Overview & Scrutiny

Health in Hackney Scrutiny Commission

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

Tuesday, 8th June, 2021

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 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

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Accessibility

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Further Information about the Commission

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

Public Involvement and Recording

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

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.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

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.

All those visually recording a meeting are requested to only focus on recording councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

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

Providing oral commentary during a meeting is not permitted.

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Overview & Scrutiny

Health in Hackney Scrutiny Commission

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

Tuesday, 8 June 2021 at 7.00 pm

Hackney Town Hall, Mare St, E8 1EA

The press and public are welcome to join this meeting remotely via this link:
https://youtu.be/XvXBP2SjI_E

If you wish to attend otherwise, you will need to give notice and to note the guidance below.

Contact: Jarlath O'Connell, Overview & Scrutiny Officer
☎ *0771 3628561/ 020 8356 3309* ✉ jarlath.oconnell@hackney.gov.uk

Ian Williams
Acting Chief Executive, London Borough of Hackney

MEMBERS: **Cllr Kam Adams**
Cllr Kofo David
Cllr Michelle Gregory
Cllr Ben Hayhurst
Cllr Deniz Oguzkanli
Cllr Emma Plouviez
Cllr Peter Snell

VACANT: **2 Labour, 1 Opposition**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**Election of Chair and Vice Chair**	**19.00**
2	**Apologies for absence**	**19.02**

3	**Urgent items/ Order of business**	**19.02**
4	**Declarations of interest**	**19.03**
5	**Confirmation of Terms of Reference**	**19.03**
6	**Appointment of 3 Members to Inner North East London Joint Health Overview and Scrutiny Committee for 2021/22**	**19.04**
7	**New NHS East and South East London Pathology Partnership**	**19.05**
8	**Treatment pathways for 'Long Covid'**	**19.25**
9	**Community Mental Health transformation and recovery from Covid-19**	**20.05**
10	**Re-design of the specification for the Homecare Service**	**20.35**
11	**Covid-19 update – FOR NOTING**	**20.50**
12	**Minutes of the previous meeting**	**20.59**
13	**Work programme for the Commission for 2021/21**	**20.59**
14	**Any other business**	**21.00**

Guidance on public attendance during Covid-19 pandemic

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

The Town Hall is not presently open to the general public, and there is limited capacity within the meeting rooms. However, the High Court has ruled that where meetings are required to be 'open to the public' or 'held in public' then members of the public are entitled to have access by way of physical attendance at the meeting. The Council will need to ensure that access by the public is in line with any Covid-19 restrictions that may be in force from time to time and also in line with public health advice.

Those members of the public who wish to observe a meeting are still encouraged to make use of the live-stream facility in the first instance. You can find the link on the agenda front sheet.

Members of the public who would ordinarily attend a meeting to ask a question, make a deputation or present a petition will be able to attend if they wish. They may also let the relevant committee support officer know that they would like the Chair of the meeting to ask the question, make the deputation or present the petition on their behalf (in line with current Constitutional arrangements).

In the case of the Planning Sub-Committee, those wishing to make representations at the meeting should attend in person where possible.

Regardless of why a member of the public wishes to attend a meeting, they will need to advise the relevant committee support officer of their intention in advance of the meeting date. You can find contact details for the committee support officer on the agenda front page. This is to support track and trace. The committee support officer will be able to confirm whether the proposed attendance can be accommodated with the room capacities that exist to ensure that the meeting is covid-secure.

As there will be a maximum capacity in each meeting room, priority will be given to those who are attending to participate in a meeting rather than observe.

Members of the public who are attending a meeting for a specific purpose, rather than general observation, are encouraged to leave the meeting at the end of the item for which they are present. This is particularly important in the case of the Planning Sub-Committee, as it may have a number of items on the agenda involving public representation.

Before attending the meeting

The public, staff and councillors are asked to review the information below as this is important in minimising the risk for everyone.

If you are experiencing covid symptoms, you should follow government guidance. Under no circumstances should you attend a meeting if you are experiencing covid symptoms.

Anyone experiencing symptoms of Coronavirus is eligible to book a swab test to find out if they have the virus. You can register for a test after checking your symptoms through the NHS website. If you do not have access to the internet, or have difficulty with the digital portals, you are able to call the 119 service to book a test.

If you're an essential worker and you are experiencing Coronavirus symptoms, you can apply for priority testing through GOV.UK by following the guidance for essential workers. You can also get tested through this route if you have symptoms of coronavirus and live with an essential worker.

Availability of home testing in the case of people with symptoms is limited, so please use testing centres where you can.

Even if you are not experiencing covid symptoms, you are requested to take an asymptomatic test (lateral flow test) in the 24 hours before attending the meeting.

You can do so by visiting any lateral flow test centre; details of the rapid testing sites in Hackney can be found here. Alternatively, you can obtain home testing kits from pharmacies or order them here.

You must not attend a lateral flow test site if you have Coronavirus symptoms; rather you must book a test appointment at your nearest walk-through or drive-through centre.

Lateral flow tests take around 30 minutes to deliver a result, so please factor the time it will take to administer the test and then wait for the result when deciding when to take the test.

If your lateral flow test returns a positive result then you must follow Government guidance; self-isolate and make arrangements for a PCR test. Under no circumstances should you attend the meeting.

Attending the Town Hall for meetings

To make our buildings Covid-safe, it is very important that you observe the rules and guidance on social distancing, one-way systems, hand washing, and the wearing of masks (unless you are exempt from doing so). You must follow all the signage and measures that have been put in place. They are there to keep you and others safe.

To minimise risk, we ask that Councillors arrive fifteen minutes before the meeting starts and leave the meeting room immediately after the meeting has concluded. The public will be invited into the room five minutes before the meeting starts.

Members of the public will be permitted to enter the building via the front entrance of the Town Hall no earlier than ten minutes before the meeting is scheduled to start.

They will be required to sign in and have their temperature checked as they enter the building. Security will direct them to the Chamber or Committee Room as appropriate.

Seats will be allocated, and people must remain in the seat that has been allocated to them. Refreshments will not be provided, so it is recommended that you bring a bottle of water with you.

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Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Confirmation of Terms of Reference**	Item No **5**

OUTLINE

As it's the first meeting of the municipal year Members are asked to note the terms of reference of the Commission.

ACTION

The Commission is requested to note the attached.

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Article 7 - Overview and Scrutiny

The Overview and Scrutiny function is carried out by the Scrutiny Panel and the Scrutiny Commissions. They are set up to hold the Elected Mayor and Cabinet to account. The role of Scrutiny is to be non-adversarial, non-partisan and act as a critical friend to challenge decision makers within the Council as well as external agencies.

7.1 The Council must appoint at least one Overview and Scrutiny Committee to: -

i) Hold the Cabinet to account, by examining decisions that are about to be taken; taken but not yet implemented (known as the call-in process); and that have been implemented (post-hoc review) in connection with the discharge of any functions which are the responsibility of the Cabinet;

Ii) Review the general policy framework document and policies generally and make suggestions for improving them;

iii) Contribute to continuous improvement in service delivery through consideration of service delivery performance, participation in Service and value for money reviews, and investigations of budgets;

iv) Review and make recommendations relating to the discharge of non-executive (regulatory) functions;

v) Consider and make recommendations to Full Council and external partner stakeholder organisations on any matters having a direct bearing on the economic, social or environmental well-being of Hackney Citizens;

vi) In the case of the Health in Hackney Scrutiny Commission, to review and scrutinise matters relating to the health service in the authority's area and to make reports and recommendations on such matters in accordance with any Regulations and Directions made under the Health and Social Act 2001. The Health in Hackney scrutiny commission may, from time to time, decide to appoint a Joint Health Scrutiny Committee, which may involve one or more other local authorities;

vii) In the case of the Living in Hackney Scrutiny Commission, to review and scrutinise decisions made, or other actions taken, in connection with the discharge by the responsible authorities of their crime and disorder functions. To make reports or recommendations to Full

Council and to provide copies of reports to such responsible authorities and co-operating persons and bodies as appropriate, in accordance with the Police and Justice Act 2006, with respect to the discharge of those functions;

viii) Request information from relevant external partner authorities, invite interested parties to comment as appropriate and to make recommendations.

ix) Consider any referral by a Councillor under the Councillor Call for Action, and if considered appropriate to scrutinise decisions and/or actions taken in relation to a matter;

x) Consider matters referred to in accordance with the Council's Petition Scheme as set out in Part 6 of this Constitution

7.2 The Scrutiny Panel and Commissions may make recommendations arising from such work to the Cabinet, Full Council and external partner / stakeholder organisations.

Attendance by Elected Mayor, Cabinet Councillors and other persons

7.3 The Scrutiny Panel and Commissions may require the Elected Mayor, Cabinet Councillors or Chief Officers to attend before it to answer questions and may invite other persons to attend meetings of the Commissions.

7.4 It shall be the duty of any Councillor or Officer to comply with any requirement so made.

7.5 A Councillor must not be involved in scrutinising a decision in which they had been directly involved.

7.6 A person is not obliged to answer any question. However, they would be entitled to refuse to answer a question in or for the purposes of proceedings in a court in England and Wales.

Role and Function of the Scrutiny Panel

7.7 The Council shall appoint a Scrutiny Panel to coordinate and oversee the work of the Scrutiny Commissions

7.8 The Panel will be responsible for establishing task-finish scrutiny panels and for considering a request made by any 5 non-executive Members for the call-in of a cabinet decision or a decision of the Joint committee of the Six Growth Boroughs. The Scrutiny Panel's terms of reference are set out

in Part 3 of the Constitution

7.9 The Scrutiny Panel shall comprise 9 Members, who cannot be Members of the Cabinet. It shall include the Chairs and Vice-Chairs of the Scrutiny Commissions and a Councillor of the larger opposition group, if not already represented as a Chair or Vice-Chair of a commission.

7.10 The Scrutiny Panel's Chair shall be a Member of the majority political group of the Council. Chairs of the Scrutiny Commissions are not eligible for the position of Chair of the Scrutiny Panel. The Vice-Chair of the Panel should be a member of the larger opposition party.

7.11 The Scrutiny Panel may invite the Elected Mayor and the Deputy Mayor to attend meetings of the Panel to assist in consideration of the scrutiny work programme, and how the Elected Mayor and Deputy Mayor can participate in the Panel's work programme. The Scrutiny Panel may also invite the chairs of the Audit and Corporate Committees to assist with discharging the functions of the Panel.

Role and function of the Scrutiny Commissions

7.12 Full Council will appoint the following Scrutiny Commissions as set out in the table below:

Commission	Scope
Living in Hackney Scrutiny Commission	Quality of life in local communities covering neighbourhoods, place, wellbeing and amenities.
Skills, Economy and Growth scrutiny Commission	Prosperity of the borough and development, in particular economic development, employment and large-scale schemes.
Health in Hackney Scrutiny Commission	Health Services, Adult Social Services, Older People
Children and Young People's Scrutiny Commission	Children and Young People, Hackney Learning Trust

7.13 The Children and Young People Scrutiny Commission shall include in its membership the following voting representatives: -

a) One London Diocesan board for Schools (Church of England)

representative;

b) One Roman Catholic Westminster Diocesan Schools Commission representative;

c) Two parent governor representatives: and the following non-voting representatives;

d) One Orthodox Jewish community representative;

e) One representative from the North London Muslim Community Centre;

f) One representative from the Free Churches Group;

g) One representative from the Hackney Schools Governors' Association; and

h) Up to five representatives from the Hackney Youth Parliament.

7.14 Within their terms of reference, the Scrutiny Commissions may: -

i) Develop a rolling programme of scrutiny and review which shall be reviewed on a quarterly basis;

ii) Exercise an overview of the Sustainable Community Strategy for the purpose of contributing to policy development;

iii) Review and/or scrutinise decisions or actions relating to the discharge of the Council's functions within its terms of reference. This could include reviewing decisions before they have been taken (policy development) or after they have been implemented (post-hoc review);

iv) Where referred to it, consider a request made by any 5 non-executive Members for the call-in of a Cabinet decision

v) Make reports and / or recommendations to the Cabinet for possible forwarding to Full Council and/or the Cabinet, and/or Corporate Committee and/or any Ward Forum with the discharge of any Council functions; and

vi) Exercise responsibility for any resources made available to them.

Specific functions of Scrutiny Commissions

7.15 Scrutiny Commissions specific functions are: -

i) **Policy Development and Review**

- To assist Full Council and the Cabinet in the development of the budget and policy framework by in-depth analysis of policy issues;
- To conduct research and consult with the community on policy issues and options available to the Council;
- To consider and implement mechanisms to encourage and enhance community participation in the development of policy options;
- To liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working; and
- To consult or question councillors of the Cabinet and senior officers about their views on issues and proposals affecting the area.

ii) **Scrutiny**

- To review and scrutinise Cabinet decisions made by the Elected Mayor, the Cabinet, by an individual Councillor of the Cabinet, by a Committee of the Cabinet, or by an Officer of the Council;
- To review and scrutinise the work of the Council in relation to its policy objectives, performance targets and/or particular service areas;
- To question Councillors of the Cabinet and senior Officers about their decisions and the performance of the services for which they are responsible, whether generally in comparison with service plans and targets over a period of time or in relation to particular decisions initiatives or projects;
- For the Health in Hackney Scrutiny Commission, to carry out health Scrutiny in accordance with Section 244 Regulations under that section of the National Health Services Act 2006 (as amended by the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 relating to reviewing and scrutinising local health service matters). Where the proposal relates to more than one local authority area, it must be considered by a Joint Health Scrutiny Committee appointed by each of the local authorities in question;

- For the Living in Hackney Scrutiny Commission, to discharge the functions conferred under the Police and Justice Act 2006;
- To make recommendations to Cabinet arising from the outcome of the scrutiny process for possible forwarding to Full Council;
- To review and scrutinise the performance of other public bodies in the area, invite them to address the Scrutiny Commission, and prepare reports about their initiatives and performance;
- To gather evidence from any person or organisation outside the Council;
- To consider referrals from Ward Forums and Enhanced Tenants Residents Associations and initiate reviews of issues as deemed appropriate.

iii) **Community Representation**

- To promote and put into effect closer links between Overview and Scrutiny Members and Citizens;
- To encourage and stimulate an enhanced community representation role for Overview and Scrutiny Members including enhanced methods of consultation with local people;
- To liaise with the Council's consultative Ward Forums and Enhanced Tenants Residents Associations on matters that affect or are likely to affect the local area;
- To keep the Council's area-based governance arrangements under review and to make recommendations to the Scrutiny Panel, to the Cabinet and / or Full Council as to how participation in the democratic process by local people can be enhanced;
- To receive petitions, deputations and representations from local people and other stakeholders about matters of concern within the Scrutiny Commission's remit. Where considered appropriate, to refer them to the Cabinet, an appropriate Committee or Officer for action, with a recommendation for a report back if requested.

iv) **Developing the Work Programme**

In considering their work programme, the Scrutiny Commissions shall have regard to the following:

- Recommendations received from the Scrutiny Panel;

- Cross-cutting items proposed for the programme by the Scrutiny Panel;
- Petitions received from the public;
- The contents of the Cabinet Meetings and Key Decisions Notice;
- Issues emerging from the ward/representational role of any Councillor;
- Issues relating to Councillor Call for Action;
- Referrals made by Healthwatch Hackney relating to health and social care matters;
- Referrals by any Councillor of the Council on any matter relevant to the functions of the Scrutiny Commission;
- Referrals by any Councillor on a local crime and disorder matter;
- Referrals to it by Full Council, the Cabinet or another Committee;
- Issues which, whilst not the direct responsibility of the Council, have a direct bearing on the economic, social or environmental well-being of the borough's Citizens;
- Issues relating to Joint Overview and Scrutiny Committees.

Proceedings of Overview and Scrutiny

7.16 The Scrutiny Panel and Commissions will conduct their proceedings in accordance with the Overview and Scrutiny Procedure Rules set out in Part 4 of this constitution

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4.5 Overview and Scrutiny Procedure Rules

1. **Arrangements for overview and scrutiny**

1.1 The Council will have a Scrutiny Panel and four Scrutiny Commissions as set out in Article 7 of this Constitution. Article 7 sets out the broad framework for the operation of the Council's overview and scrutiny function. These rules set out some of the more detailed working arrangements.

2. **Meetings of the Scrutiny Panel and Commissions**

2.1 There shall be 4 Ordinary Meetings of the Scrutiny Panel in each year. In addition, Extraordinary Meetings may be called from time to time as and when appropriate. A Scrutiny Panel meeting may be called by the Chair of the Panel or by the Monitoring Officer if they consider it necessary or appropriate.

2.2 The Scrutiny Commissions are each expected to meet at least 8 times a year, but this may include site visits and informal meetings undertaken as part of a review.

3. **Quorum**

3.1 The quorum for the Scrutiny Panel and the Scrutiny Commissions shall be one quarter of voting Members or three voting Members, whichever is the greater.

4. **Chairs and Vice-chairs**

4.1 The Chairs of the Scrutiny Panel and the Scrutiny Commissions shall be appointed by their voting members at their first meeting of each municipal year.

4.2 The Scrutiny Panel's Chair shall be a Councillor of the majority political group of the Council. The Vice-Chair shall be a Councillor of the largest minority political group of the Council. The Chairs of the Scrutiny Commission are not eligible for the position of Chair.

5. **Reports from Scrutiny Panel or Commissions**

5.1 Once it has formed recommendations, a Scrutiny Commission or the Scrutiny Panel will prepare a formal report and its recommendations to the Monitoring Officer for consideration by the Elected Mayor, a Cabinet Councillor, the Executive or Full

Council (usually only if the recommendation would require a departure from or a change to the agreed budget or policy framework) as appropriate. Where recommendations are made that relate to an external organisation (such as an NHS Trust) the report will also be submitted to that body.

5.2 If the Scrutiny Panel or Commission cannot agree on one single final report, then up to one minority report may be prepared and submitted for consideration alongside the majority report.

5.3 Where referred to Full Council or the Executive, the report of the Scrutiny Panel or Commission will be considered at the next scheduled meeting.

6. **Ensuring that reports are considered by the Cabinet and other bodies**

6.1 Where the Scrutiny Panel or Commission publishes a report which includes recommendations, it will submit a copy of the report to the relevant decision-making person or body. It will copy the report to the Elected Mayor (unless the Elected Mayor is the decision-maker) and the Monitoring Officer indicating the decision-maker(s) to whom the report has been sent.

6.2 The following sub-sections govern the procedure to be followed according to the decision-maker receiving the report:

i. Where the decision-maker is Full Council:

When Full Council meets to consider the report, it shall also consider the response of the Executive to the recommendations. The outcome of the discussion at Full Council will be placed on the agenda of the next scheduled meeting of the Scrutiny Panel and/or Commission

ii. Where the decision-maker is Cabinet:

The report will be considered under the standing item “Issues Arising from Overview and Scrutiny”, unless it can be considered in the context of the Executive’s deliberations on a substantive item on the agenda. The Executive shall also consider the response of the lead Cabinet Councillor(s) for the portfolio area(s) to which the report’s recommendations relate. The outcome of the discussion by the Executive will be

placed on the agenda of the next scheduled meeting of the Scrutiny Panel and/or Commission.

iii. Where the decision-maker is the Elected Mayor or another individual Councillor of the Cabinet:

The Councillor with delegated decision-making power must consider the matter and report back to the Scrutiny Panel and / or Commission within 2 weeks. If the Councillor does not accept some or all of the recommendations then they must include within that report the reasons for not doing so, send a copy of their response to the Monitoring Officer, and attend the meeting of the Scrutiny Panel and/or Commission that considers their response.

iv. Where the decision-making is an external (non-Council organisation):

a) Where that organisation has a statutory duty to respond to the Scrutiny Panel and / or a Commission, a written response shall be requested within the timescale required, or if mutually agreed, by another set deadline, so the response can be placed on the agenda of the next scheduled meeting of the Panel and / or Commission;

b) Where that organisation does not have a statutory duty to respond to the Scrutiny Panel and/or a Commission, a written response shall be invited within a reasonable period of time noting that, if submitted, the response would be placed on the agenda of the next scheduled meeting of the Panel and/or Commission.

6.3 The Scrutiny Panel and each Scrutiny Commission will in any event have access to the Executive Meetings and Key Decisions Notice and timetable for decisions and intentions for consultation. Even where an item is not the subject of detailed consideration by the Panel or a Commission, the Panel or Commission will be able to respond in the course of the Executive's planned consultation process in relation to any Key Decision.

7. **Rights of access to documents**

7.1 In addition to their rights as elected Councillors, members of the Scrutiny Panel and Commissions have the additional right to documents, and to notice of meetings as set out in the Access to Information Procedure Rules in Part 4 of this Constitution.

7.2 Nothing in this Rule prevents more detailed liaison between the Executive and the Scrutiny Panel and Commissions as appropriate, depending on the particular matter under consideration.

8. **Members and Officers giving account**

8.1 The Scrutiny Panel and any Scrutiny Commission may scrutinise and review decisions made, or actions taken, in connection with the discharge of any Council functions relevant to the issues it is examining. As well as reviewing documentation, in fulfilling the scrutiny role it may require any member of the Executive, the Head of the Paid Service and / or any senior Officer and, subject to contractual arrangements, any other person delivering a Council service, to attend before it to explain in relation to matters within their remit:

i. Any particular decision or series of decisions;

ii. The extent to which the actions taken implement Council policy;

iii. The performance of relevant services; and / or

iv. As required under the Council Petition Scheme; and it is the duty of those persons to attend if so required.

8.2 Where any Councillor or Senior Officer is required to attend the Scrutiny Panel or a Commission under this provision, the Chair of that Panel / Commission will inform the Monitoring Officer who shall inform the Councillor or Senior Officer in writing giving at least 5 working days' notice of the meeting at which their attendance is required. The notice will state the nature of the item on which they are required to attend to give account and whether any papers are required to be produced for the Commission. Where the account to be given to the Commission will require the production of a report, then the Member or Senior Officer concerned will be given sufficient notice to allow for

preparation of that document

8.3 Where, in exceptional circumstances, the Member or Senior Officer is unable to attend on the required date, the Scrutiny Panel / Commission shall, in consultation with the Member or senior officer, arrange an alternative date for attendance, or, an alternative attendee

8.4 A Senior Officer may determine that another Officer should attend because of their knowledge and experience is more relevant to the issue being discussed

9. **Attendance by others**

9.1 The relevant Scrutiny Panel or Commission will be able to exercise legal rights to require attendance by individuals who are not Officers, or Councillor of the Council, such as the right to require attendance by an Officer of a local NHS body [as conferred by the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2013]; the right to require attendance by Officers or employees of responsible authorities and co-operating bodies of a local Community Safety Partnership [as conferred by the Crime and Disorder (Overview and Scrutiny) Regulations 2009]; and the right to require information from partner authorities which relate to local improvement targets [as conferred by the Local Authorities (Overview and Scrutiny Committees) (England) Regulations 2012].

9.2 A Scrutiny Panel or Commission may invite people other than those referred to above to address it, discuss issues of local concern, and/or answer questions. It may for example wish to hear from Citizens, stakeholders and Members and/or officers in other parts of the public or private sector; and shall be free to invite such people to attend.

10. **Call-in**

10.1 Call-in of executive decisions should only be used in exceptional circumstances. These are where any 5 non-executive Members have evidence which suggests that:

i. The decision-maker did not take the decision in accordance with the principles set out in Article 13.2; or

ii. The decision-maker acted contrary to the policy framework; or

iii. The decision-maker acted not wholly in accordance with the Council's budget; or

iv. The decision-maker failed to consider relevant evidence when taking a decision; or

v. The decision would not be in the interests of the borough's residents and a preferable alternative decision could be adopted.

