Overview & Scrutiny

Health in Hackney Scrutiny Commission

All Members of the Health in Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows

Wednesday 15 November 2023

7.00 pm

Council Chamber, Hackney Town Hall, Mare Street, London E8 1EA

The press and public are welcome to join this meeting remotely via this link:
https://youtube.com/live/h7lq7voQdEM

Back up live stream link:
https://youtube.com/live/YKlZXyrQu7o

If you wish to attend please give notice and note the guidance below.

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Dawn Carter-McDonald
Interim Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Kam Adams, Cllr Grace Adebayo, Cllr Frank Baffour, Cllr Sharon Patrick (Vice-Chair), Cllr Ifraax Samatar, Cllr Claudia Turbet-Delof and Cllr Humaira Garasia**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

6	**Minutes of the Previous Meeting (20.50)**	(Pages 81 - 96)
7	**Health in Hackney Scrutiny Commission Work Programme (20.52)**	(Pages 97 - 104)
8	**Any Other Business (20.59)**	

ACCESS AND INFORMATION

Public Involvement and Recording

Public Attendance at the Town Hall for Meetings

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at https://hackney.gov.uk/council-business or by contacting Governance Services (020 8356 3503)

Following the lifting of all Covid-19 restrictions by the Government and the Council updating its assessment of access to its buildings, the Town Hall is now open to the public and members of the public may attend meetings of the Council.

We recognise, however, that you may find it more convenient to observe the meeting via the live-stream facility, the link for which appears on the agenda front sheet.

We would ask that if you have either tested positive for Covid-19 or have any symptoms that you do not attend the meeting, but rather use the livestream facility. If this applies and you are attending the meeting to ask a question, make a deputation or present a petition then you may contact the Officer named at the beginning of the agenda and they will be able to make arrangements for the Chair of the meeting to ask the question, make the deputation or present the petition on your behalf.

The Council will continue to ensure that access to our meetings is in line with any Covid-19 restrictions that may be in force from time to time and also in line with public health advice. The latest general advice can be found here - https://hackney.gov.uk/coronavirus-support

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the

start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting.

Disruptive behaviour may include moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording Councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease, and all recording equipment must be removed from the meeting. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

Advice to Members on Declaring Interests

Advice to Members on Declaring Interests

Hackney Council's Code of Conduct applies to all Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- Director of Legal, Democratic and Electoral Services
- the Legal Adviser to the Committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the meeting when the item in which you have an interest is being discussed. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the meeting and participate in the

meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.

If you have other non-pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

ii. You may remain in the meeting, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission, or licence matter under consideration, you must leave the meeting unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the meeting. Once you have finished making your representation, you must leave the meeting whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non-pecuniary interest.

Further Information

Advice can be obtained from Dawn Carter-McDonald, Director of Legal, Democratic and Electoral Services via email dawn.carter-mcdonald@hackney.gov.uk

Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app')

Health in Hackney Scrutiny Commission

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Hackney

Health in Hackney Scrutiny Commission 15th November 2023 **Tackling breast cancer in Hackney - discussion meeting**	Item No **4**

PURPOSE

To discuss with key stakeholders the challenges around tackling breast cancer in Hackney. This would encompass - the latest data, the performance of the screening programme and efficacy of current breast awareness programmes in ensuring early diagnosis. The aim of the session is to explore what is being done locally, what more can be done and how partnership working here might be enhanced.

CONTEXT *(data from Public Health)*

Breast cancer is the most common type of cancer in the UK.

● It accounts for almost one in five newly diagnosed cancers in City and Hackney (123 residents were diagnosed in 2018).

● As of December 2020, there were almost 1,600 people living with breast cancer locally (44% of all people living with cancer).

The majority of people diagnosed with breast cancer are women over the age of 50, but it also affects younger women and (rarely) men.

● One in seven women will be diagnosed with breast cancer.

● Breast cancer is the most common cause of cancer in females aged 15 and over; over a third of women in Hackney are diagnosed under the age of 50 and it is the leading cause of death among female Hackney residents aged under 49 (and one of the main causes of death among women aged 50+).

● Locally, less than 1% of breast cancer diagnoses are in males.

PAPERS

Attached please find papers from:

4b Public Health

4c Central and East London Breast Screening Service

4d NE London Cancer Alliance

4e to g City and Hackney Cancer Collaborative (local GPs)

4h CoppaFeel! (VCS org)

FORMAT

This is a Discussion item so the format will be brief introductions to the papers submitted followed by a Q&A with the Commission Members.

CONTRIBUTORS

Role	Organisation	Job title	Name
The Alliance	NEL Cancer Alliance (part of NHS NEL)	Early Diagnosis Prog Lead Managing Director	**Caroline Cook** **Femi Odewale**
Screening service	Central and East London Breast Screening Service	Lead Breast Cancer Nurse Health Promotional Lead	**Clare Mabena,** **Dr Mansi Tara**
Public Health	Hackney Council/ City of London Corporation	Director of Public Health Consultant in Public Health	**Dr Sandra Husbands** **Jayne Taylor**
Secondary care	Barts Health NHS Trust	Consultant Medical Oncologist in Breast Cancer	**Dr Katherine Hawkesford**
	Homerton Healthcare	Lead Nurse - Cancer	**Mary Flatley**
Primary care	City and Hackney Cancer Collaborative	Chair. Local GP Cancer Facilitator	**Dr Reshma Shah** **Jessica Lewsey**
3rd sector	CoppaFeel!	Head of Services Health Information Manager Director of Education & Health Communications	**Helen Farrant** **Emma Walker** **Sophie Dopierala-Bull**

DIMENSIONS TO EXPLORE

a) **Screening criteria** are all set nationally and neither Public Health nor NHS NEL can apply local criteria or run local pilots to target certain cohorts.

b) The most effective tool to ensure early diagnosis among young breast cancer patients is to **promote breast awareness** so that cancers are found and diagnosed as early as possible. This involves enhancing public understanding that breast cancer can happen to people of any gender, age, or ethnicity, as well as awareness of breast cancer signs and symptoms, the significance of regular self-checks, and how to conduct them.

c) It is noted that **Black women** are typically diagnosed with breast cancer at a much younger age than White women (48 versus 60). This is significant considering that national screening commences at 50, which is two years after the average age of breast cancer diagnosis among black women. Likewise members of the Ashkenazi Jewish community are more likely to be diagnosed with breast cancer at an earlier age due to the prevalence of the BRCA gene within their community.

d) The concern therefore is that the current blanket breast screening programme might be missing key cohorts and thus **exacerbating health inequalities** in certain populations.

e) Homerton Healthcare has also been observing an increasing incidence of breast cancer among younger women locally. The local data shows that 12.6% of women living with or beyond breast cancer are under 49 in North East London, compared to the national average of 7.8%. This indicates a specific challenge with breast cancer in younger individuals in our region.

ACTION

The Commission is requested to give consideration to the reports and discussion and make any recommendations as necessary.

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Why is breast cancer an important public health issue?
Briefing note for Health in Hackney Scrutiny Committee
15 November 2023

City & Hackney Public Health Team

Breast cancer is common[1]

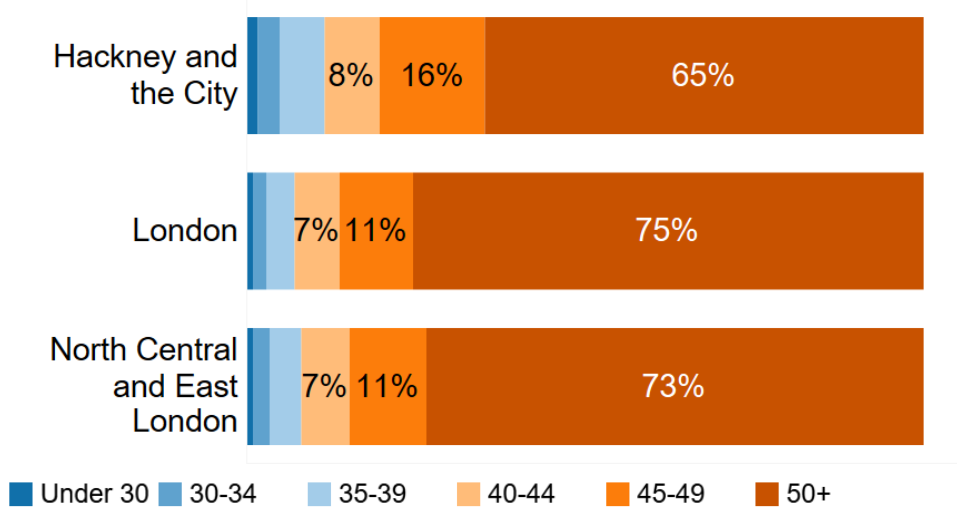
Breast cancer is the most common type of cancer in the UK.

- It accounts for almost one in five newly diagnosed cancers in City and Hackney (123 residents were diagnosed in 2018).
- As of December 2020, there were almost 1,600 people living with breast cancer locally (44% of all people living with cancer).[2,3]

The majority of people diagnosed with breast cancer are women over the age of 50, but it also affects younger women and (rarely) men.

- One in seven women will be diagnosed with breast cancer.
- Breast cancer is the most common cause of cancer in females aged 15 and over; over a third of women in Hackney are diagnosed under the age of 50 and it is the leading cause of death among female Hackney residents aged under 49 (and one of the main causes of death among women aged 50+).
- Locally, less than 1% of breast cancer diagnoses are in males.[4]

Percentage of breast cancer cases diagnosed by age group and area of residence (females), 2014 to 2018



[1] Cancer Research UK. (2023) Breast cancer statistics. Available at: https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer (Accessed: 03 October 2023).
[2] National Disease Registration Service (NDRS). (2022) England Cancer Prevalence Statistics 2019.
[3] Living with a primary diagnosis of breast cancer since January 1995.
[4] National Cancer Registration and Analysis Service (NCRAS). (2019) CancerStats: Incidence age standardised rates dataset

Some groups and communities are affected more than others (inequalities)

The main risk factor for breast cancer is older age, as described previously. This largely reflects cell DNA damage accumulating over time, resulting from biological processes or exposure to other risk factors. Other important 'non-modifiable' risk factors include genetics and family history. 'Modifiable' risk factors are described on the next page of this briefing.

Ashkenazi Jewish people face a higher risk of breast cancer due to the prevalence of BRCA gene mutations in this group, occurring at a rate of one in 40 (compared to an estimated one in 200 in the general population).[5] This could be of particular concern in Hackney, given the relatively large resident Jewish community (6.7% of the local resident population, compared with 0.5% nationally).[6]

A 2008 study conducted at Homerton Hospital found that black women were diagnosed with breast cancer at a significantly younger age (21 years earlier) than white women.[7]

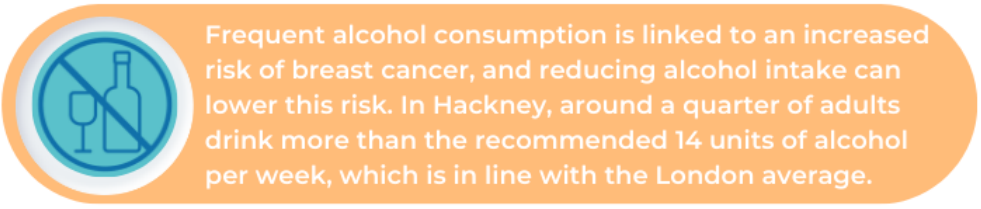
Source: https://breastcanceraf.org/blog/breast-cancer-risk-factors/

[5] Macmillan Cancer Support. (2023) *BRCA genes.* Available at: https://www.macmillan.org.uk/cancer-information-and-support/worried-about-cancer/causes-and-risk-factors/brca-gene .
[6] Office for National Statistics (ONS). (2022) *Census 2021*
[7] Bowen, R. L., et al. (2008) *Early onset of breast cancer in a group of British black women.* British journal of cancer, 98(2), 277–281

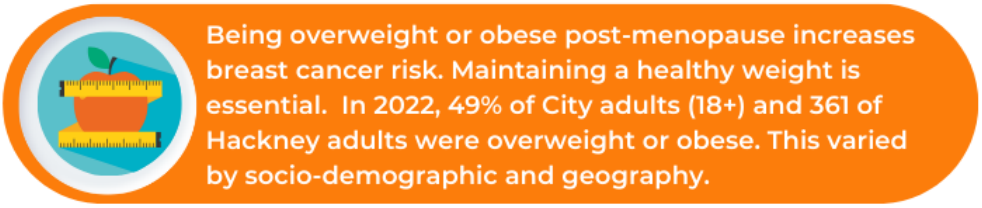
There are many opportunities for prevention and early intervention to save lives

Almost a quarter (23%) of breast cancer cases in the UK are preventable.[8] Action on a number of modifiable 'lifestyle' factors can significantly reduce the risk of developing breast cancer.[9,10, 11]

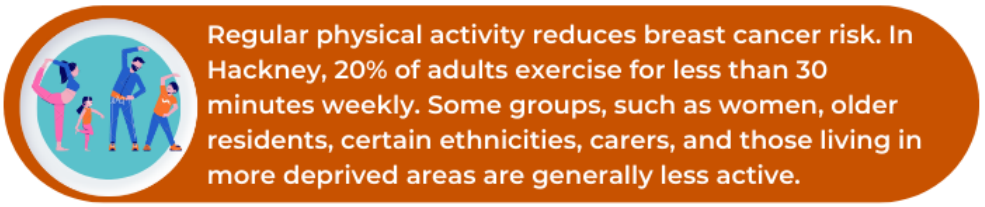
Alcohol consumption



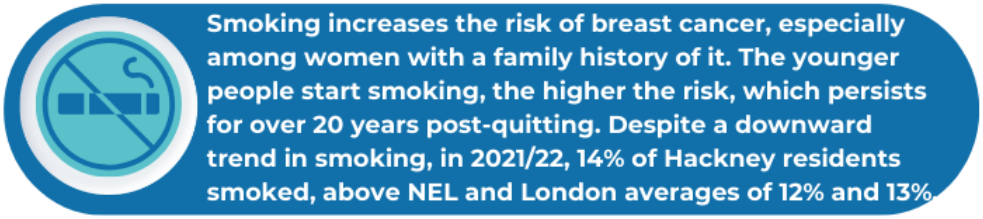
Healthy Eating



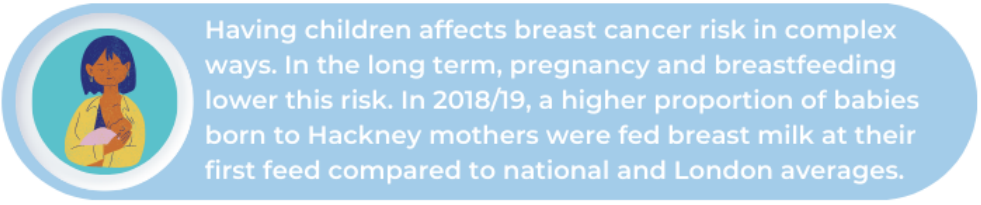
Physical activity



Smoking



Pregnancy and breastfeeding



[8] Cancer Research UK. (2023) *Breast cancer statistics.* Available here
[9] Breast Cancer Now. (2022) *Physical Activity and Breast Cancer Risk.* Available here
[10] Breast Cancer Now. (2022) *Weight, Obesity, and Breast Cancer Risk.* Available here
[11] Office for Health Improvement and Disparities (OHID). (2023) Fingertips, Public Health Data. Available at: https://fingertips.phe.org.uk/

Targeted breast awareness campaigns are key to informing people about the early signs and symptoms of breast cancer, and encouraging them to regularly examine their breasts and seek medical advice if they notice any changes. As well as national breast cancer awareness month during October each year, a number of targeted local campaigns promoting breast awareness and screening (see below) are delivered by NEL Cancer Alliance in partnership with the City & Hackney Cancer Collaborative.

Screening is a form of 'secondary' prevention in which pre-cancerous or early cancerous changes can be detected, leading to earlier diagnosis and treatment and better outcomes. The UK breast screening programme offers a mammogram every three years to cisgender women (and some trans men, trans women and non-binary people) aged between 50 and 71.

- In March 2020, there was a significant pause and subsequent backlog in the delivery of screening programmes in the UK due to COVID-19. As of December 2022, breast cancer screening alone accounted for around 25% of the total shortfall in cancer diagnoses as a result of the pandemic.[12] This continued a decline in breast screening coverage since 2012.

Early access to cancer treatment has been driven by the following national waiting time standards, which set out how long a patient should expect to wait between specific milestones of their cancer journey. Since 1 October 2023, the two week wait targets to see a specialist have been abolished in favour of a focus on faster diagnosis standards.

- 93% of patients should be seen by a specialist within two weeks of an urgent GP referral for suspected cancer [withdrawn]
- 93% of patients should be seen by a specialist within two weeks of an urgent GP referral for breast symptoms (where cancer is not initially suspected) [withdrawn]
- 75% of patients should have cancer diagnosed or ruled out within 28 days of an urgent GP referral for suspected cancer (by 2024).

Local performance has been consistently at or above these standards in recent years, including (in the most part) during the pandemic.

Screening and early diagnosis can help to identify cancer at an earlier stage and provide access to faster treatment, which typically leads to better outcomes. The national standard is for 75% of cancers to be diagnosed at stage 1 or 2 (before the cancer has spread). In 2020, 84% of breast cancers were diagnosed at stages 1 or 2 across NEL (no Hackney level data available), which is in line with the national average.[13]

[12] Breast Cancer Now. (2023). *Our Blueprint to Transform Breast Screening by 2028.* Available at: https://breastcancernow.org/about-us/campaign-news/our-blueprint-transform-breast-screening/
[13] National Cancer Registration and Analysis Service (NCRAS). (2022) *CancerData.* Available at: https://www.cancerdata.nhs.uk/.

Key points

Access to up-to-date local data on (breast) cancer is limited, which hampers a full understanding of local need to inform appropriate action.

- No local data (Hackney or NEL) are available on inequalities in cancer prevalence.[14]
- Data on new cancer diagnoses in Hackney are only available up to 2018.
- Local data on cancer diagnoses by ethnicity are not available.
- Local (Hackney) data on cancer survival are not available, nor have we been able to access local data (Hackney or NEL) on inequalities in survival.
- Ethnicity coding in breast screening records is incomplete and no data on screening coverage are available by age group.
- No data are available on inequalities in stage of diagnosis by cancer type at local level.

Survival rates are comparatively low locally, but improving.

- Between 2015 and 2019, NEL had the lowest one year age-standardised breast cancer survival rate in England, but this survival rate has increased faster than the national average since 2004.[15]

Breast cancer incidence is relatively low and diagnoses are falling locally, but across London diagnoses are increasing in some age groups.[16]

- In 2018, the age-standardised incidence rate for breast cancer was lower in City and Hackney (and NEL) than the London average.
- There was a decline of almost 30% in newly diagnosed breast cancer cases in City and Hackney between 2014 and 2018.
- Across London in 2019-20, there was an increase in breast cancer diagnoses among 70-74 year olds (28%), and to a lesser degree among younger age groups (25-34 and 45-49).

Locally, breast screening coverage lags behind national standards and significant inequalities in coverage and uptake remain.[17,18,19]

- The decline in coverage observed across the country between 2012 and 2022 was less severe in Hackney than London as a whole. However, coverage in Hackney (55%) remains significantly below the national average (65%).
- By September 2023, roughly 21,3000 eligible residents in City and Hackney had not taken up breast cancer screening in the recent three year screening window.

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[14] Prevalence is defined as the number of individuals who are living with or after a cancer diagnosis at a specific point in time.
[15] National Cancer Registration and Analysis Service (NCRAS). (2022) *CancerData.* Available at: https://www.cancerdata.nhs.uk/.
[16] Incidence is defined as the total number of individuals who are diagnosed with cancer over a specific time period.
[17] Coverage refers to the percentage of people *eligible* for screening at a particular point in time who have had a test with a recorded result at least once within the screening round. Uptake is the percentage of those *invited* for screening in the year who were screened adequately within six months of invitation.
[18] Office for Health Improvement and Disparities (OHID). (2023) *Fingertips, Public Health Data.* Available at: https://fingertips.phe.org.uk/.
[19] Clinical Effectiveness Group (CEG). (2023) *Cancer Screening Programmes Dashboard: North East London.*

- Breast screening coverage is significantly lower than average among eligible residents in City and Hackney with learning disability, serious mental illness and those experiencing homelessness.
- As of March 2021, breast screening uptake was *higher* among eligible black and south Asian residents of City and Hackney compared to white residents.

