NOTICE OF MEETING

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 1 October 2021, 10:00 a.m.
Hendon Town Hall, The Burroughs, London, NW4 4AX

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 Derek Levy (Enfield Council), Pippa Connor and Khaled Moyeed (Haringey Council), Tricia Clarke and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Claire Johnson, Robert Mack, and Peter Moore.

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

AGENDA

1. ELECTION OF CHAIR FOR 2021-2022

To elect a Chair for 2021-22.

2. ELECTION OF VICE-CHAIR(S) FOR 2021-22

To elect a Vice-Chair(s) for 2021-22.

3. 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.

4. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

5. 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 13 below).

6. DECLARATIONS OF INTEREST

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

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

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

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

7. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

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

8. MINUTES (PAGES 1 - 12)

To note the minutes of the North Central London Joint Health Overview and Scrutiny Committee briefing on 25 June 2021 as a correct record.

9. DIGITAL INCLUSION AND HEALTH INEQUALITIES (PAGES 13 - 26)

To receive an update on digital inclusion and health inequalities, focusing on health inequalities.

10. UPDATE ON MENTAL HEALTH (PAGES 27 - 34)

To receive an update on Mental Health.

11. UPDATE ON INTEGRATED CARE SYSTEMS (ICS)

To receive an update on Integrated Care Systems (ICS). **(To follow)**

12. WORK PROGRAMME (PAGES 35 - 52)

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

13. NEW ITEMS OF URGENT BUSINESS

To consider any items of urgent business as identified at item 5.

14. DATES OF FUTURE MEETINGS

To note the dates of future meetings:

26 November 2021
28 January 2022
18 March 2022

Robert Mack, Principal Scrutiny Officer / Fiona Rae, Principal Committee Co-ordinator
Tel – 020 8489 2921 / 020 8489 3541
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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
River Park House, 225 High Road, Wood Green, N22 8HQ

Thursday, 23 September 2021

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 Agenda Item 8

MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE BRIEFING HELD ON FRIDAY, 25TH JUNE, 2021, 10.00 AM - 1.20 PM

PRESENT: Councillor Pippa Connor (Chair), Councillor Tricia Clarke (Vice Chair), and Councillors Alison Cornelius, Paul Tomlinson, Derek Levy, and Khaled Moyeed.

1. FILMING AT BRIEFINGS

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

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Linda Freedman, Larraine Revah, and Christine Hamilton.

3. URGENT BUSINESS

There was no urgent business.

4. DECLARATIONS OF INTEREST

Cllr Connor noted that she was a member of the Royal College of Nursing and that her sister worked as a GP in Tottenham.

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Chair noted that a deputation had been received from NCL NHS Watch on the Integrated Care Systems (ICS) White Paper, integration and innovation and primary care post-Centene.

Professor Sue Richards, NCL NHS Watch, explained that NCL NHS Watch had addressed the Committee in March 2021 and that, since then, further information had been provided in a White Paper. It was noted that the written deputation set out a number of concerns and the Joint Health Overview and Scrutiny Committee (JHOSC) was urged to raise these concerns.

It was stated that the core NHS ICS Board was expected to have three additional partners from primary care from the local NHS, from general practice, and from social care. Professor Sue Richards noted that there was no local authority or public representation and that there was no mention of any documents being open to the public. It was stated that private providers could be on this Board and that they were not subject to Freedom of Information requests. The JHOSC was urged to argue for

parity of representation, or at least increased representation, for primary care and local authorities to ensure accountability. Professor Sue Richards added that NCL NHS Watch believed that independent providers should be excluded from resource allocation boards.

There were concerns that the proposals set out in the White Paper would result in the increased allocation of contracts to private providers. NCL NHS Watch asked the JHOSC to argue to make NHS organisations ‘preferred providers’.

Professor Sue Richards noted that the social care proposals had been further deferred which was concerning and that the plans for public health were brief. She asked the JHOSC to argue for more investment in social care and public health and for comprehensive reform of social care.

NCL NHS Watch noted that there had been a significant shift to virtual services, particularly as a result of the Covid-19 pandemic, but considered that face-to-face consultations should be made a right for patients. The JHOSC was also asked to urge the reconsideration of capped budgets which may have a significant impact on health services, particularly following recent reductions in funding and spending required to react to or recover from Covid-19.

It was stated that there was significant pressure in primary care which provided 90% of patient contacts but received 10% of NHS funding. Professor Sue Richards noted that primary care was generally much cheaper than emergency care but that pressures had resulted in staff leaving. It was added that, in relation to contracts, there was an uneven playing field for GP providers as large, multinational companies could use substantial teams to respond to tenders. The JHOSC was asked to raise the issues noted by NCL NHS Watch to support and ensure the preservation of primary care.

Jo Sauvage, NCL CCG Chair and Primary Care Lead, stated that the primary focus of the CCG was to ensure that residents were satisfied and able to access GP practices. It was highlighted that the ICS framework had been published recently and that the CCG was still considering the detail. It was added that some things were mandated by central government and that other things could be influenced locally.

Sarah Mansuralli, Executive Director of Strategic Commissioning, noted that national discussions were ongoing but that the CCG was starting to discuss possible structures with partners. It was explained that the CCG was due to present a paper to the JHOSC in September 2021 which would set out the initial response to the requirements set out in the ICS design framework. The Chair added that the ICS design framework and the current selection regime for providers had been included in the agenda pack, under the work programme item, so that JHOSC members could familiarise themselves with some introductory information before the September meeting.

Paul Sinden, CCG Chief Operating Officer, explained that there would be some changes in commissioning in the move to ICS. It was noted that the ICS was likely to take on direct commissioning of primary care providers, including community pharmacy, optometry, and dentistry and that there would be opportunities to further

integrate services locally. Paul Sinden stated that, to support the local and primary care voice within ICS, the system would be talking with the five councils about the role of integrated borough partnerships which would inform ICS planning and commissioning. It was added that the borough partnerships may be asked to provide services or support, such as the Covid-19 vaccination delivery programme. It was explained that the CCG was also supporting GPs to form a GP provider alliance to ensure that their voices were represented clearly within the ICS. It was noted that these representatives would be selected locally and that private providers, such as AT Medics, would only be on ICS groups if they were selected locally.

Paul Sinden noted that the CCG had created an inequalities fund and would be working with borough partnerships to respond to inequalities. It was explained that the fund was £2.5 million this year and that this would increase to £5 million next year. It was noted that the White Paper had set out a greater focus on inequalities.

It was commented that the CCG had committed to look at its procurement processes which was linked to the item on AT Medics. It was noted that there would be consideration of different ideas, such as a greater weighting for social value in the procurement process. It was added that the process was governed by a procurement framework but that there was some flexibility within this. It was also commented that AT Medics had started as a small, local practice before the recent change of ownership.

The Chair noted that concerns relating to ICS and AT Medics had been discussed over the last few meetings and she wanted the Committee to focus on its recommendations. The Committee generally supported the recommendations set out in the deputation.

Cllr Tricia Clarke suggested that there should be greater protection for patient data. She noted that the deadline for patients to opt out of data sharing should be extended and that the process should be simplified. The Chair noted that data sharing was referenced in the item on GP Services.

Cllr Paul Tomlinson stated that the highest decision making body in the ICS should be public. He added that the ICS framework document did not refer to the Community Partnership Forum; he enquired what had happened to this forum and what role the public would be able to have. Professor Sue Richards, NCL NHS Watch, stated that the ICS Board would need patient, public, local authority, and primary care representation to ensure good decision making. She acknowledged that there was a GP Alliance but highlighted that the NHS ICS Board would have decision making powers and expressed concerns that the representation and proposals were not robust enough. In relation to increased weight for social value in procurement, Professor Sue Richards noted that this would have to be a significant increase to have a meaningful impact.

Cllr Derek Levy expressed concern about local authority representation within the ICS. He stated that local authority representation was important in presenting the voices of residents. Jo Sauvage noted that there was some scope for manoeuvre in the guidance and that this could be helpful in providing opportunities for partners to be included; she added that there were strong local relationships in North Central London

and that opportunities in the guidance could be used advantageously to embed democracy.

The Chair noted that the CCG had agreed to meet with the key local authority representatives in advance of primary care commissioning and was looking to include a greater weighting for social value within the procurement process. The Chair stated that there were a number of health providers throughout London who were owned by partner or parent companies and that there should be safeguards to ensure that referrals were based on health, rather than commercial, reasons. The Chair suggested that the ICS should have an identified committee that was aware of any business relationships between primary, secondary, and tertiary providers to ensure openness and transparency.

RESOLVED

The Committee made the following recommendations:

1. The Integrated Care System (ICS) and its committees should be as open to the public as possible.
2. The NHS ICS Board should include local authority representation, local authority voting rights, and the ability to discuss and challenge decisions. It should also ensure that all agendas, minutes, and relevant documents are open to the public. It was considered that this would ensure transparency and accountability.
3. The role of the Joint Health Overview and Scrutiny Committee (JHOSC) should be maintained, including the ability to scrutinise all decisions made by the ICS. It was also considered that the JHOSC should retain the right of refer matters to the Secretary of State.
4. The ICS should consider how patient and resident voices would be included in its processes. The JHOSC felt that patient and resident voices should be included at all levels, including the top level.
5. The JHOSC also requested further detail on the arrangements for the NHS ICS Board, the governance and committee structure within the ICS, and the relationship between the different committees, and how the voices of patients and residents would be included.
6. The ICS should have an identified committee that was aware of any business relationships between primary, secondary, and tertiary providers to ensure openness and transparency.
7. To support the NCL NHS Watch recommendations.

6. MINUTES

The Chair noted that, following a previous resolution by the Committee, she had sent a letter to Professor Stephen Powis, National Medical Director of NHS England and NHS Improvement to urge the use of protected funding for Long Covid pathways. It was reported that a response had been provided which included some positive information relating to funding. It was noted that there was due to be £100 million of additional funding in 2021-22, including £70 million to expand Long Covid services in addition to the £24 million already allocated to Post-Covid Assessment Clinics. It was also noted that there were currently 89 Long Covid clinics and that 15 Post-Covid

Assessment Clinics would be established in children and young people hubs. Cllr Tomlinson enquired how many of the clinics would be based in North Central London and it was noted that this would have to be checked.

RESOLVED

To note the minutes of the North Central London Joint Health Overview and Scrutiny Committee meetings on 12 March 2021 and 19 March 2021.

7. MENTAL HEALTH AND COMMUNITY SERVICES REVIEW

Joanne Murfitt, Programme Director, introduced the report which provided information about the mental health and community services review. It was explained that these were two reviews that were being run concurrently as they provided a number of related services. A key aim of the review was to ensure that there was a core, consistent offer across North Central London.

