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

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

1. FILMING AT MEETINGS

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

2. APOLOGIES FOR ABSENCE

There were no apologies for absence.

3. URGENT BUSINESS

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

4. DECLARATIONS OF INTEREST

There were no declarations of interest.

5. MINUTES

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

RESOLVED

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

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

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

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

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

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

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

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

6. PRIMARY CARE DURING THE COVID-19 PANDEMIC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED

1. To note the report.

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

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

7. SECONDARY CARE DURING THE COVID-19 PANDEMIC

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED

1. To note the report.

2. To receive a report on missing cancer patients.

8. POST-COVID SYNDROME SERVICE

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

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

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

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

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

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

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

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

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

RESOLVED

1. To note the report.

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

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

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

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

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

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

RESOLVED

To note the report.

10. WORK PROGRAMME

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

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

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

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

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

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

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

29 January 2021

- Post-Covid syndrome pathway, including communications, the financing for the therapies teams, and a section about which communities were presenting with post-Covid syndrome given concerns about the disproportionate amount of white British people presenting.
- The mental health impact of the Covid-19 pandemic, including carers.
- Digital inclusion, including the NCL Board report and Equality Impact Assessment, specific reference to Black, Asian, and Minority Ethnic communities, faith communities, and specific data.

26 March 2021

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

RESOLVED

To note the report, subject to the above amendments.

11. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

12. DATES OF FUTURE MEETINGS

It was noted that the dates of future meetings were:

29 January 2021
26 March 2021

CHAIR:

Signed by Chair ………………………………..

Date …………………………………

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