Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Thursday, 30th July, 2020

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Emma Plouviez, Cllr Kam Adams and Cllr Michelle Gregory**
Apologies:	**Cllr Patrick Spence and Cllr Kofo David**
Officers In Attendance	**Denise D'Souza (Interim Strategic Director of Adult Services) and Dr Sandra Husbands (Director of Public Health)**
Other People in Attendance	**Dan Burningham (City and Hackney CCB), Dr Waleed Fawzi (Older Adult Consultant Psychiatrist, ELFT), Councillor Christopher Kennedy, David Maher (NHS City & Hackney Clinical Commissioning Group), Councillor Yvonne Maxwell (Mayoral Advisor for Older People), Edwin Ndlovu (ELFT), Michael Vidal (Healthwatch Hackney Board Member), Jon Williams (Director, Healthwatch Hackney) and Neil Ashman (Barts Health NHS Trust)**
Members of the Public	
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllrs Spence and David and for lateness from Cllr Snell.

1.2 Apologies were also received from: Anne Canning, Group Director CACH, LBH); Richard Fradgley Director of Integrated Care, ELFT and Eugene Jones, Director of Strategic Transformation, ELFT.

2 Urgent Items / Order of Business

2.1 The Chair stated that there would be an urgent item to be taken under AOB comprising an update from the Director of Public Health on the Covid-19 response in the borough.

3 Declarations of Interest

3.1 There were none.

4 Developing COVID-19 resilient services at Mile End Hospital, including relocation of inpatient dementia assessment services to East Ham Care Centre

4.1 The Chair stated that this special meeting had been called at short notice to consider a proposal from East London NHS Foundation Trust, Barts Health NHS Trust and City and Hackney CCG concerning the urgent plans to develop COVID-19 resilient services at Mile End Hospital, including relocation of the inpatient dementia assessment services to East Ham Care Centre.

4.2 Members' gave consideration to a report from Eugene Jones (Director of Service Transformation, ELFT) which had been published in a Supplementary Agenda.

4.3 The Chair stated that both Eugene Jones and also Richard Fradgley (Director of Integrated Care) from ELFT had had to give apologies as they were on annual leave but he welcomed to the meeting the following:
Dr Waleed Fawzi (**WF)**, Consultant Psychiatrist and Clinical Lead for Older People Mental Health at ELFT
Edwin Ndlovu **(EN)**, Director of Operations, ELFT
Neil Ashman **(NA),** Chair of the Medicine Board and Outpatient Transformation, Barts Health NHS Trust
Dan Burningham **(DB)**, Programme Director Mental Health, City & Hackney CCG
David Maher **(DM)**, MD, City & Hackney CCG
He added that Commission Members were well aware of the sites and he had visited Mile End in particular on 3 occasions on site visits although the Commission does now have some new members who would not be familiar with them.

4.4 EN thanked the Commission for the opportunity to present this proposal at short notice noting that the Columbia Ward move had come to the Commission previously. The plan was to relocate 21 older adult mental health beds to East Ham Care Centre as part of system wide Covid-19 mitigation plans. This would be an interim move and would ensure the clinic at Mile End for treating those shielding for some time could be set up as coded 'Green' or Covid-safe. The users of those out -patient services would be people identified as high risk or clinically vulnerable. The older adult mental health inpatients at issue here would be going to Cazubon Ward at East Ham Care Centre which is currently empty but has 23 beds. Currently there were only 13 on Columbia Ward and 3 of those were from City and Hackney. It had been necessary to speak to patients, family and staff/carers at a rapid pace and to forego the usual consultation processes because of urgency of the move. They have again gone through the transport implications for the patients, families and carers. One of the key advantages of the move would be that there would now be a

critical mass of patients at EHCC with both physical and mental health care issues so they would be able to receive a more holistic offer. In terms of triage the main adult ward for this, Leadenhall, would remain at Mile End. This ward does pre-assessment. Once they've identified that patients have organic mental health conditions they would be moved to Columbia. By having all of these moved from Columbia and co-located at EHCC they can offer a more holistic care package. In addition, Columbia Ward was on the 1st floor but Cazubon (at EHCC) was on the ground floor and it opened up to an adjacent garden for the patients.

