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24 June 2021

To: All Members of the Adults & Health Scrutiny Panel

Dear Member,

Adults & Health Scrutiny Panel - Thursday 24th June 2021

I attach a copy of some additional information for the above-mentioned meeting:

4. AT MEDICS TRANSFER OF HOLDINGS TO OPEROSE HEALTH LTD (PAGES 1 - 22)

The additional information provided here are the minutes of two meetings of the North Central London Joint Health Overview & Scrutiny Committee which included discussions of the transfer of holdings from AT Medics to Operose Health Ltd:

- 12th March 2021 (refer to Deputation 1 under item 5)
- 19th March 2021 (refer to item 6)

Yours sincerely

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Agenda Item 4

MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON FRIDAY, 12TH MARCH, 2021, 10.00 AM

PRESENT:

Councillors: Pippa Connor (Chair), Clarke (Vice-Chair), Cornelius, Freedman, Gantly, Hamilton, Lucia das Neves, Cllr Revah, Smith (Vice-Chair) and Tomlinson,

ALSO ATTENDING: Cllr Callaghan (Camden).

1. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein.

2. APOLOGIES FOR ABSENCE

Apologies were received from Paul Fish, Royal National Orthopaedic Hospital

3. URGENT BUSINESS

None.

4. DECLARATIONS OF INTEREST

None.

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

Deputation 1

The Committee received a deputation from NCL NHS Watch and led by Professor Sue Richards, on the sale of AT Medics to a subsidiary of Centene Corp, which was large American health insurance company. The key points of the deputation were:

- Concerns were expressed with the decision by NCL CCG to agree a change in control of the 8 APMS contracts in North Central London which had hitherto been held by the company AT Medics Ltd, allowing them to pass over the

contracts to Operose, a wholly owned subsidiary of Centene Corporation, a US health insurance company which provides medical cover for Medicare, Medicaid and the Affordable Care Act (Obamacare).

- Further concerns were expressed around the fact that Centene had received a number of fines from US regulators for regulatory breaches.
- It was suggested that there were strong public objections to this change, both politically in the affected boroughs as well on the ground with residents and in the local press.
- It was felt that the CCG would not have selected a subsidiary of Centene in open competition due to its poor track record and the political fallout from doing so. Instead, it was felt that the purchasing of AT Medics Ltd along with the contracts it held was effectively a Trojan horse to afford Centene access to NHS primary care contracts. It was felt that if this was allowed to go ahead, then this would only be the beginning and Centene would look to acquire more and more health contracts in the UK. The deputation party questioned what the CCG would do if they bid for more contracts in NCL.
- Contrary to assurances given to the Primary Care Commissioning Committee (PCCC) by the directors of AT Medics that they would remain in place and working practices would not be affected, all six directors resigned their position in February and had been replaced with employees of Centene and Operose. Particular concerns were raised that the CCG were aware of this when they subsequently ratified the change of ownership in late February.
- Concerns were also put forward that during the PCCC meeting on 17 December, no mention was made of Centene being involved. Instead, this information was confined to Part 2 of the meeting which was not made available to the public and from which all non-voting members, including the community member, was excluded.
- It was contended that NCL CCG was likely put under a lot of pressure by NHSE to waive through this change of control and it was speculated this was part of a wider political strategy by the government to agree a free trade deal with the USA.

The following arose in discussion of the deputation:

a. In response to a question around what should happen now, the deputation party suggested that the CCG needed to acknowledge that they had created a big problem and that their actions had resulted in a lack of trust. It was also suggested that the JHOSC should seek assurances from the CCG about what their strategy was for future contracts.
b. In response to a question, it was clarified that there were four practices in Camden, two in Islington and one in Haringey and that the CCG should write to the patients in the affected practices and give them the option to either change practice or remain in place.
c. In response to a question, Professor Sue Richards stated that, ultimately, it was the CCG who had responsibility for agreeing this and she considered that the CCG could have re-procured the contract rather than authorise the change of control. There was provision for the Secretary of State to intervene, but he had declined to do so despite being directly questioned on this by the Shadow Health Secretary.

d. The Committee sought clarification as why the deputation party wanted NHSE to push this through. In response, the deputation party commented that this could be because they did not want any disruption of service or perhaps it was because of wider political pressures.
e. The Committee sought clarification as to who exactly was at the meeting of the Board of NCL CCG when this decision was made. Clarification was also requested as to why the CCG ratified the change in ownership even after the Directors of AT Medics resigned.
f. The Committee queried why patients weren't consulted on this change of control of the contracts and how long the contract was in place.
g. The Committee raised concerns about the scrutiny of this process and what would happen if Centene did not meet the provisions of the contract, given their record in the USA. In response, the deputation party commented that all of these decisions were made several years ago before the creation of the joint CCG and it was speculated that the decision may not have received the level of consideration that it should have.
h. The Chair thanks the deputation party for their input and for answering questions where they could. It was acknowledged that they were not officers and could not be expected to know the answers to all of the questions.
i. The Chair set out that the JHOSC were due to have a special meeting on 19 March 2021 to consider this topic further and advised that any questions that were not answered would be put to officers at the next meeting.

Due to time constraints, the CCG representatives did not have an opportunity to respond to any of the points raised. It was agreed that this would be carried over to the meeting on 19 March 2021.

