Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2023/24
Date of Meeting: Mon 12 Feb 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 Frank Baffour**
Cllrs joining remotely	**Cllr Claudia Turbet-Delof, Cllr Adebayo**
Cllr apologies	**Cllr Sharon Patrick (Vice Chair), Cllr Grace Adebayo and Cllr Ifraax Samatar,**
Council officers in attendance	**Chris Lovitt,** Deputy Director of Public Health **Carolyn Sharpe,** Consultant in Public Health **Bryn White,** Childhood Immunisations Programme Manager, 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	**Jillian Bradley,** Deputy Chief Nurse, Homerton Heatlhcare **Sadie King,** Programme Lead, Neighbourhoods Programme **Joel Reynolds,** Head of Adult Community Rehabilitation Team, Homerton Healthcare
Members of the public	99 views
YouTube link	View the meeting at: https://www.youtube.com/watch?v=dQvaOJNXnmU
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Councillor Ben Hayhurst in the Chair

1 Apologies for absence

1.1 Apologies were received from Cllr Patrick, Cllr Adebayo, Cllr Kennedy, Dr Sandra Husbands, Dr Stephanie Coughlin, Louise Ashley. It was noted that Cllrs Turbet-Delof and Cllr Adebayo joined remotely.

1.2 The Chair welcomed Jillian Bradley Deputy Chief Nurse at the Homerton in place of the Chief Executive.

2 Urgent items/order of business

2.1 There was none.

3 Declarations of interest

3.1 There were none.

4 Neighbourhoods Programme 24-27

4.1 The Chair stated that this item was to receive a briefing on the progress of the Neighbourhoods programme.

4.2 He welcomed for the item:
Sadie King (**SK)**, Programme Lead, Neighbourhoods Programme
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP

4.3 Members gave consideration to:
a) Neighbourhoods update - presentation
b) Research paper on *Neighbourhoods Models Options appraisal: Phase One Research into current approaches to Integrated Neighbourhood Teams*

4.4 SK took Members through the slides in detail. The presentation covered: *Overview of the programme; What is Neighbourhoods; Why Neighbourhoods; Case Study - what would this mean for Peter?; Examples of working with Neighbourhood forums; Neighbourhood Programme priorities for 24-27; Who we are working with?; Structure; Transforming Neighbourhoods; CYPMF services mobilising to Neighbourhood models; CYPMF services preparing for transition; CYPMF services in early planning stages of transition; CYPMF Neighbourhood Level Pilots; Culture; Supporting the workforce; Impact; Neighbourhoods Evaluation Approach: Contribution analysis and evaluation deep dives; Neighbourhoods future.*

4.5 Members asked questions and the following was noted:

a) The Chair asked what the budget was in 2018 vs now and is the programme likely to evolve to a 'business as usual' project.
SK replied that the funding was from the Better Care Fund change programme. The placement of the funding was moving away from having just change managers to structural changes. There has been a significant investment in resident involvement through the Neighbourhood Forums. There were structures to engage with community pharmacists to engage in Neighbourhood working. There were Care Coordinators funded for the next 3 years and the admin roles that support the Multi Disciplinary Meetings are being expanded to support leadership groups and staff meetings. The proposal was to decline the investment over the next 2 years in strategic project management staff as this service becomes business as usual.

b) The Chair asked what the change in the annual budget has been?
SK it was £1m currently and in 2 years will reduce to c. £800k for the following year and declines further the year after.

c) The Chair asked if it was correct that the programme funded the leadership management to facilitate greater integration and not core delivery.
SK replied that yes it funded a programme of change and not new services.

d) A Member complimented the Well St Common Neighbourhood Group and asked how residents were informed about programmes and the support they can access. She also asked how they reach out to young people and to new people.
SK replied that the Neighbourhood Forums were key mechanisms for resident involvement and the model for that was that there were 4 Neighbourhood Forum facilitators seconded from grass root organisations. A huge amount of work happens between the forums that engage residents. If services want to work with a particular group of residents that work will

happen and Well St had good examples of that. Re young people, these issues were discussed at the Forums. They are looking forward to the integration of children's service with family services and having the Family Hubs. There will be new resident engagement mechanisms and these will be linked up In terms of improvement and delivery. She added that they need to do a lot more in using social media to get the message out. They also want to encourage long term involvement and they are training people on that. There are also those who don't have time to participate in that way so they are working on different opportunities for families and YPs to be involved in health and care services. They are also supporting the workforce to do co-production and it will take a while to embed this and get the resources available to them.

