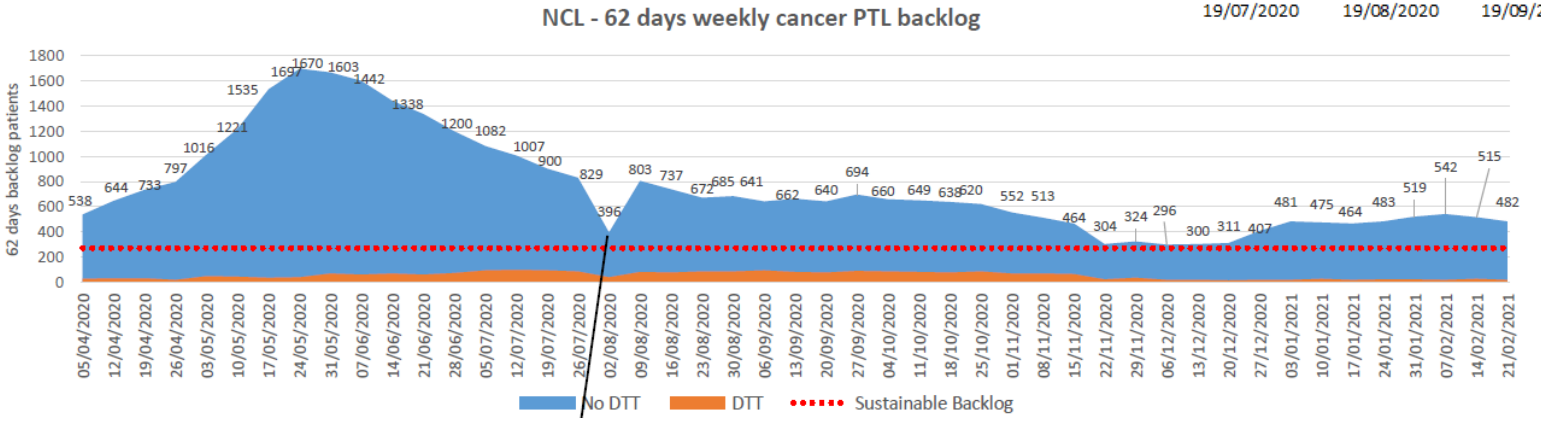
Diagnostic and treatment services

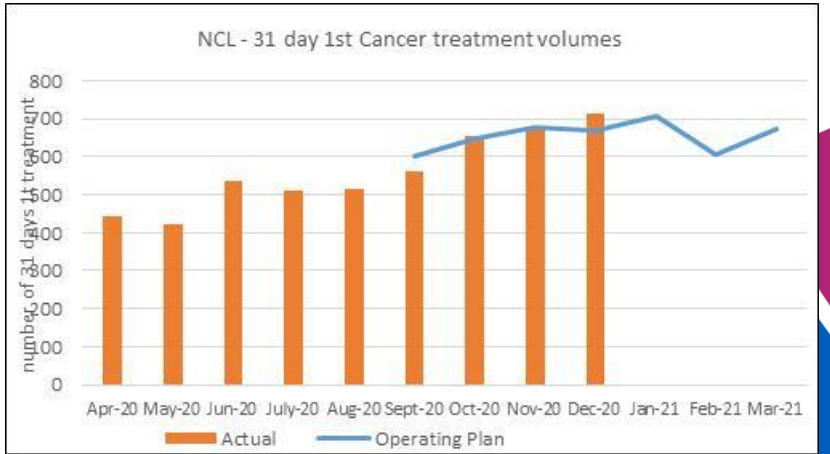
Diagnostic and treatment services have been affected, although much less than in the first wave, but concerns remain. Evidence developed during first wave has given confidence in infection prevention measures. However non-urgent backlogs have been rising.

- High priority cancer surgery has continued at the Hub based at UCH Westmoreland St, and private facilities (Wellington, Princess Grace and Harley St Clinic) – expected to fully return by April.
- Imaging and outpatients for cancer has continued. 'Vague symptoms' pathways at UCLH and NMUH re-established.
- Chemotherapy and Radiotherapy has continued despite significant Covid-related staff absence and redeployment.
- 31 day cancer treatment activity was broadly in line with the planned levels from October to December. Weekly data suggests that when January data is published treatment activity will be lower than planned.
- The number of patients waiting >62 days for treatment has stayed close to pre pandemic levels; during latest surge some patients chose not to attend,



Endoscopy never stopped but was severely constrained – all urgent/cancer endoscopy is maintained but non-urgent backlog has increased

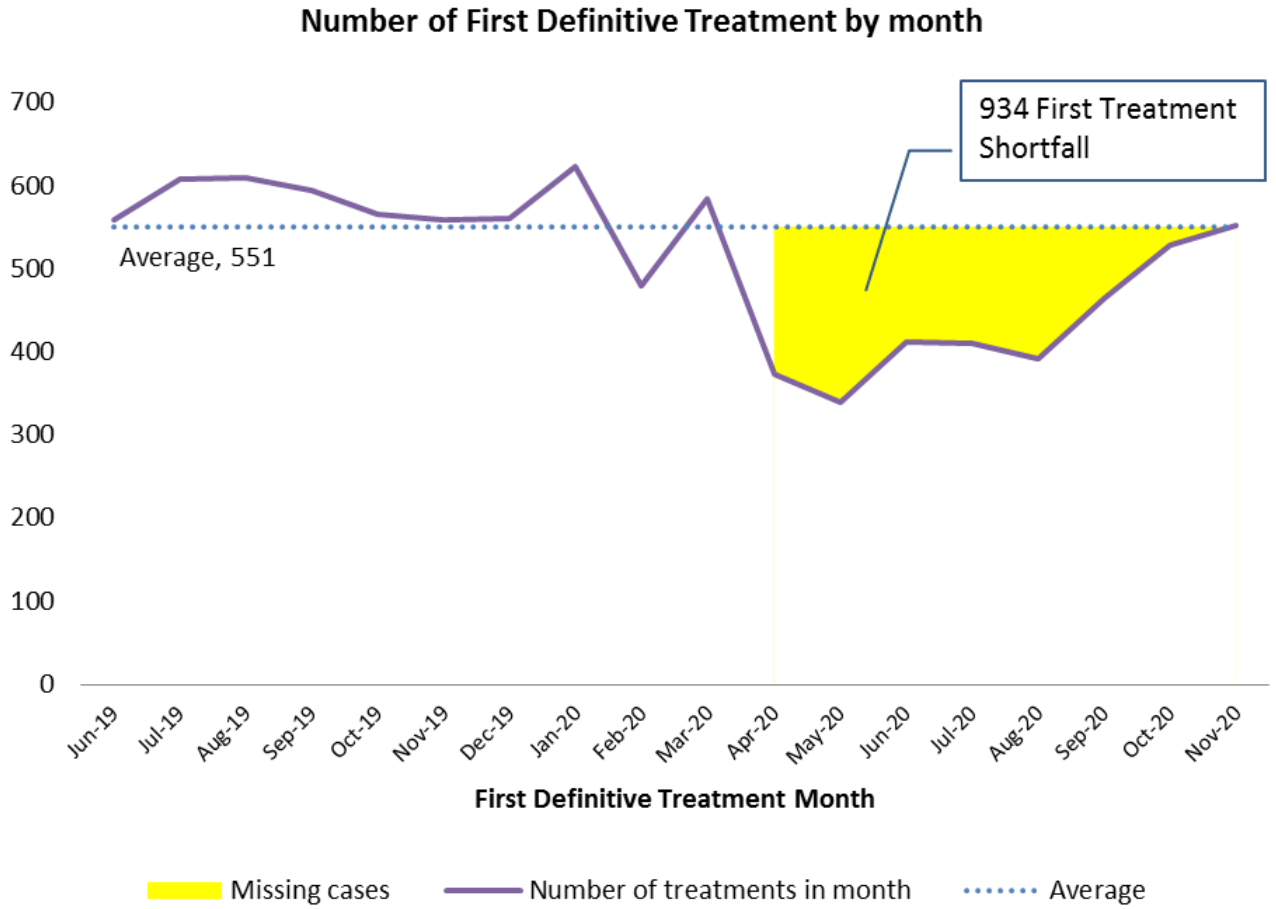




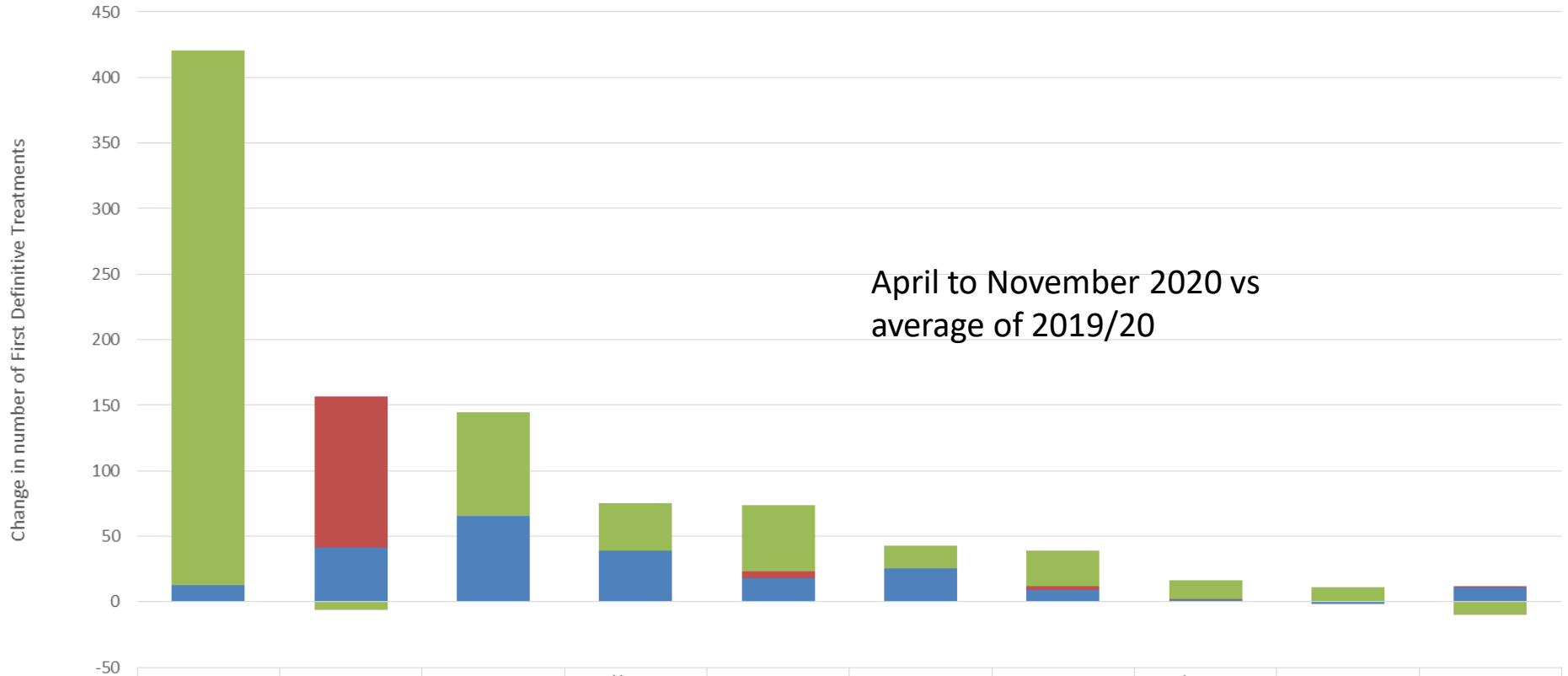
RFL didn't submit data to NHS Digital for w/e 2ndAugust due to data migration to a new patient tracking system

Reduced number of diagnosed cancer patients

- The yellow area shows the estimated number of missing cancer patients between April and November 2020
- The number of diagnosed cancers is below historical levels. Using the number of treatments as a proxy, over five months (April to August), there is a 934 case shortfall. This does not take into account the effect of the latest Covid surge
- This analysis represents both the volume of cases presenting and trusts' ability to work through these cases by the end of November.
- By October, NCL trusts achieved 19/20 average number of first treatment.



Reduced number of diagnosed cancers – by type



	Urological	Breast	Skin	Upper Gastrointestinal	Lung	Head & Neck	Gynaecological	Lower Gastrointestinal	Other	Sarcoma
TWW	408	-6	79	36	51	18	27	14	11	-10
Screening	0	115	0	0	5	0	3	1	0	1
Other routes	13	41	65	39	18	25	9	2	-2	11

- A key concern is the breast screening deficit – would largely be early stage cancers so there is concern that they will not present until a later stage
- Risk is variable across specialties. For example, majority of Urological cancers are slower progressing Prostate cancers.
- For patients already on routine waiting lists there is work underway to improve the process of 'upgrading' them to urgent pathways.