10.2 The procedure for a call-in is:

i. When an executive decision is made by the Elected Mayor, at a Cabinet meeting, or, by an individual member of the Cabinet, or a key decision is made by an Officer (under delegated authority) the decision shall be published. The Chair of the Scrutiny Panel will be sent copies of the records of all such decisions within the same timescale by the person responsible for publishing the decision.

ii. All such decisions will include the date published and will specify that the decision will come into force, and may then be implemented, on the expiry of 5 working days after the publication of the decision, unless that decision is called-in by at least 5 non-executive members in writing and submitted to the Monitoring Officer. Each of the 5 non-executive members requesting the call-in shall either sign the call-in request or individually email the Monitoring Officer indicating their support for the request.

iii. The Monitoring Officer shall call-in a decision for scrutiny by the Scrutiny Panel if so notified and shall then notify the Elected Mayor and Cabinet of the call-in. They shall place the call-in on the agenda for the next Scrutiny Panel meeting. If no meeting is scheduled to take place within 10 working days, a special meeting of the Panel will be convened as soon as reasonably practicable taking into account the existing calendar of Council meetings. The Panel may

agree a procedure for convening such a meeting.

iv. If, having considered the decision, the Scrutiny Panel feel that a preferable alternative decision should be taken it may refer the decision back to the decision-maker for reconsideration, setting out in writing the nature of its concerns and recommendations. Where the Panel considers that its recommendations would have an impact on the Council's budget or policy framework, it may instead refer the matter to Full Council.

v. If the decision is referred to an individual member of the Executive, or to an officer, they will then re-consider the proposed decision, and may amend it. If the Member or Officer rejects any or all of the recommendations made, they will submit a written statement to the next meeting of the Scrutiny Panel setting out their reasons.

vi. If the decision is referred to the Executive, the item will be placed on the agenda for the next Executive meeting. They will then reconsider the proposed decision and may amend it. If the Executive rejects any or all of the recommendations made to it, it will then reconsider the proposed decision, and may amend it. If the Executive rejects any or all the recommendations made to it, it will submit a written statement to the next meeting of the Scrutiny Panel setting out its reasons.

vii. If the decision is referred to Full Council, the item will be included on the agenda for the next ordinary meeting for reconsideration.

viii. If Full Council does not refer the decision back to Cabinet, the decision shall become effective on the date of the Full Council meeting.

ix. Full Council may only change a Cabinet decision if it is contrary to the policy framework or contrary to or not wholly consistent with the budget.

x. Unless that is the case, Full Council shall refer any decision with which it does not concur back to the decision-making person or body, together with Full

Council's views on the decision. That decision-making body or person shall choose whether to amend the decision or not. Its determination shall then be implemented.

xi. Where the decision was taken by the Cabinet as a meeting, or by a Committee of it, a meeting shall be convened to reconsider the decision within 15 working days of the Full Council meeting. Where the decision was made by an individual, the individual shall reconsider the decision within 15 working days of the Full Council meeting. In either case, a written statement shall be submitted to the next meeting of the Scrutiny Panel setting out the outcome.

xii. If, following a call-in, the Scrutiny Panel does not refer the matter back to the decision-maker, the decision shall take effect on the date of the Scrutiny Panel meeting.

xiii. If the decision-maker or Full Council does not amend a decision under the above circumstances, and the Scrutiny Panel still feels a more appropriate decision should have been taken, it may add the matter to its own work programme or the work programme of a Commission and monitor the implementation of the decision.

11. **Call-in and urgency**

11.1 The call-in procedure set out above shall not apply where the decision being taken is urgent. A decision will be urgent if any delay likely to be caused by the call-in process would seriously prejudice the Council's or the public interest. The record of the decision, and notice by which it is made public, shall state whether in the opinion of the decision-maker, the decision is an urgent one, and therefore not subject to call-in. The Chair of the Scrutiny Panel must agree both that the decision proposed is reasonable in all the circumstances and to it being treated as a matter of urgency. In the absence of the Chair, the Speaker's consent shall be required. In the absence of both, the Head of the Paid Service, or their nominee's, consent shall be required. Decisions taken as a matter of urgency must be reported to the next available meeting of Full Council, together with the reasons

for urgency.

11.2 The operation of the provisions relating to call-in and urgency shall be monitored annually, and a report submitted to Full Council with proposals for review if necessary.

12. **Councillor Call for Action**

12.1 The Councillor Call for Action is a procedure which enables Councillors to have a matter referred to the Scrutiny Panel or relevant Scrutiny Commission for consideration. Prior to requesting such reference, Councillors are invited to raise the matter with the relevant Group Director or Lead Councillor in order to achieve settlement without the need for formal reference. Notwithstanding, the option for formal reference shall remain available.

12.2 Any member of any Scrutiny Panel / Commission, may by giving written notice of at least 15 working days to the Monitoring Officer, prior to the date of the meeting at which the Councillor wishes to raise the matter, request that any matter which is relevant to the functions of the Scrutiny Panel or Commissions, as the case may be, is included in the agenda for discussion at a meeting of the Panel or Commission.

12.3 Any Member of the Council, may by giving written notice of at least 15 working days to the Monitoring Officer, request that any local government matter (pursuant to Section 21A of the Local Government Act 2000) which is relevant to the functions of the Scrutiny Panel or Commissions is included in the agenda and is discussed at a meeting of the Panel or Commission.

12.4 Any Member of the Council, may, by giving written notice of at least 15 working days to the Monitoring Officer, request that a local crime and disorder matter (pursuant to section 19 of the Police and Justice Act 2006) is included in the agenda for discussion at a meeting of the Living in Hackney Scrutiny Commission.

12.5 A local government matter pursuant to Rule 12.3 shall not include:

i. Any matter relating to a planning decision;

ii. Any matter relating to a licensing decision;

iii. Any matter relating to an individual or entity in respect of which that individual or entity has a right of recourse to a review or right of appeal conferred by or under any enactment;

iv. Any matter which the Monitoring Officer determines to be vexatious, discriminatory or not reasonable to be included in the agenda for, or to be discussed at, a meeting of the Scrutiny Panel or Commissions.

A matter shall not fall within a description in Rule 12.5(i)-(iv) above if it consists of an allegation that a function for which the authority is responsible has not been discharged at all or that its discharge has failed or is failing on a systematic basis, notwithstanding the fact that the allegation specifies or refers to a planning decision, a licensing decision or a matter relating to an individual or entity in respect of which that individual or entity has a right of recourse to review or right of appeal conferred by or under any enactment.

12.6 The Scrutiny Panel and Commissions will undertake their proceedings pursuant to the powers set out in Article 7 of the Constitution.

12.7 Where a local government matter is referred to the Scrutiny Panel or one of the Commissions by a Member of the local authority, in considering whether or not to exercise any of its powers in relation to a matter, the Scrutiny Panel/Commission may have regard to:

i. Any powers which a Councillor may exercise in relation to the matter by virtue of section 236 of the Local Government and Public Involvement in Health Act 2007 (exercise of functions by local Councillor s in England); and

ii. Any representations made by the Councillor as to why it would be appropriate for the Scrutiny Panel / Commission to exercise any of its powers to include a matter on the agenda for discussion at a meeting of any Panel/Commission.

12.8 If the Scrutiny Panel or Commission decides not to exercise any of those powers in relation to the matter, it shall notify the

Councillor of –

i. Its decision; and

ii. The reasons for it.

12.9 The Scrutiny Panel or Commission shall provide the Councillor with a copy of any report or recommendations which it makes to the authority or the Cabinet if the matter is included in the agenda and discussed at a meeting of the Scrutiny Panel / Commission.

13. **Crime and Disorder Matters**

13.1 The Living in Hackney Scrutiny Commission is the designated Crime and Disorder Commission. A “crime and disorder matter” means a matter concerning crime and disorder (including in particular forms of crime and disorder that involve anti-social behaviour or other behaviour adversely affecting the local environment) or the misuse of drugs, alcohol and other substances in that area.

13.2 Where the Living in Hackney Scrutiny Commission, as the Crime and Disorder Commission makes a report or recommendations to Full Council it must:

i. Provide a copy of the report or recommendations to any member of the authority who referred the local crime and disorder matter in question to the Commission;

ii. Provide a copy of the report or recommendations to such of the responsible authorities, co-operating persons and bodies as it thinks appropriate.

13.3 Where a copy of a report or recommendations is provided to a responsible authority, co-operating person or body under paragraph 13.2 above that authority, person or body shall:

i. Consider the report or recommendations;

ii. Respond to the Living in Hackney Scrutiny Commission indicating what (if any) action it proposes to take;

iii. Have regard to the report or recommendations in

exercising its functions.

14. **Joint Committee of the Six Growth Boroughs**

14.1 This Committee is a formally constituted Joint Committee undertaking executive functions on behalf of the Six Growth Boroughs including Hackney

14.2 Decisions of the Joint Committee may be called-in by one or more participating boroughs pursuant to the Joint Committee's Procedure Rules. Each of the boroughs shall apply their existing overview and scrutiny arrangements to decisions of the Joint Committee

14.3 Upon publication by the Chief Executive of the record of Joint Committee decisions, Members of Hackney Council may call-in any such decision pursuant to the Joint Committee Procedure Rules

15. **Procedure at Scrutiny Panel and Commission meetings**

15.1 The Scrutiny Panel and Commissions shall include within their agendas the following business:

i. Declarations of interest (including whipping declarations);

ii. Minutes of any previous meetings;

iii. Consideration of the body's own work programme;

iv. Other business.

15.2 Where the Scrutiny Panel or Commissions conducts investigations (e.g. with a view to policy development), the Panel/Commission may also ask people to attend to give evidence at meetings which are to be conducted in accordance with the following principles; that:

i. The investigation be conducted fairly and all Councillors (including co-opted Members) of the Panel / Commission be given the opportunity to ask questions of attendees, and to contribute and speak;

ii. Those assisting the meeting by giving evidence be treated with respect and courtesy;

iii. the investigation be conducted so as to maximise the efficiency of the investigation or analysis;

iv. Evidence collected is analysed; and

v. Any recommendations made are based upon that evidence.

15.3 Following any investigation or review, the Scrutiny Panel or Commission, may prepare a report for submission to the relevant decision-maker, Executive and/or Full Council as appropriate and shall make its report and findings public except to the extent that they may include confidential or exempt information.

15.4 These rules shall apply to any Scrutiny Commissions and working parties.

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Hackney

REPORT OF DIRECTOR FOR LEGAL AND GOVERNANCE SERVICES

APPOINTMENT TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE **Health in Hackney Scrutiny Commission 8 June 2021**	**Classification** Public **Ward(s) affected** All	**Enclosures** **None** **AGENDA ITEM No** **6**

1. INTRODUCTION

1.1 This report invites the Health in Hackney Scrutiny Commission to agree the appointment of **3** Members to the Inner North East London Joint Health Overview and Scrutiny Committee for 2021/22. The Committee comprises one member from the City of London Corporation, and three each from the London Boroughs of Hackney, Newham, Tower Hamlets and Waltham Forest.

2. RECOMMENDATIONS

2.1 **To appoint 3 Members as Hackney's representatives on the Inner North East London Joint Health Overview and Scrutiny Committee for 2021/22.**

3. FINANCIAL CONSIDERATIONS

3.1 The recommendations to appoint new members to these Committees to deal with the issues specified in the report will not result in any significant additional cost to the Council. Any costs arising from the hosting of or attendance at meetings of the Joint Committee will be met from existing budgets.

4. LEGAL CONSIDERATIONS

4.1 Sections 190 and 191 of the Health and Social Care Act 2012 ("HSCA 2012") made various changes to the system of review and scrutiny of the health service. Under the HSCA 2012 health scrutiny functions were conferred upon the council itself. Health scrutiny became a statutory function of the council (as opposed to an overview and scrutiny Committee of the local authority). Health scrutiny functions are not functions of the executive under executive arrangements. Under section 244 of the NHS Act 2006, local authorities were no longer required to have a Health Overview and Scrutiny Committee to discharge health functions. The Council chose to continue its existing Health

Overview and Scrutiny Commission as set out in the report to full council on 20 March 2013 upon the setting up of the Health and Wellbeing Board.

4.2 Article 11.4 of Article 11 of the Constitution provides that the council may be required to form a joint Health Scrutiny Committee with other boroughs being consulted by local health providers that are planning changes to the way they deliver services which could be considered to be a substantial and arrange for the Joint Health Scrutiny Committee to review and scrutinise matters relating to the health services and make reports and recommendations on such matters. The process by which this is established shall be agreed by the Health in Hackney Scrutiny Commission on a report from the Monitoring Officer.

4.3 By virtue of Article 11 of the Constitution, Health in Hackney Overview and Scrutiny Commission has been delegated the Council's statutory functions in accordance with section 244 of the National Health Service Act 2006 and associated regulations to set up a Joint Health Overview and Scrutiny Commission and appoint members from within the membership of the Committee to any Joint Overview and Scrutiny Commission with other local authorities, as directed under the NHS Act 2006.

4.4 The arrangements for the Joint Health Overview and Scrutiny Committee must comply with the relevant provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Joint Health Overview and Scrutiny Commission will be established under Regulation 30(1), which enables two or more local authorities to appoint a joint overview and scrutiny committee and arrange for health scrutiny functions to be exercisable by the joint committee, subject to such terms and conditions as the authorities consider appropriate. Under Regulation 30(6) the Joint Health and Overview and Scrutiny Commission may not discharge any functions other than health scrutiny (relevant functions) in accordance with Regulation 30.

5. DETAIL

5.1 INEL JHOSC and ONEL (Outer North East London) JHOSC emerged from the then pan-London JHOSCs formed to scrutinise heart and stroke services and the Darzi reforms c. 2008. INEL JHOSC has met formally 4 times during 2020/21 in virtual meetings. The main focus of its work is to scrutinise the **East London Health and Care Partnership** (ELHCP) which has evolved into **North East London Integrated Care System** (NEL ICS) which came into being in shadow form on 1 April in and will be formally in place from 1 April 2022. In the past year the work programme of the committee has been dominated by providing scrutiny of the sub-regional response to the Covid-19 pandemic.

5.2 The East London Health and Care Partnership footprint crosses 8 boroughs and it will significantly shape the local NHS in east London. The Health and Care Bill 2021, announced in the Queen's Speech on 11 May, will put ICSs such as this partnership on a statutory footing.

5.3 The ELHCP comprises 20 organisations (NHS providers, CCGs and councils) across the 7 previous CCG areas and 8 local authority areas in north and east London. The 7 previous CCGs have also as of 1 April 2021 now formally merged into a Single North East London CCG, with a Single Accountable

Officer, Henry Black. Marie Gabriel CBE has also been appointed as the Independent Chair of the NEL ICS.

5.4 The North East London patch has, for historical reasons, had two joint health scrutiny committees covering it. Outer North East London (ONEL) comprising Havering, Barking and Dagenham, and Redbridge and INEL which comprises Waltham Forest, Tower Hamlets, Newham, City and Hackney.

5.5 The custom has been that the Chair of the Committee rotates among the 5 boroughs every two years. This usually followed the municipal calendar however a delay meant that Newham held the chair from Feb 2019 to Feb 2021. At a meeting on 10 February 2021 Cllr Ben Hayhurst (Chair of Health in Hackney Scrutiny Commission) and one of the three Hackney reps was elected as Chair of INEL for a two-year term. This also means that Hackney Council now has the Secretariat for the Committee from Feb 2021 to Feb 2023.

5.6 Over the past year the Committee has considered the following items. The 24 June 2020 meeting considered:

a) Covid-19 response from the ELHCP partners
b) Overview of borough level scrutiny of Covid-19 issues in each borough

5.7 The 30 September 2020 meeting considered:

a) Covid-19 response: update from ELHCP on managing the emergency
b) Covid-19 response: discussion with east London's Directors of Public Health
c) The eligibility of overseas visitors for funded NHS Treatment: a briefing from Barts Health NHS Trust

5.8 The 25 November 2020 meeting considered:

a) Covid-19 response and an update on 'winter preparedness' in acute trusts: briefings from ELHCP and Barts Health
b) Whipps Cross Hospital Redevelopment Update: briefing from Barts Health

5.9 The 10 February 2021 meeting considered:

a) Election of Chair and Vice Chair
b) Covid-19 impacts in secondary care across NEL
c) Covid-19 strategy for roll-out of the vaccination programme across NEL
d) North East London System response to NHSE consultation on '*Integrated Care next steps to building strong and effective Integrated Care Systems across England'* briefing from ELHCP
e) Update on recruitment process for new Senior Responsible Officer for ELHCP /Accountable Officer for North East London Commissioning Alliance.

5.10 The first meeting of 2021/22 takes place on 23 June 2021 and it will consider the following:

a) Challenges to building back elective care post Covid-19 pandemic
b) Implications for NEL ICS of the Health and Care Bill 2021
c) Covid-19 vaccinations programme in NEL
d) Accountability of processes for managing future changes of ownership of GP Practices

5.11 In 2021/22 the Committee will meet on 23 June, 13 Sept, date tbc Dec and date tbc March 2022. The Membership for 2020/21 was:

City of London: Common Councilman Michael Hudson
Hackney: Cllrs Ben Hayhurst, Peter Snell, Patrick Spence
Newham: Cllrs Winston Vaughan, Anthony McAlmont, Ayesha Chowdhury
Tower Hamlets: Cllrs Gabriela Salva-Macallan, Shah Suhel Ameen, Mohammed Pappu
Waltham Forest: Cllrs Umar Ali, Nick Halebi, Richard Sweden
Observer Member: Cllr Neil Zammett (LB Redbridge)

Please note that memberships will change after the boroughs' AGMs this month.

5.12 Cllr Munn from Hackney chaired the Committee from 2014-2016 and Cllr Hayhurst from Hackney has been one of the Vice Chairs since 2016 and in February was elected Chair. Hackney Members have played an active role in the Committee and ensured that there isn't duplication in the work programmes of INEL JHOSC and Health in Hackney SC.

Dawn Carter-McDonald
Director for Legal and Governance Services

Report Originating Officer: Jarlath O'Connell ☎020-8356 3309
Legal Comments: Dawn Carter McDonald ☎020-8356 4817

Background papers:

The following documents were used in the preparation of this report:
- Local Government Act 1972 (as amended) - Access to Information

For reference:
Agenda papers for 10 Feb INEL JHOSC

Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **New 'NHS East and South East London Pathology Partnership'**	Item No **7**

OUTLINE

The issue of pathology services at the Homerton hospital and the need to respond to national changes to pathology provision has come up regularly over the past few years. In January 2020 the Commission last discussed the matter with the CE of the Homerton who described the plans for a new Pathology Partnership with Barts Health. Members asked for assurances that the autonomy Homerton and the quality of the service locally would be protected in the new proposed collaboration with Barts Health.

On 1 May 2021, the pathology services of three London NHS Trusts came together to form the **NHS East and South East London Pathology Partnership**. The new organisation, jointly owned by Barts Health NHS Trust, Homerton University Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust will be one of the largest pathology providers in the NHS. Here is the press announcement from Barts Health who are the lead https://www.bartshealth.nhs.uk/news/new-pathology-partnership-forms-to-serve-the-population-of-east-and-south-east-london-and-beyond-10606

The partnership will operate laboratories across seven hospital sites: Homerton University Hospital, Newham Hospital, Queen Elizabeth Hospital, Royal London Hospital, St. Bartholomew's Hospital, University Hospital Lewisham and Whipps Cross Hospital, with the Royal London as the hub.

We noted that a series of service changes are planned for the partnership, so that by Dec 2023 all laboratories will operate as a single network, on a single, shared laboratory information management system.

Since then, the HSJ has reported on 23 April that NHSE had just issued guidance on new diagnostic imaging networks:
"*New diagnostic imaging networks will be of such scale that they will be 'significant operation businesses in their own right' and will 'need a distinct identity and arm's length separation from the trusts', NHS England has said".*
https://www.hsj.co.uk/commissioning/commercial-partners-could-take-over-entirety-of-planned-imaging-networks/7029943.article

The Commission has asked:

Tracey Fletcher, CE of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board for City and Hackney,

to attend to answer questions on how the new partnership is progressing, the impact on jobs and on turn-around times particularly for local GPs and the implications for Hackney of NHSE's moves to make diagnostic imaging networks into separate entities.

Also present will be:

Dr Vinay Patel, Local GP/Chair of City & Hackney Local Medical Committee
Dr Mark Rickets, Local GP/CCG Clinical Chair for City and Hackney
Siobhan Harper, Director of CCG Transition for City and Hackney
Cllr Chris Kennedy, Cabinet Member for Health, Social Care and Leisure.

Attached please find a copy of the Barts Health news release and the HSJ story on the wider national issue.

ACTION

The Commission is requested to give consideration to the briefing.

New pathology partnership forms to serve the population of east and south east London and beyond

Posted Thursday, 29 April 2021 by Aine McCarthy

On Saturday 1 May 2021, the pathology services of three London NHS Trusts will come together to form the NHS East and South East London Pathology Partnership. The new organisation, jointly owned by Barts Health NHS Trust, Homerton University Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust will be one of the largest pathology providers in the NHS.

The new partnership, which will be hosted by Barts Health, brings together the strengths of each of these trusts' pathology services into a single NHS organisation, which will be entirely focussed upon the provision of pathology. Its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services in east and south east London and beyond.

Tom Butler, clinical lead for the NHS East and South East London Pathology Partnership said: "From shared learning and access to the latest testing technologies to professional development opportunities for staff and the resilience of more robust services, this partnership will bring many benefits to local communities and its staff, while keeping pathology testing within the NHS. Our pathology labs do amazing things every day that benefit thousands of patients, and we are excited by the opportunity this partnership offers to do more."

Andrew Knott, managing director of the NHS East and South East London Pathology Partnership said: "Pathology plays an essential role in approximately 70% of patient pathways. The creation of a shared network for pathology across east and south east London reflects the wider NHS pathology strategy to meet the changing needs of patients and to be able to take full advantage of new diagnostic tests and techniques as they emerge."

The partnership will operate laboratories across seven hospital sites: Homerton University Hospital, Newham Hospital, Queen Elizabeth Hospital, Royal London Hospital, St. Bartholomew's Hospital, University Hospital Lewisham, Whipps Cross Hospital.

Minimal service changes will happen across these seven sites when the partnership forms on 1 May. Following this, a series of service changes are planned for the partnership, so that by December 2023 all laboratories will operate as a single network, on a single, shared laboratory information management system.

"Commercial partners" could take over "entirety" of planned imaging networks

By Sharon Brennan 23 April 2021

New diagnostic imaging networks will be of such scale that they will be 'significant operation businesses in their own right' and will 'need a distinct identity and arm's length separation from the trusts', NHS England has said.

Guidance published yesterday gave trusts "until 2023" to set up diagnostic networks which will have their "own distinct leadership [and] governance arrangements" and will be responsible for asset management, financing, quality, staffing and location of all elective and non elective imaging across England.

The networks were first proposed in NHS England's 2019 long-term plan as a way to increase testing turnaround time, reduce waiting times for scans and make more efficient use of staff. The NHS planning guidance for 2021-22 said the new networks were essential to help capacity keep pace with growing demand, which to date it has failed to do, and would be "particularly critical to support elective recovery" in the wake of the pandemic.

In new operational guidance, NHS England has outlined seven models the networks can take, which include "outsourcing the service in its entirety, including ownership of the capital assets required for delivery of the service, to a commercial partner".

The other options are: collaboration or alliance contracting, both of which offer "poor autonomy" as decisions must be approved by all trusts; a "host trust" using delegated authority from other network members to make decisions; two joint venture models or a community interest company. All three would need HMRC approval for VAT exemption and are suitable for foundation trusts.

