NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 27 November 2020, 10:00 a.m.
Remote meeting – 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 **(Vice Chair)** (Enfield Council), Pippa Connor **(Chair)** and *Vacancy* (Haringey Council), Tricia Clarke **(Vice Chair)** and Osh Gantly (Islington Council).

Support Officers: Anita Vukomanovic, Andy Ellis, Robert Mack, Pete Moore, and Vinothan Sangarapillai.

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

Members of the Committee are invited to identify any disclosable pecuniary or prejudicial interests relevant to items on the agenda. A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which a 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 their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

5. MINUTES (PAGES 1 - 14)

To confirm and sign the minutes of the North Central London Joint Health Overview and Scrutiny Committee meeting on 25 September 2020 as a correct record.

6. PRIMARY CARE DURING THE COVID-19 PANDEMIC (PAGES 15 - 28)

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

7. SECONDARY CARE DURING THE COVID-19 PANDEMIC (PAGES 29 - 46)

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

8. POST-COVID SYNDROME SERVICE (PAGES 47 - 54)

This paper provides a summary of the Post-Covid Syndrome Clinic at University College London Hospital (UCLH).

9. WRITTEN RESPONSE TO DEPUTATION - TEMPORARY SERVICE CHANGES MADE IN RESPONSE TO COVID-19 (PAGES 55 - 58)

This paper provides a written response to the deputation made at the North Central London Joint Health Overview and Scrutiny Committee meeting on 25 September 2020 on temporary service changes made in response to Covid-19.

10. WORK PROGRAMME (PAGES 59 - 64)

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

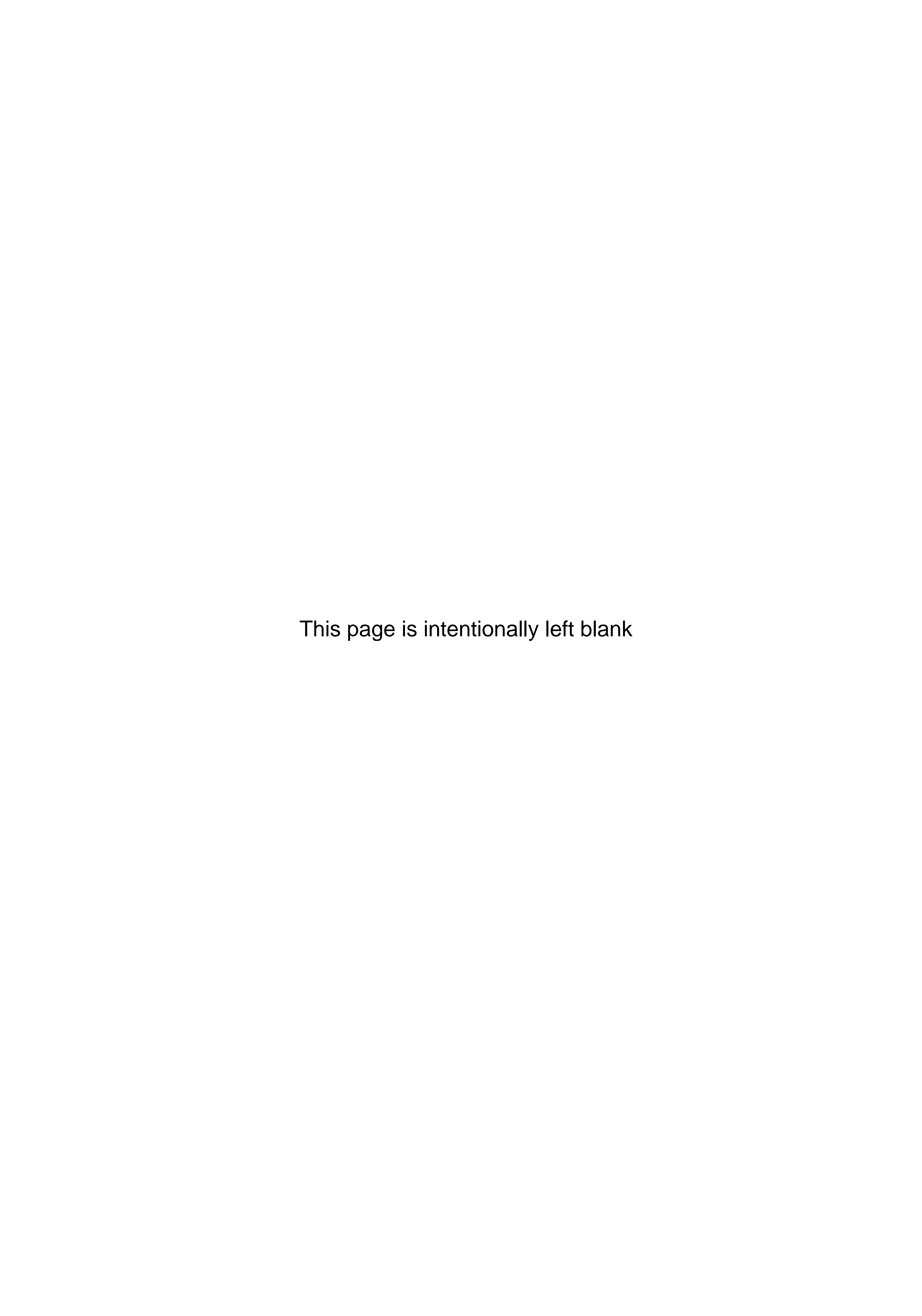
11. NEW ITEMS OF URGENT BUSINESS

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

12. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

29 January 2021
26 March 2021



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Agenda Item 5

THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 25TH SEPTEMBER, 2020** at 10.00 am in Remote Meeting via Microsoft Teams. The meeting can be watched live via https://councilmeetings.camden.gov.uk.

MEMBERS OF THE COMMITTEE PRESENT

Councillors Pippa Connor (Chair), Tricia Clarke (Vice-Chair), Edward Smith (Vice-Chair), Alison Cornelius, Linda Freedman, Christine Hamilton, Larraine Revah and Jonathan Simpson

MEMBERS OF THE COMMITTEE ABSENT

Councillors Lucia das Neves, Osh Gantly and Paul Tomlinson

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. ELECTION OF CHAIR

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

RESOLVED –

THAT Councillor Pippa Connor be elected as Chair of the North Central London Joint Health Overview and Scrutiny Committee (NCL JHOSC) for the municipal year 2020 - 21.

2. ELECTION OF VICE-CHAIRS

Councillors Tricia Clarke and Edward Smith were nominated as Vice-Chairs of the Committee.

The Chair welcomed all newly appointed members to the Committee.

RESOLVED –

THAT Councillor Tricia Clarke and Councillor Edward Smith be elected as Vice-Chairs of JHOSC for the municipal year 2020-21.

3. GUIDANCE ON REMOTE MEETINGS HELD DURING THE CORONAVIRUS NATIONAL EMERGENCY

The Guidance was noted.

4. TERMS OF REFERENCE

The Terms of Reference were noted.

5. APOLOGIES

Apologies were received from Councillor Lucia das Neves (LB Haringey) and Councillor Paul Tomlinson (LB Camden). Councillor Tomlinson was substituted by Councillor Jonathan Simpson.

6. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

Councillor Cornelius declared a Non-Pecuniary interest in relation to item 11 (Update on the Impact of Covid-19 on Care Homes) that she was a Council appointed member of Eleanor Palmer Trust. It was a voluntary role, she was the Vice-Chair of the Trust which was located in High Barnet.

Councillor Connor declared that she was a member of the Royal College of Nursing (RCN) and that her sister worked as a GP in Tottenham.

7. ANNOUNCEMENTS

Webcasting

The Chair announced that the meeting was being broadcast live to the internet and would be capable of repeated viewing and copies of the recording could be made available to those that requested them. Those participating in the meeting were deemed to be consenting to being recorded and broadcast.

8. DEPUTATIONS

The Chair announced that she had accepted a deputation request from North Central London NHS Watch. The deputation related to changes made to NHS services under emergency powers due to the pandemic without consultation with

local authorities or residents. The deputation statement had been included in the supplementary agenda.

Andrew Morton and Brenda Allen presented the deputation to the Committee.

The main issues they highlighted were that

- Prior to Covid-19 the NHS was already struggling with waiting lists and reorganisation, during the pandemic they expected reorganisation to slow but this was not the case, rather, they were of the view that care to patients slowed and reorganisation gathered pace with less scrutiny and less consultation than before.

- The document entitled '*Journey to a New Health and Care System'* outlined a highly centralised, streamlined and virtual approach to health and care. This presented a major and rapid change to London's NHS indicating that it also set out the intention to keep many of the changes in place on a permanent basis with very little mention of consultation with local authorities.

- Practical examples of changes made on the ground without consultation included, Enfield Older Peoples Assessment Unit moved from Chase Farm Hospital Enfield to Barnet with access to Barnet being more difficult particularly for older people, the Electronic Consult Scheme and Primary Care accessing GP Services, this was a real problem for many patients. The changes nationally to accessing emergency care via the 111 service with 111 being the gateway to A&E, the Test Track and Trace System by passed many local public health services, Paediatric A&E being moved from UCLH, Royal Free to Whittington.

- Were aware that things had to change during the pandemic but they felt that there could have been more consultation as this would have led to better services for patients and residents.

They requested that JHOSC

- Require North London Partners to set out the changes that had been made in services under the emergency powers and state whether there were plans for keeping the changes into the future.

- For those changes that were proposed as permanent, request they were halted until local councils had been consulted.
- Set out how they would meet their statutory obligations for public consultation on Primary Care
- Since many of the current changes would have serious implications for health inequalities (e.g. digital by default), ask to see a detailed health inequality impact assessment of their proposals
- Require full public consultation on any plans to take over any aspect of social care from Local Authorities
- Ask the ICS to set out the steps it would take to ensure that the Government's privatised Test, Track and Isolate system could be better integrated with both local NHS testing arrangements and local public and environmental health services' expertise and capacity for track and trace.

In response to the deputation and members questions, Rob Hurd (System Lead, North Central London Integrated Care Systems) made the following comments:

- It was acknowledged that the unprecedented impact of Covid-19 had additional pressures put on the health services.
- Frontline staff were doing an enormous amount of work to keep things on track throughout this period.
- All changes were temporary as the NHS was responding to a national major incident, unknown disease pandemic and responding as a health care system as the situation unfolded on a daily, weekly basis.
- As indicated all changes were made on a temporary basis there was an acknowledgement of the legal obligation to consult before permanent change occurred, however under the emergency powers put in place to address the pandemic, clinical led advice was what was leading the response on a day to day and week to week basis in the best interest of residents and the best way the service could respond under the circumstances.
- There were a number of changes that had been made, NHS Partners were happy to share these changes with the Committee. However because of the wide nature of the changes the NHS Partners would have to provide a follow up of this further information of these changes in writing.

ACTION BY: System Lead NCL Integrated Care Systems

- The document shared with the Committee on 31st July 2020 highlighted the various temporary changes brought in from March 2020 to July 2020 at that point in time.
- Since July, Barnet emergency Paediatric Department had re-opened. Planning has been ongoing for the second surge – this included access to emergency services in the southern part of the North London Boroughs, providing access for children at Royal Free UCLH and Whittington by

consolidating staffing throughout winter as it was anticipated that this would be an extremely pressurised period.

- Nobody could tell when this would be over as the NHS was having to plan for a range of scenerios, which in addition to the already challenging usual previous winter pressures, the addition of the Covid -19 surges involved having to plan for temporary changes to ensure the service was as resilient and open for business as much as possible.
- The concerns were rightly raised given the impact of both Covid-19 and the knock on impact of other services restructured to cope with that.
- In relation to paediatric issue of children's A&E the likely process was that emergency access ambulances were likely to be diverted there from next week for children requiring emergency services over the winter.
- There would be more resilience over the winter for Adult Services. The Older People's Assessment unit at Chase Farm was an example of changes that had to be made temporarily. This was under review to bring back in the weeks ahead. There was the need for clinical advise to work out the balance of risks as set up and would be considered on a case by case basis.
- In terms of planned elective urgent care, there had been extreme pressures on the waiting list because the NHS was unable to keep the service running in May. There was the intention to keep those services going throughout the winter so that this would not lead to levels of cancellation that the service experienced during the first phase of the pandemic
- Prevent mechanisms were in place to ensure safe care of patients.
- Best efforts had been made to communicate with stakeholders about the temporary changes, NHS Partners would need to continue to work with JHOSC and local communities to keep them informed of the changes.
- A formal commitment was made to commission an Equality Impact Assessment around access via digital mechanism into GPs and other health care settings. NHS partners would be looking to learn and reach out how to mitigate the risk.