*Children's cancer and Haematological cancers excluded from analysis due to data limitations. Small volume of missing lung screening cohort likely due to data error in 2019/20.

Data source: CADEAS.
Collated by Centre for Cancer Outcomes

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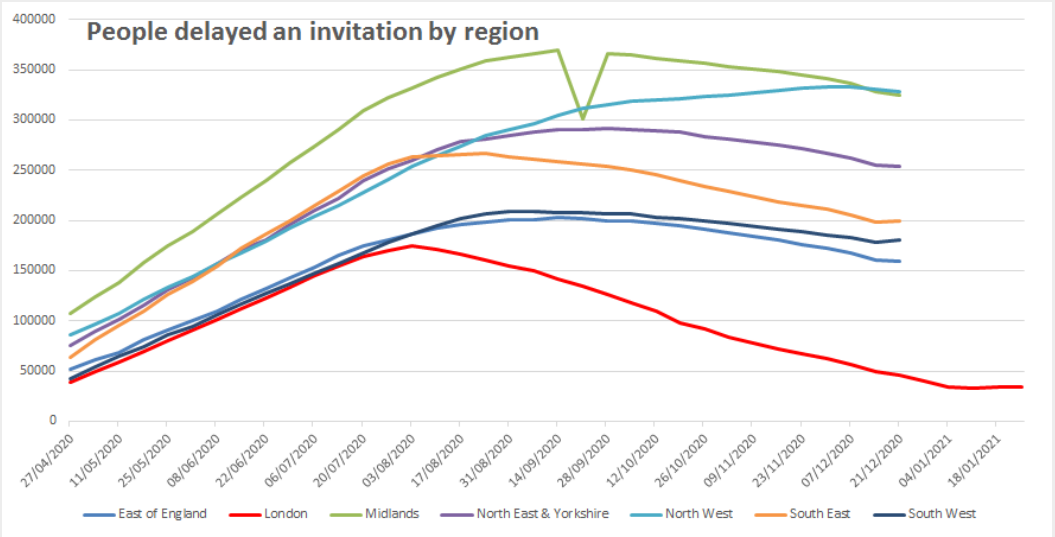
Cancer Screening Recovery

Normally accounts for 5% of diagnoses. Cervical and bowel screening have recovered well. Concerns remain around Breast Screening.

Bowel screening
Largely recovered; some additional unwillingness to attend for colonoscopy during latest Covid surge; London compares well nationally



Cervical screening
Has recovered well since first surge but year on year deficit remains dating back to March-June 2020.

Youscreen – study to offer self sampling its launched in Barnet, Camden and Enfield (historically lowest uptake)

19/20 vs 20/21 deficit	
NCL	15,079
Barnet	3,734
Camden	2,301
Enfield	3,308
Haringey	3,050
Islington	2,686

Breast screening

North London Breast Screening Service (update as of w/c 28 January 2021)

Current backlog – c39,000 (includes residents in Barnet, Enfield, Haringey and NW London, West Herts); number of available clinics has been increased to 44 from a target of 42

Invitations – sent 2,390 invites, up 400 on week prior at 1,982. This is the largest number of invites sent since Nov 2020

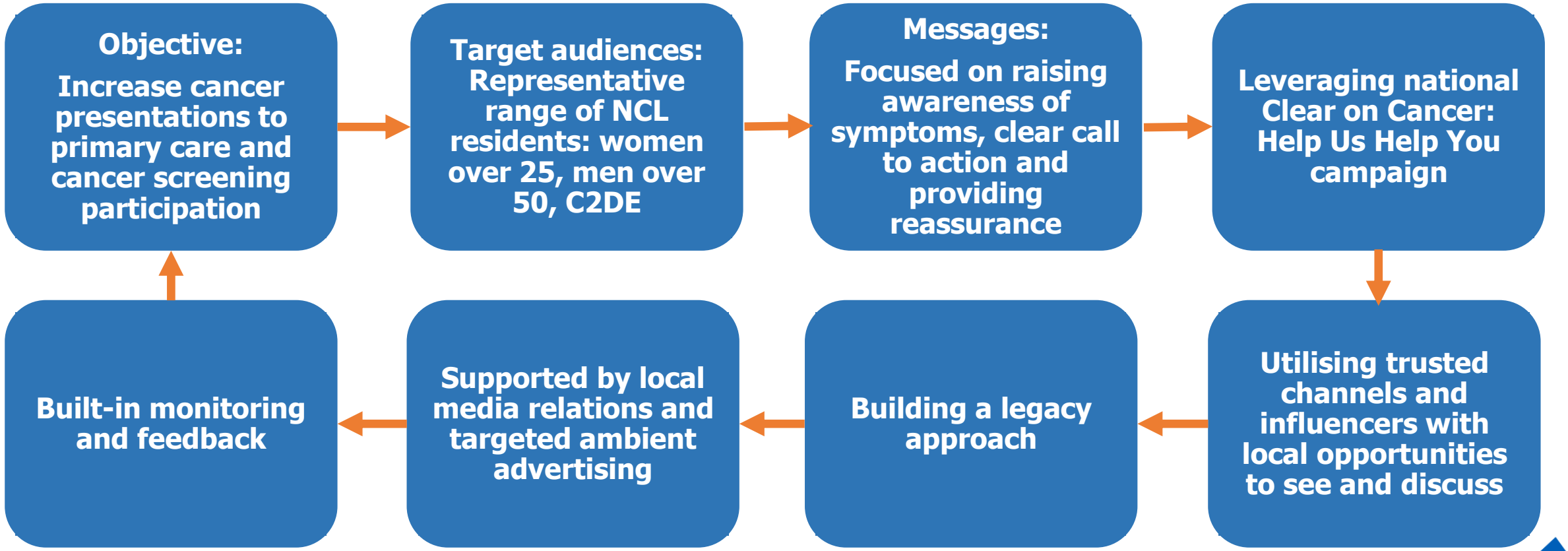
Central and East London Breast Screening Service (update as of w/c 28th January 2021)

- Current backlog – c11,800 (includes residents in Camden, Islington and inner east London); Capacity increased by approximately 200 screening appointment slots per week

Expected to decline by 10 – 20% from pre-Covid levels. NHSE as lead commissioner looking at available data on inequalities and uptake.

Cancer Alliance funding two posts conducting reminder calls

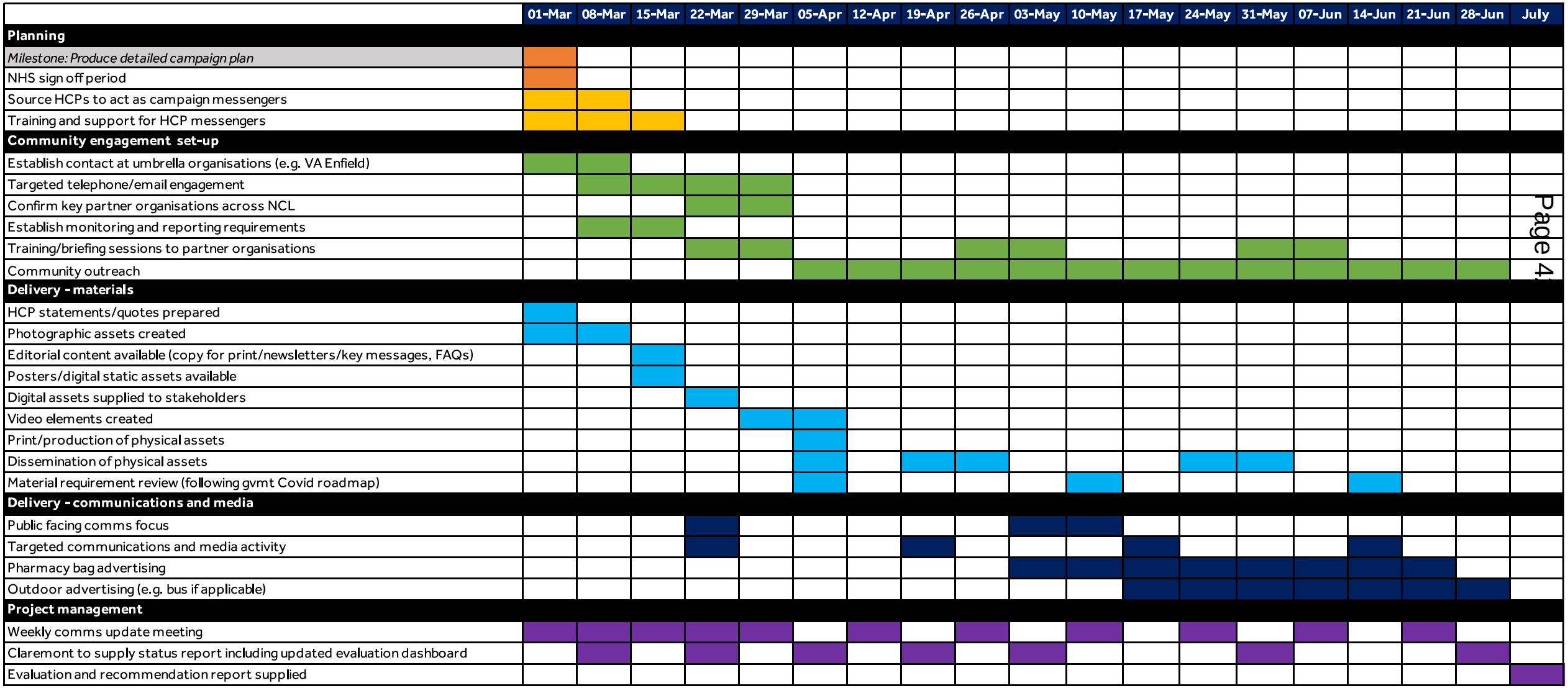
NCL cancer awareness campaign planned



Main channels for communications activity

Utilising healthcare settings and healthcare professionals as influencers:	• displaying campaign materials on noticeboards, TV screens and online, peer-to-peer communications, Making Every Contact Count with patients
Formal and informal partnerships with voluntary and community sector (VCS)	• displaying campaign materials, message training staff and volunteers, events and recruiting community ambassadors; engage 1-3 VCS orgs per borough with high input; a further 20-30 per borough with 'base package of input'.
Partnerships with pharmacies:	• to appear on campaign materials, displaying campaign materials, message training, referrals, pharmacy bag advertising
Local media relations:	• Case study lead approach: with Healthcare professionals and residents, radio phone-ins to tie in with radio advertising
Local ambient advertising:	• radio, social media, household leaflet drop, pharmacy bags, bus, street/billboard

Communications campaign timeline



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Addressing Health inequalities

JHOSC meeting 12 March 2021

Summary

This paper provides an overview of our work to reduce health inequalities covering:

1. Context

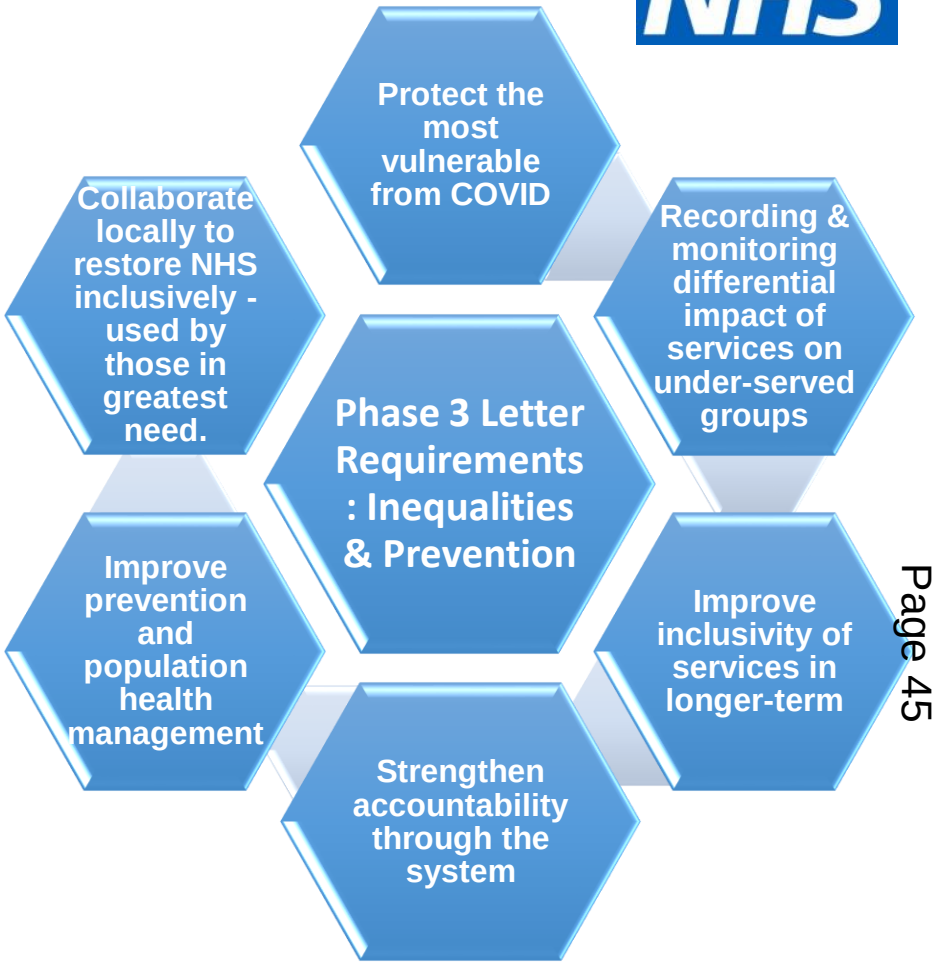
Inequalities in NCL's population has driven marked differences in health outcomes for different groups in population – and this worsened since 2010 & in pandemic:

'Health inequalities' are avoidable, unfair and systematic differences in health between different groups

Worsening Health Inequalities: Marmot Review 10 years On & Related Reports suggest:
*"Inequalities in health arise because of **inequalities in society** – in conditions in which people are born, grow, live, work & age"*
"The last decade has been marked by deteriorating health and widening inequalities"
"Why do we treat people then discharge them back to the conditions that made them sick?" (Marmot 2015)

Black Lives Matter and Health Inequalities: People from BAME groups in the UK are **more likely to**:
- Be diagnosed with mental health problems & admitted to MH hospital;
- Experience a poor outcome from treatment or to disengage from MH services.
- Be affected by biological weathering

Impact of COVID-19:
National Policy Institute: People and places in London most vulnerable to COVID -19 (Sept 2020) *"The economic & housing indicators show…the risks are highest in five Boroughs [including] **Haringey and Enfield."***
PHE Beyond the Data: *"It is clear…COVID-19 did not create health inequalities, but **rather exposed and exacerbated longstanding inequalities affecting BAME groups**"*



The 3rd Phase of NHS Response to COVID has included a specific focus on Inequalities & Prevention

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1. National expectations

PHE report *Beyond the Data*	Eight Urgent Actions	Inclusion and monitoring
• Mandate ethnicity data collection • Community Participatory Research • Improve access, experience and outcomes • Culturally competent risk assessments • Fund health prevention and education • Health promotion • Reduce inequalities caused by wider determinants	• Protect the vulnerable • Restore services inclusively • Develop digitally enabled pathways that are inclusive • Accelerate prevention pathways • Prioritise mental health • Leadership and accountability • Improve datasets • Improve local collaboration	• Restore services inclusively - monthly NHS reporting will include measures of performance in relation to patients from the **most deprived 20% and BAME** • Monitoring will compare service use and outcomes across **emergency, outpatient** and **elective care**, including Cancer referrals and waiting time activity • **Challenge: how do we ensure this looks at the general population not just those 'in the system'…?**

2. NCL Clinical Commissioning Group: Aims

To ensure a continued focus across the work of the CCG we established the Communities portfolio and programme in late 2020. The team works across all Boroughs and with partners and is in place to:

- Work with partners to operationalise NCL CCG commitment to health inequalities
- Reduce variation in access, outcomes and experience across NCL
- Identify the highest priority needs to address in order to achieve this – including a review of the traditional understanding of 'need'
- Develop projects and cases for interventions that would reduce health inequalities
- Help shape decision making processes and funding arrangements to drive and enable a more equitable approach
- Spread a culture where health inequalities is at the top of everyone's agenda and an integral part of everyone's role
- Add value to work of Borough Partnerships by leveraging the benefits of NCL CCG and ICS working to focus areas of greatest need within each of the five Boroughs.

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2. Link to borough partnership – inequality priorities

Each ICP has its own priorities and approach to addressing inequalities, coproduced with local authorities, residents and partners. **All partnerships** have a current focus on COVID Vaccine uptake with shared learning & common challenges.

Borough	*Examples* of current priorities and plans to address health inequalities
Camden	• Collaborative working between public-sector, voluntary sector and community groups to tackle inequalities
	• Evidence-based approach to expand and develop locality-based facilities to ensure solutions more equitable
	• Implementing multiagency plan to vaccinate 1,500 homeless residents and asylum seekers in the borough
Islington	Joint work across the ICP to understand and address the short and longer term impact of COVID: • The disproportionate impact of COVID across the Borough's population; • The impact on the mental health of the population as a whole; • The life chances of young people - particularly in terms of education, training and employment
Enfield	• Implementing a project to address inequalities associated with childhood obesity
	• Healthwatch commissioned report into health inequalities with focus on Eastern European communities
	• Joint working on inequalities between Council and CCG – exploring improved opportunities on housing
Barnet	• Inequalities workstream includes equitable same-day access to health services
	• Improving equitable access, outcomes and experience in paediatrics and in mental health
	• Multiagency approach to address inequalities in vaccine take-up with community partners
Haringey	• Multi-agency programme for tackling racism/inequality across multiple health and social aspects of opportunity
	• NHS NCL Charities bid with Enfield to tackle inequalities in mental health, long COVD and digital inclusion
	• Approach to address inequalities in vaccine take-up co-led by CCG & Public Health with community partners

3. Impact to date

3i. Funding

- **£150K** for Community Participatory Research into families with childhood obesity, supported by Enfield Council contribution of **£250K (Fenton recommendation)**
- **£670K (£1.14m over 2 years)** NHS Charities bid – joint bid across the Haringey & Enfield partnerships focusing on : disproportionate health outcomes for young black males, post Covid and community champions and digital inclusion (**Fenton recommendations being applied as part of process**)
- **£282K** for Hypertension and Diabetes models – health inequalities focus
- **£200k** Shared Outcomes Fund to support homeless health/hospital discharge

3ii. Strategic Planning

- Team recruited and **work programme developed** based on NCL priorities and NHSE 8 urgent actions
- Development of **NCL Map of Need** to underpin proportionate universalism/resource distribution aspiration.
- Contributing thinking to the emerging **Population Health approach** – driving the shift to a resource distribution approach more explicitly aligned to areas of need and inequality within communities
- Stocktake of **Anchor Institution** approaches across NCL organisations to inform principles and expectations including commitment to leveraging additional social value and to NCL communities and partnership working to address areas of greatest need.
- **Benchmarking and baselining Care Home support models** – moving towards more equitable provision

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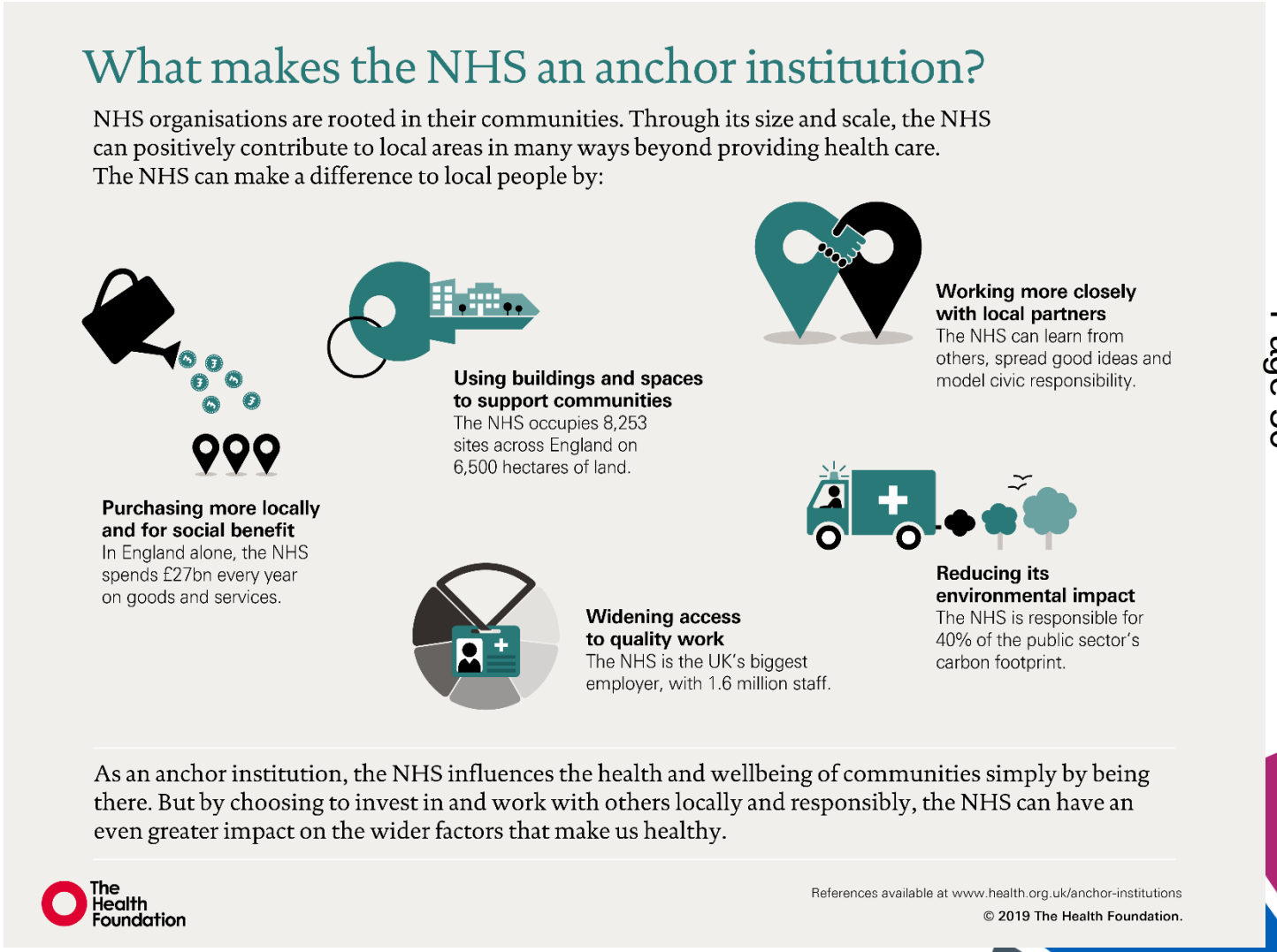
3iii Anchor Institutions – developing and embedding in NCL

Anchor institutions are big and locally rooted organisations like councils, further education colleges, universities, hospitals and big businesses with local headquarters. Anchors get their name because they are unlikely to relocate given their connection to the local population.

Recognising that the decisions the NHS takes can have an impact in areas of deprivation and contribute to our NHS Long Term Plan and local ambitions to address inequalities.



3.iii Anchor institutions – examples of local work

North Mid purchased Christmas fruit baskets from a Haringey based organisation. The Haringey based organisation aims to reduce food poverty. Now looking for the organisation to provide food stall at the hospital.

Islington care and health academy – structured programme to increase local employment into GP practices

Royal Free used a personal protective equipment (PPE) factory in Haringey during first phase of covid. Gowns are also washable (up to 50 washes).

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3.iv. Digital exclusion and 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]

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

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

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3.iv. Digital exclusion and inclusion defined

Example: Haringey digital inclusion project

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

- In response, Haringey 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. This reports via the Borough Partnership.

- 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 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.

3.v. Health inequalities and Covid-19 vaccination

In order to support us to address differential uptake across communities:

All CCG teams and Borough Partnerships are currently focused on maximising uptake of the COVID vaccine and in doing so building relationships with communities and group within and addressing long standing health inequalities in access, experience and outcome

Boroughs are provided with “real time” information about uptake from Healtheintent – by ethnicity, deprivation/ward, age, gender and first language spoken.

This is enabling each borough to modify and maximise engagement and communication to local needs.

Examples include:

- Communities “myth-busting” webinar - Enfield
- Diverse vaccinators reflecting community – Camden
- Vaccination in faith settings – Haringey
- Videos of Mayor and different communities being vaccinated – Islington
- Co-delivery with Hatzola Jewish Ambulance Service – Barnet

Further information in the appendix about the approaches being taken locally.

3.v. Health inequalities and Covid-19 vaccination

To support us to address inclusion health we are:

Working with Borough leads, primary care, public health and UCLH Find and Treat to develop programme to ensure vaccination uptake from underserved populations including people experiencing homelessness, asylum seekers, and traveller communities.

Links to wider focus on the health of these populations and is informing pan-London work/offer.

Key element is preparing people and accommodation providers to support programme – including provision of vaccination to front line staff.

This includes peer developed leaflets, webinars led by clinical lead and pre-visits.

We are working with peer and lived experience groups to inform engagement approaches.

Data is being collected to monitor uptake which will be reviewed ongoing through the NCL Vaccine Board. This will continue to inform planning and development of programme.

Considering innovative approaches to certain population groups – eg Vaxi Taxi and Doctors of the World.

Key link to wider health inequalities and support beyond covid vaccination.

