Overview & Scrutiny

Health in Hackney Scrutiny Commission

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

Wednesday 20 March 2024

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/waLzaO48qKo

Back up live stream link: https://youtube.com/live/kIHJS9rVP-I

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, Cllr Humaira Garasia and Cllr Ian Rathbone**
1 Conservative vacancy

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

7 Health in Hackney Scrutiny Commission Work Programme (20.56) (Pages 71 - 78)

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

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')

Scrutiny Panel

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Hackney

Health in Hackney Scrutiny Commission 20th March 2024 **Homerton Fertility Centre - suspension of licence**	Item No **4**

PURPOSE

To receive a verbal update from the Chief Executive of Homerton Healthcare to the suspension of the licence of the Homerton's fertility centre.

OUTLINE

On 8 March 2024 Homerton Healthcare announced that the Human Fertilisation & Embryology Authority which governs the running of fertility units in England has suspended the licence of Homerton's fertility centre. This means that the centre will not be able to accept any new bookings for treatment. However, existing patients can still access their services.

Attached in the letter which the Trust issued in response to the incidents which led to suspension.

The issue received national press coverage such as here by the BBC:
https://www.bbc.co.uk/news/health-68510577
And here by the Guardian
https://www.theguardian.com/uk-news/2024/mar/08/east-london-homerton-fertility-clinic-has-licence-suspended-after-losing-embryos

Invited for this item is: **Basirat Sadiq, Chief Executive Designate, Homerton Healthcare**

ACTION

The Commission is requested to give consideration to the report and discussion.

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Homerton Healthcare
NHS Foundation Trust

Homerton Healthcare
Trust Offices
Homerton Row
London
E9 6SR

Tel: 020 8510 7244

08th March 2024

Important Information regarding the Fertility Unit

I am writing to keep you updated on recent events in the Fertility Unit. If you, your eggs, sperm or embryos have been affected by these events directly, you will have already been contacted by our clinical teams.

We have now had 3 separate incidents in the last year within the unit, which have highlighted errors in a small number of our freezing processes. Tragically, this has, in some cases resulted in a small number of embryos either not surviving or being undetectable. We have external clinical experts investigating these incidents and, whilst they have not been able to find any direct cause to explain this, we have made changes in the unit to prevent re-occurrence of such incidents. These include:

1. All our staff now work in pairs to ensure all clinical activities are checked by 2 healthcare professionals.
2. We have re-checked all competencies of staff within the unit.
3. We have increased the security and access points in the unit.

I would like to apologise to those affected and for the concern this may cause you even if you, your eggs, embryos or sperm are unaffected. I felt, however, that it was essential to keep you fully updated as soon as possible.

We have and continue to be working alongside the Human Fertilisation and Embryology Authority (HFEA) and are keeping them fully appraised of the situation. Today they have suspended our license to practice until May 2024. However, they have made provisions within the suspension for all current patients who are undergoing treatment to complete their treatment and for all eggs, embryos and sperm to continue to be stored in the clinic.

You may have questions regarding this letter and what to do next so we have set up a helpline to answer as many of your questions as possible. Once again, if you, your eggs, sperm or embryos have been affected by these events directly, you will have already been contacted by our clinical teams.

DETAILS OF HELPLINE: 0208 510 5211 opening hours are from 8am – 6pm 7 days a week.

Please accept my sincere apology for the distress this may have caused. We will update you with any new developments.

With Best Wishes

Louise Ashley
Chief Executive and Place Based Leader

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Hackney

Health in Hackney Scrutiny Commission 20th March 2024 **Estates Strategy for GP Practices and Out of Hospital Care in Hackney - Discussion**	Item No **5**

PURPOSE

To examine again the ongoing challenges with out of hospital estates in Hackney (GP Practices, Neighbourhoods, out of hospital care). To examine the current and future model for this provision and to discuss with key stakeholders ways in which progress can be made in both extending and improving the current estates provision to meet the new models of care.

OUTLINE

This issue arose from Members, from responses to the annual scrutiny survey, and in requests from the LMC and the Primary Care Clinical Lead.

It has been some time since the Commission was able to address these issues in detail. It devoted most of a meeting to the strategic issues (including estates) which drives primary care locally at its meeting on 16 March 22. The minutes and documents are here: https://hackney.moderngov.co.uk/mgAi.aspx?ID=39530

A larger meeting had been planned in Spring 2020 but was cancelled due to the pandemic. Prior to that there had been a session on the NEL Estates Strategy on 26 Sept 2018. The minutes and documents are here: https://hackney.moderngov.co.uk/mgAi.aspx?ID=32503

The meeting will attempt to explore the following questions.

1) Where are we now post pandemic with NEL Estates Strategy over all?
2) What has been done in defining the model of care needed and the estates needed to then deliver on that?

3) How does capital allocation work in NEL and where does C&H primary care fit into current NEL priorities?
4) What are the drivers for change here:

- *state of disrepair in surgeries*
- *limitations in activities while the system wants primary care to do more*
- *changing demographics*
- *GPs retiring and GP Practices closing and merging*
- *recruitment and retention challenges*

5) What are the opportunities here (e.g. due to national policy changes)?
6) What are the main barriers to progress (local, sub-regional, national)?
7) How can this be achieved in the context of NHS cost cutting overall?
8) How can the Council be more proactive in planning for primary care provision with the NHS partners?
9) What is the current status of provision on GP surgeries within the infrastructure delivery plan part of LP33 - the Local Plan https://hackney.gov.uk/lp33 and how is it being revised?
10) How has the LBH Strategic Property worked with NHS partners recently?

Attached please find:

1) Presentation from NHS NEL Primary Care
2) Joint presentation from the Neighbourhoods Programme and the Office of Primary Care Networks for City and Hackney
3) Presentation from Hackney Council - Strategic Property

NHS NEL's key documents, previously at INEL are here, but are from 2018
https://www.northeastlondonhcp.nhs.uk/ourplans/foundations-the-enablers/estates/
The overarching document is this
https://www.northeastlondonhcp.nhs.uk/wp-content/uploads/2023/05/18_10_NEL_ELHCP_Strategic_Estates_plan.pdf

CONTRIBUTORS

The following have been invited to contribute to the discussion.

No.	Representing	Title	Name
1	NHS NEL Primary Care	Director of Delivery for Primary Care Commissioner	William Cunningham-Davis Richard Bull
2	NHS NEL Primary Care	City and Hackney Clinical Lead for Primary Care	Dr Kirsten Brown
3	NHS NEL - Estates	Deputy Director of Regeneration and Infrastructure and Co-chair the Task and Finish Group Primary Care Estates	Louise Phillips
4	C&H Office of Primary Care Networks	Operations and Programme Director Clinical Directors 1 of 6	Agnes Kasprowicz TBC
5	Neighbourhoods Programme C&H	Neighbourhoods Programme Lead	Dr Sadie King
6	Local Medical Cttee (BMA)	Chair for City and Hackney	Dr Vinay Patel TBC
7	Homerton Healthcare	Head of Integration Director of Estates, Facilities and Capital Deputy Director of Estates	Annabelle Burns Natalie Firminger Tony Wright
8	Hackney Council	Director of Strategic Property Senior Asset Management Advisor	Chris Pritchard David Borrell
9	Healthwatch Hackney	Executive Director	Sally Beaven

ACTION

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

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NHS
North East London

Estate update from the C&H primary care team

Partnership working with LBH

City and Hackney (C&H) primary care team (was CCG now ICB) has been working in partnership with LBH Strategic Property Services since 2018 to address long-standing areas of need in the primary care estate. Underpinned by section 256 funding (i.e. the CCG part-funded 2 x LBH estates posts with this arrangement ending Sep 2023), this work has involved:

- Capacity, advice and support in dealing with CHP and NHSPS to address issues with existing buildings and relocate practices into vacant space. Examples include moving Wick HC into the long empty ground floor at Kenworthy Road; design stages relating to the redevelopment of John Scott Health Centre (as well as securing S106 funding) and Somerford Grove/Barrett's Grove; temporary extension to Trowbridge Surgery (which was subsequently abandoned)
- Identification of unused sites within the LBH property portfolio for potential redevelopment as primary care facilities; this included Stamford Hill Library as well as the two big capital projects below
- Where sites have been identified, working to obtain capital funding (LBH has provided its own capital for Portico/Belfast) and with practices on the design of the developments (as part of the wider design team) and supporting the primary care team on governance around approval of reimbursable rent including provisional value for money assessments from the District Valuer
- Two significant capital projects now nearing completion (see details to the left) and a further project to refurbish 92 Well Street as a multi-agency homelessness hub and new home for the Greenhouse Homeless Practice

The Portico

New home for Lower Clapton Group Practice

Due to be completed Jan/Feb 2024

18 consulting rooms

6 treatment rooms

1 minor procedures room

Administrative, staff and patient accommodation and reception areas

Belfast Road

New home for Spring Hill Practice

Due to be completed Apr 2024

20 consulting rooms

3 treatment rooms

1 minor procedures room

Administrative, staff and patient accommodation and reception areas

Business cases for additional space

Circumstances where practices would like to take on or create additional space for service delivery under their core contract require commissioner (ICB) approval, principally for the increased revenue costs associated with rental reimbursement but in most cases also for additional IT equipment and associated infrastructure.

Requests of this nature can involve practices located in leased premises seeking to occupy vacant space in the same building (if and when this becomes available) or practices seeking to develop or reconfigure space within a partnership owned building. Both scenarios can have revenue implications for the ICB and the latter may also involve capital investment (normally through an Improvement Grant (IG) – see next slide).

When we were a CCG approval in principle of increased rental reimbursement associated with business cases has been relatively straight forward through the local Primary Care Commissioning Advisory Group. However, value for money reports from the District Valuer (DV) needed for final sign off often take several months resulting in delays to increased reimbursement. In the past, there has also been delays relating to provision of additional IT equipment and infrastructure due to the availability of capital funding and pressure on GP IT revenue budgets.

Due to its current financial situation the ICB has put a temporary hold on agreeing any new applications (which currently applies to the Greenhouse relocation).

Business cases approved since 2021

- F84015 Kingsmead – practice reconfigured parts of their building previously unused for service provision at own cost. CCG/ICB approved increased rental reimbursement.
- F84008 Barton House – practice occupied vacant space in their building, leased from NHSPS, resulting in increased rental reimbursement. Space used as clinical admin room facilitating more efficient use of consultation rooms.
- F84105 Lea Surgery – practice occupied vacant space in their building, leased from LBH, resulting in increased rental reimbursement. Again, new space facilitates more efficient use of consulting rooms.
- F84620 Wick HC – practice occupied two additional, previously vacant consultation rooms in Kenworthy Road. Additional rental reimbursement approved.
- F84096 Lawson Practice – Redevelopment of 2nd floor space previously unused for GMS service provision. Subject of IG application (see next slide).
- F84632 Greenhouse – Additional space at 92 Well Street development (see previous slide).
- Also approved the b/case from Shoreditch Park PCN to take on the vacated Whiston Road premises (which the PCN did not take up due to cost of NHSPS service charges)

Business cases expected in coming months

- Y00403 Trowbridge – request to take on vacant consultation rooms at Kenworthy Road, in addition to existing premises, following multiple previous attempts to address acute space issues at current site (portacabin project abandoned).
- F84015 Kingsmead – seeking approval for increased rental reimbursement for further reconfiguration of building to create additional consultation rooms.

