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

Thursday, 9th July, 2020

7.00 pm

Until further notice, all Council meetings will be held remotely. This meeting will be livestreamed on YouTube at https://youtu.be/zA21cOIB-NQ

Contact:
Jarlath O'Connell
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✉ jarlath.oconnell@hackney.gov.uk

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 Cllr Kofo David**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**Apologies for Absence (19.00)**	
2	**Urgent Items / Order of Business (19.00)**	
3	**Declarations of Interest (19.01)**	
4	**Homerton Hospital and its contract for soft services (19.02)**	(Pages 1 - 10)
5	**City & Hackney Restoration and Recovery Plan post Covid-19 (19.30)**	(Pages 11 - 38)
6	**An Integrated Care System for North East London update (20.00)**	(Pages 39 - 40)
7	**Covid-19 response: Test, Trace and Isolate in Hackney update (20.20)**	(Pages 41 - 42)

Hackney

8 Election of Vice Chair (20.40) (Pages 43 - 44)

9 Minutes of the Previous Meeting (20.41) (Pages 45 - 58)

10 Health in Hackney Scrutiny Commission- 2020/21 Work Programme (20.42) (Pages 59 - 68)

11 Any Other Business (20.44)

Access and Information

This meeting will take place online and can be viewed on the Council's YouTube Channel at https://youtu.be/zA21cOIB-NQ

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app') http://www.hackney.gov.uk/individual-scrutiny-commissions-health-in-hackney.htm

Public Involvement and Recording

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at http://www.hackney.gov.uk/l-gm-constitution.htm or by contacting Governance Services (020 8356 3503)

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The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

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If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease and all recording equipment must be removed from the meeting room. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

Hackney

Health in Hackney Scrutiny Commission 9th July 2020 **Homerton Hospital and its contract for 'soft facilities' services**	Item No **4**

PURPOSE OF ITEM

To discuss with HUHFT and with representatives of the union concerns brought to the Commission's attention about the broader implications of the extension of the soft services contract at the Trust.

OUTLINE

At its meeting on 29 January 2020 the Commission discussed an employment dispute which had been taking place at Homerton University Hospital NHS Foundation Trust (HUHFT) with the Chief Executive. This issue had arisen because of concerns by residents, UNISON and Members about the pay and conditions of staff who work in catering, cleaning, security and portering functions, collectively known as "soft services", at Homerton Hospital and who are employed by a sub-contractor called ISS.

The minutes of that item are here and the relevant section begins at item 5.5
http://mginternet.hackney.gov.uk/mgAi.aspx?ID=35921

Following the discussion the Chief Executive undertook to report back as follows:

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.**

Since then the Commission learnt that the Board of HUHFT had announced its intention to renew its contract with ISS on 30 June for a period of 5 years and HUHFT UNISON, in a letter to the Commission on 8 June, has raised their concerns, as have others. Critics of the decision have complained about its haste and a lack of, what they see, as a proper consultation.

In response the Chair wrote to HUHFT requesting that the decision to renew the contract be postponed subject to further consultation. The Chief Executive has responded.

Attached please find:

1) Letter from UNISON to the Commission dated 8 June
2) Letter from the Chair to the Chief Executive of HUHFT dated 15 June
3) Response from Chief Executive of HUHFT dated 26 June

The purpose of the item is to hear from both sides on the current status of this issue and about possible next steps.

The Covid-19 crisis has brought another dimension to the issue it that it has highlighted the vulnerability of frontline support staff in the NHS particularly those from ethnic minority backgrounds, who make up the majority of support staff, and who are disproportionately affected by the virus.

The Chair has invited the following for this item:

Tracey Fletcher, Chief Executive, HUHFT
Lorna Solomon, Homerton UNISON

ACTION

Members are asked to give consideration to issue and make any recommendations as necessary.

Homerton Hospital
c/o Staffside Office, Education Centre
Homerton Hospital
Homerton Row
London
E9 6SR

8th June

Councillor Ben Hayhurst
c/o Member Services
Town Hall
Mare Street
London
E8 1EA

Dear Ben

RE: Homerton Hospital award of 5-year extension to ISS for soft facilities services

We are writing from Homerton UNISON branch to raise our concerns about the news that Homerton Hospital NHS Foundation Trust has announced its intention to sign a further 5-year contract with facilities services company ISS. The Trust has issued a Voluntary Ex-Ante Transparency (VEAT) Notice to directly award the contract without a tendering process. We have been told that the contract will be signed on 30th June 2020.

As you are aware ISS have been running catering, cleaning, security and portering services at Homerton Hospital since 1st October 2015.

Homerton UNISON along with the GMB have made representations to the Trust on many occasions and in a number of ways with regard to the pay and conditions of this group of workers and with a request that the Trust enter a formal review of bringing the services back in-house.

However, there has been no formal consultation to date with the UNISON branch at the Hospital, with the UNISON representatives of ISS or the staff who work for this company. Both the UNISON branch at the Hospital and the GMB union were shocked at the news. At no stage were we, as recognised unions, given any indication that a 5-year extension was possible. In short there has not been consultation on this very significant decision.

We are also concerned that the extension of outsourced contracts for such a lengthy period without a competitive tendering process is a worrying sign in the context of the Covid-19 crisis, and the Commission should be concerned that the pandemic should not provide a cloak for continued or even accelerating privatisation within the NHS.

We are therefore asking you in your capacity as Chair of the Health in Hackney Scrutiny Commission to intervene with the limited authority at your disposal to urge the Trust to pause this process to allow a genuine consultation with all stakeholders to take place.

In the formal notification of this decision which we received on 03/06/20, Homerton Chief Executive Tracey Fletcher notes that "*during the pandemic the entire team of porters, security guards, cleaners and catering staff haves stood alongside the teams at Homerton to ensure all our patients have continued to receive care of the highest quality during this pandemic"*. She states that she is *"grateful to each and every one of them"*.

These workers have been critical to providing services during the pandemic. Further, they are critical to providing safe patient care at all times in the NHS, which is why our demand is for them to be treated equally with other directly employed NHS workers and so to receive the same terms and conditions.

It should be noted that the decision to renew the contract will have a disproportionate and detrimental impact on a predominantly minority ethnic workforce who will be subjected to worse pay, terms and conditions than their NHS colleagues for a further 5-years at least.

We are grateful to the Commission for having raised their concerns about the terms and conditions of the workers under this contract at its meeting in February. While there was discussion at that meeting about a one or two-year extension (Tracey Fletcher stating that in her opinion there was not sufficient time to look at an in-house option by this date), there was no indication that the Trust Board were considering a 5-year extension.

In addition to the Health in Hackney Scrutiny Commission writing to the Trust to ask them to pause the process to allow consultation to take place, we would be grateful if the matter could be put on any other business at the meeting on Tuesday 9 June. We appreciate that this meeting will be mostly taken up by the important panel discussion on Test, Trace and Isolate in Hackney. However, if there is time at the end, we would be grateful if it could be discussed.

We hope that you are able to assist us in this. If we can provide any further information, please do not hesitate to contact me on lorna.solomon@nhs.net.

Yours sincerely

Lorna Solomon
Homerton UNISON

CC:
Councillor Peter Snell
Councillor Deniz Oguzkanli
Councillor Emma Plouviez
Councillor Patrick Spence
Councillor Kofo David
Jarlath O'Connell.(Support Officer)

Health in Hackney Scrutiny Commission
Hackney Council
Room 118
Town Hall
Mare St E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

15 June 2020

Ms Tracey Fletcher
Chief Executive
Homerton University Hospital NHS Foundation Trust
by email

Dear Tracey

HUHFT award of 5 year contract extension to ISS for soft facility services

I am writing on behalf of the Commission to express serious concern that Homerton University Hospital NHS Foundation Trust (HUHFT) has announced its intention to sign a further 5-year contract with the facilities services company ISS, despite a number of issues apparently not having being resolved, and that you've issued a 'Voluntary Ex-Ante Transparency Notice' to directly award the contract to ISS without a tendering process. We also understand the contract will be signed on 30th June. This contract relates to provision of catering, clearing, security and portering.

As you know we discussed the matter in some detail with you and staff representatives at our meeting on 29 January (link here), when you kindly undertook 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*".