Action is needed to improve early diagnosis of breast cancer in some groups.

- People living in the most deprived areas of England are less likely to be diagnosed at an early stage than those living in the least deprived areas.[20]
- Breast cancer in younger people is more likely to be diagnosed at advanced stages, tends to be more aggressive and is therefore harder to treat. Consequently, survival rates are lower in people aged 15 to 39 compared to those aged 40-69.[21]
- A local study (previously referenced) identified that black women presented with breast cancer much earlier than white women (median age 46 and 67 years, respectively); tumours in younger women were considerably more aggressive in the black population; and, among women with smaller tumours, mortality rates were much higher.[22]
- Local insight suggests that some global majority communities are more likely to hesitate to consult their GP for possible cancer symptoms due to a range of factors including:
    - embarrassment using translators (who are often family members)
    - seeing cancer as a 'white person's disease' and not relating to promotional materials encouraging uptake of services
    - preferring holistic and homoeopathic approaches before seeking medical help
    - medical racism.

[20] Public Health England (PHE). (2019). *Early Cancer Diagnosis.*
[21] https://www.nice.org.uk/guidance/ng101/documents/health-inequalities-briefing
[22] Bowen, R. L., et al. (2008) *Early onset of breast cancer in a group of British black women.* British journal of cancer, 98(2), 277–281

world class expertise local care

NHS
Royal Free London
NHS Foundation Trust

Central & East London Breast Screening Service – Data Briefing, Health in Hackney Scrutiny Committee

Presented by:
Claire Mabena, Lead Breast Care Nurse
Mansi Tara, Health Promotion Lead
Royal Free London NHS Foundation Trust

NB: Presented data at service level, service does not report at borough level

Introduction

- The Royal Free breast screening service consists of two clinical services – The Central and East London Breast Screening Service (CELBSS), The North London Breast Screening Service (NLBSS) and the London Administration Hub

- For the purposes of this presentation and discussion around the population of Hackney, this lies within CELBSS. CELBSS currently serves an estimated total eligible population of 170,000 women aged 50-70 and covers 6 London boroughs including Camden, Islington, Newham, Tower Hamlets, City & Hackney and Waltham Forest, delivered through 3 static screening sites and 1 demountable static site. Second stage screening assessment clinics are delivered from the St. Barts site (lease held with RFL)

Key (Breast Screening Services)
- Grey – North London (RFL)
- Pink – Central & East London (RFL)
- Blue – West of London (Imperial)
- Purple – South West London (St. Georges)
- Orange – South East London (Kings)
- Green – Outer North East London (InHealth)

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Impact of COVID – 19 & London Recovery

- As a result of the COVID-19 pandemic all routine breast screening in London was paused from 23 March 2020 except for High Risk women. NHS England approved the recommencement of screening in July 2020 and all London services entered a recovery programme. There was a national requirement for all screening services to recover by June 2022

- The London backlog peaked in August 2020 at around 160,000 clients and London services are now concluding their recovery programmes

- CELBSS/ NLBSS (RFL services) were some of the first in London to conclude their COVID recovery plans and have recovered round length (the interval between screening appointments, target 36 months) and other core KPI's

- Post recovery, services are now working through 'invitation smoothing plans'. To ensure service recovery post COVID, screening activity increased in 2022/ 23 above 'normal' levels of screening. To ensure that this spike in activity isn't felt in future years, a smoothing plan for activity has been required by NHSE for all London services. This is in place and on plan for CELBSS and NLBSS

CELBSS Performance and Activity Data

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	2022-2023
% Uptake (50-70)	23.0%	58.2%	39.2%	41.2%	43.4%	46.8%	50.1%	41.4%	49.1%	51.6%	51.3%	51.7%	45.0%

	2022-2023	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	2023-2024
Roundlength within 36 months (50-70)	77.5%	61.9%	91.9%	99.2%	99.0%	99.3%	99.1%	96.6%
% Uptake (50-70)	40.6%	51.3%	N/A	N/A	N/A	N/A	N/A	51.3%
Screen to Normal	98.5%	97.6%	99.0%	98.1%	97.7%	94.4%	96.7%	97.3%
Screen to DOFOA	98.2%	62.8%	100.0%	82.0%	44.8%	15.8%	25.2%	59.7%
Screen to assessment	78.3%	45.1%	87.2%	66.5%	34.4%	14.4%	21.8%	48.4%
Total Technical Recall	2.6%	3.6%	3.0%	3.3%	2.6%	3.2%	3.3%	3.2%
No. Invited 50-70	67768	4128	4602	5305	5304	4500	4408	28247
No. Screened	35856	2484	3284	3303	3251	2608	3122	18052
No. Assessed	1426	143	177	193	117	129	118	877

CELBSS/ NLBSS Recovery – Uptake Recovery Agreed with NHSE

KPI	Target
Uptake of Breast Screening Invitation	**>70%**

NB – Uptake on previous slide includes 2022/23 figures, alongside April 2023/24 performance.

Uptake performance takes 6 months to finalise, therefore the most current uptake is April 2023.

Improvement of Uptake – CELBSS

Currently achieving >50% uptake. Pre-COVID uptake 50-55% annually.

3 month trajectory – Q1/ Q2 2023/24 – achieved
- Aim to maintain current service delivery during transition to timed appointments & recruitment of Health promotion team (achieved)

6 month trajectory – Q3/ Q4 - achieved
- Uptake takes 6 months to secure and stabilise. Sites show gradual increases in uptake >40% CELBSS

12 month trajectory – 2024/ 25 onwards
- Exceed 55% uptake CELBSS

- Services have built a health promotion team to work across NLBSS and CELBSS (Bands 3, 5 & 7 - 18-24 month fixed term posts with NHSE/ Alliance funding).
- Internal nursing team supporting multiple projects, roadshows and community events to improve uptake.
- Early focus on clients with learning disabilities and reaching areas of the population most significantly impacted by .

CELBSS/ NLBSS Service Capacity Increases

- Service expanded weekend and evening work.
- CELBSS achieving pre-COVID levels of activity and planning to increase on this through 2023/24.
- Adapted booking templates to incorporate a move back to a pre-COVID model including a 44 screening target per daily clinic.
- New booking algorithm (probability based booking) in place across the national screening programme.
- A computer algorithm determines client attendance probability based on the COVID period, post COVID, it allowed the system to effectively overbook clinics (due to the application of low attendance expectations to all clients).
- This updated algorithm has reduced the probability of attendance for specific screening clients and as a result created more appropriate and manageable clinics.

Cancers Diagnosed	Total
2019-20	349
2020-21	124
2021-22	286
2022-23	Not yet available

CELBSS Data & Activity Exception Reporting

KPI Key	Target	KPI	Target	KPI	
Round Length (invited every 36 months)	>90%	Uptake of Breast Screening Invitation	>70%	Technical Recall (repeat examinations)	<2%
Screen to Normal (Routine Recall results issues within 2 weeks of screen)	>95%	DOFOA (Assessment appointment offered within 21 days of screen)	>95%		

- Service working through COVID Recovery following Pan London pause to screening in 2020
- Round Length – 96.6% and target currently achieved by the service (one of the national expectations post COVID recovery)
- Screen to Normal – 97.3% and target currently achieved by the service
- Screen to Assessment – 48.4% and under target. Impact on this target is a reduction in assessment capacity through 2023/24. Doctors strikes have significantly impacted service delivery, assessment capacity reduced by Barts Health (estate lease owners) during COVID and service in the process of re-gaining required capacity
- Technical Recall – 3.2% and under target. Increased number of trainee mammographers working within CELBSS
- Screening Activity – Currently achieving pre COVID levels of activity
- Assessment Activity - Currently achieving pre COVID levels of activity

Breast Screening within the Hackney Population

- Through 2023/ 24 a major service focus is reducing health inequalities which increased during COVID for all of London's breast screening services
- Screening uptake fell across the national programme and within London during COVID, which is also a key focus going forward
- As a service we have expanded our team to focus specifically on health promotion initiatives and have appointed into three new posts. These include a band 3, 5 and 7, as part of a nurse led team
- We continue to engage with many stakeholders within the Hackney population including cancer alliances, GPs and community teams
- Uptake fell by up to 15% during COVID and improvement trajectories have been agreed with NHSE London commissioners. CELBSS is on track to achieve these trajectories (>40% Q2, >55-60% Q3/4 onwards (target 70%))
- Overall KPI's aside from those linked to uptake continue to perform well, above target and this applies to the Hackney population.
- Screening clinic booking templates have been adapted to incorporate a move back to a pre-COVID model including a 44 client screening target per daily clinics
- A new booking algorithm (probability based booking) is in place across the national screening programme with the aim of increasing clinic utilisation
- All women invited are sent a text reminder 1 week and 48 hours before their appointment to remind them to attend. They can call and change the time, location and date of their appointment if not convenient (weekend appointments available). They are given an appointment to a screening site closest to their home address.
- The service offers high risk screening for eligible women, this could mean more frequent screenings for eligible women or screening below the age of 50

Health Promotion within the Hackney Population

- **PWLD project:** To reduce health inequality and improve access to screening the health promotion team has been working closely with the Learning Disability (LD) team in Hackney since March 2023 to improve screening uptake among People With Learning Disabilities (PWLD). We have held 2 targeted session for this population with the LD team, booked 20% of eligible women and screened 80% of the women booked - all screened normal. We have reasonable adjustments in place for PWLD some of which include access to easy read materials, longer appointments, carer support at the appointment and pre-visits.
- **Newsletter:** During breast cancer awareness month in October 2023, we have partnered with the communications team in the Hackney council to send out an article in the Hackney council newsletter - "Love Hackney" which reaches over 120,000 residents, highlighting our work with PWLD and encouraging women to be breast aware and attend screening
- **Community champions:** We have developed links with public health strategists in the council and Volunteer Centre Hackney (VCH) to deliver community champions training for increasing awareness of breast cancer and screening within the borough population
- **Partnership**: The health promotion team is working closely with the Leanne Pero Foundation to deliver training to ambassadors working with the black community on breast awareness and screening and we are going to engage with their social media followers via Instagram
- **GP engagement:** We have engaged with the cancer alliance GP lead to make introductions to primary care. We plan to speak at the GP forum for Hackney. We update GPs on changes to screening programme, request them to encourage women from their practice who have missed their appointment to attend and offer any health promotion support they might need in terms of reports on uptake, events at their practice or resources for health promotion
- **Language project:** We have iPads in place at all our screening sites with google translate installed to reduce language barriers faced at screening. This is in addition to official translation agencies we engage with to communicate with clients when English is not their primary language.

North East London Cancer Alliance

NEL Cancer Alliance briefing to Health in Hackney Scrutiny Commission

15 November 2023.

Caroline Cook – Early Diagnosis Programme Lead, NEL Cancer Alliance
Femi Odewale – Managing Director, NEL Cancer Alliance

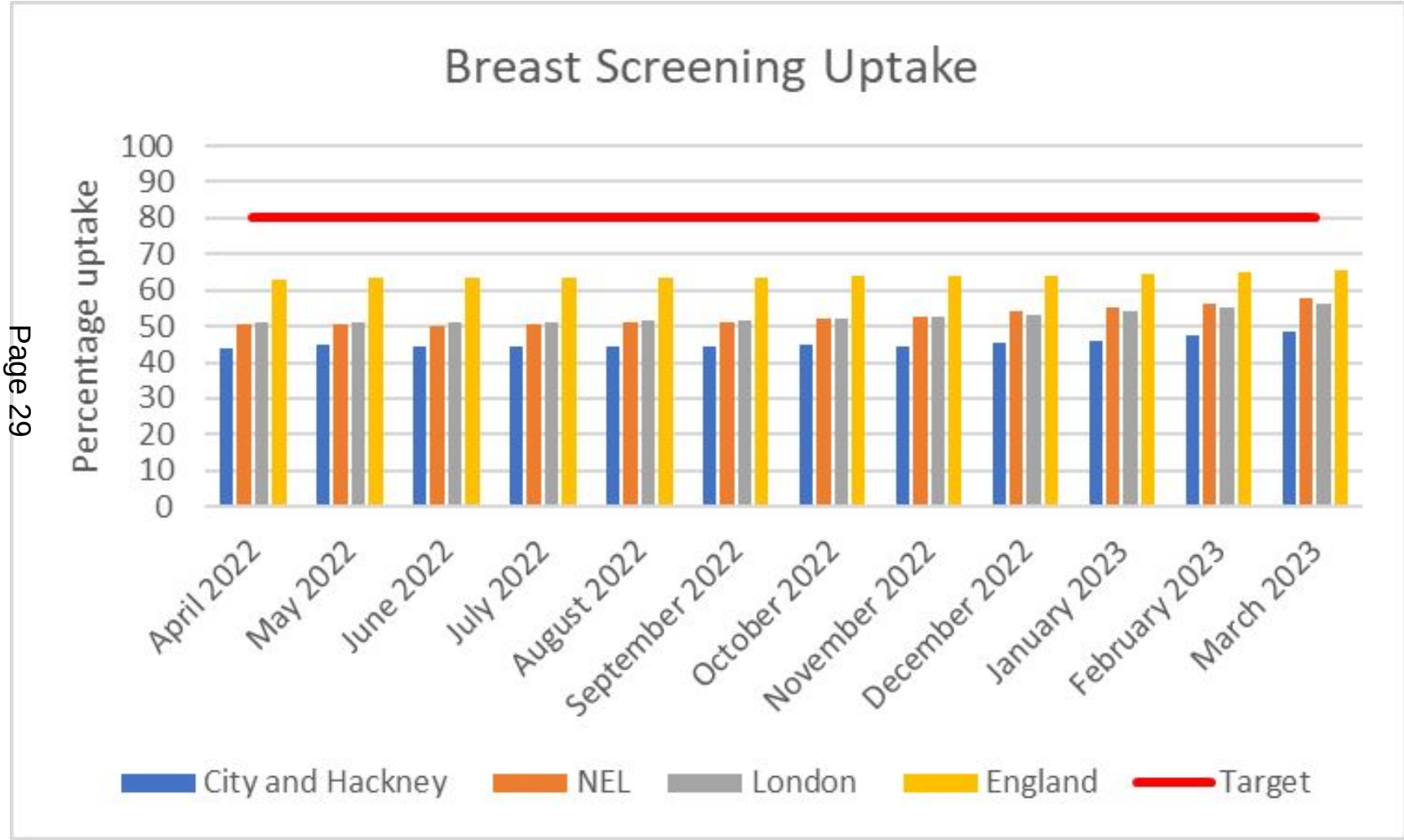
Role Cancer Alliances in Breast Cancer Screening

North East London Cancer Alliance

- The NEL Cancer Alliance does not have a commissioning role – breast cancer screening is commissioned by NHSE.
- The role of the NEL Cancer Alliance in screening is:
  - To increase participation in cancer screening to support the aim to diagnose 75% of cancers by stage 1 or 2 by 2028.
  - Bring together stakeholders across the ICS to improve screening rates in order to increase earlier diagnosis.
  - Increase awareness of cancer screening services, with a focus on populations with low participation rates.
  - Reduce inequalities of access to screening services.
- Fund improvement projects, but do not provide on-going funding for business as usual.
- Additionally:
  - PCN Directed Enhanced Service (DES) also requires PCNs to improve one type of cancer screening in a hard to reach group.
  - Voluntary and community organisations have historically raised awareness of cancer screening through outreach work – usually commissioned by CCGs.

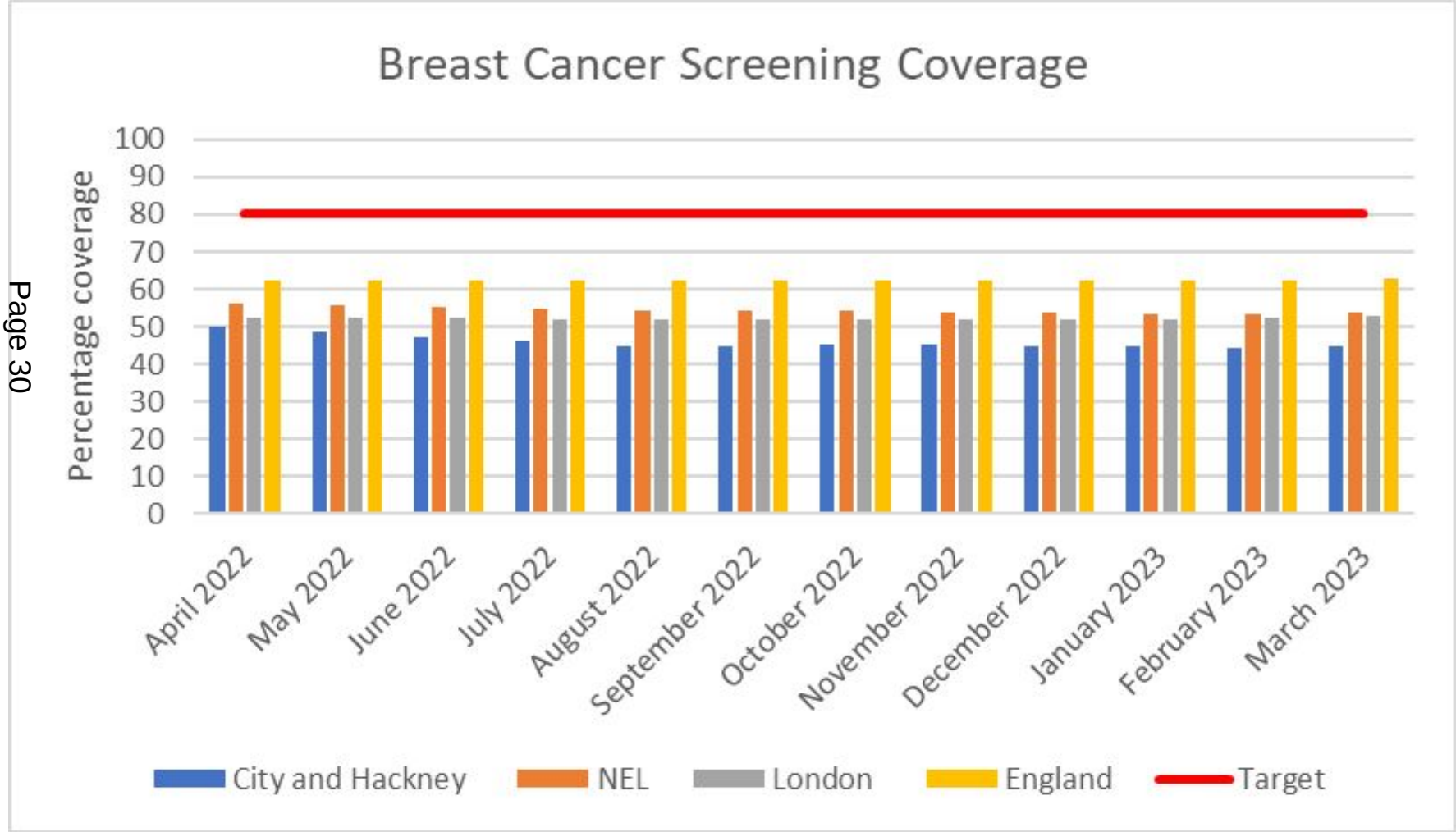
Breast Cancer Screening Uptake

North East London Cancer Alliance



Data source: Open Exeter, NHS Futures

Breast Cancer Screening Coverage



Data source: Open Exeter, NHS Futures

Breast Cancer Screening Coverage – practice level

NHS North East London Cancer Alliance

Top 5 performing practices by coverage

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
THE STATHAM GROVE SURGERY	53.05	53.99	54.44	54.94	54.46	54.50	53.81	53.59	53.36	53.40	53.23	53.95
LOWER CLAPTON GROUP PRACTICE	56.41	56.07	55.92	56.13	56.00	55.41	56.25	56.66	56.60	51.55	50.52	52.28
THE ELM PRACTICE	55.73	55.32	54.83	55.18	54.92	55.06	54.15	54.03	54.15	55.30	48.44	52.20
BARTON HOUSE GROUP PRACTICE	49.09	49.26	49.32	49.29	49.39	49.59	49.62	49.39	49.24	49.49	49.33	51.12
QUEENSBRIDGE GROUP PRACTICE	52.06	50.93	50.19	50.15	50.34	50.58	51.36	51.60	51.50	51.54	51.21	51.01