4.5 WF described the current pathway for Dementia care in east London. Most of the patient cohort come into the service via A&E or the various Dementia Teams. Most display challenging behaviours and are difficult to manage in community or care home settings. Sometimes they will go directly to Columbia if they are pre identified with a diagnosis of Dementia. Assessment at Mile End lasts 3 months on average. Then many may go into 24 hr care either in supported living or nursing home and some go into Continued Care in the NHS. They discussed this last year when the move was made from Thames Ward at Mile End to Sally Sherman ward at EHCC. Columbia was therefore the pathway leading to Sally Sherman. It was very rare for anyone to be admitted to Sally Sherman without them having first been at Columbia.
So, the broader cohort here was treated in a range of care homes or supported living and the most challenging and difficult patients, would end up in Sally Sherman and now also in Cazubon. These patients would spend up to a maximum of 2 years there and by end, because of the levels of physical and mental progression of their disease, they would be less challenging and therefore can move elsewhere, perhaps into the community setting or perhaps to receive EOLC care, thus completing the pathway.

He explained that EHCC has another ward, Fothergill, which provided End of Life Care for those with multiple conditions and coming from Newham . Some of the patients in EHCC will have End of Life Care needs so these can then be cared for there without moving them to a care home or another hospital and this would give clinicians more room for manouvre with their treatment.

The aim here was to ensure there was a more theraputic approach in these wards by adding other elements of care such as physiotherapy or Occupational Therapy etc. Being in EHCC would mean they would have synergies with Community Health Newham which was also based there and provided a very therapeutic environment. They were aiming to make EHCC a centre for excellence in care of older patients with mental health conditions.

4.6 The Chair stated that he found EHCC a much better setting than Mile End overall and he had always found the latter unsatisfactory and EHCC now seemed to provide an opportunity for more wraparound care. He stated that on the last visit he thought he had heard of plans to move both Leadenhall and Columbia to EHCC. He also expressed concern about the move being temporary because of the disruption that would cause and he asked why this wasn't just accepted as a permanent move.

4.7 EN replied that they would come back to the Commission with the more permanent plans. They appreciated the need for more extensive and thorough consultation and accepted to do this in the next 12 months. This interim move

might make a solid case for a permanent move but they would use the next 12 months in creating a safe 'Green' designated site at Mile End and EHCC but also demonstrate that the move to EHCC worked and they wanted to be able to demonstrate this in an open and transparent way. EN undertook to bring the proposal for making the move permanent back to the Commission.

4.8 The Chair asked NA to explain why Leadenhall would stay behind but Columbia needed to be moved.

4.9 NA explained that Barts Health needed to move quickly on this. The aim was to provide a safe environment for those patients who are shielded in the community but still requiring important out-patient services. At all Barts' sites the plan would be to test staff regularly and work quickly to have them designated as Green as quickly as possible. The outpatients affected typically have chronic diseases that leave them vulnerable. They are people living with cancer, sickle-cell anaemia, have had transplants or are pregnant women with cardiac issues. The Trust identified 18k people in this situation and c. 25% are from City and Hackney. The aim was to provide a site with the highest infection standards so as not to expose this vulnerable cohort to infection. To make the Mile End site Covid-safe they needed to proceed block by block. Bancroft and Grove wings at Mile End were purely for this mental health cohort and they needed to be able to control entry, to test temperatures, to check symptoms and run admission processes to ensure everyone coming in was negative. The out-patients that need to be separately treated were receiving transfusions, or infusions or immunosuppressants which used to be done in a general outpatient setting. Barts Health therefore had to ask ELFT to relocate the older adult mental health wards, which are in the midst of these spaces, so that the site overall can be made Covid-19 resilient for the wide variety of uses it currently has.

