MINUTES OF MEETING NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON FRIDAY 30TH JANUARY 2026, 10.00am - 13.00pm

IN ATTENDANCE:

Councillors Pippa Connor (Chair), Tricia Clarke, Joseph Croft, Paul Edawrds, Chris James, Andy Milne (Vice-Chair) and Matt White.

ALSO IN ATTENDANCE:

- Nic Alexander, Consultant Neonatal and Paediatric Surgeon
- Paul Allen, Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate, NCL ICB
- Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB
- Marco Inzani, Associate Director of Transformation, NCL ICB
- Fola Irikefe, Principal Scrutiny Officer
- Chloe Morales Oyarce, Head of Communications and Engagement
- Priyal Shah, Head of Communities and Inequalities, Strategy and Population Health Directorate, NCL ICB
- Professor Sue Richards, Islington Keep Our NHS Public (IKONP)
- Sophie Scott, Network Director for the North Thames Paediatric Network
- Dr Gillian Smith, Medical Director, Royal Free NHS Trust
- Anna Stewart, Director of Service Development, CYP, CAMHS, Maternity and Neonates

Attendance Online

- Councillors Kemi Atolagbe and Larraine Revah (Vice-Chair)

FILMING AT MEETINGS

Members present were referred to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'. The Chair informed those present that the meeting was being recorded for the purpose of accuracy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Joseph Croft and Matt White.

URGENT BUSINESS

None.

DECLARATIONS OF INTEREST

The Chair declared an interest in that she was a member of the Royal College of Nursing and also that her sister was a GP in Tottenham.

DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

The committee received a deputation from Professor Sue Richards of Islington Keep Our NHS Public (IKONP) on the use of Palantir Technologies in the NHS. IKONP raised their concerns and briefed that Palantir was a Federated Data Platform and the main objective of the contract with the NHS was to unify patient records from multiple sources. Professor Richards acknowledged that there is general agreement to centralize and link patient data, however, there is also growing recognition that Palantir may not be suitable due to the following concerns:

- quality –some NHS trusts and data analysts have queried the functionality of Palantir's platform, saying that it is not as good as the bespoke systems they have developed.
- Vendor lock-in - Palantir retains all the IP rights to the systems it installs, limiting the NHS's future flexibility and innovation from a wider competitive market.

- There are questions about the ethics of the other data analysis roles carried out by Palantir.
- There are also questions about how patient data may be used.

The committee were informed that there are several hospitals and Trusts that are deferring the use of Palantir products as well as the British Medical Association who voted to lobby against the continued introduction of Palantir's software into health data systems, and to terminate existing contracts. IKONP requested for the NCL JHOSC to flag up concerns and pick it up with local trusts and hospitals and review the incorporation of Palantir.

The Chair thanked IKONP and opened the committee to ask questions:
Councillor White expressed that he would like the committee to take a stand as this also fits with the wider issue and increasing use of global financial institutions in the NHS. Investors are looking for a return and their interests may not be focussed on the public.

Councillor Clarke expressed that it was good news that some ICB's are resisting and holding out and that at the very least, those who have signed up to a seven-year contract, shouldn't renew but she would like further direction about what IKONP would like the NCL JHOSC to do. Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB informed the committee that she would follow up with ICB colleague who works on digital services.

ACTION: That the JHOSC ask for an update with information as to why some of our hospitals are reluctant to sign up with Palantir. It will be important to have clear evidence regarding their concerns in order to make an informed recommendation.

Minutes of the meeting held on 21st November

The Chair commented that the actions needed to be put in bold.
Councillor Clarke expressed that when she discussed the misuse of data at the previous meeting in reference to Palantir in particular, their name wasn't highlighted and she is content with it being noted now.