ACTION BY: System Lead NCL Integrated Care Systems

- Test and Trace had been set up nationally. A lot of work had been done locally to enhance local arrangements led by borough Directors of Public Health (DPH) and Council Health Protection Teams and linking in with the national testing systems. The DPH was involved and looking at what this meant for each borough.
- There had been work on-going to support testing since April. This included LA's providing support for testing in Care Homes and other care settings considered to be at risk and not eligible to access the national testing portal.
- There were over 150 Care Homes and Supported Living Schemes in the 5 NCL boroughs. Pillar 1 capacity tests had been set up for patients and health and care workers with over 6,000 swab tests being done in care homes. This was supplementary to the national testing regime.

- In terms of digital appointments the GP services should be open for the delivery of face to face care. Also there was the need to develop a range of tools for GP's so that they were able to provide face to face care for patients.
- In terms of A&E access. Patients contacting NHS 111 already were able to be booked in for appointments with GP local treatment centres and could be advised where they would need to go for appointments.
- If patients continued to make their way to urgent or emergency care units they would be treated or directed to an appropriate service.
- There was not a closure of walk-in services. In terms of the 111 service more health professionals had been employed by NHS 111 and there was an attempt to promote the benefits of using the 111 service.

Answering further questions from members, Rob Hurd (Systems Lead NCL Integrated Care Systems) Richard Dale, (Director of Strategic Programmes NCL Integrated Care System) and Richard Elphick (Programme Lead STP Camden) commented

- Initially during the first pandemic surge there had been issues with the NHS 111 service, there had however been massive investment with an aim to improving the service to deliver the intended result of a safer and better service.
- Clinical prioritisation applied to whoever turned up at A&E, patients would still be seen, it was still open to ambulances, priority would however be given to more urgent cases.
- In terms of track and trace in Islington there was work on going between NHS Partners and DPH Islington to establish a mobile testing unit in addition to a walk up unit. The details of this would be provided to Committee members.

ACTION BY: Director of Strategic Programmes NCL Integrated Care System

- In terms of GPs providing face to face appointments, there was the need to provide communication to confirm routes patients need to use to get face to face appointments.
- 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.

ACTION BY: System Lead NCL Integrated Care Systems

- If there was an intention to turn the temporary changes into permanent changes any consultation would have to make due reference to local authorities.

The deputees asked to comment on the responses from NHS partners, noted that they were heartened that the Committee had taken their deputation seriously, shared their concerns and would take the issues up with Pan London JHOSC. They also noted however that though the changes were temporary they could only be changed

back if NHS England agreed. Although temporary changes had been focussed on there were some permanent changes which had taken place.

The Chair commented that the NHS Partners had agreed to provide a list of all the temporary service changes made in response to the national emergency. She also noted that a lot of the changes were national and might be more appropriate to be considered in the PAN London JHOSC arena.

Further proposed changes related to GPs and digital access and how residents had access to hospitals and GPs' services, there was the need for consultation further down the line to see how those services would be adapted. These issues were also of significance to NCL. There was a need to revisit these issues to see how services had changed and scrutinise these changes to ensure residents' needs were being met. The Committee would look at this with a view to how these issues could be taken forward. There had been a huge amount of service change locally, this would be discussed in the work programme to determine how best to take this forward.

RESOLVED –

THAT the Committee

(i) Discuss in the Work Programme how these issues would be taken forward.

9. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of urgent business.

10. MINUTES

RESOLVED –

THAT the minutes of the meeting held on 31st July 2020 be approved as an accurate record.

11. NORTH CENTRAL LONDON UPDATE ON THE IMPACT OF COVID-19 ON CARE HOMES

Consideration was given to a report from North London Partners in Health and Care.

Responding to questions from members Dawn Wakeling (Executive Director Adults and Health Barnet), Ruth Donaldson (Lead Director on Care Homes CCG), Richard Dale, (Director of Strategic Programmes NCL Strategic Care Systems), Richard Elphick (Programme Lead (STP) Camden) and Kay Matthews (Executive Director of Quality NCL CCG) gave the following responses:

In relation to the recent Government Winter Plan document it:

- Was welcomed because it gave additional funding to Care Homes with an increase in the Infection Control Fund by half a billion pounds, made provision for the role of Chief Nursing Officer for Social Care (which had been challenging long term to recruit qualified nursing officers nationally in Nursing Homes). Asked each local authority to prepare their own Winter Plan for Adult social Care and signalled that work would be done on the sustainability of the care market.
- Offered free Personal Protective Equipment (PPE) till the end of March 2021for all registered care providers.
- Reinforced the importance of the infection control measures as a system used to support care providers and Care Homes.
- Also talked about the continuing support in place and the excellent system working. NCL was the only part of London that had carried out a thorough after action review with Care providers which had been picked up as an example of good practice. Officers were really keen for the next wave to have this strong partnership working as a core part of the system and important part of the ICS system.

In relation to the testing of staff and patients for Covid-19 and discharge from hospitals to care homes:

- In a care home the national testing regime was really important and required that care workers in care homes were tested weekly particularly in Care Homes for people aged over 65.
- It was also important that there was effective prevention and infection control at all times which included following correct procedures, adhering to social distancing, availability of PPE and proper training in these procedures, ensuring all those engaged in the care home sector followed the very best practice in infection and prevention control.
- In the first wave of the pandemic there would have been some discharge of patients who had been in hospital for Covid-19 to Care Homes in accordance with the national guidance. This was because it was important to keep hospital capacity for people who were critically ill.
- NCL care providers and Councils adopted a range of arrangements to keep this to an absolute minimum, an example being Barnet whose policy was that patients would not be discharged from hospital to care homes unless 8 days

had elapsed from the first day the patient had experienced symptoms and no further evidence of symptoms of the virus occurred.

- There was a new Covid discharge pathways and Community Bed Surge Plan- which was a staged plan where if demand increased and the virus started to rise again, there was a plan to bring 85 community health beds across NCL. These were system beds were anybody admitted across NCL could go too.
- The protocol was nobody would be admitted to care homes direct from hospital, rather patients would go to the community health beds and tested to ensure they were non- infectious before they were moved into care homes, which was one of the recommendations from the After Action Review.
- The learning from the After Action Review was that it was the combination of testing and infection control which had made the difference and the outbreaks had been controlled to a much better extent than the situation in March and April earlier in the year.
- The national offer was rolling out with weekly symptomatic testing for care homes this had been slightly delayed over the summer because of national procurement issues but was now happening.
- There was an additional offer provided through the NHS laboratories locally which was a separate location from the care homes where symptomatic staff could get tested.
- Alongside that, NHS capacity was also being used to test care settings which were not eligible for the national offer, which included Supported Living, Extra Care and Learning Disability which related to the 6,000 tests referred to earlier during the discussion on the deputation.
- The press had recently reported on issues with accessing the national drive-through, there was active work on-going with the Directors of Public Health (DPH) to determine how these issues could be resolved.
- The turn-around time in getting results of the testing was being actively monitored with issues escalated repeatedly. Assurances had been provided that this would improve. There were fortnightly meetings with Directors of Public Health (DPH) to check the amount of capacity required and limited support could be provided by the NHS.
- This would be monitored and the fortnightly meetings with DPH would change if numbers and delays continued to rise. The NHS would step in if required.
- In relation to test results for Care Home staff not being returned in one batch at the same time, this was useful information which would be fedback to the test centres as it was important that they were fit for purpose.
- The NHS core step down beds were 200 across the 5 boroughs. The 85 Community Health Beds were located at Chase Farm, St Pancras and Edgware and were additional to support to assist with winter pressures. The

details of these could be circulated to the Committee when they become available.

ACTION BY: Programme Lead STP Camden

- Funding for the beds was provided by the NHS.
- A purpose of the Infection Control Fund was to use to pay wages of staff that were self isolating. In Barnet the majority of the money had been used for this purpose.
- A view on how this was working in individual boroughs could be obtained through the capacity data tracker.
- The Infection Control Fund was continuing, it had not stopped although funding was not as much as it had been before.

In relation to responsibility for monitoring Care Homes and Supported Living Accommodation in terms of quality, funding and safeguarding:

- In terms of the difference between and monitoring of care homes, the Care Quality Commission (CQC) was the regulator.
- 80% of care Homes in NCL were rated as good, 16% required further improvement.
- Local Authorities in general had a policy of placing residents in homes only rated either as good or outstanding.
- The CQC framework in relation to care homes focussed on criteria which were important to those areas where care homes were situated such as staffing, leadership, safeguarding, and experiences of people who lived in the homes so there would be diversity.
- In terms of money each local authority was the ultimate decision maker on how it funded social care and commissioned approach to care homes as was the CCG within the legal framework of the Care Act.
- The 5 Councils in NCL had worked together for a number of years to develop a consistent approach that involved an evidenced based and ethical approach to commissioning. This also included a shared approach to understanding quality.
- All Councils had some kind of function that supported and promoted quality in care settings. Barnet for example had a Care Quality Team with 14 permanent members of staff which supported this function. The CCG also does the same in relation to supporting quality in care settings including providing training.
- Supported Living does have CQC registration but this depended on whether they provided personal care or not.

- Supported Living was about a home and independent living for people with the ethos being for it to be as much like a home but when it gets into CQC registration it would turn into a different thing.
- From a local authority perspective when quality work was carried out this was done with Supported Living providers as well as Care Home providers.
- In terms of the track and trace application all Councils were promoting this as a policy and there was also a national campaign but nothing specifically was targeted relating to care homes.
- A data analysis of the deaths in care homes across London was contained in the After Action Review which had been included in the agenda.
- There was no statistical difference in the level of deaths due to Covid-19 across the 5 NCL boroughs or across London.
- An analysis was also carried out on whether the CQC rating made a difference to the level of deaths, this was found not to be a strong factor.
- In terms of whether Covid positive people accepted into care homes from hospitals bumped up the death rates, there was a range of factors that could cause Covid to come into Care homes and hospitals and there was not a consistent method at that particular time of testing across all care homes and hospitals so it would be difficult to tell.
- The use of step down beds was the one additional thing introduced to reduce the risk of the infection rate getting into care homes.
- The excess deaths referred to in the papers may have been Covid-related but there was not that ability at the time to determine definitely that the corona virus was the main cause of death.

In relation to visiting and extra enhanced care:

- Guidance came out over the summer giving responsibility to DPH to assess and make recommendations around visiting Care Homes. Each Council had an approach that advises and recommends what was safe for visiting, for example Visiting Policies which were communicated to providers regularly and anytime there was a recommendation for a change.
- The Winter Plan had indicated that during visits to care homes social distancing should be maintained which was a sensitive issue.
- Care providers had been innovative coming up with different ways they could keep in touch for example people had made use of devices for video calls.
- Providers had been advised to be proportionate, compassionate and sensible when it came to end of life situations. There needed to be a balance between the need to maintain friendships, family relationships, the need to connect and the need to keep people safe and reduce infection.

- Healthwatch had been doing some work around what the alternatives were for example video updates of members of their family's interactions even when they were not able to visit. Going forward more work would be done with Healthwatch.

Answering further questions from Committee members, it was noted that

- The bill for residents in care homes was covered by the Ordinary residents Bill which was part of the care Act.
- If a resident was placed in care by another local authority, the placing local authority would be responsible for funding for the duration of their time in the registered care home.
- If the placement was in Supported Living, the receiving borough would be responsible for taking on the care and support costs.
- If the individual placed themselves without interaction, the individual would be responsible for their own fees, if the person ran out of money, the borough wherever the person was would take on the responsibility.
- In terms of financial viability of care homes there was collaboration among Councils to take an evidence and ethical based approach to how fees were paid to care home fees. Councils shared the fees and worked with care providers around cost modelling taking into account differences and tried to agree a fair price that worked for both parties. Where savings had been made they had been about surplus and not related to staffing.
- There had also been work to understand the differences, specialities and styles of the different care homes. Making sure the right residents were allocated to the right homes that provided the best care possible.
- There was the need to support sustainability of care homes and work was on going with CCG to carry out cost modelling.
- A market modelling strategy was being developed to consider and look at the financial viability of care homes.
- Local authority responsibility was to make sure there was continuity of care for people affected, CQC responsibility was about overseeing care continuity but also about what happened to that home. There was going to be some work on this, required through the Winter Plan.
- In relation to safeguarding the statutory duty regarding safeguarding had not changed despite the pandemic.
- In carrying out business continuity plans, safeguarding leads were consulted to ensure risks were mitigated and the learning picked up from this was to ensure that going forward when considering any change to service, they were involved in the process from a very early stage.

