# 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

**Wednesday 18 November 2020**

**7.00 pm**

**Until further Notice, all Council meetings will be held remotely**

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ 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, Cllr Kofo David, Cllr Kam Adams and Cllr Michelle Gregory**

## Agenda

**ALL MEETINGS ARE OPEN TO THE PUBLIC**



Hackney

# Access and Information

## Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

## Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

## 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

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**Rights of Press and Public to Report on Meetings**

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital

and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

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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.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

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| | | | |
|---|---|---|---|
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| | **Cllr Kofo David** | **Cllr Michelle Gregory** | **Cllr Deniz Oguzkanli** |
| | **Cllr Emma Plouviez** | **Cllr Patrick Spence** | |

## Agenda

**ALL MEETINGS ARE OPEN TO THE PUBLIC**

**1** Apologies for Absence (19.00)

**2** Urgent Items / Order of Business (19.02)

**3** Declarations of Interest (19.04)

**4** **Care Homes and Covid-19 – PANEL DISCUSSION (19.05)**

**5** **Unplanned Care Workstream Annual Update (20.15)**

**6** **Covid 19 test and trace – verbal update (20.35)**

**7** **Briefing on senior management restructure of Adult Services (20.50)**

**8** Minutes of the previous meeting (20.58)
**9** Health in Hackney 2020/21 Work Programme (20.59)
**10** Any Other Business (21.00)



Hackney

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Hackney

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|---|---|
| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**Covid-19 and Care Homes PANEL DISCUSSION** | Item No<br><br>**4** |

**PURPOSE OF ITEM**

To examine how our local care homes, as part of the wider health and care system, are coping during the Covid-19 pandemic and to seek reassurance that the local system is now better prepared for a second wave, should it occur. To examine what lessons have been learnt from March-April when many vulnerable patients had to be discharged very rapidly from acute services into our care homes.

**OUTLINE**

The discussion with our key stakeholders will explore:

- how effective are the current processes around the discharge of elderly patients from the Homerton to local Care Homes?
- when and how are they tested and how long do they wait for results?
- are positive and/or symptomatic patients 'cohorted' into particular wards or floors/sections and what if this can't be achieved?
- is there now adequate provision of PPE?
- Have care home staff received adequate guidance on Covid?
- what is the current situation re asymptomatic testing of patients?
- what is the current situation on testing of care home staff?
- have arrangements for visitors altered and how?
- what other steps e.g. iPads have been implemented to support residents to keep in touch with families?
- what has the impact been on those on End of Life Care Plans?
- what has the impact been on the 'Discharge to Assess' system?
- how has the additional funding from central government been spent?
- what is best practice elsewhere and what can be adopted locally?

In the context of an emerging second wave of Covid, we will ask what plans are in place to ensure that our elderly are being kept safe and what work is ongoing between the Homerton, the Council/CCG and local care homes.

Attached please find a briefing paper from the Council's Adult Services team.

## PROGRAMME

| Time | Subject | Name | Position | Affiliation |
|---|---|---|---|---|
| 19.02 | Context and background to item | Cllr Ben Hayhurst | Chair | Health in Hackney Scrutiny Commission |
| **Introduction from local commissioner and a local provider** | | | | |
| 19.05 | Opening remarks from the commissioner | **Denise D'Souza** | Interim Strategic Director of Adult Social Services, Health and Integration | Hackney Council |
| 19.10 | Opening remarks from local care home provider | **Diane Jureidin** | Manager | Acorn Lodge<br><br>(part of Lukka Homes) |
| **Benchmarking best practice and a national policy perspective** | | | | |
| 19.15 | Academic perspective benchmarking national and international best practice | **Adelina Comas-Herrera** | Assistant Professorial Research Fellow in the Care Policy and Evaluation Centre https://ltccovid.org/ | London School of Economics |
| 19.20 | National policy perspective | **Simon Bottery** | Senior Fellow – Social Care<br><br>Latest papers here | The King's Fund |

### 19.25 – 20.15 PANEL DISCUSSION

The above will be joined by:

**Cllr Chris Kennedy**, Cabinet Member for Health, Social Care and Leisure, Hackney Council

**Tracey Fletcher**, Chief Executive, Homerton University Hospital NHS Foundation Trust, also Senior Responsible Office for Unplanned Care Workstream

**Nina Griffith**, Workstream Director for Unplanned Care for City and Hackney Integrated Commissioning Partnership (Hackney Council/ CCG/ Corporation of London)

**Areas of questioning**

- How to achieve **safe discharge** to Care Homes what lessons have been learnt from April.
- Access to latest **guidance, training, PPE and testing** for staff
- Human rights implications of restrictive **visiting guidance**
- Is the '**additional funding'** new and how has it been channelled to the front-line providers?
- Kings Fund has pointed out that the means-tested system has also led to a situation where the care home market relies on significant **cross subsidy** between care home residents paying for themselves and those who are funded by their local authority. On average, a self-funder's care home place costs around 40 per cent more than one paid for by the local authority
- We hear nationally about the **risk of market collapse** by providers withdrawing from offering services to council-funded clients and focusing exclusively on the self-pay market – how is this in east London?

## Some background reading

The International Long Term Care Policy Network (Dr Comas-Herrera a member) pulls together the international research

Mortality associated with COVID-19 outbreaks in care homes: early international evidence by International Long Term Care Policy Network, May 2020
Comas-Herrera A and Fernandez-Plotka JL (2020) Summary of international policy measures to limit

House of Commons
Coronavirus: Adult social care key issues and sources - House of Commons Library

HoC Health and Care Select Cttee report on future of care funding 21 Oct 20

Amnesty
https://www.amnesty.org/en/latest/news/2020/10/uk-older-people-in-care-homes-abandoned-to-die-amid-government-failures-during-covid-19-pandemic/

King's Fund
https://www.kingsfund.org.uk/publications/covid-19-magnified-social-care-problems

Health Foundation
https://www.health.org.uk/what-we-do/responding-to-covid-19
https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-impact-on-social-care-users-and-staff-in-england-so-far

**ACTION**

Members are requested to consider the reports and discussions and make any recommendations as necessary.

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# Care Homes and Covid-19

## Presentation to Hackney Health Scrutiny Committee



NHS
City and Hackney
Clinical Commissioning Group

Hackney

# The presentation will cover:

The Hackney Health Scrutiny Committee invited key partners to help the committee review the processes around hospital discharges into care homes, both during the first round of Covid-19 and how we have learnt lessons to prepare for the winter months and second wave of Covid-19. This presentation covers the specific asks of the committee:

1. Local Context



2. How effective the current processes are around the discharge of elderly patients from the Homerton to Care Homes, when and how they are tested, how long they have to wait for results before discharge, how they are accommodated in Care Homes, whether they are isolated into 'covid sensitive' wards or floors.

3. To explore how processes might have improved since the emergency in April when acute patients, including many frail elderly, had to be discharged rapidly because of the pandemic.

4. Help members learn about the current status of 'Discharge to Assess' and how Covid-19 has impacted on that policy?

5. In the context of a developing second wave of Covid -19 - what plans are in place to ensure that the elderly are being kept safe and what work is ongoing with local care homes.

# 1. Local Context

# Context - Number of Care Homes in Hackney

Within the London Borough of Hackney we have 15 CQC registered care homes with a total of 331 beds (226 in Nursing Homes). These are broken down into the following types of homes:

- 4 Care Homes for Older People that are registered for Nursing
- 6 Mental Health Residential Care Homes
- 5 Learning Disability Residential Care Homes



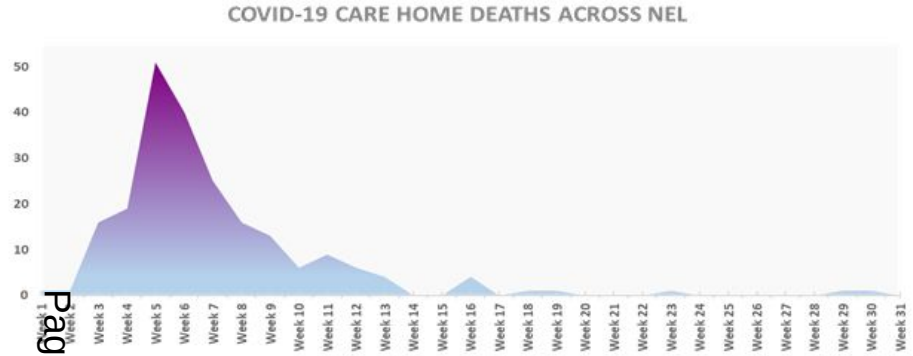
Hackney has a particularly low number of registered care homes, to put this into context as an example Redbridge have 43 Care homes and Islington 48 (information taken from the NHS Tracker)

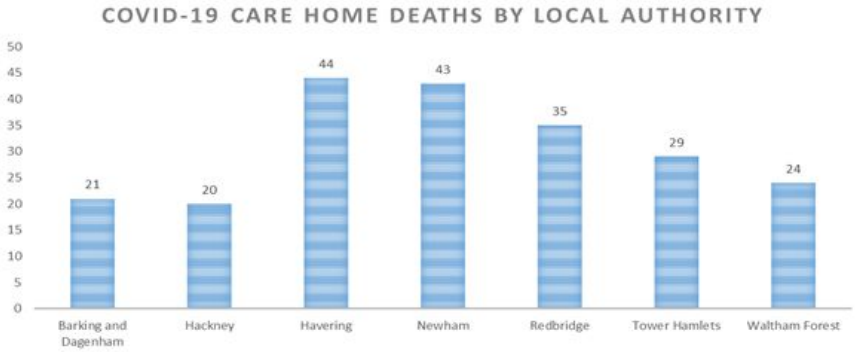
In addition there are:

- 43 Supported Living Services
- 14 Housing with Care schemes
- 22 Home Care Agencies

*Caveat: Data sourced from Adult Services People 10102020 (Service & Budget) XL dated 05/10/2020*

# Care Home Deaths related to Covid-19 (up to 16/10/20)






| Care homes with COVID-19 deaths | 20-Mar | 27-Mar | 03-Apr | 10-Apr | 17-Apr | 24-Apr | 01-May | 08-May | 15-May | 22-May | 29-May | 05-Jun | 12-Jun | 19-Jun | 26-Jun | 03-Jul | 10-Jul | 17-Jul | 24-Jul | 31-Jul | 07-Aug | 14-Aug | 21-Aug | 28-Aug | 04-Sep | 11-Sep | 18-Sep | 25-Sep | 02-Oct | 09-Oct | 16-Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Barking and Dagenham | 1 | 1 | 3 | 0 | 4 | 2 | 4 | 2 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Havering | 0 | 0 | 1 | 4 | 12 | 9 | 2 | 4 | 5 | 0 | 3 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Redbridge | 0 | 0 | 0 | 0 | 4 | 4 | 6 | 6 | 2 | 5 | 2 | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Newham | 0 | 0 | 9 | 10 | 5 | 7 | 7 | 3 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Tower Hamlets | 0 | 0 | 1 | 3 | 13 | 8 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Waltham Forest | 0 | 0 | 0 | 1 | 2 | 7 | 4 | 0 | 4 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hackney | 0 | 0 | 2 | 1 | 11 | 3 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NEL | 1 | 1 | 16 | 19 | 51 | 40 | 25 | 16 | 13 | 6 | 9 | 6 | 4 | 0 | 0 | 4 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total no. of care home deaths in NEL | 32 | 48 | 105 | 110 | 153 | 116 | 87 | 41 | 42 | 35 | 31 | 26 | 22 | 27 | 15 | 32 | 17 | 25 | 25 | 17 | 30 | 24 | 33 | 18 | 19 | 23 | 13 | 26 | 15 | 27 | 24 |
| % of care home deaths caused by COVID-19 | 3% | 2% | 15% | 17% | 33% | 34% | 29% | 39% | 31% | 17% | 29% | 23% | 18% | 0% | 0% | 13% | 0% | 4% | 4% | 0% | 0% | 0% | 3% | 0% | 0% | 0% | 0% | 0% | 7% | 4% | 0% |

# Care Home Deaths related to Covid-19 (up to 16/10/20)

- There have been 20 Covid-19 related deaths occurring in care homes in Hackney, which occured in April and May.
- Across North East London (NEL), there have been 216 Covid-19 related deaths occurring in care homes, which represents 17% of the overall deaths across the NEL footprint.
- The information used to produce these statistics is from ONS, which is based on details collected when certified deaths are registered with the local registration office. This report is published every Tuesday on a weekly basis.

# 2. The current processes around discharge of elderly patient to Care Homes

# Discharge of patients to Care Homes

- The NHS now has responsibility for testing patients being discharged from hospital to a care home, in advance of a timely discharge.
- No one will be discharged into or back into a registered care home with a Covid-19 test result outstanding, or without having been tested within 48 hours preceding discharge.
- At the Homerton, patients are being tested 24-48 hours prior to discharge; usually within 24 hours. A very small number of discharges have been delayed to await swab results.

# 3. How processes have improved since the emergency in April

# Improvements:

- Better PPE access, which now comes from a government central ordering portal
- Better access to testing, although this remains challenging for wider settings
- People are no longer  discharged to care home without testing/waiting for the results
- Patients are only discharged to settings that can self isolate
- The NHS Capacity Tracker is a national database which providers update daily, including vacancies, staffing situation, infection control status and numbers of people with infection.
- CQC new guidance and standards for designated settings are been published
- Regular training has been offered to all Care Homes, supported living accommodations  and home care staff

# Primary care and community services support to care homes

- A national Primary Care Network (PCN) Directed Enhanced Service contract officially started the 1 October and includes requirements for delivery within Care Homes. All local care homes have been aligned to our Neighbourhoods/PCNs with a GP clinical lead in place.
- GPs had already been doing weekly multidisciplinary team meetings and ward rounds under previous contracts or new Covid-19 arrangements. The GP and care home staff compose the core team and PCN pharmacists will also conduct weekly rounds with specific residents. A wider Multidisciplinary Team (MDT) may take place monthly with additional community service staff as required.
- Mental health, learning disability, community nursing and therapy leads have been identified for all care homes (as required), with only a couple gaps remaining.
- Flu immunisation: GPs have been undertaking flu vaccinations with care home residents. Community Pharmacists will support wider roll out of vaccination for residents and staff in all residential care settings.

# 4. The new Home First Policy

# Home First Policy - Headlines

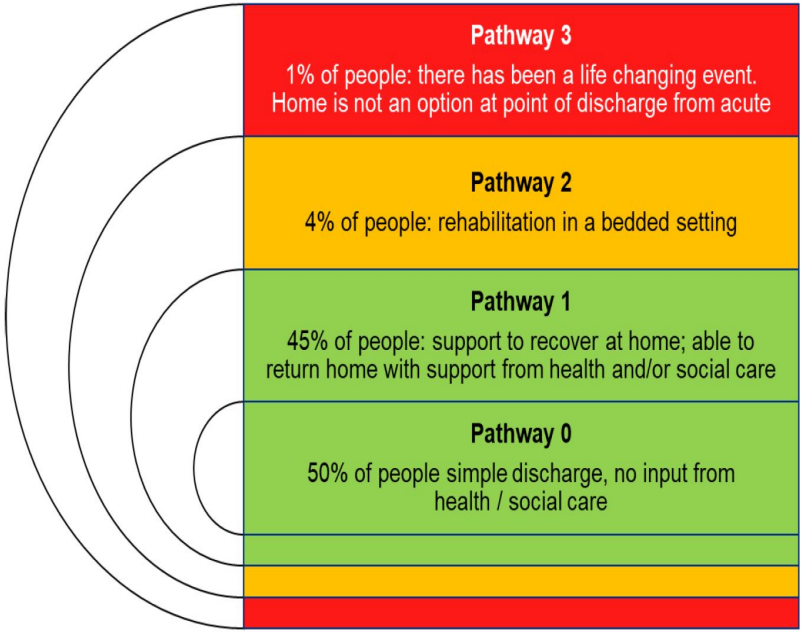
- This policy was published on 1st September with immediate effect
- Hospitals will carry out two daily ward rounds to identify those patients who no longer meet the criteria to reside who should then be discharged on the same day
- Safeguarding and mental capacity assessments will continue to occur in hospital
- Discharge should be happening 7 days per week 8a.m. - 8 pm
- NHS will pay for up to the first 6 weeks of care and/or rehabilitation
- All social care, therapy and continuing healthcare assessments to be conducted in community

Example: In the old system, a patient may have been assessed in hospital and transferred to residential care - taking 2 weeks. Now that same patient will go back home with a full care package –including a live in carer if needed. They will be assessed during the first 6 weeks and may go to residential care; or may find that they can live independently at home with a care package.