The latter three options would also be separate legal entities registered with the Care Quality Commission, and have nominated and approved accountable officers.

The networks would be overseen by a partnership board, with each member trust represented by a clinical director and either a financial or operational director. For some models non-executive directors are also required. The NHSE guidance said: "To manage the transformation, networks must have clear clinical, radiographic and scientific leadership, with these leaders given sufficient time and support from executive leaders to do their job effectively."

The papers also said the new networks would not be seen as "formed" until they each had: governance, target operating and demand and capacity models; business cases progressing through SOC/OBC/FBC stages; and plans for workforce, capital and workforce.

It said this should include an "agreement with all network member trusts to procure outsourcing, equipment support and consumables collectively." The guidance also stated that "networks will need to oversee a move away from competition between neighbouring trusts for recruitment of scarce clinical staff, and instead encourage their collaboration on plans to attract and retain staff".

Insourcing support into these networks while enough staff are recruited to cover capacity is "likely to be more cost-effective than outsourcing", according to the guidance.

Ringfenced capacity

The guidance documents said "imaging networks are strongly encouraged to invest in new equipment to separate the imaging service support for elective and non-elective services".

It said "ringfenced" non-elective capacity can reduce delays to inpatient work and protect "elective services from on-the-day cancellation of planned activity". The gudiance also reiterated "co-location" of elective imaging in the community diagnostic hubs that were recommended as part of Sir Mike Richard's diagnostics review and are currently under development.

The guidance gave five finance options for purchasing and maintaining new equipment, advising that the previous capital injection from the government to renew decade-old scannners ""cannot be relied on" to be repeated in the future.

The options are: capital spend, lease finance, joint venture with a third party; commercial loan finance and managed equipment service.

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Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Treatment pathways for 'Long Covid'**	Item No **8**

OUTLINE

The Commission has asked health and care colleagues to update it on what the Treatment Pathways currently are for diagnosing and responding to 'Long Covid" and how the CCG is planning for it. The aim is to explore what are the most common symptoms/impacts being presented, are patients being readily diagnosed and put on these pathways and how is this development changing the 'Long Term Conditions' commissioning strand in the CCG.

Please find attached a briefing report.

Attending for this item will be:

Dr Fiona Kelly, Head of Adult Therapies, Division of Integration Medicine & Rehabilitation Services, HUHFT
Charlotte Painter, Acting Workstream Director for Planned Care, NHS NEL CCG for City and Hackney Integrated Care Partnership

Also present will be:
Dr Mark Rickets, CCG Clinical Chair for City and Hackney
Siobhan Harper, Director of CCG Transition for City and Hackney
Cllr Chris Kennedy, Cabinet Member for Health, Social Care and Leisure
Helen Woodland, Group Director Adults, Health and Integration, LBH

ACTION

The Commission is requested to give consideration to the briefing.

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City & Hackney COVID Rehabilitation Service (City & Hackney CoRe) & HUH Post-COVID Specialist Assessment Clinic

Fiona Kelly (Head of Adult Therapies HUH)
Charlotte Painter (Acting Workstream Director for Planned Care NEL CCG, City and Hackney ICP)

Case definitions (NICE 2020)

- **Acute COVID-19** : signs and symptoms of COVID-19 for up to 4 weeks.
- **Ongoing symptomatic COVID-19 :** signs and symptoms of COVID-19 from 4 to 12 weeks.

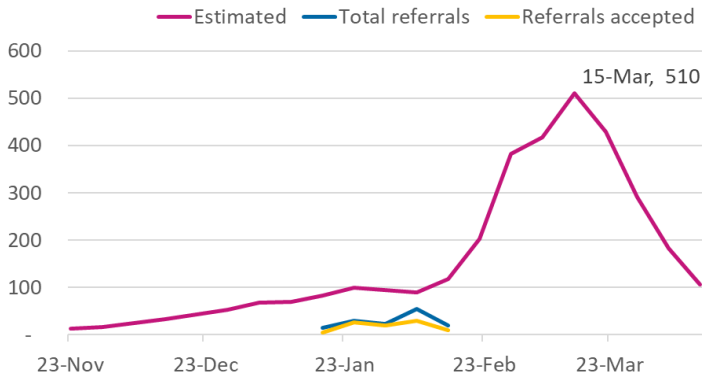
Post-COVID-19 syndrome : signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis.

In addition to the clinical case definitions, 'long COVID' is commonly used to describe signs and symptoms that continue or develop after acute COVID-19. It includes both ongoing symptomatic COVID-19 and post-COVID-19 syndrome (defined above).

The NICE guidelines [NG188]: COVID-19 rapid guideline: managing the long-term effects of COVID-19. Published 18th December 2020

NEL Long-COVID Assessment and Rehabilitation Modelling demand

- The graph shows the reported number of referrals* and the estimated** number of people needing referral each week (assuming they will be referred at 13 weeks since infection).
- Current estimates suggest that the number of people needing a referral to a NEL post-COVID clinic could reach up to 4,000 by the beginning of April.
- Estimated demand is based on an assumption that around ~2%* of symptomatic cases will continue to be ill beyond 12 weeks.



Number of people needing referral to the post-COVID clinic – total and accepted referrals and estimated* referrals*

*Reported referral data comes from NHSEI post-COVID clinic submissions via local providers. There are known gaps in the data so figures are likely an underestimation but it is anticipated that data quality will improve over the coming weeks. **Local data suggests that around 2.1% of confirmed cases may need care beyond 12 weeks. This is based on a crude estimation of health care need among people with confirmed COVID-19. However, the % is similar to the estimate derived by Zoe COVID-19 data which found that around 2.2% of symptomatic cases continued to be ill beyond 12 weeks https://covid.joinzoe.com/post/long-covid

Development of C&H Post COVID Assessment Rehabilitation Service

- City and Hackney COVID-19 Respiratory and Rehabilitation Group established in June 2020 with CCG, Health and Social Care representation across primary and secondary care and reporting to the C&H System Operational Group (SOC).
- Developed the C&H Post COVID Assessment and Rehabilitation pathway and business case, informed by local post COVID Community Rehab needs and Primary Care Audits, patient focus groups, London & national guidance and the City and Hackney framework for tackling health inequalities.
- Integrated, collaborative approach across primary, secondary, social care, local borough, Neighbourhood and voluntary partners to support patients to access the right care, with a focus on information provision and self-management at every stage.
- Co-production and resident engagement including BME Access Service, Healthwatch Hackney, Community Champion Forum and Community Navigation Network.
- Specialist Assessment Clinic and Rehabilitation Service accessed via GP Referral for people with a suspected/confirmed diagnosis of Acute COVID-19 with ongoing symptoms (>12 weeks) and based on inclusion /exclusion criteria
- Primary care provide initial assessment, screening, education and supported self-management for patients up to 12 weeks, unless there is a clinical requirement for earlier assessment via secondary care specialist referrals or the HUH Post COVID Assessment clinic.
- Collaboration across NEL COVID pathways to reduce variation with updates to NEL Clinical Advisory Group.
- NEL working groups: Digital and Data and Clinical Pathways
- **HUH Post COVID Specialist Assessment clinic commenced in Dec 2020**
- **City & Hackney COVID Rehabilitation Service commenced mobilisation on 4th Jan 2021**

Self Management and Patient Resources

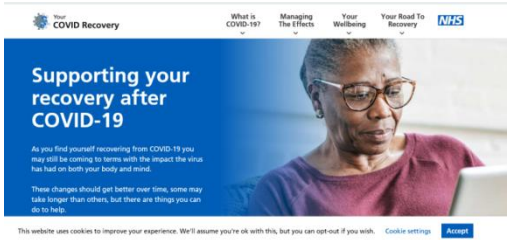
- **Referral information and resources available on C&H CCG website here**

https://gps.cityandhackneyccg.nhs.uk/service/post-covid-assessment-and-rehabilitation-services

- **Homerton one-stop-shop of patient information and resources.** This includes fatigue management, physical activity and nutritional advice. https://www.homerton.nhs.uk/covid-recovery-and-rehabilitation

- **Homerton Post COVID patient information booklet:**
  - –Managing Nutrition and COVID
  - –Managing fatigue
  - –Managing Breathlessness

https://www.homerton.nhs.uk/download/doc/docm93jijm4n6743.pdf?amp;ver=13452



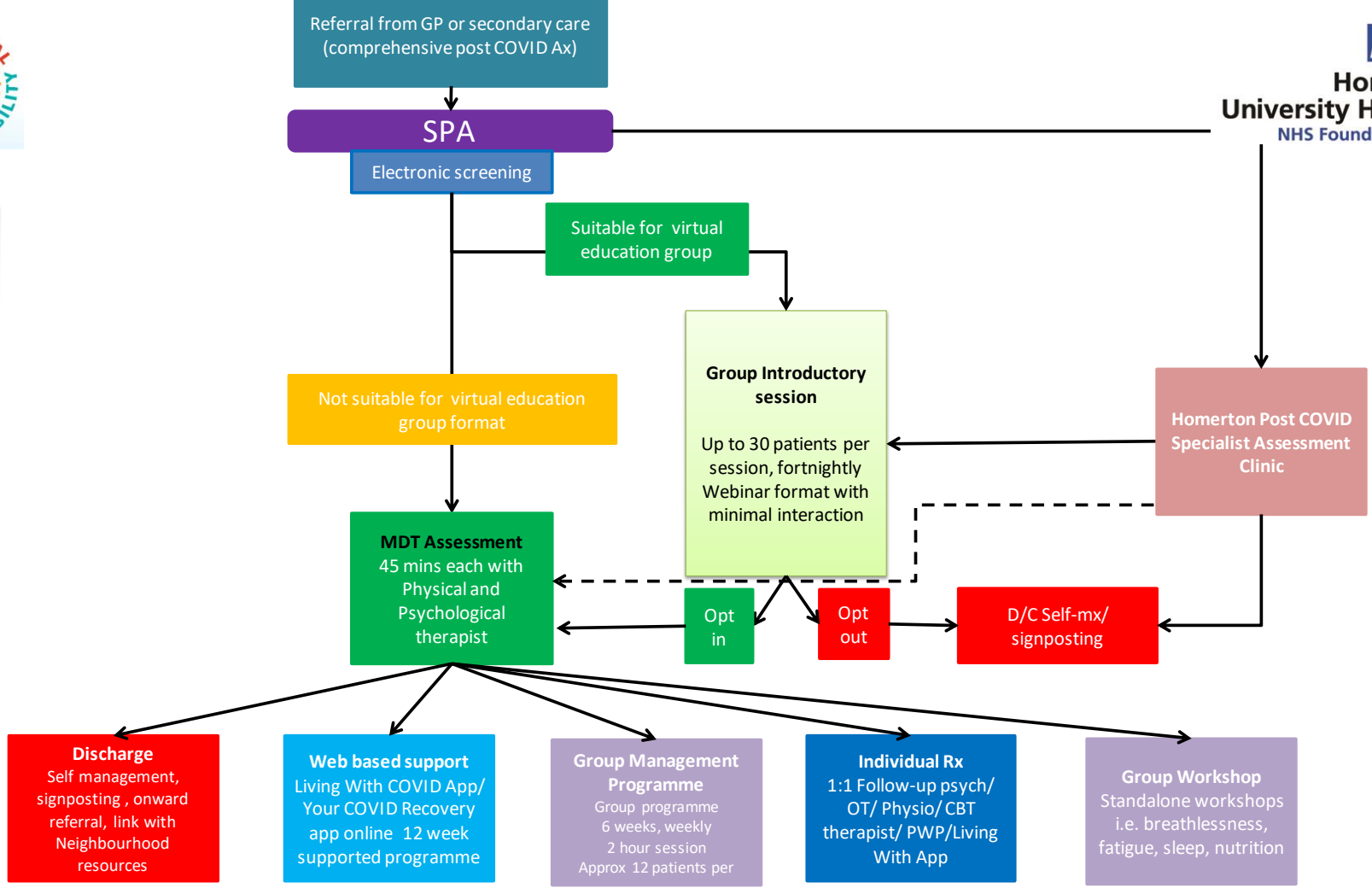
- **Nutritional Advice Homerton dietetic** team guide on eating and drinking when recovering from COVID-19

https://intranet.homerton.nhs.uk/download/doc/docm93jijm4n6708.pdf?amp;ver=13346

- **City and Hackney**:

Call Talk Changes on 020 7683 4278 or visit www.talkchanges.org.uk If you need urgent help because you worried that you might harm yourself or someone else, call the 24-hour City & Hackney crisis helpline on 0800 073 0006.

- **Non Clinical Pathways and Partnership Working** including HUH NHS Charities Bid (peer support, activities, advice and case finding).


Referral from GP or secondary care (comprehensive post COVID Ax)
SPA
Electronic screening
Suitable for virtual education group
Not suitable for virtual education group format
Group Introductory session
Up to 30 patients per session, fortnightly Webinar format with minimal interaction
Homerton Post COVID Specialist Assessment Clinic
MDT Assessment
45 mins each with Physical and Psychological therapist
Opt in
Opt out
D/C Self-mx/ signposting
Discharge
Self management, signposting , onward referral, link with Neighbourhood resources
Web based support
Living With COVID App/ Your COVID Recovery app online 12 week supported programme
Group Management Programme
Group programme
6 weeks, weekly
2 hour session
Approx 12 patients per
Individual Rx
1:1 Follow-up psych/ OT/ Physio/ CBT therapist/ PWP/Living With App
Group Workshop
Standalone workshops i.e. breathlessness, fatigue, sleep, nutrition

Dec 2020
HUH Assessment Clinic launch

4th Jan 2021
First CoRe staff started in post

23rd Jan 2021
Accepting referrals on e-RS

22nd Feb 2021
1st Introductory session webinar
94% attendance (16)

100% Opt in

24th Feb 2021
CoRe MDT Assessments started

63
Assessments HUH Clinic

40
Assessments CoRe

18.5 days
Average wait to assessment (CoRE)

45 days
Average wait to assessment (Specialist Clinic)

35%
Live in most deprived areas

67%
White ethnicity (British & Other)

44
Average age (Range 19 to 64)

Service user feedback:

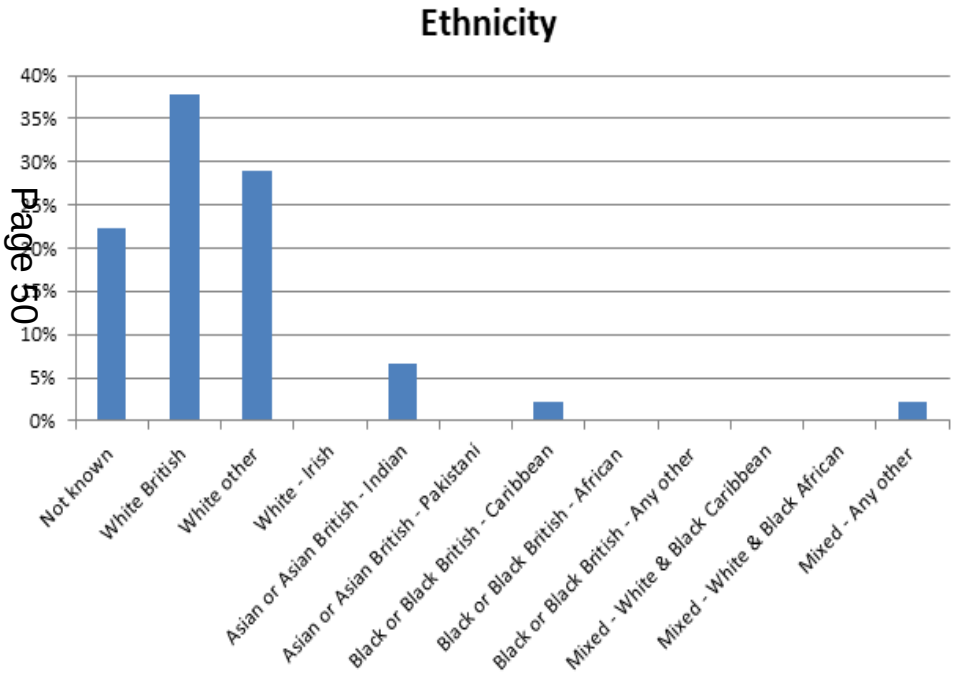
So relieved to have access to some support

Increase in confidence that my symptoms aren't all in my head

Very sympathetic and understanding tone. Much appreciated

I came away feeling like there is help at hand, and none of this is my fault. And that feels like an enormous burden lifted. I thought the team presenting were very professional and empathetic and I am looking forward to working with you all. I think it's a wonderful service

Demographics and Health Inequalities (Rehab Service)



- Also monitored within Assessment service
- Pro-Active Case Finding planned via a search of GP records to contact patients who have a recorded diagnosis of COVID or suspected COVID
- Further work is needed with community partners on helping those furthest from services to access help if they need it.
- A bid has been submitted for charitable funding to also support awareness raising and community support.

Active poll

What symptoms are you experiencing now?

0 1 4

Join at
slido.com
#91539

Wide Range of Symptoms

- Fatigue & Breathlessness –over 90% of patients with 80% of people have a breathing pattern disorder
- Chest pain/palpitations/chest pressure – 50-60%
- ENT symptoms 30-40%
- Post viral cough 30-40% predominantly more throat/laryngeal hypersensitivity
- Tinnitus 25%
- Gastrointestinal symptoms 25%
- Anxiety > depression
- Brain fog/cognitive issues
- Headaches
- Menstrual cycle changes
- Ear, Nose & Throat (tinnitus, loss of taste/smell, allergy symptoms, swallow (rare), vision.

Active poll

Page 53

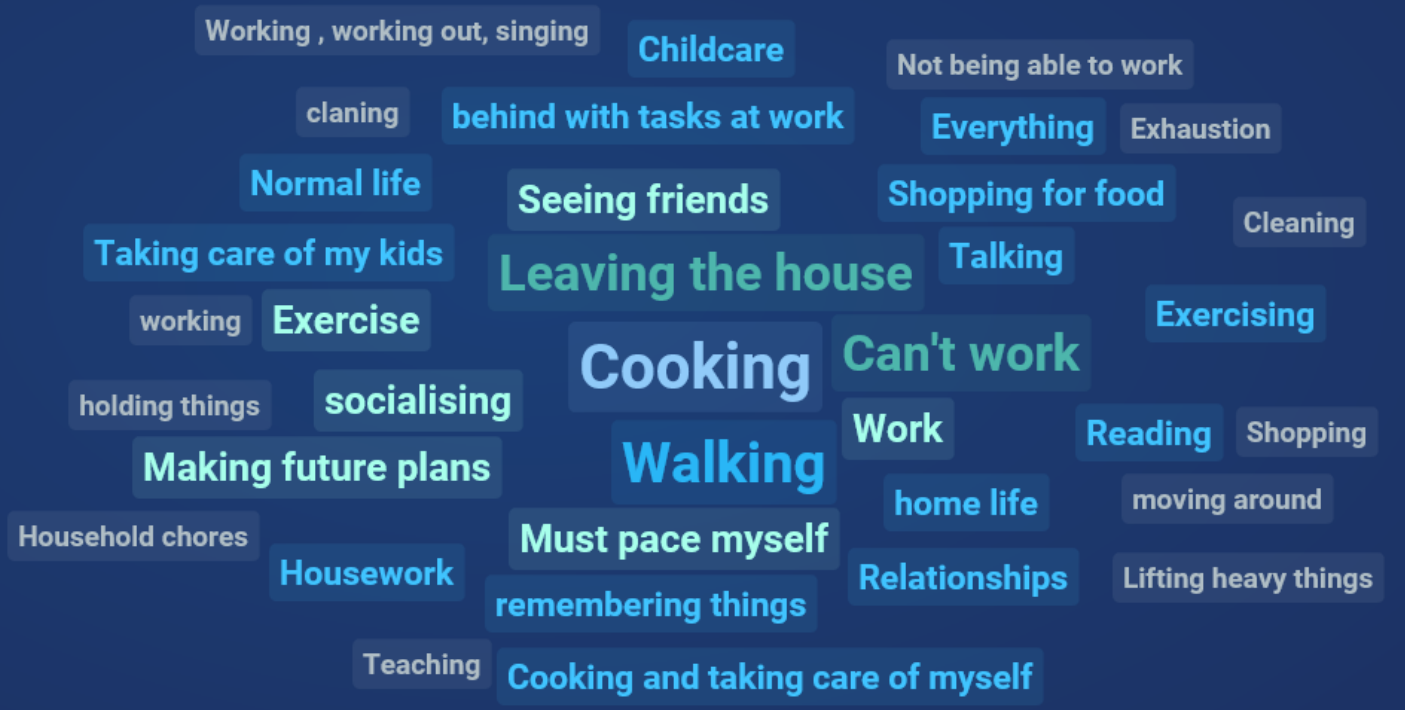
Join at

slido.com

#91539

What do your symptoms get in the way of?

0 1 4



Treatment

Continually emerging evidence base informing treatment

- Education +++
- Breathing retraining exercises
- Pacing and fatigue management
- Nutritional and lifestyle changes
- Sleep hygiene
- Heart rate monitoring
- Relaxation strategies
- For a small select (mainly hospitalised) exercise
- <15% medication

Onward Referrals & Support:

- CoRe Rehabilitation Service
- English National Opera
- Living well with COVID app
- Community resources

Returning to Activities:

Prioritising – What is important to you? Consider the activities that you enjoy and that mean something to you – not just your 'have to' activities.

Planning – Consider what your priorities are across the day/ week; what can be completed on another day or at another time in the day. Allow the time.

Pacing – Try to avoid fitting too much into the day and allow for rest breaks.

MDT

Admin

Occupational Therapist
Clinical Psychologist
CBT Therapist
Psychological Wellbeing Practitioner
Physiotherapist
Co-Clinical Lead Respiratory Physiotherapist
Co-Clinical Lead Respiratory Consultant

Service users/ resident input

C&H GPs

Dietetics

Access to secondary care specialities for MDMs – cardiology, gastroenterology, neurology, rheumatology

Next steps & Aspirations

- Plan to support Long COVID a new Long Term Condition and how this can be integrated
- To run a **sustainable AHP led service** to provide timely, comprehensive assessment and multidisciplinary biopsychosocial management of Long COVID
- To **link with Neighbourhood partners** to provide coordinated, personalised, accessible and multi-layered support for people experiencing symptoms of Long COVID that impacts on their function and everyday lives, with potential support from NHS Charitable Funds
- To **raise awareness of Long COVID locally** and encourage people to seek support – linking with existing or creating Community Champions
- To further establish and grow **resident involvement** in ongoing **coproduction** of the Long COVID support services
- To establish a **regular meeting opportunity** for Neighbourhood partners and AHPs in regional services to discuss Long COVID pathways, cases, questions, ideas
- Shared partner **training and learning** about Long COVID as evidence emerges
- Shared **data gathering** around the landscape of Long COVID across City & Hackney and particularly within diverse communities
- **Publish** and contribute to evidence base of management of Long COVID –NEL HEE Fellow
- Develop NEL-wide **efficient data transfer processes** to reduce admin burden and duplication

Our Values: Personal, Safe, Respectful, Responsibility

NHS Homerton University Hospital NHS Foundation Trust

Acknowledgements:

C&H Respiratory and Rehabilitation Group
NEL Community Based Care Group
NEL Post COVID Task and Finish Group
CoRE MDT

National NHS Resources

- https://www.yourcovidrecovery.nhs.uk/
  Helps patients to understand what has happened and what they might expect as part of their recovery. Has a range of information on wellbeing such as eating and sleeping well, getting moving again and managing daily activities.

- https://www.longcovid.org/
  A patient support group with a range of resources and patient stories.