Bottom 5 performing practices by coverage

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
THE HOXTON SURGERY	49.81	50.28	50.55	41.04	35.35	36.65	38.23	39.61	40.17	40.86	40.72	39.63
THE SPRINGFIELD HEALTH CENTRE	38.25	38.26	38.20	38.11	37.77	37.83	37.72	37.63	37.80	37.60	37.66	38.44
THE SURGERY (CRANWICH ROAD)	37.31	35.67	35.87	35.76	35.15	34.95	35.26	35.78	35.58	36.31	36.31	37.54
THE ALLERTON ROAD SURGERY	43.40	42.27	42.32	41.79	42.05	41.31	42.00	41.26	32.00	30.77	29.89	30.35
THE GREENHOUSE WALK-IN	19.78	19.57	19.15	18.95	18.95	18.95	18.28	17.39	17.39	17.58	16.67	17.98

Breast Cancer Screening Uptake – practice level

North East London Cancer Alliance

Top 5 performing practices by uptake

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
THE LEA SURGERY	47.15	50.42	50.00	50.00	50.00	50.83	49.49	50.57	53.73	55.56	61.11	60.50
THE ELM PRACTICE	31.82	29.17	26.92	28.57	23.08	30.00	35.00	34.78	40.00	57.50	62.20	58.67
LOWER CLAPTON GROUP PRACTICE	46.26	46.54	45.81	46.56	45.49	44.84	53.15	57.25	60.68	60.00	58.38	58.18
THE STATHAM GROVE SURGERY	53.49	53.96	54.50	54.89	56.50	54.71	54.64	52.31	53.24	49.48	52.11	57.58
BARTON HOUSE GROUP PRACTICE	49.40	49.86	49.56	49.25	52.07	51.40	46.95	47.33	47.98	59.42	52.99	55.70

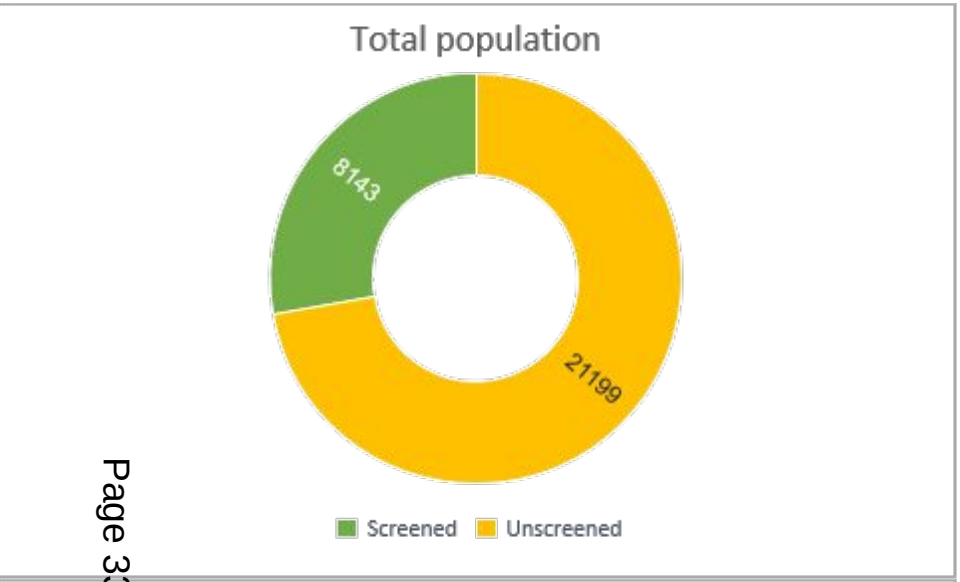
Bottom 5 performing practices by uptake

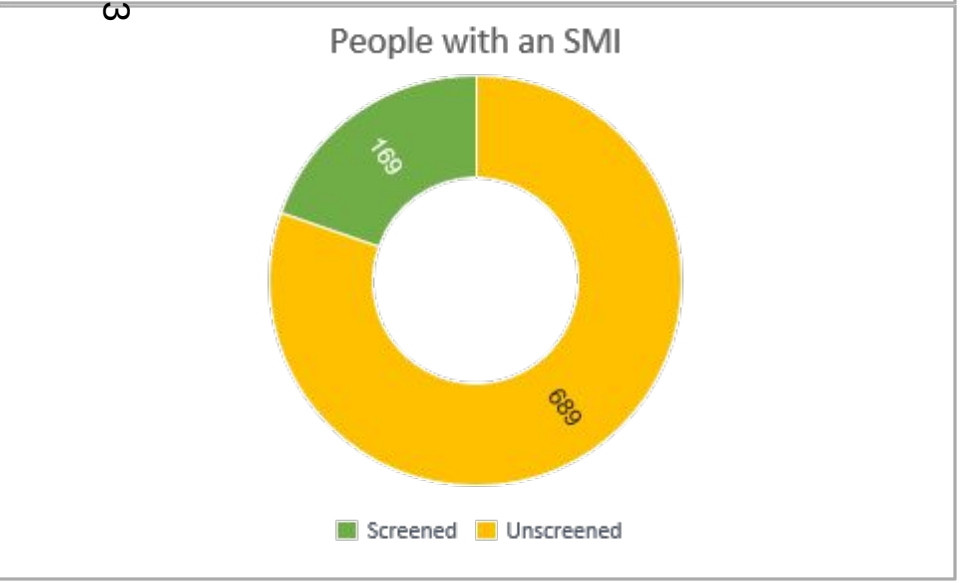
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
THE SPRINGFIELD HEALTH CENTRE	39.31	39.76	38.64	37.26	34.64	30.51	30.61	29.44	30.67	32.85	31.94	33.33
THE SURGERY (CRANWICH ROAD)	33.55	33.99	33.33	32.88	32.87	37.34	37.89	35.87	38.98	35.14	31.82	33.33
TROWBRIDGE PRACTICE (Y00403)	45.00	44.94	45.22	44.25	47.64	41.18	36.84	37.04	43.90	30.77	30.77	32.00
HEALY MEDICAL CENTRE	41.74	42.34	42.57	42.21	41.95	41.63	41.52	42.18	43.66	42.21	33.33	25.00
THE GREENHOUSE WALK-IN	14.08	14.49	10.94	11.67	12.90	10.53	10.00	10.34	5.00	5.56	10.00	13.64

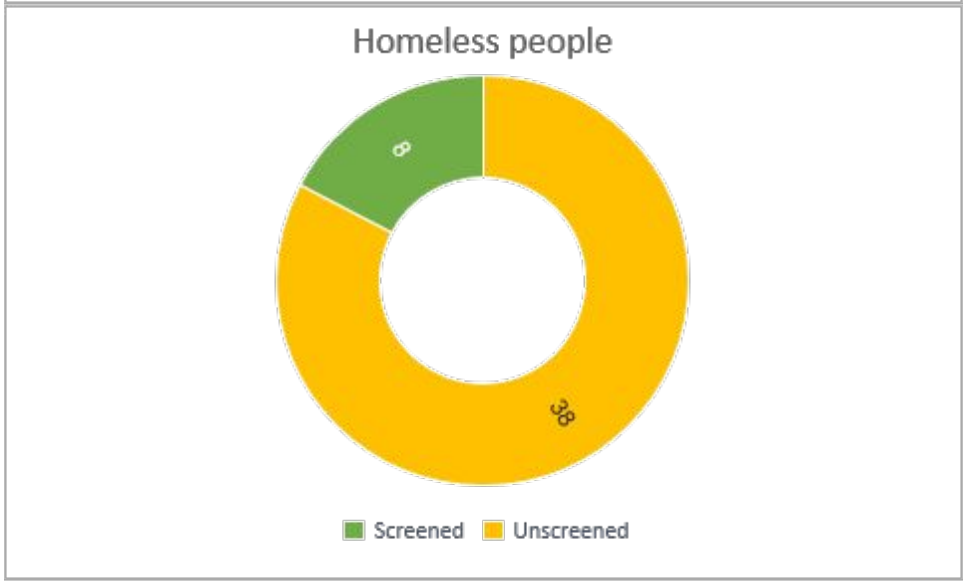
Data source: Open Exeter, NHS Futures

Breast Cancer Screening Coverage
(Snapshot at 1st October 2023)

North East London Cancer Alliance



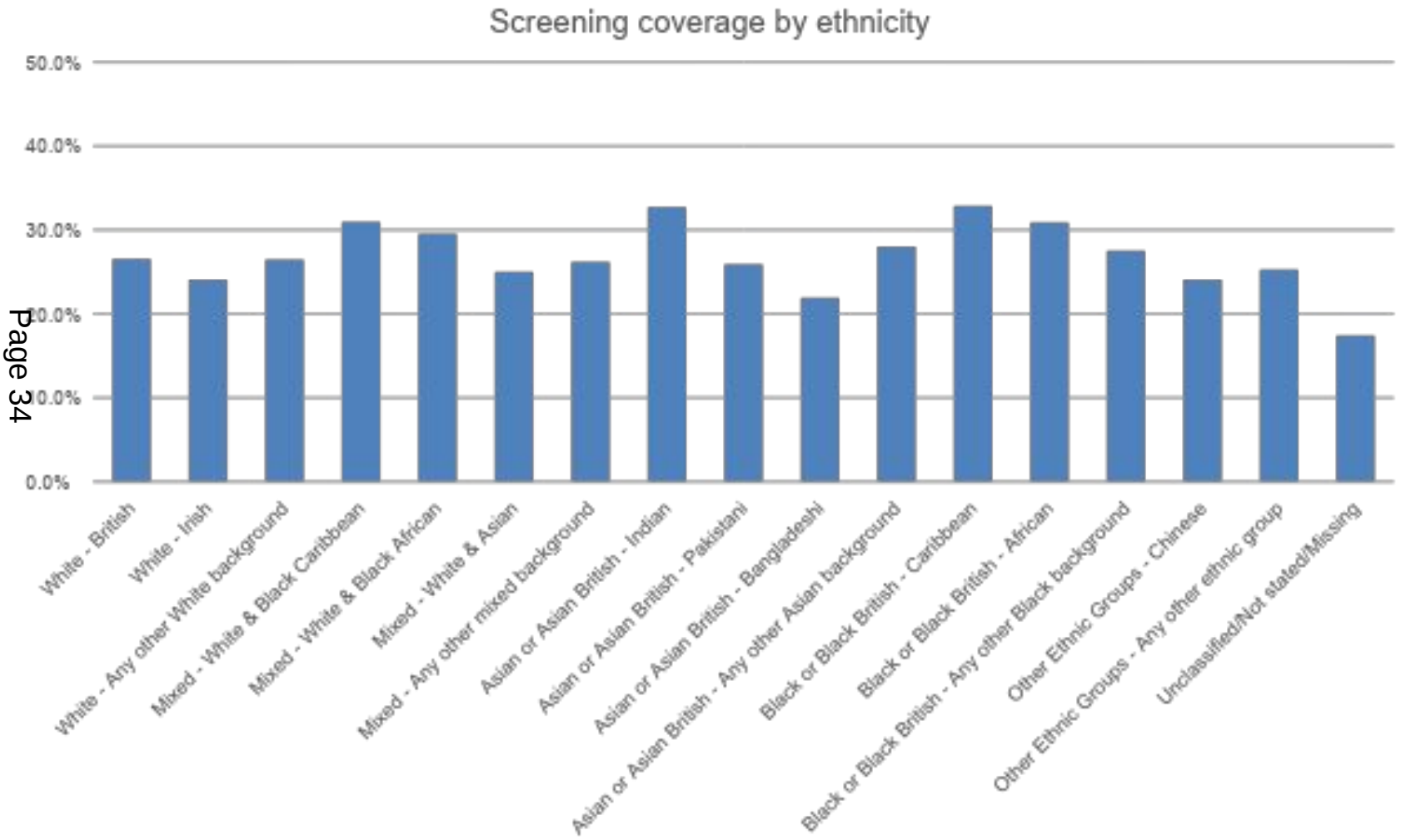




Data source: CEG Dashboards, QMUL. **N.B. Data from EMIS systems, subject to coding discrepancies**

Breast Cancer Screening Coverage
(Snapshot at 1st September 2023)

North East London Cancer Alliance



Data source: CEG Dashboards, QMUL. **N.B. Data from EMIS systems, subject to coding discrepancies**

Challenges to improvement

North East London Cancer Alliance

For intervention development

- Access to timely, accurate uptake and coverage data.
- Lack of data by protected characteristics.

Barriers to participation (from focus groups, co-production workshops and on-street surveys).

- Lack of trust in the health service/government – historic and intergenerational
- Cultural attitudes:
  - Fatalism – 'nothing I can do'
  - 'I'd rather not know'
  - Embarrassment
  - 'I feel well, so don't need screening'
- Language barriers– understanding the invitation and/or at appointments.
- Lack of prior knowledge or understanding of screening services.
- Fearful the test might be painful.
- Bad past experience.
- Fear of discrimination – e.g. for trans people
- Structural barriers
  - Accessibility of screening locations–distance, transport.
  - Costs of travel.

Increasing breast screening uptake in NEL (1)

No Time for Cancer

- Out of home and paid social media campaign to increase awareness of screening and signs and symptoms of breast cancer.
- Focus on harder to reach groups – in more deprived areas and also Black African and Caribbean, South Asian and Bangladeshi population.
- Last campaign was in May 2023
  - Impressions: 375,979
  - Reach: 88,192
  - Clicks: 2,023
  - CPC: £0.47 (industry average £0.83)
- Run again in October for Breast Cancer Awareness Month, with stock video assets.

Increasing breast screening uptake in NEL (2)

Best for my Chest

- Out of home, paid and organic social media campaign targeting the LGBTIQ+ community,
- Collaboration with OUTpatients (formerly Live Through This).
- Co-produced with members of the LGBTIQ+ community in NEL.
- Addressed some of the barriers faced.
- Faces of the campaign are from the community.
- Coupled with training for service providers across London – to reduce unconscious bias.
- Continually run through OUTpatients.
- Additional push in Breast Cancer Awareness month.
    - New video created to link with Black History Month.

Increasing breast screening uptake in NEL

North East London Cancer Alliance

Awareness in the Charedi Jewish population

- Awareness project delivered by Achienu Cancer Support (ACS).
- Breast screening and breast cancer are areas of focus – will be holding a women's health session to include this.
- Will also include discussion about genetic risk.
- Have produced information in Hebrew and Yiddish.
- Placed awareness advertisements in 3 Jewish publications.

In development

- Currently working with a marketing agency to develop interventions for the White 'Other' population, specifically Polish, Lithuanian and Turkish/Turkish Cypriot populations.
- Scoping/research completed and focus groups held with Polish and Lithuanian communities.
- Will continue to work with these groups to co-produce interventions, focussing on increasing uptake of all screening services.
- Starting to look at areas of focus for 2024/25.

DRAFT – FOR DISCUSSION

East London Health & Care Partnership

East London Health and Care Partnership (ELHCP) Cancer Board/City and Hackney ACS

City and Hackney Cancer collaborative

TERMS OF REFERENCE

Context

The NHS planning guidance for 2016/17 to 2020/21 set the expectation that health systems produce a five year, place-based Sustainability and Transformation Plan (STP) to drive the implementation of the Five Year Forward View.

One of the strands of the STP is Cancer. An STP-wide Cancer Board, called the East London Health and Care Partnership Cancer Board, has been established and a Delivery Plan has been submitted to NHS England. The plan identifies the key issues and work streams:

- Sustainable delivery of constitutional standards
- Prevention
- Earlier Diagnosis
- Improving Cancer Treatment
- Living with and beyond cancer/cancer as a long term condition
- Joint STP/UCLH Cancer Vanguard projects

The Cancer Board will align its plans with the National Cancer Task Force Strategy and the Model of Care for Cancer London 2010. They will set the ambitions across the STP and these will be delivered by the three 'delivery systems' across north-east London, namely:

- The City and Hackney Accountable Care system
- The Barking, Havering and Redbridge Cancer Collaborative
- The Inner East London Cancer Collaborative

These terms of reference relate to the City and Hackney cancer collaborative which is also part of the planned care work stream within the C&H ACS

Across North East London (NEL), a number of transformation programmes and structures exist that pre-dated STPs and for C&H there is the C&H cancer board. This group will replace that.

Purpose

The C&H Cancer Collaborative will coordinate local resources and efforts across partner organisations to

- achieve earlier diagnosis of stage I and II cancers
- improve one-year survival rates
- achieve equitable access to high quality treatment and care during and after treatment
- improve patient experience
- reduce the incidence of cancer in the population through effective prevention linking with local and ELHCP prevention programmes
- fully implement all elements of the Recovery Package
- develop and implement stratified follow-up pathways for people with breast, prostate and colorectal cancer

Scope

- The C&H Cancer Collaborative will make and implement plans to deliver the ambition set by the STP-wide Cancer Board, with specific reference to improvements required across City and Hackney to meet this ambition for the local population and in line with the requirements of the ACS transformation board.
- The Collaborative will draw upon the resources of partner organisations within ELHCP, the UCLH Cancer Collaborative, pan-London Transforming Cancer Services Team and link with cancer charities and existing local programmes to establish a number of theme specific work programmes, some of which may be time limited.
- The work programmes will also be informed by data and outputs from a range of national and local sources including national audits, Quality Surveillance, National Cancer Patient Experience Survey, patient focus groups, GP referral rates and other sources of information

- The Collaborative will report progress on a regular basis to the STP-level Cancer Board and the C&H ACS transformation board and highlight any issues that require NEL level support to unblock.

Issues that are out of scope include:

Contractual and performance management issues - oversight of Cancer Waiting Times at an NEL level will be the remit of the separate NEL-wide 62 day System Leadership Forum (SLF).

See overarching ELHCP cancer governance in Appendix 2.

Roles and responsibilities of the C&H Cancer Collaborative(C&HCC)

The C&HCC will form part of the sub-structure of the planned care work stream within the C&H ACS. In addition member organisations of the ELHCP have committed to fully support and engage with STP programmes through the STP level Memorandum of Understanding. They are therefore jointly responsible and accountable for implementing the STP Cancer Plan at a local level.

The C&HCC will therefore have the responsibility to produce a single work programme for cancer to align with the priorities of the ACS and the ELHCP.

Membership

The following are core members of the IEL Cancer Collaborative

- ELHCP Cancer Lead
- A senior clinician from HUH
- A senior level manager from HUH
- A senior level manager from
    - City and Hackney CCG

Planned care work stream representative

- A Director of Public Health
- A primary care cancer lead or Macmillan GP

Members need to be in a senior position within their organisation with delegated authority to act on their organisation's behalf.

Partnership

For our local cancer programme to be effective, wider partnerships will be built on through the sub-group structure. These stakeholders include:

- UCLH Cancer Collaborative/London Cancer
- Bart's Health

- Macmillan
- CRUK
- Transforming Cancer Services Team for London
- NEL Commissioning Support Unit – Cancer Commissioning Manager
- Health Watch/Patient groups

Meeting arrangements

The C&H cancer Collaborative shall meet every xx months in advance of the ELHCP Cancer Board and planned care board.The frequency of meetings of the theme specific work programmes will be defined by the group lead/chair

Chair: TBC (drawn from one of the ELHCP organisations (and to act as SRO for the local C&H system with responsibility to report back to ELHCP Cancer and planned care boards).
Agendas and papers will be produced by xxx and be available to each member of the Collaborative in advance and preferably at least 5 working days prior to the meeting.
Minutes taken of meetings to include agreements and actions, and a record kept of those present.
Minutes of meetings shall be made available electronically to all members within 5 working days and will also be presented and agreed at the next meeting.