e) Chair asked if GP referral was the main way in or was it up through the Neighbourhood Forums?
SK replied that the Neighbourhood Forums bring together residents, services and VCS and it is VCS led and designed. The aim is to stand in the shoes of people and listen to solutions and listen to how people are experiencing health inequalities. She described First Steps which came out of a Forum hearing from parents that young people are experiencing a lot of anxiety and there isn't enough support in place, and so moving on to create the training. The forums are about strategy and local priorities and residents being encouraged to lead that. Referrals from the statutory services are obviously key.

f) Chair asked if they had quantified how many different types of residents have participated in the 8 Neighbourhood Forums and what data they have on this.
SK we do have the data. The Forums are delivered through partnerships with the VCS and Healthwatch. It's not just the meetings. The Forum facilitators work 3 days a week so there are activities in between. We have broader data on participation which covers more than just the forums. For example in Anticipatory Care there is a resident coproduction group being supported. With all the Health Inequalities projects there are groups of residents being supported via those. It is an outreach model.

g) Members asked if there were plans to benchmark the services with other boroughs?
SK replied that across the NEL patch, City and Hackney is quite far ahead with Neighbourhoods programme. NEL has developed a Neighbourhoods Maturity Matrix and they can see that they are far ahead compared to others in terms of having all services restructured around 8 Neighbourhoods. She added that Renaisi, who specialise in doing evaluations of complex programmes, are doing an evaluation of the programme and the baseline for that should be available by April.

h) Members asked that following the collaboration with pharmacies were there plans to work with Housing Associations including the council's housing service.
SK replied that they work closely with pharmacists. There is a lead community pharmacist in each Neighbourhood and they collate information etc however pharmacists are very busy. On housing they had some housing officers already turning up to forums and leadership groups. Housing is a key issue everywhere and they need to do more in bringing Housing organisations into the Neighbourhood model.

i) Members referred to p.20 and asked why some stakeholders had not made referrals to the programme. They also asked about inappropriate referrals
SK replied that this was just a lapse in data reporting but it is coming and it reflects how far they have got with mapping the services. In relation to duplication of referrals or inappropriate referrals, she stated that it's a complex area as there are natural overlaps with

referrals. These referrals don't reflect case holding they just are numbers who are referred in and it is not really duplication as to is not inappropriate to have a referral to two or more services, in fact, she added, that's the whole point of Neighbourhood working. These services can come together at Multi Disciplinary Meetings e.g. ASC, community matrons, GPs all in the one place and looking at a person's case. She added that as long as someone is referred somewhere and that person is not lost in the system and is discussed in a holistic way in an Multi Disciplinary Team then they would get to the right services quicker than if we didn't have this programme in place. You can do this quicker if people in all those different teams know each other in a neighbourhood

j) Members asked how the Forums are advertised to residents.
SK replied that the Forums are run by the VCS and build on their own networks, they advertise online and work through their own networks to bring new people in. For the coming year they are planning a much more active push on social media using twitter and facebook to promote the Neighbourhoods and what happens in between.

k) Members commended what was being done but asked what data profiling there was to evidence delivery.
SK replied that the services were working together better. It was a work in progress but not perfect and every stakeholder is not in the same place at the same time. Some will want to co-locate or work more in the community and others may not be ready. The programme enables the structure and support for people to come together

l) Members asked if each Neighbourhood has an MDT once a week to deal with high need individuals.
SK replied that it works on different levels. Once a month there is a complex case meeting in each Neighbourhood and this system developed during the Covid period. It was important to stress that the work doesn't stop in between the meetings. There are also MDT Huddles around particular patient groups or service pathways and that is all part of the culture change the programme is driving. So there are some formal arrangements and some business as usual ways of working.

m) Chair asked if there was a strategic document to make sure each Neighbourhood has a dedicated Housing lead from the Council.
SK replied that Housing was a very complex area. They don't have one housing lead per Neighbourhood. There are relevant housing managers coming in NFs or Leadership Groups and while there isn't a single housing strategy document but housing is a priority to work on over the course of the programme.

n) The Chair asked if there would be a benefit from having a designated housing lead in each Neighbourhood in order to improve efficiency.
SK replied that if that could be organised it would help. Many people turn up at GPs with housing issues (repairs, damp, overcrowding) and Housing officers do engage but this isn't a routine process as yet.