- There was also a request that when Care Home Managers were being consulted on service issues chairs of Care Home Panels should be included in the consultation.
- At the beginning of the Covid outbreak PPE produced in the UK was 3% this had now increased to 70%

The Committee thanked all the officers for attending the meeting virtually and the information provided.

RESOLVED –

THAT the Committee note the report.

12. BARNET, ENFIELD, HARINGEY (BEH) SUB GROUP MINUTES

RESOLVED –

THAT the Sub Group minutes of the BEH meeting held on 25th June 2020 be ratified as an accurate record.

13. WORK PROGRAMME

Consideration was given to the work programme and action tracker.

Members discussed the Work Programme noting that the deputation raised a number of issues and whether these should be referred to Pan London JHOSC to address the wider issues. It was felt that the service changes had a huge impact on residents and NCL JHOSC should be provided with a further update. There should also be consideration on how these issues should be co-ordinated with Pan London JHOSC.

For the next NCL JHOSC meeting in November there should be 2 items on the agenda and agenda planning meeting would be arranged with the NHS Partners.

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 noting that this would be very useful in assisting members.
ACTION BY: ALL REPORT AUTHORS

Members agreed that items they wanted to consider at the November meeting were:

- Overview of Service Changes (Paediatrics, A&E, NHS111, Enhanced Care) and what that means for residents – including the consultation and

communication aspect and how services were going to continue during Covid-19.

- Including the disproportionate impact of the pandemic on BAME communities

RESOLVED –

THAT

(i) the work programme be amended, as detailed above; and
(ii) Future reports for the Committee should include one page of A4 summary at the front of the report of the main issues and main outcomes.

14. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

None.

The meeting ended at 1.25 pm.

CHAIR

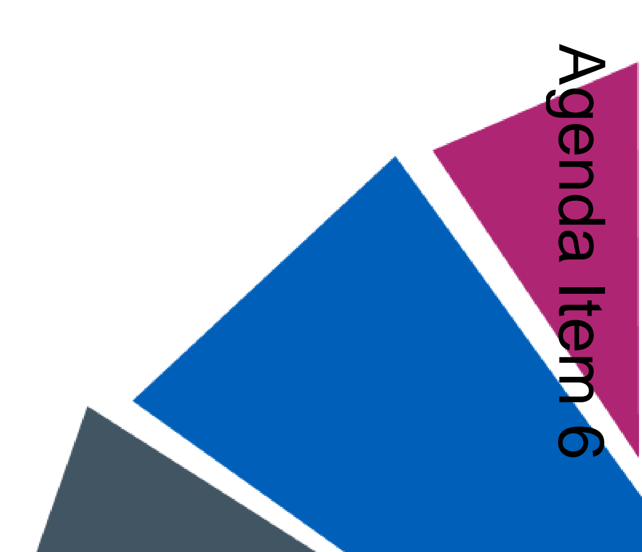
Contact Officer: **Sola Odusina**
Telephone No: **020 7974 6884**
E-Mail: **sola.odusina@camden.gov.uk**

MINUTES END

Primary Care

JHOSC paper – 27 November 2020

Agenda Item 6



Summary and contents

This paper includes an update to JHOSC on primary care in NCL during the Covid-19 pandemic, including details of what impact the pandemic has had on primary care and the measures we have put in place to respond to key issues. Key factors have been maintaining and encouraging access to primary care, learning from the first wave of Covid, the need to tackle health inequalities and improved support for care homes. The second section of the paper focuses more on primary care support for local people with long term conditions, and at the meeting Dr Katie Coleman, a local GP, will talk through in more detail what this means for patients with diabetes.

Contents

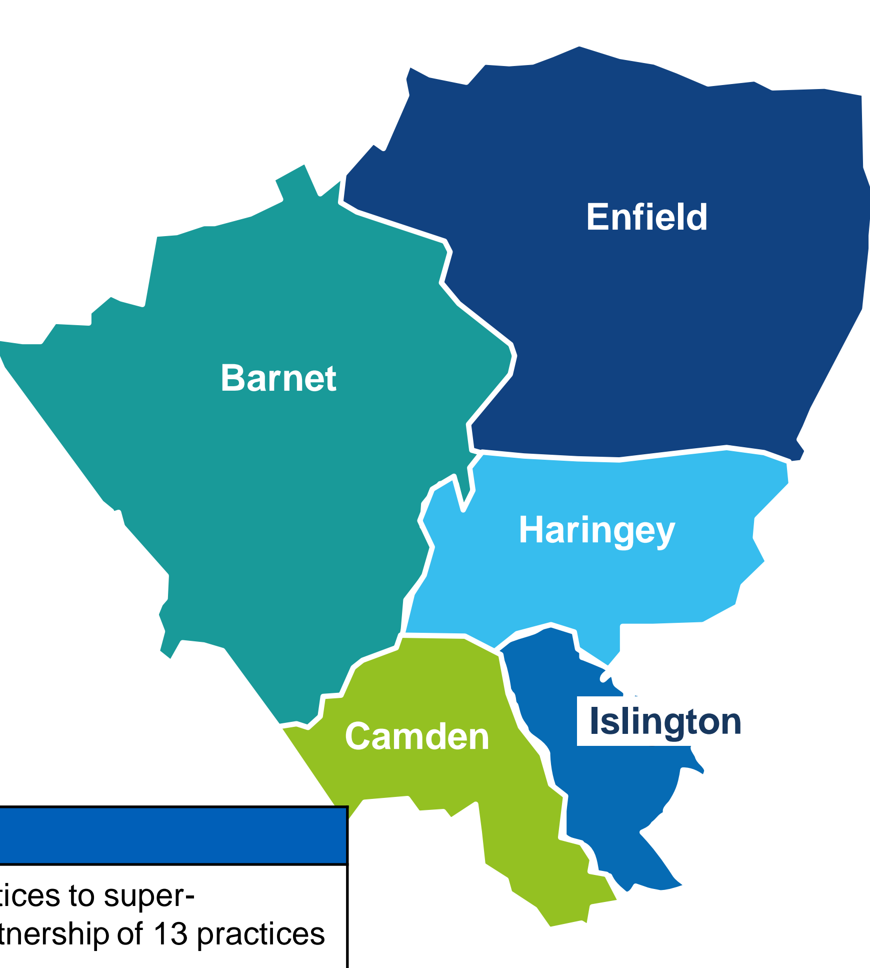
- Primary care in NCL
- Summary of Covid response
- Learning from Wave 1
- Impact of Covid on GP appointments
- Patient access to general practice
- Provision for care homes
- Health inequalities
- Caring for patients with long term conditions
- Post-Covid Syndrome pathways

NHS

Primary care in NCL

Barnet
Population: 425,395
Practices: 52
Clinical Lead: Amit Shah
Primary Care Networks: 7
Clinical Directors: 10
Federation: Barnet Federated GPs

Camden
Population: 303,267
Practices: 33
Clinical Lead: Dee Hora
Primary Care Networks: 7
Clinical Directors: 8
Federations: Haverstock Healthcare & Camden Health Evolution (CHE)



Enfield
Population: 425,395
Practices: 47
Clinical Lead: Fahim Chowdhury
Primary Care Networks: 4
Clinical Directors: 8
Federation: Enfield GP Federation

Haringey
Population: 298,418
Practices: 36
Clinical Lead: Gino Amato
Primary Care Networks: 8
Clinical Directors: 8
Federation: Federated 4 Health

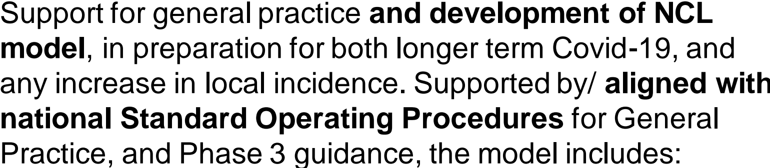
Islington
Population: 257,135
Practices: 32
Clinical Lead: Imogen Bloor
Primary Care Networks: 4
Clinical Directors: 5
Federation: Islington GP Federation

Practices & Primary Care Networks

- 200 practices ranging from single-handed practices to super-partnerships e.g. Medicus (Enfield) - super-partnership of 13 practices
- Strong history of practices working together
- 17/18 NCL developed care and health integrated networks; 19/20 practices incentivised (NHSE) to formally form PCNs (30 in NCL)

General Practice: Summary of NCL Covid-19 Response

Maintaining access to services



Support for general practice **and development of NCL model**, in preparation for both longer term Covid-19, and any increase in local incidence. Supported by/ **aligned with national Standard Operating Procedures** for General Practice, and Phase 3 guidance, the model includes:

- **Total Triage model –** following National GP SOP with all practices. Face to face appointments for patients who need them.
- **Roll out of online consultations** (99% of NCL practices); focus on digital inclusion as part of NCL GP Recovery programme
- **Maintenance of screening and immunisations** (including flu) and scaling of NCL referral support service
- **Patients to be managed remotely** as far as safely possible (from total triage to remote management with sats probes).

Model supported by access to staff testing and patient testing

Supporting General Practice

Range of tools developed to support general practice in delivering care, based on principle that all patients seen in general practice will fall into high or medium risk Covid-19 pathways:

- Provision of **PPE**
- **Completion of staff demographic risk assessments** (practice sit reps for workforce related pressures)
- Roll out of **experiential infection prevention and control training (IPC)** to all NCL GP practices, and revised practice IPC self-assessment tool
- Confirmed **process for managing outbreaks in primary care**. Development of Covid-19-specific advice and guidance for GPs/ helplines for whole patient pathway from acute phase through to Long Covid, to assist primary care with complex cases
- **Maintenance of key communications** links with practices – weekly all practice webinars, GP bulletins, delivery of specialist training and education, and supporting communications for practices e.g. remote assessment e.g. sats probes, management of febrile children, end of life care, in collaboration with NCL Training Hubs

NCL Covid Clinical Model

Face to face appointments where needed. **GPs follow appropriate and rigorous IPC procedures** to see all patients, including on home visits, whether patient has Covid-19 symptoms or not. Where a GP judges that their patient needs to be seen face to face, they will evaluate whether the patient requires assessment

- By specialist services - at hospital
- In the practice
- On a home visit

Rapid mobilisation of Covid-19 symptom services (April; initially site-based for confirmed/ suspected Covid-19 patients- CAG approved).

NCL's six GP federations **now delivering at-scale Acute Covid-19 service** with senior clinical triage, supported by remote assessment and monitoring (sats probes), and ability for GPs to refer for home visit, where own GP unable to see patients. Development of **agreed approach for scaling Covid-19-symptom services** up (or down) based on local incidence/ pressures

At-scale service developed on basis of flexibility, recognising possible requirement to scale up physical site-based services.

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General Practice: Learning from Wave One

GP recovery

- Following the first wave of the pandemic, a GP recovery group for primary care was established.
- The group was tasked with drawing out the learning from the first wave of the outbreak.
- This identified three key areas of focus – ensuring patient access and patient experience, expanding multi-disciplinary working, supporting general practice and workforce resilience.
- These priorities reflect much of what was already a focus of the Strategy for General Practice (refreshed in 2018).

NCL GP VISION pre-COVID-19

- Resilient, sustainable and thriving general practice
- High quality, equitable and person-centred safe care
- Proactive, accessible and coordinated care
- Integrated services that respond to the needs of the patient and the population

Requirements during COVID-19

- Staff and patient safety
- Separation of patients with COVID/ COVID symptoms
- Home visiting
- Shielded patients
- Total Triage
- Remote and video consultations
- Testing for staff and patients

Emerging model

- Patient access and patient experience
- Multi-disciplinary working at PCN level
- Workforce and resilience

Impact of Covid-19 on GP appointments

The reduction in GP appointments during April and May accruing from the Covid pandemic has reversed with appointment levels returning to pre-Covid levels, as practices reinstated planned care and chronic disease management work in line with national guidance, and people become more willing to make appointments. Whist appointment levels fell in April and May practices reported that this was offset by the acuity and complexity of patients being seen.