It was noted that resident engagement was at the centre of the review design principles. It was explained that there was a resident reference group with diverse membership and representation from all five boroughs; although there was a lack of younger members, there were parents within the group and efforts were being made to engage with young people. It was reported that there had been approximately 50 responses to the resident survey so far which included positive comments. Joanne Murfitt noted that the review also involved visiting and speaking to the Voluntary and Community Sector (VCS) and other groups, including statutory groups such as Health and Wellbeing Boards and Healthwatch. It was acknowledged that there had been minimal feedback from harder to reach groups and that work was underway to maximise engagement with these groups.

The Chair noted that the aim of the review was welcomed. She explained that the Committee was asked to consider the engagement in particular to ensure that all views were captured within the review. The Chair commented that the review did not plan to consider services offered by the VCS or by councils; she felt that these services should be included in order to capture the wider picture and to avoid the risk of repetition. The Chair added that it would be useful to consider how different service providers, such as the Police, local authorities, and mental health services, could communicate to improve services for patients. Joanne Murfitt explained that the CCG was working hard to include local authorities and the VCS in the review, including in the programme board, and this was positive for joint working. It was noted that the services provided by councils and the VCS were being looked at but that they were not central to the review as the CCG was not able to direct these services. It was added that improved communications between different services was slightly beyond the remit of the review but that it may be possible to consider this.

Cllr Tricia Clarke commented that it was good that the review was honest about the areas that required improvement. She stated that the Covid-19 pandemic had and would continue to have a significant impact on mental health and that it would be critical to focus on prevention and early intervention and to access more funding. Joanne Murfitt noted that more funding had been given to mental health services but

acknowledged that additional resources were always helpful. It was explained that the review had a strong focus on increased prevention and would consider whether it was possible to provide more direct services which did not require a referral.

The Chair noted that the review was seeking to engage with more young people and suggested that talking to schools might be helpful. It was stated that counselling in schools was being reduced and that school representatives would likely be interested in contributing to the review. Joanne Murfitt noted this suggestion and acknowledged that interactions at school level were helpful for long term prevention.

In response to a question from Cllr Khaled Moyeed, it was noted that a further report on the reviews would be presented to the Committee in September 2021. Joanne Murfitt stated that the speed of implementation might be dependent on the outcomes of the review but that changes would likely take place in 2022. It was explained that an outcomes framework was included as part of the review and that the Committee would be able to consider the implementation and results of the review in the longer term.

RESOLVED

To note the update and to note that a further report would be presented to the Committee meeting in September 2021.

8. GP SERVICES

Dr Katie Coleman, GP and NCL Clinical Lead for Primary Care Network Development, and Dr Peter Christian, GP and NCL CCG Board Member, introduced the report which provided an update on GP Services. Dr Peter Christian noted that the report provided an overview of primary care in North Central London. He explained that the report provided detail about the different types of contracts, including General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS), and about which services were commissioned from general practice.

It was explained that all contracts with GP practices were delegated from NHS England to Clinical Commissioning Groups (CCGs). It was noted that, in North Central London, the contracts were managed by the CCG contracts team and the Primary Care Commissioning Committee. Performance and monitoring was routinely conducted on the contracts through various mechanisms and any issues were referred to the Committee.

Dr Katie Coleman noted that primary care had worked exceptionally hard throughout the Covid-19 pandemic, including significant achievements with the vaccination programme. It was acknowledged that there had been a reduction in face-to-face provision at the beginning of the pandemic but that over 50% of appointments were now provided face-to-face. It was added that face-to-face appointments were provided if required.

It was explained that GP practices were working together with local health and voluntary services in groups, known as Primary Care Networks, and that alliances of

practices were working together to deliver primary care services, known as GP Federations. It was noted that, under the developing Integrated Care System (ICS), it was envisioned that GP Provider Alliances would ensure a strong, unified voice for primary care to influence and challenge ICS decision-making. In North Central London, it was stated that a GP Alliance reference group had been formed and was establishing its structure.

Jo Sauvage, NCL CCG Chair and Primary Care Lead, stated that the demand on primary care was immense and that some of this could be managed through digital options. It was accepted that the traditional model was still important but that the system needed to consider how it could modernise effectively to deal with demand and ensure high standards for patients and staff. It was commented that Healthwatch was very helpful in providing engagement and reports on these issues, and particularly on access. The Chair added that the recent Healthwatch report on digital exclusion was included in the Committee's agenda papers for information.

It was noted that some changes to the way NHS Digital would access and use GP data had recently been announced. It was explained that the new way to use data was called the General Practice Data for Planning and Research (GPDPR). GPs would provide data which would be pseudonymised; this meant that the data would not be directly identifiable but could be used to identify patients if needed. It was added that the data would be used to plan future services and monitor health service delivery. Dr Katie Coleman noted that the changes were due to be implemented on 21 June 2021 but had been delayed and it was acknowledged that there was a need to better engage with communities and explain the implications of the changes. Dr Peter Christian welcomed improved communications and highlighted that the changes had significant potential to improve research and patient care.

Cllr Tricia Clarke accepted that the data would be valuable for research purposes but expressed concerns about the commercial value and commercialisation of this data. She stated that it was difficult to opt out of the data sharing, that the process might need to be simplified, and that the deadline might need to be further delayed. The Chair enquired about the implications of opting out; specifically, whether this would allow data sharing for direct health purposes to continue. She added that it would be useful to clarify and provide this information to GPs and residents. Dr Katie Coleman noted that she could feed back these points to the officer who was leading on this work. She acknowledged that this was a difficult issue which was not within the control of the CCG and it was understood that the mechanisms for opting out were being considered. It was explained that there were two types of data opt outs: a Type 1 Opt Out would mean that data was not shared with NHS Digital and a Type 2 Opt Out would mean that patient data was not shared for any purposes beyond the patient's care.

The Committee noted that there were concerns about the General Practice Data for Planning and Research (GPDPR) proposals. It was considered that the governance arrangements and safeguards for patient data needed to be clearer. It was accepted that many patients were likely to consent to the use of their data for purely research-based use but would not want this data to be commercialised. The Committee considered that more action should be taken to explain the arrangements for patient data and suggested that an opt in arrangement might be more appropriate.

The Chair noted that there had been significant pressure on health and care staff, including within primary care, and enquired whether the workload was expected to reduce towards the end of 2021. Dr Katie Coleman believed that Covid-19 vaccinations would be provided for the long term and that, although the vaccinations were likely to become easier to store and process, there would still be pressure on primary care. Jo Sauvage added that there was also a backlog in elective procedures and it was anticipated that, due to some suspended services and patient lack of confidence during the pandemic, there would be a backlog for those with long term health conditions and for missing cancer patients. It was predicted that there would be increases in respiratory issues as an impact from Covid-19. It was also stated that demand was not expected to reduce in the foreseeable future.

The Chair noted the stresses on the workforce and the greater complexities faced by a number of patients, in some cases, in accessing services. She stated that how GPs communicated changes with patients was key. It was noted that the Healthwatch report, *Locked Out: Digitally excluded people's experiences of remote GP appointments*, was included in the agenda pack and set out the following principles of post-Covid digital healthcare:

- Maintain traditional models of care alongside remote methods and support patients to choose the most appropriate appointment type to meet their needs;
- Invest in support programmes to give as many people as possible the skills to access remote care;
- Clarify patients' rights regarding remote care, ensuring people with support or access needs are not disadvantaged when accessing care remotely;
- Enable practices to be proactive about inclusion by recording people's support needs;
- Commit to digital inclusion by treating the internet as a universal right.

It was noted that the Committee supported these principles.

RESOLVED

1. To note the report.

2. To submit the following statement to the North Central London Clinical Commissioning Group to pass on as appropriate:

   The Committee noted that there were concerns about the General Practice Data for Planning and Research (GPDPR) proposals. It was considered that the governance arrangements and safeguards for patient data needed to be clearer. It was accepted that many patients were likely to consent to the use of their data for purely research-based use but would not want this data to be commercialised. The Committee considered that more action should be taken to explain the arrangements for patient data and suggested that an opt in arrangement might be more appropriate.

3. To support the Healthwatch principles for post-Covid digital healthcare.

9. COVID-19 PANDEMIC UPDATE

Chloe Morales Oyarce, CCG Head of Communications and Engagement, and Sarah Mansuralli, CCG Executive Director of Commissioning, introduced the report which provided an update on the Covid-19 pandemic.

Sarah Mansuralli explained that, since the unexpected first wave of Covid-19, a number of measures had been introduced to the system, which included monitoring and escalation and surge plans. It was noted that there was now provision to rapidly provide additional step down beds and that primary care hubs could be stepped up quickly. It was added that there were also options to have more care in the community and remote monitoring in care homes. It was explained that the governance structures, escalation procedures, and collaboration arrangements developed in the first wave had put the system in a strong position for the following surges and had created some strong foundations for the Integrated Care System.

Sarah Mansuralli noted that there had been some temporary changes to paediatrics but that these had now reverted back; evaluation of these changes was underway and could be shared with the Committee when available. It was noted that the system changes had been overseen by the System Recovery Executive which included local authorities.

It was explained that there was now a focus on system recovery from the Covid-19 pandemic. It was stated that North Central London had been selected as the accelerator hub for London which meant that it needed to recover its elective lists faster. Sarah Mansuralli noted that there was an aim to provide 120% activity which was a challenge but that North Central London would be working creatively and using clinical triage, out of hospital, and other support mechanisms. Work was underway to consider how to maintain capacity in the system, including working closely with social care; it was added that the Integrated Discharge Team had been very effective and was being maintained to retain capacity. It was also explained that the pandemic had acted as a catalyst for some culture changes, including recognising the interdependency of different health and care sectors, which had resulted in improved outcomes for patients and learning for the system.

The Chair asked about oxygen resilience and funding options within North Central London. Sarah Mansuralli acknowledged that there were some global issues with oxygen supply during heights of demand and noted that she would check what arrangements were in place.

The Chair noted that, following Brexit, a number of health and care staff had left the country which increased demands on the workforce. She stated that there were concerns that the aim to provide 120% capacity as part of the Covid-19 recovery programme would have a significant impact on the workforce. Sarah Mansuralli acknowledged that this was a concern and explained that work was ongoing as part of the Integrated Care System (ICS) People Strategy to work on workforce retention and resilience. It was noted that new models of care would include progression and professional development opportunities for staff. It was noted that it might be useful for the Committee to receive an update on workforce strategies.

