Overview & Scrutiny

Health in Hackney Scrutiny Commission

All Members of the Health in Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows

Tuesday, 9th June, 2020

7.00 pm

This meeting is being held remotely to view please visit: https://youtu.be/Iopw6NkiTB0

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Tim Shields
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Peter Snell, Cllr Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Patrick Spence and David**

Agenda

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Hackney

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Hackney

Health in Hackney Scrutiny Commission 9th June 2020 **Covid-19 response – PANEL DISCUSSION**	Item No **4**

OUTLINE

The Chair has invited a range of contributors to take part in a discussion to address:

What can local authorities do to mitigate the spread of Covid-19 in their areas and what space is there for local health partners and the council to supplement the national government approach?

A.) Attached please find the following supporting documents

(i) Briefing on ***Test, Trace and Isolate in Hackney*** on the pilot, announced on 23 May, which comprises Hackney, Newham, Camden and Barnet, from Dr Sandra Husbands, Director of Public Health for Hackney and the City of London

(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) Copy of New York State's **Metrics to Guide Reopening**
Also available at https://forward.ny.gov/metrics-guide-reopening-new-york

B.) Below please find the Programme for the Discussion and the list of invited contributors.

Time	*Item*	*Contributor*	*Topic*
19.00	Introduction	Cllr Ben Hayhurst	Chair, HiH
19.05	Local test and trace and isolate pilot with Camden, Newham,	**Dr Sandra Husbands**	**Director of Public Health for Hackney and City of London** *On 23 May the government announced that London is one of 11 sites around the country for a test and trace pilot. The*

	Barnet – paper provided		*London pilot will be a joint initiative between Camden, Hackney, Newham and Barnet.*
19.15	Input from London's Public Health lead	**Professor Kevin Fenton**	**Regional Director Public Health England London** and **Regional Director of Public Health at NHSE London** Has worked in a variety of public health roles across government and academia here and in US. Before taking up the London regional director role, he was Strategic Director of Place and Wellbeing and Director of Public Health (DPH) at Southwark Council as well as a Senior Advisor at PHE.
19.25	Input from expert	**Professor Anthony Costello**	**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 *The Independent SAGE group in its report on 12 May 2020 recommended that the government move to a local approach to testing and tracing.*
19.35	Input from expert	**Professor Allyson Pollock**	**Director of Newcastle University Centre for Excellence in Regulatory Science and member of the Independent SAGE Committee** She was has set up and directed research and teaching units at Queen Mary University of London and the University of Edinburgh, establishing some of the UK's leading undergraduate and postgraduate teaching in global health. Prior to that she was Head of the Public Health Policy Unit at UCL and Director of Research & Development at UCL Hospitals NHS Trust.
19.45	Durham – background info provided	**Dr Amanda Healy**	**Director of Public Health, Durham County Council** *Learning from Durham County Council's Director of Public Health on their approach.*
19.55 to 20.30	**DISCUSSION** To provide challenge to local health and care leaders to address the following:		

	What further practical and specific steps can Local Authorities and local health partners take to mitigate the spread of COVID in their area? *Publishing data on local transmission to inform local population and settings of prevalence and risk?* *Is it possible to undertake greater local surveillance (in the absence of being provided with 111 call data or swab results (?)), can Local Authorities pool information from GPs, schools and other settings so as to gain a greater real time picture of transmission levels in their communities?* *Highlighting to local Care Homes, schools, other settings and residents best practice from abroad?* *Any room for improvement with respect to discharge from hospital to care home and/or admission of those with suspected COVID from care home to hospital?* *Any scope to work with local acute trusts to supplement national testing?* *Is it possible to further supplement national contact tracing via local GPs and public health teams?* *Increased scope for data / evidence led approach and decisions with respect to matters under LA control or influence?*

Attending the meeting will also be:

Cllr Chris Kennedy, Cabinet Member for Health, Adult Social Care and Leisure
Dr Sandra Husbands, Director of Public Health, Hackney and City of London
Dr Nicole Klynman, Consultant in Public Health, Hackney Council
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

ACTION

Members are asked to give consideration to the briefings and discussion and make any recommendations as necessary.

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Report Title	Briefing on Test, Trace and Isolate in Hackney
Meeting	Health in Hackney Scrutiny Commission
Report Owner	Sandra Husbands – Director of Public Health
Report Author	Nathan Post – Public Health Registrar
Date	9th June 2020

1. Summary:

1.1 As part of the next phase of response to the COVID-19 pandemic, a national contact tracing programme (NHS Test and Trace) has been implemented in order to maintain low levels of community transmission of COVID-19 to support the easing of nationwide lockdown.

1.2 The national system is based on a tiered system of response, with Level 1 managing complex settings or outbreaks (e.g. in schools or care homes), Level 2 giving advice to cases (people who have had a positive Coronavirus test) and identifying their contacts; and Level 3 giving advice to contacts about self isolation and symptoms to look out for.

1.3 Local Authorities will primarily be required to use local intelligence and resources to support the management of complex settings or outbreaks, alongside Level 1; investigate and manage community clusters; carry out preventive work; engage with communities to participate in testing and contact tracing; and provide support to vulnerable individuals.

1.4 Hackney has developed a high-level Local Outbreak Control Plan to guide the Hackney response and implementation of the national system and is participating in the London Learning Network (one of 11 nationwide), to rapidly implement this plan, evaluate and share learning.

1.5 Further work will include the development of local Standard Operating Procedures for management of outbreaks, engagement of the voluntary sector to encourage uptake, evaluation and a bid for funding.

2. Background:

2.1 COVID-19 is the infectious disease caused by the recently discovered coronavirus SARS-CoV-2. This virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. COVID-19 was declared a pandemic (i.e. a global outbreak) by the World Health Organization on 11 March 2020.

2.2 Most people with COVID-19 experience mild to moderate respiratory illness and recover without requiring specialist treatment. Older people, and those with underlying medical problems such as cardiovascular disease, diabetes, chronic respiratory disease or cancer are more likely to develop serious illness.

2.3 At this time, there are no specific vaccines for COVID-19 and few specific treatments. The antiviral drug remdesivir has recently been authorised by the National Institute for Health and Care Excellence (NICE) for treatment of people with severe COVID-19 disease. There

are still many ongoing clinical trials evaluating other potential treatments, as well developing vaccines.

2.4 Management of the COVID-19 pandemic in the UK has required a number of public health, NHS and wider societal measures, including hygiene advice, social distancing, capacity building (across sectors) and 'Stay at Home' / 'Stay Alert' lockdown policies.

2.5 Following the peak in hospital admissions in April, the numbers of new COVID-19 cases have fallen significantly and the Government has started relaxing social distancing measures, guided by the UK Government's COVID-19 recovery strategy. At this point, wide-scale testing and contact tracing are crucial to help prevent a rapid rise in community transmission of COVID-19.

2.6 A national contact tracing programme (NHS Test and Trace) was launched on 27th May 2020 to enable rapid isolation of contacts of possible or confirmed COVID-19 cases and maintain low levels of community transmission to support the ending of the current lockdown in the UK.

2.7 The national contact tracing programme will have phone based and digital aspects:

a. A workforce of 3,000 contact tracers (Level 2) will carry out phone-based contact tracing of and give advice to confirmed cases or, when available, symptomatic cases identifying themselves through an app
b. A workforce of 21,000 call handlers (Level 3) will follow up contacts of cases and give advice to isolate and request a test if they become symptomatic
c. Cases have the option to enter their contacts into a web-based tool, the Contact Tracing and Advice Service (CTAS), or be followed up by phone.
d. A mobile app to supplement the tiered system for symptom reporting, ordering of tests and sending tailored and targeted alerts to other app users who have been in close contact with a symptomatic and/or lab confirmed COVID-19 app user is currently being developed and is being tested on the Isle of Wight. However, the timeline for nationwide roll out of this app has not yet been confirmed.

2.8 Complex settings, such as outbreaks in homeless hostels, schools, care homes or community clusters will be escalated to and managed by local Public Health England (PHE) health protection teams (Level 1), which in London is the PHE London Coronavirus Response Cell (LCRC). The LCRC will work closely with Local Authorities, who will be able to provide local intelligence and targeted support, to manage these settings and community clusters.

2.9 In addition, Local Authorities will be required to use local intelligence and resources to carry out preventive work, engage with communities to participate in testing and contact tracing, and provide support to vulnerable individuals.

2.10 In order to support this system locally, Local Authorities are expected to develop and implement Local Outbreak Control Plans which determine the local response and how it works alongside the national system (by the end of June for all Local Authorities).

2.11 Hackney are participating in a Learning Network (one of 11 nationwide) with Barnet, Camden, Newham.The immediate aim of the Learning Network is to rapidly develop and implement a Local Outbreak Control Plan, evaluate the implementation and share learning with other Local Authorities and the national Advisory Group, before the end of June.

2.12 The pilot aims to tailor and inform Local Authority responses and ways of working between Local Authorities and the national system. The pilot is being support by DHSC.

£300 million has been made available to support Local Authorities to implement Local Outbreak Control Plans. However, details of how this funding will be allocated have not been made known yet.

3 Current work areas:

3.1 Work on developing the Hackney and City Local Outbreak Control Plan started in the first week of May, through the Hackney and City Contact Tracing Working Group.

3.2 The Local Outbreak Control Plan is a high-level plan which aims to guide the development of tailored local responses to outbreaks, local response to support vulnerable individuals affected by contact tracing/isolation, proactive preventive work to limit the risk of outbreaks occurring and maximise uptake of testing and contact tracing, establish ways of working, use of data and engagement with partners and the voluntary sector.

3.3 The plan includes the following seven areas:

a. Planning for local outbreaks in care homes and schools. This includes preventive work (including support for infection prevention and control) and the development and implementation of Standard Operating Procedures for the management of outbreaks working alongside the LCRC.
b. Planning for local outbreaks in other high-risk places, locations and communities of interest, including sheltered housing, dormitories for migrant workers, transport access points, detained settings and rough sleepers. Again, this includes preventive work and the development and implementation of Standard Operating Procedures.
c. Identifying methods for local testing to ensure a response that is accessible to the entire population, including strategies for response to local clusters and availability for those affected by the digital divide.
d. Assessing local and regional contact tracing and infection control capability in complex settings and the need for mutual aid, including Local Authority staff support to the Level 1 system if required.
e. Integrate national and local data and scenario planning through the Joint Biosecurity Centre Playbook. This includes establishing a local data hub, reviewing local requirements for data security and linkages, for example with the NHS.
f. Supporting vulnerable local people, including to get help to self-isolate. This includes a continuing and enhanced local system for support to isolating individuals, and support to individuals who are less able to access testing, the contact tracing system, or follow self-isolation guidance.
g. Establishing governance structures for local escalation and decision making.

3.4 The high-level plan has been developed and is currently awaiting agreement.

3.5 Work is continuing on developing specific aspects of the plan, including local Standard Operating Procedures for the local management of different types of outbreaks, a communications strategy and a strategy for engagement with and deployment of voluntary sector partners.

3.6 Links have been established between this work stream and other established workstreams in Hackney that are contributing to the COVID-19 response, including humanitarian assistance, the digital divide and enhanced support for care homes.

3.7 Development of the plan has been supported by materials provided by the London Council Chief Executives Task and Finish Group for contact tracing, including a Local Authority toolkit, a Joint Agreement and Standard Operating Procedures developed by LCRC, and

resources developed through a London multi agency Contact Tracing working group including membership from PHE, DsPH, GLA and NHS.

4 Future work areas

4.1 The Contact Tracing Working group will continue to develop and implement specific aspects of the plan, including:

a. Standard Operating Procedures for management of outbreaks and community clusters.
b. Identifying and providing support to vulnerable individuals who are isolating in conjunction with the humanitarian assistance team.
c. Establishing a data hub (likely to be in conjunction with regional partners).
d. Supporting the recruitment and training of volunteers to increase engagement and provide support to communities.
e. Providing capacity and support to Level 1 if required.

4.2 The implementation of the Local Outbreak Control Plan will be evaluated over the coming weeks as part of the Learning Network, with the aim to share learning with other Local Authorities. Details for the evaluation of this pilot are still awaited from the London Borough of Camden, which is the London lead Local Authority for the Learning Network.

4.3 In response to the funding commitment announced to support the Local Authority response to contact tracing, the Contact Tracing Working Group is working on a bid/business case for funding for implementation. Depending on when the funding is released this will also be supported by findings from the early evaluation of the pilot.

5. Recommendations

5.1. It is recommended that the Health in Hackney Scrutiny Commission notes this briefing.

The Independent SAGE Report

COVID-19: what are the options for the UK?

Recommendations for government based on an open and transparent examination of the scientific evidence

Independent SAGE Report of 12th May 2020

Participants:

Sir David Anthony King, Emeritus Professor in physical chemistry at the University of Cambridge, Director of the Collegio Carlo Alberto and Chancellor of the University of Liverpool (Chair of the Independent SAGE)
Professor Anthony Costello, University College London
Professor Karl Friston FRS, FMedSci FRSB, University College London
Professor Kamlesh Khunti FMedSci, Professor of Primary Care Diabetes & Vascular Medicine, University of Leicester
Professor Martin McKee CBE FMedSci MAE, London School of Hygiene and Tropical Medicine
Professor Susan Michie FAcSS FMedSci, University College London
Professor Christina Pagel, University College London
Dr Zubaida Haque FRSA, Deputy Director Runnymede Trust.
Professor Deenan Pillay, Professor of Virology, University College London
Dr Alison Pittard, Dean Faculty of Intensive Care Medicine
Professor Allyson Pollock, University of Newcastle
Professor Gabriel Scally, President of Epidemiology & Public Health section, Royal Society of Medicine

Additional contributions from:

Professor Elias Mossialos
Dr Rosalyn Moran

Contents

Preamble

On 4 May 2020 a 13-strong committee convened by former UK government Chief Scientific Adviser Sir David King discussed some aspects of the science behind the UK strategy in a two and a half hour meeting. Leading experts in public health, epidemiology, primary care, virology, mathematical modelling, and social and health policy, raised ideas and issues for consideration which we are pleased to share.

We recognise the enormous efforts of many in the development of new vaccines and therapies, which may be critical to long term control of this pandemic. Our report does not aim to critique such work. Rather, we recognise that such solutions will take time and will still require an appropriate public health infrastructure to maximise their benefit. This is the focus of our first report and the meeting aimed to offer some constructive ideas to the governments of the UK and the devolved nations about how best to tackle this crisis, to save lives, suppress the coronavirus and get the economy moving again.

Executive Summary

Our Independent SAGE focuses on the priorities for measures to be taken to support a gradual release from social distancing measures through a sustainable public health response to COVID-19. This will be essential in suppressing the virus until the delivery of an effective vaccine with universal uptake. We do not address, except as it is directly relevant, the clear structural and procedural weaknesses that contributed to the current situation as we expect these to be addressed in a future inquiry. We draw extensively on the policy considerations proposed by the World Health Organization, which provides a clear structure on which an effective policy should be based given the inevitability that the virus will continue to cross borders.

Our main recommendations are:

1. The government should take all necessary measures to control the virus through suppression and not simply managing its spread. Evidence must show that COVID-19 transmission is controlled before measures are relaxed. We detect ambivalence in the government's strategic response, with some advisers promoting the idea of simply 'flattening the curve' or ensuring the NHS is not overwhelmed. We find this attitude counter-productive and potentially dangerous. Without suppression, we shall inevitably see a more rapid return of local epidemics resulting in more deaths and potentially further partial or national lockdowns, with the economic costs that will incur.
2. The government should refocus its ambition on ensuring sufficient public health and health system capacities to ensure that we can identify, isolate, test and treat all cases, and to trace and quarantine contacts. Quarantine should be for 14 days and not seven. The government must develop a clear quarantine and messaging policy which takes account of the diversity of experiences of our population, variations in household structures, and with appropriate quarantine facilities in the community. This should be accompanied by real time high quality detailed data about the epidemic in each local authority and ward area.
3. Government ministers, NHS bodies and their officials should adhere to the Code of Practice for Statistics and the UK Statistics Authority should reports breaches of the code. There is concern about the inaccurate, incomplete and selective data presented by government officials rather than the statisticians responsible for them at the daily PM press briefings. The Office for Statistics Regulation should publish further assessments of them. The UK Statistics Authority, an independent body responsible for oversight of the statistics produced by the Office for National Statistics and other government departments and public bodies has a Code of Practice. The Code requires i) trustworthiness: confidence in the people and organisations that produce statistics and data, ii) quality: data and methods that produce assured statistics and iii) value: statistics that support society's needs for information. It is vital the public has trust in the integrity and independence of statistics and that those data are accurate, timely and meaningful.
4. The government evaluates alternatives to complement conventional epidemiological modelling, such as dynamic causal modelling—e.g., via the expertise established by the RAMP initiative. Dynamic causal modelling (DCM) enables real-time assimilation of data quickly and efficiently to estimate the current levels of infection and ensuing reproduction rates (R). The computational efficiency of DCM may allow pressing questions to be answered; for example, would a devolved social distancing and surveillance policy—based on local prevalence estimates—be more efficacious than a centralised approach? In short, there is a pressing need to evaluate alternative approaches (and hypotheses) that may support real-time policy-making.
5. Recognising the centrality of human behaviour in transmission, the government should ensure that as social distance measures are eased, measures are taken to enable population-wide habit development for hand and surface disinfection, using and disposing of tissues for coughs and sneezes and not touching the T-zone (eyes, nose and mouth).