- https://covidpatientsupport.lthtr.nhs.uk/
  Lancashire COVID Patient Support is a resource that has been developed by a group of multi-disciplinary health professionals at Lancashire Teaching Hospitals. The purpose of the website is to support individuals with their initial recovery from COVID-19. It includes a range of exercises, advice and tips.

- https://www.post-covid.org.uk/
  For people left with breathing difficulties after COVID-19, as well as their family members, carers, healthcare professionals, policy-makers and researchers.

Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Community Mental Health transformation and recovery from Covid-19**	Item No **9**

OUTLINE

The Commission has asked ELFT our key mental health provider to provide an update on the following:

- the expected surge in demand for community mental health services as a consequence of the lockdowns
- the redesign plan for the crisis care pathway
- how mental health service delivery is bedding-in at the Neighbourhoods and Primary Care Network level
- how service and service users have coped with the switch from face-to-face to digital/remote access consultations
- the impact on in-patient services post Covid and how they might be re-aligned
- the specific conditions exacerbated by Covid and the current pressure points
- the impact of a permanent move of dementia assessment to East Ham Care Centre (a further report on this is coming to our Oct meeting)

Attached please find

a) Briefing on adult mental health services and Covid
b) Presentation on the Community Mental Health transformation programme.

Attending for this item will be:

Paul Calaminus, Chief Executive, East London NHS Foundation Trust
Andrew Horobin, Deputy Borough Director City & Hackney, ELFT

ACTION

The Commission is requested to give consideration to the briefing.

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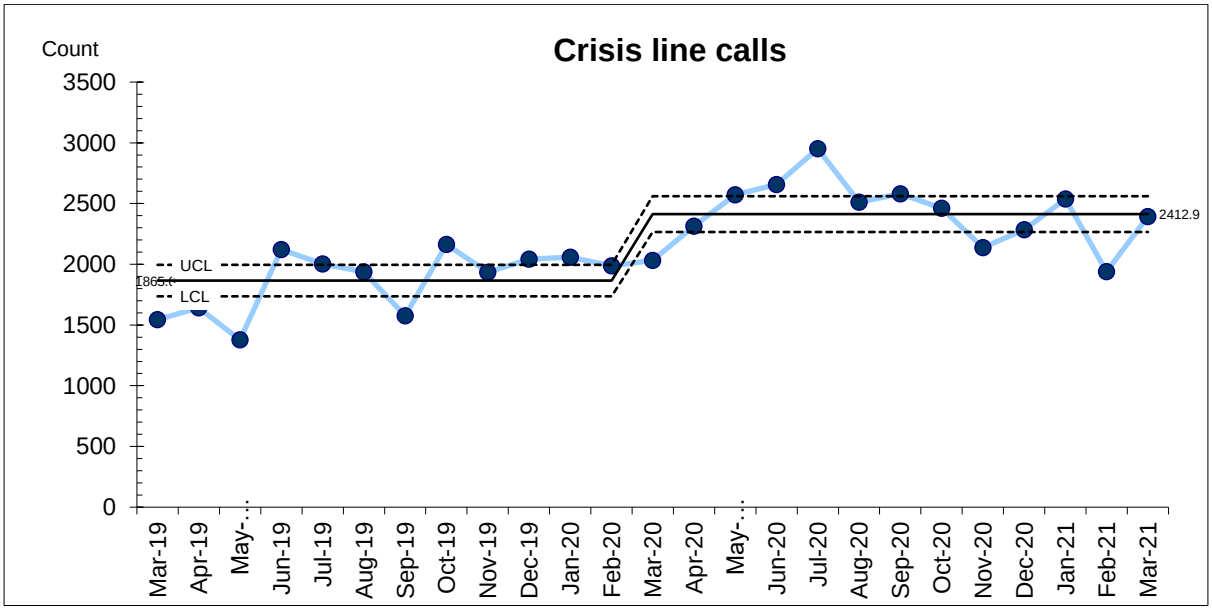
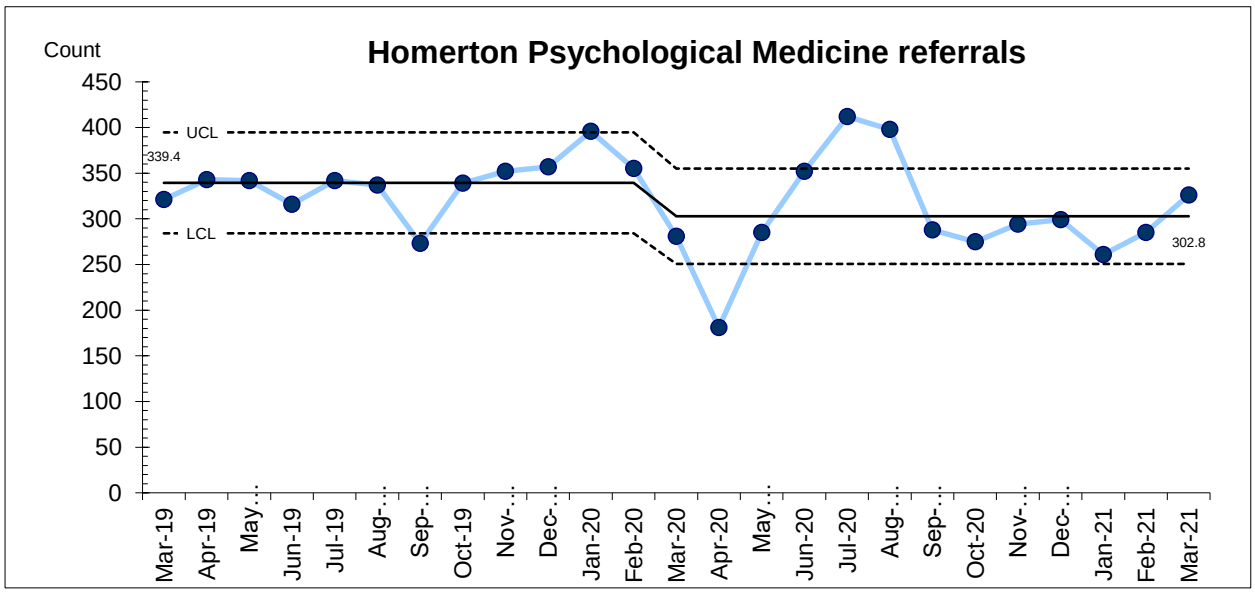
Briefing to Health in Hackney Scrutiny Commission on 8 June 2021 – ELFT Adult Mental Health Services

This paper outlines some of the key impacts of COVID in relation to adult mental health services in Hackney, as well as providing an outline of some of the service developments that are currently being taken forward in services in the borough.

Demand on Mental Health Services during and after COVID

During the first lockdown we saw a reduction in people presenting with a mental health problem. The only exception to this was on the crisis line which saw call numbers rise from March 2020 and continued to do so, peaking in July 2020 at nearly 3000 calls a month. Referrals to all our crisis services peaked around that time generally to their highest levels ever. Although currently most services have gone back to pre-COVID levels, the Crisis line continues to receive a higher number of calls than before the first lockdown.




Homerton Psychological Medicine referrals
Count
450
400
350
300
250
200
150
100
50
0
UCL
LCL
339.4
302.8
Mar-19
Apr-19
May-...
Jun-19
Jul-19
Aug-...
Sep-...
Oct-19
Nov-...
Dec-...
Jan-20
Feb-20
Mar-20
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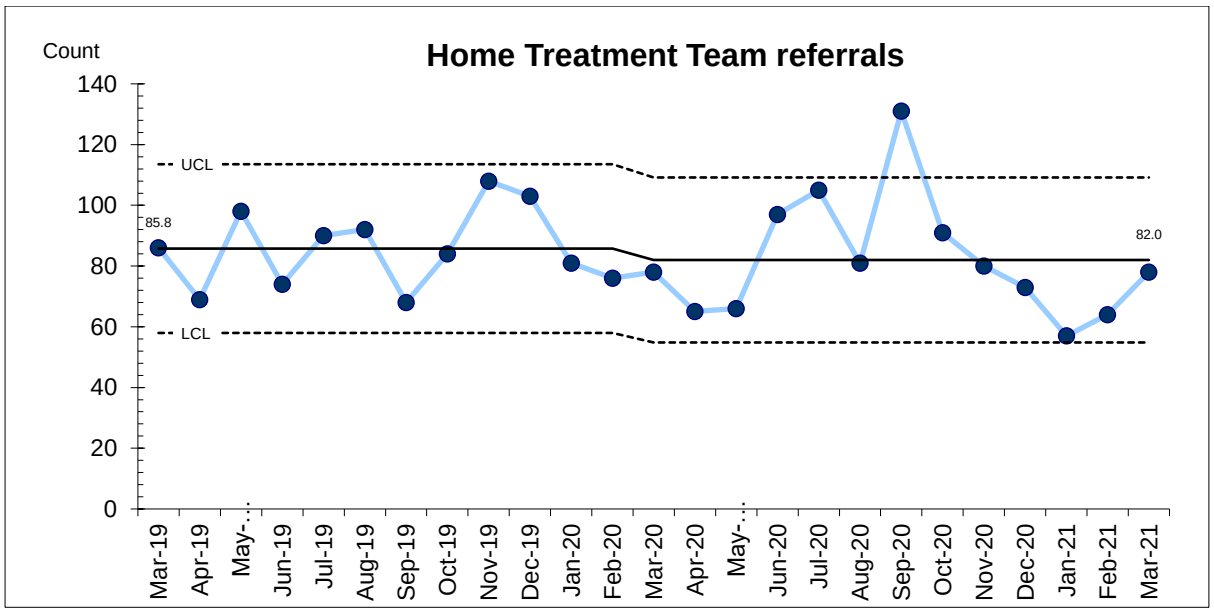
Oct-20
Nov-...
Dec-...
Jan-21
Feb-21
Mar-21


Home Treatment Team referrals
Count
140
120
100
80
60
40
20
0
UCL
LCL
85.8
82.0
Mar-19
Apr-19
May-...
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-...
Jun-20
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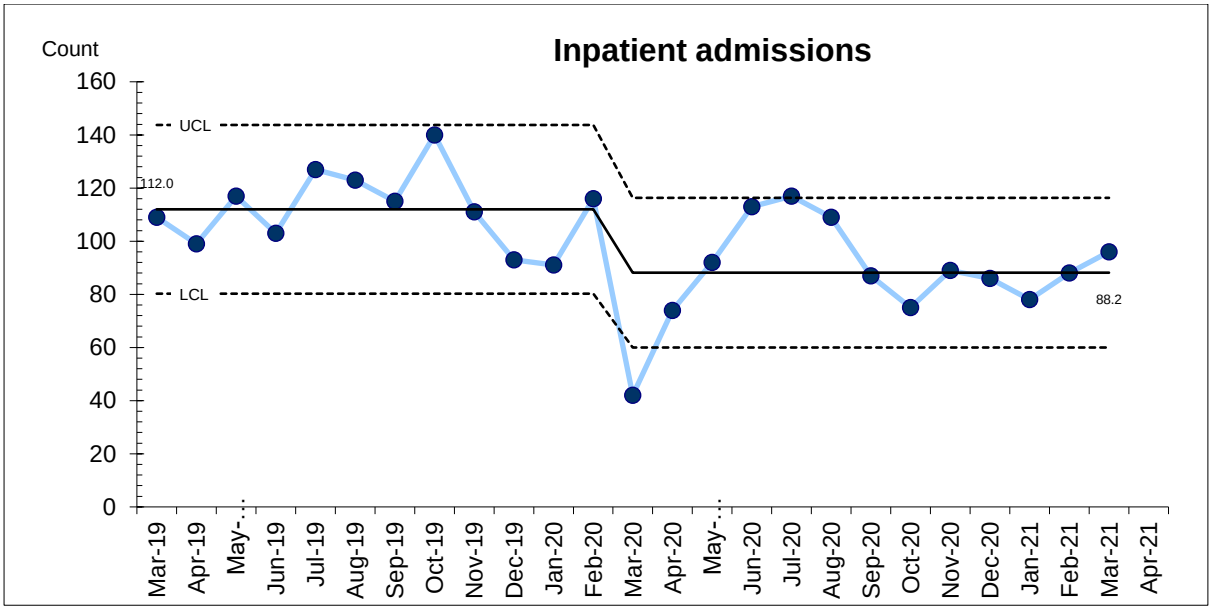
Mar-21



The principal reasons for the increase in demand for the Crisis Line appear to be the need to access urgent support remotely due to lockdown rules and an increase in mental health problems related to anxiety, social isolation and socio-economic uncertainty.

The impact on staff during this time cannot be underestimated. Those who continued to work on the frontline have experienced high levels of stress and anxiety. Those working from home have often felt isolated and sometimes guilty. The Trust and the local Directorate in Hackney have implemented strategies to ensure staff wellbeing is placed at the centre of our offer to service users. These include staff risk assessments, HR led video wellbeing groups, drop-ins, one to one supervision, alternative transport to work, flexible working and during the height of lockdown, accommodation for staff nearer their workplaces.

As lockdown eases we're slowly starting to see another rise in presentations. It is anticipated that we will see a 20-30% increase in demand for mental health services over the coming months (Centre for Mental Health) as the full after effects of the pandemic are felt. Loss and grief, trauma symptoms as well as anxiety and depression are expected to be amongst the expected presentations. Exacerbation of symptoms for some people with an existing mental illness is also likely.

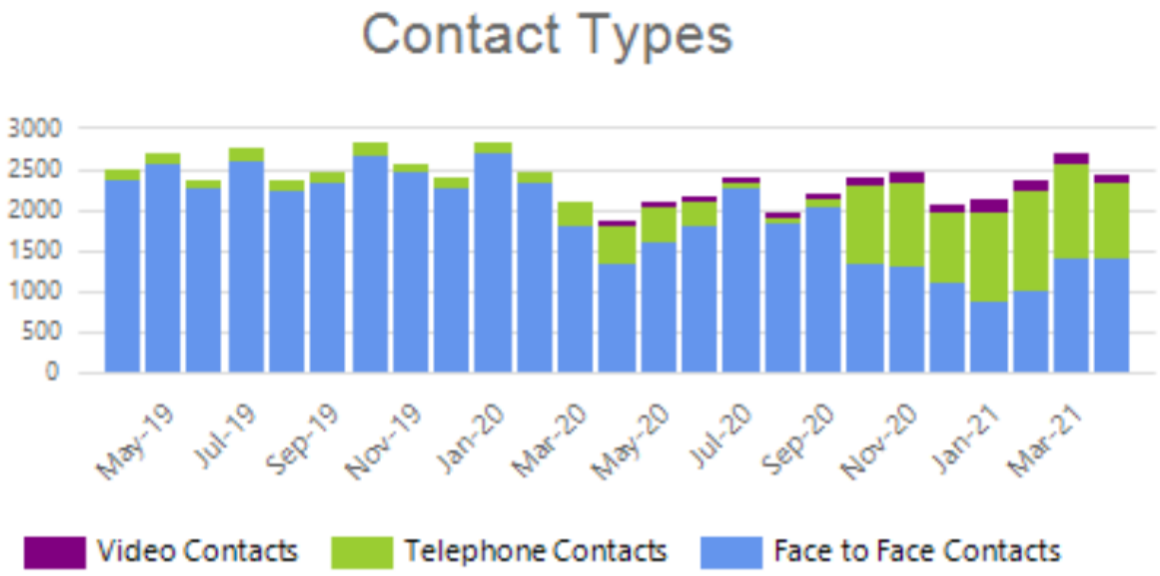
During 2020, beds for adults with organic mental health problems (including those from Hackney) were temporarily moved from the Mile End Hospital site to the East Ham Care Centre site. This move has been positively received, and the Trust plans to work with Healthwatch over the summer of this year to formally gather views on the impact of the move, including relating to transport, to report back to scrutiny committee in October 2021.

Face to Face vs Digital contacts

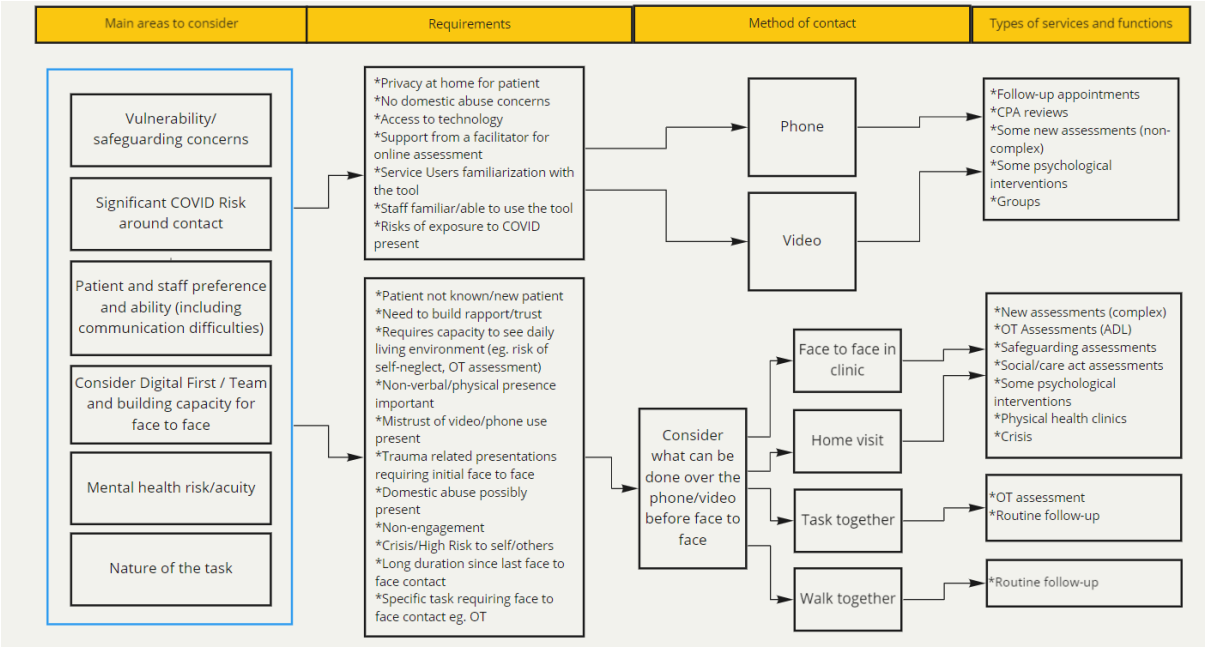
During lockdown our Crisis Services (Home Treatment, Urgent Assessment, Homerton Psychological Medicine (A&E Liaison) continued with face to face visits as normal – although service users were offered a telephone or video meeting. A COVID safe premises in the City and Hackney Centre for Mental Health is still provided for those service users wishing to come in for a consultation.

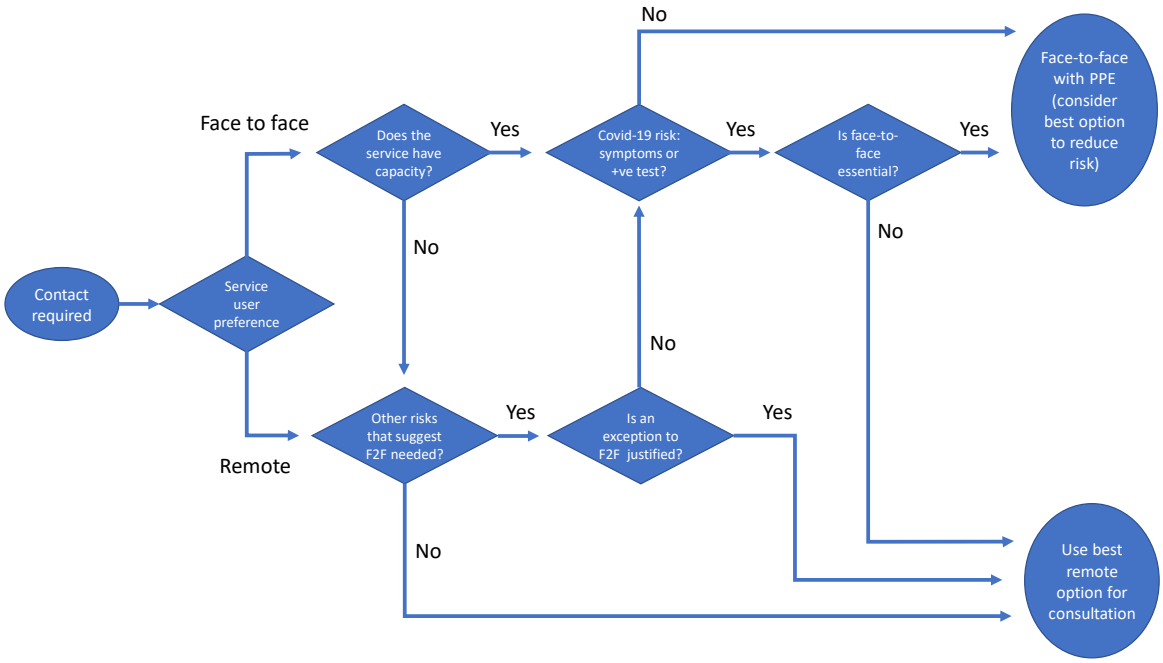
The below chart demonstrates that although there was a slight reduction in patient contacts – due in part to the suspension of our Adult Autism Diagnostic Service, ADHD assessment service and some primary care mental health services - contacts were generally at the same level. It is worth noting

that some services were suspended in order to redeploy staff to our crisis services where it was anticipated the need would be greater.



Our Community Mental Health Teams developed a protocol detailing when a face to face visit would be imperative.





All service users open to a community mental health team have been risk assessed according to both vulnerability to COVID and increased mental health need.

Service user feedback on the 'digital experience' is below.

If you have experienced telephone/video sessions, were these helpful?
City and Hackney > Autism service
[It was very helpful, permitting to get help even during the pandemic.]
[Yes]
[Yes it was very helpful. Without this, the process in me receiving my diagnosis would have been a lot longer.]
City and Hackney > CMHT North Team (Vivienne Cohen House)
[Again not aware these were avaliable]
[Did not had any..]
[yes very helpful]
City and Hackney > Early Intervention (EQUIP)
[They were helpful]
[Yes]
[Yes. Very helpful and reliable.]
[Yes. We have had both telephone and video sessions which have been very helpful.]
City and Hackney > Home Treatment Team
[I didn't use them]
[just telephone, didn't help me too much]
[Just today it was very useful]
[NO]
[No never]
[no yet]

[One telephone session, bed experience on the phone because they told me they would stop my care]
[only telephone call. it was useful.]
[telephone: it went well]
[they came in]
[Yes]
[yes I did video chat - very useful I could see the person's face]
[yes it was good and useful]
[yes telephone it was quite helpful]
[you have organised video session with perinatal psychiatrist for me and it was really really good.]
City and Hackney > Homerton Psychological Medicine
[Crisis line would have been more convenient, but I called 101 so before I knew it police were taking me to A&E. I have the Crisis Line now.]
[n/a]
[that would be fine]
[Yes]
City and Hackney > Joshua Ward
[I have not used it yet.]
[n/a]
[NO]
[Television]
[Video sessions were very helpful and a great opportunity as a group.]
City and Hackney > Mother and Baby Unit
[I havent]
[Yes helpful]
City and Hackney > Perinatal Mental Health Team
[As above.]
[I didn’t have any.]
[Very helpful]
[Yes]
[Yes.]
[Yes. It would’ve been very difficult to attend sessions with my children]
City and Hackney > Rehabilitation and Recovery
[I don’t have any of those sessions]
[I feel better when staff call me on my phone.]
[I find it helpful from staff when they call me.]
[I found it very helpful because I get nervous during meetings where a group of people are in the room but found myself calm during a Video Meeting.]
[I get phone calls from my Care Workers on a weekly basis. I find that to be very helpful because I get good information about my care and how to keep safe from the virus.]
[I had a CPA yesterday by phone which went well. I found it helpful because it was to cold to go out.]
[I have not had a telephone/video session.]
[I receive phone calls but will like more face to face contact with my carer.]
[n/a]

[N/A.]
[NO]
[Telephone they helped very strongly .]
City and Hackney > Service User Network (SUN)
[Absolutely yes.]
[I have, but they were not.]
[Incredibly helpful]
[No because time you get connected time is up and some time one person could take most off the session with they issues]
[Not used them]
[Telephone. Very helpful.]
[Very helpful]
[Yes but more tailored signposting to further help on issues raised in meetings would be appreciated, especially when time is more pushed. It's nice to have a supportive venting space among people who "get it" and to often get helpful input from peers, however that input can be hit and miss, so moderators routinely responding with recommendations for sources of further help or for educating yourself to self-help would be good.]
[Yes I attend telephone sessions they are life saving for me]
[yes very helpful]
[Yes, v much so]

Going forward it is intended to continue with many of the elements introduced to maintain safety in the COVID environment. Social distancing and safe environments are essential for both service users and staff as more people are anticipated using our buildings. Care will likely be provided digitally where appropriate but face to face contacts will always be available.