NCL CCG: GP appointments by month since April 2019

Month	Appointments
Apr-19	446,604
May-19	469,685
Jun-19	444,341
Jul-19	508,393
Aug-19	428,068
Sep-19	488,553
Oct-19	576,515
Nov-19	520,428
Dec-19	453,735
Jan-20	524,785
Feb-20	471,533
Mar-20	470,446
Apr-20	324,658
May-20	348,230
Jun-20	435,984
Jul-20	478,466
Aug-20	433,904
Sep-20	636,407
Oct-20	569,046

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Patient access to general practice

- NCL **GP practices have remained open throughout the covid-19 pandemic**. The GP model of access has been shaped by national guidance - practices must operate a 'total triage' model i.e. patients triaged by telephone, video or online consultation and managed remotely wherever safely possible. Face to face appointments continue to be offered for those who need them.
- NCL Healthwatch data highlighted that the majority of residents were able to find required support and information during the first wave. **Many local people reported a positive experience of using digital health services***. However digital services are difficult for people who are not IT savvy, for whom English is not their first language or who have additional access needs e.g. learning disability or hearing loss.
- Further work is required to **enable digital inclusion**. All practices were asked to proactively contact vulnerable patients throughout the summer, and a pilot project is underway in Haringey which focuses on digital inclusion.
- Childhood immunisations, 8 week baby health checks and other essential GP work has continued throughout. National cancer screening programmes were restarted over the summer. All NCL GP practices have resumed cervical and other cancer screening activities. The NCL cancer alliance is running webinars to support primary care with updates on national cancer guidance and local pathway changes.

*Healthwatches in Camden, Enfield, Haringey and Islington surveyed patients in June 2020.

Encouraging access to general practice

- iPlato message sent to all NCL residents over 16 years plus registered with a GP practice:
  Don't ignore new symptoms, your GP is here during lockdown to help and can offer telephone, video consultations and at the practice if required**.**

- NCL CCG social media, Accessing services - GP practices and importance of attending diagnostic appointments, Antenatal/Childhood Vaccinations, getting possible cancer symptoms checked

- Healthwatch Q&A in Camden with questions from public about general practice recovery and how we are dealing with covid-19.

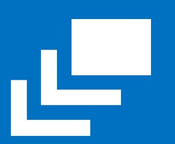
- Camden Council Covid update in Camden New Journal. - If you're worried about your mental or physical health, need to speak to your GP, or have a scheduled appointment coming up, please know that local health services are still here for you.

- Forthcoming event with Healthwatch Enfield. Q&A with clinicians and the public on the impact of covid-19 and what services are open

- Self-Care Week event in Barnet – covers NHS is open and encouraging attendance at routine and hospital appointments, including vaccination and screening appointments

- Barnet First Magazine – Article reminding Barnet residents that the NHS is open and encouraging attendance at routine and hospital appointments, including vaccination and screening appointments

Responsive primary care – provision for care homes



Implementing national guidance on primary care support to care homes – clinical lead for CQC registered care homes. Provided enhanced clinical support to all care homes. Included development of new Barnet locally commissioned service and care homes clinical support team to deliver multi-disciplinary team reviews. Significant increase in primary input to care homes; many GPs undertaking daily virtual reviews. System working (including LAs, CCG, GP federations, PCNs and community providers) required to provide national service specification for *Enhanced Health in Care Homes* since October 2020.

Co-created NCL tiered model of clinical support to care homes – outlines basic, good and excellent clinical support to care homes, based on local knowledge and experience and national recommendations to develop the standard of care for NCL. Model focuses on personalised care plans and multi-disciplinary team working.

Gap analysis: clinical support to care homes – response to the Enhanced Health in Care Homes mobilisation. Collated quantitative and qualitative data identifying gaps in clinical support to care homes against guidance, and areas where significant clinical support is already provided.

Establishing virtual consultations – digital maturity assessment to establish additional requirements to deliver virtual consultations; how the Facebook Portals can be used to support. Equipment being procured for care homes. Development of training for care home staff and governance for care homes to undertake observations. Significant increase in care homes who have access to NHS Mail (now 190/225 or 84% at time of writing) – which enables safer information sharing. 300 Facebook Portals disseminated to NCL care homes, enabling residents to maintain family contact.

Implementation of remote care home support/supervision – Significant challenge to support care homes workforce. NCL training hubs developed a remote care home support/supervision offer to all care home workers from care home staff to GP clinical leads. Collaboration with HEE, NCL clinicians supported to develop facilitation skills, offer regular supervision sessions, and identify ways to ensure succession planning to ensure a legacy is in place.

Pharmacy and medication–medicines management teams developed policies on medication re-use in care homes, and stocking end of life medications in nursing homes to facilitate supplies and timely administration of medications. Pharmacy Cell and Care Homes Task Force supported implementation of structured medication reviews into care homes.

NCL Webinars for primary care - set up a series of fortnightly webinars for NCL GPs around Covid-19 and End of life care. Each webinar co-hosted by a borough GP and a consultant from one of the community palliative care teams. Subjects included updated guidance, advance care planning, death verification, PPE and supporting care homes. These have been transformed into monthly training and information sessions.

Community Palliative Care teams - Community services moved to remote patient support; phone via video consultation. Almost all Covid End of Life Care patients died in hospital so community teams focused on non-Covid patients at home. All community service teams increased weekend capacity during the Covid peak, available for phone advice seven days a week. Also offered virtual ward rounds to all care homes, assistance relating to death verification, supported clinicians and family members that had to do this. Daily meetings with district nurses to fully support patients at home, and that services supported each other.

Reviewing adoption and roll out of pan-London symptom control medicines authorisation and administration records (MAAR) chart

Health inequalities

Outlined below are a few examples of how primary care services are tackling health inequalities.

Flu vaccination campaign

- Higher national vaccination targets for 2020/21 flu campaign due to covid-19 context.
- Also national drive to increase uptake amongst BAME population and other cohorts that are more vulnerable to covid-19.
- NCL GPs have been given additional funding to support targeted approaches to those populations at greater risk of health inequalities.
- NCL communications team have worked with local GPs who speak other languages to translate materials into most frequently spoken languages in NCL.

Enhanced health in care homes

- There has previously been significant variation across NCL in the level of support offered to care home residents by GPs. E.g. Barnet, which has the highest number of care homes in NCL, did not have a borough wide GP service to support care homes.
- During wave one of the pandemic, an NCL steering group with local authority, CCG and GP membership to support rapid mobilisation of support to care homes.
- Since October, primary care networks in NCL are now delivering a national specification for enhanced health in care homes. This includes a regular virtual home round, personalised care and support plans, structured medication reviews and hydration and nutrition support.

Digital inequalities pilot project – Haringey

- The CCG and Healthwatch are setting up a pilot project in Haringey to train volunteers to take tablets/ smart phones to patients homes, allowing them to access GP, community health, mental health and acute outpatient appointments. This will be particularly targeted to patients who would otherwise be unable to use online services.

Quality Outcomes Framework (QOF)

- The QOF is an annual incentive scheme for general practice by which GPs are funded to deliver targeted activities e.g. annual healthchecks for patients with specific long term conditions such as diabetes, hypertension etc.
- The 2020/21 guidance requires GPs to take a population stratification approach to identify and prioritise the highest risk patients for proactive review – this includes those patients most vulnerable to harm from covid-19 such as patients from BAME groups and those from the 20% most deprived segments of the population.
- In NCL, GPs have been encouraged to use a range of risk stratification tools developed by UCL Partners to ensure that we are proactively targeting those parts of our population that particularly need support.

NHS

Long term conditions and Covid

People with long-term conditions are disproportionately affected by covid-19. It has also exposed a number of health inequalities that we need to address as we respond to the needs of patients with LTCs in primary care.

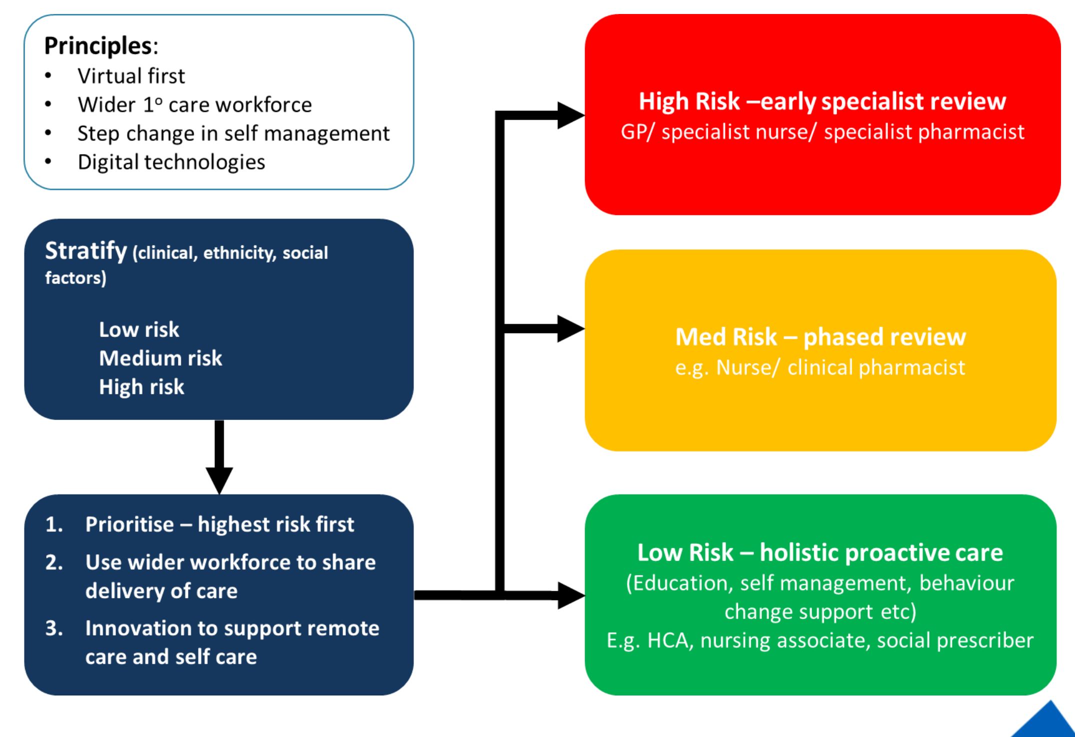
Since the end of wave one of the pandemic, an immediate priority has been supporting routine care, and ensure that primary care and community services, working together, reach out proactively to clinically vulnerable patients, particularly those whose routine care has been delayed or disrupted.

Doing this has required ensuring that primary care multi-disciplinary teams (MDTs) have the tools and skills required to do this work, drawing on expertise across the system, and making best use of enablers like data, risk stratification, workforce and technology.

UCL Partners developed a series of frameworks for local adaptation to support proactive management of long-term conditions in post-COVID primary care.

These frameworks were rolled out across NCL, and UCLP and the NCL training hub ran a series of training webinars for GP practices to support with proactive management of long term conditions within the Covid context.

NCL CCG has also recently launched a new project to support GP practices to increase patient self-management through virtual group consultations and remote blood pressure monitoring.



NCL long term conditions programme

- Covid-19 has shone a light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that Covid-19 has had a disproportionate impact on many who already face disadvantage and discrimination, and has a chronic trajectory that is only now beginning to become apparent. The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. Covid-19 risks further compounding inequalities which had already been widening. We need to mitigate these as far as possible.

- Developing a population health approach to improving outcomes for people with long term conditions will enable us to:
    - understand the needs of people who have long term conditions
    - Understand where inequalities exist
    - design and deliver improved models of care that span traditional service siloes and organisations.

- A whole system approach will enable collaboration across NCL providers and commissioners, learning from others to improve outcomes and to ensure service delivery is as effective and efficient as possible.

- The phase three implementation plan of the NHS response to the Covid-19 pandemic contains priority actions directly relating to the care of people with long term conditions. Over the past few months, a NCL long term conditions steering group has developed a response to Covid-19 in primary care and community settings to support patients with long term conditions who are most at risk from Covid-19. The NCL Local Care Forum has approved the formation of an long term conditions programme which brings together existing work (e.g. Diabetes transformation programme)

- Our proposed model of working has borough CCG, provider and public health teams leading on the development of different areas of long term conditions provision across NCL:
    - Barnet – Respiratory
    - Camden – Chronic Kidney Disease
    - Enfield – Cardio Vascular Disease
    - Haringey – Multi-morbidity
    - Islington - Diabetes

- Using the following model, and a population health approach, we will map existing provision and opportunities for improvement / spreading of best practice. We are testing this approach in Camden, who are currently carrying out this work for Chronic Kidney Disease, in acknowledgement that stage 5 patients have recently been added to the list of people who are clinically extremely vulnerable during the Covid-19 pandemic.