London Improvement Grant (LIG)

- The ICB receives an annual capital allocation to support practices with premises improvements from Infection Prevention and Control (IPC) compliance to substantive redevelopments of their buildings.
- Current LIG regulations stipulate that grants can only cover 66% of the cost, with practices having to meet the remainder, which sometimes deter applications.
- All applications are subject to extensive due diligence processes involving processes to ensure value for money, validation of current lease arrangements and longevity, landlord permission and, for more substantive work, building and planning regulations. Practices do not always have the experience or expertise to manage this process.
- Grants awarded for works on practice owned buildings are subject to abatement on associated increases in rental reimbursement, meaning that a proportion of the increase resulting from the grant funded works will be deducted to compensate for NHS capital investment. This only applies to notional rental reimbursement.
- The table below contains a summary of approved LIG schemes at City and Hackney practices for 23/24 (some rolling over into 24/25). There was also expressions of interest submitted by practices at Fountayne Road Health Centre, Trowbridge Practice and Athena Medical Centre for various reconfiguration and IPC related works but these were subsequently withdrawn by the practices.

Practice	Description of works	Value of grant (66%)
Well Street Surgery (F84069)	Conversion of 2 admin rooms & 1 seminar room on 2nd floor to create 4 new clinical consulting rooms, associated works and fees	£78,200
Lawson Practice (F84096)	Conversion of 2nd floor office space into clinical rooms x 8 (please ensure room sizes meet minimum standards) and associated clinical compliant works to new rooms	£46,200
Elsdale Street Surgery (F84601)	Clinically compliant sinks, Clinically compliant flooring, Fire regulation works to exits, lighting in clinical rooms	£23,100
Allerton Road Medical Centre (F84716)	Installation of Lift (revenue), Installation of clinically compliant flooring to clinical rooms, Convert open plan areas into three clinical rooms	£137,940

Neighbourhoods

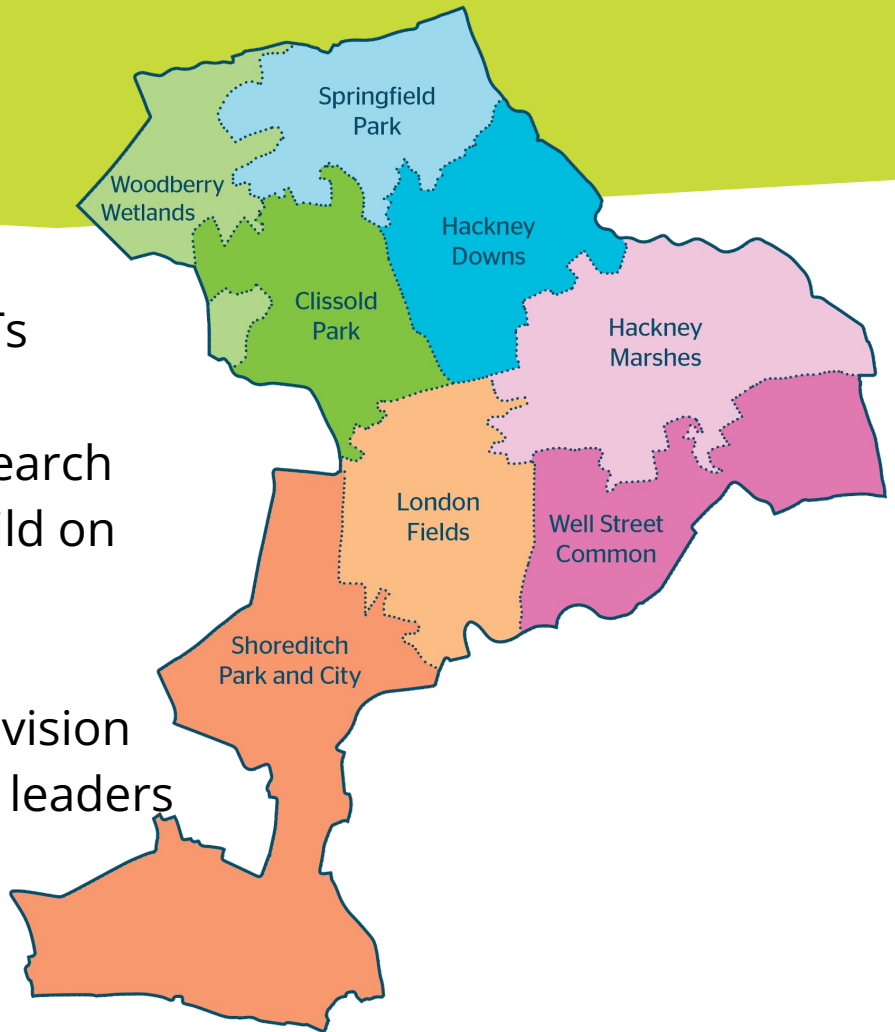
City & Hackney Living Better Together

Neighbourhoods Estates Planning - March 2024

Sadie King Neighbourhoods Programme Lead

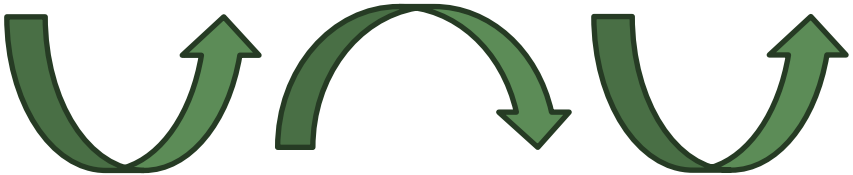
Neighbourhood & Estates

1. Where we are going- INNs or INTs
2. Key issues for estates needs
3. Examples of location of INTs research
4. Examples of good practice to build on
5. A Neighbourhood pilot example
6. Approach to estates planning
7. Neighbourhood hubs: emerging vision
8. The role of local Neighbourhood leaders



Where are we going - Neighbourhoods?

A Programme of Change



Business as usual

The current trajectory of Neighbourhoods:

a) Shaping teams around the 8 footprint
b) Creating structures to support working together, resident engagement and population health management
c) Creating colocated matrix teams (core team) that works with complex cases and wider 'team' that feeds in specialist support and wider determinant service support like housing or cost of living.

There is a consultation underway to review that trajectory. Integrated Neighbourhood Network or Integrated Neighbourhood Team? Research and mapping paper discuss this in more detail.

Key issues for planning for estates.

1. LTC and complexity served better. Personalisation and secondary prevention = Office space, hot desk for matrix team to work together. Assessment space: Community therapies. Case coordination and one to one space: navigators, mental health teams.

2. Primary prevention, addressing Health inequalities and addressing the wider determinants of health = resident activity space where prevention and wider determinant services can be delivered.

Key issues for planning for estates.

3. There is no primary care estate available for extra team members or services to collocate. We have to look into the Neighbourhoods for other options.

4. Each Neighbourhood is different. We need to unlock estate by understanding local need and mapping resources in each location. Negotiating access to space.

Examples of location of INTs and INNs from our research

Permanent Physical Space

- In the research we found 7 clear examples of INT's being located in a permanent physical space
- All of these INT's are quite well established as a core INT of health and care services and some with broader non health and care team members such as VCS services or housing colleagues
- Wigan has 7 Neighbourhoods with a community hub, they acknowledge the hubs that have enabled the best integration and collaboration are those with open plan offices
- In some areas Covid has meant they have needed to think INT location and challenge working from home where it is felt to be affecting relationships
- In Leeds they are working more closely with third sector organisations to utilise physical space in Neighbourhoods. Flexibility to see residents and meet with staff has helped build relationships and efficiencies.

Blended in person and online

- Blended approaches to working together across organisations have evolved iteratively in response to opportunities of available estates, culture and expectations resulting from the home working during the pandemic
- Birmingham's INT's use a mixture of online and face to face work. Currently based in GP surgeries with face to face colocation 2 days a week
- Liverpool are now working to reinstate face to face meetings to about 50%
- Many teams spoke about their use of the chat function on MSteams and where appropriate 'what's app' chats to keep the teams connected and dynamic

Examples of good practice to build on

- Community Connectors and Wellbeing Practitioners work flexibly across locations as they are guided by what works for their resident e.g. local cafes, outdoor locations like parks, home visits, community centres or GP practices. Other VCS colleagues are often based in their organisations offices for example Shoreditch Trust or Peter Bedford in Haggerston.

- Community Nursing teams have bases in 4 community locations; Fountayne Road; John Scott Health Centre; Lower Clapton Health Centre; and Dalston Practice. This enables them to store supplies, complete their records and interact with primary care colleagues.

- The C&H Integrated Learning Disability Team work (not Neighbourhood structured) work collocating from a range of health and local authority locations as well as online. Many service leaders are keen to explore digital opportunities and ensure the digital offer works for staff and teams.

Neighbourhood Pilot: Adult Community Rehabilitation Team (ACRT) Neighbourhood Assessment Clinic/Co-location project

ACRT would like to work with partners to co-locate and offer a multi-disciplinary assessment to clients who are on an ACRT waiting list, awaiting assessment by the physical physiotherapy team.

The proposal is for a pre-identified cohort of clients who can independently access the community, to attend a neighbourhood based initial ACRT assessment. We are currently identifying 2 community locations, 1 north and 1 south of the borough which would be a space that other community services could also access.

This equates to 40% of all physical team referrals. This is approx. 627 clients that could be seen quicker in an environment where other activities may be available.
ACRT waiting times fluctuate and the service cannot always see clients within 8 weeks.

Approach to developing Neighbourhood Estates plans

1. Gain system agreement on the refreshed vision for Neighbourhoods working: INN or INT?

2. Dedicated 1 year fixed term post (secondment. Band 7) to work with NEL team and Neighbourhood leadership groups to create a plan of work and support unlocking of estate for each Neighbourhood. This would include ICT support needs.

3. Build a clearer picture of the needs of each Neighbourhood and support growth of colocation.

Current emerging request from staff and resident consultation: A Neighbourhood Hub

- Complex monthly MDMs to be blended and collocated in a setting that also has hot desk and good internet access so that Neighbourhood partners can work together on that day. Meeting space with a screen and internet.
- Resident space with café and/or other activities that present opportunities for non-medicalised, non-stigmatised, assessment care and information sharing.
- Group meeting space for Neighbourhood Forums and other activities where residents can be in a working dialogue with the Neighbourhood professionals.
- Private one to one meeting space for assessments, talking therapy, smoking cessation, blood pressure monitoring and wide range of care coordination
- A place of reference that both staff and residents recognise as their health and care touch point in the Neighbourhood
- Office space for hotdesking or permanent location of a core Neighbourhood team sharing case load (if that is confirmed as the future option)

The new Neighbourhood Leadership Groups and the Neighbourhood Forums are pivotal in this work.

The purpose of the Neighbourhoods Leadership group is to empower the wider 'Neighbourhood team' to work collaboratively with different services and improve outcomes for residents. Health inequalities are identified, and interventions are developed through new projects or improving existing services. The PCN is the heart of the leadership group and works closely with the Neighbourhood forum to ensure local views are heard.

Leadership Groups who have met and how many times:

- Shoreditch Park and the City x 4
- Woodberry Wetlands x 3
- London Fields x 3
- Well Street Common x 3
- Hackney Marshes x 3
- Hackney Downs – x 1
- Springfield Park - Introductory meeting, complete - Date to be confirmed for first Leadership meeting
- Clissold Park - Introductory meeting, complete - Date to be confirmed for first leadership meeting

Services who are part of the leadership group:
HCVS, Hackney Council, Homerton, Adult Social Care, CYPMF, Community Nursing, Social Prescribers, Housing, Strategy Leads, Healthwatch

The new Neighbourhood Leadership Groups and the Neighbourhood Forums are pivotal in this work.

