Hackney

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

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

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

1 Apologies for Absence

1.1 Apologies for absence were received from Dr Sandra Husbands.

2 Urgent Items / Order of Business

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

3 Declarations of Interest

3.1 There were none.

4 Care Homes and Covid 19

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

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

4.3 The Chair welcomed for this item

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.9 Members asked detailed questions the following responses were noted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 Unplanned Care Workstream - Update

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

5.2 The Chair welcomed:

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

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

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

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

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

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

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

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

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

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

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

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

6 Covid-19 Test Trace and Isolate

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

6.2 The Chair welcomed for this item:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Senior Management Restructure in Adult Services

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

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

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

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

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

8 Minutes of the Previous Meeting

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

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

9 Work Programme 2020/21

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

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

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00-9.00 pm