SUPPLEMENTARY AGENDA II

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Fiona Rae / Robert Mack

Friday 12 March 2021, 10:00 a.m.
MS Teams (watch it here)

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Edward Smith (Enfield Council), Pippa Connor and Lucia das Neves (Haringey Council), Tricia Clarke, and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Andy Ellis, Robert Mack, and Peter Moore.

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 10)

To consider any requests received in accordance with Part 4, Section B, paragraph 29 of the Council's constitution.

Fiona Rae, Principal Committee Co-ordinator
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John Jones
Monitoring Officer (Interim)
River Park House, 225 High Road, Wood Green, N22 8HQ

Thursday, 11 March 2021

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Agenda Item 5

Deputation to JHOSC, North Central London, 12 March 2021

Background

NCL CCG have given their agreement to a change in control of the 8 APMS contracts in North Central London which have 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 vast American insurance company which makes its money from providing medical cover for Medicare, Medicaid and the Affordable Care Act (Obamacare). Centene has a litany of violations of its responsibilities and has been heavily fined by the US regulators. A T Medics held 49 contracts across London, including the 8 NCL practices. This makes Operose /Centene the biggest provider of GP services in England.

There has been strong public objection to this change both through the local press, through all Executive lead members on Health and Social Care in the five boroughs, and through motions in local political parties. There would undoubtedly have been street demonstrations had it not been for lockdown. It is inconceivable that the CCG would have selected a subsidiary of Centene Corp in open competition. Its track record in the USA would have ruled it out. Centene used a less objectionable locally based company, AT Medics Ltd as a Trojan horse, buying them up and with that their contracts with the NHS. Profits after tax for A T Medics Ltd for the years 2016 -2020 from their 49 contracts across London was £28.4m and it is rumoured that the six GPs who were the directors of A T Medics Ltd received £140m for the sale of their company.

What NCL CCG did and did not do

NCL CCG claims that their hands were tied. Transfer of NHS contracts between companies is prohibited unless allowed by the commissioner if they are satisfied with assurances that the contract will operate as before and that the current contract holders ask permission in advance. If this process is not followed, the commissioner may re-procure the contract. A T Medics Ltd gave the assurance that as they would remain directors of the company control would remain unchanged in practice. This was recorded in the minutes of the primary Care Commissioning Committee (PCCC) of 17 December 2020 and the minutes were confirmed as correct at their next meeting on 18 February 2021. But A T Medics directors all informed Companies House on 10 February that they had resigned as directors of A T Medics. They were replaced by people who were employees of Centene and Operose. In an emailed letter on 20 February from 19 health campaigning organisations the CCG was informed of that situation but during the following week they took the decision anyway to agree the transfer. So they had the opportunity legally to put a stop to this Trojan horse manoeuvre but did not do so.

Moreover, although they claim that the issue was fully discussed by all members of the PCCC on 17 December, no mention was made there of Centene. The information that they

were involved 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 members, were excluded. The CCG clearly knew it had something to hide.

Had they taken the decision to re-procure the contracts, It is likely that A T Medics / Operose/ Centene would have kept their service in place to allow that to happen, and they may have been contractually obliged to do that. Even if they had not done so, the GP Federations could have been asked to supervise the service being delivered by the current salaried GPs working in the practices, new salaried doctors or locums. We have heard that the Islington Federation would have been willing to do that.

We are sure that NCL CCG was put under a lot of pressure by NHSE to waive through this change of control, making the most of the current emergency to make changes they wanted to make anyway, as discussed in our deputation to you in September 2020. We believe this is not unconnected to the desire to have a free trade deal with the USA and to demonstrate that US health interests would be welcome in the UK.

Strategic issues raised by this matter

1. The CCG had the choice of serving the interests of the public of North Central London in the decision, or following instructions from NHS England. How will they seek to restore the broken trust of leading members of the local authority, with whom forthcoming legislation requires them to work in partnership, and how will they restore the trust of the wider public
2. What lessons have they learned about the need for transparency from the decision to confine discussion of the presence of Cetene in this matters to the closed Part 2 of a public meeting. Will they acknowledge that recent public statements and letters from the CCG have falsely claimed that there was full discussion by the PCCC. Will they guarantee not to use the Part 2 device in future for matters of public interest, reserving it for matters where confidentiality for individual people is required.
3. Will the CCG write to members of the public covered by these 8 practices, explaining what has happened and also that they have a choice about which practice they wish to use, and further explain how they should go about transferring elsewhere. This letter should contain messages in languages other than English showing how the user of that language can find out more. The same information should be available on the CCGs website.
4. What is the remaining term of all APMS contracts and what are the arrangements for rolling over or re-commissioning them. Are there other APMS contracts in North Central London held by other companies. What contingency planning has the CCG undertaken about how to respond if Centene / Operose make a similar takeover bid for those companies. How will the CCG respond in future if an existing PMS / GMS practice fails. Will they create a new APMS contract.