<u>Deputation 2</u>

The Committee received a deputation from Haringey and Islington Keep Our NHS Public, which set out concerns that the temporary Covid GP Access policy would become a permanent policy in NCL. The deputation party was made up of Rod Wells, Frances Bradley and Jan Pollock. Chloe Morales Oyarce and Will Huxter from NCL CCG were also present. The key points of the deputation were noted as:

- Concerns were noted that if the temporary Covid GP access Policy became permanent then there was a serious risk of damaging health outcomes for vulnerable sectors of the population i.e. the elderly, the disabled, those with mental health issues, people with learning difficulties and autism, the BAME community and migrants.
- The deputation set out the clinical need for, and the right to face-to-face access to a GP/clinician. If face-to-face appointments were reserved largely for the elderly or the digitally illiterate, this would compromise safe healthcare for large numbers of other patients. It was suggested that face-to-face appointments allowed clinicians to assess patients and receive information which was not visible on a computer screen or via a phone, such as mobility levels, temperature etc.
- It was felt that access based on digital first exacerbated existing health inequalities. This was an issue for significant minority groups, such as people with mental health issues, learning difficulties the BAME community. Although

digital access to a GP undoubtedly suited some people, particularly those with simple medical conditions or with easily diagnosable problem and who were comfortable with using digital technology. However, for other people, it was felt that this prioritising of digital delivery would reduce access.

- There was a need to tackle digital exclusion.
- The use of e-consult was deemed to be problematic as booking online appointments was not feasible for everyone and the system itself was not easy to use. It was suggested that a dedicated helpline was needed to offer support and, if that failed, patients should be allowed to contact the GP surgery directly. Only 4% of Haringey residents said they would use e-consult when surveyed by the CCG.
- Concerns were raised about how the work the CCG was doing to help people to gain digital access to primary care, through Primary Voices was being publicised so that everyone who needed help could be supported.

The following arose in discussion of the deputation:

a. The Committee noted concerns around digital inclusion effectively creating barriers to some patients and sought clarification about what some of the challenges to accessing GP services were.
b. In response to a question the Committee was advised that the deputation party were aware of problems in getting access to the online system and having to wait a long time on hold when trying to access services via telephone. There were also experiences around photos not being accepted or recognised. This was made worse by a lack of IT support.
c. In response to a question, the Committee considered that the elderly were particularly vulnerable to digital exclusion 59% of over 75s did not use the internet.
d. It was suggested that there were 9 million people who could not use the internet unaided compared to 26m who could.

6. MINUTES

RESOLVED

That the minutes of the meeting held on 29th January were agreed as a correct record.

7. HEALTH INEQUALITIES

Clerk's note - due to the availability of the speakers, the JHOSC agreed to amend the order of the agenda items: to take the Health Inequalities item first, then Missing Cancer Patients, then Digital Inclusion. The minutes reflect the order I which the items were discussed.

The Committee received a presentation on Addressing Health Inequalities from the Ruth Donaldson, Director of Communities for North Central London Clinical Commissioning Group (NCL CCG). The presentation was set out in the

supplementary agenda pack at pages 45 – 76. The following arose during the discussion of the presentation:

a. The Committee sought assurances around the low uptake of vaccinations within vulnerable and minority groups. In response, officers acknowledged that there was trend of lower uptake levels amongst a number of communities who were at risk of inequalities. Officers advised that they working with specific groups who had low uptake rates and had held a series of open community meetings. A number of targeted community events had also taken place in different languages and adverts had also appeared on Somali language TV, for example. NCL staff had also been working with organisations such as Groundswell to reach the homeless cohort.
b. The Committee expressed particular concern for the relatively low uptake rate amongst social care staff and queried why this might be. In response, officers advised that an Enfield Healthwatch report had set out that a historic mistrust of public services from certain communities was a key factor. It was suggested that this should be characterised as hesitancy rather than refusal to be vaccinated and that a lot of work was going on to provide information and additional assurance around this.
c. The Committee queried what new initiatives could be undertaken around health inequalities and how could local councillors be involved in these. The Committee welcomed any opportunity for local councillors to be involved in decision making. In response, the Committee was advised that there were a number of ideas for anticipatory care models including ‘ageing well’, which were about putting more prevention into people’s care and more resources into deprived areas. Although need and budgets were compiled at a central NCL level, officers outlined a model used in Leicester were local areas bid for funds and individual schemes. It was envisaged that the development of a NCL population health committee would be one of the opportunities that could arise from moving to an Integrated Care Partnership.
d. In response to a request for clarification, it was confirmed that the colours in the indexes of deprivation in the presentation highlighted the top 20% and that the fact that Barnet was only shown in the fuel poverty index was accurate.
e. The Committee commented that it was not necessarily the NHS’s fault that historic mistrust in health services and vaccines existed from some people who may come from parts of the world where there were good reasons for that mistrust including corruption. It was queried the extent to which socio-economic factors played a role in access to health care given that health care was free. It was suggested that there were a range of other factors at work such as the relationship between childhood obesity and indices of poverty. In response, NCL acknowledged concerns around the uptake of vaccines in certain communities but suggested that it was not a straightforward as suggested and that there were differential take-up rates between Black British demographic groupings and White British demographic groupings. It was highlighted that there were concerns about disproportionate access rates to services and it was hoped that the community participatory research would help elucidate this further.
f. The Committee welcomed the work done in the presentation overall to link health inequalities to poverty and highlighted disproportionate inequalities around BAME access to mental health services and a paucity in the availability of talking therapies in particular. In response, NCL officers advised that one of

the key issues was the massive disproportionate access to severe mental health services for young black males in Edmonton and north Tottenham and their disproportionate access to talking therapies. Officers commented that it wasn't just about provision, it was about the stigma attached to accessing those services.