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3.v. Supporting vaccination for people with Learning disabilities and autism spectrum disorder

24th Feb JCVI amended the criteria for Priority Group 6 to include all adults with LD, including those with 'mild to moderate' needs. Carers are also to be prioritised as part of priority 6. In addition to this, NCL CCG has taken the decision to also provide access to the vaccine for people with Autism, aged 16+. In NCL we have also taken the following actions:

- Identifying eligible individuals by cross-referencing LD team service user lists with GP registration data
- Identifying most vulnerable/high needs individuals known to services, particularly those who are known to struggle with vaccinations as learned through the flu vaccination
- Providing easy read information and advice about the vaccine
- Identifying those who may not have capacity to make a decision about the vaccine
- Developing processes to support people w/LD who are needle-phobic. Needle desensitisation work will need to be delivered in advance for this group.
- Developing advice for marshals/ volunteers at vaccination centres - for recognising hidden disabilities (Barnet)
- Identifying opportunities to provide reasonable adjustments that support vaccine delivery, e.g. Enfield have reached agreement with BEH to use a space within Chase Farm hospital as a LD vaccination hub, which supports adjustments such as longer appointment times and sensory needs (e.g. quiet space).
- Clinical staff within local teams are receiving vaccine training, enabling them to support PCNs with delivering vaccines to people with LD, utilising their expertise of working with this cohort, and being able to adjust their approach so care is personalised. In many cases, locally trained LD colleagues will also know the individual being vaccinated, and this will provide further reassurance to individuals. In Islington, support is also being provided to residents to book vaccine appointments and arrange transport.
- Liaising with carers groups to share vaccine information, run Q&A sessions and encouraging carers to register their caring status with their GP, to ensure they are included within priority group 6.

4. Next steps

- Health inequalities will widen and the cost to the system will increase if we don't intervene to support improved outcomes and reduce variation so we need a disproportionate focus on areas of highest need
- We are looking at ways of working and opportunities to apply data and insight to identify need and address it (population health) via local and system-wide interventions e.g. building relationships with communities; developing our insights; scoping a system investment fund for health inequalities

5. Appendices

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Core pillars of NCL Inequalities approach

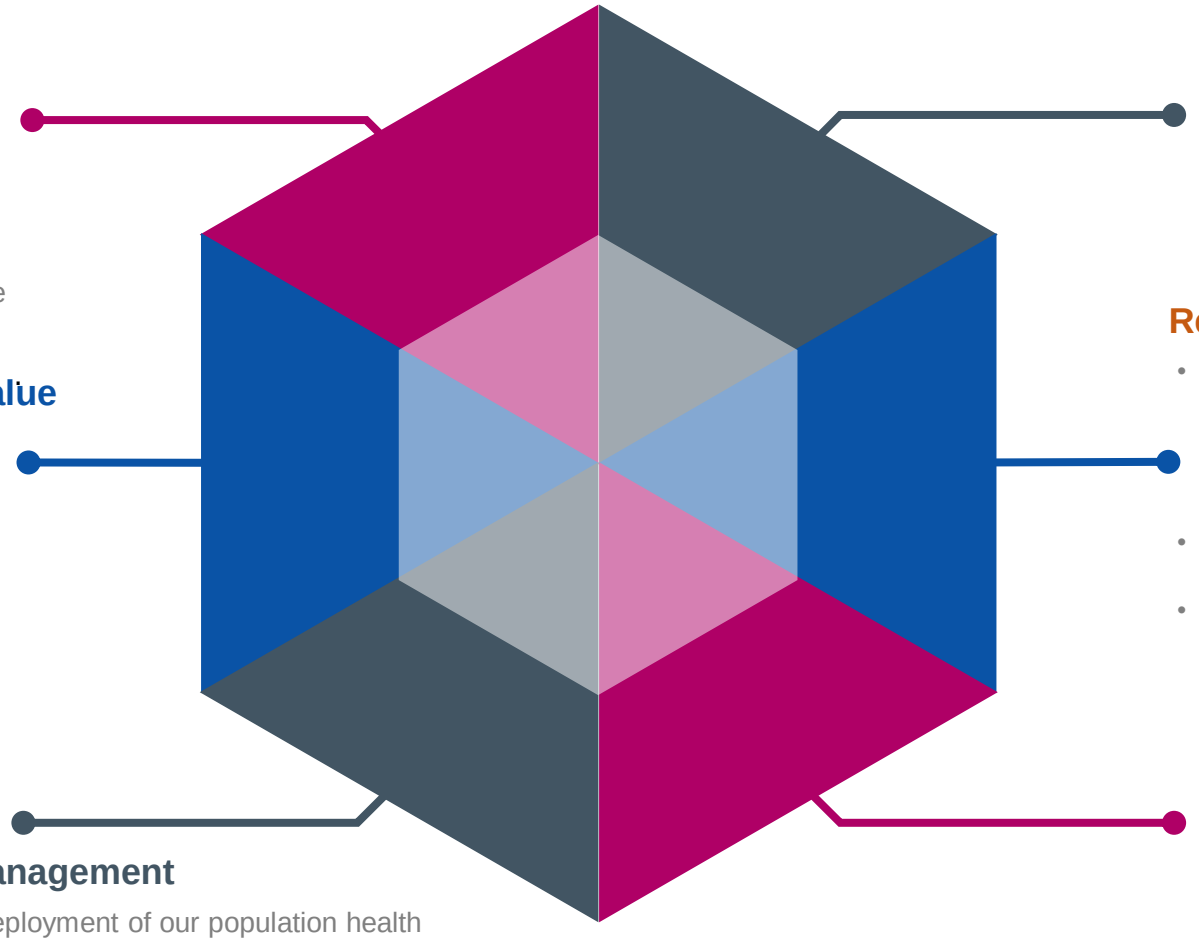
Race and ethnic inequalities

- We will approach all our deliberations on inequalities by applying this lens
- We will build on the strengths of our diverse communities, including local faith leaders
- Through our community engagement plans, we will ensure that BAME communities have the opportunity to engage in the development of strategies, plans and services, including those where English is not their first language

Anchor organisations and social value

We will support our communities by working as a network of anchor organisations, embedding social value:

- Looking at how we can use more of our levers to address factors that contribute to health inequalities
- Capitalise on public sector organisations as employers, with a focus on lower paid staff, many of whom live locally
- Ensure that we are making full use of apprenticeships and other employment opportunities



Population health management

- Continuing with the deployment of our population health management system, HealtheIntent, which will enable the systematic use of data to improve access to services for different equalities groups, vulnerable individuals and populations, as well as improvements in the quality of care

A strengths-based approach

- We will build on individual and community strengths to improve health
- North Central London has a very large voluntary and community sector, as well as business assets that we will work with to address inequalities
- This means ensuring we have a highly networked community with “neighbourliness” / citizenship at its heart

Resource distribution to tackle inequalities

- **Addressing health and care inequalities will be a criterion in reviewing and evaluating future investments, including how we support longer term gains (e.g. for children)**
- **Marmot principle of “proportionate universalism” will be applied**
- **We will achieve parity of esteem between resourcing mental health and physical health services and prevention**

Prevention & early intervention

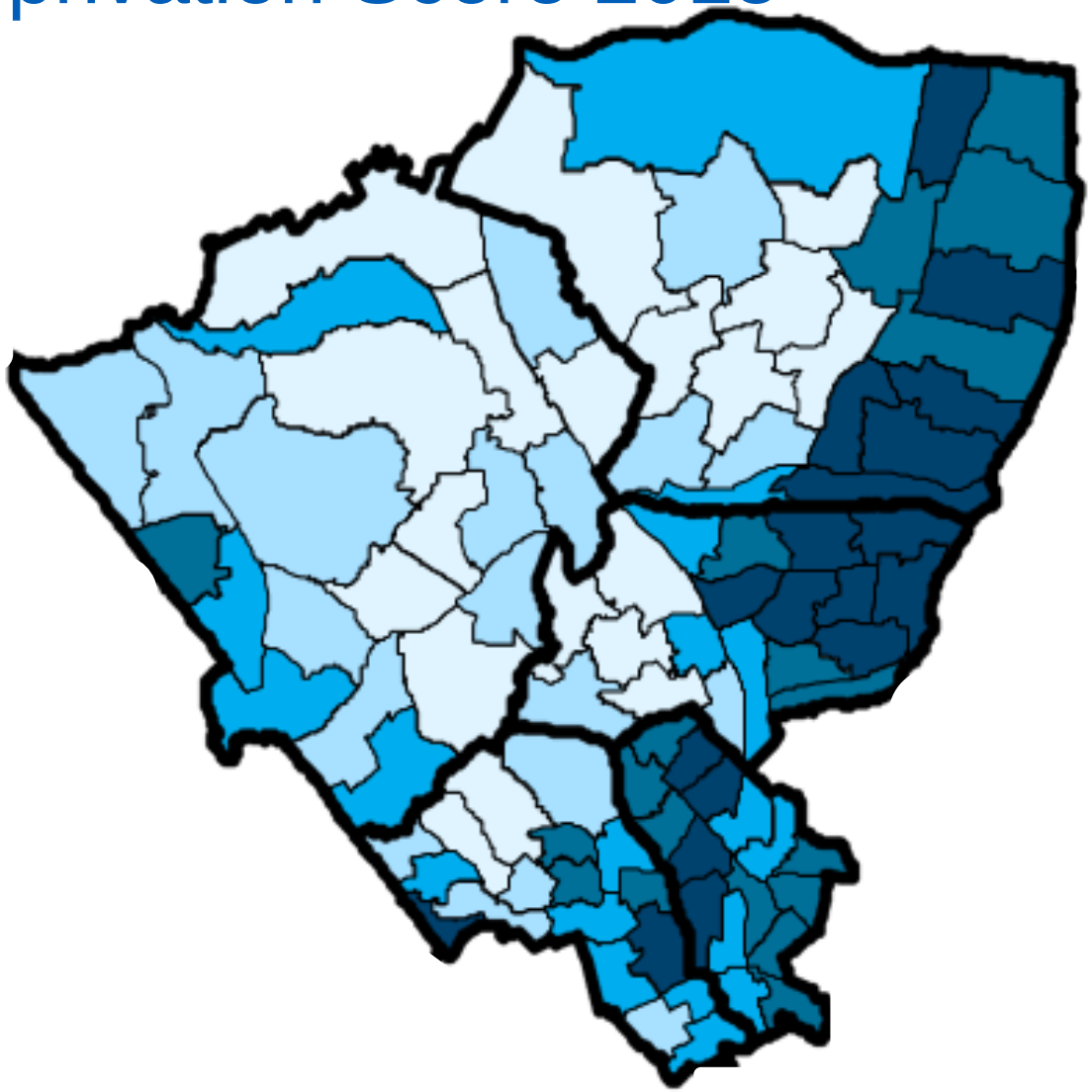
- We will review our prevention and early intervention plans to ensure we are making the biggest impact in the shortest time. Particular areas of focus likely to be: mental health, smoking, cardiovascular risk, alcohol, overweight and obesity

Maps of need across NCL

Index of Multiple Deprivation Score 2015

NCL Top 20%

Ward	Borough	IMD
Northumberland Park	Haringey	52.6
Edmonton Green	Enfield	47.0
White Hart Lane	Haringey	45.9
Tottenham Green	Haringey	43.6
Finsbury Park	Islington	42.4
Tottenham Hale	Haringey	41.5
Bruce Grove	Haringey	40.2
Upper Edmonton	Enfield	39.2
St Pancras and Somers	Camden	38.6
Noel Park	Haringey	38.3
Turkey Street	Enfield	38.2
Lower Edmonton	Enfield	37.1
Ponders End	Enfield	36.5
West Green	Haringey	36.3
Kilburn	Camden	36.0
Holloway	Islington	35.5
Caledonian	Islington	35.5
Tollington	Islington	35.3
Haselbury	Enfield	34.8



Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Should we look at this from a **ward / needs level** rather than borough level?

The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of deprivation, based on the IMD deprivation score.