6. Outbreak risks must be minimised in high vulnerability and institutional settings. No-one should be discharged from hospital to another high-risk setting such as a care home without having been tested and found to be non-infected. The government should rapidly invest in the elimination of transmission in the currently recognised "high risk" settings, including but not limited to social care and health service facilities, prisons and migrant detention facilities, homes in multiple occupancy, and households that are overcrowded or contain multiple generations. This includes staffing, testing, protective equipment and guidance for effective household isolation. Community facilities and requisitioned hotels are likely to be needed to house a significant proportion of infected people and their contacts.
7. Ensure preventive measures are established in workplaces, with physical distancing and support to enable personal protective behaviours. Health and safety regulations appropriate for COVID -19 suppression and adequate surveillance should be agreed with trade unions and other staff representatives, with sanctions that are large enough to deter unsafe practices. There should also be a facility for workers to report unsafe working conditions, with no victimisation for those using it.
8. The procurement of goods and services in order to ensure responsive and timely supply of goods for primary and secondary care, and community infection control, in anticipation of a second wave of infection. Reform should learn as much as possible from the document challenges and failures of procurement over the last three months.
9. Manage the risk of importing cases from other countries, with consequent high-risk of transmission. This should be introduced as soon as possible, treating Great Britain and the island of Ireland as distinct health territories. We welcome the government's recent commitment to establish a port control and quarantine strategy as an adjunct to other control measures. Managing the testing, thermal assessment, collection of contact details and quarantine facilities, such as requisitioned hotels, will be essential to stop imported cases.
10. Communities and civil society organisations should have a voice, be informed, engaged and participatory in the exit from lockdown. This pandemic starts and ends within communities. Full participation and engagement of those communities on issues such as childcare and public transport will assist with enabling control measures. Conversely, a top-down approach risks losing their support and trust. We are deeply concerned about the effects of the infection and the lockdown on BAME, marginalised, and low-income groups. There is an urgent need for government to demonstrate such active participation from communities from around the country.
11. The government should take steps to ensure all children, irrespective of their backgrounds, have access to technology and internet at home, and where required additional learning support which does not rely on parents at home. The government should also ensure that resources are available for schools to conduct remote learning. The closure of schools due to the COVID-19 pandemic has caused unprecedented challenges for everyone involved – students, teachers and parents, but we are particularly concerned about the detrimental impact (and widening of educational inequalities) of long term social distancing measures on learning for children from lower socio-economic backgrounds. Education is a human right which should not be compromised in the context of COVID-19.
12. The government must ensure that health and social care services are planned, strengthened, and prepared for future waves of infection while continuing to provide the full range of services to all. For health services, this will require planning to ensure there are capacity and resources to meet need safely and to resume elective services including hospital, mental health and community health services. For social care this will require having accurate data on all staff and needs of residents; making good the serious shortages in staffing, increasing qualified staffing levels, and ensuring all staff terms and conditions of services include full sickness benefits when they fall ill.
13. The government should rapidly strengthen the social safety net, including addressing low income benefits and housing, thereby ensuring protection of the most vulnerable in our population. It is

now clear that COVID-19 has disproportionately affected older people, low income groups living in deprived areas, BAME communities, and those who are otherwise marginalised. We also note the over-representation of BAME communities as low paid care workers in health and social care settings which makes them vulnerable to COVD-19-related infection and deaths.

14. The management of often multi-organ COVID-19 disease has been based in hospital and ICU settings. Hospitals have had to radically alter non-COVID patient flows in order to deal with these pressures, and Nightingale facilities have also needed to be developed. There is clear evidence of increasing non-COVID mortality in association with the pandemic. The government should work with the Royal Colleges and professional societies to ensure that capacity and treatment guidance is updated and disseminated as evidence emerges.
15. There should be a re-evaluation of current plans to reduce overall hospital beds in the NHS per head of population and consider ICU bed and staffing requirements to provide future surge capacity. We also recommend a rapid engagement with primary care and community health settings to support those recovering from COVID-19 disease, and sequelae, including mental health problems, as well as support to rapidly identify and manage future local outbreaks.
16. The government should urgently review and improve co-ordination in the response to the pandemic across the multiple bodies tasked with pandemic planning, both within England, including different government departments, the NHS, PHE, and local authorities, and others, and among the Westminster and devolved administrations, the government should review and improve co-ordination..
17. In order to underpin our recommendations, the future long-term management of the pandemic should be based on an integrated and sustainable public health infrastructure. The government has adopted a top-down approach with vertical structures for test and trace programmes. The over-dependence on outsourcing of key operational functions limits the sustainability of this approach. A more appropriate infection control response will require adaptation for local needs. Leadership from local public health and primary care professionals is essential. We do not specify which organisations should be responsible for these roles and functions as this will vary in the four nations of the United Kingdom but, in each of them, there should be a clear system map setting out responsibilities, accountability, and lines of communication.
18. In the longer term we recommend that legislation to enable an integrated National Health and Social Care System for England is considered, along the lines of the NHS in Scotland and Wales and the integrated NHS and social care system of Northern Ireland.
19. The Independent SAGE will continue to meet to consider some of these specific recommendations and to offer constructive solutions to government to ensure that the coronavirus is suppressed, that lives are saved and that the economy is able to recover as rapidly as possible.

The current state of knowledge.

After the first cases of SARS-CoV-2 community transmission within the UK on 28th February 2020, an exponential growth in cases followed until growth flattened following lockdown. To date (12 May 2020), the UK has had well over 215,000 confirmed cases and 31,000 deaths, with both certain to be underestimated. While debate about how best to measure the disease burden continues, it is clear that, whether measured by seasonally adjusted excess mortality or deaths per million population, the UK has experienced one of the highest COVID-19 death rates in the world. Even taking into account a range of proposed explanations, such as population density or timing of the epidemic, it is clear that the UK can and must do better in preventing as many infections as possible and protecting our disadvantaged and vulnerable populations as we emerge from lockdown.

It is easy to forget that we are only five months into the existence of this new human virus infection and many questions remain. It has taken many years of detailed biological, clinical, and epidemiological studies to generate a strong evidence base of understanding prevention, treatment and immunity for other infections. By contrast, despite more than 4,000 peer reviewed research publications since January, we remain pretty much in the dark regarding the nature of immunity, the pathogenesis of disease, optimal diagnostic tests, its transmission pathways and duration, and appropriate prevention, treatment and vaccines. Despite this uncertainty, we need to develop recommendations for UK control and management of the pandemic based on current knowledge and first principles, to limit further loss of life and economic hardship.

What is known?

Susceptibility: Given that this is a new virus, scientists have assumed 100% population susceptibility. This may be true, although studies of outbreaks on cruise ships, for instance, demonstrate less than 50% attack rate.[1] Overall susceptibility therefore remains unclear, and it is possible susceptibility grows with age,[2] with young children in particular having reduced risk of infection. Nevertheless, those highly exposed, such as health care workers, and household contacts, are more likely to become infected.

Infectivity: Infected individuals are most infectious from 2-3 days prior to onset of symptoms to around 7 days after onset.[3] Up to 40% of transmissions may come from those who are asymptomatic, creating a challenge for optimal interruption of transmission.

Disease: Age, co-morbidities such as hypertension, heart disease, respiratory disease, diabetes, obesity, and factors such as socio-economic disadvantage and BAME are all associated with higher risk of disease severity.[4] However, caution is needed in interpreting the available evidence because of uncertainties about causal pathways involving multiple risk factors where there are risks of confounding or collider bias that could produce misleading conclusions.

Diagnostics: PCR from throat/nasal swabs remains the gold standard for diagnosing infection, although even in the absence of a positive test a characteristic clinical and radiological presentation can be used as a diagnosis. The role of antibody tests in acute diagnosis appears very limited at present. However, once they have been assessed to be of sufficient sensitivity and specificity these tests will be useful for population estimates of exposure. Their role in providing "immune passports" remains unclear for three main reasons. Firstly, we do not know whether antibodies fully protect from subsequent infection; secondly, we are not confident that these immune responses are durable; and thirdly a policy of "immune passports" might actively encourage people to get infected, particularly the economically vulnerable who need to work.

Prevention: There is good evidence for the effectiveness of increasing protective behaviours of social distancing and hand cleansing, less for interventions to increase appropriate tissue use, not touching eyes, nose and mouth, disinfecting surfaces and wearing face masks in the community. There is good evidence for the effectiveness of wearing personal protective equipment in high-risk situations.

Treatment: There remains scanty evidence for efficacy of any drug therapy. Effective therapy is likely to include a combination of antiviral treatment, life sustaining therapy, including support for respiratory and renal function as appropriate, treatment to reduce the effects of the virus on different tissues, for example by stabilizing endothelial cells, and damping of the hyperimmune response seen in severe cases. In the first category, a phase 2 trial of combination of interferon beta-1b and two types of antiviral therapy, lopinavir–ritonavir, and ribavirin, achieved alleviation of symptoms and shortened the duration of viral shedding and hospital stay in patients with mild to moderate COVID-19, although as the authors noted, a larger trial is needed.[5]

Vaccines: Very rapid vaccine development in underway, with early clinical trials in progress. However, it may take 12 months or more to demonstrate clinical efficacy, and there is no certainty that we can depend on this route out of the pandemic. A challenge is that the candidate vaccines are using a very wide range of approaches, including nucleic acid (DNA and RNA), virus-like particles, peptides, viral vectors (replicating and non-replicating), recombinant proteins, live attenuated viruses, and inactivated virus approaches.[6] Several of these draw on methods used in other fields, such as immunotherapy for cancer, and have not been used previously for viral vaccine production.

Multiple epidemics: The COVID-19 pandemic is not just one large homogenous epidemic. It is made up of hundreds, if not thousands, of outbreaks, each at a different stage, in progress throughout the country. Whereas England had its first confirmed cases on 30 January and its first death was reported in early March, Scotland did not have its first confirmed cases until 1 March, via a traveller returning to Tayside from Northern Italy, and its first death until 17 March. Some parts of Scotland and, indeed England (like Rutland, Hartlepool and Blackpool and Isle of Wight) had no reported cases until late March or early April. Molecular epidemiological studies confirm multiple introductions of virus into the UK. Serological surveillance to understand progression of the pandemic is now underway through several initiatives. Coordination of these efforts is required.

The International Context

By 24 February, the World Health Organization (WHO) had published a compelling and informative WHO China mission report – but as the WHO assistant director general, Bruce Aylward, commented: '*Much of the global community is not yet ready, in mindset and materially, to implement the measures that have been employed to contain COVID-19 in China'.* He went on to say: '*These are the only measures that are currently proven to interrupt or minimize transmission chains in humans. Fundamental to these measures is extremely proactive surveillance to immediately detect cases, very rapid diagnosis and immediate case isolation, rigorous tracking and quarantine of close contacts, and an exceptionally high degree of population understanding and acceptance of these measures.'*

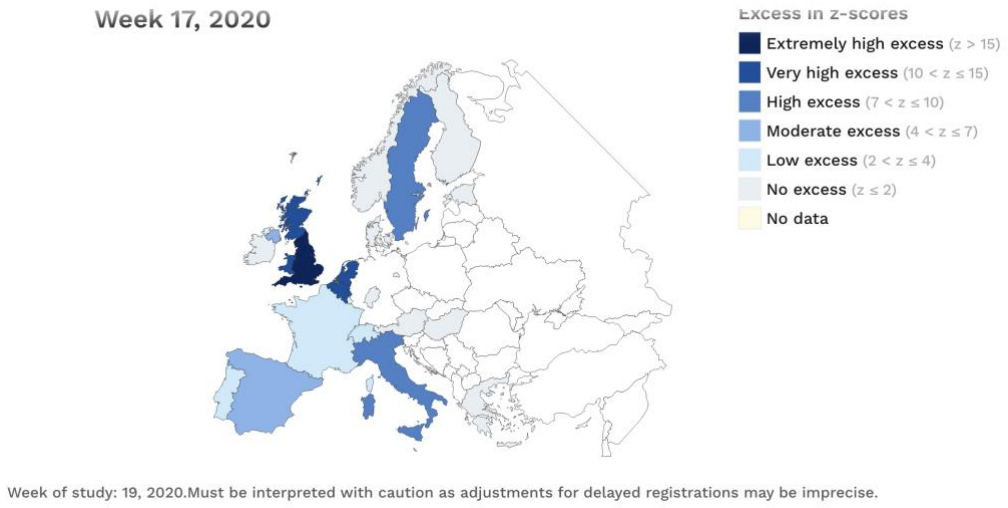
How has the UK done?

Inevitably, there has been much interest in comparisons of the course of the pandemic in different countries. Thus, in its daily press briefing, the UK government regularly presents graphs showing the number of cases in the UK and in other countries. The data presented indicate that the UK is experiencing one of the most severe epidemics in Europe. However, ministers, other politicians, and political commentators have stressed the limitations of such comparisons, invoking arguments such as differences in population density, age distribution within the population, and extent of trading links.

We recognise that there are many limitations to these data. Professor Sir David Spiegelhalter has raised concerns about constructing league tables of deaths at a time when mortality data collection methods vary across countries. But he has also pointed out that useful international comparisons can nonetheless be made at this stage. We agree.

It is important to take account of differences in how data are reported, with some countries measuring only deaths in people that have had a positive test, and some only those occurring in hospitals or care homes. The problem can be seen from an analysis undertaken by The Economist, which started from the number of seasonally adjusted excess deaths in a country. In the absence of any alternative explanation, it is likely that most of these are caused directly by COVID-19, while some may be associated with the unintended consequences of countermeasures, especially those who should attend hospital for an acute and serious condition but do not. The figures calculated by The Economist show that the percentage of all excess deaths attributed to COVID-19 varies considerably, as follows: Germany 97%; France 93%; Sweden 91%; Belgium 87%; Spain 71%; UK 54%; The Netherlands 51%. We also know that things can change. For example, until recently, the UK only reported deaths in hospital but now also reports those in care homes too. Given these challenges, there is a strong case for focusing attention on weekly figures for excess all-cause age and seasonally adjusted mortality, based on data reported by ONS. For European comparisons, data can be obtained from the website of the EUROMOMO project (Figure 1), although caution is required because of time lags in reporting, as in Ireland, and incomplete coverage of some countries such as Germany.[7] Other data using this approach are collated by the Financial Times, which include both countries beyond Europe and sub-national comparisons in some, such as the UK, USA, and Italy. Using their data, the most striking comparison is the difference between countries that took action quickly (S. Korea, Hong Kong, Japan, China, Taiwan, Singapore, Vietnam, Thailand, Greece, Germany, Norway, Denmark) and those that did not (Italy, Spain, UK, Netherlands, Sweden, Brazil and the USA).

Figure 1 Excess mortality in European countries reporting to EUROMOMO



Source: https://www.euromomo.eu/graphs-and-maps/

Given the limitations of the existing data, we recommend that mortality attributable to the pandemic is most appropriately tracked by means of weekly age and seasonally adjusted excess all-cause mortality. We are aware that discussions are taking place among European statistical offices to enable the publication of timely data and we urge the government to engage with other countries through appropriate multinational mechanisms to advance this process. Ideally, these data should be reported at subnational level in large countries. Thus, using data published by the Financial Times, we can see that Italy was successful in limiting excess all-cause mortality to under 50% of what would be expected normally in all but four of its 20 regions, while the UK has a much more generalised epidemic, with excess mortality exceeding this figure in seven of the 12 reporting units.

In the meantime, recognising the exceptional efforts that ONS are putting into reporting data on a timely manner, we hope that further analyses be undertaken to understand better the contribution of COVID-19, through its diverse direct and indirect effects, to the overall excess mortality being observed.

Learning from others

While most countries are adopting broadly similar policies, with a few notable exceptions, there are some individual differences and they are progressing at different rates. We commend the various international initiatives to bring together the necessary evidence, such as the COVID Response Monitor website produced by the European Observatory on Health Systems and Policies and European Regional Office of the World Health Organization,[8] as well as work by OECD. We note statements that the government is learning from the experiences of other countries, but we would wish to see more detailed evidence of how this learning is feeding into UK policies.

Some examples of where we believe that the UK could have learnt lessons include the experience of South Korea, which rapidly expanded their testing programme on 22 February when they had suffered just three deaths and 433 confirmed cases. They did not undertake more than 19,000 tests on any single day however, and they introduced only a partial lockdown in two of the 17 provinces. They also used a digital app to help monitor symptoms from cases and contacts, and to monitor quarantine. They suppressed their new cases within three weeks. So far, they have had 256 deaths in a population of 51 million, with only seven cases reported per day over the past week.

Greece introduced a partial lockdown on 27 February when their first three cases were reported without a death, and a full lockdown on 22 March when they had 624 confirmed cases and ten deaths. On 7 May they had suffered 148 deaths from a population of 11 million, with only 15 cases reported.

By contrast, in the UK the government pivoted community testing and tracing towards hospitals on 12 March when we had eight deaths and 459 confirmed cases. On 13 March Sir Patrick Vallance said "Our aim is to try and reduce the peak, broaden the peak, not suppress it completely; also, because the vast majority of people get a mild illness, to build up some kind of herd immunity so more people are immune to this disease and we reduce the transmission, at the same time we protect those who are most vulnerable to it. Those are the key things we need to do" The policy was to allow the epidemic to spread and build herd immunity. The policy revised again shortly after and national lockdown was imposed on 23 March when confirmed cases had risen to 8,164 and we had seen 423 deaths. By 7 May we had suffered 30,689 deaths, 207,977 confirmed cases and 5,064 new daily cases on average during the previous week.

Transitioning from lockdowns and closures

The World Health Organisation has published detailed guidance on transitioning from lockdowns and closures.[9,10] It sets out four key components to managing transitions and modulating restrictive measures, six conditions that should be used as the basis to implement transitioning measures, and four cross-cutting mechanisms. We believe that these provide an appropriate, evidence-based framework for action and we have structured our report around this guidance, and specifically the six conditions for easing restrictions, adapting them to the situation in the United Kingdom. The guidance is as follows:

Four key components to managing transitions and modulating restrictive measures
1. Public health and epidemiological considerations must drive the decision-making process.
2. Available capacity for dual-track health system management to reinstate regular health services, while at the same time continuing to address COVID-19.
3. Leveraging social and behavioural perspectives as tools for responsive engagement with populations.
4. Social and economic support to mitigate the devastating effects of COVID-19 on individuals, families and communities.
Six conditions should be used as the basis to implement/adapt transitioning of measures
1. Evidence shows that COVID-19 transmission is controlled.
2. Sufficient public health and health system capacities are in place to identify, isolate, test and treat all cases, and to trace and quarantine contacts.
3. Outbreak risks are minimized in high vulnerability settings, such as long-term care facilities (i.e. nursing homes, rehabilitative and mental health centres) and congregate settings.
4. Preventive measures are established in workplaces, with physical distancing, handwashing facilities and respiratory etiquette in place, and potentially thermal monitoring.
5. Manage the risk of exporting and importing cases from communities with high-risks of transmission.
6. Communities have a voice, are informed, engaged and participatory in the transition.
Four cross-cutting mechanisms that are essential enablers throughout the transition process
1. Governance of health systems.
2. Data analytics to inform decisions.
3. Digital technologies to support public health measures.
4. Responsive communication with populations.

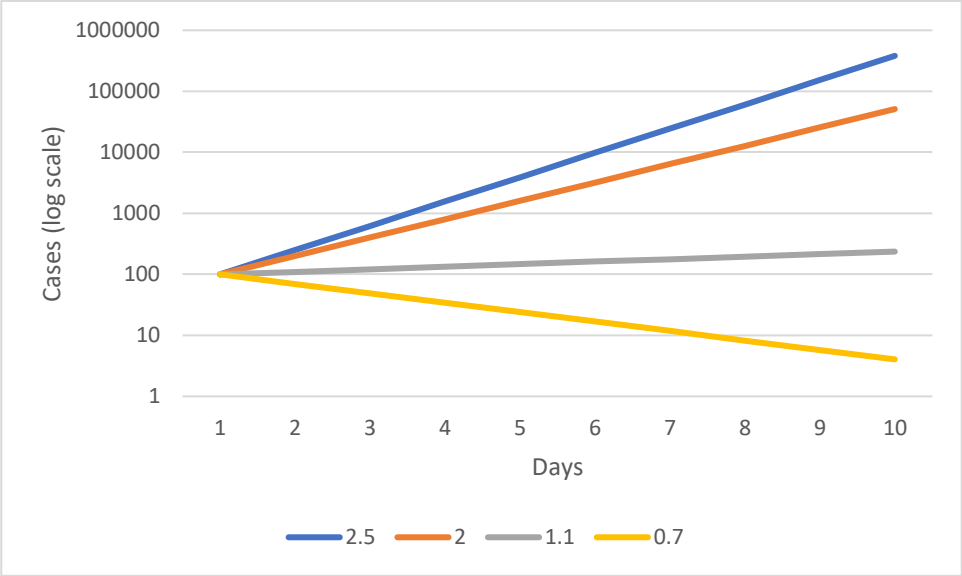
Source: WHO

Control COVID-19 transmission

By definition, the pandemic is under control when the reproduction number (R) is consistently below 1. Current estimates are that R is between 0.5 and 0.75.[11] However, R may be misleading in this context, since it is not uniform across the population – as Prof John Edmunds said on 7 May in evidence to parliament,[12] although community transmission is now low, transmission is high in hospitals and care homes, and these pockets of infection combined with a vulnerable population in these locations is causing infections and deaths to stay high. Whatever we do next, the government must urgently reduce the spread in these places through measures such as rigorous testing and tracing, supporting quarantine of affected people, regular deep cleaning of physical spaces and effective protective gear for all staff.

The importance of achieving this can be seen in Figure 2. Starting with 100 people who are infected, it assumes that each transmits the infection to the number of people implied by the value of R on each of 10 consecutive days. Current best estimates suggest that this value is between 2.5 and 3 in the absence of any restrictions. Consequently, in this scenario being modelled here, the 100 cases would increase to over 380,000 new cases by day 10. Reducing this to 0.7 would reduce the hundred cases to only four on day 10. However, if this crept up even slightly above one, to 1.1, there would be 235 new cases by day 10.

Figure 2 Impact of different values of R on numbers of cases



Measures to keep R low

While lockdown has worked to reduce R, the hope is that not all of the measures that are included in lockdown are necessary and that we can ease some restrictions. There are challenges in monitoring R, described further in the appendix, but we recommend that every easing of a restriction should be accompanied by a statement of the expected impact on R and the underlying prevalence of infection—as well as any mitigating measures that might be taken to reduce this increase.

Other countries have instituted their own versions of lockdown and are now emerging with different policies. There are also countries that have controlled R via aggressive test, track and trace policies

(South Korea being the most notable example). As noted above, it is essential that we learn from the global experience to design a set of measures suitable for the UK. Equally important is that we design in flexibility to allow for rapid escalation or de-escalation of measures as new evidence emerges (either of changes in the UK effective R or efficacy of mitigation measures).

Hunter et al have recently reviewed global social distancing measures.[13] The evidence suggests that the most effective strategies are banning mass gatherings and closure of some (but not all) commercial businesses, such as the hospitality industry. Closing educational facilities also appeared effective, but whether the main effect was for primary, secondary or tertiary education is as yet unclear (but important to determine with future evidence). Closing all non-essential businesses and stay at home orders appear to have less effect. The evidence of the use of face coverings in public or for workers with high person-to-person interaction (e.g. shop assistants, bus drivers, home health visitors /carers, some factory workers) is too preliminary to determine its impact. On the one hand, face coverings have been supported by an evidence review[14] and by a report by the Royal Society[15] but on the other, attention was drawn to a Bayesian review, noting that people's everyday behaviour of touching their masks/coverings as they wear them and take them off provides an additional potential vector for viruses on hands to be transmitted via fomites, as does putting face masks/coverings onto surfaces after wearing them.[16] This is an issue on which members of Independent SAGE disagree, in part because of differences in whether they are viewed as protection for the wearer or for other people and the extent to which data from studies of other respiratory infections apply to coronavirus.

Hellewell et al used mathematical modelling to show that a highly effective test, trace and case isolation policy (successful tracing of >90% of contacts) is sufficient to control a new outbreak of COVID-19 within three months even with R of around 3.5.[17] This may seem unachievable in the UK, but importantly, Hellewell et al also show that if R is only moderately higher than 1 (between 1 and 1.5), then control of an outbreak might be achieved with a test and trace effort that only manages to successfully trace 50% of contacts. This seems much more achievable.

Thus if measures such as banning mass gatherings and closing some commercial businesses, general hygiene and social distancing were in place and kept R below 1.5, then even a moderately effective test, trace and isolate policy across the UK could be enough to contain any outbreaks of COVID-19 over the coming year.

This is not a recommendation that the UK aims for an R of about 1.5 nor that we should aim for a mediocre track, trace and isolate policy. Instead, we believe that the reasoning that perfect tracing is impossible is no justification for not implementing a case finding, test, trace and isolate policy alongside social distancing measures.

On modelling and data

A recurrent theme in our discussions was the distinction between strategic advice from the WHO (with an explicit focus on public health) versus the management policies that appear to be adopted by the UK government. This divergence was seen in relation to PPE and recommendations for the duration of isolation, but is also evident in terms of the distinction between short-term management of the current outbreak (to prevent flare-ups) and longer-term strategic considerations (to prevent a second wave).

The difference between short-term policies and long-term strategies was acknowledged at several levels. Given this, it may be important not to conflate the two – and acknowledge that they have different objectives, epidemiological mechanisms, and testing imperatives.

Short- and long-term objectives

The short-term objectives are to avoid a rebound by premature relaxation of social distancing. This highlights the pressing need to assess the level of immunity (irrespective of the protection it affords) to better predict the impact of relaxing lockdown. Furthermore, these policies should be predicated

on appropriate metrics and criteria, including prevalence of infection, transmission strength, interpersonal contact etc. In turn, prevalence rests upon estimates that require large scale PCR testing (for which the government has already built the capacity).

The strategic long-term issues have a distinct focus and accompanying set of unknowns. The mechanism behind a second wave (in a few months) is very different from a flareup or rebound. This mechanism rests upon the degree to which short-term immunity is lost, either through an influx of susceptible people into the population or through loss of immunity. The unknowns here are the degree to which antibodies are neutralising and—if they are neutralising—the ensuing period of immunity. These are crucial unknowns that will only be disclosed in the fullness of time.

In the interim, there is a window of opportunity, during which the prevalence of infection makes it feasible to implement testing, tracking, and tracing. The aim here is to defer any second wave (due to loss of immunity and hidden levels of infection). This deferment can only be to an epidemic equilibrium – where levels of infection are stable in the population. That level of infection may or may not be affected by a vaccine (the hope is that a vaccine would reduce levels to near zero, but there is no certainty that this can be achieved). This suggests that the focus on vaccination should be replaced by a more pressing focus on the virology that determines immunity and its loss.

The UK government has already committed to a centralised response mode. This is somewhat counter to the provisional (modelling) evidence from the USA[18]. In brief, a local (regional) approach is preferred over a national (federal) response at several levels. First, the criteria that underwrite policies are better based on local estimates of prevalence—not pooled estimates at the national level. Second, the mediation of this kind of policy will require proper [re]building of primary health care capacity and devolved control. Note that a policy that has consensus at a national level can be enacted at a regional level, based on regionally specific quantitative criteria and thresholds.

How should statistics be used?

We should refocus reporting the measured consequences of the pandemic (e.g., new cases) onto estimates of the causes (e.g., prevalence of infection). Further, we should operationalise policies in terms of (estimated) latent causes—using real-time (dynamic causal) models and data assimilation—to complement conventional epidemiological models.

The data presented at daily press briefings are compelling but may not be useful indicators of the underlying causes of the pandemic—and might come to be regarded as politicised metrics of government performance. The data, in and of themselves, are useless:[19] it is the underlying latent causes of the epidemiology that matter. These can be estimated using a forward or generative model (that generates consequences from causes). In turn, these estimates should be evaluated as the basis of policies (e.g., the prevalence of infection today, as opposed to R over the past week).

Note, that the consequences of social distancing are expressed days or weeks later (e.g., occupancy of critical care units, deaths, etc.). In short, the useful aspect of data is that they reduce uncertainty about states of affairs that will be manifest in a week or so. An interesting example of this is the use of the effective reproduction rate (R). This is a statistic that reflects the consequences of at many latent causes. Perhaps this issue is not so important, in terms of quantifying progress; however, it becomes operationally crucial, when predicating social distancing policies on one quantity or another. Put simply, there is no point in implementing a control theoretic approach using effective reproduction ratio if it reflects what was happening a week or so ago. Using data to guide policy making requires us to infer the current prevalence of infection, transmission strength, number of contacts etc. that determines the reproduction rate in the forthcoming weeks. This will require real-time modelling; possibly using variational modelling (e.g., approximate Bayesian inference), as opposed to Monte Carlo simulations (e.g., approximate Bayesian computation).

With real-time modelling is put in place, it may be easier to forecast what will happen when we move from this level of social distancing to another—and share this with the public in a clear, quantitative

and explainable fashion. The analogy here would be the flood warnings issued by the meteorological office: people know that they are subject to a force of nature, they know there is a known uncertainty, and can prepare appropriately in a measured fashion.

Test, Trace, Isolate, Support, Integrate

In Wuhan, the lockdown and travel restrictions were accompanied by local intelligence gathering and local, on-the-ground contact tracing and medical observation. Even without mass testing capacity (it appears there were only 10,000 RT-PCR tests conducted in a population of 11m) the Chinese authorities controlled the infection, combining contact tracing with house-to-house symptom checking and quarantining and isolation, travel restrictions, and lock down. All these measures were necessary and had been increased.

Public Health England (PHE) lacked sufficient capacity to undertake contact tracing: it had fewer than 300 staff to do contact tracing operating out of just nine regional hubs covering 151 top-tier local authorities. No attempts were made to strengthen this capacity initially. By 12 March, when all community testing and contact tracing was stopped, PHE had only contacted 3,500 people of which around 125 were confirmed positive on testing.

Test

There was also perceived to be a lack of testing capacity - fuelled by the now administrative separation of PHE from NHS laboratories, and the delay in delegating the initiative to hospital laboratories. As a result, we currently have a mixed model for SARS-CoV2 PCR testing; PHE laboratories, NHS laboratories (and allied university sites), and standalone Lighthouse laboratories, linked to drive through testing centres run by private contractors. Reports of confusion and lack of integration of data from the Lighthouse led testing programme are concerning. Care home testing has also not been dealt with appropriately through this system, and local Public Health Directors have been asked to intervene.[20] Recent modelling also suggest that the current testing strategy itself may be suboptimal for pandemic control.[21]

The Lighthouse laboratories are staffed by many volunteers (university scientists, for instance) and with equipment from research institutes elsewhere, which limits their long-term existence. They are therefore inadequate to deal with the next phase of the pandemic, which will be likely be characterised by peaks of infection on the background of lower overall incidence over a significant period of time. There is an urgent need to plan for migration of testing back from the emergency Lighthouse laboratories into a more integrated future “normalisation” of such increased capacity across our existing PHE/NHS laboratories, in order to monitor for the inevitable future waves of infection, and local outbreaks. Even more local use of forthcoming point of care (POC) PCR tests based, for instance, in primary care /community settings may play an important role, providing sufficient integrated NHS/PHE data sharing.

We underline the importance of viewing “testing” as merely one component of the pathway from initial symptoms through to diagnosis, and subsequently a clinical and/or infection control process. The goals of “total number of tests”, or “test capacity” are no alternative to an integrated prevention and infection control structure.

Trace

With further waves of the epidemic likely, resumption of contact tracing is critical. Each of the four nations needs to institute scores of locally-led, nationally-coordinated and funded teams to trace, find and test contacts. Based in top-tier local authorities in England and health boards in Scotland and Wales, their composition should be locally determined, drawing from a range of expertise, especially amongst local Directors of Public Health, field epidemiologists, EHOs, GPs, local NHS laboratories, NHS 111, test centres, plus volunteers if required. In England, strong public health regional leadership

of the system, in conjunction with NHS England should be established reporting directly to the Chief Medical Officer.

The potential advantages of app-based contact tracing have been widely discussed. We note that symptom-based (as compared to positive test-based) identification of cases will severely over-estimate the number of cases, and that it remains unclear whether a sufficient proportion of the population will agree to use these. Concerns over privacy and security of data, and users potentially being financially penalised for following app advice to quarantine for 14 days on the basis of symptom-based case finding are likely to undermine engagement and hence effectiveness. Given the importance of rapid testing of potential cases, the 50-mass drive-in test centres need to be better integrated with local NHS capacity and directed to support local contact tracing, as well as strategically targeting most at-risk groups.

Isolate

The current position of seven days isolation seems to be untenable given our knowledge of the possible period of infectivity. The WHO recommendation of 14 days appears to be evidence-based, more generally accepted, and should be adopted. Evidence from China suggests that while maximum viral shedding after symptoms arise is in the first seven days, in more severe cases it can be longer, especially in those with severe symptoms. However, it is important to take account of the possibility that some examples of apparent continued shedding may be due to detection of non-infectious RNA fragments. This would have particular relevance in respect of the UK's only land border, which is with the Republic of Ireland. In many countries, identification of an infected case is followed by moving sick patients to hospital; mild/moderate cases to community adapted facilities for care, isolation and monitoring; and, asymptomatic cases to either self-isolate or to be offered requisitioned hotel accommodation if they are unable to isolate at home. It remains unclear what is the UK quarantine policy and availability of facilities, let alone specific recommendations for isolation in multioccupancy homes.

Support

It is far easier for some people to self-isolate than others. Policies must take account of the challenges that face those who are living alone, who are living in homes in multiple occupancy, who do not have access to gardens, who are in abusive relationships, need financial support to remain at home, or who lack social support, for example, to bring them groceries. While recognising that some measures have been taken to alleviate these challenges, much more needs to be done. A recent review of the wider consequences of restrictions on mobility identified the many different facets of life that are affected.[22] We urge the relevant authorities to develop appropriate plans that address these issues, taking particular account of the challenges of working across organisational boundaries that seem to have been so problematic already in the course of this pandemic.

Integration

We note that GPs and primary care workers form the backbone of a future sustainable response, closely linked with local authority outbreak management teams within a coordinated public health structure. Initially, general practitioners were assumed to play a limited role as patients were directed to NHS111 COVID centres. Patients were told to stay at home if they had symptoms and not phone their GPs.

The key characteristics of our future "case find, test, track, trace, isolate, support" system should therefore be integrated locally, ease of access for those requiring a test, speed (from sampling to receipt of result), and rapid infection control action. This should include flexibility of response where for instance there is a need for more active surveillance of high-risk environments, such as healthcare and social care settings. It should also include engagement of communities in discussing this to promote understanding of and engagement with the system.

Mindful that various mobile platforms are in late development for enabling self-reporting of symptoms and identification of close contacts, we caution that less than 20% of initial COVID-19 type symptoms may actually be due to the virus, with this proportion decreasing as underlying COVID-19 incidence declines. It is paramount that we ensure viral diagnostic confirmation (rather than symptom-based infection control) if we are to avoid a large amount of unnecessary isolation and quarantining, loss of income and possibly of jobs for those in low paid and precarious employment.

We argue that a future sustainable system is based locally, making full use of existing primary and secondary care networks, including local laboratory capacity, as well as local authority based public health and social care. Partnerships should be engaged with local and national organisations representing the community e.g. faith-based and mutual aid organisations. Examples of innovation include the further use of mobile devices to transmit important data on cases, and contacts, but also a mode of communication with health providers; the use of real time information dashboards to ensure community engagement, and near real time virus sequencing (as established through the UK COVID genomics consortium) to facilitate linkages within local outbreaks, and providing opportunities to break transmission chains.

Such examples of innovation would build on the existing strength of NHS IT integration, and more traditional contact tracing where necessary. The adaptation of these approaches to all localities will minimize the social inequalities in access to high quality COVID-19 prevention services and ensure that co-morbidities and clinical risk assessment can be undertaken at source. Essentially, we are supporting a systematic mapping of the functions that need to be in place, from accurate population registers to quality control of tests, and with a particular focus on mobilising an in-location workforce, based in local authority public health and environmental health departments.

Trust is too often undervalued. It is not encouraged by giving contracts to unproven commercial entities with uncertain reputations in the public eye. The least the government can do is to provide clarity on all the functions needed to implement a test, trace, and isolate strategy and then overlay it with every organisation necessary to make it happen, with clear lines of communication, performance management and accountability. If this does not include a strong role for local government and, especially, its public and environmental health departments, it will fail.

Coming out of lockdown

There is no doubt that lockdown reduced the spread of COVID-19 in the UK, even in the absence of a test, trace, and isolate policy. If the reproduction number, R, is equal to 1 across the UK, then each infected person will on average infect one other person, so that the number of new infections will stay about the same every day. But as long as daily new infections are high (in the thousands as currently), even a stable number of new infections will cause significant burden on the NHS while also making it much harder to keep R low. This is why the timing of lifting of lockdown measures has to be determined by a combination of current effective R number and current prevalence of COVID-19.

Once daily numbers of new infections are sufficiently low they can, in principle, be managed in the medium term, perhaps until a vaccine is widely available, with a strong test, trace, isolate, support and integrate strategy—as outlined above, combined with social distancing.

