Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Thursday, 9th July 2020

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Patrick Spence and Cllr Kofo David**
Officers In Attendance	**Denise D'Souza (Interim Strategic Director of Adult Services), Dr Sandra Husbands (Director of Public Health) and Mario Kahraman (IT Programme Manager)**
Other People in Attendance	**Councillor Christopher Kennedy (Cabinet Member, Health, Social Care and Leisure, David Maher (MD, NHS C&H CCG), Councillor Yvonne Maxwell (Mayoral Advisor for Older People), Dr Mark Rickets (Chair, NHS C&HCCG), Councillor Carole Williams (Cabinet Member for Employment, Skills and Human Resources), Jon Williams (Director, Healthwatch Hackney), Naomi Byron (HUHFT UNISON), Michael Etheridge (Area Organiser, UNISON), Lola McEvoy (Area Organiser, GMB), Thomas Nettel (Director of Workforce and OD, HUHFT), Lorna Solomon (HUHFT Unison), Phill Wells (Director of Finance, HUHFT) and Councillor Michelle Gregory**
Link to YouTube recording of meeting:	https://youtu.be/zA21cOIB-NQ
Members of the Public	**112**
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 There was an apology for lateness from Cllr David.

1.2 There was an apology from Tracey Fletcher (CE of HUHFT).

2 Urgent Items / Order of Business

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

3 Declarations of Interest

3.1 There were none.

4 Homerton Hospital and its contract for soft services

4.1 Members gave consideration to the background papers for this item: a letter from UNISON with the original request to consider the item; the letter from the Chair to the Chief Exec of HUHFT raising the Commission's concerns; and her response.

4.2 The Chair welcomed for this item:
Phill Wells (PW), Director of Finance, HUHFT
Thomas Nettel (TN), Director of Workforce and Organisational Development, HUHFT
Michael Etheridge (ME), UNISON Area Officer
Naomi Byron (NB), UNISON rep at ISS
Lola McEvoy (LM), Regional Organiser for NHS, GMB union

4.3 In opening the discussion the Chair congratulated HUHFT on receiving its recent rating of 'Outstanding' from the CQC. This was echoed by all Members. He added that while everyone was immensely proud of the Homerton, and justifiably so, this didn't mean that there were areas where the Commission would provide some challenge and holding to account. He asked all present to be respectful of others views in what was a contentious item.

4.4 The Chair provided an outline of the ISS contract issue. The Trust had outsourced its soft services (catering, portering, cleaning, security) to ISS and there were about 200 posts involved. The contract was up for renewal in Sept and HUHFT had decided to seek a new 5-year contract with ISS. Concerns had been raised about the length of this sudden extension and a lack of adequate consideration of possible in-sourcing options, although it was understood that with a contract this extensive HUHFT could not move quickly to in-sourcing. There has been concerns about the Equality Impact Assessment and the handling of the VEAT process. VEAT stands for 'voluntary ex-ante transparency notice', which would allow a new contract to be awarded without the usual going out to tender and was utilised because of the current emergency situation due to the pandemic. There had also been concerns about the lack of occupational sick pay for about half of the 200 workers who had joined ISS since 2015 (the balance having been TUPE'd from a previous contract). Those joining since 2015 don't receive any sick for the first 3 days of absence and on day 4 onwards only receive Statutory Sick Pay which is £92 per week. They would otherwise earn c. £80 to £100 a day, representing a substantial reduction in their take home pay. There also had been concerns about the fact that those with Covid-19 were likely to be coming into work while ill because of the sick pay situation. It was noted that 72% of that 200 strong work force were from ethnic minority backgrounds and so were disproportionally affected by Covid and the broader concern was that by signing this contract extension HUHFT was seen to be locking-in the existing

disparities. The Chair stated that each invitee would make opening remarks and there would then be a Q&A.