Examples of current work

London fields HI projects:

- supporting their residents with housing issues and looking into holding housing clinics to be able to offer face to face support within surgeries.
Focus on childhood obesity, through strengthening referral pathways, bringing clinicians together, working with schools to develop educational days at the surgery around healthy weight.

Woodberry Wetlands HI projects:

- Helping one of their surgeries (Allerton Road) that has a small Orthodox Jewish population with a health fair, which will include vaccines, dental care, dietetics and useful information. Providing money to support the fair.
- There is currently a grant application being put together to support asylum seekers with cooking provision at the Redmond centre. The Leadership group are developing a plan to help the case worker who works with the asylum seekers, setting up health provisions around the sessions. A working group is being coordinated to take forward the plan.

Estates has been raised in some of the Leadership groups, it will be added to all of the agendas as a standing item.

Thank you

Sadie King
s.king33@nhs.net

Neighbourhoods

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Strategic Property & NHS North East London Integrated Care Board

Health in Hackney - Discussion on Estate Strategy

Strategic Property: working with NHS Partners

Over 6 years to September 2023 strategic property provided professional asset and estate management support to City and Hackney CCG and NHS NEL ICB via a Section 256 Agreement. Examples of the projects include:

- Collation and preparation of an Asset Register of GP Surgeries
- Space utilisation review and handback of void accommodation to NHS Property Services
- Relocation of the Wick Practice to Kenworthy Road
- Securing of £150k of OPE funding for a Healthcare demand and capacity analysis for St Leonards Hospital.
- Securing circa £280k of Section 106 funding for primary care projects
- RIBA Stage 2 review of expansion options for John Scott Health Centre.
- Somerford Grove Health Centre - Potential redevelopment project
- Trowbridge Practice - Potential relocation/development options

Strategic Property: recent working with NHS Partners

Since the expiry of the Section 256 Agreement strategic property continue to lead on the development of:

The Portico - Grade II Listed new Surgery for Lower Clapton Group Practice

- 18 Consulting Rooms
- 6 Treatment Rooms
- 1 Minor Procedures Room

Belfast Road - New Build Surgery for Springhill Practice

- 20 Consulting Rooms
- 3 Treatment Rooms
- 1 Minor Procedures Room

92 Well Street - Potential Relocation of the Greenhouse GP Surgery and Homeless Prevention Service Hub

Planning: GP Surgeries & Infrastructure Delivery Plan

The main policy in the Hackney Local Plan 2033 (July 2020) dealing with community facilities is LP8 `Social and Community Infrastructure' and in the supporting text it does state that the 2018 Infrastructure Delivery Plan has identified the need for additional GP capacity within the Borough up 2033.

- As well as The Portico and Belfast Road developments there have been discussions at various levels regarding works to other existing facilities such as Somerford Grove Practice, the John Scott Centre, Lower Clapton Health Centre, and previously the use of Stamford Hill Library as a PCN.
- The Council needs to work with a network of bodies such as the NHS North East London Integrated Care Board, East London Health and Care Partnership, NHS Property Services to take account of their plans and strategies and type of facilities and services including GPs needed to improve the health and wellbeing of the local population.
- Work to review Hackney's Local Plan is due to start towards the middle / end of 2024, it will include an update of the Infrastructure Delivery Plan, which takes into account the 2021 census, latest population and development projections.

Hackney

Health in Hackney Scrutiny Commission 20th March 2024 **Minutes of previous meetings**	Item No **6**

OUTLINE

The draft minutes of the meetings held on 10 January and 12 February are attached as well as the Action Tracker.

ACTION

The Commission is requested to agreed both sets of minutes as a correct record and note the action tracker.

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Wed 10 January 2024 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 Sharon Patrick and Cllr Claudia Turbet-Delof**
Cllrs joining remotely	**Cllr Frank Baffour**
Cllr apologies	**Cllr Ifraax Samatar, Cllr Grace Adebayo**
Council officers in attendance	**Georgina Diba**, Director - Adults Social Care and Operations **Dr Sandra Husbands,** Director of Public Health **Amy Wilkinson**, Director of Partnerships, Impact and Delivery, C&H PBP **Helen Woodland**, Group Director, Adults, Health and Integration
Other people in attendance	**Sally Beaven,** Executive Director, Heatlhwatch Hackney **Dr Stephanie Coughlin**, Clinical Director, C&H PBP **Cllr Chris Kennedy**, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture **Basirat Sadiq,** Deputy Chief Executive, Homerton Healthcare
Members of the public	84 views
YouTube link	View the meeting at: https://youtube.com/live/He0nB5ppjIc
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 Apologies were received from Cllrs Adebayo and Samatar.

1.2 The Chair thanked Louise Ashley who had announced she will be leaving as CE of Homerton and the Place Based Leader for City and Hackney and thanked Basirat Sadiq Deputy CE at Homerton Healthcare who was present in her place.

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Update on implementation of Right Care Right Person

4.1 The Chair stated that this item was a follow up to the discussions at the Commission on 17 July. The new system had been due to come on 30 Aug but had been delayed to 1 Nov. They'd asked officers to come back to update us on how it was bedding in. He reminded Members that this represented a fundamental change to when Police will be deployed around welfare concerns, mental health incidents or missing persons or those who have absconded from hospital.

4.2 He welcomed for the item: Georgina Diba (**GD**), Director Adult Social Care and Operations.

4.3 Members gave consideration to 'Right Care Right Person' briefing note.

4.4 GD took Members through the report in detail. It was noted that change meant the Met Police could reconsider when police have to be deployed and there would be a change of approach to call handling. She provided reassurance that there were a number of structures in place to look at how it was being implemented and they had been given an additional two months. She stated she was pleased there had been no major concerns or escalations since it came in on 1 Nov. Early indications were that there had been an increase in demand to NHS 111 with Mental Health calls. A S136 Hub had been implemented. Overall the change had gone smoothly with a lot of work in the background to ensure that structures were in place. They were waiting for feedback on costs to other parts of the system.

4.5 Members asked questions and the following was noted:

a) Chair expressed a concern about those calling 999 being referred to 111 and if there was somebody on the line that didn't meet the threshold were they patched through to ELFT or told to phone 111.
GD replied that, unfortunately, there was a double contact and so it is not the 'soft handover' they would have expected so the system does create some risks. She added that police deployments had reduced from 44% to 31% of in scope calls i.e. call relating to welfare calls if someone was missing in the community or AWOL from a health facility or in mental health crisis. There had been a 13% reduction in police deployment therefore. She clarified that even though the police were not deployed it didn't mean a service wasn't deployed.

b) The Chair asked if there was a beefed up ELFT triage service that could be deployed if for example LAS wasn't needed.
GD replied that additional resources were deployed to make sure there was a response. There had also been a reduction in the number detained under MH Act and this was a positive result.

c) Members asked if the fluctuation in numbers might be as a result of people not being sure that a service is there for them
GD replied that the S.136 Hub allowed police to call in and ask for advice on cases, so what RCRP is doing is shifting how those conversations happen and it has forced partners to start communicating in a different way.

d) Members asked when the budgetary impact of the new system on the health and care partners will become clear?
GD replied that all areas across London are examining this. There was an NEL oversight group pulling together information on the costs and the costs across London will vary across local authority and ICS areas.

e) Chair asked whether it had even been discussed that some of the police budget be reallocated to fund this?
GD replied that the view was that there wasn't additional money for this.

f) The Chair asked how in a usual 999 emergency the police can allocate a case over to an NHS response and why this automatic handover doesn't happen here.
GD replied that it can be done and that had originally been discussed in the briefings given. She had observed a Hackney case where they were told to call for an ambulance. She undertook to ask the police why there wasn't a soft handover in these instances.

g) *The Chair stated that unless there was a recording those who call and get referred to another service could drop out and it could be a serious case that was then not followed up. It does seem that this needs to be monitored quite carefully and careful handovers be put in place.*

h) Sally Beaven for Healthwatch Hackney commented that they were doing Enter and View inspections to closed mental health wards and that as part of it they had asked staff about RCRP. They heard concerns that when a patient absconds, in the past, the police would go out but now this falls on the hospital staff who are overstretched and this will present a major burden for them to leave the ward.
GD replied that she had not seen evidence that this was yet happening. There was a London wide policy on absconsions and all that is happening here is that the police are asking health and care to take proportionate actions that are within their power such as calling the person's next of kin or making general enquiries. It was not taking over the police's full responsibility to be deployed if there is a risk of the individual harming themselves or others. It is rather that the police have asked partners to take a proportionate response before calling them.

i) The Chair asked if we could monitor and push for the soft handover to make sure it is really happening as there was a tangible risk of people not making that second call. He asked how we can be assured that a soft handover between services is embedded in the system.
GD undertook to seek this assurance and provide a written response to the Commission.

ACTION:	**Director of Adult Services and Operations to seek assurances from the Met Police and provide a written response to the Commission that a carefully monitored soft handover is being done since the implementation of RCRP.**

j) Members asked if there was a mechanism for a review of RCRP at some point in the future to make sure the system is working.
GD replied that the approach was now in place and wouldn't be pulled back. It had been implemented in Humberside over a 2-3 year period. There was a London group overseeing implementation and as part of that they are reviewing the data and incidents that come up and will be reviewed over next two years.

k) Members asked how the London Ambulance Service was coping with the introduction of RCRP.
GD replied that she didn't have a firm response on that. There had been an increase in calls to LAS and they have been deployed to people in mental health crises as well as just to accompany people to a hospital.

4.6 The Chair thanked GD for her update. He stated that in 6 months it might be appropriate to receive a brief update. He reiterated that he wanted assurances that a soft

handover is happening in all circumstances. If necessary the Commission could write to the head of the Met Police to ask what needs to be done to make sure it is happening.

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

5 Update on future options for soft facility services at Homerton Healthcare

5.1 The Chair stated that this item was to receive an update from Homerton Healthcare on the current status of discussions about the future of the 'soft facilities services' at the Trust including possible insourcing. The Commission had previously discussed this on 8 Feb 2023 and 9 July 2020. Soft services refer to catering, portering, cleaning, security services etc

5.2 He welcomed for the item: Basirat Sadiq (**BS**), Deputy Chief Executive, Homerton Healthcare and for her detailed the history of the Commission's previous items on this.

5.3 BS gave a verbal update. The contract is up for renewal in 2025. The plan to review the service has been delayed by a year because of changes in leadership in the Trust and the estates function being moved under another director. The Trust has been recruiting to a substantive new post of Director of Estates. In the meantime they've appointed on 6 month secondment one of the key figures who did the insourcing work on facilities at Barts Health and he had started two weeks previously. They will need to look at the options through a Value for Money Framework and are committed to ensuring they improve working conditions of these key staff. They've also been discussing this with the other trusts who are part of the Acute Provider Collaborative. There is now an Estates Provider Collaborative and they are having conversations on a joint agreement around estates issues. She's also discussed this with the Group Director of Barts Health. She'd also met with the unions to hear their concerns. As the plans progress they will look at an opportune moment to come back to the Commission with an update.