Since then the Covid-19 pandemic has intervened and made this issue, if anything, more complex. We have the following concerns

a) According to UNISON there has been no formal consultation with them or the GMB with regard to pay and conditions despite their attempts to request that the Trust enter a formal review of bringing the services back in-house. They also report being shocked that at no stage in the discussions was the intention to offer ISS a 5 year extension raised. Indeed at our meeting on 29 January there was mention of 1-2 year extension because of the difficulties of bringing such a complex range of services in-house but there was no indication that a 5 year extension was being contemplated.

b) There is a broader concern with respect to the extension of outsourced contracts for such a lengthy period without a competitive tendering process.

c) There is concern whether the new contract will incorporate substantial improvements in pay, terms and conditions for the outsourced staff, leaving a substantial gap between these workers and directly employed NHS staff in comparable roles on full Agenda for Change contract. Since the pandemic began much has been made by HUHFT senior management of the critical role that these support staff also play in providing safe patient care, which is further reason for them to be treated equally with other directly employed NHS workers and to receive the same pay and conditions.

d) Crucially, there does not appear to be any provision for occupational sick pay for all those employed on the ISS contract (a significant minority of those staff TUPE'd from Medirest in 2015 retained occupational sick pay and they have apparently been asked to move on to the basic ISS employment contract). Occupational sick pay is clearly crucial in supporting infection control, especially given the prospects of a 'second wave' of the novel coronavirus and future outbreaks of highly communicable diseases. The risk is clear - low paid hospital staff, some with precarious work contracts, choosing to continue to go to work when ill because they cannot afford not to and because their sick leave provision is inadequate.

e) You will be well aware of all the reports (including the recent one from PHE) about the disparities in impact of Covid-19 on frontline staff and in particular support staff from ethnic minorities. UNISON has pointed out that should this contract be renewed it will have a detrimental impact on the predominantly ethnic minority workforce who are affected by this contract extension, and it will also risk locking in these disparities for another five years. Have the equality implications been assessed of continuing this contract for a further 5 years?

We therefore urgently ask:

(i) that the plan to proceed with signing this on 30 June is paused to allow a proper consultation to take place;

(ii) that if an interim contract or extension is required (because the current one is coming to expiry), that this be as short as possible and addresses the disparity with respect to occupational sick pay or leaves open scope for this to be done – particularly given the public health concerns as set out above

(iii) that you might attend our next meeting on **Thu 9 July at 7.00** pm to discuss the matter

I look forward to hearing from you.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Mayor Philip Glanville
Diane Abbott MP
Meg Hillier MP
Cllr Christopher Kennedy, Cabinet Member for Health, Adult Social Care and Leisure
Members of Health in Hackney Scrutiny Commission
Dr Sandra Husbands, Director of Public Health, Hackney and City of London
Jon Williams, Director, Healthwatch Hackney

Homerton University Hospital
NHS Foundation Trust

Homerton University Hospital
Trust Offices
Homerton Row
London
E9 6SR

Tel: 020 8510 7144
Fax: 020 8510 7608
www.homerton.nhs.uk

Councillor Ben Hayhurst
Chair
Health in Hackney Scrutiny Committee
Hackney Council
Room 118, Town Hall
Mare Street
E8 1EA

26th June 2020

Dear Councillor Hayhurst

Re Soft facilities services – Homerton University Hospital NHS Foundation Trust

I am writing in response to your letter to update you on the Trust's approach to the continuing provision of the soft facilities (cleaning, catering, portering, security etc.) within the acute site and Mary Seacole Nursing Home and regarding the Trust's intention to sign a five year contract with ISS.

First, I wish to make clear that the role that ISS and their staff have played in recent months during the COVID19 pandemic has been significant and is fully recognised and acknowledged. They have undoubtedly played a key role in our overall response to this pandemic and one which has contributed to keeping our patients and staff as safe as possible.

ISS and the team on site have provided a high quality service supporting our hospital and nursing home services throughout recent years. Cleanliness standards in the hospital are very good and catering services to patients and staff have been working well. We have a dedicated portering and security service supporting all aspects of our operation and crucially supporting the delivery of patient services at the Trust. In considering future arrangements we have therefore wanted to ensure that any new contract with ISS is virtually like-for-like – there are no changes to the services that will be delivered and certainly no diminishing of services. It is also worth noting that a number of the services we provide for patients through this contract are much better than in many other NHS Trusts – for example our inpatients have the option of two or three hot meals per day, breakfast (porridge), lunch and dinner whereas other Trusts now only provide one hot meal, usually in the evening. While there have been a small number of changes to certain contractual mechanisms, these are all designed to ensure the partnership between Homerton and ISS continues to develop and secures stability for the Trust, and importantly for the services it provides to patients.

This stability and continuity will be crucial at a time when our energies will be required to be also focussed on the gradual but steady return of services to pre-emergency levels, whilst mindful of having to adapt to any re-emergence of coronavirus in our communities. Additionally, it is still expected that the UK will leave the transition period following departure from the European Union (EU) at the end of this year and the lack of clarity around the arrangements of this departure adds to the uncertainty around services such as these. The primary rationale for the decision we have taken is about patient safety and ensuring the most stable position for Soft Facilities Management services during these incredibly uncertain times.

We have been involved in ongoing dialogue with our unions at the Trust and have also facilitated discussions between ISS and Unison, the union recognised by ISS. We have listened to ISS staff concerns on a number of issues. We have sought firm assurances from ISS that these concerns have been addressed and we are pleased that significant improvements in ISS management have been recognised by the unions in recent weeks. Nonetheless we will separately set clear expectations and seek assurance from ISS regarding the management and leadership development we expect them to undertake; and that these are in line with Homerton University Hospital Foundation Trust's values and behaviours should a new contract be agreed.

Equally the Trust continues to work closely and in detail with ISS and Unison to review the terms and conditions that ISS staff will receive under a new contract. This includes ensuring that we can align the London Living Wage uplifts to ensure that all employees receive the uplift at the earliest opportunity and, where we can, to align the rates of pay within the two current existing contract types. This will benefit the ISS team at the Homerton and is the right thing for us to do but does come at a financial cost to the Trust. We are also currently discussing in detail with ISS what options are available for making further improvements to the sickness policy for those working at the Homerton. Making the scheme more generous will add cost to the contract which would then need to be offset elsewhere through the necessity of savings being made within the overall Trust's expenditure base.

We have not dismissed the in-house option for some facilities services in the future and will explore this option over the medium to longer term but we are simply not in a position to undertake such work over the next few months, which would be required.

In response to the specific questions you raise at the end of your letter;

1. No contract will be signed on the 30th June 2020.
2. The Trust has considered all options around the length of any contract and believes that a five year contract provides the necessary stability and continuity required during these uncertain times.
3. I am actually on leave on the 9th July 2020 but I will discuss with the team at the Trust.

Yours sincerely

Tracey Fletcher
Chief Executive

Hackney

Health in Hackney Scrutiny Commission 9th July 2020 **City & Hackney Restoration and Recovery Plan post Covid-19**	Item No **5**

PURPOSE OF THE ITEM

To give consideration to the City and Hackney CCG led restoration and recovery plan for health and care in the borough in the context of the Covid-19 pandemic.

OUTLINE

The Commission received briefings from the key local health and care stakeholders at its informal meeting on 30 March, soon after lockdown had begun. At its last meeting the Commission focused on the test trace and isolate plans and heard from external experts as well as the Director of Public Health. The minutes of that and the reports are here:
http://mginternet.hackney.gov.uk/mgAi.aspx?ID=36596

In item 7 she will provide a further update.

In City and Hackney a 'System Operational Command' led by the CE of HUHFT was set up in the immediate aftermath of the pandemic. The CCG and the local health partners have been working on a Restoration and Recovery Plan for the borough's health economy and this give Members an opportunity to ask questions about the Plan.

The Chair has invited the following for this item:

David Maher, MD, City and Hackney CCG
Dr Mark Rickets, Chair, City and Hackney CCG

ACTION

Members are asked to give consideration to the plan and make any recommendations' as necessary.