Cllr Tomlinson enquired whether the use of North Central London as an accelerator hub would result in extended hours. Sarah Mansuralli explained that surgery would be extended to provide additional hours during the week and during the weekend. Paul Sinden, CCG Chief Operating Officer, stated that the system was looking to protect elective capacity and general capacity for winter pressures and/ or Covid-19 surges. It was explained that North Central London had been given accelerator status as it was organised in a way where it was able to provide additional capacity.

The Chair noted that there had been some changes to services, particularly services for children, during the Covid-19 pandemic. It was stated that there was some confusion amongst patients and that some children and parents were now attending A&E when it was not essential. It was enquired whether services were likely to change again and whether additional or improved communications were anticipated. Sarah Mansuralli explained that the paediatric units had now reverted to their previous service provisions and no immediate changes were planned, although it was acknowledged that it was not always possible to predict what would be required in the future, in the event of a further surge. She noted that a number of lessons relating to communications had been learned during the pandemic and that some good relationships had been developed, including with local authorities and schools. It was added that some communications in relation to common childhood conditions were being produced and this would be shared with the various communications networks soon.

RESOLVED

1. To note the update on the Covid-19 pandemic.

2. To request a future workforce update.

10. UPDATE ON AT MEDICS

This item was considered under Item 5, Deputations / Petitions / Presentations / Questions.

11. WORK PROGRAMME

1 October 2021

- Digital Inclusion and Health Inequalities
- Review of Mental Health and Community Services
- Mental Health Update
- Integrated Care Systems

The Chair noted that there were a number of items on the Committee’s forward plan and that a more detailed discussion of the agenda for November would be discussed at the Committee’s next meeting. It was added that the Chair would receive briefings on some other developments, such as service changes at Barndoc, and would report back to the Committee if required.

26 November 2021

- Fertility Review
- Royal Free Maternity Services
- Missing Cancer Patients
- Children’s Services
- Finance
- Winter Planning
- Screening and Immunisation
- Emergency and Recovery Planning Update
- Estates Strategy Update

12. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

13. DATES OF FUTURE MEETINGS

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

1 October 2021 (previously 24 September 2021)
26 November 2021
28 January 2022
18 March 2022 (previously 25 March 2022)

CHAIR: Councillor Pippa Connor

Signed by Chair ………………………………..

Date …………………………………

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Health Inequalities: update on the work of the CCG Communities team and work with local partners

1. NCL CCG & Health Inequalities

This report focused on work being driven by our Communities Team – a new team in place as part of NCL CCG Borough Directorate since November 2020.

The team was developed to support a cross-organisational focus on inequalities and the development and delivery of clear plans to address these. Five key objectives were set:

1. Work with teams across NCL to reduce variation in access, outcomes and experience

2. Identify the highest priority needs to address in order to achieve this, including through review of the traditional understanding of 'need'

3. Support the development and delivery of interventions to reduce health and wider inequalities

4. Recommend change to priorities and/or decision making approaches where this will support greater equity and equality

5. Foster and spread a culture of equality and ensure addressing health inequalities is an integral part of everyone's role

Our objectives were reinforced by guidance issued throughout 20/21 and 21/22. This includes the 21/22 Planning Guidance (which required a focus on the most deprived 20% within our population) and ICS Guidance, which has consistently emphasised the need to improve outcomes in population health, tackle inequalities in outcomes, experience and access, and take account of the wider determinants of health.

Most significantly, our objectives have been shaped by our learning from COVID and the COVID vaccination campaign, our work with health inclusion groups (those experiencing homelessness, refugees and asylum seekers) and our active development of new relationships with community and voluntary sector organisations who are a crucial partner in local partnerships and delivery.

In the five months since our last update, key achievements driven via the Communities team with support from CCG colleagues and wider system partners have included:

- £400k identified for Community Participatory Research in families with childhood obesity (£150k CCG plus Enfield Council contribution £250k) and with Enfield Council, successfully procured community participatory research, community health champions and a community chest which are launching in September 2021

- Additional £1m secured for the Shared Outcomes Fund monies to support the health of people experiencing homelessness and their discharge from hospital in NCL. Implementation in progress including accommodation and homeless intermediate care team

- Coordinating and supporting the delivery of COVID vaccinations for people experiencing homeless and people seeking asylum currently accommodated in hotels in NCL.

- LCS developed and commissioned to ensure we have a primary care support offer for people seeking asylum and the development of a sensitive and appropriate wraparound support offer delivered through an MDT approach

- Development of thinking to inform the future ICS approach to needs assessment, planning and financial allocation e.g. looking at options / opportunities to target resources to areas of greatest inequality. For example, the Fenton report highlights the need for community participatory research to contribute to local needs assessment. Projects such as the childhood obesity research in Enfield will enable local communities to contribute to the needs assessment and co-produce solutions. We are also working with finance partners to look at how outcomes from the inequalities fund can feed into wider ICS financial planning.

- Ideas Exchange: events held for CCG and joint commissioning teams to help capture and share learning, embed understanding of inequalities and ensure addressing health inequalities is an increasingly integral part of everyone’s role. This is an informal meeting space where the Communities Team present analysis and progress on initiatives, and wider staff can then contribute ideas or reflections.

- Community wealth building and Anchor Institutions:
    - established a Greener NCL programme to develop plans to address the climate emergency and deliver on NHSE&I’s Greener NHS’ expectations of a zero carbon NHS.
    - working with procurement leads across the system to establish and extend social value procurement in NCL

    - working with local authority partners to develop and improve local recruitment into health and social care jobs.

- Work started alongside the CCG Communications and Engagement team to develop a local VCS Strategy. Closer engagement has been a key part of progress made throughout the pandemic, but this is now being formalised in a document to be presented by the Communications and Engagement team.

  The VCSE strategy includes:
    - A best practice approach for staff across the organisation.
    - An approach which can be used at NCL level and can be practically applied through Place-based partnerships.
    - Key areas identified so far for the strategy are:
        - ensuring the voice of the VCS is heard within the ICS & as it develops
        - developing procurement processes which support the VCS to work with us – from larger organisations to grass roots VCS
        - developing how we commission community projects so that our approach supports and empowers local communities
        - Measuring impact: as a system developing the case for investing in community-led & strength based projects

- NHS England have also provided funding and support to set up an NCL VCS alliance and details are being fully developed, led by the VCS in NCL
    - The VCS alliance will consist of a steering group made up of 5 VCS umbrella organisations – alongside 5 further organisations that represent key community groups across NCL.
    - The steering group will feed directly into the ICS board & Community Partnership Forum

- The strategy will be developed alongside & with the VCS alliance – both will complement the other & ensure we embed the VCS within NCL ICS

In addition to the above, the team worked with the CCG Strategic Commissioning and Finance teams and with partners, to shape and launch a major investment programme – the NCL Inequalities Fund. This is outlined in more detail in the following sections.

2. Inequalities Fund

2.1 Background and purpose of the Inequalities Fund

In May 2021, NCL CCG and health partners created an Inequalities Fund to support new ways of working with our communities and help address disparities in access, experience and outcomes between our most deprived and least deprived communities.

The purpose of the fund is to support partnerships within North Central London to address the wider determinants of health inequalities, taking into account the recommendations in PHE's *Beyond the Data* report and the need to focus on the 20% most deprived wards as set out in the 2021/22 NHS Planning Guidance.

The objectives of this fund are as follows:

- To fund innovative and collaborative approaches to delivering high impact, measurable changes in inequalities across NCL
- Solutions which break down barriers between organisations and develop both new and extend existing relationships
- Targeting the most deprived communities and to reach out proactively to our resident black and minority ethnic populations
- Help form Borough, Multi-Borough and NCL wide partnerships to deliver high impact solutions
- Engage our population, the VCS and our partners across health and care in making a difference to the lives of our people

Each Borough Partnership was allocated for a proportion of the fund with the proportion relative to deprivation and need in each borough. There was also a sum available for partnerships who wished to work across more than one borough.

2.2 Investment

The total value of non-recurrent investment for the first half of 21/22 is £2.5m, with the majority of this (£1.9m) being directed towards planning guidance priorities focused on deprivation within boroughs and a smaller proportion (£250K) being directed towards other local inequalities priorities within and across NCL plus £250k contingency. A further non-recurrent £1.25m has been set aside for the second half of 21/22 and there is a commitment to an annual non-recurrent investment next year of £5m. Investment is required to be spent in the financial year the funds are been allocated. The funding is currently being allocated on a non-recurrent basis and work is underway on the future investment in health inequalities post 22/23.

The planning guidance element of the funding was apportioned relative to the number of wards in the most deprived 20% in NCL. This resulted in the following headline values:

- Camden: 8 Proposals with a total value of £293,150
- Enfield: 7 Proposals with a total value of £652,156
- Haringey: 5 Proposals with a total value of £588,970
- Islington: 4 Proposals with a total value of £366,680
- Barnet does not have any wards in the 20% most deprived, but submitted proposals against the local priorities pot (see below).

Against the £250k funding for Local Priorities we received 8 proposals, of which 6 are being funded, with allocations as outlined below:

- NCL Cancer Alliance: £36,384
- Barnet - £28,500
- Camden: £25,000
- Haringey: £26,000
- Royal Free London – Barnet, Enfield Camden: £83,500
- Islington: £50,616

2.3 Proposals Received/Approved

Borough Partnerships, and other groups of local health and care partners, worked together to agree interventions and schemes that will positively impact outcomes locally and submitted these plans for review by an NCL-wide panel that included Public Health, Lay Members and Patient and Public Representation.

32 proposals were received against the first tranche of monies in June 2021. Appendix 1 provides an overview of the funded schemes from phase 1, including a summary of the scheme and a timescale for the anticipated impacts. Approximately £200k of the contingency was approved for short term work in the area of Children's Therapies to help mitigate inequalities in access to services and £50k has been identified for programme evaluation to inform the development of the Inequalities Fund in future years.

Examples of the schemes submitted are below:

- **Islington ICP: Early prevention – Black Males (£130k):**
  To address inequalities experienced by black men, such as a 10-year lower life expectancy and being four times more likely to be over represented in psychiatric hospitals, Islington ICP are rigorously test out culturally competent community crisis and trauma interventions to address systemic inequalities in high ward deprivation areas. The programme is structured in three parts covering early intervention (focused on Holloway and Tollington Park), crisis prevention intervention (Holloway and Finsbury Park) and whole system training. Over-arching goals to reduce crisis presentation at secondary care or acute level services in the medium to long term.

