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 ……