Service Redesign

Throughout the period of COVID, services have continued to work with a range of primary care, local authority, service user and voluntary sector partners on the development of a more local, neighbourhood model of mental health services. The aim of this work is to provide easier access to a local team, with a broader range of social and community based interventions available than has traditionally been the case, and doing so at a neighbourhood level. The attached presentation summarises the work of this project to date and the work that we aim to take forward in the borough.

We are also beginning to review the provision of crisis services, not least based on the experience of COVID. The City and Hackney Crisis Services incorporate the Home Treatment Team, Crisis Line, Urgent Assessment Team, Homerton Psychological Medicine as well as the Crisis Café and Service User Network (SUN). The Home Treatment Team was set up almost 20 years ago and over time has grown to incorporate these various other functions. Since then, as demand has increased and accessibility has changed, there has been little strategic planning on service delivery. Whilst the care given is safe and responsive we want to ensure standardisation of assessment across the pathway and a renewed emphasis on the social determinants of mental health crisis in a recovery-focussed way, aligning with the philosophy of the new Neighbourhood Mental Health Teams.

We will also be continuing our work to ensure the provision of excellent inpatient estate. There will be a need to ensure that provision for Hackney is of a suitable standard, with en suite facilities, for example.

In all of these area we will of course continue to work with all our partners in the borough, and to keep Hackney Scrutiny Committee fully informed as any proposals are developed.

Neighbourhood Steering Group
Community Mental Health Transformation

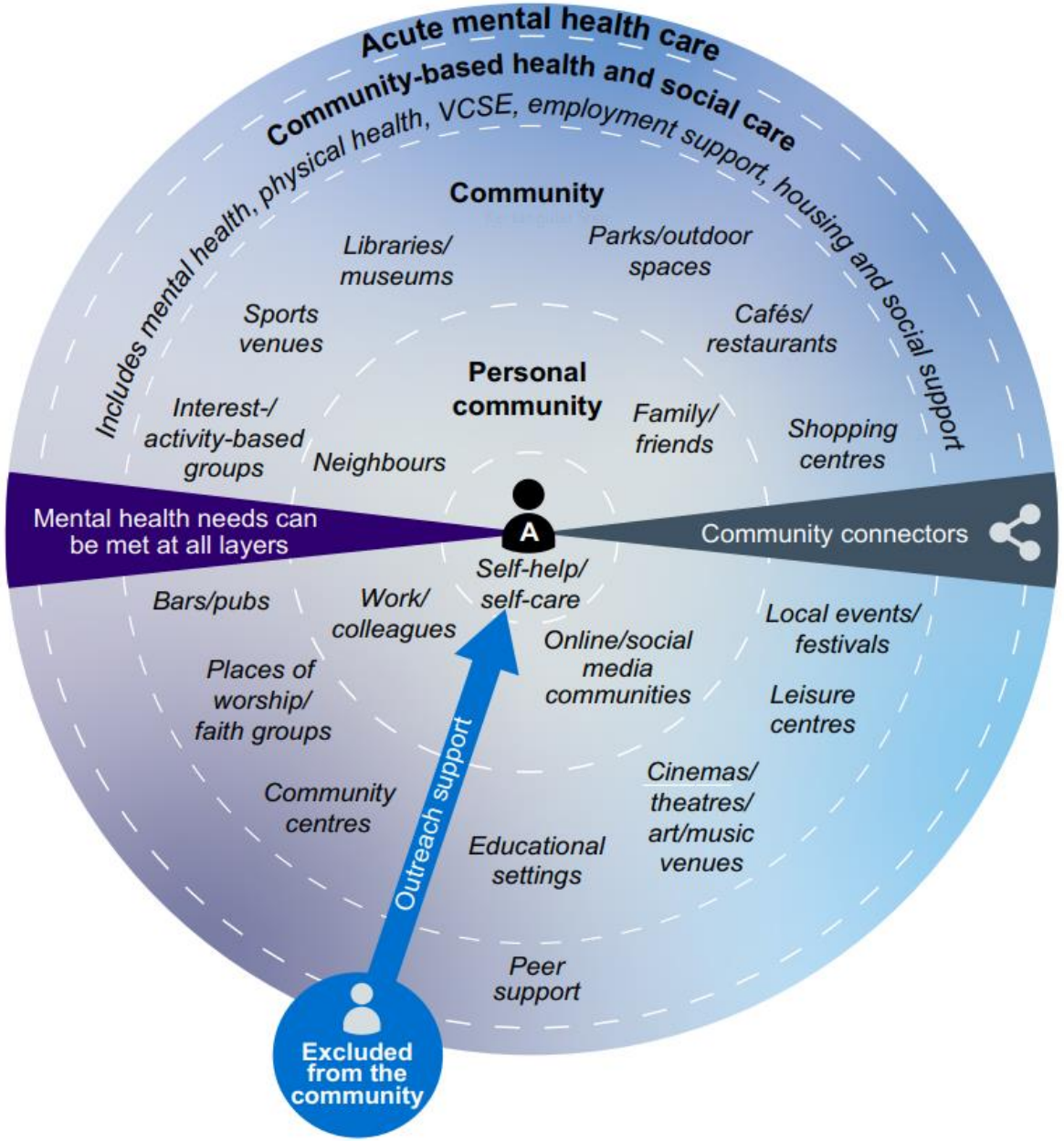
May 2021

City & Hackney GP Confederation
A community interest company

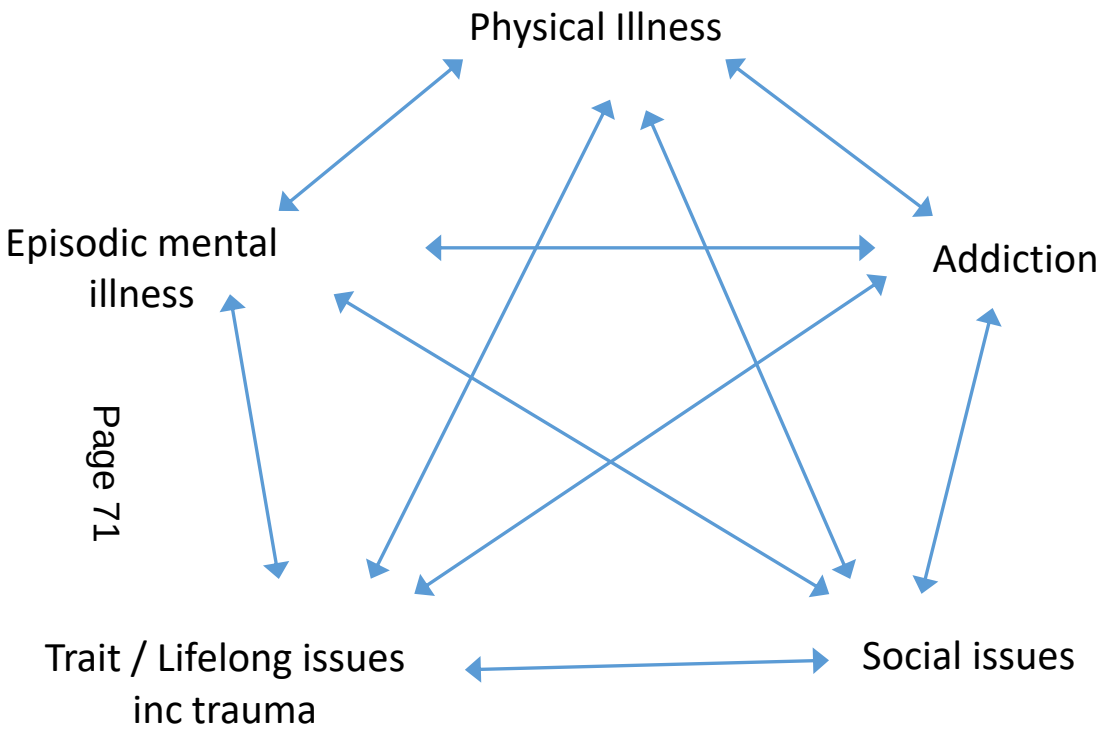
East London NHS
NHS Foundation Trust

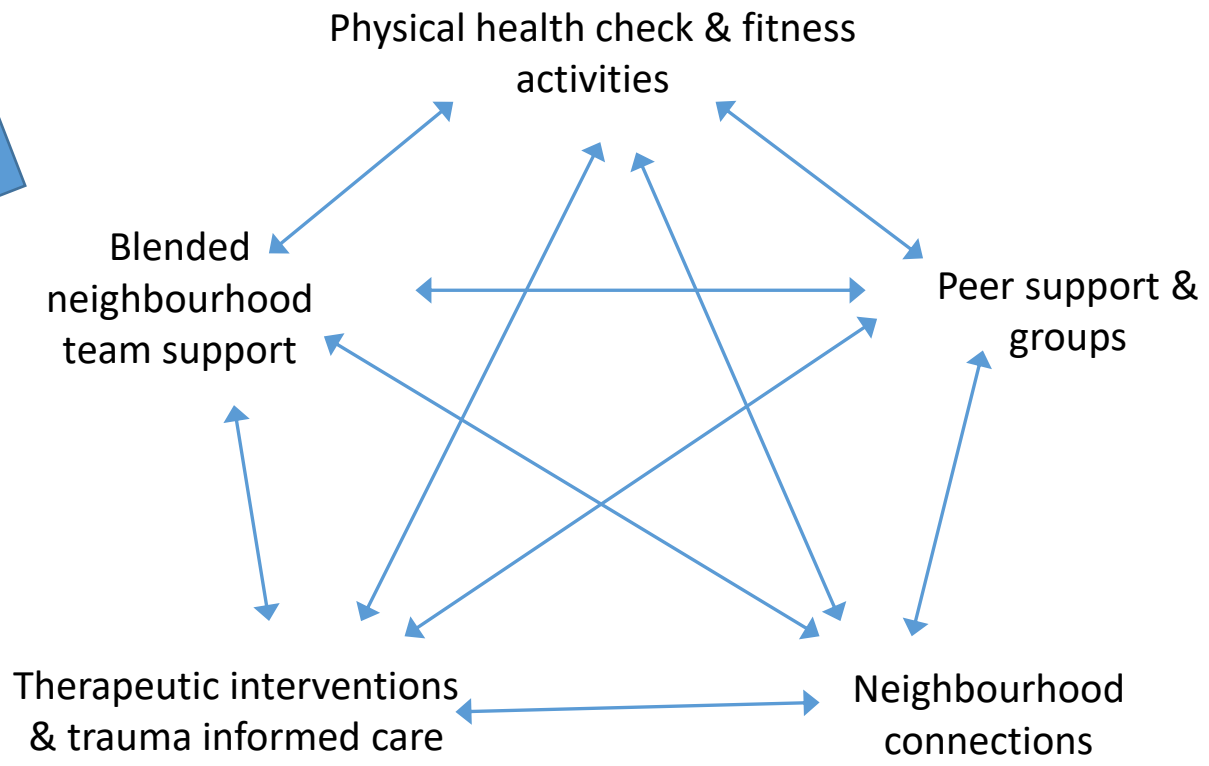
City and Hackney WELLBEiNG NETWORK

The Neighbourhood vision for mental health



Our Aim – Moving from Web of Complexity to Web of Support





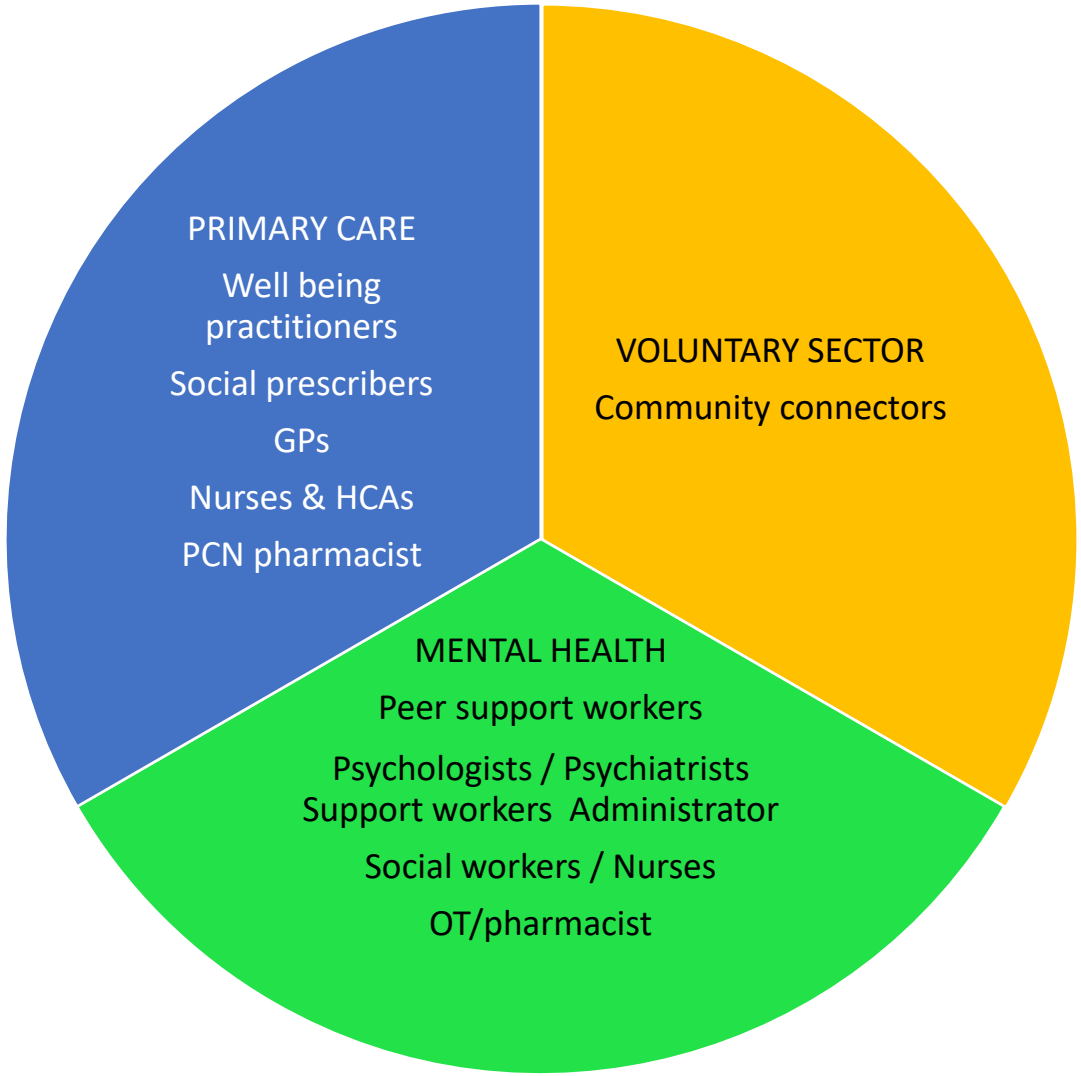
By creating Neighbourhood Mental Health Teams

The Neighbourhood Mental health team brings together colleagues in primary care, the voluntary sector and mental health in one blended team.

We have 4 pioneers sites: Hackney Marshes, Clissold Park, Well Street Common & Woodberry Wetlands and plan to roll out to all neighbourhoods by July 2021.

The Wellbeing Network is our voluntary sector partner, providing community connectors and wider links.

Turning Point, Core Arts, Engage Hackney Housing and the Portman & Tavistock NHS Foundation Trust are all members of the team also.



1. A focus on what matters to the resident

- **Resident innovation club** formed so that residents co produce changes with services
- Residents co producing information, videos, pathways etc
- A range of **neighbourhood based activities** and clubs are being set up including cycling, football, table tennis, gardening and cookery
- **Dialog+ outcome tool** being used to ensure a focus on what matters to the resident
- Co produced recovery focused care plan will be used in the neighbourhood teams
- A new web and app based resident held record, called **Patient Knows Best**, being developed

2. A new flexible model of care focused on social factors

- Focus on **complexity and wider social factors** that impact on mental health – as well as diagnosis
- **Trauma informed care approach** and more psychological therapies in neighbourhoods
- A wider and more **flexible range of support**, where people can be flexed up into higher or lower levels of care
- Moving away from culture of closing cases so that people don't have to be re-referred but can access support quickly when it's needed
- People are offered support tailored to their strengths & needs rather than a rigid set of 4 contacts a year

3. An increased offer of community support

- **Community connectors** supporting people to make links in their neighbourhoods and access community and voluntary sector support
- A range of **new groups and activities** led by connectors, peer support workers, social workers, OT and psychology staff
- Plans to hold activities in **community halls and spaces** once Covid restrictions permit
- Forming more **partnerships with the voluntary sector** to co-design and deliver new services
- More integrated support available with health and social care partners via the Neighbourhood Programme e.g. the Neighbourhood Conversations, which bring together the community, voluntary and statutory sector partners

4. More support and blended team working

- Blended **neighbourhood team** includes voluntary sector, primary care, mental health and colleagues from other partners
- **Daily and weekly meetings**, as well as using MS Teams, encourages team members to talk to each other for support and joint solutions
- The ethos is about the team working together to come up with **formulations and support packages** rather than handing off to an individual professional
- **A wider range of support** is available such as pharmacy input

5. A more responsive service

- Residents are getting **faster and more responsive** service
- Daily meetings have regular input from wide range of team members including community connector, psychologists and doctors
- **GP able to drop into daily and weekly meetings** to discuss a referral for either supporting in the practice or accessing the team for more support
- Professionals from **the wider virtual neighbourhood team**, such as housing or substance misuse, can drop in

Next milestones

- Expanding resident led activities as we come out of lockdown
- Continuing to develop the community offer, groups and activities with partners
- Roll out to remaining PCNs by July
- Developing the high complexity service
- Agreeing and implementing a new neighbourhood medical model
- Gradually moving across people from outpatients into the new neighbourhood teams
- Developing the neighbourhood psychological therapies partnership and model
- Race equalities work with partners
- ‘Live well’ task and finish group on personalised care
- Community connector procurement
- Evaluation
- Handover in September

Learning

- Need to support community groups and voluntary sector to develop the community offer – exploring small grants
- Importance of OD and reflective space
- The tension of QI approach (ambiguity) and project plan (black & white)
- The tension between responsiveness & meeting burden
- Process outcomes balanced with relational outcomes
- The weight of process while trying to keep to the vision
- Impact of pandemic on inequalities
- Impact of pandemic burnout
- Increase in demand

Feedback

‘I thought the patient we discussed today in the daily blended team meeting was a good example of the blended team/neighbourhood doing a great job – in the past this man would simply have been ‘rejected’ by the secondary psychology service (SPS) and sent back to GP; but now with the new way of working I phoned him and discovered someone at risk of suicide in the near to medium term; we formed a plan, and I phoned him just now.

He was immensely grateful at having been thought about and for the plan we put in place. His mood has improved considerably as a result.

Worth it!’

Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Redesign of the specification for the Homecare service**	Item No **10**

OUTLINE

The Commission has asked Adult Services for a briefing on the work being done to redesign the specification for the provision of Homecare services which is being completely re-commissioned. The specification is being developed as is the plan for co-production and engagement with residents on the re-design of these services.

Attached please find a briefing paper.

Attending for this item will be:

Helen Woodland, Group Director Adults Health and Integration
Ann McGale, Director of Adult Social Work and Operations
Cllr Chris Kennedy, Cabinet Member for Health Social Care and Leisure

ACTION

The Commission is requested to give consideration to the briefing.

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Homecare recommissioning - update report

Scrutiny Committee 8 June 2021

Introduction

- Currently the Council spends in excess of **£21m** per year on homecare and supports over **1,200 people**.
- Given the importance of the service, commissioners wanted to ensure that elected members and partners were sighted on this work and had chance to comment on the proposals before the model is fully finalised and presented to Cabinet later in the year for formal approval.
- Commissioners have completed a number of engagement and co-production events with residents, staff and partners over the past year to determine the best model of homecare for re-procurement. The proposed model is discussed in this presentation for comment and approval by the committee.

What is Homecare?

- Home care is a form of support and assistance provided to people in their own homes and is a Care Quality Commission (CQC) registered service, meaning it is regulated and inspected through the CQC.
- Care can be provided through an agency, or through a personal assistant that the individual requiring care recruits themselves through the use of personal budget.
- The type of care provided is focused on supporting people to perform what are known as activities of daily living (ADL) such as bathing, dressing, eating, taking medication etc.
- Individuals must be eligible for care and support under the Care Act (2014) to be in receipt of homecare. The criteria are set nationally as 10 ‘eligible outcomes’ covering issues such as, maintaining personal hygiene, managing and maintaining nutrition, and maintaining a habitable home environment.

What is Homecare?

- For a person to be eligible for services, their needs must relate to an impairment or illness which means they are unable to achieve at least two of the 10 eligible outcomes on a day-to-day basis, and that this has a significant impact on their wellbeing. This means that individuals will have high levels of need in order to qualify for social care support.
- Home care, along with most other forms of care provided by the council, is not free at the point of contact. People who are assessed as having eligible needs are also required to undergo a financial assessment which will determine what financial contribution they will need to make towards their care. Most people are required to contribute financially to some degree to their care. Some people are assessed as needing to pay for their care in its entirety. These people are known as self-funders.

Background

Adult Services

- 41 providers for Adult services, deliver 1,180,700 hours per week for 1,200 vulnerable adults
- For ASC, 8 framework providers deliver 78% of all hours and receive 79% of all spend (£16.8m)
- The remaining 33 providers commissioned on a spot purchase basis deliver 21% of all hours between them at a total spend of £4.6m
- 80% of all homecare staff are Hackney residents
- 7 framework providers and 15 Spot providers are registered as being based in Hackney

Children & Young People Services

- 238 Service Users (143 0-12 yr olds & 95 13-17 yr olds)
- Annual spend - £1 .5M
- 123,759.48 hours per year

Background

- The current average hourly cost of care in Hackney is £18.22 ph.
- This enables providers to pay care workers the London Living Wage and includes travel time, training costs, holiday pay, overheads, back office costs and a surplus (profit) for providers.
- The single biggest framework provider in Hackey provides care to 264 individuals.
- The smallest 2 framework providers are culturally specific to the Orthodox Jewish Community and provide care for just over 30 individuals between them. It is important to note that the carers are not from the Orthodox Jewish Community, but they do receive training and support around cultural considerations when delivering care.

What we have achieved through current commissioning arrangements

- All providers are required to pay the LLW to their staff;
- Homecare benchmarking has highlighted that LBH is one of the few Local Authorities to insist on the LLW being paid;
- All framework providers are required to sign up to the Unison Ethical Care Charter which:
  - Promotes continuity of care,
  - incorporates travel time,
  - aims for the reduction in the use of zero hours contracts and ensures care worker are given regular training.
- The Council recognises how home care workers are valued and how they are an integral to the health and social care system through the annual Hackney Care Workers Award.
- Home care workers during the first and second wave of the pandemic were the backbone of the service, ensuring our vulnerable residents could receive care.