- **Enfield & Haringey ICPs (joint scheme) – Family Mentoring (Parentcraft) (£188k 21/22, £327k 22/23)**
  Analysis of children aged <1 year (infants) presenting to A&E has indicated that as much as 50% of presentations are for self-limiting illness and avoidable. Since May 2019, NMUH has been piloting workshops (basic child health and family wellbeing curriculum) covering child health concerns, Basic Life Support (BLS), illness prevention, and health services education. Parents have co-produced the workshops. An important aspect has also been that parents are invited to stay in touch through a peer Whatsapp group. The funding strengthens and extends delivery all parents of under 1s in Enfield

and Haringey in the most deprived wards in both. NMUH leading the delivery in close partnership with LA, CCG, primary care and families.

- **Barnet ICP – Early Years Oral Health (£29k 21/22, £50k 22/23)**
  Aiming to reduce inequalities and the burden of children's preventable oral disease through the introduction of a targeted supervised tooth brushing programme. One quarter of Barnet's children have visibly decayed teeth by age five. Children eligible for free school meals are significantly less likely to brush their teeth twice per day than other children aged five. Pilot to offer supervised tooth brushing to 40 EY settings in Barnet for up to 3,200 children. It would cover at least Colindale, Burnt Oak, Woodhouse and Childs Hill wards where over one third of children live in poverty.
  The programme contributes to three of the 2021/22 NHSE operational planning guidance priorities – namely improving local health outcomes and addressing health inequalities, transforming community care to prevent inappropriate attendance at emergency departments by reducing dental disease and the need for extractions, and working collaboratively across the system through the engagement of both health and educational sectors.

- **Camden ICP – race and autism (£25k)** A Local Authority led bid to develop an autism and race equality action plan to address unequal outcomes across the life course of autistic residents with a commitment to work meaningfully with our citizens, autistic-led organisations, partners across health, education, social care, police, the third sector and organisations specialising in race equality. The plan will include actions and recommendations for innovative co-design, co-producing plans for intervention and service development, reducing barriers between organisations.
  Funding will be used for autistic-led & race equality organisations to lead the work, Community Researchers to facilitate focus groups with stakeholders, data collection and other project costs (i.e. interpretation, reward and recognition for people's contributions).

Borough partnerships and scheme leads were notified of successful bids in early July. Since then detailed work has been done including: detailed mobilisation plans; development of scheme metrics; funding draw down & contracting arrangements; set-up of local and NCL oversight & reporting arrangements; communications to partners; development of job descriptions & recruitment; development of engagement approaches; and, phase 2 planning.

2.4 Initial reflections

To date the Inequalities Fund has fostered a spirit of collaboration within - and across - Borough Partnerships and groups within NCL, led to increased levels of engagement with inequalities, and the development of innovative approaches to address entrenched inequalities challenges.

There is qualitative evidence to suggest the Fund is helping partnerships build on the momentum of the COVID and flu vaccination campaigns and deliver against action plans developed in response to the stark inequalities the pandemic shone a light on.

In a testament to the partnership working accelerating locally, Borough Partnerships and other groups of partners within NCL were able to coalesce around plans and proposals and take decisions together about the projects that should be put forward for approval in a matter of weeks.

In phase one many plans were ready to go, but as we move into phase two for 21/22 (and into 22/23), partners are keen to work with a longer timeframe to allow time for reflection and learning, for new schemes to be developed with detailed mobilisation plans, and to ensure there is the opportunity to consider synergy between and across schemes and to partner where sensible (given a number of boroughs came together to work with shared populations and patient groups). In phase two, our financial allocation methodology will also be updated to take account of work needed in smaller pockets of deprivation within wards.

We will also further embed co-production in the process and approach to the Fund. Whilst many schemes are about innovation and joint working alongside communities, partners have noted the need to build community capacity to ensure those at most risk of suffering health inequalities, are given sufficient opportunity to contribute to the development of solutions.

As we move forward and into the ICS, grassroots involvement is increasingly needed to understand barriers to good health and wellbeing and to identify and coproduce interventions with local communities. Coproduction achieves better outcomes, builds stronger communities and optimises resources. This has been demonstrated in the COVID vaccination programme, where outreach work has been undertaken across

The impact of coproduction, asset-based and place-based approaches

Example: The Wigan Deal
Since 2010, public services in Wigan have been through a major transformation process, driven by the need to build a different relationship with local people. The new approach to delivering services is known as the 'Wigan Deal' which invests in social infrastructure and communities. The Deal takes an asset-based approach in which public services seek to build on the strengths and assets of individuals and communities. The Deal has also allowed innovation and had a focus on place-based working. Examples of changes include community groups taking over the running of services, community investment projects, personalising packages of care. As well as improving outcomes for residents, the Deal has achieved savings of £160m over 10 years for the council.

NCL to understand differential uptake in the vaccine across communities and respond to this. Borough Partnerships and others need to continue to embed this approach as we move forward:

The Inequalities Fund is an early example of health and system partners in NCL working in new ways with communities and investing further upstream in proactive and preventative care and support. It is also an early example of resources being shared via partnerships (as opposed to individual services or sectors) with shared learning across NCL.

An early benefit is the ability to expand schemes which started as local initiatives into bids for national funding. For example the Enfield Serious Youth Violence scheme (DOVE) has underpinned an NCL bid for three years' worth of NHSE/I funding to address Serious Youth Violence across NCL, with local work enabling us to demonstrate and articulate need and how local partnerships would deliver this work.

Recently, the Communities Team were asked to present the NCL Inequalities Fund work to the National Health Inequalities Network chaired by NHSE/I Director of Inequalities Dr Bola Awolabi. The scheme was extremely well received with much interest in how our emerging ICS is focusing on the inequalities agenda.

We are keen to demonstrate the impact of our work around inequalities; however, given many schemes are comparatively small-scale interventions, and that deep seated health inequalities will not be resolved quickly, we must apply a proportionate level of monitoring and accountability. Each scheme is reporting against tailored measures (set out in their approved bids) and will be asked to participate in an overarching evaluation by an external partner. We are keen to understand impact at an individual level on access (for example, of outreach workers working with local black communities), experience (level of control / agency, feeling as though you are treated with dignity and respect), and outcome (for example, reaching or avoiding crisis). System finance leads will consider individual and system benefits later this month.

2.5 Next Steps

We are mobilising phase one schemes and planning for phase two of the Inequalities Fund. For Phase two the intention is to retain an allocative formula based on NCLs 20% most deprived communities but to increase the proportion available to cross-borough bids, wider inequalities objectives (such as Learning Disabilities and Inclusion Health groups) and schemes that address pockets of deprivation within wards (Lower Super Output Areas – LSOAs). We plan to develop work with partners to develop schemes in October 2021 and mobilise January - April 2022. Proposals will need the formal support of Borough Partnerships, before being submitted for formal consideration and approval.

Racial inequality is a particularly important element of our work around health inequalities more broadly. Inequalities Fund schemes such as the Camden mental health programme focusing on needs of Bengali and Somali communities and Enfield Black Health Improvement Programme will be built upon, with further work planned to develop our understanding through engagement and Population Health Management analysis.

3. Next steps in addressing inequalities

The Inequalities Fund is only one of a number of ways in which NCL CCG and partners are looking to develop our understanding of our population and address inequalities.

Other elements contributing to this include the development of a population health strategy and tools, working towards agreed measures of need across the five boroughs, reviews of Mental Health and Community provision and the development of ICS principles which articulate our commitment to tackling inequalities through a renewed partnership with the people and communities most impacted by them.

As we move into the second half of 21/22, the Communities team specifically will be driving work with the wider CCG and partners to address inequalities including further work in the following key areas:

- Support those who are homeless or without fixed accommodation
- Work with refugees and asylum seekers and recent arrivals from Afghanistan
- Work on the Green agenda and Carbon Net Zero
- Work with the region on the evolution of HIV care in London supporting delivery of commitments made by the London Mayor.

As we move into this ICS, the priorities described above and our approach to these will continue to develop.

4. Conclusion

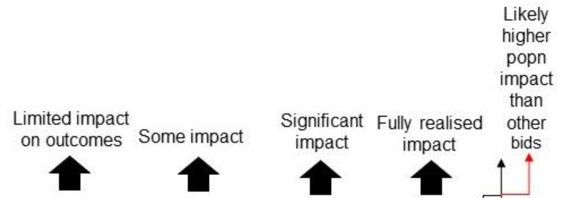
The JHOSC is asked to: Note and comment on the contents of this report and the direction of travel for this important work.

Appendix 1: Overview of funded schemes in phase 1 of the NCL Inequalities Fund

Impact Timeline – Planning Guidance (£2m)

Key to Potential Impact for Slides

KEY
See table below.
20% DR = Residents living in 20% most deprived areas
MF = 'Match Funded'



Source	Bid Name, Cost, Target	Issues Addressed & Impact	Anticipated Timeline for Delivery				MF
Source of Bid	Bid Name, Cost, Target Popn. + Target Nos./Impact	**Focus of Inequalities in Bid** Expected Health/Life Chance Outcomes	Partial	Partial	Partial	Full (H)	Yes – financial or In Kind or No
		Anticipated Secondary Care Impact	Partial	Partial	Partial	Full (H)	

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Haringey/ Enfield ICPs	**13/20. Family Mentoring Parentcraft** (£188k 21/22, £327k 22/23 reaching 1,140 parents from 3,000 target infants. c 5,200 & 770 EDs & NELs 0-2 per annum 19/20)	**Focussed east Boroughs/20% DRs** Promote ethnicity-related inequality Promote best start in life/parenting Address family social/MH needs	Partial		Partial	Full	H	N
		Reduced 0-3 utilisation of ED/GP 0-3	Partial	Partial	Partial	Full	H	
Haringey ICP	**21. Start Well MH Arts/Sports** (£146k 21/22, £250k 2022/23 reaching 250-300 12-19 vulnerable/at risk; no specific relationship to secondary care)	**Cross-Boroughs but 75% in 20% DR** Promote ethnicity-related inequality Proactive MH/well-being for YP Support for vulnerable groups	Partial	Partial		Full		Y - £25k match fund
		Not stated but potential future benefit					Full	
Haringey ICP	**22. Tottenham Talk: MH Support** (£155k 21/22, £217k 22/3; target 1.9%-2.2% of east popn with SMI; reduces risk of crises – leading to secondary care but no specific target	**Focussed east Boroughs/20% DRs** Promote ethnicity-related inequality Proactive MH mgt for SMI individuals Support for wider social issues	Partial	Partial	Full		H	N
		MH secondary care crisis prevention	Partial	Partial	Partial	Full		