Theme Specific Work Programmes/Task and Finish groups:

Projects and pieces of work will be allocated to sub-groups and task-and-finish groups attended by subject matter experts. These groups will report to the C&H CC to enable it to report progress on delivery to the ELHCP Cancer Board and ACS planned care work stream.
Each group will be led by a core member of the collaborative with the responsibility to report back to the IEL CC chair.

Quorum

The quorum necessary for the transaction of business shall be 50% of the core membership plus the chair (or named deputy chair in their absence)

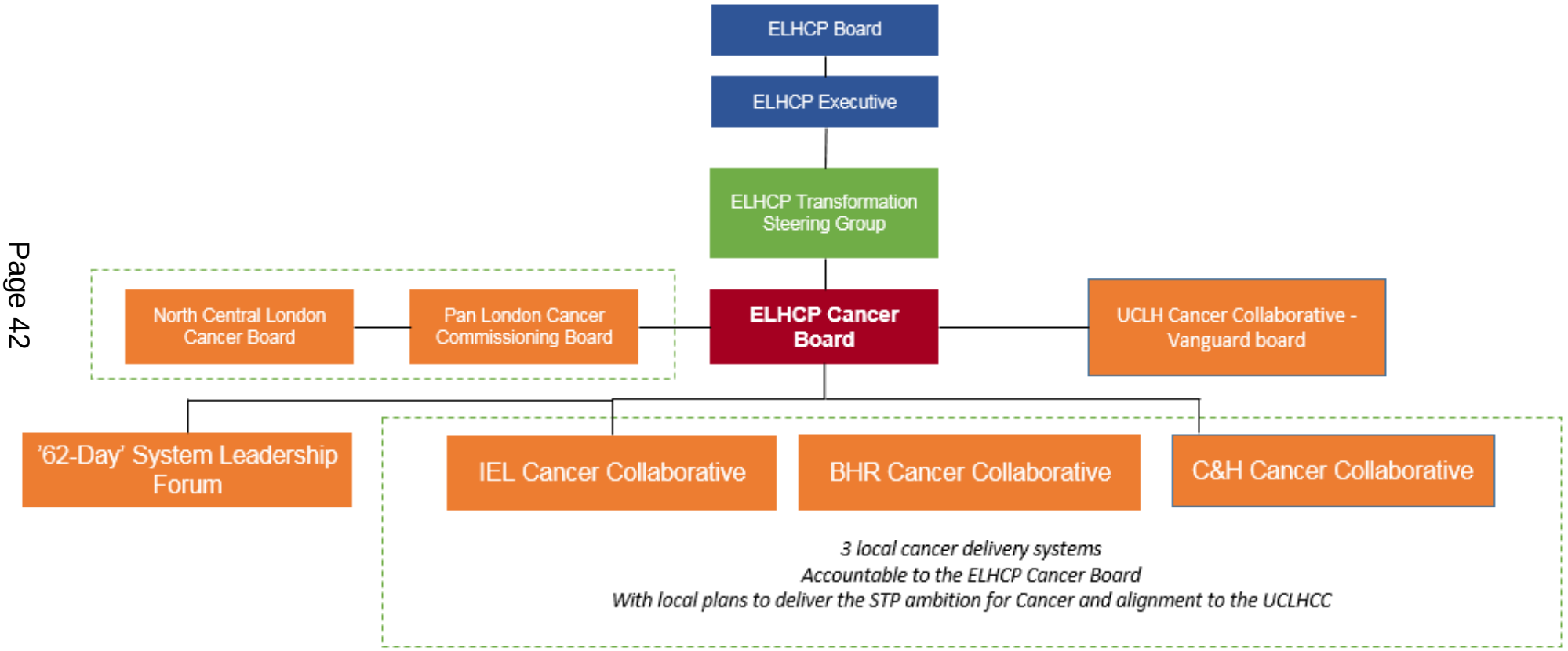
Review

The effectiveness of the collaborative, structure/sub-structures and these Terms of Reference will be reviewed on a six monthly basis

DRAFT – FOR DISCUSSION

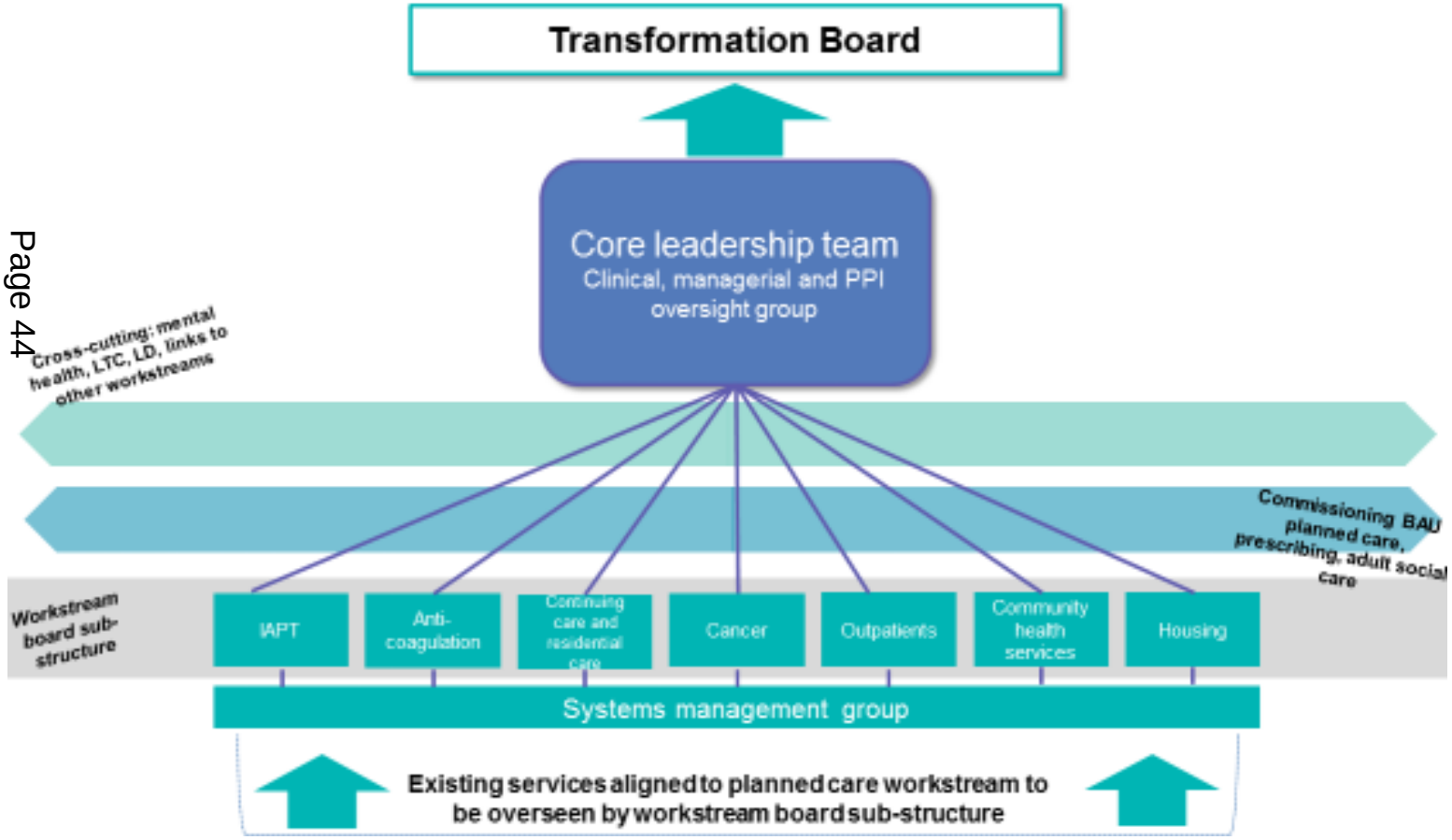
East London Health & Care Partnership

Appendix 1: ELHCP Cancer Governance Structure



Appendix 2: City and Hackney Accountable care system- Planned Care Work stream outline governance

Planned care workstream proposed outline governance



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Locality	SubLocality	Eligible for Breast Cancer Screening (Exclude mastectomy)	Breast Cancer(3y) Done	Breast Cancer(3y) % Done	Breast Cancer(3y) not done
City & Hackney	Clissold Park (NW2)	3,483	765	22.00%	2,718
City & Hackney	Hackney Downs (NE2)	3,725	1,225	32.90%	2,500
City & Hackney	Hackney Marshes (SE1)	4,335	1,946	44.90%	2,389
City & Hackney	London Fields (SW1)	4,135	682	16.50%	3,453
City & Hackney	Shoreditch Park & City (SW2)	4,377	1,363	31.10%	3,014
City & Hackney	Springfield Park (NE1)	2,511	866	34.50%	1,645
City & Hackney	Well Street Common (SE2)	3,535	308	8.70%	3,227
City & Hackney	Woodberry Wetlands (NW1)	3,206	871	27.20%	2,335

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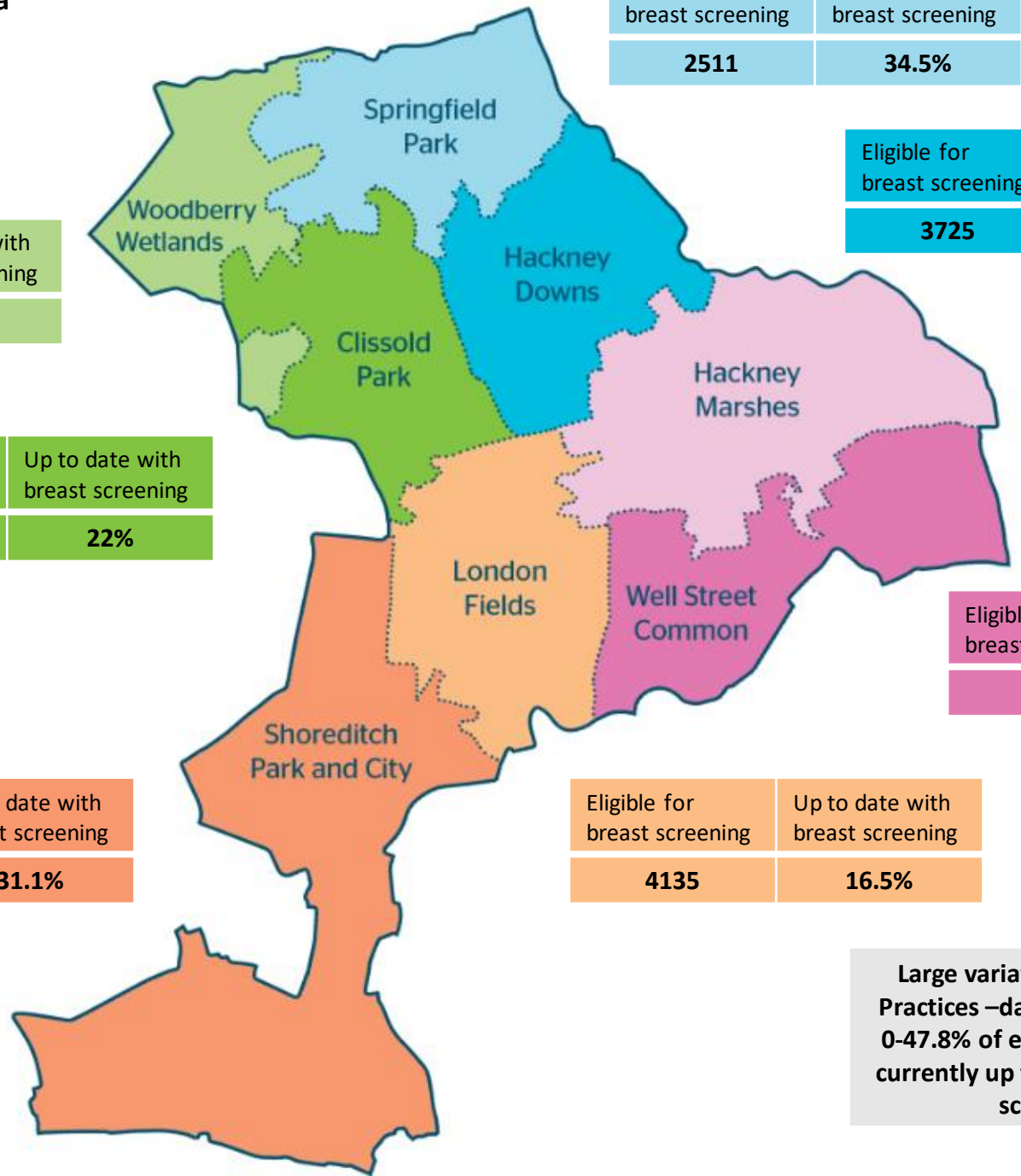
CEG Breast Screening data September 2023



Eligible for breast screening	Up to date with breast screening
2511	34.5%

Eligible for breast screening	Up to date with breast screening
3725	32.9%

Eligible for breast screening	Up to date with breast screening
3206	27.2%

Eligible for breast screening	Up to date with breast screening
4335	44.9%

Eligible for breast screening	Up to date with breast screening
3483	22%

Eligible for breast screening	Up to date with breast screening
3535	8.7%

Eligible for breast screening	Up to date with breast screening
4377	31.1%

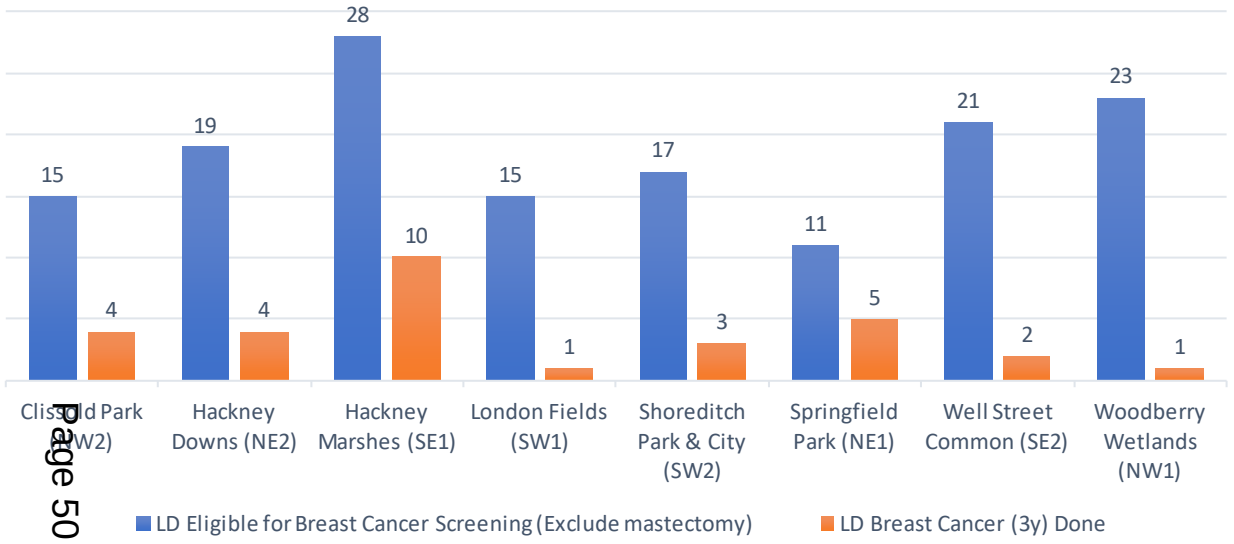
Eligible for breast screening	Up to date with breast screening
4135	16.5%

Large variation across 39 GP Practices –data shows between 0-47.8% of eligible patients are currently up to date with breast screening.

CELBSS	City & Hackney
Dec 2022	45.06%

CEG Sep 23 Eligible for breast screening	CEG Sep 23 Up to date with breast screening
29,307	27.4%

Patients registered with a Learning Disabilty

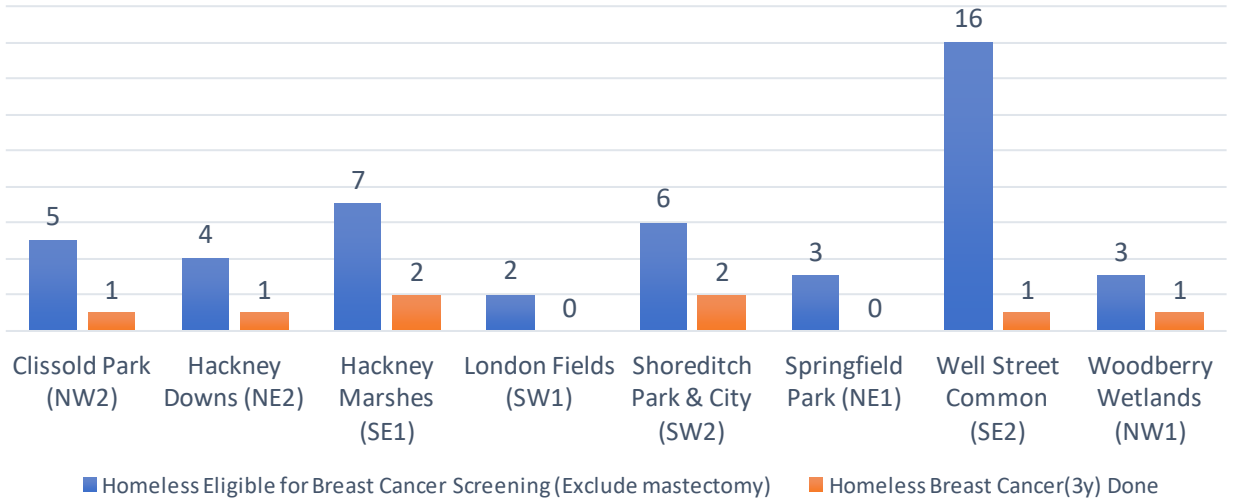


Currently CEG Data from QMUL can only be broken down further to identify patients registered with serious mental illness (SMI), learning disabilities (LD) and homeless across all three cancer screening programmes.

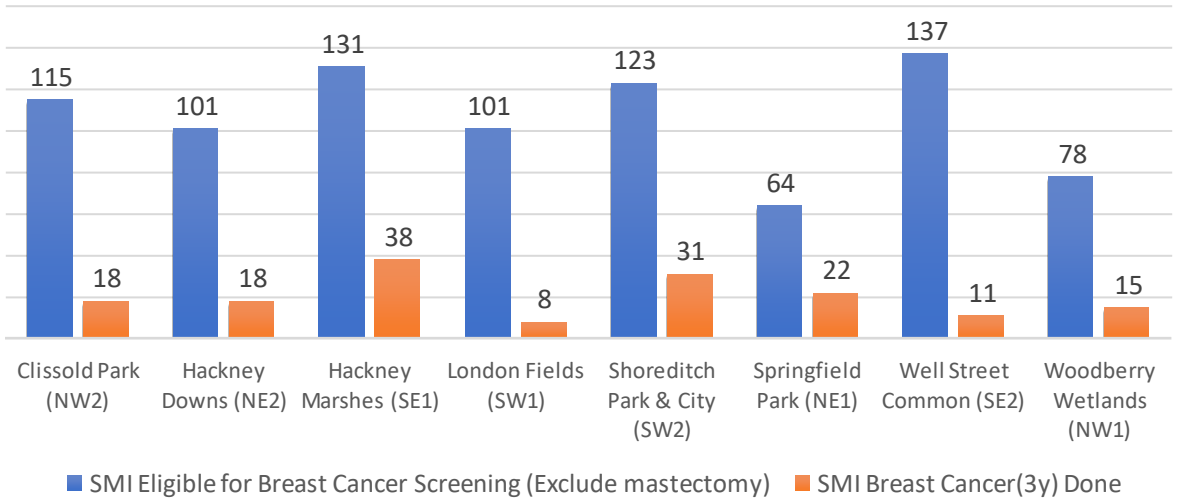
Access to detailed and up to date information is limited and so restricts focused interventions, including for early cancer diagnosis PCN DES work.

CEG are currently working on creating an ethnicity dashboard.