4.5 Michael Etheridge (Area Organiser, UNISON) made the following points in his opening remarks. The extension of this contract would be devastating for these staff and they felt a betrayal of trust by the NHS Family in the middle of a pandemic. The unions had been lobbying for months on the issue and generally opposed such outsourcing because it was bad for workers and the community, it drove down the Terms and Conditions, created casualisation of the workforce, intensification of work practices, lower pay and terms and conditions which often resulted in a cutting of corners on safety. Staff retention rates were lower for outsourced workers because of the poor terms and conditions. Outsourcing created a 2-tier workforce, it led to very low morale as the workers felt they were treated as 2nd class citizens. He added that the fact that the majority of the workers involved here were from BME backgrounds had made this all the more shameful in the current context. The workers involved were responsible for stopping the spread of the infection in hospital, they were essential front-line workers and their contribution was no less valuable than that of Trust staff. He added that ISS had made hundreds of millions of profits last year, they didn't generally pay proper London Living Wage. They only paid for a period and then rates had fallen behind again with the result that many staff were owed thousands in back pay. He concluded that renewing this contract would be an endorsement by the Trust of this 'immoral purpose'.

4.6 Lola McEvoy, GMB organiser for the NHS and contracted out workers in London, made the following points in her opening remarks. The key issue here was the timing and the process, and the fact it was wholly lacking in any public or official scrutiny. They also had major concerns about the legality of the use of the VEAT process in this instance. The process demonstrated a disrespect for the workers and would result in locking them into 5 more years of poverty inducing terms and conditions and she asked what did this say about us as a borough and how much we really valued these people when it came to it. There were also serious concerns about the disproportionate impact of Covid 19 on BME workers in the NHS and why anyone would want to extend the contract against instructions of trade unions at national level was puzzling, she added. There were going complaints about ISS nationally on bullying and harassment. Refusal to pay sick pay to those with serious illnesses and those self-isolating because of Covid 19 was a disgrace in her view. She stated that ISS did have an occupational sickness pay but had refused to pay it and had told some very ill people that they'd only get SSP. This represented a 70% cut in real wages after 3 days. ISS was in her view and irresponsible employer. She added that the union had taken legal advice on the decision to use the VEAT process and had been advised that VEAT could only be used in very specific circumstances if there were absolutely no problems whatsoever in the contract. The only reason you can extend was if the contract has been almost perfect and both parties were totally supportive of the performances of the provider. This was not the case here, she added.

4.7 Naomi Byron, UNISON rep at HUHFT, made the following points in her opening remarks. The Covid 19 pandemic had reminded us all what workers really were essential. UNISON had had to fight really hard to negotiate sick pay for those self-isolating and shielding. Staff had been called in to hearings for taking sick leave whilst self-isolating. Outsourcing entrenched the structural

inequality which existed and this was why her union opposed it. Outsourcing itself was a mechanism of structural inequality. 70% of the affected staff here were BME and keeping them in low paid jobs with few opportunities for progression only further extended that inequality. These workers were at increased risk and received less reward. They deserved the same dignity and respect as their white colleagues and this situation was an opportunity for HUHFT as a Trust to show the Black Lives Mattered. She added that older workers were disproportionately affected by outsourcing as was the case here. Gender inequalities too were entrenched because of these contracts and for example in this case 80% of cleaners were women and 85% of the security staff were men. While she understood that continuity of such a key contract for soft services at this difficult time was vital, it nevertheless should not be achieved at the cost of the poorest members of the workforce. The Trust stated it was under financial pressure, but it had also of late shown healthy surpluses year on year, she added. What UNISON was asking was that the existing provision be given a short extension so that the parties can fully explore in-sourcing options and they wanted to see parity of terms of conditions of ISS staff with the Trust staff.