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NCL proposed long term conditions model of care

Agencies involved		Outcomes
Primary care, community provider, VCSE, local authority, care homes, hospices	EoL	Multi-agency actioned advanced care plan
Primary care, hospital, community provider, local authority, care homes	Multi-morbidity / frailty	Multi-agency actioned management plan
Primary care, community provider, hospital, local authority	Uncontrolled	Actioned multi-agency personalised care and support plan to control symptoms
Primary care, community provider, VCSE sector , local authority	Controlled	Actioned personalised care and support plan, monitoring in place
Primary care, community provider, hospital	New diagnoses	Education and support, shared decision making around treatment options
Public health / local authority, primary care, community health champions	Screening	Risk stratification of cohort inc helath inequalities, increased uptake of screening for at risk groups
Public health / local authority, self-care	Prevention	Whole population aware of risk factors, self-care and healthy lifestyle, targeted messaging to reduce health inequalities

This shows the different health and care professionals involved and expectations for the different stages of the patient pathway for people with long term conditions and we'll talk through what this means for patients in more detail at the meeting.

Developing post-Covid Syndrome pathways

- Supporting people to recover from Covid-19 is a priority for the health and care system in North Central London – we are currently mobilising post-Covid syndrome (or Long Covid) pathways to meet the needs of people with symptoms of post-Covid syndrome. This has been designed with input from clinicians from across the health system, including General Practice, mental health services, hospitals and community rehabilitation providers.

- The pathway, approved by North Central London's Clinical Advisory Group, will cover everything from the identification of symptoms of Post-Covid syndrome, the investigations and assessments patients with suspected Post-Covid syndrome will need, through to attendance at post-Covid clinics and referral to specialist rehabilitation for those who need it. Patients' post-Covid mental health and social care needs will also be overseen as part of this pathway.

- Many services needed to deliver the post-Covid pathway already exist in all of our boroughs, and though they may differ in scope and availability, hospitals are already running post-Covid clinics in many areas. The focus is to make sure there will be a consistent offer for all patients in North Central London, so everyone receives the highest quality care based on latest clinical evidence, and that everyone who needs to be seen in a post-Covid clinic is identified and referred to one.

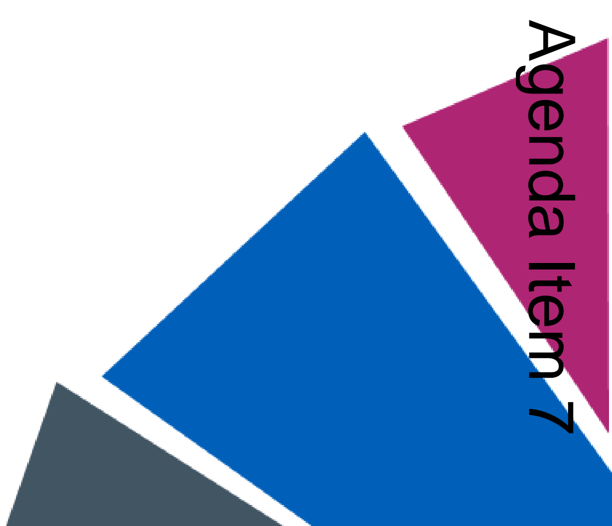
- A post-Covid Syndrome task and finish group formed to mobilise the pathway and report progress updates to NCL's Clinical Advisory Group and to our Local Care Forum. The key areas of work for this group are:
  - Modelling current demand for post-Covid Syndrome services in each borough based on available public health and hospital datasets
  - Rollout of a standard approach to managing post-Covid Syndrome in primary care, advising on assessment, investigations and symptom management
  - Development of a local care post-Covid multi-disciplinary team who will pick up complex cases either through primary care or hospital discharge and oversee their care planning and treatment
  - Engagement with acute providers to design a standardise advice and guidance offer to primary care and community services and to consult on delivery models for post-Covid clinics
  - Work with community providers, led by Central North West London NHS Trust on a safe and standardised rehabilitation offer in all boroughs

- NHS England/ Improvement have recently published national guidance on post-Covid clinics which we are incorporating into our standard operating procedures for the post-Covid Syndrome pathway. We will report our plans for post-Covid clinics to them as a condition of receiving future post-Covid Syndrome funding as a system. They will be monitoring delivery of the services through agreed service outcomes.

- As our understanding of PCS is still rapidly evolving we do not yet have data on expected prevalence within NCL but are working with public health to understand what the potential need for these pathways might be, and to ensure that patient care is provided equitably.

Secondary Care during Covid

JHOSC update – 27 November 2020



Summary and Contents

This paper covers NCL's response to the Covid-19 pandemic in secondary care, including measures we have put in place to ensure that we recover planned care services and reduce waiting times. The second section of the paper is a more detailed look at cancer services, and what we are doing to encourage patients to present with cancer symptoms and how we are supporting recovery of services, including screening services, to prioritise timely diagnosis and treatment for cancer patients. Naser Turabi, Programme Director, NCL Cancer Alliance, will talk through at the meeting what this means for patients, and what may have changed for them during the pandemic.

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A&E attendance figures

NCL providers A&E attendances January 2018 to date

4500
4000
3500
3000
2500
2000
1500
1000
500
0

week 41 07012018, week 44 28012018, week 47 18022018, week 50 11032018, week 53 01042018, week 3 22042018, week 6 13052018, week 9 03062018, week 12 24062018, week 15 15072018, week 18 05082019, week 21 26082018, week 24 16092018, week 27 07102018, week 30 28102018, week 33 18112018, week 36 09122018, week 39 30122018, week 42 20012019, week 45 10022019, week 48 03032019, week 51 24032019, week 2 14042019, week 5 05052019, week 8 26052019, week 11 16062019, week 14 07072019, week 17 28072019, week 20 18082019, week 23 08092019, week 26 29092019, week 29 20102020, week 32 10112020, week 35 01122020, week 38 22122020, week 41 12012020, week 44 02022020, week 47 23022020, week 50 15032020, week 1 05042020, week 4 26042020, week 7 17052020, week 10 07062020, week 13 28062020, week 16 19072020, week 19 09082020, week 22 30082020, week 25 20092020, week 28 11102020

Barnet Hospital
Royal Free Hospital
Whittington Hospital
6 per. Mov. Avg. (Royal Free Hospital)
Linear (Whittington Hospital)
North Middlesex Hospital
UCLH
6 per. Mov. Avg. (North Middlesex Hospital)
6 per. Mov. Avg. (UCLH)

National phase 3 response guidelines

On 31 July 2020 NHS England / Improvement published further guidance on managing Covid within hospitals, with an emphasis on:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between and the summer and winter;
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further covid spikes locally and possibly nationally;
- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

NHS phase 3 response to Covid

On 21 September NCL submitted our Phase III Plan covering the period from September 2020 to March 2021. This drew on the same themes and priorities which has underpinned NCL's system response to the long term plan and set them in the new context of Covid recovery, rather than being a change in direction.

The plan, in particular built on existing work through the elective recovery programme, and demonstrates the following:

- Recovery of the 62-day cancer waiting time standard (from GP referral to treatment) by March 2021, with a 50% reduction in the backlog of people waiting over 60 days from September 2020 to March 2021;
- A recovery in outpatient activity to 90% of levels in 2019/20, with the ambition in the Phase III plan being to deliver 100% of prior year levels of outpatient activity;
- A recovery in elective daycase and inpatient activity to 88% of levels seen in 2019/20, against an ambition that activity for the rest of the year is a minimum of 90% of prior year levels;
- A 40% reduction in people waiting over 52 weeks from September 2020 to March 2021, with this excluding Royal Free London who have suspended national reporting of referral-to-treatment (RTT) waiting times;
- Sector wide plans for diagnostics are in place for recovery of both endoscopy and imaging test capacity.

Referral to treatment times

The impact of covid on elective pathways continues to show a reduction in the overall waiting list for North Central London Trusts from 125,000 in February 2020 to 120,000 in March 2020, and 108,000 in June 2020.

The fall in the overall waiting list accrued from a sharp reduction (75%) in referrals from primary to secondary care from the end of March 2020 as the Covid pandemic hit. Referral levels in June had only recovered to 33% of pre-covid levels, and are currently running at 65% of pre-covid levels.

However, at the same time there was an increase in the waiting list backlog (patients waiting over 18 weeks for their treatment from GP referral) from 17,000 in February to 22,000 in March and 55,000 in June.

Given the above, the number of people waiting for their treatment at NCL Trusts for more than 52 weeks has continued to increase from 450 at the end of May, 952 at the end of June, to a current figure of 2,400 in September.

These figures exclude Royal Free London who have suspended national reporting of referral-to-treatment waiting lists since February 2019.

NCL elective (planned care) recovery plans

The elective recovery plan has been clinically led and driven by evidence and best practice standards, and focuses on:

- Adopting best practice principles including Getting It Right First Time (GIRFT) across all specialties, as was used to develop the service model for Adult Elective Orthopaedic Services;
- Clinical prioritisation of existing waiting lists through NCL Clinical Networks for each specialty to ensure people are treated in order of clinical need. All high-priority patients have been offered an appointment, and Trusts are now offering appointments to medium priority patients. This NCL approach has been used elsewhere;
- A process and principles for low clinical priority work agreed, with work underway in some areas including cataracts;
- Trusts have designated capacity for elective work, separate from Covid and emergency capacity, to ensure that elective work can continue if there is an increase in demand due to Covid. Identified elective hubs in NCL include Moorfields Eye Hospital, Chase Farm, and Royal National Orthopaedic Hospital (RNOH).
- Recovery in six high volume low complexity specialties, and the use of elective centres to maximise throughput. The specialties are orthopaedics, ophthalmology, ENT, urology, general surgery and gynaecology. Co-ordinating providers and clinical leads, from Trusts and primary care, appointed for each specialty to maximise recovery;
- Continued use of independent sector capacity in line with the national contract where no alternative NHS capacity;
- Implementation of referral support services across the five NCL boroughs to standardise referral pathways into hospitals including access to advice and guidance from consultants to GPs as an alternative to outpatient referral;
- Adoption of revised national infection prevention control (IPC) standards;
- Addressing inequalities, informed by equality impact assessments, for the clinical prioritisation of waiting lists and adoption of infection prevention control guidance

How is elective (planned care) recovery going?

From the above NCL is demonstrating a recover in elective activity, with the position at the end of September showing:

- Elective inpatient activity at 84% of pre-Covid levels compared to 33% at the beginning of May and 59% at the end of July;
- Daycases at 73% of pre-Covid activity levels compared to 26% at the beginning of May and 45% at the end of July;
- Outpatients at 70% of pre-Covid activity levels compared to 49% at the beginning of May and 64% at the end of July;
- NCL recovery is ahead of London averages, but requires further pace from the actions above to meet the targeted recovery levels covering September 2020 to March 2021 (100% for outpatients and 90% for electives and daycases compared to pre-Covid levels).

Reducing waiting times for planned care

The NCL system response and mitigations to address the 52-week wait backlog includes:

- 41% of the 52-week waiters fall within the six high volume elective specialities (Trauma and Orthopaedics, Ophthalmology, Urology, General Surgery, Gynaecology and ENT) and are in scope of the system interventions, such as:
  - High volume elective hubs going live (September Chase Farm and Moorfields Eye Hospital; UCLH Phase 4 November);
  - Exploring mutual aid in capacity across providers facilitated by the clinical network – speciality operational leads from organisation to review waiting lists collectively;
  - Expanding the mutual aid initiative to community service providers (e.g. pain management and gynaecology);
- Surgical Clinical Prioritisation Group set up to help optimise how Independent Sector capacity is used with input from each of the core surgical specialities (acknowledging the current contractual risks to future provision);
- Paediatric Dentistry initiative between GOSH and UCLH to hold high volume “tooth fairy weekends” to reduce the waiting list backlog;
- Implementation of new evidence-based primary care pathways, including the use of advice and guidance from hospital consultants to GPs as an alternative to referral;
- An addendum to provider access policies has been developed to support providers in managing access during covid recovery, supporting patients opting to defer their appointments due to concerns about covid-19 infection and challenges relating to compliance with self-isolation guidance.

Diagnostics

During the first wave of the pandemic median waits for diagnostic tests moved from 2.1 weeks in February 2020 to 9.6 weeks in May 2020 as routine activity was paused. As recovery plans have been mobilised and activity has been reinstated June saw a reduction in the median waiting time for a diagnostic test (8.5 weeks compared to 9.6 weeks in May).

Recovery plans developed, in line with elective pathways, are based on clinical prioritisation of existing waiting lists to set priorities for treatment based on clinical need.