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PLEASE NOTE – this document is a first draft and currently undergoing iteration and development with involvement of multiple partners

City and Hackney System Operational Command:

Phase Two Restoration and Recovery Plan

Draft submitted for HiH Scrutiny Commission (9th July 2020)

Produced by: City and Hackney System Operational Command

NHS Homerton University Hospital NHS Foundation Trust

City & Hackney GP Confederation A community interest company

hackney cvs #FairerHackney

NHS East London NHS Foundation Trust

City of London

Hackney

NHS City and Hackney Clinical Commissioning Group

Background and context

- At the end of March 2020, System Operational Command arrangements were established in City and Hackney to provide a coordinated emergency planning and resilience response across the local health and care system during the pandemic
- During Phase One of the pandemic response, SOC co-ordinated operational leadership of the local system, ensuring successful joint working between GP practices, community health services, social care, mental health services, the voluntary sector, the local acute hospital, and links to wider public services. SOC was able to build on strong relationships and leadership structures which existed already through City and Hackney's integrated commissioning programme
- All transformation programmes and Workstream Programme Boards under City and Hackney's Integrated Commissioning Programme architecture were suspended, and the Integrated Commissioning Board moved to a short monthly update call
- During Phase One, System Operational Command was able to respond swiftly and effectively to the pandemic as CCG assurance and approval processes were streamlined and safely minimised. National changes, including the direction to suspend activity-based contract payments and implement block contracts supported this streamlined response
- As we move from the crisis footing of Phase One into a second 'restoration and recovery' phase, SOC's priorities will be to ensure that service delivery is fully restored in the context of the ongoing pandemic (addressing the 12 Expectations) but also to restart our existing programmes of transformation work and reshape our long term plan ambitions in a new context. In Phase Two SOC will move from managing delivery of a short-term Action Plan to a longer-term Integrated Delivery Plan
- SOC will need to continue to provide the swift and effective operational leadership of our pandemic response that it achieved during Phase One. It will also need to co-ordinate the delivery of our programmes of transformation work during a period of transition, as we implement the necessary changes to establish an Integrated Care Partnership within NEL ICS
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, drawing on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as part of the Integrated Delivery Plan

An ongoing system commitment to reducing health inequalities

- The terrible toll exerted by the COVID-19 pandemic serves as another reminder of the deep social and economic inequalities which affect the health and wellbeing of our local populations
- The organisations that make up City and Hackney's local health and care system remain committed to a long term change programme which will move our focus from health and care service provision towards a better understanding of and response to the wider determinants of health; achieving more effective outcomes for local people and responding more holistically to the complexity of their needs, and to the specific needs of different local populations. Our vision of integrated care supports frontline staff to work with local people, harnessing their strengths and connecting them with resources to support their wellbeing; and advocating on behalf of our most complex and vulnerable service users
- This vision has run through our commitment to integrated commissioning, our Neighbourhoods programme, our local Long Term Plan response and through close partnership working between provider organisations. It will be at the heart of our Integrated Delivery Plan and will inform the restoration and recovery work of the SOC in Phase Two.

Our vision

Working together across City and Hackney to support people and their families to live the healthiest lives possible and receive the right care when they need it.

- **More support** for patients and their families to get healthy, stay well and be as independent as possible
- **Neighbourhoods** where people and communities are actively supported to help themselves and each other
- **Joined up support** that meets the physical, mental and other needs of patients and their families
- **High quality** GP practices, pharmacies and community services that offer patients more support closer to home
- **Thriving local hospitals** for patients when they need them

Our strategic objectives

We have developed five strategic objectives for the programme:

- **Deliver a shift in resource and focus on prevention** to improve the long term health and wellbeing of local people and address health inequalities
- De**liver proactive community based care** closer to home and outside of institutional settings where appropriate
- **Ensure we maintain financial balance as a system** and achieve our financial plans
- Deli**ver integrated care** which meets the physical, mental health and social needs of our diverse communities
- **Empower patients and residents**

The following partner organisations have been involved for some time in City and Hackney's existing integrated commissioning work:

- The London Borough of Hackney
- Corporation of the City of London
- City and Hackney NHS Clinical Commissioning Group
- East London NHS Foundation Trust
- City and Hackney GP Confederation
- Homerton University Hospital NHS Foundation Trust
- City and Hackney Local Pharmaceutical Committee
- Schools and Children's Centres
- Hackney Centre for the Voluntary Sector
- A range of local voluntary and community organisations
- Healthwatch City of London
- Healthwatch Hackney

SOC Phase Two Plan sections

City and Hackney SOC Phase 2 Plan sections	
OOH service recovery: Restoration, access & safety	This section of our plan sets out how we will ensure as a system that all Out of Hospital services: • Are fully restarted (where services have been reduced or paused as a result of the initial pandemic response) • Are compliant with Infection Prevention and Control guidance, inc. appropriate segregation and remote access • Have resilience plans in place to respond to surges in demand associated with a second peak • Have considered the equalities impact of service changes and taken steps to address these or escalate to SOC • Specific support to Shielded Patients, Care Homes, and packages of care for vulnerable people with LTCs
Restoration of elective work: Maintaining tight integration with the local system	• Linking our local support packages for long term conditions with changes in planned care • Ensuring that primary care and Neighbourhoods links and pathways with secondary care are maintained (ie. Advice and guidance, diagnostics, MDT involvement) • Ensuring effective local patient engagement, communications and co-design in relation to planned care restoration • Maintaining effective discharge pathways with changes to planned care
Updated transformation plans: Delivering our Long Term Plan and integrated care ambitions	• Integrated Delivery Plan for Phase 2 • Urgent care and rapid response – before hospital • Population Health Management and Intelligence • Clinical leadership – expanded role of Clinical Practitioner Forum • Inequalities Framework
Phase Two governance and support arrangements	• Revised SOC Term of Reference • Roadmap for creation of a local Integrated Care Partnership including SOC links to wider local system changes (establishment of a Neighbourhood Health and Care Partnership, establishment of single CCG) • Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence • Revised system PMO arrangements

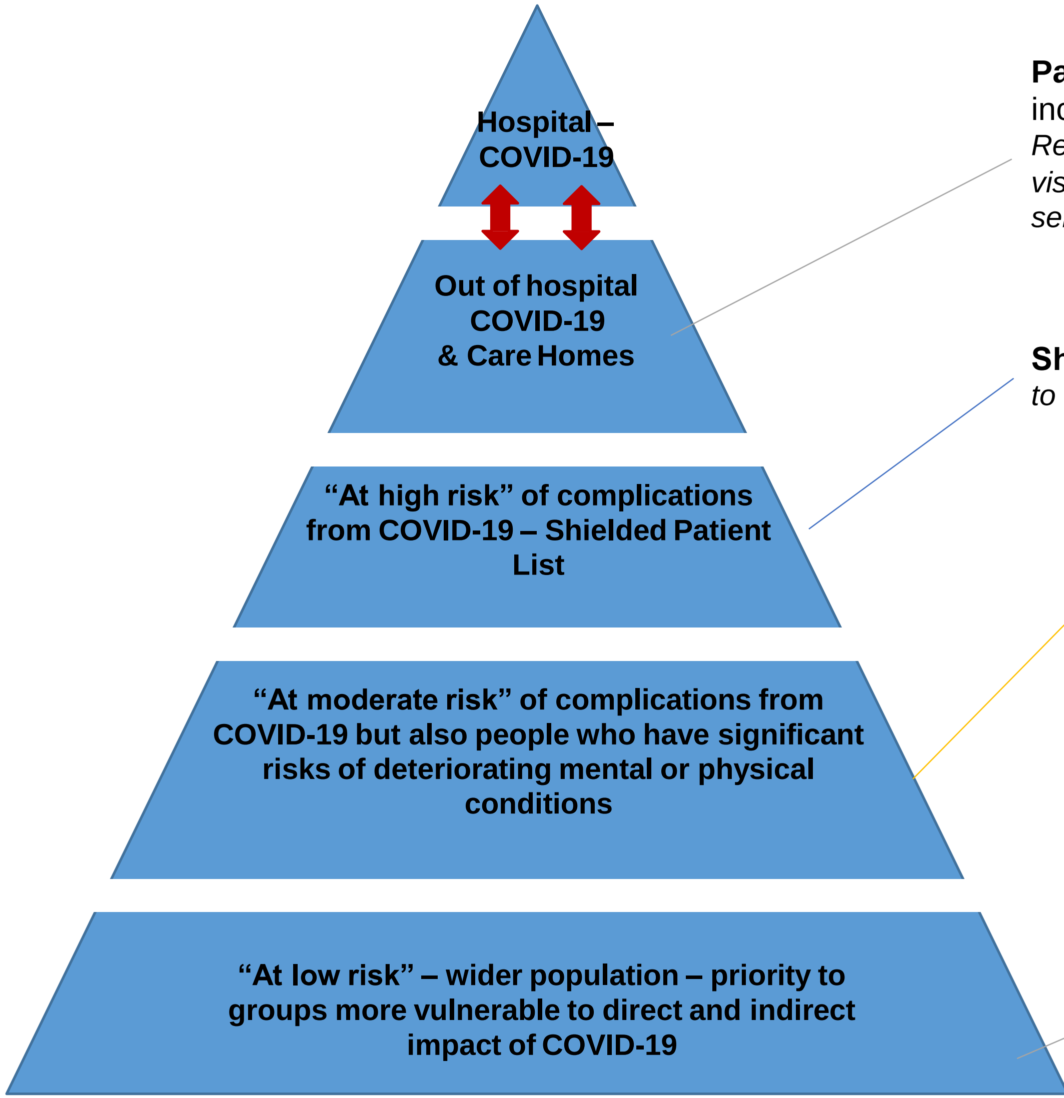
Out of hospital local service recovery:

