Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Wednesday, 12th February, 2020

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held at Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair), Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	**Cllr Deniz Oguzkanli**
Officers In Attendance	**Simon Galczynski (Director - Adult Services), Dr Sandra Husbands (Director of Public Health), Ian Williams (Group Director of Finance and Resources), Sofie Jobson and Charlotte Taylor (Strategic Programmes Manager, CACH)**
Other People in Attendance	**David Maher (NHS City & Hackney Clinical Commissioning Group), John Makepeace (Local Pharmaceutical Committee), Dr Nick Mann (GP Well St Practice), Dr Mark Rickets (City and Hackney CCG), Sunil Thakker (City and Hackney CCG), Jon Williams (Director, Healthwatch Hackney) and Malcolm Alexander (Healthwatch Hackney)**
Members of the Public	
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Oguzkanli and Anne Canning.

1.2 It was noted that John Makepeace was present for Kirit Shah from the Local Pharmaceutical Committee.

2 Urgent Items / Order of Business

2.1 There were no urgent items and the order of business was as on the agenda.

3 Declarations of Interest

3.1 Cllr Maxwell stated she was a member of the Council of Governors of HUHFT.

3.2 Cllr Snell stated he was chair of the board of trustees of the disability charity DABD UK.

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the draft minutes of the meeting held on 29 January 2020 and noted the matters arising.

RESOLVED:	**That the minutes of the meeting held on 29 January 2020 be agreed as a correct record and that matters arising be noted.**

5 Hackney Local Account of Adult Care Services 2019-20

5.1 Members gave consideration to the Hackney Local Account of Adult Care Services 2018/19. The Chair stated that the Commission considered this each year.

5.2 The Chair welcomed for this item:

Simon Galczynski (SG), Director Adult Services, CACH
Charlotte Taylor (CT), Strategic Programmes Manager, CACH
Sophie Jobson (SJ), Programme Manager, CACH

5.3 Officers took Members' through the report. They highlighted: that co-production is now central to their work; the work done on the campaign to tackle financial abuse; the work on direct payments; the work done on developing pages on autism for the website; the success in recruiting permanent work force and the development work being done in embedding best practice.

5.4 Members asked detailed questions and the following points were noted:

(a) Members asked where new cost savings could be made, considering the volume of savings already made. Ian Williams (Group Director, Finance and Corporate Resources) replied that savings were required from all quarters as they develop the next Medium Term Financial Strategy and news on the latest government funding settlement was awaited. Nationally the funding for both adult and children's social care and to tackle homelessness was a serious issue and after 10 years of austerity there was a need to look at budgets very closely. There was a strong commitment however within the Council to protect services for the most vulnerable.

(b) Further to 3.2 on p.18, Members asked officers to explain what "3 Conversations" was. CT explained that it was about putting the individual at the centre of a number of conversations and about providing support at the right time. The aim was to look at the positives in people's lives and how services can fit within this. The first conversation is focused on the individual's overall situation to assess the issues in their lives and to respond as necessary with adaptations or telecare or support via the voluntary sector or personal support. The second conversation relates to those in crisis and focuses on how to

respond differently if a person hits a crisis point. The third conversation relates to provision of long term support.

(c) Further to p.54, Members asked how the new Carers support service was working out. SG replied that the need to improve the quality of life of carers drove the development of the new model and after much work, the organisation 'Carers First' had been commissioned and the response to the new model had been very positive thus far. "Carers assessments" as they used to be termed were now completed by social workers under the new system.

(d) The Chair stated that at the January meeting the Unplanned Care Workstream, the Workstream Director in her report had stated that they had been dealing with a 27% increase in Delayed Transfers of Care which contradicted what was in this report. He asked whether the discrepancy was due to both looking at different timelines. He added that the Overall Financial Position report, which went to Scrutiny Panel, had referred to a near £3m cost pressure on care support commissioning. He asked whether the challenge was in securing a suitable location for them. SG replied that the discrepancy between the two reports had been because of different timelines. There had been an upturn over Dec-Jan but this had now started to turn around. He added that HUHFT was good at moving people through their services quickly but the struggle was in a lack of nursing home placements and delays by clients not wanting to move outside Hackney. Plans were in train to develop other care settings and they were also looking at more flexible use of the Home Care service so that volumes could go up and down more easily and so they can better respond to the surges which HUHFT predicts. The Chair asked whether they were looking for a location in Hackney like the previous facility in Median Rd where people could be supported locally. SG replied that they were looking closely are opportunities to support people in Hackney there was a need to plan more flexibly. Money spent to relieve short term pressures this year would not be available in the next. In addition needs were now more complex than they had been in the 90s when he had started his career as a social worker.

