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.