o) Members asked about the number of officers involved as everyone is very busy and whether the review is likely to draw attention to this and also whether residents will be part of the review exercise.
SK stated that the capacity of front line services to cope with demand is a challenge. Capacity of services is beyond the scope of the Neighbourhoods Programme as the programme is about reorganising the services we have around neighbourhoods. The Neighbourhood way of working has the potential to allow services to do assessments more quickly, to get people into services faster but in terms of overall capacity that is beyond the scope of her work. The Review will no doubt include each service commenting on the ongoing work to deepen the joint ways of working e.g. whether one team needs to co-locate

close to another which might address a capacity issue but it would be up to the strategic leads to feed that into the development of the programme and for them to consider all of that as they set out the future direction for Neighbourhoods. She added that residents would be involved in the Review. They were also doing some consultation with the Community Advisory Team and some residents are working on specific services and pathways such as Anticipatory Care.

p) The Chair asked if they were mapping the 770 referrals to establish if one Neighbourhood is disproportionately represented in some way and he asked if the review will go into this level of granularity.
SK replied that yes they do this. Healthwatch has been commissioned to produce a Neighbourhood level inequalities report and it has data on resident experience of the services and on capacity issues. So if there was a startling disparity across neighbourhoods that would be highlighted there. She added that this is linked to the Leadership Groups who have just begun meeting but who will work through all of this. They are using a Population Health Management way of working which is the core of what they do.

q) Chair asked if the programme draws on the valuable population health data which Public Health built up during Covid.
SK replied they did and that they work with them on the health inequalities project. They have created a tool kit which will be available to everyone on the steps to be used in carrying out a population health management approach. The work will be data informed but also about resident involvement. She stated they have projects on CVD prevention and they are working with different groups such as in the World Cafe events. They are examining why people may not be engaging and the toolkit should help explain ways in which these problems can be tackled. There will be 7 steps into how you do health inequalities work which will be really accessible for any team to take up.

r) Members asked how many sessions are provided for resident involvement?
SK clarified that there are different methods of involvement. The structures are the Neighbourhood Forums which meet 4 times a year in each Neighbourhood. She added that they were proposing changing that to more bespoke involvement work happening in between the meetings and have fewer meetings. But there are many other opportunities she explained that a person could apply to be a resident on the community advisory team, given a laptop, and trained to work on meaningful project on a long term as a volunteer, for example. Then there are particular services that have either their own resident involvement group eg people with lived experience of the condition they are trying to support.

s) The Chair asked when the Renaisi evaluation will be ready?
SK replied that it would be ready by the end of March but there would then be a follow up in a year to do the first measurement of progress and then they'll be able to self measure against agreed outcomes. The first baseline report will be in April however.

4.6 The Chair thanked SK for her report and attending to answer questions. He suggested that they might want to come back in a year or so to update on how the programme has been progressing post its evaluation.

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

5 Embedding Anticipatory Care in City & Hackney

5.1 The Chair stated that this item was to receive a briefing on the Anticipatory Care programme which is a key component of the national Ageing Well Programme. He stated that anticipatory care has been relabelled proactive care and those who attend INEL JHOSC will be aware of NELs focus on this.

5.2 He welcomed for the item:
Joel Reynolds (**JR**), Head of Adult Community Rehabilitation Team, Homerton Healthcare

5.3 Members gave consideration to a tabled presentation *Proactive Care Team* and JR the Operation Lead took Members through the presentation in detail. It covered: *Proactive care in City and Hackney; Rationale; Background; the Team; Who do we support?; What does it involve; "What matters to you"?; Common concerns; Typical interventions and support; Resident involvement; 3x case studies; Health inequalities mitigation projects; Operational challenges; Wider supporting pathway;*

5.4 JR stated that the Anticipatory Care pathway is part of an NHSE initiative and included in the Long Term Plan it also comes out of the national Ageing Well programme. Anticipatory Care also includes end of life care so NHSE renamed it Proactive Care. In this instance City and Hackney made a decision to use a targeted population health approach to delivering this, using personalisations to focus on what matters to people and to intervene early before people get into an acute crisis.