Restoration, access and safety

SOC assurance on service safety, resilience and restoration

- During Phase Two SOC has a responsibility to ensure that local health and care services have resumed and are accessible and safe in the context of the pandemic response, and that service users are aware of changes to services, and that the equalities impact of changes have been considered and addressed
- Individual organisations remain statutorily and legally responsible for health and care services they provide, including CQC responsibilities. SOC does not intend to duplicate Board Assurance Frameworks and other accountability frameworks, but to co-ordinate a local system response
- During June 2020 SOC is requiring each organisation providing out of hospital health and care services to provide it with an assurance that all of their services:
    - Have plans in place during Phase Two to resume a **full service (**where services were reduced in scope or paused during the phase one crisis response)
    - Are **complying with infection prevention and control guidance in relation to service access and service segregation, as well as safeguarding guidance**, and have plans in place for delivering any remedial actions and deadlines for resolution
    - Have prepared **emergency resilience and surge plans in preparation for a second peak** of COVID-19 infections
    - Have effectively communicated service changes and engaged with **service users and communities** over service restoration work
- SOC acknowledges that the size of organisations and levels of risk involved in services will have an impact on their ability to respond. SOC will identify common themes where support and guidance may be needed, particularly for smaller grant-funded organisations
- In particular SOC will ask organisations to provide specific details about any problematic areas or risks in relation to these service restoration plans, and by mid-July SOC will develop a **Service Restoration Exception Plan**
- From mid-July a sub-group of SOC will ensure that all outstanding issues relating to IPC compliance, service access and restoration, the equalities impact of changes, and surge and resilience planning are escalated and resolved, and that all exceptions have been addressed

Our risk stratified response to COVID-19 in City and Hackney



Patients with COVID symptoms supported out of hospital including care homes – *Remote consultations, COVID treatment centre in primary care, visiting arrangements for a patient in their home, community services*

Shielding Patient List (“At high risk”) –*Defined according to Chief Medical Officer definitions (circa 1.28m nationally).*

Vulnerable cohort (“At moderate risk”) - *Medically vulnerable based on eligibility for flu jab – (circa 19m nationally).*

There is a national definition for those at moderate risk (eligibility for flu jab). Locally we would also add those who are vulnerable for social reasons (e.g. homeless) or because of mental health (e.g. SMI)

3. Wider population (“At low risk”) – Wider population impacted by the changes associated with COVID-19 e.g. economic impact

Restoration of elective work:

Maintaining tight integration with the local system

A NEL-wide approach to the restoration of acute elective work

Complex elective procedures

Complex elective procedures typically have more co-dependencies and require a more specialist workforce. Complex cases are higher risk and therefore require the strictest protocols for screening, testing and segregation. Therefore the first component of our model is the consolidation of complex elective care across a smaller number of sites. This will increase the resilience of the workforce for these services, and enable us to deliver these services in a COVID-protected space.

Complexity in elective care may refer to the nature of the surgery, the needs of the patient or both. There are patients who are complex and require additional support during their hospital stay.

Simple elective surgical procedures

‘Simple’ elective services are higher in volume and have greater throughput. In NEL there is a backlog of activity which needs to be worked through, due to the suppression of activity over the first COVID peak, against a backdrop of long waits in some services that must also be addressed.

The second component of the NEL-wide elective care model is the creation of high volume centres for the management of simple elective surgical procedures. This will enable us to make the most efficient use of our theatre space and workforce, as well as maintaining COVID protected space for elective care. To support the delivery of this, we are developing lead providers for our high volume specialties across NEL. Initial proposals for these lead providers have been developed, though they need further work before they can be formally agreed.

Outpatient services

The next component of the NEL model is the safe delivery of **outpatient services**. The COVID pandemic has expedited much transformation of outpatient services, including the expansion of virtual consultations, advice and guidance and community services. Retaining the progress made will be critical to our elective model going forward and we plan to move to virtual by default. Further work is required to assess how we should configure outpatient services across the sector while retaining equitable access.

Diagnostics

Finally, the delivery of diagnostics is a critical enabler for the model as outlined above and across NEL we have established a diagnostics and imaging hub with Barts Health as the lead provider to progress this work.

Local considerations in relation to the restoration of elective work

As part of the work under our Integrated Delivery Plan, in Phase Two we will work to ensure that:

- Our local proactive support packages to primary care for specific cohorts of patients with long term conditions (who are at greatest risk of exacerbation or deterioration) continue to link in with proposed changes in elective care delivery, including diagnostics, monitoring, outpatient activity and advice and guidance links to secondary care clinicians
- Effective MDT links with secondary care which have been established through the Neighbourhoods programme and PCN development are maintained during changes in elective pathways
- Our plans for communications and engagement will ensure that:
    - The successful Practitioner Forum which we established during Phase One is fully informed and engaged in changes to elective care
    - We effectively explain these changes to local people and service users and involve them in co-design and co-production of changes where possible
- The rapid discharge pathways we have developed in partnership with social care partners remain effective in the context of any changes to elective care pathways
- Our local system approaches to cancer screening, diagnosis and referrals are still effective
- We work as a local system to recast our operating plan in the light of changes in activity in the past few months to ensure that resources continue to be allocated most effectively

Based on analysis of local non-elective emergency admissions for high risk conditions in March and April compared to a baseline of previous years, data shows a concerning drop in activity which potentially suggests a 'storing up' of presentations of acute illness, which could lead to a peak of non-COVID-related emergency admissions in the coming months. Our plans to address this risk include:

- Working with partners to further analyse data to understand whether a reduction in emergency activity could be the result of more effective out-of-hospital interventions - and if so, building our learning from this
- Ensuring that further activity and capacity planning and analysis is done in the high-risk areas which gave greatest cause for concern: MI, ischaemic heart disease, cellulitis, sepsis, heart failure, COPD, asthma, diabetes and paediatric injuries

Updated transformation plans:

Delivering our Long Term Plan and integrated care ambitions through Neighbourhoods

Our Integrated Delivery Plan

Building on the success of our co-ordinated system leadership in phase one, we believe that a future system delivery plan is best organised around a single **thematic view** of groupings of **population health outcomes and improvement areas** rather than four or five plans reflecting the way that services are structurally organised

Our Integrated Delivery Plan is featured as a 'plan on a page' on the next slide, and SOC is currently going through a process to develop a full and detailed plan to use in co-ordinating our work during Phase Two.

The functional areas we have grouped our planning actions around:

- Follow the aims of the Long Term Plan in wishing to avoid the influence of historic organisational and contractual structures, with greater priority placed on keeping people healthy and independent in **out of hospital** settings (at home or in the community)
- Loosely map to **life course stages**, in order to link with wider partnership work on reducing health inequalities
- Maintain our focus on **Neighbourhoods** as the building blocks of integrated community support
- Encourage a focus on **population health outcomes, prevention** and **wellness (**as opposed to illness) as supported by local residents through our Outcomes Framework

It is our aim during Phase Two to build a single delivery-focused view of our various transformation plans as a local system which encourages cross-cutting approaches and the greater collaboration necessary to deliver integrated care. This will include consideration of how best to utilise and develop existing integrated programme approaches.