5.4 Members asked questions and the following was noted:

a) The *Chair commented that in his 11 years on the Commission this was the most promising news he'd heard on this issue and he asked about the timescale. He asked about the option to have another NHS partner such as Barts Health providing the service adding that he hoped the review won't take too long and will prevent any need to extend the current provider just because time had run out.*
BS replied that it was helpful to bring a key contact from Barts Health to lead the review. She was aiming to take his first draft of the review to the Trust Board and the Finance and Policy Committee in July-August. The schedule is to ensure they have enough time and she was conscious that there shouldn't be a need to extend the current contract if that wasn't a necessary option.

b) Members asked what form will the involvement of the unions take?
BS replied that when they met there were a number of issues that need to be addressed with ISS, the current contractor, which was separate. As they proceed through the procurement exercise they have stakeholders who will be part of that process. They meet with the unions regularly as part of the staff engagement process. They would have full involvement in the

tendering process. Outside of that they will continue to meet with them as part of normal business.

c) Members asked what the budget impact of going in-house will be, noting that the contractor now also pays sick pay and London Living Wage.
BS replied that this will be part of the review. She added that there is an initial cost as you try to align terms and conditions and then you look at impact long term. The learning from Barts Health had been that there is definitely a cost impact as you try to align the terms and conditions but that will be part of the review.

d) Members asked what the financial impact would be of TUPE'ing all the staff.
BS replied that they need to consider the costs and the impact of TUPE as part of the review. Costs will be dependent on the structure if they go down a route with the Acute Provider Collaborative then the structure would look different. She clarified for the Chair that if the staff were brought into Barts Health for example there would be a legal obligation to undertake a TUPE arrangement.

e) Members asked if HH decides to go in-house how prepared is the Trust and how quickly could it happen.
BS replied that it would be part of the tendering process and it's one of the things they would have to consider as they go through the due diligence. Once you have a start date it can be rapid however. She added that if a decision was made to bring them in house it would follow a detailed management timeline approach.

5.5 The Chair thanked BS for her update and reiterated that the Commission would welcome in-housing if possible and asked to be kept appraised of developments.

ACTION:	**A further update to be scheduled for the Sept or Oct meetings of the Commission.**

5.6 The Chair asked about the status of the recruitment proces for a new Chief Executive for Homerton Healthcare as that person was also the Place Based Leader for City and Hackney. BS replied that the job advert would close on 19 Jan with interviews in early February and it was likely that someone at that level would be on 6 months notice. It was noted that Lousie Ashley would depart in May so there might be a hiatus before the replacement was in post. It was noted that Cllr Kennedy would be on the interview panel in his role as the Cabinet Member for Health and Chair of the Health and Care Board.

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

6 Integrated Delivery Plan for City & Hackney Place Based System

6.1 The Chair stated that this item was suggested by the Clinical Director to update members on the progress being made by the City and Hackney Place Based Partnership which sits under the North East London Integrated Care Board. He reminded Members that at its meeting on 15 Nov the Commission had discussed the organisational structures of the City and Hackney Place Based System.

6.2 He welcomed for the item:
Dr Stephanie Coughlin (**SC**), Clinical Director, C&H PBP
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP

6.3 Members gave consideration to the following papers:

a) Integrated Delivery Plan 22-24 for C&H Place Based System
b) C&H PBP Governance Chart
c) NEL ICB System Planning Cycle 24/25

6.4 SC and AW took Members through the reports. SC explained the situation regarding the *Clinical Care and Professional Leadership (CCPL)* roles. They had recruited to a refreshed model in March '23 after extensive engagement to establish what would work with a small reduction in resources. That was on the basis that these roles would be in place until March '25. Now, in the context of a more difficult financial landscape a change was made in July to put these roles in scope for cost savings. Following this they had been asked to find a 30% reduction in Place based roles in clinical leadership. This was a difficult position to be in but reflective of the challenging financial landscape of the NHS. As a Place Based Partnership, having stable CCPL roles had been key to how they maintained the high quality of their care. There had been discussion across the PBP to understand how they might mitigate these reductions, recognising that a lot of their funding is on a non-recurrent basis. She added that they had agreed at Health and Care Board that afternoon how they would mitigate the cut by identifying some non recurrent monies that could be used for this but this would only apply for one year. The difficulty will be for 25/26 in how to reconcile differences between what's sustainable in terms of ongoing resources and what else might be available from the ICB. They will examine how they can utilise existing resources in the PBP more effectively and how they prioritise with limited resources. She added that there were obvious risks to further reductions in CCPL roles which they are very mindful of. What had been positive however was that all the stakeholders absolutely recognise the value of CCPL and they are committed to do all they can to retain this level of resource.

6.5 Members asked questions and the following was noted:

a) The Chair asked what a 30% reduction in these posts will look like?
SC explained how they quantify this by using numbers of sessions, with one session being 4 hrs either morning or afternoon and currently they have 35 sessions per week across the PBP. This would go down to 24.5 that's the equivalent of losing 5 days of work per week or 4.5 to 5 FTE posts engaged in this work.

b) The Chair asked what Dr Coughlin's current split was as the Clinical Lead.
She replied her time was 50% Clinical Lead (i.e. CCPL work) and 50% her own GP surgery work. She added that there would also be additional asks on her time for NEL wide areas of work (on top of City and Hackney work). She added that while there were no plans to reduce her or Dr Brown's (Primary Care Clinical Lead) work there will be more expectations on them for other NEL wide work in future.

c) The Chair asked who funded the Money Hub and if it was from a non-recurrent pot?
AW replied the council but there was a significant contribution from the NHS. They were going through an exercise to highlight all non recurrent funding streams that are potentially at risk as we move into new financial year. They want to prioritise those that have proved to be effective. There is a little bit of flexibility but they need to see what arises from the ICB budget planning exercise.

d)The Chair asked when it was funded to?
Cllr Kennedy said it had been for a year. He had just come from a meeting on the Poverty Reduction Work and where they were looking at how they restructure the Money Hub as there will have to be a reduction. They still hadn't had confirmation that the government's Household Support Fund, which funded it, would continue. The Council and partners aim to keep the Money Hub going especially those elements that have the biggest impact on people's lives. The Chair commented that it was a tangible outcome and obviously very successful (£13m unclaimed benefits claimed for Hackney alone) and so it needed to continue.

e) Members commented that while it was very successful they had also heard experiences of residents who are waiting some time for a response. They asked if there could be plans to expand it.
AW replied that expansion was unlikely and Cllr K added that continuation at the same level would be a win at present.

f) In relation to the childhood immunisation challenge, the Chair stated that the previous meeting they had heard from pharmacies about their potential increased role in immunisation campaigns. He asked if more could be done here?
SC replied that immunisations were a key priority. They have a dedicated Immunisation and Vaccination Clinical Lead since April to do some of this targeted work in Springfield Park PCN. The latest dashboard information has shown improvements and linking in with pharmacies was part of that. One of things they had taken away from recent data was that they had perhaps been too PCN focused and there was a need to recognise that some of their communities lived outside that PCN and there were other areas such as Hackney Downs which they needed to look at who might be missing out so the aim was to bring other GP Practices into the work. Pharmacies were key but they were practical challenges. Not all pharmacies can deliver these childhood vaccinations, but their outreach work with them was making a difference. Through individualised work they were considering how they can flex what is working on one PCN to other nearby postcodes.

g) Members asked if they had reached out to independent schools to target parents of large families who drop a child off at a school and they may have other small children with them who could be targeted at a Pop up clinic. She added that councillors might be able to assist in signposting to particular VCS groups in communities which need to be better targeted.
SC thanked Cllrs for the suggestions. She added that lessons learnt from flu and Covid outreach work could be applied to MMR work. They were expecting some non recurrent resource from NHS NEL for an MMR catch up campaign. They will also follow up with schools and all local VCS organisations. Also links will be made with Vaccination UK. One of the challenges with the flu campaign this winter had been getting consent from parents so that vaccines could be given when the pop up clinic arrived. They needed to do more to unpick the barriers to overcome the exact nature of the concerns and also to review whether the methods being used here need refining. It's an ongoing and continuing effort.

h) Members asked about reaching out to InterLink.
Cllr Kennedy replied that they talked to Interlink on a regular basis and the new head was meeting the Mayor that day. AW added that they also work with the Jewish Health

Partnership and with Hatzola and they had piloted small grants for this kind of work during the pandemic. She added that they were expecting the devolution of vaccinations responsibility to ICS i.e NHS NEL in our case in 2025 and this could open up new opportunities.

i) Members asked about the Anticipatory Care Pathway and whether new money came with it and how was this money being spent.
AW replied that they were currently using funds they had reallocated from last year and they had routed this work through the Neighbourhoods Programme. It was part of the government's Ageing Well funding and was non recurrent and it was not specific additional funding.

j) The Chair commented that there had been a notable increase of 10-18 % in demand for CAMHS and asked how it was being addressed.
AW replied that the numbers were a concern since Covid, but there are also issues around severity and complexity and clinicians being overstretched. They had put investment on it into schools and the voluntary sector. They were also thinking about navigation through other youth health services. Key areas affected include autism and ASD/ADHD and they'd put a lot of mitigations in there. They are looking at the provider collaboratives, providers, systems and NEL to jointly address it. They are looking at how they can support families who are at the pre diagnosis stage according to their needs. Overall it was stabilising in terms of demand but it was still a case of fire fighting this problem.

k) The Chair asked how long parents have to wait for diagnosis?
AW replied that for the under 5 pathway it was up to 20 weeks and for the 5-19 pathway it was up to 19 weeks. Children and families were given help however while they were awaiting diagnosis. She added that this problem was across all NEL and City and Hackney was in a better position than other neighbours.

l) The Chair asked if they had cascaded a communications message to parents that it was not the fault of the schools and if they were giving parents a realistic time frame of when they are likely to go through the gateway.
AW replied that they had introduced a Single Point of Contact so a plethora of CAMHS services were now together so there is only one way in the system. This was starting to bear fruit. A lot more needed to be done in terms of communications however and getting the message across that there is support also while people are waiting.

6.8 The Chair commented that if effective communications could go out to parents such as a generic letter explaining the background and the position the school was in it would make a difference. AW agreed and added that they also have mental health workers in the schools.

6.9 The Chair commented that it was good to understand whether we can find a way to keep the current clinical leadership resource in City and Hackney. Another issue for a future item would be the future of the GP Confederation's work because of the benefit it brought and how that might be protected in a revised structure.

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

7. Cabinet Member Question Time - Cllr Kennedy

7.1 The Chair stated that it was customary for each Cabinet Member to attend one Cabinet Member Question Time Session each year with their relevant Scrutiny Commission. The purpose was to allow Members to ask questions on areas separate from a review or other key work programme items being considered during that year.

7.2 To make these sessions more manageable they are confined to three agreed topic areas and Cllr Kennedy had been asked to answer questions on these 3 areas:

1.) How is the Neighbourhoods Programme working for Hackney, what have been its successes and what are its challenges?

2) Is the City and Hackney Place Based System working well for Hackney residents and has 'Place' been central enough in the governance of NEL ICB since its inception?

3) What could Hackney Council in particular do to help enact the 5 Missions in the recent Cancer Research UK Manifesto

Cllr Kennedy gave a verbal report and the following was noted:

NEIGHBOURHOODS PROGRAMME

7.3 Cllr K explained that the idea was about care closer to home. It started 5 years ago and City and Hackney is the envy of NEL as we have 8 Neighbourhoods and 8 PCNS that are coterminous. His Cabinet equivalent in Barking and Dagenham had remarked that they were lucky as their PCNs were not linked to their Neighbourhoods. He added that the office of PCNS in City and Hackney had agreed to a merger with GP Confederation as they were so closely aligned already. It had been agreed at the October Health and Care Board. Many others look to our system as role model and 7 are in the top ten in terms of patient satisfaction. The idea therefore is how can you get this level of cooperation into the rest of the health service. The NHS was working on getting community nursing, mental health, occupational health and community pharmacy all much closer to people and working in much closer collaboration in the Neighbourhoods. The Council was also doing this with its 4 Family Hubs which will serve 2 Neighbourhoods each and so be aligned to them. So, the NHS services will function at this level, the HCVS runs Neighbourhood Forums at that level also. Renaisi were also doing an external evaluation of the Neighbourhoods Programme.

7.4 What typified Neighbourhoods were Multi Disciplinary Meetings looking at individual cases and looking at constant attenders with reps from 4 or 5 different teams coming together to discuss one particular individual and how best they can be supported. He described the Neighbourhood Leadership Groups. He described the Women's Health Hubs which had been created at GP practices so women can talk to different professionals in one site. He described the work on Proactive Care happening at Neighbourhood level. They have looked at people with 3 or more conditions and proactively getting in touch with everyone over 65 and looking at their living circumstances and checking their medication. This was proactive as this was the

cohort most likely to end up in hospital. The aim was to get in early to put in simple interventions in place e.g. to remove trip hazards, or ensure medication compliance or find solutions to help reduce social isolation. He described the pilot projects on being Autism Friendly in London Fields Neighbourhood and the Speech and Language project Hackney Downs. He described how the set up sessions to speak to families suffering long wait times to access CAMHS to explore interim support for example via VCS organisations. There was a separate Parental Wellbeing Session also rolled out across the 8 areas.

7.5 He stated that he had spoken to a mental health community connector in one of the Neighbourhoos and they had discussed what was working really well. This includes referrals to the Wellbeing Network, in-house health budgets and the benefits advisors. Also the community connectors worked with social prescribers to share information about what is out there. What was working poorly in the Neighbourhoods, he was told by this worker, was the internal referrals e.g in ELFT and how data sharing was poor with ASC teams. He heard that they had got twice the caseload they had been told they would have. He'd also learned that some GPs make many referrals via community connectors and some make none.

7.6 One of the worrying things he had learned was that if an individual was in insecure housing the community connectors could not then refer them to mental health services for psychotherapy as it was judged that the person's problems are so driven by their housing problems that a course of psychotherapy would not be useful at that point as they wouldn't get the benefit of it.

7.7 He stated that the clear message coming through from Neighbourhoods was that they were having to deal with the "crunchy Marmot problems" involving the wider determinants of ill health and this of course was not easy. One of the challenges he wanted to make was to ask where Housing was in the Neighbourhoods system, as the links appeared tenuous. There has to be separate referrals. He was not suggesting that any of this was easy but he felt that the system needed to change its ways of working to be better able to address these Marmot "wider determinants" issues.

7.8 He referred Members to two charts - one an organogram of the NEL System where Neighbourhoods didn't appear and a second chart, in NEL Integrated Care Partnership papers, of the system model where the 47 Neighbourhoods in NEL are not very prominent. This exemplified, in his view, the challenge of where the focus was.

7.10 *On the issue of Housing and Neighbourhoods System the Chair asked therefore if there was a need to review the structures to for example give greater weight in PCN ratings or KPIs to how they provide advice/support on housing issues.*
Cllr Kennedy replied that if we take a "Health in All Policies" approach and build on The King's Fund's "4 Pillars" there needs to be more focus on wider determinants. Where is the health in our housing policies or in our housing management he asked? Where is the freedom for a housing repairs operative who goes to fix a leaky pipe to say that this person is not looking after themselves and has lots of trip hazards. They

could take an initiative and nail down a carpet trip hazard but are they supported to do so.

7.11 *Members commented on the housing and psychotherapy issue that we shouldn't allow ourselves to give up on such residents. They asked about how the Neighbourhoods offer is communicated to the whole population of the borough.*
Cllr Kennedy commented that many reviews including scrutiny reviews in the past had the recommendation about data sharing and it was a perennial and knotty question. We will have to keep working at it, keep sharing information and encouraging others to discuss it as well, he added. One of the effective things we can do is put information on the offer to residents on the websites and share it in our channels and platforms.

7.12 *Members asked about where the Family Hubs are located and how do people access them?*
Cllr K replied that they were not in place yet. They are part of a re-working of government money to replace children's centres and we'd been part of that pilot. When they come on stream they will also be put on the same Neighbhourhood footprint. There will be 1 Family Hub in each Quadrant, representing two Neighbourhoods, so four in all.

PLACE BASED SYSTEM

7.13 Cllr Kennedy stated that the City and Hackney Place Based System was working pretty well for over all. It comprises the same organisations who have worked together very well in the past. He quoted Nye Bevan's comment that "there exists in the medical profession a great resistance to going under the authority of local government" and added that 70 years on this hadn't changed. The creation of the ICSs was just another iteration of the endless cycles of restructuring the NHS. He stated that the Public Accounts Committee's report on ICSs talked about a lack of a coherent workforce strategy. One had been published last year but many said it wasn't sufficient. There was no clear estates plan, no dentistry plan and there was no real leadership at DHSC according to PAC and the revolving door of Secretaries of States for Health had not helped. The system itself does not help us and what used to be 7 CCGs had become 1 ICS but at PBP level there are people who have been involved locally going back to the PCT days and this strong institutional memory is there. The satisfaction surveys at PCN level were good overall. It was disappointing therefore to see a 30% cut in clinical leadership staff as that represents a loss of knowledge. That reduction in strategic clinical time has a danger inherent in it. This was happening not because of anything City and Hackney did but because the resource isn't there and so because of this we shouldn't say the Place Based System itself isn't working. Our Place Based teams have a good understanding and we have NEL Chief Exec who was a former council chief executive. He added that he was taking over from former Mayor Glanville as Hackney's council rep on the ICB and one of 2 LA reps on it. He stated that the ICB holds its meetings going round all the 8 boroughs. They meet in the places being discussed and begin with an hour long presentation on the local area before the wider system meeting. There is a genuine

commitment to Place in NEL probably more so than in any other ICS around the country.

7.14 At the Health and Care Board meeting that day they had agreed the assessment they will do of the Place Based System's outcomes across the 3 priorities. An outcomes framework was agreed to examine not just the quantitative data but also the qualitative data on our system priorities. The City and Hackney system had retained some of their commissioners. He had asked the vexed question of what actually had been delegated down to us. They also had their own presentation on Right Care Right Person and they will monitor the outcomes on that. They had approved five bits of Better Care Fund and Section 256 spend locally. These were relatively small spend approvals however. They had hoped the Place Based Partnerships would be looking to spend on everything that wasn't spent by the Acutes and that is not happening. He stated that when you ask at an NEL wide meeting they reply that they hadn't worked out how much of that can be delegated yet. This is partly because their own system funding is uncertain. He added that there was good Patient Participation work with the Health Watches. The 'Big Conversation' consultation was going on across NEL and to be welcomed. The hospital discharge rate and flow through the hospital in City and Hackney is the envy of other systems. He also added that Richmond Rd GP Practice had just won national awards for its Reception and The Greenhouse had won the national award for clinical improvement for its work with homeless people. This was very significant as there were national awards.

7.15 *The Chair stated that Cllr Kennedy going on the ICB would mean that our local system should have some more influence. He commented that we went from a system where CCGs were GP led and they commissioned the acutes and now we're back to the old system which was more acute dominated. Is more of that money getting sucked into the acutes at the expense of Place? Do the Acutes, in effect, suck up the bulk of the funding in their overspends and is the rest of the system suffering as a consequence, he asked?*
Cllr Kennedy replied that the problem was that the Acutes are getting nowhere near hitting their efficiency targets. ELFT and NELFT are doing well and everything else outside the ICB is doing OK. He commented that every day of strike action costs the NEL system £1m and we had 6 of them and this didn't count the cost of rearrangement, the extra severity that might ensue and lead to the need for new diagnoses of patients, so the duplication then gets piled onto the system. There are extraordinary pressures, he concluded.

CANCER MANIFESTO

7.16 Cllr Kennedy stated that Cancer Research UK was a great organisation and this is the one big items that local systems need to work on over the next 5 years.

Member noted that the 5 Missions are:

Mission 1: Rebuild the UK's global position in biomedical research.
Mission 2: Prevent thousands more cancer cases.
Mission 3: Diagnose cancers earlier and reduce inequalities

Mission 4: Bring tests, treatments and innovations to patients more quickly
Mission 5: Build a national movement to beat cancer, together.

He stated he wanted to focus on 2 and 3 in more detail.

7.17 In relation to mission 1 however he stated that the UK has a global position in biomedical research and he actually chairs a local committee on this. In relation to Mission 4 he stated there are elements that can be addressed locally such as the work Imperial College has been doing on looking at groups with very low interaction with screening programmes. It was clear that having a Pop Up Screening van outside a big Tescos for example was very effective as people who are unlikely ever to book a screening will engage because it's there. In relation to Mission 5 he stated that it was about building national ways to help people.

7.18 In relation to Mission 2 he stated that our Public Health team do a lot of this already. They were for example re-procuring the Smoking Cessation Service and also looking at smoking prevention and getting in early in schools. More work is being done in Trading Standards on illegal tobacco and vapes coming into the borough and he chaired the local Tobacco Control Alliance. In relation to Alcohol they had a great local awareness day on foetal alcohol syndrome disorder and they were carrying out an audit of their work against the NICE guidance.

7.19 He went on to list and highlight some key public health activity that was taking place already:

- C&H Recovery Service supporting those with Alcohol and substance misuse issues
- The adult weight management service at the Homerton
- The organisation Henry providing support on healthy eating for children under 5
- A Power Up programme for older children on healthy eating.
- Healthy cooking classes for families
- Walking classes
- A focus on infection control as that can lead to cancer
- HPV vaccine promotion
- A new draft of the Sexual Health Strategy, which includes a target of no new HIV patients by 2030, has been produced
- An offer of Hep A and Hep B testing within the recovery service aimed at intravenous drug users
- Young Hackney's free condom distribution scheme

7.20 In relation to Mission 3 he stated that there will be a Cancer Needs Assessment which will have a focus on reducing inequalities. He also referenced the letter the Commission had sent to the House of Commons Health and Social Care Select Committee on the need to improve the operation and the level of data sharing of breast cancer screening. He added that taking the screening programmes to where people are is key. Other issues to be tackled are adequate delivery of appointment times for screening and working with VCS and community health champions and working closely with the NEL Cancer Alliance.

7.21 Members asked about how to drive up greater usage of texts, emails and social media to reach residents.
Cllr Kennedy replied that GPs are now starting to better use data in all forms and the system is starting to use social media for public health messaging. The whole system paying for ad pop ups reminding the public they can not get a free tests was an example. Being over 55 he had recently received, unprompted, a bowel cancer screening kit. This was another example.

7.22 The Chair asked Dr Husbands about the public health strategy on cancer diagnosis and reducing inequalities and if that could be presented at a future meeting. SH replied that it was more of a needs assessment at this juncture and it will need to be analysed. She undertook to liaise with the O&S officer on a good time to present this to the Commission.

ACTION:	**Director of Public Health to advise on timing of bringing the cancer diagnosis needs assessment to a future meeting.**

7.23 The Chair asked if the funding for the Neighbourhoods was slowly diminishing. Cllr Kennedy replied that he had learned that at Well St Common Forum that their funding was going down c. 20%. Neighbourhoods was also temporary funding and had been set up on the idea that it might eventually be mainstreamed.

7.24 The Chair thanked Cllr Kennedy for his attendance and detailed replies which would help the INEL Members with the issues they wished to raise there. He welcomed that having a Hackney Cllr as one of the two local authority reps on NEL ICB, for now, would help us gain even more useful insights.

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

8 Minutes of the previous meeting

8.1 Members gave consideration to the draft minutes of the previous meeting and the action tracker.

RESOLVED:	**That the minutes of the meeting held on 20 December 2023 be agreed as a correct record.**

9. Work programme for the Commission

9.1 Members noted the updated work programme

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

10. AOB

10.1 The chair reminded Members of the site visit to Oswald St Day Centre on that Friday.

Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Mon 12 Feb 2024 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 Frank Baffour**
Cllrs joining remotely	**Cllr Claudia Turbet-Delof, Cllr Adebayo**
Cllr apologies	**Cllr Sharon Patrick (Vice Chair), Cllr Grace Adebayo and Cllr Ifraax Samatar,**
Council officers in attendance	**Chris Lovitt,** Deputy Director of Public Health **Carolyn Sharpe,** Consultant in Public Health **Bryn White,** Childhood Immunisations Programme Manager, Public Health **Amy Wilkinson**, Director of Partnerships, Impact and Delivery, C&H PBP **Helen Woodland**, Group Director, Adults, Health and Integration
Other people in attendance	**Jillian Bradley,** Deputy Chief Nurse, Homerton Heatlhcare **Sadie King,** Programme Lead, Neighbourhoods Programme **Joel Reynolds,** Head of Adult Community Rehabilitation Team, Homerton Healthcare
Members of the public	99 views
YouTube link	View the meeting at: https://www.youtube.com/watch?v=dQvaOJNXnmU
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 Apologies were received from Cllr Patrick, Cllr Adebayo, Cllr Kennedy, Dr Sandra Husbands, Dr Stephanie Coughlin, Louise Ashley. It was noted that Cllrs Turbet-Delof and Cllr Adebayo joined remotely.

1.2 The Chair welcomed Jillian Bradley Deputy Chief Nurse at the Homerton in place of the Chief Executive.

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Neighbourhoods Programme 24-27

4.1 The Chair stated that this item was to receive a briefing on the progress of the Neighbourhoods programme.

4.2 He welcomed for the item:
Sadie King (**SK)**, Programme Lead, Neighbourhoods Programme
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP

4.3 Members gave consideration to:
a) Neighbourhoods update - presentation
b) Research paper on *Neighbourhoods Models Options appraisal: Phase One Research into current approaches to Integrated Neighbourhood Teams*

4.4 SK took Members through the slides in detail. The presentation covered: *Overview of the programme; What is Neighbourhoods; Why Neighbourhoods; Case Study - what would this mean for Peter?; Examples of working with Neighbourhood forums; Neighbourhood Programme priorities for 24-27; Who we are working with?; Structure; Transforming Neighbourhoods; CYPMF services mobilising to Neighbourhood models; CYPMF services preparing for transition; CYPMF services in early planning stages of transition; CYPMF Neighbourhood Level Pilots; Culture; Supporting the workforce; Impact; Neighbourhoods Evaluation Approach: Contribution analysis and evaluation deep dives; Neighbourhoods future.*

4.5 Members asked questions and the following was noted:

a) The Chair asked what the budget was in 2018 vs now and is the programme likely to evolve to a 'business as usual' project.
SK replied that the funding was from the Better Care Fund change programme. The placement of the funding was moving away from having just change managers to structural changes. There has been a significant investment in resident involvement through the Neighbourhood Forums. There were structures to engage with community pharmacists to engage in Neighbourhood working. There were Care Coordinators funded for the next 3 years and the admin roles that support the Multi Disciplinary Meetings are being expanded to support leadership groups and staff meetings. The proposal was to decline the investment over the next 2 years in strategic project management staff as this service becomes business as usual.

b) The Chair asked what the change in the annual budget has been?
SK it was £1m currently and in 2 years will reduce to c. £800k for the following year and declines further the year after.

c) The Chair asked if it was correct that the programme funded the leadership management to facilitate greater integration and not core delivery.
SK replied that yes it funded a programme of change and not new services.

d) A Member complimented the Well St Common Neighbourhood Group and asked how residents were informed about programmes and the support they can access. She also asked how they reach out to young people and to new people.
SK replied that the Neighbourhood Forums were key mechanisms for resident involvement and the model for that was that there were 4 Neighbourhood Forum facilitators seconded from grass root organisations. A huge amount of work happens between the forums that engage residents. If services want to work with a particular group of residents that work will

happen and Well St had good examples of that. Re young people, these issues were discussed at the Forums. They are looking forward to the integration of children's service with family services and having the Family Hubs. There will be new resident engagement mechanisms and these will be linked up In terms of improvement and delivery. She added that they need to do a lot more in using social media to get the message out. They also want to encourage long term involvement and they are training people on that. There are also those who don't have time to participate in that way so they are working on different opportunities for families and YPs to be involved in health and care services. They are also supporting the workforce to do co-production and it will take a while to embed this and get the resources available to them.

e) Chair asked if GP referral was the main way in or was it up through the Neighbourhood Forums?
SK replied that the Neighbourhood Forums bring together residents, services and VCS and it is VCS led and designed. The aim is to stand in the shoes of people and listen to solutions and listen to how people are experiencing health inequalities. She described First Steps which came out of a Forum hearing from parents that young people are experiencing a lot of anxiety and there isn't enough support in place, and so moving on to create the training. The forums are about strategy and local priorities and residents being encouraged to lead that. Referrals from the statutory services are obviously key.

f) Chair asked if they had quantified how many different types of residents have participated in the 8 Neighbourhood Forums and what data they have on this.
SK we do have the data. The Forums are delivered through partnerships with the VCS and Healthwatch. It's not just the meetings. The Forum facilitators work 3 days a week so there are activities in between. We have broader data on participation which covers more than just the forums. For example in Anticipatory Care there is a resident coproduction group being supported. With all the Health Inequalities projects there are groups of residents being supported via those. It is an outreach model.

g) Members asked if there were plans to benchmark the services with other boroughs?
SK replied that across the NEL patch, City and Hackney is quite far ahead with Neighbourhoods programme. NEL has developed a Neighbourhoods Maturity Matrix and they can see that they are far ahead compared to others in terms of having all services restructured around 8 Neighbourhoods. She added that Renaisi, who specialise in doing evaluations of complex programmes, are doing an evaluation of the programme and the baseline for that should be available by April.

h) Members asked that following the collaboration with pharmacies were there plans to work with Housing Associations including the council's housing service.
SK replied that they work closely with pharmacists. There is a lead community pharmacist in each Neighbourhood and they collate information etc however pharmacists are very busy. On housing they had some housing officers already turning up to forums and leadership groups. Housing is a key issue everywhere and they need to do more in bringing Housing organisations into the Neighbourhood model.

i) Members referred to p.20 and asked why some stakeholders had not made referrals to the programme. They also asked about inappropriate referrals
SK replied that this was just a lapse in data reporting but it is coming and it reflects how far they have got with mapping the services. In relation to duplication of referrals or inappropriate referrals, she stated that it's a complex area as there are natural overlaps with

referrals. These referrals don't reflect case holding they just are numbers who are referred in and it is not really duplication as to is not inappropriate to have a referral to two or more services, in fact, she added, that's the whole point of Neighbourhood working. These services can come together at Multi Disciplinary Meetings e.g. ASC, community matrons, GPs all in the one place and looking at a person's case. She added that as long as someone is referred somewhere and that person is not lost in the system and is discussed in a holistic way in an Multi Disciplinary Team then they would get to the right services quicker than if we didn't have this programme in place. You can do this quicker if people in all those different teams know each other in a neighbourhood

j) Members asked how the Forums are advertised to residents.
SK replied that the Forums are run by the VCS and build on their own networks, they advertise online and work through their own networks to bring new people in. For the coming year they are planning a much more active push on social media using twitter and facebook to promote the Neighbourhoods and what happens in between.

k) Members commended what was being done but asked what data profiling there was to evidence delivery.
SK replied that the services were working together better. It was a work in progress but not perfect and every stakeholder is not in the same place at the same time. Some will want to co-locate or work more in the community and others may not be ready. The programme enables the structure and support for people to come together

l) Members asked if each Neighbourhood has an MDT once a week to deal with high need individuals.
SK replied that it works on different levels. Once a month there is a complex case meeting in each Neighbourhood and this system developed during the Covid period. It was important to stress that the work doesn't stop in between the meetings. There are also MDT Huddles around particular patient groups or service pathways and that is all part of the culture change the programme is driving. So there are some formal arrangements and some business as usual ways of working.

m) Chair asked if there was a strategic document to make sure each Neighbourhood has a dedicated Housing lead from the Council.
SK replied that Housing was a very complex area. They don't have one housing lead per Neighbourhood. There are relevant housing managers coming in NFs or Leadership Groups and while there isn't a single housing strategy document but housing is a priority to work on over the course of the programme.

n) The Chair asked if there would be a benefit from having a designated housing lead in each Neighbourhood in order to improve efficiency.
SK replied that if that could be organised it would help. Many people turn up at GPs with housing issues (repairs, damp, overcrowding) and Housing officers do engage but this isn't a routine process as yet.

o) Members asked about the number of officers involved as everyone is very busy and whether the review is likely to draw attention to this and also whether residents will be part of the review exercise.
SK stated that the capacity of front line services to cope with demand is a challenge. Capacity of services is beyond the scope of the Neighbourhoods Programme as the programme is about reorganising the services we have around neighbourhoods. The Neighbourhood way of working has the potential to allow services to do assessments more quickly, to get people into services faster but in terms of overall capacity that is beyond the scope of her work. The Review will no doubt include each service commenting on the ongoing work to deepen the joint ways of working e.g. whether one team needs to co-locate

close to another which might address a capacity issue but it would be up to the strategic leads to feed that into the development of the programme and for them to consider all of that as they set out the future direction for Neighbourhoods. She added that residents would be involved in the Review. They were also doing some consultation with the Community Advisory Team and some residents are working on specific services and pathways such as Anticipatory Care.

p) The Chair asked if they were mapping the 770 referrals to establish if one Neighbourhood is disproportionately represented in some way and he asked if the review will go into this level of granularity.
SK replied that yes they do this. Healthwatch has been commissioned to produce a Neighbourhood level inequalities report and it has data on resident experience of the services and on capacity issues. So if there was a startling disparity across neighbourhoods that would be highlighted there. She added that this is linked to the Leadership Groups who have just begun meeting but who will work through all of this. They are using a Population Health Management way of working which is the core of what they do.

q) Chair asked if the programme draws on the valuable population health data which Public Health built up during Covid.
SK replied they did and that they work with them on the health inequalities project. They have created a tool kit which will be available to everyone on the steps to be used in carrying out a population health management approach. The work will be data informed but also about resident involvement. She stated they have projects on CVD prevention and they are working with different groups such as in the World Cafe events. They are examining why people may not be engaging and the toolkit should help explain ways in which these problems can be tackled. There will be 7 steps into how you do health inequalities work which will be really accessible for any team to take up.

r) Members asked how many sessions are provided for resident involvement?
SK clarified that there are different methods of involvement. The structures are the Neighbourhood Forums which meet 4 times a year in each Neighbourhood. She added that they were proposing changing that to more bespoke involvement work happening in between the meetings and have fewer meetings. But there are many other opportunities she explained that a person could apply to be a resident on the community advisory team, given a laptop, and trained to work on meaningful project on a long term as a volunteer, for example. Then there are particular services that have either their own resident involvement group eg people with lived experience of the condition they are trying to support.

s) The Chair asked when the Renaisi evaluation will be ready?
SK replied that it would be ready by the end of March but there would then be a follow up in a year to do the first measurement of progress and then they'll be able to self measure against agreed outcomes. The first baseline report will be in April however.