4.8 She later added that when management pointed to the excellent results delivered by ISS they were referring to these same staff whom they refused to bring in-house. She explained how Covid-19 self-isolation pay had been a problem. Initially it had not been paid to ISS staff and it took over a week of begging to rectify this, which had scared some staff about the possibility of not receiving it in future. She added that UNISON had been told since then of staff with Covid-19 symptoms coming into work because they were scared that they wouldn't get paid. UNISON had also been told of staff off sick for several weeks with Covid-19 symptoms being told they wouldn't get self-isolation pay for the whole period, and feeling pressured into using up Annual Leave to make sure they didn't lose pay while off sick with Covid or Covid symptoms. UNISON had been told there was a 3 week limit on self-isolation pay for ISS staff. She added that the union's view was that there was a long-standing culture of bullying, and of short-paying, in ISS at Homerton. Some staff were so scared that they wouldn't even let UNISON approach payroll to sort these issues out. The Trust kept telling UNISON that they were not receiving enough proof of alleged bad practices, however by announcing that they wanted to give ISS another 5 year contract, UNISON believed that the Trust had made ISS staff even more fearful of coming forward. Staff had told them that they felt betrayed, abandoned and undervalued. She wanted the Trust to listen to their staff and show that they valued the vital role ISS staff played by establishing equality i.e NHS pay and conditions for NHS work. The simplest and cheapest way to do this would be to bring staff back in-house, she concluded.

4.9 Chair asked the HUHFT reps to respond and in particular to address: why they were not opting for a shorter period to allow insourcing to happen; what was happening with occupational sick pay; what about the use of VEAT process, and the racial disparity with respect to 72% of staff being from ethnic minority communities.

4.10 Phil Wells (Director of Finance, HUHFT) thanked all for the recognition for their CQC 'Outstanding' rating. He thanked the unions for the dialogue they were involved in. Soft FM services had been outsourced for many years and would expire in Sept and the Board had agreed a 5-year extension using VEAT Notice

which set out the rationale for the extension. This decision reflected the general uncertainty in soft FM market and general uncertainty in the economic fall-out arising from leaving EU and the devastating effect of Covid crisis. The most important thing was to ensure continuity of vital soft FM services which ensured a clean hospital and safe working environment. ISS played a key role in achieving the CQC Outstanding rating because their service standards particularly during the pandemic had been exceptional as all technical audits had made clear. The MRSA rates at HUHFT were some of the lowest and they were very proud of that. They had been negotiating the contract with ISS for a considerable period and it would largely be like for like. There would be a small number of changes of commercial and technical nature. Two fundamental issues had not been addressed – sick pay and LLS uplift and they were very keen to progress these and they were optimistic that would reach agreement on these. He added that they were within touching distance but couldn't say more as the negotiation was ongoing and they were completely determined to have a negotiated contract with ISS that would recognise their valued contribution.

Tom Nettel (Director of Workforce and Organisational Development, HUHFT) described the extent of the discussions. There were meaningful disagreements with union colleagues and he acknowledged the concerns articulated. He wanted to make clear that any concerns unions had could be raised with them and that they could also raise general themes and HUHFT management would actively pursue these with ISS and examine them in detail. He stated that a month previously a detailed response had been sent to UNISON on issues which had been raised including pay and pay dates and the processing of annual leave. ISS's responsiveness had improved considerably in recent times and they have a meaningful and active dialogue. There were not in agreement about how often they'd talked but they had responded proactively and they remained in active discussion with union colleagues.

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

(a) The Chair stated that 100 staff were affected by the old contract which allowed for proper Occupational Sick Pay therefore the focus was on the other 100 not covered. He understood HUHFT's sickness absence rate was 3% prior to Covid and had calculated that for this group of ISS workers the additional cost to the Trust of providing full sick pay to this cohort would be c. £80k to £90k out of a turnover of £250m. Some of the cost would be reclaimed from statutory sick pay. Bearing in mind levels of disparities here he asked why can't the Trust say to ISS that they're happy to pay the extra cost. PW replied that it was very difficult to answer in detail at this time as they were in the middle of a negotiation with ISS. He stated that the Chair was a little out on his financial assumptions and the cost would be a bit more and of course this seemed small considering the large revenue base. HUHFT's revenue was £340m but the Trust overall was a breakeven trust. Their revenue position was supported by Provider Sustainability Fund which involved bonuses given to Trusts for meeting specific targets. They were now a 'break-even trust' so that whatever they added to the cost base will provide a challenge in how to funded it and the money would need to be found in efficiencies elsewhere. He stated that the Chair was correct that ISS would simply charge the Trust for the additional costs. There were a range of commercial aspects that they could build around the negotiations. He explained too that the system of refunding SSP had been abolished in 2015. The government no longer refunded organisations but rather required them to have their own system in place. He concluded that the

deal they strike recognised the efforts ISS have put in to supporting the Trust during this very challenging time.