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

(a) Members asked: for details on the Travel Plan; how the rate of Covid related deaths at EHCC compared with other similar sites; were patients being put in a higher risk setting at EHCC. EN replied that as Hackney was furthest away there would need to be a more detailed Travel Plan including provision of taxis for families and carers. They would also provide full details on the public transport options timetables and timings.

(b) Members asked for a pledge that the same level of transport support as had been offered previously would be provided including giving families a full induction, a number to call and a commitment that this would not be removed after a year. EN replied that Covid had meant that they had had to provide an even more extensive Travel offer and this would be extended to this cohort for the period they're in EHCC.

(c) Members asked how use of transport would be audited. They also asked how many visitors the Hackney patients had been receiving on site and if there was any evidence that the numbers had dropped because of the more distant location. EN replied that they do monitor friends and family visitor numbers and these had held up. Visiting habits had changed because of Covid however, because not as many were confident to visit and of course there had been

restrictions. To mitigate this, they had also provided iPads and digital equipment to enable families to have online video calls with patients.

On the issue of infections WF stated that they had had fatalities across both sites, but it was difficult to compare because the patients at EHCC were more seriously ill and many were on an End of Life Care pathway. There had been a higher incidence of death at EHCC not because of the care but because of the frailty of the patients involved. Initially testing capacity also had been limited, like everywhere, but now there was weekly testing of all patients on the ward and that early spike should not be repeated.

(d) Members commented that this plan appeared to be in the pipeline prior to the pandemic and the pandemic had just expedited the plan. They asked if the intention was to make it permanent and not just for 12 months. EN replied that their ambition was that it should be a permanent move but because of the Covid crisis urgent interim arrangement were needed. They must now however work up the case for the permanent move and they would be happy to return with an updated proposal in 12 months on why the move should be permanent

(e) Members asked if Leadenhall ward would also move. EN replied that it was not involved as it was not in Bancroft wing and there were advantages to being adjacent to some of the other wards at Mile End. Sometimes the patients at Leadenhall were very disturbed and more nursing staff needed to be deployed to provide support. Once Leadenhall patients were diagnosed with an organic mental health condition they would be moved to Columbia, and now to EHCC.

(f) Healthwatch Hackney Director stated that they had worked with ELFT on the previous move to EHCC and would like to do so again. He added that often relatives will be elderly themselves and so travel will be big challenge. The main concern Healthwatch had related to what appeared to be a rapid regionalisation of services. Historically, temporary moves usually become permanent he added and there was a need for greater involvement of families and the community on these moves and issues needed to picked up on early when there was still time to effect some change. EN replied that they would welcome Healthwatch Hackney's involvement over the next year as they work up the plan.
Chair commented that Healthwatch's contribution was insightful and that in the past the Commission had been presented with more cost-oriented cases for change but acknowledged this was driven by the Covid situation. He stated that the Commission would welcome some auditing on the impact on visitor numbers and if Healthwatch can provide assurance on this this would be most helpful.

(g) Michael Vidal (Public rep on Planned Care Workstream) asked for clarification on the order of the moves and who was left behind, wondering whether the Functional Older Adult (FOA) cohort had in effect been left stranded at Mile End while other cohorts around them had been moved to EHCC. He also asked why the Engagement Manager at City and Hackney CCG had been contacted, even if this was urgent, to have it at their PPI committee and asked if this could be adopted as best practice in future urgent situations.

WF replied that the FOA cohort had not been stranded and were in the ward where he worked at Mile End. The challenge with these cohorts was about whether their physical needs or their mental health needs outweighed one another. For most in Leadenhall the mental health issues outweigh the physical but with dementia patients it was often the other way around. On Leadenhall the mental health support was greater and they needed support from surrounding services.