g. In relation to the role played by factors other than deprivation, NCL officers outlined that digital exclusion was a key factor and that this predominantly affected the elderly population. However, deprivation would likely impact the ability for a young person to own the required equipment, even if they had the knowledge and skills to use it.
h. The Committee emphasised the importance of some of the stories behind the data and how that added a richness to understanding some of the problems discussed. The Committee queried disproportionate access for some deprived areas to GP surgeries. In response, officers acknowledged these concerns and set out the need to provide system level responses but ones which were delivered locally.
i. The Chair requested that this item came back to a future meeting and the Chair would pick this up with Ruth Donaldson offline. **(Action: Cllr Connor).**

RESOLVED

That the update in Addressing Health Inequalities was noted.

8. MISSING CANCER PATIENTS

The Committee received a presentation which set out the impact of COVID-19 on Cancer treatment in NCL. The presentation was introduced by: Professor Derralynn Hughes, Haematologist at Royal Free and Dr Clare Stephens, GP and NCL CCG governing body member. Nasser Turabi, Managing Director for the NCL Cancer Alliance was also present for this agenda item. The presentation was as set out in the supplementary agenda pack at pages 35-44. The following arose from the discussion of the presentation:

a. The JHOSC noted that cancer referrals were down 30% in January 2021 from January 2020, however this position had improved from a drop of 70% in April 2020. Cancer referrals were now back to pre-Covid levels, however it was cautioned that this was not the whole picture as it related to referrals from GP practices and that there were longer term considerations in other areas.
b. The JHOSC raised concerns about the impact on staff from increased waiting times and backlogs and queried the extent to which staff may be close to being burnt-out. In response, NCL officers acknowledged these concerns and advised that there were not many opportunities to expand the staffing base as the field of cancer treatment was very specialised. This was also compounded by existing staffing shortages. The Committee were advised that Trusts were allowing staff to carry over leave and were also providing opportunities for them to take this leave. The JHOSC were advised that overall, cancer services were not of particular concern, as the prioritisation and funding for cancer treatment was there. Other NHS services were likely to be more affected due to the high volume of usage such as ENT or orthopaedics.

c. In relation to a follow-up question around why there was a shortage of anaesthetists, the JHOSC was advised that critical care doctors and anaesthetists received the same training and so when critical care was ramped up in the wake of Covid, anaesthetists were the first to be drafted into critical care.
d. NCL officers assured the Committee that although there was a backlog and that this was more acute in community care settings, that everyone who need urgent cancer care would have access to it. Other, non-urgent, cases may need to be mitigated in order to prioritise the urgent cases.
e. In response to a query about whether, in order to support those with longer term manageable issues, other services needed to be bought in from other providers, NCL reiterated that, overall, cancer was prioritised and urgent cancer services had been protected but that some people whose condition could be managed would see delays. It was suggested that having to bring in support from other areas and other providers was more applicable to other areas of NHS care.
f. The JHOSC queried whether there were areas within NCL that could benefit from improved communications around the services that were offered and, conversely, those not available?. In response, it was noted that they had NCL were not aware of a big variation in the services required from area to area. It was suggested that, in relation to cancer treatments the numbers at a ward by ward basis would be quite small so it would be hard to draw any firm conclusions from analysing the data at that level.
g. In response to a query around other areas of interest, NCL staff advised that there was good joint working on system awareness as a result of the joint-Covid working and that there would be opportunities going forward to exploit this joint working further.
h. In relation to items for possible inclusion on the work programme, it was suggested that the committee may want to monitor how cancer outcomes from screening services changed over the next 12 months.

RESOLVED

Noted.

9. DIGITAL INCLUSION

The JHOSC received a presentation on digital inclusion, which was introduced by Will Huxter, Director of Strategy– NCL CCG and Chloe Morales Oyarce, Head of Communication and Engagement - CCG. The presentation was set out in the supplementary agenda pack at pages 5-34. The following arose from the discussion of this agenda item:

a. The JHOSC raised concerns about the risk of non face-to-face GP appointments, brought in because of Covid, being introduced permanently and emphasised the importance of being able to see a GP in person. In response, NHSE advised that face-to-face appointments would continue but that they also wanted to give people a choice about accessing services. NCL CCG set out

that services were starting to go back to normal but that a range of digital services would be available for those that wanted them.

b. The JHOSC sought assurances that the IT systems were in place to support this and that these systems were up to the job. In response, the CCG acknowledged these concerns and advised that these were long-term commitments about how services were offered and that as part of the roll-out of the projects within this digital approach there would be opportunities to improve the IT systems and IT processes in partnership.
c. The Committee emphasised the importance of user research and engagement when changing services. NCL CCG acknowledged that there was more that could be done about improving the experience of patients. However, there was an online representative board in place, which had local representation, however this did not include political representation. It was noted that the political oversight was done through the overarching programme board.
d. The JHOSC also emphasised the centrality of equalities legislation and the fact that the NHS would have to set out specifically how each of the protected groups would not be unduly affected by NCL's digital approach. This point was acknowledged by NCL CCG and the committee was advised that they were looking to develop an action plan around this.
e. In response to a question, the JHOSC was advised that the responses to E-Consult even in Enfield were relatively low, so it was difficult to say why the scheme had performed better there than elsewhere. It was suggested that this was likely due to it being better communicated to residents in key locations, such as local GP surgeries.
f. Will Huxter agreed to circulate an updated annotated version of the slides which included a glossary of terms. **(Action: Will Huxter).**
g. The JHOSC sought further assurance about the absolute right of patients to see their GP in person. NCL CCG reassured the JHOSC that this was absolutely the case and that the term 'right to digital' was just about giving people a choice.
h. The JHOSC raised concerns about the possibility of patients who accessed services digitally being given first choice of appointments, for example. In response, Members were advised that GPs would respond appropriately and that there was no desire to just funnel people down digital means of access.
i. The CCG agreed to share more information with the JHOSC in relation to GP access and ensuring in person access continued in view of the digital approach. **(Action: Will Huxter).**
j. The JHOSC emphasised the importance of a GP being able to see a patient in person and the ability to assess a range of issues such as mobility, that may not be noticed over the phone or through Zoom.
k. In relation to a question around care homes, NCL CCG assured the JHOSC that they wanted to strengthen the services available in care homes rather than reduce them.
l. The Chair set out that she would like further assurance around the right to see a GP face-to-face being enshrined and how this would be communicated to service users. It was suggested that much of this would be developed as part of

the impact assessment. The Chair requested a further update be brought back to the JHOSC at an upcoming meeting in early summer to provide additional assurance about the long terms plans, before the proposals were implemented. **(Action: Will Huxter).**

RESOLVED

That the update in relation to digital inclusion be noted.

10. WORK PROGRAMME

The JHOSC considered the draft work programme.

In relation to additional items for inclusion on the work plan, the following items were put forward:

- Follow-up/feedback on the Royal Free discussion from a previous meeting. (September).
- Item on Integrated Care Systems and the local authorities role within this. (TBC)
- Funding inequalities/finance element of health inequalities. To include Public Health review funding allocations. (September).
- GP Services, to include the GP federation. (June)
- Digital exclusion (June)
- Services for young adults transitioning to adult hood. (TBC)

It was agreed that the Scrutiny Officers would circulate a draft work programme via email for further comments. **(Action: Rob Mack).**

RESOLVED

The North Central London Joint Health Overview & Scrutiny Committee:

I. Noted the work plan for 2020-21;
II. considered proposals for agenda items for meetings in 2021/22;
III. agreed provisional items for the first meeting of the Committee of 2021/22, which would be on 25 June 2021.

11. NEW ITEMS OF URGENT BUSINESS

N/A

12. DATES OF FUTURE MEETINGS

19th March 2021.

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON FRIDAY, 19TH MARCH, 2021, 10.00 AM - 1.20 PM

PRESENT: Councillor Pippa Connor (Chair), Councillor Edward Smith (Vice Chair), Councillor Tricia Clarke (Vice Chair), and Councillors Alison Cornelius, Linda Freedman, Larraine Revah, Paul Tomlinson, Christine Hamilton, and Lucia das Neves.

1. FILMING AT MEETINGS

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

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Paul Fish, Royal National Orthopaedic Hospital.

3. URGENT BUSINESS

There was no urgent business.

4. DECLARATIONS OF INTEREST

Cllr Cornelius noted that, in case care homes were discussed, she would like to note a non-pecuniary interest as she was a Council appointed Trustee of the Eleanor Palmer Trust. Cllr Connor also noted that she was a member of the Royal College of Nursing and that her sister worked as a GP in Tottenham.

ORDER OF BUSINESS

Due to the availability of the presenters, the Committee agreed to receive Item 5 (Deputation on Integrated Care Systems), followed by Item 7 (Integrated Care Systems), and then Item 6 (Procurement of GP Services (AT Medics)).

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The Chair noted that a deputation had been received from NCL NHS Watch on Integrated Care Systems (ICS).

Brenda Allan, NCL NHS Watch, explained that she had addressed the Committee before in relation to ICS and that a white paper, *Integration and innovation: working together to improve health and social care*, had now been published.

She noted that there had not been a lot of consultation but that the proposals were far reaching and would amalgamate local authority and NHS assets and services. It was acknowledged that the stated goals in the white paper were laudable but that there was a significant lack of detail in relation to the proposed positions, context, and practical arrangements.

NCL NHS Watch had concerns that the proposals would result in an unequal partnership with a lack of democratic accountability. It was stated that the letter accompanying the white paper noted that the composition of the proposed NHS Board would need to support effective decision making; it was felt that this would lead to limited representation on the main, decision making body and that not all parties would be equal partners. Although there were borough based partnerships, it was felt that these would be NHS dominated and that there would be no new funding for local authorities.