(b) Members asked for clarity on whether the contract had been signed and when doing the EIA whether they were signing up workers to something that might put their health at risk.

PW replied that a contract of this scale had to receive board approval before it could be signed and they were working on bringing it to the 29 July Board meeting. TN added that there was a need to ensure that the elements which affected the workers be agreed first then EIA would follow after. Members asked if the Board would see the EIA first. TN replied that yes it would form part of the discussion at the board. Chair asked if it was public or private. TN replied that this had not been decided yet and they would review this. He was clear that the final discussion would be, partly at least, in public.

(c) Members commented that if NHS Nightingale had been built so quickly why could this not be dealt with as quickly. They added that the letter from the Chief Exec of HUHFT had stated that insourcing was only being explored "over the medium term" and stated that they and many residents could not accept this.

TN replied that it was important to understand that NHS Nightingale had been a significant extra cost to the NHS and was totally unprecedented. Any undertaking of that scale was something they would not be able to do. He had examined another Trust which was pursuing insourcing at pace and it was clear circumstances there were meaningfully different to those at HUHFT. Their services had objectively delivered to an excellent level. PW added that there was no ideological opposition to insourcing at HUHFT. What NHS had miraculously done around NHS Nightingale was of a different order, HUHFT instead would be expected to deliver within its existing cost base and would have no additional support. He added that they had once chance to bring services in-house and if they got it wrong there would be not interim coverage so they had decided to take their time to do it carefully over next few years and involve a number of stakeholders. It's not a 'no' forever he added but they need to explore options in detail. He gave the example of Waste Management. They do not have and cannot build an incinerator on site so that could never be insourced. They wanted to use the next few years to examine all options open to them. The Chair asked why not a 2 yr break clause and PW replied that it would be insufficient time as it would mean going out to market in just 12 months' time. The Chair asked about a break clause in years 3 or 4 and PW replied that this would result in a much higher price in the contract.

(d) Members asked about the consultation process and on the timing of the EIA vis-à-vis the contract e.g. what if there were worrying findings in the EIA and what remedies would then be open to the Trust. Members also asked about a 3 year break clause if 2 was not achievable, adding that the cost savings should not be at the cost of workers rights.

TN replied that he was confident they would reach an agreement in the coming weeks. He would ensure the EIA was done before signing the contract and would speak to them again before if necessary. He added that he was not aware in his professional experience of the need for any formal consultation with unions before this type of contract was signed. The areas where they

were close to agreement had arisen exactly from the dialogues they'd had with UNISON and GMB and their views have been considered and they have had influence. This doesn't necessarily mean that it covered everything discussed and there were some key areas that they were addressing further with ISS. The Chair stated that surely ISS would have built in 15% profit margin and wouldn't that offset costs. PW replied that any break clause was priced in as risk by the outsourced agent. Any increase in the cost of contract would have to be found within cost base at HUHFT. He added that this contract wasn't a case of sign it and then let ISS do what they wanted. It's at Tier 3 contract and so had most significant level of scrutiny as well as contractual KPIs and even some open-book access to what is going on within ISS. The contract would be very tightly managed he added. One area they were insisting came to future performance meetings with ISS was sick pay as well as the other issues raised by the unions.

(e) Members asked what efforts HUHFT had taken to reach out for external advice on the insourcing aspects and why couldn't the contract be staggered so as to have the option of being more flexible. They added that it was vital that the EIA be done and the comment was made that HUHFT was rushing too fast.