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Haringey/ Enfield ICPs	**12/24. People with Severe & Multiple Disadvantage (SMD) who are HIUs** (£82k 21/2, £140k 22/3 reaching 130 HIUs. 40% fall in EDs/NELs for group)	**Focussed east Boroughs/20% DR** Promote ethnicity-related inequality Proactive PH & MH management Addressing SMD social/housing need	Partial	Partial		Full		Y – In kind
		Reduced utilisation of ED/NEL by HIU	Partial			Full	H	
Haringey/ Enfield ICPs	**10/23. Multi-agency LTC (CHD/CHF/diabetes/ multi-morbidity) Support Model** (£319k 21/2, £548k 22/3 reach 1k people at risk of/ with LTCs. Reduced ED/NEL	**Exclusive east Boroughs/20% DRs** Promote ethnicity-related inequality Reduced risk of acquiring LTCs Proactive LTC, social & housing mgt	Partial	Partial		Full	H	Y - £25k VCS Funds
		Reduced (by 22%) ED/NEL utilisation	Partial	Partial	Partial	Full	H	
Enfield ICP	**9. Black Health Improvement Outreach Project** (£37k 21/2, £55k 22/3 target 12% popn from black ethnic backgrounds – higher % in 20% DRs with LTCs/MH	**Focussed east Boroughs/20% DRs** Promote ethnicity-related inequality Reduced risk of acquiring LTCs/MH Proactive health, social & housing mgt	Partial	Partial	Partial	Full	H	Not referenced
		Not stated but potential reduced utilisation of GP, acute/non-acute care	Partial		Partial	Partial	Full	
Bronde-bsury Medical Centre (Camden - Not ICP)	**8. Health Equalities Programme** (£51k 21/2, £68k 22/3 to target 50-55 year olds in Kilburn & ethnic groups via health checks)	**Focus 20% DRs/ethnicity inequalities** Proactive PH & MH management Reduced risk of/worsening LTC	Partial	Partial	Partial	Full		N
		Not stated but potential reduced utilisation of GP, acute/non-acute care		Partial	Partial	Full		

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Enfield ICP	**11. Enfield/NMH Connections** (£72k 21/2, £107k 22/3 – to 40% NMUH EDs/NELs from 20% DRs – with worse health/ social outcomes. No specific targets for reduced NEL/ED)	**Focussed east Boroughs/20% DRs** Promote ethnicity-related inequality Reduced risk of/worsening LTCs Proactive LTC, social & housing mgt	Partial	Partial	Partial	Full		Y - In kind
		Reduced repeat ED/NEL attendances	Partial	Partial	Partial	Full		
Enfield ICP	**14. Divert & Oppose Violence Worker** (£55k 21/2, £99k 22/3 to east YP who have worse outcomes; no targets for numbers or ED reduction)	**Focussed east Borough/20% DR** Partly address ethnicity inequality Address social issues in C&YP	Partial	Partial	Partial	Full		Y-30k LBE relate
		Reduced serious youth violence ED/NELs		Partial	Partial	Partial	Full	
Enfield ICP	**15.VCS/Primary Care Smoking Cessation** (£300k target @ 28k (6k with comorbidity) smokers in east – DRs have higher LTC rate. No targets for ED/NEL reductions).	**Exclusive to east Boroughs/20% DRs** Partly address ethnicity inequality Reduced risk of/worsening LTC Support for wider social issues	Partial		Partial	Full	H	Y–30k LBE-related
		Not stated – likely to be ED/NELs		Partial	Partial	Partial	Full	

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Camden ICP	**1. Barriers to Accessing Post-Covid Syndrome Services** (£14k 21/2 one-off; target engagement with PCS-affected DRs & ethnic groups. No targets for engagement)	**Focus on 20% DRs/other inequalities** Improved public-sector engagement Improve health recovery & LTC mgt Improve social life chances	Partial Research Completed Oct		Full			Limited – in kind
		Not stated but potential future benefit			Full			
Camden ICP	**2. Camden Childhood Immunisation Programme** (£29k 21/2, £38k 22/3 target at 20% DR families & specific ethnic groups. No targets for no. of people engaged/impact	**Focus on 20% DRs/other inequalities** Improved public-sector engagement Improved health life chances	Partial	Partial	Partial	Full	H	Limited – in kind
		Not Stated						
Camden ICP	**5 MH Empowerment in Bengali & Somali Communities** (£29k 21/2, £50k 22/3 target at woman in communities with poor MH outcomes. No targets for no. of people engaged or secondary care impact)	**Focus on ethnicity inequality**/20% DR Improved public-sector engagement Improve health recovery & LTC mgt Improve social life chances	Partial	Partial	Partial	Full		Potential
		Not Stated						

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Camden ICP	**4. LD Annual Health Check Audit** (£25k one-off target those with LD in 20% DR practices, 1/3 1+ LTC. No targets for no. cases/ secondary care impact	**Focus LD-related inequality/20% DRs** Proactive LTC management Improve social & health life chances	Partial (Audit Completed)	Full				N
		Not stated - mitigated secondary care?		Partial	Full			
Camden & Islington ICPs	**5/18. PrimroseA** (£133k 21/2, £142k 22/3 target engage-ment with SMI patients of 20% DR PCNs. No targets no. of patients/impact on secondary care)	**Focus on 20% DRs/other inequalities** Promote ethnicity-related inequality Proactive MH & LTC management Addressing SMD social/housing need	Partial	Partial	Full		H	N
		Reduced MH secondary care activity	Partial	Partial	Full		H	
Camden ICP	**6. Self-Care Community Champions** (£16k 21/2 one-off target at specific people from non-WB backgrounds. Target 200+ people but no impact on secondary care	**Focus on ethnicity inequality/20% DR** Improved public-sector engagement Improved PH & MH & social mgt	Partial (Project Completed)	Full				N
		Not stated – but potential impact on mitigating ED/NELs	Partial	Partial	Full			
Brondesbury Medical Centre (Camden - Not ICP)	**7. Kilburn Ward Outreach** (£72k 21/2, £96k 22/3 target engagement to practice patients in 20% DR/ethnic groups. No targets for no. of people engaged or secondary care impact)	**Focus on 20% DRs/other inequalities** Promote ethnicity-related inequality Improve health prevention Improve MH & LTC & social needs	Partial (Project Completed)	Full				Y – 50% LBC MF
		Not stated - mitigated secondary care	Partial	Partial	Full			

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Islington ICP	**16. Respiratory Well Project** (£100k 21/2, £171k 22/3 targeted at 20% DRs with respiratory & other LTCs – 10%+ all NCLs respiratory. No targets for no. cases/ secondary care impact	**Focus on 20% DRs with LTCs** Reduced risk of acquiring LTCs Proactive LTC, social & housing mgt	Partial	Partial		Full	H	N
		Reduced utilisation of ED/NELs	Partial		Partial	Full	H	
Islington ICP	**17. Early Prevention – Black Males & MH** (£130k to address MH & social issues. No targets no. of patients/ secondary care impact)	**Focus on ethnicity-related inequality** Proactive MH/wellbeing management Address social needs	Partial	Partial	Full		H	Y-LBI 50% match
		Reduced acute/non-acute activity	Partial	Partial	Partial	Full		
Islington ICP	**19. PHM Approach in 20% DRs** (£60k 21/2, £80k 22/3 targeted at specific ethnic children & adults. Target 200+ people but no impact on secondary care	**Focus on 20% DR/ethnicity inequality** Improve population health mgt Improve health prevention Improved LTC & MH and social mgt	Partial		Full			Y-LBI 50% match
		Not stated but potentially linked						

Impact Timeline – Local Priorities (£250k)

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Islington ICP (across Haringey & Islington)	**LP 8. Ambulatory outreach interventions on marginalised and hard-to-reach groups** (*Funding to be confirmed* health-orientated engagement with 20% DRs. No targets for no. people engaged/acute care impact)	**Focus on 20% DRs/other inequalities** Improved health prevention Improved LTC & social needs mgt	Partial	Partial	Full			N
		Reduced ED/NEL activity		Partial	Partial	Full		
Haringey ICP	**LP 7. Complex Autism Project** (£26k 21/2, £59k 22/3; part of wider project which 'non-20% DR' IF could contribute – no specific targets	**Cross-Borough** Proactive mgt of complex cases Proactive MH mgt of clients Support to address social needs	Partial	Partial	Full			Y – match fund
		Reduced MH inpatient activity	Partial	Partial	Partial	Full		
Camden ICP	**LP 6. Focused autism and race equality project** (£25k one-off targeting autistic children & adults from specific ethnic groups. No targets for number of people to be engaged or impact on secondary care	**Focus on ethnicity-related inequality** Improve social & health life chances Improved public-sector engagement Improve community participation	Partial (Research Completed)		Partial	Full		Y – in kind
		Not stated but potential					Full	

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Barnet ICP	**LP 5. Early Years Oral Health** (£29k 21/2, £50k 22/3: target 3.2k children in Barnet deprived wards – x3 higher tooth decay. Savings estimated no acute targets	**Focus on deprived/ethnicity inequality** Improved social outcomes	Partial	Partial	Full			Y – in kind
		Not stated						
NCL Cancer Alliance	**LP 4. Support Earlier Cancer Presentation** (£36k 21/2, £53k 22/3 targeted at 20% DRs & ethnic groups to address late diagnosis. No targets for numbers & impact	**Focus on 20% DRs** Improved ethnicity-related inequality Improved public-sector engagement Improved LTC & cancer outcomes	Partial		Partial	Full		Y - £10k for evln
		Not stated – but likely to be ED/NELs		Partial		Partial	Full	

Further Work Needed – For Pipeline

Source	Bid Name, Cost & Target	Issues Addressed & Impact	Q3/4 21/22	2022/23	2023/24	2024/25	Post-24/25	MF
Camden ICP	**LP 2. Lifestyle Hubs** (£83k 21/2, £152 22/3). Target lifestyle changes for people identified by RFL, Camden, Islington, Barnet. No targets for numbers & impact	**Cross-NCL, some focus on 20% DRs** Reduced risk of/worsening LTC Support for wider social issues	Partial	Partial	Partial		Full	N
		Not stated – likely reduced ED/NELs		Partial		Partial	Full	

Agenda Item 10

REPORT TITLE NCL Mental Health Programme Update	
REPORT OF North Central London Clinical Commissioning Group	
FOR SUBMISSION TO Joint Health Overview and Scrutiny Committee	**DATE** September 2021

SUMMARY OF REPORT

This paper provides the Committee with an update on the NCL mental health programme. In particular the paper will focus on:

- the mental health service response to the Pandemic ;
- system wide investment in to mental health services in 2020-21 and 2021-22;
- transformation activities carried through the first year of the Pandemic to date, and;
- mental health system challenges; meeting demand sustainably

Local Government Act 1972 – Access to Information

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

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RECOMMENDATIONS
The Committee are asked to **NOTE** the contents of the report

1. INTRODUCTION

1.1 This paper provides the Committee with an update on the NCL mental health programme. In particular the paper will focus on:

- the mental health service response to the Pandemic;
- system wide investment in to mental health services in 2020-21 and 2021-22;
- transformation activities undertaken during the Pandemic to date, and;
- mental health system challenges; meeting demand sustainably

2. RESPONDING TO COVID

2.1 Like most areas of the North London health and care system, in response to the Pandemic the Mental Health system came together to rapidly implement services to support people through the Pandemic

2.2 To divert adult patients away from A&Es, the system established a mental health clinical assessment service at St Pancras Hospital that is open to self-referral, ambulance conveyance and referral or redirection from A&E departments across NCL.