Patients registered as homeless



Patients registered with SMI



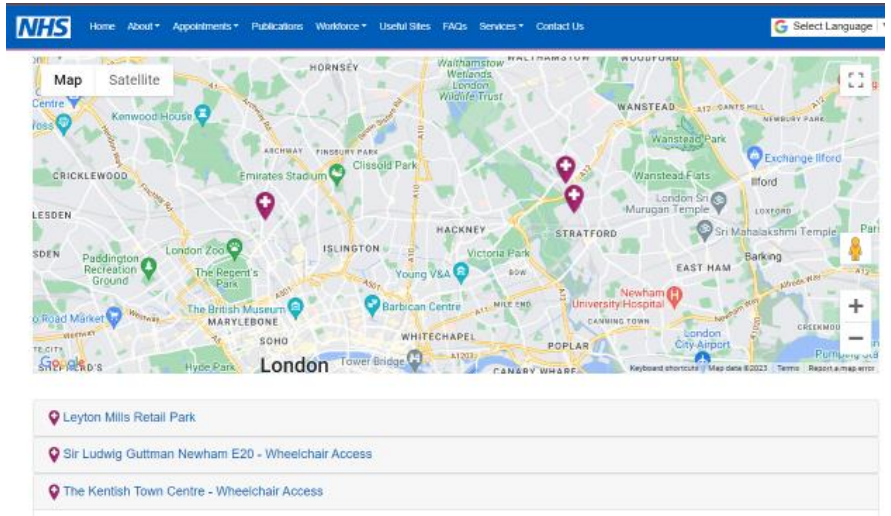
Breast screening in Primary Care

PCN Cancer Facilitator role – Community Links/NELCA - Currently working with practices/PCNs to find out how breast screening data is received and managed. Aiming to determine how this process can be improved to enable targeted and local interventions to increase screening uptake and early diagnosis of breast cancers.

North East London Cancer Alliance

<u>Current issues highlighted so far:</u>

- Reliance on postal results for breast screening appointment outcomes (attendance / did not attend / normal result)
- Results received then must be coded on to practice systems manually
- Lack of convenient local sites for residents to attend screening (shown in image below) some satellite locations also available but currently not listed
- GP practices trialing their own systems to find out if patients have been to screening recently to try a more targeted approach to recall
- Lack of capacity for results coding, call and recall
- Issues supporting to patients to rebook
- No standard processes across primary care
- No incentives for coding / attendance (unlike cervical screening)



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CoppaFeel!

HEALTH IN HACKNEY SCRUTINY COMMISSION

15th November 2023

OUR STORY

CoppaFeel! was founded in 2009 by Kris Hallenga and her twin sister Maren. Kris (on the right) was diagnosed with secondary breast cancer at the age of 23.

Kris visited three GPs with symptoms of breast cancer before she was finally referred and diagnosed with secondary breast cancer. Kris was unaware that breast cancer could affect people in their twenties and knew very little about the disease. It struck her that there was a lack of information out there for young people, educating them about breast cancer and how they could be looking after themselves.

Kris' incurable diagnosis could have been prevented had her cancer been detected earlier. She wanted people to learn from her story and become proactive about their own health.

The idea for CoppaFeel! was born, and our chest-checking mission began.

HEALTH INEQUITIES

- Breast cancer is the most common cancer in the UK
- Breast cancer is most commonly diagnosed in women over the age of 50 and is rarer in younger people
- **However, 2400 women under the age of 40, and 400 men are diagnosed with breast cancer each year.**

Our own research tells us that young people aren't being breast aware:

- Only 28% of young people aged 18-24 check their chest regularly (at least once per month)
- Over half of young people aged 18-24 say that ‘at my age I am not concerned about breast cancer.’

The health inequities Kris experienced still exist today.

- Young people are being diagnosed with breast cancer too late compared to their older counterparts.
- Black women are more likely to be diagnosed at stage 4, despite less incidence among this demographic.
- Pregnant women are more likely to be diagnosed at stage 4.

To ensure all breast cancers are diagnosed early it is crucial for people of all ages to know the signs and symptoms of breast cancer and practice breast awareness - which is the term used by the NHS.

This is particularly important for younger people at pre-screening ages.

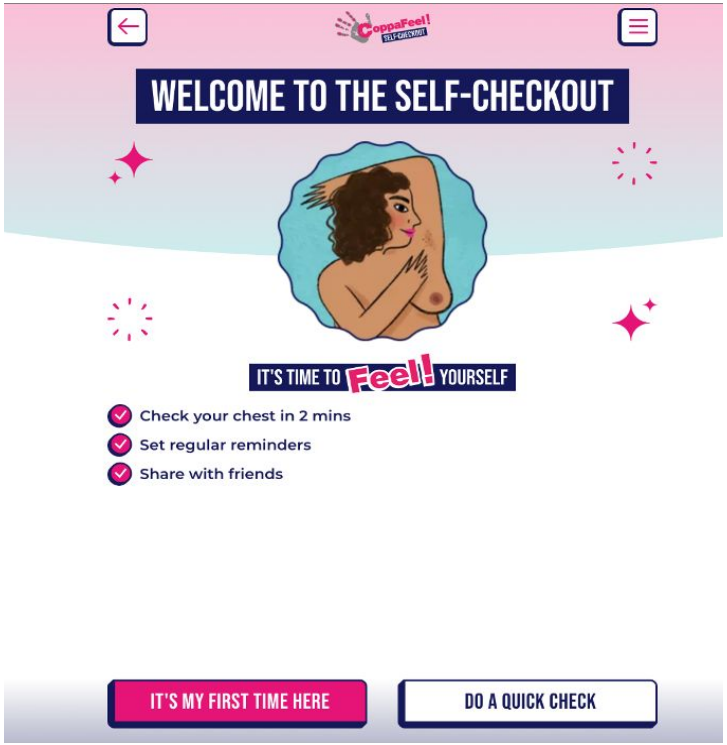
THE BREAST AWARENESS MESSAGE

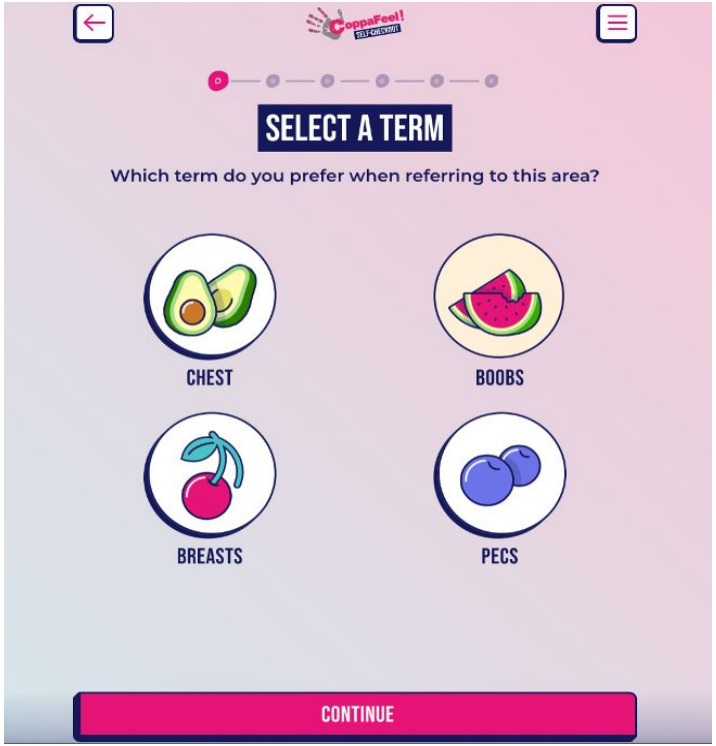
We educate young people on the signs and symptoms of breast cancer, and disseminate the following breast awareness messaging:

- Look at your chest AND feel your chest
- Check ALL breast tissue (this includes the areas under your armpits and up to your collarbones.)
- Check roughly once a month.
- Get to know YOUR normal

CoppaFeel!

TOOLS TO ENCOURAGE REGULAR CHECKING:





The CoppaFeel! Self Checkout web app

ANYONE OF ANY AGE OR GENDER CAN BE AFFECTED BY BREAST CANCER

SIGNS AND SYMPTOMS MAY INCLUDE:

LOOK
changes in skin texture
e.g. puckering/dimpling

FEEL
lumps and thickening

LOOK
nipple discharge

LOOK
nipple inversion and
changes in direction

LOOK
swelling in your armpit
or around collar bone

FEEL
constant, unusual pain in
your chest or armpit

LOOK
a sudden change in size
or shape

LOOK
a rash or crusting of the
nipple or surrounding area

CoppaFeel!

HOW WE RAISE AWARENESS OF BREAST CANCER:

Education

IN SCHOOLS

We take our message into schools to encourage healthy behaviours from a young age. From lesson plans to support modules, posters to school visits, we equip teachers and educators with the tools they need to talk about breast cancer awareness.

OUR WORK IN EDUCATION

Uni Boob Teams

AT UNIVERSITIES

With the help of our student ambassadors, our message reaches campuses and Students' Unions up and down the UK. Find out more about getting involved from your university by clicking below.

OUR WORK AT UNIVERSITIES

Ambassadors

WITH OUR BOOBETTES

Our Boobettes volunteer their time to share their personal experience with breast cancer with the nation. Using their story to inspire others to get to know their bodies, they visit workplaces, schools, youth groups and more. Find out more by clicking below.

OUR BOOBETTES

Healthcare Professionals

IN HEALTHCARE

We know healthcare professionals, particularly GPs and nurses, play an important role in diagnosing breast cancer early, which is why we are here to support them to promoting our message. From webinars to resources, click below to find out more about our work in healthcare.

HEALTHCARE PROFESSIONALS

[CoppaFeel! website page: What we do]

WHY IS THIS IMPORTANT IN HACKNEY?

- Hackney is a relatively young borough with 25% of its population under 20 and a further 23% aged between 20-29 years old.
- Black women are typically diagnosed with breast cancer at a much younger age than White women (48 versus 60). This is significant considering that national screening commences at 50, which is two years after the average age of breast cancer diagnosis among black women.
Members of the Ashkenazi Jewish community are more likely to be diagnosed with breast cancer at an earlier age due to the prevalence of the BRCA gene within their community.

- Breast cancer awareness is a national priority - By 2028: The target is 75% of cancers diagnosed at stage 1 or 2, 55,000 more people will survive more than 5 years after diagnosis.
- The Women's Health Strategy for England 2022 has specifically outlined in their 10 year ambitions the importance of women and girls knowing how to be breast aware.

CoppaFeel!

SHARING SUCCESS STORIES - FINDING OPPORTUNITIES TO COLLABORATE

- Targeted public awareness campaigns and messaging
- Cancer awareness in schools: PSHE packs, collaborations with CASS
- HPV vaccination programme:

  Vaccination UK has the contract in Hackney, and will begin rolling out the HPV vaccine in the summer term 2024. CoppaFeel! to provide free resources as part of an information pack handed to young people receiving the vaccination.

- GP surgery text messages: CoppaFeel! has a free monthly text reminder service, look at ways to integrate this.

WORKING TOGETHER TO IMPROVE AWARENESS OF BREAST CANCER IN HACKNEY

- Free resources and training from CoppaFeel!
- Awareness campaign collaborations
- Early Diagnosis Programme Delivery Group
- Share data and insights

THANK YOU

Helen Farrant
Head of Services

helen@coppafeel.org

Sophie Dopierala-Bull
Director of Education & Health Comms

sophie@coppafeel.org

Emma Walker
Health Information Manager

emma@coppafeel.org

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Tackling Breast Cancer in Hackney

Briefing Paper for Hackney Scrutiny Commission from Homerton Healthcare November 2023

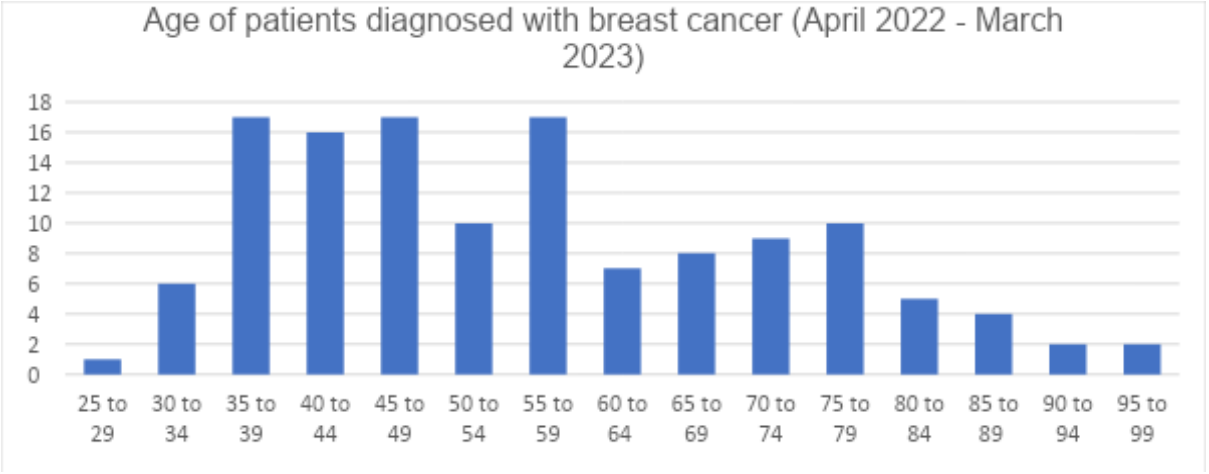
Introduction

Homerton Healthcare diagnoses and provides surgical treatments and follow up care to people diagnosed with breast cancer. The team at Homerton work very closely with Barts Health where the Breast medical and clinical oncology team provide the systemic anti-cancer treatments (referred to as SACT), radiotherapy and other appropriate treatments. There is a joint multidisciplinary meeting where all patients are discussed and a plan of care decided and agreed by all team members.
One of the Barts oncology team Dr Kathryn Hawkesford has a follow up oncology clinic at the Homerton.
(Appendix 1 summarises the treatments available).

Patients are mainly referred by their GP on an urgent 2 week wait (2WW) pathway. Patients who undergo screening and are found to have breast cancer are referred directly to Barts Health.

From April 2022 to March 2023, Homerton Healthcare received 4,509 referrals on a 2 week wait pathway to be investigated for breast cancer. Of these referrals, 4,378 did not have cancer. 131 people were diagnosed with breast cancer, 129 women and 2 men.

The following tables highlight the age and ethnicity of patients diagnosed at Homerton from April 2022 -March 2023



Ethnicity of Patients diagnosed with breast cancer (April22-March 23).

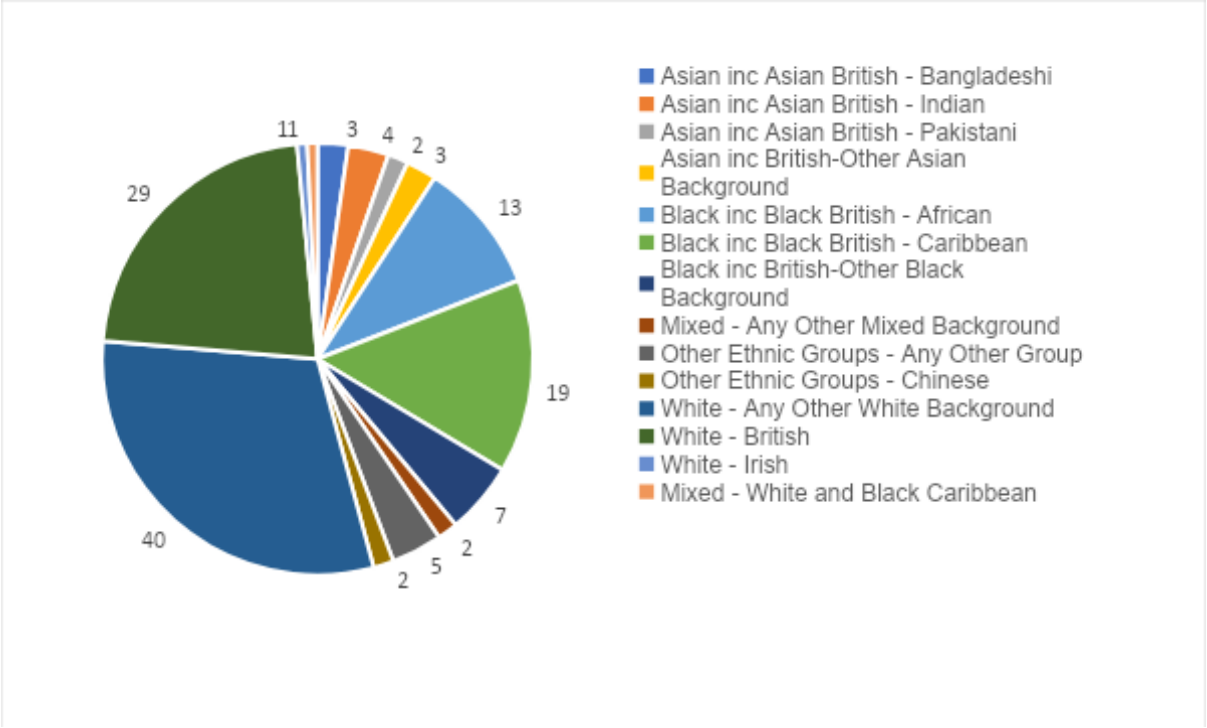


Figure1 below is an illustration of the breast cancer pathway. This is the process by which people are referred to the Homerton, diagnosed and treated for this cancer. Following their main treatments, (some treatments may continue long term) patients are followed up at the Homerton in the open access follow up service. This consists of

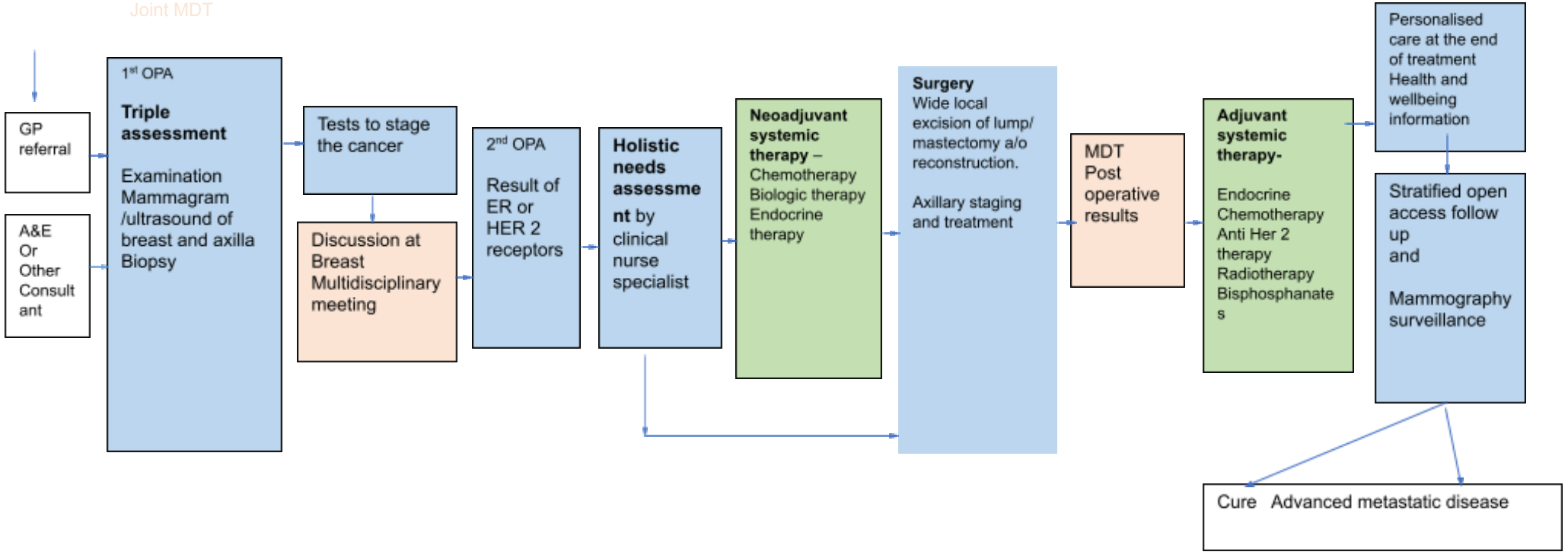
- End of treatment clinic appointment with a nurse
- Holistic needs assessment
- A written summary of all the treatment.
- Health and wellbeing information.
- Education about ‘red flag’ symptoms, i.e. things to look out for that might be worrying and how to be seen if any of these occur.
- They are informed of the plan for their surveillance.