(f) Members commented that if a full risk assessment of this contract had been done it would have identified the risk to Hackney residents, many of whom were very concerned about the risk of extending a contract which doesn't provide satisfactory sick pay to frontline health workers. They added that this contract renewal wasn't a surprise so why hadn't it been properly planned two years in advance and by doing it now didn't it put the Trust in a more difficult negotiating position. They asked if perhaps a short-term extension even be considered even if it costs more to allow time to properly explore insourcing as an option.

PW replied that the reason no contact had been brought to the Board was because they didn't feel they yet had a contract with dealt with the issues being raised. The negotiations were to address exactly the point being raised so that the risks were not ignored in the future. In terms of the efforts to seek external expertise on insourcing, they did do this. It was their intention to look at the future of this contract over coming months and years so that they have fully worked up proposition for the Trust. If they got it wrong there would be a considerable cost so getting it right first time was of paramount importance.

The Chair reiterated about why discussions hadn't begun two years previously. TN replied that he had talked to another Trust and they had learned a lot from their attempts to insource at pace. The situations were not comparable however. He added that they had an incredibly robust process for managing risk in HUHFT. The unions had raised a number of concerns and they had taken time over these but the work had then been delayed by the Covid crisis. They had provided a detailed response to the unions. There wasn't sufficient evidence to justify not proceeding with extension when it was necessary. There was best practice management with a range of KPIs in place and there they had examined a range of evidence to meet the standards the Trust had set for themselves.

4.12 The Chair drew the item to a close and thanked all for their participation.

ACTION:	**HUHFT officers to provide a briefing to the Commission, once the contract with ISS has been signed, to address what further progress had been made particularly on London Living Wage uplift and whether parity with Agenda for Change pay scales has been achieved and on the payment of sick pay. The Commission also requests sight of, or a summary of the key issues raised in, the Equalities Impact Assessment which HUHFT Board will have considered prior to agreeing the contract.**

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

5 City & Hackney Restoration and Recovery Plan post Covid-19

5.1 Members' gave consideration to a report from the CCG entitled *City and Hackney System Operational Command: Phase Two Restoration and Recovery Plan.*

5.2 The Chair welcomed for this item:
Dr Mark Rickets (MR) (Chair, City and Hackney CCG)
David Maher (DM), (Managing Director, City and Hackney CCG)

5.3 DM took Members through the report in detail and highlighted some key aspects. He stated that the plan brings together the partnership approach across all the NHS bodies, the council and VCS in Hackney. The borough remained in emergency level 4 position and this dictated action the CCG had to take subject to national guidance. That morning's ICB had discussed for example some of the practical steps to be taken to tackle n digital inclusion. They key elements of the plan related to: out of hospital recovery; restoration of elective work and updating the Transformation Plans. The Long Term Plan has been to the Commission in January and they were now going back to it and refreshing it in context of Covid-19 and resetting the transformation plan. There was also a refreshed look at inequalities as well as a look at governance of the ICS and the merger of the CCGs. He added that the borough was not trailing upwards towards a second peak in Covid-19 but it needed to plan for one which could coincide with the annual flu season and the usual winter pressures. The Communications and Engagement Group of the ICB was chaired by the head of Healthwatch and it was taking a number of initiatives including the Let's Talk events and getting out into the neighbourhoods. There was also a focus on producing culturally appropriate material e.g. using community languages. On the issue of re commencing elective work there was the key issue that many diagnostic procedures are aerosol generating and so plans had to be made carefully. The CCG continued to see HUHFT deliver expert surgical services locally but there was an ongoing discussion to reset the various specialisms across the NEL area. City and Hackney was well placed with its Neighbourhood Model to meet patient needs in advance of admissions and to use secondary care at the neighbourhood level and City and Hackney had a progressive model for out of hospital services. He would deal with the ICS issues under item 6.