DB from CCG replied that the reason this proposal hadn't gone to the PPI or Older People's Reference Group was because it was a Covid-19 emergency measure, therefore full consultation was not possible in the timeframe available. If this became permanent it would go to full consultation and they would look at the overall configuration of all the beds and the various plans involved. The CCG had raised this issue but it was something they were living with since the pandemic started. DM added that the pace necessitated a streamlining of the process but that he was happy to take on board the issues raised. The Chair commented that while there were different scales of response required here but it was still an important principle to notify the PPI group at the CCGs.

(h) Members asked if because of the higher number of fatalities they had reviewed their risk assessments of EHCC and were they assured that the patients moved there were at no higher risk. They also asked if the costs were different at EHCC compared to Mile End and if there was a financial incentive involved.

WF replied that Covid was a special situation and they had many assurances in place, patients were tested on arrival and on the unit. There had been no visitors for 4 months and this would continue at EHCC as long as necessary. PPE was used currently across all units in EHCC for example and the same standard of heightened risk assessments applied across all sites. EN replied that there were no financial benefits to the move. The major gain from this would be on clinical outcomes and better patient experience at EHCC than at Mile End. NA added that from Barts Health perspective they wouldn't gain at all and were in fact losing a good tenant in these wards.

(i) Members asked whether the transport arrangement would really be sustainable in the long run if this becomes a permanent move and was there any similar move that they could learn from. EN replied that ELFT was committed to the transport plans being permanent and this would form one of the foundations of the proposal for making the arrangement permanent. They were pleased that patients could be consolidated in a site which could then become an exemplar or centre of excellence.

(j) Cllr Maxwell (Mayoral Adviser for Older People and the Dementia Champion and former member of the Commission) stated that she had been on the last site visit and acknowledged that EHCC was a much better site. It would be great to have it in Hackney however the patient numbers involved would not merit that. She stated that her concerns remained as per the last discussion which was that she wanted Healthwatch Hackney involved in reviewing the permanent move and in talking to stakeholders. She also wanted travel for carers monitored to ensure there would be no obstacles to this. She also called for a full consultation in the next year, hopefully moving beyond the Covid issue. Healthwatch Hackney Director concurred adding that this would help

deepen their own relationship with ELFT. Cllr Maxwell asked to be kept in the loop on these arrangements.

4.11 The Chair thanked ELFT for bringing this proposal and everyone for their attendance.

ACTION:	**a) ELFT to provide a copy of the Transport Plan for families and carers affected by the various moves of this cohort from Mile End to East Ham Care Centre** **b) ELFT to engage with Healthwatch Hackney on monitoring the impacts and to agree a process for engaging 'patient voice' on such service changes especially if urgent.** **c) ELFT to provide a commitment to a fuller and more widespread stakeholder and public consultation if this becomes a permanent move.**

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

5 Minutes of the Previous Meeting

5.1 Members gave consideration to the draft minutes of the meeting held on 9 July 2020 and the matters arising.

RESOLVED:	**That the minutes of the meeting held on 9 July 2020 be agreed as a correct record and the matters arising be noted.**

6 Health in Hackney Scrutiny Commission Work Programme

6.1 Members noted the updated work programme for the year. The Chair stated that an element of flexibility was being kept in the planning but that a further update on the Covid-19 test and trace issue would be on the agenda for September.

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

7 Any Other Business - Update on Covid-19 response from Director of Public Health

7.1 The Chair stated that there was one urgent item under AOB. He had requested the Director of Public Health to provide another verbal update on the Covid-19 numbers and the test and trace situation in Hackney and he welcomed Dr Sandra Husbands (**SH**) (Director of Public Health) to the meeting.

7.2 The Chair stated that he noted the progress on the new Covid-19 dashboard and noted that Hackney had more cases than anywhere else in London. There had been 97 reported cases in the last two weeks and wanted to know if it had increased dramatically because of the additional mobile testing. He also wanted to know the percentage infection level within the Charedi community, whether the community was fully aware it was high and what stress testing the local Public Health team were doing with PHE on what the next steps needed to be.

7.3 SH stated that she would give an overview on infection rates and numbers in Hackney and what was being done. Members' gave consideration to a tabled slide presentation and she took Members through it in detail.

7.4 SH stated that Hackney didn't have the highest rate in London but rather had the highest rate of increase. 920 confirmed cases had been logged to date. During each of the 14 day counting periods the numbers had fluctuated. The reason for this was twofold. With PHE they looked at the recent period and at the baseline period early on in pandemic and made a calculation as to whether the rate was more or less than they would have expected. The rate of increase has been far more than expected in the past two weeks.

7.5 She explained that that day there had been 13 new cases reported which had been the highest increase in a number of weeks and most likely related to the Mobile Testing Unit work in Stamford Hill on the previous Sunday. They've had the highest increase of any London borough in the previous fortnight. But to put this in context however she compared Hackney to Tower Hamlets, Newham, Waltham Forest and Barnet but also nationally to Blackburn with Darwen, where they've had to take some extra measures, and with Leicester where three's been a significant problem, but which is now on the way down. She added that the London average was 400 cases.

7.6 She described the analysis being done from the national dashboard which counted rates per 100k population. From 11 May when lockdown measures had eased cases locally had tended to be younger. Also, a number of household clusters in N16 area had been identified. From 11 May to 28 July 91 additional cases and 42% of those (i.e. 95) had been in the N16 area. Of those 95 cases in Stamford Hill area a fair proportion were household clusters associated with c. 2 households. A significant number were single cases not associated with any household or setting.

7.7 The Chair asked whether the analysis points to a higher proportion overall from this N16 area. SH clarified that there was, but it wasn't the majority borough wide. She added that another trend they'd seen was that recent cases were not just in N16 area but tended to be younger than those seen earlier. This could be as a result of the fact that they'd changed the testing regime and were now testing more young people rather than, predominantly, older people in care homes etc. She added that as younger people were out and about much more there was a reasonable expectation of greater transmission among them. In last period since 11 May the wards most affected were: Cazenove, Hackney Down, Springfield and Stamford Hill West. She described PHE's national 'Exceedance Report' which showed diagnoses by date with Pillar 1 testing results coming from health care settings and Pillar 2 from the community or home testing.

7.8 In relation to what is being done she described how 3 weeks previously they had noticed a couple of linked household clusters in Stamford Hill and were able to target information and support accordingly. They instigated an immediate communications campaign with a direct leaflet drop and including additional information for Stamford Hill. Letters were sent to schools, they worked with the Rabbinate, they alerted local GP practices who the sent out text messages. Many in this community do not engage with technology and

this presented a challenge. They were working with GOPs on a communications toolkit. They have a Covid-19 Incident Management Team for dealing with spikes which operated on the same basis as if handling a full outbreak. They looked at risks, at key settings, at potential sources for clusters of infections and what needed to be done to get the key messages out quickly. They've got the Environmental Health Team involved in supporting Public Health and currently they are prioritising Stamford Hill and working with synagogues by ensuring they have proper risk assessments in place. They're also working with colleagues in Haringey because the Charedi community straddled both boroughs. They had the second Incident Management Team that day. They were expecting to see the curve of cases flattening off. They were putting more measures in place, monitoring it very closely, developing more communications and were working on future planning to support the Charedi community more during the upcoming religious festivals in September and October.

7.9 The Chair asked, for the last two weeks, what was the percentage infection rate within the Charedi community specifically and how this equated to rates in the rest of the country. He also asked whether in meetings with PHE they had discussed the various layers e.g Hackney, North Hackney, Charedi community. As there were only 27k Charedi population the infection rate within it must be very high in comparison with the spike areas nationally, he asked. He commented that maybe the borough response currently was appropriate but once you burrowed down to the level within a specific risky community the rate was surely much higher. SH replied that the Incident Management Team was looking almost exclusively at the clusters of cases in the Charedi community and they were very aware of numbers of cases and with support of PHE they could go beyond just postcode data and identify and focus on those specific clusters.

7.10 The Chair asked whether we have to communicate more about specific clusters and whether Public Health was satisfied that people in these areas were aware of the extent of infection rate compared to other places. SH replied that there was an important balance to be struck here between making people understand there is a risk and issuing them with information within their community and not putting so much focus on one single community so it seems that they are the issue. She added that they worked with the community to make sure messages go out in ways that help the public engage with them. They do this by engaging local community groups and making sure communications are sensitive and culturally appropriate. They also work with the Behavioural Change team within Public Health to ensure the messaging is effective. She added that it is not always most effective to talk numbers to people, there are a variety of approaches.

7.11 A Member asked whether there was a traffic light system so that when a certain level daily infections was reached, there was then a move to lockdown and it triggered various actions. She also asked if it was likely to have a London or borough level lockdown. SH replied that she couldn't say there wouldn't not be a London lockdown. At a borough level however a lockdown would be very difficult to achieve and enforce. She stated she is involved in discussions with PHE and the GLA on what local lockdowns would entail. On the 'traffic light' issue she stated that it was not as straightforward as having daily infection rate thresholds. A number of factors would need to be taken into consideration. She

added that Hackney had a significant increase in the number of cases but starting from a low base and against a background of low circulation levels of the virus in London. Our immediate current position might look terrible vis-à-vis London but compared to the rest of England it was not. Outbreaks do need to be nipped in the bud and they were working on this. There was a danger they might miss out on other clusters by focusing on one area for example. She added that in terms of being concerned about the potential of going into another lockdown, Hackney was very far from that scenario.

She added that before more stringent measures would be imposed, we would have to be having high numbers and the mitigations would have to be having no impact. Also, other circumstances would have to be affecting us which would for example prevent us from taking specific actions – it's a question of looking at the whole context.

She stated that we need to monitor our processes and we need a consistent approach in each borough given we can't lock down individually. We also need a consistent approach to closing a premisis, for example, which Public Health now has the power to do. If we had and outbreak in a factory, for example, an efficient way to get on top of that would be to close the premises down depending on the context and the nature of the factory and of the work force and where they all lived etc. Different levels of compliance in different cohorts would also have to be taken into consideration.

7.12 The Chair asked what the next stage up would be if the rates don't drop and what is the next tool in Public Health's armoury. SH replied that we would ask people to comply with special measures that they aren't doing now like greater wearing of masks. There were a number of intervention measures that could be taken with the consent of the community. The message would be that people would have to recognise that by complying this would avoid a full lockdown, which is what is happening in Blackburn with Darwen.

7.13 SH stated that the things we are doing currently will work but it will take a bit time because people are not fully compliant with current guidelines. We need to get people complaint with these existing measures before we try to instigate new ones. We need to double down on getting people to focus on current measures and comply with social distancing, hand washing and respiratory hygiene. She added that social distancing had appeared to have slipped. The Government messaging had changed from 2m to 1m distance and had confused people. The key point was that if you cannot manage 2m you need to be 1m apart and the two of you then then need to have a "plus" i.e. an additional mitigation. It wasn't the distance alone. She concluded that the virus was a parasite and it needed a host and to be able to pass from person to person so therefore social distancing measures were vital.

7.14 The Chair thanked SH for her update and asked if she and Cllr Kennedy could continue to keep the Commission updated on the two rolling 2 week figures. Should that increase it would heighten Members' concern and they would appreciate if the Commission could maintain this overview.

ACTION:	**Director of Public Health to provide a briefing to the 23 Sept meeting updating on the Covid-19 rates and the test and trace programme.**

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

Thursday, 30th July, 2020

Duration of the meeting: 7.00 - 8.30 pm