London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Wed 10 January 2024 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 Sharon Patrick and Cllr Claudia Turbet-Delof**
Cllrs joining remotely	**Cllr Frank Baffour**
Cllr apologies	**Cllr Ifraax Samatar, Cllr Grace Adebayo**
Council officers in attendance	**Georgina Diba**, Director - Adults Social Care and Operations **Dr Sandra Husbands,** Director of Public Health **Amy Wilkinson**, Director of Partnerships, Impact and Delivery, C&H PBP **Helen Woodland**, Group Director, Adults, Health and Integration
Other people in attendance	**Sally Beaven,** Executive Director, Heatlhwatch Hackney **Dr Stephanie Coughlin**, Clinical Director, C&H PBP **Cllr Chris Kennedy**, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture **Basirat Sadiq,** Deputy Chief Executive, Homerton Healthcare
Members of the public	84 views
YouTube link	View the meeting at: https://youtube.com/live/He0nB5ppjIc
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Councillor Ben Hayhurst in the Chair

1 Apologies for absence

1.1 Apologies were received from Cllrs Adebayo and Samatar.

1.2 The Chair thanked Louise Ashley who had announced she will be leaving as CE of Homerton and the Place Based Leader for City and Hackney and thanked Basirat Sadiq Deputy CE at Homerton Healthcare who was present in her place.

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Update on implementation of Right Care Right Person

4.1 The Chair stated that this item was a follow up to the discussions at the Commission on 17 July. The new system had been due to come on 30 Aug but had been delayed to 1 Nov. They'd asked officers to come back to update us on how it was bedding in. He reminded Members that this represented a fundamental change to when Police will be deployed around welfare concerns, mental health incidents or missing persons or those who have absconded from hospital.

4.2 He welcomed for the item: Georgina Diba (**GD**), Director Adult Social Care and Operations.

4.3 Members gave consideration to 'Right Care Right Person' briefing note.

4.4 GD took Members through the report in detail. It was noted that change meant the Met Police could reconsider when police have to be deployed and there would be a change of approach to call handling. She provided reassurance that there were a number of structures in place to look at how it was being implemented and they had been given an additional two months. She stated she was pleased there had been no major concerns or escalations since it came in on 1 Nov. Early indications were that there had been an increase in demand to NHS 111 with Mental Health calls. A S136 Hub had been implemented. Overall the change had gone smoothly with a lot of work in the background to ensure that structures were in place. They were waiting for feedback on costs to other parts of the system.

4.5 Members asked questions and the following was noted:

a) Chair expressed a concern about those calling 999 being referred to 111 and if there was somebody on the line that didn't meet the threshold were they patched through to ELFT or told to phone 111.
GD replied that, unfortunately, there was a double contact and so it is not the 'soft handover' they would have expected so the system does create some risks. She added that police deployments had reduced from 44% to 31% of in scope calls i.e. call relating to welfare calls if someone was missing in the community or AWOL from a health facility or in mental health crisis. There had been a 13% reduction in police deployment therefore. She clarified that even though the police were not deployed it didn't mean a service wasn't deployed.

b) The Chair asked if there was a beefed up ELFT triage service that could be deployed if for example LAS wasn't needed.
GD replied that additional resources were deployed to make sure there was a response. There had also been a reduction in the number detained under MH Act and this was a positive result.

c) Members asked if the fluctuation in numbers might be as a result of people not being sure that a service is there for them
GD replied that the S.136 Hub allowed police to call in and ask for advice on cases, so what RCRP is doing is shifting how those conversations happen and it has forced partners to start communicating in a different way.

d) Members asked when the budgetary impact of the new system on the health and care partners will become clear?
GD replied that all areas across London are examining this. There was an NEL oversight group pulling together information on the costs and the costs across London will vary across local authority and ICS areas.

e) Chair asked whether it had even been discussed that some of the police budget be reallocated to fund this?
GD replied that the view was that there wasn't additional money for this.