2.3 For children and young people, a similar model was established, with two hubs operating to divert children and young people away from A&E, where appropriate to do so. Additional liaison, out of hours and specialist eating disorders capacity was also secured recognising the increased demand.

2.4 The mental health system in NCL also brought forward plans to introduce an all age crisis line and put in place the crisis lines as part of the system response to the first wave of the Pandemic.

2.5 Following the first wave of the Pandemic, the system utilised Mental Health Investment Standard (MHIS) funding to maintain services established in response to the first wave, recognising the need to prepare and respond to future surges which were likely to increase demand for mental health services. In addition, to comply with infection prevention and control guidelines, the system secured additional bed capacity to minimise the need for out of area placements.

2.6 To ensure the sustainability of services set up as part of the Pandemic response NCL invested an additional £17.9m in to mental health services in 2020-21. This funding was disproportionately weighted towards children and young people's services in accordance with NHS planning guidance relating to the MHIS funding.

3. IMPACT OF THE PANDEMIC ON MENTAL HEALTH SERVICES

3.1 The NHS learns more each day about the physical effects of Covid-19, however the longer term impact on mental health remains unknown, experts are predicting that there will be a surge in mental health demand

3.2 Children and young people have spent long periods away from school and friends. Not all children respond in the same way to the stresses of long periods in 'lockdown'. The system in NCL has already started to see an increase in demand for services. In particular, Eating Disorders services for children have seen a substantial increase in the volume and acuity of referrals.

3.3 Adults and the elderly are also likely to be impacted by the negative effects of long periods of social isolation, as are health workers whose health has been directly at risk in responding to the Pandemic.

3.4 Mental Health providers in NCL have been instrumental in establishing the NCL Mental Health and Well Being hub for all health and care staff.

4. TRANSFORMATION OF MENTAL HEALTH SERVICES 2021-22

4.1 In 2021-22 following significant investment in 2020-21, the system continued to invest in mental health services

4.2 NCL ICS intends to invest £39m in to mental health services in 2021/22 with plans for utilising this investment geared towards addressing areas of poor performance, ensuring more equitable access to care and a greater focus on the impact of inequalities for the communities we serve.

4.3 The challenge in 2022-23 will be to maintain the range of provision in light of increased demand and acuity of presentations while continuing to meet recovery and performance trajectories. A summary of areas of transformation is set out below.

4.4 CURRENT AREAS OF TRANSFORMATION IN MENTAL HEALTH SERVICES

4.4.1 Crisis and liaison care

4.4.1.1 Our NCL mental health system set an ambition for comprehensive crisis pathways able to meet the continuum of needs across our population whether it be in communities, people's homes or emergency departments. We will continue to work with system partners including Local Authorities, the VCS, Police and LAS to deliver comprehensive and accessible crisis pathways to improve outcomes for patients and the wider system.

4.4.1.2 Current areas of transformation are as follows:

- **Single Point of Access 24/7 crisis lines**: People living in NCL will have a single point of access to timely universal mental health crisis care, joined up with NHS 111 pathways via our MH Trusts Single Point of Access 24/7 crisis lines.
- **Urgent and emergency services - Liaison on acute sites:** working together to ensure people are directed to the right level of care. All NCL acute hospitals will have an all-age mental health liaison service in A&E departments and inpatient wards. There is increased funding (£1.25m) to deliver mental health liaison services in NCL Acute Trusts A&Es and wards.
- **Crisis café and crisis house provision:** We are increasing capacity and extending a number of alternative forms of crisis support provision to provide a more suitable alternative to A&E for people experiencing a mental health crisis. Interventions include a crisis café in every borough, as well as increased capacity and support in a Crisis House in the northern boroughs of NCL.
- **Mental Health Crisis Assessment Service:** Established during the first wave of the pandemic to divert mental health patients without a co-existing physical health need to a Crisis service outside of acute trusts. The service will continue to support delivery of Mental Health Liaison Standards, supporting local acute sites as we move through the winter period.
- **London Ambulance Service;** We are extending the joint London Ambulance Service paramedic and Mental Health Nurse outreach service, which provide a quick response car with specialist mental health clinicians, rather than ambulance, to be able to see patients at home or on the street, and in many cases avoid transferring to A&E.
- **THINK 111:** We will be piloting the extension of the THINK 111 service to incorporate a 'press 2' option for patients calling in mental health crisis to reach a specialist mental health professional and to be able to directly book appointments into the most appropriate services
- **Rough Sleepers:** The Rough Sleeping Mental Health Service is a new service and will work with around 120 – 150 people many of whom will have experience of psychosis, difficulties with personality problems, anxiety and depression. The level of interventions will range from triage assessments to short-term casework/treatment.

4.4.2 Inpatient care

4.4.2.1 Throughout the Pandemic and as we move through the winter period, flow through our inpatient wards has been a high priority. As a system, through greater working between our Trusts and the extension of initiatives to support discharge, we intend to improve hospital flow and reduce the need for out of area placements. In the former part of pandemic, flow was impacted due to the need for cohorting patients to avoid hospital transmission of COVID-19. This was necessary due to old estate. The opening of Blossom Court has minimised the need for cohorting patients.

Cohorting refers to keeping those patients who have or are suspected to have COVID-19 in the same space (wing, ward) separate to those who are COVID-19 negative to minimise the spread of the virus.

4.4.2.2 Current areas of transformation are as follows:

- **Inpatient bed provision:** As a system, we have invested in additional bed capacity at Barnet, Enfield and Haringey MH Trust to reduce the number of patients requiring placement out of area and to support Covid clinical management and infection prevention and control requirements.
- **Mutual aid between providers:** All inpatient teams are working towards eliminating out of area placements through mutual aid, sharing beds where appropriate to do so.
- **Improved flow and management of demand**: Additional funding has been invested in a range of discharge schemes to support flow and discharge management.

4.4.3 IAPT

4.4.3.1 Increasing access in IAPT therapies for the IAPT population cohort, embedding digital approaches and reducing disparities in the experience and outcomes of protected groups are core priorities for the system in NCL.

4.4.3.2 Current areas of transformation are as follows:

- **Digital and online support:** NCL IAPT providers are securing additional capacity.
- **Patients from Black and Minority Ethnic backgrounds (BAME)** all services are planning to use the 2021/22 investment to recruit therapists' with a role in outreach to BAME groups.
- **Long Term Conditions (LTCs):** IAPT services have embedded LTC pathways in their services, working closely with community health providers.
- **Post Covid Syndrome Pathway** is being developed to support patients requiring access to IAPT

4.4.4 CAMHS - Children and young people's mental health

4.4.4.1 We know that many people first start to experience mental health difficulties when they are children, and that the incidence of childhood mental health concerns has been rising. This is why we will be investing in children and young people's (CYP) mental health services at a faster rate than mental health services overall. This reflects the significant impact our children have faced during the pandemic.

4.4.4.2 Current areas of transformation are as follows:

- **Diversion hubs and Enhanced liaison**: NCL CAMHS crisis service to increase to include seven sites, including the north and south hubs operating 0900-00:00, as well as the 5 NCL hospitals. This will support diversion from the A&Es departments.
- Additional investment provided to the **specialist Eating Disorders** service taking account of the increase in demand seen through the Pandemic. In addition, the system will invest in additional **community Eating Disorders** support in to generic CAMHS teams.
- **Community CAMHS capacity has** increased through investment in to CAMHs Home Treatment Teams and the generic CAMHS team.
- **Crisis line:** The specialist NCL CAMHS 24-7 Crisis line operates alongside the BEH 24-7 Crisis Line and provides a dedicated CYP MH crisis support 17:00 – 00.00 on weekdays and 09:00 – 00.00 on weekends and bank holidays. Investment will ensure there is a designated CAMHs call handler operating everyday between 09:00 and 17:00, alongside the core team who can provide immediate and specialist CAMHS guidance to CYP and their carers.
- **Mental Health Support Teams (MHSTs)** are jointly delivered in partnership with schools. MHSTs are intended to provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing. Across North London there are eleven Mental Health Support Teams working across a range of education settings. In Islington and Camden the teams, of which there are two in each borough, work with all of the state funded primary and secondary schools in the borough. In Barnet, Enfield and Haringey the Mental Health Support Team offer is more targeted. Currently not all schools have access to a Mental Health Support Team, however through further waves of roll out we expect to move to a position where we achieve 100% coverage of the programme across NCL.

Table 1. Mental Health Support Team provision across North London

Borough	Camden	Haringey	Barnet	Enfield	Islington
Start date	Jan 2019	Jan 20	Jan '20 (W2); Nov '20 (W3)	Jan 20	Jan 20
No of MHSTs	▪ 2 MHST: North Camden MHST and South Camden MHST	• 2 MHSTs: sharing primary and secondary settings in east Haringey	• 2x MHSTs in west (W2); • 1x MHST in east and south (W3)	• 2 x MHST (Service now called ***My Young Mind Enfield***)	• 2 MHSTs: north and south of borough (called School Wellbeing Service locally)
Coverage	• All state funded mainstream schools • 10 X Secondary schools • 19 primary schools	• Primary and secondary schools in the east of the borough	• 55 state funded mainstream schools and colleges	• 16 schools Phase 1 January 2020 • 25 additional schools	• All state funded mainstream schools • 10 secondary schools • 45 primary schools

4.4.5 Adult Community Transformation

4.4.5.1 A priority area for investment is Community Mental Health Transformation Programme, which will deliver new and integrated models of community mental health care, embedded and wrapped around Primary Care Networks (PCNs) across NCL. To support residents with mental illness to have speedier access to a multi-disciplinary team of mental health staff to support them to live well in their communities. This will ensure that there is a core offer with equity of access and equity of outcome for all our residents

4.4.5.2 As part of the community transformation, programme existing multi-agency pathways are being reviewed. Currently within local systems, joint working occurs through a range of different mechanisms, such as multi-agency risk assessment conferences, which involve community safety, mental health staff, social work and other key agencies.