# 3. Discharge to Assess - “Home First”

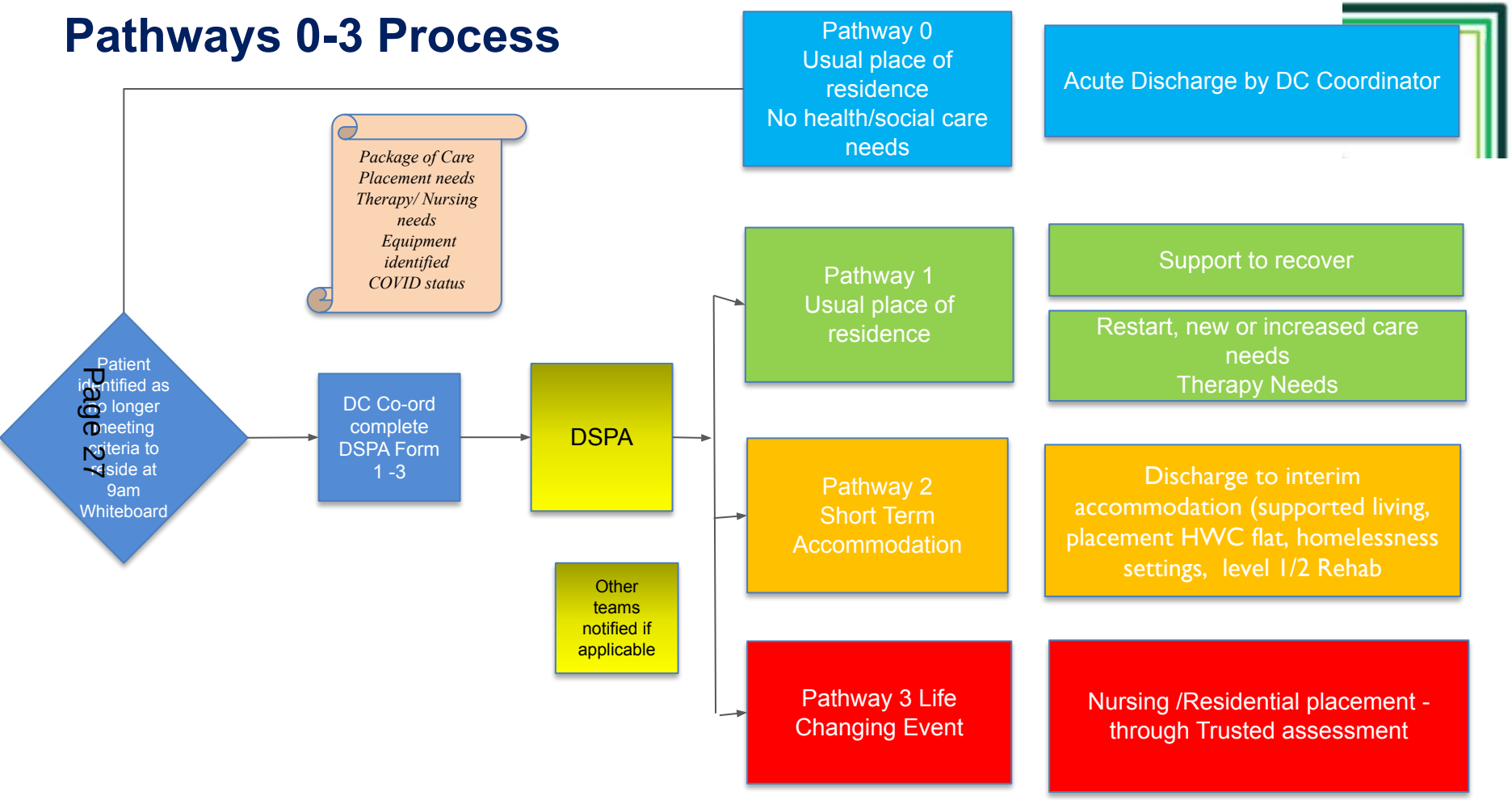



The new Discharge Single Point Access (DSPA)




Pathways defined in new policy

# Pathways 0-3 Process



# 5. What plans are in place to ensure that the elderly are being kept safe and what work is ongoing with local care homes

# Summary:

Here is a summary of all the new support that has been given since the first wave of Covid:

- The government has provided 2 rounds of **Infection Control Funding** which has been given to providers on a per bed basis, which equated to £1,945 per bed per home. This is to support full pay to staff who are self isolating, hiring staff to reduce staff moving between homes and a variety of other infection control measures.
  The NHS **Capacity Tracker** is the new national database which helps us identify vacancies, review how homes are managing their PPE supplies, staffing and infection control measures.
- The Public Health team developed **Standard Operating Procedures** for CQC registered and non-registered settings and Visitor Policies to ensure safe visitation.
- **Staff Training** and **Peer Support** has continued to be provided throughout the year.
- The government has required to to find **Designated settings** for people leaving hospital who are infected and to ensure they meet the new CQC standards.
- GP Confederation **Swabbing Service** training, advice, and testing support

# Infection Control Fund

On 13th May the Government announced an additional £600 million to support providers through a new adult social care infection control fund.

At the end of September a second tranche of the infection control funding was announced.

The Hackney allocation for the second tranche is £991,677. Unlike Tranche 1, where 75% split of the funding went directly to registered care homes and 25% was distributed at our discretion, Tranche 2 is required to be split as follows:



**80% of funding to:**

- Care Homes
- Community Care Providers (including Dom Care/Home Care)
- Other care settings

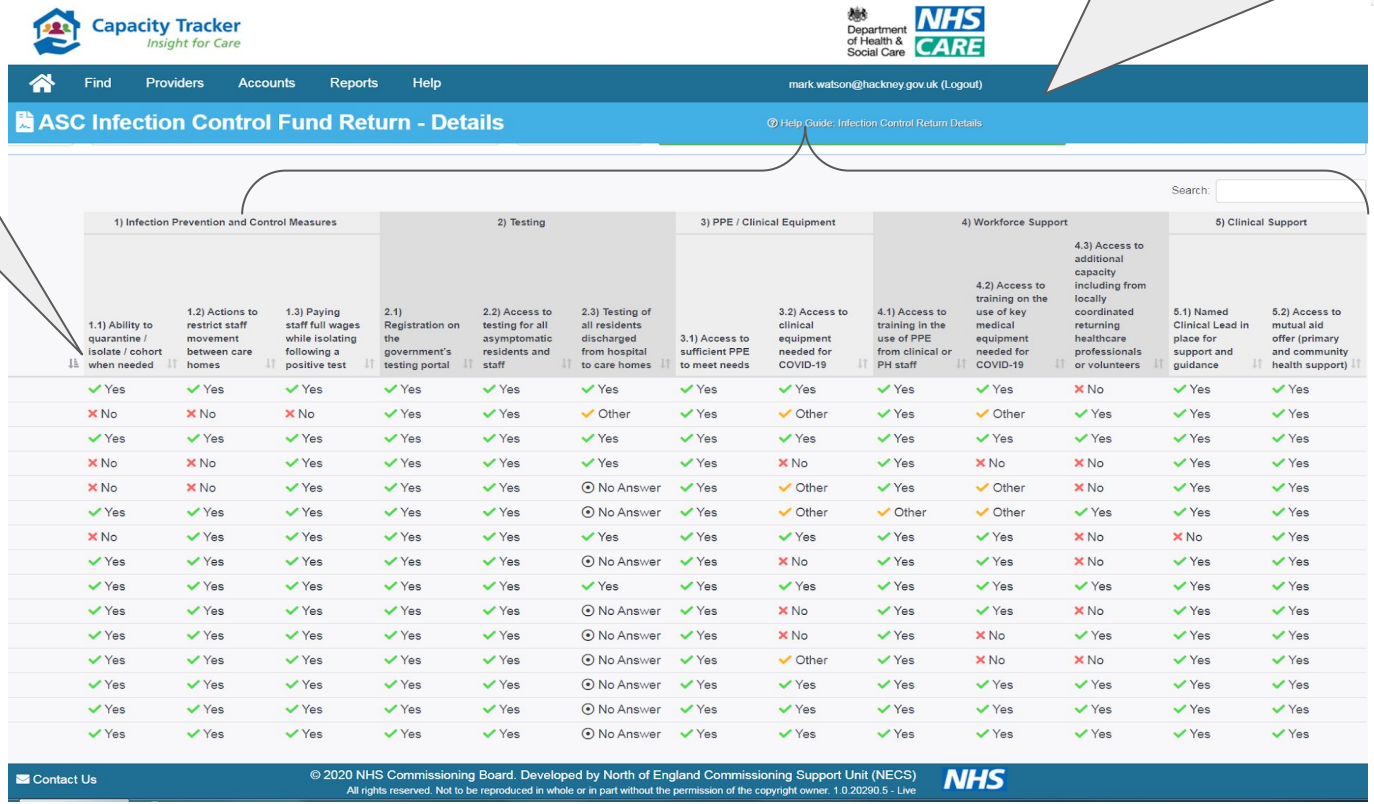
**20% local discretion - Allocated to:**

- Supported living providers
- Single homeless pathway providers
- Women's Refuge services

# NHS Capacity Tracker

These indicators show the measures put in place by each home

Those homes who have the ability to isolate/ quarantine when needed



# Visiting Policy

- New guidance was published on the **5 November** to support safe care home visits during lockdown (https://www.gov.uk/government/news/new-guidance-to-support-safe-care-home-visits-during-lockdown)
- The guidance will enable care home providers, families and local professionals to work together to find the right balance between the benefits of visiting on wellbeing and quality of life, and the risk of transmission of COVID-19 to social care staff and vulnerable residents.
- Public Health has arranged a meeting with Care providers to offer advice and support in implementing the guidance.

We will be working with local providers to ensure when developing their visiting policies, they undertake both an overall risk assessment and individualised ones for residents that balance their needs and vulnerabilities.

Providers will be encouraged to use the new infection control funding to fund any necessary changes.

- In the event of an outbreak in a care home, the home should stop visiting except at end-of-life.
- Options for safe care home visits in line with the guidance could include:
    - visits using COVID-secure visiting areas/pods with floor to ceiling screens and windows where the visitor and resident enter through different entrances, are separated by screens and visitors do not need to enter or pass through the care home
    - visits at windows, where the visitor doesn't need to come inside the care home or where the visitor remains in their car, and the resident is socially distanced
    - outdoor visits with one other person
    - further support for virtual visits, encouraging the use of video calls

# Residents Mental Health & Wellbeing

- Whilst observing COVID Infection control measures, Care homes have continued to deliver activities to ensure residents  Mental Health & wellbeing is maintained.
- Activities include (walks around the garden, board games, visiting the library), hairdressing, hand massages, reading to residents, music sessions including singalongs, activities for residents who require 1 to 1 support (e.g. cognitive)
- Extra resources have been used to increase activities (e.g extra staff)
- Residents are keeping in touch with relatives/friends via technology (iPads, secure video calling in addition to any new visiting arrangements)

# Staff Training & NEL Group /Peer support

System partners worked together and with the care homes to identify their training needs and delivered training through a weekly webinar and individual calls with homes

- Dementia support; Infection Prevention and Control (IPC); Community support and signs of deterioration; ParaDoc and Integrated Independence Team
  Infection Prevention and Control, focus on Personal Protective Equipment (PPE); NHS Coordinate My Care (CMC)
  Infection Control Training from NHS England and how to keep safe when travelling; Mental capacity, DoLS and testing for Covid 19
- medication used in psychotic conditions
- training on supporting people who are non-compliant or have beliefs around medication, also for identifying patients who may be over medicated;
- MIND provided psychological support to care homes/supported living organisations. Interventions forming a Stepped Care model which focus on enhancing mutual resources.



## North East London Commissioning Support Unit (NEL CSU) Infection Prevention and Control Team Advice:

- Clinical infection control advice, including pathophysiology of infection, and IPC
- Management of an individual with an infection
- Outbreak management
- Water management
- Decontamination management
- Estates management including new builds and refurbishment, and adherence to relevant Health Technical Memorandum (HTMs) and Health Building Notes (HBNs)
- Audit and surveillance of alert organisms and conditions

# Training by GP Confederation

The GP Confederation have been commissioned to offer the following specific training:

- An overview of Covid-19: transmission, who is vulnerable, symptoms, daily clinical observations of residents
- Infection control: handwashing, PPE and cleaning advice. A video demonstration on how to put on and take off PPE, is provided
- An overview of the Swabbing Service: what is available and when can care homes and supported living establishments access the service
- Current government guidance on how to manage residents and staff with symptoms of Covid-19 and what to do in an outbreak
- Overview of Antibody testing (they don't provide this test; however, it is accessible to social care staff)
- How and when to test for Covid-19. A video demonstration is also provided

# Testing

**National Requirement on Testing for Employer referral for essential workers:**

Employers can refer essential workers for testing if they are self-isolating because either they or member(s) of their household have coronavirus symptoms. They can do this by uploading the names and contact details of self-isolating essential workers to the secure employer referral portal.Referred essential workers will then receive a text message with a unique invitation code to book a test for themselves (if symptomatic) or their symptomatic household member(s) at a regional testing site.

**Current Resource**; Walk-in Test Centres (Location) ; Antibody Testing; & Home Kits;



**These are some of the Challenges we have had regarding testing:**

- Lack of access to test kits for all providers as national portal is for CQC Registered Care Homes only and initially was only for older adults;
- Delays in receiving test results where staff continue to work while asymptomatic
- Booking appointments can be problematic;

City and Hackney CCG commissioned the GP Confederation to provide a Covid-19 swabbing service for 15 CQC and 75 Non CQC registered establishments. The service will:

- Screen asymptomatic staff and residents in CQC registered homes using the PCR test (polymerase chain reaction)
- Test symptomatic residents in other settings for Covid-19, using the PCR test
- Test all staff and residents during an outbreak of Covid-19, using the PCR test
- Provide infection control advice
- Provide training in infection control related to Covid-19

# Designated Setting

A designated settings is:

- a Care home or facility that can accept Covid positive individuals from hospitals or from the community. The setting needs to be CQC rated ‘Good’ or above and be able to meet the new CQC Infection Control standards. It must be able to provide self isolation and staff well trained in infection control. Housing with Care, Supported Living and Extra care facilities will not met this criteria

Local Approach

- We nominated Acorn Lodge to be our designated setting
- CQC have said we cannot use this provider as a designated setting as they require them to be rated Good or above. Acorn Lodge was assessed the 17 October 2019 and CQC rated ‘Requires Improvement’.
- Our own QA teams are confident the home has made all the necessary improvements and would meet Good criteria. A meeting has occurred the 3 November with the CQC, LBH staff and Care Home Manager to provide evidence on action plans, LBH Quality Assurance team visits and attempts to find other Designated Settings. We are awaiting a response from CQC.

# Second Wave Plans

- We have developed a comprehensive Winter Plan 2020/21 using the national guidance and confirmed to the Department that we have this in place.
- As part of the Winter Plan Public Health have developed Flu Vaccinations communications
PPE access has now become available through a national portal
- NHS Capacity Tracker will continue to be used to monitor the health of Care Homes
- Training will continue to be offered every fortnight
- Infection Control Fund second round of funding has been announced and funding being distributed
- NHSx iPad Offer - local homes should each receive 1 iPad (excluding Beis Pinchos who has indicated they already have devices)

# Conclusion

- We have taken a whole systems approach - NHS, Council, Providers, Public Health, CQC Voluntary sector, and local businesses: this system response has allowed us to be proactive where possible and reactive where necessary with changing issues and fluctuating national guidance
- All providers adapted well to the emergency - we collectively continue to learn and reflect
- Safe discharge is our priority
- We are mindful of the wellbeing of all those working and volunteering in social care
- We hold central the impact the pandemic is having on residents and families who can't visit loved ones, and will work collectively to find safe ways to enable this to happen as soon as possible

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Hackney

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| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**UNPLANNED CARE Workstream of the City & Hackney Integrated Commissioning Partnership** | Item No<br><br>**5** |

**OUTLINE**

Each of the 4 Workstreams in Integrated Commissioning report annually to the Commission on their progress.

Attached pleased find the annual update from the Unplanned Care Workstream.

Attending for this item will be:

**Tracey Fletcher**, Chief Exec of HUHFT and Senior Responsible Officer for the Unplanned Care Workstream of City and Hackney Integrated Commissioning. (To be Confirmed)

**Nina Griffith**, Workstream Director – Unplanned Care, LBH-CCG-CoL

**ACTION**

The Commission is requested to give consideration to the report and to make any recommendations as necessary.

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**Integrated Commissioning**: Unplanned Care Workstream

**Update to Health in Hackney Overview and Scrutiny Committee**
**November 2020**

## 1. Introduction and context

The Unplanned Care workstream last reported to this committee in January 2020.
Since this time, health and care partners in City and Hackney have had to respond to the CoVID 19 pandemic and resultant impact on health outcomes and inequalities. In tandem with this, we are in the process of implementing a new local health and care system structure alongside the North East London CCG merger.

For this reason, much of the existing programme governance, plus the financial and performance targets that the workstream had responsibility for have shifted.
Whilst the governing structures that have driven our work have changed (and will shift further over the next six months), our workstream objectives are still being delivered, and indeed the pressures of the pandemic emphasised their importance.

Throughout the pandemic all of the services within the scope of the workstream have remained open, continuing to deliver crucial and life-saving support to residents in City and Hackney in significantly challenging circumstances. In addition to responding to the pandemic, all services have had to rapidly adjust their service models to reduce the risk of nosocomial infection.

## 2. Workstream objectives

The ambitions and main areas of transformation that the unplanned care board were driving have continued to be progressed through 2020, and in many cases expedited, as the pressures on certain parts of the health and care system and resultant health inequalities arising from the pandemic further demonstrated their importance.

In 2018, the workstream agreed the following strategic priorities:

- Develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- Provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- Develop urgent care services that provide holistic, consistent, care and support people until they are settled
- Work together to prevent avoidable emergency attendances and admissions to hospital
- Provide timely access to urgent care services when needed, including at discharge
- Deliver models of care that support sustainability for the City and Hackney health and care system.

We established three transformation areas that the workstream was overseeing to realise these priorities: Neighbourhoods, Integrated urgent care and discharge.

We have continued to progress each of these areas, and have also put a much stronger focus on two additional areas that were always within the portfolio of the workstream but more recently have required much more focused attention owing to the pandemic; End of life care and Winter Planning.

## 3. Update on areas of work

The following provides updates on what we have achieved in year and what we are planning for the coming year against each of our main areas of work:

### Neighbourhoods

We continue to progress our system-wide neighbourhoods programme. The neighbourhoods are working to deliver locally integrated services that respond to local population need. The eight neighbourhoods are now well established and we have an agreed operating model for neighbourhoods that all system partners are committed to implementing.

Key achievements and activities include:

Implementation of neighbourhood multi-disciplinary meetings (MDMs) which bring together a wide range of health, care, and voluntary sector partners within each neighbourhood. The MDMs support individuals that require a multi-agency response. The MDM model was being piloted in Clissold Park neighbourhood from December 2019, however we rolled the model out across all neighbourhoods during the pandemic in order to strengthen community services and support vulnerable people and those with more complex needs We are now establishing links from the MDMs into housing, welfare, debt advice, and employment services.

HCVS have co-ordinated a series of Neighbourhood Conversations which bring together VCSE partners with residents and statutory services to address key issues within each neighbourhood. Conversations have focused on topics such as: Digital divide, Health impact of COVID, signposting and connecting people to support and services and developing community connections/mutual support. The conversations have provided a forum to address key issues but also provide a structure to bring together VCSE partners within a neighbourhood.

Community nursing, adult social care and community mental health have developed and tested how they will re-organise their services to be delivered on a neighbourhood footprint. These will be fully rolled out in 2021. Further work is underway to do develop and test similar neighbourhood models for community therapies.

We are progressing a new model of community navigation. This includes better alignment between existing social prescribing/navigation services and also piloting new posts, well-being practitioners, that provide more focused support to people with complex needs. The well being practitioners pilot launched in January 2020 and is currently being evaluated. Navigation services are vital to meeting people's wider holistic needs, supporting vulnerable people and providing a link between statutory and voluntary sector services.

### Integrated Urgent Care

We continue to progress our work to develop an urgent care system that:

- Triages and navigates people to the most appropriate place at every entry point into the system,
- Develops strong and effective community based services as an alternative to hospital wherever possible.

Since June, there has been a broad programme of work in City and Hackney to deliver the 'Think 111 First' agenda. This is a national incentive that aims to increase the capability and capacity of 111 services so that they can successfully resolve more issues and are appropriately book patients directly into a wider range of hospital, community and primary care services. The national ambition is to reduce the overall pressure on hospitals where patients can be appropriately managed within primary or community services, and also introduce direct booking from 111 into EDs, in order to reduce crowding and therefore reduce the risk of nosocomial infection in departments.

Within Hackney, we have worked with local and North East London (NEL) partners to deliver this agenda, and have achieved the following:

- We have increased capacity within the NEL 111 service to improve access. We are also monitoring the service closely to ensure that it is effectively clinically triaging patients.
- We have increased the number of primary care slots available for 111 to book into, supported by improved technical interoperability between 111 and GP systems. We have also agreed a chest pain pathway which will allow 111 to safely book certain presentations of chest pain into primary care that would previously have always been conveyed to hospital. This is the first of a number of clinical pathways that we plan to launch.
- We are piloting a pathway from 111 directly into the Homerton Early pregnancy unit so that women who have complications surrounding their pregnancy can be directed straight to a specialist clinic from 111. This is our first pilot of patients being referred from 111 directly into a hospital specialist service.
- At the end of November we will enable direct booking from 111 into the Hometon ED. This means that, rather than just being told to go ED, 111 book them an appointment slot in ED within a clinically appropriate time window. This should support a better patient experience and also minimises risk of crowding in waiting rooms and EDs.

Through all of these actions there is an aspiration that people use 111 as an alternative to walking to ED. We do recognise that 111 is not used by all of our local population. We have continued to inform patients to call their own GPs during practice opening hours as we still think that this is the best entry point into the urgent care system for most people. We also continue to offer walk in access to EDs.

A new *High Intensity User Service* started 1st April 2019 to support frequent attenders to A&E and frequent callers to 111 and 999. The service is provided in partnership between ELFT, the Homerton, Family Action and the Hackney Volunteer Centre and addresses patients' physical, psychological, and social issues. A six month interim evaluation of the service showed that it is effectively supporting people and reducing inappropriate use of urgent care services, we are currently undertaking a further evaluation to determine the long term service model.

**Discharge**

We continue to see the benefit from bringing together hospital, local authority and voluntary sector partners to support improved discharge for our residents. Through the pandemic there was increased focus on discharge and step down services in order to reduce unnecessary pressures on hospitals and also to ensure safe and appropriate step down services.

A new national discharge protocol was launched in August. In the main, this guidance aligned to our local ambitions as it promotes a multi-disciplinary discharge service and use of the 'home first' model, whereby patients receive assessments for ongoing care at home.
The policy requires services to determine whether a patient has a 'right to reside' in hospital, and if they do not, that they will discharged on the same day. We do not think this language is helpful, and the policy does not adequately describe how patients will be involved and supported through their admission in advance of discharge. Therefore we are working locally to ensure that patients are well informed about discharge processes throughout their admission, including agreeing the expected data of discharge with them as early as possible.

Key achievement in Hackney include:

In line with the guidance we have put in place a new Discharge Single Point of Access (DSPA) which includes staff from the Integrated Independence Team (IIT), Adult Community Rehabilitation Team (ACRT) the Integrated Discharge Service (IDS) and Age UK. The team will support wards and help the system to fully embed a discharge to assess (D2A), home first model.

We are expanding the Take Home and Settle discharge support service from Age UK. This was initially a short term agreement through the pandemic, but has been extended to the end of the year. The expanded service includes more capacity in the core service, a handyman service to provide small home improvements to enable discharge and also a small humanitarian fund that staff could use to purchase anything that would better support people following discharge such as food, clothes and bedding.
It is worth acknowledging that during the pandemic Age UK worked well beyond their service criteria to provide practical and emotional support to a wide range of vulnerable people including homeless people placed in temporary accommodation who were not part of the discharge cohort.

We are setting up a dedicated team based in the Homerton to support hospital and discharge pathways for homeless people. The service is based on a model advocated by the Pathways charity, which sees a hospital admission as an opportunity to engage with homeless people to support their immediate health and care needs, facilitate a safe discharge and guide them into ongoing services as required. The team comprises a GP, nurse, therapist, social worker and housing officer. Whilst the work to develop this team started well in advance of the pandemic, the rising inequalities and specific risk to homeless people from the pandemic and the response to the pandemic have further demonstrated the need for this.

There has been extensive, system wide support to care homes within City and Hackney. This included ensuring each home had a dedicated GP and community services provision, including regular patient reviews, delivery of regular training to care homes on a range of issues and mutual aid support with PPE supplies. We have had very good primary care services to the nursing homes in Hackney for a number of years, however, through the pandemic we also put in place better services to all care homes, including those for mental health and learning disabilities.

**End of life care**

There was significant cross-system work to improve end of life care across the borough through the pandemic. This was undertaken rapidly and in very challenging circumstances, and was a real testament to clinical colleagues from St Joseph's, Homerton geriatrics and palliative care teams, community nursing, Marie Curie, Paradoc, care homes primary care and adult social care.

We developed new primary care guidance for end of life so that GPs could better support people in the community. This was enabled by access to end of life medicines in the community and on-line training on a range of topics provided by St Josephs and Homerton specialists. Homerton geriatricians and St Joseph's also provide a telephone hotline to provide advice to all health and care professionals, this was widely publicised and utilised.

We already have a well established care planning process in City and Hackney, utilising an electronic tool, 'Co-ordinate my care' (CMC) which all partners can view in order to ensure that people receive the care that they want in an emergency situation. Through the pandemic, GPs spoke to many of their most vulnerable patients to ensure that their care plans were up to date and reflected residents wishes.

In January 2020 we launched a pilot Urgent end of life care service, which provides rapid access to palliative care in the home for people that are in the last few weeks of life and want to die at home. The service is provided by Marie Curie and runs overnight, which is when there is a gap in current services. This service provided much needed support to residents, including both covid deaths and deaths from other causes.

The St Joseph's Hospice Bereavement service was expanded during the pandemic to provide services to children and young people who have suffered a bereavement, in addition to the adult bereavement service they already provide to all residents of City & Hackney. Additionally, the team has provided some specific training to local IAPT providers on traumatic bereavement. Information leaflets for the bereaved have been produced by the NEL team, and signposting to bereavement services has been included as part of the Hackney volunteer hub, while consideration of referral to appropriate (traumatic bereavement) services following a suicide has been included in the suicide response framework.

**Winter planning**

The ongoing pandemic and the risk of a concurrent flu outbreak as well as 'normal' winter pressures mean that the pressures on health and care services could be unprecedented over the next few months. As such, we have taken a broader and more comprehensive approach to winter planning.

Historically winter planning has been a discrete exercise involving mainly urgent and emergency care (UEC) services/partners. This year, we have taken a whole system approach to planning for and minimising the risks from the coming winter and second covid peak. This means that a wider range of services have undertaken winter planning to ensure service continuity, and also to consider their role in keeping people well over winter. This has included community health services, primary care, community pharmacy, learning disabilities and prevention services.

There has also been a much stronger, whole system focus on flu, ensuring that we are prepared for a potential outbreak and considerable work to increase uptake of vaccinations.

## 4. Workstream structure and governance

In March, we ceased the unplanned care programme board, initially in order to allow partners to focus on the pandemic response. We have subsequently not reconvened this

board. This is in part because the interim structures put in place during the pandemic have brought together the same partners and played an equivalent function as the unplanned care board and, in part, because of broader system structure shifts that are currently underway to form an Integrated Care Partnership Board and a Neighbourhoods Health and Care Board. Since March the workstream objectives have been overseen by the System Operational Command Group, which was initially put in place as a short term response to the pandemic, but now provides a wider role to bring partners together to support recovery from covid and covid preparedness over a six to twelve month horizon.

## 5. Outcomes and Performance

Historically, the two key performance metrics that the workstream oversees were the A&E four hour wait, and delayed transfers of care (DToC).

Since March 2020, hospitals were asked to stop reporting DToC numbers in order to reduce bureaucracy and reporting burden on hospitals and local authorities. DToC is unlikely to be re-introduced as a metric, and will likely be replaced by something that aligns to the new national discharge policy. Locally, the Discharge team in the Homerton have maintained a log of patients that are ready for discharge in order to support operational delivery. Now that the new service is in place we will reinstate appropriate local reporting on discharge delays in advance of a national measure.

Performance against the A&E four hour wait has continued to be reported, although there has been no national or regional scrutiny on this metric. Homerton continues to report excellent performance, in 2020/21 the trust has achieved 94.39% patients treated and left the department within 4 hours, against 79.78% across NEL.

Preventing emergencies and reducing inappropriate use of emergencv services is a key measure of success for the workstream, and we monitor ED attendances and emergency admissions as a measure of success. However, this year, emergency activity has been driven by the pandemic rather than services or interventions by the workstream therefore this data is not a useful comparison. There was a large reduction in emergency admissions from the end of March throughout the summer, which gradually increased back to the levels of previous years by September. The reduction was the result of the pandemic and the lock-down, with far fewer accidents taking place and reticence to seek health care by many people.

Significant work was undertaken through the summer to both reassure people that the NHS was open and safe to attend, and also by GPs to undertake reviews of vulnerable people and those with long term conditions, in order to identify any deterioration in conditions through the initial lock down.

## 6. Financial Performance

As part of national emergency measures, all NHS trusts were given a nationally prescribed block of funding for 2020/21. This means that there is no possibility for the system to either overspend or make a financial saving if hospital activity increases, or is within plan. Furthermore Trusts, CCGs and Local authorities have also, at various points, been given some additional resources for specific elements of the covid response.

As such, the normal financial arrangements that underpin the workstream have not been applicable this year. Each organisation has continued to work to deliver a balanced budget.

The financial regime for 2021/22 has not yet been set.

## 7. Risks and Challenges

Although the workstream board is not meeting, risks are monitored by the workstream team and have continued to be reported to the Integrated Commissioning Board. The following are the top rates risks within the scope of the workstream.

| Issues, risks and challenges: | Progress/ Actions being taken to address: |
|---|---|
| Risk that there is an increase in non-elective acute demand - either driven by a return to normal levels of admissions or a further peak in COVID-19 demand. | • Delivery of the 'Think 111 First' to reduce A&E attendances<br>• Implementation of a wide range of measures to strengthen community support including Neighbourhood Multi-Disciplinary Teams, Primary Care Long Term Condition Management and the Urgent end of life care service<br>• Escalation plans in place in HUHFT in advance of further COVID-19 peaks.<br>• Bed modelling in place across North East London to understand demand and capacity in relation to a second peak and winter – this is refreshed weekly<br>• Comprehensive Winter Planning Process in place. |
| Risk that we do not understand and/or do not reduce the impact of health inequalities for local populations across the workstream, and this is exacerbated in the context of the COVID-19 pandemic. | • The neighbourhoods programme is focused on addressing inequalities:<br>• The neighbourhoods approach means that we take a population health approach across a small population of 30-50,000, which allows a very local focus on health needs and inequalities<br>• Work with the voluntary sector within each neighbourhood to identify of inequalities and in-reach into particular communities<br>• New and enhanced services for our most vulnerable residents, including homeless people and those in care homes<br>• Use of the City and Hackney inequalities matrix and equality impact assessments to support planning and any changes to services |

## 8. Conclusions

The work described in this report will continue to be driven by partners in City and Hackney through the remainder on 2020 and into 2021. Looking forward, we will be supporting the development of new system structures in City and Hackney. We will also be working with services to manage within the context of the continuing pandemic.

Whilst 2020 has brought unprecedented challenges to the health and care system, the commitment, compassion and dedication shown by staff across health and care services over the last eight months cannot be overstated.

**Nina Griffith**
**Unplanned Care workstream director,**
**November 2020**

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Hackney

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| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**Covid-19 Test, Trace and Isolate – verbal update from Director of Public Health** | Item No<br><br>**6** |

**OUTLINE**

Since the outbreak of the pandemic the Director of Public Health and presented monthly updates to the Commission on the current situation.

Attending for this item will be:

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

An up to date slide pack which she will present at the meeting will be circulated on the day.

**ACTION**

The Commission is requested to give consideration to the report.

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# COVID-19 update to the Hackney Scrutiny Commission

18 November 2020

Chris Lovitt
Deputy Director of Public Health
City and Hackney Public Health

# Key messages

- A national lockdown has been imposed from 5 November until at least 2 December, after which date the government's intention is to move back to a regional tiered system - we do not yet know which tier London will be placed in or if the lockdown will continue
- Numbers of cases of coronavirus are still high in Hackney, but there are some recent (tentative) signs that the rate of increase *may* be slowing
- While rates are decreasing overall, they are increasing in people aged 60+
- National regulations are designed to protect lives and keep people safe
- Local guidance for businesses on how to manage COVID-19 cases or outbreaks in the workplace is available on the council website



Hackney

# National lockdown restrictions - overview

Restrictions in place from 5 November until at least 2 December

- Stay at home except for specific purposes, including:
  - for childcare or education
  - for work where you cannot work from home
  - to exercise outdoors or visit an outdoor place (with people you live with, your support bubble, one other person when you are on your own)
  - for medical reasons (e.g. to attend medical appointments or in case of emergency) or to escape injury or harm (e.g. from domestic abuse)
  - to shop for basic necessities (e.g. food, medicines)
  - to visit members of your support bubble, care for a vulnerable person or volunteer
- Do not mix with people you don't live with (or outside your support bubble), except for specific purposes
- Certain businesses and venues must close

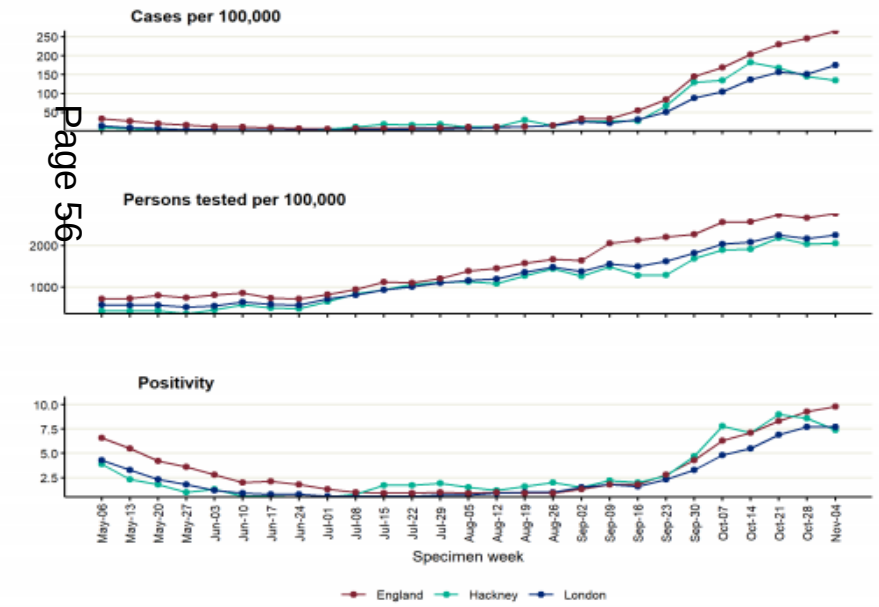
https://www.gov.uk/guidance/new-national-restrictions-from-5-november



Hackney

# Incidence, positivity and testing rates have reduced recently - all now in line with the London average and lower than the England average

New cases, testing and positivity rates in Hackney, by specimen date (5 May to 10 November 2020)




Data source: Public Health England. Most recent days subject to reporting delay.