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

(a) Members asked about the Terms of Reference of the System Operational Command commenting that it seemed 'officer heavy' and lacking community engagement e.g. from Healthwatch etc. Members also asked about the complex multi morbidity issues at NHS Nightingale and the fact that it was difficult to segregate Covid and non-Covid patients. They asked why Covid specialisms were set up when the evidence appeared to be that this was unhelpful

DM replied that it was challenging to configure hospitals to operate in both a Covid and non-Covid way simultaneously. As regards the language used to describe the SOC this was nationally mandated and NHSE had put these structures in place. Supporting people to be discharged into safe settings in the community in order to create spare capacity in acute hospitals had been essential at the height of the pandemic. They had therefore been set up in a very operational way. Now however the system was moving to another phase of redesign and that would involve wider engagement with the VCS for example. He added that the wasn't a model for future and needed to change.

(b) The Chair asked whether the CCG was required to maintain the SOC in the medium term, in place of ICB, and when the CCG could move back to a more collaborative approach which included local authorities.

DM replied that local authorities were included. Commissioning from CCGs had been suspended by NHSE and they had taken over the bulk of commissioning powers. The CCG was now paying providers from block contracts under instruction from NHSE. They were responding to a set of jointly developed plans and were putting these through ICB and Scrutiny. This Plan was a live document and the engagement on it was part of what they were trying to achieve. On the leadership issue there was a debate going on. The issues was how it is possible to take best bits of SOC (which had got a lot done quickly and safely) and hardwire it into next chapter of work as an new Integrated Commissioning System and he wanted to see local authorities hardwired into this.

The Chair asked MR to respond on the Covid vs non-Covid planning; on the balancing of elective vs emergency care in the new context and on the loss of expertise and the broader points raised by Dr Gary Marlowe in his letter to the Head of NHSEL on behalf of the City and Hackney GPs about the concerns about a rushed move to an ICS.

MR explained that in relation to NHS Nightingale it had been designed for a time in the pandemic when we were asked to plan for the shape of curve to be a lot worse than it actually turned out to be. They had thought critical care would be overwhelmed and so resources had to be thrown at them and quickly. Two things happened instead: firstly, critical care had been ramped up so effectively with huge changes within hospitals that capacity was created very quickly, the other issue was that those in ICU with Covid became critically ill with things like renal disfunction and blood clots so it was not just a respiratory issue. NHS Nightingale had not been skilled up with staff and kit to deal with these kinds of patients who were much more ill than had been expected.

On Elective Care he stated that the response needs to be that you just reduce the likelihood that patients contracting Covid by regular testing and testing on admission, in order to minimise the risk. If patients admitted for just simple

surgery acquire Covid in the hospital their outcomes tend to be very poor indeed. It was necessary therefore to split activities between Covid and non Covid and this provided a real challenge around training and rotas. Surgeons will now have to rotate more quickly than they used to between specialisms. The NHS had to work with the Covid situation that presented itself and it required some dramatic changes.

(c) Members asked about population health outcomes and how these relate to health inequalities pointing out that there was no reference to Public Health in the SOC paper despite them having an important expertise. There was also concern about central government largely sidelining local Public Health teams.

DM replied that this was an omission but that Jayne Taylor one of the Council's Consultant's in Public Health was a key member of the SOC group and was actually leading on a major piece of work on Covid and health inequalities together with Anna Garner from the CCG. The Director of Public Health was also chair of the Pandemic Leadership Group.

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

6 An Integrated Care System for North East London update

6.1 The Chair welcomed Dr Mark Rickets (MR) Chair and David Maher (DM) Managing Director from City and Hackney CCG for this item which was taken jointly with item 5 above.

6.2 The Chair stated that if it was not for the pandemic the CCG would be coming to this meeting with an update on where it was with consulting the CCG Members on the move to the single CCG for NEL and asked whether this work had been paused.