Integrated delivery plan on a page – functional areas

This high-level plan details the major programmatic areas of integrated health and care provision which will be delivered by local mental health, primary care, social care, community health and voluntary sector organisations working in partnership in City and Hackney

ICS planning with focus on a larger population

- NEL maternity network
- Specialist consolidation
- Urgent and emergency care
- NEL acute and diagnostic pathways
- NEL Cancer Alliance

Delivery of care at local system level

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Children, young people and maternity

- Support to expecting women and mothers
- Support to families
- Health and wellbeing links with schools
- Immunisation strategy (children)
- Support to children and families with disabilities and additional needs
- CAMHS transformation
- LD and autism

Neighbourhoods and communities

- Supporting people with complex needs
- Primary urgent care
- Community-based rapid response services
- Integration of services in Neighbourhoods
- Social prescribing
- Outpatients redesign
  - New referral pathways
  - Out of hospital service development
- Closer integration with voluntary sector and communities
- Community-based support for people with LTCs
- Community support for people with SMI and PD
- PCN development

Rehabilitation and independence

- Discharge pathways
- Continuing Healthcare
- Cancer
  - Early diagnosis
  - Screening
  - Referrals
- Dementia
- End of Life
- Virtual support package for care homes
- Housing and homelessness 'In For Good'
- Immunisation strategy (flu - adults)
- PCN DES Care Homes

Workforce development to embed proactive and preventative interventions in support of more integrated care (MECC)

COVID-specific response across all areas: *COVID service segregation | virtual consultations | testing and contact tracing | remote monitoring / telemedicine | support to excluded groups*

- Humanitarian assistance via volunteers and VCSE
- COVID discharge and rehabilitation pathways
- Supporting shielded people

Safeguarding across all areas: Children's safeguarding | Adult safeguarding

Prevention and health inequalities: *Themes map to life course stages – major output areas are reflected on our Inequalities Framework*

Supported by system enabler functions: *Workforce and OD | Digital and IT | Comms and engagement | Estates | Community connection & VCS | Primary Care | Pop Health intelligence*

A focus on neighbourhoods and communities

Our Neighbourhoods Programme continues to be at the heart of the way we are organising out-of-hospital services, managing our population health response and collaborating with Primary Care Networks and local public services. In Phase Two key actions and milestones are:

High-level actions in Phase Two	Milestones	Functions on the Integrated Delivery Plan this meets
Phase one: Establish adults MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (this is to cover the period we've asked PCNs to chair / lead initially although the will have all launched by mid-end of June)	Supporting people with complex needs Integration of services in Neighbourhoods
Phase one: Establish children and families MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (to be checked with Amy Wilkinson)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Phase two: Embed adults and children and families MDTs in all including the provision of OD support for leadership and wider Neighbourhood team.	July 2020 to end of March 2021	Integration of services in Neighbourhoods
Develop and agree a sustainable model for all Neighbourhood MDTs. This includes MDT chairing, administration and a sustainable model for care coordination / navigation.	End of September 2020 (sustainable model commencing from 2021/22)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Initial development of population health needs and inequalities (in light of COVID-19) and identification of priorities within Neighbourhoods	End of September 2020	Prevention and health inequalities (cross-cutting)

In Phase Three the following high-level actions will take place by March 2021:

- Evaluation approach established to capture the learning / impact of Neighbourhood Teams and MDTs
- Deliver service transformation to fully align services with Neighbourhoods in the following areas (for the adults MDT): Adult Community Nursing, Adult Community Therapies, Adult Social Care, Mental Health, Care coordination / Community Navigation and Voluntary Sector
- Develop and test models for Neighbourhood Partnerships including learning from other areas
- Further development and engagement of population health priorities within Neighbourhoods

What the Neighbourhood MDT looks like

Input from other specialist providers where this is needed

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What we are now working towards:

- Regular review of patients who are most vulnerable within a virtual Neighbourhood MDT
- A focus on supporting people with complex and acute needs and vulnerabilities
- A core group of professionals who are actively involved
- Resourced administration for Neighbourhood MDTs
- Effective routes of referral into virtual Neighbourhood MDTs initially from GP Practices but then from individual organisations
- Remote monitoring support to enable remote consultation wherever possible

Other supporting work in neighbourhoods and communities

Urgent care and rapid response before hospital

In Phase Two we will work with NEL partners to develop improved pathways from 111 to support reduction in ED attendances and agree specific pathways from 111 into primary care and into SDEC or hot clinics at the Homerton hospital site

Primary Care Networks development

PCNs are central to the clinical leadership and delivery of our vision for Neighbourhoods. In Phase Two we will:

- Work with PCNs to establish their role within the local system as providers and as system leaders
- Work with the GP Confederation to continue to support PCNs to develop their management infrastructure
- Continue to build capacity in Neighbourhoods teams so they can support PCNs to work with partners in taking a population health approach and provide multi-agency care

Community-based support for people with LTCs

In Phase One we developed local proactive support packages to primary care targeted to specific identified cohorts of patients with long term conditions (who have been identified as being at greatest risk of exacerbation or deterioration). In Phase Two this work will continue with further support for remote monitoring and telemedicine as well as self-care support and resources

Taking a population health approach

In Phase Two we plan to build on tools already provided by CEG and partners and request further support from NEL ICS colleagues with provision of more effective and proactive population health data tools to support targeted work at Neighbourhood and practice level

Supporting clinical leadership

In Phase Two we will expand upon and build the role of the Practitioner Forum which has been an effective virtual forum for clinical and practitioner leadership and engagement. We will adapt plans for embedding and supporting collaborative quality improvement projects led by clinical staff as part of our Neighbourhoods OD and PCN development work.

Closer integration with the voluntary sector and communities

In Phase Two we will confirm a local VCS Target Operating Model and establish the VCN strategic enabler by July 2020

Responding to mental health challenges in Phase Two

Mental health responses are embedded in our approaches across our Integrated Delivery Plan, reflecting our commitment to integrated care including consideration for wellbeing and recognising the impact of mental health on physical health. However, in Phases Two and Three we face a number of significant challenges, and our plan response is as follows:

High-level challenge	Plan response in next two weeks:	Plan response in next month:	Plan response by end of Phase Two:	Plan response in next six months:
Capacity to meet mental health demand HLP predict a 30% increase in mental health demand across London as a result of the pandemic. Services have reduced capacity due to high staff sickness and absence. LTP Mental Health investment is also largely on holding pending clarifications re. contracts and financial flows.	Mental health capacity and demand modelling completed highlighting key gaps	Develop costed plans to address gaps	Implement plans	Monitor implementation
Mental health inequalities Health inequalities for mental health service users have in many instances been exacerbated by the pandemic because of the effect of deprivation on the digital divide and access to the resources that maintain wellbeing, as well as the impact on cultural practices and communities.	Complete offer of SMART phones through personal health budgets	Agreed plans with providers for: i) Socially distanced IT hubs for patients who are not able to access digital services ii) plans for face to face contract prioritising patients who are either can not use or are not best served by digital services iii) clarifying BAME community group plans to support mental health within specific communities	Implement plans	Monitor implementation
Shielded and vulnerable patient psychological wellbeing Those on the shielded list and those part of vulnerable groups e.g. those with an LTC are likely to experience a higher level of mental health problems due to the the stress of an ongoing restricted lifestyle. People recovering from Covid may also be experiencing the effects of trauma.	Develop and send out psychological wellbeing pack for those on the shielded list with links to IAPT. Adapt the IAPT website to more clearly address Covid related needs.	Develop a stronger pathway between LTC patients and IAPT services	Monitor IAPT access and LTC access rate	Monitor IAPT access and LTC access rate
CAMHS return to schools The return to school presents an opportunity to resume the schools CAMHS Transformation Plans. This could however create a surge in demand. There are also risks attached to children who do not return.	Agree plans including how to reach children not returning	Implement plans including restoration of CAMHS transformation plans	Monitor implementation	
Return to BAU for suspended MH services *This will be covered under the first part of this plan, Out of Hospital Service Recovery, alongside all other health and care services*				

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Addressing health inequalities in Phase Two

- The direct impacts of COVID-19 disease are disproportionately experienced by people from certain minority ethnic groups, older people, men, people with underlying health conditions, working in particular occupations and those living in socially deprived circumstances (untangling the contribution of these various overlapping risk factors is complex).
- The indirect impacts of lockdown and social distancing are also affecting some of the most vulnerable people and communities, including many of those described above as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.
- In Phase One SOC co-ordinated work to provide additional targeted support to vulnerable communities and groups such as the Charedi community and people in the community living with serious mental illness and personality disorder, working with community partner organisations. Our plans in Phase Two will build upon these targeted interventions and go further in tackling long-standing inequalities.

City and Hackney SOC Inequalities Framework	
Purpose:	• To ensure phase 2 planning retains an explicit focus on reducing health inequalities • To form the basis of a population health framework for City & Hackney
Principles:	• We will prioritise actions which target those who have been most detrimentally affected by COVID-19, and where we can make most impact as a partnership (taking a stratified approach) • No action will be taken as part of our phase 2 plans that further exacerbates pre-existing inequalities • Longer-term, we will continue to prioritise actions to reduce long-standing inequalities
Tools:	• Prioritisation matrix: a visual tool to highlight priority areas for action and help identify gaps/where plans not already in place • Decision-making tool - rapid EIA to guide decisions about phase 2 plans and make explicit our expectations about inequalities impacts • Equalities 'dashboard' - to monitor progress/impact of our actions

Phase Two governance:

Towards a local Integrated Care Partnership

Changes in governance during Phase Two

- We are moving from the reactive crisis footing of Phase One into the second phase of our response to COVID-19, and SOC is required to co-ordinate a ‘new normal’; addressing both the new realities of service delivery under the pandemic (addressing the 12 Expectations) but also continuing to make the necessary changes to deliver our local long term plan response as an Integrated Care Partnership within NEL
- NEL ICS is maintaining level 4 incident command and control for phases one and two of the recovery plan, and during phase two other SOC groups within NEL are renaming themselves as Integrated Care Partnership Delivery Groups, in acknowledgement of this transitional phase for local systems. In Phase Three NEL will implement the ICS structures it will agree over the next 5-6 months.
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, and this will draw on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as they are agreed, and they will form part of the Integrated Delivery Plan

This section of our plan sets out:

- Revised Terms of Reference for the SOC in Phase Two of recovery and restoration
- Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence)
- Revised system PMO arrangements

Terms of Reference

Membership

Tracey Fletcher – Chair
Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Simon Galczynski (Adult Social Care LB Hackney)
Chris Pelham (City of London)
Laura Sharpe (C&H GP Confederation)
Dean Henderson (C&H Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Lead)
Vanessa Morris (Voluntary & Community Sector)
Nic Ib (PMO)

Minimum meetings frequency

- Weekly on a Thursday
- Papers circulated afternoon before meeting

Meetings and administration

- Nominated admin support –*PMO team*
- Actions formally logged
- Decisions taken
- Notes, actions, decisions out to all members within one day

Purpose & Remit

In Phase Two of the COVID-19 response, the C&H SOC group will perform three main functions:

- Finalising and implementing the recovery plan for the City and Hackney local system, including recasting local transformation plans in the context of the 'new normal'
- Tracking activity and capacity locally to respond quickly to early signs of a second peak in COVID-19 infections and to initiate necessary resilience plans
- Co-ordinating our strategic programmes of delivery at system level during a transition period when governance and structures will adapt in preparation for establishing an Integrated Care Partnership in City and Hackney during Phase Three

At weekly meetings the group will review delivery progress against the SOC Integrated Delivery Plan and regular population health modelling reports.

The group will establish more effective and direct relationships with the local system strategic enabler functions so that their work more effectively supports delivery of the SOC Integrated Delivery Plan

The group will engage with NEL ICS workstreams as necessary and will escalate 'asks' to these in relation to local delivery work. The group will report in to the NEL ICS Recovery and Restoration Group as required, who will provide overall oversight for the ICS Recovery programme

In Phase Two the SOC will continue to provide a forum for leads to discuss challenges in development and/or implementation of plans and to seek support in resolving issues.

Activities OUT of scope

Non-Covid-19 related activities other than consideration of plans for phase three of the recovery and restoration plan.

Accountability and Authority

Accountable to NEL ICS Recovery and Restoration Group

Close liaison with Accountable Officers Group to ensure appropriate governance for significant decisions which impact on system partner organisations

Key interdependencies with other working groups and ICC activities

- City and Hackney C-19 Health Protection Board (formerly Pandemic Leadership Group)
- Local authority local resilience forums
- NEL ICS workstreams

Accountability and authority

LB Hackney
Local Resilience Forum strategic co-ordination group

Gold: Tim Shields

City of London
Local Resilience Forum strategic co-ordination group

Gold: Peter Lisley

C-19 Health Protection Board (formerly Pandemic Leadership Group)

Chair: Sandra Husbands (Dir Pub Health)

- Provide infection control expertise
- Lead development and delivery of Local Outbreak Plan (DPH)
- Link directly to regional PHE team and London Coronavirus Response Cell (LCRC)

Escalation

City and Hackney Integrated Care Board

Acting as Local Outbreak Control Board providing public-facing oversight of local public health response

City and Hackney Accountable Officers Group

Providing a periodic opportunity to step back from the immediate focus of System Operational Command / ICS DG and reflecting strategically on the wider links to the local authorities and local partners

Escalation

City & Hackney System Operational Command (Integrated Care Partnership Delivery Group)

Chair: Tracey Fletcher (Homerton CEO)

Operational system management of the major re-organisation of provision within the local health and care system, in response to COVID-19

SOC/ICP DG Leads

System Operational Command / ICP DG Leads are accountable for delivery of the Integrated Delivery Plan:

Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Clinical Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Laura Sharpe (GP Confederation)
Simon Galczynski (Adult Social Care LBH)
Chris Pelham (City of London)
Dean Henderson (Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Programme Lead)
Vanessa Morris (Community and Voluntary Sector)

Escalation

NEL ICS Recovery and Restoration Group
(formerly Strategic Operational Command)

Chair: Jane Milligan (AO)

NEL workstream groups:

- Acute care
- UEC
- Cancer
- Out of Hospital Care
- Public health
- Primary care
- Mental health
- Maternity
- Enablers (Finance, Digital, Corporate Governance, Comms, Workforce, Estates)

Support required from system enabler functions during Phase Two

- During Phase One of the COVID-19 response, we did not formalise links between existing system enabler functions and SOC, although several SROs of enablers are members of SOC
- These functions are essential to delivery of Phase Two recovery plans and it will now be appropriate to agree clearer lines of responsibility in relation to SOC in order to align the work of enablers more effectively with phase two operational delivery
- In June and July, SOC will work to more directly align the work of the enabler groups with integrated delivery plans and programmes of work, including establishing a population health intelligence enabler group.
- This work will go hand in hand with the development of the Integrated Delivery Plan

Workforce

- System workforce strategy & vision to support integrated care in Neighbourhoods
- Workforce planning
- Education & Training
- System Organisation Development support & cultural change
- Nursing/midwifery/AHP leadership and engagement
- Psychological impact of the pandemic on staff

EXISTING

Digital and IT

- Single view of a person's health and care record
- Coordinated care and care planning
- Information and control for patient/empowerment
- Supporting a co-ordinated local approach to virtual consultations and telemedicine

EXISTING

Estates

- Local system estates strategy & planning
- Capital & investment strategy
- Estates delivery
- Primary care provision
- Commercial developments
- Corporate governance: estates and facilities

EXISTING

Comms and engagement

- Overarching system-wide communications & engagement
- Intelligence on community and service user responses to pandemic
- System support for co-design and co-production
- Support for legal consultation duties in response to service changes

EXISTING

Community connection and VCS

- Local system co-ordination of work involving links with community organisations and the voluntary sector
- System co-ordination of community navigation and connection roles and functions

EXISTING

Primary care

- Responsible for ensuring that population-level enhanced services contracts support admissions avoidance, LTP ambitions and integrated of services through PCNs in Neighbourhoods
- Required as part of delegated primary care commissioning governance

EXISTING

Population health intelligence

- Responsible for modelling local COVID-19 response and co-ordinating local early warning triggers for second peak response
- Population health – data sets and support for anticipatory care and other data-informed new service models

NEW

Revised PMO arrangements during Phase Two

- In support of establishing our Integrated Delivery Plan, during June and July, SOC Leads will arrange for PMO and programme leads from major transformation programmes to co-ordinate with each other and review opportunities to streamline and simplify programme support and reporting arrangements. This will also be informed by plans for development of a local Integrated Partnership Board.

