Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Wednesday 14 October 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 Emma Plouviez, Cllr Patrick Spence, Cllr Kofo David and Cllr Kam Adams**
Apologies:	**Cllr Michelle Gregory**
Officers In Attendance	
Other People in Attendance	
Members of the Public	
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence (19.00)

Apologies for absence were received from Dr Sandra Husbands, Andrew Carter, Malcolm Alexander and Anne Canning.

2 Urgent Items / Order of Business (19.03)

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

3 Declarations of Interest (19.04)

3.1 There were none.

4 Integrated Commissioning - update from Children Young People and Maternity Workstream (joint item with Members of CYP Scrutiny Commission) (19.05

4.1 Members gave consideration to a briefing paper from the CCG "The future of health and care for the people of north east London" and the Chair welcomed for this item

Dr Mark Rickets (MR), Chair, City and Hackney CCG
David Maher (DM), Managing Director, City and Hackney CCG
Tracey Fletcher (TF), Chief Executive, Homerton University Hospital NHS Foundation Trust (HUHFT)
Laura Sharpe (LS), Chief Executive, City and Hackney GP Confederation

4.2 The Chair explained the background and context for the creation of a single CCG over the NEL footprint. It was noted that the GP Practices who are members of City and Hackney CCG will be voting in Oct on the merger to create a single CGG covering the 8 north east London local authority areas.

4.3 DM and MR took Members through the briefing paper in detail. He described the long history of partnership working and the long plans for devolution. Working in a collaborative way had created integrated workstreams across health and care which had been very successful. Stakeholder engagement was currently on going and they would seek members endorsement in October. This would then allow the current Integrated Commissioning Board in City and Hackney to transform into an Integrated Care Partnership (ICP) which would also have on the key local providers on it. Staff would be TUPE'd to the single CCG but would be posted back to continue their work in City and Hackney. Covid had delayed the process but NHSE London still requires a vote by October. The discussions with the Primary Care Network leaders locally were very constructive they will be co-producing with them the governance documents over quarters 3 and 4. The Neighbourhoods Programme (the PCNs) were progressing well and fit well with the required new system. There will follow a series of Transformation Programmes which come out of the Strategic Operational Command (SOC) led by Tracey Fletcher and set up to respond to the Covid crisis and the Enabled Groups in Integrated Commissioning are making these happen. A Neighbourhood Health and Care Board (NHCB) will be established under the ICP. The current CCG staff will align themselves with what is needed to deliver the Neighbourhoods system and will stay within C&H.

The new local ICP and NHCB have been established under an Accountability Framework and will include both execs and non-execs from all the commissioning and provider partners locally. Commissioning decisions, where necessary, will yield to the legislation currently in place and where there has to be conflict of interest boundaries e.g. primary care commissioning these will continue to be respected.

He added that the two Health and Wellbeing Boards (Hackney Council and City of London) will be critical in shaping the wider population healthcare management approach as they will focus on wider determinants of ill health and attitudinal issues. The Health and Wellbeing Board will therefore be supported by new Population Health Hub which is being developed between the CCG and the Director of Public Health. This will provide a focus for co-ordination wider population health strategies and will lend its expert support to the NHCB.

Clinicians will be involved at each level and decision making will be at 'Place' level, unless it is clearer that more can be achieved on a particular issue at the NEL level. A principle of subsidiarity will therefore apply.

In terms of finance flows, 98% of existing CCG allocation will be devolved back down to City and Hackney to be deployed via the local ICP and NHCB. The ICS for NEL will retain a 1% budget for corporate costs and all ex CCG staff will be employed by NEL. There will also be a 0.5% contingency and 0.5% risk reserve as was the case

previously. He added that these allocations were subject to national policy and post pandemic resources may of course differ. He noted that the Chancellor was deferring the budget to support Covid during the winter period so CCGs are working on the basis of current allocations in these models. He concluded that co-production and clinical leadership would be key, that the providers in C&H were all high functioning and driven by quality. On Primary Care leadership they were proposing that the clinical leadership executive of it will be reshaped. Jane Milligan would remain the Accountable Officer at NEL level of course at the ICP level there will be Elected Member input from the Council.

4.4 Members asked detailed questions the following responses were noted:

(a) Chair expressed concern that CCG members were being asked to consider a merger without seeing the new Constitution or what formal powers they were giving up. Assurance was also needed on the 80:20 split agreement.

DM replied that a draft of the Constitution went to Members that afternoon. The focus was less about the NEL Constitution per se but more about the working relationships locally and that is what members were seeking clarity on. MR explained about the scheme of delegation and how a principle of subsidiarity would guide it going forward. It was noted that much of the practical detail would be in the Operating Handbook. This would describe in more detail the financial framework, the allocations and how the money would flow down the system. There would also be new money under the Long Term Plan and detail on how that would be manged at NEL level. 98% of the funding would come down to City and Hackney level and all of the previous Primary Care budget. He added that he was working with his equivalent in Tower Hamlets on a Declaration of Principles which all CCGs have signed up to which articulates the principles against which they would be judged in the future.

(b) Chair stated that currently under primary legislation our local CCG as a body got c. £450m for commissioning and this provided some solidity. Without formal agreements what would happen in say 5 years if NEL didn't want the same provision at HUHFT. More attention needed to be paid therefore to the medium and long term implications of this for Hackney.

DM replied that he didn't think that level of detail would be articulated in any Constitution. A CCGs responsibility was to purchase services for its population and a Constitution wouldn't go into detail about where the provision would come from. He added that City and Hackney was playing to its strengths here with the framework it had now been presented with. City and Hackney had been recognised as a sub-system within the ICS. Tracey Fletcher as CE of HUHFT as member of the system would now be part of it and they were was an additional tethering of accountability back to the local health system and back to the new ICP. The counterbalance to the Constitution was the Acountability Framework which they had established so that City and Hackney would get the best outcomes. The mandate that City and Hackney ICP will receive from NEL will include this detail and will state the outcomes expected of City and Hackney and will also outline what resources will be available to them to deliver these.

(c) Members asked how accountability could be clarified without seeing the full Constitution. They commented that the Constitution alone wouldn't address all of the issues of concern re the dissolution of C&HCCG and that there needed to be clarity and what would happen down the line. They asked whether the 80% referred to

money or levels of operation. They asked if there was evidence that the 1% admin costs represented value for money and asked whether a decision could be deferred until these issues were clarified. They gave the example of the ISS issue at HUHFT as an example of the need to future proof constitutional arrangements stating that certain provisions in the Constitution could affect the wider community interest.

DM reiterated that they would share the draft. He stated re the HUHFT example that the Constitution would not be able to illustrate how parameters for that kind would work. He stated that the Constitution was a nationally mandated NHSE framework document. MR replied that CCG Members were looking at the draft Constitution at the moment and that most of the nuance councillors were seeking would be expressed instead in the Operating Handbook. He stated that they had wanted to defer the vote because of the pandemic but NHSE had refused stating that NEL already had been given an additional year, unlike other STP areas, and it was a requirement to get on with the process. This allowed for very little wriggle room. They would like to have been further ahead with it but this had not been possible because of the Covid situation.

(d) Members asked if the Constitution was not set in stone was there scope to change it.

MR replied no and that any changes to the framework document would have to be agreed nationally by NHSE and it was instead in the Operating Handbook where there would be more leeway to make changes.

(e) Members asked for clarity of the 80:20 ratio and on admin costs.

MR replied that this was not a prescriptive rule but rather an overarching principle. DN stated that this principle had been put forward very early in the whole process in order to illustrate the potential local levels of devolution. In C&H it was actually 98% in terms of financials. He added that CCG staff would be employed by the ICS NEL but the majority will continue to work locally. The money, the staffing, the activity, the scheme of delegation will all try to follow the 80:20 principle. On the 1% admin costs, this was a requirement on every CCG from NHSE. C&HCCG had always underspent by about 20% which was then reinvested in front line. At the same time NHSE also required CCGs to deliver 20% efficiency savings on running cost. The 3 subsystems were working through all of this. He viewed the performance of the C&HCCG team as being excellent value for money.

(f) Members questioned whether now was the right time to make these changes (in the context of the pandemic upheaval) they stated that in their view the case did not seem to be made. They expressed concern about the loss of local involvement and asked how much the actual change process would cost and whether it was taking away valuable resources from the front line at a difficult time.

DM replied that the draft Constitution provided the material detail CCG members will need to vote on. A draft went out that day and he would be meeting other CCG Chairs later that day. The draft Operating Handbook would flesh out, in as much detail as possible at this stage, a lot of the issues of concern here but the plan was to finesse this and improve it over Q3 and Q4 in order to get it right. He was leading a group on developing that process and Tracey Fletcher was doing the same with a group developing the City and Hackney Neighbourhood Health and Care Board sorting out

its membership and operational procedures. As the Operating Handbook developed they would keep the Commission updated on the progress.

(g) Members asked to be reminded what the original premise was behind the centralisation of CCGs both in NEL and nationwide.

DM replied that NHSE's Long Term Plan had set out expectations that ICS would be set up by April 2021 to work across larger population footprints of 1m people plus and the expectations that Primary Care should begin to organise itself into Primary Care Networks bult on populations of 30-50k. They would work at a more granular population level and the intention was that by leveraging providers and commissioners together at a wider scale this would allow the grassroots to drive change and improvement through the Primary Care Networks. In the LTP Simon Stevens had expressed that the legislative change had to happen to remove competition from the market. The requirement for commissioners of services to use market forces to define best value did not seeing to be playing out under the current legislation yet it was there in the NHSE Commissioning Board principles. The changes under the LTP would break down the purchaser-provider boundaries and allow greater robustness to manage those market forces until new legislation could be put in place. MR added that allowing us to move away from the traditional contractor provider relationship was positive. The focus was on co-working until the legislation can be changed. The contractual formal arrangements will allow all partners to come together to share planning, the Accountability Framework and financial control and there will still be a need for a CCG. The checks will be there but it allowed us to move into a shared way of working to manage population health in a much more holistic way. The new approach would also allow us to marshal resources better to manage the wider determinants of ill-health and to work more with the VCS for example and to work in a model where the focus will be at neighbourhood level. Commissioning already done at NEL level will continue at that level and new money for specialist commissioning will also flow through the system. This was why C&H needed to be at that STP table. These changes came with real opportunities for C&H and the best of them represented an important step change for the local health economy.

(h) Members questioned how local accountability can be maintained across 8 boroughs.

DM outlined how the current accountability structures work locally including the CCGs Members' Forums, the role of the Single Accountable Officer and how she holds the 7 CCG MDs to account. He was also held to account by the CCG Governing Body and the local Members Forum. The future model would not be that different he explained. There would be 7 Members Forums elected by the local Practice Members, they will then elect a chair to be part of the NEL ICS Governing Body and as part of the local ICP structure they will sit on key decision making bodies in City and Hackney. Jane Milligan was also held to account in each of the 7 CCG areas. Executives from the Providers are also now on the ICP and there will be Executive Lead sitting on the ICP Board so accountability is locked in locally. In addition, there were excellent Healthwatches continuing in each of the 8 boroughs. He added that local representation and accountability to this Commission would continue and of course the local provider partners would be locked into this structure and made accountable also via Scrutiny.

(i) The Chair expressed a concern that the NEL ICS governance structure might be too unwieldy as it would have over 20 chairs of trust boards and council leaders holding another board with over 20 chief execs on it to account.

DM replied that they were confident that with 98% of resources flowing down into each local system they stood a very good chance of getting on with the work and making the changes needed locally. The response to Covid-19 demanded something akin to an ICS Board to already be created and it had worked well. Tracey Fletcher had been working very closely too with the key Provider partners across the Provider Alliances in the NEL patch. The work was already happening. It was important that we worked with partners across a wider geography, he added, because that is the nature of trying to coordinate scarce health services in a more equitable way.

Tracey Fletcher commented on the changes from the Acute Provider perspective, stating that a lot of what they provide locally was determined by Regulation and not commissioning structures. Any changes at that level had never sat with CCGs but much more in Regulatory Frameworks and there was a vital need to work on that at an NEL level. During Covid relationships improved greatly between the acute providers. She added that acute providers don't of course provide all that is necessary and they hope that these arrangements will better solidify how they need to improve for example the local care pathways on cancer. This change should lead Acutes to have more leverage to improve these. She described how at HUHFT they already provided particular specialist services to NEL in neo natal care and in bariatric surgery. She added that while it is easy to talk about what may be lost from there changes there are also opportunities to really gain. They expend a lot of hours and a lot of energy in commissioner-provider battles or in provider to provider battles and one of key shifts needed in this whole process was to engender a better sharing of this responsibility. She added that a new and different financial regime is almost certainly going to come in and with that will come different challenges and different opportunities to operate as a system. Arguably it will bring different incentives and different pressures too for all the acute trusts but it's going to happen and in her view the removal of commissioner-provider battle locally will help this and provide an emphasis on making the system work collectively. This was an opportunity and we should emphasise this rather than focusing on potential losses.

4.5 The Chair thanked TF, MR and DM for their comments and contributions.

ACTION:
Prior to the CCG Members' vote, the MD of CCG to provide Commission Members with
A working draft of the new Constitution
A draft of the Operating Handbook
A governance structure chart for the overall NEL ICS
so that the Commission may be able to make representation on them, if necessary.

RESOLVED:
That the briefing paper and discussion be noted.

5 City & Hackney Safeguarding Adults Board Annual Report 2019/20 (19.45)

5.1 Members gave consideration to a presentation “Covid-19 update” in the agenda and also to an updated presentation from Public Health tabled at the meeting.
5.2 The Chair welcomed Chris Lovitt (Deputy Director of Public Health) who is new to the role and thanked him for deputising for the Director who had to give apologies.

5.3 The Chair stated that many are requesting testing and so many can’t get them. The key metric to watch now was hospitalisation levels. He added that there had been some modelling the previous weekend which stated that by the next weekend the country could be at the same level of prevalence as in April. He asked Tracey Fletcher (Chief Executive, HUHFT) for an update from the acute sector perspective.
5.4 TF stated that as of that morning there was 1 patient in ICU with Covid-19 as well as 7 inpatients awaiting test results. They had not seen the same levels as BHRUT hospital. They had seen a very small increase overall and they were in the midst of planning and reorganising to prepare for increased levels of admissions over the coming weeks. In response to the Chair, she stated that they were in regular contact with the Public Health team and she had met with the Cabinet Member Cllr Kennedy also to discuss more frequent sharing of data from now on and he could be a conduit of information to the Commission Members also.
5.5 The Chair asked what was different this time than from the March-April period in relation to discharges of patients to care homes. What improvements had been made.
TF replied that they had a good record on safe discharges particularly in relation to Mary Seacole Home. The key factor was how they worked with care home staff to minimise transfers and the risks during them. Patients were tested through admission and before they are discharged. She added that sometimes it would be more risky for vulnerable older patients to remain in hospital rather than go out to care homes and the key was to ensure that there were similar levels of infection control in place across both settings.
5.6 CL took members through his presentation in detail. The Chair thanked Public Health for providing greater triangulation of testing data by also including and comparing it with number of calls going into primary care, numbers contacting NHS 111 and data on staff related absences.
5.7 Members asked detailed questions and in the response the following was noted:
(a) Members asked why the incidence in Shacklewell went from second highest to lowest in a couple of weeks. They asked what was being done to ensure social distancing in shops and to enforce mask wearing on buses and what was the % success rate of test, trace and isolate in Shacklewell.
CL replied that the ward level numbers were small and availability of testing here was the key factor. It was not possible to make conclusions about success at ward level based on these numbers, but he would examine the data further and reply in writing to the Ward Members. They were focusing on wards where numbers were high and comparing it with GP data. They had asked PHE for outbreak testing rather than routine testing in order to better contain these local outbreaks. He added that a change in the guidance would be more helpful in providing greater clarity. He stated that face coverings must be worn indoors in hospitality settings. They were currently not mandatory everywhere in public but would become so. He added that re shops Environmental Health was also playing a role and there would be an escalated approach to inform, visit, enforce, fine and close down, as necessary. Regarding compliance with mask wearing on buses the levels of compliance appeared to be generally very good and concerns about this needed to be directed to TfL. The messaging here had been clear for some time.

(b) Chair asked whether councils new role in test-track-isolate would mean that they were being left with the more challenging cases while the private providers running the national system pick off the low hanging fruit of more easier cases at that level. He also asked whether more funding would be received to cope with the task and how the monitoring would operate.

CL replied that this was a very recent development. The success rate for NHS Test and Trace in Hackney was not where it should be but we were not alone in this. There were challenges around deprivation, English not as first language, and suspicion around the role private public partnerships involving organisations that do not have a good track record and on whom you would not want to place the NHS brand. If the national system had been unsuccessful in contacting the index case than that information would be supplied to the local Public Health team and local contact centre staff and environmental health officers would try to contact the individuals using the records they have in the council, they might for example have a mobile phone number for the contact. The previous day they had went live on this new system and had 6 cases referred and they had been able to contact 3 of them quickly.

He added that he was keen to get the views of local NHS partners on how, after a few weeks if they had been unsuccessful in contacting certain cases, whether they could pass them to local NHS bodies to fill the missing gaps. They would not be asking them to act on the information now but rather to give an indication about how effective contact tracing might be if further data could be shared. Public Health had already received the national data sharing protocols, these were nationally driven and they had to go through a lot of stages to ensure that staff were sufficiently trained and that they locally have the required data protections in pace. He added that they were using the Contact Centre staff who were very used to dealing with Hackney residents and, so far, the feedback from residents contacted had been very positive. This should allow Public Health to reach all the individuals who need to be contacted and to help ensure that they are self-isolating.

(c) Members expressed concern re the point on p.24 that ethnicity data was not available for half the records referred to. This was a worry considering the disproportionate impact of the virus on ethnic minority groups.

CL replied that it was indeed important to draw attention to poor recording of ethnicity data and he would take this back to the national system because data quality was crucial.

(d) Members asked why the 7-day incident rate in Hoxton and Shoreditch was so high and what the cause might be. They also asked what the eligibility criteria would be for the £500 welfare payment to those on low incomes forced to self-isolate.

CL said that Hoxton was the 3rd highest and while it was tempting to try to give ward level analysis it would be remiss to do that on the basis of these numbers. The general point to be made was that the area had a younger population with higher levels of social mixing. Perhaps the influx of students might be a factor as well as the recent better availability of testing, he added. If it persisted there would need to be more tailored interventions. He added that they were looking at a similar picture across a number of other hotspots and high levels of socialising was a factor in generating higher numbers of cases.

On the £500 payments he stated that this guidance had been issued on Sunday and the Council was busy trying to implement aspects of that. He shared the link to the guidance document with Members. It was important too that those who won't be eligible don't waste time in applying, he added.

Cllr Kennedy commented that Professor Kevin Fenton (PHE London) had recently explained that in mid-August London had been testing 90000 a week but by mid-September this had fallen to 65000 a week. This represented a huge drop off and a re-allocation of testing capacity away from London at a time when it was needed most.

On the £500 payment, he stated that the irony here was that you had to have a positive test to be eligible for it. So just as testing levels were falling rapidly people were required to prove a positive test to get the support they need to afford to self-isolate.

5.8 The Chair thanked CL and Public Health for their very detailed and helpful briefings.

ACTION:
Deputy Director of Public Health to provide more detailed ward based analysis of the Covid-19 testing data, where possible, particularly to the Ward Members for Shacklewell and for Hoxton and Shoreditch.

RESOLVED:
That the 2 reports and discussion be noted.

6 Homerton University Hospital NHS FT - Quality Account 2019/20 (20.15)

6.1 Members gave consideration to a report Update on the Planned Care Workstream of the Integated Commissioning Board .

6.2 The Chair welcomed for this item:

Siobhan Harper (SH), Workstream Director – Planned Care

SH stated that Andrew Carter, the SRO for the Workstream, had to give his apologies as he had been having technical difficulties connecting to the meeting.

6.3 SH took members through the highlights of the report. The focus of the Workstream had been on recovery and restoration of services post the peak months of the Covid-19 pandemic and ensuring people were accessing the care they needed. She explained how they had established Acute Provider Alliances across the NEL patch where the key providers had formally come together to deliver elective care and to ensure that they all met the stringent infection control guidance under Covid so that operating theatres, for example, can be kept Covid free. There were plans for developing surgical hubs for low acuity and high volume conditions and there will be designing sites for specific surgeries to help deliver the restoration of elective care, as per the rigorous targets set for them by NHSE as part of the national recovery. She also drew Members' attention to the fact that cancer surgery did actually continue during pandemic and many did get treatment e.g. from private providers via Barts Health. There were however serious delays in more diagnostic parts of the care pathways e.g. endoscopy, because there were restrictions on how many patients could be seen in one day. She added that cancer screening services had been reinstated and women were being encouraged to ensure they have their checks. Another issue for the Workstream was the fact that many were experiencing symptoms of "long Covid" and were finding recovery quite difficult. Together with partners in primary care and mental health they were developing Covid specific pathways for patients whose conditions are complex, multi-faceted and which present in many ways.

6.4 Members asked detailed questions and in the responses the following was noted:

(a) The Chair suggested that there was scope for a communications campaign by Public Health in relation to 'Long Covid' and the long lasting health ramifications for many people of the virus.

(b) The Chair asked whether 'virtual by default' in primary care was exacerbating the digital divide and what action plans were in place to support those who are on the wrong side of this divide and feel they are being locked out of the system.

SH replied that the ICB's IT Enabler Group, led by the Digital Team at Hackney Council, were working on a number of fronts on this for example there was a piece of work on maximising opportunities to learn about digital world, there was a specific project on helping those with learning disabilities to access additional hardware and work was being done in Mental Health services involving supporting clients to use their personal budgets to purchase the equipment they need. She added that the health services locally were very mindful that the digital divide posed a real risk to services because only those who know how to navigate the systems can get access. They were looking at this in detail and asking Providers to monitor the situation. It was important not to make assumptions that people have the equipment or that they have the space to even receive a private video call with a medical practitioner. DM added that the policy across NEL on managing in the Covid era was not 'digital by default' but rather 'digital when appropriate'. This helped them to identify where digital solutions worked and to have appropriate pathways in place for this for those who needed them. The Chair added that in the Council there was a similar challenge in relation to school children and how they can accessed learning and there needed to be more joined up services here.

(c) Members asked if report writers could be more careful about the use of confusing acronyms. SH apologised and stated she would ensure more attention to this in future.

(d) Members asked about the high variances in prescribed medicines and GPs role in offering cheaper alternatives.

SH replied that the cost of generic vs prescribed medicines was an ongoing one. They did encourage GPs but they generally feel that GPs are now more mindful of prescribing costs because of the requirements to deliver best value and to offer more equitable and effective medicines. MR added that in the clinical system in use in GP Practices there was a prescribing formula embedded in it which, among other things, offered equivalent medicines which would be less expensive, thus saving money from the prescribing budget. GPs will usually go with the least expensive options but there are occasions where it is medically necessary to prescribe a patient a particular branded item. Member commented that her GP asked her if she wanted the less expensive item. SH added that GPs have got used to being more efficient with resources and that they try to engender these commissioning modes of thinking without making it onerous on the doctors.

(e) Members asked about the centralisation of surgical hubs and whether a proper consultation document would emerge proposing which forms of elective care will go to which sites.

SH replied that the Acute Providers Alliance would be bringing something along these lines to a future meeting of the INEL and ONEL JHOSCs. She added that Jane Milligan at the C&HCCG AGM had made a commitment that the changes as a result of Covid-19 weren't substantive and that if there were any long term arrangements as a result of the pandemic then they would be properly consulted on and Equality Impact Assessments would be undertaken etc. These arrangements were an attempt to clear the long waiting lists which had built up in the NEL system because of the pandemic and for example in C&H alone there had been 17000 people on the outpatient waiting lists.

(f) The Chair asked what specific plans as regards transport were being put in place to support patients who will have their elective treatments, for the present, mov3ed to a more remote site.

SH replied that a lot of thought had gone into this. Initial Infection Control Guidance for patients had been very stringent e.g. all patients asked to self- isolate for two weeks prior to surgery, this had lessened and as part of the initial conversation with patients, they would be looking at transport. Also, with day care procedures for example you cannot attend unless you have someone to accompany you home. A lot of attention was given to this as part of the re-booking process for those awaiting operations, she added.

(g) The Chair asked if they had an estimate of when elective care might get back on track, notwithstanding the current impending threat of a possible second wave.

SH replied that the situation was fluid because of the potential of a second wave but re-iterated that there were no plans to close services as had been done back in March. That had been a unique situation and there shouldn't be the same impact this time on waiting lists.

6.5 The Chair thanked SH for her report and for her attendance.

RESOLVED:

That the report and discussion be noted.

7 Covid-19 verbal update on Test, Trace and Isolate (20.35)

7.1 The Chair stated that each year the Commission considered the Annual Report of the local Healthwatch and the Chair welcomed for this item:

Jon Williams (JW), Executive Director, Healthwatch Hackney

7.2 Members' gave consideration to the Annual Report 2019/20 of Healthwatch Hackney and the associated presentation.

7.3 JW took members through the highlights of the report. He also gave apologies for the interim Chair, Malcolm Alexander, who had been unable to attend. He added that a permanent Chair would be recruited in due course. He suggested that there should be closer work with the local VCS on the digital divide issues as, in his view, this problem would only get worse. More generally, over the year they were detecting a lot of frustration from residents about a top-down approach in the NHS e.g. the surgical hubs or the move of the dementia beds to East Ham. There had been a small drop in satisfaction levels but this had also been the trend. The need for better support for long term mental health patients was also a concern, much of the focus was on the lower level clients seeking IAPT. He stated that Healthwatch had been very proud of its large volunteer base. He stated that many residents were concerned about the government's hostile environment policies and that charging poor and vulnerable people was a deterrent to them seeking vital health care and represented very bad policy making. He explained that the co-chaired the Communications Enabler Group of ICB and more work needed to be done to understand how greater public involvement can be taken forward. He also highlighted the existence of the Involvement Alliance which aided existing organisations to work better together. In terms of funding, they continued to be well funded by the Council despite the pressure it was under and they had also received much funding support from the CCG. They had discontinued their involvement in City Healthwatch.

7.4 Members asked questions and in the replies the following points were noted:

(a) The Chair commended Healthwatch for striking such a good balance between being funded by both the Council and the CCG and at the same time holding both to account so well.

(b) Members commended the quality and accessibility of the report again this year.

(c) A Member commented that there was a low level of awareness about how the local GP Confederation sets minimum standards for GP Practices and that this was an excellent way to achieve consistent approaches across them all but residents were not

aware of this function. He asked if a piece of work could be done to look at the awareness of the public on the existence of these common standards and whether Healthwatch had done any surveys on this.

JW replied that this was an excellent point and that they had not done any specific surveys on this but it was something they could pick up with the Confederation focusing on patients' rights and service user rights akin to the Complaints Charter.

He added that people don't know what their rights are or what to expect and if you put it to them in a simple way that would be very helpful to patients but we should be surveying GPs to ensure that they are working to a consistent standard.

(d) The Chair asked whether the digitisation of access to primary care during the pandemic was having the effect of widening the digital divide and whether the borough had a joined up approach in terms of access and what the best practice was elsewhere and what could be learnt from those examples.

JW stated that this was a major challenge and he was expecting it to get worse. He was appreciative of the work HCVS was doing in this area. Given state of economy many are going to be struggling more and there will be a rise in unemployment which would exacerbate this. One of the challenges was that those on the wrong side of the digital divide were very hard to reach in the first place. He added that a recent survey had shown a lack of confidence in what both central government and local govt was saying. He said he expected the former but was surprised that local government was now coming across as being mistrusted and was seen as not listening. It was really important that as a system we worked together with community groups, faith groups and others who can help to give us access to groups who are seldom heard and who may be losing out more in the digital divide.

(e) MR added that the CCG would welcome being part of the piece of work which JW outlined on GP access. They had 1.6m consultations last year in C&H and they needed to explore whether this was a problem of some Practices not being organised on the day or did it highlight a more systemic problem and that more insight on this would be most welcome.

7.5 The Chair asked if there was scope for Healthwatch and the GP Confederation to work together on perhaps developing a Protocol to standardise approaches to the digital divide issues across the GP Practices in Hackney. He added that the issue might be difficult but that in the current situation many on the wrong side of the digital divide were feeling shut out by primary care and this was a problem because it disproportionately affected the more vulnerable residents. JW undertook to explore this.

7.6 The Chair thanked JW for his report and for his attendance.

ACTION:

Executive Director of Healthwatch to explore with the CE of the GP Confederation on developing a Protocol for GP Practices on supporting those who cannot readily access their GPs via digital means and on establishing a consistent standard across all the Practices in Hackney.

RESOLVED:

That the report and discussion be noted.

8 Minutes of the Previous Meeting (20.55)

8.1 Members gave consideration to the draft minutes of the meeting held on 30 July and noted the matters arising.

RESOLVED:

That the minutes of the meeting held on 30 July be agreed as a correct record and that the matters arising be noted.

9 Any Other Business (20.59)

10.1 There was none.

10 Health in Hackney Scrutiny Commission- 2020/21 Work Programme (20.57)

9.1 Members' gave consideration to the updated work programme for the Commission. The Chair stated that he wanted to continue to keep some spaces open in order to respond to fast changing situations such as Covid and that they would request a further verbal update on Test and Trace for next month.

RESOLVED:
That the updated work programme be noted.

Duration of the meeting: Times Not Specified