(e) Members asked about workforce pressures. SG replied that they were now nearly at the full complement of permanent staff. There had just been another round of recruitment in the Learning Disabilities Service. The Day Centre also now had more permanent staff. Housing with Care was recruiting an additional 10 to 12 and they were also looking closely at improving career paths for staff. On retention, they were working on developing the Apprenticeship in Social Work which would eventually lead to a degree.

(f) Further to p.59, Members asked about the continuing long waiting times for IAPT. SG undertook to provide further detail on the numbers. Jon Williams (Executive Director, Healthwatch) added that Healthwatch would be completing an 'Enter and view' of ELFT services and they also had concerns about IAPT waiting times. He also wanted to know how the CCG and the Neighbourhoods system would be working to better support carers and what practical steps they would be taking to listen to carers. Each Neighbourhood would have the data, they would know the clients who already have carers and so they would be in a position to do more to learn how to design support around the carers. SG replied that carers were fully part of the Neighbourhoods model and these points would be taken on board.

ACTION:	**Director of Adult Services to provide further background and latest data on the waiting times for access to psychological therapies (IAPT)**

(g) A resident asked about whether any preference in employment could be given to residents of Hackney. SG replied that they recognised the value of having staff who worked in the borough and great progress had been made for example with the internships for local people with disabilities. A lot of work was going on in relation to Workforce and the key element was how to make it more attractive to potential employees as, for example, retail work. IW added that Members may have seen the recent adverts on the tube promoting working locally, which referred to 'commutable positions'.

5.4 The Chair thanked officers for another impressive annual report and stated that as well as the further detail on IAPT waiting times the Commission was interested, going forward, to see greater feedback from carers as well as progress on developing another setting in the borough which would help to reduce 'Delayed Tranfers of Care'.

RESOLVED:	**That the report and discussion be noted.**

6 An Integrated Care System for North East London

6.1 The Chair stated that he had asked for this item because the issue was now developing and that Jane Milligan the Chief Accountable Officer for ELHCP had provided some insights on this the previous nigth at INEL JHOSC. Members gave consideration to three briefing reports from the CCG.

6.2 The Chair welcomed to the meeting:

Dr Mark Rickets (MR)**,** Chair, City and Hackney CCG
David Maher (DM)**,** Managing Director, City & Hackney CCG
Sunil Thakker (ST)**,** Finance Director, City & Hackney CCG
Ian Williams (IW), Group Director Finance and Corporate Resources, LBH
Laura Sharpe (LS), CE of GP Confederation
Dr Nick Mann (NM), LMC representative

6.3 DM introduced the reports by running through the history of development of the STP and now the proposal for an Integrated Care System. The Long Term Plan had evolved from the devolution pilot of 2016 which was focused on getting better value from the local health resources. This had led to the creation of the ICB whose Workstreams were now well established. A further development from this was the new Neighbourhoods Framework, so City and Hackney had a well-articulated story of progress to report. The Long Term Plan acknowledged that everything City and Hackney had been doing up to now was what was needed. There was a need to reduce administration cost with 20% being a target figure. City and Hackney however had always underspent its budget. As thinking on the ICS developed the idea of having 3 subsystems had been accepted. These would comprise: BHR, WEL and C&H. One of the key areas of contention now is how to evolve from three systems already in operation to a single overarching system with 3 sub-systems beneath it. Work was being done to define a 'Set of Asks' to the system on what C&H

would want NEL to do. The obvious areas of specialised commissioning, maternity beds and mental health beds were best delivered across a bigger footprint. This set of Asks would also ask for more control and autonomy.

6.4 Members asked detailed questions and the following points were noted:

(a) The Chair asked what the timeline was for the effective handing over of power to a single CCG in April '21. Didn't all the CCGs have to agree to the proposal in their Governing Bodies during this summer? DM replied that it was about the distribution of power within the system not a 'handing over' and it was incorrect to view this as some kind of spectre. It was instead, he added, about having the power to shape a new system to benefit everyone in NEL. They were not using the term 'shadow' board either for the period from April '20 to April '21, instead there would be a steady planned transition from the 7 formal CCGs, which already operate in 3 systems in any case, to a single ICS which would provide strategic oversight as well as economies of scale. He reminded Members that the Joint Commissioning Committee of the ELHCP already existed to do some of this strategic commissioning and was already working. MR added that there had been agreement within NEL that powers will reside in place based systems and there will be safeguards. He also added that as a CCG they were already totally accountable to the same overarching body for everything, which is NHSE. The general principle was that everything goes on at the 'place based level' (usually borough level) unless and by exception it is best addressed at the NEL footprint level, which will be the ICS. Generally the aim was 80% at place based level and 20% at the ICS level. The current 5 year financial settlements would continue to flow down to 'place based' level. Overall these changes represent an evolution not a 'big bang'.