4.4.5.3 Current areas of transformation are as follows:

- **Primary Care Network Integration**: additional mental health staff in 23 of 30 primary care networks. Core integrated teams will also wrap around PCNs,
- Enhancement of community teams
- Other more intensive/specialist services such as Early Intervention Psychosis are also being expanded.

5. SYSTEM CHALLENGES

5.1 Mental Health LTP performance is expected to be enhanced significantly as we move toward 2022-23. In addition, there is considerable demand and higher levels of acuity in those presenting with mental health difficulties.

5.2 The post Pandemic surge in demand for Mental Health services has and will put the system under significant pressure. Community transformation will be crucial to managing demand in this area as will supporting people to live well in the community through earlier identification and support.

5.3 The system response to the Pandemic has shown that collaborative working can deliver significant transformation, mutual aid and sharing best practice. This desire to collaborate has continued, with the mental health system leading the way in matrix working between organisations and teams.

5.4 Over time, we will develop this way of working to ensure equitable provision and access to care through greater levels of collaboration and mutual aid. This will also support workforce resilience, staff recruitment and retention and reduce fragility of some specialist provision as well as reliance on out of area capacity.

5.5 The investment into mental health services is dependent on securing the workforce. To date, substantial recruitment has taken place to support the expansion in service

delivery and a comprehensive workforce plan underpinning the service developments has been required. There will be further work to do in this regard as the demand for a skilled workforce continue to grow.

6. ALIGNMENT WITH MENTAL HEALTH REVIEW

6.1 JHOSC members will be aware of the strategic reviews of both mental health and community services that is currently underway. There has been much work to ensure that the work of developing the core mental health offer is aligned to the service developments that have taken place in mental health services as part of the NHS Long Term Plan (LTP) deliverables.

6.2 This includes the patient and public feedback that we have gained about mental health services which we have used to develop the core offer for mental health services.

6.3 The reviews are progressing well with impact and gap analysis against the core offer with existing provision. This will inform the future commissioning and transition plan for moving to delivery of the core offer over the transition period agreed across the ICS.

7. RECOMMENDATIONS

7.1 The Committee are asked to **NOTE** the contents of the report

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	01 October 2021

SUMMARY OF REPORT

This paper reports on the 2021-22 work programme of the North Central London Joint Health Overview & Scrutiny Committee and also requests confirmation of the reports for the next meeting.

Local Government Act 1972 – Access to Information

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

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RECOMMENDATIONS

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

a) Note the work plan for 2021-22 and consider any updates that may be necessary;

b) Confirm the agenda items for the next meeting, which is currently scheduled to take place on 26 November.

1. Purpose of Report

1.1 This paper outlines the areas that the Committee has chosen to focus on for 2021-22 so far. The Committee is asked to note the list of topics that have been identified as a potential agenda items for the year and consider any amendments that may be required.

1.2 The next meeting of the JHOSC is scheduled to take place on 26 November 2021 and the Committee is also asked to confirm the items for this. The items currently scheduled to be on the agenda for this are as follows:

- Mental Health and Community Services Review
- Fertility Review

1.3 The Committee is also asked to identify any particular matters that they would like to be addressed within these items. Full details of the JHOSC's work plan for the year are listed in **Appendix A**.

2. Terms of Reference

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

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

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

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

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

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

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

3. Appendices

Appendix A – 2021/22 NCL JHOSC Work Programme
Appendix B – Action Tracker

Appendix A – 2020/21 NCL JHOSC work programme

25 June 2021

Item	Purpose	Lead Organisation
GP Services	• How the CCG commissions GP services (including commissioning at different levels, delegations, CCG responsibilities); • Oversight and managing performance and contract issues (including brief description of the role of CQC); • What is commissioned from practices, PCNS, GP Federations and the developing NCL GP Alliance; • Digital inclusion and access to services and the right to face-to-face appointments. To include an update on the Equality Impact Assessment report commissioned by NCL to review the impact of the introduction of digital options. Also a brief overview of patient data (what is collected/ shared and how can patients opt out?); • Primary Care recovery plans; • Barndoc – written update on how services are being provided post-Barndoc.	NCL partners
Update on AT Medics	• How ICS Boards work and transparency is ensured; • How residents/Councillors/HOSCs may be alerted to issues at an early stage, can be involved and may be able to influence/scrutinise decisions; • How standards of care can be maintained in GP services, what would happen if there was a fall in standards.	NCL partners
Mental Health and Community Services Review	• An overview of what the review is aiming to achieve; • Scope and timelines; • The approach to stakeholder and service user engagement; • Specific ask for the JHOSC: to feedback on how can they contribute/support the reviews?	NCL partners
Covid-19 Pandemic Update	• Temporary changes to services – what we learned, for example changes to paediatric services evaluation.	NCL partners

	• Collaboration and integrated working – how this provided support during the pandemic in areas such as critical care, mutual aid, discharge workforce, the vaccination programme. • Recovery – particularly elective recovery work and how we are working as a system to reduce waiting lists. • How our system has developed which has built foundations for a mature ICS. • Lessons learnt.	

01 October 2021

Item	Purpose	Lead Organisation
Digital Inclusion and Health Inequalities	To receive an update on the wider piece on digital inclusion (in secondary care, mental health etc) and an update on health inequalities work.	NCL partners
Mental Health Update	To receive an update on Mental Health Services, to include CAMHS and mental health provision in schools and how services are commissioned (e.g. across the 5 boroughs v. locally).	NCL partners
Integrated Care Systems	To receive an update on Integrated Care Systems, including how we are moving to shadow ICS, governance structures, and how ICS will work with local authorities.	NCL partners

26 November 2021

Item	Purpose	Lead Organisation
Mental Health and Community Services Review	To receive an update on the Mental Health and Community Services Reviews.	NCL partners
Fertility Review	To receive an update on the Fertility Review.	NCL partners

To be arranged

Item	Purpose	Lead Organisation
Royal Free Maternity Services	Update on responding to recommendations of CQC report	Royal Free
Missing Cancer Patients	To monitor how cancer outcomes from screening services changed over the last 12 months	NCL partners
Children's Services	To focus on periods of transition and to include young people with learning difficulties and children in care.	NCL partners
Finance	A report to respond to address funding and finance issues. To include Public Health funding and potential funding inequalities.	NCL partners
Winter Planning		NCL partners
Screening and Immunisation	NCL partners to confirm focus and scope.	NCL partners
Continued Emergency and/or Recovery Planning	Updating on plans for emergency planning and recovery planning.	NCL partners
Estates Strategy Update	Update on progress with the Estates Strategy for NCL.	NCL partners
Workforce Update		NCL partners

2021/22 Meeting Dates and Venues

- 25 June 2021 - Virtual
- 1 October 2021 - Barnet
- 26 November 2021 - Camden
- 28 January 2022 – Enfield
- 18 March 2022 - Haringey

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Appendix B – NCL JHOSC Action Tracker

Meeting	Item	Action	Action by	Progress
25-Jun-21	Covid-19 Pandemic Update	To request a future update on Workforce.	Chloe Morales Oyarce/ Sarah Mansuralli	This has been added to the work programme.
25-Jun-21	Covid-19 Pandemic Update	It was noted that an evaluation of the temporary changes to paediatrics during the Covid-19 pandemic was being undertaken and that this could be shared with the JHOSC when complete.	Chloe Morales Oyarce/ Sarah Mansuralli	This would be emailed to JHOSC members in late September 2021.
25-Jun-21	Deputation – Integrated Care Systems	The JHOSC requested further detail on the arrangements for the NHS ICS Board, the governance and committee structure within the ICS, and the relationship between the different committees, and how the voices of patients and residents would be included.	Chloe Morales Oyarce/ Sarah Mansuralli	This was due to be presented to the JHOSC at its meeting on 1 October 2021.
19-Mar-21	Integrated Care Systems (ICS)	The JHOSC requested further information in relation to Integrated Care Systems (ICS). The full list of queries is listed in the minutes.	Chloe Morales Oyarce/ Will Huxter	It was requested that this information be provided in time for the JHOSC to re-consider Integrated Care Systems in September or November 2021.
12-Mar-21	Health Inequalities	The JHOSC asked to receive an update on health inequalities at a future meeting.	Ruth Donaldson/ JHOSC Chair	This is due to be reported to the JHOSC at its meeting on 1 October 2021.
12-Mar-21	Missing Cancer Patients	The JHOSC noted that it might be useful to monitor how cancer outcomes from screening services changed over the next 12 months.	Rob Mack	This has been added to the work programme.

25-Sep-20	Deputation – Temporary Services Changes made in response to the Covid-19 Pandemic	A formal commitment was made to commission an Equality Impact Assessment around digital access to GPs and other health care settings. NHS partners would be looking to learn and reach out how to mitigate the risk.	Rob Hurd	The Equalities Impact Assessment is being commissioned in November and North London Partners will update the Committee on progress.
25-Sep-20	Deputation – Temporary Services Changes made in response to the Covid-19 Pandemic	In terms of the abolition of Public Health England and replaced by the National institute for Health Protection and the lack of consultation, this would be taken away and comments would be provided to members at a later date.	Rob Hurd	
25-Sep-20	All future reports	For future reports, Committee members requested that officers provide at the front of the report a summary, no more than one side of A4 of the main issues and outcomes.	Report authors	Ongoing.
4-Sep-20	Orthopaedic Services Capacity	To receive a report on the issue of capacity in 12-18 months (Sept 2021-March 2022).	Anna Stewart	
4-Sep-20	Orthopaedic Services Review	To receive an update on how the Programme Team had managed to deliver on the performance metrics which tracked achievements and performance. The Committee also requested that when the update report came back that it also included views from Care Co-ordinators as well as the Patient Representatives.	Will Huxter and Anna Stewart	
Jul-20	LUTS Clinic	To receive a written update on what was happening with regard to the LUTS clinic, a matter on which the Committee had received a number of deputations from concerned patients over the past few years.	Frances O'Callaghan, Richard Dale	Frances O'Callaghan said she would liaise with the relevant officer (Richard Dale) about providing a written update on the topic. A written update is due to be provided to the JHOSC at its meeting on 1 October 2021.

