Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Minutes of the proceedings of the INEL JHOSC held from Council, Chamber, Hackney Town Hall, Mare St, London E8 1EA

Date of meeting: Tue 1 March 2022 at 7.00pm

Chair	Councillor Ben Hayhurst (Hackney)
Members in attendance	Councillor Kam Adams (Hackney) Common Councilman Michael Hudson (City of London) Councillor Susan Masters (Newham) Councillor Peter Snell (Hackney) Councillor Richard Sweden (Waltham Forest)
Members joining remotely	Councillor Neil Zammett (Chair, ONEL JHOSC, Chair of Redbridge Health Scrutiny Committee (Observer at INEL)
All others in attendance remotely	Marie Gabriel CBE, Independent Chair, NEL ICS Zina Etheridge, CEO Designate, NEL ICS Henry Black, Acting Accountable Officer for NEL CCG and SRO East London Health and Care Partnership Rt. Hon. Jacqui Smith, Chair in Common, Barts Health and BHRUT Dame Alwen Williams DBE, Group Chief Executive, Barts Health Tracey Fletcher, Chief Executive, HUHFT Paul Calaminus, Chief Executive, ELFT Jacqui von Rossum, Acting Chief Executive, NELFT Prof Sir Sam Everington, Clinical Chair for Tower Hamlets, NEL CCG Dr Ken Aswani, Clinical Chair for Waltham Forest, NEL CCG Dr Mark Rickets Clinical Chair for City & Hackney, NEL CCG Siobhan Harper, Director of Transition for TNW, NEL CCG Diane Jones, Chief Nurse and Caldicott Guardian, NEL CCG and ICS Sandra Moore, Deputy Director of Continuing Healthcare, NEL CCG Matthew Norman, Continuing Healthcare Prog. Manager, NEL CCG Alison Glynn, Head of Commissioning & Contract Management, NEL CCG Dr Anju Gupta, Clinical Lead for Fertility Services, NEL CCG Mark Gilbey-Cross, Director of Nursing, NEL CCG Cllr Chris Kennedy, Cabinet Member for Health, Social Care and Leisure, Hackney Council Chris Lovitt, Deputy Director of Public Health, City and Hackney Don Neame, Senior Communications Consultant, NEL CCG Marie Price, Director of Corporate Affairs, NEL CCG Roger Raymond, Scrutiny Team, Newham Jill Szymanski, Scrutiny Team, Redbridge Jarlath O'Connell, Scrutiny Team, Hackney

Member apologies:	Councillor Faroque Ahmed (Tower Hamlets) Councillor Shah Ameen (Tower Hamlets) Councillor Ayesha Chowdhury (Newham) Councillor Gabriela Slava-Macallan (Tower Hamlets)
YouTube link	The meeting can be viewed here:https://youtu.be/tNaJs-pRnzU
Officer contact:	Jarlath O'Connell 020 8356 3309 jarlath.oconnell@hackney.gov.uk

---

1. Welcome and apologies

1.1 The Chair welcomed everyone and stated that the meeting was being recorded and live-streamed for public and press access. Apologies were received from Cllrs Salva-Macallan, Ameen, Ahmed and Chowdhury.

1.2 The Chair welcomed Zina Etheridge, the Chief Executive Designate of NEL ICS to her first meeting and the Rt Hon Jacqui Smith the Chair in Common of Barts Health-BHRUT. ZE thanked the Chair and talked about her plans for the role and stated that as a previous chief executive of a local authority she looked forward to being able to strengthen the partnership working between the NHS and the councils as well as with VCS organisations and Healthwatches.

1.3 On behalf of the Committee, the Chair thanked two of the senior NHS leaders in East London who are stepping down from their roles. Tracey Fletcher was moving on from Chief Executive of HUHFT to a role in East Kent and Dame Alwen Williams had announced her retirement as Group Chief Executive of Barts Health. He thanked both for their invaluable contributions not just to their organisations but to the community in east London. It was clear from the reactions of their staff that they would both be greatly missed, he added. Dame Alwen thanked the Chair and reflected on her 40 years in the NHS and her optimism for the future of integrated care now that the ICS were coming in.

2. Urgent items/ order of business

2.1 There were none and the order of business was as on the agenda..

3. Declarations of interest

3.1 It was noted that Cllr Masters was employed as Director of Transformation by HCVS (Hackney Council for Voluntary Services) in a post funded by NEL CCG, that Cllr Snell was Chair of the Trustees of the disability charity DABD UK and that Cllr Sweden was a Trustee of Leyton Orient Trust who deliver health services in inner London.

4. Implementation of ICS Structure

4.1 The Chair welcomed for this item:

Henry Black (HB), Acting Accountable Officer, NELCCG/Acting SRO NEL HCP
Marie Gabriel CBE, Independent Chair of NEL ICS

Zina Etheridge, CEO Designate of NEL ICS
Rt. Hon. Jacqui Smith (JS), Chair in Common, Barts Health-BHRUT

4.2 Members gave consideration to a briefing paper *NEL Integrated Care System Update.*

4.3 Marie Gabriel thanked Henry Black for stepping up for 10 months as the Acting Accountable Officer and leading the sector through the difficult period of the pandemic. She also welcomed the change from NHSE to allow elected members to sit on ICSs.

4.4 HB took Members through the briefing paper. He reported that elected members would now be able to sit on the ICPB and that the new live date for the ICS would be 1 July. Zina Etheridge had started as Chief Executive Designate the previous week and the focus now was on recruiting to the next top 6 executive roles. These comprise 3 statutory roles: Finance & Performance, Nurse and Medical Officer and 3 additional roles covering: People & Culture, Development and Participation. There would also be recruitment for 3 non executive board members. On the issues of finance flows he stated that the new model would ensure that partnership plans deliver the objectives. From this they would then work out the governance and the funding flows required. The ICS was fully supportive of the principle of subsidiarity and the working assumption was to only retain at NEL level what is best done at that level. The 'place based' partnerships would retain the level of flexibility they currently enjoy.

4.5 The Chair asked for a diagram on changes to funding flows for June mtg which would outline where funding would flow vis a vis the previous structure to make clear what would be system based and what would be place based.

4.6 The Chair asked how the 'Payment By Results' system, which drives Acute Trusts, was consistent with the new approach to joint working. HB replied that a purely activity driven payment system has not served us well in tackling inequalities. The new system would help deliver the backlog by being better able to flex capacity and deliver results in a more coordinated way. Some sites might be able to do more activity in the future than they do now. The core funding mechanism was based on population but additional activity based targets on top of that would be required to help clear backlogs but there would be no return to the old PbR system.

4.7 Cllr Adams asked who exactly the two Local Authority reps on the Board would be - members or officers? Marie Gabriel replied that local authority colleagues had been asked to decide on that and they were expecting a common approach.

4.8 Cllr Snell asked about the transition from local jointly commissioned services. HB explained how this gave the ICS the opportunity to build on the excellent model as in C&H, for example. The structure of 3 committees, which sit jointly, should be continued at each 'place level' e.g. C&H. They would be reinforcing and retaining all placed based structures.

4.9 Cllr Masters asked whether the new ICS would end up cost neutral in terms of the cost of its structures. HB said they will absolutely focus on this, the aim was that it would not cost more than currently. The ICB would have a running cost allowance and the legacy CCGs historically underspend their individual running cost allowances and they expected the cost of the new structure to be the same.

4.10 Chair asked about the duration of new budget settlement for each ICS and how long north east London has until there is a new budget settlement. HB replied that the national funding process was still within the emergency funding regime. He added that we know that the current settlement will be c. 0.7% higher this year. They don't know yet the precise way it will be allocated and he offered to bring this back to the next meeting once it is clear. HB added that under the Long Term Plan their financial settlement had been for 5 years but this year they've only got the 2022/23 allocation clarified because of the emergency situation.

4.11 The Chair asked about the impact of the national 'levelling up' agenda on London councils' budgets and how London might lose out as a consequence of NHSE using a different approach to the formulas and the local weightings. HB replied that this will be a matter for ICB to consider very carefully as their overarching requirement will be to reduce health inequalities and they will have to try and achieve this in a way that minimises financial instabilities.

4.12 Common Councilman Hudson commented that he was very sceptical that these changes won't increase management and administrative costs.

4.13 The Chair thanked officers for their paper.

ACTION:	**HB to include in the ICS update to the 29 June meeting a diagram on the changes to funding flows (system vs place-based) comparing the 5 CCGs to the new ICS with the aim to understand how, apart from the significant slice going to the Acutes, the other budget lines will map across in the new ICS and which will end up 'system' level and which will remain place-based.**

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

5. Partnership updates

5.1 The Chair welcomed for this item:

Henry Black (**HB**), Acting Accountable Officer, NEL CCG
Rt. Hon. Jacqui Smith (**JS**), Chair in Common, Barts Health-BHRUT
Dame Alwen Williams DBE (**AW**), Group CEO, Barts Health NHS Trust
Tracey Fletcher (**TF**), Chief Executive, HUHFT
Paul Calaminus (**PC**), Chief Executive, ELFT
Jacqui von Rossum (**JvR**), Acting Chief Executive, NELFT
Professor Sir Sam Everington, Deputy Clinical CCG Chair/Clinical Chair Tower Hamlets, NEL CCG
Dr Ken Aswani (**KA**), Clinical Chair, Waltham Forest, NEL CCG
Dr Mark Rickets, Clinical Chair, City and Hackney, NEL CCG
Siobhan Harper, Director of Transition for TNW, NEL CCG

5.2 Members gave consideration to two papers:
a) NEL Health update
b) NEL Covid-19 vaccination programme and flu immunisation programme data pack

5.3 JS provided a verbal update on the succession plan for the new Group Chief Executive and the need to make progress on the joint collaboration between the two trusts without unnecessary organisational change. She explained the move towards having a joint CE for Barts Trust and BHRUT so that it could be a strong voice for north east London. Both Trusts will remain separate statutory organisations with their own Boards. Much work was being done to strengthen the site based leadership and she was also recruiting Vice Chairs, one for each of the Trusts.

5.4 The Chair asked whether the Department of Health was dictating direction of travel here, insisting on one large acute trust in each ICS area. JS replied that this trend was increasing across the country. What had driven the local decision however was the view that this was the most appropriate way to drive the necessary collaboration that was needed while maintaining the leadership in each Trust. It was not mandated but they felt it was in the best interests of their patients and built on existing close working relationships.

5.5 Paul Calaminus (CE of ELFT) described what was driving the similar plan for joint ELFT-NELFT Chair. He illustrated some successes coming out of joint collaboration. He explained that there had been a significant increase in the mental health needs of children and young people since the pandemic and with the two trusts working together in borough partnerships they'd been able to sharpen the approach. Some of this work had led to more appropriate hospital admissions and fewer young people going into hospital. This had resulted in a 40% reduction in length of stay and then being able to reinvest those savings in for example a new resource/service for treatment of eating disorders across the 8 boroughs. He added that NEL was the only ICS area in London not sending adults out of the area for mental health treatment. There were many examples to take forward which were about consolidating joint working which was in turn improving outcomes.

5.6 AW gave an update on waiting lists in the acute hospitals. The issue of long waiters was predominantly a Barts Health issue but they'd successfully worked in collaboration with HUHFT and BHRUT to give mutual aid to support Barts with their backlog. They were always balancing capacity and workforce to target the very urgent category. The focus now was on the 104 and 52 week backlog lists. They had achieved a 50% reduction in the 104 wk list (1800 in Jan, now down to 900). There was now a national elective policy and all 104 wk waits would need to be eliminated by July. In terms of 52 wk wait they had reduced this to just over 8000 which was a 54% reduction over the past 6 months. In terms of national 'ask' the refining their elective recovery plan for 22-23. Nationally the aim would be to eliminate all 52 wk waits by March 2025. She also described the use of surgical centres of excellence which focused on high acuity but low volume. She was very conscious that given the scale of the challenge this configuration of surgical centres successfully used during the pandemic would endure. She concluded that there was a strategic element to all this too given the future demands of a rising population.

5.7 TF gave an update on waiting lists at HUHFT and on current priorities. They were below national thresholds. Their priority with Barts Health was to try and establish which patients can most easily transfer into them either directly or indirectly so that the overall system can tackle this huge elective challenge. Such mutual aid joint working between St Barts and the Homerton had existed for many years. There was a need to get back on top of the backlog. Pre Covid there had been many conversations about demographic pressures but now, collectively, there was a need to think again about possible impacts. Planning on a NEL scale wasn't easy but they practised it over the past two years of the pandemic and they now needed to establish it on a planned footing rather than on a crisis footing.

5.8 Cllr Snell asked how extra capacity was being created to clear the backlog and what were the other ways of working that allowed us to get people through the system more quickly. AW described the high volume-low acuity surgical centres. The outpatient pathways would remain local, she added. It was usually a staircase surgery approach with HUHFT for example specialising in gynae and general and Newham in orthopaedic. This means they can treat more patients more quickly in these centres because the clinicians have come together. They were also planning with the Independent Sector and were working separately to secure capital investment to expand capacity in NEL. In June they would have completed the planning round and would be able to report more. One of key constraints was that they still had to segregate patients because of covid and this was having an impact on how many patients they can have in a theatre each day. They were also looking at pathways of care linking into community care and innovative work was taking place at this level.

5.9 Cllr Masters expressed a concern that the public was being led by a political narrative that the pandemic was over, in order to drive up activity, while the risk remained. AW replied that very stringent infection control measures were still in place in all sites. The numbers were much lower and severity was very much lower but there was still a need to reduce transmission. They would abide strictly by clinical control of infection advice but with a degree of relaxation happening they would be able to treat more patients.

5.10 Cllr Sweden thanked AW for her service and asked whether there was sufficient bed capacity in acute mental health. He also asked about greater use of community treatment orders. He also asked whether they had sufficient capacity to drive up cancer diagnostics. PC replied that they had 90-94% acute capacity in mental health. There were big differences between rates for male vs female and as between different boroughs. On the reduction in use of ‘community treatment orders’ there had been a reduction overall in their use and instead more and different crisis offers were being put in place, as well as enhanced use of crisis lines. AW replied on further investment in cancer diagnostics stating that further investment was being made. MIle End Early Intervention Centre had opened last year, a similar centre had opened at Barking Hospital and more were on the way. Because of the Mile End Centre they had cleared the endoscopy backlog really effectively.

5.11 Cllr Hudson on what the relative cost of independent vs NHS care was. He also asked about the rate of loss of staff. AW replied that the same NHS tariff was used in the independent sector for outer NEL and they had extricated themselves from the use of inner London providers. In terms of recruitment and retention, broadly there was a degree of stability but this masked that a lot of recruitment was being done, turnover was high and so they needed to increase the workforce.

5.12 The Chair asked whether there was an evidence base that governance was more effective when you consolidated trusts and spread it across a large number of organisations and how we were judging quality and effectiveness. PC replied that there were approaches to areas of collaboration where we can really demonstrate better outcomes. This was very much about how we really support organisations to collaborate well. This has been about the experience over the last two years and trying to continue that.

5.13 Jacqui van Rossom (NELFT) replied on the advantages of joint governance. The focus was on improving outcomes by building on the existing collaborations. NELFT had worked closely with partners in Essex for some time. The issue then was how to give support to a joint Chair and to add capacity so that they don't dilute the Chair's presence and effectiveness. This approach helps not only in east London but also in the other geographical patches they both work in.

5.14 Cllr Adams asked whether an NEL system pathway for Long Covid existed. Dr Ken Aswani explained the system treatment pathways that were in place for Long Covid across NEL. The GPs assess the patients and refer them to specialists. If however a more multi disciplinary approach is required they are referred into a Long Covid pathway and an individual plan is built around the patients needs so as to support them with, for example, rehabilitation.

5.15 Cllr Masters asked about the challenges of uniting different cultures in inner and outer in these collaborations. JS replied on the need to optimise capacity across the 2 trusts with a strong strategic leader at the top while maintaining some stability in the leadership at each site. Organisational development work would be done to bring the leaders together and they were beginning to see some progress on sharing of learning e.g. on Equality, Diversity and Inclusion or on Sustainability and Net Zero. She commented that she didn't necessarily agree that there were two different 'cultures'.

5.16 The Chair thanked the officers for their detailed report and attendance.

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

6. Harmonising Continuing Healthcare policies

6.1 The Chair welcomed for this item:
Diane Jones (**DJ**), Chief Nurse and Caldicott Guardian, NEL CCG and ICS
Sandra Moore, Deputy Director of Continuing Healthcare, NEL CCG
Matthew Norman (**MN**), Continuing Healthcare Programme Manager, NEL CCG

6.2 Members gave consideration to a briefing paper '*NEL Continuing Healthcare Harmonisation of Policies - communication and stakeholder engagement plan'*.

6.3 Diane Jones (Chief Nurse, NEL CCG) took members through the briefing paper.

6.4 The Chair asked whether Adult Social Care heads were co-designing this with the NHS. DJ replied they were and it was also being developed with communities. They wanted to create new policies across the system.

6.5 The Chair asked whether the end game here was fully pooled budgets for these services. DJ replied that the Better Care Fund and Section 75 agreements had already moved partnership working along on this and potentially they wanted to explore with councils options on expanding possible pooled funding.

6.6 Cllr Snell asked about CHC assessments being nationally mandated and whether an audit was being done here to underpin this harmonisation. DJ replied that given that CHC was under her leadership it was absolutely about an individualised assessment of individuals needs and not the budget envelope. They needed to look at who can provide the best care to meet an individual's needs. They have processes in place to assure themselves that the care packages are cost effective and meet people's needs. Part of what they were doing was looking at the benefits of services and looking at the best care provided across the boroughs.

6.7 Cllr Sweden asked about how seldom heard groups were being engaged and whether provision of advocacy would be considered as part of this. He had a concern that the articulate and sharp-elbowed would do well here. He asked whether an advocacy service could be commissioned as part of this for those who will need it. DJ replied they will engage with families but also advocacy groups. When an individual doesn't have family members to support then advocacy services would be needed.

6.8 Cllr Sweden commented that because the determination of who is eligible for CHC is a defined area, you must have expertise in health funded continuing care in order to be able to advocate in the first place. DJ replied that the intention was that they would make advocacy services available to those who required it. It was not routinely provided but they would take this point away. Cllr Snell added that there was an advocacy service in C&H supported by Mind and it was critical that we don't lose any of these services and this needs to be part of the broader analysis here.

ACTION:	**DJ to take on board in the engagement proposal the need to offer Advocacy, where appropriate, in relation to CHC. Noted that the determination of who is eligible for CHC is a defined area and one must have expertise in it to be able to advocate properly.**

6.9 Chair asked whether the driver of harmonisation was just cost related. DJ replied that this was truly about getting consistency in the pathway across NEL and they acknowledged that some people would have been on a painful journey in securing CHC and would have had to challenge decisions etc. The aim here was to go on this journey with families and not to be adversarial.

6.10 The Chair expressed concern that greater budgetary pressure is not put on Social Care because of this, given that council budgets have been dramatically slashed over the past 10 years. It was a job for those carrying out this consultation to ensure that Directors of Social Care are happy with this process and that this doesn't have a budgetary knock-on effect on other council services.

6.11 The Chair asked about ensuring that the consultation was as wide as possible. DJ replied that they were using all social media platforms and they had an engagement plan. Matthew Norman detailed how they were using Healthwatches, using surveys, publishing on websites and distributing various leaflets and pamphlets across a variety of settings.

6.12 Cllr Masters asked about the need with this consultation to go deeper than just Healthwatches in order to reach those not in touch with the system. DJ said they certainly were looking at the range of voluntary groups they could reach out to as they wanted it to be as far reaching as possible. They also asked for suggestions from Members which they would follow up on. Cllr Masters requested a list of VCS organisations being consulted.

ACTION:	**DJ to provide a list of VCS orgs across NEL who are being consulted as part of the consultation on Continuing Healthcare harmonisation.**

6.13 The Chair thanked the officers for their report and their attendance.

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

7. Harmonising of Fertility Services policies

7.1 The Chair welcomed:

Diane Jones (**DJ**), Chief Nurse and Caldicott Guardian, NEL CCG and ICS
Alison Glynn (**AG**), Head of Commissioning & Contract Management, NEL CCG
Dr Anju Gupta, Clinical Lead for Fertility Services, NEL CCG

Mark Gilbey-Cross, Director of Nursing, NEL CCG

7.2 Members gave consideration to a briefing paper '*NEL CCG development of a single fertility policy*'. The Chair asked that if there were plans to reduce the number of IVF cycles or the age parameters involved this must be made explicit as part of this consultation.

7.3 Diane Jones took Members through the briefing paper.

7.4 The Chair asked whether the changes here will be cost neutral. DJ replied that they need to complete the engagement first to see what the final policy would look like but this initiative was not a cost saving one.

7.5 Common Councilman Hudson asked if the cost was more, how would it be funded. DJ replied that they would have to look at other areas of service provision. There would need to be a financial impact assessment and an EIA. Both would go through due process to ensure they can meet the needs of the policy.

7.6 Cllr Snell stated that the proposals would need to be discussed with 'critical friends' in order to improve them and he asked about Stonewall's concern re services for gay couples. Alison Glynn (NEL CCG) described the engagement plans adding that they had already engaged with clinicians in all the local trusts and were contacting relevant patient groups. They were also talking to Public Health colleagues across NEL on sexual health services. They had also engaged with LGBTQ and BME groups internally to begin with. There would be wider engagement in the summer and she asked Members to suggest groups that should be added to their stakeholder mapping.

7.7 The Chair asked if there would be a needs assessment to support the policy development. AG replied that they had used an independent health policy support unit who had reviewed 5 of their policies against NICE guidelines. They had also undertaken a large mapping exercise on impact, cost and capacity and clinicians were examining that. The Needs Assessments would come up from the next round of engagement.

7.8 The Chair asked what variation there was currently across NEL. AG replied that in BHR they offered 1 embryo transfer, up to age 40. In the INEL boroughs they offered up to 3 embryo transfers up to age of 40 and 1 up to age of 42, and this inequity was why there was a need for harmonisation.

7.9 The Chair asked about the cost implications of applying the current Inner policy in Outer NEL. AG replied that it was difficult because they looked at different parameters in each. What they provide in INEL was only up to age 42 whereas NICE guidelines includes 42 yr olds. It was difficult therefore to segregate what the additional costs would be. It would be in the low millions if they went for a full change. There were other areas also not in line with NICE guidelines. It was not just about age and number of embryo transfers.

7.10 The Chair asked whether NICE guidance recommended how many cycles there should be. AG replied that it recommended 3 cycles and you can have more transfers within that but it depended on the individual. The Chair asked that the Committee sees both consultation documents when ready. He also requested that the consultation needs to be clear about specific planned changes adding that it would be counterproductive to white wash over a possible reduction in one area within a broader vague consultation about the service, as this would lead to great distrust. They must be as open and candid in these consultation documents as possible.

ACTION:	**DJ to ensure that both consultation documents (CHC and Fertility) be sent to the Committee as soon as they are available.**

7.11 The Chair thanked the officers for their paper and their attendance.

8. Special Whipps Cross JHOSC update

8.1 Members gave consideration to a briefing note from Cllr Sweden providing an update on the 26 January meeting of the Whipps Cross JHOSC.

8.2 Cllr Sweden summarised the discussions and added that sustainability and flood prevention would be on the next agenda. He added that there appeared to be a delay in final sign off of some funding which had delayed the submission of the Outline Business Case but this was in hand. The JHOSC had recommended that they should continue to revise the bed capacity as long as additional information come forward which might affect it particularly as only outline planning consent had been given. He added that the issue of calling for a full statutory consultation was still in the air.

8.3 The Chair asked about the argument in relation to the statutory consultation and if it was because this was not deemed a significant change to trigger one. Cllr Sweden replied that it was and the counter argument from the NHS was that it wasn't a substantial variation or a change of location. He added that the CCG and Barts Health were very cautious about getting embroiled in a matter of process that could postpone the start of building works. He added that there was unanimity that the new hospital was badly needed.

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

9. Minutes of previous meeting

9.1 The Chair stated that as there was no member from Tower Hamlets present the Committee was inquorate and the minutes from 16 Dec would be agreed with the minutes of this meeting at the next meeting of the Committee on 29 June.

10. INEL JHOSC future work programme

10.1 Members noted the updated work programme document. The Chair stated that the ICS would formally come into being two days after the next meeting and so they would wish for an update on that. There would also be a 'health update' and two slots reserved for issues which health leaders might wish to bring.

10.2 Cllr Snell asked for on overview of all the new specialist centres/hubs and asked for a map of these.

ACTION:	**HB asked if the Health update to the 29 June meeting could include an overview of the specialist hubs/centres of excellence which are being developed across NEL, with a map to illustrate which specialisms are moving where.**

10.3 Cllr Masters commented that these hubs had been previously mooted and the pandemic was being used to speed up their implementation. The Chair commented that a map of what is going where would be most helpful.

10.4 Common Councilman Hudson thanked everyone for the collaborative way in which the Committee had worked and wished everyone good luck in the upcoming elections.

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

11. Any other business

11.1 There was none.