(b) A Member asked whether the new structures were driven less by the needs of the population and more by the needs of the big acute Trusts some of which are too big to fail and was there a danger City and Hackney could be dragged down financially by a need to bail them out in the future. DM replied that there wasn't and instead this was an opportunity to look at our NHS organisations and how they can work better together. The plan for a Provider Alliance will add leadership to the system not diminish it, he added. The Accountable Officer will be answerable to each CCG area also and within each area of course there will be a local election model to elect the Clinical Director within each CCG. They will sit on the ICB and the ELHCP Executive and the ICB has already appointed its first Chair, Marie Gabriel (previously Chair of ELFT). The idea of 'meetings in common' between each CCG and the ELHCP Board is being explored and the best of commissioning behaviours won't and can't be lost in the new system, he added.

(c) The Chair stated that what was in the briefing was all very laudable but it was general and aspirational. The Commission had yet to see a document on the constitutional and governance structure of the ICS. Was the 80:20 split in commissioning codified for example? These changes represented in his view a massive centralisation and there was an important need to see the plans codified in a governance document. MR replied that this will be ready in the summer when the full CCG Membership and then the Governing Body will be asked to give views. Work on this had been accelerated and it was on the way, he had seen a working draft.

(d) The Chair asked about the 15% of commissioning activity which was already going through the NEL Joint Commissioning Committee. ST confirmed this figure and added that in relation to the ICS it needed to be worked out how the funding will be devolved to the three sub-systems and how reserves which are unspent will be used. The expectation was that an element will be held in the centre and part devolved down.

(e) A Member asked about the governance of joint Council and CCG commissioning. IW replied that S.75 agreements have gone through Cabinet for some years now and these type of arrangements will continue. He commented that the good relations between the Council and the CCG in City and Hackney were to be valued because this meant that the partners were in a good place to implement change as compared to other boroughs where this relationship is more adversarial. The task will be to keep and develop a constructive working relationship between the local NHS and the Council.

(f) A Member asked what the advantage was, if any, to the Council of these proposals. IW replied that the Council always supported greater integration for reasons of value for money. The Council has a role here in influencing the local NHS as it evolves to their mutual benefit. He added that there will be a need for this Commission to test these changes and a role for the Council to lobby hard to ensure that Hackney's interests are protected. A Member asked what the challenges would be. IW replied that it was in the ability to navigate the new structure effectively when there will be a single CFO for the whole NEL system.

(g) The Chair stated that C&HCCG had worked locally to help devise solutions for local residents but when, for example, City and Hackney's reserves go upwards to help balance the NEL budget then some local flexibility will be lost. IW replied that this was an obvious risk.

(h) Another Member added that he could not see how the new system could be better for Hackney as commissioning was being centralised. The CCG was locally accountable and if you centralise it you will lose local accountability, he added. He also expressed concern about the reference on p.72 about "less focus on contractual discussion and more on transformation and collective processes". He also had a general concern that as the commissioning function shrinks power would move to larger providers. DM replied that these changes to the contractual framework need to be looked at in the context of changing to a new wider NHS family of organisations. He explained how the HUHFT and ELFT and the GP Confederation (the main providers) already have Quality Review meetings with the CCG where the two sides are brought together to focus on quality rather than having separate groups looking at the same information. The focus would be on how we would do it differently if we worked more closely, he added. HUHFT is anchored in the borough, like the Town Hall, and why should commissioning sit remotely from that. This provides an opportunity. There has been 10 years now of the commissioner-provider split and it needed to be re-looked at. He added that we have integrated teams already working in the Workstreams. HUHFT and the GP Confederation were already doing work jointly on workforce development. He concluded that he felt passionately that this change provided a valuable opportunity to do things differently with the local partners. MR added that the bulk of commissioning would remain locally and only by exception would it be elevated. He added that

this would improve working practices as a lot of contractual issues currently get in the way. 80:20 wasn't an exact rule but an aspiration. 15% of commissioning was already being done at the JCC and the other 5% referred to commissioning flows out of City and Hackney e.g. to UCLH.

