Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Monday, 8th April 2019

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair) and Cllr Patrick Spence**
Apologies:	**Cllr Deniz Oguzkanli and Cllr Emma Plouviez**
Officers In Attendance	**Anne Canning (Group Director, Children, Adults and Community Health), Tessa Cole (Head of Strategic Programmes and Governance), Penny Heron (Joint Strategic Commissioner Learning Disabilities) and Ann McGale (Head of Integrated Learning Disabilities Service)**
Other People in Attendance	**Richard Bull (Programme Director Primary Care, CCG), Siobhan Harper (Workstream Director, Integrated Commissioning, CCG/LBH/CoL)), David Maher (Managing Director, CCG), Dr Mark Rickets (Chair, CCG), Kirit Shah (City & Hackney Local Pharmaceutical Committee), Michael Vidal (Public Rep on Planned Care Workstream), Andrew Carter (SRO Planned Care Workstream and Director at CoL) and David Hodnett (Programme Delivery Lead The NHS App, NHS Digital), Tristan Stanton, (Implementation Lead – NHS App, NHS England), Dr Phil Kozan, NHS England)**
Members of the Public	**4**
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies were received from Cllrs Plouviez and Oguzkanli.

1.2 Apologies were also received from Cllr Demirci and Dr Sue Milner.

2 Urgent Items / Order of Business

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

3 Declarations of Interest

3.1 Cllr Maxwell stated that she was a member of the Council of Governors of Homerton University Hospital NHS Foundation Trust.

3.2 Cllr Snell stated that he was chair of the Board of Trustees of the disability charity DABD UK.

4 Minutes of the Previous Meeting and Matters Arising

4.1 Consideration was given to the minutes and matters arising from the meeting held on 12 March.

RESOLVED:	**That the minutes of the meeting held on 12 March 2019 be agreed as a correct record and that the matters arising be noted.**

CLOSURE OF SORSBY MEDICAL PRACTICE

4.2 The Chair stated that further to the AOB item on the closure of Sorsby GP Practice at the previous meeting he had submitted a number of follow up questions to the CCG as Members had some ongoing concerns about the issue.

4.3 Members gave consideration to the following email responses received from the CCG:

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1) Which neighbouring Practices are taking up the Sorsby patients and can you demonstrate that they have the capacity to cope? He would like to see a map to indicate the distance patients will have to travel.

Since 11th April 484 out of 4200 patients have already registered with a new practice. 37% have gone to Lower Clapton Surgery; 26% to Wick Surgery; 13% to Lea Surgery. The nearest practices confirmed that between them they have capacity to take on over 10,000 extra patients (Sorsby has 4,200). The CCG is providing financial support to surrounding practices to help them cope with the spike in new registrations. At point the CCG's assessment is that practices can cope. Based on the current trend only two practices appear to have more patients registering than they said they could cope with – Nightingale is forecast to receive 52 patients (an increase on its current list size of <0.5%) and Athena is forecast to receive 364 patients and has capacity to take on 300 patients. Based on current numbers about 3% of patients may have to register with their second choice of practice. The CCG is monitoring the numbers on a weekly basis. If patients register at the current rate then the list should be fully dispersed before the end of June. About 15% of the Sorsby list live outside of Hackney or live outside of the Clapton Park Estate.

2) What happens to those requiring home visits?. Members are well aware that this Practice is in the most deprived corner of the borough and the patient cohort is

particularly vulnerable with a lot of older people and people with complex needs. Transport provision is not good in this area and transport for those who are elderly or with limited mobility to the other Practices IS a problem. There is one bus. Are there plans therefore to increase the number of home visits to accommodate these patients and if not why not?

There are 52 patients on the current Sorsby home visiting list. Receiving practices will be required to carry out home visits where clinically indicated as part of their contractual duties.

3) Members also have concerns that the consultation was inadequate in that the meetings were held during the day and for a proper engagement some should have been held in the evening so those working full time could attend. Complaints have been made to Members about this.

This was engagement rather than consultation and all patients were written to.

4) Has the meeting with King's Park Ward Cllrs happened yet and if so what was the outcome of it? Is there an action list?

Yes – Mark Rickets and myself met with Councillors Demirci, Patrick and Rennison on 4th April, 8am, at the Town Hall.

It was agreed that I would contact Paul Williams, Operations at Clapton Park Management Organisation regarding additional local communications; that I would write to TfL regarding the proposed reduction in the 242 bus route and that I would provide the Councillors with monthly reports on the numbers of patients re-registering. First report sent last Friday. Next report due 2/5/19.

Richard Bull
Programme Director – Primary Care, City & Hackney CCG

4.4 The Chair added that Dr Mark Rickets (MR) (Chair, CCG) and Richard Bull (RB) (Programme Director for Primary Care) were joining the meeting to answer some further questions and he also welcomed 2 residents affected by the closure who had asked to contribute to the discussion.

4.5 A resident stated that her 83 year old mother-in-law had been a patient at Sorsby for 45 years and she was aware of a number of other elderly patients who were also very concerned about the impact of the closure on them. She detailed the difficulty of a bus journey to the alternative practices especially in winter for someone who was elderly and frail. There was only one bus route and the buses were overcrowded, with school children in particular, and she would have a walk at either end. She added that in her view the surgery had been deliberately run down over a number of years and had been providing a bad service. She stated that there was always difficulty trying to get through on the phone, then 10 minute appointments which were not sufficient for elderly people. She added that this area of the borough badly needed more doctors.

4.6 The Chair asked whether additional home visits would now be offered for these elderly and vulnerable patients. He added that Members had heard a lot about the new Neighbourhoods Model and had that taken into account addressing what needs to be done when there is a loss of GP capacity.

4.7 MR replied that it had been very disappointing that they had been unable to find a GP partner to take on the practice despite great efforts over the past few years. Lower Clapton Medical Practice had run it on an interim basis but no longer wanted to do so. There was no deliberate running down of the service. The premises was owned by NHS Property Services and the CCG had been trying to engage them on improving the facilities for many years. As regards Home Visits this was part of the Core Contract for GPs and would be provided when requested. In addition the CCG had increased capacity for supporting older and vulnerable patients by enhancing the basic offer with proactive visits up to 4 times a year to frail and elderly patients. The offer on home visits in Hackney was far better than in other CCG areas. He re-iterated that if elderly patients were unable to get to the surgery they could phone to request a home visit.

4.8 The resident replied that officers needed to understand that change was very difficult for elderly people and that the communications on the closure of the practice must be better tailored for elderly and vulnerable patients in future. Her mother in law was finding it difficult to negotiate the processes she already had to contend with and yet people like her, wished to retain their independence. The letter to residents in November was bland and implied there would be no issues and they heard nothing until they were told the practice would be closing and she had to take a day off work to accompany her mother in law to the practice to try and sort things out. Her mother in law had not registered with the new practice yet as she didn't know what to do. She asked why Lower Clapton Medical Centre did not wish to continue at Sorsby. The Chair added that there was a strong requirement here for link person in the surgery to help with vulnerable patients who were struggling.

4.9 RB replied that Lower Clapton had run the practice for 9 years and spent their own money on it. They could not get GPs to work there and this had nothing to do with the patients but was mainly because of the poor condition of the premises. 10 nearby practices had been identified where patients on the Sorsby list could be moved to. He said the CCG had been very proactive in identifying those who needed additional support through the transfer and registration process and additional resources had already been allocated to the receiving Practices to ease this transition.

4.10 A Member stated that the Commission should consider a future review on "Service Change and Transport" because this issue had come up fairly regularly over the years. Members agreed.

4.11 The Chair asked that officers, outside of the meeting, provide direct advice to the residents who had attended. He also stated that he would also write to Transport for London lobbying on the proposed reductions to the 242 bus route as the closure of Sorsby illustrated yet again the hardship that change would cause in a deprived neighbourhood and to lobby them to re-instate it in full.

ACTION:	**Chair to write to Transport for London on the proposed reductions to the 242 bus route and lobbying that they be reversed because of the hardships they will cause adding that the closure of the GP Practice has increased the need for transport solutions particularly for the frail**

	and elderly.

ACTION:	**CCG Primary Care Team to provide a further update the Commission on the progress of the dispersal of the patient list from Sorsby.**

5 Integrated Learning Disabilities Service - update on new model

5.1 The Chair stated that this was the third in a series of updates on the review of the Integrated Learning Disabilities Service which the Commission had requested, the last one being in September 2018.

5.2 Members gave consideration to the update report and the Chair welcomed for the item

Anne Canning (AC), Group Director CACH
Ann McGale (AM), Head of Integrated Learning Disabilities Service
Tessa Cole (TC), Head of Strategic Programmes and Governance
Penny Heron (PH), Joint Strategic Commissioner – Learning Disabilities

5.3 In introducing the report TC stated that this was the third update and the new model was in place and the service now had a 2-provider model with ELFT and LBH. One of the big challenges was to recruit permanent staff and much progress had been made with 6 new social workers and a new permanent Head of Service in place.

5.4 AM added that there had been extensive consultation on a redesign of the service and they now had a much more joined-up offer. The focus was much more on achieving independent outcomes. She described the 4 new pathways which were being rolled out: *Preparing for Adulthood; Referral and Review; Intensive Support; Ongoing Support*. The Intensive Support model would focus on dual diagnosis patients (mental health and learning disability) for example. Multi disciplinary teams were working to prevent crisis and with an increased focus on preventions. The Referral Pathway would focus for example on those who were new in the area or whose needs had changed and on reviews against the set Performance Indicators. The Ongoing Support pathway had a focus on social care for health. Officers had been asked to report back specifically on out of borough cases and she explained that this was a complex area. Many were historic and had been out of borough for 20 or 30 years. These were given a chance to return and ensure if they did they are properly linked into local services and in receipt of the advocacy they needed.

5.5 Members asked about staffing. AM replied that the staffing establishment remained the same and the service worked in multidisciplinary teams to avoid duplication. There were 48 FT and PT and 6 new permanent social workers would help reduce the dependence on agency staff. This issue was a national one.

5.6 Members commended the co-production approach and the user forums and commented that forums might not always be representative and asked how people got appointed on to them. They also asked what was being done to ensure outreach to groups such as the elderly, BME and LGBT groups.

5.7 AM replied that many had been on the forums for a long time but much work was going on to attract new members. The new Supported Living organisations in the system were also represented and the health staff were also bringing in new people via the programmes such as those on healthy living, movement, dance, dieting etc. They were also reaching out to young people still in education and generally focused on being more outward facing.

5.8 The Chair asked about the ongoing and serious budget pressures in the service and if there was no reduction in staff and no diminution of service how could the savings be made.

5.8 AC replied that one of the key challenges was that the SEN pressures were already feeding through into ILDS as those young people reached maturity. AM replied that there were two elements to the cost savings challenge: rising demand and cost pressures on the budget because of increased costs for nursing care/support in the community/daycare and these cost pressures were national. So, needs were going up and providers' costs were also going up. In response they were looking a possibilities such as more local provision and at better advance planning by looking at projections of the numbers that would be coming through for the schools etc. Generally there was a need to move away from high cost residential accommodation.

5.9 The Chair asked how the new strategy would ease the cost pressures?

5.10 AC replied that the main reason for the redesign was to come up with a better and more fit-for-purpose model rather than simply cost savings. They looked at more appropriate local accommodation for example but central to the approach was to be clearer on the principles underlying the assessments. The Group Director for Finance and Resources and his officers were working very closely with the service on responding to the cost pressures. Also if additional monies came through from savings as a result of integrated commissioning, she added, this is where it would be directed. The key point was that this was a statutory service and structurally it was not funded at the level it needed to be and this was a national issue.

5.11 Members asked why it was so difficult to recruit staff.

5.12 AM replied that there was a national crisis in recruitment of social workers and so it was necessary to consider the full offer to these workers. The focus therefore was to ensure that support for mentoring newly qualified staff was in place as well as ongoing support.

5.13 The Chair asked whether with the 130 out of borough placements if they did decide to return they would be able to do so.

5.14 AM replied absolutely yes, it was their choice and obviously a whole number of issues would need to be considered such as the mental capacity of the patient and the ability to deliver the correct care to them. All out of borough placements had been reviewed and most wanted to stay put because they had lost links with the borough etc. The challenge was to ensure proper step-down care in assisted living for example was in place for them where they were. AC added that moving them back would not necessarily produce any significant

savings. In most cases however it had the advantage of putting them closer to home and with a provider that the Council knew well and it would be easier to ensure there were no gaps in their provision.

5.5 The Chair thanked officers for the report stating that it was clear that the new pathways were now more intuitive and sensitive. He stated that if in the next year there had to be any diminution of the service that this be explained to the Commission and if officers could return in a year with an update.

ACTION:	**Adult Services to provide update on ILDS in March 2020.**

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

6 Integrated Commissioning PLANNED CARE Workstream - regular update

6.1 The Chair stated that this was the latest in the rolling programme of updates from each of the Workstreams in Integrated Commissioning. This time it was the Planned Care Workstream and Members gave consideration to the detailed report.

6.2 The Chair welcomed:

Siobhan Harper (SH), Workstream Director – Planned Care, CCG-CoL-CCG
Andrew Carter (AC), Senior Responsible Officer for Planned Care Workstream and Director of Community and Children's Services, City of London Corporation.
David Maher (DM), Managing Director, City and Hackney CCG

6.3 SH took Members through the report in detail. She stated that Andrew Carter from City of London was the new SRO for the Workstream having taken over from Simon Cribbens. On outpatient transformation she stated that they were looking at ways in which care was delivered and described examples such as the 'virtual fracture clinic' and the dermatology service where the use of digital photo submissions was transforming the approach and avoiding patients having to come in for minor consultations face to face. On the issue of the over performance in elective care at the Homerton she started that the CCG had been able to mitigate it and there had been an external audit of the data to better understand the pathways and what the drivers were. A full audit was expected at the end of Q1 and then appropriate financial adjustment were expected. She added that in relation to the over spend in ILDS it would not be possible to commission ones way out of the financial pressures. By using joint funding arrangements they were trying to establish the level of health need and match it to the level of care need that was not being served. They was also some non-recurrent funding which was being used to alleviate the financial challenge. She stated that they had been successful in their bid to the Prioritisation and Investment Committee of the CCG to secure funding for the 'Housing First' programme and this was now out to procurement. This was a health integration model which would provide benefit to the whole system. On the issue of Continuing Health Care things were looking much better. Great progress had been made in ensuring the clients were assessed within 28 days and more was being done on arranging for assessments to take place out of hospital and in either the home or in the care home. On Cancer performance the data remained hugely disappointing. The system was capturing more

people at Stage 1 and Stage 2 which was good but screening remained a problem and so people were not being diagnosed early enough. Work was going on to drive up screening and detection rates. Bowel cancer which was very treatable still had rates which were too high and there was targeted work going on about that.

6.4 Members asked about the over spend in elective care. What were the drivers and whether this would result in a backlog and longer waiting times. Members also asked if this problem had just emerged in the past year.

6.5 SH replied that there wasn't a concern about waiting times in this context. The 18 week targets were good and one might have expected longer waiting times but this had so far not occurred. The problem was that the partners involved could not mutually agree what the drivers of the problem were and so an external audit was carried out to try and resolve it. She added that it was monitored closely and after the issue emerging at Q1 last year it was reported regularly to ICB. It varied every year but this change was not found to be statistically significant there was no issue about GP referrals for example. DM added that it was necessary to distinguish between a plan and how it was executed. A plan is always based on historical data as a starting point. The issue now was whether this was a new normal and there would be a need to adjust future plans. Discussions were ongoing with HUHFT on how to structure the contract better for the next year.

6.6 A resident, Mr Sills, described his experience of prostate cancer diagnosis and added that it was vital that early detection rates go up.

6.7 The Chair added that the figures on cancer were a concern. The Commission had heard in the past year or more about poor performance on cervical and breast screening and asked whether it would be better if both of those were devolved more locally. He added that detection, referral and conversion rates traditionally varied considerably between GP Practices and asked what was being done to tackle this.

6.8 SH replied that the CCG had an experienced GP dedicated to this one day a week and he was visiting Practices, examining their data and the literature etc that they were distributing to patients. An App had been developed for Hackney clinicians to assist them with this work. Generally the CCG and the Confederation was looking at what they could put in place to support GPs and a Clinical Practice event on it would take place on 1 May to look at what additionality could be put in place. Within Integrated Commissioning they were driving the 'Make Every Contact Count (MECC)' initiative and trying to employ a system based approach. Much more educating needed to be done about the importance of screening. The Chair commented that he had noticed that on the digital first primary care review that Tower Hamlets CCG had dedicated a GP 3 days a week to that urgent issue and asked whether there was scope to put more dedicated clinical resource onto this problem.

6.9 AC commented that it was not just about increasing clinical capacity there was also a role here for Local Authorities on public health messaging. There was a very high prevalence of certain cancers among Black Men and while some success had been achieved by the use of community champions etc there was an urgent need to do more on driving up screening.

6.10 The Chair stated the Cabinet Member Cllr Williams had been campaigning on the issue of rare and uncommon cancers and had 35 GPs attend a seminar on the issue the previous week. This had been a great success and she was keen to replicate this model and would be having talks with Cllr Demirci and health partners to develop this.

6.11 The Chair thanked the officers for their detailed update and for their attendance.

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

7 REVIEW on Digital First Primary Care... - evidence from NHS Digital on The NHS App

7.1 The Chair stated that this was the final evidence session at committee for the Commission's review on 'Digital first primary care and the implications for GP Practices'. He welcomed to the Commission:

David Hodnett (DH), Programme Delivery Lead – The NHS App, NHS Digital
Tristan Stanton (TS), Implementation Manager, NHS England
Dr Phil Kozan (PK), NHS England

7.2 The Chair added that Members had been sent the links to the background information about The App from the NHSE website and had been encouraged to download it in advance of this discussion.

7.3 DH stated that beginning in 2016 NHSE had centralised the planning for an App for primary care functions. It was now in a national roll-out phase. A new system for 'Log In' was in place requiring the applicant to submit a photo from their phone and a photo of their passport to assist with confirmation of ID. This was for those who don't already have an online account with their own GP. 15.3 million people now had an online account. The App would allow patients using a smartphone or tablet to: check symptoms, find out what to do when they need help urgently; book and manage appointments with their GP; order repeat prescriptions; securely view their GP medical report; register to be an organ donor and choose how the NHS uses their data. He added that the test programme had 3000 users on it and the majority never had an online account. There was a large procurement exercise around the App and 4 platforms had been selected to progress the work: EMIS, TPP, Vision and Microtest. They were on track for the 1 July date for full roll out.

7.4 The Chair asked how the App would integrate with all the various local systems for online triage that they had been looking at as part of the review.

7.5 DH explained that on the first version of the App had no online triage at the front end. They were working on this functionality now and had started with one of the providers E-consult and would proceed to the next three, they would not be locking any provider out but had to start somewhere. They had 32 applications, whittled it down to 7 and were now working with EMIS, TPP, Vision and Microtest. What they were currently saying to patients was that if appointment booking was not currently on the App for their GP they could

always proceed outside of the app and book online in the normal way using the various platforms which GPs are using such as Patient Access or Evergreen Life etc. This was like a modular system whereby various pieces would be added on as they become ready. They were also working on electronic referral systems and enhancements such as electronic prescriptions but for now the focus was very much on primary care.

7.6 PK and TS explained that another key part of the mix was the NHS Log-in which would make accessing all of this easier. The reach of the App so far has been great with 15m signed up most of whom had never accessed the NHS digitally before. There were 40m to go. The big difference with this was that an individual, once signed up, would use it throughout the various stages of their life. They were also working with social care providers on e-referrals. This was not about putting other offers out of business and they were not replicating other systems and the NHS App would function as part of a vibrant market.

7.7 In response to a Member who stated his Practice was not yet signed up TS stated that this was a staged roll out. They wanted to take the time to engage and organised it around a staged roll out in different geographical areas. City and Hackney would go live on 13 May. He added that there would be a large national advertising campaign from September to raise public awareness of it. This was held off until most of the country would be live and to give the new system a chance to bed-in.

7.8 Members stated that some would obviously benefit much more than others from this and what was being done to maximise take up.

7.9 TS stated that they were working on a number of approaches directed at target groups such as the homeless and those who with a low educational background who were digitally excluded. He undertook to share a link to their pathfinders programme which included the “Empower the Person” programme. He added that it should be considered that if appointments were freed up by digital this released resources to provide more support to those who could not use digital methods. PK added that as part of this they were working to how to engage service providers to make better use of the advantages that would come from the App. The Chair commented that the challenge was to get them to meaningfully engage. DH replied that 12000 names for the different clinical interactions had been identified and there would be a need for clinical interactions and appointment types to be renamed and standardised so that the system operate better. Pharmacists were also very important to the App and they were working with them using an iterative approach on the business change needed.

7.10 Michael Vidal, a resident, asked why all this functionality could not be added to the existing Patient Access system and what was being done for those who have neither a smartphone nor a tablet.

7.11 PK responded that this change could not be a bolt-on. NHS Trusts and CCGs had been engaging their own providers on a range of digital tools for patients. There was a need for a national App and to try and integrate and build on what had been developed by the 4 leading platform providers and there had been an extensive period of learning before they started. As regards accessibility standards in the NHS these were the highest possible and the NHS App had

received the highest rating from the Government Service which rates all Apps which are used on public projects. They also want to get the public to go on using a wide range of services. On the issue of access by digitally excluded patients there were a number of approaches. Patients could use iPads at GP Practices and in Libraries and there was also a system for proxy access for example for the elderly living at home whereby a family member or care could log-on on their behalf. DH added that a programme for those on offline pathways was being developed. Pharmacists were also going to set up the ID element of the App also and a web version of the App would follow. They were not charging Practices for any of this.

7.12 Members asked about parents logging on for children or elderly relatives.

7.13 DH replied that they were working on the system for carers to log on for adults and parents and guardians to log on for children. There were significant safeguarding issues in relation to children which had to be taken into consideration. 13 year olds and over can use the App. 13-16 year olds must have id verified in the Practice and only over 16s could use NHS log in.

7.14 Chair asked about the problems with the algorithm and public being annoyed by lots of questions on these systems when they're trying to do something simple quickly.

7.15 DH replied that for online triage this was totally under control of the individual Practices. Some GPs (or CCGs encourage their GPs) to open their whole appointment calendar to online requests, others offered a limited selection and some locked it down. The design of the online triage element can be tailor made. Under new GP Contract a minimum number of online appointments will have to be offered by all GPs however. TS added that some contacts will require that the digital provision is of a sufficient quality.

7.16 A Members stated that as with the shift to electronic banking they were stripping out the bulk of direct face to face contact and this had implications for quality and also meant lots of receptionists potentially being made redundant.

7.17 PK replied that this was true but the reality was that General Practice was not coping with its current workload so something had to be done. The days of being on the phone for 20 minutes at 8.00 am trying to get through had to end, there was no effective triage it was luck of the draw in getting through. In relation to staffing he did not foresee any reductions in staff instead there would be different roles for receptionists within Practices. Some people will of course insist on seeing a doctor face to face and this will need to be managed.

7.18 The Chair asked DM what training was being planned for GPs in City & Hackney in the run up to 13 May and how would it be advertised to patients.

7.19 DM replied that this was being led by Niall Canavan in the IT Implementation Group and by the GP Confederation and he undertook to provide members with the implementation plan.

ACTION:	**MD of CCG to provide the implementation plan in the run up to the 13 May go live date for The NHS App in City & Hackney.**

7.20 TS added on training that there was an extensive progamme of online training for GPs including webinars, toolkits, social media campaigns, posters and any practices which might struggle were being identified. A lot was happening locally in each CCG area. Waltham Forest was taking the lead as the Accelerator Site for this work in North East London.

7.21 Kirit Shah (Local Pharmaceutical Committee) asked about training for Pharmacists on this.

7.22 DH replied that the toolkit currently was for NHS clinicians but that community pharmacists provided a really valuable component of primary care and were being part of the plans. Work was going on to develop a triage system with pharmacists for example. PK added that this was about system change and so not just about GPs.

7.23 A member asked who was on the governance bodies overseeing the development of this.

7.24 DH replied that there was a board in NHS Digital which in turn was overseen by a governing board in NHSE and above that by DHSC.

ACTION:	**DH to provide information on the governance structure and the members of the governing bodies overseeing The NHS App work.**

DH added that part of what they oversaw was Security Penetration Testing and Technical Reassurance. Every time they released an updated version of the app there was a significant number of governance tests that had to be gone through to ensure security was maintained.

7.25 The Chair thanked the officers for coming from Leeds to contribute to the review and thanked them for their time.

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

8 Inner North East London Joint Health Overview and Scrutiny Committee - verbal update

8.1 The Chair gave a verbal update on the meeting of INEL JHOSC held on 3 April. He stated that there were two substantive items the NEL Estates Strategy and the 10 year NHS Long Term Plan. He added that while the funding bids from ELHCP (the NEL STP) had failed the bid to Cabinet Office for some seed funding to work up proposals for the options for redeveloping the St Leonard's site, as part of the 'One Public Estate' pilot, had been successful. One of the issues to be considered was when the time would be right to run an engagement event in the community.

8.2 A resident (Mr Sills) added that as a borough Hackney needed to decide what it wanted to do with the site and there was some urgency here.

8.3 The Chair stated that his preference was to organise a Scrutiny Engagement event on the future of St Leonard's which could involve a public meeting with a panel from CCG, HUHFT, ELFT, LBH. A member stated that he was confused what had happened to the London Devolution Pilot and whether this had been superseded by the ELHCP. The Chair added that there was a need to hear from the local NHS about: St Leonard's, the possible transfer of mental health beds from HUHFT to Mile End (Barts Health) and plans for GP re-configuration. He added that there was a view that there was a trade-off being made between increased elective capacity and mental health beds.

8.4 David Maher (MD of C&HCCG) replied that the Neighbourhood Model was key here. The development of St Leonards as part of One Public Estate provided key opportunities for the borough. The issue in relation to the move of mental health beds was not about an exchange. He was the mental health lead for ELHCP and what was envisaged was similar to what been achieved successfully for stroke and cancer services i.e a vision for a mental health centre of excellence which would drive up outcomes for the local population. The Chair replied that there would be a degree of political unhappiness if different aspects appeared to be traded off against each other and this would require careful handling and appropriate engagement and consultation.

8.5 Michael Vidal stated that he as a public rep on the Planned Care Workstream and was involved in initial work on the St Leonard's issue and he undertook to liaise with the O&S Officer on the more appropriate timing for holding a possible engagement event. The Chair thanked him for this.

ACTION:	**MV to liaise with O&S officer on timing for a possible scrutiny event on the St Leonard's site.**

8.6 The Chair reported that the items for the next two INEL JHOSC meetings would be as follows:

19 June 2019:

- Waltham Forest formally welcomed into the INEL JHOSC family
- NELCA /ELHCP Accountable Officer update
- Early Diagnostic Centre for Cancer at Mile End
- INEL System Transformation Board

18 September 2019 joint meeting with Outer North East London JHOSC:

- NELCA /ELHCP Accountable Officer update
- NHS Long Term Plan and Workforce
- Estates Strategy update
- Moorfields Eye Hospital

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

9 Work Programme for the Commission for 2019/20

9.1 Members gave consideration to the work programme for the Commission.

9.2 The Chair stated that the final part of the evidence gathering for the 'Digital first primary care' review would comprise focus groups with were being run by Hackney Matters and which would feed into the review.

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

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00 - 9.15 pm