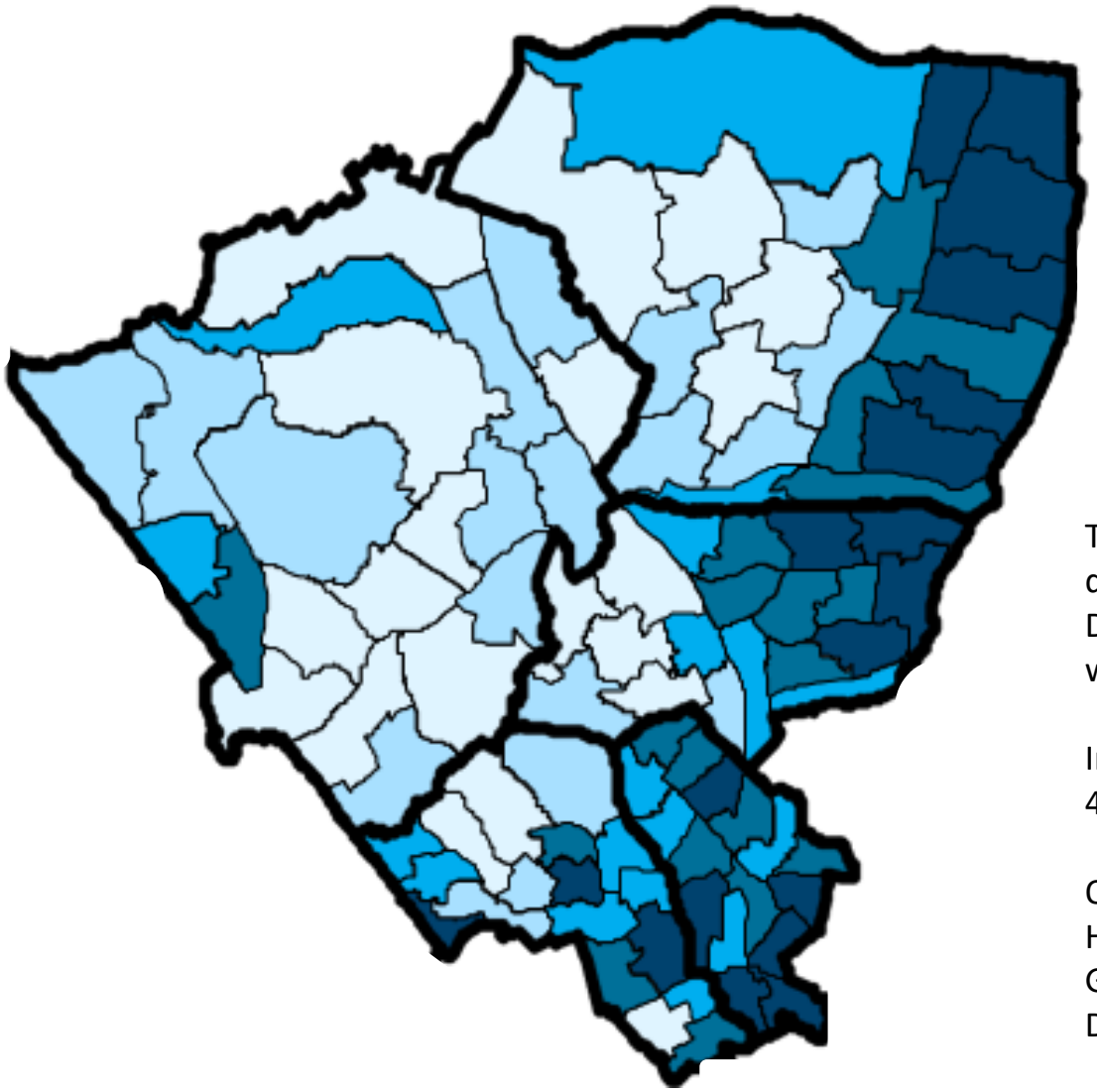
Indicator values range from 9.5 to 52.6.

Original Data Source: Ministry of Housing, Communities and Local Government, Index of Multiple Deprivation 2015

Child Poverty, English Indices of Deprivation 2015, IDACI

NCL Top 20%

Ward	Borough	IDACI
Bunhill	Islington	44.6
St Pancras and Somers Town	Camden	43.3
Kilburn	Camden	42.9
Turkey Street	Enfield	42.8
Enfield Lock	Enfield	42.5
White Hart Lane	Haringey	42.3
Lower Edmonton	Enfield	42.3
Northumberland Park	Haringey	42.1
Tottenham Hale	Haringey	41.7
Caledonian	Islington	40.9
Finsbury Park	Islington	40.8
Edmonton Green	Enfield	40.4
Haverstock	Camden	40.3
Enfield Highway	Enfield	40.1
Clerkenwell	Islington	38.3
St Peter's	Islington	37.9
Tottenham Green	Haringey	37.8
Canonbury	Islington	37.7
Ponders End	Enfield	37.0



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher levels of child poverty.

Indicator values range from 5.1 to 44.6.

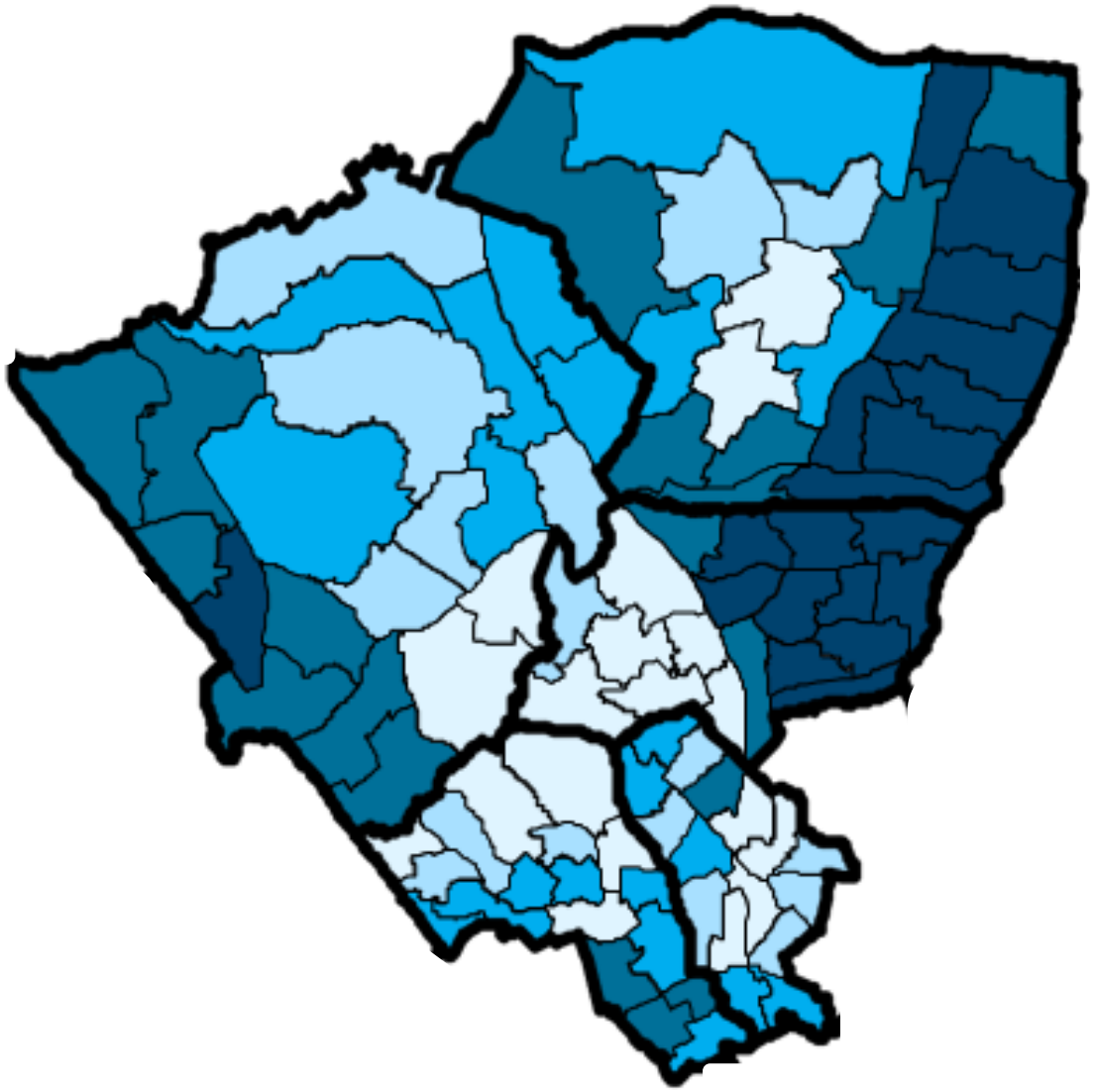
Original Data Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2015

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Fuel poverty

NCL Top 20%

Ward	Borough	%
Bruce Grove	Haringey	18.4
Noel Park	Haringey	18.1
St Ann's	Haringey	17.1
Woodside	Haringey	16.7
White Hart Lane	Haringey	16.4
Tottenham Hale	Haringey	15.9
West Green	Haringey	15.6
Tottenham Green	Haringey	15.3
Seven Sisters	Haringey	15.0
Northumberland Park	Haringey	14.6
Haselbury	Enfield	14.6
Lower Edmonton	Enfield	14.6
Upper Edmonton	Enfield	14.1
Jubilee	Enfield	13.4
Ponders End	Enfield	13.3
Colindale	Barnet	13.2
Edmonton Green	Enfield	13.2
Enfield Highway	Enfield	13.2
Turkey Street	Enfield	13.1



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of households estimated to be fuel poor.

Indicator values range from 6.4% to 18.4%.

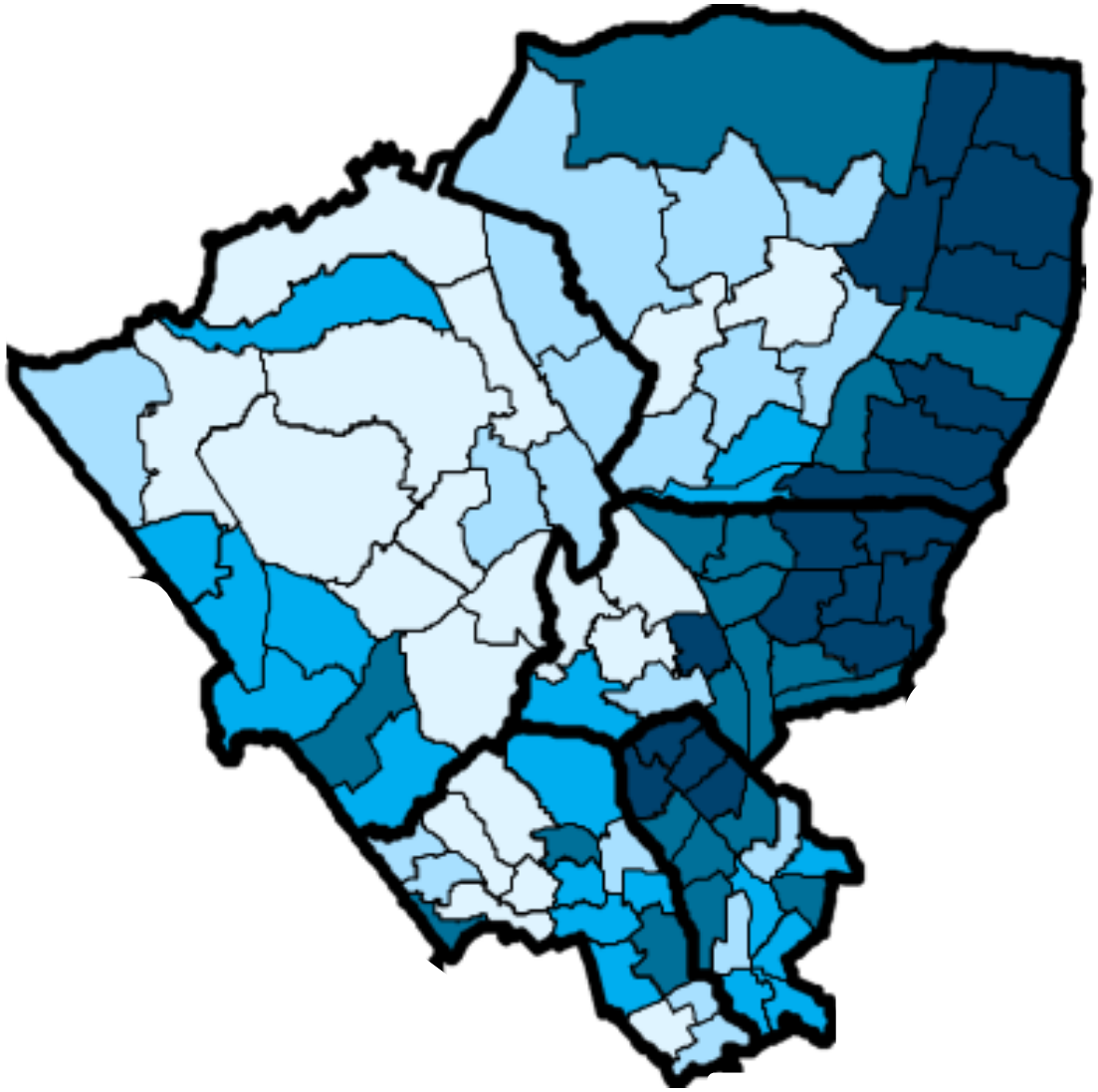
Original Data Source: Department for Business, Energy and Industrial Strategy – modelled estimates (2016). A household is considered to be fuel poor if they have required fuel costs that are above average and, if they were to spend that amount, they would be left with a residual income below the official poverty line.