(i) A Member commented that getting rid of the commissioner-provider split was probably a good thing but the concern was that in doing so the NHS was not compensating for loss of local accountability. The tension created by the commissioner-provider split provided some accountability and so the answer has to be some kind of collective democratic accountability. DM stated he agreed with this and it illustrated for example the importance of Scrutiny Committees. He added that the ICB already provides some stringent oversight. The big debate on quality mattered at ICB and in the past HUHFT wasn't in the room for those because it was a provider. MR concurred stating this this was about bringing the conversations into one room. They key thing was not to lose these good commissioning behaviours. NHSE requires one CCG per STP area and there was a need to make the best of this. There are many advantages to the current system in C&H and it also helps the wider system out already year on year and it was to be expected that this would continue. Also the JCC makes unanimous decisions and there is a local safeguard there also.

(j) A Member commented that the handling of the recent measles outbreaks demonstrated the importance of having local autonomy as the local system was able to move fast with its own response. The key test of a new system would be whether we would still have the flexibility to do this in future.

(k) The Chair stated that his test would be, for example, whether the ICS Accountable Officer in six years' time could downgrade the Homerton. The question therefore is what safeguards are in place. While he accepted that the commissioner provider split had had its flaws City and Hackney was the author of its own success and this was not being acknowledged. There were a number of consequences which needed to be thought through. DM replied that over the past two years he would typically spend 2 days a week at NHSEL HQ defending C&H performance and this was unproductive there would be someone at ELHCP overseeing this in the new system. He added that he could not envisage a world where any logical argument could be made for merging the current A&E sites and that this power did not rest solely with the Accountable Officer of the ICS in any case.

(l) A member of the public stated that because the new system would be unified it could bring the standards up to that of the best and Whipps Cross could for example be brought up to the level of HUHFT. MR replied that the Clinical Senate across NEL already shares best practice as a matter of course. He clarified too that some patient pathways will continue to go outside the NEL system e.g. to UCLH as it does currently.

(m) A representative of Hackney Keep Our NHS Public commented that the key issue with the NEL system plan was that is solely a clinically led strategy. What residents want to protect is local provision of non-specialised services so that families and friends can visit locally.

(n) The Chair of the Healthwatch and Public Involvement Association commented that the issue of public voice and lay representation in the new structures was

not clear and would need to be sorted. DM replied that City and Hackney had a high performing PPI Committee and in the new structure there was a proposal for a People and Places Committee to continue this important role. MR added that NEL was currently not as rich an environment for co-production than City and Hackney had been and this would need to change.

(o) The Chair commented that the recent history was that City and Hackney had more than its share taken by the NEL system and asked the Chief Exec of the GP Confederation how these new proposals would impact on them and how the impact might be minimised. LS replied that the first plus was that City and Hackney continued to be defined as a 'place' in the new structure and maintaining that was very important.

(p) LS stated that there were three ways in which the new system could be accountable in City and Hackney. Firstly in the delivery of the 'nuts and bolts' of the system where there was a record of successful delivery thus far. Then the revised Integrated Care Board would now have providers at the table hopefully making it more integrated and accountable. Finally for out of hospital delivery, the three key providers in the borough (HUHFT, ELFT and GP Confederation) would now formally work more closely to lock in delivery at Neighbourhoods level thus securing more local autonomy and integrated working. The net result of these actions should protect local funding and have a stronger case for keeping it local. The Provider Alliance needs to demonstrate how it will be accountable and Scrutiny had a role here. The Provider Alliance will also be able to hold the ICS itself to account. The key to it will be to lock in clinical and patient voices in the new system.

6.5 The Chair thanked the officers and stated that what was important now was to see the detail of the Governance and of the ICS before this was agreed by City and Hackney CCG Governing Body. DM cautioned that this needed to be debated first separately by the CCG Members (the local GPs) but they would of course be able to provide further details for the Commission. The Chair stated that the Commission would not accept receiving the plan as a *fait accompli* at the end of a process. He stated that these changes effectively meant nearly £500m per year going upwards to the ICS and the Commission would need to see the constitution and governance details and if this was not forthcoming then referral to the Secretary of State was always an option. He added that he would like the Commission to see the plans after the CCG had had their own deliberations but before they made any final vote on it. DM agreed but stated that they had statutory duties to their Members which took priority and it would be necessary to map out a possible timeline for this. The Chair asked when the deal would be done. DM replied that it was not a deal but an iterative process. CCG Members would have agree to de-constitute themselves and this would likely take place over the early summer so they might be in a position to come back in late summer. The Chair thanked the Chair and MD of the CCG for their continuing co-operation and engagement with the Commission and asked again if this issue could return before any final vote is made.