Diagnostic capacity (imaging and endoscopy) is a key interdependency for cancer, referral-to-treatment and primary care recovery plans, with examples being phlebotomy being required across chronic disease management, cancer and elective pathways, and endoscopy for cancer (where additional capacity from the independent sector is being used to reduce backlogs).

Diagnostic Recovery

A Diagnostic Imaging Recovery Plan for NCL has been prepared during August and has a focus on:

- By 1 October 2020: bring tests back up to 100% of October 2019 levels;
- By 31 March 2021: restore the NCL waiting list backlog to pre-COVID levels;
- By 31 December 2021: establish a provider network to deliver a sustainable long term imaging service that meets the needs of the residents of North Central London;
- Short-term focus on maximising NHS capacity and use of independent sector capacity, and standardising GP Direct Access criteria/thresholds;
- Longer-term focus (from 2021/22) on interoperability and establishing community diagnostic hubs.

Cancer pathways

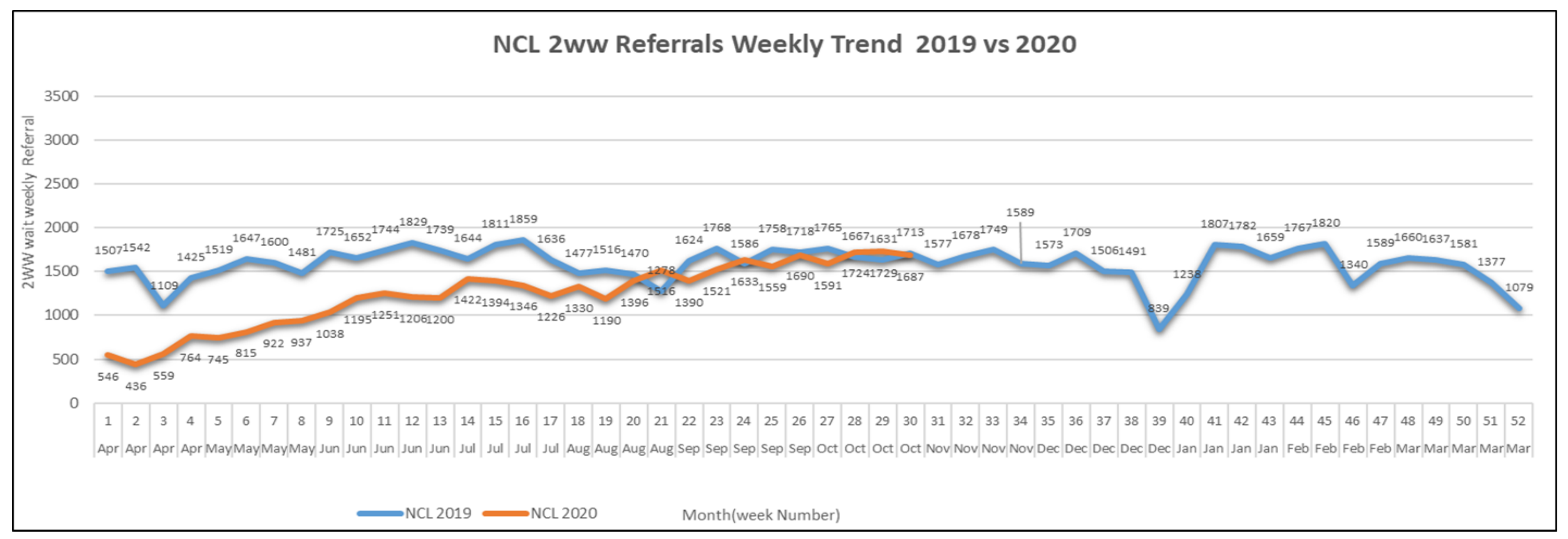
At the peak of the pandemic in April and May, there was a reduction in 2-week wait cancer referrals to NCL acute hospitals by up to 70%. Since then referrals have increased steadily to 70% of pre COVID-19 levels in July, and back to pre-covid levels at the end of August. Some reduction in referrals compared to historic levels is expected from changes to pathways that optimise the use of diagnostic rule-out tests to reduce referrals where appropriate.

Treatment of the most clinically urgent patients has been prioritised, and plans to treat all patients waiting more than 104 days for their treatment are being developed. In line with current protocols clinical harm reviews will be undertaken on all patients waiting more than 104 days for their treatment.

During the covid pandemic cancer and other urgent activity has been prioritised over routine work. Due to limited capacity for diagnostics and treatment, all patients were reviewed and allocated a priority level based on need. A surgical hub for NCL was set up to match demand and capacity which included utilising independent sector capacity. This was done to ensure that time-critical cancer surgery continued, and NCL maintained surgery throughput at higher levels than elsewhere.

Cancer pathways – impact of Covid

- GP Suspected Cancer Referrals ("Two week waits") dropped by 70% year on year in April, but returned to pre pandemic levels in August – normally we would expect 30% of cancer diagnoses through this route
- No variation in recovery by age, sex or socioeconomic status

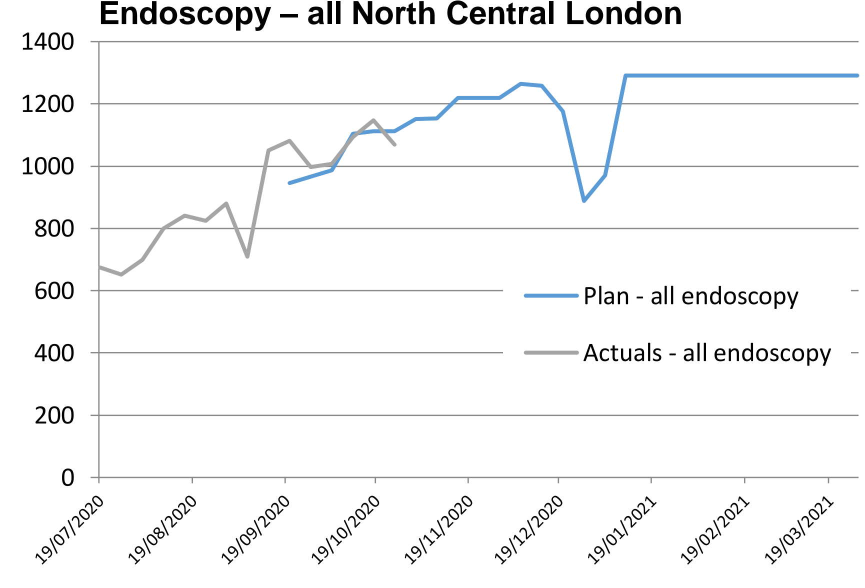


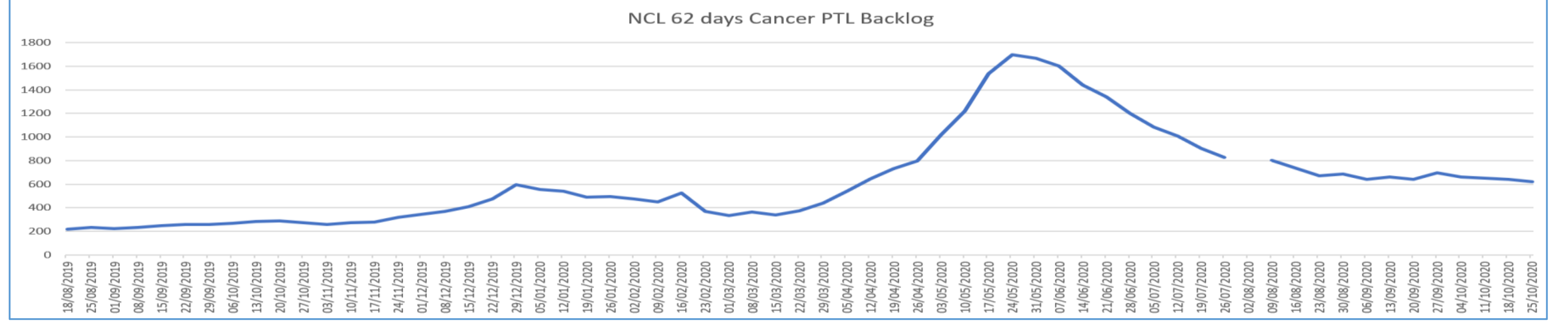
- A further 30% of cancer diagnoses come from routine outpatient appointments – but routine referrals are still below pre-pandemic levels
- Anecdotal evidence that we are seeing a greater proportion of later stage cancers

Diagnostic and treatment services

Diagnostic and treatment services were affected but are now back at pre-Covid levels. Huge effort to clear backlogs and maintain services – all services have reduced throughput because of infection prevention and control measures so trusts are increasing overall sessions – commitment to maintain service provision through pandemic

- High priority cancer surgery was protected during height of pandemic at Surgical Hub based at UCH Westmoreland St, and two private facilities – now returned to NHS sites; Clinical Prioritisation group on standby if further changes are required.
- Endoscopy briefly stopped because of concerns relating to covid spread and 'aerosol generating procedures' but now on track to clear backlog – major programme to work extended hours and expand physical capacity
- Chemotherapy and Radiotherapy was reduced because of risk of covid to immuno-compromised cancer patients, but now back at pre pandemic levels
- Risks remain as cancer treatment is highly specialised so gaps due to e.g. a site becoming overwhelmed by covid, or staff illness or isolation constrain service delivery, are hard to fill.
- The number of patients waiting longer than 62 days for treatment has reduced to close to pre pandemic levels; a key issue is some patients refusing to attend because of fears of covid

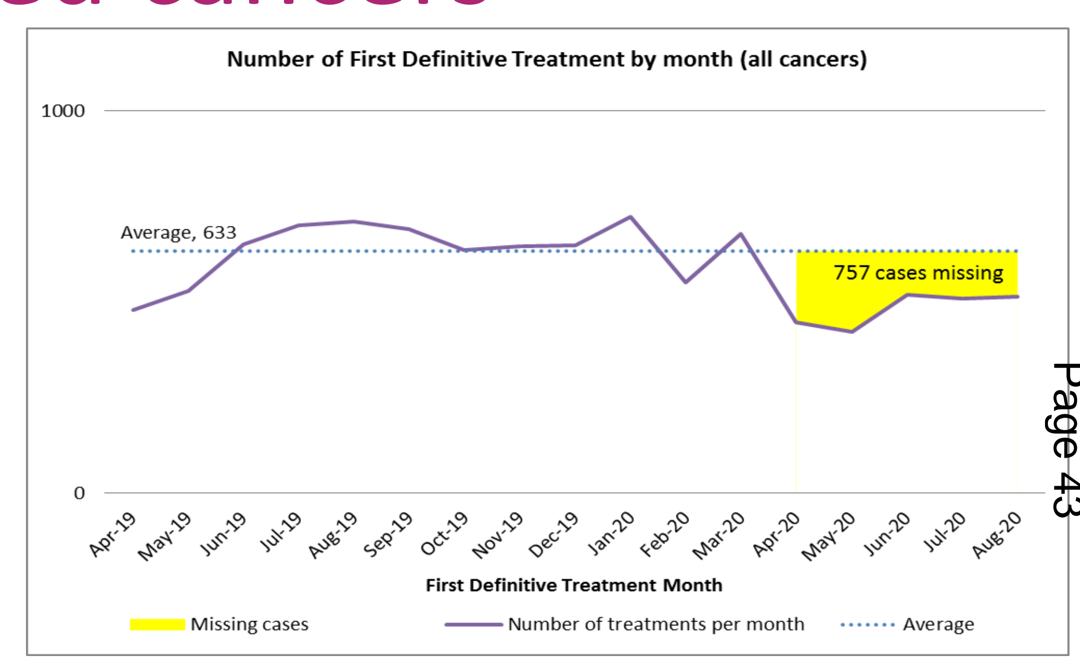




Reduced number of diagnosed cancers

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 757-case cancer treatment shortfall, of which 630 have not presented in NCL

- Between April and August 2020, on average **481** First Treatments were delivered by NCL per month, c.f. **633** pre February 2020, a shortfall of 757 patients.
- Of these 757 cancer patients, at week ending 30 August 2020:
- 127 within the suspected cancer backlog
- **This leaves an estimated 630 cancer cases that have not presented**
- If these cases were to present along pre-pandemic routes to diagnosis then we would expect 214 cases from GP Suspected Cancer referral, 385 cases from emergency presentation, inpatient and other outpatient routes, 31 cases from Screening referrals. However it is not clear how these patients will present in the current environment.



