Hackney

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

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

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

Councillor Ben Hayhurst in the Chair

1 Apologies for absence

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

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Responding to increasing mental health need

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

4.2 He welcomed the following invitees:

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

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

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

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

4.7 Members asked questions and the following was noted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.10 The Chair thanked all the participants for their contributions.

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

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

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

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

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

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

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

5.5 Members asked questions and the following was noted:

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

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

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

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

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

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

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

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

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

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

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

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

6 Healthwatch Hackney Annual Report 2022/23

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

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

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

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

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

6.5 Members asked questions and the following was noted.

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

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

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

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

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

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

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

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

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

7 Minutes of the previous meeting

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

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

8. Work programme for the Commission

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

8.2 The Chair went through some of the outstanding suggestions.

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

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

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

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

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

9. AOB

9.1 There was none.