Overview & Scrutiny

Health in Hackney Scrutiny Commission

All Members of the Health in Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows

Wednesday 31 March 2021

7.00 pm

Until further Notice, all Council meetings will be held remotely

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Tim Shields
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Peter Snell, Cllr Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Patrick Spence, Cllr Kofo David, Cllr Kam Adams and Cllr Michelle Gregory**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**AGENDA PACK**	(Pages 5 - 118)
2	**Minutes of meeting on 31 March 2021**	(Pages 119 - 126)

Hackney

Access and Information

Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app') http://www.hackney.gov.uk/individual-scrutiny-commissions-health-in-hackney.htm

Public Involvement and Recording

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at http://www.hackney.gov.uk/l-gm-constitution.htm or by contacting Governance Services (020 8356 3503)

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital

and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

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The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

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Providing oral commentary during a meeting is not permitted.

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Tim Shields
Chief Executive, London Borough of Hackney

Members:	**Cllr Ben Hayhurst (Chair)**	**Cllr Peter Snell (Vice Chair)**	**Cllr Kam Adams**
	Cllr Kofo David	**Cllr Michelle Gregory**	**Cllr Deniz Oguzkanli**
	Cllr Emma Plouviez	**Cllr Patrick Spence**	

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	Apologies for Absence	19.00
2	Urgent Items / Order of Business	19.02
3	Declarations of Interest	19.04
4	**Covid-19: update from Vaccinations Steering Group**	**19.05**
5	**Population Health Hub and Health Inequalities Steering Group briefing from Director of Public Health**	**19.35**
6	**Digital and remote NHS services – CCG analysis**	**20.05**
7	**New governance structure for C&H Integrated Care Partnership**	**20.35**
8	Minutes of the previous meeting	20.55
9	Health in Hackney 2020/21 Work Programme	20.56

Hackney

10	Any Other Business	20.57

Access and Information

This meeting can be viewed live on the Council's YouTube channel at https://youtu.be/asLj31SYPOc

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31st March 2021

City and Hackney Integrated Care Partnership – Covid-19 vaccination uptake challenge and how we are tackling this locally

We know and understand the concerns around the uptake rates within Hackney. As the Covid-19 vaccination programme continues to be rolled out in City and Hackney, it is crucial that local communications and engagement approaches reflect the latest vaccine uptake data and community insight.

Key themes underpinning this are lack of accessible information (including in community languages), fear of side effects, lack of digital literacy, hesitancy to travel to vaccination sites and wider, longstanding issues around health inequalities and trust in the statutory sector.

Delivering our local outreach work, in partnership with our community partners is in line with our commitment to reducing inequalities and co-producing services and initiatives with our communities. We believe that this will help with rebuilding trust with cohorts of our communities who have been disproportionately affected by Covid-19

There is a huge local partnership effort underway to understand why some of our residents are choosing not to be vaccinated and finding solutions to get them booked in. All system partners are involved and working together on this challenge to encourage eligible people to come forward for their vaccine and refute misinformation. Please see an overview of the work that has been completed to date, and we are continuing to do.

Latest uptake data for City and Hackney as of 16th March:

- Total cohorts 1-4: **75%**
- Total cohorts 1-6: **69%**

General communications and engagement

Activity	What we have done	What we are doing	Who is leading on the work
Information events	• Healthwatch Hackney Covid-19 vaccine information event - *24th Jan* • Online Q&A with Mayor and Dr Sandra Husbands hosted by Hackney Gazette – *25th Feb* • Webinar Q&A to Peabody by Dr Nicole Klynman – *4th March* • Healthwatch City of London online webinar with Dr Sandra Husbands and Dr Mark Rickets – *10th March*	• TBC	• Communications and Engagement Task and Finish Group • Wider system partners - Healthwatches
Community champions	• Recruited over 150 community champions across City and Hackney	• Monthly community champion forum	• Public Health with support from communications team

	which are representative of our local communities – our champions share key messages/ information amongst their communities and feedback insight to help shape our communications/ engagement moving forwards	• Weekly newsletter • Communications toolkit regularly updated for champions • Additional recruitment drive • Ability to translate materials when required	
Regular communications/ campaigns to residents	• Regular Leaflet drops to all households – additional mail out being planned for cohorts 1-6 that will be translated into key community languages • Local authority publications with latest messaging and advice • Targeted social media to residents • Regular newsletter to residents • Wealth of assets developed locally (addressing concerns) that are fronted by local GPs/ influencers • Additional resources needed for community champions		• Communications and Engagement Task and Finish Group • LBH/ CoL leading with support of NHS

Communications around local pharmacies	• Information on local pharmacies is included in all communications (currently four sites open in the local area)	• Additional communications drive needed - especially in The City to coincide with Boots Fleet Street opening to:
		  ○ Raise awareness of their availability
		  ○ Outline how bookings can be made
			• Communications and Engagement Task and Finish Group

Walk in clinic (including for undocumented residents) ***(part of new bid for additional resource from NHS E)***	n/a	• Walk in clinic for all eligible cohorts (1-9) taking place on 11th April at John Scott Vaccination Centre • We have a process in place to vaccinated all eligible residents that turn up, including if they are unregistered – this will involve registering them to a GP with	• GP Confed with support from communications team

		no questions asked on the spot	
Vaccination information bus ***(part of new bid for additional resource from NHS E)***	n/a	• Commission roving bus to provide information and vaccine booking sessions • Includes GP registration and vaccination booking • We will at route/ locations to stop based on uptake data and places of worship etc.	• Communications and Engagement Task and Finish Group • Public Health/ LBH/ CoL leading with support of NHS • Significant involvement from Community Champions
Additional community vaccination clinics at local sites or a community setting ***(part of new bid for additional resource from NHS E)***	• Details of clinics that we have already delivered can be found in the below table	• Further community vaccination clinics based on impact of current planned events with local community groups • Looking into a Turkish and Kurdish community take over event at local vaccination centre John Scott – *April/ May*	• Communications and Engagement Task and Finish Group based on insight and uptake data • NHS leading with support of community champions
Door to door visits ***(part of new bid for additional resource from NHS E)***	n/a	• Welfare check and visit to non-responders in partnership with LA, using cross matched shielding, social care and unvaccinated list	• Public Health/ Adult Social Care
Standardisation and increase call/recall at Practice level particularly for cohorts 4 & 6 ***(part of new bid for additional resource from NHS E)***	n/a	• Provide additional resource for clinicians/care navigators to telephone patients, address any concerns and book appointments	• GP Confed/ NHS to lead with support from voluntary sector
Increase dispersal to GP Practices ***(part of new bid for additional resource from NHS E)***	n/a	• Support practices with administration support and delivery service for vaccines	• GP Confed/ NHS

Roving bus/ mobile vaccination team ***(part of new bid for additional resource from NHS E)***	n/a	• Focus on high density social housing estates • Including multigenerational vaccination if permitted	• Vaccine steering group/ Homerton community teams

PLEASE NOTE *(part of new bid for additional resource from NHS E) – as of 31st March, this funding has not been approved but we are planning to carry out this work in the next 2 to 6 weeks.

Targeted communications and engagement to our local communities

Please note: all the below communities are represented by our community champions

Community	Uptake data as off 16th March (eligible cohorts 1-6)	What we have done already	What we're doing/ planning	Who is leading on the work
Black communities	• African: **54%** • Caribbean: **49%** • White and Black African: **52%** • White and Black Caribbean: **49%** • Other Black, African or Caribbean background: **40%**	• Community Conversation for Black residents in City and Hackney – *18th Feb* • Vaccine focus group with Black residents throughout Feb • Hackney African Community Network online event – *13th March* • Community take over event at local vaccination centre Bocking Street took place on *28th March*	• Targeted community engagement and outreach project with CAN and SWIM – vaccination clinics to take place w/c 12th April with support from Excel vaccine team • Co-producing communications materials to support with tackling concerns	• Communications and Engagement Task and Finish Group • Wider community partners including GP Confederation
Orthodox Jewish	n/a although will fall into one of the following: • Other White background: **64%** • Any other ethnic group: **55%** • Not stated: **55%**	• Three Charedi community take over events have taken place at local vaccination centre John Scott – these were run by the communities ambulance service Hatzola and were very successful	• Continuing to work with the community and Hatzola – potential for additional events in the future if there is additional demand (please note: the community now see the John Scott site as a 'safe'	• Communications and Engagement Task and Finish Group • Wider community partners including GP Confederation and Hatzola

		• Vaccination information event with the Chair of Kehillah North London – *30th March*	place so have been booking in for general appointments	
Turkish/ Kurdish	n/a although will fall into one of the following: • Other White background: **64%** • Any other ethnic group: **55%** • Not stated: **55%**	• Derman vaccine information session for Turkish &Kurdish residents – *2nd March* • Online Q&A for Turkish, Kurdish and Turkish Cypriot residents by Haringey, Hackney and Enfield Councils – *9th March*	• Working closely with community champions to co-produce materials/ translating information	• Communications and Engagement Task and Finish Group
South Asian community	• Bangladeshi: **72%** • Indian: **72%** • Pakistani: **57%** • White and Asian: **67%** • Any other Asian background: **66%**	• Bangla Housing Vaccine Q&A – *11th Feb*	• Community Conversation aimed at Asian residents (Pakistani & Bangladeshi) – *1st April* • Identifying places of worship (local mosques) to hold vaccination clinics – Friday 9th April following prayers prior to Ramadan (12th April), has been confirmed at North London Mosque	• Communications and Engagement Task and Finish Group
Chinese	Chinese: **64%**	n/a	• Identifying with relevant community groups what the community needs - information events or dedicated vaccination clinics at a local centre	• Communications and Engagement Task and Finish Group • Community Champions
Migrant/ refugee/	n/a	• Hackney Migrant and Refugee Forum vaccine conversation – *4th Feb*	• Co-producing materials to outline rights to access Covid-19 services	• Communications and Engagement Task and Finish Group

undocumented residents			• Walk in clinic at John Scott taking place on 11th April	
Homeless	n/a	• Greenhouse Practice (practice for homeless patients) are vaccinating at Bocking Street	• Additional outreach to hostels is being planned for	• Communications and Engagement Task and Finish Group • Wider partners including the Excel team
Local workforce	7,809 first doses have been administered	• Covid-19 vaccine hesitancy seminar for practice staff incl. admin and reception staff – *11th Feb*	• Weekly City and Hackney Practitioner Forum • Campaign to be developed for local workforce – in particular our care sector	• CCG Head of GP Engagement • Communications and Engagement Task and Finish Group
Mental health	n/a	• Excel team are supporting with vaccinating mental health patients in secure settings • Covid-19 vaccine and mental health session with Dr Sandra Husbands, Prof Palmer and IRIE Mind – *24th Feb*	• Additional activity to be identified	• Communications and Engagement Task and Finish Group
Learning disabilities	n/a	• Hackney Learning Disability Special Interest Group meeting – *22nd March*	• Communications being pulled together for LD residents and their carers in relation to what support is available when receiving a vaccine	• Communications and Engagement Task and Finish Group

City and Hackney:
Vaccine Programme Update for HiH

31st March 2021

Homerton University Hospital NHS Foundation Trust

City & Hackney GP Confederation
A community interest company

#FairerHackney hackney CVS

East London NHS Foundation Trust

City of London

Hackney

City and Hackney Clinical Commissioning Group

Where we are and progress to date

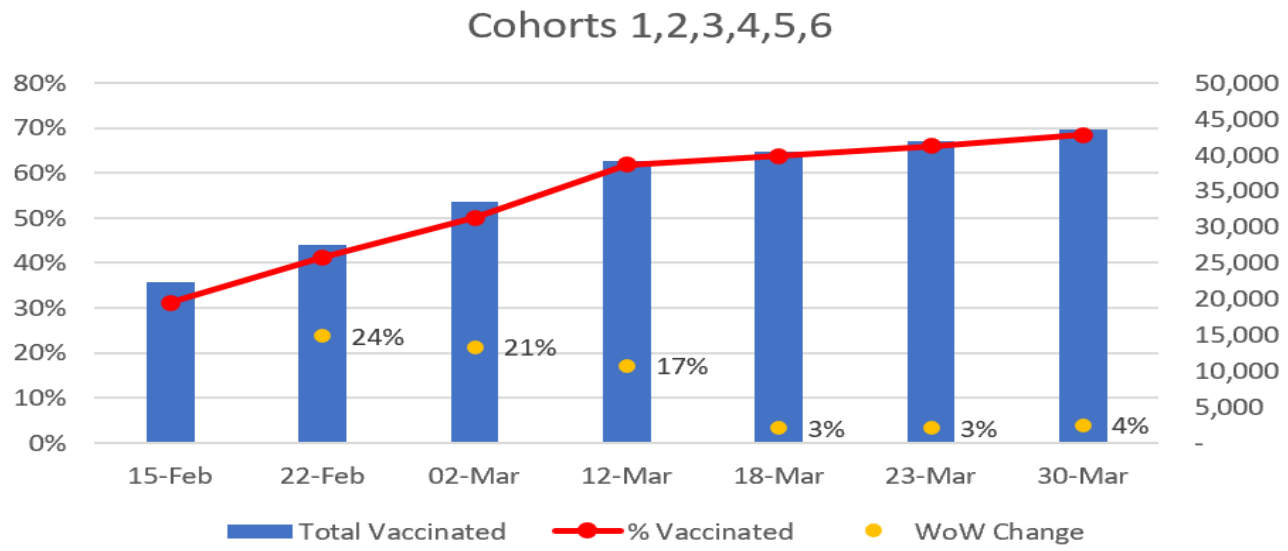
- ***As of 16th March 2021:***
  - Cohort 1-4: **75%**
  - Cohort 1-6: **69%**

- ***Dependable factors to be aware of:***
  - Vaccine supply
  - Staffing

- ***Local sites currently operating:***
  - Primary Care - John Scott and Bocking Street
  - 4 x Pharmacy sites (Fleet Street opening this week for City)
  - Mass vax sites
  - Homerton/ Barts Hospital hubs for staff

Week on week progress

	15-Feb	22-Feb	02-Mar	12-Mar	18-Mar	23-Mar	30-Mar
% Vaccinated	31%	41%	50%	62%	64%	66%	69%
Total Vaccinated	22,259	27,552	33,433	39,176	40,489	41,860	43,534
WoW Change		24%	21%	17%	3%	3%	4%
Total Cohort(s)	71,485	66,705	66,732	63,369	63,416	63,492	63,546



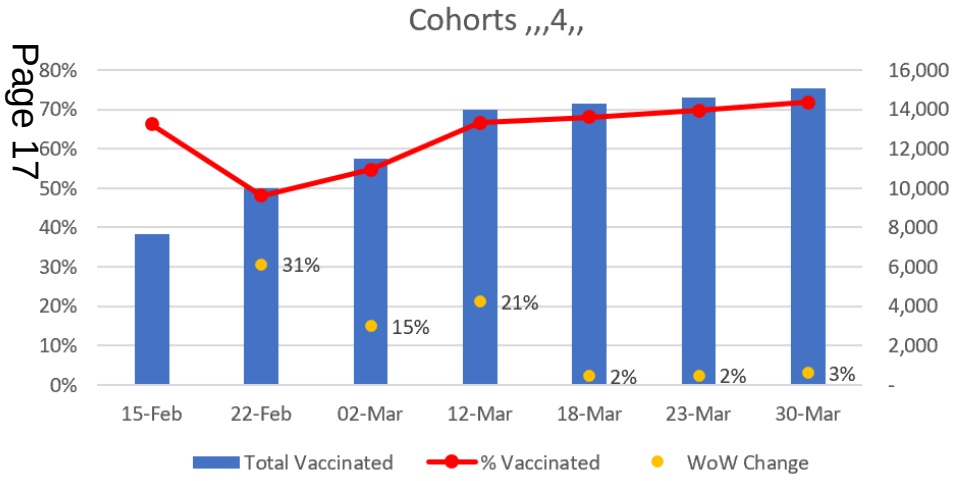
- There is a huge local partnership (LBH, CoL, Public Health, NHS, community champions, voluntary sector) effort underway to understand why some of our residents are choosing not to be vaccinated and finding solutions to get them booked in – the C&H Covid-19 vaccine communications, engagement and insight task and finish group (set up in February 2021) leads on this work with input from the Vaccine Steering Group
- Key themes underpinning this are lack of accessible information (including in community languages), fear of side effects, lack of digital literacy, hesitancy to travel to vaccination sites and wider, longstanding issues around health inequalities and trust in the statutory sector

Vaccination of JCVI priority cohorts
WoW changes (Cohort 4 & 6)

Source: NEL Covid vaccination: Invite & uptake coded in Primary care
Updated: 30/03/2021

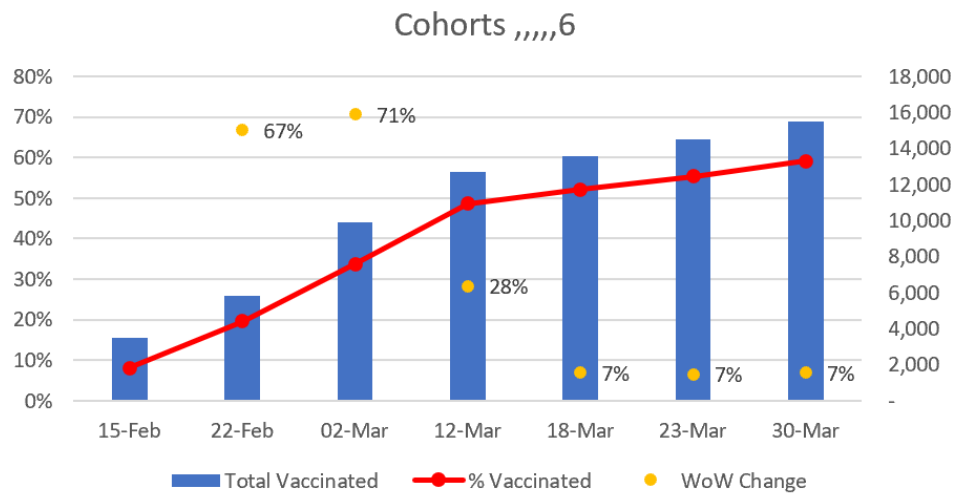
Cohort 4

	15-Feb	22-Feb	02-Mar	12-Mar	18-Mar	23-Mar	30-Mar
% Vaccinated	66%	48%	55%	67%	68%	70%	72%
Total Vaccinated	7,668	10,018	11,514	13,961	14,276	14,621	15,081
WoW Change		31%	15%	21%	2%	2%	3%
Total Cohort(s)	11,572	20,840	21,032	20,964	20,984	20,990	20,983



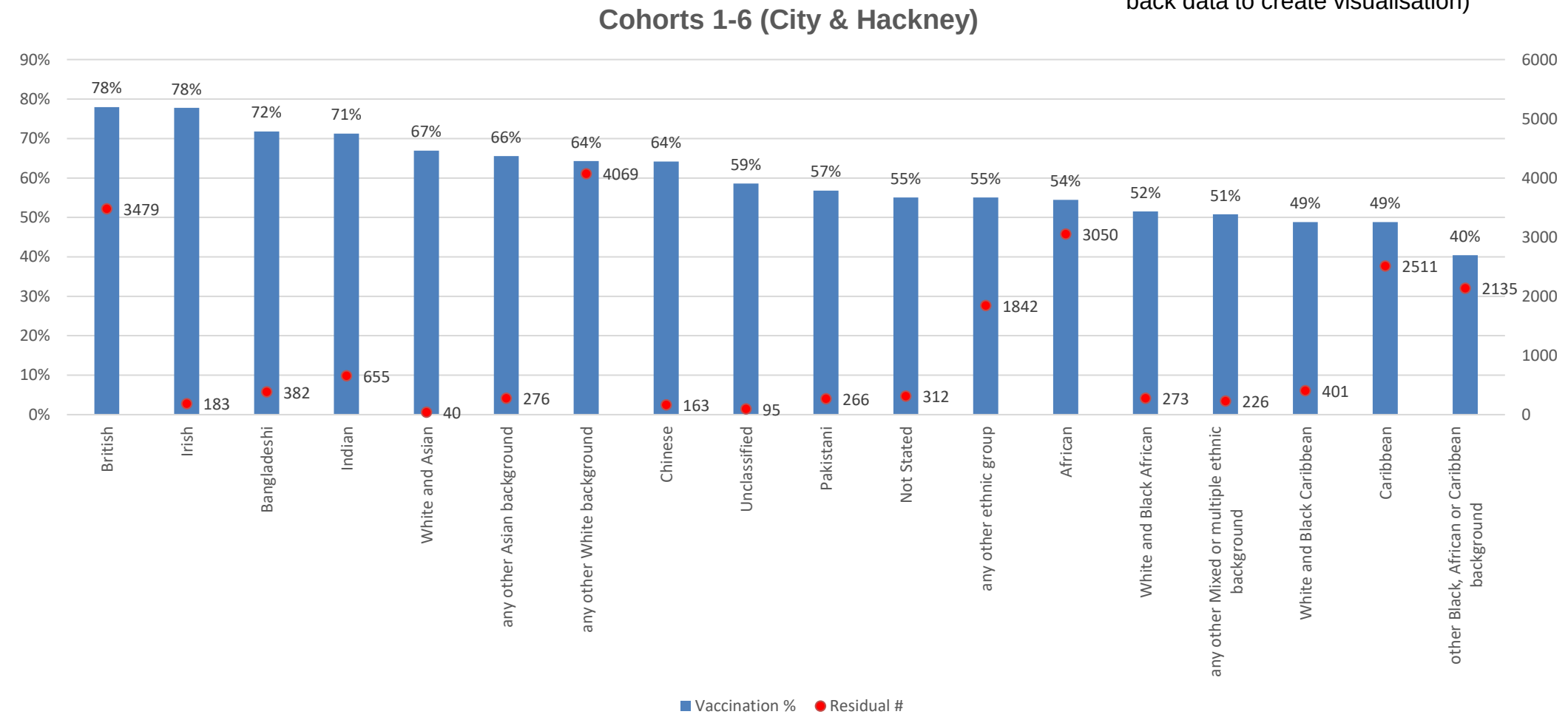
Cohort 6

	15-Feb	22-Feb	02-Mar	12-Mar	18-Mar	23-Mar	30-Mar
% Vaccinated	8%	20%	34%	49%	52%	55%	59%
Total Vaccinated	3,476	5,798	9,902	12,708	13,602	14,492	15,492
WoW Change		67%	71%	28%	7%	7%	7%
Total Cohort(s)	42,908	29,607	29,424	26,119	26,135	26,174	26,219



Uptake broken down by ethnicity

Updated: 16/03/2021
Source: CEG ethnicity dashboard (used back data to create visualisation)



What we're doing

***Please see appendix for more detailed overview of the below**

As a local system (LBH, CoL, Public Health, NHS, local voluntary sector, community champions), we have submitted a bid to NHS E for additional funding to support the outreach work that is already underway. This work will be taking place over the next 2-6 weeks and includes:

- ***Additional community vaccination clinics at local sites or appropriate community settings based on insight/ uptake data:***
  - Targeted community engagement and outreach project with CAN and SWIM for our black communities is confirmed – vaccination clinics to take place **w/c 12th April** with support from Excel vaccine team at Pembury Centre
  - Identifying places of worship (local mosques) to hold vaccination clinics – **Friday 9th April** has been confirmed following prayers prior to Ramadan (12th April), has been confirmed at North London Mosque
  - Further clinics for our Turkish/ Kurdish and Chinese communities being explored

- ***Walk in clinics at John Scott (including for undocumented residents):***
  - First walk in clinic is being set up for **Sunday 11th April** for all cohorts 1-9

- ***Additional community conversation events including based on insight/ uptake data:***
  - Community Conversation aimed at out South Asian residents on **1st April**

- ***Vaccination information bus which will result in booking residents in for vaccinations:***
  - Commissioning of moving bus to provide information and book residents into appointments
  - Route/ locations to stop based on uptake data and places of worship etc. – community champions to provide support

- ***Door to door visits:***
  - Welfare check and visit to non-responders in partnership with LA, using cross matched shielding, social care and unvaccinated list

- ***Standardisation and increase call/ recall at Practice level particularly for cohorts 4&6:***
  - Provide additional resource for clinicians/care navigators to telephone patients, address any concerns and book appointments

- ***Potential for a roving bus/ mobile vaccination team:***
  - Focus on high density social housing estates and to include multigenerational vaccination if permitted

- ***Refreshed comms campaign:***
  - For residents with a particular focus on our communities – translating of materials, working with community champions, refugee/ migrant groups
  - Campaign to also be developed for local workforce – in particular our care sector

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Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **Covid-19: update from Vaccinations Steering Group on the vaccine hesitancy work**	Item No **4**

OUTLINE

The roll out of the vaccinations programme for Covid-19 is dominating the work of the local NHS bodies.

Following on from the discussion at February's meeting the Chair invited the NHS to provide an update on the vaccinations roll out with a specific focus on the communications and engagement work being done to reduce vaccine hesitancy.

Attached please find a briefing report.

Attending for this item will be:

Dr Stephanie Coughlin, Local GP and Chair of the Vaccinations Steering Group
Siobhan Harper, Director of CCG Transition for City and Hackney and SRO for the Vaccinations Steering Group
Dr Mark Rickets, CCG Clinical Chair for City and Hackney
Tracey Fletcher, CE of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board for City and Hackney,

ACTION

The Commission is requested to give consideration to the briefing.

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City and Hackney Covid-19 update – 19th March

This update includes an overview of the vaccine delivery to various groups including our residents in current eligible cohorts, health and social care staff and vulnerable individuals. This briefing will also provide an overview of the work taking place, to address concerns around uptake figures.

Current eligible cohorts:

In line with the JCVI guidance, we are now vaccinating people in priority groups 1 to 9:

Cohorts 1-4:

- ***Residents aged 70 or above or clinically extremely vulnerable (high risk):*** We are encouraging this cohort to contact their GP if they have not had their first vaccination
- ***Frontline health and social care workers:*** We are encouraging this cohort to speak to their managers to find out how to get an appointment locally

Cohort 6:

- Residents aged 16-64 who are ***clinically vulnerable (moderate risk)*** or **r**esidents who are in ***receipt of a carer's allowance***, or are the ***main carer of an elderly or disabled person*** who is at increased risk of Covid-19 mortality and therefore clinically vulnerable - We are encouraging this cohort to please wait for their GP or council to contact them

Cohort 5,8 and 9:

- ***Residents aged 50-69:*** We are encouraging this cohort to please book an appointment using the national booking system for a list of sites or wait to be contacted by their GP

Vaccine delivery overview for residents:

- We currently have **four local vaccinations sites in City and Hackney:**
    - ***Primary Care sites*** – Bocking Street and John Scott (booked through GPs)
    - ***Pharmacy sites*** – Clapton and Mare Street (booked through the national booking portal)
    - ***Two additional pharmacy sites*** – are launching on 22nd March in Homerton and Haggerston (again these can been booked through the national booked portal)
- Eligible patients can choose to be vaccinated at other sites showing on the national booking portal (mass vaccination centre at Excel or pharmacies in neighbouring boroughs)
- **71%** of cohorts 1-4 have received their first vaccination (as of 12th March). This is a week on week **increase of 11%**
- **62%** of cohorts 1-6 6 have received their first vaccination (as of 12th March). This is a week on week **increase of 12%**

Vaccine delivery overview for other groups:

- ***Care Homes:***
    - **91%** of all CQC registered care home residents have received first vaccination dose
- ***Housebound patients:***
    - **77%** of all housebound patients have been vaccinated

- ***Other vulnerable cohorts:***
    - A number of homeless residents have been vaccinated with The Greenhouse Practice (practice for homeless patients) at Bocking Street Vaccination Centre
    - NHS Excel Centre team are supporting us with vaccinating other vulnerable groups using roving models including sex workers, asylum seeker, mental health patients in secure settings and our traveller community

- ***Total health and social staff vaccinated at HUH hospital hub:***
    - **7,062** frontline health and social care workers (including voluntary sector and HUH staff)

- **Planning for second doses and national supply disruption:**
    - Since the start of the vaccination programme supply has gone up and down and we have run clinics and delivered vaccinations according to availability. Up until 18th March 2021 over 500,000 people in North East London have already been vaccinated, 20 million across England, and we remain on track to vaccinate everyone (who accepts the offer) over the age of 18 by the end of July.
    - Supplies have already been allocated for the second doses and any reported disruption to supply should not impact on booking appointments or residents ability to access their second dose. We will be communicating to our residents over the coming weeks on how their second dose will be booked.

Addressing concerns around uptake:

- We know and understand the concerns around the uptake rates within Hackney.
- As the Covid-19 vaccination programme continues to be rolled out in City and Hackney, it is crucial that local communications and engagement approaches reflect the latest vaccine uptake data and community insight
- In particular, insight gathered to date from a number of community conversations, focus groups and surveys identifies that residents from Black African, Black Caribbean and Black British heritage communities are more vaccine cautious. Key themes underpinning this are lack of accessible information, fear of side effects, hesitancy to travel to vaccination sites and wider, longstanding issues around health inequalities and trust in the statutory sector. In addition to the above, current vaccine uptake data tells us that the percentage of eligible residents from Black African, Black Caribbean and Black British heritage communities who have had their vaccine is lower when compared to White, White Other and some sections of our Asian communities
- Delivering our local outreach work, in partnership with our community partners is in line with our commitment to reducing inequalities and co-producing services and initiatives with our communities. We believe that this will help with rebuilding trust with cohorts of our communities who have been disproportionately affected by Covid-19

Leading on from this, there is a huge local partnership effort underway to understand why some of our residents are choosing not to be vaccinated and finding solutions to get them booked in. All system partners are involved and working together on this challenge to encourage eligible people to come forward for their vaccine and refute misinformation.

Work underway by the C&H Covid-19 vaccine communications, engagement and insight task and finish group (set up in February 2021 with input from across system partners – NHS, London Borough of Hackney, City of London Corporation, Public Health) includes:

- ***Insight and data:*** gathering, collating and analysing insight and using local uptake data to set priorities
- ***Inform:*** sharing vaccine information via community contacts, VCS and public health community champions (we have over 150 across the community now). Ensuring we have materials in community languages has been key and is something we continue to improve on
- ***Involve:*** series of community conversations and focus groups in order to understand barriers and enablers. The next community conversation we have planned is on the 1st April with our Asian communities ahead of Ramadan.

- ***Targeted outreach:*** dedicated clinics co-hosted with VCS partners (e.g. evening clinics for our Charedi communities, pop up clinics for our Black Caribbean and Black African communities planned for end of March/ early April)
- ***Community led:*** working with and through community leaders, VCS organisations and public health champions
- ***Evaluate:*** working with public health to monitor changes in knowledge, attitudes and behaviour

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Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **Population Health Hub and Health Inequalities Steering Group - briefing**	Item No **5**

OUTLINE

Since the inception of the Integrated Commissioning Board the Commission has received regular updates from each of the 4 Workstreams of the ICB (Planned Care, Unplanned Care, CYP & Maternity, and Prevention). The Prevention Workstream has now been replaced with a new '*Population Health Hub'*.

In addition, the pandemic has magnified the existing health inequalities and reducing these will be the key challenge coming out of Covid. To address this the Health and Wellbeing Board has adopted The King's Fund's 'Population Health Model' and has created a '*Health Inequalities Steering Group'* as a sub-committee of the Board to drive forward this work. Officers have been invited to brief Members on both of these new developments.

Attending for this item will be:

Jayne Taylor, Consultant in Public Health and Lead for Health Inequalities portfolio, Hackney Council and City of London Corporation

Dr Sandra Husbands, Director of Public Health for Hackney and City

ACTION

The Commission is requested to give consideration to the briefings and discussion.

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CITY & HACKNEY POPULATION HEALTH HUB

BRIEFING TO HEALTH IN HACKNEY HEALTH SCRUTINY COMMISSION

31 MARCH 2021

Sandra Husbands

Jayne Taylor
Anna Garner
Diana Divajeva
Chris Lovitt
Mark Golledge

BACKGROUND AND CONTEXT

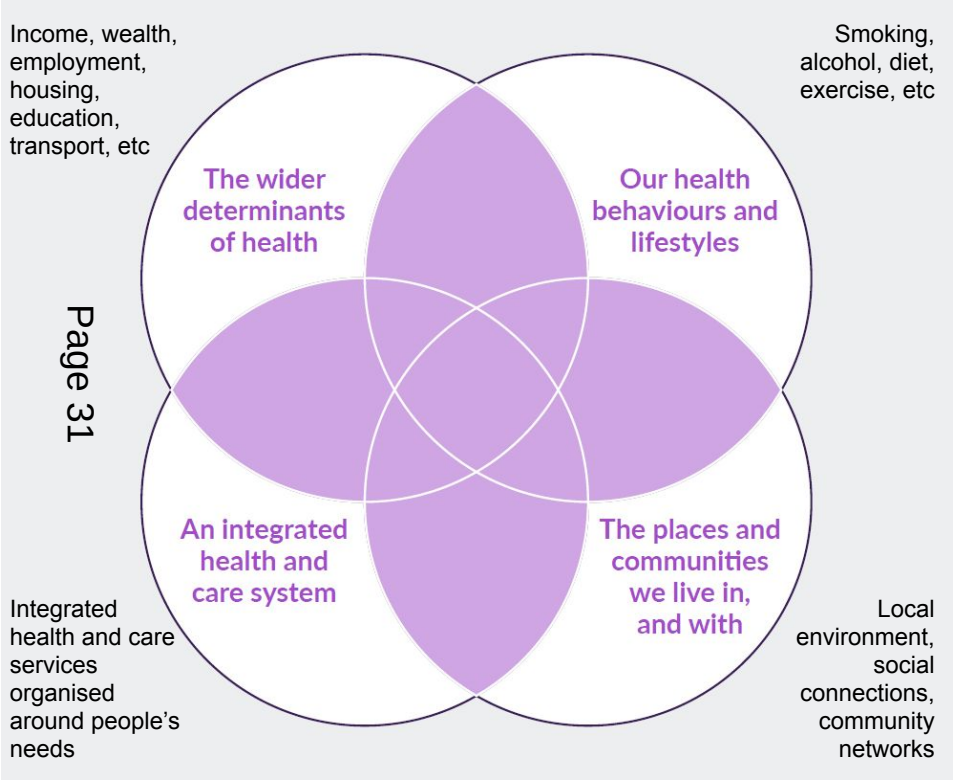
In August 2020, City and Hackney ICB approved the dissolution of the Prevention Workstream (one of four workstreams established to deliver transformation programmes in support of the objectives of the City & Hackney integrated care system) and endorsed the recommendation to create a new Population Health 'Hub'.

Around the same time, both Health and Wellbeing Boards (in the City and Hackney), as well as City & Hackney ICB, adopted the King's Fund population health framework to guide local action to improve population health and reduce inequalities.

Since then, a new City & Hackney Health Inequalities Steering Group has been convened, focused initially on mitigating the inequalities impacts of COVID-19. The Steering Group has identified a number of priorities for action that fall within the scope of the proposed Population Health Hub.

This scoping paper sets out initial proposals on the purpose, functions and required resources for the new Population Health Hub. Detailed work will be undertaken over the coming weeks and months to firm up and implement these proposals - including governance arrangements.

POPULATION HEALTH FRAMEWORK



Source: King's Fund

Population health is described by the King's Fund as...

"*...an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. Improving population health and reducing health inequalities requires action across all 'four pillars' of a population health system.*"

Taking a population health approach means:

- rebalancing investment across the four 'pillars'
- focusing attention in the areas of overlap and intersection (the 'rose petals') - where there are the greatest opportunities for impact
- system partners taking shared responsibility for improving population health.

Effective, system-wide action requires a common understanding of population health drivers, outcomes and effective interventions.

PURPOSE

The proposed City and Hackney Population Health Hub will be a **shared, system resource** with the following broad aim.

- To provide timely and actionable intelligence, develop practical tools and lead specific projects to influence and support system partners to improve population health and reduce health inequalities.

It will do this by:

supporting the development and implementation of both the City's and Hackney's Health and Wellbeing Strategies
supporting the C&H Integrated Care Partnership to take a population health approach in the design and delivery of health and care services for local people - enabling more efficient use of system resources and improving outcomes
3. supporting the development and implementation of Neighbourhood population health plans
4. working in partnership with the C&H Health Inequalities Steering Group to support delivery of its priority action plans
5. leading on the delivery of key population health programmes and initiatives (incl Make Every Contact Count, Prevention Investment Standard, community health champions).

Rather than a formalised group with associated governance structures, it is envisaged that the Hub will be a collaborative of existing and new capacity and resources that will combine to develop and implement a programme of work as part of a City and Hackney population health framework.

The Hub will ensure effective deployment of appropriate analytical resources in response to system needs.

PROPOSED FUNCTIONS OF THE HUB

	ACTIVITIES TO SUPPORT POPULATION HEALTH OBJECTIVES	Role of Hub
1 Intelligence & analysis	• Timely analysis of data (including linked individual-level data, in accordance with Caldicott principles) to inform decision making • Integrate qualitative and quantitative intel to create actionable insights • Utilise existing population health intelligence (JSNA, Neighbourhood Profiles, etc) and community insight to produce recommendations for action • Produce/maintain accessible and interactive dashboards for users to produce their own intelligence • Undertake population health needs assessments, service monitoring and evaluation, health/equality impact assessments, health equity audits, etc • Training function to build wider system analytical capacity • Health economic analysis	Lead
2 Evidence & guidance	• Proactive and reactive literature reviews to inform service redesign, commissioning and wider strategy development • Rapid evidence reviews to inform timely decision-making; full lit reviews as part of longer-term strategic planning • Leverage wider knowledge management resources e.g. from Public Health England • Ensure planning informed by latest evidence-based guidelines (from NICE etc)	Lead
3 Research & evaluation	• Agree priorities for research and use to establish/cement academic partnerships, and collaborate on funding bids, for population health research & evaluation. Ensure research is locally relevant and results implemented for improvement	Lead
4 Community insight	• Expertise and support in the design of community insight and research activity • Analysis and interpretation of community insight on population health needs and assets	Support
5 Service improvement	• Use of population health intelligence, evidence and research as part of an enhanced Quality Improvement approach that drives innovation through whole service/pathway improvement	Support
6 Embed prevention & health equity in local decision-making	• Development of tools, resources and interventions to (a) leverage a shift in focus and investment towards prevention (b) incentivise and facilitate routine consideration of health equity in decision making and service planning	Lead/support

EXISTING RESOURCES & SUPPORTIVE INFRASTRUCTURE

CITY & HACKNEY

PEOPLE / GROUPS

C&H System Intelligence Group
- C&H Public Health Intelligence Team
- LBH Data & Insights Team
- NHS Information and Performance teams (CCG, Homerton, ELFT, ?GPC)
- LBH and CoL Information & Performance teams (adults, children)

C&H Public Health specialist staff
NHS Quality (Improvement) Teams C&H IC comms & engagement group
IT Enabler

DATA & INSIGHTS

JSNA, Neighbourhood/PCN Profiles, Ward Profiles
Population needs assessments
Service evaluations and audits
Commissioned services activity/performance data
NHS acute, community, primary care data
LBH Policy & Strategic Delivery insights
City, Hackney Healthwatch resident feedback
NHS, local authority comms & engagement team insights
HCVS/VCSE community insights

DATABASES, SYSTEMS, PLATFORMS

PH COVID-19 Tableau dashboard
C&H JSNA website
NHS patient databases/systems
CoPlug
Qlik, Mosaic (LBH)

NEL

NEL Inequalities Intelligence & Insights Group
NEL analysts group (informal)
CEG (WEL, C&H)
WEL Financial Strategy Team
NEL CSU
NHSE ICS Pop Health Management Development Programme - NEL group

CoPlug?
East London primary care database (CEG)
Discovery
NEL CCG data warehouse/repository
NEL COVID-19 Recovery & Resilience and Leading Indicators dashboards

LONDON & NATIONAL

PHE London Knowledge & Evidence Specialist

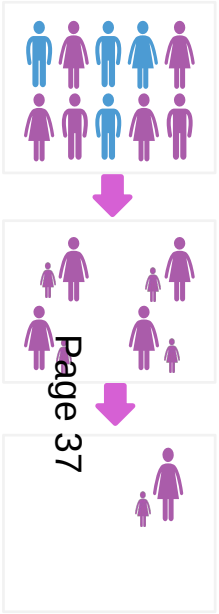
GLA Datastore
PHE Fingertips

RESOURCE REQUIREMENTS - CORE TEAM/CAPACITY

ROLE/FUNCTION	RESOURCED FROM
Accountable Officer (DPH)	Public Health
Lead Public Health Consultant for Population Health	Public Health
??Senior day-to-day strategic programme lead (1xFTE)??	TBC
Pop Health programme manager (1xFTE)	Public Health
C&H ICP Head of Performance & Pop Health input	CCG/ICP
Principal Public Health Analyst input	Public Health
Population health analyst (1xFTE)	TBC
Qualitative research/community insight methods expertise	TBC
Behavioural science expertise	LB Hackney Change Support Team
Health economics expertise	TBC
Knowledge management/evidence review expertise	TBC
Quality improvement expertise and capacity	TBC
Academic partnership(s)	UEL/QMU/UCLP/TBC
Population health project officer (specific projects TBD) x2	TBC
Admin support	TBC

CASE STUDY EXAMPLE:
Benefits of a C&H Population Health Hub resource

ANTICIPATORY CARE APPROACH IN NEIGHBOURHOODS



1. We need to understand the numbers and breakdown of people living with multiple long-term conditions within each Neighbourhood
e.g. numbers living with 2+, 3+, 4+, 5+ LTCs and the breakdown by age, ethnicity and list of LTCs.

2. With practitioner / clinical input we need to define a manageable cohort (of those with multiple LTCs) that would benefit from proactive and coordinated care in the community and associated numbers e.g. people in a particular high risk cohort (severe COPD) + more than 2 LTCs.

3. The Neighbourhood Team (inc. care coordinators) need to run a list of these residents for proactive contact (risk stratification) e.g. run a list from EMIS (across the Neighbourhood / PCN as a whole rather than GP Practice) to identify patients. Referrals by professionals into MDTs will continue.

4. The Neighbourhood Team (including care coordinators) will focus on person-centred engagement with residents. This will focus on what matters to people and develop a person-centred care plan. It will be supported by evidence-based interventions and bring together the MDT to deliver coordinated support.

Anticipatory care is about taking a population-health approach to supporting residents within Neighbourhoods. It will (in due course) become a core contract requirement for Primary Care Networks - but requires work from all system partners to be successful.

We are already progressing with this approach in City and Hackney because it is key to delivering Neighbourhoods. It will build on the Neighbourhood Multi-Disciplinary Meetings which were established last year.

This approach involves:

- A focus on holistic person-centred care (rather than supporting individual long-term condition pathways).
- A proactive and preventative approach that identifies a specific cohort of residents within a Neighbourhood with rising needs. They will often have long-term care needs in the community.
- Person-centred discussions with residents which focus on what matters to them.

Over time we would want to develop a more sophisticated approach which takes into account wider social factors.

The population health hub can support in the areas highlighted on the following slide.

ANTICIPATORY CARE: HOW POPULATION HEALTH HUB CAN ASSIST

The Population Health Hub can support the delivery of anticipatory care in the following areas

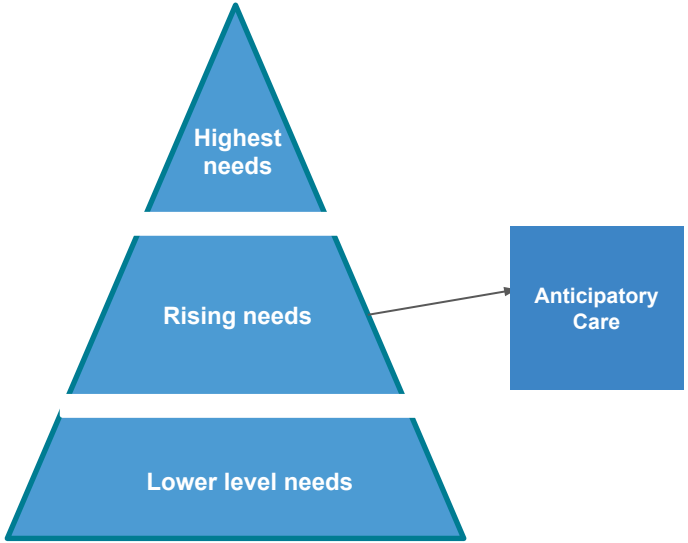
1. **Evidence based research** into approaches that support people with multiple long-term conditions i.e. what evidence of impact locally, regionally and nationally that supports people at an earlier stage.

2. **Initial analytical modelling (alongside clinician and practitioner input) to define the cohort of residents** (in this case people with multiple long-term conditions) that can be supported through the anticipatory care approach.

3. **Support the development of a theory of change and evaluation framework** (working alongside Cordis Bright who are providing input to this).

4. **Three part data review which (taking the identified cohort) considers:**
    a. **Data analysis of the cohort of residents across City and Hackney** and by each Neighbourhood - including breakdown by population characteristics (ethnicity, age, gender etc.)
    b. **Resident engagement which identifies what matters to people** and real world challenges
    c. **Engagement with care teams and professional** providing care or supporting the population to understand their perspective on the cohorts needs and assets

5. **Throughout - intelligence and evidence-led service design / quality improvement methodologies** to deliver on the project.



Anticipatory care is about focusing on those residents with rising and supporting them at an earlier stage to manage their needs well in the community.

Case finding (be it electronically and via professional judgement) will focus on those at risk of escalation rather than those for whom the crisis episode is happening.

It is about holistic person-centred needs rather than individual long-term condition pathway management.

QUESTIONS, COMMENTS?

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CITY AND HACKNEY HEALTH INEQUALITIES STEERING GROUP

BRIEFING FOR HEALTH IN HACKNEY SCRUTINY COMMISSION - 31 MARCH 2021

1. Context and purpose

COVID-19 is acting as a catalyst for local action to tackle long-standing health inequalities, with a huge amount of work already underway across the City and Hackney to mitigate the inequalities impacts of the pandemic, as well as longer-term plans to improve the wider social and environmental influences on health.