f) The Chair asked how in a usual 999 emergency the police can allocate a case over to an NHS response and why this automatic handover doesn't happen here.
GD replied that it can be done and that had originally been discussed in the briefings given. She had observed a Hackney case where they were told to call for an ambulance. She undertook to ask the police why there wasn't a soft handover in these instances.

g) *The Chair stated that unless there was a recording those who call and get referred to another service could drop out and it could be a serious case that was then not followed up. It does seem that this needs to be monitored quite carefully and careful handovers be put in place.*

h) Sally Beaven for Healthwatch Hackney commented that they were doing Enter and View inspections to closed mental health wards and that as part of it they had asked staff about RCRP. They heard concerns that when a patient absconds, in the past, the police would go out but now this falls on the hospital staff who are overstretched and this will present a major burden for them to leave the ward.
GD replied that she had not seen evidence that this was yet happening. There was a London wide policy on absconsions and all that is happening here is that the police are asking health and care to take proportionate actions that are within their power such as calling the person's next of kin or making general enquiries. It was not taking over the police's full responsibility to be deployed if there is a risk of the individual harming themselves or others. It is rather that the police have asked partners to take a proportionate response before calling them.

i) The Chair asked if we could monitor and push for the soft handover to make sure it is really happening as there was a tangible risk of people not making that second call. He asked how we can be assured that a soft handover between services is embedded in the system.
GD undertook to seek this assurance and provide a written response to the Commission.

ACTION:	**Director of Adult Services and Operations to seek assurances from the Met Police and provide a written response to the Commission that a carefully monitored soft handover is being done since the implementation of RCRP.**

j) Members asked if there was a mechanism for a review of RCRP at some point in the future to make sure the system is working.
GD replied that the approach was now in place and wouldn't be pulled back. It had been implemented in Humberside over a 2-3 year period. There was a London group overseeing implementation and as part of that they are reviewing the data and incidents that come up and will be reviewed over next two years.

k) Members asked how the London Ambulance Service was coping with the introduction of RCRP.
GD replied that she didn't have a firm response on that. There had been an increase in calls to LAS and they have been deployed to people in mental health crises as well as just to accompany people to a hospital.

4.6 The Chair thanked GD for her update. He stated that in 6 months it might be appropriate to receive a brief update. He reiterated that he wanted assurances that a soft

handover is happening in all circumstances. If necessary the Commission could write to the head of the Met Police to ask what needs to be done to make sure it is happening.

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

5 Update on future options for soft facility services at Homerton Healthcare

5.1 The Chair stated that this item was to receive an update from Homerton Healthcare on the current status of discussions about the future of the 'soft facilities services' at the Trust including possible insourcing. The Commission had previously discussed this on 8 Feb 2023 and 9 July 2020. Soft services refer to catering, portering, cleaning, security services etc

5.2 He welcomed for the item: Basirat Sadiq (**BS**), Deputy Chief Executive, Homerton Healthcare and for her detailed the history of the Commission's previous items on this.

5.3 BS gave a verbal update. The contract is up for renewal in 2025. The plan to review the service has been delayed by a year because of changes in leadership in the Trust and the estates function being moved under another director. The Trust has been recruiting to a substantive new post of Director of Estates. In the meantime they've appointed on 6 month secondment one of the key figures who did the insourcing work on facilities at Barts Health and he had started two weeks previously. They will need to look at the options through a Value for Money Framework and are committed to ensuring they improve working conditions of these key staff. They've also been discussing this with the other trusts who are part of the Acute Provider Collaborative. There is now an Estates Provider Collaborative and they are having conversations on a joint agreement around estates issues. She's also discussed this with the Group Director of Barts Health. She'd also met with the unions to hear their concerns. As the plans progress they will look at an opportune moment to come back to the Commission with an update.

5.4 Members asked questions and the following was noted:

a) The *Chair commented that in his 11 years on the Commission this was the most promising news he'd heard on this issue and he asked about the timescale. He asked about the option to have another NHS partner such as Barts Health providing the service adding that he hoped the review won't take too long and will prevent any need to extend the current provider just because time had run out.*
BS replied that it was helpful to bring a key contact from Barts Health to lead the review. She was aiming to take his first draft of the review to the Trust Board and the Finance and Policy Committee in July-August. The schedule is to ensure they have enough time and she was conscious that there shouldn't be a need to extend the current contract if that wasn't a necessary option.

b) Members asked what form will the involvement of the unions take?
BS replied that when they met there were a number of issues that need to be addressed with ISS, the current contractor, which was separate. As they proceed through the procurement exercise they have stakeholders who will be part of that process. They meet with the unions regularly as part of the staff engagement process. They would have full involvement in the

tendering process. Outside of that they will continue to meet with them as part of normal business.

c) Members asked what the budget impact of going in-house will be, noting that the contractor now also pays sick pay and London Living Wage.
BS replied that this will be part of the review. She added that there is an initial cost as you try to align terms and conditions and then you look at impact long term. The learning from Barts Health had been that there is definitely a cost impact as you try to align the terms and conditions but that will be part of the review.

d) Members asked what the financial impact would be of TUPE'ing all the staff.
BS replied that they need to consider the costs and the impact of TUPE as part of the review. Costs will be dependent on the structure if they go down a route with the Acute Provider Collaborative then the structure would look different. She clarified for the Chair that if the staff were brought into Barts Health for example there would be a legal obligation to undertake a TUPE arrangement.

e) Members asked if HH decides to go in-house how prepared is the Trust and how quickly could it happen.
BS replied that it would be part of the tendering process and it's one of the things they would have to consider as they go through the due diligence. Once you have a start date it can be rapid however. She added that if a decision was made to bring them in house it would follow a detailed management timeline approach.

5.5 The Chair thanked BS for her update and reiterated that the Commission would welcome in-housing if possible and asked to be kept appraised of developments.

ACTION:	**A further update to be scheduled for the Sept or Oct meetings of the Commission.**

5.6 The Chair asked about the status of the recruitment proces for a new Chief Executive for Homerton Healthcare as that person was also the Place Based Leader for City and Hackney. BS replied that the job advert would close on 19 Jan with interviews in early February and it was likely that someone at that level would be on 6 months notice. It was noted that Lousie Ashley would depart in May so there might be a hiatus before the replacement was in post. It was noted that Cllr Kennedy would be on the interview panel in his role as the Cabinet Member for Health and Chair of the Health and Care Board.

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

6 Integrated Delivery Plan for City & Hackney Place Based System

6.1 The Chair stated that this item was suggested by the Clinical Director to update members on the progress being made by the City and Hackney Place Based Partnership which sits under the North East London Integrated Care Board. He reminded Members that at its meeting on 15 Nov the Commission had discussed the organisational structures of the City and Hackney Place Based System.

6.2 He welcomed for the item:
Dr Stephanie Coughlin (**SC**), Clinical Director, C&H PBP
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP

6.3 Members gave consideration to the following papers:

a) Integrated Delivery Plan 22-24 for C&H Place Based System
b) C&H PBP Governance Chart
c) NEL ICB System Planning Cycle 24/25

6.4 SC and AW took Members through the reports. SC explained the situation regarding the *Clinical Care and Professional Leadership (CCPL)* roles. They had recruited to a refreshed model in March '23 after extensive engagement to establish what would work with a small reduction in resources. That was on the basis that these roles would be in place until March '25. Now, in the context of a more difficult financial landscape a change was made in July to put these roles in scope for cost savings. Following this they had been asked to find a 30% reduction in Place based roles in clinical leadership. This was a difficult position to be in but reflective of the challenging financial landscape of the NHS. As a Place Based Partnership, having stable CCPL roles had been key to how they maintained the high quality of their care. There had been discussion across the PBP to understand how they might mitigate these reductions, recognising that a lot of their funding is on a non-recurrent basis. She added that they had agreed at Health and Care Board that afternoon how they would mitigate the cut by identifying some non recurrent monies that could be used for this but this would only apply for one year. The difficulty will be for 25/26 in how to reconcile differences between what's sustainable in terms of ongoing resources and what else might be available from the ICB. They will examine how they can utilise existing resources in the PBP more effectively and how they prioritise with limited resources. She added that there were obvious risks to further reductions in CCPL roles which they are very mindful of. What had been positive however was that all the stakeholders absolutely recognise the value of CCPL and they are committed to do all they can to retain this level of resource.

6.5 Members asked questions and the following was noted:

a) The Chair asked what a 30% reduction in these posts will look like?
SC explained how they quantify this by using numbers of sessions, with one session being 4 hrs either morning or afternoon and currently they have 35 sessions per week across the PBP. This would go down to 24.5 that's the equivalent of losing 5 days of work per week or 4.5 to 5 FTE posts engaged in this work.

b) The Chair asked what Dr Coughlin's current split was as the Clinical Lead.
She replied her time was 50% Clinical Lead (i.e. CCPL work) and 50% her own GP surgery work. She added that there would also be additional asks on her time for NEL wide areas of work (on top of City and Hackney work). She added that while there were no plans to reduce her or Dr Brown's (Primary Care Clinical Lead) work there will be more expectations on them for other NEL wide work in future.

c) The Chair asked who funded the Money Hub and if it was from a non-recurrent pot?
AW replied the council but there was a significant contribution from the NHS. They were going through an exercise to highlight all non recurrent funding streams that are potentially at risk as we move into new financial year. They want to prioritise those that have proved to be effective. There is a little bit of flexibility but they need to see what arises from the ICB budget planning exercise.

d)The Chair asked when it was funded to?
Cllr Kennedy said it had been for a year. He had just come from a meeting on the Poverty Reduction Work and where they were looking at how they restructure the Money Hub as there will have to be a reduction. They still hadn't had confirmation that the government's Household Support Fund, which funded it, would continue. The Council and partners aim to keep the Money Hub going especially those elements that have the biggest impact on people's lives. The Chair commented that it was a tangible outcome and obviously very successful (£13m unclaimed benefits claimed for Hackney alone) and so it needed to continue.

e) Members commented that while it was very successful they had also heard experiences of residents who are waiting some time for a response. They asked if there could be plans to expand it.
AW replied that expansion was unlikely and Cllr K added that continuation at the same level would be a win at present.

f) In relation to the childhood immunisation challenge, the Chair stated that the previous meeting they had heard from pharmacies about their potential increased role in immunisation campaigns. He asked if more could be done here?
SC replied that immunisations were a key priority. They have a dedicated Immunisation and Vaccination Clinical Lead since April to do some of this targeted work in Springfield Park PCN. The latest dashboard information has shown improvements and linking in with pharmacies was part of that. One of things they had taken away from recent data was that they had perhaps been too PCN focused and there was a need to recognise that some of their communities lived outside that PCN and there were other areas such as Hackney Downs which they needed to look at who might be missing out so the aim was to bring other GP Practices into the work. Pharmacies were key but they were practical challenges. Not all pharmacies can deliver these childhood vaccinations, but their outreach work with them was making a difference. Through individualised work they were considering how they can flex what is working on one PCN to other nearby postcodes.

g) Members asked if they had reached out to independent schools to target parents of large families who drop a child off at a school and they may have other small children with them who could be targeted at a Pop up clinic. She added that councillors might be able to assist in signposting to particular VCS groups in communities which need to be better targeted.
SC thanked Cllrs for the suggestions. She added that lessons learnt from flu and Covid outreach work could be applied to MMR work. They were expecting some non recurrent resource from NHS NEL for an MMR catch up campaign. They will also follow up with schools and all local VCS organisations. Also links will be made with Vaccination UK. One of the challenges with the flu campaign this winter had been getting consent from parents so that vaccines could be given when the pop up clinic arrived. They needed to do more to unpick the barriers to overcome the exact nature of the concerns and also to review whether the methods being used here need refining. It's an ongoing and continuing effort.

h) Members asked about reaching out to InterLink.
Cllr Kennedy replied that they talked to Interlink on a regular basis and the new head was meeting the Mayor that day. AW added that they also work with the Jewish Health

Partnership and with Hatzola and they had piloted small grants for this kind of work during the pandemic. She added that they were expecting the devolution of vaccinations responsibility to ICS i.e NHS NEL in our case in 2025 and this could open up new opportunities.

i) Members asked about the Anticipatory Care Pathway and whether new money came with it and how was this money being spent.
AW replied that they were currently using funds they had reallocated from last year and they had routed this work through the Neighbourhoods Programme. It was part of the government's Ageing Well funding and was non recurrent and it was not specific additional funding.

j) The Chair commented that there had been a notable increase of 10-18 % in demand for CAMHS and asked how it was being addressed.
AW replied that the numbers were a concern since Covid, but there are also issues around severity and complexity and clinicians being overstretched. They had put investment on it into schools and the voluntary sector. They were also thinking about navigation through other youth health services. Key areas affected include autism and ASD/ADHD and they'd put a lot of mitigations in there. They are looking at the provider collaboratives, providers, systems and NEL to jointly address it. They are looking at how they can support families who are at the pre diagnosis stage according to their needs. Overall it was stabilising in terms of demand but it was still a case of fire fighting this problem.

k) The Chair asked how long parents have to wait for diagnosis?
AW replied that for the under 5 pathway it was up to 20 weeks and for the 5-19 pathway it was up to 19 weeks. Children and families were given help however while they were awaiting diagnosis. She added that this problem was across all NEL and City and Hackney was in a better position than other neighbours.

l) The Chair asked if they had cascaded a communications message to parents that it was not the fault of the schools and if they were giving parents a realistic time frame of when they are likely to go through the gateway.
AW replied that they had introduced a Single Point of Contact so a plethora of CAMHS services were now together so there is only one way in the system. This was starting to bear fruit. A lot more needed to be done in terms of communications however and getting the message across that there is support also while people are waiting.

6.8 The Chair commented that if effective communications could go out to parents such as a generic letter explaining the background and the position the school was in it would make a difference. AW agreed and added that they also have mental health workers in the schools.

6.9 The Chair commented that it was good to understand whether we can find a way to keep the current clinical leadership resource in City and Hackney. Another issue for a future item would be the future of the GP Confederation's work because of the benefit it brought and how that might be protected in a revised structure.

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

7. Cabinet Member Question Time - Cllr Kennedy

7.1 The Chair stated that it was customary for each Cabinet Member to attend one Cabinet Member Question Time Session each year with their relevant Scrutiny Commission. The purpose was to allow Members to ask questions on areas separate from a review or other key work programme items being considered during that year.

7.2 To make these sessions more manageable they are confined to three agreed topic areas and Cllr Kennedy had been asked to answer questions on these 3 areas:

1.) How is the Neighbourhoods Programme working for Hackney, what have been its successes and what are its challenges?

2) Is the City and Hackney Place Based System working well for Hackney residents and has 'Place' been central enough in the governance of NEL ICB since its inception?

3) What could Hackney Council in particular do to help enact the 5 Missions in the recent Cancer Research UK Manifesto

Cllr Kennedy gave a verbal report and the following was noted:

NEIGHBOURHOODS PROGRAMME

7.3 Cllr K explained that the idea was about care closer to home. It started 5 years ago and City and Hackney is the envy of NEL as we have 8 Neighbourhoods and 8 PCNS that are coterminous. His Cabinet equivalent in Barking and Dagenham had remarked that they were lucky as their PCNs were not linked to their Neighbourhoods. He added that the office of PCNS in City and Hackney had agreed to a merger with GP Confederation as they were so closely aligned already. It had been agreed at the October Health and Care Board. Many others look to our system as role model and 7 are in the top ten in terms of patient satisfaction. The idea therefore is how can you get this level of cooperation into the rest of the health service. The NHS was working on getting community nursing, mental health, occupational health and community pharmacy all much closer to people and working in much closer collaboration in the Neighbourhoods. The Council was also doing this with its 4 Family Hubs which will serve 2 Neighbourhoods each and so be aligned to them. So, the NHS services will function at this level, the HCVS runs Neighbourhood Forums at that level also. Renaisi were also doing an external evaluation of the Neighbourhoods Programme.

7.4 What typified Neighbourhoods were Multi Disciplinary Meetings looking at individual cases and looking at constant attenders with reps from 4 or 5 different teams coming together to discuss one particular individual and how best they can be supported. He described the Neighbourhood Leadership Groups. He described the Women's Health Hubs which had been created at GP practices so women can talk to different professionals in one site. He described the work on Proactive Care happening at Neighbourhood level. They have looked at people with 3 or more conditions and proactively getting in touch with everyone over 65 and looking at their living circumstances and checking their medication. This was proactive as this was the

cohort most likely to end up in hospital. The aim was to get in early to put in simple interventions in place e.g. to remove trip hazards, or ensure medication compliance or find solutions to help reduce social isolation. He described the pilot projects on being Autism Friendly in London Fields Neighbourhood and the Speech and Language project Hackney Downs. He described how the set up sessions to speak to families suffering long wait times to access CAMHS to explore interim support for example via VCS organisations. There was a separate Parental Wellbeing Session also rolled out across the 8 areas.

7.5 He stated that he had spoken to a mental health community connector in one of the Neighbourhoos and they had discussed what was working really well. This includes referrals to the Wellbeing Network, in-house health budgets and the benefits advisors. Also the community connectors worked with social prescribers to share information about what is out there. What was working poorly in the Neighbourhoods, he was told by this worker, was the internal referrals e.g in ELFT and how data sharing was poor with ASC teams. He heard that they had got twice the caseload they had been told they would have. He'd also learned that some GPs make many referrals via community connectors and some make none.

7.6 One of the worrying things he had learned was that if an individual was in insecure housing the community connectors could not then refer them to mental health services for psychotherapy as it was judged that the person's problems are so driven by their housing problems that a course of psychotherapy would not be useful at that point as they wouldn't get the benefit of it.

7.7 He stated that the clear message coming through from Neighbourhoods was that they were having to deal with the "crunchy Marmot problems" involving the wider determinants of ill health and this of course was not easy. One of the challenges he wanted to make was to ask where Housing was in the Neighbourhoods system, as the links appeared tenuous. There has to be separate referrals. He was not suggesting that any of this was easy but he felt that the system needed to change its ways of working to be better able to address these Marmot "wider determinants" issues.

7.8 He referred Members to two charts - one an organogram of the NEL System where Neighbourhoods didn't appear and a second chart, in NEL Integrated Care Partnership papers, of the system model where the 47 Neighbourhoods in NEL are not very prominent. This exemplified, in his view, the challenge of where the focus was.

7.10 *On the issue of Housing and Neighbourhoods System the Chair asked therefore if there was a need to review the structures to for example give greater weight in PCN ratings or KPIs to how they provide advice/support on housing issues.*
Cllr Kennedy replied that if we take a "Health in All Policies" approach and build on The King's Fund's "4 Pillars" there needs to be more focus on wider determinants. Where is the health in our housing policies or in our housing management he asked? Where is the freedom for a housing repairs operative who goes to fix a leaky pipe to say that this person is not looking after themselves and has lots of trip hazards. They

could take an initiative and nail down a carpet trip hazard but are they supported to do so.

7.11 *Members commented on the housing and psychotherapy issue that we shouldn't allow ourselves to give up on such residents. They asked about how the Neighbourhoods offer is communicated to the whole population of the borough.*
Cllr Kennedy commented that many reviews including scrutiny reviews in the past had the recommendation about data sharing and it was a perennial and knotty question. We will have to keep working at it, keep sharing information and encouraging others to discuss it as well, he added. One of the effective things we can do is put information on the offer to residents on the websites and share it in our channels and platforms.

7.12 *Members asked about where the Family Hubs are located and how do people access them?*
Cllr K replied that they were not in place yet. They are part of a re-working of government money to replace children's centres and we'd been part of that pilot. When they come on stream they will also be put on the same Neighbhourhood footprint. There will be 1 Family Hub in each Quadrant, representing two Neighbourhoods, so four in all.

PLACE BASED SYSTEM

7.13 Cllr Kennedy stated that the City and Hackney Place Based System was working pretty well for over all. It comprises the same organisations who have worked together very well in the past. He quoted Nye Bevan's comment that "there exists in the medical profession a great resistance to going under the authority of local government" and added that 70 years on this hadn't changed. The creation of the ICSs was just another iteration of the endless cycles of restructuring the NHS. He stated that the Public Accounts Committee's report on ICSs talked about a lack of a coherent workforce strategy. One had been published last year but many said it wasn't sufficient. There was no clear estates plan, no dentistry plan and there was no real leadership at DHSC according to PAC and the revolving door of Secretaries of States for Health had not helped. The system itself does not help us and what used to be 7 CCGs had become 1 ICS but at PBP level there are people who have been involved locally going back to the PCT days and this strong institutional memory is there. The satisfaction surveys at PCN level were good overall. It was disappointing therefore to see a 30% cut in clinical leadership staff as that represents a loss of knowledge. That reduction in strategic clinical time has a danger inherent in it. This was happening not because of anything City and Hackney did but because the resource isn't there and so because of this we shouldn't say the Place Based System itself isn't working. Our Place Based teams have a good understanding and we have NEL Chief Exec who was a former council chief executive. He added that he was taking over from former Mayor Glanville as Hackney's council rep on the ICB and one of 2 LA reps on it. He stated that the ICB holds its meetings going round all the 8 boroughs. They meet in the places being discussed and begin with an hour long presentation on the local area before the wider system meeting. There is a genuine

commitment to Place in NEL probably more so than in any other ICS around the country.

7.14 At the Health and Care Board meeting that day they had agreed the assessment they will do of the Place Based System's outcomes across the 3 priorities. An outcomes framework was agreed to examine not just the quantitative data but also the qualitative data on our system priorities. The City and Hackney system had retained some of their commissioners. He had asked the vexed question of what actually had been delegated down to us. They also had their own presentation on Right Care Right Person and they will monitor the outcomes on that. They had approved five bits of Better Care Fund and Section 256 spend locally. These were relatively small spend approvals however. They had hoped the Place Based Partnerships would be looking to spend on everything that wasn't spent by the Acutes and that is not happening. He stated that when you ask at an NEL wide meeting they reply that they hadn't worked out how much of that can be delegated yet. This is partly because their own system funding is uncertain. He added that there was good Patient Participation work with the Health Watches. The 'Big Conversation' consultation was going on across NEL and to be welcomed. The hospital discharge rate and flow through the hospital in City and Hackney is the envy of other systems. He also added that Richmond Rd GP Practice had just won national awards for its Reception and The Greenhouse had won the national award for clinical improvement for its work with homeless people. This was very significant as there were national awards.

7.15 *The Chair stated that Cllr Kennedy going on the ICB would mean that our local system should have some more influence. He commented that we went from a system where CCGs were GP led and they commissioned the acutes and now we're back to the old system which was more acute dominated. Is more of that money getting sucked into the acutes at the expense of Place? Do the Acutes, in effect, suck up the bulk of the funding in their overspends and is the rest of the system suffering as a consequence, he asked?*
Cllr Kennedy replied that the problem was that the Acutes are getting nowhere near hitting their efficiency targets. ELFT and NELFT are doing well and everything else outside the ICB is doing OK. He commented that every day of strike action costs the NEL system £1m and we had 6 of them and this didn't count the cost of rearrangement, the extra severity that might ensue and lead to the need for new diagnoses of patients, so the duplication then gets piled onto the system. There are extraordinary pressures, he concluded.

CANCER MANIFESTO

7.16 Cllr Kennedy stated that Cancer Research UK was a great organisation and this is the one big items that local systems need to work on over the next 5 years.

Member noted that the 5 Missions are:

Mission 1: Rebuild the UK's global position in biomedical research.
Mission 2: Prevent thousands more cancer cases.
Mission 3: Diagnose cancers earlier and reduce inequalities

Mission 4: Bring tests, treatments and innovations to patients more quickly
Mission 5: Build a national movement to beat cancer, together.

He stated he wanted to focus on 2 and 3 in more detail.

7.17 In relation to mission 1 however he stated that the UK has a global position in biomedical research and he actually chairs a local committee on this. In relation to Mission 4 he stated there are elements that can be addressed locally such as the work Imperial College has been doing on looking at groups with very low interaction with screening programmes. It was clear that having a Pop Up Screening van outside a big Tescos for example was very effective as people who are unlikely ever to book a screening will engage because it's there. In relation to Mission 5 he stated that it was about building national ways to help people.

7.18 In relation to Mission 2 he stated that our Public Health team do a lot of this already. They were for example re-procuring the Smoking Cessation Service and also looking at smoking prevention and getting in early in schools. More work is being done in Trading Standards on illegal tobacco and vapes coming into the borough and he chaired the local Tobacco Control Alliance. In relation to Alcohol they had a great local awareness day on foetal alcohol syndrome disorder and they were carrying out an audit of their work against the NICE guidance.

7.19 He went on to list and highlight some key public health activity that was taking place already:

- C&H Recovery Service supporting those with Alcohol and substance misuse issues
- The adult weight management service at the Homerton
- The organisation Henry providing support on healthy eating for children under 5
- A Power Up programme for older children on healthy eating.
- Healthy cooking classes for families
- Walking classes
- A focus on infection control as that can lead to cancer
- HPV vaccine promotion
- A new draft of the Sexual Health Strategy, which includes a target of no new HIV patients by 2030, has been produced
- An offer of Hep A and Hep B testing within the recovery service aimed at intravenous drug users
- Young Hackney's free condom distribution scheme

7.20 In relation to Mission 3 he stated that there will be a Cancer Needs Assessment which will have a focus on reducing inequalities. He also referenced the letter the Commission had sent to the House of Commons Health and Social Care Select Committee on the need to improve the operation and the level of data sharing of breast cancer screening. He added that taking the screening programmes to where people are is key. Other issues to be tackled are adequate delivery of appointment times for screening and working with VCS and community health champions and working closely with the NEL Cancer Alliance.

7.21 Members asked about how to drive up greater usage of texts, emails and social media to reach residents.
Cllr Kennedy replied that GPs are now starting to better use data in all forms and the system is starting to use social media for public health messaging. The whole system paying for ad pop ups reminding the public they can not get a free tests was an example. Being over 55 he had recently received, unprompted, a bowel cancer screening kit. This was another example.

7.22 The Chair asked Dr Husbands about the public health strategy on cancer diagnosis and reducing inequalities and if that could be presented at a future meeting. SH replied that it was more of a needs assessment at this juncture and it will need to be analysed. She undertook to liaise with the O&S officer on a good time to present this to the Commission.

ACTION:	**Director of Public Health to advise on timing of bringing the cancer diagnosis needs assessment to a future meeting.**

7.23 The Chair asked if the funding for the Neighbourhoods was slowly diminishing. Cllr Kennedy replied that he had learned that at Well St Common Forum that their funding was going down c. 20%. Neighbourhoods was also temporary funding and had been set up on the idea that it might eventually be mainstreamed.

7.24 The Chair thanked Cllr Kennedy for his attendance and detailed replies which would help the INEL Members with the issues they wished to raise there. He welcomed that having a Hackney Cllr as one of the two local authority reps on NEL ICB, for now, would help us gain even more useful insights.

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

8 Minutes of the previous meeting

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

RESOLVED:	**That the minutes of the meeting held on 20 December 2023 be agreed as a correct record.**

9. Work programme for the Commission

9.1 Members noted the updated work programme

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

10. AOB

10.1 The chair reminded Members of the site visit to Oswald St Day Centre on that Friday.