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

% of working age population claiming out of work benefit

NCL Top 20%

Ward	Borough	%
Northumberland Park	Haringey	5.1
Ponders End	Enfield	3.5
Edmonton Green	Enfield	3.5
Bruce Grove	Haringey	3.4
Hornsey	Haringey	3.3
Lower Edmonton	Enfield	3.1
Tollington	Islington	3.0
Tottenham Green	Haringey	3.0
White Hart Lane	Haringey	2.9
Tottenham Hale	Haringey	2.9
West Green	Haringey	2.9
Finsbury Park	Islington	2.9
Hillrise	Islington	2.7
Turkey Street	Enfield	2.7
Enfield Highway	Enfield	2.7
Upper Edmonton	Enfield	2.6
Southbury	Enfield	2.6
Enfield Lock	Enfield	2.6
Junction	Islington	2.5



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of the population claiming out of work benefit.

Indicator values range from 0.5% to 5.1%.

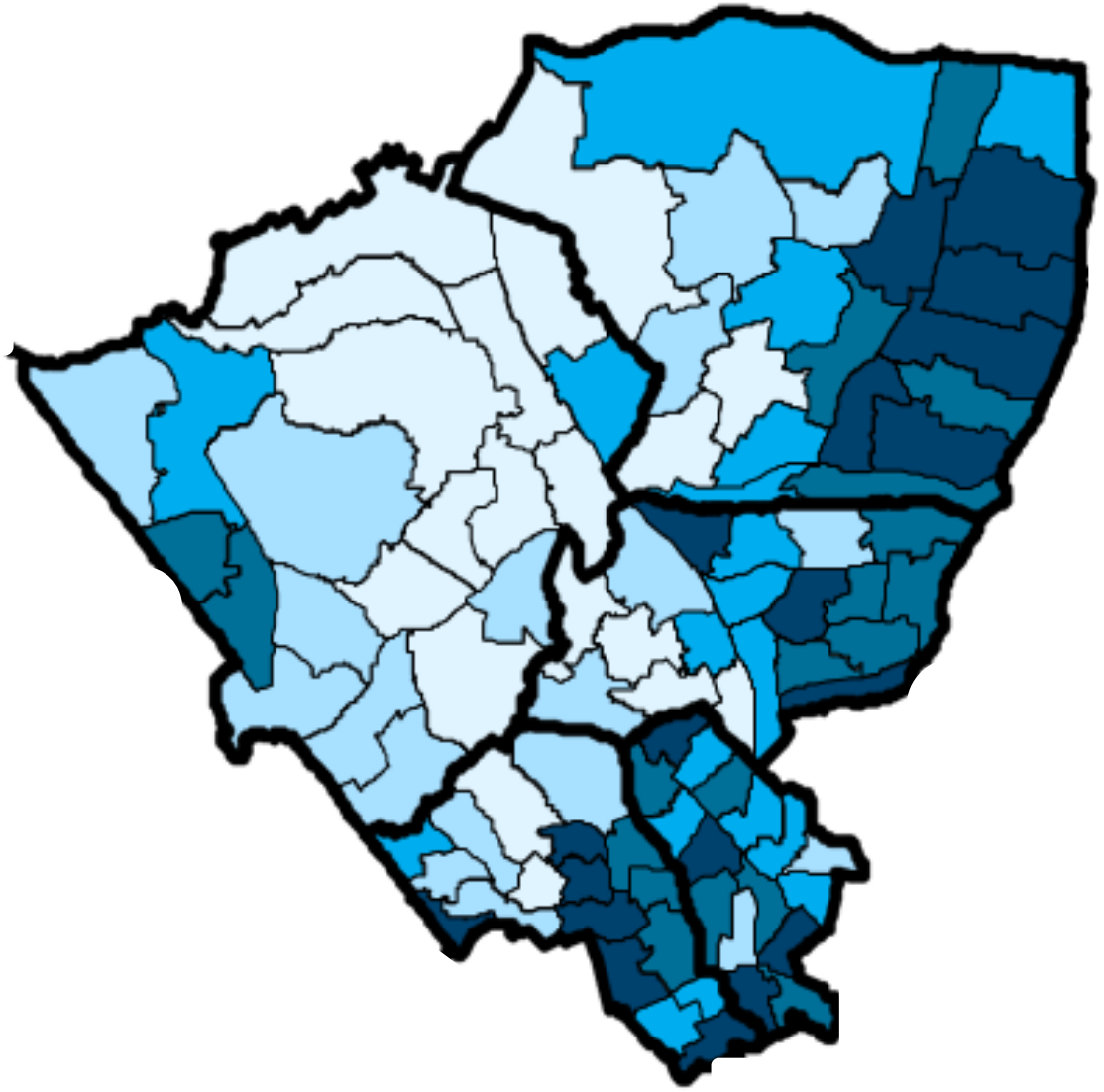
Original Data Source: NOMIS Labour Market Statistics (2017/18)

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Child Development at age 5 (%)

NCL Bottom 20%

Ward	Borough	%
Jubilee	Enfield	54.5
Southbury	Enfield	54.5
Holloway	Islington	54.1
Gospel Oak	Camden	53.9
St Peter's	Islington	53.4
West Green	Haringey	53.1
Bounds Green	Haringey	52.6
Clerkenwell	Islington	51.9
Ponders End	Enfield	51.8
Hillrise	Islington	51.6
Haselbury	Enfield	51.4
Haverstock	Camden	50.7
Seven Sisters	Haringey	50.4
Holborn and Covent Garden	Camden	50.3
Enfield Highway	Enfield	50.3
Camden Town with Primrose Hill	Camden	48.8
Kilburn	Camden	48.7
Edmonton Green	Enfield	48.4
Regent's Park	Camden	47.0



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with lower proportions of children achieving a good level of development at age 5.

Indicator values range from 47.0% to 76.0%.

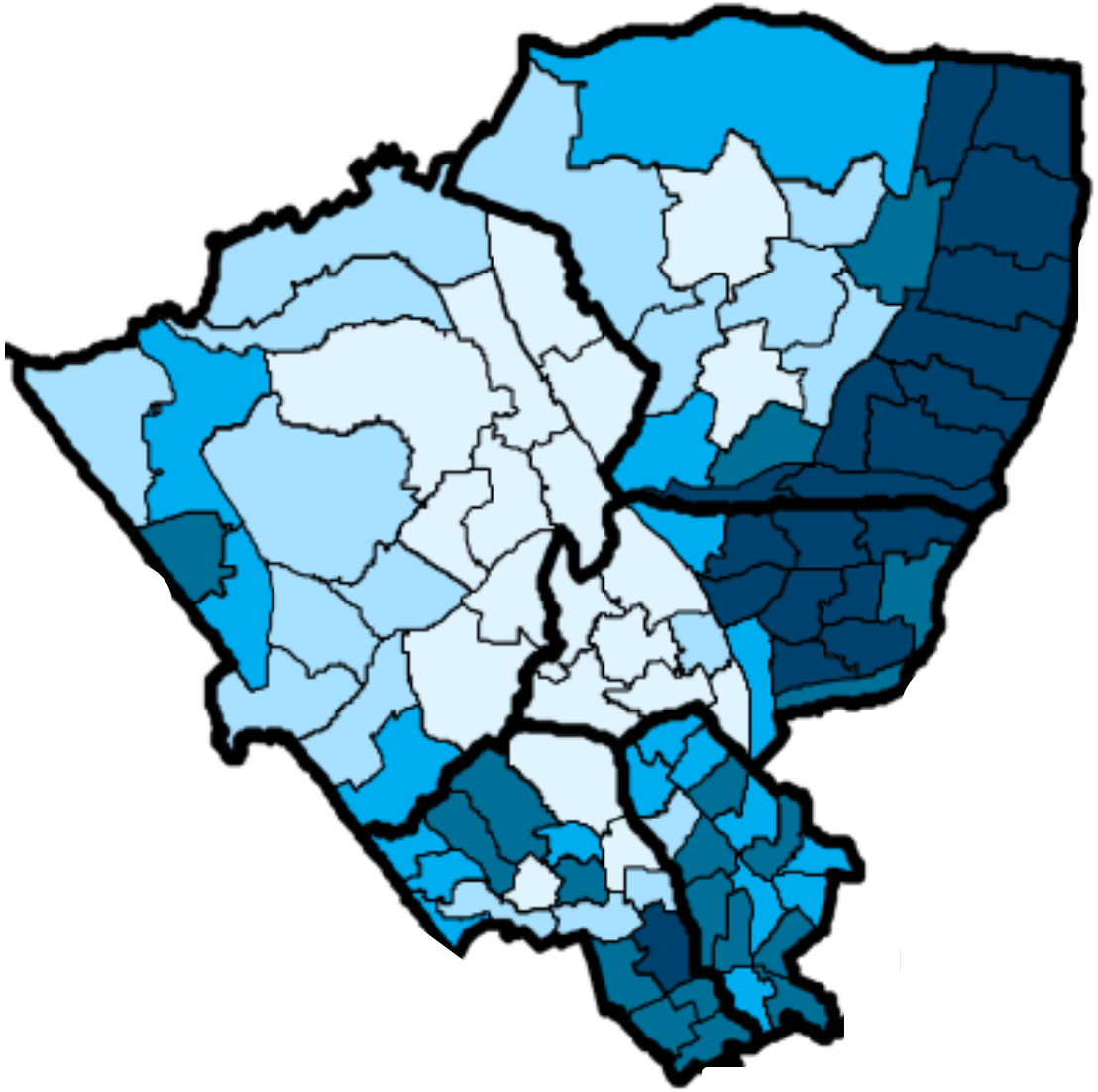
Original Data Source: Department for Education, EYFS Profile 2013/14.

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Obese children Year 6, three year average

NCL Top 20%

Ward	Borough	%
White Hart Lane	Haringey	32.1
St Pancras and Somers Town	Camden	30.9
West Green	Haringey	30.9
Enfield Lock	Enfield	30.1
Lower Edmonton	Enfield	30.1
Northumberland Park	Haringey	30.0
Haselbury	Enfield	29.7
St Ann's	Haringey	29.5
Noel Park	Haringey	29.3
Ponders End	Enfield	29.2
Tottenham Green	Haringey	29.1
Edmonton Green	Enfield	28.9
Jubilee	Enfield	28.8
Woodside	Haringey	28.8
Upper Edmonton	Enfield	28.6
Turkey Street	Enfield	28.6
Bruce Grove	Haringey	28.6
Enfield Highway	Enfield	27.9



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of obese Year 6 children.

Indicator values range from 9.0% to 32.1%.

Original Data Source: National Child Measurement Programme, 2015/16 – 2017/18

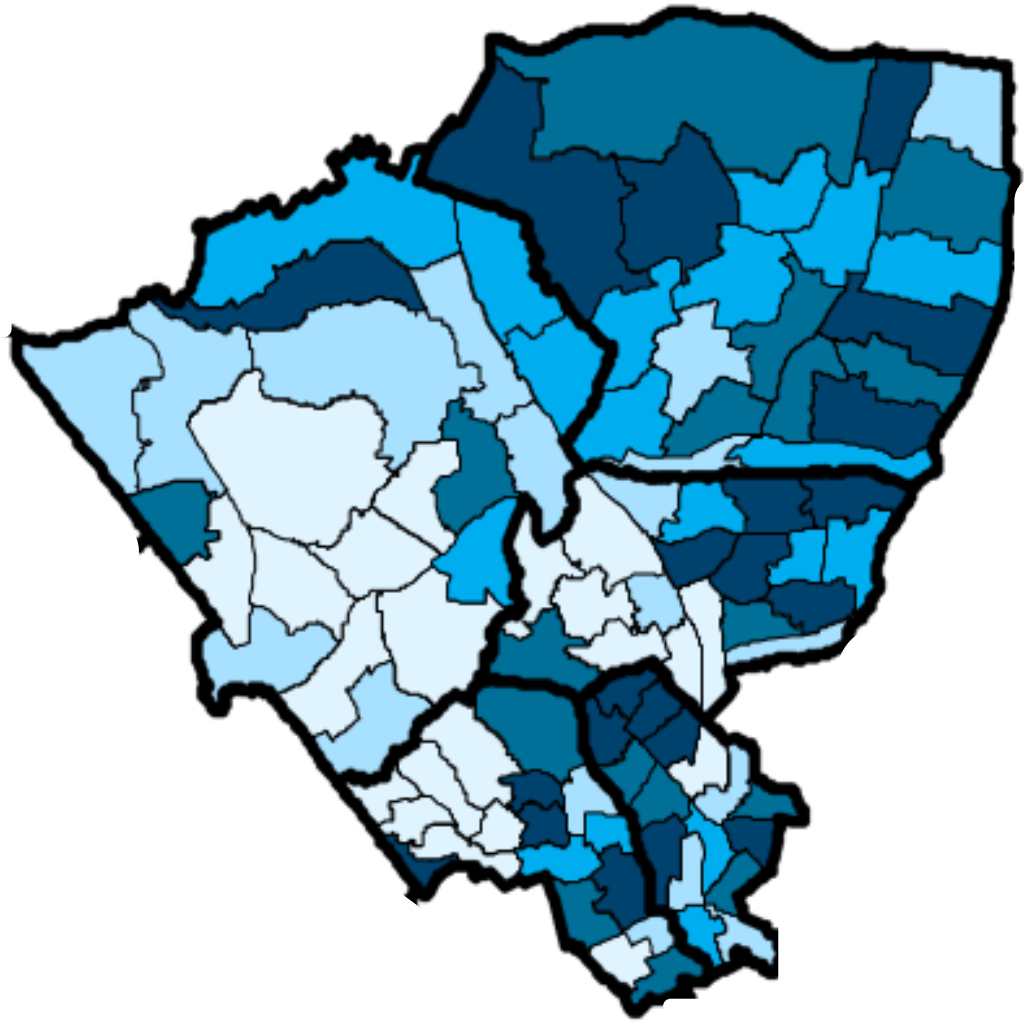
Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

Percentage of people who reported having a limiting long-term illness or disability

NCL Top 20%

Ward	Borough	%
Kilburn	Camden	18.5
St Pancras and Somers Town	Camden	18.4
Gospel Oak	Camden	18.2
Haverstock	Camden	18.1
Finsbury Park	Islington	17.6
Caledonian	Islington	17.5
White Hart Lane	Haringey	17.4
Hillrise	Islington	17.3
Underhill	Barnet	17.2
Canonbury	Islington	17.2
Turkey Street	Enfield	17.1
Noel Park	Haringey	17.0
Tollington	Islington	17.0
Junction	Islington	16.8
Northumberland Park	Haringey	16.7
Edmonton Green	Enfield	16.6
Jubilee	Enfield	16.5
Tottenham Green	Haringey	16.4
West Green	Haringey	16.3

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/



The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher proportions of their population who report having a limiting long-term illness or disability.

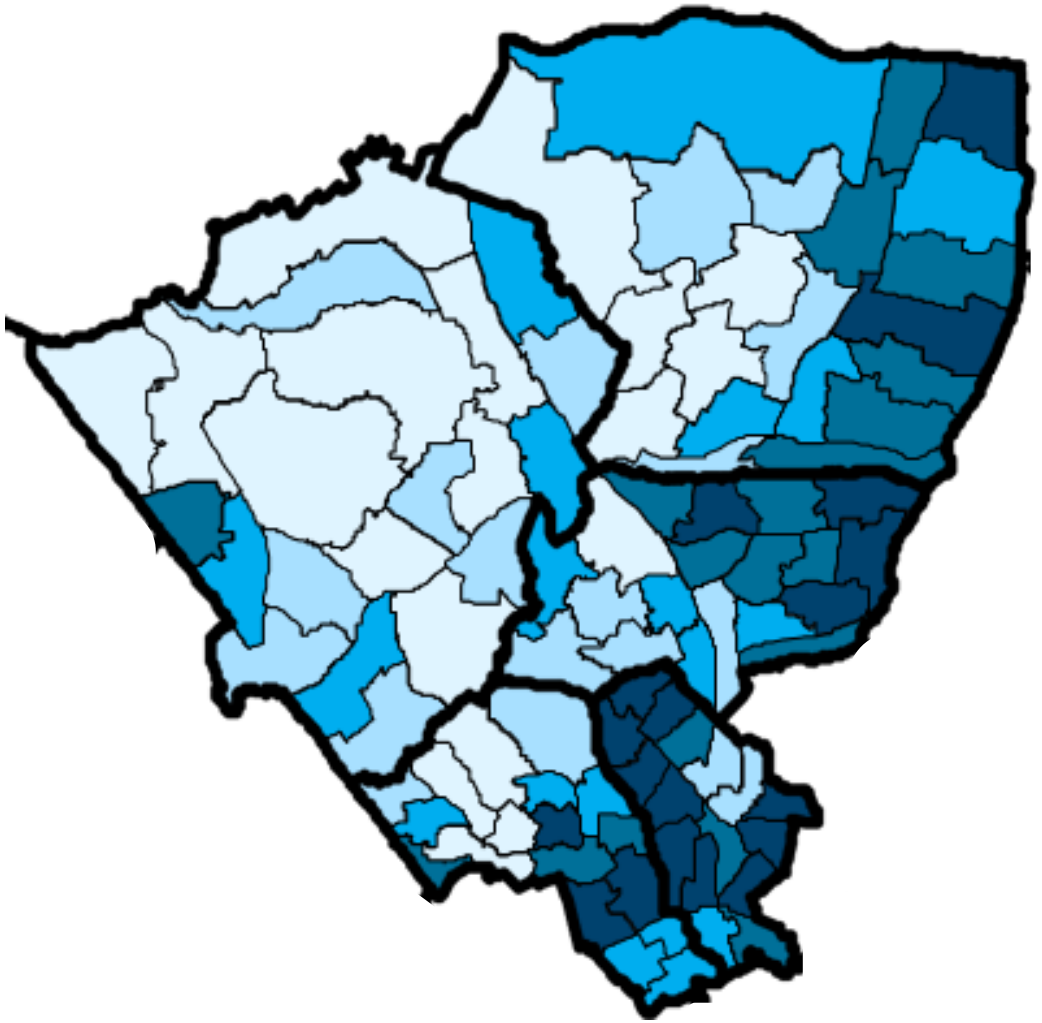
Indicator values range from 9.4% to 18.5%.

Original Data Source: ONS Census 2011

Deaths from causes considered preventable, all ages, standardised mortality ratio

NCL Top 20%

Ward	Borough	SMR
St Pancras and Somers Town	Camden	144.7
Northumberland Park	Haringey	140.0
Junction	Islington	137.5
Mildmay	Islington	128.4
Tottenham Green	Haringey	127.6
Barnsbury	Islington	125.0
Tottenham Hale	Haringey	123.0
Caledonian	Islington	120.8
St Peter's	Islington	120.8
Tollington	Islington	119.7
Hillrise	Islington	119.3
Holloway	Islington	116.6
Woodside	Haringey	116.2
Jubilee	Enfield	112.1
Canonbury	Islington	111.5
St George's	Islington	110.1
Enfield Lock	Enfield	109.3
Haverstock	Camden	107.6
Regent's Park	Camden	107.4



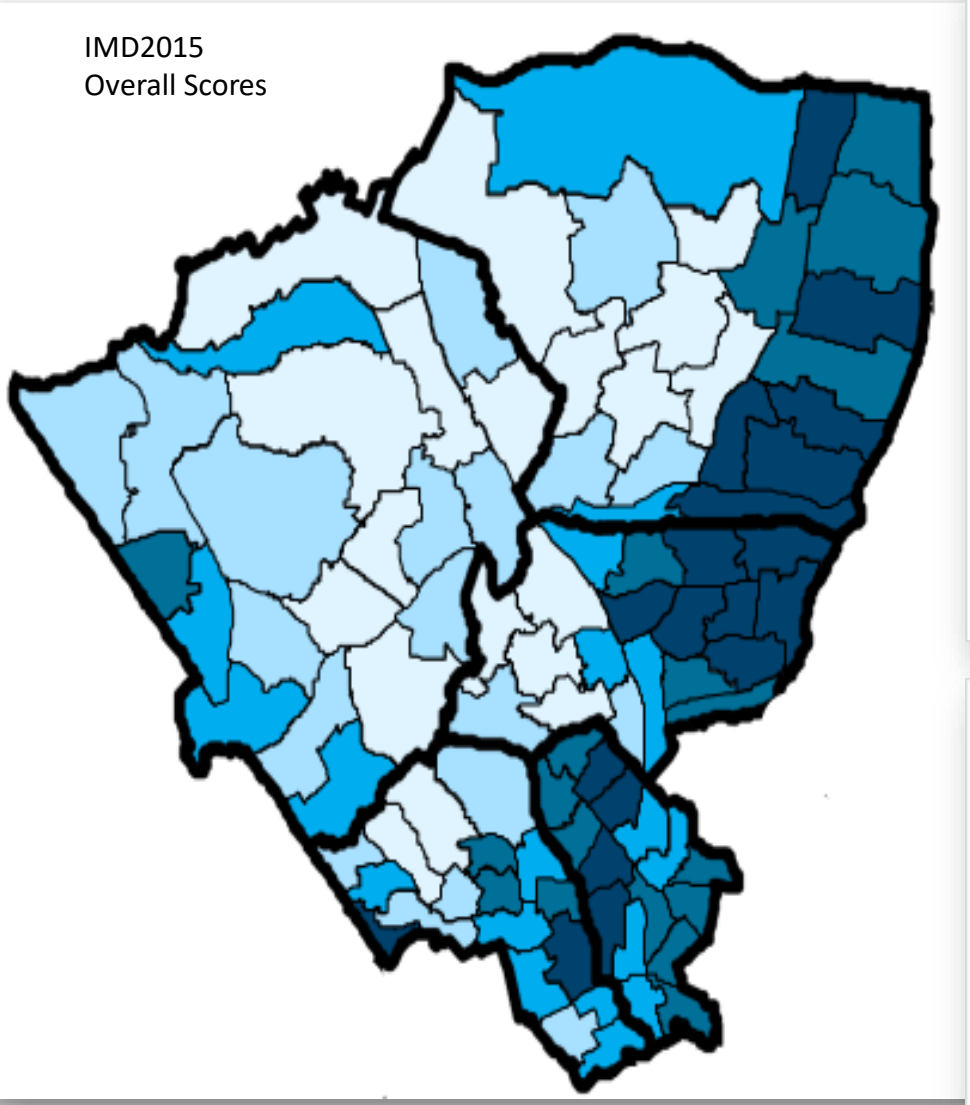
The colours on the map show different quintiles across NCL. Darker colours indicate the wards with higher rates of deaths from causes considered preventable.

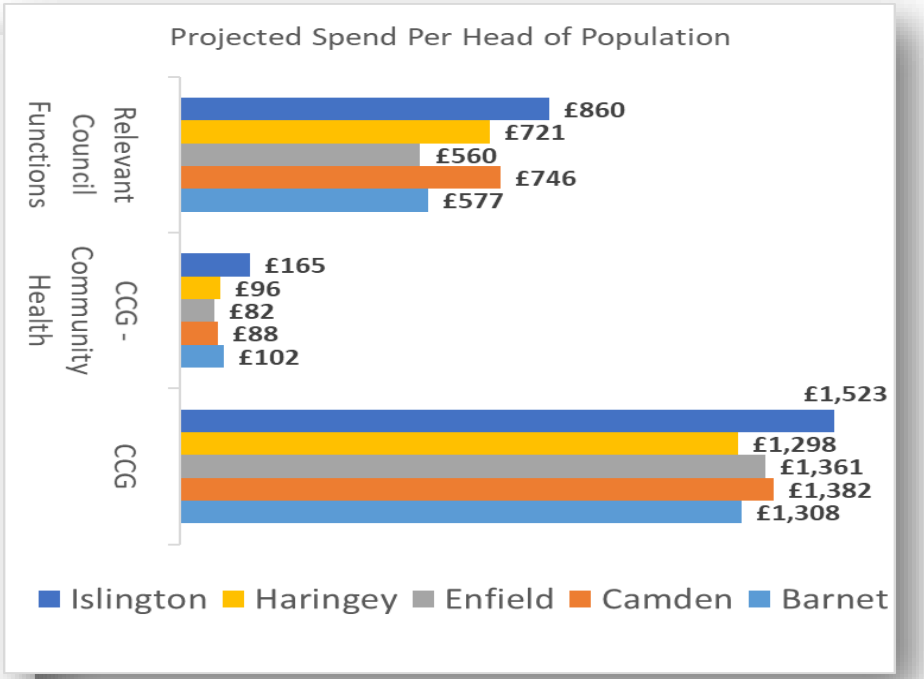
Indicator values range from 38.6 to 144.7.

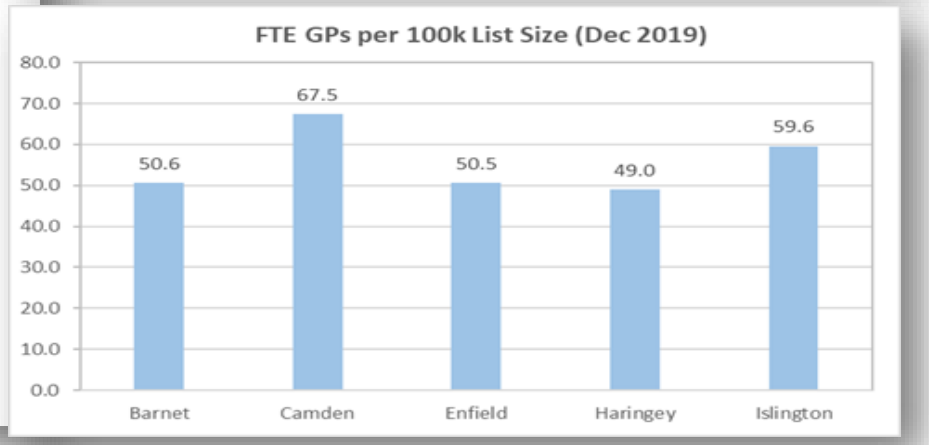
Original Data Source: ONS; Public Health England Annual Mortality Extracts 2013-17.
Preventable mortality refers to causes of death where all or most deaths could potentially be prevented by public health interventions in the broadest sense (subject to age limits if appropriate).

Source for all data: PHE Fingertips https://fingertips.phe.org.uk/profile/local-health/

CURRENT RESOURCE ALLOCATION – DEPRIVATION AS AN EXAMPLE (resources are insufficiently focused on populations – they are focused on institutions….)







Resources are NOT disproportionately focused on areas of greatest need

This leads to a 'double jeopardy':

- Wards with marked deprivation are more likely to need community interventions
- If these aren't sufficiently well resourced, then residents may need more intensive interventions later – e.g. increased hospitalisation.
- Result is % available for community investment becomes less in more deprived areas

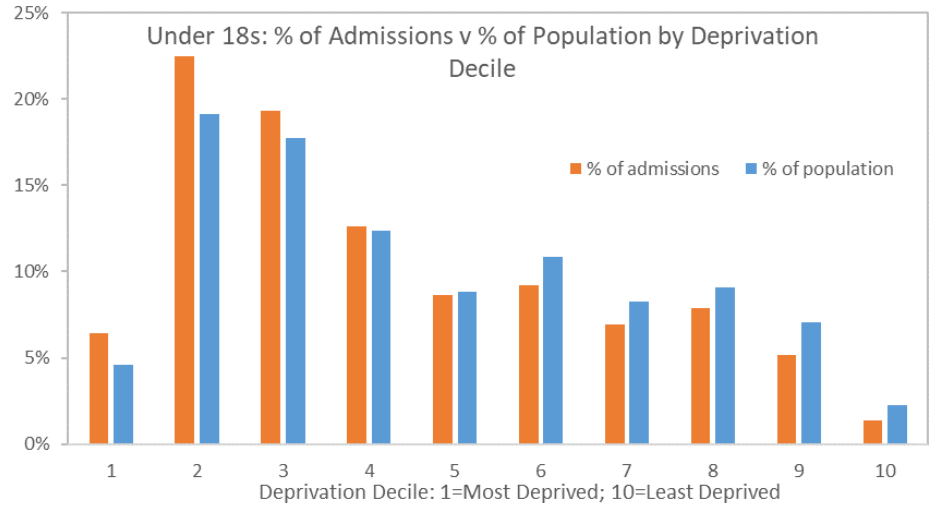
** 'Relevant Council Functions' relates to Revenue Account submission from Councils on children's and adult social care, public health and housing options/homelessness only*

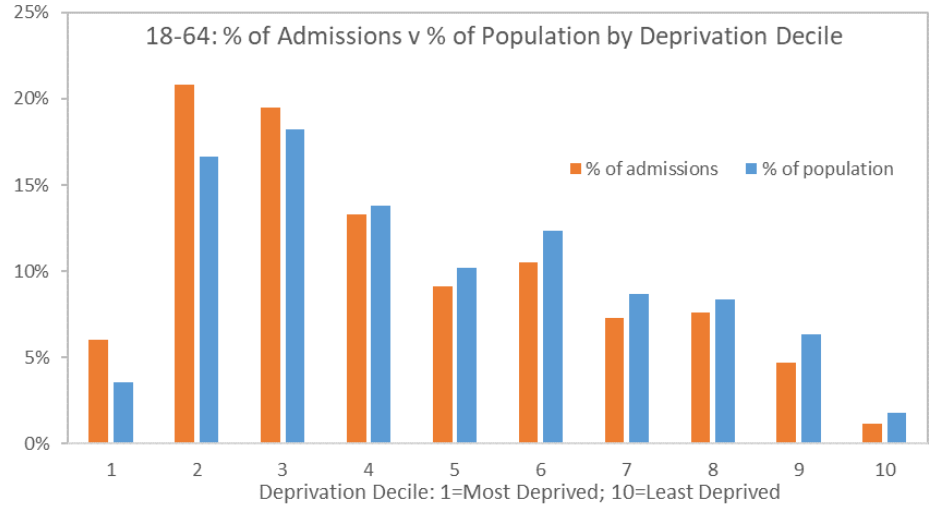
NORTH LONDON PARTNERS in health and care

Emergency admissions by deprivation and age

19/20 Emergency Admissions per 1000 Population by IMD2019 Deprivation Decile and Age Group

Deprivation Decile	Under 18	18-64	65-79	80+	Total
1	72	81	289	564	107
2	60	60	203	487	81
3	55	51	185	496	73
4	52	46	173	464	68
5	50	43	156	458	68
6	43	41	143	463	66
7	43	40	123	440	65
8	44	43	124	410	71
9	37	35	101	394	63
10	31	31	81	296	51





- Across all age groups, there is a higher rate of admissions for those living in the most deprived areas of NCL.
- Among adults, admission rates for younger age groups in the most deprived areas are the same or similar to admission rates for older age groups in the least deprived areas (see circled values above).

Sources: Admissions data from SUS; Population data from ONS Mid-2019 Population Estimates

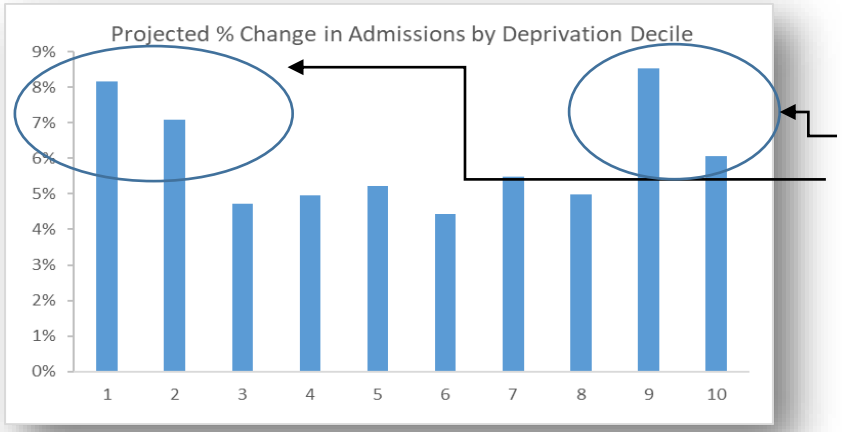
NORTH LONDON PARTNERS in health and care

How will this change over the next five years?

NCL's population will change in 2025 – what will this mean for the pattern of admissions across age groups?

Scenario: 'No Change to Current Pattern of Allocations' and applying deprivation-related & age-specific population projections*

Based on GLA population projections, NCL's population is expected to grow by 2.3% by 2025, slightly lower than the ONS CCG estimates. However, age groups (particularly older people) with the highest expected levels of growth are consistent between two sources.



Using this assumption, it's possible to predict:

- Large older populations often in more affluent areas are expected to see high increases in admissions – this is being driven by an increase of those aged 80+;
- NCL's more deprived areas are likely to see higher rates of growth in admissions - from an already high level;

	% MSOA Population Change	19/20 Emergency Admissions	2025 Projected Admissions	Admissions Change	% Admissions Change	Additional PbR Cost Impact**
Under 18	-1.2%	16,888	16,675	-213	-1.3%	-£290,078
18-64	1.3%	47,518	48,459	941	1.2%	£1,814,929
65-79	14.8%	20,664	23,898	3,234	13.1%	£11,643,280
80+	10.9%	23,101	25,357	2,256	8.5%	£9,468,559
Total	**2.3%**	**108,171**	**114,389**	**6,218**	**5.7%**	**£22,636,689**

Impact of COVID

- Emerging national evidence suggests higher levels of infection, hospitalisation & deaths for people in the most deprived areas – at least twice as high mortality rates in Wave 1 were reported in both BMJ and King's Fund research
- Impact is likely to be further compounded as NCL has a higher proportion of people from black ethnic backgrounds than national position – and this ethnic group known to be disproportionately impacted by COVID, including post-COVID syndrome

It's possible increased costs over next 5 years in terms of NEL admissions are likely to be even higher

Financial impact on a Borough & Trust basis varies, e.g. those Trusts seeing more deprived residents likely to have greater increase – 'double jeopardy'

Sources: *GLA MSOA Population Projections (2018) – projections before impact of Covid; **PbR Cost at 19/20 tariff prices: average admission price per age group: Under 18: £1,359; 18-64: £1,928; 65-79: £3,600; Over 80: £4,198

Imagine that we could address some of the issues we've highlighted about navigation – what difference might it make now and by 2025

Example 1: Reduce the rate of emergency admissions for the population living in the 20% most deprived areas (deciles 1 and 2) to the rate currently experienced by the decile 3 population

2019 Population

	Under 18	18-64	65-79	80+	Total
Total (2019) Population: Deciles 1 and 2	78,728	200,866	21,814	7,993	**309,401**
Number of Admissions: Deciles 1 and 2	4,886	12,757	4,780	4,011	**26,434**
Rate of Admissions per 1000: Deciles 1 and 2	62.1	63.5	219.1	501.8	**85.4**
Rate of Admissions per 1000: Decile 3	55.4	51.1	184.9	495.8	**73.4**
Decile 1/2 Admissions if @ Decile 3 Rate	4,360	10,259	4,033	3,963	**22,615**
Admissions Saved	**526**	**2,498**	**747**	**48**	**3,819**
Admission Cost Saved	**£714,524**	**£4,817,815**	**£2,689,261**	**£200,663**	**£8,422,264**

2025 Population Projection

	Under 18	18-64	65-79	80+	Total
Total (2025) Population: Deciles 1 and 2	81,424	211,559	26,368	8,281	**327,632**
Number of Admissions: Deciles 1 and 2	5,053	13,436	5,778	4,156	**28,423**
Rate of Admissions per 1000: Deciles 1 and 2	62.1	63.5	219.1	501.8	**85.4**
Rate of Admissions per 1000: Decile 3	55.4	51.1	184.9	495.8	**73.4**
Decile 1/2 Admissions if @ Decile 3 Rate	4,509	10,805	4,875	4,106	**24,295**
Admissions Saved	**544**	**2,631**	**903**	**50**	**4,128**
Admission Cost Saved	**£738,995**	**£5,074,280**	**£3,250,641**	**£207,903**	**£9,271,818**

Example 2: Reduce the rate of emergency admissions for the population living in the 40% deprived areas (deciles 1-4) to the rate currently experienced by the decile 5 population

2019 Population

	Under 18	18-64	65-79	80+	Total
Total (2019) Population: Deciles 1-4	178,710	519,487	56,095	20,135	**774,427**
Number of Admissions: Deciles 1-4	10,282	28,330	10,949	9,865	**59,426**
Rate of Admissions per 1000: Deciles 1-4	57.5	54.5	195.2	489.9	**76.7**
Rate of Admissions per 1000: Decile 5	49.8	42.7	156.1	458.3	**67.8**
Decile 1-4 Admissions if @ Decile 5 Rate	8,899	22,183	8,757	9,228	**49,068**
Admissions Saved	**1,383**	**6,147**	**2,192**	**637**	**10,358**
Admission Cost Saved	**£1,878,741**	**£11,853,312**	**£7,889,403**	**£2,674,444**	**£24,295,900**

2025 Population Projections

	Under 18	18-64	65-79	80+	Total
Total (2025) Population: Deciles 1-4	179,382	533,852	66,427	21,435	**801,095**
Number of Admissions: Deciles 1-4	10,321	29,113	12,966	10,502	**62,901**
Rate of Admissions per 1000: Deciles 1-4	57.5	54.5	195.2	489.9	**76.7**
Rate of Admissions per 1000: Decile 5	49.8	42.7	156.1	458.3	**67.8**
Decile 1-4 Admissions if @ Decile 5 Rate	8,933	22,797	10,370	9,824	**51,923**
Admissions Saved	**1,388**	**6,317**	**2,595**	**678**	**10,978**
Admission Cost Saved	**£1,885,805**	**£12,181,074**	**£9,342,550**	**£2,847,075**	**£26,256,505**

MSOA and age-specific population projections used for 2025 population estimate.

NORTH LONDON PARTNERS
in health and care

NHS

Anchor areas for development

Environment	Estates	Procurement	Civic behaviour	Employment
Plans and actions which support a greener public sector Commitment and progress to zero carbon	Opening facilities to the community Social impact of new developments	Increasing % of spend with local suppliers & SMEs Enabling local businesses & VCS to bid for NHS contracts Social value in practices	Leadership and partnership with other anchor organisations Offering volunteering for staff and communities	Pathways into careers in health Progression for priority groups Training & apprenticeship schemes

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