Hackney

**London Borough of Hackney**
**Health in Hackney Scrutiny Commission**
**Municipal Year: 2022/23**
**Date of Meeting: Wed, 16 November 2022 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

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| **Chair** | **Councillor Ben Hayhurst** |
| **Cllrs in attendance** | **Cllr Kam Adams, Cllr Frank Baffour, Cllr Eluzer Goldberg, Cllr Deniz Oguzkanli and Cllr Sharon Patrick (Vice Chair)** |
| **Cllrs joining remotely** | **Cllr Grace Adebayo** |
| **Cllr apologies** | **Cllr Ifraax Samatar** |
| **Council officers in attendance** | **Nina Griffith, Director of Delivery, City and Hackney Place Based Partnership**<br>**Andrew Trathen, Consultant in Public Health** |
| **Other people in attendance** | **Louise Ashley, Chief Executive, Homerton Healthcare**<br>**Richard Bull, Primary Care Commissioning, NHS NEL**<br>**Tam Bekele, Secretary, East London and City Local Dentistry Committee (LDC)**<br>**Dr Dewald Fourie, Dentist, Chair, East London and City LDC**<br>**Siobhan Harper, Transition Director Primary Care, NHS NEL**<br>**Cllr Chris Kennedy, Cabinet Member Health, Adult Social Care, Voluntary Sector and Culture**<br>**Dr Reza Manbajood, Dentist, Treasurer, East London & City LDC**<br>**Breeda McManus, Chief Nurse and Director of Governance, Homerton Healthcare**<br>**Catherine Perez Phillips, Deputy Director of Operations, Healthwatch Hackney**<br>**Dr Mark Rickets, NEL ICB Member for Primary Care**<br>**Cllr Claudia Turbet-Delof, Member Champion for Mental Health**<br>**Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry, Pharmacy, NHS England London** |
| **Members of the public** | 34 views |
| **YouTube link** | **The meeting can be viewed at:**<br>**https://www.youtube.com/watch?v=M6KZ82RHcwE** |
| **Officer Contact:** | **Jarlath O'Connell, Overview and Scrutiny Officer**<br>jarlath.oconnell@hackney.gov.uk; 020 8356 3309 |

**Councillor Ben Hayhurst in the Chair**

## 1 Apologies for absence

1.1 Apologies for absence were received from Cllr Samatar, Dr Stephanie Coughlin, Dr Sandra Husbands, Dr Kirsten Brown, Caroline Millar, Janet McMillan and Helen Woodland.

1.2 The Chair welcomed Louise Ashley and Breeda McManus to their first meeting of the Commission.

## 2 Urgent items/order of business

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

## 3 Declarations of interest

3.1 There were none.

## 4 Discussion with new Leader of NEL ICS City and Hackney Place Based Partnership

4.1 The Chair welcomed:
Louise Ashley (**LA)**, Chief Executive, Homerton Healthcare and new Place Based Leader for City and Hackney Place Based Partnership.
Breeda McManus (**BM**), Chief Nurse and Director of Governance, Homerton Healthcare
Nina Griffith (**NG**), Director of Delivery, City & Hackney Place Based System

He welcomed Louise and Breeda to their first meeting of HiH and stated that the purpose of this item was to question the recently appointed CE of our largest acute trust Homerton Healthcare and the Place Based Leader for the City and Hackney Place Base Partnership, which is part of NEL ICS.

4.2 Members gave consideration to a background report: *North East London Integrated Care System & City and Hackney Place Based Partnership*

4.3 LA thanked Members for the welcome and gave a verbal update the key points of which were noted:

(a) Background as general nurse, paediatric nurse, health visitor, then chief nurse in many places, spending the past 4 years as CE of Dartford and Gravesend Trust. Worked in Homerton previously and set up their Starlight Paediatric Services Unit.
(b) The ground work that's gone into integrating health and care in City and Hackney has put in it a very good place and is way ahead of comparators.
(c) Having the Mayor on the ICB and Cllr Kennedy as Chair of the City and Hackney Health and Care Partnership Board, both providing a strong voice for

the borough, shows a commitment to joint working which is not present in other places.

(d) Conscious that there continues to be a nervousness locally about Barts and fears that the Homerton could not survive on its own but there are excellent working relationships between the two trusts already in place and the good work in integrating care is down to this.

(e) Understand the concerns about finance flows pre vs post ICS and noted that the ICS is working on a financial strategy but this work moves slowly.

(f) She and her Chair, Sir John Gieve, continuously point out that others can learn from C&H and so removing the resource from us to level up elsewhere, where there weren't similar levels of investment say in primary care in the past,is not the way to go. She has excellent working relationships with both Marie Gabriel and Zina Etheridge.

(g) It looks like there will be some sort of return to Payment by Results after two years of block contracts (due to pandemic). There will be money to place based commissioning for development work and there will be transformation monies also..

(h) Currently no appetite to devolve all commissioning and monies down to Place level and while that might sound like an attractive option it would only distract us from some of the development work we need to do in the Neighbourhoods for example. They do not want lots of additional work thrown down from the ICB without the resources to deal with it.

(i) On the elective backlog at the Homerton itself, most elective work had to be stopped during the pandemic and so they have about 25k on waiting lists now. Prior to Covid it was about 19k. Some of that increase is down to various coding changes.

(j) Their 18wk wait rate is still 4500 and this hangs heavily· However nobody at Homerton is on the 104 wks or 78 wk wait unlike in other parts of NEL. Homerton does have 72 patients who have waited a year and this is not good enough. They are steadily working through them and remain one of the best performing in London..

4.4 Members asked detailed questions and in the responses the following was noted:

(a) The Chair asked, notwithstanding the Acutes beng directly commissioned from the ICS for certain activity, would the bulk of the money which used to be spent by the CCGs remain at Place or be kept at the ICS level. LA replied that some would still come down to place; there has been a top slice of that across NEL for transformation i.e. developments that will then be allocated out to areas. It is still unclear, she added but there won't be a reduction in what City and Hackney receives but some of the development funding might be directed to other areas which may be further behind.

(b) The Chair stressed that there was a need to protect Hackney's interests and there need to be absolute transparency and if money flows were essentially

being diverted to other areas then this can't just be done at ICS level without proper, accountability, scrutiny or knowledge adding that he appreciated that Outer NEL has older population and that there are counterbalancing arguments but there needs to be transparency about these money flows.

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| **ACTION:** | **CE of Homerton Healthcare to provide high level breakdown by category of funding which City and Hackney CCG received and spent in its final year. This is to assist discussions at both HiH and INEL on comparing financial flows.** |

(c) A Member asked about the relationship between Barts and the Homerton, the latter not having a seat on ICB board. LA replied that Homerton Healthcare protects itself by being high performing and that Hackney is miles ahead on the way we do integrated health and social care and on the development of the Neighbourhoods. She added she has a very close working relationship with Shane DeGaris the CE of Barts Health and he has no interest in consuming the Homerton. The focus needs to be on patients and the population and we need to get the best deal for residents and the Homertron has excellent relationships with the specialist services at Barts and indeed it could not provide what they provide and they do it really well.

(d) The Chair asked about the impact of the advent of the Acute Provider Collaborative on the Homerton. LA replied she was the Deputy Chair of the APC and that feeds into the Population Health and Care Cttee which feeds into the ICB. The APC has worksteams on children maternity etc and all feed into APC board and work on things across the system such as elective and emergency care. A lot of the focus has been on other trusts currently because of ambulance waiting times and A&E performance in the wider system. She added that while the Homerton does not have a seat on the IBC the Mayor does and that Shane DeGaris represents Acute Providers on it, not just Barts. Sir John Gieve (Homerton Healthcare Chair) also chairs the APC Board.

(e) A member asked of the 25k on elective waiting list what percentage are classified as urgent or life saving treatments. LA explained how in urgent care patients are classified into 4 categories (P1 to P4). P1 refers to life threatening cases and they get top priority obviously.

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| **ACTION:** | **CE of Homerton Helathcare to provide breakdown of the elective care waiting list by category.** |

(f) A Member asked if the 8 Neighbourhoods have the resources required to meet their priorities and for an update on the St Leonards redevelopment plan. LA replied that the 8 Neighbourhoods aligned to PCNs have some

development funding but there is never enough to do what they want to do. They are exploring closer working relationships including with academia to support their work and of course each Neighbourhood has different needs and this also needs to be factored in. On St Leonards she stated that they had been offered the opportunity to take over the site which is currently owned by NHS PropCo and there is a way for this transfer to be arranged but before that can happen very many assessments that need to be done to ensure they can do it. She added that if they just took over St Leonard's currently there is no money to support it being re-developed and that is not acceptable. So there have been assessments of land values et t and looking at similar hospital developments where parts of the land need to be sold to pay for the hospital redevelopment. She added that it was a bid they'd like to develop but they have to get it right and it will take time to complete all these assessments. She commented that If she had the capital funding to do this tomorrow she would. She undertook to keep Members updated.

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| **ACTION:** | **CE of Homerton Healthcare to provide an update on the progress of the plan to redevelop St Leonards Hospital site. Item to be scheduled once there is sufficient progress to report.** |

4.5 The Chair thanked LA and colleagues for their attendance and asked if LA could return at the appropriate time with an update on the St Leonard's development and if the officers could assist with providing a comparison of the budget flows for City and Hackney pre and post the ICS.

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

## 5 NHS Dentistry in Hackney - Panel Discussion

5.1 The Chair stated that the purpose of this discussion was to hear from the commissioners, local dentists, Public Health and Healthwatch about the current provision of dentistry and oral health services in Hackney as there had been concerns from a number of quarters about the service and in particular access and cost and the challenges facing the providers working with an outdated contract and pricing system. He added that commissioning of dentists would soon be devolved from NHSE London to the sub region - NHS North East London, and so this provided an opportunity to improve the services and make them more locally accountable and responsive. He added that unfortunately that the Dr Stephanie Coughlin the Clinical Lead for City and Hackney Place Based System who had championed the need for this item was now unable to be present but her overview of the current commissioning landscape would be provided by Andrew Trathen one of the

Council's Consultants in Public Health. He was representing the Director of Public Health who was ill and unable to be present.

5.2 He welcomed to the following contributors, comprising current and future commissioners, local dentists and Public Health

Jeremy Wallman (**JW**), Head of Primary Care Commissioning, Dentistry, Optometry, Pharmacy, NHS England London

Richard Bull (**RB**), Primary Care Commissioning, NHS NEL
Siobhan Harper (**SH**), Transition Director Primary Care, NHS NEL

Tam Bekele (**TB**), Secretary, East London and City Local Dentistry Committee (LDC)
Dr Dewald Fourie (**DW**), Dentist, Chair, East London and City LDC
Dr Reza Manbajood (**RM)**, Dentist, Treasurer, East London & City LDC

Cllr Chris Kennedy (**CK**), Cabinet Member Health, Adult Social Care, Voluntary Sector and Culture, Hackney Council
Andrew Trathen (**AT**), Consultant in Public Health, Hackney Council

And the following who also contributed to the discussion:

Catherine Perez Phillips (**CP**), Deputy Director of Operations, Healthwatch Hackney
Dr Mark Rickets (**MR**), NEL ICB Member for Primary Care
Cllr Claudia Turbet-Delof (**CT**), Member Champion for Mental Health

5.3 Members gave consideration to the following background briefing notes:

5a - Background note setting out the context
5b - Data sheet from the current commissioner - NHS England London
5c - Note from the sub region NHS North East London Primary Care Team
5d - Note from NHS NEL 'Roadmap to Recovery of Dental Services the next 5 years'
5e - Note from Public Health on Hackney and City Oral Health Prevention and Promotion Service
5f - Report from Healthwatch Hackney 'Access to dental care in Hackney – when, where, how' from January 2022.

5.4 Cllr Kennedy (Cabinet) and Andrew Trathen (Public Health Consultant) standing in for the Director of Public Health introduced the briefing paper and gave an overview of the commissioning landscape for dentistry in Hackney. AT summarised the situation with the 2006 contract and how the payment system operates, how dentists receive business rate reductions and on the Public Health needs assessment which identified that oral health particularly for children in Hackney is poor. A key concern is that access rates for children during the pandemic had dropped 14%. He explained what Kent Community Health Trust provides in Hackney and the work on prevention in schools and

the focus on the Orthodox Jewish community where there was a particular need.

5.5 Tam Bekele (Secretary of East London and Local Dentistry Committee) introduced his presentation. The key focus was Access issues and the significant problems caused by the current national contract. The contact value of it was determined in 2004-5 when dental uptake was low and the rates were not based on a proper needs assessment. The 2006 contract which followed and is still in place also abolished catchment areas and patients can now come from anywhere. He added that we have a diverse population, some without a culture of visiting the dentist regularly. The key issue is that payment is based on UDAs (unit of dental activity) and rates have in no way kept up with costs and the system militates against ongoing or preventative work as the number of UDAs are capped and once a Practice reaches its allocated maximum it has to stop offering service as it won't get paid for any of the additional work.

5.6 Dr Dewald Fourie, local dentist, without growth being built into the contract the only way to grow is to see people privately. With the UDA system you get paid the same for 1 or 10 fillings, which is an issue particularly with new patients. No show appointments is another serious issue as this causes funding clawback from commissioners. Covid was also very difficult for the sector as they had to purchase air purifiers etc. He commented that patients think everything is on the national health and therefore must be free and it isn't. If you take on new patients, inevitably needing lots of fillings etc it takes up more time for the same pay.

5.7 Dr Reja Manbajood, local dentist explained that the current contract covers just about 50% of the population's needs. The contract itself is not functioning and small changes at the edges are not enough. Associate Dentists before 2006 earned £80K a year but their incomes have dropped. Many therefore choose to work privately and don't want to join the NHS because financially they are losing money. There hasn't been an uplift in 16 years yet all costs have risen such as electricity and rates of pay rightly demanded by dental nurses. A 20% uplift of contract this year would be required to solve the recruitment problem and thus enable practices to take on more patients.

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5.8 Jeremey Wallman (Commissioner for dentistry at NHSE London) introduced his briefing. He stated he was a longtime advocate for contract reform but commissioners have to play the hand they are dealt. The current contract doesn't work for patients or dentists, however the situation in London, although not great, is far better than in other regions. Dentistry, Optometry and Pharmacy are being delegated from NHSE London out to the ICBs from 1 April 2023 and his team who commission for all of London will be hosted by

NHS NEL from then. This was a very positive thing and they are aware that the need in NEL is greater than in many parts of London and he's pleased he'll be hosted by an organisation who understand dental commissioning. The contract as it stands won't change as it is enshrined in law and an Act of Parliament would be required to change it. In terms of what can be done he suggested that the move into ICS will allow them to drill down a bit more on population needs and look at issues from a borough perspective. He added they probably won't see new money but changes of structures should provide a level of flexibility and cross working with public health teams and local authorities which means that hopefully more can be achieved.

5.9 JW described how the urgent care infrastructure for dentistry was transformed during the pandemic and this remains and is being held up as an exemplar across the country. It works via NHS 111 but goes through to commissioned triage service and 40 urgent care hubs in London both in an out of hours so no patient in pain has to suffer. Most will be seen within 24 hrs as appropriate. Urgent Care delivery is for those who can't access a dental practice or choose not to. Even NHS charges are prohibitive to some people he added, He concluded that there was a sense of frustration as a commissioner re the contract as there are wider issues that need to be resolved.

5.10 Members asked detailed questions and in the Panel Discussion the following was noted:

(a) The Chair asked for the incoming commissioners' thoughts on how the system might be improved and enhanced. Siobhan Harper (NHS NEL Primary Care) described what would be involved in setting up working arrangements with the other 4 ICBs and how improvements can be owned at ICB level. Contracts worth c. £870m would be transferring across and a lot of due diligence work needs to happen. The Primary Care Team within NEL has a lot of experience working in this domain already and having Jeremy's team will give them a degree of advantage. They will need to think about lobbying in the right places where these systemic problems need to be addressed.

(b) Richard Bull (NHS NEL Primary Care) added that NHS NEL had put in a case to secure the dentistry team. He hoped they would utilise more of the Making Every Contact Count approach in primary care in pharmacies and working with the voluntary sector on equalities aspects. 'Change Please' programme who run a bus for street homeless will now have a dental service as part of that and this is just one example of what can be done.

(c) The Chair asked if NEL ICS would really be the local commissioner or just hosting the London commissioners. SH explained that it will become a deleaged function with a Memorandum of Understanding between NEL ICS and the other four ICSs in London. There were parallels with how GP services had been delegated locally while there is still a national contract but enhanced services are added and hopefully there will be development opportunities down the line.

(d) JW explained that the dismantling of the current NHSEL team is not possible. There are just 22 FTEs in the team and this is where the experience lies. They will deliver across London but be hosted by NEL ICS. Each ICS won't have its own bespoke function but they will build in a level of resilience within each ICS build on that. Over time they should build up a bigger resource to work round this.

(e) Members asked how the new contract will work and what will come out of it in the prevention work with older people and with children; also on the high incidence of delta caries in Orthodox communities and whether other communities were surveyed in a similar way and why Kent Community Healthcare is delivering a service in Hackney. AT expelled that the Orthodox Jewish data was bespoke data from that community and so led to the intervention. They needed to involve those who understood the issues within that community and this is why they secured the data. On KCH, they got the contract through open competition. They are experienced in delivering training, have a good academic base and a good track record, he added.

(f) Members expressed concern about both access to NHS dentists and then poor quality of personal care when they get one with one Member detailing poor personal service to children in particular. DF explained how the processes behind access to an NHS dentist works and how if a new patient is taken on then someone else potentially may lose out as there is a cap on UDAs and it can't be increased. New patients take more time as they need more attention because they most likely haven't had it. A normal check up is 30 mins but a new patient needing many fillings or root canal could take up 5 hrs. Retention of associate dentists and dental nurses to cover the work is a huge challenge.

(g) The Chair explained how the 2006 contract was based on an assumption of need then and pay not keeping up with inflation means a real term decrease. DF added that his practice has 12k UDAs and once that is filled they no longer get paid. Often taking on new patients would put a practice over its limit.

(h) The Chair asked JW about quality assurance stating that with GPs for example there is support to be had from a GP Confederation and if similar support could not be put in place for dentists in order to drive up quality and standards. JW explained that since 2006, and contrary to popular belief, there is no process of formal registration with an NHS dentist. As long as a dentist can deliver a service there is no obligation to take on new patients and the obligation to patients exists only for the duration of the specific treatment undertaken and that is it. On quality assurance he said there is thorough training and a formal complaints handling system to maintain professional standards. He commented that there is nothing in the current contract that actually rewards prevention work. A key flexibility in future hopefully will be working more closely with public health and local authority colleagues on these issues.

(i) Catherine Perez Phillips (Healthwatch Hackney) described the feedback they receive which is primarily on access and the problem of people having to phone round maybe 16 practices to get taken on. She added that when people do get seen the feedback they've had has been pretty positive with 83% being positive on quality and empathy. She questioned that it was not clear how these commissioning changes would improve access. JW replied

that there is an element of the unknown as they enter the new commissioning environment however it affords a level of flexibility to drill down a bit more on issues and there is a sizable budget involved and part of the challenge will be if they can re badge monies to focus on the more acute areas of need. SH added that there was a need to think more about ways of working and how to get under the skin of the issue and that having the team closer and having that overarching ambition to reduce inequalities will help. This could only be achieved by everyone coming together.

(j) A Member asked about the backlog of NHS patients not being seen and why dentists are doing more private work in this scenario. RM stated that the NHS and private work were separate things. Many cannot wait a long period and will try and get treatment privately when they can afford it. Providing comprehensive dental treatment for the whole population under this contract is not really possible because of the payment barriers. He added that prior to Brexit some EU dentists accepted the low rates in the UK but since then UK dentists generally will not. Dentists are not coming from other countries and there is an urgent need to recruit from abroad.

(k) The Chair asked if the recruitment issues were preventing practices from taking on new NHS patients. RM replied it was and gave the example that in 2011 he would receive 50 or 60 applications and now gets none.

(l) The Chair asked SH if a supplement could be given to help recruit dentists as has been done in the past to recruit GPs locally. RM commented that an uplift of 20% is needed to pay a higher UDA to dentists. SH added that in broad terms money is very tight now in the NHS and there is a recruitment crisis across all sectors of it.

(m) Cllr Turbet-Deloff (Mental Health Champion) commented on the severe impact of lack of dentistry on mental health forcing people to choose care over debt. She also presented statistics on the mental health of dentists themselves and expressed concern regarding the lack of a national screening campaign for oral cancers and asked if a local solution could be provided to this. TB replied that oral cancer rates in east London were comparatively high. He explained that dentists do provide cancer checks as a matter of course in treatment. DF confirmed that at every check up there should be hard tissue and soft tissue screening for oral cancers and it is always included. Cllr Turbet-Deloff commented however that recent BMJ research was showing that a third of dental practices did not appear to be completing these checks and could City and Hackney province reassurances on this. RM stated that every dentist knows they must do cancer checks. He added that locally they also have very effective referral pathways to hospital if potential cancers are found. He added however that because of the backlog fewer routine check ups were taking place and this could be a factor in rates for finding cancers early.

(n) SH replied on the mental health issues around dentistry and stated that in the new arrangements they hopefully would have the opportunity to build on this work. The KCH service at St Leonard's already works with those with learning disabilities and with mental health issues. She added that there does need to ber more lateral thinking on meeting patients' needs in a more holistic way and this must include services to those in mental health wards.

(o) Members asked at what point can the Council ensure that there is a fair review of this contract. JW replied that there is no quick answer and there was a long way off having a totally new contract. Some small changes had been

made as the BDA negotiates with DoH on behalf of the professions. They have to work with what they've got but olly a reformed dental contract will help and there needs to be concerned lobbying hopefully by ICS to achieve this.

(p) The Chair commented that, reading between the lines ,was it the case that the government doesn't want to redo it as it would only go one way in terms of costs. JW replied that reform of charging was just one aspect and there needed to be root and branch review in order to improve things.

(q) Members asked about the lottery in terms of accessing dental treatment and what can be done. JW reiterated that it was a big challenge but contract reform was crucial. He explained that access was much worse in other regions of England and we must put it in perspective while doing all we can to improve the situation in London.

(r) The Chair welcomed the 40 urgent care hubs. JW stated that they had set those up in direct response to the pandemic. There are 40 with a 24/7 delivery from a triage service and nowhere outside London has these. People can be fast tracked quickly. The Chair asked if the pathway was only via 111. He noted that there would likely be an issue over advertising the service adding that it was not completely understood that they exist but it is great that they are there. JW replied that demand was great and they would be stuck without them. RM added that his practice in Stoke Newington provided one of those hubs and without these it would have been much worse in London than outside.

(s) The Chair asked about dentistry appearing in the ICS Strategic Plan and the profile of it there. SH welcomed this point and undertook to take it back and she also thanked Cllr Turbet-Delof for raising the oral cancer issue which was important.

5.11 The Chair thanked all the contributors for their briefings and for their attendance and summed up by noting the political point on the need for lobbying. He added that in a year from the devolution he would like the Commissioners to return to report on progress.

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| **ACTION:** | **The Chair to write to the CE of NHS NEL to progress the issues arising from this discussion.** |

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

## 6 Minutes of the previous meeting

6.1 Members gave consideration to the draft minutes of the meetings held on 29 June 2022 and 21 September and the Matters Arising.

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| **RESOLVED:** | **That the minutes of the meetings held on 29 June and 21 September be agreed as a correct record and that the matters arising be noted.** |

## 7 Health in Hackney Work Programme 2022/23

7.1 Members gave consideration to the draft work programme for 2022/23.

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| **RESOLVED:** | **That the Commission's rolling work programme for 2022/23 be noted.** |

## 8 Any other business

8.1 There was none.