Minimise outbreak risks in high vulnerability settings

Anywhere that people are brought together in close proximity creates opportunities for rapid spread of infection. When an infection gets into a facility, for example inside a prison, it often moves quickly through those present. As some of those who are thereby placed at risk move between the facility and the community in which it is situated, the facility will act as an institutional amplifier.[23] This was seen early in the course of the pandemic in cruise liners. It is especially likely where there is a group of individuals within the facility who, by virtue of their age or their pre-existing conditions, are especially vulnerable. Consequently, all of these facilities, whether they are care homes, prisons, or

migrant detention centres must be viewed as a very high priority for preventive measures. It will also be important to be vigilant as other settings not previously considered to act in this way, such as meat processing factories, are doing so.[24] In addition, although on a smaller scale, households where people are living in overcrowded conditions or houses in multiple occupancy should also be seen as high risk. The precise measures that will have to be taken will vary according to the particular setting, but it is essential that a detailed plan is prepared for each of them taking account of the specificities.

It is now clear that health and social care workers in the UK are at very high risk of infection. International comparisons demonstrate that this is not inevitable. Other countries have managed to avoid any deaths in health and care workers.

There are several issues to be considered here. First, it is essential that all deaths in health and care workers are adequately investigated. The chief coroner for England has recently issued guidance that there should be a low threshold of suspicion that a death from COVID-19 in a health worker is attributable to their employment.[25] His guidance also states that it is not the place of coroners to investigate wider policy failures, such as the widely publicised failures to procure adequate supplies of Personal Protective Equipment (PPE) of appropriate quality. However, individual coroners can issue a 'Report on Action to Prevent Future Deaths' (PFD) as set out in regulation 28 of the Coroners (Investigations) Regulations 2013 if they judge that action must be taken to prevent future deaths. This can be sent to any organisation or individual who the coroner considers has the power to take that action. The Industrial Injuries Advisory Council (IIAC), an independent scientific advisory body with the responsibility to advise and make recommendations to the Secretary of State for Work and Pensions might usefully consider making COVID-19 a 'prescribed' industrial disease for those whose work places them at risk, thereby enabling those affected to obtain compensation.

Second, adequate supply of PPE and other protective equipment is crucial. This is a widely known problem and the BBC Panorama programme exposed of the many failures leading up to and during the recent surge.[26] The government must now address those urgently and prepare for a next surge. All key workers should be protected and not just those working in the highest risk environments within hospitals. This means also protecting staff working on acute COVID wards outside of HDU/ICU , transport staff, care home workers and home visitors – for instance the Office of National Statistics published a report on 11th May 2020 highlighting the increased numbers of deaths due to COVID-19 among social care staff.[27]

Finally, care homes are a particularly challenging environment for preventing outbreaks – care homes across the world have become epicentres of not just COVID-19 transmission but high mortality as their residents are almost all high risk. In the UK, protective equipment and testing for care home staff and residents has been lacking (patients discharged from hospital to care homes were only routinely tested for COVID from mid-April[28] and routine testing for care homes was only introduced from 29 April).[29] As discussed above, current transmission and disease burden in the UK is concentrated in care homes.[12] While this new widespread testing of staff and residents is welcome and necessary, it must be combined with adequate protective equipment for all staff and financial support for care homes to employ more staff, undertake frequent deep cleans and configure their environments to be able to isolate infected residents (many residents might have end of life plans that preclude hospital admission and live with conditions such as dementia which makes isolation even more challenging). Additionally, we must recognise that care home staff are often poorly paid and vulnerable themselves: more likely to live in challenging housing situations, less able to self-isolate, more likely to be of BAME background [30] or living with underlying health conditions.

Manage the risk of exporting and importing cases from countries with high risks of transmission

The government has decided that everyone coming to the UK, except those travelling from the Republic of Ireland or transport workers such as lorry drivers, should be required to self-isolate for a

period of 14 days. We welcome this measure although it is not clear why there is a delay in implementing it. However, we note that there is a serious loophole in it. It will be perfectly possible for someone to fly from somewhere where the level of infection is extremely high, such as New York, to Dublin and then change planes to travel to London. For this, and for other reasons related to the extent of movement across the Irish border, it makes much more sense either to treat the two main islands of Britain and Ireland as separate entities for human health purposes, as is already the case for animal health, or for the UK and Republic of Ireland to agree a common approach.

Establish preventive measures in workplaces

The Prime Minister's messaging on 10 May about easing restrictions included calls for "respecting others in the workplace and the other settings that you will go to." Respecting others, whilst obviously an excellent thing to do, is another general phrase that does not communicate what either employers should be doing, or employees should be expecting and demanding. Timing of communications and the context of communications is also vital for managing transition if personal, social and economic costs are to be avoided. To encourage return to work at short-notice without a new, appropriate health and safety framework having been agreed by Parliament nor with the trades unions, endangers lives and will cause high levels of stress, and in some cases trauma and job resignations in a bid to protect vulnerable families from having the virus brought from work into the home.

Ensure communities have a voice, are informed, engaged and participatory in the transition

Engagement of key stakeholders, including devolved administrations

One of the main criticisms of the response by the UK government so far has been the highly centralised approach that it has taken, in some cases excluding the governments of the devolved administrations from key decisions. The elected administrations in Scotland, Wales and Northern Ireland have the powers to determine their own policies in many aspects of the response to the coronavirus pandemic. While the general position has been to adhere to the decisions made in Whitehall, each administration has the opportunity to determine the distinctive measures needed to safeguard the well-being of the population for which it is responsible. The pattern of infection with the virus appears to vary markedly across the UK and the devolved administrations should take the opportunity, where possible, to engage fully in the introduction of our strongly recommended approach of case finding, testing, tracing, and isolation. This should be a cornerstone of their approach. Northern Ireland is a particular case, having a land border with the Republic of Ireland. We urge the Northern Ireland Assembly Executive to seek to harmonise their policies with those of the Republic of Ireland in keeping with the commendable Memorandum of Understanding that has been agreed between the two jurisdictions in relation to the coronavirus crisis.

Representatives of local government, including most of the large metropolitan authorities, have also been largely excluded. Similarly, civil society organisations and business have complained that they have had little input into the development of policies and practices. For example, companies with a long tradition of manufacturing products, such as ventilators and PPE, often struggled to find out who to contact.

Instead, in a number of critical areas, the government has turned to outsourcing accountancy and consulting companies with no obvious technical experience in the tasks they are being asked to do. There have been particular concerns about procurement of both goods and services.

This approach, based on a vertical programme disconnected from existing structures, resembles those that have been tried and have failed over many decades in low income countries. Importantly, even in very resource poor settings, such as some African countries, it has been possible to develop effective responses using existing community-based structures, many of which have been developed

in response to Ebola and with a recognition that highly centralised programs often fail. These local initiatives succeed because they are well connected with local administrative systems and achieve a very high level of trust among the populations they serve. This is in marked contrast with the widespread scepticism that has greeted some of the responses, such as the target for numbers of tests to be conducted daily, in the UK. It will be essential going forward that all measures are closely linked to local communities.

A major problem for England has been that the Health and Social Care Act 2012 created a fragmented system and the absence of local and regional area health bodies has removed structures that could have facilitated a more effective response.

Communications and other measures to manage the transition of easing restrictions

There has been little engagement of communities throughout this process; if adherence to guidance is to be maintained throughout the complexities of transitioning, engaging and listening to a wide variety of communities is going to be essential, including neighbourhood and work communities, local authorities and trades unions (see later section).

For government communications to be effective in promoting adherence to guidance and in avoiding confusion, anxiety and distrust, they need to be clear, precise and consistent. This includes being behaviourally specific, i.e. advice as to who needs to do what in what situations, and what should not be done. Advice should be closely linked to action. Reasons for the advice should be given; explanation increases motivation to adhere and provides people with understanding that means that they can apply principles beyond the specific advice, as appropriate.

An example of unclear messaging is that given on 10 May by the Prime Minister of ‘Stay alert, control the virus, save lives’. It is not clear what people are meant to be alert for, nor indeed what they should do if they are alerted to something. Similarly, “control the virus” is an empty slogan without an indication of how to do this. “Save lives” is uncontroversial but without context in the rest of the message is likely to have little impact. The old saying “coughs and sneezes spread diseases” whilst not directly telling people to use tissues and to dispose of them immediately, does provide people with an understanding of causal mechanism which means that other messages are likely to have more impact. It also has the essential quality of being memorable – people need to be able to access advice in their head in the situations when they face choices about how to behave.

With the government's five tests not having been met, we are concerned that “stay alert, control the virus and save lives” is not a helpful message in terms of guiding behaviour. Dropping the ‘stay at home’ message in favour of generalised alertness may be taken as a green light by many to not stay at home and begin socialising with friends and engaging in other activities that increase the risk of transmission. This could potentially undermine the impressively sustained high levels of adherence to lockdown the public has achieved, even in very challenging situations. It is regrettable that the government does not appear to be taking on board behavioural science evidence and the principles of how to communicate effectively to enable, support and guide behaviour.

The decision not to involve devolved nations in this change of messaging has led to wider confusion. Scotland, Wales and Northern Ireland are sticking with 'Stay at Home, Protect the NHS, Save Lives’.

Any easing of restrictions needs to be accompanied by not only effective, targeted messages, but changes in the physical and social environment that enable the key behaviours to suppress transmission:

- maintain social distancing in all places outside the home including transport and workplaces,
- wash hands when coming into buildings or before eating and preparing food,
- cough or sneeze into tissues that are immediately disposed of and hands washed afterwards,
- disinfect surfaces and don’t touch eyes, nose or mouth (which is where the virus enters the body) without washing hands first and after.

Inequalities

One issue that the 10 May announcement has brought into sharp relief is increasing inequalities. People who can work from home, thereby avoiding potentially unsafe travel and workplaces, tend to be more middle-class than those in jobs that cannot be performed at home. The latest data from ONS reveal large occupational differences in the risk of COVID-19 deaths, with men in the lowest skilled occupations at greatest risks, and with taxi drivers and chauffeurs, bus and coach drivers, chefs, and sales and retail assistants at especially high risk.[14] Men and women working in social care, a group including care workers and home carers, also had significantly raised rates of death involving COVID-19. To prevent increasing the divide whereby poorer people expected to risk their lives to get the economy going whilst wealthier people stay in the safety of their homes, the government should continue to provide furlough for all workers who have not been guaranteed safe work and transport to work, and work much harder to achieve safety for all.

Effective clinical care for patients and staff

Lockdown is unsustainable until a vaccine is available. As we come out of it, it is possible that any combination of measures will not be enough to prevent a second surge. We need to learn now from the problems experienced in March and April (particularly those that were not anticipated). Many of these are avoidable and must be avoided in future. The worst case would be for such a surge to coincide with the winter flu season, when hospitals are often overwhelmed even in normal years. The government should use this time to prepare for such a surge, gathering together experts from across disciplines, including (but certainly not limited to) the clinical community, the social care and public health community, systems engineering, operational research, industry, supply chain specialists and local government.

Critical care capacity

The lockdown has worked well in allowing the NHS to cope within its surge capacity. This surge capacity has been staffed by those within critical care working beyond their normal, already extensive, hours and work patterns; by the redeployment of healthcare professionals from other services (for example Anaesthesia and Surgery) to critical care, and by the cancellation of NHS activity like elective surgery. Critical care staff continue to work above and beyond their normal working patterns. It will not be possible to sustain that level of activity indefinitely and any future central NHS modelling must take staff sustainability and wellbeing into account. Healthcare staff are comprehensively trained for patient safety and cannot be created overnight, however alternative models of delivery of care have been used during the pandemic and this affords us an opportunity to build resilience into future modelling. For instance, high requirements for breathing support stressed hospital supplies of oxygen that led to critical incidents, as in Northwick Park Hospital.[31] Systems engineers, mathematical modelers and clinicians can work together to design treatment pathways and oxygen supply chains to optimize the use of oxygen within hospitals and across the system.

Returning to normal NHS activity

As other activity in the NHS begins to return, this will impact the surge capacity currently possible in critical care. It is important, and the Faculty of Intensive Care Medicine and the Royal College of Anaesthetists have provided guidance to support hospitals in making the decision on why they can begin to reopen normal activity.[32] It is also important that rather than this being a top-down process, that this decision is made at the Health Board / Trust level as each hospital's number of COVID cases, pre-existing case mix and floorplan will be different. The guidance produced gives a red-amber-green (RAG) rating for hospitals to make an informed decision about this whilst protecting their staff resilience and pandemic preparedness.

Guidance from NHS England outlines a phased approach to nurse staffing.[33] In reference to the strategy document, any critical care unit that is using a phase 3 or 4 staffing model (i.e. with triple or quadruple the normal nursing numbers), or is more than double its baseline capacity, would be red. If using phase 2 and/or is at double baseline capacity the unit would be amber. If returned to pre-pandemic staffing levels or capacity, then it would be green. This is line with what the Faculty of Intensive Care Medicine (FICM) set out in a joint statement by the British Association of Critical Care Nurses.[34] Going forward, there will be reduced efficiency in the acute hospital setting, partly due to the need to separate COVID-19 and non COVID-19 patients but also because of the need to undertake social distancing between staff and between patients, particularly in the Emergency Department and Out Patient clinics. Crucially, as the Royal College of Anaesthetists has been stating in all senior NHS briefings and in media work, staff are the central resource for our patients. Their position statement on sustainable working patterns during COVID-19 pandemic, which covers senior doctors, Advanced Critical Care Practitioners and Critical Care Pharmacists, provides more information on this important area.[35]

Co-ordination between specialties

We now realise COVID-19 is a complex multi-system disease and not the classic viral pneumonia that we first suspected.[36] There is a wealth of research emerging almost every day, providing insights on the effects of the virus on the blood vessels, kidneys, nervous system, and other parts of the body. This is offering new insights into possible opportunities for prevention and treatment, from reducing the risk of infection to stabilising the lining of the blood vessels and managing the often fatal inflammatory storm. The UK's Recovery Trial, ensuring that candidate treatments are evaluated rigorously, is an exemplar of what can be done,[37] but it is difficult to avoid the conclusion that too many of the discussions are taking place in clinical silos - there are currently 35 MHRA approved COVID-19 therapeutic clinical trials in the UK. The sheer volume of evidence can seem overwhelming, and of course until it is peer reviewed it must be treated with caution. What we do need is a clear mechanism to ensure that a wide range of front line clinical and basic science expertise is brought together, for which no obvious mechanism exists.

Collateral effects on non-COVID-19, or post discharge COVID-19 patients

Collateral damage from the lockdown is being felt. Within hospitals, competing resources for, for instance, renal disease (manifest in 30% COVID cases) are problematic.[38] There are rising numbers of excess deaths from non-corona causes as people die at home instead of calling an ambulance and all routine and elective care is cancelled. Community services have been cancelled so there is little hands-on chiropody, physiotherapy, mental health services, and occupational and speech therapy - GP appointments are being replaced with telephone calls and video conferencing. These are vital services for older people for whom telephone calls are often an inadequate substitute for hands on care. Meanwhile, in many hospitals, wards are half empty and some staff are under-occupied as the COVID surge recedes. Bed occupancy has fallen, the Nightingale hospitals are empty and clinical need is rising. There is an opportunity to consider an alternative use for the Nightingale hospitals, to alleviate some of the pressure that will inevitably continue, such as regional weaning units or rehabilitation centres. Although not initially designed for this it would facilitate earlier hospital discharge, provide a bridge between secondary and primary care and liberate capacity for GPs, particularly as hospitalised COVID-19 patients are much more likely to have existing health conditions. Failing to plan for this will lead to a high number of readmissions to hospital or even severe sequelae such as significant additional morbidity or death.[39]

Mental health

Many people, especially the elderly and those in single households are essentially in solitary confinement and, as a result, at increased risk of mental anguish (not least those with depression or incipient or actual dementia). Residents in care homes are confined in their rooms, with no visits from

relatives – even when gravely ill or dying – often with minimal interactions with staff.[40] The decision to exclude relatives means that care homes have become closed institutions, increasing the risk of neglect, or even abuse.[41]

Health, social and economic protections for women, marginalised and BAME groups

Recent data have suggested increased mortality in BAME communities in UK which requires urgent exploration through robust analysis of routinely collected prospective data on COVID-19. This will not only explore risks and outcomes associated in BAME populations but for the entire population. This important information must be communicated in an accessible and culturally appropriate way. However, to get a clearer picture of ethnic and socio-economic disparities in incidence and outcome in the UK, we need detailed national data linkages with some of the best data globally.

Racial Disparities in COVID-19

The new report by ONS on coronavirus by ethnic group shows the important role of socio-economic and housing circumstances in explaining some of the racial disparities between ethnic groups in relation to COVID-19 deaths (although racial disparities still remain even after taking these factors into account). Factors include age, sex, underlying morbidity, place of residence, area clustering, socio-demographic factors, laboratory measures, and burden of undiagnosed disease to determine if the observed signal between ethnicity and COVID-19 outcomes is real or an artefact. Some of these data are already available. However, mixed methods research will be required to fully understand the complex interplay between the various biological, social, and cultural factors underlying these early findings. We welcome the recent launch call from NIHR and UKRI for research on COVID-19 and ethnicity.

Notably, the report did not discuss the important factor of racial discrimination in understanding the different experiences of poverty and deprivation between ethnic groups. An analogy that could be used here is we know that social class is a strong predictor of educational performance (like poverty is for health outcomes), but the reasons for why black and Gypsy Roma Travellers (GRT) working class children are performing poorly in education are somewhat different for why white working class children are performing poorly in education. Racial discrimination and racism (as manifested in disproportionate school exclusions of black and GRT children) is an important explanatory factor.

The equality and migrant sector, including Runnymede Trust, have repeatedly tried to illustrate how COVID-19 is not just a health crisis, but also a social and economic one – bringing into sharp relief pre-existing socio-economic and racial inequalities. These factors matter because we may all be weathering the same storm, but we're not in the same position to manage and recover from the storm.

Strengthen social security

While there is a great deal of heterogeneity among BAME groups, BAME people are much more likely to be among poorer socio-economic groups, living in poorer-conditioned, multigenerational and overcrowded housing, working in low-paid and insecure jobs and over-represented among low paid key-workers e.g. carers, transport and delivery drivers, cleaners etc. In the context of COVID-19 this raises questions about the extent to which BAME people can social distance, but also highlights the extent to which poorer BAME groups (including those in working households) rely on social security as a large part of their income and housing costs.

While the government have taken several steps to mitigate the economic impact of COVID-19, these measures have not equally benefitted all groups in the labour market (as well as those not economically active in the labour market). Many women and BAME groups at the bottom end of the socio-economic spectrum, as well as those on route to settlement (with or without leave to remain) are currently falling through the net into poverty and destitution because of barriers to social security.

Of those groups who are able to access benefits, including Universal Credit, there are still major financial barriers which are pushing people 'just about managing' into poverty. The current level of Universal Credit is too low and does not take account of changes in social circumstances due to COVID-19. Families with children at home as a result of school closures and childcare facilities being closed will face increased food and utility costs. Child benefits, therefore, need to be increased to £50 per child per week to cover gaps in free school meals and to cover extra costs of children being at home full time. In addition, benefit caps, under-occupancy benefits and the two-child limit in Universal credit (which means that families with three or more children, born after April 2017, do not receive support for these children) all need to be lifted. And housing allowances must reflect local rents, particularly in cities where the cost of housing is pushing families into poverty and destitution.

There is also a five week wait for Universal Credit, which is currently covered by 'advanced payments' in the form of loans. The food bank, Trussell Trust have argued that this is creating more debt for families, and Women's Budget Group and Fawcett Society have recommended that this form of advanced payment should be converted to 'non-repayable grants'.

There are also concerns about the level of Statutory Sickness Pay in the context of COVID-19. Currently, is too low (£95.85 per week) and is not enough to live on for working families. Low levels of statutory sick pay, and restricted eligibility increase the risk that people who are ill, or around those who have been ill, are spreading coronavirus. Around one in five workers are not eligible because of low or intermittent pay/zero-hours contracts.

No Recourse to Public Funds

There are additional concerns about the government's No Recourse to Public Funds (NRPF) condition imposed on migrants with limited leave. Under the NRPF condition migrant workers with limited leave cannot access public funds including Universal Credit, Child Benefit or Housing Benefit. Yet many of these working migrant groups are in low paid work, including low paid care work – which on its own is rarely sufficient for food and housing costs. With children now at home, this increases the risk of food poverty and challenges the extent to which such families can social distance if they are forced to work because of risks of poverty.

Engagement with Civil Society

Finally, the government needs to work closer with civil society organisations representing vulnerable and BAME groups to ensure that their measures are sufficiently protecting and shielding these groups from COVID-19. One area where the government has increasingly been listening to civil society organisations are the domestic abuse charities, which have rightly highlighted concerns about the increase in domestic abuse since the lockdown (the National Domestic Abuse Helpline reported a 25% increase in calls and online requests for help since March 2020). The government needs to mirror this listening and engagement approach with all frontline civil society organisations representing vulnerable groups from all walks of life.

What is needed for the future?

A safe vaccine with near 100% efficacy for long term protection and high global uptake provides an ideal route out. However, it would be foolish to base all plans on that. It is likely that the virus will persist in the UK for at least a year, and, in the absence of the optimal vaccine, will possibly become endemic within the population. In this scenario the country will be subject to recurrent local outbreaks requiring rapid intervention. It follows that exit from the current lockdown must encompass a strategy of searching for the virus wherever it appears, understanding and intervening in transmission networks, as well as protecting those with disease. This requires a virus control system which has long term sustainability. It must be built into an enhanced public health protection system, taking advantage of the primary and secondary health care system, but also incorporating locality-based integration (integrated Care Systems) including local government and social care, and crucially with community participation.

In order to guide future infrastructure requirements, it is important to appreciate how the UK have come to a situation where "lack of testing and infection control capacity", has been used to justify the suboptimal UK government response to the pandemic.

There is an urgent need to rebuild an integrated public health infrastructure of the form required to deliver optimal protection of the people of Britain and Northern Ireland. This needs to assimilate the highest quality diagnostics, data collection, management analysis and sharing, and innovative social and behavioural science, as a critical component of our protection from this and future pandemics.

Appendix

The utility of R for policy and strategy planning

The basic or initial reproduction number R_0, is an important epidemiological parameter that quantifies the number of secondary infections from initial (index) cases of an infected individual. At early stages in the outbreak it is a useful summary to communicate the likely infectiousness and to explore possible trajectories of infection. However, the reproduction number is not a biological measure—it incorporates many factors; e.g., the number of contacts an individual makes. To understand the utility of this, now, well-known metric, in terms of forward planning by governments and individuals, one must consider whether the value can be estimated in real-time and if not, what is the lag.

Currently, even highly robust and technically sophisticated techniques can only estimate changes in R (the effective reproduction number) with a lag of several days, using retrospective data. It has been used, for example, by the Imperial College London group (Report 13) to investigate the consequences of social distancing and lockdown measures (and their accumulated effects).[42] And even here, robust R estimates were reported by taking into account data from many countries. In short, a real-time metric may be of greater utility for social distancing advice and policy planning.

Technically, Report 13 used (hierarchical) Bayesian Regression to infer R using known times of change in numbers of contact; i.e. date stamped lockdowns on bars and gyms, etc.—with estimated infections, using known deaths and an assumed infection fatality ratio. This is state of the art regression yet as the authors explain, it is retrospective, looking after a change in policy has been rolled out.

A generative model (that does not rely on regression methods) may be necessary to infer current infection rates. The Dynamic Causal Model for COVID-19[43] provides such estimates real time infection rate estimates, which formally incorporate behavioural adjustments in the community. These kind of 'here and now 'estimates may become increasingly important to plan surveillance strategies, for example, 'How many tests should I carry out in my area tomorrow in order to identify the requisite percentage of new cases?'.

In terms of forward planning one can envisage a 'traffic light 'scheme.[44]; much like the weather forecast or flood warnings (after the news, for example)—where the public are alerted to current levels of infection in their area: will tomorrow be Green, Amber or Red? If infections are high in Leeds for example then more social distancing (and testing) may be necessary, while Dorset may be 'Green ' on Tuesday and require less.

Modelling approaches

If we focus on models that are fit to data, there are two key aspects that need to be considered. First, the nature of the model and its parameters. Second, the mathematical procedures used to recover or estimate the model's parameters. In terms of the form of the model, most models assume one can be in a particular state or another (e.g., am I infected or not?). The model parameters then control how quickly one moves from one state to another (e.g., the rate at which people become infected). A key question is what states are included in the model. In short, which states matter?

Current models range from simple models with a handful of states (for example, I can either be susceptible to infection, exposed to infection, infected, or recovered). At the other end of the scale, one can have fine-grained models that include where I am; e.g., whether I am at home, work, a care home or hospital. The choice of states is in part determined by the kind of data available. There will always be an optimum number of states for any given data. The objective is to find the model who states have the greatest evidence (technically, the model under which the data are the most likely). This is important because it means that there is no true model—there is only the best model, or

explanation, for the data at hand, which may be more or less complex. This speaks to the second aspect of modelling; namely, how one fits models to data and assesses their evidence.

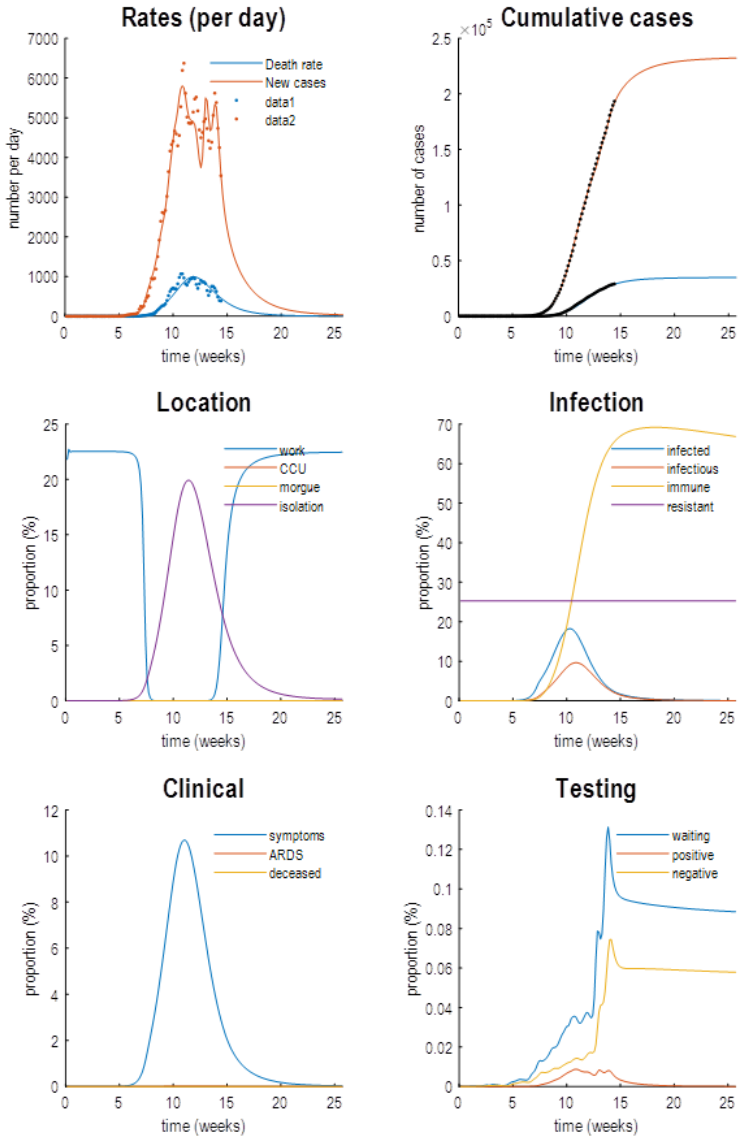
Broadly speaking there are two ways to fit models to data. One can simulate large numbers of trajectories of what might happen in the future and pick those simulations that, in some sense, are close to the observed data. These are known as sampling approaches and are used widely in weather forecasting. These procedures dominate most epidemiological modelling. However, there is a more efficient way of fitting models, where one replaces millions of samples with a single probability distribution over the unobserved (latent) states causing observable outcomes. These techniques arose in physics and are known as mean field approximations and variational procedures. The advantage of variational procedures is that they match faster than sampling-based approaches (e.g., simulating an outbreak in minutes as opposed to hours)[45-47]. This efficiency is important, because it means that one can fit lots of competing models to the same data and evaluate their evidence. This is known as Bayesian model comparison. Model comparison is a key part of optimising the model of any timeseries data. In neurobiology, this is known as dynamic causal modelling[48].

Dynamic causal modelling may have a potentially important role to play because it enables one to test different hypotheses about (i.e., models of) the pandemic and our responses to it. For example, one can evaluate the evidence for models of social distancing predicated on the prevalence of infection vs. The numbers of new cases vs. the R ratio. Note that with dynamic causal models of this sort, everything that matters can be built into the model—including social distancing responses. In contradistinction to conventional epidemiological modelling, this means that one can predict not only the morbidity but also our responses in the future. In other words, our response to the pandemic becomes part of the epidemiological process. This ability to model responses is potentially important when comparing data from different countries. For example, one can ask whether the efficacy of the German response to COVID-19 is mediated by enhanced testing or a greater emphasis on primary health care (e.g., surveillance of symptoms in the community). In short, the ability to model ‘everything that matters ’in a comprehensive and efficient way may become increasingly important as we face choices about the deployment of resources—and start to consider other costs beyond the mortality rate of COVID-19 per se.

Based upon the data so far, dynamic causal modelling of the pandemic has provided slightly different predictions from conventional epidemiological models. For example, they predict (or predicted) that the Nightingale hospitals would not be required. They predict (or predicted) lockdown will start to be relaxed in the UK on 8 May. Perhaps more importantly, dynamic causal modelling suggests a decentralised regional response mode (as opposed to a centralised, federal mode) is not only a better explanation for what is happening in the United States – it will also save lives[18].

Figure 3 is based upon current new cases and death rates. It shows the kind of predictions that can be made, in terms of the latent (underlying) causes of mortality. The dots represent the data up until the present day, while the curves project into the future. These simulations suggest that things may not be quite as bad as they could be. Indeed, we are already witnessing the (start of) soft relaxation of social distancing—as predicted by the model (and witnessed by the streets of London).

Figure 3 *Illustrative predictions of the course of the epidemic*



This figure summarises the kind of estimates furnished by modern-day (variational) approaches to timeseries analysis. These approaches inherit from statistical physics and the characterisation of population dynamics in neuroscience. The basic idea is to model the underlying causes that generate data by building a generative or forward model—and then estimating the causes from the observed consequences, using variational procedures such as dynamic causal modelling. In this example (taken from Testing and Tracking in the UK: a dynamic causal modelling study: in preparation), data on daily cases and deaths (the dots in the upper panels) have been used to infer the underlying causes (in the lower panels). These courses can be multifactorial in nature. Here, the pandemic has been modelled in terms of four attributes of people in the United Kingdom; namely, where they are (*location*), their infection status (*infection*), their clinical status (*symptoms*) and their testing status (*testing*). The solid lines represent the most likely trajectory of these causes or attributes over six months. Note that having a generative model underneath the data allows one to estimate the past and the future. For example, installing social distancing responses into the model allows one to predict when social distancing will be relaxed. Here, social distancing is manifest in terms of the probability of leaving home to go to work (blue line in the *location* panel), which—according to the model—should have been partially relaxed at the time of writing. This kind of model may be particularly useful because it provides instantaneous (real-time) estimates of the prevalence of infection and quantities like the reproduction rate. In short, in contrast to curve fitting, dynamic causal modelling estimates the

causes of morbidity and mortality by leveraging our knowledge about all the factors that matter in a quantitative way. For technical details and a full description of this figure format please see[18].

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Extract from New York State Website https://forward.ny.gov/metrics-guide-reopening-new-york

Metrics to Guide Reopening New York

Overview

Governor Cuomo outlined guidelines that will help regions create individual plans based on facts and data to reopen New York.

Map of the 10 regions of the state and a list of counties within each region.

The state will monitor core factors to determine if a region can reopen.

The loosening of restrictions in New York will be considered on a regional basis, based on the following criteria. These criteria are designed to allow phased reopenings to begin in each region only if:

- The infection rate is sufficiently low;
- The health care system has the capacity to absorb a potential resurgence in new cases;
- Diagnostic testing capacity is sufficiently high to detect and isolate new cases; and
- Robust contact-tracing capacity is in place to help prevent the spread of the virus.

Regional Control Rooms

The regional control room will monitor regional metrics during the reopening process. These regional control rooms will monitor the hospitalization rate, death rate, number of new hospitalizations, hospital bed capacity, ICU bed capacity, testing and contact tracing within its region during reopening and alert the state if the region's metrics no longer meet the reopening guidelines and adjust the reopening plan for that region accordingly.

View a list of members of each regional control room.

Monitoring New Infections

The first key to reopening is continuing to control the rate of transmission of COVID-19, which limits infections and ensures that healthcare facilities are not overwhelmed.

Metric #1: Decline in Total Hospitalizations

The Centers for Disease Control and Prevention (CDC) recommends that reopening be dependent on a downward trajectory of hospitalizations and infections over a 14-day period. Before a phased re-opening begins, a region must experience a sustained decline in total net hospitalizations – the total number of people in the hospital each day, calculated on a three-day rolling average – over the course of a 14-day period. Alternatively, regions that have seen few COVID cases overall will satisfy this metric if the daily net increase in total hospitalizations (measured on a three-day rolling average) has never exceeded 15.

Metric #2: Decline in Deaths

Before reopening, a region must experience a sustained decline in the three-day rolling average of daily hospital deaths over the course of a 14-day period. Alternatively, regions that have seen few COVID cases overall will satisfy this metric if the three-day rolling average of daily new hospital deaths has never exceeded 5.

Metric #3: New Hospitalizations

In addition to monitoring the decline in disease trajectory, it's important to monitor the absolute level of infection in each region. This is because it's possible for a region that has seen a high level of infections – for example, New York City – to see a sustained decline in hospitalizations and deaths over a 14-day period, while still having an underlying infection rate that is too high to allow for a safe phased re-opening.

A phased re-opening for each region will be conditioned on the occurrence of fewer than two new hospitalizations per 100,000 residents (measured on a three-day rolling average).

Health Care Capacity

This pandemic has made clear that having enough hospital capacity is critical. Upon the recommendations of public health experts, every region must have the healthcare capacity to handle a potential second surge in

cases – regions must have at least 30 percent of their total hospital and ICU beds available at all times.

Metric #4: Hospital Bed Capacity

In addition to ensuring that disease progression is contained, guidance from both the CDC and World Health Organization (WHO) require that regional health system capacity remain sufficient to absorb a potential resurgence of new cases. Phased re-openings will therefore be conditioned on the hospital bed capacity in each region. Regions must have at least 30 percent of their total hospital beds available before a phased re-open can begin.

Metric #5: ICU Bed Capacity

Nearly 30% of hospitalizations for COVID-19 ultimately require critical care. It is therefore critical that regional health care systems not only maintain sufficient bed capacity for a potential resurgence in cases, but also achieve sufficient capacity for ICU beds specifically. Accordingly, regions must have at least 30 percent of their ICU beds available before a phased re-opening can begin.

In addition, to ensure nurses and doctors have the personal protective equipment (PPE) they need, every hospital must also have at least 90 days of PPE stockpiled. The State is working with the hospitals, nursing homes, and other facilities to develop a timeline to build a robust stockpile. We can't afford to risk another scramble for PPE while medical personnel are left under-protected.

Diagnostic Testing and Contact Tracing Capacity

The key to controlling the virus is aggressive testing and tracing, so that hotspots can quickly and effectively be isolated.

New York has worked hard to scale up testing at rates higher than any state or country in the world. Hospitalization rates are important, but testing identifies the full rate of spread. Regions can watch that rate move, and adjust their reopening strategies as needed.

Widespread testing is also key to effective contact tracing. This allows health officials to identify asymptomatic carriers, who are spreading the virus undetected, and isolate them before they infect others.

Metric #6: Diagnostic Testing Capacity

Widespread diagnostic testing is a key lynchpin on which our ability to contain the spread of the virus depends. Testing is critical to identifying new infections, isolating them, and tracing their contacts. Phased re-openings will depend on the ability of each region to achieve 30 tests per 1,000 people per month, consistent with the recommendation of Dr. Deborah Birx of the White House Coronavirus Task Force. New York scaled up testing at rates higher than any state or country in the world. The State is committed to continuing to rapidly expand our capacity statewide to help all regions meet this threshold.

Metric #7: Contact Tracing Capacity

The CDC and WHO also recommend that robust contact tracing programs be in place before local governments consider easing restrictions. Contact tracing helps prevent the spread of COVID-19 by rapidly interviewing positive patients; identifying their close contacts; interviewing and alerting those contacts to the risk of infection; and instructing those contacts to quarantine or isolate for 14 days, to be sure they don't spread COVID-19 to others. The New York State Department of Health (DOH) has partnered with former New York City Mayor Michael Bloomberg, the Johns Hopkins University School of Public Health, and Vital Strategies to recruit and train an army of contact tracers to meet the needs of each region statewide, including from State, City and County Health Departments. In collaboration with these partners, DOH has established region-specific thresholds for the number of contact tracers required, based on the characteristics within each region.