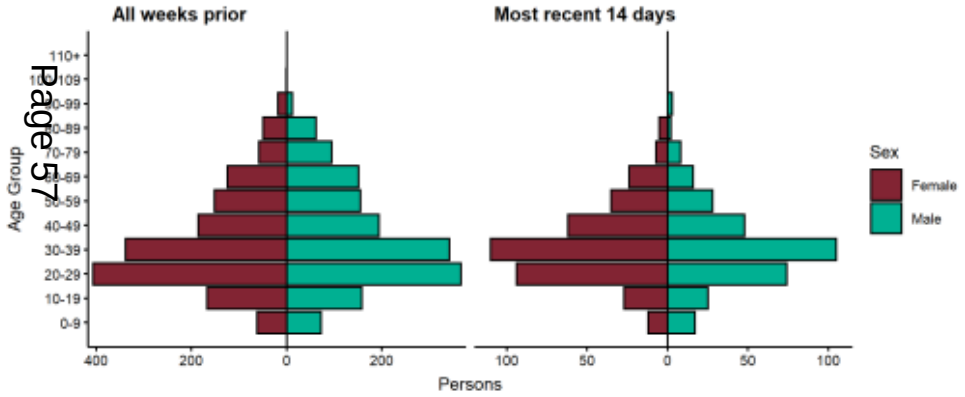
- As of 15 Nov, a total of 4,279 coronavirus cases had been registered among residents in Hackney
- The rate of new cases (incidence) has reduced over the last few weeks and is now similar to/slightly below the London average
- Data for the most recently available 7 day period (4 to 10 Nov) shows the incidence rate to be 134.8 per 100,000 population; this is lower than the previous three weeks
- However, the rate of testing in Hackney has levelled off since around the middle of September, in line with London; local and London testing rates are lower than the England average
- Hackney's positivity rate (% tested who have a positive test result) appears to have stabilised in recent weeks, and is now in line with the London average. Currently, the local positivity rate is 7.8%.



Hackney

# Most cases are now being diagnosed among residents aged 20 to 39

Number of cases by age in Hackney (most recent 14 days: 26 Oct to 8 Nov)

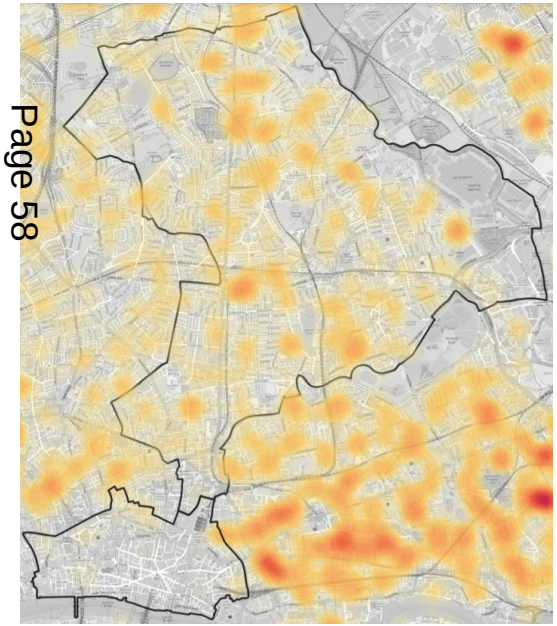



- The most recent cases continue to be diagnosed among younger age groups, for both females and males
- Recently, more cases have been diagnosed among residents aged 30 to 39 (previously the largest number of cases had been seen in the 20-29 age group)
- **Over the last two weeks, COVID-19 incidence rates have either remained stable or decreased in all age groups except residents aged 60+** (incidence in this age group is about 120 per 100,000 compared with 100 per 100,000 in the previous two weeks)

Data source: Public Health England. Most recent days subject to reporting delay.

# New cases are no longer concentrated in the north of the borough

Geographical distribution of COVID-19 cases in Hackney (1 to 14 Nov)





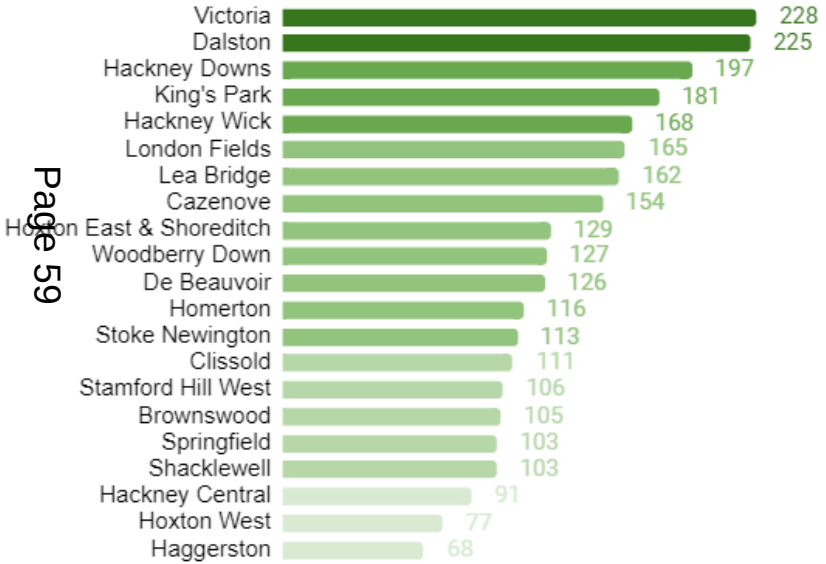
- COVID-19 cases are more dispersed across the borough compared with the situation in early/mid-October, when relatively more cases were registered in the north of Hackney
- An increasing proportion of cases have been attributed to household clusters in the most recent fortnight of available data (1 to 14 November), at 31% compared with 23% over the whole course of the pandemic so far
- The Wards with the highest number of household clusters (1 to 14 Nov) were Springfield (13 clusters) and Cazenove (9 clusters)

Data source: Public Health England.

Hackney

# Rates are still high in parts of the north of Hackney, but not as high as previously

Incidence rate (new cases) per 100,000 population, per week (4 to 10 Nov)

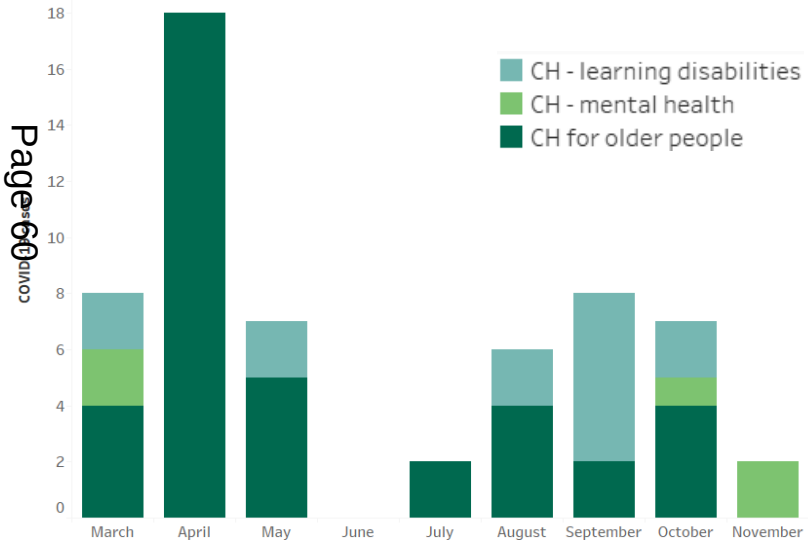



- Cazenove, Stamford Hill West, and Springfield Wards have recorded among the highest incidence rates throughout the pandemic, peaking around the third week of October (at about 500 per 100,000 population)
- The rate of new infections has reduced considerably since the peak in these areas, although they continue to record seven-day incidence rates of above 100 cases per 100,000 population.
- Over the past two weeks, Springfield has recorded a significant decrease in incidence rates whereas Hackney Downs has recorded a significant increase. All other Wards showed relatively stable rates.

Data source: Public Health England. Most recent days subject to reporting delay.

# The majority of care home COVID-19 cases were recorded in care homes for older populations

Number of Covid-19 cases recorded among residents of care homes in Hackney and City by setting type and month (up to 11 November 2020)*




- So far, 51 cases of COVID-19 have been recorded among residents of Care Homes in Hackney and the City of London
- The highest number of cases (18 cases) were recorded in April
- Of the 14 CQC and non-CQC registered care homes in Hackney and the City of London, 8 recorded cases of COVID-18 (57%)
- The majority of cases were recorded in care homes for older populations:
    - 39 cases (76%) CH for older populations
    - 14 cases (27%) CH for people with learning disabilities
    - 5 cases (10%) CH for people with mental health issues
- The top three providers with the highest number of COVID-19 cases were all care homes for older populations: Beis Pinchos (17 cases), St Annes (12 cases), Acorn Lodge (10 cases)
- One care home residents has been identified as a potential contacts of a traced COVID-19 cases through NHS Test and Trace.

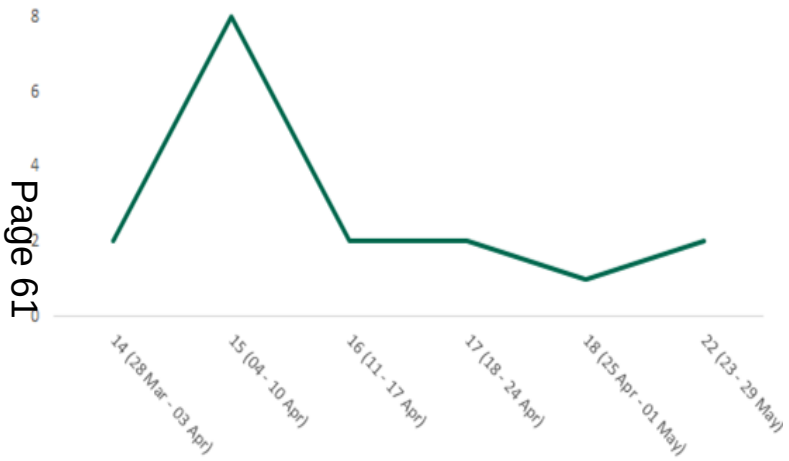
Data source: Public Health England. *PHE data on COVID-19 cases was linked to care homes based on postcode data and address data where available. Cases ages under 65 were excluded from analysis when linked to care homes for older populations.



Hackney

# Between March and September, 11% of the 234 deaths due to or involving Covid-19 were recorded among care home residents

Number of deaths due to or involving Covid-19 in care homes in Hackney and City by week (up to 29 May 2020)*




- Between March and September 2020, 234 deaths due to or involving Covid-19 were recorded among residents of Hackney and the City of London. 20 (8%) of these were recorded in care homes, and a further five deaths (2%) were recorded in hospital among residents of care homes.
- The majority of deaths occurred between the 4th and the 10th April, in line with the highest number of cases
- 17 deaths occurred in Hackney care homes, 12 of these on site and 5 in residents who were hospitalised. Deaths as a percentage of resident capacity
  - Acorn Lodge (12%)
  - Beis Pinchos (8%)
  - St Anne's Home (10%)
  - Mary Seacole Nursing Home (3%)
- The remaining 8 deaths occurred in care homes outside of the borough:
  - Bridgeside Lodge Nursing Home - Islington
  - Manor Farm Nursing Home - Newham
  - The Lodge Care Home - Hemel Hempstead

**Data source**: Primary Care Mortality Database deaths registered in City and Hackney residents March to September 2020.
**Notes:** An additional Covid death occurred in an Enfield resident in one of the Hackney care homes. The ONS weekly data total of 20 care home deaths for City and Hackney residents include only deaths recorded on care home site and includes City and Hackney residents who died in care homes outside the borough.



Hackney

# Success rates of contacting COVID-19 cases have increased from 73% to 80% since the introduction of Hackney and the City of London's local contact tracing programme

- The NHS Test and Trace system started operating on the 28 of May; between then and 1 November, 3,165 COVID-19 positive residents of Hackney and the City of London had their information transferred to the NHS Test and Trace system.
- Of all these cases 78% were contacted and received advice, while about 20% of contacts failed.
- A higher success rate has been noted since the introduction of Hackney and the City of London's local contact tracing programme on 22 September: between 25 May and 21 September, 73% of cases were successfully contacted, whereas between 22 September and 1 November 80% of cases were successfully contacted.
- Rate of success ranged by age from around 80% in age group 20-59 to around 58% among residents aged 80 and over; residents over the age of 60 had a higher proportion of cases that failed on follow-up, in general.
- The rate of successfully completed cases are comparable across the ethnic groups, with an exception of those whose ethnicity was unknown - only about 57% of these cases are successfully completed.
- On average it takes residents 2.5 days between becoming symptomatic and taking a COVID-19 test & further 4.5 days to be contacted by contact tracers.



Data source: Public Health England. Based on PHE Covid-19 contact tracing cases data

Hackney

Hackney

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| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**Senior management restructure in Adult Services** | Item No<br><br>**7** |

**OUTLINE**

The Chair has asked officers for a short briefing on the recent senior management restructure in Adult Services.

Attending for this will be:

**Denise D'Souza**, Interim Group Director for Adults, Health and Integration.

Attached please find the briefing note.

**ACTION**

The Commission is requested to give consideration to the briefing.

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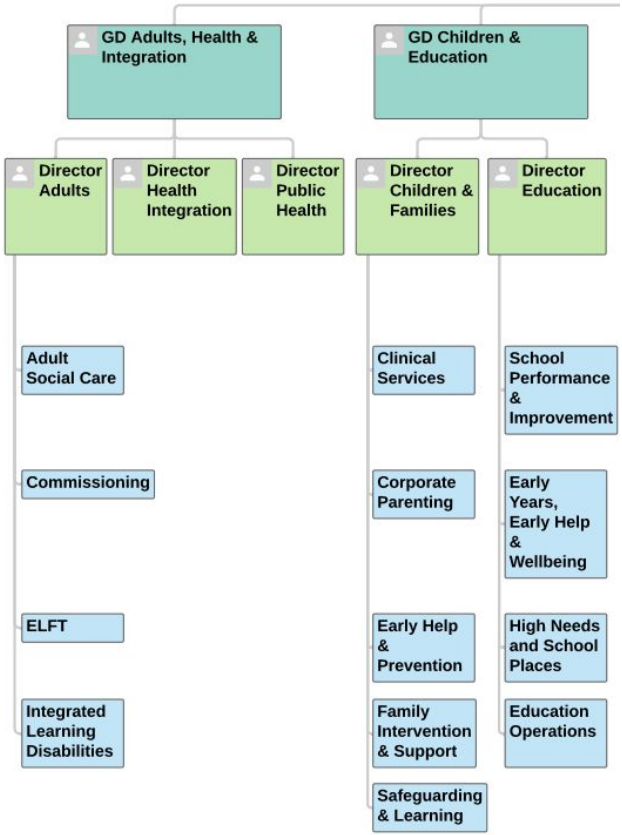
# Adult Services Senior Management Restructure

**Health in Hackney - Wednesday 18 November 2020**

# Adults and Community Health / Children and Education



# Adult Services Senior Management Restructure

**The New Directorate Allows for:**

- Greater focus on Adults Care Services
- Gives an opportunity for greater collaboration between Public Health and Adult Services
- Director of Integration - opportunities to work with the our health partners and wider health partner

# Adult Services Senior Management Restructure

**We Need to Ensure:**

- Adults Services  and Public Health maintain the joint work across with Children & Education as well as wider colleagues

- The services are linking and engaging with wider colleagues through ADASS (Association of Directors of Adult Social Services)

- Learn from best practice

Hackney

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| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**Minutes of the previous meeting and matters arising** | Item No<br><br>**8** |

**OUTLINE**

Attached please find the draft minutes of the meeting held on 14th October 2020.

**MATTERS ARISING**

**Actions from 23 September meeting**

Action at 7.6

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| *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.* |

This is awaited.

**Actions from 14 October meeting**

Action at 4.4(b)

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| *ACTION:* | *Workstream Director CYP&M to provide further detail on recent waiting times for access to CAMHS and the trend.* |

Workstream Director replied below on 3 Nov:

In response to the query below around **how long the wait for mental health referrals** and access to support for Children and Young people ('access times') is, the September 20020 data from HUFT and ELFT shows:

- for **HUFT services** (First Steps and CAMHS Disability), 85% of CYP referrals were seen and started support within 4 weeks. The remainder (15%) took longer than that.

- for **ELFT services** (Specialist CAMHS and Adolescent Psychiatry service), 87% of CYP referrals were seen and started support within 4 weeks. The remainder (13%) took longer than that.

This is in line with our North East London neighbours but better than other areas in the UK, although we still have considerable work on this to do.

Additionally, if a CYP presents in **crisis** (YP either presents at A&E or contact is made via crisis phone number), the response is as follows:
1. If presenting in person between 9am and 9pm, the CYP will be seen by the crisis team, assessed, then either sent home with a safety plan or admitted if necessary the same day. They are followed up the next day by the Crisis Team before being handed over to the appropriate
service.
2. If consultation with CYP or supporter is by phone, management and safety planning is done on that call until first available Crisis team or Specialist CAMHS Appointment (emergency appointments often same or next day), or if necessary, CYP can be advised to come to A&E for the process above.

I'm also waiting for the access data from our in-house clinical service for children known to children's social care and will update once it arrives.
Let me know if you have any queries.

Amy Wilkinson
Integrated Commissioning Workstream Director
Children, Young People, Maternity and Families
City and Hackney Clinical Commissioning Group / London Borough of Hackney / City of London
0208 356 5989

Action at 6.4(d)

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| *ACTION:* | *To add to the Work Programme an item on the future plans for St Leonards as part of the wider Estates Strategy for NEL.* |

This is to be scheduled.

Action at 10.4

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| *ACTION:* | *CCG to provide*<br>*a) Briefing on the new governance structure for the City and Hackney ICP and how it forms part of the new NEL Integrated Care System*<br>*b) Future briefing from Tracey Fletcher in her role as system lead for the Neighbourhood Health and Care Services Board of the City and Hackney ICP.* |

These have been scheduled for the 31 March 2021 meeting.

**ACTION**
The Commission is requested to agree the minutes and note the matters arising.

Hackney

**London Borough of Hackney**
**Health in Hackney Scrutiny Commission**
**Municipal Year 2020/21**
**Date of Meeting: Wednesday, 14th October 2020**

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

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| **Chair** | **Cllr Ben Hayhurst** |
| **Councillors in Attendance** | **Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Emma Plouviez** |
| **Members of CYP Scrutiny Commission for item 4** | **Cllr Sophie Conway, Cllr Margaret Gordon, Cllr Sade Etti, Cllr Sharon Patrick, Shabnum Hassan, Jo MacLeod and Ernell Watson** |
| **Apologies:** | **Cllr Michelle Gregory, Cllr Patrick Spence** |
| **Officers In Attendance** | **John Binding (Head of Service – Safeguarding Adults), Martin Bradford (O&S Officer for CYPM Scrutiny Commission), Denise D'Souza (Interim Strategic Director of Adult Social Services, Health and Integration), Dr Sandra Husbands (Director of Public Health) and Amy Wilkinson (Workstream Director – Children Young People and Maternity Workstream of ICB)** |
| **Other People in Attendance** | **Malcolm Alexander (Interim Chair, Healthwatch Hackney), Dr Adi Cooper (Independent Chair, City & Hackney Safeguarding Adults Board), Cllr Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure), Cllr Yvonne Maxwell (Mayoral Advisor for Older People), David Maher (MD, NHS City & Hackney CCG), Catherine Pelley (Chief Nurse and Director of Governance, HUHFT), Dr Mark Rickets (Chair, NHS City and Hackney CCG) and Jon Williams (Executive Director, Healthwatch Hackney),** |
| **Members of the Public** | **8** |
| **YouTube link** | **https://www.youtube.com/watch?v=RTVuluSoKfg&feature=youtu.be** |
| **Officer Contact:** | **Jarlath O'Connell**<br>020 8356 3309<br>jarlath.oconnell@hackney.gov.uk |

**Councillor Ben Hayhurst in the Chair**

## 1 Apologies for Absence

1.1 Apologies for absence were received from Cllr Gregory, Cllr Spence and from Anne Canning. An apology for lateness was received from Cllr Adams.

1.2 The Chair requested that there be no questions on the cyber attack on the Council which took place that week as it was still an ongoing crime investigation. He added that there would be a time in the future when it would be appropriate to ask questions and seek reassurances but not now.

## 2 Urgent Items / Order of Business

2.1 There was no urgent business. The Chair stated that item 10 Any Other Business would be taken after item 5 and it would comprise a brief verbal update from the CCG on the progress of the vote on the merger to create a single CCG for NEL.

## 3 Declarations of Interest

3.1 There were none.

## 4 Integrated Commissioning – update from Children Young People and Maternity Workstream JOINT ITEM WITH MEMBERS OF CYP SCRUTINY COMMISSION

4.1 The Chair welcomed 7 members of the Children and Young People Scrutiny Commission for this annual joint item. Members gave consideration to a briefing paper from the CYPM Workstream and the Chair welcomed:

Amy Wilkinson (AW), Workstream Director, CYPM Workstream, LBH-CCG-CoL

4.3 AW took Members through her briefing paper in detail.

4.4 Members asked questions the following responses were noted:

(a) CYP SC Chair asked about the reluctance of many young people to engage with mental health services using virtual channels, or their inability to do so, during the Covid period and the impact this was having. AW responded that they had also looked at this at CYP SC in May. CAMHS services had been very quiet in the early stages of the pandemic but the service had now gone back to face to face appointments. They were prioritising face to face and it iwas no longer virtual by default. The capacity was there and additional DfE education support was also going in to support students. Mental Health support staff were back in schools since September.

(b) The Chair asked how long it would take for a young person to get a mental health referral and whether it would be weeks or months before meaningful support could be provided. AW undertook to get back with the full detail but stated that access times were much shorter than they had been and were certainly less than a couple of weeks.

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| **ACTION:** | **Workstream Director CYP&M to provide further detail on recent waiting times for access to CAMHS and the trend.** |

(c) Chair asked about an upswing in referrals during lockdown. AW detailed the treand in referrals and added that an increase in referrals was coming through also in the Domestic Violence service for example. She added that they had also increased other support including providing the Bereavement Service offfer.

(d) Members asked about the practicality of 'Prevention' offer to children and young people and on the decline in rates of childhood immunisation and on what plans were in place to increase these. AW explained how prevention cuts across all the strands of the Workstream. She added that they had been rolling out 'trauma informed training' for staff in schools since the beginning of the crisis and the further offer from the DfE built on that quite well. They were starting with further support for teachers and focusing on enabling them to have their classes. There had also been extensive communications campaigns on getting children back to schools and about how to access help during the crisis. The volume of immunisations had been increased as has the flu jab programme and there was an ongoing project with GPs to drive up childhood immunisations. Health Visitors were also delivering immunisations in 8 Childrens Centres. 2500 flu vaccinations for 2-3 yr olds were already being delivered in car park sites and this model would be used also for the MMR campaign.

(e) Chair asked about the importance of flu or measles vaccines during Covid period and the challenge caused by data flow issues. AW replied that the GP Confederation was locating all the data points and doing major piece of work on immunisations. They had a dedicated post on it who would streamline all the data and aim to put it in one place. The Chair asked about priorities at present in relation to flu prevention, the difference for other years and whether the concern was more about the older population getting Covid during flu season. AW replied that City and Hackney had historically low immunisation rates so it was vital that there be no outbreak of infections diseases at a time when the system was also battling Covid. Their programmes were continuing as normal. There was a lot of work to do to spread the message that the NHS was open. The key issue was the more people who were vaccinated against flu the better as this gave the NHS more capacity to deal with Covid. Other Covid related capacity issues also had to be considered such as the re purposing of children's wards in acute sites and centralising them, to particular centres within the NEL system, in order to ensure stricter infection control during the pandemic. Much work was going on in co-ordinating services across the NEL acute sites.

(f) Members asked about the learning from CAMHS improvement programme over all. AW replied that there were many aspects to this and that they were now working with 'Programme System Influencers' on it, for example. There was a need to join up the services and the really helpful engagement with young people that came out of the CAMHS improvement programme could now be built on and fed into on other evaluation work.

(g) Chair of Healthwatch asked about resistance to flu vaccinations in the community and whether there was ward level data on this. AW replied that there was definitely anti vaccination sentiment out there but they didn't necessarily know the detail at ground level because those who object just didn't turn up. They were piloting work in the PCN in the North East of the borough on vaccine hesitancy and they wanted to scale up this work. There is no real data on vaccine hesitancy as such because people don't say that is why they are not attending, however the numbers coming through the

programmes will point to areas where hesitancy is a factor and they can then work on that.

(h) Chair asked about policy re partners attending scans and also births in the Homerton's maternity unit. AW replied that they were working closely with NEL partners across childrens and maternity services on this. At the early states of the pandemic it was virtual appointments for all ante and post natal appointments and initially no partners were allowed. Subseqently this was relaxed to 2 partners at the birth and visiting was allowed for 3 hrs per day from 14.00-17.00 hrs, then they were relaxed further and face to face ante natal sessions were permitted. The aim now is to fully restore services to the previous position. Most trusts in NEL were in a similar position of not allowing visitors and not partners at scans but this was gradually being relaxed. She added that in April and May they had seen bookings at HUHFT rise 20% so now were expecting 150 extra deliveries there during Oct and Nov. This would stretch the service because of the vital need to ensure full Covid safe settings. HUHFT was currently reinstating face to face appointments and managing strict infection control measures. For the past two months there had been no Covid positive women giving birth at all and in the last 2 or 3 weeks just a handful of positive tests coming through from asymptomatic women.

(i) Chair asked what was cause of upsurge in bookings at HUHFT Maternity department and during first peak and if partners were stopped from attending births. AW reiterated that partners had been stopped for a short period but they had since reinstated a policy of 1 partner and now will allow 2 people. The upswing happened because normally 70% of Hackey mothers give birth at HUHFT with the remainder going mostly to UCL. However during the pandemic, with everyone working from home, Hackney mothers chose to move their appointments to the more local hospital.

(j) The Chair asked whether Hackney maternity might become full because of the forthcoming peak and during a possible second wave. AW explained that women already booked would always be taken. The advance bookings for December look more normal and the peak was just expected in Oct and Nov. If there is a second wave of Covid they might also have to reinstigated the no partners rule. She stated that this is constantly monitored and it changes by the week. Decisions are made at Trust level and they would also revert to no partners at scans and only 1 partner at births if they had to. They would be reluctant to revent but might be forced to.

(k) Chair of CYP SC asked about the importance of ongoing support via the Integrated Commissioning Board CYPM Workstream for both the range and reach of services being provided by the local Children's Centres. AW replied for some time now much work was going on in aligning the Neighbourhoods Programme with the services being provided in the Children's Centres and building on this. There already was a very strong health offer delivered in Children's Centres with services as diverse as Speech and Language and Occupational Therapy and continuing this approach was a key priority for the Workstream.

(l) Members asked about the need for additional mental health support for mothers giving birth during the stressful period of the Covid pandemic. AW replied that it was really difficult and she was glad Members had flagged up this issue. How current care pathways are working to support mothers was a concern and it had been flagged up at the NEL level. There is concern about there having to be less face to face appointments because of infection control and there are also concerns about Health Visitors being really stretched because they are also working frontline on the Covid response. Locally

the had put in some perinatal mental health support and they were looking to NEL to do more work on this.

(m) Members asked about the CYPM Project Manager in the Neighbourhoods Programme being only funded for 1 year. AW replied that she agreed with Members concerns about this and thanked them for raising it. The Workstream is seeking more funding from the Neighbourhoods Programme to go through the City and Hackney Integrated Commissioning System to better support this important work and concrete plans for this are now being developed.

(n) The Chair asked what changes we expect to see in terms of the existing care pathways for Children and Families arising from the Neighbourhoods Programme, as it beds in over the next year. AW replied that in terms fo the 0-5 cohort the work is quite integrated already as this is mostly via the CCGs. The question is about how to bring in midwifery and health searices and link it to GPs and can the links be strengthened so that everyone can know who is working with a particular family for example. Re. 5-19 years olds Primary Care sees less of these but schools see more and how for example can links to safeguarding be brought in also. A piece of work was ongoing around families. During Covid family focused Multi Disciplinairy Meetings (MDMs) had worked really well and this needed to be expanded. If the families have children than the children's practitioners need to be in the MDMs so that a joined up family approach is achieved. Most of this work is about relationships and linking up the partners across very specific service areas. There is also a pilot on immunisations going on, related to this, which they also want to roll out ot other areas.

(o) The Chair asked how the CYPM Workstream will evolve as a result of the Single CCG reorganisation. It looked like it would remain largely intact he added. AW replied that in terms of CYPM it would remain largely intact. Families they support were already more integrated in the system than others as they were tied into the education system, for example. The NEL interface had already strengthened CYP services across the patch and this had to be built on, she added. A lot of the work which City and Hackney ICB had started can also be continued with NEL partners getting involved as appropriate.

4.5 A Member complained about use of acronyms in these Workstream reports. AW undertook to correct this in future.

4.6 The Chair thanked AW for her detailed report and her attendance.

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| **RESOLVED:** | **That the briefing paper and discussion be noted.** |

## 5 City and Hackney Safeguarding Adults Board Annual Report 2019/20

5.1 Members gave consideration to 3 papers

(a) Cover report on the Annual Report 2019/20 of the CHSAB

(b) Annual Report 2019/20 of CHSAB

(c ) CHSAB Safeguarding Streategy 2020-2025

5.2 The Chair welcomed

Dr Adi Cooper (AC), Independent Chair, City & Hackney Safeguarding Adults Board

Denise D'Souza (DD), Interim Strategic Director of Adult Services, LBH

John Binding (JB), Head of Safeguarding Adults Service, LBH

5.3 AC took members through the covering report in detail reminding Members that it was a statutory requirement to produce this annual document.

5.7 Members asked questions and in the responses the following was noted:

(a) Members commended the quality of the report and the clear work to improve the governance and make the Board more relevant. They asked why police attendance at the CHSAB meetings had been poor (p32 of agenda). They also asked for further clarity on the nature of the Section 42 referrals and 'accepted other enquiries' and asked about the reference to the need to address "higher executive capacity".

AC replied that police representation had been sporadic and there had been a high turnover of officers involved in CHSAB work. In the monthly Exec meetings they challenged all partners on front line delivery. One of the functions of the regular meetings was to see how Covid 19 was impacting on adult safeguarding. So far there was no evidence of significant impacts. Regarding enquiries this refers to how the data is collected nationally by NHS Digital and is dependent on the technical interpretation of the data. On the 'higher executive capactiy' this referred to the issue of when someone is making a decision about risk, do they fully understand the implications of the decision they are making and do their actions make clear that they've understood it. for example dealing with people who have fluctuating mental capacity or drug use issues. The question then is whether the system is supporting them appropriately to make the right decisions as regards risk noting that there is positive as well as negative risk taking.

JB said there was both strategic and operational involvement by the police. There was very positive engagement at the operational level e.g. on domestic abuse. There had been anxieties in the past about the impact of merger of public protection unit with Tower Hamlet's but no long term detriment could be discerned from that. The police were more available now than in the past as the role was more specific to public safety and public protection. At the Strategic level personnel does change and this can have an impact but at the operational level co-operation is strong

He explained the difference between the Section 42.1 and Section 42.2 investigations. The difference lies in what is progressed as 'safgeguarding' and what isn't. 42.1 refers to how you gather the information and 42.2 is the detailed next steps. At the first stage the outcome may just be a need for better signposting for example. It refers to a lower category of enquiry which is progressed via different channels and is not a formal safeguarding inquiry. In relation to 'other enquiries' these would normally engage the Quality Assurance team and issues would then be progressed that way. He added that there is a national issue about conversion rates (from alerts to inquiries) and how they are monitoried and benchmarked. City and Hackney has remained at about a third and this is right in the middle in terms of performance against other Safeguarding Boards across the country.

On 'higher executive capacity' he illustrated the issue with a case of visiting a client at home and there being a disconnection between what they tell you and your professional judgement about the client's potential to resolve things or to improve their own situation. It's about not taking things at face value, he added. He stated that, locally, Occupational

Therapists do a great job of providing what is know as 'respectful challenge' and Safeguarding is probably less good at this and needs to learn more. There are issues here to be taken up in multi disciplinary team discussions. It's about testing out when everything would be OK for an individual.

(b) The Chair asked for a description of what changes were implemented resulting from the 2 formal SARs (Safeguarding Adult Reviews) in past year. AC replied that there were two ways SARs had an impact: one is about raising awareness generally about the issues revealed in the inquiry and this crosses all partners and the other was a series of specific recommendations which agencies and partners have to act on. Recommendations are monitored through the SAR sub group of the CHSAB to ensure over time that all the actions have been followed up, be it about changing specific policies, procedures or ways of working. There have been changes specific to Learning Disabilities Services arising from the 'Jojo' SAR (see report) and in relation to the 'Mr Yi' SAR (see report) they did make some really good changes on raising awareness of staff to be more understanding of cross over issues and when cases involve both homelessness and safeguarding need.

(c ) Members asked how relevant the Mental Capacity Act was to the work. JB replied that it was core business in terms of what they do as well as the Care Act which gives the Board its primary powers and responsibilities in law. He added that with both the JoJo SAR and the Mr Yi SAR there were actions that needed to be done collectively and some were specific to particular agencies for example the District Nursing service had to enhance their knowledge of Learning Disabilities in the community. There was also an issue about better engagement with advocacy services. AC added that they had produced 7 min briefings on the website which give key facts as well as short videos to disseminate the learning from SARs and they will do more of these.

5.8 The Chair thanked AC and JB for their very detailed and considered. briefings.

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| **RESOLVED:** | **That the 3 reports and discussion be noted.** |

## 6 Homerton University Hospital NHS FT – Quality Account 2019/20

6.1 Members gave consideration to:

(a) The Commission's letter of 4 Sept 2020 formally responding to the draft Quality Account

(b) HUHFT's Quality Account 2019-20 as submitted to NHSE/NHSI

6.2 The Chair welcomed for this item:

Catherine Pelley (CP), Chief Nurse and Director of Governance, HUHFT

and stated that he would also like to ask about preparedness for a second wave of Covid-19. He also congratulated HUHFT for achieving an 'outstanding' CQC ranking, the first acute hospital in NEL to do so, and he commended the leadership team at the Trust for their work during the pandemic.

6.3 CP explained what a Quality Account was and that the format was dicated by statutory regulation. When the pandemic hit they had been told one would not be required this year but then told in June to produce a more truncated version. The

Trust agreed therefore to produce a report to meet the statutory requirements. She added that they had set out some objectives in last year's report but all these had not been met. They had set themselves some stretching targets but were overtaken by the pandemic. There was however a significant amount of success to report across all the measures. She stated that she would be replying formally to the points raised in the letters by the Commission, the CCG and Healthwatch.

6.4 Members asked questions and the following points were noted:

(a) The Chair asked about Covid planning for a possible 2nd wave. What were the current numbers, what was the stretch capability, was Children's Pediatrics going to be relocated temporarily to Barts Health, how much elective surgery was being cancelled and where the Trust was on discharge to care homes and the speed of getting test results for those being transferred to care homes.

CP replied that when the pandemic hit they had moved from 8 to 30 beds in their ICU in a week and managed hundreds of cases. Sadly they had lost 151 patients and 3 members of staff. They then spent the summer rebuilding and ensuring all services were in line with the new Infection Control Guidance which itstelf changed three tiems. Patients having elective care had to be swobbed 3 days before admission and to stay in isolation before they came in. Flow of patients through the Emergency Department had 'red' and 'green' pathways based on what the patients level of risk was. Building work was currently going on in the Emergency Department to make it more Covid secure and to strengthen infection control. They were allowing visiting in maternity wards and they were on a London wide group working on this issue in order to maintain visits for partners in maternity services. They have a Covid preparation group which meets twice a week and examines what is coming down the line and looks at the experiences in neighbouring hosptials. Decisions are made there on what needs to be communicated to staff, when and how. There was a significant throughput of new rules and regulations to keep on top of. Anyone visiting the hospital would be screened and expected to wear a mask throughout. New mechanisms to communicate with staff had been put inplace such as webinars and videos etc.

As of that day there were zero Covid positive patients in ICU (which had 11 patients in it). In the medical beds there had been 1 confimed case and some waiting for results. There had been some small numbers going though maternity, as Amy Wilkinson had outlined in item 4. Covid was not overwhelming the Trust currently, allowing it to continue planned care and outpatient work. They were however reminding Community Nursing staff that they were more at risk now in doing community work.

On the issue of care homes, patients had to be swobbed before they leave if the destination is a care home or other hosptial. Results were coming back promptly from Royal London and this was not delaying discharges. They worked closely with care homes and care homes have their own systems including isolation plans in place and this has been working well. Two rounds of testing all the patients in the Mary Seacole Nursing Home (which HUHFT operates) had all been negative. All care homes are being tested through pillar 2 of the national system.

(b) The Chair asked how frequently staff got tested at Mary Seacole. CP replied that it was weekly for staff and monthly for patients, in accordance with CQC guidance. There is a need to understand risk and how providers could cope of a lot of asymptomatic staff had to go off at the same time.

(c) The Chair asks on how frequently staff at HUH main site were tested. CP relied that there was no testing of asymptomatic staff at the HUH site and no requirement on them to do that. Staff that ARE symptomatic get tested under the pillar 2 system of the national Test and Trace system. There is no asymptomic staff testing across NEL. They need to be confident that patient testing on symptomatic patients is robust. It had been vulnerable because there had been lab issues. They therefore did not want to put that at risk by asymptomatic staff testing. The concern was about the impact on overall testing capacity. In relation to 'Discharge to Assess' they had to make changes due to changes in national guidance. PPE was provided to staff who have to go to patients homes. Arrangements were working well and the biggest challenge in the past week had been the cyber attack on Council but they were working round that. Staff had been very flexible and responsive throughout and this had been very impressive.

(d) Chair of Healthwatch asked about exhaustion of staff if new wave of Covid emerged. He also asked about the future development plan for St Leonard's which they reasied in their response to the QA letter as being a vital issue.

CP replied that they had encouraged all staff to take their 40% of their annual leave before end of September and strongly encouraged everyont to take a break. There had been much work done on ensuring staff wellbeing because of the impact on staff of losing colleagues and the trauma they had to deal with at the peak. The previous week had been Recognition Weeek, the Chief Exec had sent personal cards to all 4K staff and there were things like free breakfasts. Wellbeing of staff was a crucial factor considering there might be a second wave going into winter. The focus was on the need to keep helping and supporting the staff and recognising that everyone is experiencing difficulties in the personal lives at the moment because of covid.

On St Leonard's, she added that HUHFT was part of the wider discussions going on at NEL level. The Chair interjected that he like to would bring this issue back to the Commission as a separate item as soon as it is possible.

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| **ACTION:** | **To add to the Work Programme an item on the future plans for St Leonards as part of the wider Estates Strategy for NEL.** |

(e) The Vice Chair asked about the status of the Coordinate My Care system which the commission had studied during its review on End of Life Care. He stated that the was disappointed that no reference had been made to the CMC issue and this was even more important at the time of Covid and that reassurance was needed on it. CP replied that it was fully in place and they were always working on how it can be improved.

(f) Members asked about asymptomatic testing for staff and why it was not being done considering that universities were doing it. CP replied that there wasn't an expectation that they test asymptomatic staff currently. The logistics of testing over 4000 staff plus contracted staff would be considerable. The test would require 2 swobs and they needed to work out what they would do of there was a significant number of positives and yet have to maintain services. It would need to be carefully throught through. The issue was how could it be done safely and how often it would need to be repeated. There would need to be a common approach to this across the NEL sites also. Testing capacity was a risk and they could not jeopardise patient testing capacity by testing all asymptomatic staff at this time, when it was not essential.

(g) Director of Healthwatch asked how risk assessments on staff including contracted staff would be be updated in the context of Covid. CP replied that they did covid risk assessments on all members of staff also linked to the concerns about their BAME staff. This was extended to all the contractors (ISS, ERS and Steris etc) as they shared their risk assessment tool with them. This was a dynamic situation and some staff would need their risk assessments updated and some would not. There was also a need to consider what it imight mean if there were further lockdowns. There were weekly webinards on covid HR and these issues were being picked up there.

6.5 Dr Sandra Husbands (Director of Public Health) thanked HUHFT for providing flu vaccinations for all the social care staff. These had been excluded in the national guidance and she wanted to publicly thank HUHFT for stepping in. CP replied that they were happy to help out on this and 20% of their staff had already received flu vaccines in one week.

6.6 The Chair thanked CP for her report and for her attendance and for the extension of flu vaccines to those front line council staff. He noted that CP would be sending a formal reply to his Quality Account letter in due course.

| **RESOLVED:** | **That the report and discussion be noted.** |
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## 7 COVID-19 verbal update on Test, Trace and Isolate – verbal udpate

7.1 The Chair welcomed Dr Sandra Husbands (SH), Director of Public Health for a regular update on the Covid 19 situation in the borough.

7.2 SH took Members through her slide presentation based on latest PHE data. In the last 2-3 weeks the curve in City and Hackney was steeper so we have a higher incidence rate than other boroughs, now 129/100,000. It was important to understand this in the context of the numbers tested and the no of positive tests. We were now around 10.5% positivy rate which was higher than most other boroughs. The 7 day average incidence rate for the whole of London was 94/100,000. Anything above 50/100,000 made it an area of intervention and she noted that other areas in the country went into local lockdowns with lower rates than we currently have. 12 London boroughs were now over 100/100,000 and she said that it was anticipated that all of London would be over this rate which would trigger discussions at Gold meetings about new interventions. She added however that other areas such as Nottinghamshire, Knowsley, Liverpool had much higher rates than London. One difference in London was that the rates of admissions to hosptials was much lower than in the north of England. Community transmission was at a high rate but not yet translating into high hospital admissions. They were also seeing the virus spill over into older age groups. Recent outbreaks had been among younger people i.e. 20-39 yr olds. Clusters were now all over not just in the north of the borough and the majority of cases were now happening not in clusters linked to households but among individuals. Only 14% had been identified as household clusters. Several wards were over 100/100,000 and so were areas of intervention. On the other indicator – health care utilisation – there has been an increase in suspected cases being diagnosed by GPs and via 111 and there is a repeat of the pattern elsewhere that 3 weeks after spikes in cases more people are admitted to hospital and eventually there are more

deaths. This was not a given she added but it was a waring and the key point was that we still have an opportunity to intervent and do something about it

7.3 The Chair asked about an apparent decrease going into October. SH replied that this was not significant and case numbers were still going up. She went on to describe the locally supported contact tracing system which had just been put in place 3 weeks previously. NHS Test and Trace had been reaching 70 to 74% of cases in City and Hackney but only 50% of these people's contacts were then being reached. The national system seemed also to be struggling to keep up with demand. Locally they try to bridge the gap and reach the 30% not being contacted in the first 24hrs by the national system. City and Hackney have slightly different approaches. In the City Environmental Health officers do follow up in Hackney it is Customer Service team as they are more familiar with the motivational type of conversations which are required. There had been some disruption because of the cyber attack, they had for example to go back to PHE with a new IP address for the council so that data could continue to be shared with us and she commended the IT team for supporting getting the tracing system back up so quickly. Much training is going on and the team had to jump from 3 cases a day to 70 and coped well. They are working on how best to reach people and the Customer Service team has access to the Public Health team for further support and if complex cases escalate.

7.3 Members asked questions and the following was noted:

(a) The Chair asked about the success of conversion rates in contact tracing and how it differs between boroughs depending on the different types of staff used for the task (Environmental Health (City), Customer Services (Hackney), or primary care (Tower Hamlets). SH replied that there were very few cases in City so it was very difficult to compare. In Hackney in the first week they reached 54% of cases. Where they had not been able to succeed this was a combination of the national system not providing correct information or where people didn't answer. Individuals get a text and the Team uses the information they have. It says the person will get a telephone call and explains what it's about and so tries to warm them up in advance. This has been quite effective but where phone calls and texts don't work they will have to consider a door knocking approach in future. Cllr Kennedy (Cabinet Member) clarified that 140 of 356 contacts had been successful thus far.

(b) Members asked about possible joint efforts in contact tracing with the local NHS and how this might work better and whether there was any further progress on what the Deputy Director of Public Health reported last month. SH replied that they were still developing the overall system and a consultant was leading on this project to try and triangulate all the data. Generally it was not that the council did not have any useful information on contacts but that many didn't pick up the phone or were busy.

(c) Dr Mark Rickets (CCG Chair) commented that the spike in cases in September presenting via primary care co-incided with the schools going back. Lots of children shared viruses and worried parents then thought their children might have Covid. He added that with a child under 12 if they are unwell, have a runny nose or fever it was highly unlikely to be Covid but if they get very unwell it needs to be checked out. SH concurred and added that another factor at the time was that the spike co-incided with a period when it was difficult to get a test.

(d) Members asked what the vectors of transmission were in Hackney. SH replied that the majority of transmission is within households but clearly some will catch it at work

(there had been a few workplace clusters) or via socialising in other households or out meeting friends. NHS Test and Trace has been working on trying to pin this down and they've been under pressure on this but it was not possible to say that one or two particular types of activity were the main causes of the spread. If one person gets it in a household they are very likely to give it to everyone else.

7.7 The Chair thanked SH for her report and attendance.

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

## 8 Minutes of the Previous Meeting

8.1 Members gave consideration to the draft minutes of the meeting held on 23 September and noted the matters arising.

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| **RESOLVED:** | **That the minutes of the meeting held on 23 September be agreed as a correct record and that the matters arising be noted.** |

## 9 Health in Hackney Scrutiny Commission- 2020/21 Work Programme

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. He added that in addition to the test and trace item they would have a substantial item on 'Covid and care homes' as well as an update from the Unplanned Care Workstream and would look at the executive response to the Commission's own review on 'Digital first primary care'.

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

## 10 Any Other Business

10.1 Chair explained that the CCG was mid way through voting on the merger to create a single CCG for North East London and he would like to ask if Members had any questions now the they had sight of some of the key documents. He welcomed David Maher (DM) MD of the CCG and Dr Mark Rickets (MR), Chair of the CCG for this additional item.

10.2 Chair asked the CCG leaders present about the fact that while 98% funding might continue to flow down to City and Hackney from NEL ICS how could the borough future proof this to protect local services. DM replied that voting had opened that day because they had extended the dates at the request of Londonwide LMC and the voting would conclude the following Monday. As regards the finances, he stated that the allocation they received as a CCG was a capitated one and the DHSC and the CCG agreed a formula for healthcare spend partly based on deprivavation. So long as DHSC continued to use a formula that weighted deprivation Hackney should continue to receive a similar

allocation. He added that this was about as much assurance as he could give and of course allocations were also dependent on the Annual Spending Round announcements from the Treasury. He added that the Deprivation Indices hadn't moved in the 10 years he had been working in City and Hackney and as long as the formula remained the same they would expect the same amount of resource. Dr Rickets added that two years previously C&H had received a 5 year allocation which would be upheld. The 98% allocation came from this. NHSE could now or in the future seek to change this and of course Parliament can always change this in many different ways. He added that the formula weighted age as well as deprivation. In addition it was important to note that new money was coming into NEL arising from the Long Term Plan, whatever City and Hackney decided to do.

10.3 The Chair stated that the changes appeared to bring together commissioners and the large secondary care providers and would do away with the internal market in commissioning and asked if this was something to be welcomed.

DM replied that the origin of the Integrated Commissioning Model was the Long Term Plan itself and that a side letter was published to that (which was also in the Foreword) which set out an 'ask' to Parliament to remove competition from the powers within the NHS ecosystem and to revise the Competition and Markets Authority's powers in relation to it. The creation of the Single CCG does inherently pull together Providers and Commissioners in a way that does completely erode the purchaser and provider split which Commissioning have been working with for some time. He added that this represented a benefit in NEL because of strength of our local anchor organisations and their history of partnership working so, from the point of view of City and Hackney CCG, this was a positive outcome of the LTP.

10.4 The Chair asked if the new structure, should it go through, be explained in a briefing to the Commission and that this should also cover the governance process. He added that a lot of focus in terms of the day to day delivery will move essentially to Tracey Fletcher's role within the Integrated Commissioning Partnership giving her a more prominent role in pulling providers together. In the future therefore he would envisage having a separate item to hold her to account in this role, totally separate from her role as heading up HUHFT.

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| **ACTION:** | **CCG to provide**<br>**a) Briefing on the new governance structure for the City and Hackney ICP and how it forms part of the new NEL Integrated Care System**<br>**b) Future briefing from Tracey Fletcher in her role as System Lead for the Neighbourhood Health and Care Services Board of the City and Hackney ICP.** |

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| **RESOLVED:** | **That the discussion be noted.** |

**Duration of the meeting:** 7.00 - 9.10 pm

Hackney

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| **Health in Hackney Scrutiny Commission**<br><br>18th November 2020<br><br>**Work Programme 2020/21** | Item No<br><br>**9** |

**OUTLINE**

Attached please find the latest iteration of the Commission's Work Programme. Please note this is a working document and is regularly updated.

**ACTION**

The Commission is requested to note the updated work programme and make any amendments as necessary.

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# Health in Hackney SC - Rolling Work Programme for 2020-21 as at 11 Nov 2020

| Date of meeting | Item | Type | Dept/Organisation(s) | Contributor Job Title | Contributor Name | Notes |
|---|---|---|---|---|---|---|
| **9 June 2020** | **Covid-19 Response** | Discussion Panel | Public Health | Director of Public Health | Dr Sandra Husbands | |
| deadline 31 May | | | Public Health England | Regional Director for London | Prof Kevin Fenton | |
| | | | Independent SAGE/ UCL | Professor at UCL | Prof Anthony Costello | |
| | | | Independent SAGE/ University of Newcastle | Professor at Newcastle | Prof Allyson Pollock | |
| | | | Durham County Council | Director of Public Health | Amanda Healy | |
| | **Appointment of members to INEL JHOSC** | Decision | Legal | Monitoring Officer | | |
| | | | | | | |
| **9 July 2020** | **Election of Vice Chair 20/21** | Decision | Legal | O&S Officer | | |
| **deadline 30 June** | **Homerton Hosptal's contract for soft services** | Inquiry | HUHFT | Director of Finance | Phil Wells | |
| | | | HUHFT | Director of Workforce and Organisational Development | Thomas Nettel | |
| | | | UNISON | Area Officer for NHS | Michael Etherdige | |
| | | | UNISON | Unison rep at ISS | Naomi Byrne | |
| | | | GMB Union | Regional Organiser for NHS | Lola McEvoy | |
| | **An Integrated Care System for NEL** | Briefings | City & Hackney CCG | Managing Director | David Maher | |
| | | | City & Hackney CCG | Chair | Dr Mark Rickets | |
| | **Covid-19 City & Hackney Restoraton and Resilience Plan** | Briefings | City & Hackney CCG | Managing Director | David Maher | |
| | | | City & Hackney CCG | Chair | Dr Mark Rickets | |
| | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | | | | | | |
| **30 July 2020 URGENT** | **Re-location of inpatient dementia assessment services from Mile End Hospital to East Ham Care Centre** | Urgent briefing | ELFT | Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health | Dr Waleed Fawzi | |
| | | | ELFT | Director of Operations | Edwin Ndlovu | |
| | | | Barts Health NHS Trust | Chair of Medicine Board and Outpatient Transformation | Neil Ashman | |
| | | | City & Hackney CCG | Programme Director Mental Health | Dan Burningham | |
| | | | City & Hackney CCG | Managing Director | David Maher | |
| | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Director of Public Health | Dr Sandra Husbands | |
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| **23 Sept 2020** | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Deputy Director of Public Health | Chris Lovitt | |

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| deadline 14 Sept | **An Integrated Care System for NEL** | Briefings | City & Hackney CCG | Managing Director | David Maher | |
| | | | City & Hackney CCG | Chair | Dr Mark Rickets | |
| | | | HUHFT | Chief Executive | Tracey Fletcher | |
| | **Planned Care Workstream** | Annual update | CCG-LBH-CoL | Workstream Director Planned Care | Siobhan Harper | |
| | **Healthwatch Hackney Annual Report 2019/20** | Annual report | Healthwatch Hackney | Executive Director | Jon Williams | |
| | | | | | | |
| **14 Oct 2020** | **City & Hackney Safeguarding Adults Board Annual Reprot 2019/20** | Annual report | CHSAB | Independent Chair | Dr Adi Cooper OBE | |
| deadline 5 Oct | | | CHSAB/LBH | Head of Service Safeguarding Adults | John Binding | |
| | **Children, Young People, Maternity and Families Workstream -** Joint item with CYP Scrutiny Commission | Annual update | CCG-LBH-CoL | Workstream Director CYPMF Workstream | Amy Wilkinson | |
| | **HUHFT Quality Account 2019-20** | Annual report | HUHFT | Chief Nurse and Director of Governance | Catherine Pelley | |
| | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | | | | | | |
| **18 Nov 2020** | **Covid-19 and Care Homes** | Discussion Panel | Adult Services | Interim Strategic Director of Adult Social Services, Health and Integration | Denise D'Souza | |
| deadline 9 Nov | | | Acorn Lodge Care Home | Manager | Diane Jureidin | |
| | | | LSE | Assistant Professorial Research Fellow in the Care Policy and Evaluation Centre | Adelina Comas-Herrera | |
| | | | The King's Fund | Senior Fellow - Social Care | Simon Bottery | |
| | | | HUHFT | Chief Executive | Tracey Fletcher | |
| | | | CCG-LBH-CoL | Workstream Director Unplanned Care | Nina Griffith | |
| | | | LBH | Cabinet Member for Health Social Care and Leisure | Cllr Chris Kenndey | |
| | **Unplanned Care Workstream** | Annual update | CCG-LBH-CoL | Workstream Director Unplanned Care | Nina Griffith | |
| | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | **Senior management restructure in Adult Services** | Briefing | Adult Services | Interim Strategic Director of Adult Social Services, Health and Integration | Denise D'Souza | |
| | | | | | | |
| **6 Jan 2021** | **TBC** | | | | | |
| deadline 18 Dec | **Covid-19 update on Test, Trace and Isolate** | Monthly briefings | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | **Digital divide impacts in primary care** | Panel Discussion? | | | | |

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| | **Work towards developing a Protocol for Primary Care digital consultations** | Briefing requested Sept 2020 | GP Confederation | Chief Executive | Laura Sharpe | |
| | | | Healthwatch Hackney | Executive Director | Jon Williams | |
| | **REVIEW on Digital first primary care and the implications for GP Practices** | Executive Response | LBH | Cabinet Member for Health Social Care and Leisure | Cllr Chris Kenndey | |
| | | | | | | |
| **23 Feb 2021** | **Hackney Local Account of Adult Care Services** | Annual report | Adult Services | Interim Strategic Director of Adult Social Services, Health and Integration | Denise D'Souza | |
| deadline 12 Feb | **TBC** | | | | | |
| | **TBC** | | | | | |
| | **TBC** | | | | | |
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| **31 March 2021** | **New governance structure for the C&H Integrated Commissioning Partnership and the NEL Integrated Care System** | Briefing | NEL ICS | Managing Director C&H | David Maher | |
| deadline 19 March | | | NEL ICS | Chair C&H | Dr Mark Rickets | |
| | **Neighbourhood Health and Care Services Board** | Briefing | NEL ICS | System Leader for City and Hackney NHCSB | Tracey Fletcher | |
| | **New Population Health Hub of Integrated Commissioning Partnership** | Briefing | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | **Work programme discussion for 2021/22** | | | | | |

*Note: There are no meetings scheduled for Dec or April. Separately, the Mayor of London and London Assembly elections will take place on 6 May 2021. Purdah begins c. 1 April.*

## ITEMS AGREED BUT NOT YET SCHEDULED

| | | | | | | |
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| **Possible date** | | | | | | |
| July 2021 | **Relocation of inpatient dementia assessment services to East Ham Care Centre** | Update requested from July 2020 | ELFT | Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health | Dr Waleed Fawzi | |
| | | | CCG or NEL ICS | Programme Director Mental Health | Dan Burningham | |
| | | | Healthwatch Hackney | Executive Director | Jon Williams | |
| TBC | **Extension of ISS contract for soft services at HUHFT** | Update requested from July 2020 | HUHFT | Chief Executive | Tracey Fletcher | |
| | | | UNISON | | | |
| TBC | **Pathology Partnership between HUHFT and Lewisham & Greenwich NHS Trust** | Update requested from Jan 2020 | HUHFT | Chief Executive | Tracey Fletcher | |

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| TBC | **Covid-19 action plans to address disproportionate impact on minority ethnic communities** | Either separate of focus of a monthly briefing | HUHFT | | | |
| | | | ELFT | | | |
| | | | Adult Services | | | |
| | | | Primary Care | | | |
| TBC | **Cabinet Member Question Time** | Annual item | LBH | Cabinet Member for Health Social Care and Leisure | Cllr Chris Kennedy | |
| TBC | **Integrated Learning Disabilities Service** | Update on new model | Adult Services | Head of LD Services | Ann McGale | |
| TBC | **Implementation of Ageing Well Strategy** | Update requested Dec 2019 | SPED | Head of Policy and Strategic Delivery | Sonia Khan | |
| TBC | **City and Hackney Wellbeing Network** | Update on new model | Public Health | Consultant in Public Health | Dr Nicole Klynman | |
| Postponed from March | **Air Quality - health impacts** | **Full meeting** | King's College London | Academic | Dr Ian Mudway | |
| | | | Public Health | Public Health Consultant | Damani Goldstein | |
| | | | Environment Services Strategy Team | Head Environment Services Strategy Team | Sam Kirk | |
| Postponed from March | **King's Park 'Moving Together' project** | Briefing | King's Park Moving Together Project Team | Project Manager for 'Moving Together' project | Lola Akindoyin | |
| | | | Public Realm | Head of Public Realm | Aled Richards | |
| Postponed from 1 May | **Tackling Health Inequalities: the Marmot Review 10 Years On** | **SCRUTINY IN A DAY** | Public Health | Director of Public Health | Dr Sandra Husbands | |
| | Sub Focus on Objective 5: Create and develop healthy and sustainable communities | | NEL ICS | MD City and Hackney | David Maher | |
| | | | Planning | Head of Planning and Building Control | Natalie Broughton | |
| | | | Neighbourhoods and Housing | Head of Area Regeneration Team | Suzanne Johnson | |
| | | | Benchmarking other London Borough | | | |
| Postponed from July | **Neighbourhoods Development Programme** | Annual Update | GP Confederation | Chief Executive | Laura Sharpe | |
| | | | GP Confederation | Neighbourhoods Programme Lead | Mark Golledge | |
| TBC | **Future use of St Leonard's Site and NEL Estates Strategy** | **Discussion Panel** | LBH Chief Exec | | Tim Shields | |
| | | | Adult Services | | Denise D'Souza | |
| | | | NEL ICS | | Jane Milligan | |
| | | | NEL ICS | | Dr Mark Rickets | |
| | | | NEL ICS | | David Maher | |
| | | | HUHFT | | Tracey Fletcher | |

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| | | | ELFT | | Paul Calaminus | |
| | | | GP Confederation | | Laura Sharpe | |
| | | | Healthwatch Hackney | | Malcolm Alexander | |
| | | | HCVS | | Jake Ferguson | |
| | | | Hackney Keep Our NHS Public | | | |
| | **How health and care transformation plans consider transport impacts** | Suggestion from Cllr Snell | | | | |
| | **Implications for families of genetic testing** | Suggestion from Cllr Snell | | | | |
| | **Accessible Transport issues for elderly residents** | Suggestion from Cllr Snell | | | | |
| | **What does governance look like at Neighbourhood level** | Suggestion from Jonathan McShane | | | | |

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Hackney

**London Borough of Hackney**
**Health in Hackney Scrutiny Commission**
**Municipal Year 2020/21**
**Date of Meeting: Wednesday, 18 November 2020**

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

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| **Chair** | **Councillor Ben Hayhurst** |
| **Councillors in Attendance** | **Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence** |
| **Apologies:** | |
| **Officers In Attendance** | **Denise D'Souza (Interim Group Director for Adults, Health and Integration) and Chris Lovitt (Deputy Director of Public Health)** |
| **Other People in Attendance** | **Councillor Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure), Councillor Yvonne Maxwell (Mayoral Advisor for Older People), David Maher (MD, NHS City & Hackney CCG), Dr Mark Rickets (Chair, City and Hackney CCG), Nina Griffith (Workstream Director Unplanned Care, Integrated Commissioning, CCG), Jon Williams (Executive Director, Healthwatch Hackney), Tracey Fletcher (Chief Executive, Homerton University Hospital NHS Foundation Trust), Diane Jureidin (Manager, Acorn Lodge), Simon Bottery (Senior Fellow – Social Care, The King's Fund), Adelina Comes-Herrera (Assistant Professorial Research Fellow in Care Policy and Evaluation Centre, LSE), Laura Sharpe (Chief Executive, City & Hackney GP Confederation)** |
| **Members of the Public** | **7** |
| **YouTube link** | https://youtu.be/6VE2Pk5CnGU |
| **Officer Contact:** | **Jarlath O'Connell**<br>☎ 020 8356 3309<br>✉ jarlath.oconnell@hackney.gov.uk |

**Councillor Ben Hayhurst in the Chair**

## 1 Apologies for Absence

1.1 Apologies for absence were received from Dr Sandra Husbands.

## 2 Urgent Items / Order of Business

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

## 3 Declarations of Interest

3.1 There were none.

## 4 Care Homes and Covid 19

4.1 The Chair stated that the purpose of this item was to examine how local care homes are coping during the Covid-19 pandemic and to seek reassurance that the local system is now better prepared for the second wave, should it occur. He explained that there would be four short briefings from Adult Services, the Manager of Acorn Lodge and two external guests from LSE and from The Kings Fund after which there would be a panel discussion.

4.2 Members gave consideration to a briefing paper from Adult Services.

4.3 The Chair welcomed for this item

Denise D'Souza (DD), Interim Group Director for Adults, Health and Integration
Diane Jureidin (DJ), Manager, Acorn Lodge
Adelina Comes-Herrera (AC), Assistant Professorial Research Fellow, Care Policy and Evaluation Centre, LSE
Simon Bottery (SB), Senior Fellow – Social Care, The King's Fund
Cllr Christopher Kennedy (CK), Cabinet Member for Health, Social Care and Leisure
Tracey Fletcher (TF), Chief Executive, HUHFT
Nina Griffith (NG), Workstream Director Unplanned Care, Integrated Commissioning

And stated that DD, DJ, AC and SB would give brief presentations and then open the item up for discussion.

4.4 DD took Members through the briefing paper in detail. She explained the context of care home provision in Hackney. She stated that there had been 20 Covid related deaths during the March-April peak in Hackney. She explained the local structures and how there were 16 CQC registered care homes in Hackney with 331 beds but only 4 were nursing homes for elderly people with 226 beds in total. Islington, by contrast has 48 care homes she said. She stated that the new policy of Home First came in on 1 Sept. She detailed its three levels relating to levels of need. She stated that new funding had come from the NHS to pay for the first 6 weeks of care and that Adult Services then carried out assessments to plan the next steps for those patients. The big challenge was the lack of PPE and difficulties with the delivery of that. There had been a lot of concern about staff and their health and wellbeing and managing staff sickness had been an issue. They had received grants to improve infection control which they were able to pass on to Providers. A new national policy on care home visits had come in and there was also now a

dashboard which provided national tracker system giving vital live information on case rates and capacity across the system. There had been new training for staff. There had been a 3% uplift for 3 months for Providers to help with PPE purchase. Now the focus was on the winter plan and on testing of all patients before discharge. Another key aspect of the work was the alignment with Neighbourhoods programme.

4.5 DJ described their experience at Acorn Lodge Care Home since March. A big issue for them had been infection control and getting up to speed was a challenge. Also accessing PPE in the first 6 wks of the pandemic had been another challenge. Another issue was identifying the more obscure symptoms of Covid in frail patients with co-morbidities. Keeping families informed and reducing their anxiety and adapting End of life Care plans was another key focus. Managing care home staff who needed to isolate and covering shifts was another challenge. Acorn Lodge benefited from valuable close working with their GP. There had been no real testing until the second half of May she explained. If second wave come about, she stated, systems were now in a much better place and there was sufficient PPE, testing was happening weekly for staff and every 4 weeks for residents. If residents showed symptoms they were tested on the same day and then isolated. She explained that they didn't mix staff or residents across units. Visiting continued to provide the biggest challenges however. Window visiting and zoom video conferencing were taking place. Risk assessments were done on those at end of life stage so that 1 or 2 members of the family could visit. There was much more confidence and surety in the whole system now she concluded.

4.6 AC described some international comparisons e.g. with Hong Kong and Singapore. The share of residents who died in care homes was the same as proportion who died outside care homes which tells us that despite all attempts it was still very difficult to keep virus out of care homes. She stated that the practice of cohorting was an excellent measure and has had impact internationally. She stated that it was all down to test, trace and isolate and the isolate bit was the most difficult in care homes. Infrastructure remained a challenge in care homes and the characteristics of many people in care homes e.g. patients with dementia, means that it will always be difficult to implement these principles (very hard to keep patients compliant) and that it requires resourcing. She added that it was also very difficult to measure the numbers of those dying in the community. Excess deaths in private households were an issue. Many were relying on carers and many of them were self-funders. What is their access to PPE and who is paying for it, she added. Care homes were never designed to be isolation facilities and so many have trouble converting. She stated that in parts of Asia they had a very strict policy of moving positive patients out of care homes. It was controversial but enabled care homes to keep outbreaks to just 1 or 2 patients and this was something to consider when a care home doesn't have the right facilities. Using another space outside is an option worth exploring she concluded.

4.7 The Chair asked whether the pandemic had acted as a catalyst for a reform of the care home sector. SB replied that with social care reform it was very difficult to predict what was going to happen next.

4.8 SB gave a verbal presentation where he summarised 5 sets of issues which he thought a Scrutiny Commission should attend to and these were:

*(a) Are our care home residents safe*
The focus here needed to be on adequacy of testing, keeping an eye on adequate provision of PPE and more broadly on the tension between the safety and the happiness of residents.

*(b) Are our care home residents happy*
The average care home stay was 18 months and if residents had to remain isolated in their own rooms how would this impact on their mental health and wellbeing. It was necessary to look at how visiting policies are devised and operated. The government had a pilot on visiting policies and it would be necessary to keep an eye on this.

*(c) Are our care homes in the right places*
Were proper assessments done before discharge from acute settings or elsewhere. He stated that there was some Red Cross research on what happens to people afterwards which had revealed instances of no proper follow up. Percentages of who is in what care pathways needed to be examined and the national guidance should not be seen as an absolute guideline for every authority. In relation to costs, there was the issue about discharging paying care home residents in an emergency into places where the rates are higher than what the Council normally pays for them. What would be done long term for those patients in terms of the council's ability to afford to continue to keep them in that setting, he asked.

*(d) How will the care home sector survive the pandemic*
He stated that a 90% occupancy level was the minimum that care homes needed in order to survive. Numbers had generally dropped to 85% in the pandemic. The numbers of self-funders, who pay more, fell by a third and those who are council funded also fell sharply as individuals and families decided not to move into a care homes at the present time because of fears of catching covid. The compounded cost of PPE is another major budget issue.

*(e) How will it be possible to staff care homes in any second wave.*
High levels of staff sickness and isolation initially had now levelled off and vacancy rates in sector, s a whole, had been falling, he explained. One impact of the recession (exacerbated by Covid) was that more people were now happy to work in the sector than before. The government plans to limit the number of people working in more than one home would also have an economic impact.

4.8 Chris Lovitt (Deputy Director of Public Health) (present for item 6) presented some slides on care home Covid incidence and deaths. There had been more Covid cases in the beginning of the first wave and of course there had been less testing then. Hackney then had a second spike in Aug-Sept but much fewer cases because of the mitigation work which had taken place, so there had been successes. There were obvious continuing challenges in nursing homes and the issue in homes for those with Learning Disabilities or Mental Health were quite different.

4.9 Members asked detailed questions the following responses were noted:

(a) The Chair commented that the significant excess deaths which took place nationally in care homes over and above those who tested positive should be noted and that there was a need for some caution in deducing that the figures being

published show the full picture. He also asked whether the other 3 nursing homes in Hackney were able to 'cohort' and if not what they were doing to ensure safety. DD responded that in newer built homes it was easier to cohort but in converted buildings it proved more difficult. There was also much work being done on designated beds and in roll out of the latest standards on infection control. Nina Griffith (Unplanned Care Workstream Director) described the local approach to cohorting and the audit that took place. 2 of the 4 nursing homes can cohort (Acorn Lodge and Mary Seacole). Across the Learning Disability and Mental Health homes there was a more mixed picture. They had however put in place contingency arrangements for those. They also had also 6 interim Supported Living flats in which to discharge people to before they go back to their homes or Housing with Care settings.

(b) Members asked whether staff moved between homes? DD replied that they didn't. NG explained the strict national guidance on this. It was not easy to police she added but the issue hadn't arisen locally, and they had been given assurances by the providers and they worked very closely with them. DJ added that Acorn Lodge do not use agency staff and staff do not move around. She added that she and the Clinical Manager also did clinical care when the need arose.

(c) Members asked when rules had come in regarding testing prior to discharge from acute settings. They also asked whether a Director of Public Health might be able to override isolation warnings from the NHS Test & Trace App once risk assessments had been in place by a Provider. Cllr Snell gave an example of an issue he came across as Chair of a Learning Disabilities charity providing services in another borough. He also described how families in effect do their own risk assessments. He also praised Acorn Lodge for how it encourages people to mix and socialise and he asked if more could have been done to support them.

NG replied that the rule came in re discharge testing 15 April and she described the timeline leading up and how the rules had become stricter. Associated Guidance however had been vague she added.

(d) The Chair asked Tracey Fletcher (CE of HUHFT) about the current discharge rules at the Homerton. TF stated that patients were tested 2 days before they anticipated a discharge and they waited for results to come back before anyone was discharged. If there was an extreme example, as outlined by Cllr Snell, they would only ever discharge to a care home when a plan was discussed and fully agreed with the receiving care home about how they would manage that patient. She added that now test results were coming back much more rapidly thus facilitating more prompt discharge.

(e) The Chair asked about managing the impact of staff testing positive and what do to and would a risk assessment override an NHS T&T isolation warning. Cllr Snell stated he had written to the CE of Hackney Council on the general points. Once the NHS T&T app identifies that you've been with someone who has been infected you are warned about the fines if you don't comply and this was preventing key workers from attending work, which was then causing problems for many small care charities. The Chair asked if there were systems are in place to troubleshoot scenarios like these. DD replied that you cannot override the Test and Trace instructions and you have to obey the App. Rapid testing was the solution in a scenario like this, she added.

(f) The Chair asked about people in private households needing care and whether that was being monitored and if they were being provided with support and PPE. DD

replied that they were of course reaching out to home care providers. A lot of these clients would be paying for private care and the Council would not be across that. They had also been reaching out with PPE offers to carers. There was a general worry about the stability of the care home market as many were choosing not to go into care homes at present and people were also not wating care or support staff to be coming into their own homes, despite often needing advanced care, and this needed to be tackled.

(g) The Chair asked AC re best practice on accessing self-funders in order to assist them. AC stated that these issues were long term and there isn't a national system of data to enable us to identify self-funders. The care system can identify diagnoses of dementia and can offer PPE. She added that there was certainly scope for more proactive policies here. DD agreed that that informal carers also needed access to support.

(h) The Chair asked DJ about the CQC rating of Acorn Lodge possibly impacting on its 'designated setting' for the discharge of Covid patients from acute hospitals. You need to have the highest two ratings for this designation.

DJ replied they had a past infection control inspection that wasn't fully compliant, they since had a re-inspection but had not received the outcome of that, which would enable them to be formally confirmed as a designated setting. In the meantime, they were continuing to accept acute discharges because the few cases involved were being tested and they were able to isolate them in their own private rooms in the home when not ready to go into their Covid cohort section. As of that week they had no covid positive patients. They had had one asymptomatic outbreak in July. All staff were negative and all residents were negative.

(i) Members asked about the lack of choice for Hackney residents in care home provision and about the monitoring of quality of delivery, of safety and of resources

DD detailed the Quality Assurance Framework they have in place and the broader CQC regulatory system for care homes. The Council has its own QA mechanisms and they worked with the care home managers. They supported the Acorn Lodge evidence to CQC in order to assist them because they had all the QA evidence on record that was needed by the CQC.

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| **ACTION:** | **Interim Group Director Adults Health and Integration to provide Members with a note on the Quality Assurance Framework on Care Homes commissioned by the borough and to provide clarification on how regularly the risk assessments of Care Homes are being updated.** |

(j) Members asked how often risk assessments are updated. NG replied that through the pandemic the Commissioning Team Council were very regularly in contact with all the care homes. There was a normal update cycle but much more regular weekly conversations with the care homes since the pandemic for example about working out how 'cohorting' would operate.

(k) The Chair asked about whether rapid discharge was the correct policy at present. NG replied that all got tested before they left the hospital. Only designated care homes can receive people that are positive and Mary Seacole should soon have the

same arrangement in place as Acorn Lodge. Also, interim supported living arrangements had been put in place and nobody was being discharged into a regular care environment.
(l) The Chair echoed SBS point about ensuring the best care environment for a person. SB added that in the rush to get people out of acute settings during the peak of the pandemic there needed to be an analysis of whether those patients always ended up in the right place for them. NG added that different rates of pay between providers did provide a challenge in planning but it was important to note that there were no current bed pressures at HUHFT, unlike at BHRUT for example, and no rash decisions were having to be taken. They had a 'Discharge Single Point of Access' system in place which was now mandated through national guidance and this had worked really well in the City and Hackney system. This referred to a hospital-based hub that brings together all the partners involved in a patient's discharge: OTs, care workers, hospital staff etc. They do also have to place some people out of borough on occasion which is not ideal, but they were not placing anyone in the wrong place for them.

(m) The Chair asked about the lessons which had been learned from the second wave in the North West of the country and what had emerged there about the impact on care homes. AC replied that it wasn't easy to compare both times because for example the testing situation had been so different the first time. Share of deaths in hospitals of care home residents was increasing a little bit. They were also hoping that this time people who have Covid will be more readily admitted to hospital and in addition they now have much better treatments in place, than in April, so even very old people are responding better to treatment.

(n) The Chair asked Tracey Fletcher whether, because pressures had been so great during the first wave, eligibility thresholds for care home residents being admitted to acute settings had been raised unduly.

TF replied that it was always based on a clinical assessment. The policy would never have been not to take care home patients. She added that City and Hackney was in a fortunate position in that it worked really well as a system. They had never got into the position of having people queuing up outside the hospital. Anyone who needed to be admitted was.

4.10 The Chair thanked all the contributors for their comments and contributions and the Care Home and NHS staff for their excellent work at this very difficult time.

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| **RESOLVED:** | **That the briefing paper and discussion be noted.** |

## 5 Unplanned Care Workstream - Update

5.1 Members gave consideration to a presentation "Integrated Commissioning – Unplanned Care Workstream Update".

5.2 The Chair welcomed:

Tracey Fletcher (TF), Chief Executive, HUHFT and SRO for the Unplanned Care Workstream of Integrated Commissioning
Nina Griffith (NG), Workstream Director Unplanned Care, Integrated Commissioning

5.3 In introducing her paper NG stated that she had last spoken to the Commission in January and when writing this update was shocked at how much had changed since then. She stated that the pandemic had emphasised the importance of the work they were doing on the Neighbourhood model and on better integrated discharge and indeed prompted them to progress it more quickly. She added that End of Life Care is a key element of their portfolio of work and a lot of thinking and more focused work had gone into it since the pandemic. Since the summer they were working on the Winter Planning and this also required a renewed focus in light of the pandemic. The danger of a second wave coinciding with the normal winter pressures must be averted.

5.4 Members asked detailed questions and in the response the following was noted:

(a) Chair asked about the problems with NHS 111 and scope for a reform to it that might provide some confidence. He commented that C&H had gone from being badly served by a poor private provider to having a locally run top-class service to seeing that being replaced by a poorer quality sub-regional solution where, at best, only 30% of callers got to speak to a doctor.

NG admitted that there had been a lot of recent national policy direction on NHS 111. Initially patients are dealt under a standard algorithm until they are progressed into triage. National money had gone in to increase capacity and the recent KPIs were showing that the service had responded very well to the pandemic despite a shaky start. The system does well on access and on the numbers who receive a clinical assessment, she added, but they are getting feedback that the public are feeling like they're talking to an algorithm that doesn't suit their needs. The structures in place are now good she added and there is an NEL Urgent and Emergency Group which is chaired by Tracey Fletcher and this gives C&H more levers to improve the system than it had previously and also levers to work better with London Ambulance Service. She added that when your GP is open it is always a better option than contacting NHS 111. They are also aware that there needs to be better targeting of 111 to get the right people to use the system and there is a need to accept that there will always be a few who will walk through the A&E front door and they will have to be supported too.

(b) Jon Williams (Executive Director, Healthwatch Hackney) expressed concern about the lack of patient and public involvement in recent health changes mainly because of speed of change during the pandemic and on concerns they have about the return of a more medicalised model of health care. He said there will be a need to recover the situation once the pandemic had passed. He noted that the emerging partnership priorities coming out of the Integrated Commissioning Board were very medicalised and care needed to be taken about this. If we lose sight of the wider ambitions for public involvement, he added, we won't be able to tackle the transformation work which is necessary.

NG replied that through the emergency response they were moving at such a pace that they didn't consult and collaborate with service users in the way they normally would have because it hadn't been feasible to do so. They had now started doing this again and have public representatives on the Discharge Steering Group for example. She referenced a CCG event that week on Winter Pressures involving the community and hoped to work more closely with Healthwatch on more of those. On the over

medicalised model, she stated she was surprised to hear this and said she had seen the opposite in the winter planning work where they were much more focused on how to support vulnerable communities. It had taken a broader and much less medicalised approach but she would take Healthwatch's comments on board.

(c) Members asked about the need to improve on the Coordinate My Care system. Cllr Snell reminded members that the Commission's own End of Life Care review had uncovered that some care homes were unhappy about discharges from acute to care home settings and of a poor working relationship between acute providers, London Ambulance Service and the care homes. NG replied that 'My CMC' was about to be implemented as the next phase of CMC and that is would be the more user-led side of this care planning tool.

(d) Members asked about the national announcement of a write-off of the debts of NHS Acute Trusts and expressed concern that top down reorganisation of the NHS would be imposed on Hackney and the borough would then be impacted by the much higher debts in neighbouring CCG areas. TF explained the budget changes in the NHS due to the pandemic. The issue of 'control targets' had been altered as a consequence of the whole financing regime changing with a shift to block contracts and use of new Covid money coming in to the system and the impact of unplanned expenditure which they hadn't anticipated. She explained the difference between 'aged debt' and the inability of some trusts to operate within their 'positive run rate' and how some trusts struggled with one or both of these requirements. She stated that HUHFT for example received £340m and planned to operate within that but some trusts find they cannot do so under their allocation, some were carrying over historical debt for whatever reason. It was the historic debt element that is affected by the changes, it is being taken out of the budget methodology which includes Revenue and being put in the Public Revenue Capital element. She added that this was quite a technical change and her Director of Finance would be in a better position to give a more detailed response. The Chair thanked her for this and stated that he and Cllr Snell would pick this up at the next INEL JHOSC meeting.

5.5 The Chair thanked TF and NG for their attendance and for their briefings and for their hard work during the whole pandemic period.

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

## 6 Covid-19 Test Trace and Isolate

6.1 Members gave consideration to a tabled presentation *Covid 19 update to Health in Hackney Scrutiny Commission*. This was tabled in order for it to be up to date on the day of the meeting.

6.2 The Chair welcomed for this item:

Chris Lovitt (CL), Deputy Director of Public Health, City and Hackney

6.3 CL took members through the highlights of his slide presentation on the latest Covid data for Hackney. It also detailed the latest news on the fast-developing plans for vaccinations. He stated that the tentative indications were that the rate of increase in infection was now slowing and they were hoping that the lockdown was now starting to have an impact. There were some worrying signs that rates for over 60s were rising again in Hackney and were higher than

the London average. A key concern was that that's where you got most of hospitalisations and deaths. The number of people being tested was slightly below the average for London but holding up well. The positivity rate was now back towards the average for London. Most of the Covid cases being diagnosed were in the 20-29s yr group and now rising in the 30-39s yr group. If the rise continued to creep up the age range there would be problems

6.4 The Chair asked whether the recent spike had been linked to parents of children in school. CL replied that it wasn't and recently there was quite a proportion of cases who picked it up pubs and hospitality venues. He illustrated the dense red spots in the map where there were a number of clusters. Over the border in Tower Hamlets there were spots arising from student halls of residence. Previously there had been a North-South split in the borough, but this was no longer the case. Wards in the North had seen significant drops. He stated that they were seeing the successes of the local contributions to the Test and Trace programme and there was a desire nationally now for local authorities to take on more of a role. The target for the national Test & Trace was 80% and City and Hackney locally had been able to get up to that level. He stated that there was obviously much interest in vaccinations and the finding of the latest efficacy trials was fantastic news. Public Health was still not able to get all the information necessary for example when will the vaccine be licensed and delivered and who will get priority and what the technical details of distribution will be. Work is ongoing and they were making plans at speed but he cautioned that what people were seeing in the news was the latest press releases from the vaccine manufacturers but a lot more detailed information was required by the Public Health system. On Rapid Testing he stated that they were now waiting for more detailed information from DHSC on the requirements and licences for these tests. Soon they should be able to provide more rapid test results and so be able to deploy to asymptomatic people. The new test centre in Stamford Court would begin the day after the meeting as a 7 day a week testing centre, thus increasing the capacity in the north of the borough. Capacity was now good.

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

(a) The Chair asked about Hackney being in the pilot for new lateral flow tests noting that local authorities were supposed to get 10k of them, but it was unclear whether there would be strings attached. CL clarified that C&H would get 10k tests at first and then up to 10% of local population perhaps every fortnight. It was not yet clear what the dynamics of that testing regime will be, and which areas or cohorts would be targeted for rapid testing and the frequency of that testing. He added that we needed to be clear whether this was a pilot and for how long as it is always a challenge in public health to know when to stop doing something as much as when to start.

(b) Members asked what was being done to prevent second spike in north of borough and about the need for more data on the spread of Covid in schools

CL replied that it would be difficult to predict when any second spike might occur. Lots of work had been undertaken to improve communications and messaging in the north of the borough as well as some enforcement and these had proved successful There

was a need to ensure we don't get those high rates again, he added. If this happened, they would immediately up the messaging and engagement, as necessary. As regards schools, they did not have a league table on Covid. All schools have school bubbles and he could provide more detail on specifics on request. There was a detailed spread sheet. He added that if we get the lateral flow testing, schools would be very good places to start to deploy them.

(c) Members asked about how vulnerable residents might secure help with transport to test centres as some are remote and also about the risks to the elderly in pubic parks from accidental exposure from passing joggers and what might be done to mitigate this e.g. one way systems in park.

CL replied that for those having transport issues they could always access tests by going online and the test would be sent to them to arrive the next day. They had ensured there was a good distribution of test centres and there were four in the borough and one in the City.

On the issue of dangers from joggers, most transmission was via droplets so it was a concern. The suggestion of one-way traffic systems in parks was a good one and he would take that away and discuss with the other relevant departments in the Council. Public Health encouraged people, particularly the elderly, to get out and do physical activity so this shouldn't be curtailed but again, it would be important to keep a 2m distance from joggers where possible.

(d) JW asked whether harsher police enforcement would be properly publicised to the community in advance, in order to assist better community relations, as many in the community can be distrustful of institutions.

CL replied that Cllr Kennedy was fully aware of the work being done here with the police on ensuring that there is clear messaging in the community. They were making it clear that if you don't comply with the public health regulations you run risk of enforcement action and fines of up to £10K have been levied. There was more to be done but there was very clear messaging and those fines were very substantial for an individual.

(e) Cllr Kennedy commented that he had been on a group call of a Cabinet Members for Health with the Secretary of State and when Mr Hancock was asked when and how the lateral flow tests would be resourced he had replied "Yes, I can hear you".

6.5 The Chair thanked CL for his report and for his attendance.

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

## 7 Senior Management Restructure in Adult Services

7.1 The Chair stated that he had asked for an update on some significant senior management changes which had taken place in Adult Services in the Council and Members gave consideration to a short briefing note. He welcomed for this Denise D'Souza (DD), Interim Group Director for Adults, Health and Integration.

7.2 DD stated that she had started work in Hackney relatively recently and when she had arrived she fully supported the plans in train to split the Adults and Childrens' Divisions. A previous authority she had worked at had trialled a merger and it had not been a success. She stated that in terms of the statutory responsibilities she is answerable to CQC and DHSC whereas Anne Canning is answerable to DfE and Ofsted. When she first joined the CACH directorate meetings were heavily focused on children's issues, as necessary, and adults' issues sat further down the pecking order on the agenda. The new structure will afford greater focus on Adult Services and because there can have more time, they can do things a bit differently and support each other in different ways. The system has to work for the borough she added and while "twin hatters" as they're described can work in very small boroughs, it is not suitable in a borough like Hackney. There was also a need to ensure that Public Health can keep its own focus and of course there was an ongoing challenge around transition to adult services. Because of this they will of course keep a focus on the joint work and try and enhance it. In the context of Covid pressures, pressures on the care system and the impact of the recent cyber attack, she was confident that this change was the right decision for the borough.

7.3 The Chair asked whether the Director of Health Integration was a permanent post. DD replied that it has now been fully funded. In the original DPR it had been for just 2 years but would now be a permanent post.

7.4 The Chair thanked DD for her report and for her attendance.

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

## 8 Minutes of the Previous Meeting

8.1 Members gave consideration to the draft minutes of the meeting held on 14 October and noted the matters arising.

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| **RESOLVED:** | **That the minutes of the meeting held on 14 October be agreed as a correct record and that the matters arising be noted.** |

## 9 Work Programme 2020/21

9.1 Members' gave consideration to the updated work programme for the Commission. The Chair stated that the next meeting would include a focus on the digital divide in primary care and some concerns about poor access during the pandemic and the challenges there.

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

## 10 Any Other Business

10.1 There was none.

**Duration of the meeting:** 7.00-9.00 pm