Winter Planning Update, the Chair emphasised that making sure people caring for others are ok and being supported representatives to carry out an audit around support for carers taking on more than they would have done in the past**. ACTION.**

NCL Inequalities Fund

Ruth Donaldson, Director of Strategy, Communities and Inequalities, NCL ICB gave an overview of the impact and what has been achieved through the Inequalities Fund. The Director of Strategy, Communities and Inequalities explained it was the third year of the Inequalities Fund being used to address underlying need as well as prevention. The committee were briefed that the fund was allocated based on deprivation and the Trust were aware of the intersectionality of inequality and it's not always geographical. The Director of Strategy, Communities and Inequalities informed the committee that deprivation is growing in NCL as 28% of inhabitants are now in the most deprived bracket so they aim to work with communities, developing partnerships with them for insight, backed by evidence for oversight.

The committee heard that they have used various methods for evaluation including qualitative and quantitative analysis and with every pound invested, there is a return of £1.47. Priyal Shah, Head of Communities and Inequalities, Strategy and Population Health Directorate, NCL ICB provided an oversight of the developments and the multi-dimensional review carried out to look at the outcomes and there have been improvements including mental health and wellbeing support projects with positive outcomes for children and young people in Islington, Haringey and Enfield. These interventions have also seen an improvement in terms of educational attainment and school exclusion for this cohort of children.

Smoking cessation, 25% reduction in a community in Enfield where smoking is entrenched. The other benefit of the fund is the reach that it has and the community capacity building. In Camden, up to 50 mental health champions amongst the Somali and Bengali communities have been trained, improving the mental health and wellbeing of the individuals and assisting them to support their communities. Outreach in Enfield has led to improved health checks and GP registration. The committee were briefed that GP registration means that access to healthcare means improvements to health. In terms of economic evaluation, this has shown a net saving of £1.7 million. There as also been a 25% reduction in hospital admissions for those over fifty years old in deprived areas as a result of the inequalities fund.

The Head of Communities and Inequalities, Strategy and Population Health Directorate explained they they would continue to work on improving how they demonstrate impact, working with UCL. New data on deprivation means they will be thinking more about how they will allocate funding in future for smoother commissioning especially when working with the voluntary sector. The next steps for them will focus on developing neighbourhoods for the Neighbourhood Health Plans.

Councillor Clarke expressed that she was unhappy with the re-allocation of funds-based indices of deprivation 2025, as although less deprived than other boroughs overall, Islington has on of the highest rates of child deprivation. It was felt that Islington is being disadvantaged for a small improvement in deprivation across the board and enquired what the new approach to allocation will mean for Islington? The

Director of Strategy, Communities and Inequalities responded that the Indices of deprivation looked at not just rates of poverty but also volume so it has to be proportionate. Haringey and Enfield had greater volume of deprivation and funds were allocated based on data regarding and where they will have the greatest impact. It was reported that other ways and sources of funding for example smoking cessation schemes will still be funded through other means. **ACTION:** provide information on what the implications of what the figures will mean for Islington.

Councillor Edwards enquired about the impact on pockets of deprivation in a borough like Barnet which is seen to be more affluent overall. The Director of Strategy, Communities and Inequalities explained that Barnet will now be given a proportion of the Inequalities Fund due to the increase in pockets of deprivation and they have always received some due to this.

Paul Allen, Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate added that there was a finite budget as deprivation has gone up all round but they are now allocating the fund in a different way now. They are required to follow the patterns within NCL, across the board there has been a growth in the 10% most deprived and there has also been a growth in the number of those in deep poverty. The Chair expressed that it would be interesting for the committee to have a look at the Rowntree report which they were informed about and in particular get a better understanding of the pockets of poverty that is deepening**. ACTION**.

Councillor White enquired if the programmes in place for people diagnosed with Type 2 diabetes requiring less intensive treatment and managed through GP that is prevalent amongst certain demographics often also facing structural inequalities will actually be impacted by the limited amount of funding given to address the issues, what impact will it have in managing Type 2 diabetes? The committee heard about the Haringey diabetes project which is amongst the intervention projects working well. They are working with primary care to look at targets and intervention methods. Education and self-management support with information in different languages to help people better understand their condition is also a part of the approach as explained by the Head of Communities and Inequalities.