   Prof Sue Richards, on behalf of NCL NHS-Watch, 9 March 2021

Haringey and Islington KONPs Deputation on GP Access to NCL JHOSC,

12 March 21 SUMMARY

Haringey and Islington KONP are extremely concerned that the "temporary Covid GP Access policy" is becoming a permanent policy in NCL and risks damaging health outcomes for vulnerable sectors of the population ie the elderly, the disabled, those with MH issues, people with Learning Difficulties and Autism, the BAME community and Migrants .

We believe there are 3 Issues for the JHOSC to consider:

- The clinical need for, and the right to face-to-face access to a GP /clinician
- That the policy of "digital first" is detrimental to the long term health and wellbeing of NCL residents, most particularly to vulnerable groups with protected characteristics, as defined by the Equality Act (2010)
- Problems of equity with GP access systems, now and in the future

(Details of our concerns on the attached document)

HKONP and IKONP have the following questions for the JHOSC:

- 1/ Can JHOSC seek assurances from NCL CCGs that face-to-face GP appointments will be reintroduced as the norm post lockdown?
- 2/ Will the CCG acknowledge patients' right to face-to-face appointments for both primary and secondary care post lockdown, and publicise this at every GP surgery and on their website?
- 3/ when will the results of the Health Impact assessment be available and will it cover all protected groups and include the elderly, disabled people, people with MH issues, people with LD and Autism, the BAME community, migrants and victims of domestic abuse?
- 4/ what action is the CCG taking to avoid any potential discrimination resulting from this policy on the above groups?
- 5/ How will NCL CCGs make sure that isolated, vulnerable people/elders who are digitally excluded will not disproportionately suffer if they cannot contact their GP by telephone in a timely manner?
- 6/ how will CCGs deal with problems of access to GPs now, and in using e-Consult?
- 7/ How will Haringey CCG address the privacy concerns raised by the use of Public Voice volunteers and/or public libraries as access points in Haringey?
- 8/ CCG to give more details Initiative on digital access from Whittington etc.
- 9/ What are the numbers of face to face appointments available now in NCL ?

Rod Wells, Haringey KONP; Frances Bradley, Islington KONP

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- Problems of equity with GP access systems, now and in the future

KONP believe that this policy is not just a temporary Covid response but part of a permanent NHSE policy known as "digital first" under the NHS Long Term Plan. HKONP have twice raised concerns about this policy with NCL CCG since Nov 2020,

We now ask JHOSC to ensure NCL CCGs provide answers to each of the questions 1-7 set out at the end of this document.

Clinical Need for Face-to-Face Examination

We at KONP believe people have a "right "to face-to-face treatment, as the NHS constitution clearly states, i.e.

"You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences." (1)

If face-to-face appointments are reserved largely for the elderly or the digitally illiterate, this will compromise safe healthcare for large numbers of other patients. CCGs know that good clinicians often gather diagnostic clues from a patient's movements, skin tone, and speech patterns etc., which are not visible on a computer screen or via a phone. In addition, people of all ages whether vulnerable or not - particularly non-native English speakers – can find the digital interface makes it more difficult to speak openly to medical personnel. This all means that some important diagnostic clues are likely to be missed during online and telephone consultations.

Patient-GP rapport which is more easily established by face-to-face consultation and helps patients speak in confidence on sensitive subjects, for example, concerning mental health issues. Also importantly, a good doctor-patient rapport encourages treatment compliance.

The BMA has warned that doctors "[feel] that a greater use of … technology....could potentially be detrimental to some patients who require face to face appointments." (In September 2020, (2)

And furthermore, recent research published in the BMJ “reveals that increased continuity of care by doctors is associated with lower mortality rates” because at traditional face-to-face appointments, doctors can observe changes in their patients over time. BMJ ref..... (3).

.So KONP believe that this policy is a switch from a genuine widening of choice for clinicians and patients, to “digital first “will have long term costs for health outcomes and the wellbeing for patients of NCL

Health Inequalities Impact on vulnerable populations of “ digital first “access

This is an issue for significant minority groups, such as people with mental health issues, LD, the BAME community and migrants.

Although digital access to a GP undoubtedly suits some people - those with simple medical conditions who need a straightforward fix for an easily diagnosable problem and who are comfortable with using digital technology, we believe that for others this prioritising digital will reduce access.

Clearly not all patients, or their medical conditions, fit into simple categories. For example, elders - who as a group have the greatest health needs - are much less likely to be able to use digital technology to access their GP. Unequal access is already recognised as a prime cause of health inequality across different population groups.

KONP therefore asks that qualitative research be undertaken to determine if “digital first” creates a barrier to timely access to healthcare for patients. Bear in mind that late presentation and diagnosis tends to mean greater medical intervention is needed, and lead to worse health outcomes.