Appendix

Reminder of the 8 tests and 12 expectations

SOC Phase Two: Reminder of 8 tests

Meet patient needs			Address new priorities		Reset to a better health & care system		
1. Covid Treatment Infrastructure	2. Non-Covid Urgent Care	3. Elective Care	4. Public Health Burden of Pandemic Response	5. Staff and Carer Wellbeing	6. Innovation	7. Equality	8. The New Health & Care Landscape
Maintain the total system infrastructure needed to sustain readiness for future Covid demand and future pandemics	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Quantify the backlog; act now to slow growth in backlog as much as possible; develop the plan for clearing over time	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Catalogue the interventions now in place; identify additional actions now to support staff; develop the plan for recovery	Catalogue the innovations made; determine those to be retained; evaluate; plan for widespread adoption	Understand the needs of people and places who are the most impacted by inequalities and co-create models based on what matters to them	Catalogue the service and governance changes made and made more possible; deliver the new system
(e.g., capacity and surge capability in primary care, critical care, equipment, workforce, transportation, supply chain; strict segregation of health and care infrastructure; treatment innovation; role of the Nightingale)	(e.g., reductions in presentations; reduced access for cancer diagnostics and treatment; implications of screening programme hiatus; care for those with long-term conditions)	(e.g., prevention and community-based treatment, the rapid increase in 52 week waiters and the overall RTT backlog; major increase in capacity to diagnose and treat; use of independent sector for waiting list clearance)	(e.g., mental illness, domestic violence, child abuse, other safeguarding issues, lack of exercise, economic hardship; retaining the positives such as handwashing/ acceptance of vaccination, air quality, greater self care for minor conditions)	(e.g., meeting physical and psychological burden; developing a "new compact and a new normal" for support to staff in social care, primary care, community care, mental health, critical care, acute care settings; BAME staff and carers a particular priority)	(e.g., virtual primary care. outpatients, remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, pace and urgency to decision making, financial models)	(e.g., capturing the right data to inform service design, need models of identifying and reaching out proactively to meet need; integrated health and care approaches to addressing inequalities)	(e.g., stepping up the new borough-based ICPs; domiciliary and residential care infrastructure; configuration of specialist services; governance and regulatory landscape implications; streamlined decision-making)
#1 We retained resilience to deal with on-going pandemic needs	**#2 We did everything we could to minimise and morbidity causes**	**#3 We returned to the right level of access elective cases clinical need**	**#4 We put in place an effective other effects on the pandemic**	**#5 We helped our people to recover from pandemic and new compact with them**	**#6 The positive innovations we made during were retained, generalised**	**#7 The new health and social care system that fundamentally addressing inequalities**	**#8 The new health and social care system that materially higher productive and better governed**

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SOC Phase Two: Reminder of 12 expectations

1. A way of operationalising strict segregation of the health & care system between covid and non covid and a much stricter separation between urgent and elective work especially by site, with international best-in-class infection prevention and control practices
2. A permanent increase in critical care capacity and surge capability, centred on tertiary sites
3. Virtual by default unless good reasons not to be: primary care, outpatients, diagnostics, self care, support services
4. Triage/single points of access/resources and control at the front end of pathways e.g., through sector-level PTLs for all pathways prioritised by need and "talk before you walk" access to keep people safe and best cared for
5. New community-based approaches to managing long term conditions/shielded patients
6. New approaches to minimise hospital stay to that which is required to meet needs e.g. discharge models which maintain reductions in DTOCs/Long Length of Stay, same day emergency care, community-based rapid response
7. Disproportionate focus and resources for those with most unequal access and outcomes
8. Further consolidation and strengthening of specialist services
9. A single, more resilient ICS-level platform for corporate support services and further consolidation and sharing of clinical support services
10. New integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care
11. Further alignment and joining together of institutions within the ICS
12. A new approach to consent through systematic deliberative public engagement e.g. citizens juries

Hackney

Health in Hackney Scrutiny Commission 9th July 2020 **An Integrated Care System for North East London - update**	Item No **6**

PURPOSE OF THE ITEM

To receive a verbal update from the MD of City and Hackney CCG on the accelerated plans for the Integrated Care System for North East London in the context of Covid-19.

OUTLINE

At its meeting on 12 February the Commission considered a detailed proposal on the plans for a single Integrated Care System for the 8 north east London boroughs which form the East London Health and Care System (the STP). Members discussed it with both Finance Directors from the CCG and the Council as well as the leadership of the CCG and the GP Confederation and a representative of the Local Medical Committee. A copy of that report and the discussion are here: http://mginternet.hackney.gov.uk/mgAi.aspx?ID=35992

The MD undertook to return with an update as follows:

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.**

The Covid-19 situation has intervened in the interim and while it has delayed some of the constitutional actions it has also served as a catalyst for closer integration. The Chair has invited the CCG to provide an update.

Attending for this item are:

David Maher, MD, City and Hackney CCG
Dr Mark Rickets, Chair, City and Hackney CCG

ACTION

Members are asked to give consideration to the briefing and make any recommendations' as necessary.

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Hackney

Health in Hackney Scrutiny Commission 9th July 2020 **Covid-19 'Test, Trace and Isolate in Hackney' – briefing 2**	Item No **7**

PURPOSE OF THE ITEM

To receive a verbal update from the Director of Public Health on the progress made since the last meeting on the Test, Trace and Isolate programme in Hackney in response to the Covid-19 pandemic.

OUTLINE

At the previous meeting the Director of Public Health presented a briefing paper on the Test Trace and Isolate pilot which Hackney had just commenced with the boroughs of Newham, Camden and Barnet as one of 11 pilot programmes nationally. That report and the minutes of that item are here:

The Chair has asked the DPH to return with a verbal update on progress.

Attending for this item are:

Dr Sandra Husbands, Director of Public Health for City and Hackney

ACTION

Members are asked to give consideration to the briefing and make any recommendations' as necessary.

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Health in Hackney Scrutiny Commission 9th July 2020 Election of Vice Chair	Item No **8**

PURPOSE OF THE ITEM

To elect a Vice Chair.

OUTLINE

At the previous meeting there were two nominations for Vice Chair and it was agreed that the final vote be postponed to this meeting.

The vacancy arises because Cllr Yvonne Maxwell has stepped down from the Commission after being appointed as a Cabinet Adviser.

ACTION

Members are asked Elect a Vice Chair.

Hackney

Health in Hackney Scrutiny Commission 9th July 2020 **Minutes of previous meeting**	Item No **9**

OUTLINE

Attached please fined the draft minutes of the meeting held on 8 June 2020.

MATTERS ARISING

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.

Actions from 9 June meeting

Action at 7.2

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

This is dealt with under item 4.

ACTION

To agree the minutes and note the matters arising.

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

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

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

2 Urgent Items / Order of Business

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

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

3 Declarations of Interest

3.1 There were no declarations of interest.

4 Covid-19 Response - PANEL DISCUSSION

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

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

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

The Chair also welcomed the following:

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

4.3 Members gave consideration to the following supporting papers:

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

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

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

(iv) Tabled presentation slides from Professor Costello.

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

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

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

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

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

a) On behalf of PHE he had completed a report for government on the disproportionate impact of Covid 19 on ethnic minority communities and as part of it had engaged with c. 4000 individuals from BME groups. In his presentation he wanted to reflect on the epidemic in London, on the outcome of this 'disparities' review and on the key recommendations emerging from it.
b) He stated that 26k Londoners had been infected and 6k had died and these had not been randomly distributed in the population. Older people, males, those from BME groups had borne the brunt of the disease and the challenge was how to get back on track. London had responded well as a city however and was now was among the regions with the lowest rates in the country
c) He outlined 5 dimensions to the problem: (i) how can we emerge from the epidemic and deal with the number of new health issues which will emerge as a result of the lockdown and the likely economic devastation caused by it and how can we get back on track quickly (ii) Covid-19 hasn't created inequalities but merely exaggerated the existing ones and what more can we do to address these; (c) how can the health system getsback on track in responding to the ongoing health challenges around cardiovascular disease, cancer, diabetes etc; (d) how can we ensure that we have good data in order to respond effectively to the pandemic and (e) how can we ensure we're using all the tools available to us already to ensure maximum suppression of the virus.
d) There were four key issues that emerged from the stakeholder workshops he added. Firstly, the risk that social and economic deprivation plays and in particular the vulnerabilities within BAME communities. Secondly, the occupational risk where BAME communities are facing a higher risk from Covid-19 by virtue of the frontline jobs they do e.g. bus drivers, care home staff etc. Thirdly, co-morbidities such as diabetes, obesity, hypertension and CVD, which are more prevalent within these communities, and fourthly the wider structural issues including racism, discrimination, stigma, distrust and fear which underpin those disparities. They found for example that there was still excess mortality among BAME people even when you allowed for the other risk factors
e) There would be an ongoing requirement to continually stress the guidance on hand washing, staying at home, self-isolation and face covering and nationally there would most likely be a need for local level lockdowns.
f) In terms of the data on disparities in London, the report outlined how those who were 80 years and over are 70% more likely to die and PHE was looking closely at the age factor and what was driving those excess deaths.

g) In terms of acting on the data there was a need to look at pace and impact of the pandemic and to use culturally competent messaging in each community.
h) There was a need to address how we can implement all the public health tools we currently have in our differing local communities and in terms of prevention, how communities can be made more resilient.
i) Lastly, there was a need to look at the importance of the social and structural context within which communities are now going to have to rebuild.