DM replied that it had been paused but the overall timescale not changed however active work had had to stop. He reflected that the various Gold Command type meetings which he attended at an NEL level and his leadership on End of Life Care and Mental Health for example had demonstrated how so much was now coordinated at an NEL level and the response to Covid-19 had represented an ICS in action. All the providers had come together to do the planning and there had also been a greater sense of ownership from local boroughs in terms of their relationships with the health service across NEL. What this practically meant for the CCG was that they had started to engage again with the local CCG Members. City and Hackney stood out by having its CCG, its acute provider and its mental health provider now all having been rated as Outstanding as well as highly regarded services from the local authority. They were very mindful of the successful building blocks they already have in place and this structure will be a critical part of next four months work as the ICS is put in place.

6.3 The Chair asked when C&HCCG will go to its membership to vote on the dissolution. DM replied that this would be no later than mid Nov according to the timetable from NHSEL. They would be having preliminary conversations up till Sept and will seek get a vote in Oct on a Constitution all can support

6.4 The Chair asked about money flows. Would 10% or 15% still go up to ELHCP (the NEL STP) for services better commissioned at that level. He also asked whether changes to the demographic weighting of the money flows would adversely impact Hackney.

DM replied that this would all have to be part of what he CCG members will need to agree. He added that there was also talk London being given its allocations at an ICS level and no longer at a CCG level. Their expectation was that a ratio of 80:20 (20% flowing up) was what they believed was necessary, but it was not possible to say anything more concrete at this point. The Chair commented that if the settlement was worse, then this would cause great alarm at the local level about an overall loss of funding arising from the merger. MR added that in terms of constructing the new constitution to make all this meaningful, this document would be a large, complex and legally binding one. He added that the Finance Director of the ELHCP would give the same answer as DM had just done. All the senior officers in NEL have been working very closely now for some time and they spoke the same language much more that they had done even 18 months previously.

ACTION:	**MD of CCG requested to provide a briefing to the Commission before the final CCG Members vote on the merger takes place outlining the key features of the deal.**

6.5 The Chair thanked the CCG representatives for their attendance.

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

7 Covid-19 response: Test, Trace and Isolate in Hackney update

7.1 The Chair stated that following the updates in March and June he had invited the Dr Sandra Husbands (SH) Director of Public Health back for a verbal update as this was a rapidly evolving situation.

7.2 SH stated that there had been a slight increase of 7 in the previous week and this had included a cluster of cases relating to a particular setting. They were benefiting from the experience of Leicester which had had to go back into a local lockdown and it was causing all to reflect more on whether local authorities are getting all the data they need to fully understand the local context. She stated they were not explicitly asking for person id's but receiving just totals wasn't much use to them. Outside London, Pillar 1 and Pillar 2 data had been collated separately, but London was now receiving both and also data of better quality was expected to come in the following week.

Since the previous meeting a lot of work had been done locally including the publication of the full Local Outbreak Plan at the end of June. This was a dynamic plan which would be updated and amended as new information came to light. She had just been on a London-wide exercise with the police and other partners examining scenarios for local outbreaks in London and establishing what specific powers might be needed. They were also producing a number of Standard Operating Procedures for such settings as schools, care homes, places of worship, work places so that those who run them know what they

need to keep it safe and to manage the people involved and what to do if they become aware of a case who might have infected others.

Work was also ongoing on the Data Dashboard, which the Chair had requested, to provide local reassurance. A key issue was collating the data and presenting it in a way that was useful to policy makers. A test version was ready and over the next two weeks the aim was to test it with various stakeholders. The need to make sure the public facing bit and the professional facing bit are both fit for purpose.

On testing she stated that since the discussion at the previous meeting they had explored with Barts Health whether they could provide lab support to local testing. They were working with ELHCP partners on this and was a seamless system. There was some capacity to do local testing either home kits or in centres. She cautioned that a limiting factor here was that there was an international shortage of the reagent for antigen testing. Supply of reagent was controlled nationally with limited provision for each lab meaning Barts Health wouldn't have enough to scale up to the level they would need for a significant local programme. She added that Queen Mary University of London was carrying out a trial of using a different approach to processing the tests and wanted to enrol all the care homes and work with GP practices. This was one of the benefits of being part of the Good Practice Network in that the borough could feed back on why things might not be working. Locally, there was a recognition that accessing testing was difficult and they were now scaling up from 9 to 15 testing units and their frequency would also increase. She concluded that as a Director of Public Health she can direct the deployment of those mobile testing centres locally, especially to premises which might be the cause of concern e.g. a cluster of related cases.