Brenda Allen, NCL NHS Watch, noted that there were concerns relating to social care, public health, and local democracy. It was stated that the current crisis in social care was not acknowledged in the white paper and it was felt that public health had not been prioritised. It was commented that the proposals would reduce the role of local government and that this would limit the ability for the full integration of health and social care. It was added that NCL NHS Watch had not been reassured by the NHS England responses to concerns raised about digital and remote consultations. It was considered that public health issues were not easily addressed by ICS and that key services addressing inequalities had been cut back by local authorities. It was stated that Joint Strategic Needs Assessments and ongoing public health work recognised the importance of addressing inequalities but that political will and funding also was required.

It was stated that there should be further consideration of how the ICS framework could be used to produce something more collaborative which genuinely involved local authorities and the public. It was suggested that further consultation was required and that the implementation of the proposals should not be rushed. In particular, NCL NHS Watch noted that further detail was required in relation to parity of representation and voting rights, how ICS would be accountable particularly where local authority services were involved, the balance of digital and in-person provision, and the role of independent providers in relation to resource allocation.

In response to a question about the importance of localised services and tackling health inequalities, Brenda Allen stated that the NHS was largely a curative organisation and that, in order to tackle inequalities, joint working with other organisations and services, such as housing and benefits, was key. She commented that the proposed structures were health dominated, that a public health approach required wider involvement, and that local authorities would have limited input on the allocation of resources. It was stated that there had been budget cuts to council services in recent years and it was not anticipated that an NHS body with no additional funding would be able to deliver significant improvements.

Some members of the Committee noted that, traditionally, the NHS did not have the same level of democratic oversight as care and it was difficult to integrate the

governance of these two systems. It was added that there were references to ICS being less bureaucratic but that the proposals included multiple committees and forums and it was not clear whether ICS would be able to achieve the objectives that had been set. Professor Sue Richards, NCL NHS Watch, explained that the Health and Social Care Act 2012 localised decision making about health and operations but that there was now a pressure to centralise, first through the mercer of the five North Central London (NCL) CCGs and now through ICS; she stated that this was not grounded in local democracy and that the role of local authorities would be reduced, particularly in the case of social care. Alan Morton, NCL NHS Watch, added that there were also concerns about increased centralisation in relation to financial control as there was likely to be more outsourcing to external companies to provide advice for issues such as digitisation and organisational change.

In response to a question about the role of independent providers in decision making and resource allocation, Brenda Allen, NCL NHS Watch, believed that there was already some conflict of interest where GPs were members of CCG boards but that this would increase under the white paper proposals. She stated that, although there were a number of boards, the ICS NHS Board would make the key decisions. This board would have a tightly controlled membership which could include independent providers; she felt that this would result in an inherent conflict of interest which would be contrary to good governance.

The Chair thanked NCL NHS Watch for the deputation and noted that the issues raised would be considered by the Committee.

6. PROCUREMENT OF GP SERVICES (AT MEDICS)

The Chair introduced the item and explained that a deputation on the procurement of GP services (AT Medics) had been received at the Committee meeting on 12 March 2021. It was noted that there had been no time for officers to reply at the previous meeting so this item had been deferred. Frances O'Callaghan, NCL CCG Accountable Officer, Jo Sauvage, NCL CCG Chair, and Will Huxter, CCG Director of Strategy, were in attendance for this response.

Frances O'Callaghan acknowledged the concerns that had been raised. It was explained that the papers relating to the decision had been published on the CCG website. It was noted that the discussions had been split between a public meeting (part 1) and a private meeting (part 2) which dealt with any items subject to commercial confidentiality. It was highlighted that the Primary Care Committee was Chaired by a lay member and frequently had private (part 2) discussions where contracts were involved. It was explained that, in the public meeting, the decision was made subject to due diligence and checks with Companies House. It was noted that the company, Centene, was not referenced in the public part of the meeting but that this was an oversight as the company name was very clear in the private meeting documentation and was not due to any ill intent. Frances O'Callaghan apologised for anything that had been unclear.

It was explained that there had been a deputation on AT Medics in January 2021 which had been heard and responded to. The concerns raised were recognised and,

in hindsight, it was acknowledged that it would have been better to proactively inform elected members. However, Frances O'Callaghan stated that she wanted to clarify what the CCG was able to do; it was explained that the CCG was committed to public sector provision but that private provision was permitted in the Health and Social Care Act 2011 and the CCG had a responsibility to act within the law otherwise it would be at risk of legal challenge and financial penalties. It was added that the CCG had now provided comprehensive responses to the deputation, councillors, and other groups and it was hoped that the position had been clarified.

In terms of next steps, Frances O'Callaghan stated that the CCG was committed to providing the best possible care. It was commented that the AT Medics contract could not be terminated but that it was rated as Good and would continue to be monitored. It was explained that, where there were workforce shortages, the NHS was sometimes reliant on external support. It was accepted that some elements of the process could have been improved but that the CCG had tried to ensure transparency and had acted in accordance with the law and other CCGs in London, including following advice from NHS England where relevant.