Contact tracing helps prevent the spread of COVID-19 through four key steps:

- First, labs report positive cases of COVID-19 to contact tracers on a daily basis via a state reporting system.
- Contact tracers then interview positive patients to identify people they may have been in contact with over the past 14 days. Based on the results of the interview, tracers will advise the positive individual to get tested, and either isolate or quarantine themselves for the following 14 days to prevent further spread of the virus.
- The contact tracer then notifies and interviews each contact of the original positive individual to alert them to their risk of infection, and instructs those contacts to quarantine or isolate for 14 days to prevent further spread.

- Finally, the contact tracer monitors those contacts by text throughout the duration of their quarantine or isolation to see if the contacts are showing any symptoms.

  Members of the tracing team will also work with any individual being traced who needs social services assistance, such as housing, food, or medicine, while they are quarantined or isolated.

Ongoing Monitoring

Once a phased reopening begins, it is essential that the rate of transmission be carefully monitored and remain under control. Each region must appoint an oversight institution as its "control room" to monitor the regional infection rate during the phased reopening. This team of local elected officials, as well as hospital and state representatives, will monitor the above metrics and other key indicators, and can slow or shut off reopening if indicators are problematic. This team will also monitor business' compliance with reopening guidelines and ensure that local officials are enforcing these rules when necessary.

Phased Reopening of Business

Each region will reopen businesses in phases, with at least two weeks in between each phase. This allows state and local leaders to monitor the effects of the reopening and ensure hospitalization and infection rates are not increasing before moving to the next phase and permitting more economic activity.

The phase-in plan prioritizes businesses considered to have a greater economic impact and inherently low risks of infection for the workers and customers, followed by other businesses considered to have less economic impact, and those that present a higher risk of infection spread.

Additionally, when phasing-in reopenings, regions must not open attractions or businesses that would draw a large number of visitors from outside the local area.

Read about the four phases and see if your business is eligible to resume operations.

NY Forward Book

A guide to reopening New York and building back better.

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Hackney

Health in Hackney Scrutiny Commission 9th June 2020 **Minutes of the previous meeting and matters arising**	Item No **5**

OUTLINE

Attached please find the draft minutes of the meeting held on 12 February 2020.

Attached please find an aide-memoire of the informal virtual meeting of the Commission held on 30 March 2020.

MATTERS ARISING

Actions from 4 December meeting

Action at 7.3(b)

ACTION:	*(a) Connect Hackney to provide more granular detail on the latest outcomes data from the programme following the statistical analysis due end of Jan.*

This is awaited.

Actions from 29 January meeting

Action at 5.4 (d)

ACTION:	*Chief Executive of HUHFT to provide Members with a summary providing more financial detail on the other options considered in the Outline Business Case on the Pathology Partnership with Barts Health and Lewisham Trusts.*

This needs to be rescheduled.

Action at 5.8

ACTION:	*Chief Executive of HUHFT to report back to the Commission in c. 3 months on the response from ISS on the pay and conditions issues raised by them and on the possibility of the Trust making a formal commitment to becoming a London Living Wage employer.*

This needs to be scheduled.

Actions from 12 February meeting

Action at 5.3 (f)

ACTION:	*Director of Adult Services to provide further background and latest data on the waiting times for access to psychological therapies (IAPT)*

This was for the CCG not Adult Services. The Mental Health Programme Director from City and Hackney CCG has responded: "*My understanding is we have been expanding the service rapidly and marketing heavily. The success of our marketing led to an increase in demand which temporarily increased supply. However in Q4 we have recruited additional therapists".*

Action at 6.5

ACTION:	*MD of the CCG to bring a briefing on the constitution and governance of the new ICS for North East London and the implications for Hackney to the Commission at a date to be confirmed in summer 2020. This needs to take place before CCG Members cast a final vote on de-constituting the local CCG.*

This needs to be rescheduled.

ACTION

The Commission is requested to:

a) **agree the minutes of the meeting on 12 Feb**
b) **Note the matters arising above**
c) **Note the 'Notes on the informal virtual meeting on 30 March'**

Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Wednesday, 12th February 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 Yvonne Maxwell (Vice-Chair), Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	**Cllr Deniz Oguzkanli**
Officers In Attendance	**Simon Galczynski (Director - Adult Services), Dr Sandra Husbands (Director of Public Health), Ian Williams (Group Director of Finance and Corporate Resources), Sophie Jobson (Strategic Programmes, CACH) and Charlotte Taylor (Strategic Programmes Manager, CACH)**
Other People in Attendance	**David Maher (MD, City & Hackney Clinical Commissioning Group), John Makepeace (Member, Local Pharmaceutical Committee), Dr Nick Mann (Local Medical Committee Member and GP Well St Practice), Dr Mark Rickets (Chair, City and Hackney CCG), Sunil Thakker (Finance Director, City and Hackney CCG), Jon Williams (Director, Healthwatch Hackney) and Malcolm Alexander (Chair, Healthwatch and Public Involvement Association)**
Members of the Public	**6**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Oguzkanli and Anne Canning.

1.2 It was noted that John Makepeace was present for Kirit Shah from the Local Pharmaceutical Committee.

2 Urgent Items / Order of Business

2.1 There were no urgent items and the order of business was as on the agenda.

3 Declarations of Interest

3.1 Cllr Maxwell stated she was a member of the Council of Governors of HUHFT.

3.2 Cllr Snell stated he was chair of the board of trustees of the disability charity DABD UK.

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the draft minutes of the meeting held on 29 January 2020 and noted the matters arising.

RESOLVED:	**That the minutes of the meeting held on 29 January 2020 be agreed as a correct record and that matters arising be noted.**

5 Hackney Local Account of Adult Care Services 2019-20

5.1 Members gave consideration to the Hackney Local Account of Adult Care Services 2018/19. The Chair stated that the Commission considered this each year.

5.2 The Chair welcomed for this item:

Simon Galczynski (SG), Director Adult Services, CACH
Charlotte Taylor (CT), Strategic Programmes Manager, CACH
Sophie Jobson (SJ), Programme Manager, CACH

5.3 Officers took Members' through the report. They highlighted: that co-production is now central to their work; the work done on the campaign to tackle financial abuse; the work on direct payments; the work done on developing pages on autism for the website; the success in recruiting permanent work force and the development work being done in embedding best practice.

5.4 Members asked detailed questions and the following points were noted:

(a) Members asked where new cost savings could be made, considering the volume of savings already made. Ian Williams (Group Director, Finance and Corporate Resources) replied that savings were required from all quarters as they develop the next Medium Term Financial Strategy and news on the latest government funding settlement was awaited. Nationally the funding for both adult and children's social care and to tackle homelessness was a serious issue and after 10 years of austerity there was a need to look at budgets very closely. There was a strong commitment however within the Council to protect services for the most vulnerable.

(b) Further to 3.2 on p.18, Members asked officers to explain what "3 Conversations" was. CT explained that it was about putting the individual at the centre of a number of conversations and about providing support at the right time. The aim was to look at the positives in people's lives and how services can fit within this. The first conversation is focused on the individual's overall situation to assess the issues in their lives and to respond as necessary with

adaptations or telecare or support via the voluntary sector or personal support. The second conversation relates to those in crisis and focuses on how to respond differently if a person hits a crisis point. The third conversation relates to provision of long term support.

(c) Further to p.54, Members asked how the new Carers support service was working out. SG replied that the need to improve the quality of life of carers drove the development of the new model and after much work, the organisation 'Carers First' had been commissioned and the response to the new model had been very positive thus far. "Carers assessments" as they used to be termed were now completed by social workers under the new system.

(d) The Chair stated that at the January meeting the Unplanned Care Workstream, the Workstream Director in her report had stated that they had been dealing with a 27% increase in Delayed Transfers of Care which contradicted what was in this report. He asked whether the discrepancy was due to both looking at different timelines. He added that the Overall Financial Position report, which went to Scrutiny Panel, had referred to a near £3m cost pressure on care support commissioning. He asked whether the challenge was in securing a suitable location for them. SG replied that the discrepancy between the two reports had been because of different timelines. There had been an upturn over Dec-Jan but this had now started to turn around. He added that HUHFT was good at moving people through their services quickly but the struggle was in a lack of nursing home placements and delays by clients not wanting to move outside Hackney. Plans were in train to develop other care settings and they were also looking at more flexible use of the Home Care service so that volumes could go up and down more easily and so they can better respond to the surges which HUHFT predicts. The Chair asked whether they were looking for a location in Hackney like the previous facility in Median Rd where people could be supported locally. SG replied that they were looking closely are opportunities to support people in Hackney there was a need to plan more flexibly. Money spent to relieve short term pressures this year would not be available in the next. In addition needs were now more complex than they had been in the 90s when he had started his career as a social worker.

(e) Members asked about workforce pressures. SG replied that they were now nearly at the full complement of permanent staff. There had just been another round of recruitment in the Learning Disabilities Service. The Day Centre also now had more permanent staff. Housing with Care was recruiting an additional 10 to 12 and they were also looking closely at improving career paths for staff. On retention, they were working on developing the Apprenticeship in Social Work which would eventually lead to a degree.

(f) Further to p.59, Members asked about the continuing long waiting times for IAPT. SG undertook to provide further detail on the numbers. Jon Williams (Executive Director, Healthwatch) added that Healthwatch would be completing an 'Enter and view' of ELFT services and they also had concerns about IAPT waiting times. He also wanted to know how the CCG and the Neighbourhoods system would be working to better support carers and what practical steps they would be taking to listen to carers. Each Neighbourhood would have the data, they would know the clients who already have carers and so they would be in a position to do more to learn how to design support

around the carers. SG replied that carers were fully part of the Neighbourhoods model and these points would be taken on board.

ACTION:	**Director of Adult Services to provide further background and latest data on the waiting times for access to psychological therapies (IAPT)**

(g) A resident asked about whether any preference in employment could be given to residents of Hackney. SG replied that they recognised the value of having staff who worked in the borough and great progress had been made for example with the internships for local people with disabilities. A lot of work was going on in relation to Workforce and the key element was how to make it more attractive to potential employees as, for example, retail work. IW added that Members may have seen the recent adverts on the tube promoting working locally, which referred to 'commutable positions'.

5.4 The Chair thanked officers for another impressive annual report and stated that as well as the further detail on IAPT waiting times the Commission was interested, going forward, to see greater feedback from carers as well as progress on developing another setting in the borough which would help to reduce 'Delayed Tranfers of Care'.

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

6 An Integrated Care System for North East London

6.1 The Chair stated that he had asked for this item because the issue was now developing and that Jane Milligan the Chief Accountable Officer for ELHCP had provided some insights on this the previous nigth at INEL JHOSC. Members gave consideration to three briefing reports from the CCG.

6.2 The Chair welcomed to the meeting:

Dr Mark Rickets (MR)**,** Chair, City and Hackney CCG
David Maher (DM)**,** Managing Director, City & Hackney CCG
Sunil Thakker (ST)**,** Finance Director, City & Hackney CCG
Ian Williams (IW), Group Director Finance and Corporate Resources, LBH
Laura Sharpe (LS), CE of GP Confederation
Dr Nick Mann (NM), LMC representative

6.3 DM introduced the reports by running through the history of development of the STP and now the proposal for an Integrated Care System. The Long Term Plan had evolved from the devolution pilot of 2016 which was focused on getting better value from the local health resources. This had led to the creation of the ICB whose Workstreams were now well established. A further development from this was the new Neighbourhoods Framework, so City and Hackney had a well-articulated story of progress to report. The Long Term Plan acknowledged that everything City and Hackney had been doing up to now was what was needed. There was a need to reduce administration cost with 20% being a target figure. City and Hackney however had always underspent its budget. As thinking on the ICS developed the idea of having 3 subsystems had been accepted. These would comprise: BHR, WEL and C&H. One of the key areas of contention now is how to evolve from three systems

already in operation to a single overarching system with 3 sub-systems beneath it. Work was being done to define a 'Set of Asks' to the system on what C&H would want NEL to do. The obvious areas of specialised commissioning, maternity beds and mental health beds were best delivered across a bigger footprint. This set of Asks would also ask for more control and autonomy.

6.4 Members asked detailed questions and the following points were noted:

(a) The Chair asked what the timeline was for the effective handing over of power to a single CCG in April '21. Didn't all the CCGs have to agree to the proposal in their Governing Bodies during this summer? DM replied that it was about the distribution of power within the system not a 'handing over' and it was incorrect to view this as some kind of spectre. It was instead, he added, about having the power to shape a new system to benefit everyone in NEL. They were not using the term 'shadow' board either for the period from April '20 to April '21, instead there would be a steady planned transition from the 7 formal CCGs, which already operate in 3 systems in any case, to a single ICS which would provide strategic oversight as well as economies of scale. He reminded Members that the Joint Commissioning Committee of the ELHCP already existed to do some of this strategic commissioning and was already working. MR added that there had been agreement within NEL that powers will reside in place based systems and there will be safeguards. He also added that as a CCG they were already totally accountable to the same overarching body for everything, which is NHSE. The general principle was that everything goes on at the 'place based level' (usually borough level) unless and by exception it is best addressed at the NEL footprint level, which will be the ICS. Generally the aim was 80% at place based level and 20% at the ICS level. The current 5 year financial settlements would continue to flow down to 'place based' level. Overall these changes represent an evolution not a 'big bang'.

(b) A Member asked whether the new structures were driven less by the needs of the population and more by the needs of the big acute Trusts some of which are too big to fail and was there a danger City and Hackney could be dragged down financially by a need to bail them out in the future. DM replied that there wasn't and instead this was an opportunity to look at our NHS organisations and how they can work better together. The plan for a Provider Alliance will add leadership to the system not diminish it, he added. The Accountable Officer will be answerable to each CCG area also and within each area of course there will be a local election model to elect the Clinical Director within each CCG. They will sit on the ICB and the ELHCP Executive and the ICB has already appointed its first Chair, Marie Gabriel (previously Chair of ELFT). The idea of 'meetings in common' between each CCG and the ELHCP Board is being explored and the best of commissioning behaviours won't and can't be lost in the new system, he added.

(c) The Chair stated that what was in the briefing was all very laudable but it was general and aspirational. The Commission had yet to see a document on the constitutional and governance structure of the ICS. Was the 80:20 split in commissioning codified for example? These changes represented in his view a massive centralisation and there was an important need to see the plans codified in a governance document. MR replied that this will be ready in the summer when the full CCG Membership and then the Governing Body will be

asked to give views. Work on this had been accelerated and it was on the way, he had seen a working draft.

(d) The Chair asked about the 15% of commissioning activity which was already going through the NEL Joint Commissioning Committee. ST confirmed this figure and added that in relation to the ICS it needed to be worked out how the funding will be devolved to the three sub-systems and how reserves which are unspent will be used. The expectation was that an element will be held in the centre and part devolved down.

(e) A Member asked about the governance of joint Council and CCG commissioning. IW replied that S.75 agreements have gone through Cabinet for some years now and these type of arrangements will continue. He commented that the good relations between the Council and the CCG in City and Hackney were to be valued because this meant that the partners were in a good place to implement change as compared to other boroughs where this relationship is more adversarial. The task will be to keep and develop a constructive working relationship between the local NHS and the Council.

(f) A Member asked what the advantage was, if any, to the Council of these proposals. IW replied that the Council always supported greater integration for reasons of value for money. The Council has a role here in influencing the local NHS as it evolves to their mutual benefit. He added that there will be a need for this Commission to test these changes and a role for the Council to lobby hard to ensure that Hackney's interests are protected. A Member asked what the challenges would be. IW replied that it was in the ability to navigate the new structure effectively when there will be a single CFO for the whole NEL system.

(g) The Chair stated that C&HCCG had worked locally to help devise solutions for local residents but when, for example, City and Hackney's reserves go upwards to help balance the NEL budget then some local flexibility will be lost. IW replied that this was an obvious risk.

(h) Another Member added that he could not see how the new system could be better for Hackney as commissioning was being centralised. The CCG was locally accountable and if you centralise it you will lose local accountability, he added. He also expressed concern about the reference on p.72 about "less focus on contractual discussion and more on transformation and collective processes". He also had a general concern that as the commissioning function shrinks power would move to larger providers. DM replied that these changes to the contractual framework need to be looked at in the context of changing to a new wider NHS family of organisations. He explained how the HUHFT and ELFT and the GP Confederation (the main providers) already have Quality Review meetings with the CCG where the two sides are brought together to focus on quality rather than having separate groups looking at the same information. The focus would be on how we would do it differently if we worked more closely, he added. HUHFT is anchored in the borough, like the Town Hall, and why should commissioning sit remotely from that. This provides an opportunity. There has been 10 years now of the commissioner-provider split and it needed to be re-looked at. He added that we have integrated teams already working in the Workstreams. HUHFT and the GP Confederation were already doing work jointly on workforce development. He concluded that he felt

passionately that this change provided a valuable opportunity to do things differently with the local partners. MR added that the bulk of commissioning would remain locally and only by exception would it be elevated. He added that this would improve working practices as a lot of contractual issues currently get in the way. 80:20 wasn't an exact rule but an aspiration. 15% of commissioning was already being done at the JCC and the other 5% referred to commissioning flows out of City and Hackney e.g. to UCLH.

(i) A Member commented that getting rid of the commissioner-provider split was probably a good thing but the concern was that in doing so the NHS was not compensating for loss of local accountability. The tension created by the commissioner-provider split provided some accountability and so the answer has to be some kind of collective democratic accountability. DM stated he agreed with this and it illustrated for example the importance of Scrutiny Committees. He added that the ICB already provides some stringent oversight. The big debate on quality mattered at ICB and in the past HUHFT wasn't in the room for those because it was a provider. MR concurred stating this this was about bringing the conversations into one room. They key thing was not to lose these good commissioning behaviours. NHSE requires one CCG per STP area and there was a need to make the best of this. There are many advantages to the current system in C&H and it also helps the wider system out already year on year and it was to be expected that this would continue. Also the JCC makes unanimous decisions and there is a local safeguard there also.

(j) A Member commented that the handling of the recent measles outbreaks demonstrated the importance of having local autonomy as the local system was able to move fast with its own response. The key test of a new system would be whether we would still have the flexibility to do this in future.

(k) The Chair stated that his test would be, for example, whether the ICS Accountable Officer in six years' time could downgrade the Homerton. The question therefore is what safeguards are in place. While he accepted that the commissioner provider split had had its flaws City and Hackney was the author of its own success and this was not being acknowledged. There were a number of consequences which needed to be thought through. DM replied that over the past two years he would typically spend 2 days a week at NHSEL HQ defending C&H performance and this was unproductive there would be someone at ELHCP overseeing this in the new system. He added that he could not envisage a world where any logical argument could be made for merging the current A&E sites and that this power did not rest solely with the Accountable Officer of the ICS in any case.

(l) A member of the public stated that because the new system would be unified it could bring the standards up to that of the best and Whipps Cross could for example be brought up to the level of HUHFT. MR replied that the Clinical Senate across NEL already shares best practice as a matter of course. He clarified too that some patient pathways will continue to go outside the NEL system e.g. to UCLH as it does currently.

(m) A representative of Hackney Keep Our NHS Public commented that the key issue with the NEL system plan was that is solely a clinically led strategy. What residents want to protect is local provision of non-specialised services so that families and friends can visit locally.

(n) The Chair of the Healthwatch and Public Involvement Association commented that the issue of public voice and lay representation in the new structures was not clear and would need to be sorted. DM replied that City and Hackney had a high performing PPI Committee and in the new structure there was a proposal for a People and Places Committee to continue this important role. MR added that NEL was currently not as rich an environment for co-production than City and Hackney had been and this would need to change.

(o) The Chair commented that the recent history was that City and Hackney had more than its share taken by the NEL system and asked the Chief Exec of the GP Confederation how these new proposals would impact on them and how the impact might be minimised. LS replied that the first plus was that City and Hackney continued to be defined as a 'place' in the new structure and maintaining that was very important.

(p) LS stated that there were three ways in which the new system could be accountable in City and Hackney. Firstly in the delivery of the 'nuts and bolts' of the system where there was a record of successful delivery thus far. Then the revised Integrated Care Board would now have providers at the table hopefully making it more integrated and accountable. Finally for out of hospital delivery, the three key providers in the borough (HUHFT, ELFT and GP Confederation) would now formally work more closely to lock in delivery at Neighbourhoods level thus securing more local autonomy and integrated working. The net result of these actions should protect local funding and have a stronger case for keeping it local. The Provider Alliance needs to demonstrate how it will be accountable and Scrutiny had a role here. The Provider Alliance will also be able to hold the ICS itself to account. The key to it will be to lock in clinical and patient voices in the new system.

6.5 The Chair thanked the officers and stated that what was important now was to see the detail of the Governance and of the ICS before this was agreed by City and Hackney CCG Governing Body. DM cautioned that this needed to be debated first separately by the CCG Members (the local GPs) but they would of course be able to provide further details for the Commission. The Chair stated that the Commission would not accept receiving the plan as a *fait accompli* at the end of a process. He stated that these changes effectively meant nearly £500m per year going upwards to the ICS and the Commission would need to see the constitution and governance details and if this was not forthcoming then referral to the Secretary of State was always an option. He added that he would like the Commission to see the plans after the CCG had had their own deliberations but before they made any final vote on it. DM agreed but stated that they had statutory duties to their Members which took priority and it would be necessary to map out a possible timeline for this. The Chair asked when the deal would be done. DM replied that it was not a deal but an iterative process. CCG Members would have agree to de-constitute themselves and this would likely take place over the early summer so they might be in a position to come back in late summer. The Chair thanked the Chair and MD of the CCG for their continuing co-operation and engagement with the Commission and asked again if this issue could return before any final vote is made.

ACTION:	**MD of the CCG to bring a briefing on the constitution and governance of the new ICS for North East**

	London and the implications for Hackney to the Commission at a date to be confirmed in summer 2020. This needs to take place before CCG Members cast a final vote on de-constituting the local CCG.

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

7 Primary Care Networks service specifications - discussion

7.1 The Chair stated that Shirley Murgraff of Hackney KONP had raised this issue with the Commission. This related to NHSE's formal consultation on the service specification for the implementation of Primary Care Networks (PCNs) known in Hackney as the Neighbourhoods Model. Both KONP and HAPIA had had serious concerns about the lack of time which had been provided for the consultation which had run over the Christmas holiday period. Members gave consideration to Mrs Murgraff's request and to a letter which HAPIA had sent to Sir Simon Stevens expressing serious concerns about the engagement process.

7.2 The Chair stated that he did not want to get into a discussion of the consultation timings as the date had now passed but he asked Members to note both the original request to the Commission and the letter which Malcolm Alexander, the Chair of HAPIA, and also a Hackney resident, had sent to NHSE. He welcomed for this item:

Laura Sharpe (LS), Chief Executive, C&H GP Confederation
Dr Mark Rickets (MR), Chair, C&H CCG
Malcolm Alexander (MA), Chair, Healthwatch and Public Involvement Association (HAPIA)
Jon Williams (JW), Chair, Healthwatch Hackney
Dr Nick Mann (NM), member of Local Medical Committee

7.3 LS stated that she was very pleased that NHSE appeared to have listened to the concerns here and this was very good news. There had been a furore from various GP bodies and the GP Committee of the BMA had thrown out the proposals. In summary the new service specifications would have meant lot of extra work for GP Practices with very few new staff. She stated that the previous Friday the new GP Contract had just been signed between DoH and the BMA and this had contained significant improvements. There would be an increase in the range of staff PCNs could recruit with an average of 20-24 staff per PCN. Locally they would have 21 new staff across a range of roles. This represented a significant increase in GP support staffing. The previous proposal required local CCGs to provide 30% of the new staffing costs but they had backed down and now 100% would be funded nationally. The second major worry about the GP contract had been the very complicated and detailed proposed service specs which were supposed to start in April. These had been pulled and the revised specs were 2 pages instead of 20. There was also a lot in the new contract about GP mentoring and on support to long term locums etc and overall this package was very good news. Now PCNs had been put on a much better footing from the new financial year. As regards the role of the GP Confed locally on this, she stated that she would be meeting with 4 of the 8 neighbourhood directors the following day to begin the work.

7.4 MR stated that he too was very surprised by how things had turned out and was pleased that 100% of the new funding would be reimbursed nationally but he had yet to see what the actual figure would be. There was a need to think creatively about how to create a new workforce, he added. It was not right to 'steal' from areas like London Ambulance Service. Decisions would be made on where additional new resources could be directed, for example, into community nursing.

7.5 MA commented that the first NHSE consultation on the service specifications had been unlawful because proper public involvement had not been possible and that's why he had written to Sir Simon Stevens. LS clarified that consultations on the national GP contract have always between NHSE and GPs representative body the BMA and have never been consulted on publicly. This particular aspect on service specs for PCNs was a separate issue and in the end got dealt with by revising the GP Contract as it was being finalised.

7.6 NM stated that a lot had happened here in a very short space of time. The local LMC did not have time to formally discuss it. The LMC continued to have concerns however about how this would all play out in the detail such as re-introducing previously discredited metrics to measure performance on the PCNs. LS agreed that there were things in the contact which were still not totally clear.

7.7 A resident asked about use of apprenticeships for some of these ancillary roles and that the public was not aware of this. LS replied that with social prescribing there were ways to expand the workforce e.g. first contact physios and these changes would give local providers the ability to recruit locally and consider apprenticeships as appropriate.

7.8 The Chair thanked guests for their contributions.

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

8 Health in Hackney Scrutiny Commission- 2019/20 Work Programme

9.1 Members gave consideration to the updated work programme for the year.

RESOLVED:	**That the updated work programme for 2019/20 be noted.**

9 Any Other Business

9.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

Notes of a Virtual Meeting of Health in Hackney Scrutiny Commission on Monday 30 March 2020 at 19.00-20.00 hrs.

As this had to be an informal meeting, because a physical meeting could not take place, the Commission could not agree minutes or make decisions at this time. The purpose of the meeting was to receive verbal briefings from the Council and NHS partners on the evolving situation regarding the local response to the Covid-19 pandemic.

Participants:

Members of the Commission	Cllr Ben Hayhurst (Chair), Cllr Kofo David Cllr Deniz Oguzkanli Cllr Peter Snell Cllr Patrick Spence
Invited speakers from the council and partners	Catherine Pelley (Chief Nurse and Director of Governance, HUHFT) Dr Mark Rickets (Chair, City and Hackney CCG) David Maher (MD, City and Hackney CCG) Laura Sharpe (Chief Executive, C&H GP Confederation) Anne Canning (Group Director, CACH, LBH) Dr Sandra Husbands (Director of Public Health for City&H, LBH)
Other elected Members	Mayor Philip Glanville Deputy Mayor Anntoinnette Bramble (Cabinet Member) Cllr Christopher Kennedy (Cabinet Member) Cllr Caroline Selman (Cabinet Member) Cllr Carole Williams (Cabinet Member) Cllr Kam Adams (Speaker) Cllr M Can Ozsen Cllr Sophie Conway Cllr Margaret Gordon Cllr Caroline Woodley Cllr Richard Lufkin Cllr Jessica Webb Cllr Clare Potter Cllr Nick Sharman Cllr Penny Wrout Cllr Yvonne Maxwell Cllr Sade Etti
Other participants	Jon Williams (Healthwatch Hackney) Amanda Elliot (Healthwatch Hackney) Carol Ackroyd (Hackney Keep Our NHS Public) George Binette, (Union link Hackney North CLP) Maia Kirby (Hackney North CLP) Michael Vidal (Public Rep on Planned Care Workstream of Integrated Commissioning) Ed Sheridan (Reporter, Hackney Citizen) Ben Bradley (Head of Mayor's Office, LBH) Tracey Anderson (Head of Scrutiny and Ward Forums, LBH) Jarlath O'Connell (O&S Officer for HiH, LBH)

1. Apologies

1.1 There was an apology from Cllr Plouviez. The Chair thanked the senior NHS and Council officers who are at the frontline of managing the crisis for giving their time to check in to this virtual meeting.

2. Briefing from Homerton University Hospital NHS FT (Catherine Pelley)

2.1 Catherine Pelley (Chief Nurse and Director of Governance of HUHFT) gave a briefing and answered questions. The following these key points were noted:

a) Situation changing rapidly from day to day, whole focus of Trust mgt currently on Covid. 7-day Command Centre in place.
b) All Planned Care and outpatients' appointments now stopped only doing urgent work and attending to urgent cancer pathway patients.
c) Staff are being redeployed to Covid support. Key skills being identified and mapped to the highest demand. Returning medical students and student nurses being engaged.
d) ICU capacity extended from normal 8-10 beds to 27-28 beds. Also have Covid dedicated wards where there are non-intrusive treatments as well as intubation.
e) Plans being developed within the system for transfer as appropriate to NHS Nightingale at Excel once that opens in a few days.
f) Currently 12% of workforce not at work because they are either symptomatic or living with someone who is. Some staff may also need to be shielding and social distancing.
g) There are currently enough PPE supplies to cope, but they are waiting for more. PPE being provided to all frontline staff from cleaners to senior medics irrespective of employment type (internal, external, contractor) and across all settings. CP commented that public are walking the streets using masks etc which are not necessary and are draining supplies.
h) Also looking at future need for more equipment and they are looking at new staffing models.
i) At the ELHCP (STP) level there is a focus on staff testing and testing those living with staff.
j) All Covid costs are being tracked but funding is not stopping any activity that is needed.
k) Staff are working to support the implementation of NHS Nightingale
l) Additional staff are being sourced from all possible sources daily.
m) A significant increase in mortuary capacity will be needed by Easter and there will need to be a 6- or 7-fold increase.
n) There are issues on the need for additional waste capacity.
o) The demand for non Covid beds has dropped significantly as people are staying away.
p) On ventilators more will be needed and there is a national drive to secure more.
q) Lockdown is now in place at HUH as well as Barts Health hospitals and strict rules on entry, with few exceptions, are in place. This will benefit patients recovery.

3. Briefing from Children, Adults and Community Health (Anne Canning)

3.1 Anne Canning (Group Director, CACH, LBH) gave a briefing and answered questions and the following key points were noted:

a) Key issue for adult services was the urgent requirement to do swift discharge from the Homerton. On Friday they had been set the challenge of a 3-hr discharge for patients. 1 hr to get medication sorted and 2 hrs to get them to their destination. They would be discharged with an initial 7-day care package
b) They are working with local hotel chains such as Travelodge to provide capacity.
c) They were looking at voids in Housing with Care service and very rapidly over the weekend getting them cleaned up and ready to receive discharged patients.
d) Same issue with staffing as NHS, many staff themselves shielding or socially isolating and having symptoms or living with those who do, and this is impacting capability.
e) They trying to avail of every available property rather than saying they would need 10 beds today and 15 tomorrow, because they don't have the evidence to direct that yet. This is a considerable change and does mean for the service users that they don't have a choice in their discharge destination and in the past, they had, but that's how it is. The service users are sent off with a package depending on the pathway, then there's four weeks and a review. Normally in the past they reviewed early, but there isn't the time to do currently

f) They're working with LSE? on London wide data sharing on care worker capacity and on modelling demand. Rate of change not proportionate to growing demand.
g) Issues with the single number dial-in for residents. This is expected to be fully operational within 2 days.
h) Council working on getting food parcels to those who are house bound because of shielding.
i) Councils in London were also working with hotel chains to house street homeless who are not displaying symptoms. Work was being done on modelling capacity and hotels were being block booked. Everything was being repurposed and reprioritised.

4. Briefing from Director of Public Health (Dr Sandra Husbands)

4.1 Dr Sandra Husbands (Director of Public Health) gave a briefing and answered questions and the following points were noted:

a) Public Health was focused on supporting colleagues across the system in co-ordinating the response and helping them to understand and interpret the PHE guidance.
b) Lots of confusion re PPE and PH is trying to help colleagues on the system planning. Also looking closely at the number of cases and deaths.
c) In response to question on resources she replied that PH in City and Hackney was well resourced compared to others and was working well.
d) AC noted word of caution that there is no one day when the borough is expected to reach its peak. SH added that models won't give us that detail. They are just sophisticated estimates based on today's data and not able to fully factor in at any one time the mitigation measures being taken today. The current strategy everywhere is to flatten the peak, but this will also have the effect of prolonging the episode. Cases are doubling every 2 to 3 days. They were not expecting a peak in two or three weeks if this worked, but a plateau over a more prolonged period. It's going to be a bit of a long haul, and there is going to be an increase in cases, she added.
e) In response to question on training in use of PPE for non-medical professions SH stated that a tranche of training was directed at those outside of the medical professions. AC added that council staff got a large distribution of PPE the previous Friday and they now have a clear line into the CCG on this. Currently satisfied that those who need it have it although there is an issue around staff anxiety about the need for protective eye wear.

5. Briefing from City and Hackney CCG (Dr Mark Rickets and David Maher)

5.1 Dr Mark Rickets (Chair) and David Maher (MD) answered questions and the following points were noted:

a) In response to a question about patients waiting three times the normal time for prescriptions, MR stated that there was no shortage of medicines and the delays were caused by anxiety and stockpiling. GPs prescription protocols haven't been changed and they will not be prescribing larger quantities. The rush appears to be a now calming. Some medicines were temporarily in short supply such as some EOLC meds and some antibiotics and this had been escalated to NHSEL and they are pressing them on it. There is a shortage to over the counter paracetamol and there would be changes to how it is prescribed.
b) DM described the Operational Command Group which the local system (ELHCP) has put in place and which is led by Tracey Fletcher (CE of HUHFT). It is critical that there is a fully coordinated approach to patient discharges from acute hospitals.
c) At NHS Nightingale there will, of necessity, be a lower staff to patient ratio than in regular hospitals.

d) It is hoped that the lockdown and strict social distancing will ultimately lead to a reduction in the demand for beds.

6. Briefing from City and Hackney GP Confederation (Laura Sharpe)

6.1 Laura Sharpe (CE of GP Confed) answered questions and the following points were noted:

a) The Confederation phones each of the 39 GP Practice each morning to assess the situation and 4 Confed staff are providing full support. The Practices are coping at various levels. A few almost had to close because of staffing levels but recovered.
b) All GPs now on telephone and video consultations and bringing very few patients in.
c) A new set of clinical guidelines is being written.
d) Key development is the move to 3 Hot Hub Sites. These will separate out the suspected Covid patients from the regular patient cohort who would be seen in adjacent 'cold sites. A wall is currently being built down the middle of Lawson Practice.
e) The 3 Hot Hubs will be: Lawson Practice, John Scott Health Centre and Well St Surgery. They could see 960 patients at the height of the surge.
f) National guidance is for one Hot Hub per PCN (8 in Hackney) but locally they are starting with 3 to begin with.
g) MR added that many practices will want to continue to see their own patients if they can.
h) Bank holiday arrangements have been suspended.

7. General Questions

a) Members expressed concern that the level of testing is unacceptably low. MR explained the difference between antibody tests and antigen tests and explained that the former would be the most helpful once it could be rolled out.

b) The Chair asked about Contract Tracing. SH replied that this was not part of the immediate NHSE plan and there was a different epidemiological approach to stemming the tide here. One key issue with rolling out tests as a possible shortage of the re-agents which form part of the test. The current strategy with testing was to test the sickest so that this can inform the urgent treatment. The next priority is to ensure all health and social care staff are fully tested.

c) Cllr Snell stressed that it was important to have a volunteer hub that was functioning properly, and he would be pursuing some problems there had been with these with the relevant Council officers. LS clarified that the volunteers she was referring to were not community volunteers delivering food parcels and medication but rather GPs who were offering additional shifts as doctors to support the effort over and above their regular GP shifts.

d) Cllr David asked about support to mental health patients. CP stated that this would need to be responded to by ELFT.

Ends

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Hackney

Health in Hackney Scrutiny Commission 9th June 2020 **Election of Vice Chair and 3rd rep on INEL JHOSC**	Item No **6**

OUTLINE

Following her appointment as a Cabinet Adviser, Cllr Maxwell stepped down from the Commission. She was also Vice Chair of the Commission and was one of the 3 representatives on INEL JHOSC. The Commission is now asked to elect her replacements.

The Commission elects its own Chair and Vice Chair following nominations presented by the political groups.

The appointment of a replacement member to INEL JHOSC is also within the Commission's remit. INEL JHOSC next meets in a virtual meeting on 24 June 2020.