Sep-19	Deputation – Patient Transport	Pan London JHOSC meeting to be arranged with representatives from NHS England, Department for Health and Kings Fund on patient experience of transport.	Policy Officer	Officers continue to work alongside the Chair to arrange a Pan London JHOSC meeting on patient transport. Awaiting confirmation from NHS colleagues. A successful Pan London JHOSC meeting was held on 16 January 2020 discussing the Mayor's '6 Tests' framework for major hospital service reconfigurations.

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JHOSC Briefing Paper – Dental Services

The JHOSC requested some further information about Dental Services. In order to provide some background information, the below is an excerpt from a presentation that was received by Camden Council. The JHOSC may decide to request further information.

Dental services were not permitted to see patients for face to face care at the start of the pandemic and this has led to significant backlog of unmet need, delayed and suspended treatments which is likely to cause a long wait before they are able to see patients for routine treatment.

The context is that NHS General Dental Services are currently operating at significantly reduced capacity due to social distancing and infection prevention and control requirements in light of the COVID-19 pandemic as set out by the Chief Dental Officer for England and Public Health England. This has an impact on the number of patient's practices can see in a single day.

In keeping with other healthcare services, there are considerable backlogs in the provision of primary, secondary and community care dentistry. Provision of urgent care has been maintained whilst there has been a phased approach to the resumption of routine services with triage, consultation and screening arrangement still in place.

The majority of dental practices are now open and able to safely provide a full range of treatments but are having to prioritise patients with highest need or priority including children and those most at risk of oral disease. Dental practices must allow for gaps between patients if they are providing aerosol generated treatments, in order to maintain a safe environment for patients and staff. Ultimately, dentists and their teams are skilled clinicians and they use their clinical judgement to assess and respond to patient need. However, capacity allowing, practices are seeing new patients and information about access to local dental services is available on NHS.UK website.

Currently Primary care practices are working at 60% of their pre-pandemic activity and unfortunately this does mean that access to services is reduced. Practices are working extremely hard to deal with urgent and outstanding courses of treatment and whilst some are in position to offer routine appointments within a reasonable timeframe, this is not uniform across London and therefore it is quite possible that private treatment may be offered as an alternative if the patient wishes to be seen sooner.

However, if a patient needs to see a dentist for Urgent Care (acute pain or facial swelling) the patient should contact NHS 111 where the call will be transferred to the London Dental Triage Service. These services are in operation 24/7 for patients who do not routinely attend a practice, have an urgent need or are unable to find a local practice which has the available capacity. If the triage service assesses that the issue is urgent, an appointment at one of the 39 commissioned urgent dental care centres will be arranged. When assessing patients the triage service will try to

ensure minimal travel but this is dependent on the services and appointments available at the time and may involve some travel.

If a patient is seeking an earlier routine NHS appointment than is currently available, a private appointment maybe offered by the practice, however the patient is not obliged to accept.

Whittington Health, LUTS update: September 2021

This paper provides an update to the North Central London Joint Health Overview and Scrutiny Committee on the pathways in place for secondary care clinicians to refer adults and children for specialist treatment of lower urinary tract conditions. The specialist service at Whittington Health (WH) is commonly referred to as The Lower Urinary Tract Service or LUTS and has operated from the Whittington Hospital site since December 2020 (previously based at Hornsey Central Health Centre). The WH service is commissioned by NHS North Central London Clinical Commissioning Group (NCL CCG) for the treatment of chronic urinary tract infections in adults in accordance with the provisions of the NHS Standard Contract.

The service is now led by Miss Rajvinder Khasriya, a urogynaecologist, who is a joint appointment with UCLH and supported by a second substantive consultant. The service is further supported by 2 Clinical Fellows and a laboratory technician. Due to the demands of the service a third consultant is also being recruited.

Update on the WH LUTS Clinic for Adults

In June 2019 it was agreed by Haringey and Islington CCGs that GPs would be consulted to determine if commissioners required any further assurances on the LUTS treatment protocol implemented by WH in June 2019.

On 24 October 2019 GPs, senior medicines management colleagues and CCG officers met to agree the commissioners' position on the referral pathway, shared care, the LUTS protocol and future monitoring. Minutes of the joint Haringey and Islington CCG Quality and Performance Committee on 19 December 2019 confirm that the Committee was satisfied with the decisions made by clinicians on 24 October 2019.

WH and representatives of the LUTS patient group were informed of the decisions made by the CCGs on 15 and 16 January 2020 respectively. An outline of the key decisions agreed on 24th October 2019 and a September 2021 update is provided below:

1. **Referral pathway**

24th October 2019 - Following a detailed discussion led by clinicians, it was agreed that due to the highly specialised nature of this tertiary service the current access criteria (i.e. referral via secondary care clinician) should remain in place.

9th September 2021 - There has been no change to the referral pathway since January 2020.

2. **Shared care protocol**

24th October 2019 - CCG clinicians highlighted that for a shared care protocol to be in place, individual GPs would need to agree to manage the patient in accordance the LUTS protocol which included the prescribing regimen. Given CCGs cannot

mandate GPs to accept shared care protocols and GPs within NCL were unlikely to agree to deviate from NICE guidance and the local prescribing formulary, it was agreed that a move to shared care could not be supported at this time.

9th September 2021 update - This remains an area of concern for WH. There is no shared care protocol in place to allow the discharge of patients from the service into primary care. Raj Khasriya, Consultant Urogynaecologist is working with Sarah Humphreys, Medical Director to consider options and an acceptable solution.

3. LUTs prescribing protocol

24th October 2019 - It was agreed that queries relating to prescribing would be put to members of the WH Drugs and Therapeutic Committee by the CCG Heads of Medicines Management for consideration when the protocol was formally reviewed in Spring 2020.

9th September 2021 update – The formal service review did not take place in Spring 2020 due to the Covid-19 pandemic. WH Pharmacy manages the dispensing of prescriptions for the LUTS service. There are no changes in the prescribing protocols.

4. Monitoring of the contract during the remainder of 2019/20 and 2020/21

24th October 2019 - In relation to the level of support within the service to support psychosexual needs, the group recommended that the resource allocated was discussed with the Trust and revisited formally as part of the annual review of the contract in Spring 2020.

9th September 2021 update- As mentioned earlier, the annual review of the contract did not take place in Spring 2020 due to the Covid-19 pandemic. As the LUTS is a specialised service, the Trust would welcome a review to assess the rising number of referrals; the difficulties arising from the lack of a shared care plan with GPs to enable safe discharge; and the complexity of cases.

5. Recent Significant enquiries:

There have been three enquiries relating to referral pathways for children to access the LUTS service:

- 1x pre-claim for potential judicial review – legal challenge regarding lawfulness of paediatric oversight. Response sent by Trust solicitor 24/06/2021 – separate responses sent by GOSH & Oxfordshire CCG as also cited. Background advice received from NHSE/I Medical Director
- 2x requests to the service directly to discuss LUTS protocol with a Welsh paediatrician – one from the paediatrician, one from the child's mother
- 1x referral request to Chief Executive Officer via MP Priti Patel 22.06.2021 (Essex) – request for child to access LUTS service. Response based on Trust solicitor's response above

6. Recent engagement with the Patient group – As above, under judicial review response

7. **Service changes due to Covid** – The service has been impacted by Covid, some virtual clinics continued but many patients required face to face appointments which have had to be delayed. This has had a further impact on backlogs.

Update on pathways for Children and Young People with chronic urinary tract infections

Tertiary pathways for NCL children with chronic urinary tract infections are provided by Great Ormond Street Hospital (GOSH) although they do not offer 'like-for-like' clinic protocols as the adult WH LUTS Clinic.

Historically, a small number of children were treated at the WH LUTS Clinic, but since 2015, no new paediatric cases have been accepted and no children have received care at the WH LUTS Clinic since 2017.

In 2015 WH invited a review of the service by the Royal College of Physicians which was published on 19 October 2016. The report recommended that treatment of children at the LUTS Clinic should be undertaken only with supervision from a consultant paediatrician. The reason for this being there is little research evidence of the benefits of long term, low dose antibiotics for chronic urinary tract infections in children and as such there would be concerns about committing children to the adult treatment protocols without an individual assessment and the input of a multi-disciplinary team to give a holistic treatment plan which should include local services.

WH was unable to source supervision from within the cohort of paediatricians employed by the Trust, as they did not have the experience or expertise to supervise this specialist service. After the retirement of Professor Malone-Lee in 2017, responsibility for care of children with chronic urinary tract infections was transferred to tertiary/specialist children's hospitals such as Great Ormond Street Hospital.

The agreed 'health system' way forward was for children and young people with chronic urinary tract infections to be cared for by their local paediatric nephrologist and their paediatric MDT.

Plans in Q3/Q4 2021/22

NCL CCG will support WH with a LUTS service review prior to establishment of the NCL Integrated Care System in April 2022.

Questions raised by the JHOSC Chair and Responses

1. Has the LUTS patient group been made aware of the latest update?

The LUTS patient group have not been made aware of the 'LUTS September 21 update' as this report was written specifically in preparation for the JHOSC agenda item very recently. WH have confirmed that as there has been no service review, there nothing yet to update or involve the patient group with in regards to service provision. There is currently no future date in the diary for the LUTS Patient Group to meet.

2. This implies stress* in the system. Is there a plan to address this whilst waiting for the review?

<u>9th September 2021 update</u> - As mentioned earlier, the annual review of the contract did not take place in Spring 2020 due to the Covid-19 pandemic. As the LUTS is a specialised service, the Trust would welcome a review to assess the rising number of referrals*; the difficulties arising from the lack of a shared care plan with GPs to enable safe discharge; and the complexity of cases.

The Trust and CCG acknowledge the reported pressures on the LUTS service and the CCG will shortly set up a meeting with WH representatives to review the risks and mitigations and discuss planning and timelines for the proposed service review prior to April 22.

3. I note the pre judicial review within the children services, when will this be heard?

On 24/06/2021, a response was drafted by Whittington Health's solicitors, Bevans, stating that: "In summary, Whittington Health does not have a legal or contractual duty to accept a referral from a child to the Adult Chronic Urinary Tract Infection Clinic in respect of the Claimant." Therefore the action was denied by WH. Since the Trust's response was sent WH have not received any further correspondence from the Claimant's solicitors.

4. Are children being referred to Great Ormond Street Hospital (GOSH) as part of a children's LUT's service or is it dependent on the child's Paediatrician?

The pathway for NCL children referral to GOSH is: i) GP to refer to NCL paediatrician in local acute Trust, ii) paediatrician in local Trust is the gatekeeper to determine whether onward referral to local tertiary paediatric nephrologist (GOSH) and paediatric MDT is recommended course of action.