Jo Sauvage noted that this had been a pan-London decision, that the CCG was not able to reverse the decision, and it was unfortunate that North Central London (NCL) had been singled out in the media. It was explained that a number of practices across London were supported by AT Medics. The concerns expressed were understood but it was stated that ensuring continuity of service to residents, particularly during the Covid-19 pandemic and the largest vaccination programme in national history, was the most important priority. Jo Sauvage commented it would not be appropriate to cease the existing contracts and commence a competitive tender; it was added that procurement involved significant time and cost and often had unintended consequences. It was highlighted that the CCG and Care Quality Commission (CQC) would continue to monitor performance metrics and there was no reason to doubt that the arrangements would continue to provide good quality and safe services.

Members of the Committee expressed concerns that local residents did not want their care to be handled by Centene, a large American insurance company that did not have a good reputation in America, and that they felt that the decision had been made without consultation or scrutiny. It was suggested that the community members of the Primary Care Committee might have raised concerns and it was enquired why they had not been present in part 2 of the meeting. It was stated that the six directors of AT Medics had resigned in February 2021, despite previous assurances that the directors would remain in post; it was asked how much had been paid to the directors and who had made the decision to transfer the contract from AT Medics to Centene.

Frances O'Callaghan explained that a change in control in itself did not allow the CCG to object except in particular situations, such as where there would be changes to services. It was stated that appropriate reasons would be necessary in order to object and the legal advice received determined that an objection would leave the CCG open to legal challenge. It was added that there was a data protection clause in the contract which did not allow any data to be shared; this was common to all contracts for primary care practices. Frances O'Callaghan stated that she was not aware of the sums paid to AT Medics and that she would only be able to confirm the NCL members who had been involved in the decision, although the full details could be provided in

writing. It was also noted that all attendees were permitted to be present during the public meeting but that only certain members were permitted to be present at the private meeting.

Some members asked about the quality of the legal advice provided. Jo Sauvage explained that the legal advice had been sought on behalf of NHS England and London CCGs. She noted that she would have to confirm the specific advisor and advice but that all papers that could be published had been published in relation to this decision.

The Committee noted that a key issue in this case was openness and transparency and it was commented that many councillors and residents had been informed of the change through unofficial channels. It was enquired whether residents had been told about the change and given the option to change services to an alternative organisation. Jo Sauvage acknowledged that choice was a fundamental element of the NHS but that there was no reason to question the current quality of service that was being delivered. It was explained that the contract would continue to be monitored, as was the case with all contracts, and it was noted that alternative provision might not be possible or practical.

It was enquired how services would be monitored to ensure that a good service level was maintained. Some members commented that the Committee should be informed when contracts were due to be renewed. Will Huxter noted that, where contracts were due to end, there was a process which included relevant forward planning but that there was a different process for a transfer of ownership. It was suggested that members could be provided with further information about procurement and the different lead in times. Jo Sauvage explained that monitoring was a standard process for all contracts and it would be possible for the Committee to have some more detail on performance monitoring. Will Huxter noted that a report could include additional details about the contract and more information on quality assurance.

RESOLVED

The Committee requested further information in relation to the following:

- The technical details in relation to who took the decision about AT Medics/ Centene.
- How much was paid to the directors of AT Medics.
- Further detail about how the CCG seeks legal advice in general and further detail about the legal advice in relation to this decision.
- Whether the CCG could have reached an alternative decision or challenged the legal advice based on the quality of the proposed company and whether there were any avenues for the CCG to challenge the decision after it had been made.
- Whether there were any avenues for local authorities to challenge the decision, including through referral to the Secretary of State.
- Additional information in relation to the AT Medics/ Centene contract and performance monitoring, as well as performance monitoring in general.
- In relation to future decisions, some assurance that the five local authorities would be informed and, if there were any concerns or issues with the proposals, whether there would be any oversight or opportunity for consultation. Also, details of how

local authorities and the public would be better informed about proposals and about how to communicate any issues.

The Chair explained that, once a response had been received in relation to these queries, the Committee could assess whether any further scrutiny was required. It was noted that this issue had highlighted the importance of trust and local accountability, openness and transparency, and ensuring that the Committee was informed about upcoming decisions.

7. INTEGRATED CARE SYSTEMS (ICS)

Mike Cooke, ICS Independent Chair, Rob Hurd, Joint System Lead, and Frances O'Callaghan, CCG Accountable Officer and Joint System Lead, introduced the item which provided an opportunity to consider and discuss Integrated Care Systems (ICS). Mike Cooke noted that arrangements would need to be put in place for the 2021-22 financial year before the official legislation on ICS came into effect in 2022. It was explained that officers would be able to present the current thoughts and proposals for North Central London (NCL) and would welcome the views of the Committee but might not be able to answer all questions on the government proposals for ICS.

It was noted that the white paper proposed a national ICS framework which was intended to formalise the existing arrangements across the country. Although the white paper did not discuss the ambitions and purpose of health and social care integration, these were set out in the long term plan which was cross-referenced in the white paper. It was also noted that the white paper did not include social care as the government had decided to deal with this separately.

It was explained that the proposed approach for NCL for 2021-22 was set out on page 14 of the supplementary agenda pack. It was noted that there were five existing borough partnerships in NCL and the white paper was clear that the operation of these partnerships would be determined locally rather than detailed in legislation. In NCL, it was proposed to have a Partnership Board which would agree the overall ambitions and policies of the ICS and would include local authority Leaders. There would also be a NCL Steering Committee which would oversee operational activity and which would include local authority representatives. In addition, NCL would have a Community Partnership Forum to engage proactively and a Population Health and Inequalities Committee. It was considered that NCL was well placed to meet the ambitions set out in white paper and would be addressing some important priorities in 2021-22, including delivery of the Covid-19 vaccination programme, service recovery, and strategic reviews of community services and mental health services.

Some members of the Committee felt that the proposed structures reduced the involvement of councillors and stated that there should be some changes to the governance structure to ensure a continued scrutiny-based approach. Members enquired about the role that provider Chairs and prospective providers would play in decision making, particularly at the top level and in comparison to other parties, such as councillors and members of the public. Some concerns were also expressed about

the lack of detail in the white paper regarding the relationship between health and social care.

Mike Cooke noted that he was an independent ICS Chair and explained that local authority scrutiny arrangements were not expected to change in any new arrangements. He explained that the white paper envisaged that the body making decisions about NHS spending would involve local authority representation and would be subject to the normal scrutiny arrangements. It was added that the integration of health and care was striving to bring NHS and local authority powers and decision making together in an active partnership.

It was stated that the role of provider Chairs was critical and their engagement with NCL ICS would assist them in redesigning services to be more community orientated. In relation to the community voice, it was highlighted that borough partnerships would continue to be an important element of the arrangements for NCL and would be maintained in the proposals for the ICS. In relation to social care, it was explained that adult social care colleagues worked closely with the CCG, hospitals, and community trust colleagues and a level of service integration had already been developed, particularly during the Covid-19 pandemic.

The Committee noted that some residents and local groups had concerns, particularly following the recent AT Medics and Centene decision, that they were not sufficiently included in decisions or informed about developments; it was enquired how the proposed structures would prevent future issues. Mike Cooke explained that primary care was provided by independent and sometimes private companies; this had not fundamentally changed and could not be prevented in the NHS.

The Chair understood that the white paper proposed to remove the power of scrutiny to refer matters to the Secretary of State. It was added that it would be important for the proposals to ensure transparency and accountability and it was suggested that there should be assurances that the ICS Board meetings should be held in public. Mike Cooke noted that the white paper was the first step and there were likely to be changes and additional detail following parliamentary consideration; he added that he did not envisage any changes to the current scrutiny process. It was acknowledged that the power for scrutiny to refer matters to the Secretary of State was not included in the white paper but it was suggested that this was likely to be raised during consideration of the bill. Mike Cooke stated that it was standard practice for all NHS Boards to meet in public; this would be the case for the arrangements in 2021-22 and it was expected that this would be required under any new legislation.

The Committee noted that the white paper did not mention whether there would be any public health representatives on the Board and stated that it would be important to include public health appropriately in the ICS. Mike Cooke noted that local authority Leaders were ultimately responsible for public health and could provide this input. It was stated that the membership of boards was often a finely balanced issue as groups which were too large often lost their ability to function effectively. It was added the Population Health and Inequalities Committee would require specific public health representation and that there would be opportunities for public health views to be presented.

Some members noted that the five boroughs' CCGs had been merged into one NCL CCG which had removed some local powers and it was stated that this was demonstrated through the transfer of GP services contract from AT Medics to Centene. Frances O'Callaghan explained that the NCL CCG was the strategic commissioner for the wider area but also worked with the boroughs to deliver appropriate local arrangements. It was added that work had begun to ensure a more strategic approach to mental health and community services and to address inequalities. In relation to the AT Medics and Centene decision, Frances O'Callaghan explained that there had been some misunderstanding about what the CCG had been able to do in relation to this decision. It was noted that the CCG had a number of legal requirements in relation to service provision, including ensuring continuity of service. It was added that the CCG was committed to transparency and that the papers relating to the decision had been published online, although it was acknowledged with hindsight that it would have been beneficial to contact councillors to make them aware of the issue.

It was enquired whether the Partnership Board would report to one of the other committees and how this relationship would operate. Mike Cooke explained that the Partnership Board would not have a parent committee but that all of the committees would have some relationship, depending on the issues in question. Some members of the Committee stated that the proposals were being developed quite quickly and it was queried whether it was appropriate to wait until after the Covid-19 pandemic to allow for more planning and consultation. In relation to the timing, Mike Cooke acknowledged these concerns but explained that it was not possible to continue with ad hoc governance. It was noted that the proposals for 2021-22 had been developed across the partnership to enable NCL to transition well and to improve; it was added that the final proposals were, to a large extent, in the government's control. It was also noted that the deputation had mentioned that the NHS would be controlling local authority funding but it was highlighted that this was not proposed in the white paper.

The Chair noted some concerns that the white paper proposed that the NHS would report to the Secretary of State which would result in more direct influence rather than a separation of power. Mike Cooke noted that the white paper and the corresponding communications suggested that the Secretary of State would have the power to make directions. It was accepted that this was a form of direct control but it was anticipated that this would relate to matters such as performance targets and would not be widely used in relation to normal operations. It was added that this sort of arrangement was not unusual and also existed between local authorities and the Ministry for Housing, Communities, and Local Government (MHCLG).

It was noted that any decisions about finances could be contentious and it was enquired how these types of decisions would be made, including the distribution of funding between different boroughs. Rob Hurd noted that, currently, funding was often allocated directly to hospitals, primary care, and other services. Under the new ICS proposals, there would be no changes to the formulas for calculating funding but all funding would be managed and locally allocated by the ICS.

A member noted that pharmacies had been very important during the Covid-19 pandemic and it was enquired how the proposals would ensure the equal integration of pharmacies. Frances O'Callaghan acknowledged that pharmacies had been critical

in delivering preventative work and in reducing the strain on hospitals. It was explained that pharmacies came under direct commissioning through NHS England but it was envisaged that they would be more integrated into the ICS in future.

Some members stated that the purpose of the Community Partnership Forum was similar to the purpose of the Joint Health Overview and Scrutiny Committee. It was felt that this may lead to some duplication of work and that it may be more appropriate to strengthen the scrutiny arrangements rather than introducing a new forum. Some members noted concerns that the structure would need to ensure that residents were engaged in a meaningful way and that their comments, which often resulted in enhanced decisions, were taken into account. It was also enquired how the members of the forum would be chosen.

Mike Cooke noted that the Community Partnership Forum was not fully developed at present as more direct input was required from partners; it was added that any suggestions were welcome. It was envisaged that the proposals would enable community members to be equal partners. Frances O'Callaghan explained that the NHS had traditionally been monitored on targets, including those relating to A&E and finances, but that borough partnerships offered an opportunity to be held to account on a different set of population health outcomes. It was explained that the borough partnership and community arrangements would allow NCL to address complex issues in partnership.

The Chair noted that it would be useful to clarify the formal relationships of the boards within the proposed structure and to ensure that issues could be raised and dealt with appropriately. It was enquired whether all five councils would have distinct members or whether there would be a representative member and whether Directors of Adult Social Care would be included on any of the boards. It was also asked whether there would be any changes to the right for consultation and how councillors or members of the public could challenge any proposals. Mike Cooke noted that the ICS Steering Committee would likely have one council Chief Executive and one Leader representing the five councils; it was added that this would be done through mutual consent and that Cllr Watts from Islington had been identified as the initial representative Leader. It was explained that the proposals for 2021-22 would be in line with the current statutory arrangements and would be adaptable following the legislative proposals in late 2021-22. It was commented that issues relating to social care would need to be developed and would be further discussed with Dawn Wakeling, Barnet Executive Director of Adults and Health, who represented the five councils.

The Chair asked what powers partners would have to challenge decisions, particularly the relationship between the five councils. Mike Cooke explained that there would not be statutory arrangements for ICS until 2022 and that additional details could be developed over the next 12 months. He noted that, if there was a fundamental disagreement, the partnership would pause and discuss the best way forward. It was added that the legislation would likely set out relative voting rights.

Dawn Wakeling, Barnet Executive Director of Adults and Health, stated that the current proposals had very little detail and that social care would be covered separately which meant that it was difficult to comment. It was noted that there were a

number of queries regarding how decisions would be made and how different organisations and partners would be able to contribute. She agreed that too much bureaucracy could be unhelpful but that, depending on the detail of the legislation, there could be flexibility for individual systems.

The Chair noted that this was a transitional period and that not all elements of the proposals could be influenced. It was agreed that the Committee would request further information on the proposals and would further consider ICS at a meeting in September or November 2021.

RESOLVED

To request further information in relation to the following issues:

- More detail on what the Integrated Care System would look like, how it would be internally accountable (including the role of constituent organisations), and how it would be scrutinised.
- It was suggested that the proposals would benefit from greater democratic accountability and that it would be important to include appropriate council representation within the structure. It was also suggested that the Partnership Board could be unwieldy and that the structure would benefit from something more sophisticated.
- More information was requested on the anticipated role of Health and Wellbeing Boards, Directors of Public Health, and Directors of Adult and Social Care.
- The importance of openness and transparency was highlighted and assurance was sought that meetings would be held in public and minutes would be available, in particular for the top level Board decisions.
- Clarity was requested on whether there would be a right to public consultation in relation to all major proposals.
- It was requested that there be a clear commitment for co-production and engagement and more information regarding the mechanisms or processes that would ensure the inclusion of patients' and residents' voices. Also, further detail was requested in relation to how the Integrated Care System would ensure strong communications.
- There were some concerns that there was potential for work to be duplicated in the proposed structure and it was unclear what the role of the Joint Health Overview and Scrutiny Committee would be.
- Additional information in relation to the capital proposal and how this would work, in particular whether the largest or certain partners would have more influence.
- There was a significant concern that the scrutiny right of referral to the Secretary of State would be removed as part of the proposals. It was requested that consideration was given to reinstating this power or an alternative option in the case of any serious concerns.
- The relationship between the NHS/ Integrated Care System and the Secretary of State and whether there would there be any option to derogate from a Secretary of State direction.
- How pharmacies, which had been important throughout the Covid-19 pandemic, would be involved in scrutiny and integration within ICS and whether this could be equivalent to GP involvement.

- It was requested that the suggestions outlined in the deputation from NCL NHS Watch were considered.

8. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

9. DATES OF FUTURE MEETINGS

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

25 June 2021
24 September 2021
26 November 2021
28 January 2022
25 March 2022

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

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