5.5 Members asked questions and the following was noted:

a) The Chair commended the programme and asked that of the 4200 on the initial list how many had they managed to have a conversation with and of that how many had some sort of output e.g. getting benefit going to a class/activity.
JR replied that it was roughly half of those who had the initial invitation and about 25% had come and engaged and had a consultation. Once contacted on the phone people were generally very keen to engage. In the next 9 months they would do outreach with community groups using the community connectors. As regards outputs they are using the EMIS primary care record system and just that week they were able to get the first output report and some data analytics so they had got over the first hurdle.

b) Chair asked if this novel programme was NEL wide and nationwide?
JR replied that the programme was both widespread and novel and there was a national community of practice now for anticipatory care which they can draw from. He explained that it was slightly different in different parts of the borough. You can focus just on High Intensity Users and there is a separate team for that but the novel part here has been to do more work further upstream in the system to ask ourselves what can we do a bit earlier to divert these individuals so they won't end up requiring acute attention later on.

c) Members asked how the funding can be assured for this work and for the Neighbourhoods scheme and when did the national Ageing Well funding run out.
JR replied that the challenges around funding are to understand the sources. The Ageing Well funding goes through a number of boards and they have to make a strong business case. The funding is from Primary Care. A solid approach with the Clinical Directors of the PCNs is needed so the spend can best reflect local needs. The Preventative approach

makes sense as they can see the impacts on the people they're seeing and so far 90% of users have said it's a good service.

d) The Chair asked whether the Care Co-ordinators are attached to PCNs.
JR replied that there are 9 of them across the 8 Neighbourhoods/PCNs as 2 are Part Time. Each is based within one PCN so they know the area and get clinical space in one of the surgeries. He added that he works across the teams and is based in Orsman Rd. Some of the team work out of clinics and the head office as well.

e) Members asked how much of the work depends on the full engagement of local GPs considering the amount of pressures on them?
JR replied that it is very much predicated on the patients coming from those who are registered in the GP's Practice so it's in the GP's interest. They have for example removed the requirement for people to need to see a GP for a referral to the Falls Service and in this way pressure is taken off GP appointments. There are Clinical Leads and Care Coordinators so it's not a referral based system from GPs. Instead it is taking a different tack and so for example some may not be known to the GP at all and that could be about GP anxiety and so not attending a surgery. They work alongside GPs. Many GP appointments are linked to social factors - housing issues or benefits optimisation and Care Coordinators are generally best to deal with those aspects.

f) The Chair asked about the algorithm which generated the 4200 candidates for support and how confident was the team about how accurate that was in identifying the right people.
JR replied that initially there was a push to give everyone an 'electronic frailty score' but it become a clinical issue so a 'clinical frailty score' was needed. If the algorithm classifies someone as 'moderate to severe' this cohort will be quite unwell with a lot going on and so it may be a case they require a full geriatric assessment. With the 'mild to moderate' cases there would also be a lot going on for these individuals. They've examined the data over 6 months now and they are identifying people on a deteriorating curve in terms of their prognosis but before the stage when it might become too complex. The difficult part is those who haven't a diagnosis because they haven't gone to a GP and we know there are many of those who are not registered and so not coded.

g) Members asked how much leverage the team has with ASC and Housing in providing joint solutions when everyone is under pressure.
JR commented that 'leverage' was not really the best word as they don't have leverage as such but they do have good working relationships. He gave an example of London Fields PCN where housing officers came down for a housing hub discussion. On a case by case basis the stakeholders involved are trying to support people as advocates and trying to empower them. We also need to be realistic about what is available, he added. The focus is to empower people to have the right information and be realistic about what might be the outcome for that. It's a challenge but the housing clinics, for example, did have a real benefit.

h) The Chair asked about whether and how people can get follow up from an issue raised at a housing hub discussion for example.
JR replied that it depended on the type of housing and where there is a good housing officer there would be a proper acknowledgement from the Housing Association that the matter is in hand. A lot of people are living in the private rented sector though. So it becomes about

referring the person to the Housing Association or asking them to contact their Ward Cllr. Cases where the housing is contributing to their problems eg safeguarding alert as people can't leave their housing and so can't get to appointments etc will be pursued with the Council and Safeguarding for example. It's about using the routes and mechanisms that are available to them to enable that person to manage their situation better.

5.6 The Chair thanked JR for his report and insight. He stated that the Commission and the Cabinet Member were very supportive of this important preventative work. He suggested the Commission might revisit the subject in a year for an update.