Tumour groups	% of shortfall
Urological	30%
Skin	14%
Breast	12%
Lung	11%
Haematological	9%
Upper Gastrointestinal	8%
Colorectal	8%
Head & Neck	4%
Brain / Central Nervous System	2%
Gynaecological	2%
Other	1%

Cancer Screening Recovery

Screening normally accounts for 5% of cancer diagnoses. Cervical screening has recovered; bowel screening due to recover in December. Concerns that Breast Screening is behind schedule.

Breast screening

- Backlog across London – 168,000
- Open invitations have commenced at one site per service across London
  - NCL sites – Finchley Memorial and Kentish Town
  - Women sent text reminder 7 days following open invite letter; phone call after 14 days
  - Early data shows approx. 50% of clients who receive an open invitation have booked appt
- Timed appointments being issued at remaining sites and gradually phase in open invitations
- Overall progress on recovery behind schedule
- Cancer Alliance will provide interim support to the breast screening admin hub as open invites are being phased in.

Bowel screening

- People invited but not screened across London – 124,000
- Recovery of the programme in London is ahead of other regions in England
- NCL invitation rate has been increased to 164% to enable return to normal level by end of Dec 2020
- UCLH is NCL screening centre and colonoscopy backlog cleared and those on surveillance continue to be monitored
- UCLH screening colonoscopy capacity increased to accommodate new invitation rate
- No uptake figures available as of yet. Expect indication of uptake following restart of the programme to be available by end of the year.

Cervical screening

- Cervical screening invitations resumed in June. Invitation and reminders returned to normal rate as backlog has been cleared as of beginning of October
- Collected samples across London higher than predicted levels (based on pre-COVID data)
- Colposcopy backlog cleared at NMUH, RFL and Whittington. Due to be cleared at UCLH in coming weeks
- Colposcopy referral rates approaching pre-COVID levels with sharp rise seen in mid-Sept
- HSL on track to achieve 100% pre-Covid activity. Transport services to collect samples operating at pre-COVID levels

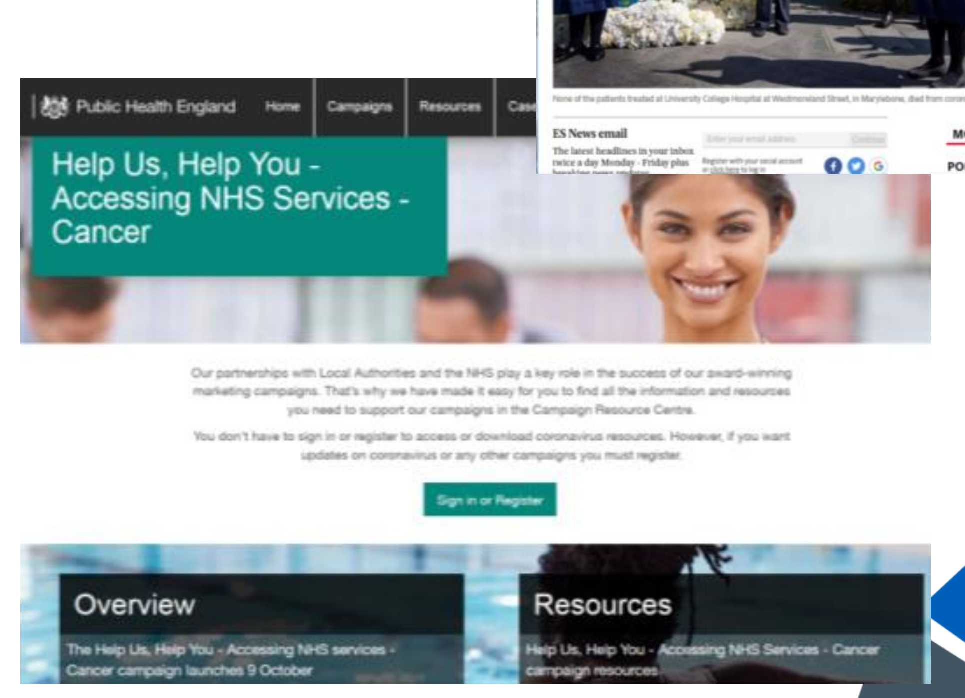
What’s changed for cancer patients?

Patient profile	What’s changed in the light of Covid?
Patients with symptoms requiring rule out of cancer - Referral on 2 week wait pathway	Increased use of evidence based rule out tests particularly ‘FIT’ for colorectal cancer to reduce unnecessary referrals; use of tele-consultations where safe to do so.
Patient attending for diagnostic tests that require sedation e.g. Endoscopy	Advise patients to follow comprehensive social distancing and hand hygiene measures for 14 days before admission. Covid test 3 days before admission and self-isolation for that period.
Patient attending for diagnostic tests that so not require sedation e.g. MRI scan etc.	Advise patients to follow comprehensive social distancing and hand hygiene measures for 14 days before admission.
Patients requiring surgical treatment	Advise patients to follow comprehensive social distancing and hand hygiene measures for 14 days before admission. Covid test 3 days before admission and self-isolation for that period
Patients requiring chemotherapy or immunotherapy	Switching IV treatments to subcutaneous or oral alternatives where this would be beneficial; using shorter treatment regimens; decreasing the frequency of immunotherapy regimens, for example moving to 4-weekly or 6-weekly; providing repeat prescriptions of oral medicines; using home delivery of oral and subcutaneous medicines where possible; using treatment breaks for long-term treatments.
Patients requiring radiotherapy	Remote visits: use phone or video assessments instead of face-to-face contact. Avoid radiotherapy if the evidence suggests there will be little to no benefit, or if an alternative treatment is available. Defer radiotherapy if clinically appropriate. If radiotherapy treatment is unavoidable, use the shortest safe form of treatment.

National and local campaign

The NCL Cancer Alliance is developing a local public facing campaign to encourage patients to attend screening and with symptoms; much media activity and patient engagement already conducted

Builds on national campaign – PHE and NHS England have provided national toolkit and launching campaign on abdominal symptoms on 11 November



University College London Hospitals NHS
NHS Foundation Trust

uclh

Post-Covid Syndrome Service

JHOSC meeting – 27 November 2020

Summary and contents

This presentation includes a summary of the post-Covid Syndrome clinic at UCLH

Contents Slide no:

UCLH Long Covid Service	3
How are patients referred	4
Patient Experience	5-6
Research into long-term symptoms	7

UCLH Long Covid Service

- UCLH has developed a post-Covid-19 service to help survivors of the virus with their long-term recovery.
- UCLH established the service at pace in response to concerns about the clinical safety of patients, given a growing appreciation of early and late post-Covid-19 complications and symptoms.
- The multidisciplinary team behind the clinic at University College Hospital have conducted some 1,000 appointments since they started seeing patients in person in May.
- The clinic is held three times a week, and is led by integrated respiratory physicians and brings together multidisciplinary and multi-professional expertise including physiotherapists, respiratory physiologists, psychologists, cardiologists, neurologists and infectious disease doctors.
- We have partnered closely with allied health professionals to understand the nature of support needed by patients and their safety to engage with it. We are increasingly concerned by the severity and nature of prolonged post- Covid-19 symptoms and we feel the need to understand the mechanism of these, and treat them better.
- Patients affected are often of working age and their quality of life has been seriously impacted. Many are NHS staff who have struggled to access adequate care through the usual routes.

How are patients referred into the service?

- UCLH accept referrals from primary care and we have offered follow-up to patients discharged from our own emergency department.
- To access the clinic, patients experiencing post-viral symptoms are encouraged to see their GP and request a referral to UCLH. Referrals from GPs can be sent via email to UCLH.respiratorymedicine@nhs.net.
- The service is currently open to all patients. It is in the process of being formally set up to receive e-referrals and clinic appointments will then be limited to patients from North Central London (NCL).
- However, the service will still provide advice and guidance to GPs outside NCL by email or telephone.
- The team is also working with partners across NCL to co-design pathways to secure appropriate and equitable access of patients to assessment, investigation and post-Covid-19 rehabilitation.

Patient experience

One of the patients who has been through the clinic is Suji Yathindra, a 45-year-old doctor who worked through the height of the pandemic in an emergency department, staying in a hotel away from his wife and children to allow him to work without fear of infecting them.

He developed symptoms of Covid-19 in mid-May. He was assessed at his own hospital and another, with multiple investigations that returned normal results. He suffered a lot of psychological stress as he felt so ill but had no identifiable reason for this.

He was unable to return to work as he could not perform CPR without being exhausted. Testing at UCLH revealed a very abnormal physiological response to exercise, and further investigations are being planned to characterise this and a rehabilitation plan has been developed for him

Suji said: “The clinic helped validate my illness. The team understood how frustrated I was and helped me get back on track. They organised an exercise routine and encouraged me throughout my journey back. They continue to organise investigations to look for a possible cure to my ongoing muscle pain and are in regular contact with me with helpful solutions. Without the clinic I am not sure I would have been able to return to work.”

Research into long-term symptoms

UCLH supports the need for urgent research into the mechanisms underlying post-Covid-19 symptoms.

We are participating in the PHOSP-COVID study (Post-Hospital Covid), a major UK research study looking at the long-term health impact of Covid-19," said infectious diseases consultant Dr Michael Marks, who is leading the UCLH component of the national study.

"We will use techniques such as advanced imaging, data collection and analysis of blood and lung samples to create a comprehensive picture of the impact of the viral infection."

Around 10,000 patients across the UK are expected to take part, making it the largest comprehensive study in the world to understand and improve the health of survivors after hospitalisation from Covid-19.

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Response
In response to the deputation from North Central London NHS Watch and members questions, Rob Hurd (System Lead, North Central London Integrated Care Systems) made a verbal statement at the meeting. The below response provides more detail and clarifies a few points that we weren't able to cover at the meeting:

- We acknowledge that the unprecedented impact of Covid-19 has put additional pressures on health and care services.
- Frontline staff have been working extremely hard during this period to ensure that we can continue to provide safe, high-quality health and care services under challenging circumstances.

Temporary service changes made in response to Covid

- All changes that have been made to services in response to Covid are temporary. These changes were clinically-led and made as the NHS responded using emergency powers put in place to address the challenges of a national major incident. Many of these service changes have since reverted to pre-Covid arrangements.
- Should any permanent changes to services be proposed we have a legal obligation to consult with staff, stakeholders and the public and we remain committed to fulfilling these obligations.
- North London Partners have previously presented and discussing in detail a list of the temporary changes at a JHOSC meeting at the end of July. The paper is available on our website: https://www.northlondonpartners.org.uk/ourplan/Areas-of-work/information-to-the-public-about-changes-to.htm
- Since the JHOSC meeting in July, additional temporary service changes have been made to children and young people's emergency and inpatient services to ensure the NHS can continue to deliver the best emergency and planned care across north central London during the winter and ongoing pandemic.

  Barnet Hospital children's emergency department has already reopened following a temporary closure.

  The changes follow a review of children and young people's health services across north central London, and include the following temporary changes:

  - **University College London Hospitals'** (UCLH) children and young people's emergency department (at University College Hospital) will remain temporarily closed over winter. UCLH specialist inpatient and day-case services, including cancer haemato-oncology and complex adolescents, will remain open.
  - **The Royal Free Hospital's** children and young people's emergency department will temporarily close as will its children and young people's inpatient beds.
  - **Barnet Hospital** children and young people's emergency department and inpatient unit has reopened and will include child and adolescent mental health services (CAMHS) crisis support

- Whittington Health's children and young people's emergency department and inpatient unit remains open and has expanded to meet forecast demand.
- **North Middlesex University Hospital** children and young people's emergency department remains open with additional capacity. Inpatient services continue.
- To ensure maintenance of access to elective services, **Great Ormond Street Hospital** will provide more room for urgent elective inpatient and some – but not all –

- We have been working hard to communicate with stakeholders about the temporary changes and we will continue to do so, we are also working with our partners, including JHOSC, councils, NHS trusts and local communities to keep them informed of the changes.

Ongoing response and recovery for services in NCL

- It is impossible to predict what the impact of the pandemic on health and care services will be, so in NCL are modelling and planning for a range of scenarios. This is aligned to planning for the already challenging period of winter pressures, and includes modelling for potential increases in demand due to Covid-19 surges. Plans have recommended some temporary changes and escalation points which aim to ensure that our services can remain resilient and can support emergency and planned care over the winter period.
- Infection Prevention and control mechanisms have been put in place to ensure safe care of patients and protect health and care staff.
- While we don't expect a Covid-19 vaccine to be widely available until 2021, the Government has asked the NHS to be ready to deliver a vaccination programme for England from December, so that those who need it most will be able to access vaccinations as soon as they are available.
- Detailed planning has been underway, building on the expertise and strong track record the NHS already has in delivering immunisations like the annual flu vaccination programme, to ensure that a Covid-19 vaccination programme does not impact on other vital services.