Going forward, if patients are found to have recurrence or metastatic disease they will be reinvestigated and will follow a metastatic breast cancer pathway at Barts Health.

Homerton Healthcare
NHS Foundation Trust

Figure 1. Breast Cancer Pathway

Undertaken at Homerton
Undertaken at Barts
Joint MDT



What Happens to Referrals

The Cancer Referrals Office within the Homerton manage all cancer referrals and track patients to ensure they are diagnosed, referred on and treated in a timely way as per the NHS Cancer Standards. This team is managed by the Cancer Performance Manager. Up until October this year, a key standard was the 2WW standard.
The performance on the 2WW standard is measured as a percentage of patients who are seen within the 2 weeks from referral. The table below shows our performance from April 22-March 23.

Quarter 1 2022	92.2%
Quarter 2 2022	96%
Quarter 3 2022	95.1%
Quarter 4 2023	90.71%

In October 2023 the standards have been reduced from 10 to 3 standards. These are now:

- The 28-day Faster Diagnosis Standard (FDS) -patients referred for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- The 62-day referral to treatment standard- patients should start treatment within 62 days of their referral
- The 31-day decision to treat to treatment standard- if a person is diagnosed with cancer and has made the decision to have treatment, they should start that treatment within 31 days.

Challenges
Patient understanding that they have been referred on an urgent pathway for suspected cancer and so being available for urgent appointments.

Homerton Healthcare Medical and Nursing Team

Surgical Consultants x 2
Mr Ioannis Spyrou
Ms Laila Parvanta together with their surgical team.

Prem Natarajan Advanced Nurse Practitioner
Sonia Hussain Open Access Follow up Nurse Specialist
Susan Flannery Breast Cancer CNS
Samira Ouchebbouk Associate CNS

Barts Health Oncology Team

Medical Oncology Team,

Dr Peter Hall, Dr Kathryn Hawkesford, (has one clinic a week at Homerton Healthcare) Dr Melissa Phillips, Dr Vassili Angelis.

Clinical Oncology Team, Dr Virginia Wolsteholme

Radiology and Pathology services

Both these services are vital to the diagnosis and treatment of cancer patients.

Challenges
Staffing and recruitment into many of these services.

Support Services at the Homerton for All Cancer Patients

Macmillan Support and Information Team

This team are available to help patients with all their information and support needs, and to help with queries about administration. They will also arrange health and wellbeing events for patients who have come to the end of their treatment. Currently, they are piloting a drop in group for anyone living with cancer in City and Hackney which takes place weekly at the Round Chapel in Hackney. The team also run cancer awareness events within the Trust.
The team consists of

- A Macmillan Information and Support Manager
- 4 Macmillan support workers one of whom works specifically with the breast nurse specialist team
- Personalised care manager
- Stratified Follow up Navigator, who's role is to ensure all patients are followed up with the appropriate investigations and in a timely way.

Prehab and Rehab Team

This is a Pilot project funded by North East London Cancer Alliance offering prehab and rehab to cancer patients.

Prehabilitation consists of a number of interventions to prepare patients for surgery or other cancer treatments. There is good evidence that it can significantly improve

the patient's ability to cope with multiple modes of treatment (including surgery, chemotherapy, radiotherapy and immunotherapy).
Prehab consists of

- **Increasing physical activity levels** with a personalised exercise programme from a physiotherapist based on an assessment of the patient's current health and fitness (and pre-existing conditions).
- **Healthy eating** advice and access to a dietitian to provide tailored support if required
- **Mental wellbeing** and emotional support if needed
- **Information, support and education** about diagnosis and planned treatment from the clinical nurse specialist, who will be supporting the patient all the way through their cancer journey.
- **Access to other services** such as help with stopping smoking if required and support from the Macmillan cancer information and support service.

Rehabilitation consists of similar interventions but take place after surgery or other treatments have ended. The team consists of:

- Physiotherapist
- Dietician
- Exercise Technician
- Project Lead

Cancer Psychology Team

This team provide psychological interventions to those people who are challenged by adjusting and adapting to the diagnosis and it's implications on a cognitive, emotional and physical/practical level, whether it be at the point of diagnosis, the impact of treatments and side effects, end of treatment, survivorship, recurrence, metastatic disease, palliative.
The team consist of

- Lead Cancer Psychologist
- Cancer Counselling Psychologist

Some of the Challenges facing those with breast cancer from a psychological perspective

- Social isolation, loneliness, lack of support (emotional and/or practical), particularly difficult for those who are non-English speaking.
- Financial challenges with the cost of cancer being significant, particularly when ability to work is interrupted and the costs of travelling to multiple appointments across different hospitals can soon become costly.
- Distress associated with pre-existing trauma's, adverse life experiences, or even previous healthcare meaning that trust in healthcare professionals or those in a position of power can make accessing care difficult.
- Given the diverse population we serve, there can be challenges associated with ethnic, cultural and religious diversity in terms of accessing care.
- A particularly young cohort of women diagnosed in or around pregnancy, or aged around 20-30 prior to family planning considerations, where there are significant challenges adjusting to cancer at this stage in the life cycle, with complex decisions to be made around fertility conservation perhaps earlier than one might have anticipated, or indeed considerations around treatments and impact whilst also adjusting to life as a new mum.
- Often there can be protective buffering where women in particular take on the emotional burden and coping in the family, and can therefore have little outlet or support for themselves.
- Challenges associated with having (sometimes very young children) and how to talk to them and explain the cancer at an age appropriate level, and/or concerns for the impact on the wider family, often there are limited support services for partners, carers or children of those with cancer, with mental health services in the community having a much higher threshold for referral acceptance, and therefore a gap in the support of the wider family which can cause concern and distress for the mother.
- Health inequalities for those in minority groups, either due to ethnicity, gender, sexuality, cognitive decline/learning disability, non-English speaking, neurodiversity, or other impairment in sensory function (deaf, blind).
- Survivorship issues, fear of recurrence, impact of living with long terms effects (be it physical and /or psychological) from cancer and it's treatments, and often less services and support available to this increasing growing cohort of the population.

Appendix 1 Treatments for Breast Cancer

1. **Surgery**: the two main types of surgery are lumpectomy and mastectomy. Advances in surgical techniques mean that full mastectomies are less common than twenty years ago. As more and more women survive breast cancer, the importance attached to reconstruction is greater to ensure patients achieve an optimum quality of life. Reconstruction can be immediate or delayed and use either the patient's own tissue or implants. The oncoplastic surgeon will discuss the patient's options with them to ensure they receive the optimum result.

2. **Radiotherapy:** radiotherapy treatment is often given post-surgery to destroy any remaining cancer cells. Generally, breast cancer patients tolerate radiotherapy well, with side effects limited to skin reactions, lymphoedema, pain and swelling. These side effects can be mediated with specialist support and are often not long lasting. A long-term risk of radiotherapy that is becoming increasingly apparent is damage to heart tissue, resulting in heart problems for women many years after radiotherapy treatment. New techniques such as breath holding have been developed to minimise damage to the heart.

3. **Chemotherapy:** in breast cancer, chemotherapy drugs are often given in combination to some patients. Cancers which are not responsive to hormone treatments are more likely to be treated with chemotherapy.

4. **Targeted therapy:** targeted drugs block the growth and spread of cancer by interfering with specific molecules on the cells' surface. Cancers which test positive for the HER2 receptor can be treated with one of the most well-known targeted therapies, Herceptin. About 15% of all breast cancers are HER2+. Herceptin is given every three months for a year and side effects can include infection, hot flushes, fatigue and diarrhoea. Patients who have heart problems are can have relative contra-indications for Herceptin.

5. **Hormone therapy:** hormone treatments either lower the levels of oestrogen or progesterone or block their effects. In order to work, the tumour must be ER+, that is have oestrogen receptors on the surface of the cell. About 70% of breast cancers fall into this category. The most common hormone treatments are Tamoxifen and Aromatase Inhibitors. They are often taken over extended periods of time (five years or sometimes longer) to both treat the tumour and reduce the risk of recurrence. The side effects mimic that of the menopause and include hot flushes, nausea, mood changes, fatigue and vaginal dryness/discharge.

Hackney

Health in Hackney Scrutiny Commission 15th November 2023 **City & Hackney Place Based System - verbal update**	Item No **5**

PURPOSE
To receive an update on the ongoing progress of the City and Hackney Place Based System

OUTLINE
With the replacement of the CCGs with NHS NEL and the evolution of the Place Based Systems Members have asked for an update on the new structures as they bed in.

The Place Based Lead has been asked to update on the number of clinical staff and commissioners who are in place and the balance of those with a City and Hackney focus to their roles vis-a-vis an NEL wide one.

This issue has been discussed at both HiH and INEL JHOSC over the past two years as part of the development of the Place Based Systems and a response has been delayed because of necessary staff consultations which had to take place on the new organisational structures. We understand these consultations are now fully completed.

Attending for this item will be:

Louise Ashley, Chief Executive of Homerton Healthcare and Place Based Leader for City and Hackney Place Based Partnership

Dr. Stephanie Coughlin, Clinical Director, City & Hackney Place Based Partnership/ NHS North East London (NEL) Digital First Lead & Lead for Virtual Wards/ GP Lower Clapton Group Practice

Amy Wilkinson, Acting Director of Delivery for City and Hackney Place Based Partnership

ACTION

The Commission is requested to give consideration to the report.

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North East London Health & Care Partnership

CITY OF LONDON

Hackney

NHS North East London

City and Hackney Place Based Partnership

Place Based structures

October 2023

Context and Outline

- The recent merge of 7 LA Northeast London CCGs to become NEL NHS ICB has seen the design and implementation of new staffing structures both centrally and at place, culminating in a full re-structure that it currently embedding. The ‘go-live’ date is December 2023, with the exception of the Chief Nursing Directorate (CNSO) that is still to agree a final structure and implement it.

- The direction of travel is to create an over- arching ICB structure that enables a focus on prevention, collaboration and creating the conditions to develop the wider Integrated Care System. The ICS will work in a different way to former CCGs, delivering different functions, and will need a different shaped organisation to enable this.

- Additionally, a key driver in the re-shaping is the nationally mandated ask by NHSE to save at least 20% on management costs. NEL ICB is operating in a position of considerable financial pressure, as are many other ICBs across the country. This has meant there is a drive to consolidate ‘back office’ and management functions centrally, which delivers economies of scale in a way we have not been able to previously.

- There is a central commitment to place based working articulated, with place based partnerships and all 6 place ‘teams’ forming part of the CPPO directorate under the Chief officer for Participation and Place - one of 6 Chief officers and Directorates. Alongside this, the wider architecture around a range of collaboratives (acute, community, mental health, primary care), enables different ways of working together across the wider system, sharing expertise.

- It remains unsure about if and how much funding would eventually be delegated to places, for delivery. As above, most contracting, informatics, HR, finance, quality, safeguarding, communications and other support functions are now managed and delivered centrally.

The new City and Hackney Place Structure

- The new City and Hackney place staffing structure is **heavily based on the previous staffing structure, re-modelled to support 3 key areas**: Start Well, Live Well, and Age Well, in line with other ICB places. This replaces previous structures (or 'workstreams') of CYPMF, Planned Care, Unplanned Care and Mental health programmes, along with primary care.

- The new structure **retains the core team of commissioners** and other staff, many of whom have been in City and Hackney for a long time, reworked into the 3 new programme areas across the life course. Additionally we describe 2 further transformation areas locally - mental health and primary care, as per the operating model.

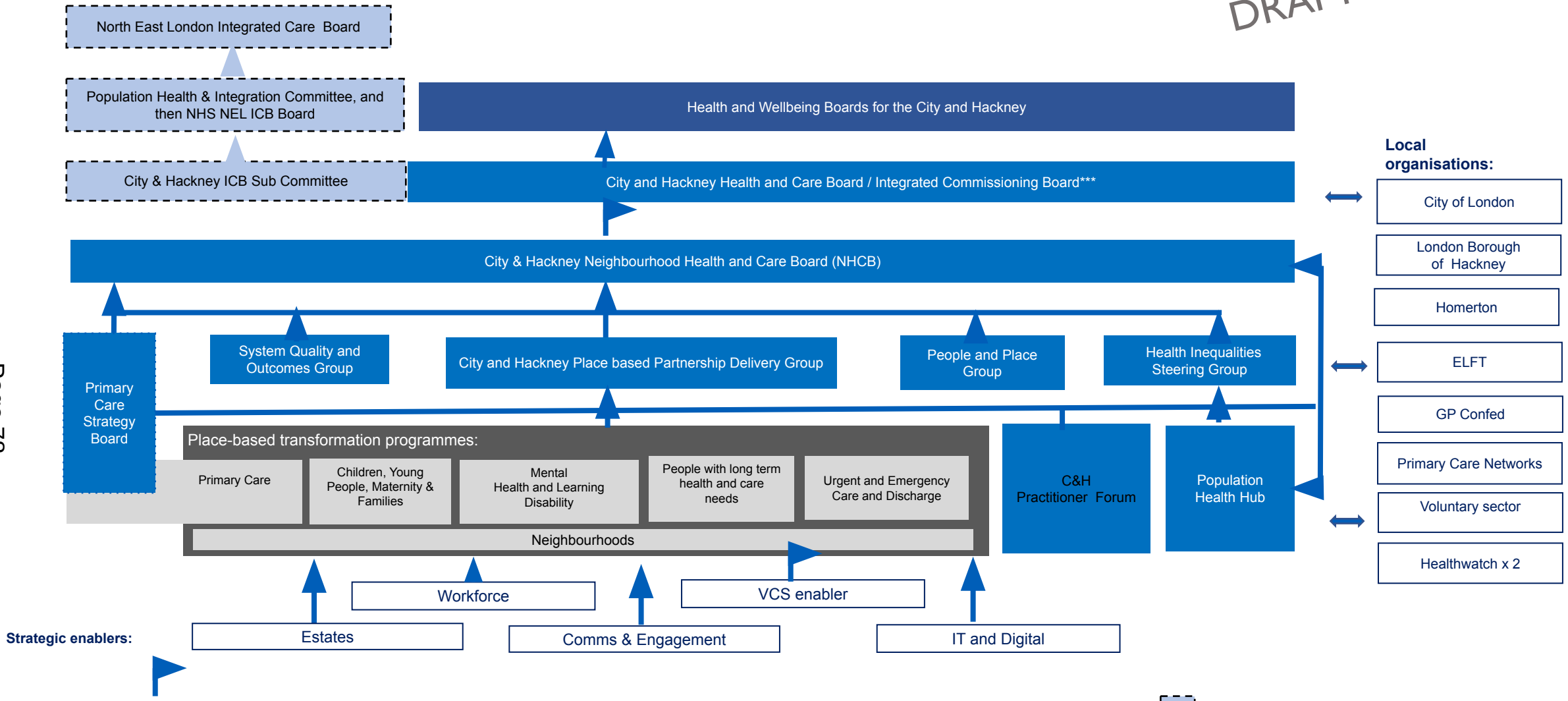
- A focus on delivery of the **neighbourhoods programme continues and** underpins our operating model. We continue to retain the non-recurrently funded neighbourhoods team delivered by Homerton Healthcare.

- The **consolidation of support functions** centrally has meant that we have reduced support from these functions, although many of our previous City and Hackney staff are now based in these central teams. Generally, the teams now work across NEL, with 1 or 2 staff members assigned to a specific place or number of places (*Eg. Medicines management has our former team centrally reporting to the Chief Pharmacist, with a reduction of 2 posts on our previous structure. Business support is managed centrally with one Band 5 allocated to each place*). Some of these functions are **still embedding**, so it is difficult to establish an exact comparison of resource for City and Hackney.

- Our historical ways of working, in terms of both **integrated working**, and working with a **lean staff team** means we are in a relatively good position moving into the place based partnership.

City and Hackney Place Based Partnership Operating Model

DRAFT



*** = The **Integrated Commissioning Board** operates under a 'committees in common' structure with sub-committees from both the City of London Corporation and the London Borough of Hackney, allowing for delegated decision making for pooled budgets.

= Formal meeting of NHS NEL ICB relating to City and Hackney PbP

= Support meeting / function to the City and Hackney PbP

= Statutory meeting of the City and Hackney Place

City & Hackney New structure

NHS North East London

Primary Care Team

Business support

Quality and Safeguarding

Finance & Contracting

Director of Partnership, Impact and Delivery – Band 9
1.0 WTE
1502

Medicines Management

Planned Care Team

Communications and Engagement

Head of Strategic Planning and PMO– Band 8C
1.0 WTE
1613

PMO Support Officer– Band 6
1.0 WTE
1627

Head of Performance and population health – Band 8C
1.0 WTE
1614

Performance and Population health Senior officer – Band 7
1.0 WTE
1623

Practitioner Participation Manager – Band 8A
1.0 WTE
1618

Head of Start Well – Band 8D
1.0 WTE
1610

CYP Strategic Lead – Band 8C
1.0 WTE
1615

Maternity Senior Manager – Band 8B
1.0 WTE
1621

CYP CTR and Project Support– Band 6
0.5 WTE
1626

Head of Live Well – Band 8C
1.0 WTE
1611

Long Term Conditions Senior Manager– Band 8B
1.0 WTE
1617

Long Term Conditions Officer– Band 6
1.0 WTE
1625

Head of MH – Band 8C/8D (TBC)
1.0 WTE

Mental Health and CAMHS Senior Manager 8B
1.0 WTE
1616

Mental Health Project Delivery Band 7
1.0 WTE
1624

Head of Age Well– Band 8C
1.0 WTE
1612

Unplanned Care Senior Manager – Band 8B
1.0 WTE
1620

Unplanned Care Senior Manager – Band 8B
1.0 WTE
1619

Start Well and Age Well Programme manager – Band 8A
1.0 WTE
1622

C&H Team

NEL Team

C&H post

Integrated post

City & Hackney Old structure

NHS North East London

Primary Care Team at Place: 1x B9, 1x8A, 1x B5

Business support

Finance & Contracting

Communications and Engagement

Director of Partnership, Impact and Delivery – Band 9
1.0 WTE

Quality and Safeguarding

Integrated Commissioning Programme Manager - Band 8B
1.0 WTE

Governance Manager Band 6
1.0 WTE

Head of Performance and Alignment – Band 8C
1.0 WTE

Performance and Population health Senior officer – Band 7
1.0 WTE

Head of membership engagement – Band 8B
1.0 WTE

Works Stream Director CYPMF
Band 8D
1.0 WTE

CYP Strategic Lead – Band 8C
1.0 WTE

Maternity Senior Manager – Band 8B
1.0 WTE

CYP CTR and Project Support – Band 7
01.0WTE

Workstream Director Planned Care – Band 8D
1.0 WTE

Head of Planned Care - Band 8B
1.0 WTE

Programme Manager - Band 8C
1.0 WTE

Commissioning Manager - Band 8B
1.0 WTE

Mental Health Programme Director 9
1.0 WTE

Mental Health and CAMHS Senior Programme Manager 8B
1.0 WTE

Mental Health Project Delivery
Band 7
1.0 WTE

Workstream Director Unplanned Care
Band 8D/C
1.0 WTE

Unplanned Care Senior Manager – Band 8B
1.0 WTE

Unplanned Care Senior Manager – Band 8B
1.0 WTE

Start Well and Age Well Programme manager – Band 8A
1.0 WTE

Planned Care Team at Place:
1x B7, 2x B6, 1x B5

Medicines Management at Place: 1x B8D, 3x B8A, 1x B7, 1x B5

Hackney

Health in Hackney Scrutiny Commission 15th November 2023 **Minutes of the previous meeting**	Item No **6**

OUTLINE

Attached please find:

b) Draft minutes of 11 September 2023 HiH meeting
c) Action Tracker

ACTION

The Commission is requested to AGREE the minutes as a correct record and note any matters arising.