4.6 The Chair thanked SK for her report and attending to answer questions. He suggested that they might want to come back in a year or so to update on how the programme has been progressing post its evaluation.

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

5 Embedding Anticipatory Care in City & Hackney

5.1 The Chair stated that this item was to receive a briefing on the Anticipatory Care programme which is a key component of the national Ageing Well Programme. He stated that anticipatory care has been relabelled proactive care and those who attend INEL JHOSC will be aware of NELs focus on this.

5.2 He welcomed for the item:
Joel Reynolds (**JR**), Head of Adult Community Rehabilitation Team, Homerton Healthcare

5.3 Members gave consideration to a tabled presentation *Proactive Care Team* and JR the Operation Lead took Members through the presentation in detail. It covered: *Proactive care in City and Hackney; Rationale; Background; the Team; Who do we support?; What does it involve; "What matters to you"?; Common concerns; Typical interventions and support; Resident involvement; 3x case studies; Health inequalities mitigation projects; Operational challenges; Wider supporting pathway;*

5.4 JR stated that the Anticipatory Care pathway is part of an NHSE initiative and included in the Long Term Plan it also comes out of the national Ageing Well programme. Anticipatory Care also includes end of life care so NHSE renamed it Proactive Care. In this instance City and Hackney made a decision to use a targeted population health approach to delivering this, using personalisations to focus on what matters to people and to intervene early before people get into an acute crisis.

5.5 Members asked questions and the following was noted:

a) The Chair commended the programme and asked that of the 4200 on the initial list how many had they managed to have a conversation with and of that how many had some sort of output e.g. getting benefit going to a class/activity.
JR replied that it was roughly half of those who had the initial invitation and about 25% had come and engaged and had a consultation. Once contacted on the phone people were generally very keen to engage. In the next 9 months they would do outreach with community groups using the community connectors. As regards outputs they are using the EMIS primary care record system and just that week they were able to get the first output report and some data analytics so they had got over the first hurdle.

b) Chair asked if this novel programme was NEL wide and nationwide?
JR replied that the programme was both widespread and novel and there was a national community of practice now for anticipatory care which they can draw from. He explained that it was slightly different in different parts of the borough. You can focus just on High Intensity Users and there is a separate team for that but the novel part here has been to do more work further upstream in the system to ask ourselves what can we do a bit earlier to divert these individuals so they won't end up requiring acute attention later on.

c) Members asked how the funding can be assured for this work and for the Neighbourhoods scheme and when did the national Ageing Well funding run out.
JR replied that the challenges around funding are to understand the sources. The Ageing Well funding goes through a number of boards and they have to make a strong business case. The funding is from Primary Care. A solid approach with the Clinical Directors of the PCNs is needed so the spend can best reflect local needs. The Preventative approach

makes sense as they can see the impacts on the people they're seeing and so far 90% of users have said it's a good service.

d) The Chair asked whether the Care Co-ordinators are attached to PCNs.
JR replied that there are 9 of them across the 8 Neighbourhoods/PCNs as 2 are Part Time. Each is based within one PCN so they know the area and get clinical space in one of the surgeries. He added that he works across the teams and is based in Orsman Rd. Some of the team work out of clinics and the head office as well.

e) Members asked how much of the work depends on the full engagement of local GPs considering the amount of pressures on them?
JR replied that it is very much predicated on the patients coming from those who are registered in the GP's Practice so it's in the GP's interest. They have for example removed the requirement for people to need to see a GP for a referral to the Falls Service and in this way pressure is taken off GP appointments. There are Clinical Leads and Care Coordinators so it's not a referral based system from GPs. Instead it is taking a different tack and so for example some may not be known to the GP at all and that could be about GP anxiety and so not attending a surgery. They work alongside GPs. Many GP appointments are linked to social factors - housing issues or benefits optimisation and Care Coordinators are generally best to deal with those aspects.

f) The Chair asked about the algorithm which generated the 4200 candidates for support and how confident was the team about how accurate that was in identifying the right people.
JR replied that initially there was a push to give everyone an 'electronic frailty score' but it become a clinical issue so a 'clinical frailty score' was needed. If the algorithm classifies someone as 'moderate to severe' this cohort will be quite unwell with a lot going on and so it may be a case they require a full geriatric assessment. With the 'mild to moderate' cases there would also be a lot going on for these individuals. They've examined the data over 6 months now and they are identifying people on a deteriorating curve in terms of their prognosis but before the stage when it might become too complex. The difficult part is those who haven't a diagnosis because they haven't gone to a GP and we know there are many of those who are not registered and so not coded.

g) Members asked how much leverage the team has with ASC and Housing in providing joint solutions when everyone is under pressure.
JR commented that 'leverage' was not really the best word as they don't have leverage as such but they do have good working relationships. He gave an example of London Fields PCN where housing officers came down for a housing hub discussion. On a case by case basis the stakeholders involved are trying to support people as advocates and trying to empower them. We also need to be realistic about what is available, he added. The focus is to empower people to have the right information and be realistic about what might be the outcome for that. It's a challenge but the housing clinics, for example, did have a real benefit.

h) The Chair asked about whether and how people can get follow up from an issue raised at a housing hub discussion for example.
JR replied that it depended on the type of housing and where there is a good housing officer there would be a proper acknowledgement from the Housing Association that the matter is in hand. A lot of people are living in the private rented sector though. So it becomes about

referring the person to the Housing Association or asking them to contact their Ward Cllr. Cases where the housing is contributing to their problems eg safeguarding alert as people can't leave their housing and so can't get to appointments etc will be pursued with the Council and Safeguarding for example. It's about using the routes and mechanisms that are available to them to enable that person to manage their situation better.

5.6 The Chair thanked JR for his report and insight. He stated that the Commission and the Cabinet Member were very supportive of this important preventative work. He suggested the Commission might revisit the subject in a year for an update.

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

6 Childhood Immunisations: Measles - update

6.1 The Chair stated that this was prompted by media coverage and local concerns about the borough's relatively very low vaccination coverage. He added that there had been a serious outbreak in the West Midlands. Members would be keen to know if there was a resource that could be tapped into at this stage to set up additional vaccination drives or was the service under the same resource constraints as previously

6.2 He welcomed for the item:
Chris Lovitt (**CL**), Deputy Director of Public Health
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP
Carolyn Sharpe (**CS**), Consultant in Public Health
Bryn White (**BW**), Childhood Immunisations Programme Manager, Public Health Unit

6.3 Members gave consideration to the following papers:

a*) Hackney Public Health Measles briefing to Hackney Cllrs 29 Jan*
b) NHS NEL briefing to MPs on Measles 22 Jan
c) UK Health Security Agency briefing on Measles in London 22 Jan

6.4 AW and CS gave a verbal update and took Members through the reports. CS described the nature of measles adding that it spreads very quickly among the unvaccinated particularly in settings such as nurseries and schools, homeless accommodations and asylum seeker accommodation. Typically most cases are in children under 10. It's also a serious issue for babies under 1 who are too young to be vaccinated, pregnant women, those with weakened immune systems. The hospitalisation rate is 20 to 40% for those unvaccinated and that is a major concern. The burden is felt in children and young people who don't have immunity through 'wild immunity' or infection. Compared to national rates local rates are heading in the wrong direction. In addition measles is endemic in some countries and so residents travelling from those places also present a problem. There has been a steady increase in cases since last April. Since the start of Oct 2023 there had been 465 cases nationally and 20% of those in London. The cases in London are concentrated in the North West but sporadic across London. There were no confirmed cases in Hackney, yet, despite Hackney having the lowest vaccination rate in the country.

6.5 Members asked questions and the following was noted:

a) Chair asked that as City and Hackney is an area with very low vaccination coverage, were they able to tap into extra funding at NEL level to do preventative immunisation that is needed now.

AW recalled the 2018 local outbreak and how they managed to get ahead of that where they picked up 1000 cases for vaccination. One of the challenges currently is the younger age children not being vaccinated, however they'd noticed that rates for 5 years olds are good so they were catching up. NHSE commissions the vaccination programmes and a lot of work was done during Covid with NHS NEL (our ICB) using non recurrent funding to create a post for a immunisation coordinator, they did grants to third sector, they did special communications etc. The good news was that NHS NEL had just announced £100K to be spent by the end of Q1 and so the Hackney team are pulling together plans for that. Luckily they have an Immunisations Coordinator in place so are in a better place vis a vis other NEL boroughs. She added that in 2025 funding for immunisations will be devolved totally to ICBs and they are now trying to influence how that might best be organised and they are pointing out that this money is best spent at Place level.

b)The Chair asked if this £100k was just for City and Hackney.

AW confirmed that it was. They are also working on a zero dose campaign and targeting children who are unregistered. This funding is based on a weighted formula

c) The Chair asked if this campaign typically involved trawling through GP lists and making phone calls

AW confirmed yes it was about Call-Recall. There will be specific allocations for top 10 PCNs across NEL which have lowest rates and there will be ring fenced funding for comms and support. There will be a range of approaches including building on relationships with VCS.

d) The Chair asked about rolling out programmes in schools and the challenges of getting permissions and parents having to be there etc

AW replied that NHS NEL has a contract with Vaccinations UK to provide schools based vaccinations. There should be catch up funding for MMR and Polio in the spring. They've constantly seen an approach in C&H of working all around schools and primary care that works best for us, she added.

e) Members asked how the team was working to combat language and culture barriers which are a significant factor in the low vaccination rates locally and how they were working with faith groups and schools.

CS replied that we know that diverse populations culturally and ethnically have lower coverage in general therefore London as a region has the lowest coverage. Urban and more diverse areas and more socially deprived areas have lower coverage. If you're a single parent with a number of jobs it can be hard to get to a timely appointment for example. It's just convenience factors rather than the parent having a position on vaccines that is the key here. She added that they had good data from the local Covid campaigns. Gypsy Roma Traveller and various Black population groups have lower averages as do the Charedi community. She added that they were developing an immunisation strategy and they want to takes a really strategic approach to improve coverage in the most targeted areas. They are challenging themselves on whether they are translating into the right languages in the right areas and they are working with community champions to support campaigns. They speak to Hackney Faith Forum on a regular basis and align with their information campaigns. She added that turning up once with the vaccination bus doesn't always do it instead there needs to be consistent and repeat messages and visits. BW added that they have put vaccination clinics in place on Sundays in the NE of the borough aimed at the Charedi community as access is a big issue. They are thinking about the languages they use in comms and the newspapers and outlets being chosen. They also work with GP Practices making them aware of translation services and the various tools on maintaining accurate records. They

do a lot at weekends and organise family and fun events where there are other offers not just vaccinations.

f) Members asked about how the team deals with the challenge of keeping track of vaccinations of children of migrant parents who might have had their first jab abroad. They also asked how much they take into account the new working styles of parents especially post Covid when many are self employed or have multiple jobs and how attending appointments can be challenging for them. Members asked about how there doesn't seem to be information on measles in hospital settings such as waiting rooms.
CS replied that on Access there are 3 aspects: convenience, complacency and confidence. They know that convenience is a huge factor. Low trust in MMS was about side effect worries. She reiterated what they're doing on access in the NE of the borough with Sunday clinics and clinics in Children's Centres. They also ensure that the mobile clinic offers other holistic health offers to be more effective. Coming on stream there will be a new offer for children preschool through GPs and for those that are school age it will be through a catch up campaign. Vaccination UK is looking at data on schools with high levels of unvaccinated children and putting in clinics. On the issue of targeting those in insecure employment she stated that they hadn't feedback on that. They have done targeted work with GP Practices across the borough and it didn't come up there. They are however doing an evidence review on the interventions that work and the ones that don't. CL added that in addition to the local focus and funding issues, data is also very important in order to make sure that the programme is having an impact.

g) The Chair asked about the previous issues around a lack of real time data flow on vaccinations and whether this remained an issue.
CS replied that they have data by GP Practice so they can see the rates of coverage but don't have granular data that can be interrogated in a bespoke way so if they wanted to cut it by ethnic group or granular geography such as by ward level or post code they can't do that as yet. They can't easily look at trends and crucially what they can't do is examine the impact of a specific intervention in a specific area so it could be evaluated. Going forward they would like to be able to have more granular data, they would like it in real time and would like it to show trends.

h) The Chair commented that presumably this is down to how Practices code information and this cannot be changed easily.
CS replied that it's a lot of work but it is already collected from GPs and it can always be collected in a better way but such data is available in other areas. They have flagged this with NHS NEL and they're trying to create a dashboard across NEL and enable them to look at data for the last 3 weeks in one PCN area by ethnicity for example.

i) The Chair asked what the barrier was here.
CS replied that you need to have a bespoke programme. Currently data is fed into a central system and they use a dashboard tool to visualise it. She added that NHS NEL are looking at this and how it can be done better. CL added that data is collected well but the issue is we cant access the data easily locally and suggested to the Chair that this might be something to raise at an INEL JHOSC level.

j) Members asked how many days notice a community group would need to give the vaccination team to attend their event
AW replied that they would be receiving news on the comms funding in the next few days and suggested that members contact Bryn about appropriate events so that he can get in contact to explore having a presence at them.

k) Members asked how the rates have varied pre and post covid. Members also asked how readily available the animal free version of the vaccine is.

AW replied that they saw a huge drop in rates during Covid and post covid. There was a reluctance to access sites or to bother NHS staff. Recently however the rates have started to stabilise and they have seen some green-shoot indicators that things are really looking better. BW added that in the 'vaccine at 5 yrs' measure they had seen an increase of 6% recently and they are tracking that. He added that the Covid effect was London wide.
CS added that they were seeing an uptake for MMR locally so that is good news. She added that the animal free version of the vaccine can always be accessed on request. She added that lack of awareness of that might be acting as a barrier. She stated that they also have confirmation from a Rabbi that the vaccine is kosher.

l) Members asked how the team uses social media to counter the quack messages which are out there about vaccines. Members also added that by visiting more community groups they'd reach more single parents.
CS stated that the links between vaccines and certain disorders have been totally discredited and their approach is to try and not amplify these messages. hey don't repeat them and they don't draw attention to them. Instead they try to mobilise the whole health and social care workforce to deliver consistent, clear and effective messaging around safety of vaccines. They talk to head teachers, schools nurses, health visitors and they need to be consistently delivering these messages. There is evidence that these people are the most trusted. The important point is to make sure that these healthcare staff are kept up to date with the latest local epidemiology and that they are repeating messages that vaccines are safe and effective..

6.6 The Chair thanked officers for all their work in this important area and for their report and attendance. He undertook to make representations at INEL JHOSC on the points about data at NEL level.

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

7 Minutes of the previous meeting

7.1 It was noted that the minutes of the 10 Jan '24 meeting would be included in the agenda for the next meeting and Members noted the updated Action Tracker.

8. Work programme for the Commission

8.1 Members noted the updated work programme. It was noted that the next meeting has moved from 14 to 20th March and will deal with the primary care/out of hospital estates programme.

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

9. AOB

9.1 There was none.

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Matter Arising from 10 January 2024 Health in Hackney Scrutiny Commission

This was the Action

10/01/2024	Right Care Right Person	Director of Adult Services and Operations to seek assurances from the Met Police and provide a written response to the Commission that a carefully monitored soft handover is being done since the implementation of RCRP.	Georgina Diba

Here is the response from the Director of Adult Services and Operations on 13 Feb. The correspondence referred to is not attached here as it identifies an individual but has been sent to the Chair.

Dear Cllr Hayhurst,

I hope this email finds you well and apologies for the delay in responding to your query. At a previous HiH you had asked for some assurance around the handover from the Met Police to the London Ambulance Service, where the Police did not deploy. It was my understanding in the lead up to RCRP that a 'soft handover' would be complete. However, I now understand that the policy stance is for there only to be that soft handover of information where a person is unable to directly call another organisation. The system I understand is not enabling a call transfer, but is text based.

From my correspondence with the RCRP Escalation Point, it is understood the LAS have requested callers come direct to them, to enable appropriate prompting of information so they can triage more effectively.

I have attached my correspondence and to note this is based on a previous Members enquiry, so you will be able to see the email trail that prompted this. The Police did deploy in the first instance, but on the information they had it was noted the LAS or a mental health professional would be more appropriate.

The Met have confirmed where a person is unable to make a further call to the LAS (or another organisation) they would pass on this information. To note Adult Social Care have always received notifications around a person deemed vulnerable through what we term Merlins or ACNs.

With kind regards,

Georgina

Georgina Diba
Director Adult Social Care Operations

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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	St Joseph's Quality Account	Site visit for Members to St Joseph's Hospice to be organised.	Jane Naismith	**This will take place on 24 April 2024.**
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.
~~10/01/2024~~	~~Right Care Righ Person~~	~~Director of Adult Services and Operations to seek assurances from the Met Police and provide a written response to the Commission that a carefully monitored soft handover is being done since the implementation of RCRP.~~	~~Georgina Diba~~	~~Reply received and shared on 13 Feb and attached.~~

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Hackney

Health in Hackney Scrutiny Commission 20th March 2024 **Work Programme for 23/24**	Item No **7**

OUTLINE

Attached please find Rolling Work Programme for 23/24 (NB this is a working document).

ACTION

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

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DRAFT Work Programme for Health in Hackney SC 23/24 as at 2 Feb

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
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 and Abigail Webster
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
			C&H Cancer Collaborative	Chair (a local GP at Latimer Health Centre)	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	Deputy Director Medicines Optimisation	Rozalia Enti
			Local GP	Hoxton Surgery	Dr Wande Fafunso
	Developing a C&H Sexual and Reproductive Health Strategy	Update post public consultation plus other aspects	Public Health	Deputy Director Public Health	Chris Lovitt
	Adult Social Care Transforming Outcomes Programme 1/3	From HW at Budget Scrutiny 25 July	Adults, Health and Integration	Director ASC and Operations	Georgina Diba
				Head of Transformation ASC	Leanne Crook
			Newton Europe	Director	Alan Rogers

				Director	Ed Bailey
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	Amy Wilkinson
	Future options for Soft Facility Services at Homerton Healthcare	Follow up 8 Feb short item	Homerton Heatlhcare	Deputy CE	Basirat Sadiq
	Update on implementaton of Right Care Right Person	Follow up from 17 July - short item	AHI	Director Adult Social Care and Operations	Georgina Diba
12 Feb	**Neighbourhoods Programme 2024-27**		City and Hackney Neighbou	Neighbourhoods Programme	Dr Sadie King
2 Feb					
	Embedding Anticipatory Care in City and Hackney	Follow up from Budget Scrutiny on 23 Oct 23	Homerton Healthcare	Head of Adult Community Rehabilitation Team	Joel Reynoilds
			Springfield Park PCN	GP and PCN Clinical Director	Dr Tehseen Khan
	Childhood Immunisations inc MMR		C&H Place Based System	Interim Director of Delivery	Amy Wilkinson
			Public Health	Consultant in Public Health	Carolyn Sharpe
20 March	**Estates Strategy for GP Practices and Out of Hospital Care in Hackney**	Follow up from items at HiH and INEL pre pandemic	NHS NEL	Director of Primary Care	William Cunningham-Davis
				Primary Care Commissioner	Richard Bull
deadline: 11 March				Deputy Director of Regeneration and Infrastructure and Co-chair the Task and Finish Group Primary Care Estates	Louise Philips
				Clinical Lead Primary Care	Dr Kirsten Brown
			Local Medical Committee	Chair	Dr Vinay Patel TBC
			City & Hackney Office of PCNs	Operations and Programme Director	Agnes Kasprowicz
			Neighbourhoods Team	Programme Lead	Sadie King
			LBH	Director of Strategic Property	Chris Pritchard
				Senior Asset Management Advisor	David Borrell
			Homerton Healthcare	Head of Integration	Annabelle Burns
				Director of Estates, Facilities and Capital	Natalie Firminger
				Deputy Director of Estates	Tony Wright

			Healthwatch Hackney		Sally Beaven
	In future items the Commission to test the performance of primary care in NEL against the principles set out in the The Fuller Report.				
June 2024	**NHS Dentistry provision - how new commissioning system is working MIGHT BE AT INEL LEVEL**	Follow up from 16 Nov 22	NHS NEL	Commissioner	Jeremy Wallman
			East London and City LDC	Secretary	Tam Bekele
			Local dentists		TBC
			Public Health	Consultant in Public Health	Andrew Trathen
June 2024	**Adult Social Care and Accommodation - planning for future need**	Follow up from 26 April. this should follow publication of Housing Strategy in summer '24	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
June 2024	**2/3 Adult Social Care Transforming Outcomes Programme**	From HW at Budget Scrutiny 25 July and HiH 20 Dec	Adults, Health and Integration	Director of Adult Social Care and Operations	Georgina Diba
			Newton Europe	Director	Alan Rogers
					Ed Bailey
Sept 2024	**Update on implementaton of Right Care Right Person**	Follow up from 10 Jan	AHI	Director Adult Social Care and Operations	Georgina Diba
Oct 2024	**Future options for Soft Facility Services at Homerton Healthcare**	Follow up from 10 Jan	Homerton Heatlhcare	Deputy CE	Basirat Sadiq
	ITEMS TO BE SCHEDULED				
Possibly July	**Cancer diagnosis needs assessment/ Enacting the 5 missions of Cancer Reasearch UK Manifesto in Hackney**	Follow up from CQT in 10 Jan	Public Health	Director of Public Health	Dr Sandra Husbands
	SUBSTANCE MISUSE & the new the combating drugs partnership - our local response to the national strategy	LiH did a comprehensive meeting on this ion 22 Jan 2023	Substance Misuse Partners; Public Health		
	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
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
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
	Safeguarding issues around hoarding and neglect		Adults Heatlh and Integration	Adult Services	
June or July	**Local response to Martha's rule (a system giving seriously ill patients easy access to a second opinion if their condition worsens)**	https://www.bbc.co.uk/news/health-68348301	Homerton Healthcare		
June or July	**Local response to BBC investigation on 'hidden waiting lists"**	https://www.bbc.co.uk/news/health-68171162	Homerton Healthcare		

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