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

6 Childhood Immunisations: Measles - update

6.1 The Chair stated that this was prompted by media coverage and local concerns about the borough's relatively very low vaccination coverage. He added that there had been a serious outbreak in the West Midlands. Members would be keen to know if there was a resource that could be tapped into at this stage to set up additional vaccination drives or was the service under the same resource constraints as previously

6.2 He welcomed for the item:
Chris Lovitt (**CL**), Deputy Director of Public Health
Amy Wilkinson (**AW**), Director of Partnerships, Impact and Delivery, C&H PBP
Carolyn Sharpe (**CS**), Consultant in Public Health
Bryn White (**BW**), Childhood Immunisations Programme Manager, Public Health Unit

6.3 Members gave consideration to the following papers:

a*) Hackney Public Health Measles briefing to Hackney Cllrs 29 Jan*
b) NHS NEL briefing to MPs on Measles 22 Jan
c) UK Health Security Agency briefing on Measles in London 22 Jan

6.4 AW and CS gave a verbal update and took Members through the reports. CS described the nature of measles adding that it spreads very quickly among the unvaccinated particularly in settings such as nurseries and schools, homeless accommodations and asylum seeker accommodation. Typically most cases are in children under 10. It's also a serious issue for babies under 1 who are too young to be vaccinated, pregnant women, those with weakened immune systems. The hospitalisation rate is 20 to 40% for those unvaccinated and that is a major concern. The burden is felt in children and young people who don't have immunity through 'wild immunity' or infection. Compared to national rates local rates are heading in the wrong direction. In addition measles is endemic in some countries and so residents travelling from those places also present a problem. There has been a steady increase in cases since last April. Since the start of Oct 2023 there had been 465 cases nationally and 20% of those in London. The cases in London are concentrated in the North West but sporadic across London. There were no confirmed cases in Hackney, yet, despite Hackney having the lowest vaccination rate in the country.

6.5 Members asked questions and the following was noted:

a) Chair asked that as City and Hackney is an area with very low vaccination coverage, were they able to tap into extra funding at NEL level to do preventative immunisation that is needed now.

AW recalled the 2018 local outbreak and how they managed to get ahead of that where they picked up 1000 cases for vaccination. One of the challenges currently is the younger age children not being vaccinated, however they'd noticed that rates for 5 years olds are good so they were catching up. NHSE commissions the vaccination programmes and a lot of work was done during Covid with NHS NEL (our ICB) using non recurrent funding to create a post for a immunisation coordinator, they did grants to third sector, they did special communications etc. The good news was that NHS NEL had just announced £100K to be spent by the end of Q1 and so the Hackney team are pulling together plans for that. Luckily they have an Immunisations Coordinator in place so are in a better place vis a vis other NEL boroughs. She added that in 2025 funding for immunisations will be devolved totally to ICBs and they are now trying to influence how that might best be organised and they are pointing out that this money is best spent at Place level.

b)The Chair asked if this £100k was just for City and Hackney.

AW confirmed that it was. They are also working on a zero dose campaign and targeting children who are unregistered. This funding is based on a weighted formula

c) The Chair asked if this campaign typically involved trawling through GP lists and making phone calls

AW confirmed yes it was about Call-Recall. There will be specific allocations for top 10 PCNs across NEL which have lowest rates and there will be ring fenced funding for comms and support. There will be a range of approaches including building on relationships with VCS.

d) The Chair asked about rolling out programmes in schools and the challenges of getting permissions and parents having to be there etc

AW replied that NHS NEL has a contract with Vaccinations UK to provide schools based vaccinations. There should be catch up funding for MMR and Polio in the spring. They've constantly seen an approach in C&H of working all around schools and primary care that works best for us, she added.

e) Members asked how the team was working to combat language and culture barriers which are a significant factor in the low vaccination rates locally and how they were working with faith groups and schools.

CS replied that we know that diverse populations culturally and ethnically have lower coverage in general therefore London as a region has the lowest coverage. Urban and more diverse areas and more socially deprived areas have lower coverage. If you're a single parent with a number of jobs it can be hard to get to a timely appointment for example. It's just convenience factors rather than the parent having a position on vaccines that is the key here. She added that they had good data from the local Covid campaigns. Gypsy Roma Traveller and various Black population groups have lower averages as do the Charedi community. She added that they were developing an immunisation strategy and they want to takes a really strategic approach to improve coverage in the most targeted areas. They are challenging themselves on whether they are translating into the right languages in the right areas and they are working with community champions to support campaigns. They speak to Hackney Faith Forum on a regular basis and align with their information campaigns. She added that turning up once with the vaccination bus doesn't always do it instead there needs to be consistent and repeat messages and visits. BW added that they have put vaccination clinics in place on Sundays in the NE of the borough aimed at the Charedi community as access is a big issue. They are thinking about the languages they use in comms and the newspapers and outlets being chosen. They also work with GP Practices making them aware of translation services and the various tools on maintaining accurate records. They

do a lot at weekends and organise family and fun events where there are other offers not just vaccinations.