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Mon 11 September 2023 at 7.00pm

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

Chair	**Councillor Ben Hayhurst (Chair)**
Cllrs in attendance	**Cllr Kam Adams, Cllr Claudia Turbet-Delof**
Cllrs joining remotely	**Cllr Grace Adebayo**
Cllr apologies	**Cllr Sharon Patrick**
Council officers in attendance	**Helen Woodland,** Group Director Adults, Health and Integration **Georgina Diba,** Director of Adult Social Care and Operations **Dr Sandra Husbands,** Director of Public Health, City and Hackney **Chris Lovitt,** Deputy Director of Public Health, City and Hackney **Joe Okelue**, Senior Lawyer, Adult Social Care
Other people in attendance	**Dr Adi Cooper OBE,** Independent Chair of CHSAB **Deboarah Cohen,** Chair, Healthwatch Hackney **Sally Beaven,** Executive Director, Healthwatch Hackney **Jed Francique,** Borough Director City & Hackney, East London NHS Foundation Trust **Dr Olivier Andlauer**, Clinical Director for City & Hackney, ELFT **Sharon Evans**, Crisis Pathway Lead for C&H, ELFT Andreas Lambrianou, Chief Executive, City and Hackney GP Confederation Dr Deblina Dasgupta, Chief Medical Officer, Homerton Healthcare
Members of the public	168 views
YouTube link	View the meeting at: https://www.youtube.com/watch?v=pY5hP2zohYw
Officer Contact:	**Jarlath O'Connell, Overview and Scrutiny Officer** jarlath.oconnell@hackney.gov.uk; 020 8356 3309

Councillor Ben Hayhurst in the Chair

1 Apologies for absence

1.1 An apology for lateness was received from Cllr Patrick. Apologies also received from Louise Ashley and Dr Stephanie Couglin.

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Responding to increasing mental health need

4.1 The Chair stated that the pressures on the local mental health services have been an ongoing concern. Recent performance data from the Health and Care Board has pointed to a major spike in demand. Last month the Commission had discussed the issue of 'Right Care Right Person' and they'd decided to ask ELFT in to discuss the wider issues involved.

4.2 He welcomed the following invitees:

Jed Francique (**JF**), Borough Director for City and Hackney, ELFT
Dr Olivier Andlauer (**OA)**, Clinical Director for City & Hackney, ELFT
Sharon Evans (**SE)**, Crisis Pathway Lead for C&H, ELFT

4.3 Members gave consideration to a detailed report from ELFT '*Responding to increasing mental health needs'*

4.4 JD, SE and OA took Members through their presentation and the following points were noted:

a) Mental health was everybody's business not just the Providers and they work very closely with the Council. VCS orgs, primary care and the police.
b) Presentation would look at both crisis services and community mental health services.
c) The gradient from green to red showed a high level of need and challenge in Hackney. Mental health is very much linked with levels of deprivation. Physical health is a more a mixed picture with some positive aspects - Hackney performance was good on physically active adults but there was also a high level of substance misuse linked to mental ill health prevalence.
d) Since the pandemic there had been a 20-25% increase in mental health needs nationally and capacity and resources haven't been able to keep up. MH difficulties are not spread equally. There is disproportionality across a range of characteristics. You're twice as likely to need mental health support if you're in the least deprived areas.
e) ELFT runs psychiatry liaison, the acute unit, and crisis line so they triage for all. The crisis cafe provides more informal access at set times. Most however are presenting at out-of-hours. In Psychiatric Liaison people get triaged, they assess need and risk and there are a number of options. They work closely with VCS.
f) 'Home Treatment' is for very acute patients where a person can get visits a couple of times a day. It is intensive and very short term c.2 weeks to a month, They then can be referred to Community Mental Health Teams as necessary.
g) A&E numbers have been going up and acuity getting more complex therefore the new presentations are coming to them quite unwell. They are using the Mental Health Act more. There has been an increase in stress, self harm, depression, psychosis and bi polar presentations.
h) The performance of ELFTs Psychiatric Liaison Service is one of the best in NEL with response times hitting targets at 81%. Issues coming through are complex relating to housing, substance misuse - and this takes longer to provide support.
i) Bed pressures which are recognised across the country are also an issue locally

4.7 Members asked questions and the following was noted:

a) Chair asked about the number of presentations for Hackney vis-a-vis NEL averages.
JF explained how local mental health bed stock and occupancy operated. They have beds in the system but there aren't enough and even though length of stay is reducing it is not doing so quickly enough, partly because of increased acuity. To supplement the provision they

have to use private sector beds to meet the demand when nothing local is free. Also, when people are starting to improve in order to test out if they are ready to return home they are put in special B&Bs with wrap-around support until they are ready to go back home. Obviously purchasing private provision is expensive.

b) The Chair asked if the figures included older adults, such as those cared for at East Ham Care Centre.
JF clarified that that was separate. The figures relate to working age adults in the City and Hackney not to older people. Matters get complex when those presenting reside elsewhere and liaison with other councils is necessary but predominantly Homerton houses City and Hackney residents. SE added that the Crisis line has seen a large increase in call volumes so they are thinking of consolidating staff so they have more staff to be there to answer calls. A longer term plan aims for a Crisis Assessment Hub at the Reybould Centre where they can support more people. SE added that retention of staff is a major issue and a lot of crisis centres suffer with high turnover and there is a need for more staff training and recruitment campaigns.

OA added that NEL was performing better than the London average. Since Covid there had been big changes with the workforce with staff leaving London. Lots of new staff adds to the burden on the experienced staff who need to supervise them. A key focus therefore is to develop alternatives to attendance at A&E. ELFTs bed capacity had never been such an issue until now and they never had to use private provision but they do now in order to ensure that flow of patients is optimal. There is also a need to respond to a changing patient profile. Acuity is higher. All services have tightened their criteria as have adult social care teams and VCS so they need to think of other activities in the ward to better meet the needs of patients. Another issue is an increase in comorbidities with more presenting with physical illnesses. They are therefore recruiting nurses also experienced in physical health, they are re-training staff and there is a GP service on the wards so they can respond to this as well as ensuring that governance processes are up to date. He concluded that they commission B&Bs as a stopgap and are commissioning their own step down beds so that those ready can be discharged easily.

c*) What is the waiting list and the waiting times*
JF replied that 2k per month calling the crisis line outstrips their capacity. There is also the issue of abandoned calls and so the focus is on getting the right level of resource into the crisis lines.

d)Do you collect data on presenting issues of frequent attenders and how do you analyse the underlying social issues here e.g. cost of living crisis, unemployment and housing.
OA replied that there is a High Intensity Users Service Team dedicated to this. They analyse how many times the person has called 999, or 111 or presented at emergency department. They do analyse the underlying issuse and this feeds into the care plans. They will link them to appropriate other services. One of the senior nurses has a QI project ongoing focused on underlying causes and what else is on offer in the community to support such clients. JF added that a range of social stresses obviously contributes to people going to mental crises.

e) Chair asked how these causes are linked to the need to use more B&Bs.
OA replied it was a very significant issue. They only send people to B&B if there is a reasonable plan for what will happen afterwards. If they know for example that a person's flat will soon be ready and it's just 3-5 weeks then they'll consider B&B. A rep from Housing Needs attends their mutil-agency meeting each week and they look at numbers who are sofa

surfing etc. One challenge is with those with No Recourse to Public Funds but they now have a specialist in this on the team

f) *Chair asked if you can put those with No Recourse to Public Funds in B&B*
OA replied they can but if they don't have a plan after 4-6 days they go back to drawing board as it's not meant to be a long term solution.

g) *Chair asked if there was more the Council can do to assist with liaison with housing on these issues and what might work better.*
JF replied that they have positive conversations with LBH to deepen and strengthen the relationships they have. They need to think of mental health more broadly and, regarding housing, if there are fundamentally different solutions that they jointly might be able to trial.

g) Chair asked if they were analysing the costs of use of B&Bs to make a spending case for better alternatives
JF replied they were gathering this data so they can examine other alternatives.

h)Sally Beaven (Healthwatch) referred to their forthcoming Enter and View visits to mental health wards the following week and asked if they could look with ELFT at the patient journey and explore what might be missing. JF welcomed this and undertook to meet outside this meeting.

i) How does centralising the Crisis Line across three boroughs improve performance
SE replied that the centralisation is a combination of things not just about staffing. Another direction is "111 plus 2" (press 2 for more information) which will direct callers to a mental health crisis line. hey've also started to work closely with sister trust, NELFT, as part of the wider collaborative work under the ICB. This is to streamline the services and the support for service users. She added that the long waits are not unique to C&H and if they can combine crisis line staff they hope they'll be able to reduce waiting times. She added that when a person needs a face to face emergency service that will always be provided locally so people don't have to travel out of area.

j) What is the data on first time users who relapse.
OA replied that it depends on how you want to see it. He did not have the data at hand but it could be provided. The focus is that they want to ensure they meet with service users well before they might reach crisis point. Early detection and working with primary care is key

k) The Chair gave the analogy with the GP Out of Hours Service. In the past Hackney had in his view a 'rolls-royce' service and you spoke to a local GP but it was centralised and pooled and now only 12% get to speak to a fully trained clinician. He added that he could see the benefit of elevating mental health as part of 111 service *but losing the local element of contact is unfortunate*. He added that this was part of the problem with A&E attendances in his view as people were just getting the algorithm and so ended up unsatisfied and so turned up at A&E. OA replied that he took the point but stated that the clinician who answers the phone will be trained in the same way and will be an ELFT clinician.

l)The Chair asked about the latest figure for 12 hr mental health waits at the Homerton A&E.

JF replied that the average the previous week was that 4% waiting longer than 12 hrs at Homerton and only 5 out of 90 patients had breached the 5 hrs target. Those instances related to very specific cases which were quite complex because they involved the joint responsibility with out of area Trusts and local authorities. He concluded that the numbers now are relatively low.

m) The Chair asked if the Met Police had relaxed its planned hard deadline on introducing the Right Person Right Care policy.
JF replied that they had not implemented in full at the end of August as had been feared and all partners were working towards a more reasonable and structured plan.

Part 2 of presentation - Community services.
JF took Members through Part 2 of the presentation. It detailed the work towards a new integrated plan for primary and community care. It's a broader model focused on IAPT and wider determinants of health and is a whole system transformation which is very ambitious in its aims. They aim to agree a system vehicle to oversee the next phases, reviewing care pathways and carrying out cultural safety training and focusing on workforce wellbeing. A key delivery is to ensure that care is delivered closer to home. The Crisis Line element takes up a lot of attention but the point of this new plan is to get upstream of those problems and produce a whole system offer. OA added that ELFT was one of 12 national pilots and was an early implementer of the Neighbourhoods strategy. ELFT staff were put in GP Practices and they consider GPs now part of the full mental health primary team, they can and do call in to meetings, as does the charity Turning Point. They've also set up Community Connectors with Bikur Cholim and Derman as well as an Employment Support Team.

n) The Chair asked about how the Wellbeing Network might be recommissioned in future in this context.
JF replied that the Mental Health Integration Committee, comprises ELFT, LBH, VCS partners and ICB partners and it holds the ring here. The Wellbeing Network and IAPT providers are also part of the key IAPT Alliance which ELFT feeds into.

o) The Chair stated that when the Wellbeing Network was recently recommissioned one of the stated objectives was to provide more high level support but isn't that taking away from other levels.
JF replied that capacity at all levels was an issue and gaps would always appear and there is an ongoing issue on how they collectively keep an eye on mild to moderate mental health cohorts. This is being worked on by the Alliance however with ELFTs input.

p) What are the "5 step-down beds"?
JF replied they are for people who are in acute beds in the Homerton and are recovering but might need an interim step-down before returning to their home. They have therefore commissioned 5 x 1-bed flats which will come with wrap-around support for this cohort. It's a 'softer landing' than going directly back to your own home.

q) Both the national and local IAPT services have high numbers of referrals but also a high drop out rate on uncompleted treatment and how is this informing future planning.
OA replied that they provide very diverse offer of talking therapies across a number of providers e.g. there is Off Centre for young people, there is Bikur Cholim and Derman for

their communities, there the Tavistock for frequent attenders at GPs as well as for those with medically unexplained syndromes. On top there is ELFT's own offer and the Neighbourhoods Teams who have a specific role in supporting issues in primary care. Within their recovery services there is a Psychiatric officer as well as a Specialist Psychotherapy Service and all of these are dealing with increased demand. He added that in ELFT there is a really important piece of work going on with Primary Care to ensure that the quality and number of referrals is more appropriate. This 'upstream' work with the Neighbourhoods is vital. They are screening more tightly those who are being referred. There is still a waiting list of a few months and it is important to consider that putting people on waiting lists who are not ready is also a waste of everyone's time. JF added they were trying to continue to understand the drop-out rate and the fit of the service offer with the needs of the client. Services should always continue to evolve to meet the patient's needs. Within the Alliance the conversations are always about who our clients are. The world is changing rapidly and needs are changing and the services have to adapt accordingly.

4.8 The Chair commented that the Commission had done a review on talking therapies in the past and it might be worth revisiting. Cllr Turbet-Delof reminded Members that IAPT is on the agenda for the next INEL JHOSC meeting also.

4.9 HW stated that the Council and health partners had jointly agreed the creation of a Joint Mental Health Commissioning Role and they are looking at a wider Integrated Commissioning Unit. The Chair welcomed this and asked if more attention could be given to the mild to moderate part of the spectrum in this work.

4.10 The Chair thanked all the participants for their contributions.

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

5 City and Hackney Safeguarding Adults Board Annual Report 22/23

5.1 The Chair stated that each year the Commission gives consideration to the Annual Report of the *City and Hackney Safeguarding Adults Board (CHSAB).*

5.2 He welcomed for the item:
Dr Adi Cooper (**AC)**, Independent Chair of CHSAB
Georgina Diba (**GD**), Director of Adult Social Care and Operations
Joe Okelue (**JO**), Senior Lawyer, Adult Social Care

5.3 Members gave consideration to the summary report and to the main *Annual Report of City & Hackney Safeguarding Adults Board 22/23*, which was tabled.

5.4 AC apologised for the late submission due to some design delays and took Members through the report in detail. She commented that she'd chaired the Board since 2015 and there were ongoing challenges as well as new ones. The report comprised the various achievements including the statutory duties carried out during the year including two published SARs and one commissioned SAR. The Board was obviously looking at the learning from all of these. In the past year much had been done on communication and engagement and a joint piece of work on tackling anti-social behaviour. Another focus this year was how the Met Police works with those who have mental illness. They also worked on the impact of the cost of living crisis and its impact on safeguarding adults. The data this

year was not significantly different than last year, at one point there had been a blip in reported cases of self neglect which they analysed.

5.5 Members asked questions and the following was noted:

a) *Chair asked if the numbers of 'concerns' raised vis-a-vis the number of S.42 'enquiries' carried out had risen and if this could be clearer in the report. He also asked for an update on the replacement of the Deprivation of Liberty Safeguards (DoLS) process.*
AC replied that it was largely in line with the previous two years. DHSC has now deferred the implementation of the change from DoLS to Liberty Protection Safeguards (LPS) so the proposal, the consultation and the feedback process has all been put on hold. She added that there were ongoing challenges with DoLS in the context of assessing safeguarding risks so it was still a live issue for partners while a government announcement is awaited.

AC added that in relation to comparative work on concerns and enquiries, due to the impact of the cyberattack on the Council they had issues with data quality. They tried to complete the gaps with data from partners but giving year on year comparisons for Hackney in particular has been problematic. She added however that the data can only take you so far on these issues but it of course prompts you to ask the right questions. GD added that the data is important for informing action and focus and they will be able to share more on request. She noted that higher levels of self-neglect and hoarding had been reported in Hackney than in our neighbours. As time moves on the Council will be able to provide much more robust year on year data. She added that in addition to quantitative data they also carry our qualitative analyses to understand people's experiences. This will help to understand service users' journeys through the safeguarding process.

b) *What was the outcome of the self assessment exercise using the self assessment tool as outlined on p.28.*
AC replied that the Safeguarding Adult Partnerships Assessment tool was a very useful tool which was widely used by partners. They asked an Independent examiner to then review the responses received and held a workshop on it. The outputs fed into their design of the strategic priorities for the Board and so was key. This was a detailed analysis which they chose, for reasons of brevity, not to put in the Annual Report but they are happy to share that with Members

ACTION:	**Director of Adult Social Care and Operations to share the report of the Independent Reviewer on the self assessment exercise using the 'Safeguarding Adults Partnership Assessment' tool.**

c) What does a mental capacity assessment look like and how is it used?
AC replied that these exist under the Mental Capacity Act and are decision specific. A number of people can undertake it so long as they have the required training capacity and skills to do it. A person's ability to to take risks in their lives might be dependent on capacity and people might have fluctuating capacity and mental capacity may be affected by learning disability or mental illness but also if there is undue influence exerted upon them by other people. Capacity can also be affected by physical conditions such as diabetes, substance misuse or alcohol. What they find from SARS is that there are a number of situations where the complexity of how the decisions are made are not fully understood by those involved in

someone's care, which is why there is ongoing drive to improve people's practice and understanding of this area of work.

d) The Chair commented that what appears to be coming out of SARS is that things could be picked up at an earlier stage by having a more informed and nuanced reply to mental capacity assessments which are being delivered by a range of partners.
AC replied that it often comes down to practitioners making assumptions that people have the mental capacity to make decisions around keeping themselves safe but they don't necessarily apply their full professional curiosity or get information from other partners to be able to say that actually maybe these decisions are not being made. 'Executive mental capacity' comes into play here i.e the ability of the person to execute the action to make themselves safe. It may not be there. She added that it's a very nuanced and ongoing area of development that practitioners need support to understand and reflect on. There is also the issue that an individual must have the right to do things that others might feel are dubious or risky but there's a question about how much one can interfere with a person's choices. We have to support people to take risks in their lives, because life itself is risky, so it's a balance.

e) The Chair added so your role is to improve the training and awareness?
AC our role is to say how do we know that your staff are being supported to support the people they work with to keep themselves safe. It also includes reflective supervision, case discussion and people having support from managers to talk through some of these complex situations. Helping someone who doesn't want their help. Taking risks on borderline cases. It's areas that are fluctuating. She gave the example of the case of the homeless man who had died in the bus shelter in Stoke Newington. A lot of mental capacity assessment had been going on however the key learning from that sad case was that his refusal to accept help from the ambulance should have been questioned. In hindsight some might have said that services should have overruled his preference to remain in the bus stop. It's a very complex and challenging area for the practitioners, she concluded.

Joe Okelue (Senior Lawyer, Adult Social Care) added that it was important to understand that there are two stages to the test - the diagnostic stage and the functional test under the Mental Capacity Act. Sometimes people can pass the diagnostic but not the functional element so it becomes very difficult to make the decision that they lack capacity

f) What are the criteria for those able to attend the Safeguarding Courses.
AC replied that in relation to training they run various levels and options for training depending on where people are in the broader system. There is a new training system just put in place and there are sites where people can see what training is on offer. They are available to anyone for whom the content may be relevant

5.6 Chair thanked Dr Cooper and the officers for their report and attendance and their continuing good work in this difficult area.

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

6 Healthwatch Hackney Annual Report 2022/23

6.1 The Chair stated that each year the Commission considers the Annual Report of the local Healthwatch which is submitted to Healthwatch England. We use the report as an opportunity to discuss the performance of the organisation during the past year and to discuss its priorities and future plans. He welcomed the new Chair

6.2 He welcomed for the Item:
Deborah Cohen (**DC**), Chair of Healthwatch Hackney
Sally Beaven (**SB**), Executive Director of Healthwatch Hackney

And he congratulated them on the Healthwatch England Awards they had received for their work on ID demands for access to GPs, work that allowed real change to happen in the local area.

6.3 Members gave consideration to the *Annual Report of Healthwatch Hackney 2022/23* and to a summary slide presentation.