Councillor White felt that it was important to push the narrative regarding education and understanding of how diabetes works, not just in terms of health outcomes but also financial benefits for the NHS further down the road e.g. prevention and education now will mean people won't need an organ transplant.

The Director of Strategy, Communities and Inequalities informed the committee that aside from their internal evaluation, they have partnered with Imperial University to carry out an economic evaluation of the Inequalities Fund. The Chair requested that the economic evaluation information should be provided to the committee. It was also recommended that the actual data with details of the financial return should be provided to the committee. In respect of the 'what to improve' section, the Chair pointed out that there is no evidence provided in the papers. **FOLLOW UP.** The Director of Strategy, Communities and Inequalities explained that as a big part of the 10 Year Plan is focussed on prevention and that is a significant premise of the

Inequalities Fund – this can be weaved into the narrative when thus is presented to the committee. **FOLLOW UP.**

The Chair enquired about the Rise Project which sounded like a positive programme supporting the Somali community but having looked on their site, there was only information from 2019. The Chair enquired if there was an expectation for the projects to have fully functioning sites as she was concerned that should people seek to access support; information was out of date. The officer expressed that the organisations are hitting their targets when speaking to the various organisations and they can provide the information and evidence. The Assistant Director – Strategy, Communities & Inequalities Development & Population Health Directorate explained that monitoring is at borough level and an annual review of the projects are carried out. The Chair re-iterated that she felt that platforms such as organisations website was the first port of call for people seeking support and so should have information and evidence that a project is ongoing. **RECOMMENDATION**.

To summarise the discussions, the Chair expressed that there are still concerns that the analytic data with the evidence isn't evident in the papers and a future report should contain this. The next update should include this and also the next steps. The committee should also have site of the work being carried out with Imperial University. **ACTION**.

North Middlesex and Royal Free Merger Update

Dr Gillian Smith, Medical Director, Royal Free NHS Trust gave an overview of the North Middlesex Hospital and Royal Free Hospital merger which took place just over a year ago. The Medical Director, Royal Free NHS Trust briefed that there had been improved performance against the NHS matrix e.g. waiting times to be seen, time taken to be diagnosed and treated for cancer patients and this has been done against the challenge of pressures on NHS waiting times. NHS England have carried out a formal review of the merger process and the improvements have been noted. Where challenges remain is the impact of the merger on staff as opposed to patients.

Councillor Croft enquired over what the impact has been on staff one year on. The Medical Director, Royal Free NHS Trust explained that there hasn't been much change in terms of sickness and attendance but there has been less responsiveness to the staff survey, with the management structure changes and changes to the clinical operating model some anxieties have also been expressed by staff. There has been less efficiency in harmonising uniforms and they were working on this with clinical colleagues putting forward suggestions for improvement.
RECOMMENDATION: The Chair recommended that information and data around staff survey should be provided for the committee to carry out proper scrutiny of the impact of the merger.

Councillor James enquired about the A&E waiting times which stated they are down to four hours but anecdotally the wait at Barnet Hospital was up to 15 hours. The committee heard that all acute hospital sites had seen sustained improvements on average for their wait times. However, there are some people waiting longer and a significant number waiting more than 12 hours, and sometimes its people that need

to be admitted and with complex needs the Medical Director, Royal Free NHS Trust reported. It was also confirmed that this is in line with everywhere nationwide. In terms of national performance, the Trust is in the top quartile for waiting times.

In respect of record keeping and being able to access record from North Middlesex, Barnet and Royal Free, Councillor James was interested in knowing how it was panning out. Clinicians can access records across all three sites including remotely and the objective is to get onto a single electronic patient record for the combined organisation and they need to work through how that will be funded.

Councillor Milne enquired if there were staff issues in terms of one organisation viewing the other as having taken over. The Medical Director, Royal Free NHS Trust expressed that there has not been a perception of a takeover, just recognition that they would be better together to support the local populations. Along with this, each hospital site is run by its own executive team to ensure they still retain a unique profile and some individuality to work effectively locally.

