Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Wed 15 November 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 Frank Baffour and Cllr Claudia Turbet-Delof**
Cllrs joining remotely	**Cllr Humaira Garasia**
Cllr apologies	**Cllr Sharon Patrick, Cllr Ifraax Samatar**
Council officers in attendance	**Helen Woodland,** Group Director Adults, Health and Integration **Dr Sandra Husbands,** Director of Public Health, City and Hackney **Jayne Taylor,** Consultant in Public Health **Abigail Webster,** Senior Public Health Analyst **Amy Wilkinson,** Acting Director of Delivery, C&H Place Based Partnership
Other people in attendance	**Louise Ashley**, Chief Executive, Homerton Healthcare NHS Foundation Trusts and Place Based Leader for C&H Place Based Partnership **Caroline Cook**, Early Diagnosis Programme Lead, NEL Cancer Alliance **Femi Odewale,** Managing Director, NEL Cancer Alliance **Claire Mabena**, Lead Breast Cancer Nurse, Central and East London Breast Screening Service **Dr Mansi Tara,** Health Promotional Lead, Central and East London Breast Screening Service **Dr Kathryn Hawkesford,** Consultant Medical Oncologist, Barts Health **Mary Flatley,** Lead Nurse - Cancer, Homerton Healthcare **Dr Reshma Shah** GP, Chair City and Hackney Cancer Collaborative **Jessica Lewsey,** PCN Cancer Facilitator **Helen Farrant,** Head of Services, CoppaFeel! **Emma Walker,** Health Information Manager, Coppa Feel! **Sophie Conway,** Head of Community and Engagement, CoppaFeel! **Sally Beaven,** Executive Director, Healthwatch Hackney **Cllr Chris Kennedy**, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture **Caroline Millar,** Chair, City and Hackney GP Confederation
Members of the public	113 views
YouTube link	View the meeting at: https://www.youtube.com/watch?v=h7Iq7voQdEM
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Councillor Ben Hayhurst in the Chair

1 Apologies for absence

1.1 Apologies were received from Cllrs Patrick and Samatar. Apologies also received from Dr Stephanie Couglin and Sophie Dopierala-Bull (CoppaFeel!).

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 Chair stated that Cllr Sophie Conway was present but in her professional capacity as the Head of Community and Engagement for CoppaFeel!.

4 Tackling Breast Cancer in Hackney - DISCUSSION

4.1 The Chair stated that the aim was to discuss with key stakeholders the challenges around tackling breast cancer in Hackney and explore what is being done locally, what more can be done and how partnership working here might be enhanced. There would be 6 elements as outlined below and there would be short questions after each one and then a fuller Q&A. He added that it was an item the Commission had not covered for some years so it was timely to do so.

4.2 He welcomed the following invitees:

Caroline Cook (**CC**), Early Diagnosis Programme Lead, NEL Cancer Alliance
Femi Odewale (**FO**), Managing Director, NEL Cancer Alliance
Claire Mabena (**CM**), Lead Breast Cancer Nurse, Central and East London Breast Screening Service
Dr Mansi Tara (**MT**), Health Promotional Lead, Central and East London Breast Screening Service
Dr Kathryn Hawkesford (**KH**), Consultant Medical Oncologist, Barts Health
Mary Flatley (**MF**), Lead Nurse - Cancer, Homerton Healthcare
Dr Reshma Shah (**RS**) GP, Chair City and Hackney Cancer Collaborative
Jessica Lewsey (**JL**), PCN Cancer Facilitator
Helen Farrant, Head of Services, CoppaFeel!
Emma Walker (**EW**), Health Information Manager, Coppa Feel!
Sophie Conway (**SC**), Head of Community and Engagement, CoppaFeel!
Dr Sandra Husbands (**SH**), Director of Public Health, City and Hackney
Jayne Taylor (**JT**), Consultant in Public Health
Abigail Webster (**AW**), Senior Public Health Analyst

4.3 Members gave consideration to the following briefing reports in the agenda pack:

4b Public Health - Why is breast cancer an important public health issue?
4c Central and East London Breast Screening Service - Data briefing
4d NE London Cancer Alliance - briefing
4e to g City and Hackney Cancer Collaborative (the ToR for the Cancer Collaborative; screening data; breast screening in primary care)
4h CoppaFeel! - briefing
4i Homerton Healthcare NHS Foundation Trust - briefing (TABLED)

4.4 JT and AW from Public Health introduced their paper. She highlighted that breast cancer is a major illness of concern, age is the main factor but also it is the highest cause of death in women under 50. A key concern was iInequalities in outcomes. Almost a quarter of

deaths here are thought to be entirely preventable by taking actions on the modifiable risk factors and if identified early and treated quickly breast cancer can be tackled. She added that the papers highlighted that access to up to date data is far from optimal and this limits how much they can respond to local inequalities. Incidence and the number of new cases is relatively low but survival rates are relatively poor. Breast screening coverage has historically lagged behind national standards and we're seeing later diagnosis leading to poorer outcomes. There is also later diagnosis and poorer outcomes among certain groups such as Black Women. She added that there was some evidence around younger age of diagnosis for black women being linked to the younger age profile of that demographic but we do not have sufficient data to determine this. There is some uncertainty around evidence and data generally. She concluded that NICE had published a review on inequalities in breast cancer nationally and she could share this on request.

4.5 CM and MT from CELBSS introduced their paper. She explained that the screening population was invited every 3 years. The programme had gone through many changes and they are also just recovered from the effects of the pandemic and so were smoothing out the service now. They had moved from an open invite system to timed appointments to drive up uptake. They see a loss of 10-20% when sending open invites. She described the health promotion activities which target local community groups to reach harder to reach groups. MT detailed the work with Learning Disabilities groups. They engaged with Hackney Council's newsletter during breast cancer awareness week. They engaged with GP Practices. They have Ipads in all their sites to help with communication and to bridge the language barriers.

4.6 CC introduced the papers from NEL Cancer Alliance. They don't commission but work with all stakeholders to reach goals set by NHSE. They work with Public Health, the screening services, patients and community groups particularly in areas where populations have low participation rates. They fund community groups to do further outreach work. She took Members through the data charts they had from NHS Futures. The data is only as good as the input and because they rely on manual coding of results at the GP Practices, data can be absent or miscoded so there can be problems with accuracy. She noted that less than a quarter with Learning Disabilities and a third with Severe Mental Illness were being screened. She explained that the screening service sends service letters back to GP Practices by post and the Practices then manually code the results into the GP primary care system. This was because the screening system had been set up a long time ago and they don't have mechanisms for the results to go automatically into the electronic patient record. On data availability, there was a lack of robust data on ethnicity and recording rates were low so overall data was often not timely or accurate. They struggled with having a lack of data by protected characteristics and were looking for possible solutions. She went through the various barriers to screening uptake such as: lack of trust in health service, historic and intergenerational issues around medicalisation of race, cultural problems linked to fatalism and not wanting to know. People were often too embarrassed to undress, there were language barriers and the letters were not sent out in community languages. Sometimes a lack of knowledge, a fear of pain, a fear of discrimination and the accessibility of the testing venues was a problem. FO added that the key concern was the various barriers to uptake and these were impacted by multiple factors so overall it was not an easy task to drive up screening rates.

4.7 RS and JL introduced their papers. RS explained that for the patients knowing what to say to the doctor and being confident to ask was key. There were two elements here for GPs: the screening service and then treating symptomatic patients. The patients she saw with lumps or symptoms need a referral to secondary care. With screening it was a very outdated paper based system and GP Practices have to code the data so a GP will not readily know accurately whether a patient has had a mammogram. Whereas with cervical screening results for example the GP would receive alerts this was not the case for breast

screening.If you know the history you can quickly do more and utilise opportunistic public health messages and empower patients. Having more data for GPs it would be helpful for every individual. Another issue was the location of screening sites with only 3 at present and more needs to be done on making it easier for patients approaching GP receptionists. There was also a gap in relation to collection of data on ethnicity. In relation to the list of lowest performing Practices these were in Stamford Hill area and more needed to be done to think about the particular needs of that local population.

4.8 KH and MF introduced their tabled paper. MF explained that the Homerton provided surgical treatment and follow up care and they worked very closely with Barts Health who provided the main treatments. They had 4509 referrals last year and of those 4378 did not have cancer. They commented that they were missing a trick with this cohort as it was a "teachable moment" when they could have affected people's health behaviours. Of the 132 diagnosed with breast cancer the mean age was 56. Generally they are seeing a younger population and also 29% are from Black ethnicities. They see people in a one-stop clinic where they assess, test, do biopsy and a Multi Disciplinary Team discuss the treatment. The key 2-week-wait indicator was the standard they worked to and they had fallen below it on 2 occasions. She explained that they will continue using the 2ww standard as well as applying the new Faster Diagnostic standard and they're achieving both. Strikes did reduce their capacity however. They were confident that they were not going to reduce focus by the requirement to use different standards/performance indicators.

4.9 KH explained that she was a medical oncology consultant across Barts Health and Homerton. She stated she was at the far end of treatment but early diagnosis was the key to increased cancer survival. They can do much more even for those with later stage cancer if they present earlier. She added that they were seeing a slightly younger population recently and this cohort can have much more aggressive cancers. They've also noticed higher incidences of Black and other global majority groups. She added that while screening was very important they also needed to look at the population under 50 which they were seeing more of. The other part of her work was follow up dealing with the after effects of treatment, helping patients to get back into life and grow families etc. Although they were seeing more younger women they were curing more also. She concluded that they have a growing population of patients who are living with cancer and the toxicities of the treatments.

4.10 EW from CoppaFeel took Members through her report. She detailed the history of the charity and ran through its activities. 1 in 7 women will be diagnosed with breast cancer in their lifetime and it's the most common cancer in adult females between 15 and 44. 400 men every year are diagnosed also. Because under 50s are only diagnosed after displaying signs and symptoms (and are not screened) this means they are often diagnosed at much later stages. Later stage diagnosis makes treatment more challenging and leads to poorer prognosis. Younger people have poorer outcomes therefore. The focus needs to be on giving people the confidence to visit GPs when they notice any changes and regular self checking. Hackney has a young population with 25% under 20 and 23% being 20-29 yrs old. Black women are being diagnosed at a significantly younger age than white women.

4.11 Members asked questions and the following was noted:

a) Chair asked about what practical and financially achievable ways were there within the current system to garner better data?
JT explained that barriers are mostly nationally based. AW added it's not uncommon to not get access to data. Since the merger of ICB they haven't been able to get Hackney data and it is not broken down demographically. They had made an application to the national data service and are hoping they can get the data even at an NEL level so we can present a united front with neighbouring boroughs. AW explained that the National Disease

Registration Service is national but the datasets they are after sit in a number of places e.g. NHSE, the screening providers, the treatment providers etc

b) Members asked if breast screening locally lagged behind national standards and what were the factors responsible for this?
JT commented that the screening service would be best to answer this specific point but the agenda papers contained a host of potential reasons e.g. lack of awareness, lack of trust, stigma, inconvenience etc and that it was a complex area and the reasons varied.

c) Cllr Kennedy asked if the local systems have any flexibility of choice of who is eligible or is it fixed nationally?
CM replied that women 50-70 will be called before their 53rd birthday and there was no local flexibility to extend these parameters. There had been a national age trial for 47 to 50 and 71-71 but it had been paused by the pandemic and so they are waiting for the analysis of the results of that in terms of any decision to extend. They have to work within national guidance.

d) Members asked for clarification of 'medical racism' as a barrier and what was being put in place to mitigate it?
CM explained that they look at all reasonable adjustments to help make the service fully accessible. Language barriers continue to be a big barrier. Having community champions within those groups to speak the positive message was really important and she detailed some recent successes with the Somali community. Getting training into those communities to help spread the breast awareness message and about the importance of attending both screenings and appointments was key.

e) Chair asked re p. 22 slide on uptake, noting that it was 40.6 for 2022/23 but for current year there was just one month data.
CM explained that screening data takes 6 months before it is logged because invitees have 6 months to respond to invites so they process map data at that interval.

f) Members asked about how the service manages follow-up after the 6 months
CM replied they can book a screening at any time. They are working closely with GPs giving them advice on how to engage with non attenders and doing outreach work. Data will only get accredited to surgeries once it is past the 6 months. At any point in the 3 yr 'round length' people can book at their nearest screening location.

g) Chair asked what's the difference between coverage and uptake?
CC replied that the Screening service would be best to explain this.

h) The Chair asked if a change to the data sharing had to be nationally made or could it be done locally?
CC replied that they were aware of some instances of changes being made in Surrey and Sussex but with all the changes with breast screening nationally and with the overall service up for re-procurement they wanted to make the changes across the whole of London. It would be a significant piece of work and would be done by NHSE.

i) Members expressed concern at 40% uptake level at Well St PCN. She added that in Well St it was difficult to get a GP appointment and was this the reason for the low recorded rate of uptake there.
CC acknowledged that getting a GP appointment was very hard everywhere at the moment. For screening they will be invited in due course. For women who are symptomatic, the first port of call is their GP however. She added that there is education to be done with Practices and with GP receptionists on what they need to be asking and how they can ensure they are given an urgent appointment if necessary. Some education work also needs to be done with

patients around awareness and about what they need to be saying to the GP and knowing what you need to say to be able to get an appointment.

m) Chair asked re p49 and Well St Common PCN where the uptake was just 8.7%. So this and not Stamford Hill was the lowest.
RS replied that the problem here was just coding and she'd be very surprised for Well St Common to be so low. JL added that just that week they had received an update and Well St Common had gone up to 17% just by pulling out more codes. She added they are trying to make it more accurate and all Practices had gone up. Some Practices were not even getting the letters so information was not being coded. She added that more support needed to go into the Practices to carry out coding. There also needed to be more education around the importance of signs and symptoms and the importance to attend when given an urgent cancer referral. The importance of the patient being available within 2 weeks to take up an urgent appointment needed to be stressed.

n) Members asked if there was therefore a disincentive for GPs to do more on uptake as it's just extra work for Practices.
RS replied that there was no specific incentive for driving uptake in Primary Care. Each PCN will choose a cancer to focus on e.g. bowel and when there is a push on cancer diagnosis uptake, Practices will often pick one to focus their efforts on and it may not be breast cancer.

o) Members asked how frequently do campaigns to drive uptake for harder to reach groups happen?
CC replied that they run 2 or 3 times per year as they don't want to overload people. They generally run through Oct and April for about 4 weeks.

p) Chair asked about the budget implications of lowering the age of screening and what practical suggestions to increase breast awareness were there to target that younger age cohort
KH replied that you may not always pick up the cancer, due to variation in breast density for example, no matter how young you might set the screening age. Having teachable moments therefore was important. Taking advantage of other treatment times to give the breast awareness message was also important e.g. with patients being treated for asthma or diabetes or cervical cancer checks and screenings. Large numbers were being referred through who don't turn out to have breast cancer so we could increase our impact by empowering them with more information.

q) Chair asked about the large cohort who are negative for cancer coming through by way of referrals and whether that was because the initial mammogram wasn't accurate
MF replied that all their patients were referrals from GPs of women with concerns about a lump and they do investigate. 93% do not turn out to have cancer so they are seeing a lot for investigation.

r) Members commented that with dentistry oral cancer checks were done by dentists routinely and patients may not even be aware of it but could something similar be done in relation to breast screening.
JL replied that this was a good idea and built on the concept of the teachable moment to empower patients who may have come in for something else. She cautioned though that the population coming in for other health needs are an engaged population already and they need to think about women not presenting to GPs at all. If English wasn't the first language there needed to be even more effort to get them to understand about the need to get care. She added that she was a Practice Nurse by background and and it was built into good practice to encourage breast awareness among patients

s) Chair asked about the Ashkenazi Jewish population where there is higher prevalence of breast cancer because of carrying the BRCA gene and was there a local system response to encourage more screening and was there a plan in place.
JT replied that they didn't have data specifically on Ashkenazi Jewish locally but there had been some targeted work on screening but not on breast awareness. CM added that there was a plan at CELBSS level where this cohort can see a breast cancer nurse locally and these cases are sent through for a genetic screening. 1 in 40 of that pop will carry the BRCA gene. The local Cancer Alliances have supported this work with some of the funding to get the clinics set up and on managing this phase. They will then go into high risk screening programme if they are diagnosed. The North London screening area had the largest population of this cohort in the country. And the screening here is not confined to over 50s.

t) The Chair asked if CELBSS has to get permission to go outside the national guidance to be able to put the funding in place to target this particular community and what were the constraints to acting more nimbly once they'd identified an evidence base?
CM explained that you have to have the MRI capacity to support a targeted intervention and that has to be built into the national systems, which are quite stretched. Alliances have supported the work with initial funding to get the staff on the ground and to get it up and running.

u) Chair asked how much was breast cancer part of GP training and was there more that can be done on that aspect. The degree of over referral did indicate that there is a greater degree of cautiousness?
RS added that in the 3 years final stage of GP training there would be weekly sessions with speakers coming to talk about different conditions including early cancer screening and diagnoses and then a one on one tutor to boost learning and these modules have to keep evolving to keep up with the latest evidence. One thing which was a continuing problem she added was that the 2ww referral pathway for breast screening started at age 18 and it was really tricky if you have someone who is younger. You then have to escalate the case to a paediatrician on call and find a care pathway with different routes that are not set or clear.

v) The Chair asked about education awareness in schools and if there was a role for Public Health to try and facilitate across the school estate in Hackney?
JT replied that potentially there was. EW added that they would like to use the HPV vaccination programme for example and they were working with Vaccination UK on linking in with that for summer term next year. Again this would be building on that teachable moment. There definitely was scope to embed wider cancer awareness training at that time. She added that CoppaFeel has school packs they could roll out at a much wider and a more streamlined level if that was possible. CC added that the previous year they worked with schools as part of the PHSC curriculum with 10 and 11 year olds in Redbridge. They had received great feedback and spoke to over 2000 children. Over 90% of those who took part were more likely to speak to their families about it. They were working on that again this year but in Tower Hamlets and Newham and trying to build something that will be sustainable. They are also doing 'train the trainer' online courses also. They will also work with the ACS charity in the Charedi community and will be holding sessions with women to talk about genetics and all cancers and breast screening.

w) The Chair asked if it was a problem that CELBSS screening footprint was not co-terminus with the ICS footprints and what challenges did this present?
CM replied that historically this is how it has been as the screening structures long predated the ICSs. From a data perspective it makes it more complicated but from a day to day perspective in running the service it's not such a problem. Breast cancer screening has never been aligned with ICBs/ICS unlike screening programmes for bowel or cervical cancer.

x) Members asked was there a lower age limit for this cancer and can someone be tested and examined before the current limit?
EW explained the Young People won't necessarily get breast cancer at a young age but by building the habits of self checking it prevents cancer down the line. Breast cancer can affect young people but the focus is on awareness so that they take that knowledge through their life course so they will be better informed if they do get it later in life.

y) The Chair asked if there was a reason why we have this convoluted system whereby the GPs are doing the coding and if there was a commissioning of breast screening services round coming up where this could be properly addressed and changed?
Cllr Kennedy commented that he wanted to thank CoppaFeel and at a time when local authorities were financially stretched it was great to hear from a VCS org that was keen to work with us and we should therefore welcome them with open arms. He added that there were opportunities to work with community champions and synergies with the council's various communication campaigns where they could carry the CoppaFeel message. In relation to schools he added that there was a whole raft of opportunities to drive more integration within the ICS and to integrate the third sector efforts here with the anchor institutions.

z) The Chair stated that there were a number of areas for action coming out of this discussion including greater coordination with schools, greater coordination between CoppaFeel and the Council, improvements that need to be made to the under 18 care pathway and the key one was support for requesting better quality data. He asked if the contract renewal for the screening service was due so that NHS NEL might revisit the whole process and how it plays out locally?
FO replied that the current contract for breast screening in the CELBSS areas was coming up for renewal at the end of 2025. The entire structure in London would not be changing but there were opportunities for other providers to bid.

4.12 The Chair stated that the current structure was very unsatisfactory and in any reformulated system the need for a re-think about data entry and data sharing was key and he suggested that this issue be raised with the House of Commons Health Select Committee.

4.13 SH (Director of Public Health) stated that there were a number of issues that need to be raised perhaps through the Select Committee such as how to make a difference at local and ICB level and to more effectively engage with people and around reducing the inequalities here. Currently local systems do not have up to date or reliable data and there are problems with how it is shared and presented. There also need to be suggestions though NHSE routes about how it would be helpful to share data in other ways. She added that the NEL Cancer Alliance presentation was not as helpful as it could have been because they did not have the demographic data. When the system is recommissioned there are things that the NHS can do differently but it's an issue of national policy. There is an evidence base around screening more generally and one also around breast cancer screening. Some of that will be about the health economics of screening programmes. The issue isn't about massively increasing the age range for example but rather finding ways the screening system could be adjusted to make it easier at local level as a patient and also for local providers so that there can be an overall increase in uptake and in the effectiveness of the system.

4.14 The Chair thanked SH and stated that he would pursue this with the local MP and with the Chair of the Health Select Committee.

ACTION:	Chair to write to the Chair of the House of Commons Health Select Committee on the issues particularly on data quality, data sharing and the system wide challenges that need to be tackled when breast screening services are next re-commissioned.

4.15 SC on behalf of CoppaFeel thanked Cllr Kennedy for his offer to them and stated they were ripe for partnership work here and would take him up on it. She reminded Members that unlike the national figure, it was the leading cause of death for women under 50 in Hackney and while this meeting had been focused primarily on screening it was important to remember that 43% of those diagnosed locally were under the age of 50. For this reason the efforts being made on screening need to be replicated in terms of driving up breast awareness campaigns. She stated she looked forward to picking up these points with the partners after the meeting.

4.10 The Chair thanked all the participants for their papers and their attendance and stated that it had been a very fruitful discussion.

RESOLVED:	That the reports and discussion be noted.

5 City and Hackney Place Based System - update

5.1 The Chair thanked officers for providing the new staffing structure. He noted that Dr Coughlin had had to give apologies for this meeting.

5.2 He welcomed for the item:

Louise Ashley (**LA)**, Chief Executive, Homerton Healthcare NHS Foundation Trusts and Place Based Leader for City and Hackney Place Based Partnership
Amy Wilkinson (**AW)**, Acting Director of Delivery, C&H Place Based Partnership

5.3 Members gave consideration to a tabled briefing paper *City and Hackney Place Based Partnership - Place based structures*

5.4 LA stated that Hackney Council was having discussions within partnership board and neighbourhood board on how much it can protect the resources in City and Hackney. The concern was that the finances behind the new structures sit very much with ICB and of course the NHS is under increasing budgetary pressure. She added that she works hard to ensure that resources aren't suddenly removed for example and there are discussions on how to better secure resources for City and Hackney and how the Place Based Partnership might look at bringing these posts (as outlined in the report) closer to City and Hackney rather than sitting in the ICB.

5.5 AW stated that this area of work was in a state of flux. The local Partnership Board was working to consolidate what exists locally and they were proud of strong partnerships and outcomes they had achieved together. The financial pressures were significant and it was important to say that at ICB level the concept of Place is seen as crucial to the functioning of the system. It is currently not clear what financial allocation might go to Place level and another key risk was around clinical leadership. Locally there was a very strong history of this at City and Hackney. The system had asked for a 30% reduction in clinical leadership capacity on top of the separate 20% administrative reduction at the beginning of 2023. It would sit at around 7.5 clinical leadership sessions a week on Place based work for the clinicians involved. Locally they were proposing a cadre of clinical leaders and to secure

some non recurrent funding to bridge the financial gap for the next year for the posts they wished to retain.

5.6 Members asked questions and the following was noted:

a) *Chair asked for clarity on what we were losing in terms of clinical leadership and if this included our previous commissioner for Primary Care City and Hackney.*
AW replied that that individual was not a clinical or care professional and this related only to our clinical professionals.

b) Chair asked if we are talking about a reduction in the resource for our Clinical Director then and what about mental health leads?
AW replied that funding clinical leadership is currently at NEL ICB and there are conversations at this point about potential devolution of that to Place. It would be groundbreaking if it was. She added that we were facing a reduction of 50% across the board in clinical input. LA added that this was about clinical leadership of programmes across the partnership and not reductions in individuals providing clinical care to the public. It is about the time clinicians will have to facilitate partnership work and advice on partnership projects and City and Hackney continues to fight its corner here. She added that it was very important to have clinicians leading these pieces of work but in the short time they would not really notice a decline. They had just recruited to these posts and they were expecting to have new people in post and a stronger sense of clinical leadership and it was disappointing that this was suddenly being reduced. They were continuing to fund this with time limited funding from the Partnership

c) The Chair asked about the financial pressures and was this about where we are with NHS NEL being at variance with financial plan and the double lock on sign off over 50k?
LA replied that this was less to do with any double lock than with expectation that we have a balanced plan financially across the system and ICBs were expected to take a large amount of that cost improvement out of their structures rather than out of providers structures, however in the end of the day it was all the same NHS money and NHS NEL like every ICS was having major financial challenges. AW explained the structure charts of what will be in place from 1 December '23. The structure would not be that different, most posts were like for like and the structures were now aligned more to the 'life course' of the individual in terms of their section titles. Roles would have similar bandings. The majority of staff had fitted into the new structure and locally they had just 3 displaced staff and 2 vacancies so they had been able to limit any disruption. They had also retained a lot of staff who had been in place for a long time so they have retained the institutional memory and familiar faces are still retained. She added that they continue to non recurrently fund the Neighbourhoods programme. The devil would be in the detail she added around the support functions. These had followed a different timeline and support functions like comms and business support were all centralised functions now and there had been reductions of 20 to 30% to core teams. The new centralised structure had drawn from the Places and reduced the staff numbers slightly. Communication was a good example, she added, in that our local manager was now part of the central team but, in her work, was posted primarily back to City and Hackney. She added that they were currently working through the full detail on the planned care staff restructure.

d) Chair asked where we were on allocation of funding and what happened to the 80:20 promise? Also at the point that the local GP Confederation contract comes up for re-commissioning have we, at Place, the funding to re-commission it?
AW replied that these discussions are ongoing. They have Place Directors meetings every week and this features in the discussions. LA replied that other boroughs are very familiar with City and Hackney's challenges to them about 'levelling down'. The problem isn't that C&H was doing well; rather it's that the other 7 Places weren't doing as well and that inequity was a problem because of a lack of resources overall. She added that all Places understand this. There hadn't been any plan for example to take 25% out of City and Hackney's current budget and and only 5% out of Havering's in order to 'level down' as it were. She added that all the lobbying C&H did had made a difference. The problem will be when there are 'growth' monies and then there would most likely be discussions that money needed to go to places who have less and she added that from a C&H perspective they would argue the case at that time. AD added that City and Hackney had always been lean in its staffing structure and that had helped so they have only had to do one round of cuts whereas other Places have had to re-submit plans.

5.7 The Chair summarised that where we are with staffing was that some support staff were technically working at ICS but brought back to Place operationally and a reformulated structure has been put in place where existing people have for the most part been slotted in but the challenge was in the Clinical leadership and the reductions there. He concluded by thanking LA and AW for fighting Hackney's corner as it were and thanked them for their efforts and for their attendance.

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

6 Minutes of the previous meeting

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

RESOLVED:	**That the minutes of the meetings held on 11 Sept 2023 be agreed as a correct record.**

7. Work programme for the Commission

8.1 Members noted the updated work programme

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

8. AOB

8.1 There was none.