6.4 DC took Members through the presentation and thanked the officers and many volunteers for their hard work. She explained that her background was as a health journalist with the BBC. She was very pleased about the HWE award as it was their main award. SB added that as well as their core statutory healthwatch function, the organisation also holds contracts through the NHS which enable them to perform a watchdog function allowing them to engage in a lot of collaborative work. They work closely with HCVS on the Forums for the Neighbourhoods and there is a focus on embedding co production. Their local insight reports draws in feedback from each of the Neighbourhoods. She described their Community Voice contract which recently included reports on: Spirometry, virtual wards, living with Covid and on patient transport. They have a significant engagement and coproduction contract with NHS but their E&C Manager acts for the whole system. She explained the System Influencers which allows young people to get involved in the system. She described the investigatory reports and their Enter & View work which have exposed poor behaviour such as patient experience in maternity care during the pandemic, or overlooked areas such as on the impact of language barriers on the Chinese and Vietnamese community. She described the mystery shopper approach they used on the report on access to emergency hormonal contraception, which had used young people to carry it out and which revealed that they were being charged when they shouldn't have been. She described the Peoples' Feedback Panel where we go through comments and their Information Exchange Meetings which are still held online.

6.5 Members asked questions and the following was noted.

a) Chair asked how Healthwatch Hackney was working with the other 7 Healthwatches in north east London on the ICB Partnership Board.
SB replied that all 8 meet fortnightly online and Hackney has reps attending ICB regularly. Maternity issues was a good example of where the 8 united on a coordinated approach to NHS NEL based on what was done initially in each borough.

b) Chair asked what were the priorities for the next year.
SB explained that she had met with the Director of Adult Social Care and Operations as they would like to do more on adult social care. They continue to prioritise work on health inequalities with a focus on particular communities. They've started a piece of work on reviewing health literature available for women and next month will launch a piece on womens' experience of menopause and how they can make sure there is appropriate local messaging for women from Black communities on this. Cllr Turbet-Delof suggested that

Hackney Healthwatch could perhaps replicate a piece of work done by a Heatlhwatch in south London on the needs of the Latin American community. SB thanked her for this.

c) How are Enter and View topic areas decided.
SB replied that Enter and Views are informed by feedback from the community. They are about to do one at the acute mental health ward at the Homerton due to recent concerns and the spike on presentations at A&E. They would also look at GP Surgeries where there are reports of poor performance. She extended an invitation to Members to join the People's Feedback Panels which are held fortnightly on Friday's from 10.00-11.00, where they got through the comments or inputs received.

ACTION:	**SB to issue a standing invite to Commission Members to their fortnightly People's Feedback Panels, held virtually on Fridays from 10.00-11.00.**

d) The Chair asked about how they strike the balance between being a watchdog and being commissioned by the NHS and the Council itself.
SB replied that working in collaboration is how to achieve results so they see their role as being a critical friend and they work collaboratively always to resolve issues. DC added what was very clear was that they don't see their role as a watchdog standing at the side. Their role is to involve people in the process and they want to be part of the solutions.

e) The Chair welcomed the plan to focus more on adult social care in the coming year and asked how Enter & Views on community care provisions might work.
SB explained that they follow the co-production charter which is about supporting services to involve residents more in the management and design of services and this is the approach they will take. They will suggest to services that they might benefit from having public reps on their planning or management groups or to involve system influencers as this will help services get back on track.

6.6 The Chair commented that there was a constant pressure on ASC with the ongoing churn of the transformation agenda and Healthwatch can play a very valuable role in bringing a residents perspective to this. He added that Members were most appreciative of all the work they do and thanked them for their report and attendance.

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

7 Minutes of the previous meeting

7.1 Members gave consideration to the draft minutes of the previous meeting.

RESOLVED:	**That the minutes of the meetings held on 17 July 2023 be agreed as a correct record.**

8. Work programme for the Commission

8.1 Members noted the updated work programme and again noted the list of suggestions which had emerged from the engagement exercise with residents and stakeholders. The Chair stated that he had now populated the draft programme and had attempted to encapsulate all the suggestions from Members.

8.2 The Chair went through some of the outstanding suggestions.

a) On the suggestion re Chagas disease, he suggested this be referred to INEL JHOSC as it would be more fruitful to look at this across an NEL footprint because of the numbers involved.
b) On the issues of poorer health outcomes for Black Women and Black Men this would be incorporated into a possible item in January.
c) On the issue of NHS charges for migrants he stated that this had been covered extensively in the past by the Commission and at INEL and there had been letters to and from Ministers and the O&S Officer could update the Member on that.

ACTION:	**O&S Officer to share papers and outputs from the various items on migrant charging with Cllr Turbet-Delof.**

d) On the issue of hoarding this would be added to the work programme.
e) On the issue of increased levels of suicide relating to cost of living this had been touched on at this meeting and also Scrutiny Panel will be revisiting that. Cllr Turbet-Delof asked for the papers on the levels of debt leading to self harm and suicide and what data there might be on presenting issues for those who are self harming. Chair replied it had been covered to some extent in the ELFT report earlier and it appeared this was very much on their radar.
f) On the issue of how the Neighbourhoods system is interacting with the PCNs and the GP Confed this will be revisited. The Chair added that they would also look at the staffing structure in the Place Based System vis-a-vis what prevailed under the CCG.
g) Cllr Turbet Delof suggested that the issue of being exposed to diseases from parasites arising from exposure to dog faeces in streets and parks should be explored. The Chair suggested that a number of these suggestions, in the first instance, would benefit from a briefing from Public Health to determine the extent of the problem and subsequently a decision could be made on making it an agenda item. These could take the form of a Members Enquiry.
h) SB added that their reps had discussed the idea of social audit of green spaces and this issue could link in with that. The Chair cautioned that this would stray into the remit of Living in Hackney SC and suggested they check with them in the first instance.

ACTION:	**Director of Public Health to respond to Member Enquiry from Cllr Turbet-Delof on the following: Chagas Disease; Suicide and self harm; and the serious health impacts of dog fouling in streets and parks.**

RESOLVED:	**That the updated work programme be noted.**

9. AOB

9.1 There was none.

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Health in Hackney Scrutiny Commission - ACTION TRACKER 2023-24				
Note: Items returning to an agenda are added to the future work programme and NOT listed here.				
Meeting	**Item**	**Action**	**Action by**	**Status**
05/12/2022	Adult Social Care reforms - fair cost of care and sustainability	Group Director AHI to provide a brief update to the Chair on the funding position for next year (on Fair Cost of Care) once it is known.	Helen Woodland	Ongoing.
08/02/2023	Community Diagnostic Centres - update from Homerton Healthcare	CE of Homerton Healthcare to inform the Chair as soon as a decision was made on the siting of the proposed Community Diagnostic Centre.	Louse Ashley	Ongoing.
13/06/2023	Air Quality Action Plan implementation	TR to provide members who would like it with access to more detailed data monitoring on air pollution.	Dave Trew/Tom Richardson	Ongoing
13/06/2023	St Joseph's Quality Account	Site visit for Members to St Joseph's Hospice to be organised.	Jane Naismith	To be arranged.
17/07/2023	Homerton Healthcare Quality Account response	Chief Nurse to provide the latest drop-out data for the Homerton's IAPT service	Breeda McManus	To follow
~~11/09/2023~~	~~City and Hackney Safeguarding Adults Board Annual Report 22/23~~	~~Director of Adult Social Care and Operations to share the report of the Independent Reviewer on the self assessment exercise using the 'Safeguarding Adults Partnership Assessment' tool.~~	~~Georgina Diba~~	~~Circulated to members on 15 Sept.~~
11/09/2023	Healthwatch Hackney Annual Report 2022/23	SB to issue a standing invite to Commission Members to their fortnightly People's Feedback Panels, held virtually on Fridays from 10.00-11.00.	Sally Beaven	Ongoing
~~11/09/2023~~	~~Work programme~~	~~O&S Officer to share papers and outputs from the various items on migrant charging with Cllr Turbet-Delof.~~	~~Jarlath~~	~~Done~~

11/09/2023	Work programme	Director of Public Health to respond to Member Enquiry from Cllr Turbet-Delof on the following: Chagas Disease; Suicide and self harm; and the serious health impacts of dog fouling in streets and parks.	Dr Sandra Husbands	Request sent to PH on 12 Sept.

Hackney

Health in Hackney Scrutiny Commission 15th September 2023 **Work Programme for 23/24**	Item No **7**

OUTLINE

Attached please find:

b) Rolling Work Programme for 23/24 (NB this is a working document)
c) Work programme for INEL JHOSC 23/24

ACTION

Members are requested to give consideration to the work programme and make any amendments as necessary.

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DRAFT PROVISIONAL Work Programme for Health in Hackney SC 23/24 as at 7 Nov

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name
13 June 2023	**Election of Chair and Vice Chair**				
	Appointment of reps to INEL JHOSC				
	Air Quality Action Plan 21-25 implementation update	Follow up from June 22	Climate, Homes, Economy	Land Water Air Team Manager	Dave Trew
			Adults, Health and Integraton	Public Health Specialist	Suhana Begum
			Climate, Homes, Economy	Environmental Projects Officer - Sustainability	Tom Richardson
	Local GP services - Access and Quality	Briefing	NHS NEL Primary Care	Clincial Lead for Primary Care in City and Hackney and PCN Clinical Director	Dr Kirsten Brown
			NHS NEL Primary Care	Primary Care Commissioner	Richard Bull
			City and Hackney GP Confederation	Chief Executive	Andreas Lambrianou
			Healthwatch Hackney	Executive Director	Sally Beaven
	St Joseph's Hospice Quality Account 22-23	Annual item	St Joseph's Hospice	Director of Clinical Services	Jane Naismith
	Work programme for 2023-24	Discussion			
17/07/2023	**Health inequalities and medical barriers faced by trans and non binary community**		Homerton Healthcare	Clinical Lead for Sexual Health and HIV and Medical Examiner	Dr Katherine Coyne
				Consultant	Dr Sarah Creighton
			NHS NEL	Chief Medical Officer	Dr Paul Gilluley
			GP Confederation	Practice Development Nurse	Heggy Wyatt
			Public Health - City and Hackney	Director of Public Health City and Hackney	Dr Sandra Husbands
			Women's Rights Network and Hackney Labour Women's Declaration		Laura Pascal
			~~Gendered Intelligence - withdrew~~		~~Cara English~~
	Met Police implementation of Right Care Right Person model	Briefing	Adults Health and Integration	Director Adult Social Care and Operations	Georgina Diba
			ELFT	Borough Director C&H	Jed Francique
			C&H Place Based Partnership	Director of Delivery	Nina Griffith
	Homerton Healthcare Quality Account 22-23 - HiH response	Annual item	Homerton Healthcare	Chief Nurse and Director of Governance	Breeda McManus
11 Sept 2023	**City & Hackney Safeguarding Adults Board Annual Report**	Annual item	CHSAB	Independent Chair	Dr Adi Cooper OBE
deadline 31 August			AHI	Director Adult Social Care and Operations	Georgina Diba

			AHI	Manager - Safeguarding Adults Board	Shohel Ahmed
	Healthwatch Hackney Annual Report 22/23	Annual item	Healthwatch Hackney	Chair	Deborah Cohen
				Exec Director	Sally Beaven
	Responding to increasing mental health needs	Discussion	ELFT	Borough Director C&H	Jed Francique
			ELFT	Clinical Director	Dr Olivier Andlauer
			AHI	Director Adult Social Care and Operations	Georgina Diba
	Developing a C&H Sexual and Reproductive Health Strategy	Update post public consultation plus other aspects	Public Health	Consultant in Public Health	Carolyn Sharpe
			NHS NEL - C&H Place Based Partnership	Clinical Director	Dr Stephanie Coughlin
15 Nov 2023	**Tackling breast cancer in Hackney (raising awareness and performance of the screening programme)**		AHI	Public Health's Population Health Hub	Jayne Taylor
deadline 6 Nov			NHSE	Central and East London Breast Screening Service	Claire Mabena, Dr Mansi Tara
			CoppaFeel! (VCS org)	Head of Services	Helen Farrant and Emma Walker and Sophie Dopierala-Bull
			C&H Cancer Collaborative	Chair (a local GP)	Dr Reshma Shah and Jessica Lewsey
			NEL Cancer Alliance	Early Diagnosis Prog Lead	Caroline Cook and Femi Odewale
			Homerton Healthcare	Lead Oncology Nurse	Mary Flatley
			Barts Health	Consultant Medical Oncologist	Dr Katherine Hawkesfod
	City and Hackney Place Based System - update	Verbal update	Homerton Healthcare	CE and Lead for C&H PBS	Louise Ashley
				Acting Dir of Delivery, C&H PBS	Amy Wilkinson
20 Dec 2023	**Community Pharmacy and Pharmacy First Model**		Community Pharmacy North East London (formerly the LPC)	CEO	Shilpa Shah
deadline 11 Dec				Pharmacy Services Manager	Dalveer Johal
			Healthwatch Hackney	Executive Director	Sally Beaven
			NHS NEL Pharmacy commissioning		Rozalia Enti TBC
	Developing a C&H Sexual and Reproductive Health Strategy	Update post public consultation plus other aspects	Public Health	Deputy Director Public Health	Chris Lovitt
			NHS NEL - C&H Place Based Partnership	Clinical Director	Dr Stephanie Coughlin
	1/2 'Delivering Better Outcomes in Adult Social Care' - series of items on new Transformation Programme	From HW at Budget Scrutiny 25 July	Adults, Health and Integration	Group Director	Helen Woodland

				Head of Transformation ASC	Leanne Crook
				Director ASC and Operations	Georgina Diba
10 Jan 2024 deadline 22 Dec	**Cabinet Member Question Time: Cllr Kennedy**	Annual CQT session	LBH	Cabinet Member for Health, ASC, Voluntary Sector and Culture	Cllr Chris Kennedy
	Integrated Delivery Plan for the City & Hackney Place Based System	Part follow up 5 Dec	NHS NEL - C&H Place Based Partnership		Dr Steph Coughlin
			NHS NEL - C&H Place Based Partnership	Interim Director of Delivery	tbc
	1/2 ESTATES CRISIS IN PRIMARY CARE (NHS Primary Care; LBH Planning; LBH Finance)	Follow up from pre pandemic	NHS NEL/ PCNs/GP Confed/ LBH Planning/LBH Finance		
12 Feb 2024	**Future options for Soft Facility Services at Homerton Healthcare**	Follow up 8 Feb short item	Homerton Heatlhcare	CE	Louise Ashley
deadline 1 Feb			Homerton Heatlhcare	CFO	Rob Clarke
	SUBSTANCE MISUSE & the new the combating drugs partnership - our local response to the national strategy				
	Update on implementaton of Right Care Right Person	Follow up from 17 July - short item	AHI	Director Adult Social Care and Operations	Georgina Diba
	2/2 ESTATES CRISIS IN PRIMARY CARE (NHS Primary Care; LBH Planning; LBH Finance)	Follow up from pre pandemic	NHS NEL/ PCNs/GP Confed/ LBH Planning/LBH Finance		
14 March 2024	**DENTISTRY how new commissioning system is working**	Follow up from 16 Nov 22	NHS NEL	Commissioner	Jeremy Wallman
deadline 5 March			East London and City LDC	Secretary	Tam Bekele
			Local dentists		Dr Dewald Fourie or Dr Reja Manbajood
	2/2 'Delivering Better Outcomes in Adult Social Care' - series of items to monitor the new transformation programme	From HW at Budget Scrutiny 25 July	Adults, Health and Integration	Group Director	Helen Woodland
	The Neighbourhoods Programme, PCNs and future of GP Confederation		Neighbourhoods Team	Neighbourhoods Programme	Sadie King
			PCN Clinical Directors	One of CDs and also Chair of LMC	Dr Vinay Patel
			GP Confederation	Chief Executive	Andreas Lambrianou
			HCVS and Healthwatch		
	Safeguarding issues around hoarding and self neglect		Adult Services		

ITEMS AGREED BUT NOT YET SCHEDULED

Pencilled dates					

	In future items the Commission to test the performance of primary care in NEL against the principles set out in the The Fuller Report.				
	New CQC inspection regime for Adult Social Care		Adults, Health and Integration	tbc	tbc
Now postponed until after general election	**Liberty Protection Safeguards - progress on implementation of new system**	Follow up 5 Dec	Adults, Health and Integration	Principal Social Worker	Dr Godfred Boahen
	Consultation on Changes to Continuing Health Care - the Hackney perspective	Follow up from INEL	Adults, Health and Integration and NHS NEL	tbc	tbc
	Revisit progress of Wellbeing Network focus on crisis support	Follow up from 24 April	Adults, Health and Integration	Senior Public Health Specialist	Jennifer Millmore
			Mind in CHWF	CEO	Vanessa Morris
	Food Sustainability Strategy (inc. revised Lunch Clubs plan)	From Chair at Budget Scrutiny 25 July	Policy and Strategic Delivery	AD Policy and Strategy	Sonia Khan
June/July 2024	**Local GP Services Access and Quality - outcome of the improvement plans for GP Access**	Follow up from 13 June	NHS NEL	Clincial Lead for Primary Care	Dr Kirsten Brown
June 2024	**Adult Social Care and Accommodation - planning for future need**	Follow up from 26 April	Adults Health and Integration	Director Adult Social Care and Operations	Georgina Diba
			Climate Homes and Economy	Strategic Director Economy Regeneration and New Homes	Stephen Haynes
Oct 2024	**Budget Scrutiny update on review of Public Health contracts one year on**	Follow up from Budget Scrutiny on 23 Oct 23	Adults Health and Integration	Director of Public Heatlh	Dr Sandra Husbands
	Housing with Care - update	Follow up from Budget Scrutiny on 23 Oct 23	Adults Health and Integration	Director of Adult Social Care and Operations	Georgina Diba
	NHS NEL's Anticipatory Care Strategy - Hackney impact	Follow up from Budget Scrutiny on 23 Oct 23	NHS NEL, Adult Social Care, Public Health		tbc

INEL JHOSC Forward Plan

Potential date	#	Agenda item	Added to agenda on/by:	Author/Presenter
July 2023	1	Community voice: Paul Atkinson re North East London Talking Therapies	Chair	Guest: Paul Atkinson
	2	Collaboratives • Mental Health, Disabilities and Autism Collaborative • Community Health Collaborative	From Feb 2023 meet	Paul Calaminus/Selina Douglas Sally Adams
	3	Health update including slides on: • NEL Big conversation and staffing structure • Financial environment and operating plan • Strike action and Trust updates (BH/ELFT/NELFT/Homerton)	Standing item	Zina Etheridge Henry Black Shane Degaris, Paul Calaminus/Jacqui Van Rossum, and Louise Ashley
	4	ICS Five Year Forward Plan	May 23 internal and external discussions	Johanna Moss
	5	System recovery and resilience • Place partnership mutual accountability framework • System recovery and resilience in Urgent and Emergency Care	From Feb 2023 and Dec 2022 meets	Charlotte Pomery Clive Walsh
	6	Continuing Healthcare policies	Request from NHS	Diane Jones / Don Neame
Nov 2023	1	Health update including: • Outcome of CHC consultation • ICS Five Year Forward Plan • NHS 111 across NEL • Centene GP sell-off update	Standing item Update Carry over From Feb 2023 meet at Chair's request	
	2	System Recovery, Resilience, and winter planning	Carry over	
	3	Recovering Access to Primary Care	Request from NHS	
Jan 24	1	Health update	Standing item	
	2	Update on outcomes of the NEL Research and Engagement Network	From Feb 2023 meet	
	3	Update on the work of the Barts Health-BHRUT Collaborative presented by the Chair in Common	From Feb 2023 meet	

	4	Financial Strategy	From Dec 2022 and Feb 2023 meets	
April 24				

ITEMS TO BE SCHEDULED

- Monitoring new Assurance Framework for GP Practices – follow up from July 2022
- NEL Estates Strategy from 21/22
- Acute Provider Collaborative – follow up from Oct 22 (is this covered by the BH/BHRUT collaborative?)

Items put forward at 12.07.23 JHOSC member meeting

- Disputes resolution procedure to come back to the committee along with any other related changes
- Consultation would have been announced and in place and the 7 place based -
- Organogram is needed re gp surgeries and other information – bring an item on this
- 111 service – **this item is set to come in November**
- Virtual wards update – continuous progress
- Bring IAPTs back as a full item
- Health outcomes for GEM people re maternity and testicular cancer for GEM population
- Parasite transmission and treatment