Box 1: Inequalities impacts of COVID-19[1]

> The ***direct*** health impacts of COVID-19 disease are disproportionately affecting certain minority ethnic groups, older people, men, people with underlying health conditions (especially those with multiple conditions), care home residents and staff, those working in other public facing occupations, as well as individuals and families living in socially deprived circumstances.
>
> Untangling the contribution of these various overlapping risk factors is complex, but it is clear that underlying structural inequalities are playing a role.
>
> The ***indirect*** health impacts of service re-prioritisation, lockdown, social distancing and the longer-term economic consequences of the pandemic will continue to affect some of our most vulnerable residents and communities for a long time to come - including many of those described above, as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.
>
> There is emerging evidence that women have been more likely to be furloughed or lost their jobs following the lockdown. And the longer-term social and economic impacts on already disadvantaged children and young people are also expected to be significant.

The City & Hackney Health Inequalities Steering Group has been convened to provide a focal point for this work, to ensure our collective efforts have maximum impact, and that we make best use of our combined resources to tackle long-standing health inequalities, through collaboration and partnership.

The draft objectives of the steering group are to:[2]

- collect and monitor information about health inequalities in the City and Hackney and the actions being taken to address these
- help prioritise further measures needed to prevent, and reverse existing, health inequalities (in the short and long-term)
- mobilise local action by working in partnership to influence decisions and empower others to act
- use our collective resources to support the effective delivery of priority actions to reduce health inequalities.

The steering group's immediate priority is to mitigate longer-term health inequalities impacts of COVID-19 through coordinated local action. Broader strategic priorities for tackling health

[1] A fuller evidence briefing on the inequalities impacts of COVID-19 is available on request
[2] Terms of Reference will be signed off at the steering group meeting in March 2021

inequalities will be developed in partnership with the Health and Wellbeing Boards, as part of the HWB strategy refresh process.

2. Membership

The work of the steering group is guided by the same population health framework adopted by both Hackney and the City's Health Wellbeing Boards and the City & Hackney Integrated Care Board (ICB). Membership of the steering group has been designed to reflect all four 'pillars' of a population health system as defined by this framework (see appendix A).

The steering group is committed to involving residents in a meaningful way in shaping its plans. Rather than appoint one or two 'resident reps' to sit on the steering group, a resident engagement framework (underpinned by a set of engagement principles) is being co-developed to guide the approach.

Table 1: City & Hackney Health Inequalities Steering Group Membership

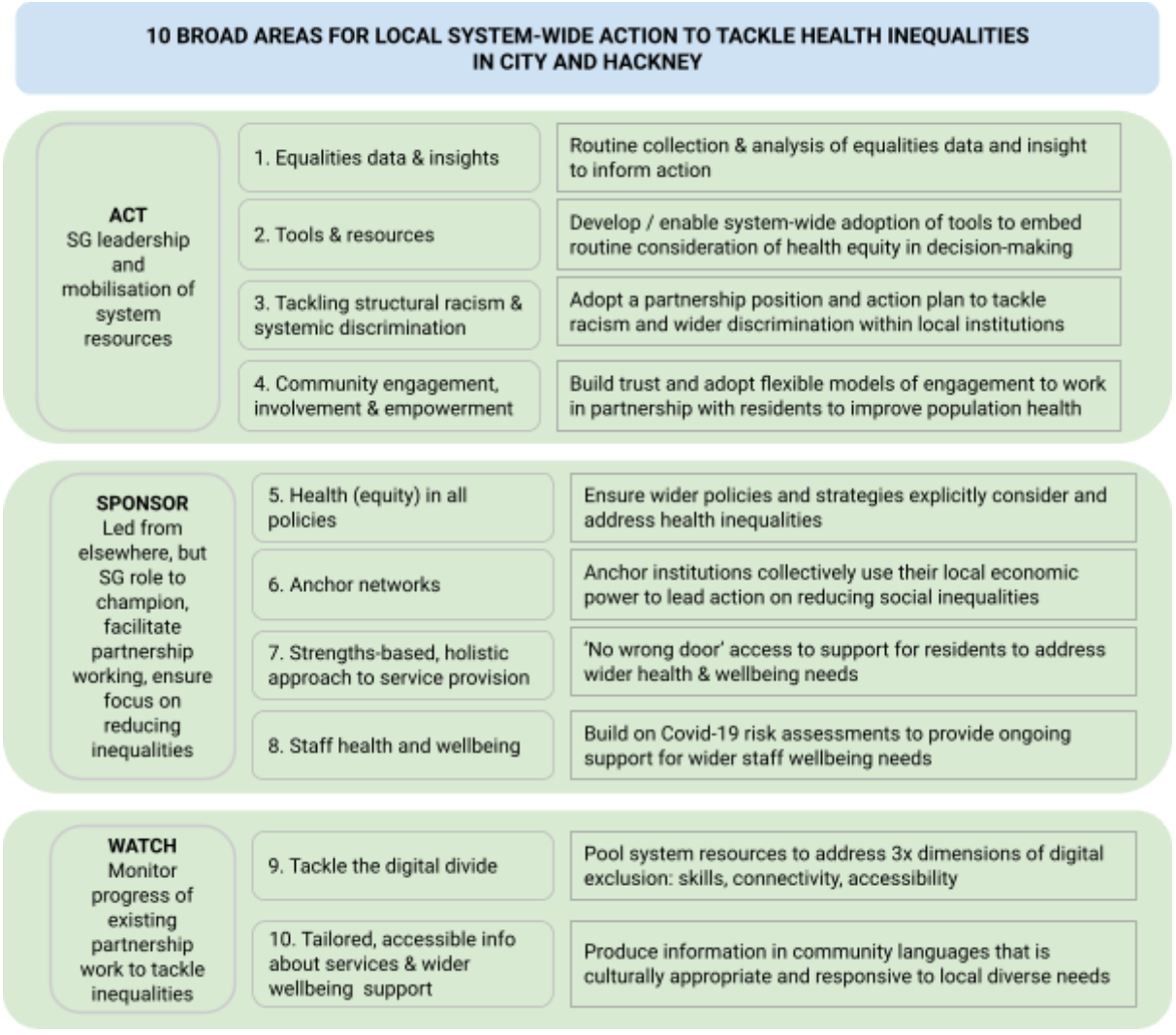
Name	Position and organisation	Role/population health system pillar representing
Sandra Husbands	Director of Public Health, LB Hackney and City of London Corporation	Chair
Malcolm Alexander	Chair, Hackney Healthwatch	Places & communities pillar
Angela Bartley	Consultant in Population Health, ELFT	Integrated health & care system pillar
Ian Basnett	Director of Public Health, Barts Health	Integrated health & care system
Gail Beer	Chair, City of London Healthwatch	Places & communities
Nick Brewer/Jenny Darkwah (shared)	PCN Clinical Directors	Integrated health & care system
Jane Caldwell	CEO, Age UK East London	Places and communities
Jake Ferguson	CEO, Hackney CVS	Places and communities
Anna Garner	Head of Performance & Integrated Commissioning Alignment, City & Hackney CCG	Integrated health & care system
Claire Hogg	Director of Strategic Implementation & Partnerships, Homerton Hospital	Integrated health & care system
Sonia Khan	Head of Policy & Strategic Delivery, LBH	Wider determinants/ Places & communities
David Maher	Managing Director, City & Hackney CCG	Integrated health & care system
Kate Smith	Head of Strategy & Performance, City of London Corporation	Wider determinants
Jayne Taylor	Consultant in Public Health, LBH and CoLC	Operational lead (PH health inequalities portfolio lead)
Resident involvement - TBC		Places and communities

3. Strategic priorities

Following two strategic priority setting workshops (in December and February), 10 broad areas for action have been defined, with four of these prioritised by the steering group to take a lead role in progressing over the coming 12 months. These four priorities were selected as areas where steering group leadership could add most value to existing work that is underway (or establish new programmes of work where needed) by collectively mobilising system resources.

A named lead for each of the four priority areas for action has been identified from the steering group membership, each of whom will be responsible for developing and overseeing implementation of detailed action plans. These plans will not start from scratch, but will build on existing programmes of work, and describe how we will explicitly address the inequalities impacts exposed by COVID-19 - e.g. which groups/communities, health outcomes and/or service areas the plans will focus on.

Figure 1: Priority areas for action



4. Governance

It is intended that the steering group will advise and support both Health and Wellbeing Boards, and the Integrated Care Partnership Board. It will provide expert advice and input to the development of the two new Health and Wellbeing strategies, as well as a population health delivery plan for City and Hackney's integrated care partnership (including Neighbourhood population health plans).

The steering group will work closely with, and provide support to, other delivery and strategic groups (at both City & Hackney and NEL level) with the relevant expertise and levers to take action to reduce health inequalities.

Governance arrangements are yet to be fully determined and will need to be flexible to wider changes within the integrated care system (including the establishment of a new City & Hackney Population Health Hub). It is also anticipated that the work of the steering group and the Health and Wellbeing Boards will increasingly align over time, as the HWB Boards take more of a leadership role in improving population health and tackling health inequalities through a 'health in all policies' approach. As such, the scope and purpose of the steering group will need to be kept under constant review.

Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **Digital and remote NHS services – CCG analysis**	Item No **6**

OUTLINE

The digital divide and health services has been a key issue for the Commission for some time. Our previous review '*Digital first primary care and implications for GP Practices*' was overtaken by events. When the pandemic hit digitisation plans which had been discussed as ambitions or long term aims suddenly had to be implemented overnight and GP consultations and appointments with clinicians in secondary care had to be done by smart phone or laptop.

Head of Quality at the CCG had been tasked with mapping some of the work on digital and remote services and the attached report from last October provides a very useful overview of the key issues here and the work done on them up until then. That paper briefly set out the issues that the CCG may wish to consider to ensure patients and carers are able to access remote and/or digitally enabled NHS services which are at least as good as, or better than, face-to-face services in terms of safety, patient experience, staff experience and clinical outcomes.

The Chair has invited **Jenny Singleton**, Head of Quality at the CCG to outline the key issues at stake here. Attached please find:

a) '*NHS and remote services'* brief update since Oct
b) CCG's main report '*NHS services delivered remotely and issues with digital exclusion*' Oct 2020
c) A separate report from The Patient's Association '*Digital health during the Covid-19 pandemic: Learning lessons to maintain momentum'*

The second report, attached for information,has been developed by the **Patient Coalition for AI, Data and Digital Tech in Health**, which aims to unite representatives from patient advocacy groups, Royal Colleges, medical charities, industry and other stakeholders committed to ensuring that patient interests lie at the heart of digital health policy and discussions.

ACTION

The Commission is requested to give consideration to the briefings.

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NHS
City and Hackney
Clinical Commissioning Group

NHS and remote services

The first lock down in March 2020 saw NHS services implement a huge and rapid shift to deliver services remotely where feasible.

GP, community and hospital services introduced new ways for patients and carers to book and attend appointments remotely using a number of nationally agreed and funded digital platforms/tools provided by a range of companies. New types of remote services were developed that have been very well received, with mental health services being a good example.

Remote and digital services offer patients and carers an amazing opportunity to get more convenient, faster and more self-directed health and care services. However, there are also pitfalls and problems that need to be recognised and addressed along the way.

NHS
City and Hackney
Clinical Commissioning Group

NHS and remote services

During 2020/21 the **CCG IT Enabler programme funded** projects to help health and care professionals communicate better and enable people to access the care they need quickly and easily, when it suits them. There are four elements of the programme: population health datasets, single view of a patient's care record, co-ordinating care and patient empowerment.

Hackney Council has a digital skills programme with "how to" videos covering basic skills/knowledge to use Gmail, Zoom, Teams etc. The focus is on upskilling residents to get online for the first time and developing their digital skills incrementally by using their motivation for activities such as online shopping and Instagram. A new Digital Inclusion Network has just been launched.

These programmes do not have a specific service user/citizen panel or overarching engagement programme of work and, whilst there are links between the Council's digital inclusion work and the NHS IT enabler programme, these could be better developed and integrated.

NHS and remote services

NHS
City and Hackney
Clinical Commissioning Group

Remote services will not work for everyone, including those from lower socio-economic groups without cheap and reliable connectivity and devices, those with poor digital literacy, and those who lack the privacy and ability to have sensitive conversations with health professionals. There are issues with safeguarding, who uses these data and how safe and secure they are.

The challenge is to develop remote services with services users rather than for them; to recognise that face-to-face services will often be preferred (and be safer and kinder) for some types of health care or service users; and to bake into these new services patient choice and transparency about information security and risk.

It is arguable that more work needs to be done to bring programmes together, to focus more on evidence about clinical and patient defined outcomes, to recognise the pitfalls and potential for better services (for both service users *and staff*) and to use the same platforms, tools and digital skills wherever possible as we go forward.

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NHS services delivered remotely and issues with digital exclusion

This paper aims to briefly set out the issues that the CCG may wish to consider to ensure patients and carers are able to access remote and/or digitally enabled NHS services which are at least as good as, or better than, face-to-face services in terms of safety, patient experience, staff experience and clinical outcomes.

In addition this paper considers current and future ways that we can capture service user and staff experience in terms of the barriers people experience and *how it feels* to use and/or deliver these services.

This paper is focussed on both digital exclusion and remote access.

1. Background – digital exclusion and remote services

The NHS has an agreed definition of what constitutes digital exclusion[1].

- **Digital skills**

Being able to use digital devices (such as computers or smart phones and the internet). This is important, but a lack of digital skills is not necessarily the only, or the biggest, barrier people face.

- **Connectivity**

Access to the internet through broadband, Wi-Fi and mobile. People need the right infrastructure but that is only the start.

- **Accessibility**

Services need to be designed to meet all users' needs, including those dependent on assistive technology to access digital services.

NHS Digital also outlines how some sections of the population are more likely to be digitally excluded than others. These are:

- older people
- people in lower income groups
- people without a job
- people in social housing
- people with disabilities
- people with fewer educational qualifications excluded left school before 16
- people living in rural areas
- homeless people
- people whose first language is not English

Digital and remote care can also significantly increase burden on carers who need to support patients to get appointments, work out how to use Webex/Teams etc. However they can also facilitate improved carer experience by enabling better engagement, convenience, less travel, and joint consultations involving the wider family.

[1] https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is

Remote care comes in many forms, including telephone, video, text messaging, email consultations, web-based portals, appointment booking, and patient access to online health records, or any combinations of all these. In addition there are more specialist areas relating to telemedicine and tele-monitoring. Most remote services are a combination of the above.

There can be significant benefits in travel time, travel costs, flexibility of appointment times, reduced DNAs, increased access, better communication, access to coaching, patient ownership and engagement with remote or digitally enabled services.

2. What do people say about their experience of local NHS services delivered online or remotely?

North east London HealthWatch organisations and the City and Hackney Community Voice are both intending to undertake work to collect user feedback about NHS online/digital services later this year.

HealthWatch England report National Voices
This was a qualitative study designed to understand the patient experience of remote and virtual consultations[2] involving 49 people, using an online platform, with 20 additional one to one telephone interviews. All participants had experienced a remote consultation during the lockdown period of the COVID-19 pandemic.

They found that for many people, remote consultations can offer a convenient option for speaking to their health care professional. They appreciate quicker and more efficient access, not having to travel, less time taken out of their day and an ability to fit the appointment in around their lives. Most people felt they received adequate care and more people than not said they would be happy with consultations being held remotely in future. The main recommendations were

- Boundaries - respecting peoples' time and where the appointments fit in with their lives
- Quality personal communication – no matter what!
- Preparation and information – providing guidance and setting expectations.
- Choice of phone, video or text/email and in person, to meet the needs of people – what is right for the person and what is right for the situation
- Test, learn and improve – designing the remote experience with patients and carers
- Being inclusive - meeting the needs of people for whom remote is not possible or appropriate
- Opportunities - such as interaction with patient notes, recording of appointments, education and training and the use of existing patient groups to provide local support networks to increase confidence and access

Healthwatch Hackney reports

[2] https://www.nationalvoices.org.uk/sites/default/files/public/publications/the_dr_will_zoom_you_now_-_insights_report.pdf

In summer 2019 Healthwatch Hackney (HWH) reviewed GP practice websites and found that the majority would benefit from some improvement. Most had no information on how to book an extended consultation, for example to discuss more than one health concern, or a more complex problem. HWH report that this information is important to patients. Short appointment times came up frequently as a concern and when Healthwatch Hackney has interviewed patients at GP practices. HWH also found that information on making a complaint was frequently hidden away on practice websites. Few websites provided an online form to simplify the process.

City and Hackney Older people's reference Group

City and Hackney Older People's Reference group sent out a paper survey in May 2020 with 106 responses[3]. The survey found that older people much prefer face-to-face or telephone contact and are generally not using digitally enabled services which are difficult for hearing impaired etc. However the general theme seems to be lack of any access or poor access to services:

- In the short to medium term, respondents are particularly anxious about cancelled appointments and the lack of information as to when these will be re-scheduled. In some cases, (e.g. ENT at UCLH) the Department is non-contactable either by phone or email, and text messages supposedly sent advising patients of cancellations have not always been received, leaving people unsure as to whether or not they should present themselves or risk losing an appointment entirely if they fail to appear.
- Face-to-face sessions with their professional advisers remain for many patients the preferred mode of engaging with them. For some it is the only way. Telephone contact has been widely used during lockdown, but there are difficulties for those with hearing impairment, those with language or learning difficulties, or those who need the reassurance of a more sociable, close encounter with a human being before they can confidently unburden themselves.

Talking to the CCG patient and public involvement lead the main issues being reported with digital services relate to connectivity and affordability.

Looking at a number of reports about digital services, younger people are much more positive about these and report higher satisfaction than any other group and there is a clear message that older people and poorer people don't/don't want to use them and find them hard to access.

Disabled people are also a group that find digital services more difficult to access. In 2017, 56% of adult internet non-users were disabled [4] and they are also more likely to older and poorer compared to non-disabled people. There are also specific issues for those with sensory disabilities[5]. Gender differences also exist in access to the internet with older women less likely to have access compared to older men.

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[3] OPRG Covid-19 Impact Survey: May 2020

[4] https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04#how-does-digital-exclusion-vary-with-age

[5] Ofcom 2019.

We therefore need to ensure that remote services do not widen existing health inequalities for some groups whilst offering a better experience, convenience and “as good” outcomes for others.

Some parts of the population don’t use social media or smart phones for religious or other reasons. Messaging to a landline would overcome this issue but video consultations and web based platforms are not accessible to such groups.

Hostels, supported living providers, housing with care and other social care providers could improve Wi-Fi access to enable better access to NHS services but residents may lack a device or smart phone. People who have a personal health budget in City and Hackney due to enduring mental health needs have been issued with a smart phone and feedback to date has been very positive; this could be expanded.

It is notable that 16.4% of adults in England have very poor literacy skills i.e. are functionally illiterate with the average reading age being 11[6]. Therefore written information about how to access and use remote services will be a challenge for many people.

Conversely GP case studies show many patients whose first language is not English often find some online consultations easier, as patients may be more confident with writing than speaking, can take more time to express themselves and may receive help from relatives or friends. In addition the flexibility afforded by the new way of working may mean that patients can be given more time in an appointment if they need a translator[7].

3. Safeguarding and data security

Safeguarding issues are a significant risk in digital services that are not yet fully understood or evidenced. Clinicians can’t tell who is in the room with the patient, will find it difficult to speak to a child without an adult present, and may miss vital visual clues during a telephone consultation. There may not be a private space available at home to speak to the clinician. A text message may come from a patient’s phone but not be sent by the patient. There may be issues with a suitably trained chaperone in the consultation. GPs and others will be aware of many of these issues but there is a need to think about how we take forward digital and remote services with safeguarding considerations fully addressed.

There is national guidance relating to safeguarding children and video consultations[8] and a new policy is in development for NELCA dealing with this issue. The main focus is on intimate images/examinations for under 18s as the Criminal Justice Act makes this fraught with risk as even the possession of an image can be a criminal offence. The

[6] https://literacytrust.org.uk/parents-and-families/adult-literacy/

[7] https://www.england.nhs.uk/wp-content/uploads/2020/01/online-consultations-implementation-toolkit-v1.1-updated.pdf

[8] https://www.gmc-uk.org/-/media/files/key_principles_for_intimate_clinical_assessments_undertaken_remotely_in_response_to_covid19_v1-(1).pdf?la=en&hash=0A7816F6A8DA9240D7FCF5BDF28D5D98F1E7B194

recommendation is that such images should not be sought, or stored unless under exceptional circumstances and any sent without prior discussion, should not be kept. GPs also need to put warnings and advice on websites etc. and provide information to patients that is clear, easy to read and accessible. In addition the guidance recommends that "it is important to ensure there are routes to support non-digital users and that patients are aware of these".

Information security and risk is rarely discussed with patients and when discussed is frequently not well understood.

4. NHS Services in City and Hackney, patient feedback and co-production

Primary Care
The NHS App enables people to:

- check their symptoms using the health A-Z on the NHS website
- find out what to do when they need help urgently using NHS 111 online

Patients can register and once they have proved who they are, they can:

- order their repeat prescriptions and view, set or change their nominated pharmacy, where they want their prescriptions to be sent
- view their GP medical record securely

In some GP practices, depending on which systems are in use, people can also:

- message their GP surgery, doctor or health professional online
- consult a GP or health professional through an online form and get a reply
- access health services on behalf of someone they care for
- view useful links their doctor or health professional has shared with them

All GP practices in England are connected to the NHS App. GP surgeries also have a number of ways for patients and carers to request a service via their website such as repeat prescription or appointments. There are also screening tools for patients to provide symptoms that determine if they need to see a GP/other clinician.

GP practices in England are free to choose any of five suppliers of consultation software which may include online patient feedback, using a national framework that meets technical specifications. Data from these five suppliers for e consultations is being sent to NHS Digital. These data are used by North East London Health and Care Partnership and then fed back down to local systems although this has not been verified to date. The focus of NEL appears to be efficiency of primary care systems.

Amongst the 40 GP practices in City and Hackney there are four suppliers of consultation software and only a minority have the ability to collect service user feedback. They are also asking patients different questions.

The four systems used in City and Hackney are:

EMIS – 30 practices (75%) of C&H practices
The majority of practices in C&H currently use EMIS as their supplier which does not have a patient feedback function: EMIS state they are developing this but there is no timeframe.

eConsult – 6 practices (15%)
This system has patient feedback built into software and asks questions about process, overall satisfaction, patient defined outcome (was your problem resolved) and friends and family test. The City and Hackney GP Confederation has this feedback and this will be shared with the CCG going forward and reported via the CCG quality report.

AskMyGP – 3 practices (8%)
Three practices use this and it has built in patient feedback. The CCG/Confed does not currently have this feedback but it will be asked for.

Engage Consult – 1 practice (2.5%)
Unclear what patient feedback can be provided.

Practices are now experimenting with online group consultations for long term conditions (diabetes) and this work is being suppported by City and Hackney Digital Divide (digital skills) programme which sits in the IT enabler group programme, using the Springhill Practice as a pilot. There is also work taking place with GPs' social prescribing schemes to address digital exclusion by prescribing a course/work to improve digital skills. There are a range of "How to do it" guides and resouces available on Hackney Council digital skills website.[9] Patients can also be referred to the digital budies programme for one to one support that has been set up by the digital skills programme.

If the CCG could agree some common questions for the 23% of practices that have inbuilt feedback function it would be possible to get a structure that would allow us to compare and contrast practices i.e. compare patient experience in more deprived practice populations with those situated in the better off areas. We could then consider how any differences could be mitigated with enhanced support. Analysis of trends would be helpful to see if, over time, people are becoming more positive about their online NHS experience. If we had some free text function we could get direct feedback on what is and is not working. Research indicates that patient enthusiasm for remote services wanes over time and there is little/no longitudinal research on patient experience[10].

Feedback is not currently being systematically collected centrally, analysed and shared and this should be taken forward as we develop remote and digital services. There is little evidence of systematic or ad hoc co-production and no overall patient and public involvement strategy.

[9] https://hackney.gov.uk/digital-skills

[10] https://medinform.jmir.org/2019/4/e13042/

Mental Health services
There is a current pilot taking place with ELFT and the CCG to develop a patient owned digital platform called "Patient Knows Best" which links to EMIS and enables all professionals involved in the patient's care to share data. The patient owns the data and it has recovery goals built into the programme so outcomes can be measured. ELFT are using patient focus groups to develop this platform and co-production principles appear to be in place. This pilot is for people with long term mental health care needs, not acute needs. ELFT also appear to be using WebEx.

City and Hackney mental Health services are also using the Silver Cloud app and group consultations delivered by the voluntary sector such as Bikur Cholim. Personal Health Budgets are being used to purchase smart phones and this has good feedback.

Acute and community services
The Homerton collects patient feedback from Attend Anywhere virtual consultations and a bespoke survey can be added on by clinical teams although only two appear to have done so (diabetes and CAMHs). Recent feedback for diabetes consultations report 89% satisfaction with this method although only 8% were over 65. Service users did report difficulties with technical issues both for themselves and the clinician involved: "brilliant, only thing VPN cut out for clinician"[11]. For video Attend Anywhere CAMHs meetings 33% reported technical issues with poor internet connection. However 90% would be happy to use it again[12]. Bandwidth is a real issue for Attend Anywhere. Professional feedback has been undertaken via a survey.

Remote services at the Homerton do not appear, however, to be have taken forward with any overall strategy for patient and public involvement and there has been very little to-date. Whilst Attend Anywhere is the preferred platform some teams are now also using Starleap. The latter allow clinicians to record sessions which is important for therapies that require baseline and other information to be collected. Anecdotally clinical teams may also be using other platforms. Setting up online consultations requires additional administrative support as patients need to be contacted and the new method explained and consent obtained. The Homerton have developed a patient leaflet for such consultations (with some translated), but again without any apparent service user involvement. A website bringing all their digital services together is under development.

City and Hackney Strategic Enabler IT Programme
City and Hackney Integrated Care System has a Strategic Enabler IT programme funded by all partners.

The current priorities are:

- Care pathways integration – digitally joining up the care providers and provider systems supporting integrated care pathways, Neighbourhoods, end of life pathways

[11] Diabetes, Attend Anywhere HUH 2020.
[12] Community CAMHs, Attend Anywhere HUH 2020.

- Telehealth, Remote Monitoring and Assistive Technology – supporting patients post COVID; care closer to the patient's home
- Websites and apps – instant and easy access to online service information and resources for patients and for health and care professionals
- Population Health – using information to direct resources and action where it is most needed and maximise impact
- Linking to the digital inclusion and digital first programmes of work

Key projects already underway include:
East London Patient Record (data sharing across health and social care) , virtual (video) patient consultations (outpatient and community services); Find Support Services for local residents; Discovery (population health); embedding Coordinate My Care across the system (shared care planning for those at end of life/vulnerable and at risk of unplanned admissions)

The IT Enabler team are working with City and Hackney CCG Workstream Directors and their teams to work up new projects to support recovery of the new NHS post COVID: telehealth/telecare capabilities, extending eLPR to further enhance collaborative working, digital resource platforms to widely share best practice and support communities of practice.

There is also work going on with the London Borough of Hackney led programme for Digital Inclusion to maximise opportunities across the local population in the adoption of technology, noting the shift to virtual first in health

1. IT Enabler working collaboratively with the wider ELHCP programmes of work including integrated urgent and emergency care, digital first for care homes, the wider social prescribing programme of work, and the personal health record (PHR - eventually linking in with care planning and remote monitoring)
2. IT Enabler working collaboratively with the One London programme on eLPR developments to support integrated care – wider data sharing and image sharing

From the above it is difficult to tell how much, if at all, service users are shaping the programme as it seems to be service driven rather than service user co-produced, which is understandable given the urgency, but needs further thought. In addition "digital first in health" seems a somewhat problematic message given what we know about digital exclusion.

5. Evidence and outcomes

Mental Health E-Therapy and Apps
These have the best track record of reliability acceptability and good outcomes. Digital mental health solutions are well evaluated.

E-therapies are programmes that use the internet or mobile devices to deliver interactive interventions for preventing and treating depression, anxiety, and other mental health problems. They usually involve users completing modules or exercises while receiving

feedback on their progress. E-therapies have proven clinical benefits and are recommended in the UK for depression and anxiety by NICE.

There is evidence to show these therapies can achieve comparable outcomes to face-to-face therapy, when the same content is delivered in an online format reinforced and supported by a suitably trained therapist. Many people prefer to access therapy in this way. However NICE states digital tools should be offered in addition to existing health and care services, not as a replacement.

App guidance recommends using resources from expert sources when possible, such the NHS Apps Library, to ensure content has been assessed for safety, effectiveness and data security. NICE recommendations acknowledge possible complications with their use and urge clinicians to take care that patients do not rely on apps as a way of avoiding seeing a professional. The guidelines also point to the uncertainty of their effectiveness when used alone, and recommends them only as supportive tools in addition to regular services.

Long term conditions
A recent review of evidence for video consultations for patients with long term conditions[13] found that

In the home setting, for patients with long-term conditions, the review of reviews indicates that there is no formal evidence in favour of or against the use of internet videoconferencing. Evidence for its impact on health outcomes suggests it mostly has equivalence with face-to-face communication. The evidence for equivalence seems to be the strongest in mental health conditions.

This review also considered NICE guidelines for long-term conditions such as psychosis and schizophrenia, HIV, diabetes, liver fibrosis, eczema, psoriasis, cancer, asthma, cystic fibrosis, arthritis, kidney and sickle cell disease. The authors report that most NICE guidelines for these conditions were compatible with internet videoconferencing.

Many of the papers that showed improved or as good as face-to-face outcomes did not involve videoconferencing alone but rather a mixed approach with text messaging, telemedicine and regular communication via a range of media between the clinician and patient. In some cases, it compared unfavourably with other methods of communication, such as web or telephone-based communication.

A 2019 systematic review of e-consultation using email and messaging or video links in primary care – largely US and UK studies - found uptake was low for older and economically disadvantaged patients and there was lack of any strong evidence about outcomes[14].

There were disparities in uptake and utilization toward more use by younger, employed adults. Patient responses to e-consultation were mixed. Patients reported satisfaction with

[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6495459/

[14] https://medinform.jmir.org/2019/4/e13042/

services and improved self-care, communication, and engagement with clinicians. Evidence for the acceptability and ease of use was strong, especially for those with long-term conditions and patients located in remote regions. However, patients were concerned about the privacy and security of their data. For primary health care staff, e-consultation delivers challenges around time management, having the correct technological infrastructure, whether it offers a comparable standard of clinical quality, and whether it improves health outcomes.

To summarise there is some evidence particularly in mental health and long term conditions that many remote and online services are as good as face-to-face services but evidence is limited and where it is present, a mixed approach appears to deliver the best outcomes. There is little evidence of the effect on clinical staff of delivering remote services.

6. Planned changes to City and Hackney NHS services – remote services

Below are changes that are expected to our local system which will have a remote and often virtual element and could be co-produced with patients and carers with built in service user feedback and staff experience.

Outpatients **Dental Services** **Long Term Conditions** **Diagnostics**	Virtual delivery methods implemented for majority of activity. Applies to: Anti coagulation; bowel screening; dermatology; endoscopy; fertility treatments; continence service; dietetics; leg ulcer clinics; MSK; pain clinics; PFD service; cardiac physiology; sexual health, Bi-Lingual Advocacy Service; TB clinics; phlebotomy; Paediatric acute and outpatients
Cancer	Cancer referrals triaged to see if a phone appointment (followed by diagnostics if necessary) or deferral would be most appropriate Booked outpatient appointments moved to telephone appointment Follow-up appointments moved to telephone appointment Follow-up appointments vetted by consultants with phone calls offered if urgent
Therapies	For most therapies, caseloads were prioritised, with only urgent appointments maintained – and wherever possible these are delivered remotely Other appointments suspended or carried out virtually Applies to e.g. Cardiac rehab; occupational therapy; speech and language therapies; physiotherapy Regional neuro-rehab unit inpatient remains open; all outpatient clinics suspended with virtual assessments being conducted

Community Services	Suspended or reduced face-to-face services except for emergencies, and/or replaced them with phone triage/phone calls/virtual services Applies to e.g. Audiology; CAMHS; community rehabilitation; Community CYP services; community gynaecology; continence service; children's therapies; dermatology; foot health; Heart failure nursing; health visiting; Dietetics; Dentistry; minor eye conditions; Locomotor services; lymphoedema service; minor surgery service; ENT; IAPT; post-operative wound care; Hear to Help; sickle cell; diabetes; asthma; COPD as well as learning disabilities; and wheelchair services
Adult Mental Health Services	Reduced face-to-face services based on a risk rating of patients and moved patients to virtual platforms where possible. Psychotherapy services open to urgent referrals only. Enhanced mental health crisis pathways e.g. 24/7 crisis telephone service. Crisis Café and SUN group are being delivered remotely (part of ELFT crisis pathway)

7. Conclusions

Remote services and in particular digital services are difficult and undesirable for some sections of the population compared to face-to-face services. There are specific issues for older people, carers, disabled people, those who don't have smart phones or use social media and economically disadvantaged communities. The move to remote NHS services may widen current inequalities for particular groups unless these issues are considered and mitigated.

Patient experience is mixed for remote services, but generally quite positive. There are considerable advantages for many groups and positive feedback. However there is little on-going work to gather it together or actively seek it in City and Hackney. There may need to be investment in administrative systems and patient support and navigation services to maximise the positive benefits of remote services.

There appears to be some evidence, particularly for people with long term physical or mental health conditions that remote services deliver at least as good if not better patient and carer experience and outcomes.

There are safeguarding implications for remote services that need to be considered.

Whilst there is a lot of work going on in City and Hackney, it does not seem to be very joined up and gathering together information for this report was difficult.

There appear to be some examples of co-production but not a strategic approach or framework to share learning and avoid consultation fatigue.

There is little work going on to gather staff experience of remote services and make improvements so they deliver a positive staff experience.

8. Recommendations

1. Bring together current remote services patient feedback from practices that are able to collect this and report this more widely including trends over time and where possible patient satisfaction for particular groups.

2. Consider a way that EMIS practices could gather feedback about remote services in the absence of an EMIS solution in the near future.

3. Link with all NHS providers in City and Hackney to understand what patient feedback is in place for digital and remote services and bring this together for learning purposes into one regular report covering the whole system so the system can learn and improve together.

4. Increase the use of patient information about remote and digital services in City and Hackney (for example for GP group consultations) and signposting for further support/information. Consider literacy levels for such guidance and the need for accessible information.

5. Consider offering support to practices to review their websites so they provide easy to navigate/find information about remote services and links to patient information and support.

6. Consider improved internet access etc. for hostels, housing with care etc.to enable access to remote and digital services.

7. Consider improved Patient Advice and Liaison (PALS) Services and administrative support to improve access and support for remote services.

8. Understand language issues and solutions for people with low literacy or little English including how best to use translation and advocacy services as part of the digital/remote offer and share solutions.

9. Understand how NHS providers are ensuring equitable access for people who are not online/unable to use digital approaches and potentially share these for learning and service improvements.

10. Consider producing a list of tools and digital approaches for City and Hackney NHS providers so that as far as possible they use common online services/tools so that service users would only have to learn how to use a couple of tools i.e. Attend Anywhere, Teams or Webex for online consultations/patient groups.

11. Link with providers in City and Hackney and understand their plans for digital services, how they are involving service users in these plans and co-producing these and share lessons and learning so service users don't experience "consultation fatigue".

12. Understand safeguarding issues when developing digital and remote services and consider producing resources and guidance for our local system.

13. Build in outcome measurement into new online services, i.e. a framework that could cover clinical, patient and professional outcomes and experience.

14. Consider producing/sharing best practice guidance for healthcare professionals using these tools to ensure a good service user and staff experience.

15. Collect professional feedback of digital approaches to ensure healthcare professionals feel competent and safe using these tools and it does not contribute to already high stress levels for staff.

Jenny Singleton
Head of Quality, City and Hackney CCG

October 2020

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Digital health during the Covid-19 pandemic:

LEARNING LESSONS TO MAINTAIN MOMENTUM

“The old argument about whether it’s right to prioritise modern technology in the NHS and our care sector is over. The pandemic has proven beyond doubt that better tech is vital for the future success of our health and care service… Now we need to focus on how we can ‘bottle’ the progress we’ve made in the last few months.”

Matt Hancock, July 2020[1]

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This report has been developed by the *Patient Coalition for AI, Data and Digital Tech in Health*, which aims to unite representatives from patient advocacy groups, Royal Colleges, medical charities, industry and other stakeholders committed to ensuring that patient interests lie at the heart of digital health policy and discussions.

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This document reflects the view of the *Patient Coalition on AI, Data and Digital Tech in Health* and may not reflect the individual views of every one of the organisations that contributed to its creation.

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FOREWORD

RACHEL POWER

CEO of the Patients Association and Chair of the Patient Coalition for AI, Data and Digital Tech in Health

The Patient Coalition for AI, Data and Digital Tech in Health has produced this report to improve our understanding of the role of digital health technology during the pandemic. In particular, given our focus on championing the patient perspective, this report focuses on shedding light on the patient experience of these technologies. We have drawn on in-depth research, a new patient survey and a collection of case studies of good practice in digital health technology to provide useful insights and policy recommendations. Our aim is to help ensure that the UK learns from the unique experience of the past year – both the good and the bad – so that we can continue to improve the implementation and uptake of digital health technology to the benefit of all patients.

While digital health technologies certainly hold incredible potential to improve the efficiency and effectiveness of health services to the benefits of patients and the NHS, this has not been the experience for all patients. Alongside examples where these technologies have helped improve care, there are also cases where patients have struggled with access or found that digital technology did not improve their care. Beyond telephone consultations, it seems we still have a long way to go before we can confidently say that patients across the UK are truly benefitting from the full potential of digital health technologies.

If we are serious about capitalising on the incredible potential value of these innovations to the benefit of all patients, we must learn from our pandemic experience. We need to ensure that digital policy better reflects patient priorities and this includes ensuring patients are more involved in the policymaking process. We also need to improve public understanding of these technologies – not just how they can be used to improve care but also the complexities of related issues like data-sharing. Ultimately, there is still much to be done to improve access to digital health so we can continue to move from pockets of progress and cases of good practice to widespread implementation and use.

As part of this process, we need to consider how the health system is designed and how it should continue to evolve if we are to make the most of digital health. Patients recognise the value of digital technologies but they also want to retain the choice to see a healthcare professional – an important aspect of healthcare that should not be lost. In our rush to embrace digital technology we need to ensure that patients still get the time and attention they need so healthcare is always something done ‘with’ patients rather than ‘to’ patients.

Over the past year, we have certainly seen the health service rapidly adapt to a difficult environment, including by embracing digital health technologies. While this has worked well for some, it has proven challenging for others and there are plenty of lessons to be learned as health services continue to evolve. We have an opportunity to build on this incredible momentum and leverage the value of digital health technologies to the benefit of patients and the NHS. Hopefully this report provides useful insights and recommendations to help support the ongoing process of digitisation and ensure that patient priorities and experience always lie at the heart of digital policy.

INTRODUCTION

The aim of this report is to provide policymakers and the NHS with recommendations for how to learn from the experience of digital health technology during the Covid-19 pandemic, both the positive and the negative. This is to help ensure that the UK can capitalise on the incredible potential of these technologies to the benefit of patients, the NHS and the UK economy.

Since March 2020, the NHS has been forced to rapidly adapt to the significant service pressures caused by Covid-19, reprioritising staff and resources to provide vital services at this difficult time. A key element of this urgent pandemic response has been the rapid implementation of digital health technology across the NHS, which has helped facilitate a significant step change in the way that health services are delivered in the UK. This includes working very quickly to free up space and capacity in acute hospitals, enable remote monitoring and communications, and reduce the risk of infection transmission in care settings.[2]

While the speed and scale of digitisation has generally been rapid, this has varied across the NHS and the rate of uptake is challenging to calculate based on the data available. While some Trusts organised online groups in a matter of days and weeks rather than the three to four years as originally planned, there have also been cases where the use of digital health technology has not been appropriate and instead worsened inequalities.[3] Ultimately, there is still limited academic evidence of the impact of digital technology on service quality and efficiency[4] beyond case studies of good practice.

Similarly, patient experience of digital health technology during the pandemic has been mixed. While parliamentarians have acknowledged that digital health technology has largely been welcomed as a positive innovation in circumstances where many medical services would otherwise be unable to meet the needs of patients,[5] research also shows patients did not always have a positive experience of digital technology in healthcare during the pandemic. Despite the large-scale celebration of the NHS over the spring and summer, emergency measures often came at a significant cost to patients. In fact, access to services became very difficult for some and many patients were left feeling unsupported, anxious and lonely.[6,7,8] Consequently, the relationship between patients and the NHS during the pandemic had actually been significantly disrupted in many ways.[9]

This is not to say that digital health technology has not also proven critical in many ways to providing vital services during this challenging time. At their best, these technologies provide tools to empower patients and provide them with more tailored, effective and efficient services. There are clearly still gaps and challenges to overcome as the system moves beyond pockets of good practice to provide diverse digital solutions to complex problems. The NHS has struggled to facilitate widespread and effective adoption of these tools so every patient has the opportunity to experience and benefit from digital health, and this systemic challenge has not been resolved over the past 10 months. Yet progress has been made and continuing the momentum that has evolved during the pandemic is crucial to the future of health services in the UK.

There is a risk that the progress made towards embracing digital health technology during the pandemic could be lost or slowed as the pandemic passes and the NHS reverts to its previous care models. It is important to learn from the pandemic experience – where digital health technologies have supported patients and the NHS, and where they have fallen short – in order to help ensure that the UK can continue to capitalise on the potential of these technologies in the future.

This report will begin by establishing the low level of digitisation that existed in England prior to the pandemic, alongside a limited public understanding of digital health. Drawing on a new patient survey and a series of case studies, this report then provides insights on the experience of digital health during the pandemic. The aim is to identify lessons and key principles that should help inform the future development and implementation of digital policy. These lessons and insights help inform a series of recommendations for how the Government and NHS can ensure the UK can continue to capitalise on the value of digital health technologies to the benefit of patients, the NHS and the economy.

WHAT WE KNOW:
DIGITAL HEALTH TECHNOLOGY BEFORE THE PANDEMIC

The digitisation of health services has been a key priority for the Government and the NHS over the past several years, and lies at the very heart of the long-term strategy for health services in the UK.[10] It has been the subject of a range of diverse programmes and pilots designed to facilitate the adoption and diffusion of digital health. There has also been significant research into evolving public perceptions of digital innovations and data as this digitisation process has continued over the years.

KEY POINTS TO CONSIDER REGARDING DIGITAL HEALTH PRIOR TO THE PANDEMIC INCLUDE:

1. England was starting from a relatively low level of digital engagement

Evidence suggests English patients were significantly less likely than patients elsewhere to use digital technologies to manage their health prior to the pandemic. By 2020, the use of mobile phone/tablet applications and wearable technology had fallen by about 15% since 2018 while 43% of patients said they were not using any digital tools to manage their health (highest of all countries surveyed including US, Australia and Norway).[11] In fact, research suggests only 4 in 10 would be willing to engage with technology in their healthcare experience.[12]

2. There was also limited awareness of the types and use of digital health technologies

Before Covid-19, just 12% of patients in England had received healthcare virtually.[13] Unsurprisingly then, when identifying different types of digital technology, patients were familiar with phones, watches and connected home tools, but most had never considered medical applications.[14]

3. The public demonstrated an interest in accessing health via digital routes

Qualitative research shows that there was optimism about new technology in healthcare as well as support for the use of new technology to augment and support clinicians, both for direct patient care and for wider efficiencies in the health system overall.[15] More broadly, 66% of English patients said they would consider using virtual care or digital therapeutics[16] and over 75% of the population were going online to find help with their care.[17]

4. Patients wanted digital health solutions to provide them with information

Research suggests the most popular types of apps were fitness, medical reference and wellbeing, which provide information and have limited other functions.[18] Patients also identified their top priorities for health apps including providing information on symptoms and medical condition, and facilitating examination of health records.[19]

5. Key barriers to embracing digital health persisted, including concerns over data sharing

It was clear that patients did not support sharing data solely for commercial purposes. While they may understand that commercial partnerships exist within the NHS to deliver services, and that these companies may need to use patient data, they saw patient data as belonging to the NHS and to be used for social good only.[20]

SURVEY: PERCEPTIONS OF DIGITAL HEALTH TECHNOLOGY DURING THE PANDEMIC

Given the significant impact of the pandemic on patients and the NHS, and the resulting rapid implementation of digital health technologies, the Coalition was keen to gain a deeper understanding of the impact of these technologies and how public perceptions of digital health may have changed over the course of the pandemic.

On November 06 2020, the Patients Association launched an online survey on behalf of this Coalition, focused on assessing perceptions and experiences of digital health technologies during the pandemic.[21] . In total, 162 people shared their opinions. The sample strongly reflects the experiences of older people with long term conditions: the majority of respondents identified as White British (**88%**) and female (**63%**). The majority (**84%**) were aged 55 or older with **40%** falling in the 65-74 age bracket. It should be noted that the online format of the survey is unlikely to have reached those without access to internet or technology, or with low computer literacy, and these groups will be underrepresented in the results. Some quotes from survey respondents have been minimally edited for clarity and language, but care has been taken to preserve the original meaning.

The sample size is too small on its own to provide rigorous insights that can be extrapolated to draw broad conclusions about public perceptions across the UK. However, the results broadly align with and reinforce the conclusions of larger patient surveys conducted during the pandemic. It therefore offers some useful anecdotal insights into how patients have engaged with digital health technologies during the pandemic as well as their key concerns and the support they need going forward.

KEY CONCLUSIONS INCLUDE:

1. Uptake of digital health technology remains limited

While about **81%** of respondents made use of telephone consultation services, take up of other digital health technologies was much lower: only **21%** used video consultations; **36%** used mobile phone apps; **4%** used remote monitoring devices; and 50% used online patient communication platforms.

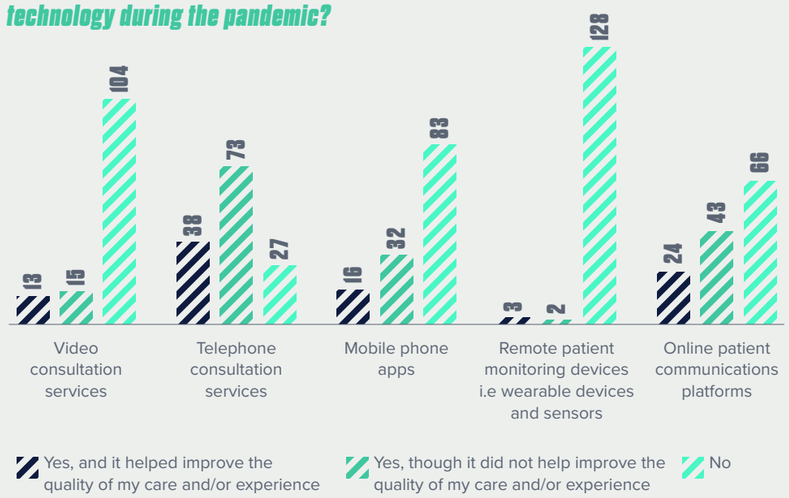
This reinforces the findings of a large Ipsos Mori survey which revealed that 67% of respondents had telephone consultations during the pandemic while only 18% used video or other online consultations and 5% used other online services or virtual agents like chatbots.[22] It also reflects the findings of a Patients Association survey which revealed a mix of opinions about how useful video and telephone consultations were during the pandemic while about 30% of respondents had not used online health services at all.[23]

2. Most of those who did use digital health technology did not feel it improved their care

Of those who used telephone consultation services, only **28%** thought it improved their care and/or experience. This was high in comparison to those who used video consultations (**10%**), mobile phone apps (**12%**), remote monitoring devices (**2%**) or online patient communications platforms (**18%**).

Taken alongside a number of more comprehensive studies, it is clear that patient experience of digital health technologies during the pandemic has been mixed. For example, in primary care, some patients have found digital services to be “amazing” and have called for a “digital by default” approach to communication,[24] while other patients struggled to understand how to book appointments using new digital triage systems or were not able to book appointments that met their needs[25]. Clearly there remain strong barriers to the effective implementation and uptake of digital health technology across the UK.

Have you used any of the following types of digital technology during the pandemic?



“The technology inconvenient to use when patients have multiple conditions”

“Online symptom reporting is NOT user (patient) friendly - I worked in IT & I find it awkward to navigate!”

“Length of time taken to respond, lack of human contact, lack of empathy and care for elderly patients”

“Can be confusing as to what bit I use for what”

“Any technology used by the health service terrifies me. I have wasted so much time in the past fiddling with it and finding it does not work that I have now given up”

“Online systems need to be easier to navigate”

"Digital technology is essential and inevitable"

"Digital technology is essential to disseminate information swiftly and efficiently"

"Used properly, it could make life easier"

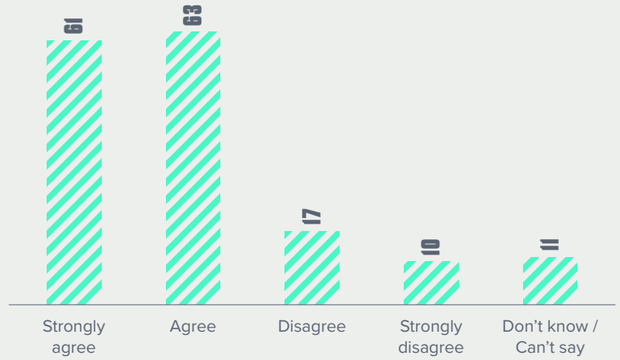
"[It is important] If properly incorporated with and enhances the human touch"

3. People strongly believe in the value of digital health technology

77% of respondents agreed to some extent that digital health technology is important to the NHS's ability to respond to the pandemic and similarly **73%** agreed it is important to the future of health services in the UK.

This aligns well with recent survey findings which showed that, if given the choice, most patients would choose virtual for basic care services, and even for specialty care. They "definitely" or "probably" would receive health and wellness advisories (58%) and remote monitoring of ongoing health issues through at-home devices (52%), and nearly half (52%) would choose virtual for routine appointments. Some are also open to receiving diagnoses virtually — 37% for illnesses, diseases and disorders and 38% for appointments with medical specialists for diagnosis or acute care.[26]

To what extent to you agree that digital health technology is important to the future of health services in the UK?

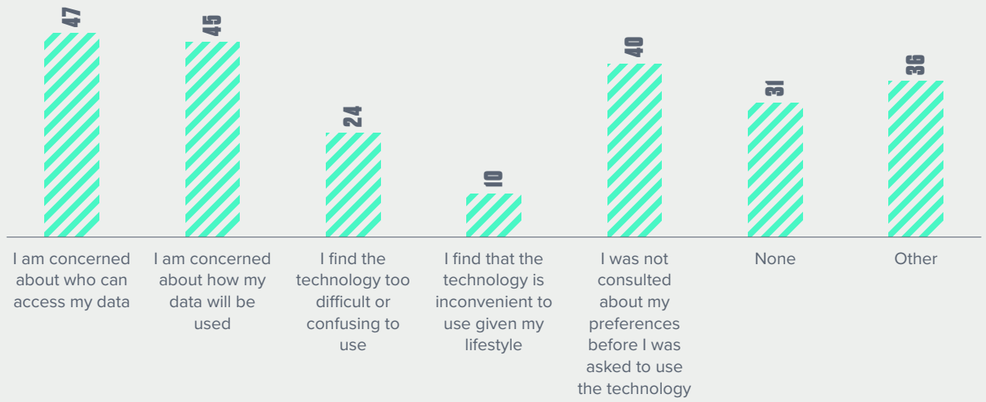


4. There are still significant concerns about using digital health, particularly around data collection and sharing

In particular, the survey revealed that **35%** of respondents are concerned about who could access their data and **34%** also expressed concerns about how that data will be used.

This reflects the well-established understanding that "most people support sharing patient data for individual care and a high proportion of people support sharing patient data for research where there is public benefit" but people generally "do not trust commercial entities" when it comes to using patient data.[27] In fact, a recent study showed about 95% of people were not willing to share their medical data with commercial industries by late 2018.[28]

What concerns do you have, if any, about using digital health technology? (Please choose any/all that apply)



5. Patients want to be more involved in their health and care

30% of respondents expressed a concern that they are not consulted about their preferences before being asked to use digital health technology. Furthermore, about **40%** want more time spent asking them about their health needs and preferences, as well as greater patient involvement in the decision-making process.

These findings reflect well-established trends where NHS England has acknowledged that national surveys show over 40% of people want to be more involved in decisions about their care, and similarly 40% of people living with long-term conditions want more support to manage their health and wellbeing on a day-to-day basis.[29]

What support do you need, if any, to overcome your concern(s)?

"It must not replace face to face but be an option"

"Mixed feelings. Patients should retain choice"

"Patients still need the option for conventional means as an alternative to new tech"

"I don't have a lot of concerns personally but think that it is important to have a range of options available to patients so they can express a preference for what they would prefer"

6. People also want the choice to use tech rather than tech replacing clinicians

Despite the fact that **73%** of respondents agree or strongly agree that digital health technology is important to the future of health services, there is clear support for ensuring people have a range of options. The healthcare professional is still seen as a vital part of health services and technology should support them rather than replace them.

Organisations like the Patients Association and Mind recently reached similar conclusions in their research. They agreed that the diversity of patient needs and preferences ensures factors such as access to technology, comfort using technology and patient environment will vary and a patient should have the ability to choose how they would like to access health services.[30,31]

"Concern regarding others not being able to use digital health technology e.g. elderly, those who do not have access to the technology"

"Technology is only as good as access to it. When it works, fine, when it doesn't people are left stranded"

"It's really useful to have it available as long as it doesn't permanently replace face to face appointments and that people without the skills or access to tech are not disadvantaged in any way"

"The Department of Health must work out how to make this accessible to everyone".

"So much more is learned by face-to-face contact I worry that digital consultations are a poor substitute and disenfranchise those without digital access"

7. Digital health technology should be used to the benefit of all patients

Throughout the survey, patients expressed concerns regarding the need to ensure the accessibility of digital health technologies. It is important to remember that '11 million people in the UK (20% of the population) lack basic digital skills, or do not use digital technology at all. They are likely to be older, less educated and in poorer health than the rest of the population. Thus, many of the people who could most benefit from digital services are the least likely to be online.'[32]

This reflects the findings of a recent report which emphasised that remote consultations will not work for everyone, including many disabled people, who are less likely to have access to the internet than non-disabled people, those in rural areas without reliable connectivity, those with poor digital literacy, and those who lack the privacy necessary for sensitive conversations with health professionals.[33]

CASE STUDIES:
LEARNING FROM GOOD PRACTICE DURING THE PANDEMIC

It has been widely acknowledged that, in an effort to address the exceptional service pressures caused by the pandemic, healthcare professionals across the UK have rapidly adopted or expanded the use of digital health technologies. In many cases, these technologies have not only allowed NHS staff to continue providing vital services but they have helped improve patient experience, save resources and reduce workforce pressures.

To help demonstrate the incredible potential of digital health technologies to improve health services and to help capture key lessons learned during the pandemic, 10 case studies have been gathered and assessed (see Appendix 1 for full details) which comprise good practice examples of digital innovation during the pandemic. These should not be taken to suggest that all patients had a similar experience with digital health technology but simply as case studies of where digital health technology has worked well to the benefit of patients and the NHS. Broadly, the key learnings across all of these case studies are that effective digital approaches tol healthcare need to:

1. Respond directly to patient needs

A key reason for the success of digital health technologies is that they were developed and implemented specifically to address a key patient service need, for example, facilitating consultations, supporting symptoms management or accelerating safe triage. Effective digital technology is something done 'with' patients rather than 'to' patients and these technologies were not introduced simply for the sake of digitising an aspect of the patient pathway.

CASE STUDY 1: DIGITAL CONSULTATION SERVICES FOR PARKINSON'S DISEASE[34]

The challenge – The Parkinson's service at Northumbria Healthcare NHS Foundation Trust could no longer run physical clinics during the pandemic as non-urgent appointments and operations were postponed. This was problematic because they receive about 60 new referrals every month and rely on seeing patients to assess them properly.

The solution – Patients were given the option of being assessed by clinicians via video call and over the phone, either alone or with a relative or friend. This technology was used across the Trust for hospital and community services throughout Northumberland and North Tyneside.

The results – Before the pandemic, only 10% to 20% of outpatient appointments at Northumbria Healthcare NHS Foundation Trust were done digitally. By April and May, this increased dramatically to 70%, equating to almost 11,000 appointments. Waiting times fell from three to four months pre-COVID, to just two weeks, with the technology saving patients travelling more than 60,000 miles to appointments. Importantly, non-attendance rates declined and 98% of patients who used the technology said they would use it again.

2. Ensure technology is easy to use

Whether it is technology to support clinical decision-making, remote monitoring or communication, a key aspect of success is the ease with which it can be implemented, accessed and used. In the best cases, the technology in question also leverages existing infrastructure and can be implemented rapidly with minimal disruption or need for training.

3. Embrace convenience and flexibility

In order to effectively support patients and meet complex needs and preferences, digital health technologies must be offered as a choice alongside other routes to engage with the health service. They cannot be imposed as a 'one-size-fits-all' solution without considering critical issues including how a patient accesses the health service and what support they need.

4. Maintain the human aspect of healthcare

While patients may have become more accustomed to virtual services, the best digital health technologies do not undermine or remove the patient-clinician relationship. Instead, they strengthen that relationship by, for example, improving communications or patient education.

5. Support clinicians

As the implementation of digital health technologies accelerates, the most effective tools work to support NHS staff and facilitate health services rather than simply replacing staff or creating additional responsibilities. Digital health should be used as a tool to reduce pressures on healthcare professionals and to ensure patients can receive the support they need beyond their usual care settings.

CASE STUDY 2: VIRTUAL SELF-REFERRAL TO PREVENT TYPE 2 DIABETES[35]

The challenge – There are more than 12 million people at increased risk of type 2 diabetes in the UK, but the reduction in routine screening during the pandemic has meant that the number of people being referred into the NHS Diabetes Prevention Programme has dropped. As a result, many people have not been able to get the help they need to reduce their risk of type 2 diabetes.

The solution – The NHS Diabetes Prevention Programme (DPP) launched an online self-referral route via Diabetes UK 'Know Your Risk' tool allowing people who may be at risk of developing type 2 diabetes to determine their particular level of risk. If a person was found to be at moderate or high risk of developing type 2 diabetes, they were signposted to another digital tool, which allows people to search using their post code to find their local provider and sign up to the NHS Diabetes Prevention Programme.

The outcome – As of 28th September 2020, over 335,000 people had used the Diabetes UK 'Know Your Risk' tool since the end of July, which represents a 564% increase compared to two months previously. The NHS DPP has capacity to support 5,000 people every week and offers a digital stream, meaning access to the programme has been able to continue during the pandemic.

RECOMMENDATIONS

When implemented effectively, digital health technologies have proved vital to the response of UK health services to the pandemic; helping to provide vital services, save resources and reduce workforce pressures. While it has largely been welcomed as a positive innovation in circumstances where many medical services would otherwise be unable to meet the needs of patients, it is also true that patient experience of digital health technology has varied during the pandemic.

The case studies cited in this report help demonstrate the incredible potential of digital health technologies to improve services for patients and the NHS, which can be secured when they are developed and implemented effectively. Yet it is clear that digital solutions are not always the appropriate tools to deliver health services and have even helped facilitate inequalities particularly where levels of digital access and literacy amongst patients differ.[36]

The UK must build on the progress made to digitise the NHS during the pandemic rather than reverting to pre-Covid service models. In order to do so, there are important lessons to be learned from the successes and failures of implementing digital health technology in the NHS, particularly from case studies of good practice that have helped facilitate service improvements. This will help ensure that the UK can continue to capitalise on the incredible potential of digital health technologies to the benefit of patients, the NHS and the UK economy.

Moving forward, the Government should:

1. ENSURE DIGITAL POLICY REFLECTS PATIENT PRIORITIES

As digital policy continues to evolve rapidly in response to the pace of technological innovation, it is important to ensure that policymaking and implementation are ultimately driven by and focused on meeting patient needs and expectations.

2. INVOLVE PATIENTS IN THE POLICYMAKING PROCESS

In order to help ensure that patient priorities lie at the heart of digital health policy, greater effort should be made to involve patients throughout the policymaking process, from development and implementation through to evaluation and monitoring.

3. EDUCATE PEOPLE ABOUT THE VALUE OF DIGITAL HEALTH TECHNOLOGY

Given the limited uptake and understanding of digital health technology prior to the pandemic, there is a need for greater outreach and engagement to address this gap in order to help encourage people to make better use of digital innovations.

4. MAKE DIGITAL HEALTH TECHNOLOGY ACCESSIBLE TO ALL

Digital health technology has been a vital part of the NHS response to the Covid-19 pandemic but uptake and use has not been consistent across all age groups and geographies. Moving forward, there is a need to ensure that access to these transformative and life-saving technologies continues to expand across the country.

5. ENSURE THERE ARE CLEAR REGULATIONS FOR THE COLLECTION, SHARING AND USE OF PATIENT DATA

People remain overwhelmingly concerned with who can access their data and how it will be used. They need to be assured that their data and privacy are being safeguarded by strong information governance laws.

Moving forward, the NHS should:

1. EXAMINE THE PUBLIC EXPERIENCE OF DIGITAL HEALTH DURING THE PANDEMIC

Given the speed of the response to the pandemic, there was little opportunity for public involvement in policy development and implementation. It is vital to understand the public perspective on digital health to help inform future service provision.

2. ENSURE PATIENTS HAVE A CHOICE

While digital health technology has incredible potential to improve patient outcomes and experience, there is still a clear desire to maintain non-digital healthcare solutions and retain the connection between patients and healthcare professionals. Innovations should supplement that relationship, not replace it.

3. GIVE PATIENTS MORE TIME AND CONTROL OVER THEIR HEALTH AND CARE

While there is broad appreciation of the importance and value of digital health technology, there is also a clear public desire for more involvement in decision-making and more communication with healthcare professionals. This includes a more extensive discussion of health needs and service preferences.

4. REASSURE PATIENTS THAT THEIR DATA IS SAFE

Where patients are encouraged to use digital health technology which requires collecting and sharing their data, there remains a clear need to maintain a high level of transparency and ensure patients understand the processes involved, how their data will be collected and used, and the considerable benefits to their health and the health of others.

5. CONTINUE TO STRENGTHEN AND PUBLICISE DIGITAL ASSURANCE

As the use of digital health technology continues to increase, the NHS must ensure that people feel confident that digital products have been rigorously reviewed and are considered safe for patient use in all key regards.

Appendix 1:

CASE STUDIES OF DIGITAL HEALTH TECHNOLOGY DURING THE PANDEMIC

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The NHS DPP has capacity to support 5,000 people every week and offers a digital stream, meaning access to the programme has been able to continue during the pandemic.

CASE STUDY 3: SELF-MANAGEMENT APPS FOR ASTHMA AND COPD[37]

The challenge – People with asthma and COPD are particularly at risk of developing Covid-19 but could not secure appointments as easily during the pandemic. However, monitoring these conditions was vital as their situation could quickly deteriorate with fatal consequences without appropriate support.

The solution – Designed and supported by internal experts, NHS Wales launched self-management apps for asthma and COPD that included vital details such as medications, triggers and advice. They also allowed patients to log important results and information, and provided videos and articles delivered by their experts.

The results – Dr Simon Barry, Respiratory Consultant and National Clinical Lead for Wales said: *"The Healthhub apps will help us transform patient self-management for conditions such as Asthma and COPD. These apps will help patients have a greater understanding of their condition and will be an invaluable resource for us as clinicians, to offer our patients."*

CASE STUDY 4: VIRTUAL INTENSIVE CARE UNIT (ICU) SUPPORT[38]

The challenge – During the height of the pandemic in April 2020, the Royal Brompton Hospital site was caring for four times as many critically ill patients (70) as its usual ICU capacity (18 beds). To adapt, additional frontline workers were redeployed to support critically ill patients and there was an increased need for rapid communication between healthcare professionals across different parts of the hospital.

The solution – The Royal Brompton and Harefield Hospitals deployed digital technology – webcams, virtual conferencing and hand-held devices – which enabled clinicians to see all relevant real-time data for each patient. For example, a junior member of staff could stand within a patient's bed space on a video call to another clinician, showing both the patient and the ventilator screen to aid in decision-making, while also being in continuous communication with both the bedside nurse and the junior doctor.

The outcome – The new technologies allowed senior healthcare professionals to communicate across many levels within the hospital as if they were at the bedside alongside the junior staff. By relying on existing infrastructure, the costs incurred by staff were negligible and the technologies were implemented in a matter of days using hardware and software with which staff were already familiar.

Initial hesitance of those less familiar with the technology was quickly replaced with enthusiasm and, in the vast majority of cases, staff were actively seeking implementation at the earliest opportunity.

CASE STUDY 5:
GRASP TOOL TO SUPPORT THE MANAGEMENT OF POORLY CONTROLLED ASTHMA/COPD[39]

The challenge – Evidence suggests that there are an estimated 3.7 million people with COPD in the UK, yet only 900,000 people have been diagnosed. Opportunities for early diagnosis of COPD are frequently missed in primary care even before the pandemic reduced the opportunities for regular visits to healthcare professionals. As patients with COPD are vulnerable to viral respiratory tract infections, and COPD is generally a disease that affects the elderly, there was also a concern that COPD patients have an increased risk of acquiring Covid-19.

The solution – The MISSION programme piloted a new model of asthma care across Wessex using a digital tool called GRASP, which interrogates GP records across Clinical Commissioning Groups in Wessex based on a set of codes created by the user. Details examined include ED visits, hospital admissions, medications and asthma triggers.

The outcome – This simple search tool allowed practices to identify patients with the greatest clinical need and provide an assessment that reduced their risk of requiring unscheduled care, while helping to save a significant amount of time, money and inconvenience to patients in the longer term. The programme found that proactively identifying high-risk asthma patients and reducing the length of time before uncontrolled asthma is recognised reduces health costs and improves patient experience.

CASE STUDY 6:
VIRTUAL GROUP CLINICS (VGCS)[40]

The challenge – The pandemic has forced many patients with long term conditions into isolation without their usual support networks. During a pandemic, long-term condition management places additional demands on community services and many patients that have suffered from Covid-19 also face a particularly long and complex recovery.

The solution – Group consultations have long been considered a valuable tool for maintaining health for groups of patients such as those living with a long-term condition and a national programme has been exploring the use of virtual group clinics. During the pandemic, nurses at participating practices have driven the expansion of virtual consultations to offer a safe way to continue to support their patients.

The outcome – Initial feedback from the programme indicates that the virtual group clinic offers comparable benefits to face-to-face group consultations, while helping to minimise the transmission of infection. The virtual model allows a variety of health professionals and leading clinics to see more patients and spend longer with each one. Many patients greatly value the opportunity of facilitated peer support, spending more time with their clinician and making connections with others who share their condition.

As teams master these methods, they report that they save time compared to one-to-one videos with nurses and other clinicians, and are able to review up to eight times as many people in an hour of clinic time.

CASE STUDY 7:
NATIONAL COVID-19 CHEST IMAGE DATABASE (NCCID)[41]

The challenge – As the pandemic evolves, a national understanding of the imaging features is required to guide future management, national protocols, and to assist clinicians to more accurately identify and diagnose episodes of COVID-19 infection.

The solution – NCCID is a centralised UK database of X-Ray, CT and MRI images and other relevant information pertaining to patients with suspected COVID-19 from hospitals across the country. It has been created to enable the development and validation of automated analysis technologies that may prove effective in supporting COVID-19 care pathways, and to accelerate research projects to better understand the disease.

The outcome – The data has the potential to enable faster patient assessment in A&E, save Radiologists' time, increase the safety and consistency of care across the country, and ultimately save lives. There are currently 18 NHS Trusts registered for the data site and while the outcomes have yet to be determined, it is expected that the data will be used to support key activities including the validation of AI products; the development of image processing software; and teaching resources for radiologists.

CASE STUDY 8:
VIRTUAL PODIATRY SERVICE IN SCOTLAND[42]

The challenge – Diabetes foot problems are the most common causes of diabetes-related hospital admissions in the UK, and are usually preceded by serious foot infections. Consequently, timely action is crucial. However, those in shielding categories, care homes and wards during the pandemic presented a particular service challenge due to the need for physical distancing and access limitations.

The solution – This challenge provided a unique opportunity to test the utility of video assisted consultations in the delivery of wound management. Due to previous poor uptake, referrals were initially telephone triaged by foot protection podiatrists and the subsequent rapid spread and scale up of virtual consultations required clinicians to embrace new learning and ways of working quickly.

The outcome – By June 2020, over 16,000 'Near Me' consultations were being delivered each week across NHS Scotland, a staggering 5,000% increase within 4 months. The average number of referrals to the podiatry service per month pre-COVID-19 was 3,486, of which around 3.5% were new foot wounds. By May 29, 2020, 6 days after the lockdown, 33% of referrals were for new foot wounds.

1. Full list of 57 seats can be found in Annex 3

CASE STUDY 9: HANDHELD DEVICES AND TRACKING SOFTWARE TO SUPPORT INFECTION PREVENTION[43]

The challenge – Covid-19 saw many nurses redeployed, sometimes to several different wards across Gateshead Health NHS Foundation Trust, in order to flexibly meet the exceptional demand for care. This made keeping track of who is where, and when, increasingly important and was a significant part of effective infection prevention and control if patients or colleagues test positive for Covid-19.

The solution – The electronic patient record system was adapted to support updated infection prevention and control practices. Nurses and other staff access the system via handheld devices and used it to record a range of details including observations and clinical measures. The system also linked into a bed mapping system so staff could quickly obtain information such as patients who have been nursed in the same ward or bay as another Covid-19 positive patient. The hand-held mobile devices were easy to carry around and there were larger tablet-sized devices that allowed more detailed viewing and were normally used for ward rounds or viewing additional detailed documentation.

The outcome – The devices enabled staff to overview and monitor patients remotely and minimise patient contact with clinicians who were not directly caring for individuals. It also facilitated communication across multi-disciplinary teams with data feeding into one portal. Staff could see the patients they were responsible for before they started their shift and patient data was updated at the bedside after each contact to reduce risk of errors and help to track assessments, monitor wellness and support rapid response.

CASE STUDY 10: SUPPORTING PATIENTS TO SELF-MONITOR IN THE COMMUNITY[44]

The challenge – With many vulnerable patients with long term conditions required to shield during the pandemic, the difficulty was ensuring these patients still had access to the same level of care they required.

The solution – Patients with long-term conditions were provided with internet-connected equipment to support self-monitoring of key health indicators and movement. Data was sent to nursing teams via the smart home assistant device and an application was used to display trends. Nurses supported patients to understand the relevant information and how to respond. Smart devices with a screen were also provided, allowing nurses and patients to see each other during consultations and enabled nurses to support and reassure patients, for example, by supporting, assessing and observing self-administration of insulin.

The outcome – This approach helped keep many vulnerable patients safe by reducing face-to-face contact and supported the identification and stratification of which patients required different levels of assessment by a community nurse. Closer monitoring and discussions with nurses also supported patients to safely increase their knowledge and understanding of their health condition – helping them to self-care while making them more aware of subtle but relevant changes in their observations which may require further advice, help or support.

CASE STUDY 11: VIRTUAL CLINICS TO MANAGE TRANS-ISCHAEMIC ATTACK[45]

The Challenge - A Trans-Ischaemic Attack (TIA) is a clear warning sign that a person is at risk of having a stroke. In fact more than one in 12 people who have had a TIA go on to have a stroke within a week. While people with a suspected TIA are supposed to be referred to a specialist for assessment and investigation within 24 hours of the onset of symptom, many specialist TIA clinics were forced to reduce face-to-face services as a result of Covid-19.

The Solution - East Kent University Hospitals FT introduced a virtual clinic to triage suspected TIA patients. During the virtual consultation, a consultant will explore a patient's medical and drug history and health records to answer any concerns and provide reassurance. The consultant concludes the call by setting out next steps, including their investigation and treatment plan and discussing any issues resulting from the diagnosis.

The Outcome - The virtual clinic was able to triage about 60 patients in the first month. This allowed patients to be filtered out at each stage of the process and referrals requiring a subsequent face-to-face consultation were reduced by 30 to 40%. This helped reduce the risk of contracting Covid-19 and limit the spread of the disease in a clinic setting.

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Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **New governance structure for C&H Integrated Care Partnership**	Item No **7**

OUTLINE

The Commission has received a number of briefings on the transition of the City and Hackney CCG into the single NHS North East London CCG and asked for a briefing on the Governance Structure of the new system once it had been agreed.

From 1 April 2021 City and Hackney CCG will cease to exist. The well-established Integrated Care Partnership in City and Hackney will continue and Tracey Fletcher (Chief Executive of HUHFT) will take on an additional remit of **ICP Lead,** accountable to both Henry Black as the **Accountable Officer** for NEL CCG and Dr Mark Rickets as the **CCG Clinical Chair for C&H**.

To support Tracey in this role, and provide day-to-day leadership to City and Hackney based staff, Siobhan Harper (previously Workstream Director for Planned Care) will become **Director of CCG Transition** for an initial period of 6 months.

As ICP Lead, Tracey will chair the **Neighbourhood Health and Care Board** and provide executive leadership to the C&H ICP as well as being a member of the **C&H ICP Area Committee** established by the NEL CCG Governing Body.

Attached please find a briefing note on the changes.

Attending for this session will be:

Tracey Fletcher, CE of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board for City and Hackney,
Dr Mark Rickets, CCG Clinical Chair for City and Hackney
Siobhan Harper, Director of CCG Transition for City and Hackney
Cllr Chris Kennedy, Cabinet Member for Health, Social Care and Leisure.

ACTION

The Commission is requested to give consideration to the briefing.

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Progress update on our transition to a City & Hackney Integrated Care Partnership (ICP)

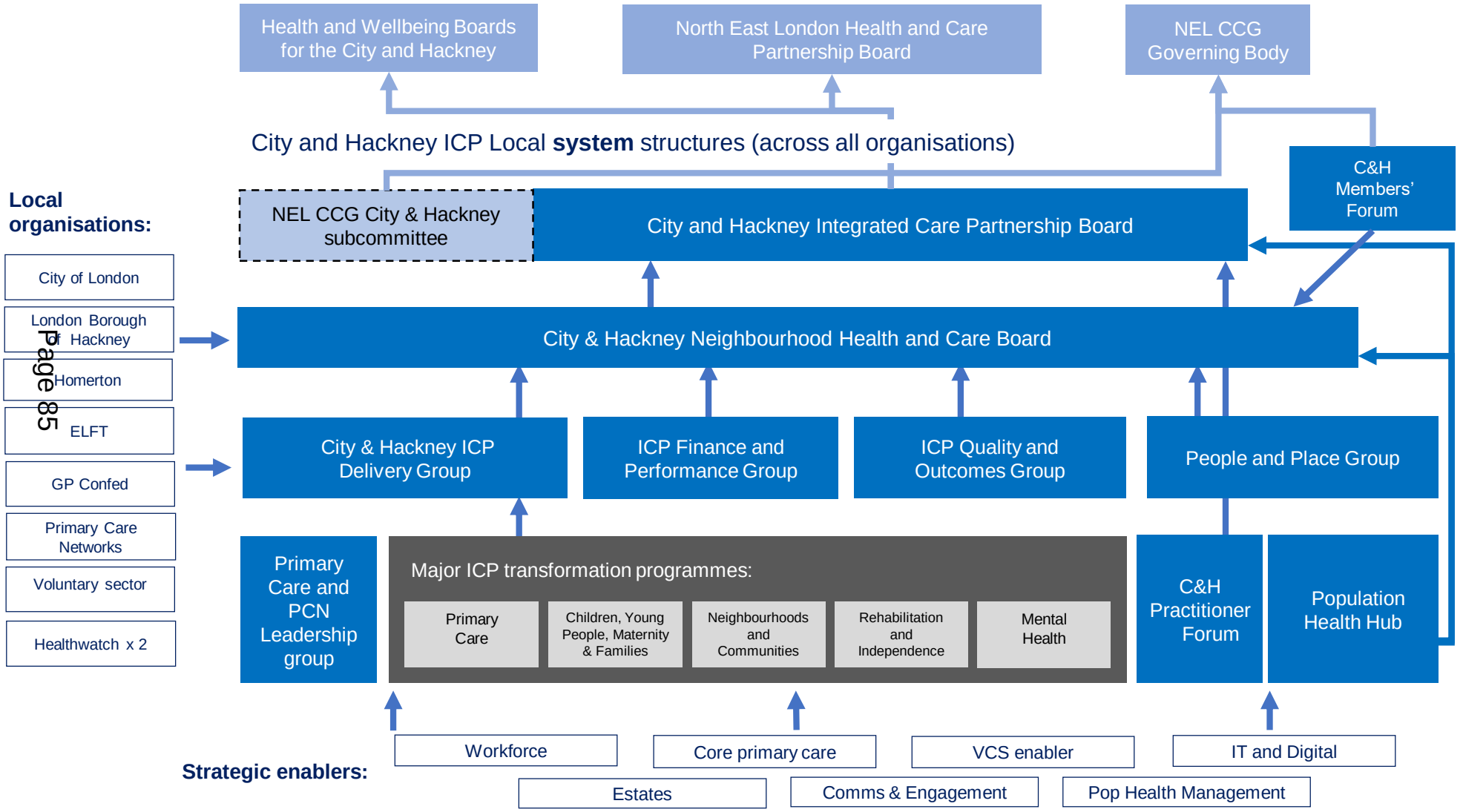
March 2021

Contents

Contents

- City & Hackney local system from April 2021
- Roles and responsibilities for the ICPB and NHCB
- Proposed membership of the boards
- Transitional management arrangements

City & Hackney local system from April 2021



Clinical leadership within the new C&H system

Clinical leadership roles:

= NEL CCG Clinical Chair for C&H

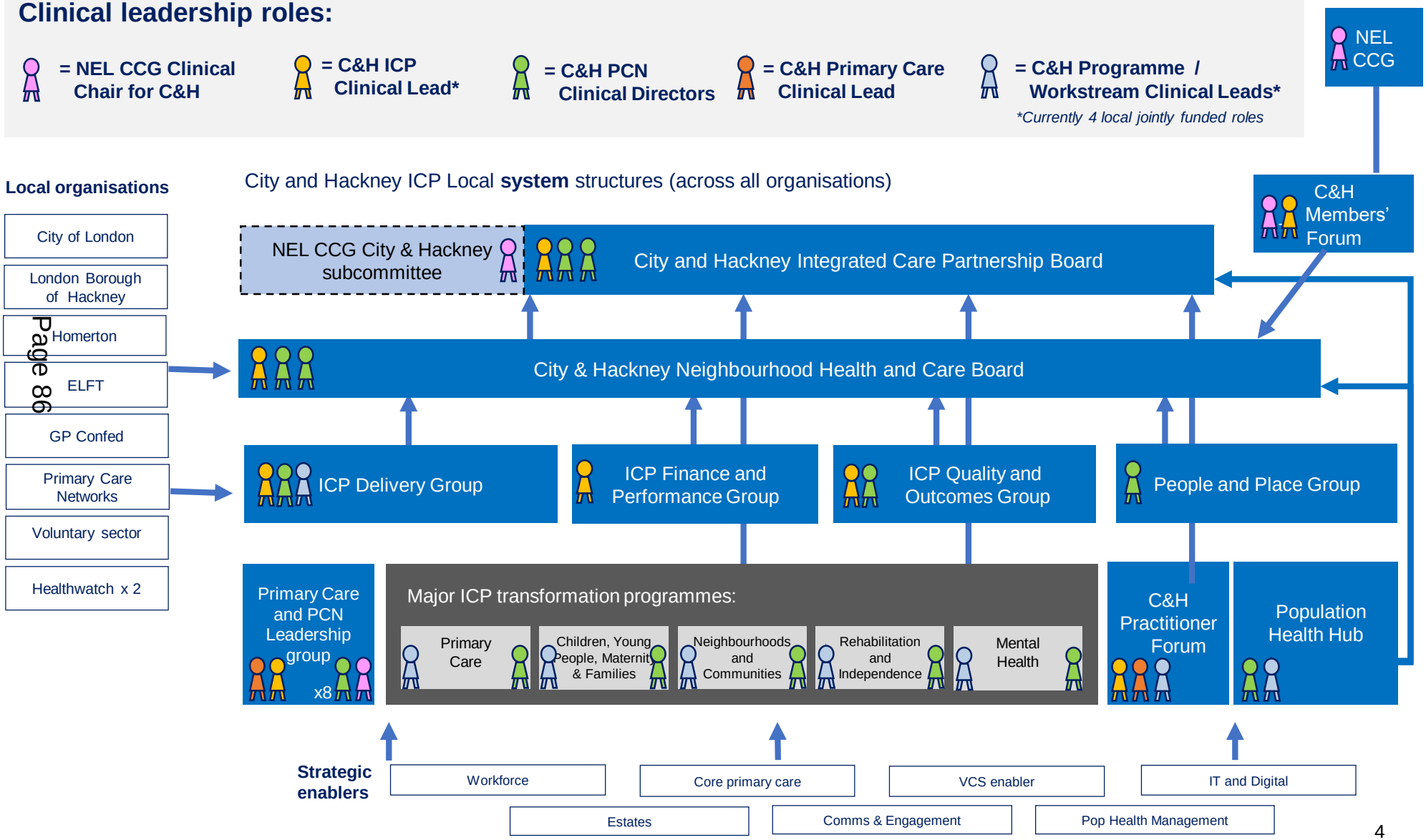
= C&H ICP Clinical Lead*

= C&H PCN Clinical Directors

= C&H Primary Care Clinical Lead

= C&H Programme / Workstream Clinical Leads*

Currently 4 local jointly funded roles



Resident involvement within the new C&H system

Resident and patient advocacy, co-production and representation roles:

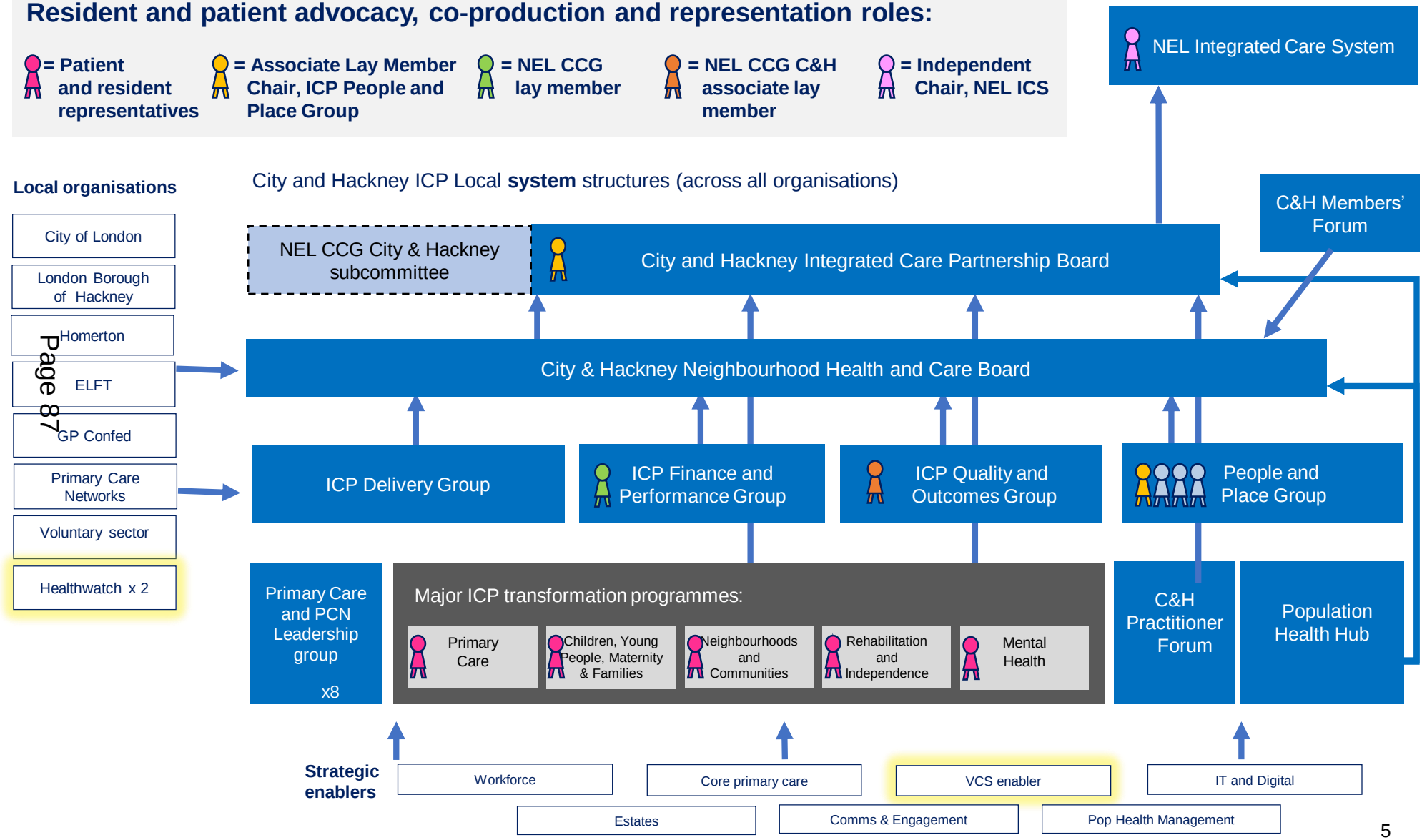
= Patient and resident representatives

= Associate Lay Member Chair, ICP People and Place Group

= NEL CCG lay member

= NEL CCG C&H associate lay member

= Independent Chair, NEL ICS



ICPB: Role and Responsibilities

- Set a local system vision and strategy, which reflects both priorities determined by local residents and communities and the City & Hackney ICP contribution to the NEL ICS. The strategy should be aligned with the health and care components of the Joint Health and Wellbeing Strategies produced by the Health and Wellbeing Boards in the City and Hackney
- Agree objectives with the NH&CB and hold the NH&CB to account for delivery of these
- Establish a local outcomes framework and assure itself that performance against this will be achieved
- Be accountable for system delivery of performance against national targets, NEL-level Long Term Plan commitments and ICP strategy
- Oversee the use of resources within delegated financial allocations and promote financial sustainability
- Ensure co-production is embedded in accordance with charter and patients and public are engaged in the work of the partnership
- Take collective decisions on matters managed on behalf of the Area Committee
- Set up and oversee working groups
- Oversee key stakeholder relationships

NHCB: Role and Responsibilities

- Formally establish a local partnership executive function in City and Hackney and a governance route for joint decision making by partners in relation to operational delivery, use and prioritisation of local system resources, and management of local system performance
- Oversee and support the transition from the current Integrated Commissioning arrangements in City and Hackney to an Integrated Care Partnership of local organisations.
- Develop and formally agree any joint proposals in relation to local services or transformation in City and Hackney which will be submitted to the Integrated Care Partnership Board for approval.
- Responsibility for and co-ordinating an integrated work programme of transformation work at 'place' level within City and Hackney, to deliver population health outcomes as agreed with the Integrated Care Partnership Board.
- Responsibility for and co-ordinating local system-level improvement and governance support functions.
- Agree the accountability, governance and safety arrangements by which joint work will take place between partners, and how these arrangements will link back to the Boards of partner organisations

The first transitional meeting of NHCB was held on 8 March

Transition of Sub Committees

- The Clinical Executive Committee (CEC) will continue to meet with the CCG Clinical Chair providing accountability to the NEL CCG via the ICPB/NEL CCG Area Subcommittee. The transition plan for CEC involves 2 principles:

  - ❑ By September 2021 moving from consortia to PCNs as the framework for peer review, delivery of the Clinical Commissioning LES, and detailed Primary Care input to emerging improvement plans by workstreams and major programmes.

  - ❑ By October 2021 (or where possible sooner) widening the membership of the new Clinical Executive Committee to include the ICP Clinical Lead and the inclusion of provider Medical, Nursing and AHP leaders from across the partnership.

- The Finance and Performance sub-committee will continue to meet with the CCG Vice-Chair & Lay Member for Primary Care providing accountability to the NEL CCG via the ICBP/NEL CCG Area Subcommittee. The transition plan for FPC involves 4 principles:

  - ❑ Maintaining grip on Finance and Performance across the City and Hackney service portfolio.

  - ❑ Providing the NEL CCG via the ICPB with recommendations on service developments, investments and recovery plans until such a time as the City & Hackney ICPB receives delegated authority to receive those recommendations and make decisions locally.

  - ❑ Developing the scope and membership of the City & Hackney Finance and Performance sub-committee to enable it to take a partnership-wide view of finance and performance on behalf of the ICPB and in support of the NH&CB.

  - ❑ Providing an accountable forum for vestiges of the City & Hackney CCG Governance in transition. These include the Primary Care Contracts Committee, and the GP Confederation Oversight Group. It also includes the Safeguarding Assurance Group until such a time as the Quality and Outcomes sub-group is established and able to take on partnership-wide advisory and oversight fora such as safeguarding.

- The PPI Committee will and in March with the People and Place Group taking on its work and beginning the process of recruiting members.

- The C&H Members Forum will continue to meet to review commissioning decisions, and inform the development of our local Clinical Executive leadership model.

Transitional management arrangements

Across NEL we are entering a transitional 12 to 14 months as we move towards the further development of the NEL Integrated Care System, the transition to the NHS NEL CCG and continued development of the City and Hackney Integrated Care Partnership and associated governance.

In light of this transition and to reflect the opportunity to work differently we have agreed the following interim leadership solution for the City and Hackney partnership:

- Tracey Fletcher, the Chief Executive of Homerton University Hospital NHS Foundation Trust, will take on an additional remit of ICP Executive Lead across City and Hackney ICP accountable to Henry Black as NEL AO and Dr Mark Rickets as the CCG Clinical Chair for C&H.

To support Tracey in this role and provide more day to day leadership of City and Hackney based staff, we have undertaken an internal recruitment process and appointed Siobhan Harper (currently Workstream Director for Planned Care) as Director of CCG Transition for an initial period of 6 months.

- As ICP Lead, Tracey will chair the Neighbourhood Health and Care Board and provide executive leadership to the C&H ICP as well as being a member of the City & Hackney ICP Area Committee established by the NEL CCG Governing Body. Siobhan will oversee the day to day management of the City and Hackney team and be accountable to Tracey in her ICP lead role, and responsible to Henry Black in his role as Interim NEL Accountable Officer. We will be backfilling Siobhan's role in due course.

- Tracey, Siobhan and Mark will work across the local partnership and with NEL colleagues to ensure the next phase of our plans are realised. We are pleased to have such a progressive leadership model in place to continue our work on the Long Term Plan and responses to the ongoing challenges of Covid during this transition phase.

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Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **Minutes of the previous meeting and matters arising**	Item No **8**

OUTLINE

Attached please find draft minutes of the meeting held on 23rd January 2021.

MATTERS ARISING

Action from 6 Jan 2021 meeting

Action at 4.7(g)

ACTION:	*Exec Director of Healthwatch to discuss education/awareness training on vaccine hesitancy for care home staff with Interim GD Adults, Health and Integration.*

This is awaited.

Action from 23 Feb 2021 meeting

Action at 5.3(e)

ACTION:	*Vaccination Steering Group to provide an update to the Commission at the 31 March meeting on the communications and engagement work being done locally on vaccine hesitancy.*

This is dealt with at item 4.

ACTION

The Commission is requested to agree the minutes and note the matters arising.

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London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Tuesday 23 February 2021

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held virtually from Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Officers in Attendance	**Denise D'Souza (Interim Director Adults, Health and Integration), Dr Sandra Husbands (Director of Public Health, Hackney and City of London) and Alice Beard (LBH-CCG Communications Officer)**
Other People in Attendance	**Siobhan Harper (Workstream Director Planned Care, CCG-LBH-CoL),Cllr Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure), David Maher (MD, NHS City & Hackney CCG), Cllr Yvonne Maxwell (Mayoral Advisor for Older People), Peter Merrifield (CEO, SWIM Enterprises), Caroline Millar (Chair, C&H GP Confederation), Dr Mark Rickets (Chair, City and Hackney CCG), Laura Sharpe (Chief Executive, City & Hackney GP Confederation), Cllr Carole Williams (Cabinet Member for Employment, Skills and Human Resources), Jon Williams (Executive Director, Healthwatch Hackney),**
Members of the Public	**61 views**
YouTube link	**The meeting in full can be viewed at** https://youtu.be/teGyKDf-7y8
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 There were none.

2 Urgent Items / Order of Business

2.1 There was no urgent business.

2.2 The Chair stated that both David Maher and Denise D'Souza would be leaving the CCG and the Council at the end of the month and on behalf of the Committee he thanked them both for their contributions to the borough. He added that David had overseen one of the most high-performing CCGs in the country and would be a great loss to the borough and wished him well in his new role with the NHS in Northamptonshire. DM thanked the Members for their kind words and stated that Tracey Fletcher would take on a system leadership role as ICP Lead for City and Hackney within NEL and that a succession plan within the CCG was also in train and would be announced shortly.

3 Declarations of Interest

3.1 There were none.

4 Covid-19 - update on vaccinations programme for GP Confed and CCG

4.1 The Chair stated that the purpose of this item was to get an overview on the roll out of the Vaccination Programme which was an at early and crucial stage. He welcomed to the meeting:

Laura Sharpe (LS), Chief Executive, City and Hackney GP Confederation
Caroline Millar (CM), Chair, City and Hackney GP Confederation
Dr Mark Rickets (MR), Chair, City and Hackney CCG
David Maher (DM), MD, City and Hackney CCG
Siobhan Harper (SH), Workstream Director Planned Care, CCG-LBH-CoL

4.2 Members' gave consideration to two tabled documents from the GP Confederation containing feedback from residents who had been vaccinated, the vast majority of which were very positive. CM summarised the findings for Members. LS gave a detailed update on the roll-out as of that day. She explained how opening hours had to vary depending on the flow of supplies but as soon as supplies were confirmed opening hrs were immediately extended so that as many could be processed as possible. She described two dedicated vaccinations sessions they had run for the Charedi community one of which ran from 8.30pm to 1.00am on a Saturday night, following their Sabbath and she described the successful visit of the Vaccines Minister Nadim Zahawi to the centre on the previous Saturday. They had now moved on to 'cohort 6' which would be a very large group but also picking up any not yet done in cohorts 1-4. They did not code anyone as a 'decline' until three attempts have been made to get them to come in. They had seen many requests for deferrals which GPs were addressing. She described the new additions to the Clinically Extremely Vulnerable cohort who had just now been added to the shielding list would have to be given priority. On staffing, she stated that GPs were doing the vaccinations but they were trialling using medical students and the results of that had been very positive. She praised the excellent work of the volunteers who were key to the success of the sessions.

4.3 Members asked questions and in the responses the following was noted:

(a) The Chair asked about the success rate from first point of refusal to finally winning people over and LS stated that conversations with the GPs were what made the difference as it was about that relationship of trust. She added that the Confederation at the same time had to support the GP Practices to get people to attend the Centres and they were also using the Council's call centre to nudge people to attend. When too many deferred this blocked the appointments book and slowed down the roll-out for everyone.

(b) Members asked about tackling myths on social media and the need perhaps for updated information sheets for the volunteers working in the centres. LS gave some examples of the myths and misinformation being shared on social media and stated that a local Comms campaign was needed to complement the national attempts to debunk these myths.

(c) Members asked about how data catch-up issues meant that some people receive a second invitation by mistake. LS replied that it can take 3 days for data from the Pinnacle system to be added to GP records and while this isn't satisfactory the situation with this was already improving.

(d) Members asked about the reasons why some residents were experiencing booking problems. LS replied that such problems were being worked through. For now the view was to stick with two large vaccination centres while preparations were made to community pharmacies into the system. John Scott Centre did have reduced hours the previous week but this was because of supply problems not capacity.

(e) Members asked about the reasons for vaccine supply problems. LS replied that it was very challenging from the Vaccination Team to plan appointments when they themselves would not know until very late what quantities of which vaccines were on the way to them. It was an ongoing problem, and they were providing challenge back on it. Other delays were caused by waiting for permission to move onto the next cohort, something which had to be modelled nationally.

(f) JW (Healthwatch Hackney) commented that there was a vital need for all involved to be careful with the language used in describing those who were refusing as there already were fears of a possible backlash against these groups, which would exacerbate the situation. A Member described a recent community meeting with the Black and Asian residents which revealed a lot of anxiety about vaccines and stated that the matter had to be treated with great sensitivity.

4.4 The Chair agreed about the need for sensitivity in use of language with this and thanked LS and CM for their excellent work on the roll-out.

RESOLVED:	**That the reports and discussion be noted.**

5. Covid-19 - briefing on a project on tackling engagement and vaccine hesitancy in ethnic minority communities in Hackney

5.1 The Chair stated that responding to concerns about taking the vaccine, particularly in ethnic minority communities, was now the key issue with Covid-

19. He stated that he'd invited Peter Merrifield of Support Where It Matters Enterprises to the meeting to discuss his work with ethnic minority communities on dealing with vaccine concern and engagement with services. The Chair welcomed to the meeting:

Peter Merrifield (PM), CEO of SWIM Enterprises
Siobhan Harper (SH), Workstream Director and lead for the Vaccine Steering Group, CCG-LBH-CoL
Alice Beard (AB), Communications Team, CCG-LBH-CoL
Jon Williams (JW), Exec Director of Healthwatch Hackney
Dr Sandra Husbands (SH), Director of Public Health
Dr Mark Rickets (MR), Chair of CCCG

5.2 PM gave a verbal report. He stated that people had a right to refuse the vaccine and he was concerned at a possible backlash against those from ethnic minority communities who do e.g. in response to sensationalist coverage in the Daily Mail which might describe them as not living well or not looking after themselves. He stated there was a need to explode the myth that these communities were 'hard to reach'. He added that there was an ongoing battle against misinformation on social media and there was a need to work with gate keepers within these communities to challenge any biased views. There was a need for example to consider those with particular conditions such as Sickle Cell and how they were treated by vaccination programmes and also issues particular to the Francophone African communities who have had a history of mistrust of vaccination programmes. SH added that there was an urgent need to work with those who know these communities well so that they get the messaging right from the outset.

5.3 Members asked questions and in the responses the following was noted.

(a) The Chair asked who was holding the ring locally on the vaccine hesitancy problem. SH replied that it was the Vaccination Steering Group but that the programme is of course run to national guidelines. MR went on to outline the pace of the programme and the work on, for example, making it easier to quickly set up fully approved pop-up vaccination clinics. PM commented that there was a need to become more agile with the programme and to use a more granular approach locally. MR described the challenge of delivering the programme at scale as we moved on to the next and really large cohorts.

(b) Members asked about possibly using councillors to assist with outreach in certain communities as ward members have key contacts with local influencers e.g from faith communities. SH agreed that ward councillors were a rich source of intelligence but there would be a need to think about how this task was co-ordinated.

(c) A Member stated that Black communities are not homogenous and asked about the different approaches needed in Black Francophone vs Black Anglophone communities, as the former had bad experiences with French health programmes in Africa and were heavily influenced by the high degrees of anti-vax sentiment in French social media.

(d) A Member stated that economic concerns were also a driver of both testing and vaccine hesitancy giving the example of carers who were too busy or tired to engage or afraid that test results would mandate self-isolating which they could not afford to do (not having other options for caring for example). AB replied that this was just one area which would be tackled by the new sub-committee of Vaccination Steering Group on Communications and Engagement, the membership of which comprised the comms and engagement staff from across all the local health partners.

(e) The Chair asked how the Steering Group would take forward its work. SH replied that insight was being gathered from a wide range of groups and this data was then being cross matched to the areas of low uptake to discern any patterns and to help plan greater outreach initiatives. The Chair asked if the Commission could be updated on this at the next meeting.

ACTION:	**Vaccination Steering Group to provide an update to the Commission at the 31 March meeting on the communications and engagement work being done locally on vaccine hesitancy.**

5.4 The Chair thanked Mr Merrifield and the officers for their attendance for this item.

RESOLVED:	**That the report and discussion be noted.**

6. Covid-19 – monthly update from Director of Public Health for Hackney & City

6.1 Members gave consideration to a tabled presentation 'Covid-19 Update', from Dr Sandra Husbands (SH), Director of Public Health, continuing her monthly updates to the Commission.

6.2 SH took Members through the report which detailed how incidence rates and positivity rates had been declining since January. She stated that while rates were decreasing overall, they remained high among certain age groups. Populations aged 18 to 24 and 60 to 79 were currently recording the highest incidence rates. There also continued to be variations in incidence rates by ward, however, this variation did not follow any obvious geographical pattern. The rate of decline had not been consistent between ethnicities either. 'Other ethnicities' recorded the greatest decrease in incidence rates, and Bangladeshi populations recorded the smallest. In line with decreases in COVID-19 cases, COVID-19 bed occupancy and staff absences had been decreasing since mid-January.

6.3 Members asked questions and in the responses the following was noted:

(a) The Chair asked about the national rate of decline plateauing vs the local rate declining and the reasons for this. SH explained that this was because of the difference between the two datasets used which don't tell you the same thing.

(b) A Members asked about interpreting incidence across the different communities. SH described the differences between ethnic groups with regard to this data. She explained that during the peak of the pandemic, generally, it was found that black people and people of South Asian origin were more likely to become more seriously ill and die, but there also had been a significant decline in Black people being affected during the second peak. The picture locally looked rather different too, and the issue was about the different ways in which these groups are engaged with. She referenced to PHE's blog on the 'ethnicity impacts' and how it turned out to have affirmed the approach taken by PHE nationally.

(c) JW (Healthwatch Hackney) asked about how Public Health team would cope with schools reopening on 8 March. SH replied that all pupils and staff would be given test kits to test twice a week either in school or at testing centres and this plan had been worked up since before Christmas.

(d) A Member asked at what point does prevalence fall low enough to utilise the test, trace and isolate system to the full. SH replied that much work had been put into capacity building of the local test and trace system exactly so that it can be flexed in this way. They worked very closely with the national system and locally they can handle tens of cases a day. The challenge was to develop plans to support people with major barriers to self-isolating e.g. those in HMOs, and they are working on possible provision of isolation facilities.

6.4 The Chair thanked SH again for another detailed report and suggested that the lessons learnt from the data analyses in Public Health need to be now used to help inform the Vaccine Steering Group work.

RESOLVED:	**That the report and discussion be noted.**

7. Cabinet Member Question Time – Cllr Kennedy

7.1 The Chair welcomed Cllr Christopher Kennedy (CK), Cabinet Member for Health, Social Care and Leisure to his first Cabinet Member Question Time Session with the Commission. He stated that it was customary for each Cabinet Member to attend one such session with the relevant Scrutiny Commission each year. The purpose was to allow Members to ask question on areas separate from reviews or other items being considered during that year. To make the sessions manageable questions were confined to three agreed topic areas and for this session they had been agreed as follows:

1) *What are your reflections over the past year?*
2) *What are your 3 personal ambitions for your portfolio over the year ahead and where would you like to make a personal difference?*
3) *What do you see as the biggest challenge over the next year and why?*

7.2 CK stated that his comments would focus on the challenges in the relationship between local authorities and central government in executing pandemic response as well as a personal reflection on the impact of pandemic on everyone's mental health. He raised the excellent work done by front line workers, the various mutual aid groups, the 450 volunteers helping with the

vaccine rollout and the 150 local community champions and stated that the statutory sector would have not been able to achieve what it had without them. He described how with the government's food parcels programme for those shielding resulted in them being sent large plastic bottles of orange concentrate too heavy for frail people to lift and it illustrate the lack of thought given to what was being distributed. He talked about managing the issue of the opening of a test centre at Stamford Court and again central government not understanding the local situation and the need to take on board the residents' concerns. He described the frustration of having to watch with officers the daily 5.00 pm tv briefings from Downing St to find out what was going on or what might be coming downstream the next day. He went on to talk about the cumulative impact on everyone's mental health of both managing and living with the pandemic and gave many examples of the challenges faced by residents, officers and councillors on the front line. The wider societal impact was seen in how for example calls to CAMHS were up 30%.

7.3 CK stated that the 3 ambitions for his Portfolio during coming year would be: to get out more into the community post the pandemic; a number of 'nuts and bolts' issues around staffing, structures and in-sourcing; and on ensuring that the changes to the wider health system which have been introduced in NEL will works for Hackney. He stated that a new Director of Adult Social Work and Operations had just been appointed but not yet announced adding to the already announced new Group Director for Adults Health and Integration. The coming year would see the re-commissioning of three key services: Housing with Care, Home Care and Telecare and there were hopes that the latter might be insourced. Another challenge for the borough was the borough just have 4 care homes and there was an ambition that the Median Rd building might be brought into the mix. The challenge with the ICS would be to ensure that the commitments made about 'Place' were stuck to by the NHS. He added that the hospital discharge system worked well in the crisis and proved that integration works. There would be a need to put an integrated Better Care Fund on a more solid footing. He added that there were big challenges ahead on overcoming health inequalities and the 'Neighbourhoods' system was where this would be achieved. He stated that he was particularly struck by Peter Merrifield's call "Don't let the people disproportionately affected by Covid become the people disproportionately un-vaccinated." The pandemic had magnified all the health inequalities and reducing these was the key challenge now. To address this the Health and Wellbeing Board had adopted the King's Fund's 'Population Health Model' and created a 'Health Inequalities Steering Group' as a sub-committee of the Board to drive this work forward.

7.4 The Chair thanked Cllr Kennedy for his reflections and for outlining the priorities. Because of time there were no further questions.

RESOLVED:	**That the verbal update be noted.**

8. Minutes of the previous meeting and matters arising

8.1 Members' gave consideration to the draft minutes of the meeting held on 8 January 2021.

8.2 With reference to the action from the November meeting, Members noted that the Interim Group Director for Adults, Health and Integration had now delivered the requested 'Quality Assurance Framework on Care Homes' document and it had been circulated to Members.

RESOLVED:	**That the minutes of the meeting held on 8 January 2021 be agreed as a correct record and that the matters arising be noted.**

9. Work Programme 2020/21

9.1 Members gave consideration to the updated work programme. The Chair stated that an update on the vaccination programme with a focus on vaccine hesitancy work would be added to the items for the next meeting on 31 March.

RESOLVED:	**That the updated work programme be noted.**

10. Any Other Business

10.1 There was note.

Hackney

Health in Hackney Scrutiny Commission 31st March 2021 **Work Programmes**	Item No **9**

OUTLINE

Attached please find:

HiH work programme 2020/21
HiH draft work programme 2021/22
INEL work programme 2021/22

ACTION

The Commission is requested to note the updated work programmes and make any amendments as necessary.

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Health in Hackney SC - Rolling Work Programme for 2020-21 as at 23 Mar 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
9 June 2020	**Covid-19 Response**	Discussion Panel	Public Health	Director of Public Health	Dr Sandra Husbands	
deadline 31 May			Public Health England	Regional Director for London	Prof Kevin Fenton	
			Independent SAGE/ UCL	Professor at UCL	Prof Anthony Costello	
			Independent SAGE/ University of Newcastle	Professor at Newcastle	Prof Allyson Pollock	
			Durham County Council	Director of Public Health	Amanda Healy	
	Appointment of members to INEL JHOSC	Decision	Legal	Monitoring Officer		
9 July 2020	**Election of Vice Chair 20/21**	Decision	Legal	O&S Officer		
deadline 30 June	**Homerton Hosptal's contract for soft services**	Inquiry	HUHFT	Director of Finance	Phil Wells	
			HUHFT	Director of Workforce and Organisational Development	Thomas Nettel	
			UNISON	Area Officer for NHS	Michael Etherdige	
			UNISON	Unison rep at ISS	Naomi Byrne	
			GMB Union	Regional Organiser for NHS	Lola McEvoy	
	An Integrated Care System for NEL	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
	Covid-19 City & Hackney Restoraton and Resilience Plan	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
30 July 2020 URGENT	**Re-location of inpatient dementia assessment services from Mile End Hospital to East Ham Care Centre**	Urgent briefing	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
			ELFT	Director of Operations	Edwin Ndlovu	
			Barts Health NHS Trust	Chair of Medicine Board and Outpatient Transformation	Neil Ashman	
			City & Hackney CCG	Programme Director Mental Health	Dan Burningham	
			City & Hackney CCG	Managing Director	David Maher	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
23 Sept 2020	**Covid-19 update on Test, Trace and Isolate**	Monthly briefings	Public Health	Deputy Director of Public Health	Chris Lovitt	

deadline 14 Sept	**An Integrated Care System for NEL**	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
			HUHFT	Chief Executive	Tracey Fletcher	
	Planned Care Workstream	Annual update	CCG-LBH-CoL	Workstream Director Planned Care	Siobhan Harper	
	Healthwatch Hackney Annual Report 2019/20	Annual report	Healthwatch Hackney	Executive Director	Jon Williams	
14 Oct 2020	**City & Hackney Safeguarding Adults Board Annual Reprot 2019/20**	Annual report	CHSAB	Independent Chair	Dr Adi Cooper OBE	
deadline 5 Oct			CHSAB/LBH	Head of Service Safeguarding Adults	John Binding	
	Children, Young People, Maternity and Families Workstream - Joint item with CYP Scrutiny Commission	Annual update	CCG-LBH-CoL	Workstream Director CYPMF Workstream	Amy Wilkinson	
	HUHFT Quality Account 2019-20	Annual report	HUHFT	Chief Nurse and Director of Governance	Catherine Pelley	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
18 Nov 2020	**Covid-19 and Care Homes**	Discussion Panel	Adult Services	Interim Strategic Director of Adult Social Services, Health and Integration	Denise D'Souza	
deadline 9 Nov			Acorn Lodge Care Home	Manager	Diane Jureidin	
			LSE	Assistant Professorial Research Fellow in the Care Policy and Evaluation Centre	Adelina Comas-Herrera	
			The King's Fund	Senior Fellow - Social Care	Simon Bottery	
			HUHFT	Chief Executive	Tracey Fletcher	
			CCG-LBH-CoL	Workstream Director Unplanned Care	Nina Griffith	
			LBH	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kenndey	
	Unplanned Care Workstream	Annual update	CCG-LBH-CoL	Workstream Director Unplanned Care	Nina Griffith	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Dep Dir of Public Health	Chris Lovitt	
	Senior management restructure in Adult Services	Briefing	Adult Services	Interim Strategic Director of Adult Social Services, Health and Integration	Denise D'Souza	
6 Jan 2021	**Covid 19 update on Vaccinations roll-out**	Briefing	GP Confederation	Chief Exec	Laura Sharpe	
deadline 18 Dec	**Covid-19 update on Test, Trace and Isolate**	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
	NEL system response to national consultation on ICSs	Briefing	CCG	Managing Director	David Maher	
				Chair	Dr Mark Rickets	

23 Feb 2021	**Covid 19 update on Vaccinations roll-out**	Briefing	GP Confederation	Chief Exec	Laura Sharpe	
deadline 12 Feb			GP Confederation	Chair	Dr Caroline Millar	
			CCG	SRO for steering group	Siobhan Harper	
	Covid 19 - briefing on project on tackling vaccine hesitancy	Briefing	SWIM Enterprises	CEO	Peter Merrifield	
			HCVS	CEO	Jake Ferguson	
	Covid-19 update from Director of Public Health	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
	Cabinet Question Time with Cllr Kennedy	Annual	Cabinet	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kennedy	

31 March 2021	**New governance structure for the C&H Integrated Care Partnership**	Briefing	NEL ICS	Director of CCG Transition for C&H	Siobhan Harper	
deadline 19 March			NEL ICS	CCG Clinical Chair for C&H	Dr Mark Rickets	
			NEL ICS/ HUHFT	ICP Lead for City and Hackney	Tracey Fletcher	
	Covid 19 - update on Vaccinations roll-out and work to reduce vaccine hesitancy	Briefing	NEL ICS	Director of CCG Transition for C&H	Siobhan Harper	
			GP Confederation	Chair Vaccinations Steering Group	Dr Stephanie Coughlin	
	Digital and remote NHS Services' - CCG analysis	Discussion on a CCG analysis	NEL ICS - City and Hackney ICP	Head of Quality	Jenny Singleton	
	New 'Health Inequalities Steering Group' and 'Population Health Hub'	Briefing on new structures	Public Health	Director of Public Health	Dr Sandra Husbands	
			Public Health	Consultant in Public Health	Jayne Taylor	

Note: There are no meetings scheduled for Dec or April. Separately, the Mayor of London and London Assembly elections will take place on 6 May 2021. Purdah begins 22 March

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date						
TBC	**Work towards developing a Protocol for Primary Care digital consultations**	Briefing requested Sept 2020	GP Confederation	Chief Executive	Laura Sharpe	
			Healthwatch Hackney	Executive Director	Jon Williams	
July 2021	**Relocation of inpatient dementia assessment services to East Ham Care Centre**	Update requested from July 2020	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
			CCG or NEL ICS	Programme Director Mental Health	Dan Burningham	
			Healthwatch Hackney	Executive Director	Jon Williams	

TBC	**Extension of ISS contract for soft services at HUHFT**	Update requested from July 2020	HUHFT	Chief Executive	Tracey Fletcher	
			UNISON			
TBC	**Pathology Partnership between HUHFT and Lewisham & Greenwich NHS Trust**	Update requested from Jan 2020	HUHFT	Chief Executive	Tracey Fletcher	
TBC	**Integrated Learning Disabilities Service**	Update on new model	Adult Services	Head of LD Services	Ann McGale	
TBC	**Implementation of Ageing Well Strategy**	Update requested Dec 2019	SPED	Head of Policy and Strategic Delivery	Sonia Khan	
TBC	**City and Hackney Wellbeing Network**	Update on new model	Public Health	Consultant in Public Health	Dr Nicole Klynman	
Postponed from March	**Air Quality - health impacts**	**Full meeting**	King's College London	Academic	Dr Ian Mudway	
			Public Health	Public Health Consultant	Damani Goldstein	
			Environment Services Strategy Team	Head Environment Services Strategy Team	Sam Kirk	
Postponed from March	**King's Park 'Moving Together' project**	Briefing	King's Park Moving Together Project Team	Project Manager for 'Moving Together' project	Lola Akindoyin	
			Public Realm	Head of Public Realm	Aled Richards	
Postponed from 1 May	**Tackling Health Inequalities: the Marmot Review 10 Years On**	**SCRUTINY IN A DAY**	Public Health	Director of Public Health	Dr Sandra Husbands	
	Sub Focus on Objective 5: Create and develop healthy and sustainable communities		NEL ICS	MD City and Hackney		
			Planning	Head of Planning and Building Control	Natalie Broughton	
			Neighbourhoods and Housing	Head of Area Regeneration Team	Suzanne Johnson	
			Benchmarking other London Borough			
Postponed from July	**Neighbourhoods Development Programme**	Annual Update	GP Confederation	Chief Executive	Laura Sharpe	
			GP Confederation	Neighbourhoods Programme Lead	Mark Golledge	
TBC	**Future use of St Leonard's Site and NEL Estates Strategy**	**Discussion Panel**	LBH Chief Exec		tbc	
			Adult Services		Helen Woodland	
			NEL ICS		Dr Mark Rickets	
			HUHFT		Tracey Fletcher	
			ELFT		Paul Calaminus	
			GP Confederation		Laura Sharpe	
			Healthwatch Hackney		Malcolm Alexander	
			HCVS		Jake Ferguson	

			Hackney Keep Our NHS Public			
	How health and care transformation plans consider transport impacts	Suggestion from Cllr Snell				
	Implications for families of genetic testing	Suggestion from Cllr Snell				
	Accessible Transport issues for elderly residents	Suggestion from Cllr Snell				
	What does governance look like at Neighbourhood level	Suggestion from Jonathan McShane				

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Health in Hackney SC - Rolling Work Programme for 2021-22 as at 23 Mar 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
8 June 2021						
deadline						
8 July 2021						
deadline						
11 Oct 2021						
deadline						
17 Nov 2021						
deadline						
9 Dec 2021						
deadline						
10 Jan 2022						
deadline						
9 Feb 2022						
deadline						
16 March 2022						

deadline						

Note: The Local Council Elections in London take place on 5 May 2022. Purdah begins c. 20 March

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date						
TBC	**Work towards developing a Protocol for Primary Care digital consultations**	Briefing requested Sept 2020	GP Confederation	Chief Executive	Laura Sharpe	
			Healthwatch Hackney	Executive Director	Jon Williams	
July 2021	**Relocation of inpatient dementia assessment services to East Ham Care Centre**	Update requested from July 2020	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
			CCG or NEL ICS	Programme Director Mental Health	Dan Burningham	
			Healthwatch Hackney	Executive Director	Jon Williams	
TBC	**Extension of ISS contract for soft services at HUHFT**	Update requested from July 2020	HUHFT	Chief Executive	Tracey Fletcher	
			UNISON			
TBC	**Pathology Partnership between HUHFT and Lewisham & Greenwich NHS Trust**	Update requested from Jan 2020	HUHFT	Chief Executive	Tracey Fletcher	
TBC	**Integrated Learning Disabilities Service**	Update on new model	Adult Services	Head of LD Services	Ann McGale	
TBC	**Implementation of Ageing Well Strategy**	Update requested Dec 2019	SPED	Head of Policy and Strategic Delivery	Sonia Khan	
TBC	**City and Hackney Wellbeing Network**	Update on new model	Public Health	Consultant in Public Health	Dr Nicole Klynman	
Postponed from March	**Air Quality - health impacts**	**Full meeting**	King's College London	Academic	Dr Ian Mudway	
			Public Health	Public Health Consultant	Damani Goldstein	
			Environment Services Strategy Team	Head Environment Services Strategy Team	Sam Kirk	
Postponed from March	**King's Park 'Moving Together' project**	Briefing	King's Park Moving Together Project Team	Project Manager for 'Moving Together' project	Lola Akindoyin	
			Public Realm	Head of Public Realm	Aled Richards	
Postponed from 1 May	**Tackling Health Inequalities: the Marmot Review 10 Years On**	**SCRUTINY IN A DAY**	Public Health	Director of Public Health	Dr Sandra Husbands	
	Sub Focus on Objective 5: Create and develop healthy and sustainable communities		NEL ICS	MD City and Hackney		

			Planning	Head of Planning and Building Control	Natalie Broughton	
			Neighbourhoods and Housing	Head of Area Regeneration Team	Suzanne Johnson	
			Benchmarking other London Borough			
Postponed from July	**Neighbourhoods Development Programme**	Annual Update	GP Confederation	Chief Executive	Laura Sharpe	
			GP Confederation	Neighbourhoods Programme Lead	Mark Golledge	
TBC	**Future use of St Leonard's Site and NEL Estates Strategy**	**Discussion Panel**	LBH Chief Exec		tbc	
			Adult Services		Helen Woodland	
			NEL ICS		Dr Mark Rickets	
			HUHFT		Tracey Fletcher	
			ELFT		Paul Calaminus	
			GP Confederation		Laura Sharpe	
			Healthwatch Hackney		Malcolm Alexander	
			HCVS		Jake Ferguson	
			Hackney Keep Our NHS Public			
	How health and care transformation plans consider transport impacts	Suggestion from Cllr Snell				
	Implications for families of genetic testing	Suggestion from Cllr Snell				
	Accessible Transport issues for elderly residents	Suggestion from Cllr Snell				
	What does governance look like at Neighbourhood level	Suggestion from Jonathan McShane				

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INEL JHOSC Rolling Work Programme for 2020-21 as at 23 March 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
27 January 2020	**New Early Diagnosis Centre for Cancer in NEL**	Briefing	Barts Health NHS Trust	Clinical Lead	Dr Angela Wong	
			NCEL Cancer Alliance	Interim Project Manager	Karen Conway	
	Overseas Patients and Charging	Item deferred				
11 February 2020	**NHS Long Term Plan and NEL response**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			Barking & Dagenham CCG	Chair	Dr Jagan John	
			East London HCP	Director of Transformation	Simon Hall	
			East London HCP	Chief Finance Officer	Henry Black	
	New Joint Pathology Network (Barts/HUHFT/Lewisham & Greenwich)	Briefing	Barts Health NHS Trust	Director of Strategy	Ralph Coulbeck	
			Homerton University Hospital NHS FT	Chief Executive	Tracey Fletcher	
	Municipal Year 2020/21					
24 June 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Chief Executive	Alwyn Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			East London NHS Foundation Trust	COO and Dep Chief Exec	Paul Calaminus	
			Newham CCG	Chair	Dr Muhammad Naqvi	
			Waltham Forest CCG	Chair	Dr Ken Aswani	
			Tower Hamlets CCG	Chair	Dr Sir Sam Everington	
			WEL CCGs	Managing Director	Selina Douglas	
			City & Hackney CCG	Managing Director	David Maher	
	How local NEL borough Scrutiny Cttees are scrutinising Covid issues	Summary briefing FOR NOTING ONLY	O&S Officers for INEL			
30 September 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			East London HCP	Director of Trasformation	Simon Hall	
			East London HCP	Director of Finance	Henry Black	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			ELFT	COO and Deputy Chief Executive	Paul Calaminus	
			WEL CCGs	Managing Director	Selina Douglas	

			City and Hackney CCG	Managing Director	David Maher	
	Covid-19 discussion panel with the local Directors of Public Health	Discussion Panel	City and Hackney	DPH	Dr Sandra Husbands	
			Tower Hamlets	DPH	Dr Somen Bannerjee	
			Newham	DPH	Dr Jason Strelitz	
			Waltham Forest	DPH	Dr Joe McDonnell	
	Overseas Patient Charging - briefings from Barts Health and HUHFT	Briefing	Barts Health NHS Trust	Group Chief Medical Officer	Dr Alistair Chesser	
25 Nov 2020	**Covid 19 update and Winter Preparedness**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Whipps Cross Redevelopment Programme	Briefing	Barts Health NHS Trust	Whipps Cross Redevelopment Director	Alastair Finney	
			Barts Health NHS Trust	Medical Director, Whipps Cross	Dr Heather Noble	
10 Feb 2021	**Covid-19 impacts in Secondary Care in INEL boroughs**	Briefing	Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Covid-19 Strategy for roll out of vaccinations in INEL boroughs	Briefing	East London HCP	SRO	Jane Milligan	
			City and Hackney CCG	Chair	Dr Mark Rickets	
			City and Hackney CCG	MD	David Maher	
	North East London System response to NHSE consultation on ICSs	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
	Update on recruitment process for new Accountable Officer for NELCA/SRO for ELHCP	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Municipal Year 2021/22			
23 Jun 2021	**Covid-19 vaccinations programme in NEL**				Henry Black	
					tbc	
	Implications for NEL ICS of the Health and Care White Paper				Henry Black	
	Accountability of processes for managing future changes of ownership of GP practices				Marie Gabriel	
	Challenges of building back elective care post Covid pandemic				tbc	
13 Sept 2021						

14 Dec 2021						
15 Mar 2022						
	Items to be scheduled/ returned to:					
	NEL Estates Strategy					
	Whipps Cross Redevelopment					
	Cancer Diagnostic Hub					
	Review of Non Emergency Patient Transport					
	Digital First delivery in NHS					
	Mental Health					
	Homelessness Strategy					

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Wednesday 31 March 2021

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held virtually from Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, and Cllr Emma Plouviez.**
Officers in Attendance	**Helen Woodland (Group Director Adults, Health and Integration), Jayne Taylor (Consultant in Public Health, Hackney and City of London) and Alice Beard (LBH-CCG Communications Officer)**
Other People in Attendance	**Dr Stephanie Coughlin (GP and Chair of the Vaccinations Steering Group), Graham MacDougall (Senior Programme Manager Vaccinations Programme, NEL SCU Consulting for C&HCCG), Siobhan Harper (Director of CCG Transition for City and Hackney/SRO for the Vaccinations Steering Group), Dr Mark Rickets (CCG Clinical Chair for City and Hackney), Tracey Fletcher (Chief Executive of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board) and Cllr Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure).**
Members of the Public	80 views
YouTube link	**The meeting can be viewed at https://youtu.be/asLj31SYPOc**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies were received from Cllr Spence, Laura Sharpe (GP Confederation), Malcolm Alexander and Jon Williams (Healthwatch Hackney).

2 Urgent Items / Order of Business

2.1 There was no urgent business and the order was as on the agenda.

3 Declarations of Interest

3.1 There were none.

4 Covid-19 - update from Vaccinations Steering Group

4.1 The Chair stated that following on from the discussion at the February meeting NHS colleagues had been invited to provide an update on the vaccinations roll out with specific focus on the communications and engagement work being done to reduce vaccine hesitancy. The Chair welcomed for this item:

Dr Stephanie Coughlin (SC), Local GP and Chair of the Vaccinations Steering Group at GP Confederation
Graham MacDougall (GM), Senior Programme Manager for the Vaccinations Programme, NEL SCU Consulting for C&HCCG
Siobhan Harper (SH), Director of CCG Transition for City and Hackney and SRO for the Vaccinations Steering Group
Dr Mark Rickets (MR), CCG Clinical Chair for City and Hackney, NEL CCG
Tracey Fletcher (TF), CE of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board for City & Hackney
Alice Beard (AB), Communications Team CCG and LBH

4.2 Members' gave consideration to three documents from Dr Couglin:

(a) *Covid-19 update – 19 March*
(b) *Covid-19 vaccination uptake challenge and how we are tackling this locally* (listing the activities being carried out with each cohort/community)
(c) *City & Hackney vaccination programme update* as at 31 March

4.3 SC took members through the presentation which detailed the progress of the roll-out across all the various cohorts. She also described vaccination data broken down by ethnicity. SH then described the strategic approach being taken by the Vaccine Steering Group and AB concluded with details on the outreach and engagement work specifically on tackling vaccine concern/hesitancy, including "community conversations' with specific communities and plans for a possible mobile vaccination team bus.

4.4 Members asked detailed questions, and in the responses, the following points were noted:

(a) In response to a question by the Chair on how constrained the work might be by funding, SH explained that a bid had been made to NHSE to fund expanded outreach work. She added that resources were at capacity because this is a piece of major outreach work.

(b) In response to a question on what the target % of population to be vaccinated was SC replied that the national target was 92.5%.

(c) The Chair asked how the data was being segmented and then used to inform the targeting of outreach events. She described how it operated. She commented that the 'other white' category in the dataset had been harder to break down.

(d) Members asked how officers would respond to worries about types of vaccines and managing flow in vaccine in the centres. SC explained that they followed the national rules on managing flows of bookings and the nationally mandated guidance from the JCVI on how to proceed and who gets vaccinated next. It is a national system. In response to a comment on sharing best practice, she added that they could share the approach taken to outreach work in communities which are more vaccine hesitant with both NEL neighbours and more widely.

(e) Members asked how the local NHS was doing on vaccinations of care home and domiciliary care staff. SC described the workforce data. 58% staff in care homes had been vaccinated thus far. GM replied that the programme was doing very well with care home staff but was homecare providers things were proving more of a challenge and the efforts were ongoing.

(f) A Member asked about targeting messaging into areas with low uptake and making access easier. MR described the approach on vaccination decliners and on shared learning and best practice from elsewhere in north east London. A person can only be recorded as declined after three attempts are made with them. The importance of a 1:1 GP contact in turning people round was vital, they had learned.

(g) Members asked about the possible impact of a potential drop in supply expected in April and the efficacy of vaccines against the new variants. SC replied that all second does vaccines had already been badged and guaranteed and also that anyone wanting a first dose in April would be able to get one. One dose of a vaccine regardless of strain was having a huge impact in reducing both the severity of Covid and in reducing hospital admissions. She described the current thinking on booster doses and stressed that the number of vaccines delivered in an outreach event on any one day should not be the only measure of success. The huge efforts going into the general community outreach work which delivers long term results should also not be underestimated.

4.5 The Chair stated that the vaccine programme now seemed to be much more targeted and data driven than it had appeared the previous month and he thanked the contributors for this and for their briefing papers and attendance.

RESOLVED:	**That the reports be noted.**

5 Population Health Hub and Health Inequalities Steering Group briefing from Director of Public Health

5.1 The Chair stated that since the inception of the Integrated Commissioning Board the Commission has received regular updates from each of the 4

Workstreams of the ICB (Planned Care, Unplanned Care, CYP & Maternity, and Prevention). The Prevention Workstream had now been replaced with a new '*Population Health Hub'*. In addition, the pandemic has magnified the existing health inequalities and reducing these will be the key challenge coming out of Covid. To address this the Health and Wellbeing Board had adopted The King's Fund's 'Population Health Model' and had created a '*Health Inequalities Steering Group'* as a sub-committee of the Board to drive forward this work. Officers had been invited to brief Members on both of these new developments and he welcomed:

Jayne Taylor (JT), Consultant in Public Health and Lead for Health Inequalities portfolio, Hackney Council and City of London Corporation
Helen Woodland (HW), Group Director Adults, Health and Integration, Hackney Council

5.2 Members gave consideration to two briefing reports:

(a) *City & Hackney Population Health Hub*
(b) *City & Hackney Health Inequalities Steering Group*

JT took Members through the reports explaining the rationale for this change in that prevention work needed to be better embedded across the system and that health inequalities required greater attention. The Health Inequalities Steering Group therefore would be a focal point for a whole range of work being a carried out by the partners.

5.3 Members asked questions and in the response the following was noted:

(a) The Chair asked how it will be possible to get meaningful buy-in from the partners in order to make this a success. SH set it in context and described how there was a large emphasis in health inequalities in the latest national NHS Guidance and that this was driving the local approach.

(b) Members asked about the need to collect data on wider determinants/personal circumstances of individuals e.g. their housing conditions. They asked whether there was an adequate system in primary care to consider environmental factors on health and how this aspect would be approached. JT explained the Public Health England Intelligence Function had replaced the old Health Observatories and recording personal circumstances information was of course key. She added that GPs on the Steering Group had stressed the need to have the tools at their fingertips to both record and respond to personal circumstances and this aspect would now be worked on.

(c) Members asked about 'anticipatory care' as outlined in the briefing and who actually would carry out this work. JT described how the system operated by using the data to identify the cohorts and then working out who was best placed to deliver the help needed. HW added that it would be whoever was best placed within the Multi-Disciplinary Team. It might be a combination of people for example when it was a person with complex needs. SH described the Neighbourhoods Teams role in prevention by bringing the various professionals together and then deploying the

correct resources. The Chair asked that the challenge would be whether funding could be sustained in a system that is perhaps too much geared towards 'fire-fighting'. SH explained how 'Long Term Conditions' treatment management works to pursue measures which will also be preventative around the specific long term condition. The PCNs will get resourced for the 'anticipatory care' contracts too and this is how the support would be rolled out.

5.4 The Chair thanked the officers for their reports and their attendance. He concluded that the Commission would like an update on progress in 12 months.

RESOLVED:	**That the reports and discussion be noted.**

6 Digital and remote NHS services – CCG analysis

6.1 The Chair stated that the pandemic had of course accelerated the adoption of digital and remote NHS services and practically overnight GPs had had to provide virtual consultations once lockdown was imposed. Members had noted that the CCG in October had asked its Head of Quality to map some of the work on digital and remote services across City and Hackney and this had provided a useful overview report of the key issues. He had asked the CCG to come and discuss the report and welcomed:

Jenny Singleton (JS), Head of Quality at C&H CCG to the meeting.

6.2 Members gave consideration to the following reports:

a) '*NHS and remote services'* presentation providing update since October report
b) CCG's main report '*NHS services delivered remotely and issues with digital exclusion*' Oct 2020
c) A separate report from The Patient's Association '*Digital health during the Covid-19 pandemic: Learning lessons to maintain momentum*'

6.3 JS explained the background to the report and took members through the main recommendations.

6.4 Members asked questions and in the responses the following was noted:

(a) Chair asked what resource there was in the CCG to implement these recommendations e.g. in helping GP Practices to develop and improve their websites to enable better remote access. He referred to the Commission's own review on this subject which found that there wasn't a dedicated resource to co-ordinating the IT landscape across all of NEL. JS replied that it was more about bringing people together to work better as a system rather than just specific new funding and that these initiatives were the work of the IT Enabler Group of the Integrated Commissioning Board which itself had substantial funding. The key was to develop a framework to take this work forward in a unified way that is grounded in the patient feedback GP practices already have.

(b) Members asked about the danger of marginalising further those elderly who are digitally excluded with some, for example, unable to use touch-tone phones. MR cautioned that the enhanced remote offer hasn't replaced the face-to-face appointments and Practices didn't close during Covid. He explained how the CCG had always funded 'Enhanced Services' including proactive visiting of vulnerable patients and proactive practice based reviews.

(c) Members asked about case work they'd received about elderly residents finding it difficult to access GPs and asked if the structure could be standardised.

(d) Members asked about living conditions and asked about the need for a single system for remote access and about recording wider personal circumstances. There were 4 different GP remote access systems locally. MR explained how GP Practices currently record wider personal data and about the use of template triage forms which are designed by the Clinical Effectiveness Group. He also described the Quality-Capacity-Access conundrum in the provision of primary care which relates to how an in increase in any one of these will lead to a reduction in one or more of the others and so there is a constant effort to keep them in balance. C&H had some of the best ratios of GPs to patients in the country, he added. Members asked if GP Confederation could improve how the data on personal circumstances derived from the remote access system could be better optimised to provide a more targeted support to patients.

(e) The Chair asked whether Covid-19 had impacted on numbers of patients switching to GP at Hand and other such companies. MR replied that the now enhanced local online offer was proving very popular and so was reducing the local demand for these other providers.

(f) The Chair asked who was holding the ring on this issue and that one of the key findings of the Commission's own review on digital primary care prior to Covid-19 was that nobody had been leading on it within the system. JS described how this was ongoing work, and that some of course were finding that these remote services were much better for them and much more suited to their needs e.g. those with poor English language proficiency.

6.5 The Chair thanked JS for her report and attendance and stated that the Commission would be revisiting these issues.

RESOLVED:	**That the report and discussion be noted.**

7 New governance structure for C&H Integrated Care Partnership

7.1 The Chair stated that the Commission had received a number of briefings on the transition of the City and Hackney CCG into a single NHS NEL CCG and that he had asked for a briefing on the governance structure of the new system once it had been agreed.

7.2 The Chair welcomed to the meeting:

Tracey Fletcher (TF), Chief Executive of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health & Care Board for C&H
Dr Mark Rickets (MR), Clinical Chair for C&H, NEL CCG.

And explained her new system leadership role (on top of her job as CE of the Homerton). He explained that she was accountable to Henry Black as the NEL Accountable Officer and to Dr Mark Rickets as the CCG Clinical Chair for C&H within the NEL System. He also explained that Siobhan Harper would serve as Director of CCG Transition, initially for six months, and would effectively be replacing David Maher in overseeing the day to day management of the CCG team in City and Hackney.

7.3 Members gave consideration to a detailed presentation on '*Progress update on our transition to a City and Hackney Integrated Care Partnership'*.

7.4 Members asked questions and in the responses the following was noted:

(a) In response to a question on who sits on the ICP, TF detailed the memberships of both the **Integrated Care Partnership Board (ICPB)** and the **Neighbourhood Health and Care Board (NHCB)** underneath it which she would Chair.

(b) In response to a question about ensuring how the ICPB doesn't become a rubber stamp, TF set out the vision for the Board, the challenges and the timescales and how it would hold the more operational NHCB to account. It would have a challenge role, she added. She described how both clinical leadership and resident involvement will work within the new system. She outlined the roles and responsibilities of ICPB vis-à-vis the NHCB and how the transition from the old committees will work. She added that it was important to ensure that processes that had served them well were retained and built on. Work was advanced on having a new System Team in place that will be committed to making this work. MR stressed that the local area team and sub-committee of the NEL CCG Board was very well embedded therefore a strong local focus would be maintained. At the sub-regional level, the new NEL CCG Governing Body would be meeting for the first time on the following day, 1 April.

(c) Members queried the sustainability of these local structures and whether the sufficient level of engagement needed to make them work well would be maintained. TF explained that it is difficult to predict because it was not known how the NEL System will be expected to react to the changes coming down stream. Leaving room for refining it and improving the structure was really important therefore. She cautioned that a lot will depend on the changes which are coming through in the legislation and guidance relating to ICSs in the Health and Care Bill. The key was to make sure that nothing important was dropped in these changes and that the system was simplified. The changes would achieve a greater partnership approach between commissioners and providers than had been possible in the old system.

7.5 The Chair thanked TF for her detailed presentation and commended the approach being taken so far.

RESOLVED:	**That the report and discussion be noted.**

8 Minutes of the previous meeting

8.1 Members gave consideration to the draft minutes of the meeting held on 23 February and the Matters Arising.

RESOLVED:	**That the minutes of the meeting held on 23 February be agreed as a correct record and that the matters arising be noted.**

9 Health in Hackney Work Programme

9.1 Members gave consideration to the updated work programmes.

RESOLVED:	**That the Commission's work programmes for 20/21 and 21/22 and the rolling work programme for INEL JHOSC be noted.**

10 Any other business

10.1 There was none.