The Chair followed on from Councillor Milnes point expressing that the wording in the paper, describing the North Middlesex as becoming a ‘health unit’ gives the perception that it is no longer a hospital. In respect of A&E timings and the fact that corridor care is a rising concern, it would be useful to know where people are experiencing it across the three hospitals in future reporting. **ACTION.**

The Chair enquired about the financial information presented which wasn’t very clear. The Medical Director, Royal Free NHS Trust reported that the projected transactional benefit of the merger and the integration of the corporate structures had led to a £5.3 million saving to date. For the period 2025/26, as an organisation they had a deficit plan amounting to 88.5 million in terms of the underlying position and a financial plan targeted at £125 million with pre-existing debt. The Chair enquired about the pre-existing years impact debt to which it was clarified that both organisations entered the partnership in debt but there could be financial benefits delivered through measures such as a single electronic patient record.

The Chair sought further clarity about the savings plan for the organisation in its entirety and enquired where exactly will the savings be made and will there be impacts on particular sites and what does the impact of the merger really mean for patients. Councillor White agreed and added that it would be helpful to understand what makes up the deficit, what it is, what is causing it, is it structural and can it be addressed through the savings programme.

It was heard that efficiency plans, won’t result in services being closed and key local services will continue to be run. North Middlesex efficiency target is less had they remained a stand-alone organisation. The enlarged organisation has allowed them to put more money into the urgent and emergency care infrastructure

The Chair expressed that greater financial clarity would help support better understanding for the committee in future. **RECOMMENDATION**. Further update to clarify the financial position and the questions raised. Councillor Croft enquired over how they are able to demonstrate the sharing of expertise and strengthening

leadership though the merger? It was heard that it will be measured through patient outcomes, experience, safety and performance.

In respect of the deputation earlier on Palantir system, the Chair expressed that the papers detail Royal Free as signed up but not having started yet and for North Middlesex it is listed as not using but under pressure to start. The committee will be following up on this element during discussions when considering the10 Year Plan the Chair informed. **FOLLOW UP.**

The Chair enquired further about the new mental health A&E unit at Chase Farm which they learnt is yet to open and work continues with the ICB and with North London Partnership Foundation NHS Trust. The chair requested information regarding how many people it would cater for, the reach and the impact on other crisis units. Also, regarding the maternity service, the Chair sought re-assurance on the level of care we can provide as the maternity service has simply moved from 'inadequate' to 'requiring some improvement' and so a written update on how that is being addressed should be provided. **FOLLOW UP.**

Paediatric Services Review Update

Anna Stewart, Director of Service Development, CYP, CAMHS, Maternity and Neonates briefed that the commissioning approval for the changes to paediatric surgery was made September 2025 and they are now looking into the implementation with colleagues from the North Thames Paediatric Network. In respect of emergency surgery and planned care, the committee heard that they are focussing on under 3's and under 5s as the skills needed by anaesthetists and surgeons for very young children of this cohort is very specialist. The care for children over five will continue to be provided locally.

The case for change is around elective care and there are long waiting lists as with the rest of the country, there are skills shortages and issues with retention and recruitment. National recommendations for paediatric care in terms of paediatric surgery includes separate recovery areas and child friendly spaces. For emergency care, for NCL children the tertiary centre is at GOSH but there is no A&E so quick access for children at this stage can be difficult. Extensive consultation was carried out and presented to both the JHOSC and individual HOSC's regarding the initial set of proposals for enhancing the facilities at GOSH for an extra receiving centre and extra beds. Consultation and feedback from clinicians meant that they realised it wasn't ideal for the enhanced entryway to be at GOSH.

During the summer 2025, further engagement was carried out with staff and patient groups to develop a model and how to work with other specialist hospitals such as Royal London and Chelsea and Westminster to help manage the care pathway. For emergency care they will be partnering with Chelsea and Westminster, St Mary's and the Royal London. UCL will also take on the day cases for very young children in NCL. It was reported that there are no changes to the specialist pathways including cardiac care and neurological conditions. They will be setting up a paediatric referral hub and a 24-hour emergency call line to match specialist service with clinicians.

The Chair enquired that should parents at GOSH have concerns to raise about treatment – there were provision to support them. Assurance was provided that parents can raise concerns as a whole and should they want a second opinion they're concerns will be taken forward. Nic Alexander, Consultant Neonatal and Paediatric Surgeon, St Mary's explained that they will be building in parent and patient feedback throughout the process. The committee heard about the Marthas rule hotline (an initiative in England allowing patients and their loved ones to request independent clinical if their conditions aren't improving or concerns not being addressed) which will be advertised.

Following an enquiry about who has signed up to Martha's rule, the panel heard that all tertiary centres have signed up to Martha's rule and Hillington Hospital is the only hospital that hasn't. **ACTION:** feedback on progress of Marthas rule, how feedback is collected and assurance around paediatric services and how improvements are being made.

Councillor Clarke enquired whether Chelsea and Westminster and St Mary's were part of the new merged footprint and enquired how we would scrutinise them in the future. The Director of Service Development, CYP, CAMHS, Maternity and Neonates confirmed that this was something we would have to consider as it covers a wider space although the changes pre-date the merger.

The Chair enquired about where they felt the risks were and what is being done to mitigate them. The Director of Service Development, CYP, CAMHS, Maternity and Neonates confirmed that there are inherent risks in terms of delays, financial risks, set up of referral hub, clinical engagement and 'buy in' so when the hub is up and running there may be further issues that may come up.

The Associate Director of Transformation expressed that with any change there is a risk and to mitigate risk they ensure thorough data collation and the system is already operating informally. The Chair enquired if there has been push back from clinicians because specialist centres will have an impact on specialist staff at hospitals. The committee were briefed that they will keep the same skills and competencies in district general hospitals as they will continue to treat the over 5's. There is a skills gap nationwide of surgeons for the under 3's.

Councillor James enquired about transport costs if parents arrive at North Middlesex and they then must go to St Marys. It was heard that in this instance there is usually ambulance transfer, but should a child be admitted parents can be supported by re-imbursement. It was suggested that once a child is admitted, a questionnaire should be prompted to ask parents how they get to hospitals as travel costs can be an added strain for parents and there should be an easy system put in place to go about getting re-imbursed. **RECCOMENDATION**.

Councillor White asked about the algorithm for deciding where cases are sent and what happens when there are changes. The committee heard that everything is data driven to put children in the right place, but the system is pliable to changes. The Chair expressed that a future update should provide information on the 'enablers' and information on how data is working to support services and an overview of the

finances, any risks and the communication and engagement regarding how things are progressing. **FOLLOW UP**.

NCL JHOSC Terms of Reference

The Chair requested that the committee agree the final terms of reference presented which stipulated that once JHOSC support, currently provided by Haringey has done six months in post, supporting the next officer where the Chair is from, following that the other officer will fully manage the JHOSC meetings and work programme. The chair explained that a commitment from all authorities of the JHOSC to contribute to the post was not agreed and so this proposal was the next bet option.

The chair recommended that once the Chair has been appointed in the new municipal year, the terms of reference should be re-visited in the new municipal year.

Councillor White expressed his strong disappointment that there wasn't a commitment to contribute to the support officer post whilst local authorities still attend the meetings. All members re-iterated the disappointment. The Chair also stressed the importance of the JHOSC given that Healthwatch would become an internal organisation within the NHS. The Chair highlighted that once the new chair is appointed, the level of work involved will become apparent and a resolution will need to be found.

Councillor White suggested that it is agreed with a clear point that the rotating officer is not likely not to work and that officers should be permanent and all boroughs contribute in the future. The Chair recommended that the officer should ideally be from the same authority as the chair to make the support more seamless. **RECOMMENDATION.**

The committee agreed that they would send a formal letter to their Chief Executives and finance officers with all the signatures of the whole committee. Councillor Milne suggested that the joint letter with everyone's signature should be sent by members of the JHOSC from themselves individually. **ACTION**. Following the new municipal year, the letter that goes out should emphasise the statutory role of JHOSC and Healthwatch becoming an internal organisation within the NHS.