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

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

## 1. FILMING AT BRIEFINGS

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

## 2. APOLOGIES FOR ABSENCE

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

## 3. URGENT BUSINESS

There was no urgent business.

## 4. DECLARATIONS OF INTEREST

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

## 5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**RESOLVED**

The Committee made the following recommendations:

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

## 6. MINUTES

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

Tomlinson enquired how many of the clinics would be based in North Central London and it was noted that this would have to be checked.

**RESOLVED**

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

## 7. MENTAL HEALTH AND COMMUNITY SERVICES REVIEW

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

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

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

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

review had a strong focus on increased prevention and would consider whether it was possible to provide more direct services which did not require a referral.

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

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

**RESOLVED**

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

## 8. GP SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

It was noted that the Committee supported these principles.

**RESOLVED**

1. To note the report.

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

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

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

## 9. COVID-19 PANDEMIC UPDATE

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

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

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

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

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

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

Cllr Tomlinson enquired whether the use of North Central London as an accelerator hub would result in extended hours. Sarah Mansuralli explained that surgery would be

extended to provide additional hours during the week and during the weekend. Paul Sinden, CCG Chief Operating Officer, stated that the system was looking to protect elective capacity and general capacity for winter pressures and/ or Covid-19 surges. It was explained that North Central London had been given accelerator status as it was organised in a way where it was able to provide additional capacity.

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

**RESOLVED**

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

2. To request a future workforce update.

## 10. UPDATE ON AT MEDICS

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

## 11. WORK PROGRAMME

**1 October 2021**

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

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

**26 November 2021**

- Fertility Review

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

## 12. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

## 13. DATES OF FUTURE MEETINGS

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

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

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……