New Proposed Contract Model

- The most significant change being proposed is that Hackney splits the delivery of homecare into 2 or 3 zones, known as patches. These patches would be clustered around the proposed Neighbourhoods and allow for a smaller geographic delivery area for providers. There would be 2 or 3 patches, as opposed to 8 neighbourhood. This is to allow for enough hours per provider to be attractive and give economies of scale and financial stability.
- The overall number of providers Hackney commissions would be reduced, with 2 lead providers per zone delivering 80% of all homecare in that zone for older and physically disabled people.
- It is further proposed that the delivery of 'specialist' homecare services is commissioned through specific lots to cover the whole of Hackney, as the volume is not large enough to warrant a smaller split. Specialist services includes: mental health, learning disabilities and Children and Young People home care.
- Volumes for LD/MH and CYP home care are small (less than 200 residents), so a single lot covering all specialist provision may be necessary.
- Further data analysis, engagement and modelling is being undertaken to determine the exact size, number and type of patches and lots required.

New Proposed Contract Model

- Further consideration needs to be given as to whether we need to commission culturally specific services, for example, specific providers to support the Orthodox Jewish Community and the Turkish Kurdish Community or whether this can be made a requirement that can be met through patch providers.
- A further 'Approved Provider' lot would also be commissioned to ensure sufficient capacity in the market to meet increasing demand, and to provide an element of choice to service users who do not want to use the providers in their patch for whatever reason. An approved provider lot would also allow the council to support smaller, Hackney based providers to build their capacity and retain their ability to deliver services in Hackney.

Model considerations - A patch based model

Benefits	
Closer relationships between providers, the council and GPs	More financial certainty allows for more flexible use of allocated hours and more person centred, outcome based care
An overall reduction in the number of framework providers to allow for stronger relationship building and closer quality monitoring	Allows providers enough certainty around commissioned hours that they should be able to offer better economies of scale and better terms and conditions for staff
Patch based Framework providers have more financial stability which allows for longer term, planning, and the ability to offer fewer zero hours contracts	Fewer providers allows commissioners and social workers to support providers with more training for staff, for example, in manual handling, infection control or medication management
Providers supported and trained to work in a reablement/enablement way with residents	Greater stability and consistency for care workers and residents.
Better ability to work with providers to maximise the use of telecare and reablement approaches	Reduced travel time for carers

Model considerations - A patch based model

Challenges	Mitigations
Larger contracts usually mean bigger, potentially less local providers would be more likely to be able to win the contracts	Commissioners would work with procurement to support local providers with procurement training, and the approved provider list would be specifically tailored to attract smaller, Hackney based companies
Potentially reduced ability to manage any market failures	Each patch would have two different providers, and no provider would be allowed to deliver in more than one patch (possibly 2 if 3 patches in total). The approved provider list could be used to provide additional capacity
The number of existing providers in the market would potentially reduce	Any provider that is unsuccessful in bidding for the core patches would be able to bid to be part of the approved provider list
Reduction in choice of provider for residents	If a resident had a strong view or reason to want a provider other than the patch based providers, this could be accommodated through a direct payment or agreement by exception
Disruptive to existing care arrangements	The majority of care workers would likely be eligible for TUPE transfer to the new patch providers. However, individuals could also be offered a direct payment to maintain their current care arrangements if necessary

Consideration to bringing services back in-house

Commissioners have also given consideration to whether services could or should be brought back in-house. Whilst there are some clear benefits to bringing the service back in, there are a considerable number of challenges to this. These are both set out in the table below.

	Commissioned	In-house
Staff paid the LLW	✔ Yes	✔ Yes
Reduction in zero hours contracts	✔ Yes	✔ Yes
Named pool of carers for each client	✔ Yes	✔ Yes
Cost	£21m	£24m (cost of core service only, not including increase management, overhead and office costs)
Existing management expertise	✔ Yes	X No
Enhanced training and development for workforce	✔ Yes	✔ Yes
Council ability to meet Care Act (2014) responsibility to provide market sustainability and choice and control	✔ Yes	X No
Guaranteed payment for travel time, training and uniform allowances	✔ Yes	✔ Yes

Engagement Consultation and Co-Production (ECCP)

Engagement & Consultation - September 2020 to June 2021

- Health Watch Hackney consulted service users, carers and care workers; overall response was low (C-19 pandemic). The key theme frequently stated was praise for care workers and their work is valued by service users and family.
- Focus groups have been held with health and social care practitioners, Brokerage and Finance and are on going
- Market Engagement events to gain view of the market have also been held and are ongoing

Co-Production June 2021 - December 2021

- Further co-production groups are being developed for service users/carers and health and social practitioner, the groups will feed into the development of the service specification and be part of the procurement process to select providers for the new contract model.
- Further iterations of the model will be tested with residents, staff and partners through these groups, including identifying mechanisms for feedback once the new model has been implemented and ongoing.

A project board and working group has been developed to support the recommissioning, both the board and working group have good representation from health and social care practitioners and strategic partners for example City and Hackney Dementia Alliance, CHCCG, Integrated Independent Team and East London Foundation Trust.

Next Steps & Timeline

- Co - Production Group established

  June 2021

- Business Case/Option Appraisal to Cabinet Procurement & Insourcing Committee (CPIC)

  September 2021

- Tender out to the market

  September 2021

- Tender returned and evaluated completed

  end January 2022

Home Care Demographics*

Fig 1. Gender

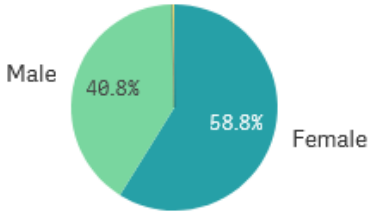


Fig 2. Carer?

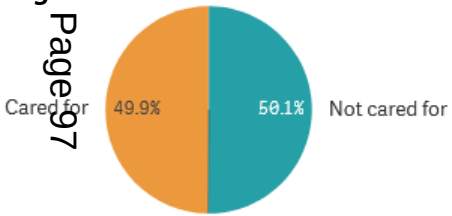
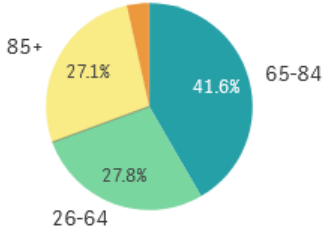
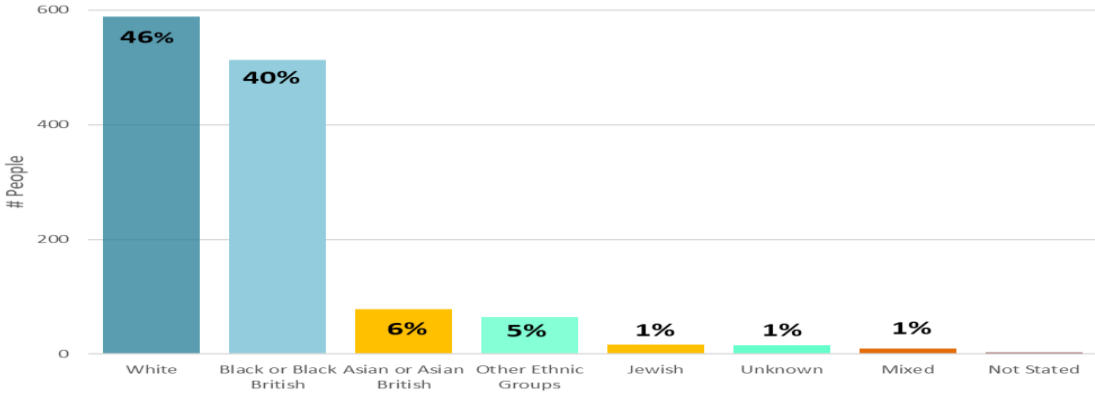


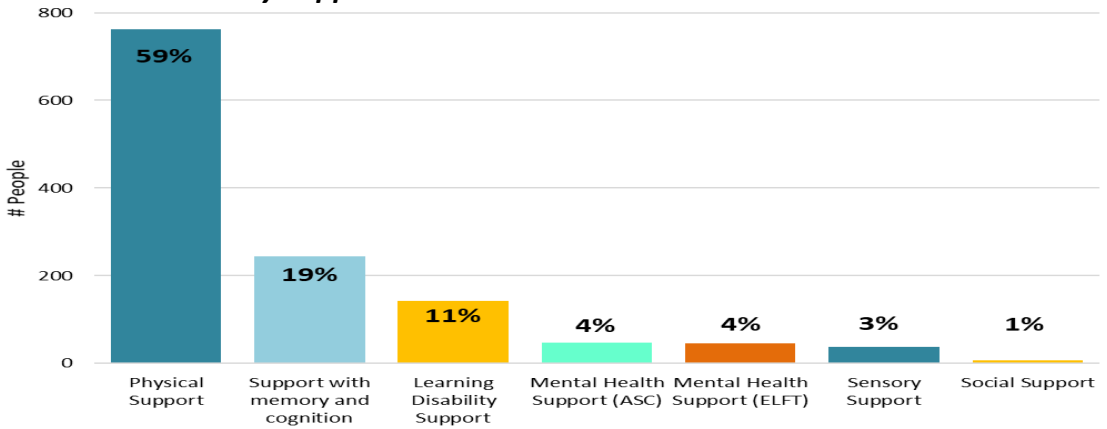
Fig 3. Age Band



Ethnicity



Primary Support Reason



**Qlik ASC Demand Model – Snapshot Oct 2020*

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Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Covid-19 update – for noting**	Item No **11**

OUTLINE

The roll out of the vaccinations programme for Covid-19 is dominating the work of the local NHS bodies and we heard in detail about it at the previous meeting on 31 March. We've asked for an update from the Vaccinations Steering Group (CCG/GP Confed).

This is a fast-moving situation and to ensure that the briefing is as up to date as possible for 8th June officers will submit it to members on the 7th and it will be included in the published document folder and tabled on the night.

The update will be for noting.

ACTION

The Commission is requested to note the briefing.

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City and Hackney COVID 19 Vaccination Programme

Briefing to Health in Hackney overview and scrutiny committee

7 June 2021

Update on the local vaccination roll-out

1. Overall over 120,000 1st & 63,000 2nd dose vaccinations have been undertaken
2. Although there has been 3% increase in vaccination uptake for 1st doses across Cohorts 1-9 (i.e aged over 50) since the last meeting, 26,600 residents remain unvaccinated
3. 17,000 residents in cohorts 1-6 (i.e aged over the age 65 and severe underlying health conditions) remain unvaccinated
4. Pfizer and Moderna now recommended for all those under 40 years of age
5. All those 30 years old and over now eligible to book their vaccine in addition to cohorts 1-9
6. Vaccinating Pharmacies and local vaccination centres now delivering Pfizer or Moderna as well as AstraZeneca (AZ)
7. Outreach work continues through June and July to provide support to specific communities and areas with local outbreaks with variants of concern
8. Further work required to encourage uptake of 2nd dose AZ and Primary Care Network led event to deliver 250 2nd dose vaccinations at Spring Hill Practice on 6 June 2021 with further weekend sessions planned
9. NEL planning a mass vaccination event for 10,0000 at Olympic Park similar to event in NWL at Twickenham with date to be confirmed.

Key actions in the next two weeks

- Planning feasibility for a local weekend-based booked and walk-in surge mass vaccination event to deliver 5,000 doses within next 4-6 weeks
- Range of activities to increase uptake of vaccination by wider social care workforce and carers (see slide 5)
- Roll out of ‘at scale’ general practice vaccination through launch of additional Primary Care Network centres, with Spring Hill commenced 6 June, then Lawson Practice and then further roll out plans
- Just under 1,000 unvaccinated patients in cohort 1-9 requested Pfizer 1st dose and now being booked into Pfizer clinics over next few weeks
- Roll-out of community outreach events to targeted communities with unequal uptake continues; aligning community groups funded for engagement to dates agreed with Excel team for outreach clinics

Vaccination of JCVI priority cohorts 01-11

Overview

Source: NEL Covid vaccination: Invite & uptake coded in Primary care
Updated: 02/06/2021

Cohort	Cohort Description	Cohort Size	First Vaccination	% Vaccinated	Fully vaccinated	% Second Vaccination	Declined	% Declined	WoW change (%)	WoW change (#)
1	Older adult residents in a care home	335	304	91%	267	80%	16	5%	1%	4
2	80 years of age and over	5181	4293	83%	3935	76%	646	12%	0%	14
3	75 years of age and over	3953	3299	83%	3070	78%	415	10%	0%	7
4	70 years of age and CEV	20964	15981	76%	13292	63%	2477	12%	0%	55
5	65 years of age and over	7021	5619	80%	4938	70%	580	8%	0%	19
6	16-64 years of age and at risk of COVID	26484	17167	65%	12399	47%	2895	11%	1%	136
7	60 years of age and over	6625	4757	72%	3274	49%	526	8%	1%	38
8	55 years of age and over	10265	7026	68%	3129	30%	722	7%	1%	56
9	50 years of age and over	12799	8541	67%	2909	23%	795	6%	1%	75
10	40 - 49 years of age	39532	21207	54%	3811	10%	164	0%	5%	937
11	30 – 39 years of age	73354	22401	31%	4621	6%	186	0%	47%	7,202
12										
	Totals Cohort 1-4	**30,433**	**23,877**	**78%**	**20,564**	**68%**	**3,554**	**12%**	0%	80
	Totals Cohort 1-6	**63,938**	**46,663**	**73%**	**37,901**	**59%**	**7,029**	**11%**	1%	235
	Totals Cohort 1-9	**93,627**	**66,987**	**72%**	**47,213**	**50%**	**9,072**	**10%**	1%	404
	Totals Cohort 1-12									

Vaccination Model:

- 2 key local vaccination hubs: Bocking Centre and John Scott Health Centre
- Housebound and care home residents vaccinated through roving model (GPs and DNs)
- 5 Community Pharmacies in Hackney & 1 in the City of London
- Mass vaccination centres at Excel & Westfield Shopping Centre in Newham

Commentary:

- WoW change from dashboards released on 25.05.21 and 01.06.21
- Cohort 4 increased from 11,571 to 20,840 due to updated in how shielding guidance from 15.02.20

Care home (a) residents and (b) staff and carers vaccination data uptake Hackney

(a)

	Total number of residents	Number of eligible residents reported to be vaccinated with at least one dose	% of eligible residents reported to be vaccinated with at least one dose	Number of eligible residents reported to be vaccinated with a 2nd dose	% of eligible residents reported to be vaccinated with a 2nd dose
Older adult care homes	225	199	88.4%	193	85.8%
Younger adult care homes	65	60	92.3%	57	87.7%
Total	**290**	**259**	**89.3%**	**250**	**86.2%**

(b)

	Total number of staff	Number of eligible staff reported to be vaccinated with at least one dose	% of eligible staff reported to be vaccinated with at least one dose	Number of eligible staff reported to be vaccinated with a 2nd dose	% of eligible staff reported to be vaccinated with a 2nd dose
Domiciliary Carers	1,603	601	37.5%	103	6.4%
Younger adult care homes	85	68	80%	47	55.3%
Older adult care homes	321	212	66%	186	57.9%
Non- registered settings & all other frontline social care	10,532	5,042	47.9%	1,478	14%
Total	**12,541**	**5,923**	**47.2%**	**1,814**	**14.5%**

Source: Figures relating to staff are as recorded on the Capacity Tracker tool and have been developed jointly with the Department of Health and Social Care.

Period: Extracted from Capacity Tracker on 30th May

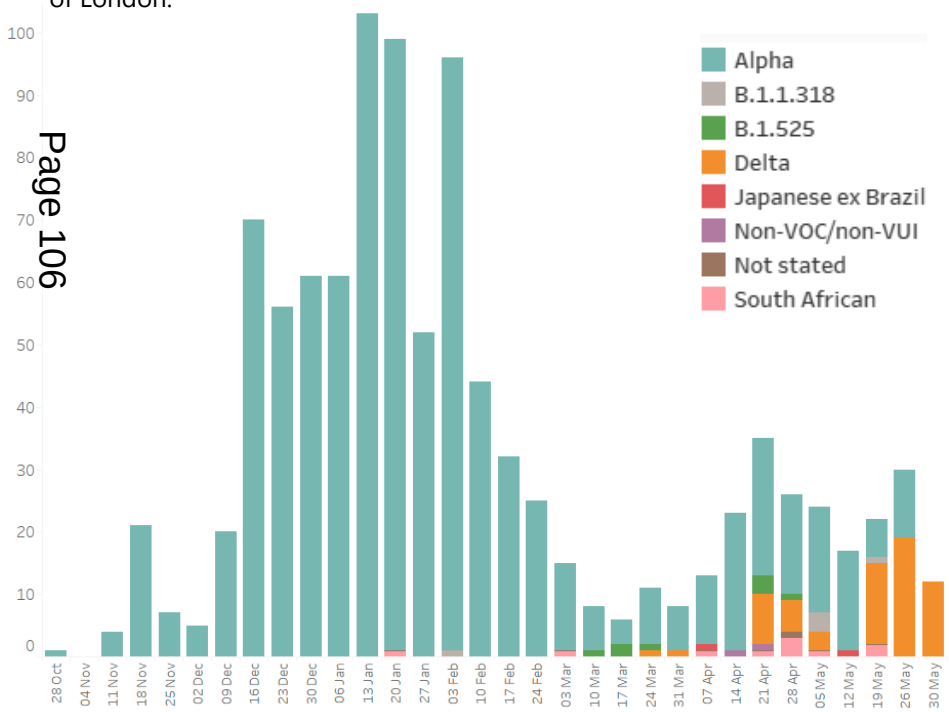
Update on work to improve vaccination uptake in carers

1. Validate self reported vaccine uptake from care providers & twice weekly vaccine uptake reports
2. Engagement session with provider managers & vaccine improvement plans
3. Q&A sessions from Public Health and GP clinical leads with provider staff on vaccinations
4. Fast track access to vaccinations for care staff at vaccine centres
5. Financial incentive for staff to be vaccinated
6. Mobile vaccination service to be commissioned to take vaccinations to staff

Update on variants of concern (VOC) and variants of interest

The Alpha variant has accounted for 91% of VOCs recorded in Hackney and the City of London to date, while the Delta variant made up 83% in the latest week

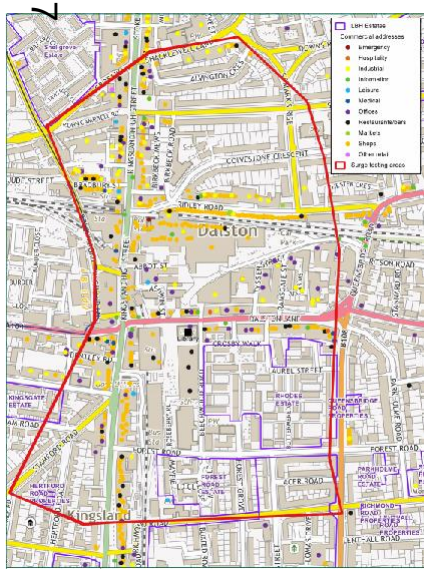
Number of VOC and VUI cases by week and type, Hackney and the City of London.



- In London, as of 25 May, there were 5 variants of concern (VOCs) and 9 variants under investigation (VUIs).
- As of 30 May 2021, 1,003 VOCs/VUIs had been detected in Hackney and the City of London: 983 in Hackney and 21 in the City.
- While 91% of those recorded to date have been the Alpha (Kent) variant, 83% of those recorded in the latest week (ending 30 May 2021) were the Delta (Indian) variant.
- In the latest week of available data there were 24 VOC/VUI recorded, making up 42% of all cases recorded in Hackney and the City of London that week.
- Below is a breakdown of all VOCs to date by lineage:
  - Lineage B.1.1.7 (first detected in Kent): 916
  - Lineage B.1.617.2 (India): 59
  - Lineage B.1.351 (South Africa): 10
  - Lineage B.1.525: 8
  - Lineage B.1.1.318: 5
  - Lineage B.1.617.1 (India): < 5
  - Lineage P1 (Japan ex Brazil): < 5

Data source: Public Health England.

Update on targeted testing in Shoreditch and Dalston



- Small number of beta & delta variants detected in Shoreditch & Dalston concentrated in a 3 businesses
- 2 weeks of targeted PCR testing started 14th May in order to identify further cases & limit transmission
- Genomic syncing of all positive PCR tests in London activated
- Mobile PCR testing units setup at St John's Baptists Church & Geffrye Centre
- COVID Community Champions undertook engagement in Shoreditch & Dalston stressing the support from the council for people who tested positive & importance of testing
- 2,000 businesses were approached and given test kits
- 15,451 test kits distributed with 3,355 completed tests returned to local drop off & other kits returned by post
- Analysis of tests for variants of concern is being undertaken by Public Health England and date will report in due course
- Vaccinations promoted throughout the 2 weeks and additional outreach vaccination centres set up at Gillett Square, Dalston 26th May, 2nd, 5th & 6th June and at St Leonards Hospital every Thursday in June & 1st July

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Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Minutes of the previous meeting**	Item No **12**

OUTLINE

Attached please find draft minutes of the meeting held on 31st March 2021. There were no matters arising.

ACTION

The Commission is requested to agree the minutes.

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Wednesday 31 March 2021

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, and Cllr Emma Plouviez.**
Officers in Attendance	**Helen Woodland (Group Director Adults, Health and Integration), Jayne Taylor (Consultant in Public Health, Hackney and City of London) and Alice Beard (LBH-CCG Communications Officer)**
Other People in Attendance	**Dr Stephanie Coughlin (GP and Chair of the Vaccinations Steering Group), Graham MacDougall (Senior Programme Manager Vaccinations Programme, NEL SCU Consulting for C&HCCG), Siobhan Harper (Director of CCG Transition for City and Hackney/SRO for the Vaccinations Steering Group), Dr Mark Rickets (CCG Clinical Chair for City and Hackney), Tracey Fletcher (Chief Executive of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board) and Cllr Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure).**
Members of the Public	80 views
YouTube link	**The meeting can be viewed at https://youtu.be/asLj31SYPOc**
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 were received from Cllr Spence, Laura Sharpe (GP Confederation), Malcolm Alexander and Jon Williams (Healthwatch Hackney).

2 Urgent Items / Order of Business

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

3 Declarations of Interest

3.1 There were none.

4 Covid-19 - update from Vaccinations Steering Group

4.1 The Chair stated that following on from the discussion at the February meeting NHS colleagues had been invited to provide an update on the vaccinations roll out with specific focus on the communications and engagement work being done to reduce vaccine hesitancy. The Chair welcomed for this item:

Dr Stephanie Coughlin (SC), Local GP and Chair of the Vaccinations Steering Group at GP Confederation
Graham MacDougall (GM), Senior Programme Manager for the Vaccinations Programme, NEL SCU Consulting for C&HCCG
Siobhan Harper (SH), Director of CCG Transition for City and Hackney and SRO for the Vaccinations Steering Group
Dr Mark Rickets (MR), CCG Clinical Chair for City and Hackney, NEL CCG
Tracey Fletcher (TF), CE of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health and Care Board for City & Hackney
Alice Beard (AB), Communications Team CCG and LBH

4.2 Members' gave consideration to three documents from Dr Couglin:

(a) *Covid-19 update – 19 March*
(b) *Covid-19 vaccination uptake challenge and how we are tackling this locally* (listing the activities being carried out with each cohort/community)
(c) *City & Hackney vaccination programme update* as at 31 March

4.3 SC took members through the presentation which detailed the progress of the roll-out across all the various cohorts. She also described vaccination data broken down by ethnicity. SH then described the strategic approach being taken by the Vaccine Steering Group and AB concluded with details on the outreach and engagement work specifically on tackling vaccine concern/hesitancy, including "community conversations' with specific communities and plans for a possible mobile vaccination team bus.

4.4 Members asked detailed questions, and in the responses, the following points were noted:

(a) In response to a question by the Chair on how constrained the work might be by funding, SH explained that a bid had been made to NHSE to fund expanded outreach work. She added that resources were at capacity because this is a piece of major outreach work.

(b) In response to a question on what the target % of population to be vaccinated was SC replied that the national target was 92.5%.

(c) The Chair asked how the data was being segmented and then used to inform the targeting of outreach events. She described how it operated. She commented that the 'other white' category in the dataset had been harder to break down.

(d) Members asked how officers would respond to worries about types of vaccines and managing flow in vaccine in the centres. SC explained that they followed the national rules on managing flows of bookings and the nationally mandated guidance from the JCVI on how to proceed and who gets vaccinated next. It is a national system. In response to a comment on sharing best practice, she added that they could share the approach taken to outreach work in communities which are more vaccine hesitant with both NEL neighbours and more widely.

(e) Members asked how the local NHS was doing on vaccinations of care home and domiciliary care staff. SC described the workforce data. 58% staff in care homes had been vaccinated thus far. GM replied that the programme was doing very well with care home staff but was homecare providers things were proving more of a challenge and the efforts were ongoing.

(f) A Member asked about targeting messaging into areas with low uptake and making access easier. MR described the approach on vaccination decliners and on shared learning and best practice from elsewhere in north east London. A person can only be recorded as declined after three attempts are made with them. The importance of a 1:1 GP contact in turning people round was vital, they had learned.

(g) Members asked about the possible impact of a potential drop in supply expected in April and the efficacy of vaccines against the new variants. SC replied that all second does vaccines had already been badged and guaranteed and also that anyone wanting a first dose in April would be able to get one. One dose of a vaccine regardless of strain was having a huge impact in reducing both the severity of Covid and in reducing hospital admissions. She described the current thinking on booster doses and stressed that the number of vaccines delivered in an outreach event on any one day should not be the only measure of success. The huge efforts going into the general community outreach work which delivers long term results should also not be underestimated.

4.5 The Chair stated that the vaccine programme now seemed to be much more targeted and data driven than it had appeared the previous month and he thanked the contributors for this and for their briefing papers and attendance.

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

5 Population Health Hub and Health Inequalities Steering Group briefing from Director of Public Health

5.1 The Chair stated that since the inception of the Integrated Commissioning Board the Commission has received regular updates from each of the 4

Workstreams of the ICB (Planned Care, Unplanned Care, CYP & Maternity, and Prevention). The Prevention Workstream had now been replaced with a new '*Population Health Hub'*. In addition, the pandemic has magnified the existing health inequalities and reducing these will be the key challenge coming out of Covid. To address this the Health and Wellbeing Board had adopted The King's Fund's 'Population Health Model' and had created a '*Health Inequalities Steering Group'* as a sub-committee of the Board to drive forward this work. Officers had been invited to brief Members on both of these new developments and he welcomed:

Jayne Taylor (JT), Consultant in Public Health and Lead for Health Inequalities portfolio, Hackney Council and City of London Corporation
Helen Woodland (HW), Group Director Adults, Health and Integration, Hackney Council

5.2 Members gave consideration to two briefing reports:

(a) *City & Hackney Population Health Hub*
(b) *City & Hackney Health Inequalities Steering Group*

JT took Members through the reports explaining the rationale for this change in that prevention work needed to be better embedded across the system and that health inequalities required greater attention. The Health Inequalities Steering Group therefore would be a focal point for a whole range of work being a carried out by the partners.

5.3 Members asked questions and in the response the following was noted:

(a) The Chair asked how it will be possible to get meaningful buy-in from the partners in order to make this a success. SH set it in context and described how there was a large emphasis in health inequalities in the latest national NHS Guidance and that this was driving the local approach.

(b) Members asked about the need to collect data on wider determinants/personal circumstances of individuals e.g. their housing conditions. They asked whether there was an adequate system in primary care to consider environmental factors on health and how this aspect would be approached. JT explained the Public Health England Intelligence Function had replaced the old Health Observatories and recording personal circumstances information was of course key. She added that GPs on the Steering Group had stressed the need to have the tools at their fingertips to both record and respond to personal circumstances and this aspect would now be worked on.

(c) Members asked about 'anticipatory care' as outlined in the briefing and who actually would carry out this work. JT described how the system operated by using the data to identify the cohorts and then working out who was best placed to deliver the help needed. HW added that it would be whoever was best placed within the Multi-Disciplinary Team. It might be a combination of people for example when it was a person with complex needs. SH described the Neighbourhoods Teams role in prevention by bringing the various professionals together and then deploying the

correct resources. The Chair asked that the challenge would be whether funding could be sustained in a system that is perhaps too much geared towards 'fire-fighting'. SH explained how 'Long Term Conditions' treatment management works to pursue measures which will also be preventative around the specific long term condition. The PCNs will get resourced for the 'anticipatory care' contracts too and this is how the support would be rolled out.

5.4 The Chair thanked the officers for their reports and their attendance. He concluded that the Commission would like an update on progress in 12 months.

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

6 Digital and remote NHS services – CCG analysis

6.1 The Chair stated that the pandemic had of course accelerated the adoption of digital and remote NHS services and practically overnight GPs had had to provide virtual consultations once lockdown was imposed. Members had noted that the CCG in October had asked its Head of Quality to map some of the work on digital and remote services across City and Hackney and this had provided a useful overview report of the key issues. He had asked the CCG to come and discuss the report and welcomed:

Jenny Singleton (JS), Head of Quality at C&H CCG to the meeting.

6.2 Members gave consideration to the following reports:

a) '*NHS and remote services'* presentation providing update since October report
b) CCG's main report '*NHS services delivered remotely and issues with digital exclusion*' Oct 2020
c) A separate report from The Patient's Association '*Digital health during the Covid-19 pandemic: Learning lessons to maintain momentum*'

6.3 JS explained the background to the report and took members through the main recommendations.

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

(a) Chair asked what resource there was in the CCG to implement these recommendations e.g. in helping GP Practices to develop and improve their websites to enable better remote access. He referred to the Commission's own review on this subject which found that there wasn't a dedicated resource to co-ordinating the IT landscape across all of NEL. JS replied that it was more about bringing people together to work better as a system rather than just specific new funding and that these initiatives were the work of the IT Enabler Group of the Integrated Commissioning Board which itself had substantial funding. The key was to develop a framework to take this work forward in a unified way that is grounded in the patient feedback GP practices already have.

(b) Members asked about the danger of marginalising further those elderly who are digitally excluded with some, for example, unable to use touch-tone phones. MR cautioned that the enhanced remote offer hasn't replaced the face-to-face appointments and Practices didn't close during Covid. He explained how the CCG had always funded 'Enhanced Services' including proactive visiting of vulnerable patients and proactive practice based reviews.

(c) Members asked about case work they'd received about elderly residents finding it difficult to access GPs and asked if the structure could be standardised.

(d) Members asked about living conditions and asked about the need for a single system for remote access and about recording wider personal circumstances. There were 4 different GP remote access systems locally. MR explained how GP Practices currently record wider personal data and about the use of template triage forms which are designed by the Clinical Effectiveness Group. He also described the Quality-Capacity-Access conundrum in the provision of primary care which relates to how an in increase in any one of these will lead to a reduction in one or more of the others and so there is a constant effort to keep them in balance. C&H had some of the best ratios of GPs to patients in the country, he added. Members asked if GP Confederation could improve how the data on personal circumstances derived from the remote access system could be better optimised to provide a more targeted support to patients.

(e) The Chair asked whether Covid-19 had impacted on numbers of patients switching to GP at Hand and other such companies. MR replied that the now enhanced local online offer was proving very popular and so was reducing the local demand for these other providers.

(f) The Chair asked who was holding the ring on this issue and that one of the key findings of the Commission's own review on digital primary care prior to Covid-19 was that nobody had been leading on it within the system. JS described how this was ongoing work, and that some of course were finding that these remote services were much better for them and much more suited to their needs e.g. those with poor English language proficiency.

6.5 The Chair thanked JS for her report and attendance and stated that the Commission would be revisiting these issues.

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

7 New governance structure for C&H Integrated Care Partnership

7.1 The Chair stated that the Commission had received a number of briefings on the transition of the City and Hackney CCG into a single NHS NEL CCG and that he had asked for a briefing on the governance structure of the new system once it had been agreed.

7.2 The Chair welcomed to the meeting:

Tracey Fletcher (TF), Chief Executive of HUHFT/ ICP Lead for City and Hackney/ Chair of the Neighbourhood Health & Care Board for C&H
Dr Mark Rickets (MR), Clinical Chair for C&H, NEL CCG.

And explained her new system leadership role (on top of her job as CE of the Homerton). He explained that she was accountable to Henry Black as the NEL Accountable Officer and to Dr Mark Rickets as the CCG Clinical Chair for C&H within the NEL System. He also explained that Siobhan Harper would serve as Director of CCG Transition, initially for six months, and would effectively be replacing David Maher in overseeing the day to day management of the CCG team in City and Hackney.

7.3 Members gave consideration to a detailed presentation on '*Progress update on our transition to a City and Hackney Integrated Care Partnership'*.

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

(a) In response to a question on who sits on the ICP, TF detailed the memberships of both the **Integrated Care Partnership Board (ICPB)** and the **Neighbourhood Health and Care Board (NHCB)** underneath it which she would Chair.

(b) In response to a question about ensuring how the ICPB doesn't become a rubber stamp, TF set out the vision for the Board, the challenges and the timescales and how it would hold the more operational NHCB to account. It would have a challenge role, she added. She described how both clinical leadership and resident involvement will work within the new system. She outlined the roles and responsibilities of ICPB vis-à-vis the NHCB and how the transition from the old committees will work. She added that it was important to ensure that processes that had served them well were retained and built on. Work was advanced on having a new System Team in place that will be committed to making this work. MR stressed that the local area team and sub-committee of the NEL CCG Board was very well embedded therefore a strong local focus would be maintained. At the sub-regional level, the new NEL CCG Governing Body would be meeting for the first time on the following day, 1 April.

(c) Members queried the sustainability of these local structures and whether the sufficient level of engagement needed to make them work well would be maintained. TF explained that it is difficult to predict because it was not known how the NEL System will be expected to react to the changes coming down stream. Leaving room for refining it and improving the structure was really important therefore. She cautioned that a lot will depend on the changes which are coming through in the legislation and guidance relating to ICSs in the Health and Care Bill. The key was to make sure that nothing important was dropped in these changes and that the system was simplified. The changes would achieve a greater partnership approach between commissioners and providers than had been possible in the old system.

7.5 The Chair thanked TF for her detailed presentation and commended the approach being taken so far.

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 February and the Matters Arising.

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

9 Health in Hackney Work Programme

9.1 Members gave consideration to the updated work programmes.

RESOLVED:	**That the Commission's work programmes for 20/21 and 21/22 and the rolling work programme for INEL JHOSC be noted.**

10 Any other business

10.1 There was none.

Hackney

Health in Hackney Scrutiny Commission 8th June 2021 **Work Programme for the Commission**	Item No **13**

OUTLINE

Attached please find the latest iteration of:

HiH work programme 2021/22
INEL work programme 2021/22

These are working documents and updated regularly.

ACTION

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

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Health in Hackney SC - Rolling Work Programme for 2021-22 as at 28 May 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
8 June 2021	**New NHS East and SE London Pathology Partnership**	Update requested from Jan 2020	NEL CCG and HUHFT	ICP Lead for City & Hackney also CE of HUHFT	Tracey Fletcher	
deadline 27 May			Local Medical Cttee	Chair	Dr Vinay Patel	
	Treatment pathways for 'Long Covid'	Briefing	NEL CCG	Director of CCG Transition - City & Hackney	Siobhan Harper	
			NEL CCG	CCG Clinical Chair for City and Hackney	Dr Mark Rickets	
			HUHFT	Head of Adult Therapies	Dr Fiona Kelly	
			NEL CCG - C&H	Acting Workstream Director for Planned Care	Charlotte Painter	
	Community Mental Health Transformation and Recovery from Covid-19	Briefing	ELFT	CEO	Paul Calaminus	
			ELFT	Deputy Borough Director - City and Hackney	Andrew Horobin	
	Redesign of specification for Homecare	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
				Director Adult Social Work and Operations	Ann McGale	
	Covid-19 update - for noting	Noting only	CCG and GP Confed			
8 July 2021	**TBC**					
deadline 29 June	**TBC**					
	Healthwatch Hackney Annual Report 20/21	Annual item	Healthwatch Hackney	Executive Director	Jon Williams	
	HUHFT Quality Account 2020/21	Annual item	HUHFT	Chief Nurse and Director of Governance	Catherine Pelley	
11 Oct 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	
deadline 30 Sept			CCG or NEL ICS	Programme Director Mental Health	Dan Burningham	
			Healthwatch Hackney	Executive Director	Jon Williams	
	What is Adult Social Care - overview of current provision?	Discussion	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
				Director Adult Social Work and Operations	Ann McGale	
	TBC					
	TBC					
17 Nov 2021	**Transformation Programme for Adult Social Care**	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
deadline: 8 Nov				Director Adult Social Work and Operations	Ann McGale	
	TBC					
	TBC					
9 Dec 2021	**TBC**					
deadline: 30 Nov	**TBC**					

	TBC					
	TBC					
10 Jan 2022	**Overview of capital build proposals in Adult Social Care**	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
deadline: 22 Dec 2021				Director Adult Social Work and Operations	Ann McGale	
	TBC					
	TBC					
9 Feb 2022						
deadline: 31 Jan						
16 March 2022						
deadline:7 March						

Note: The Local Council Elections in London take place on 5 May 2022. Purdah begins c. 20 March

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date						
TBC	**Future of virtual consultations in primary care - next steps**	Briefing requested Sept 2020	GP Confederation	Chief Executive	Laura Sharpe	
			Healthwatch Hackney	Executive Director	Jon Williams	
			NEL CCG	Primary Care Commissioner	Richard Bull	
TBC	**Extension of ISS contract for soft services at HUHFT**	Update requested from July 2020	HUHFT	Chief Executive	Tracey Fletcher	
			UNISON			
TBC	**Implementation of Ageing Well Strategy**	Update requested Dec 2019	Inclusive Economy, Policy and New Homes	Head of Policy and Strategic Delivery	Sonia Khan	
Postponed from March 2020	**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 2020	**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 2020	**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		
			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 2020	**Neighbourhoods Development Programme**	Annual Update	GP Confederation	Chief Executive	Laura Sharpe	
			GP Confederation	Neighbourhoods Programme Lead	Mark Golledge	
Postponed from July 2020	**Future use of St Leonard's Site and NEL Estates Strategy**	**Discussion Panel**				
	Follow up on planned Healthwatch Community Event wk of 12 July 2021					
	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				

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INEL JHOSC Rolling Work Programme for 2020-21 as at 23 March 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
27 January 2020	**New Early Diagnosis Centre for Cancer in NEL**	Briefing	Barts Health NHS Trust	Clinical Lead	Dr Angela Wong	
			NCEL Cancer Alliance	Interim Project Manager	Karen Conway	
	Overseas Patients and Charging	Item deferred				
11 February 2020	**NHS Long Term Plan and NEL response**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			Barking & Dagenham CCG	Chair	Dr Jagan John	
			East London HCP	Director of Transformation	Simon Hall	
			East London HCP	Chief Finance Officer	Henry Black	
	New Joint Pathology Network (Barts/HUHFT/Lewisham & Greenwich)	Briefing	Barts Health NHS Trust	Director of Strategy	Ralph Coulbeck	
			Homerton University Hospital NHS FT	Chief Executive	Tracey Fletcher	
	Municipal Year 2020/21					
24 June 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Chief Executive	Alwyn Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			East London NHS Foundation Trust	COO and Dep Chief Exec	Paul Calaminus	
			Newham CCG	Chair	Dr Muhammad Naqvi	
			Waltham Forest CCG	Chair	Dr Ken Aswani	
			Tower Hamlets CCG	Chair	Dr Sir Sam Everington	
			WEL CCGs	Managing Director	Selina Douglas	
			City & Hackney CCG	Managing Director	David Maher	
	How local NEL borough Scrutiny Cttees are scrutinising Covid issues	Summary briefing FOR NOTING ONLY	O&S Officers for INEL			
30 September 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			East London HCP	Director of Trasformation	Simon Hall	
			East London HCP	Director of Finance	Henry Black	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			ELFT	COO and Deputy Chief Executive	Paul Calaminus	
			WEL CCGs	Managing Director	Selina Douglas	

			City and Hackney CCG	Managing Director	David Maher	
	Covid-19 discussion panel with the local Directors of Public Health	Discussion Panel	City and Hackney	DPH	Dr Sandra Husbands	
			Tower Hamlets	DPH	Dr Somen Bannerjee	
			Newham	DPH	Dr Jason Strelitz	
			Waltham Forest	DPH	Dr Joe McDonnell	
	Overseas Patient Charging - briefings from Barts Health and HUHFT	Briefing	Barts Health NHS Trust	Group Chief Medical Officer	Dr Alistair Chesser	
25 Nov 2020	**Covid 19 update and Winter Preparedness**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Whipps Cross Redevelopment Programme	Briefing	Barts Health NHS Trust	Whipps Cross Redevelopment Director	Alastair Finney	
			Barts Health NHS Trust	Medical Director, Whipps Cross	Dr Heather Noble	
10 Feb 2021	**Covid-19 impacts in Secondary Care in INEL boroughs**	Briefing	Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Covid-19 Strategy for roll out of vaccinations in INEL boroughs	Briefing	East London HCP	SRO	Jane Milligan	
			City and Hackney CCG	Chair	Dr Mark Rickets	
			City and Hackney CCG	MD	David Maher	
	North East London System response to NHSE consultation on ICSs	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
	Update on recruitment process for new Accountable Officer for NELCA/SRO for ELHCP	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
Municipal Year 2021/22						
23 Jun 2021	**Covid-19 vaccinations programme in NEL**	Briefing	NEL ICS		Henry Black, Simon Hall and a GP Clinical Chair	
	Implications for NEL ICS of the Health and Care White Paper	Briefing	NEL ICS		Marie Gabriel, Henry Black, Dame Alwen Williams	
	Accountability of processes for managing future changes of ownership of GP practices	Briefing	NEL CCG		Henry Black, NEL Primary Care Commissioning rep, NELSON rep	

	Challenges of building back elective care post Covid pandemic	Briefing	Barts Health and HUH		Dame Alwen Williams and Tracey Fletcher	
13 Sep 2021						
TBC Dec 2021						
TBC Mar 2022						
	Items to be scheduled/ returned to:					
	NEL Estates Strategy					
	Whipps Cross Redevelopment					
	Cancer Diagnostic Hub					
	Review of Non Emergency Patient Transport					
	Digital First delivery in NHS					
	Mental Health					
	Homelessness Strategy					

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Tuesday 8 June 2021 at 7.00pm

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

Chair	**Councillor Ben Hayhurst**
Councillors in attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David and Cllr Emma Plouviez.**
Councillors joining remotely	**Cllr Michelle Gregory and Cllr Deniz Oguzkanli**
Council officers in attendance	**Helen Woodland (Group Director Adults, Health and Integration)** **Chris Lovitt (Deputy Director of Public Health for City and Hackney)** **Zainab Jalil (Head of Commissioning, Adult Services)** **Alice Beard (LBH-CCG Communications Officer)**
Other people in attendance	**Cllr Christopher Kennedy (Cabinet Member-Health, Social Care Leisure)** **Cllr Yvonne Maxwell (Cabinet Adviser for Older People)** **Tracey Fletcher (Chief Executive of HUHFT/ ICP Lead City & Hackney)** **Fiona Kelly (Head of Adult Therapies, Division of Integration Medicine & Rehabilitation Services, HUHFT)** **Dr Mark Rickets (CCG Clinical Chair for City and Hackney)** **Siobhan Harper (Director of CCG Transition for City and Hackney)** **Charlotte Painter (Acting Workstream Director for Planned Care, NHSE NEL CCG for City and Hackney ICP)** **Paul Calaminus (Chief Executive, East London NHS Foundation Trust)** **Andrew Horobin (Deputy Borough Director for City & Hackney, ELFT)** **Jon Wiliams (Executive Director, Healthwatch Hackney)**
Members of the public YouTube link	42 views **The meeting can be viewed at https://youtu.be/XvXBP2SjI_E**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Election of Chair and Vice Chair

1.1 It being the first meeting of the O&S Officer opened the meeting and invited nominations for Chair. Cllr Adams nominated Cllr Hayhurst and Cllr David

seconded. There were no other nominations. Cllr Hayhurst was elected unanimously as Chair.

1.2 Cllr Hayhurst took the Chair and invited nominations for Vice Chair. He nominated Cllr Snell and Cllr Plouviez seconded. There were no other nominations. Cllr Snell was elected unanimously as Vice Chair.

2 Apologies for Absence

2.1 Apologies were received from Dean Henderson (ELFT) and Dr Vinay Patel (LMC)

3 Urgent items/order of business

3.1 There was no urgent business and the order was as on the agenda. The Chair stated that this was the first hybrid meeting with some Members in the Council Chamber and others and all guest joining remotely.

4 Declarations of interest

4.1 There were none.

5 Confirmations of Terms of Reference

5.1 The Chair stated that as it was the first meeting of the new municipal year the Commission, as usual, noted its Terms of Reference.

RESOLVED:	**That the terms of reference and procedure rules be noted.**

6 Appointment of 3 Members to Inner North East London Joint Health Overview and Scrutiny Committee for 2021/22

6.1 The Chair drew Members' attention to the report and stated that the proposal was that he, Cllr Snell and Cllr Adams be proposed as the three representatives for the year. Members voted unanimously to accept this proposal.

RESOLVED:	**That Cllrs Hayhurst, Snell and Adams be appointed to INEL JHOSC for 2021/22.**

7 NHS East and South East London Pathology Partnership

7.1 The Chair stated that the issue of the 'path lab' at the Homerton had been discussed at previous meetings and in Jan 2020 the Chief Executive of HUHFT had undertaken to update the Commission. Since then, a new pathology partnership for East and South East London had come into being on 1 May 2021. This new organisation is jointly owned by Barts Health, the Homerton and Lewisham and Greenwich NHS Trusts.

7.2 The Chair welcomed for this item:

Tracey Fletcher (TF), CE of HUHFT and ICP Lead for City and Hackney

7.3 Members' gave consideration to a copy of Barts Health's news release announcing the partnership and a HSJ article "*Commercial partners could take over 'entirety' of planned imaging networks*" outlining NHSE's recent announcement that diagnostic imaging networks will become separate entities.

7.4 TF gave a verbal presentation describing the partnership, which went live on 1 May. It was noted that the 'GP direct access' staff element would move from the Homerton to the new hub at the Royal London in July and also that the end of 2022 would be the completion date for the associated upgrade at HUHFT.

7.5 Members asked questions, and in the responses the following points were noted:

(a) In response to a question from the Chair on the separate issue of the impact on the Homerton of the new collaborative between Barts Health and BHRUT, TF stated that in the very long term it was not clear what the impact would be. Arrangements were being made for BHRUT and Barts Health to have a joint Chair and they were trying to establish how they can work in a collaborative way to both of their advantages. She added that there was an opportunity also for HUHFT and ELFT and NELFT to think about where they all can fit in by working as 3 way or as a 5 way set of organisations for the future. There would obviously be economies of scale and savings on some elements of procurement which would be to everyone's benefit HUHFT already had clinical arrangements with Barts Health over many years. She added that the change would allow HUHFT to iron out wrinkles within their current clinical pathways to everyone's benefit. She explained that HUH did not have certain specialisms such as in-patient neurology and patients already needed to go to Barts, therefore collaborative working was already built into the system.

(b) In response to a question on job losses at HUHFT as a consequence of Pathology Partnership, she stated that there shouldn't be any but there would be some shifts in roles. She was not anticipating any losses across the three departments involved as they were all already carrying vacancies.

(c) Members' asked about local GP concerns about slow turnaround of pathology results from Barts in the past. In response to a question on why the single system hadn't been put in place before the communications network, TF replied that they had had to put a team in place first to get the components ready for the new hub and spoke system. They needed a level of expertise coming together so bringing the team together and getting them working together and establishing leadership was more helpful in subsequently establishing the transfer of services. She added too, that the building work at HUHFT would not be delaying any matters regarding the partnership.

(d) In response to a question on why the partnership was with Lewisham and Greenwich rather than with Barts and BHRUT, TF stated that BHRUT had been content with their own arrangements and the pathology network discussion had

begun three years previously and so they did not feel they needed to join the HUH-Barts-L&G arrangement.

(e) The Chair stated that the people of Hackney were proud of HUHFT and stated that any loss of independence for the Trust going forward would be met with much local resistance. He asked if there were any board level discussions at HUHFT about any possible merger of governance with Barts-BHRUT. TF replied there weren't any discussions about merging with Barts and that she would have concerns about that. Currently she added HUHFT was in very robust state but both Barts Health and BHRUT needed to resolve a number of internal issues for them and coming together was a way for them to achieve that. She added that Barts-BHRUT acknowledged that the City & Hackney system was further ahead in terms of place based care and they wanted to follow this model.

7.6 The Chair asked TF to undertake to return to the Commission if anything new was floated in terms of the future of HUHFT as they would want to scrutinise the potential local impact in good time, because Members would not be happy if changes were presented as a fait accompli. TF replied that she would and that she would also ensure that the leadership within both Barts Health and BHRUT were made fully aware of City and Hackney's views and considered them too in their deliberations.

7.7 The Chair asked if the Trust could reply to the Commission on the numbers of first and second doses of the Covid vaccination had been given to staff at the Trust.

ACTION:	**TF to report back on number of first and second doses of the Covid vaccinations given to staff at HUHFT.**

7.8 The Chair asked Dr Mark Rickets (CCG Chair) about a local press story, highlighted to him by Healthwatch, on GP Practices asking for ID before allowing people to register and what was being done about this unwarranted barrier to access. MR replied that he was not aware of the story, but the regulations were clear that you do not have to present ID to register with a GP.

8 Treatment pathways for Long Covid

8.1 The Chair stated that the Commission had asked for a briefing on Long Covid following concerns raised by residents.

8.2 Members gave consideration to a briefing report '*C&H Rehabilitation Service and HUH post-Covid Specialist Assessment Clinic'* and he welcomed to the meeting:

Dr Fiona Kelly (FK)**,** Head of Adult Therapies, Division of Integration Medicine & Rehabilitation Services, HUHFT
Charlotte Painter (CP), Acting Workstream Director for Planned Care, NHS NEL CCG for C&H Integrated Care Partnership
Dr Mark Rickets (MR), CCG Clinical Chair for City and Hackney
Siobhan Harper (SH), Director of CCG Transition for City and Hackney

Helen Woodland (HW), Group Director Adults, Health and Integration, LBH

and he added that that report contained estimated figures vs total figures and so was not fully up to date.

8.3 FK and CP took Members' through the briefing in detail, concluding that it was now necessary to treat Long Covid as a new Long Term Condition (LTC) which would stay with us. She added that the data slide contained estimates and needed updating but that there had been a spike in referrals in March arising from a rise in cases in January. She drew members' attention to slide 5 which highlighted all the resources created to help people manage their condition. FK described the clinical aspects of Long Covid and the patient pathway via GP referrals, then clinical triage and then directly to assessment in community or at HUH. She stated that they had 300 referrals to date across the service and 95 assessments in clinic and 40 in community service. A lot of out of area referrals had to be redirected. She stated that they tracked ethnicity which highlighted some gaps and so they were doing proactive case finding with the help of local VCS orgs. The symptoms of long covid were wide ranging but usually involved persistent fatigue and breathlessness which have a long terk impact. One of the risks was of people attempting to do too much too soon and getting worse. She described the diverse multi-disciplinary team across physical and psychological services at the Centre and the use of digital tech to support patients. CP stated that building a sustainable service was now the focus and that there was a need for more awareness raising and engagement and a need to monitor demand and presentations in order to better plan ahead. A Clinical Fellow post across NEL had been created to keep on top of the evaluation.

8.4 Members asked detailed questions and the following responses were noted:

(a) Chair expressed concern about people having to wait 12 weeks and asked whether the NICE guidance had got this right. FK replied that a large number of patients the condition would resolve itself in the post-acute phase therefore the focus was on getting the timing of the support right. Initially the approach was self-management by signposting to the comprehensive interactive guidance which is available. She added however that they were flexible on earlier referrals but it was very challenging to choose when the cut-off point must be.

(b) Members asked about how the Clinic worked, if at all, with those with complex medical diagnoses who had been kept in acute rather than covid hospitals and presumably this cohort would not have a 12 week wait. FK replied that there were established processes. There is clinical triage so if it is decided that a person is better supported though a known pre-existing LTC pathway and if they are already well known to those teams then they would be redirected to them. The clinical conversations take place in a Multi-Disciplinary Team. The logic in standing up some standalone capacity was essentially that this is a new LTC. If these patients had been badged in the normal way, then the system would have run the risk of being overwhelmed at a time when specialist staff were being redeployed to deal with Covid front line and so waiting times to support those with long Covid would have been even longer. It's about how we support and understand the current need while looking to

the future and how we will be able to integrate it into current range of services, she added. CP added that the team was strongly linked into the relevant specialities and can seek advice so that aspect is working well.

(c) Members asked if there had been any asymptomatic cases of Covid dealt with in the Clinic who then presented with symptoms later on. FK replied she didn't think there were. CP added that severity of initial presentation is not necessarily linked to long Covid and it's not a predictor.

(d) Members asked about two distinct cohorts: people who have been through life threatening illness in intensive care and still haven't fully recovered and others who are appearing later on with alarming symptoms, and who are often younger. FK replied that those who had a very serious illness requiring acute critical care are followed up on via a different care pathway post ICU and many of those end up in patient rehab. The other cohort is people presenting via the Single Point of Access and these are less likely to have required an acute admission but have recovered with support in the community and now have debilitating and long-term symptoms. She added that the age of this cohort is on average, 44.

(e) Members asked about how to promote healthy lifestyles to those who for various reasons haven't taken the vaccines and if this has been considered e.g. how to keep safe, having regular tests etc and on the follow-up post discharge from acute services. FK replied that across all services they make every contact count and provide information and education to make informed choices as part of recovery e.g. looking at nutrition, sleep etc. As for follow-up on hospital discharge, this is on a needs basis as they can't provide a preventive follow up for everyone regardless of need.

(f) The Chair asked about the communications strategy around this clinic/service because for those who got Covid in first wave the system was not in place then. CP replied that they were planning to do proactive contact via GP Practices to patients registered with a code of either 'Covid' or 'suspected Covid' and this speaks to the health inequalities issue about missing out on those who haven't presented. This is a large number so there will need to be a staged approach. She added that more culturally competent Communications and Engagement via community groups and VCS partners for example was very important and she would appreciate input from Members and residents on how to do this best. The Chair suggested that perhaps they needed to join up efforts with the vaccination teams as both encouraging vaccine take up and outreach on long covid are both needed at the same time. SH described the vaccination efforts using community champions and the VCS and the Chair asked if these details could be passed on to this clinic so that they can use it for outreach work.

(g) The Chair asked about education and training for GPs and CP replied that they had done a lot of it from early on. In the first wave patients were presenting and GPs were not fully sure what to do with them before this service had been set up. They had produced a resource pack with the self-management resources for the GPs to distribute to those presenting. The take up from GPs has been excellent and the process is ongoing and evolving all the time are more is being learnt.

(h) Members asked if someone presented with long covid do you do an antibody test and can you have long Covid without evidence of that in the first place. FK replied that they accept people into the service who have been clinically diagnosed as a presentation of Covid (and this was not an easy task early on in the pandemic). They were not routinely doing antibody testing but basing it on clinical assessment within primary care. MR concurred saying that it's based on clinical assessment at primary care stage and an antibody test isn't a gatekeeper.

(i) Jon Williams asked if Healthwatch can be involved in the development of the service and further about what has been done about identifying people with pre-existing disabilities, because the disabled have been one of the worst impacted groups with Covid, and whether the clinic has been in contact with Adult Social Care in terms of contacting the Homecare service users because of the high levels there. CP replied that they certainly wished to ramp up engagement work with Healthwatch. On disabilities data, she was not sure but the point on closer collaboration with ASC was well made and they would pick this up as part of their proactive searches on identifying cases. FK added that in setting up the service they did a clinical audit of all those with pre-existing LTCs to understand the issues, the need and the required configuration. They were also able to access people's clinical records who were referred to them so they would be able to easily identify those with disabilities. She stated that they would take on board the suggestion that this one of the markers in the regular stats reporting in future.

8.5 The Chair thanked the team for their excellent work and for attending the meeting. He stated that it's something that they would keep a watching brief on and would like to return to at the appropriate time.

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

9 Community Mental Health transformation and recover from Covid-19

9.1 The Chair stated that he had asked ELFT, our key mental health provider, to provide an update on the status their services as a consequence of the lockdowns and the subsequent need to redesign their crisis care pathways and adapt to a mix of face to face and remote access consultations. He welcomed for the item:

Paul Calaminus (PC), Chief Executive, East London NHS Foundation Trust
Andrew Horobin (AH), Deputy Borough Director City & Hackney, ELFT

and Members gave consideration to two papers: '*ELFT adult mental health services'* and *'Community mental health transformation'*.

9.2 AH took Members through the papers. It was noted that while initially during lockdown there had been a huge reduction in usual contacts, calls to crisis line had doubled and most were not known to mental health services. The community crisis service had continued with 100% home visits during the lockdowns. There had also been a spike in calls to Children and Young People's Services during lockdown. As regards the Transformation

Programme, the 8 x Neighbourhood Teams were now in place and fully blended teams would be operational by September. The blended teams were bigger as they included representatives from the local VCS, Turning Point, Tavistock & Portman Trust etc and so a more diverse offer could be provided. He described the role of the Community Connectors created with the VCS to help counter social isolation in the community and how they were working with Healthwatch to gather views on the temporary move of older adult mental health wards to the East Ham Care Centre. PC described the importance of the community model going forward and pointed out how the referrals predominantly related to issues also around housing and employment etc. The Chair thanked the officers and added that a general concern down the years had been about gradual reduction in bed capacity locally and Members would want to keep a closer eye on that.

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

(a) Members asked about a court ruling which now required 'hospital manager hearings' (hospital-based assessments) in mental health be done face to face instead of remotely. PC replied that all assessments were now being done face to face and they had had to contact those who had had remote assessments (in this context) and repeat them.

(b) Chair asked how ELFT saw its services evolving in post-Covid world, considering the increase in the number of crisis calls and, on the switch to video consultations when preferred and appropriate. PC replied that going forward the service would be a much more blended one. Face to face was important particularly for first assessment. They had also discovered that for certain types of therapy work remote consultations had worked really well with clients who, for example, were able to stay at home and in familiar surroundings. AH added that early interventions teams and those working with young people had really embraced digital. They had to be mindful of course about digital poverty. A lot of work had been done to devices to people and to then make sure people were able to use them. The advantages of remote services include that staff can communicate with clients much more quickly and easily but face to face will still be vital when there is a need to establish an initial rapport with the client and when staff need to see the living conditions of a client. PC added that they were working hard on re-designing the hybrid model together with service users.

(c) Members asked whether the 'pioneer sites' were coterminous with the PCNs. They asked whether 'community connectors' and 'social prescribers' were employed by ELFT and what is difference was and they asked how ELFT will take on board the importance of providing training and support to Estates Officers in Housing as so much of their work is taken up with supporting tenants with mental health problems. AH explained the timeline for putting mental health teams fully in place in the 8 PCNs which are coterminous with the 4 Neighbourhoods. The Neighbourhoods (each covering 2 PCNs) had been brought in one at a time. They also involved Community Mental Health Recovery Teams. The Community Connectors were subcontracted to the VCS and were provided by Mind who employ them. The difference with 'social prescribers' is that the 'community connectors' also do therapeutic interventions themselves and "walk beside the user" as it were, going to appointments with them if needs be. In relation to support for Estate Officers, AH agreed that social determinants

were the key and they have regular meeting with Housing who, for example, join in 'ward discharge' meetings but they have not, as yet, done direct training for them. He added that they needed to work more closely and this was something they could take forward.

(d) Members asked how the Neighbourhoods system worked with both IAPT and the Wellbeing Network. AH replied that ELFT chairs the Psychological Therapies Alliance and all the partners were on that. They are working on getting IAPT reps into the Neighbourhood meetings also. He added that it was challenging as IAPT has a different provider. The Wellbeing Network operated by Mind hosts the 'Community Connectors' so they meet with them regularly also, he added.

(e) The Chair asked about the wider discussions which have been ongoing about the Estates Strategy and previous plans to move mental health beds from HUH to create more surgical capacity there, and also the creation of a more specialist mental health hub at Mile End and asked whether the move of the older adult 'organic' mental health beads to East Ham Care Centre was part of this. PC replied that the older adults move was not related to that broader Estates work it was rather an urgent requirement for a short term move in order to make the site at Mile End Covid Secure at the height of the pandemic. The putative plan from two years ago on estates hadn't progressed since the pandemic, he added. There is a discussion that needs to take place on creating an in-patient estate that works much better for residents of Hackney and there is a need to renew the current provision and re-build because, he added, some of estate in Hackney still has, for example, shared bathrooms.

(f) A Member asked whether there were any ID access barriers to accessing mental health services (further to concerns about ID being incorrectly demanded for GP access). PC replied that there weren't.

9.4 The Chair thanked the senior officers for their detailed reports and giving their time to attend. He stated that the Commission would want to return to the broader issue around estates for mental health services in the future. He commented that the evidence base for mass consolidation was a contested one and the dynamics were actually more complicated, and he asked PC to keep the Commission updated.

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

10 Redesign of specification for the Homecare Service

10.1 The Chair stated that he had asked Adult Services for a briefing on the work being done to redesign the specification for the provision of Homecare services which, was about to be completely re-commissioned. The specification was being developed as was the plan for co-production and engagement with residents on the re-design of these services. He welcomed for this item:

Helen Woodland (HW), Group Director Adults Health and Integration

10.2 Members gave consideration to a report '*Homecare recommissioning – update report'.*

10.3 HW took Members' through the report highlighting moving to 2 or 3 areas in a Neighbourhood model would give the Providers some economy of scale combined with a geographical patch to focus on.

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

(a) Members asked what's the difference between zones, patches and neighbourhoods. HW replied that patches or zones were how you configure the service geographically around the 8 Neighbourhoods (created by the PCNs). The plan was for 2 or 3 zones/patches.

(b) The Chair asked how you might in-source this whole service and what the barriers would be to doing so. HW replied that cost was the key barrier to insourcing as to deliver homecare as an in-house service was estimated at £28.50 p/h compared to an estimate of £18 p/h when purchased externally. It would add £4-5m per year to the Adult Services budget and they would have to find that money elsewhere in efficiency targets etc. She added too that one of the duties on the Council under the Care Act was to "maintain and promote a stable market".

(c) The Chair asked what contributed to the difference because surely a private provider also had to factor in a profit margin. HW replied that it was mainly the pension obligations which add the additional £10p/h.

(d) Members asked about the cheaper costs paid by councils being supported by the private payers and wondered if the whole market in care was distorted by those who paid privately. HW replied that broadly that situation applied only to care homes but not to Homecare, where the vast majority was purchased by local authorities. The private element there was specific agencies linked to self-funders not individuals purchasing themselves.

(e) Members stated that with in-house there was likely to be greater continuity of care and a better and more secure employment model. With councils having to bail out individual providers on occasion was it not time to set up an in-house Homecare service to serve as quality barometer for the sector against which other services could be measured and which would serve as a back-up if any providers failed? HW replied that the issue of councils' role in quality was an interesting and complex one. One of reasons for moving to a zone-based model was that they'll have fewer providers to work more closely with and that it allows the council to develop stronger relationships and deliver more training and support to staff. They could, for example, work more with staff in the Providers to support them to develop Occupational Therapy Assistant qualifications, enabling them in turn to deliver over and above the current offer they provide. She added that Adult Services also wanted to work with health partners on what tasks Homecare providers could deliver which was currently being delivered by Community Nurses, in order to achieve better continuity of care. In terms of stability of employment, she added, they were signed up to the Care Charter and they worked with providers to reduce the amount of zero hours contracts. They would be better able to do that if providers were given more

consistency of work and hours and so better able to plan their workforce and offer better conditions. There were a number of ways to achieve these aims, she concluded.

(f) The Chair asked if you're signing up for 2 contractors the risk is that you don't have the multiplicity of choice you'd have with 8 contractors and what was the duration of the contracts. HW replied that the standard was 5+1+1 yrs but they can also terminate if poor quality. She added that they also have an Approved Provider list which is a back-up list of providers that meet their quality standards. Because of this, if a resident in a zone/patch doesn't want to work with either of the 2 homecare providers allocated to it, they can be offered an alternative. This gives the ASC team a group of providers they can support and develop should there be any market failure.

(g) The Chair asked whether the budget envelope for the re-commissioning was the same as the previous level of funding. HW replied that it was but that they were a demand-led service so the budget envelope had to adapt to fact that care must be provided to anyone who requests it and is eligible under the Care Act. Because of this the development of more preventative work and working with partners in Neighbourhoods was vital in order to help ASC manage that demand going forward.

10.5 The Chair thanked the Group Director for her detailed report and for her attendance.

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

11 Covid-19 update from Public Health and Vaccination Steering Group

11.1 The Chair stated that this item had been planned as 'for noting' but because of the developments he had asked if officers would answer some questions and he welcomed to the meeting:

Chris Lovitt (CL), Deputy Director of Public Health for City and Hackney
Siobhan Harper (SH), Director of CCG Transition for City and Hackney
Helen Woodland (HW), Group Director Adults Health and Integration

11.2 Members gave consideration to a tabled report *City and Hackney Covid-19 vaccination programme*

11.3 The Chair stated that the latest data was troubling because Hackney appeared to be up 200% in a week and there had been a tripling of case numbers to 43/100k.

11.4 CL took Members through the briefing in detail. He stated that the numbers were headed in the wrong direction, but this was to be expected as soon as social distancing measures were relaxed. The Delta Variant was now the most dominant and was more transmittable. The vaccination programme was rolling down the ages but in NEL overall they were 330 vaccinations behind plan, however and work was being done on surge vaccination events. A lot of

activity was taking place and the message to test was being pushed heavily. Hopefully, the planned opening on 21 June would not take place he added. London was different from elsewhere and a key concern was that there were still 70k clinically extremely vulnerable people unvaccinated. Most of the new infections were among younger age groups. If the R rate, which was now above 1, remained there they would soon see unvaccinated people presenting in the acute hospitals.

11.5 Members asked questions and in the response the following was noted:

(a) The Chair stated that whereas nationally 76% had their first dose and 53% had their second, in Hackney just 23% had both and 45% had one. We appeared to be the lowest in the country together with Tower Hamlets and we could be one of the worst hit places if there was another wave. He asked if this was too pessimistic a view? CL replied that the plan had been to vaccinate those most at risk first recognising the limits on supply. He cautioned that it was not always possible to make clean comparisons as you need instead to look in particular at how the cohorts 1-6 are faring. He added that Hackney has had lower numbers overall as our population is younger and our uptake isn't as good as it could be because of vaccine cautiousness in a number of local communities. He went on to describe the phenomenon of 'crowding out' of the vaccination slots as you opened up to younger cohorts and that this prevents getting the earlier cohorts fully covered. Because of this Hackney had run low threshold events where you can just walk up and get vaccinated. He also explained how Community Pharmacies and HUH will help with the surge vaccinations. He concluded that the headline figures can hide the real priorities and the real concern is the 17k unvaccinated who are older and Clinically Extremely Vulnerable. SH went on to describe the plans to mitigate any possible third wave and the need to give out specific advice and about trying to reduce the vulnerable cohorts. It was difficult to keep focus because, as you open up, the next thresholds and huge volumes of people then become eligible, those more vulnerable who are still not vaccinated but in higher up cohorts can get squeezed out.

(b) Members commented that carers are possible vectors of transmission as they often can have multiple vulnerable clients. The vaccination level for domiciliary care staff was still far too low (37% one dose, 6% two). Members asked how the officers plan to target that part of the population so they too don't get lost in the rush. CL replied that domiciliary care workers were at front line and have been eligible since the beginning and sometimes the national messaging focused almost exclusively on NHS to the detriment of care. A significant element of staff were from ethnic minority groups with a high degree of vaccine cautiousness amongst them. They had been successful by taking a clear focus on older adult care homes to get vaccination rates up in those. They'd identified that they wanted to double the vaccination coverage for all care workers. There was a need to understand better where the barriers lay and potentially start incentivising the providers so they would pay from time off for staff to attend vaccination centres. He added that staff would often be younger so there was a need to make sure the Pfizer offer was available for them. There was a need to do engagement sessions with the staff and he had done Q&As with 'provider forums' as part of this. It's about taking the vaccines to these staff and making it as easy as possible for them. This work can involve more use of the Community Pharmacies and using the mobile vaccinations service. He added

that there was a lot of evidence from flu vaccination programmes that you have to keep on it, and you have to have a clear aspiration and clear metrics and to work to encourage and cajole the providers. He added that the news that the government was considering making vaccinations compulsory for care staff would not help in his regard as it played further into that narrative of an overbearing government. There was a need to improve here and they are also looking at pockets of best practice from elsewhere within NEL. HW reinforced what CL said and stated that they were very aware that Homecare is not where it should be on this. They had just employed a Project Manager specifically on it and were trying a number of different approaches. There were multiple and complex reasons why people were vaccine hesitant and it takes a lot of concerted effort.

(c) Members asked about the surge testing in Dalston and Shoreditch. CL replied that this had now concluded. He added that one of the really welcome changes was that all positive PCR tests in London were now being sequenced for variants of concern testing. He added that now that they had concluded the surge testing they were awaiting the results and for the variant of concern mapping it does take a number of weeks. In the two weeks since the Dalston testing, the delta variant had become the dominant one across the UK, so all new cases were now assumed to be delta variant. Things were moving fast and that is why they were asking for caution and hoping the planned reopening on 21 June would pushed back by at least 2 weeks. CL concluded by stressing the importance of the second dose and that it would be the key communication message in the next 10 days.

11.6 The Chair thanked the council and NHS officers for all their efforts here and for the excellent updates.

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

12 Minutes of the previous meeting

12.1 Members gave consideration to the draft minutes of the meeting held on 31 March and the Matters Arising.

RESOLVED:	**That the minutes of the meeting held on 31 March be agreed as a correct record and that the matters arising be noted.**

13 Health in Hackney Work Programme

13.1 Members gave consideration to the updated work programmes.

RESOLVED:	**That the Commission's work programmes for 21/22 and the rolling work programme for INEL JHOSC be noted.**

14 Any other business

14.1 There was none.

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