Access to primary care

- Primary care is 'still open for business', but continuing to make full use of remote triage, telephone, video consultations in the first instance and use of face to face consultations only where clinically appropriate and safe to do so.
- All our practices are seeing patients face-to-face where people need it (like childhood immunisations, smear tests or monitoring long term conditions). How practices organise this does vary depending on the size and layout of the practice and their workforce. Practices have had training in IPC to enable this to happen safely.

Planned elective care,

- There have been extreme pressures on the waiting lists for planned care following national guidance in March to suspend planned care due to the increase in demand due to Covid. Elective services were restarted in June in NCL, and we are planning to keep those services

running throughout the winter, if at all possible, so that we are able to provide care for both Covid and non-Covid patients.

Digital appointments/consultations

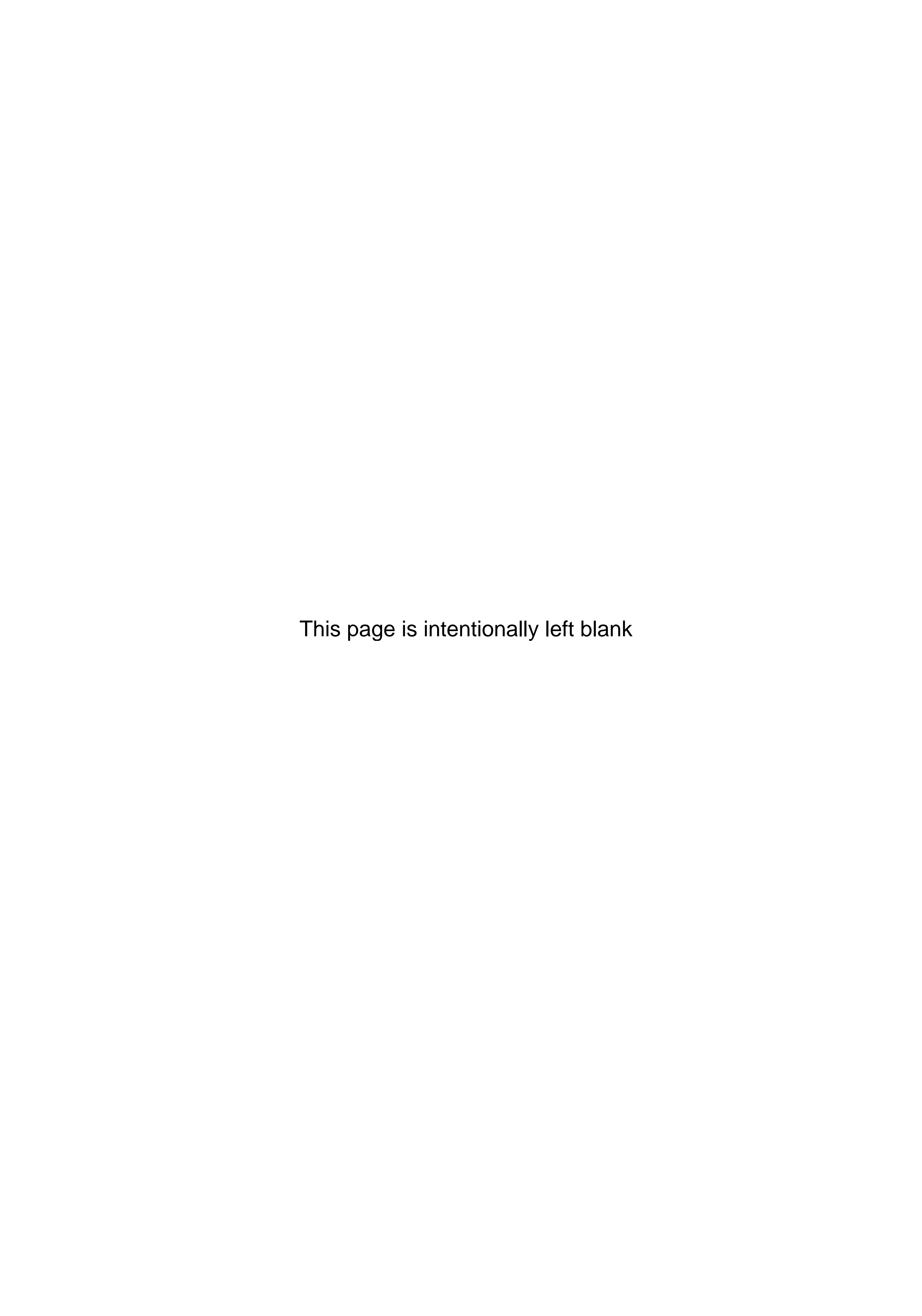
- GP services are open for the delivery of face to face care for those patients with a clinical need. We have also developed alternative digital tools for GPs so that they are able to provide ongoing care for patients and maintain infection prevention and control. GPs can offer telephone and video consultations in addition to face to face appointments.
- A formal commitment was made to commission an Equality Impact Assessment around access via digital mechanism into GPs and other health care settings. NHS partners would be looking to learn and reach out how to mitigate the risk. This Equalities Impact Assessment is being commissioned in November and NLP will update the Committee on progress.

Urgent and Emergency Care

- For residents who have urgent and emergency care needs, we are able to offer additional support through NHS 111. Our NHS 111 provider can already book appointments with GP surgeries and urgent care treatment centres. We are gradually introducing the ability to book A&E appointments at NCL hospitals through NHS 111 to patients who have an urgent clinical need. North Mids was the first hospital to offer this with Barnet Hospital also now using this approach.
- This is an additional ability of NHS 111, so that we can minimise the number of people waiting in A&E waiting rooms, it will reduce the risk of infection from Covid if residents are advised when and where to attend for a booked appointment.
- If patients continued to make their way to urgent or emergency care units they will still be treated or directed to an appropriate service, depending on their clinical need. NCL's NHS 111 service has employed more health professionals to meet the expected increased demand.

Testing

- Test and Trace had been set up nationally. A lot of work had been done locally to enhance local arrangements led by borough Directors of Public Health (DPH) and Council Health Protection Teams and linking in with the national testing systems.
- There had been work on-going to support testing since April. This included LA's providing support for testing in care homes and other care settings considered to be at risk and not eligible to access the national testing portal.
- Pillar 1 capacity tests had been set up for patients and health and care workers with over 6,000 swab tests being done in care homes. This was supplementary to the national testing regime.
- There are now mobile testing units (MTUs) taking place across NCL including in Islington. The location of these is directed by borough directors of public health based on need.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Agenda Item 10

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	**London Boroughs of Barnet, Camden, Enfield, Haringey and Islington**

REPORT TITLE
Work Programme 2020-2021

REPORT OF
Committee Chair, North Central London Joint Health Overview & Scrutiny Committee

FOR SUBMISSION TO	**DATE**
NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	27 November 2020

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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E-mail: rob.mack@haringey.gov.uk

RECOMMENDATIONS

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

a) Note the contents of the report; and
b) Consider the work programme for the remainder of 2020-21.

1. Purpose of Report

1.1 This paper provides an outline of proposed areas the Committee might choose to focus on in the rest of 2020-21. This has been informed by topics highlighted previously by the JHOSC and through a review of key health and care strategic documents that impact on North Central London. The Committee is asked to consider the list of topics highlighted in Appendix A, as well as any other areas of interest and use these to populate the committee work programme for the remainder of the municipal year.

2. Terms of Reference

2.1 In considering topics for 2020-21, 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;

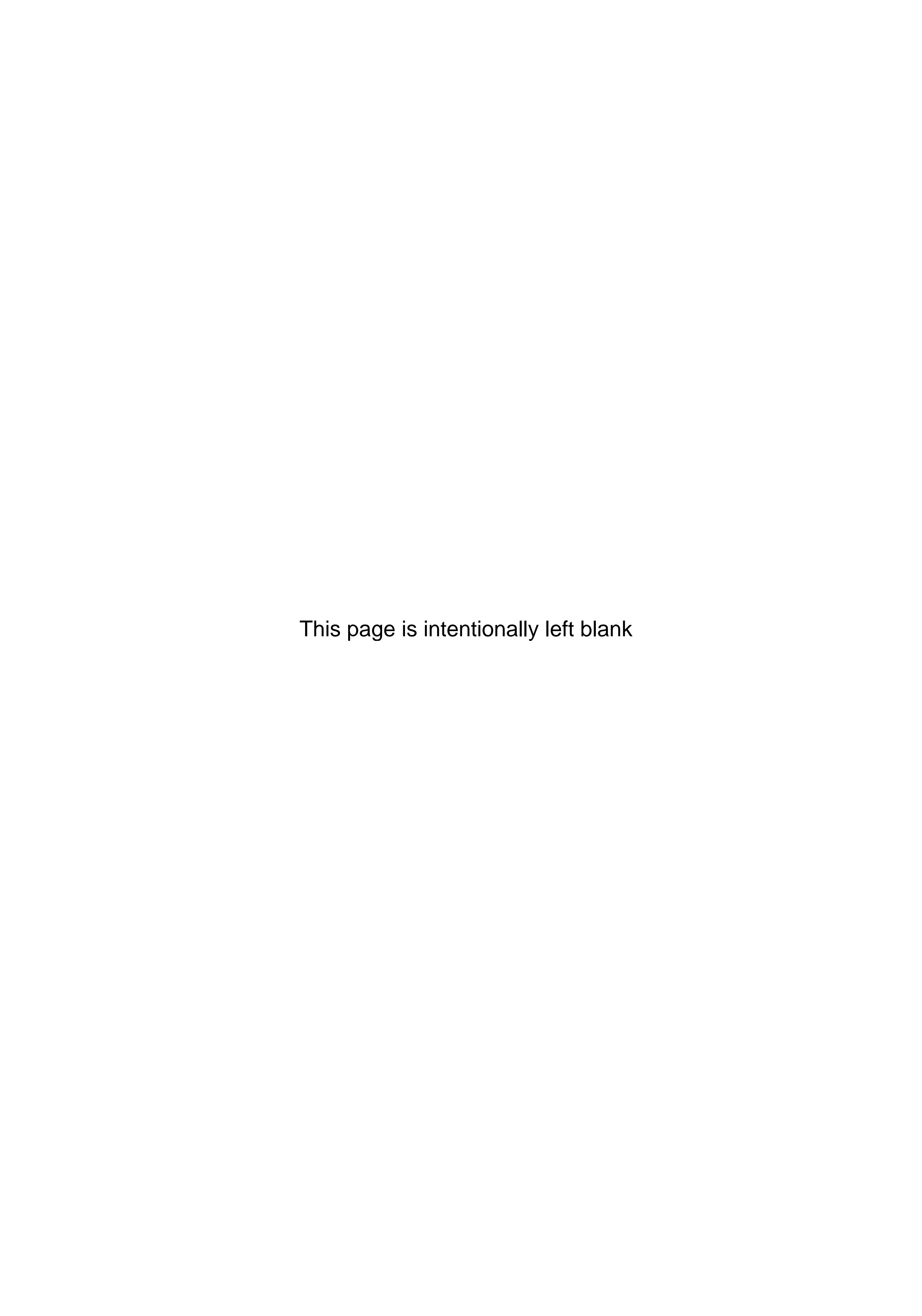
- The joint committee will work independently of both the Cabinet and health overview and scrutiny committees (HOSCs) of its parent authorities, although evidence collected by individual HOSCs may be submitted as evidence to the joint committee and considered at its discretion;

- 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 – Items to be considered for the 2020/21 NCL JHOSC Work Programme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Appendix A – Items to be considered for 2020/21 NCL JHOSC work programme

27 November 2020

Item	Purpose	Lead Organisation
Primary Care – Patient Pathways	What is known about access to care, primary care numbers, diabetes case study, dentistry.	NCL partners
Secondary Care – Patient Pathway	Underlying access to secondary care, disparities between groups, rates of access/referral. Deep dive around cancer (multi-faceted).	NCL partners
Post-Covid Syndrome Service	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

To be arranged

Item	Purpose	Lead Organisation
General Practice as the foundation of the NHS: improving health and well-being	Update of new roles of GPs to improve residents' health and wellbeing, by embedding other health care professionals including social prescribing, pharmacists into GP practices and examples of how this will improve care	NCL partners
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

Digital GP paper	Maximising the amount of space available for people who need it. Not moving everything to digital	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

Timetable of meetings:

- 29th January 2021; and
- 26th March 2020.