This current municipal year is effectively being extended until an AGM of Full Council can be held. Once it takes places the memberships of all the Committees will change and the newly appointed commission will be able to elect a new Chair and Vice Chair and appoint a new set of reps to INEL JHOSC.

The appointment to these positions therefore will run until the next AGM and serve to replace Cllr Maxwell.

ACTION

Members are asked to

a) **Elect a Vice Chair**
b) **Elect a 3rd person to join the Chair and Cllr Spence as the Hackney representatives on the Inner North East London Joint Health Overview and Scrutiny Committee**

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Hackney

Health in Hackney Scrutiny Commission 9th June 2020 **Work programme 2020/21**	Item No **7**

OUTLINE

Attached please find the first draft of the work programme for the Commission for the new municipal year. Also attached for information is last year's work programme.

Because of the lockdown disruption a number of items had to be cancelled or postponed because other work has taken priority and because of the pressures generally on officers in health and social care. The work programme is being completely re-drawn in the light of this and pressure on agenda time as a result of slower and shorter virtual meetings.

ACTION

The Commission is requested to note the updated work programme for 2020/21.

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Health in Hackney Scrutiny Commission

Future Work Programme: June 2020 – April 2021 (as at 1 June '20)

All meetings will take place online until further notice and will be livestreamed via YouTube.

This is a working document and subject to change

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Tue 9 June 2020 Papers deadline: 31 May	Dr Sandra Husbands Prof Kevin Fenton Prof Anthony Costello Prof Allyson Pollock Dr Amanda Healy	Dir of Public Health PHE-NHSE L Independent SAGE Univ Newcastle DPH Durham County Council	**Covid-19 Response – DISCUSSION PANEL ON What can local authorities do to mitigate the spread in their areas?**	What space is there for local health partners to supplement or backfill the national government strategies. What are we allowed to do Can we publish own data How will contract tracing systems play out locally
THESE ITEMS WILL BE RESCHEDULED				
		All Members	**Election of Chair and Vice Chair for 202/21 and appointments to INEL JHOSC**	To Elect the Chair and Vice Chair for 2020/21 To appoint 3 Members to the INEL JHOSC Cttee for 2020/21 To be postpone until after the rescheduled AGM. Until then current memberships stand.
	Public Health SPED HUHFT CCG GP Confed		**Covid 19 Response – Disproportionate impact on BME communities**	Input from Council's Public Health and SPED depts, HUHFT etc

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	CCG ELHCP KONP		**Covid 19 Response – An Integrated Care System for NEL and role for local authorities**	Follow up from Feb meeting and in response to increased concerns from KONP and others on the press reports that NHSE is speeding up plans for implementing ICSs in full
Postponed from March	King's College London	Dr Ian Mudway (expert on air quality)	**Air Quality – health impacts: briefing from expert.**	Briefing from external expert on health impacts of poor Air Quality
Postponed from March	Public Health Consultant Environment Services Strategy Team	Damani Goldstein Sam Kirk	**Air Quality – health impacts: update on Hackney's Air Quality Action Plan**	Briefing from Public Health on the implementation of the Actions to reduce the health impacts of air quality in Hackney's own *Air Quality Action Plan 2015-2019*
Postponed from 1 May	**SCRUTINY IN A DAY**	*Public Health Environmental Health*	*Health Inequalities – Marmot 10 Years On*	*Scrutiny in Day Session*
Postponed from March	Public Health (Sport England Project) Public Realm	Lola Akindoyin Aled Richards	**Sport England project in King's Park ward**	Briefing on the programme of the Sport England funded project.
	LBH/CoL/CCG Planned Care Workstream	Siobhan Harper, Workstream Director Andrew Carter, SRO	**ICB - PLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams. To also include an update on the **Housing First** pilot.
	HUHFT	Tracey Fletcher, CE	**Industrial dispute at HUHFT re soft facilities contractor ISS**	Update on pay dispute at HUHFT relating to ISiS the soft facilities contractor. Three month follow up requested at the meeting on 29 Jan.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	LBH/CoL/Prevention Workstream	Anne Canning SRO Jayne Taylor Workstream Director	**Integrated commissioning PREVENTION Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	GP Confed Integrated Commissioning	Laura Sharpe Nina Griffith	**Neighbourhoods Development Programme**	Follow up on item at July 2019
LIKELY DELAYED/ NOT HAPPENING Letter for Noting Only	HUHFT		**HUHFT Draft Quality Account 2019/20**	Trust's Quality Account has to be submitted to local scrutiny cttee before submission to NHSE/NHSI
LIKELY DELAYED/ NOT HAPPENING Letter for Noting Only	St Joseph's		**St Joseph's Hospice draft Quality Account**	Trust's Quality Account has to be submitted to local scrutiny cttee before submission to NHSE/NHSI
INEL JHOSC Wed 24 June 2020 Virtual Meeting	*TBC*		***TBC***	
Thu 9 July 2020 Papers deadline: 30 June				

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
POSTPONED Possible separate engagement event hosted by the Commission	LBH CCG HUHFT ELFT Healthwatch	Tim Shields/ Ian Williams/ Anne Canning David Maher Tracey Fletcher Dr Navina Evans Jon Williams	**Options for future use of St Leonard's site**	Scrutiny will host an engagement event with the senior officers from the relevant stakeholders and the Cabinet Members to discuss the emerging plans for the St Leonard's Site.
Wed 23 Sept 2020 Papers deadline:				
INEL JHOSC Wed 30 Sept 2020				
Mon 12 Oct 2020 Papers deadline:				
Joint with Members of CYP Scrutiny Commission	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director Anne Canning, SRO	**Update on Integrated Commissioning – CYPM Workstream**	Series of updates from each of the Integrated Commissioning Workstreams

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Wed 18 Nov 2020 Papers deadline:				
			REVIEW: Digital first primary care and the implications for GP practices	12 month update on implementation of the recommendations of the Commission's review, agreed in Nov 2019
INEL JHOSC Wed 25 Nov 2020				
Thu 28 Jan 2021 Papers deadline:				
	Eugene Jones Dan Burningham Jon Williams	ELFT CCG Helathwatch	**Update on impact of consolidation of dementia and challenging behaviour in-patient wards at East Ham Care Centre**	Follow up from meeting on 29 Jan 2020 mtg including focus on the uptake of the transport offer to families and friends of the patients moved from Thames House Ward at Mile End Hospital..
	LBH/CoL/CCG Unplanned Care Workstream	Nina Griffith Workstream Director Tracey Fletcher, SRO	**Integrated commissioning – UNPLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
INEL JHOSC Feb 2021 Date tbc				
Tue 23 Feb 2021 Papers deadline:				
Wed 31 March 2021 Papers deadline:	LBH/CoL/CCG Planned Care Workstream	Siobhan Harper, Workstream Director Andrew Carter, SRO	**ICB - PLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams. To also include an update on the **Housing First** pilot.
			Work Programme discussion for 2021/22	

Items agreed but yet to be scheduled

July TBC			**New Integrated Care System for North East London Borough of Hackney**	Follow up from 12 Feb meeting.
To be rescheduled as Response has been delayed at request of Cabinet Member	LBH CCG GP Confed ELHCP	Mayor and or new Cabinet Member	**Executive Response to REVIEW on 'Digital first primary care and the**	To note the Executive Response – if available…

			implications for GP Practices"	
To be scheduled		New Cabinet Member	**Cabinet Member Question Time**	Postponed from December 2019
To be scheduled	Adult Services	Ann McGale Penny Heron Tessa Cole Anne Canning	**Integrated Learning Disabilities Service**	Update on development of the new model
To be scheduled		Sonia Khan Soraya Zahid	**Implementation of Ageing Well Strategy (focus on community transport for elderly)**	To focus on "You Said, We Did". Follow up from Dec mtg. Specific update on community transport for elderly requested.
To be scheduled	Public Health Adult Commissioning Network providers	Anne Canning Dr Nicole Klynman Gareth Wall	**City & Hackney Wellbeing Network**	To receive update on the revised model for the Wellbeing Network being put in place following an evaluation report.
To be scheduled	Adult Services Oxford Brookes University researcher Camden Council rep	Gareth Wall and Simon Galczynski	**Market Making in Adult Social Care**	Report on Adult Services Market Position Statement and benchmarking on how to develop the local market for social care providers.
To be scheduled			**How health and care transformation plans consider transport impacts?**	Suggestion from Cllr Snell. Possible review/item to understand how much Transformation Programmes take transport impacts for patients and families into consideration and whether these can be improved.
To be scheduled			**Implications for families of genetic testing**	Suggestion from Cllr Snell. Briefing on impact on families of new technologies such as genetic testing.

To be scheduled			**Accessible transport issues for elderly residents**	Suggestion from Cllr Snell after Dec mtg.
To be scheduled			**What does governance look like at the Neighbourhood level?**	Suggestion from Jonathan McShane at Dec mtg

Health in Hackney Scrutiny Commission

Future Work Programme: June 2019 – April 2020 (as at 1 June 2020)

All meetings will take place in Hackney Town Hall, unless stated otherwise on the agenda.

This is a working document and subject to change

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Thu 13 June 2019 Papers deadline: 3 June		Jarlath O'Connell	**Election of Chair and Vice Chair for 2018/19**	
	Legal & Democratic Services	Dawn Carter McDonald	**Appointment of reps to INEL JHOSC**	To appoint 3 reps for the year.
	St Joseph's Hospice	Tony Mclean Jane Naismith	**Response to Quality Account for St Joseph's Hospice**	To comment on the draft Quality Accounts for 2018/19 from the local NHS Services who request them.
	HUHFT	Catherine Pelley	**Response to Quality Account for HUHFT**	Discussion with Chief Nurse of HUH issues raised in the Commission's annual Quality Account letter to the Trust.
	HUHFT Hackney Migrant Centre	Catherine Pelley Rayah Feldman/ Mamie Joyce	**Overseas Visitors Charging Regulations**	To consider response received from Baroness Blackwood (Health Minister) to Commission's letter.
	NELCA CCG	Alison Glynn, NELCA Siobhan Harper, Workstream Director Planned Care Dr Nikhil Katyiar (C&HCCG GB) David Maher, CCG	**Consultation on 'Aligning Commissioning Policies' across NE London**	NELCA is consulting on 'Aligning Commissioning Policies' across the NEL patch. It closes on 5 July. INEL will take this forward but the Chair has invited the CCG and NELCA to brief the Commission on these changes to eligibility for certain procedures which will no longer be routinely offered by NHS.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	All Members		**Work Programme for 2019/20**	To consider work programme suggestions received from stakeholders, Cabinet, Corporate Directors and others and to AGREE an outline work programme for the year to be sent to Scrutiny Panel's 18 July meeting for comment
Wed 10 July 2019 Papers deadline: 1 July	LBH/CoL/Prevention Workstream	Anne Canning SRO Jayne Taylor Workstream Director	**Integrated commissioning – PREVENTION Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	Unplanned Care Workstream GP Confederation	Nina Griffith Laura Sharpe	**City & Hackney Neighbourhoods Development Programme**	Update requested at July 2018 meeting.
	Healthwatch Hackney	Jon Williams Rupert Tyson	**Healthwatch Hackney Annual Report**	To consider the annual report of Healthwatch Hackney
		Jarlath O'Connell	**REVIEW on 'Digital first primary care….'**	Recommendations discussion
Thu 12 Sept 2019 Papers deadline: 2 Sept		Jarlath O'Connell	**REVIEW on Digital first primary care and implications for GP Practices**	Consider draft report.
	C&H CCG	David Maher Nina Griffith Dr Mark Rickets	**The NHS Long Term Plan – draft C&H submission**	To consider a draft of the C&HCCG's formal response to NHSE on The NHS Long Term plan to be submitted by 27 Sept. This is a key consultation on the future shape of the NHS.
	C&H CCG	Dr Mark Rickets David Maher	**Future of NEL CCGs**	Update from CCG on suggestions that there needs to be a public consultation on plans to merge CCGs as part of the

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Hackney KONP	Dr Nick Mann Nick Bailey		national development of ICSs and implementation of the NHS Long Term Plan.
	Chair of CHSAB Adult Services	Anne Canning Simon Galczynski John Binding	**Annual Report of City & Hackney Safeguarding Adults Board**	Annual review of SAB work. Annual item. Apologies from Dr Adi Cooper (CHSAB Chair) so presented by Anne Canning
	ASC Unplanned Care Workstream	Simon Galczynski Nina Griffith	**Intermediate Care Beds**	Follow up from suggestion at March 2019.
INEL JHOSC Thu 19 Sept 2019 at 19.00 hrs at Old Town Hall Stratford	*ELHCP/NELCA*	*Various*	***Moorfields Eye Hospital Relocation NHS LTP – NEL response Waltham Forest joining INEL Redbridge observer status Revised ToR and Protocols***	Update from AO of ELHCP Early Diagnostic Centre for Cancer at Mile End Hospital Update on implementation of new Non- Emergency Patient Transport system (to Barts Health sites) Work of the new **INEL System Transformation Board** Aligning Commissioning Priorities summary of response to the consultation
Mon 4 Nov 2019 Papers deadline: Thu 23 Oct	Public Health LMC	Dr Sandra Husbands Dr Andy Liggins Shivanghi Mehdi Dr Fiona Sanders (LMC Chair) Dr Nick Mann	**Sexual and Reproductive Health Services in GP Practices**	Request from LMC to examine the impact of this on primary care.
Joint with Members of CYP Scrutiny Commission	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director Anne Canning, SRO	**Update on Integrated Commissioning – CYPM Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	ELFT CCG	Eugene Jones Dan Burningham	**Consolidating dementia and challenging behaviour in-patient wards – proposal from ELFT**	A proposal involving 2 inpatient wards within East London NHS Foundation Trust by consolidating Thames Ward (Mile End Hospital) within Sally Sherman Ward (East Ham Care Centre).

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Adult Services Healthwatch Hackney	Simon Galczynski Ilona Sarulakis Jon Williams	**'Housing with Care' Improvement Plan – update**	Updates from both Adult Services and Healthwatch Hackney 8 months on about implementing the Action Plan from CQC inspection of the Housing with Care service. Re-inspection by CQC took place in July. This moved from Sept.
		Jarlath O'Connell	**REVIEW on Digital first primary care…**	Agree FINAL report. Also considered at Sept mtg.
6 Nov 2019 at 19.00 hrs <u>At East Ham Town Hall</u>	***JOINT WITH Members of the Outer North East London (ONEL) JHOSC***	*ELHCP Moorfields Eye Hospital*	***Relocation of Moorfields Hospital issues from consultation***	Annual joint meeting with the Outer North East London JHOSC (Barking & Dagenham, Havering Redbridge) covering items relevant to both JHOSCs. Item on NHS Long Term Plan – the NEL response pulled by ELHCP because of purdah rules.
Wed 4 Dec 2019 Papers deadline: 22 Nov	Integrated Commissioning Planned Care Workstream	Siobhan Harper Jonathan McShane	**Neighbourhood Health and Care - redesigning Community Services**	Suggestions from Cabinet Member and from CCG Outline briefing. Will require more detailed follow up items.
	Policy Team	Sonia Khan Soraya Zahid	**Development of Hackney's Ageing Well Strategy**	Input to the development of this key new strategy being developed by the Council
	Connect Hackney	Tony Wong	**Legacy plan for Connect Hackney**	Briefing and discussion on how the legacy of Connect Hackney, which ends in |March 2021 could be taken forward.
	Adult Services	Gareth Wall	**Assistive Technology in social care**	Suggested by Adult Services To explore potential demand and hear about the small pilots taking place and the plans to recommission telecare service.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
INEL JHOSC Mon 27 Jan 2020 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Various*	• Cancer Diagnostic Hub • Overseas Patients and charging (withdrawn)	*Postponed from 29 November because of purdah.*
Wed 29 Jan 2020 Papers deadline: 17 Jan	ELFT CCG	Eugene Jones Dr Waleed Fawzi Dan Burningham	**Consolidating dementia and challenging behaviour in-patient wards**	Follow on from Nov meeting. Revised proposals involving two inpatient wards within East London NHS Foundation Trust by consolidating Thames Ward (Mile End Hospital) within Sally Sherman Ward (East Ham Care Centre). Members going on site visits on 24 Jan.
	ELFT	Dr Priscilla Kent Nichola Gardner Dean Henderson	**Community Mental Health Transformation Pilot**	NHSE has awarded ELFT funding to undertake a radical redesign of community mental health services arising from the national Community Mental Health Framework for Adults and Older Adults
	LBH/CoL/CCG Unplanned Care Workstream	Nina Griffith Workstream Director Tracey Fletcher, SRO	**Integrated commissioning – UNPLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
		Tracey Fletcher, CE	**Update from Homerton University Hospital NHS Foundation Trust**	Updates requested from CE on the announcement about the new Pathology Partnership and on the outcome of the recent wage dispute.
Joint INEL and ONEL JHOSCs Tue 11 Feb 2020 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Various*	• NHS Long Term Plan • Pathology Services across NEl	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Wed 12 Feb 2020 Papers deadline: 31 Jan	CCG LBH	David Maher, CCG Sunil Thakker, CCG Ian Williams	**An Integrated Care System for North East London**	Update from C&H CCG focusing on Hackney impacts.
	Adult Services	Simon Galczynski Sophie Jobson	**Hackney Local Account of Adult Care Services 2019/20**	Annual item on publication of the Local Account of Adult Services
	GP Confederation CCG LMC Keep Our NHS Public	Laura Sharpe David Maher Dr Fiona Sanders Shirley Murgraff	**Primary Care Networks – national service specifications: discussion**	Concerns regarding rushed consultation over Christmas period by NHSE on the service specification for the Primary Care Networks – known in Hackney as the Neighbourhoods Programme – and the implications for Hackney.
Mon 30 Mar 2020 Papers deadline: 18 Mar **CHANGED TO INFORMAL VIRTUAL MEETING and previous announced items all postponed.**	CCG HUHFT CACH Public Health GP Confed	David Maher Catherine Pelley Anne Canning Dr Sandra Husbands Laura Sharpe	**Borough preparedness for Coronavirus**	This meeting had to be changed to an informal one because until the legislation was changed all formal committees had to be physical. Once the new law came into force formal virtual meetings were then scheduled with the first onc for HIH taking place on 9 June 2020.

The Scrutiny in Day session which had been scheduled for 1 May was also cancelled.

Please note the Mayor of London and London Assembly elections which had been scheduled for Thu 7 May 2020 will now take place in May 2021 due to the pandemic. The election purdah had been due to run from last week in March.

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