f) Members asked about how the team deals with the challenge of keeping track of vaccinations of children of migrant parents who might have had their first jab abroad. They also asked how much they take into account the new working styles of parents especially post Covid when many are self employed or have multiple jobs and how attending appointments can be challenging for them. Members asked about how there doesn't seem to be information on measles in hospital settings such as waiting rooms.
CS replied that on Access there are 3 aspects: convenience, complacency and confidence. They know that convenience is a huge factor. Low trust in MMS was about side effect worries. She reiterated what they're doing on access in the NE of the borough with Sunday clinics and clinics in Children's Centres. They also ensure that the mobile clinic offers other holistic health offers to be more effective. Coming on stream there will be a new offer for children preschool through GPs and for those that are school age it will be through a catch up campaign. Vaccination UK is looking at data on schools with high levels of unvaccinated children and putting in clinics. On the issue of targeting those in insecure employment she stated that they hadn't feedback on that. They have done targeted work with GP Practices across the borough and it didn't come up there. They are however doing an evidence review on the interventions that work and the ones that don't. CL added that in addition to the local focus and funding issues, data is also very important in order to make sure that the programme is having an impact.

g) The Chair asked about the previous issues around a lack of real time data flow on vaccinations and whether this remained an issue.
CS replied that they have data by GP Practice so they can see the rates of coverage but don't have granular data that can be interrogated in a bespoke way so if they wanted to cut it by ethnic group or granular geography such as by ward level or post code they can't do that as yet. They can't easily look at trends and crucially what they can't do is examine the impact of a specific intervention in a specific area so it could be evaluated. Going forward they would like to be able to have more granular data, they would like it in real time and would like it to show trends.

h) The Chair commented that presumably this is down to how Practices code information and this cannot be changed easily.
CS replied that it's a lot of work but it is already collected from GPs and it can always be collected in a better way but such data is available in other areas. They have flagged this with NHS NEL and they're trying to create a dashboard across NEL and enable them to look at data for the last 3 weeks in one PCN area by ethnicity for example.

i) The Chair asked what the barrier was here.
CS replied that you need to have a bespoke programme. Currently data is fed into a central system and they use a dashboard tool to visualise it. She added that NHS NEL are looking at this and how it can be done better. CL added that data is collected well but the issue is we cant access the data easily locally and suggested to the Chair that this might be something to raise at an INEL JHOSC level.

j) Members asked how many days notice a community group would need to give the vaccination team to attend their event
AW replied that they would be receiving news on the comms funding in the next few days and suggested that members contact Bryn about appropriate events so that he can get in contact to explore having a presence at them.

k) Members asked how the rates have varied pre and post covid. Members also asked how readily available the animal free version of the vaccine is.

AW replied that they saw a huge drop in rates during Covid and post covid. There was a reluctance to access sites or to bother NHS staff. Recently however the rates have started to stabilise and they have seen some green-shoot indicators that things are really looking better. BW added that in the 'vaccine at 5 yrs' measure they had seen an increase of 6% recently and they are tracking that. He added that the Covid effect was London wide.
CS added that they were seeing an uptake for MMR locally so that is good news. She added that the animal free version of the vaccine can always be accessed on request. She added that lack of awareness of that might be acting as a barrier. She stated that they also have confirmation from a Rabbi that the vaccine is kosher.

l) Members asked how the team uses social media to counter the quack messages which are out there about vaccines. Members also added that by visiting more community groups they'd reach more single parents.
CS stated that the links between vaccines and certain disorders have been totally discredited and their approach is to try and not amplify these messages. hey don't repeat them and they don't draw attention to them. Instead they try to mobilise the whole health and social care workforce to deliver consistent, clear and effective messaging around safety of vaccines. They talk to head teachers, schools nurses, health visitors and they need to be consistently delivering these messages. There is evidence that these people are the most trusted. The important point is to make sure that these healthcare staff are kept up to date with the latest local epidemiology and that they are repeating messages that vaccines are safe and effective..

6.6 The Chair thanked officers for all their work in this important area and for their report and attendance. He undertook to make representations at INEL JHOSC on the points about data at NEL level.

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

7 Minutes of the previous meeting

7.1 It was noted that the minutes of the 10 Jan '24 meeting would be included in the agenda for the next meeting and Members noted the updated Action Tracker.

8. Work programme for the Commission

8.1 Members noted the updated work programme. It was noted that the next meeting has moved from 14 to 20th March and will deal with the primary care/out of hospital estates programme.

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

9. AOB

9.1 There was none.