7.3 Members asked detailed questions and in the replies the following was noted:

(a) Members asked why we weren't enabling GP to be able to actively refer and do testing as recommended by Professor Costello at the previous meeting.

SH replied that it was not possible for GPs to do tests in the way the system was currently designed. She had been to a meeting with DHSC lead on testing and they indicated they were now standing down the army they couldn't be used further rather than going to private contractors for various elements they had not answered.

SH clarified that while Public Health locally does not get full names and addresses of those tested they are able to deduce from full postcodes if cases are related to a particular setting a tower block or a side of a street. She stated that Public Health England's argument was that if there was an issue relating to a complex setting locally e.g. a school they would notify Hackney but they don't circulate full names and addresses to them.

(b) Members asked what was happening in relation to the 'Isolate' part of TTI.

SH replied that they get data on how many cases have been identified by Contact Tracing System and how many contacts of those have been successfully contacted by System. Currently it's about 50-75% from week to week with 75% being contacted within 48 hrs. If it's beyond 48 hrs they don't

bother to follow up as it's too late. There is an ongoing challenge that people don't engage as they have lost faith. She added that the efficacy rate of the contact tracing system was not good compared to normal times (e.g. other contagious disease breakouts in the past). There are gaps in the data so NHS Test and Trace does produce data reports and so collect information about where work and ethnicity that would help local Public Health build up clearer local picture e.g. 20 people of all Turkish origin but if the System is not collecting the information effectively about ethnicity or places of work then they cannot associate the cases appropriately. She stated the PHE was not in total control of it as it was run by DHSC and its commissioned companies but PHE was doing its best to feed back. Another significant challenge was the relative inexperience of the call handlers. These were difficult conversations and the interviewers need much more training and experience.

(c) A Member described a local coffee shop owner experience where he had been told keep record of all siting in the coffee shop but there was timeline with it and generally there was a poor understanding by business owners of how the data should be kept. Also, many were refusing to give details so how can you balance the protection of public health with support to small businesses.

SH replied that when information is not being collected and kept in a way that was not useful this was a major problem. PHE had produced an easy toolkit for small businesses to help with exactly this problem. It was currently online only and Public Health locally were working on how to disseminate it quickly. She added that a combination of ignorance and distrust of the system on the part of many residents was a challenge and therefore they were working closely with VCS partners to help educate local people and rebuild trust so that they understand that the issue for people is about keeping themselves and their families safe and not about collecting data to be used for any nefarious purposes.

(d) A Member detailed how residents he knew had got results within 48 hrs so the system was also working for many also. SH replied that she was pleased to hear this.

7.4 The Chair thanked SH for her update and for her attendance and added that the Commission would appreciate a more formal update at the next meeting on 23 Sept.

ACTION:	**Director of Public Health to provide briefing on Covid 19 test trace and isolate for the next meeting on 23 Sept.**

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

8 Election of Vice Chair

8.1 The Chair stated that there was a vacancy for Vice Chair following the resignation of Cllr Maxwell after her appointment as a Cabinet Adviser.

8.2 The Chair called for nominations. Cllr Spence proposed Cllr Snell and Cllr Plouviez seconded. There were no other nominations.

8.3 The Commission unanimously voted Cllr Snell as Vice Chair.

RESOLVED:	**That Cllr Snell be elected as Vice Chair of the Commission.**

9 Minutes of the Previous Meeting

9.1 Members gave consideration to the draft minutes of the meeting held on 9 June and the matters arising.

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

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

10.1 Members gave consideration to the updated work programme for the Commission. The Chair added that he wanted to maintain an element of flexibility in the programming because of the fast moving situation regarding the impact of Covid-19. He stated he would communicate with Members on developing the programme.

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

11 Any Other Business

11.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm