Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2020/21
Date of Meeting Tuesday, 9th June 2020

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Patrick Spence and Cllr Kofo David**
Apologies:	
Officers In Attendance	**Denise D'Souza (Interim Strategic Director of Adult Services), Tracey Anderson (Overview and Scrutiny Officer), Anne Canning (Group Director, Children, Adults and Community Health), Dr Sandra Husbands (Director of Public Health), Mario Kahramann (IT Programme Manager), Sonia Khan (Head of Policy and Strategic Delivery), Dr Nicole Klynman (Consultant in Public Health) and John Boateng (IT Officer)**
Other People in Attendance	**Carol Ackroyd (Hackney KONP), Dean Henderson (East London NHS Foundation Trust), Councillor Christopher Kennedy (Cabinet Member Health, Adult Social Care and Leisure), David Maher (MD, NHS City & Hackney Clinical Commissioning Group), Jon Williams (Director, Healthwatch Hackney), Tracey Fletcher (CE, Homerton University Hospital NHS Foundation Trust), Mayor Philip Glanville, Councillor Michelle Gregory, Councillor Yvonne Maxwell (Mayoral Advisor for Older People), Catherine Pelley (Chief Nurse, HUHFT), Dr Mark Rickets (Chair, City and Hackney CCG), Laura Sharpe (CE, City & Hackney GP Confederation), Michael Vidal (Public rep Planned Care Workstream ICB), Professor Anthony Costello (Independent SAGE/UCL), Professor Kevin Fenton (Regional Director London, Public Health England), Amanda Healy (Director of Public Health, County Durham) and Professor Allyson Pollock (Independent SAGE, Newcastle University)**
Members of the Public	**52**
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 There was an apology from Simon Galczynski (Director, Adult Services).

2 Urgent Items / Order of Business

2.1 The Chair reminded all those participating that the meeting was being both recorded and livestreamed.

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

3 Declarations of Interest

3.1 There were no declarations of interest.

4 Covid-19 Response - PANEL DISCUSSION

4.1 The Chair stated that the purpose of this item was to explore what can local authorities can do to mitigate the spread of Covid-19 in their areas and what space there was for local health partners and the Council to supplement the national government approach?

4.2 The Chair welcomed the following participants for the panel discussion:

Dr Sandra Husbands (SH), Director of Public Health for Hackney and City of London
Professor Kevin Fenton (KF), Regional Director Public Health England London and Regional Director of Public Health at NHSE London
Professor Anthony Costello (AC), Member of Independent SAGE Committee and a director of the Institute for Global Health at University College London and a former Director at World Health Organization
Professor Allyson Pollock (AP), Director of Newcastle University Centre for Excellence in Regulatory Science and member of the Independent SAGE Committee
Amanda Healy (AH), Director of Public Health, Durham County Council

The Chair also welcomed the following:

Cllr Chris Kennedy, Cabinet Member for Health, Adult Social Care and Leisure
Dr Nicole Klynman, Consultant in Public Health, Hackney and City of London
Denise d'Souza, Interim Strategic Director of Adult Services
Dr Mark Rickets, Chair, City and Hackney CCG
David Maher, Managing Director, City and Hackney CCG
Tracey Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust
Laura Sharpe, Chief Executive, City and Hackney GP Confederation
Jon Williams, Director, Healthwatch Hackney
Carol Ackroyd, representative of Hackney Keep Our NHS Public

4.3 Members gave consideration to the following supporting papers:

(i) Briefing paper on *Test, trace and isolate in Hackney* from Dr Sandra Husbands,

(ii) Report of The Independent SAGE group on '***Covid-19 what are the options for the UK***' published on 12 May. Professor Costello and Professor Pollock are members.

(iii) Background information (Cabinet report) from Amanda Healy, Director of Public Health of Durham County Council on their approach including the use of population health management to ensure residents with multiple vulnerabilities are supported to self-isolate and on their approach to testing locally, including in care homes.

(iv) Tabled presentation slides from Professor Costello.

4.4 In introducing the item, the Chair described the Hackney context for Covid 19 and noted that 68% of the cases in Hackney were from those born outside the UK vs 37% of the population being foreign born. He gave each panellist 10 mins after which there would be questions from the Commission Members.

4.5 In introducing her report Dr Sandra Husbands (SH) highlighted the following points:

a) London was one of 11 national pilots just announced for the Test, Trace and Isolate progamme and Hackney together with Camden, Newham and Barnet comprised the London pilot. This programme represented an enlarged version of a normal PHE contract tracing system.
b) Level 1 focused on outbreaks, level 2 on following up cases and testing and level 3 involved use of call handlers to reach out to contacts and follow up with advice on how to self-isolate for 14 days, how to look out for symptoms and how to get tested.
c) Local authorities already have Local Outbreak Control Plans in place and had been advised to build on the existing flu pandemic plans and a Strategic Command Group was set up.
d) Initially numbers were high but have reduced significantly and the focus now has moved on to how it will be possible to move beyond the national test and trace phase and work up an effective local response.
e) One of the key challenges is that the message is not getting through locally to get tested, another is the urgent need to generate trust in the Test and Trace system so that it succeeds. There are fears locally about data collection.
f) The flow of data up and down to PHE remains a challenge. There are information governance restraints on what data flows down which means that the local PHE and GPs for example would not be aware of cases. The council receives daily figures of how many people have been tested but does not know when these tests occurred or who has been tested. They also receive the number of people who have been through the system who have tested positive and the number of their contacts, but no specific details of their names or addresses. PHE has been working on providing more timely data and more detailed information.

g) The challenge as a local Director of Public Health is that being told the number of positive tests or contacts traced is not particularly useful because without any further information they don't know if its related for example to a care home resident or a care home worker and there is no way to establish this locally if PHE can't promptly relay the information from the national system. The information they were receiving thus far had been quite sparse in terms of helping them to understand what needed to be done locally to get on top of the pandemic, to stop the spread and to support people across a range of settings. The Council could more easily provide support to people proactively if it had better quality data coming down.

4.6 Professor Kevin Fenton (KF) gave a verbal briefing and made the following key points:

a) On behalf of PHE he had completed a report for government on the disproportionate impact of Covid 19 on ethnic minority communities and as part of it had engaged with c. 4000 individuals from BME groups. In his presentation he wanted to reflect on the epidemic in London, on the outcome of this 'disparities' review and on the key recommendations emerging from it.
b) He stated that 26k Londoners had been infected and 6k had died and these had not been randomly distributed in the population. Older people, males, those from BME groups had borne the brunt of the disease and the challenge was how to get back on track. London had responded well as a city however and was now was among the regions with the lowest rates in the country
c) He outlined 5 dimensions to the problem: (i) how can we emerge from the epidemic and deal with the number of new health issues which will emerge as a result of the lockdown and the likely economic devastation caused by it and how can we get back on track quickly (ii) Covid-19 hasn't created inequalities but merely exaggerated the existing ones and what more can we do to address these; (c) how can the health system getsback on track in responding to the ongoing health challenges around cardiovascular disease, cancer, diabetes etc; (d) how can we ensure that we have good data in order to respond effectively to the pandemic and (e) how can we ensure we're using all the tools available to us already to ensure maximum suppression of the virus.
d) There were four key issues that emerged from the stakeholder workshops he added. Firstly, the risk that social and economic deprivation plays and in particular the vulnerabilities within BAME communities. Secondly, the occupational risk where BAME communities are facing a higher risk from Covid-19 by virtue of the frontline jobs they do e.g. bus drivers, care home staff etc. Thirdly, co-morbidities such as diabetes, obesity, hypertension and CVD, which are more prevalent within these communities, and fourthly the wider structural issues including racism, discrimination, stigma, distrust and fear which underpin those disparities. They found for example that there was still excess mortality among BAME people even when you allowed for the other risk factors
e) There would be an ongoing requirement to continually stress the guidance on hand washing, staying at home, self-isolation and face covering and nationally there would most likely be a need for local level lockdowns.

f) In terms of the data on disparities in London, the report outlined how those who were 80 years and over are 70% more likely to die and PHE was looking closely at the age factor and what was driving those excess deaths.
g) In terms of acting on the data there was a need to look at pace and impact of the pandemic and to use culturally competent messaging in each community.
h) There was a need to address how we can implement all the public health tools we currently have in our differing local communities and in terms of prevention, how communities can be made more resilient.
i) Lastly, there was a need to look at the importance of the social and structural context within which communities are now going to have to rebuild.

4.7 Members' gave consideration to a tabled slide presentation from Professor Anthony Costello (AC). The Chair commented that just that day Independent SAGE, of which Prof Costello was a key member, had published a further report on 'Integrated Test Trace and Isolate'. The presentation outlined the origins of the outbreak, the symptoms, the principles of control and behaviour for tackling an outbreak, successful early strategies in South Korea, the principles of find-test-trace-isolate-support, key findings thus far of the reports published by the Independent SAGE group, 3 possible Coronavirus scenarios, the role of WHO, and an exploration of whether we will get a vaccine and when, concluding that it may take 2 years before there is large scale availability of a possible vaccine.

4.8 Professor Allyson Pollock (AP) gave a verbal briefing and made the following key points:

a) So far the government had not been following the formal legal notification system already in place for handling epidemics. Instead it had put in place a totally unevaluated, centralised, privatised and fragmented system and local directors of public health have been left to pick up the pieces.
b) There was a need to examine how it should work and the consequences of it not working.
c) The NHS had not notified the suspected cases and GPs were not allowed to have any testing so there had been no testing in the community yet there were much more cases in the community than in hospital settings. The hospitals were merely the tip of the iceberg. There therefore were lots of deaths in the community and GPs hadn't see them.
d) NHS labs had also been frozen out in favour of private labs with the result that many tests had gone missing and had not been returned. Another concern was the large number of false negatives.
e) There also was insufficient local data because data did not flow locally. By contrast, in Germany for example, it was against the law for data to just flow upwards to the national level but here safeguards had just been relaxed.
f) The result has been a loss of trust in the government's handling and lots of unanswered questions. Had the government followed the legal notification system GPs would have been notified of all cases and Public Health departments and NHS Labs would not have been frozen out. The government was not following its own processes.
g) There were concerns about the treatment of low paid contract workers in the NHS who did not have the same conditions of employment as NHS staff. In Hackney she noted that HUHFT was renewing its contract with its 'soft

services' contractor despite concerns raised about the conditions for these staff. Generally speaking low paid workers on zero hours contracts are less likely to declare themselves if they do not receive sick pay and this is very serious in the context of a pandemic.

h) There has been a general trend of understaffing both in hospitals and care homes and the pandemic had exacerbated these challenges. Had staff from hospitals, for example, been deployed to care homes more lives would have been saved.

4.9 Amanda Healy (AH), Director of Public Health for Durham County Council introduced her briefing paper on the response in Durham. She had been invited to provide some benchmarking information. Durham was one of the first authorities to team up with local trusts to do local testing. In her introduction the following points were noted:

a) County Durham has population of 525k, a mix of urban and rural, and has significant health inequalities. In Durham they had strong local community nursing teams to visit residents and took a local integrated approach to testing. They did asymptomatic testing and they were able to maximise local lab capacity. This route also allowed for staff testing. They tested 1k care home residents of which 50% were positive and were able to quickly isolate.
b) Subsequently the roll-out of the national scheme actually had the effect of taking away local control and knowledge and had thwarted their efforts. The mobile testing had undermined their local approach.
c) They also utilised community hubs in their areas and used Prevention funding for Population Health Management work. Their Prevention Board received funding to put Consultants in Public Health directly into their local NHS trusts.
d) The data which subsequently came down on shielding allowed them to plan to focus on those patients with multiple health and social vulnerabilities and thus they were able to create a 'risk pyramid'.
e) They also focused on having a very proactive approach using all the local partners to achieve this.
f) Newcastle and South Tyneside had used the same approach and she was the public health lead for the combined area.

4.10 The Chair opened the Panel Discussion by asking the contributors why, with all the limitations and the repeated problems with the centralised national system for test and trace, local authorities could not set up their own hotlines and create their own local system?

4.11 Professor Costello (AC) replied that he didn't see how the current centralised system can work. It was noted that GPs still can't get involved in testing and can only get tests for themselves. He stated that in each borough you only needed about 10 GP hubs, you could set up 'hot rooms' and set up testing sites. Contact tracing should also involve GPs as they have local knowledge and the whole thing needs to be integrated. He stated that home testing was not ideal because it lowered the quality of the testing overall. He had similar criticism of the testing sites in car parks set up by Deloitte as these tests were again proving poor quality. The government must allow GPs to get involved and to have solid data flowing back. AP added that the Secretary of State should instruct PHE to work with local authorities rather than, in her view,

squandering money on commercial approaches like the contract with commercial testing lab Randox which cost £133m for just one month. The Durham example was a good one and there was also good best practice coming out of Germany. She cautioned that local authorities could not 'take the bull by the horns' and do this themselves. There was a need to engage retired health staff and other volunteers and you need a lot of help from the local public health teams. She stated that Hackney Council was great for trail blazing and she offered to help with contacts in Germany and Scotland etc who could advise further.

4.12 The Chair asked Tracey Fletcher (TF) (Chief Executive, Homerton University Hospital NHS Foundation Trust) why HUHFT can't do local testing for the community. She replied that their lab had not been set up to do these specific tests, and as part of the collaboration with Barts Health these tests, for the hospital only, were being done at the Royal London. They get a good service from them and the turnaround times are good. Dr Husbands added that discussions were ongoing about local testing and some testing in North East London was already taking place outside the national system. There would be an issue for example about capacity within the Barts Health group and it was not possible, as yet, to provide a timeframe on scaling up a local approach to testing.

4.13 Members expressed sympathy with the position the local healthcare system had found itself in. They praised the speed and flexibility of the efforts shown thus far in which various types of staff had been redeployed to respond to the pandemic. They asked whether there was sufficient staff in place locally to handle contact tracing.

4.14 SH replied that there wansn't. There were Public Health and Environmental Health teams but there was a tension between flexing capacity for contract tracing and providing the normal standard service to the rest of the system. Financing was another issue. An additional £300m was provided to local authorities but it was not clear when and how it would be distributed. There were positive and ongoing discussions with the VCS about what they could do but again there was a cost involved. There was a need to evaluate what we can achieve with the resources we currently have and it was important too to work closely with Public Health England because they had the expertise among their Health Protection Specialists.

4.15 A Member asked what political support could be provided to officers and what the priorities were. SH replied that the key problem was not getting the test information which is needed locally to follow up Suspected Cases. Currently there wasn't enough resource in place to do that follow up. There's a need to be mindful of various impacts of testing on those affected and of the need to balance individual wellbeing with the wellbeing of the whole community, she added.

4.16 A Member stated that the borough had been thrown a huge political challenge in that it needs the data and resources to tackle this adding that all local politicians have a responsibility to take this to a London level and work through London Councils and with the Mayor of London as we have a responsibility especially to our ethnic minority communities who have suffered so badly already. There was a political responsibility to make a case for a better system.

4.17 A Member asked why central government didn't trust either the existing disease notification system or local GPs or the local Public Health system and there was a fundamental failure of governance here. AP replied that in her view this was because of decades of austerity where public health departments had been hugely eviscerated and fragmented and the 2012 Health and Social Care Act had resulted in them being carved out of the local health service. In March PHE had written a note to SAGE asking for more capacity but the government hadn't responded as in her view the government saw it as an ideological issue. It was a priority for them to build up private diagnostic capacity and not return data to patients. NHS 111 has not been returning good quality data back to GPs.

4.18 A Member asked whether it was safe to open schools particularly those with a large proportion of ethnic minority students, who have been disproportionately affected by Covid-19 and should the Council take a stronger view on it. Also, the government's Test and Trace App would not work for those who don't have mobiles or won't use them and there were significant equalities impacts here. He cited the example of epilepsy monitoring books which could be used as a model for encouraging those affected to keep track of their contacts. AC responded that local authorities should consider whether they should have their own local criteria for opening schools. He added that the criteria which Independent SAGE had wanted to apply before opening was a) how many infections locally and b) whether there was an effective Test Trace Isolate Protest shield in place. He stated that they had quantified the risks of children going back on 1 June and came up with a risk level of 1 in 25 to being exposed and 1 in 50 to getting infected. The risk of death for children was tiny but the risk was to their families back home and in particular to BME families and those from deprived populations. He added that they had recommended a delay of 2 weeks from 1 June to 15 June, in order to allow Test Trace and Isolate to get more settled. The trouble was, he added, that we don't know how many cases are around, there is no sufficient test and trace system up and running and the 'R' numbers, by their nature, are 2 or 3 weeks out of date. AP added that councils have a problem because they don't have the data to act on. She added that Independent SAGE had also recommended using football stadiums, playing fields, parks, private schools etc for children to use while schools are closed. We need to be creative and do other things for them, she added. The risk of being exposed in the open air was very low, so open air 'school' spaces was something councils should think about creatively.

4.19 The Chair commented on how nightclubs in South Korea had to collect names and contacts for their customers and asked how it might be possible to think creatively about licensing requirements for example or about enabling track and trace to be heavily focused in cluster areas. He also asked about the problem of lack of trust and of poor engagement in some communities in relation to finding cases and what practical suggestions there might be to alleviate this.

4.20 KF replied that the pandemic presented an opportunity for innovation and learning from other countries because we were moving into a unknown territory in terms of living with Covid. The App was one way in which innovation can be used but there might be other strategies which emerge as we progress into this phase. There was some excellent work going on in London councils' but we must be careful not to duplicate services at every level in the system. Locally

councils know their businesses and workplaces and the relationships you build now would give you an advantage in fighting off any future epidemic and capacity had to be built into local authorities. There was a need also for culturally competent local messaging and contact tracing. On the issue of bypassing GPs in the approach taken, KF added that there was a need to be careful about attempting to open up epidemic infection control to primary care to do everything, because there were capacity issues and also a need for national level co-ordination and expertise. AC commented that GPs had told him that they could do most of this work and wouldn't it be more efficient if local GP hubs were a key part of the system? KF replied that it was important to note that the guidance was clear that if someone had symptoms they must stay at home as the risk of onward transmission by walking into a primary care setting was too high. Because of this therefore, home testing is the way forward, notwithstanding some of the limitations it also has.

4.21 Dr Mark Rickets (Chair C&HCCG) added that, as of that day, they were able to order antibody tests for primary care staff. They would love to be able to do other testing in primary care. The current priority was to encourage Practices to restart essential and routine care and immunisations etc and then moving onto managing those who are frail, vulnerable, at end-of-life care stage or have long term conditions. There was a lot of work going on that the Covid 19 response would have to fit in to. We also now have video consultations and home monitoring for the vast majority etc. In terms of Covid-19, there was a need for good quality local data on suspected cases. They had also benefited from being able to work closely with the team at QMUL on data collection. We could get much better data on suspected cases, which will really help going forward, he added.

4.22 The Chair thanked everyone for their attendance and for their briefings. He concluded that real time data flow was one key area which Members can lobby on at a political level.

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

5 Minutes and matters arising

5.1 Members gave consideration to the minutes of the previous meeting and the matters arising as well as the notes of the informal meeting on 30 March.

RESOLVED:	**a) That the minutes of the meeting held on 12 February 2020 be agreed as a correct record.** **b) That the matters arising be noted.** **c) That the note on the informal meeting on 30 March 2020 be agreed as a correct record.**

6 Election of Vice Chair and 3rd rep on INEL JHOSC

6.1 The Chair stated that the Vice Chair of the Commission Cllr Maxwell had stepped down from the Commission after having been appointed as a Cabinet Adviser. There had been two nominations from within the Commission for Vice Chair from Cllr Snell and Cllr David.

6.2 Cllrs Snell and David gave a brief outline of their reasons for standing and the issues they would like to progress. The Chair stated that Members would give consideration to these and there would be a formal vote to elect a Vice Chair at the next meeting.

6.3 The Chair then stated that the Commission would also have to appoint a third representative on the Inner North East London Joint Health Overview and Scrutiny Committee to replace Cllr Maxwell who also had held this position. The Chair asked for nominations. Cllr Snell proposed himself. There was a vote and Members unanimously elected Cllr Snell.

RESOLVED:	**That Cllr Snell be appointed as the third representative of the Commission on INEL JHOSC.**

7 Health in Hackney Scrutiny Commission- 2020/21 Work Programme

7.1 Members' gave consideration to the work programme. The Chair stated that because of the current health crisis he wanted to retain some flexibility in the programming of items for the next meeting because the Commission needed to be responsive to a rapidly evolving situation.

7.2 The Chair stated that the impending decision of HUHFT to extend the contract for soft services to ISS for another 5 years was a major cause of concern. The Commission had debated this contentious issue in January with the Chief Executive of HUHFT and this announcement had caught many by surprise. Members stated that it was always permissible to update a forthcoming contract in the light of emerging issues and this needed to be taken on board. One of the key issues was the impact of these work arrangements on those from ethnic minority groups who make up the largest proportion of the workers affected. A key concern was payment of sick pay especially during a pandemic and the immediate concern about the disproportionate impact of Covid 19 on this same cohort of workers. Members agreed that the Chair should write to the CE of HUHFT asking questions on and expressing concern about this course of action and inviting her to the next meeting.

ACTION:	**Chair to write to CE of HUHFT re the extension of the soft services contract and invite her to the next meeting to discuss.**

7.3 The Chair stated that another key issue for July was to hear from local health stakeholders on the drive from NHSE London to accelerate the pace of integration, in the context of Covid-19, of the local health service into a single Integrated Care System for north east London.

8 Any Other Business

8.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

Tuesday, 9th June, 2020