A lack of access of high-tech coincides with higher rates of poverty across all age groups. This is exacerbated within BAME communities where English is not the mother tongue, as well as in more insular or distinct groups, such as the Hasidic Jewish community, where the majority of households do not have a TV, smartphone or Internet at home (Jewish Post, 6/10/20).

KONP press the CCG to describe what action they are taking to assist the above groups to access primary care so that treatment is “appropriate ...and reflects their preferences”

Addressing digital exclusion- sources of support for digital access

Many people in the protected groups have relatives or friends who can help and support them to access their GP via digital technology. But it is not safe to assume that everyone is happy to speak openly about their health concerns in front of others, or that family or friends are necessarily benign.

For people who don’t have someone to help them navigate the internet, charities and local libraries (when they are open) are expected to provide access and to help people master the necessary technology. And we are aware of Public Voices project in training elders in digital technology –see later

Designing a system of access which depends on charity/PV to enable certain people to access health care goes against the NHS founding principle of appropriate care for all individuals at the point of need.

Discrimination/Health Impact Assessment of "digital first"

KONP do not believe the health inequalities of these protected groups have been addressed fully by the CCG**.**

We welcome the CCG doing a Health Impact Assessment for the elderly and people with LD but assessment must cover all protected/vulnerable groups.

Furthermore, NCL CCGs must be able to demonstrate that their policy of "digital first" will not discriminate against any group which has limited access to/facility with, the necessary technology, or people who are not fluent in English. Again this refers to the protected groups identified in the Equality Act (2010).

How will the detrimental effects will be addressed as they arise, because the health of vulnerable people is at stake here?

Because of existing social inequality KONP need written assurance that differential access to health care particularly across vulnerable groups will be closely monitored to ascertain any detrimental effects on long-term health outcomes and trends in death rates.

Monitoring is therefore necessary to ascertain that everyone who needs health care is indeed able to access their GP in the way that suits their capacities and their needs, as well as respects their privacy.

When and how will NCL CCGs publicise their findings?

Joint Initiative with Whittington Health North Middx and Barnet and Enfield and Haringey MHT on Digital Access

This pilot is "to understand how we can better support patients to access NHS services digitally and to help inform future commissioning approaches."(Rachel Lissauer CCG 14/1/21)

KONP therefore asks what analysis will be done of the needs of different vulnerable groups for face-to-face appointments and how will these needs be addressed? Have these Hospital Trusts contacted local authority/voluntary organisations which support the different groups for advice?

KONP suggest that in-depth monitoring of the "digital first" pilot study must demonstrate that sufficient time is allocated for face-to-face GP appointments. People who are ill must not be forced to wait a long time for an appointment, and potentially suffer worse health outcomes as a result.

When will a report into this be available?

Access to GPs Now: face-to-face/ telephone/e-Consult

We understand that in January 2021 the level of face-to-face access was 20/40% in Haringey. One HKONP member found themselves 14th in a phone queue and waited 48 minutes for an answer. This raises the question, what is the current availability of a) face-to-face and b) telephone appointments per head of population across NCL boroughs?

The problem of waiting a long time to get through to a GP/practice nurse will be prohibitively expensive for poorer people who tend to use a pay-as-you-go phone. How many patients cannot afford the time or money to wait this long on the phone?

How will CCGs enable these people to have *equitable* access to GP appointments?

Use of Public Voice volunteers in Haringey

We acknowledge the work the CCG is doing in Haringey via Public Voice to help people to gain digital access to primary care This input makes it appear that the “digital first” policy is to be permanent. Though

We have concerns with PVs project

- how this is being publicised? How will the CCG know they have adequately supported everyone in Haringey who needs assistance?
- Privacy - the presence of a ‘volunteer’ for what should be a private interaction may feel intrusive and insensitive.
- Issuing mobile phones and laptops in public libraries raises the question of privacy and confidentiality and whether people can successfully connect with GPs

A report on the efficiency and effectiveness of Public Voice project in reaching digitally excluded groups is needed. When will this be available?

Using e-consult

This system of access seems problematic .To be entitled to book online appointments is a big hurdle and one member of HKONP - with a good level of computer literacy - reports being unable to navigate e-consult, which indicates the programme’s poor design is a barrier to access.

At least a dedicated helpline is needed to offer support and, if that fails, patients must be allowed to contact the GP surgery directly. We understand from the CCGs engagement, only 14% of Haringey residents said they would use e-consult.

. What will be done to ensure e-consult is not overly complex and the lack of support addressed, if patients are to rely on e-Consult?

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References

1/ NHS Constitution -"Access to health services" https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-rights-and-the-nhs-pledges-to-you

2/ BMA https://www.bma.org.uk/bma-media-centre/evidence-on-digital-appointments-needs-scrutiny-says-bma-as-government-instructs-more-to-use-the-technology-in-the-nhs

3 BMJ https://bmjopen.bmj.com/content/8/6/e021161

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