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

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

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

likely to declare themselves if they do not receive sick pay and this is very serious in the context of a pandemic.

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

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

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

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

4.11 Professor Costello (AC) replied that he didn’t see how the current centralised system can work. It was noted that GPs still can’t get involved in testing and can only get tests for themselves. He stated that in each borough you only needed about 10 GP hubs, you could set up ‘hot rooms’ and set up testing sites. Contact tracing should also involve GPs as they have local knowledge and the whole thing needs to be integrated. He stated that home testing was not ideal because it lowered the quality of the testing overall. He had similar criticism of the testing sites in car parks set up by Deloitte as these tests were again proving poor quality. The government must allow GPs to get involved and to have solid data flowing back. AP added that the Secretary of State should instruct PHE to work with local authorities rather than, in her view, squandering money on commercial approaches like the contract with commercial testing lab Randox which cost £133m for just one month. The

Durham example was a good one and there was also good best practice coming out of Germany. She cautioned that local authorities could not ‘take the bull by the horns’ and do this themselves. There was a need to engage retired health staff and other volunteers and you need a lot of help from the local public health teams. She stated that Hackney Council was great for trail blazing and she offered to help with contacts in Germany and Scotland etc who could advise further.

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

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

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

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

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

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

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

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

4.20 KF replied that the pandemic presented an opportunity for innovation and learning from other countries because we were moving into a unknown territory in terms of living with Covid. The App was one way in which innovation can be used but there might be other strategies which emerge as we progress into this phase. There was some excellent work going on in London councils' but we must be careful not to duplicate services at every level in the system. Locally councils know their businesses and workplaces and the relationships you build now would give you an advantage in fighting off any future epidemic and capacity had to be built into local authorities. There was a need also for culturally competent local messaging and contact tracing. On the issue of bypassing GPs in the approach taken, KF added that there was a need to be careful about attempting to open up epidemic infection control to primary care to do everything, because there were capacity issues and also a need for national level co-ordination and expertise. AC commented that GPs had told him that they could do most of this work and wouldn't it be more efficient if local GP hubs were a key part of the system? KF replied that it was important to note that the guidance was clear that if someone had symptoms they must stay at home as the risk of onward transmission by walking into a primary care setting was too high. Because of this therefore, home testing is the way forward, notwithstanding some of the limitations it also has.

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

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

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

5 Minutes and matters arising

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Any Other Business

8.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

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Health in Hackney Scrutiny Commission 9th July 2020 Work programme for 2020/21	Item No 10

OUTLINE

Attached please fined the updated work programme for the Commission.

Please note that a number of items which had to be postponed because of the Covid-19 crisis have not yet been found confirmed slots.

ACTION

To give consideration to the work programme and agree any amendments as necessary.

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Health in Hackney Scrutiny Commission

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

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

<u>This is a working document and subject to change</u>

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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 Amanda Healy	Dir of Public Health Regional Director London PHE and NHSE London Independent SAGE /UCL Independent SAGE/ Univ. of Newcastle DPH Durham County Council	**Covid-19 Response – DISCUSSION PANEL**	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?
			Appointment to INEL JHOSC	To appoint 1 member to INEL JHOSC to replace Cllr Maxwell. Cllr Snell was appointed. As there was no AGM in May 2020 previous appointments to committees from May 2019 roll over until an AGM is scheduled.
INEL JHOSC Wed 24 June 2020 Virtual Meeting		*Chair and AO for ELHCP; Chairs and MDs of all the CCGS for North East London; CEO Barts Health; CEO HUHFT; Deputy CEO, ELFT; Reps of North East London Save Our NHS*	***INEL boroughs' response to Covid-19 pandemic***	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Thu 9 July 2020 Papers deadline: 30 June		All Members	**Election of Vice Chair for 202/21**	To elect a Vice Chair to replace Cllr Maxwell who has stepped down on becoming a Cabinet Adviser.
	HUHFT Chief Nurse and Director of Governance Homerton UNISON	Catherine Pelley TBC Lorna Solomon	**Homerton Hospital and its contract for soft services**	Follow up from January meeting and request from Homerton UNISON and from Members. Concern that the 5 year extension of the ISS contract was announced hastily and without proper consultation despite ongoing concerns about staff pay and conditions, exacerbated by Covid-19 situation.
	CCG Chair and MD	David Maher Dr Mark Rickets	**An Integrated Care System for NEL**	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
	CCG Chair and MD	David Maher Dr Mark Rickets	**Covid-19 City and Hackney Restoration and Resilience Plan**	Follow up from discussions at March and June meetings.
	Director of Public Health	Dr Sandra Husbands	**Covid-19 update on Test, Trace and Isolate Pilot**	Follow up from June meeting on progress of roll out of testing locally and the Test Trace Isolate Pilot which Hackney is participating in with Newham, Camden and Barnet.
Wed 23 Sept 2020 Papers deadline: 14 Sept	Independent Chair of CHSAB Head of Safeguarding Adults	Dr Adi Cooper John Binding	**Annual Report of City & Hackney Safeguarding Adults Board 2019-20**	Usually scheduled in Sept-Dec period
tbc	Public Health SPED HUHFT CCG GP Confed	TBC	**Covid 19 Response – Disproportionate impact on ethnic minority communities**	Input from Council's Public Health and SPED depts, HUHFT etc

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Postponed from March 2020 tbc	LBH/CoL/CCG Planned Care Workstream	Siobhan Harper, Workstream Director Andrew Carter, SRO	**Integrated commissioning- PLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams. To also include an update on the **Housing First** pilot.
INEL JHOSC Wed 30 Sept 2020	*Barts Health* *ELHCP* *ELHCP*		TBC but likely to include ***- Overseas Visitor Charging Regulations*** ***- ICS implementation*** ***- Covid-19 response***	
Mon 12 Oct 2020 Papers deadline: 30 Sept	TBC			
Joint with Members of CYP Scrutiny Commission *TBC*	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director Anne Canning, SRO	**Integrated Commissioning – CYP&M Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
Wed 18 Nov 2020 Papers deadline: 9 Nov	TBC			
Postponed from June TBC	LBH/CoL/Prevention Workstream	Jayne Taylor Workstream Director Anne Canning SRO	**Integrated commissioning PREVENTION Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	Cabinet Member	Cllr Kennedy	**REVIEW: Digital first primary care and the**	The Cabinet Response to this due in March was delayed because of the Covid-19 crisis. Instead this will be a Cabinet

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
			implications for GP practices	Response and an update 12 months on from the publication of the original review report.
INEL JHOSC Wed 25 Nov 2020 ***Joint meeting with ONEL***				
Thu 28 Jan 2021 Papers deadline:	TBC			
	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
INEL JHOSC Feb 2021 Date tbc			TBC	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Tue 23 Feb 2021 Papers deadline:	Director Adult Services		**Hackney Local Account of Adult Care Services**	Annual Report for 2020/21?
	TBC			
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.
	TBC			
			Work Programme discussion for 2021/22	

Items agreed but yet to be scheduled

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	**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			**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

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ITEMS POSTPONED DUE TO COVID-19 AND YET TO BE SCHEDULED

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 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.
Postponed from 1 May	**SCRUTINY IN A DAY**	*Public Health Environmental Health*	***Health Inequalities – Marmot 10 Years On***	*Scrutiny in Day Session*
Postponed from July	GP Confed Integrated Commissioning	Laura Sharpe Nina Griffith	**Neighbourhoods Development Programme**	Follow up on item at July 2019
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.

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