ACTION:	**MD of the CCG to bring a briefing on the constitution and governance of the new ICS for North East London and the implications for Hackney to the Commission at a date to be confirmed in summer 2020. This needs to take place before CCG Members**

	cast a final vote on de-constituting the local CCG.

RESOLVED:	**That the report and discussion be noted.**

7 Primary Care Networks service specifications - discussion

7.1 The Chair stated that Shirley Murgraff of Hackney KONP had raised this issue with the Commission. This related to NHSE's formal consultation on the service specification for the implementation of Primary Care Networks (PCNs) known in Hackney as the Neighbourhoods Model. Both KONP and HAPIA had had serious concerns about the lack of time which had been provided for the consultation which had run over the Christmas holiday period. Members gave consideration to Mrs Murgraff's request and to a letter which HAPIA had sent to Sir Simon Stevens expressing serious concerns about the engagement process.

7.2 The Chair stated that he did not want to get into a discussion of the consultation timings as the date had now passed but he asked Members to note both the original request to the Commission and the letter which Malcolm Alexander, the Chair of HAPIA, and also a Hackney resident, had sent to NHSE. He welcomed for this item:

Laura Sharpe (LS), Chief Executive, C&H GP Confederation
Dr Mark Rickets (MR), Chair, C&H CCG
Malcolm Alexander (MA), Chair, Healthwatch and Public Involvement Association (HAPIA)
Jon Williams (JW), Chair, Healthwatch Hackney
Dr Nick Mann (NM), member of Local Medical Committee

7.3 LS stated that she was very pleased that NHSE appeared to have listened to the concerns here and this was very good news. There had been a furore from various GP bodies and the GP Committee of the BMA had thrown out the proposals. In summary the new service specifications would have meant lot of extra work for GP Practices with very few new staff. She stated that the previous Friday the new GP Contract had just been signed between DoH and the BMA and this had contained significant improvements. There would be an increase in the range of staff PCNs could recruit with an average of 20-24 staff per PCN. Locally they would have 21 new staff across a range of roles. This represented a significant increase in GP support staffing. The previous proposal required local CCGs to provide 30% of the new staffing costs but they had backed down and now 100% would be funded nationally. The second major worry about the GP contract had been the very complicated and detailed proposed service specs which were supposed to start in April. These had been pulled and the revised specs were 2 pages instead of 20. There was also a lot in the new contract about GP mentoring and on support to long term locums etc and overall this package was very good news. Now PCNs had been put on a much better footing from the new financial year. As regards the role of the GP Confed locally on this, she stated that she would be meeting with 4 of the 8 neighbourhood directors the following day to begin the work.

7.4 MR stated that he too was very surprised by how things had turned out and was pleased that 100% of the new funding would be reimbursed nationally but he had yet to see what the actual figure would be. There was a need to think

creatively about how to create a new workforce, he added. It was not right to 'steal' from areas like London Ambulance Service. Decisions would be made on where additional new resources could be directed, for example, into community nursing.

7.5 MA commented that the first NHSE consultation on the service specifications had been unlawful because proper public involvement had not been possible and that's why he had written to Sir Simon Stevens. LS clarified that consultations on the national GP contract have always between NHSE and GPs representative body the BMA and have never been consulted on publicly. This particular aspect on service specs for PCNs was a separate issue and in the end got dealt with by revising the GP Contract as it was being finalised.

7.6 NM stated that a lot had happened here in a very short space of time. The local LMC did not have time to formally discuss it. The LMC continued to have concerns however about how this would all play out in the detail such as re-introducing previously discredited metrics to measure performance on the PCNs. LS agreed that there were things in the contact which were still not totally clear.

7.7 A resident asked about use of apprenticeships for some of these ancillary roles and that the public was not aware of this. LS replied that with social prescribing there were ways to expand the workforce e.g. first contact physios and these changes would give local providers the ability to recruit locally and consider apprenticeships as appropriate.

7.8 The Chair thanked guests for their contributions.

RESOLVED:	**That the letters and discussion be noted.**

8 Health in Hackney Scrutiny Commission- 2019/20 Work Programme

9.1 Members gave consideration to the updated work programme for the year.

RESOLVED:	**That the updated work programme for 2019/20 be noted.**

9 Any Other Business

9.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm