Health & Wellbeing Board

AGENDA REPORTS PACK

Wednesday, 10th January, 2018 at 6.00 pm

Room 102, Hackney Town Hall, Mare Street, London E8 1EA

Contact: Peter Gray
Governance Services Officer
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Tim Shields
Chief Executive

The press and public are welcome to attend this meeting

Health & Wellbeing Board

Board Membership and Additional Attendees

Board Members	
Cllr Jonathan McShane Cabinet Member, Health, Social care and Culture (Chair)	**Dr Clare Highton** Chair, City and Hackney Clinical Commissioning Group
Dr Penny Bevan Director of Public Health Hackney Council	**Paul Fleming** Chair, Hackney Healthwatch
Alistair Wallace Health and Social Care Forum	**Tracey Fletcher** Chief Executive, Homerton University Hospital NHS Foundation Trust
Navina Evans Chief Executive, East London Foundation Trust	**Cllr Anntoinette Bramble** Cabinet Member, Children's Services
Anne Canning Group Director, Adults, Children's Services and Community Health , Hackney Council	**Kim Wright** Group Director, Housing and Public Realm Hackney Council
Paul Haigh Chief Officer, City and Hackney Clinical Commissioning Group	**Laura Sharpe** GP Confederation
Raj Radia Chair, Local Pharmaceutical Committee	

NHS England Representative	

Independent Advisers	
Jim Gamble Chair, City and Hackney Safeguarding Children Board	**Adi Cooper** Chair, City and Hackney Safeguarding Adult Board

Additional Attendees	
Moira Griffiths Group Care and Support Director, Family Mosaic Better Homes Partnership	**Jackie Brett** Health and Social Care Forum
Peter Gray Governance Services Officer Hackney Council	
Ida Scoullos Community Empowerment Network	

Health & Wellbeing Board

AGENDA
Wednesday, 10th January, 2018

ORDER OF BUSINESS

Health & Wellbeing Board

ADVICE TO MEMBERS ON DECLARING INTERESTS

Hackney Council's Code of Conduct applies to **all** Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- The Director of Legal
- The Legal Adviser to the committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

1. Do you have a disclosable pecuniary interest in any matter on the agenda or which is being considered at the meeting?

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

2. If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the room when the item in which you have an interest is being discussed. You cannot stay in the meeting room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the room and participate in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

3. Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.

4. If you have other non-pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

ii. You may remain in the room, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission or licence matter under consideration, you must leave the room unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the room. Once you have finished making your representation, you must leave the room whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the room. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non pecuniary interest.

Further Information

Advice can be obtained from Suki Binjal, Interim Director of Legal, on 020 8356 6237 or email suki.binjal@hackney.gov.uk

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

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

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

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

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

Providing oral commentary during a meeting is not permitted.

Hackney

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD

WEDNESDAY, 1ST NOVEMBER, 2017

Councillors Present: **Councillor Jonathan McShane in the Chair**

Deputy Mayor Anntoinette Bramble, Dr Clare Highton (Vice-Chair), Dr Penny Bevan, Navina Evans, Alistair Wallace, Raj Radia, Laura Sharpe

Apologies: **Paul Fleming, Anne Canning, Kim Wright, Paul Haigh, Tracey Fletcher**

Also in Attendance: **Adi Cooper, Sandra Cater, Simon Galczynski, Councillor Yvonne Maxwell, Jon Williams, Dan Burningham, Simon Galczynki, Peter Gray**

1. Welcome and Introductions

1.1 The Chair welcomed all those present and introductions were made.

1 Declarations of Interest - Members to Declare as Appropriate

2.1 There were no declarations of interest.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting were agreed as a correct record.

4. Community Voice

Elspeth told the Board of her work as a Namaste Practitioner with people with dementia including, going to people's home, memory box sessions and one to ones. Funding was provided by City Bridge and the Board noted that cuts to this service were imminent. The Chair agreed to liaise with Jon Williams on this matter.

5. A Dementia Friendly Borough

5.1 Sandra Cater, Dementia Action Alliance, and Councillor Yvonne Maxwell introduced the report outlining work being undertaken for the Borough to become dementia friendly. She outlined the priorities/work-streams as follows:

- Health and Social Care
- Housing (and Social Care)
- Arts, Culture, and recreation
- Schools, education and young people
- Transport
- Businesses, Shops, Banks and Post Offices

- Emergency Services.

5.2 Sandra Cater highlighted achievements, including that all General Practices in the Borough were working towards becoming Dementia Friendly and ensuring that their registers were up to date. All Community Pharmacists in Hackney were Dementia Friendly and participated in raising awareness events, providing medicines delivery and reviewing services for people affected. So far 4 secondary schools in Hackney were engaged and had received Dementia awareness Key Stage 12 and 13 assembly talks. The Arts, Culture and Recreation HDAA members Group were arranging an LBH Dementia Friendly Arts, Culture and Recreation Festival in Dementia Awareness Week 2018. Events in the Borough were led by people with disabilities.

5.3 Councillor Yvonne Maxwell, the Council's Dementia Champion, told the Board that it was hoped to present a motion to Council on a Dementia Friendly Borough. Meetings were on-going with leisure, public transport and the Health in Hackney Commission on how the Council's Services impacted on the Borough's population and work on accessibility had been carried out, fitting in with the Boroughs' local plan. Councillor Maxwell's told the Board of current funding difficulties and the chair agreed to raise this matter with the Council's voluntary sector team. Deputy Mayor Bramble thanked those involved in this initiative and emphasised that Council was keen to be involved in this work.

5.5 Dan Burningham, Mental Health Programme Director at City and Hackney Clinical Commissioning Group presented to the Board on the Dementia Alliance (DA) Phase 2 July 2016 – December 2017. The main focus was to look closely and unpick the key challenges identified during phase 1 and map out the whole dementia care pathway to make recommendations for innovative and new models of care to improve outcomes. £48000 had been used as back fill for providers attending work stream meetings. Dan emphasised the need to work with integrated Care Schemes. It was noted that funding of phase 1 projects was coming to an end.

RESOLVED:

To note the report.

6. Report of the City and Hackney Adults Safeguarding Board

6.1 Adi Cooper introduced the report providing an assessment of the key developments in local multi-agency adult safeguarding activities in 2016/17 in the City of London and the London Borough of Hackney. This was representative of the work carried out by statutory and other agencies to realise the vision of City and Hackney Adults Safeguarding Board, to assist people to live free from harm in communities that are intolerant of abuse. Adi referred to 4 Safeguarding Adults reviews that had been undertaken and that the aim was to work together to improve processes, systems and practice and therefore have better support and the protection for those people who may experience abuse and neglect.

RESOLVED:

To note the accomplishments of the City and Hackney Safeguarding Adults Board during 2016/17.

7. Complaints Charter

Jon Williams introduced the final Complaints Charter to the Board. The Chair thanked all those involved in the production of the Charter.

RESOLVED:

To agree to the public launch of the Complaints Charter on 10th January 2018.

8. Any other business

8.1 Deputy Mayor Bramble provided the Board with details of the forthcoming workshop around issues for young black men.

9. Dates of Future Meetings - 10th January 2018

10 January 2017

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Hackney

REPORT OF THE HEALTH IN HACKNEY SCRUTINY COMMISSION		
End of Life Care **Health in Hackney Scrutiny Commission** **15th March 2017**	**Classification** Public	**Enclosures**

FOREWORD

End of life care has been much discussed in the news because of the changing age profile within the UK and concern as to how health services are managing this change. Within London the population aged 65+ is expected to rise by over 1.5 million by 2041. Hackney has a younger profile, nevertheless the number of residents aged 85 or over is projected to grow significantly. However, given that this was not an area that we had scrutinised previously we did not restrict the review to care of the elderly.

We made site visits to St Joseph's Hospice, Richard House Children's Hospice, Beis Pinchas nursing home, Acorn Lodge Care Centre and attended a Death Café and an NHS Community Voices event "Dying well in City in Hackney" We took evidence in formal scrutiny meetings from the Homerton University Hospital, City and Hackney Clinical Commissioning Group, Marie Curie, Age UK, the Older People's reference group, Interlink Foundation and the Conscious Aging Trust.

We learned about Co-ordinate My Care a shared electronic system for recording patients' wishes about their care. We heard concerns about the difficulties when elderly frail patients are suddenly transferred to acute settings. And as always, we heard the need for agencies to work better together.

It's a timely review, working better together is at the heart of Hackney's health devolution pilot, which sees the integration of health service and social care budgets. The recommendations for this review can feed in to the pilot.

Our recommendations include additional training for nurses, more support for discussions with patients about their wishes, better awareness of available services, culturally sensitive support and the need to plan for children's palliative care across a larger area.

I would like to thank all of those who generously gave their time to give evidence to the commission or to host a site visit.

Cllr. Ann Munn
Chair – Health in Hackney Scrutiny Commission

CONTENTS

1. INTRODUCTION

1.1 End of life care refers to the care and support that is provided in the last few months or years of a person who has an incurable illness. The main aim of end of life care and support is to help people to die with dignity while ensuring that they and their families have the right levels of support to enable them to do this.

1.2 End of life care is commissioned locally by councils and clinical commissioning groups and the delivery and quality of services can therefore vary between areas however, a common feature is that care is provided by both specialist and non-specialist services including:

Hospitals	Acute, intensive care units, elderly care, oncology, respiratory and cardiac medicine
Primary care	GPs, community nurses, nursing and care homes
Specialist palliative care	In hospitals, within communities and hospice settings
Social care and additional health care	Social care packages, health and wellbeing initiatives (via PH), support from VCS sector

1.3 A London Council's briefing[1] recently outlined how:

- Despite the majority of people saying they would prefer to die in their own home[2] London has the highest proportion of people dying in hospital of all English regions. Between 2011 and 2013, 49 per cent of deaths in England occurred in hospital compared to 55 per cent in London.

- London has the highest average length of hospital stay for people with a terminal illness compared to other regions in England.

- The 2011 national VOICES survey of bereaved relatives rated overall quality of care across all services lower in London than in any other part of the country.

- The capital's population aged 65+ is projected to rise to over 1.5 million by 2041. With people living longer and with more complex health needs, an increase in demand for palliative care is expected.

- In London, less than half of the people who have palliative care needs actually receive that care. In 2014, over two thirds of hospital specialist palliative care services and over a third of community specialist palliative services were not

[1] End of Life Care In London, London Councils, Jan 2016

[2] **http://www.dyingmatters.org/overview/why-talk-about-it**

funded to provide 24/7 telephone advice and 9 to 5, seven days a week face-to-face visiting.

Background and drivers for the review

1.4 Rising demand for health and social care is primarily due to a growing population and advances in medicine, so that people live longer with complex, chronic and life-limiting conditions. Many are also living longer healthier lives with consequent demand for services later on. To meet demand there is a need therefore to improve the coordination and integration of services and to work in partnership with individuals and families to empower them to make informed choices about their care, including where the person wishes to die and the quality of care they receive at the end of their lives.

1.5 The first comprehensive strategy to promote high quality care and support for those reaching the end of their life was published by the Department of Health in 2008. Since its publication the way care is provided has shifted with a greater emphasis on person-focused care, integrated services and local decision-making and delivery. In September 2015 a new national framework for end of life care was published which acknowledges the increasing demands placed on those who commission or provide services to improve quality and efficiency with reducing resources.

1.6 The National Framework set out six ambitions to ensure a good end of life experience as well as eight 'building blocks' that need to be in place to enable those ambitions to be achieved including personalised care plans, shared records and involvement of the dying person. These are expanded upon in 5.1.2.

Why do the review now

1.7 National research shows that currently almost half of all deaths (47%) take place in hospital[3]. Nearly 30% of all hospital beds are occupied by someone in their last year of life[4]. The majority of deaths occur following a period of chronic illness such as respiratory disease, heart disease or cancer. Almost 500,000 people die each year in England, two thirds of whom are 75 years or older. With an ageing population, the number of deaths is set to increase by 17% between 2012 and 2030[5].

1.8 In 2015 **53%** of City & Hackney residents died in hospital – around the same as the London average, though higher than the national rate (see Appendix 1). The proportion of deaths occurring in hospital of local residents has fallen by about 10% over the past 10 years with a similar fall evident in national data. **24%** of City & Hackney residents die at home. There are also variations by ward (see Appendix 2). This is similar to the London and national average, and has increased in recent years. The proportion of residents who die in

[3] National End of Life Care Intelligence Network, 2015

[4] Prevalent cohort study D. Clark et al 2014 reported in CCG evidence to Commission, 5 Oct 2015

[5] Local Preferences and Place of Death in Regions within England 2010, National End of Life Care Intelligence Network (2011).

care homes (**8%**) and hospices (**11%**) have also increased in recent years, though remain below the national average[6]. This is at least partly a reflection of local demographics (a relatively low elderly population, just 7% over 65 and 3% over 75[7]). Each year a further 2.5% of residents who die, die in other places – for example outdoors or in commercial premises.[8]

1.9 One of the four priorities in the refreshed Hackney Health and Wellbeing Strategy 2015-18 is "*Caring for people with dementia, ensuring our services are meeting the needs of the older population*". The Strategy points out that the size of the Hackney population aged 85 and over is projected to grow significantly and by 2020 there are likely to be almost 2,000 people living locally with dementia.[9] In relation to dementia specifically, a Dementia Alliance has been established to bring the Homerton Hospital, East London Foundation Trust and the Alzheimer's Society together to deliver the required improvements. To make this review manageable in the limited time we had available we had to rule certain areas out of scope. We decided not focus on Dementia and Alzheimers issues. We considered both of these are of a scale and complexity to require separate reviews, however issues relating to them did obviously come up in discussions.

[6] http://fingertips.phe.org.uk/profile/end-of-life/data#page/0/gid/1938132883/pat/6/par/E12000007/ati/102/are/E09000012/iid/91756/age/1/sex/4

[7] Briefing from HUHFT to Commission on 10 Oct 2016

[8] : http://fingertips.phe.org.uk/profile/end-of-life/data#page/0/gid/1938132883/pat/6/par/E12000007/ati/102/are/E09000012/iid/91756/age/1/sex/4

[9] Hackney Health and Wellbeing Strategy 2015-18, p. 10

Core Questions

1.11 Our review set out to answer the following questions:

CORE QUESTIONS

1) With a growing elderly population and more people living with Long Term Conditions, how can the aspiration of most residents to die at home, be met by providers of health and social care in Hackney?

2.) With people now more autonomous than in the past and wishing to exercise patient choice and control in terms of their end of life care, how prepared are local providers to deliver a joined-up 24 hour system, including sufficient late-night care?

3.) With the numbers of adults who could benefit from palliative care known to hospices being just a small minority of the total, how could providers encourage a better take-up of their services and what are the funding implications?

3.) How could the communication skills of medical practitioners in terms of end of life care issues be improved?

4.) How can the public be better informed and educated about end of life care so that they better understand the mix of options generally available in home vs acute care?

5.) Are we over-medicalising end of life care and what might be done to reduce for example the amount of inappropriate medical interventions.

2. EXECUTIVE SUMMARY AND LIST OF RECOMMENDATIONS

2.1 Executive Summary

2.1.1 End of life care refers to the care and support that is provided in the last few months or years of a person who has an incurable illness. This review set out to examine how the mix of options available locally for those at end of life, their families and their carers, might be improved. It sought to address how communication issues between families and medical practitioners and between individual health partners could be improved. We also wanted to explore how to drive up use of our excellent local hospice and how the stigma around death and dying can be reduced, perhaps by community action.

2.1.2 Over the course of eleven different meetings, both formal and informal, and a number of site visits we heard from a range of commissioners and providers as well as from residents who are or have been affected by end of life care issues.

2.1.3 Our report is being published as the new Hackney Devolution Pilot is about to be implemented on 1 April. This will see the bulk of Council's and the CCG's health and social care funding going into one pooled budget overseen by a new Integrated Commissioning Board (ICB). A new Unplanned Care Board is being created underneath the ICB and this we hope will provide an opportunity to make real gains in terms of much needed integration and co-ordination of services. This will build on the *One City and Hackney* pilot which had already made progress on these issues across a number of fronts. The *Co-ordinate My Care* system (an electronic care plan which is accessible to all the care professionals) is central to the CCGs efforts here and we have made a number of recommendations to the CCG's End of Life Care Board, which is currently the hub for planning all end of life care services.

2.1.4 Our recommendations encompass: how to make the new integration work; driving up the use of *Co-ordinate My Care*; improving nurses' training; better alignment of transfers of care between care homes and hospitals; how to improve communication between medical practitioners and families, in particular in relation to having those difficult but necessary conversations; raising awareness of local hospice and other services; how the local community and voluntary sector might play a bigger role in supporting those caring for those at end of life; improving culturally appropriate services and the specific needs of children who are at end of life.

2.1.5. Our review has caused us to question whether there are perhaps unreal expectations about the nature of death and dying mixed in with the current drive by acute providers to ensure that more people die at home. Dying at home is often protracted and needs will escalate and alter over time and therefore the support services need to be both flexible and robust enough to cope. For those who live alone and may not have someone to champion their cause through the complex matrix of services, there is the added danger that they may fall between services. We hope that with devolution and integration real progress can be made on both of these fronts.

2.2 Our recommendations are:

Recommendation One
The Commission recommends that the new Unplanned Care Board use the new Quadrant work stream to ensure that processes for communication with patients at end of life and coordination between agencies are firmly in place, that they continue to be adhered to and that work is undertaken to improve them.

Recommendation Two
The Commission requests the GP Confederation, as operators of the Coordinate My Care system, to:

(a) Ensure all health partners are active in ensuring that there is greater uptake of CMC
(b) Ensure that all relevant health and care providers can and do access CMC records for patients in their care
(c) To report back on the pilot whereby social workers were given access to a GP Practice's EMIS system and the viability of extending this.
(d) Explain why patients of children's hospices are not currently included in CMC.

Recommendation Three
The Commission requests the Chief Nurse of HUHFT to explore how, as part of their initial and continuing training, the Homerton's nurses and Health Care Assistants could learn from going on secondments to Hackney's care homes to share best practice in caring for frail elderly people e.g. in washing, feeding and hydration.
The Commission would also like to be advised how the training modules for geriatric and palliative care have developed of late and what scope there is for increasing joint training with care homes.

Recommendation Four
The Commission recommends that the new Unplanned Care Board work with the City and Hackney EOLC Board to examine how outcomes for frail elderly patients at end of life might be improved if a better co-ordinated system of controlling movement between care homes and acute settings was instigated and care home staff were supported to access advice from other sources where appropriate. Furthermore we request London Ambulance Service to examine their Clinical Triage Process on responding to calls from families of very frail elderly people at end of life stage <u>in care homes</u> where families want the patient transferred to acute care. What are the guidelines here and who do the LAS staff take direction from? Are Paradoc always called out? LAS also to be mindful that advance care plans/CMC records may be in place and these would need to be consulted.

Recommendation Five
The Commission's recommends the CCG's EOLC Board to consider how lines of responsibility can be better communicated to families of EOLC patients so that it is clear to them who is taking responsibility at each stage of the process

Recommendation Six
The Commission requests the Chief Nurse of HUHFT and the Chair of the CCG's EOLC Board to report back on how training of clinicians in having difficult conversations around End of Life Care issues could be improved. This should include the need for Advance Care Planning, Advance Decision to Refuse Treatment, Do Not Attempt CPR plans and the need to get more patients onto systems such as 'Co-ordinate My Care'.

Recommendation Seven
The Commission requests St Joseph's to work with the CCG's End of Life Care Board on increasing awareness of St Joseph's services locally, including working towards equality of access for different communities in the borough and to better signpost other EOLC support in the borough. In particular there needs to be an emphasis on reaching and supporting carers. The plan should also consider how more specialist services, such as St Joseph's Namaste care, for example, can be promoted.

Recommendation Eight
The Commission recommends to the End of Life Care Board to work towards making City and Hackney a 'Compassionate Community' as per Devon's 'Compassionate Community Hub' and report back on how the issues raised in the NCPC report could be taken forward locally. This would involve close working with HCVS, Age UK East London, Older People's Reference Group and Connect Hackney. The Hub would bring together a Caring Network Forum, Peer Support Groups and community engagement activities.

Recommendation Nine
The Commission requests Connect Hackney to consider using part of its funding to increase awareness about End of Life Care issues for older people. This could focus on what is the current local offer and how it might be improved

Recommendation Ten
The Commission requests HCVS and in particular Connect Hackney and Age UK East London to examine how there might be a greater role for the sector locally in facilitating discussions with patients at End of Life stage. This could focus on the desire to die at home, the need for ACPs, the need for a will, the need to consider lasting power of attorney for health and welfare decisions etc. This builds on the work of St Joseph's 'Compassionate Neighbours' volunteers but would have a focus on end of life care planning rather than general support and befriending.

Recommendation Eleven
The Commission requests the Council's Adult Services and the Compassionate Neighbours Co-ordinator at St Joseph's to explore how the Compassionate Neighbour volunteers can better signpost clients into council advice and support services and on the other hand how social workers might be able to refer possible clients who are socially isolated into the Compassionate Neighbours scheme, therefore maximising take-up of it.

Recommendation Twelve

Whilst the Commission supports the current NHS guidance that a patients' right to know and to make their own decisions supersedes the rights of their family, the Commission would like HUHFT and St Joseph's to explain what work they are doing with the Charedi community to address that community's concerns about what they consider as a lack of culturally appropriate end of life care. The Commission also requests St Joseph's to report on progress being made in driving up the use of the hospice by other BME communities where there may be other cultural sensitivities.

Recommendation Thirteen

The Commission recommends the Cabinet Member of Health Social Care and Devolution include the concerns of the children's palliative care sector when considering the reconfiguration proposals underway as part of the NEL STP. This also applies to reconfiguration of Urgent Care and Out of Hours Services. Children's palliative care would benefit from being planned across a larger footprint than is currently the case. Variations in funding and structure of support available across borough boundaries makes it difficult for Children's Hospices to plan their services.

3. FINANCIAL COMMENTS

3.1 There are no direct financial implications for the Council arising from the recommendations contained within this report. Any subsequent costs which emerge for the Council from their implementation will need to be met from existing resources.

4. LEGAL COMMENTS

4.1 Legal has noted the contents of the report. There are no immediate legal implications arising from this report.

5. FINDINGS

5.1 CONTEXT AND INCIDENCE

5.1.1 Evidence for this review was gathered during two commission meetings and five site visits/meetings. The Commission received detailed reports from the commissioners and service providers who are involved and **we will not repeat that information here** but it can be found in the agendas for the 10 October 2016, 29 November 2016 and 16 January 2017. Instead we will draw out the main themes of our findings and the basis for our recommendations.

The National Framework

5.1.2 The first comprehensive strategy to promote high quality care and support for those reaching the end of their life was published by the Department of Health in 2008. Since its publication the way care is provided has shifted with a greater emphasis on person-focused care, integrated services and local decision-making and delivery. Then in September 2015 a new national framework for end of life care was published which acknowledged the increasing demands placed on those who commission or provide services to improve quality and efficiency with reducing resources. The National Framework sets out the following six ambitions to ensure a good end of life experience for patients and their families:

- *Each person should be seen as an individual, and their family and loved ones should be kept informed by the care providers and be given appropriate support.*
- *Each person must get fair access to quality care and support regardless of where they live.*
- *The care provided should be reviewed regularly and adjusted to ensure the person does not get distressed.*
- *Health and care providers must co-operate so that all providers are aware of the person's preferences. Support must also be available 24 hours a day, seven days a week.*
- *All staff are competent, confident and prepared to provide the needed care.*
- *Society is ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.*

Moving on from the Liverpool Care Pathway

5.1.3 The public's faith in end of life care treatment has in the recent past been tarnished because of the controversy surrounding The Liverpool Care Pathway. This had been developed by Royal Liverpool University Hospital and Liverpool's Marie Curie Hospice in the late 1990s for the care of terminally ill cancer patients. The LCP was then extended to include all patients deemed dying. It was developed to help doctors and nurses provide quality end of life care. It has since been discredited. It was widely abused as a 'tick box

exercise', with patients being casually assessed as terminal, heavily sedated, and denied water so the diagnosis became self-fulfilling. The criticism was also made that hospitals had been provided with cash incentives to achieve targets for the number of patients dying on the LCP.

5.1.4 In July 2013, the results of an independent review into the LCP led by Baroness Julia Neuberger were published. Accepting the review's recommendations, the government advised that NHS hospitals should phase out the use of the LCP over the following 6–12 months, and that "*NHS England should work with CCGs to bring about an immediate end to local financial incentives for hospitals to promote a certain type of care for dying patients, including the LCP".*

5.1.5 Since the controversy over the LCP a wealth of reports have highlighted variable standards of provision across wards and organisations and a lack of co-ordination in services for end of life care. These include: *More Care, Less Pathway: A review of the Liverpool Care Pathway 2013; Dying without Dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life* and *End of Life Care House of Commons Health Committee report 2015*.

Initiatives in London

5.1.6 In London there has been a cross-sector response to the challenges of end of life care involving directors of social services, the NHS and voluntary sector working together. A number of initiatives are underway and we learned about the operation of these from representatives of Marie Curie. These are:

Pan London End of Life Alliance - set up in partnership with the London Association of Directors of Adult Social Services (ADASS), Marie Curie and NHSE London. The Alliance also has representation that cuts across health, social care and the voluntary sector. The Alliance was tasked with bringing together different partners and stakeholders to ensure that end of life services are integrated. The Alliance's primary aim is to promote patient-centred and coordinated care commissioning and delivery models across London.

End of Life Care Charter – All London directors of adult social services have signed up to the charter which commits social care practitioners to ensuring that a sensitive, appropriate and holistic approach is provided at the right time taking account of the practical, emotional and spiritual needs of people approaching end of life and their carers.

End of Life Care Network – a proactive network with membership from across the sector including a range of statutory and voluntary agencies. The network focuses on a range of issues, for example, how inappropriate referrals to A&E can be minimised for those receiving end of life care. The network also oversees the implementation of the Charter.

London Assembly Health Committee findings on End of Life Care

5.1.7 The London Assembly's Health Committee concluded its own investigation on 'End of Life Care in London' in Sept 2016 and we noted in particular that the London Association of Directors of Adult Social Services' submission to the review identified the following needs:

- End of life training for all social and health care staff in all settings.
- Equal access in all boroughs to community nursing and specialist palliative care.
- Resources shifted from acute to community providers to manage out-of-hospital care.
- Provision of adequate housing to meet the needs of an aging population to enable care to be provided in the home.

5.1.8 The London Assembly Committee made the following findings:[10]

a) "Only 8 out of 33 London Clinical Commissioning Groups (CCGs) scored above the national average for end of life care quality indicators and fewer than half of local authorities include end of life care within their Health and Wellbeing Strategies. CCGs spend a wide range of money on each death, the least spent £540 per death and the most spent £3,740 per death.

b) 70% of hospitals in London cannot provide specialist palliative care services seven days a week and only 24% of London patients accessing palliative care have a non-cancer diagnosis.

c) Around 10% of London households are occupied by a person aged over 65 who lives alone, yet access to services is unequal, with older people, living alone, struggling to access the care they need".

They also recommended to the Mayor of London that he push for all Health and Wellbeing Boards to include end of life care in their Health and Wellbeing Strategies, something we would echo.

5.2 THE COMMISSIONING LANDSCAPE

CCG's End of Life Care Board

5.2.1 Locally end of life care services and support are commissioned by the CCG and the Council and care is provided by both specialist and non-specialist services.

5.2.2 The CCG has a responsibility for commissioning the health element of End of Life Care for the residents of City and Hackney and has an End of Life Care Board. It meets 3-4 times a year and its membership includes all relevant stakeholders, including the Homerton University Hospital Foundation Trust, St

[10] http://www.london.gov.uk/assembly-publications/end-life-care

Joseph's Hospice, Marie Curie, GP Confederation and East London Foundation Trust. The CCG has an end of life care clinical lead and an end of life care lead manager (commissioner).

5.2.3 Nationally CCGs are required to deliver on the NHS *Five Year Forward View* and the new Sustainability and Transformation Plans. NHSE's *Actions for End of Life Care* (2014/16 NHS England), *NICE Quality Standard for End of Life Care (2011)* and the findings of the London Assembly's Health Committee on *End of Life Care in London* (February, 2016) set the context for their work.

5.2.4 The Board set themselves the following priorities for 2016/7:

- Earlier identification of people approaching end of life
- Coordination of care
- Preparing patients and families for end of life
- Improved quality of end of life care
- Improved collection of patient experience and engagement of communities
- Ensuring staff feel confident and competent to have difficult conversations about end of life care

5.2.5 In our meeting with the Chair of the EOLC Board we learned about some of their key challenges such as:

Consistent care pathway: Ensuring that there is a consistent approach across the borough so that all patients receive access to the same level of care.

Unmet needs amongst vulnerable and hard to reach groups: Understanding unmet need. Some BME groups for example are not accessing palliative care as much as they should and a project has begun with St Joseph's.

*Access to interpreting and advocacy***:** Ensuring patients for whom English is not their first language can have open conversations about their diagnosis and planning end of life care.

5.2.5 As regards earlier identification of end of life care issues they have the following in place:

Training for GPs/other community staff: run by Homerton geriatricians, 1 day training, simulation based, including raising topic of dying with patient, encouraging them to express wishes, dealing with family, writing and recording advance care plan.

Enhanced Service Contract with GPs: identify patients in last year of life, offer conversations about Advance Care Plans and Do Not Attempt Resuscitation plans, creation of Co-ordinate My Care records, as appropriate

CQUIN[11] *with Homerton*: commenced in September 2015. To include: information on patient discharges from Elderly Care Unit, conversations about ceilings of treatment, prompting GPs to start/continue conversations on advance care planning and assisting GPs in identifying patients who are approaching end of life.

5.2.6 The CCG also developed the *One Hackney and City* pilot on Integrated Care. This has now concluded. It is being replaced by the incoming Quadrant Model which is part of the new Hackney Devolution Pilot which involves a pooled budget and the creation of a new Integrated Commissioning Board. In terms of end of life care issues however the One Hackney and City pilot did make a lot of progress and was successful in:

- Involvement of St Joseph's on the One Hackney and City provider board
- Extra Clinical Nurse Specialist (CNS) capacity (1 per quadrant), involvement in Multi-Disciplinary Teams (MDT) and GP Practice meetings, better identification of patients, earlier involvement of CNSs, better access to St. Joseph's services
- Improved 24/7 access and advice: extra Marie Curie night nursing capacity, St Joseph's Hospice 24/7 advice and information line, more District Nurse capacity and Out of Hours (OOH) cover (including 24/7 telephone access line for patients), work with Out of Hours provider.

5.2.7 The CCG commissions a range of end of life care related services including specialist palliative care 24 hrs a day and 7 days a week. Here is an overview:[12]

Provider	***Service***
St Joseph's Hospice	Services include a wide range of palliative care including, inpatient, day and community care offering, nursing and medical care, emotional support, practical advice, physical and psychological therapies, spiritual care, social and creative activities. Contract value: £2,362,581
Mildmay Mission Hospital UK	Provision of specialist services to people with HIV across the following strands: Neuro-cognitive impairment and complex physical rehabilitation; Respite and End of Life care; Day services Contract value: £308,498
Marie Curie	Provision of palliative night nursing service in the community (registered nurses and health care assistants). This service is managed by the Homerton Hospital. Contract value: £30,000 (through the Homerton)
Richard House	Children's palliative care (inpatient and day care) for those aged 0-19 years. Services for those with life-limiting and life threatening conditions and have complex health care needs. Richard House are working with commissioners to develop their outreach model to best support the

[11] Commissioning for Quality and Innovation is a standard NHS performance target

[12] Extract from briefing to 5 October 2016 meeting with the Commission

	needs of local families. They work collaboratively with the Community Children's Nurses at the Homerton and St Joseph's. Young people may also have access to short breaks (respite through leisure activities) funding from the council (criteria is middle or high level disability living allowance) or from the CCG's commissioned providers (KIDS Adventure Playground or the Huddleston for swimming) should they require Nursing support during these activities Contract value: £71,965
Specialist palliative care within acute trust	Within the wider acute contract with the Homerton there is provision and funding for palliative care.
Extra spend on continuing healthcare and community nursing within the Adult Community Nursing contract	There are a range of elements of service within continuing care and the Community Health Service (CHS) block contract with the Homerton that make provision for palliative care
EOLC contract across GP practices operated by the GP Confederation (including Co-ordinate My Care)	The CCG commissions the GP Confederation to deliver this service. GPs actively identify patients within their practice who may be considered to be in their last year of life using the SPICT[13] tool or other appropriate tool. The service entails the GP talking to patients who they consider are in the last year of life and placing them on the palliative care register and if appropriate on the **Co-ordinate My Care** system. The GPs also attempt to discuss with the patients and their relatives (as appropriate) advanced care planning including how to achieve a quality end of life care and DNACPR. The GP talks with the patient (and relatives where appropriate/with consent) regarding their condition(s) and then enters the patient's details onto the QOF palliative care register. The GP also talks with the patient (and relatives where appropriate/with consent) regarding Advanced Care Planning (ACP) and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). Contract value: £161,700 per annum
Triangle	This service provides rapid access to domiciliary services of personal care and respite care to individuals at home. Contract value: £125,000 per annum
Other	Additionally, the CCG provides funding for support bereavement counselling, which includes bereavement for families and carers of patients who are identified as End of life, who were not under the care of St Josephs. Such a service is also provided by St Joseph's Hospice for the carers and families of patients under the care of St Josephs. There are community nurses dedicated to palliative care funded through One City and Hackney

[13] The SPICT™ is a validated tool used to identify people at risk of deteriorating and dying with one or more advanced conditions for palliative care needs assessment and care planning

5.3 OUTCOMES

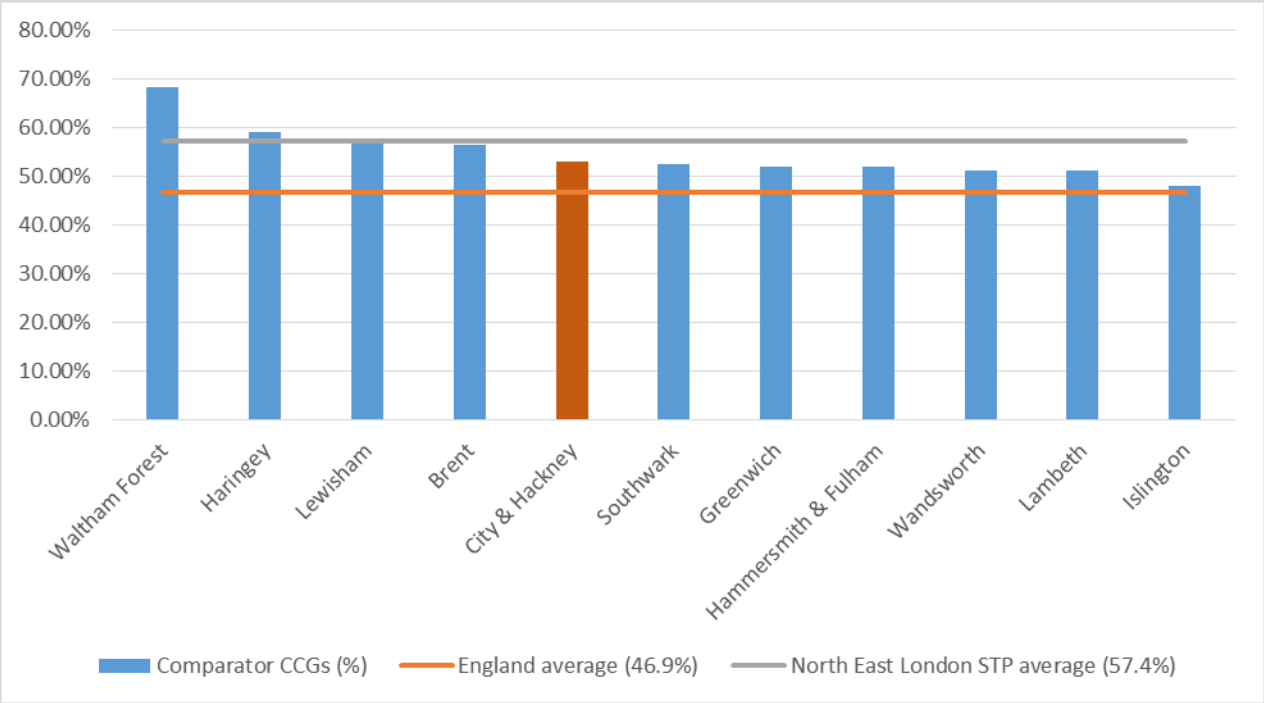
5.3.1 Nationally, survey data suggest that more people would, given the choice and conditions being right, prefer to die at home and fewer wish to die in hospital than is currently the case. Latest ONS data shows that 46.9% of people died in hospital, although the proportion of people dying at home or in care homes continue to increase (based on Q3 data 2015/16).

5.3.2 Supporting people to die in their preferred place of choice and reducing the number of deaths in hospital is a key focus of the NHS and for CCGs in developing *Sustainability and Transformation Plans*. The importance of end of life care is further highlighted by its incorporation under 2.2 (Patient Experience) in the Mandate to NHS England[14].

5.3.3 There are around 1000 deaths in City and Hackney across all age groups each year. The majority of these are in hospital but the proportion of them is decreasing over time. A higher proportion die in hospital in City and Hackney than nationally however. The National VOICES survey showed that relatives of people who died in hospital rated overall quality of care significantly worse than any other place of death. Locally a higher proportion than the national average die outside of hospital but the majority in Hackney still die in a hospital. One City & Hackney had a performance measure: "% of deaths outside of hospital". This was achieved for 2015, increasing from 43% to baseline to 45%. The latest data available on proportion of patient who die in hospital is Q3 2015/16. The table below shows City & Hackney and its comparator CCGs. C&H has a higher rate that the England average, but lower than the average of our comparator CCGs in north east London.

[14] https://www.gov.uk/government/publications/nhsmandate-2016-to-2017

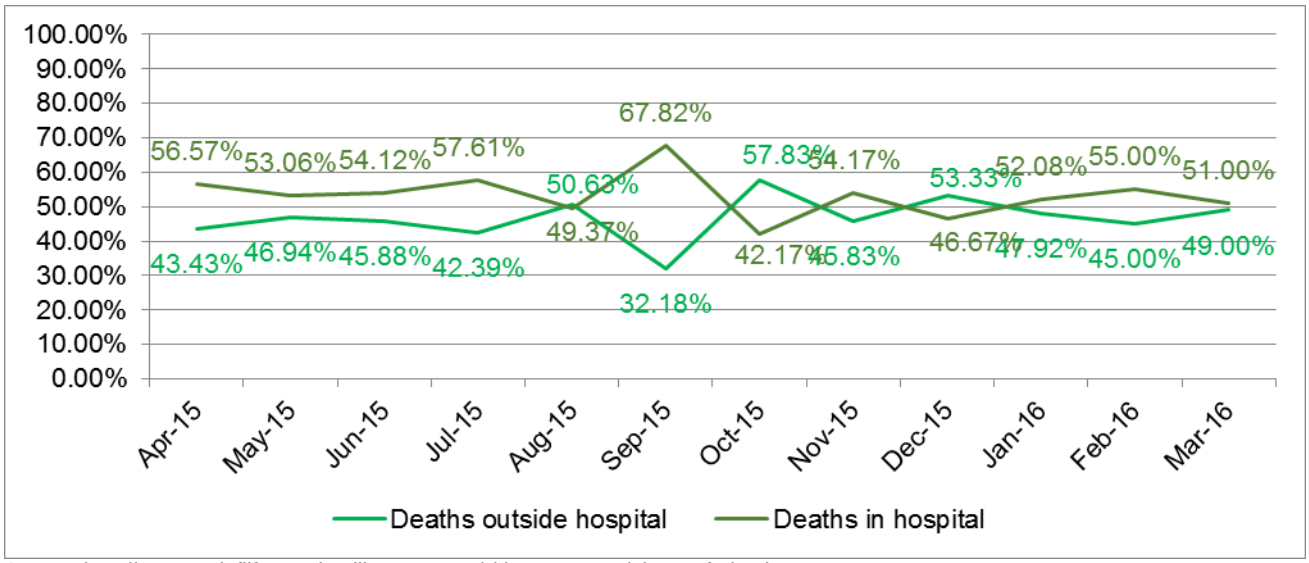
Chart 1: Percentage of deaths that take place in hospital (Q3, 2015/16)



Source: http://www.endoflifecareintelligence.org.uk/data_sources/place_of_death.

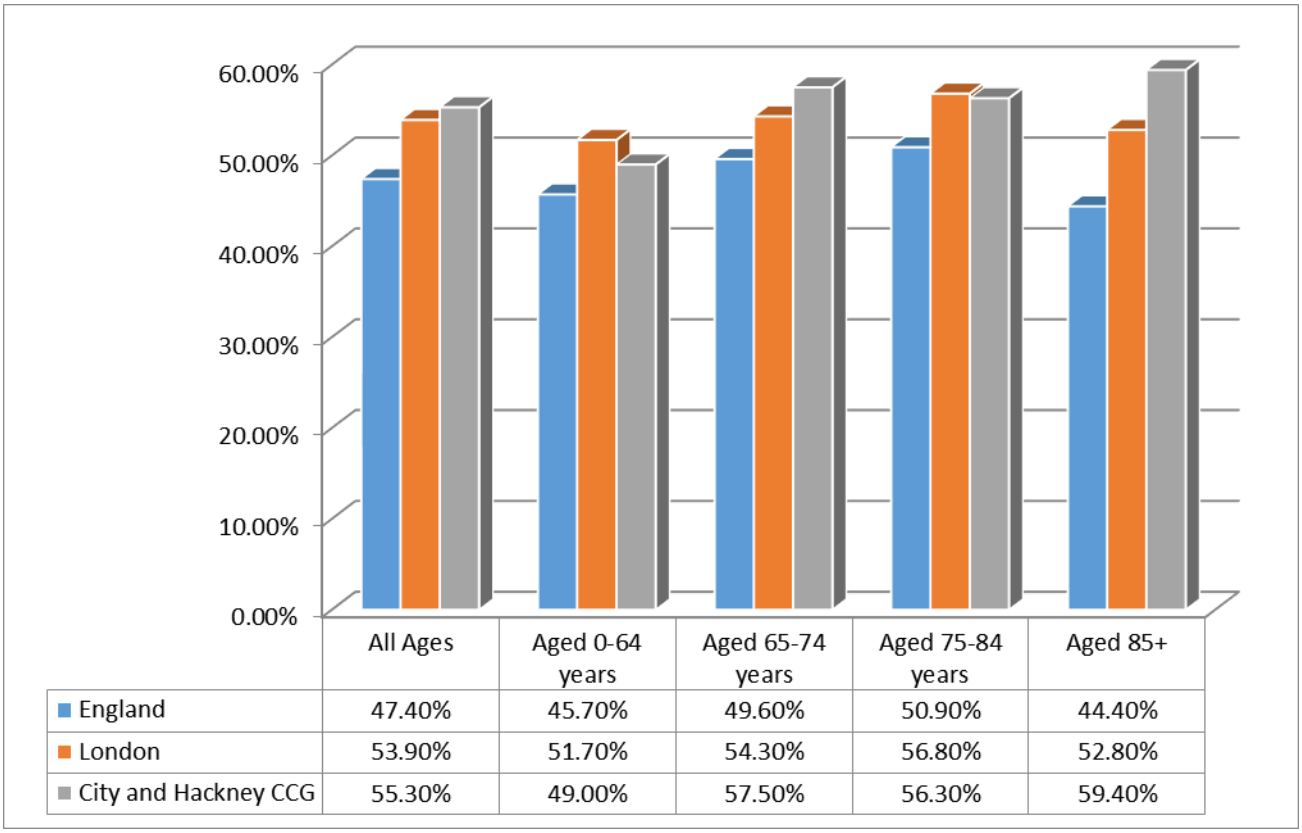
5.3.4 Looking at data over time, we are seeing a reduction in the number of deaths taking place in hospital.

Chart 2: Deaths that take place in and out of Hospital in City & Hackney



Source: http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death

Chart 3: Hospital Deaths by Age (2014): C&H compared with England and London

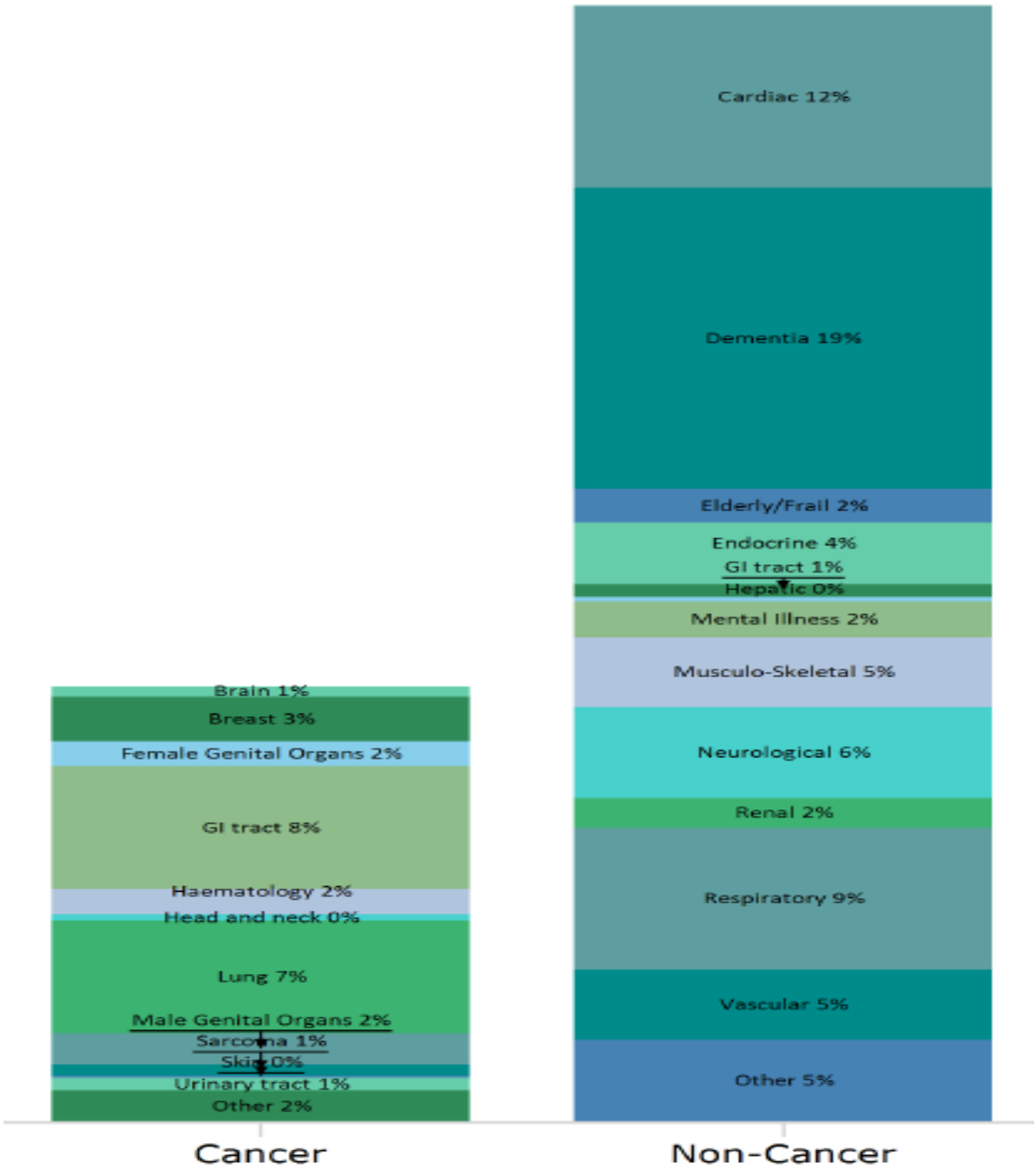


	All Ages	Aged 0-64 years	Aged 65-74 years	Aged 75-84 years	Aged 85+
England	47.40%	45.70%	49.60%	50.90%	44.40%
London	53.90%	51.70%	54.30%	56.80%	52.80%
City and Hackney CCG	55.30%	49.00%	57.50%	56.30%	59.40%

Source: http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death;

5.3.5 We also noted a range of data from the CCG from those GPs registered with the Co-ordinate My Care system. This information now also includes preferred place of death. Date presented to us in September suggested that 72% of people recorded on CMC died in their preferred place of death. Over the 12 months to September, the number of patients at the end of life that have been registered on the CMC system had increased from 548 to 741 (35% increase). The introduction of the End of Life Care contract in primary care is seen as one of the main drivers for the increase in activity relating to the co-ordination of care plans for this patient group over the last year.

5.3.6 Data from Coordinate My Care also provided the CCG with information about the primary condition of patients identified as palliative care. The chart below highlights diagnoses in two categories, those with cancer and those with non-cancer for City &Hackney. The latest data available, shows that of the palliative care patients registered with CMC, 28.1% have cancer and 71.9% are non-cancer related conditions. This challenges a common misconception that cancer predominates in the area of palliative care.



National VOICES[15] survey 2015

5.3.7 The Department of Health administers a validated national survey of bereaved relatives and carers called *VOICES or View of Informal Carers – Evaluation of Services*. Among the findings from the latest survey in 2015 we noted the following:

- 3 out of 4 bereaved people (75%) rate the overall quality of end of life care for their relative as outstanding, excellent or good; 1 out of 10 (10%) rated care as poor.

[15] The VOICES (Views of Informal Carers – Evaluation of Services) is a validated survey of bereaved relatives and carers administered nationally by DoH and locally by CCGs

- 7 out of 10 people (69%) rated hospital care as outstanding, excellent or good which is significantly lower compared with care homes (82%), hospice care (79%) or care at home (79%).
- Ratings of fair or poor quality of care are significantly higher for those living in the most deprived areas (29%) compared with the least deprived areas (22%).
- 1 out of 3 (33%) reported that the hospital services did not work well together with GP and other services outside the hospital.
- Almost 3 out of 4 (74%) respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating patients wanted to die in hospital.

The latter highlights a point also raised in our review which is that while most people want to die at home when the realities of the situation become apparent they will more often opt for a hospital death. There is a disconnection here between the perception of dying at home and the reality.

Local VOICES Survey City and Hackney 2015-16

5.3.8 In addition CCGs can carry out local versions of this research. City and Hackney's local VOICES survey[16] was funded through the CCG's Innovation Fund in 2015 and completed in October 2016. The project was managed by St Joseph's Hospice and was overseen by a steering group which comprised all local stakeholders with an interest in palliative care. The purpose of the project was to help identify areas of need and improvement in the end of life care within City & Hackney through seeking views from carers, following the deaths of a family member. Those who ran the survey acknowledge that it does have some limitations (small sample size and those having positive experiences had been more likely to complete it) but it nevertheless provides very valuable local data on end of life care.

Below are some of the key findings we noted:

- The overall quality of healthcare dying patients received within City and Hackney was rated above the national average.
- Across the different settings, hospice care was rated the highest and other care services were in line with national averages. Hospital care was perceived to require some improvements. The report suggest that this could be because of challenges specific to Hackney's community profiles which are more diverse than those found across other CCG areas.
- Ratings for dignity and respect were above the national averages
- Pain management was more successful in in-patient care than in community and home care settings and this is in line with national results
- Almost all felt that patients and carers were treated with dignity and respect during the last two days of life.
- The need to break bad news sensitively was highlighted as one of the prime areas with need for improvement.
- Care provided by doctors was rated higher than that of nurses (although it doesn't provide insight into whether other professions such as health care assistants might have influenced the perception of nursing care)
- Almost all were happy with level of involvement in decision making.

[16] VOICES Survey – City and Hackney 2015-16, City and Hackney CCG/Homerton University Hospital/St Joseph's Hospice, November 2016

- Only a minority of patients died in their preferred place of death
- The provision of information about bereavement services is limited across most care providers
- Bereavement services could be more accessible and responsive to the challenges bereaved carers and relatives face in the lead up to and after the death of a relative/friend

5.3.9 To bring another dimension to this the Royal College of Physicians recently surveyed[17] acute providers on the quality of their end of life care provision. They found the following in relation to communication and treatment decisions:

- *Where there was an advance care plan, the team took the contents into account when making decisions (91%) and it was reviewed (79%); however only **4%** (415/9302) of patients had documented evidence of an advance care plan made prior to admission to hospital.*

- *A do not attempt cardiopulmonary resuscitation (DNACPR) order was in place for 94% (8711/9302) of patients' notes at the time of death. Where sudden deaths are excluded, discussion about CPR by a senior doctor with the patient was recorded in **36%** (2748/7707). Overall, for **16%** (961/6072) there was no reason recorded why a discussion did not take place. Discussion about the CPR decision with the nominated person(s) important to the patient was documented in 81% of cases.*

- *It was recorded that 32% of patients had opportunities to have their concerns listened to and, of these, 94% were given the opportunity to have questions answered about their concerns.*

The fact that only 4% had Advance Care Plans made prior to admission to hospital and that only 36% recorded discussions with a doctor about CPR are areas of concern.

5.4 INTEGRATION ISSUES

5.4.1 It is not uncommon in Scrutiny reviews to find high standards of work being done by health and social care providers and we always welcome that but a common theme we find in many of our reviews relates to shortcomings in integration and partnership working. As health care gets more complex inevitably there is a danger that nobody is looking out for the whole person as they are so focussed on delivering their own important part of the jigsaw. This is evident in end of life care and it means that patients often do need a personal champion to ensure that a loved one can navigate the systems. The problems become exacerbated when we are dealing with often very frail elderly people at end of life stage. A common issue we heard about was criticisms about what was thought of as often unnecessary hospitalisation and poor standards of basic nursing care in acute settings. On discussing this with the Chief Nurse of the Homerton we acknowledged that what was at issue here was not the need for new processes or procedures in the treatment of the

[17] *End of Life Care Audit – Dying in Hospital*, a national report for England, Royal College of Physicians/Marie Curie; 2016

elderly, but a commitment to a higher standard of general nursing care for old people with a particular a focus on hydration, feeding and washing, all of which much take more effort and are more complex for the old.

5.4.2 The number of players involved obviously makes it difficult but the result can often be poor case handling of frail elderly people between care homes and acute settings. We heard about cases when talking to the care homes and we also considered the issues raised in a recent Safeguarding Adults Review.

A Safeguarding Adults Review Panel case history

5.4.3 We were grateful that the Chair of the City and Hackney Safeguarding Adults Board (CHSAB) drew to our attention a recent Safeguarding Adults Review (SAR) relating to an individual known as Mr GH which they were currently considering and which had a direct bearing on our review. Each year we consider the CHSAB's annual report and hold them to account on their performance and this provided a useful opportunity to use insight from that Board to enhance a scrutiny review.

5.4.4 The purpose of a Safeguarding Adults Review Panel is to commission evidence from all relevant agencies involved in the case under review, to asses and analyse that evidence and to make judgements about the lessons learnt. Mr GH, aged 80, died in St Joseph's Hospice in Aug 2015, ten days after he had been admitted. Prior to this he had lived alone in a one bedroom first floor flat in a sheltered housing scheme. He had a number of longstanding and complex health problems and the following 6 agencies were involved in his care:

- GP surgery
- Adult community nursing (provided by HUHFT)
- Acute health care (first in Homerton then in St Joseph's)
- Adult social care (care package also Safeguarding, Occupational Therapy)
- Care agency (delivering the care and support package)
- Housing association (sheltered housing)

Informally involved in his care were his sister, who lived in the south of England but who did some advocacy for him, and a private cleaner whom he had engaged and who was quite involved in his support.

5.4.5 The report of the SAR Panel, as the Chair of the Safeguarding Board pointed out to us[18], found instances of good practice by all agencies involved but also that the agencies did not keep pace with Mr GH's changing needs as he approached the end of his life. Although there was liaison, the overall coherence and coordination of care planning was missing. There were failures in communication as well as shortcoming in how some agencies responded to his needs and no one agency took a holistic view of his situation and there was no concerted approach to accommodating his changing needs speedily and effectively. As a result, they concluded, the quality of life that he

[18] Memo from Chair of CHSAB to Cllr Munn 10 Dec 2016

experienced in his final weeks was not as it should have been and he was unable to remain at home as he had wished. The SAR made a series of recommendations for individual agencies regarding coordination and leadership when someone has complex health and social care needs. As part of the next stage of that SAR review there will be a communications strategy, an action plan and reviews of progress made in implementation.

5.4.6 It was interesting to note how effective his housing manager was in raising concerns in this case and they have to be commended for this. We also noted how his GP appeared very slow in referring him to Palliative Care. Perhaps Mr GH's expressed wish for no more intervention and to remain at home was taken as a reason for limited further interventions. It would seem however that the complexity of his health and care needs were probably too severe for him to be cared for effectively at home, considering he lived alone and even without the few failures listed in this report, the option of St Joseph's or another appropriate nursing environment should perhaps have been discussed earlier. In terms of learning from the case we would argue that the expressed desire of the majority of people to die at home has to be seen in the context of their changing medical need and that dying at home is not always practical or desirable particularly for those living alone, even if they're in sheltered accommodation.

5.4.7 The case of Mr GH and our discussions with the various care agencies in our own evidence gathering made us reflect on the workings of Multi-Disciplinary Team meetings. The challenge is that while every member of a team fulfils their duty, who in the end 'owns' a case like this is vital particularly for those who might have nobody to speak up for them. The Commission suggests that partners would benefit from a more focused, collective, reflection of these issues by for example introducing regular, EOLC case review exercises to act as a multi-agency learning process. Such reviews would we suggest need to involve sufficiently senior staff from each partner to ensure that issues are taken back at a sufficiently high level to be implemented.

5.4.8 The health and social care system in Hackney is about to undergo one of its most important transformations in a generation with the creation of the Hackney Devolution Pilot. At its essence this involves the pooling of most of the health and social care budgets between the CCG and the Council and the creation of an Integrated Commissioning Board. These new arrangements replaced the One Hackney and City programme which itself was a pilot. A new Unplanned Care Board replaces One Hackney and City as, among other things, the key coordination vehicle for care of older people at end of life. We learned that there are both **GP Practice MDT** (multi-disciplinary team) meetings focusing on case management and **Quadrant MDT meetings** focusing more on case review processes. Our first recommendation therefore focuses on the need to use the opportunity the new structures provide to ensure better co-ordination of end of life care support. A key issue here is establishing clarity for patients, carers and families as who the 'Responsible Individual' is at each stage as this does not seem to be clear to service users.

Recommendation One
The Commission recommends that the new Unplanned Care Board use the new Quadrant work stream to ensure that processes for communication with patients at end of life and coordination between agencies are firmly in place, that they continue to be adhered to and that work is undertaken to improve them.

City & Hackney GP Confederation's End of Life Contract

5.4.8 The desire to better coordinate care for patients at end of life is at the heart of the CCG's *Co-ordinate My Care* system. All 43 GP Practices in City and Hackney are signed up to deliver the End of Life Contract. The aim of this CCG contract which is provided by the GP Confederation is to encourage GPs to identify those patients who may be in the last year of life and to offer them an opportunity to create an Advance Care Plan (ACP) and to record the details of this on the *Coordinate My Care (CMC)* system, if the patient agrees. The process of care planning impacts positively on the quality of care received by patients and carers.

5.4.9 CMC is an electronic care plan that is accessible to a number of healthcare professionals including London Ambulance (LAS), Out of Hours services (OOH), the Homerton A&E, the Adult Community Nurses such as District Nurses and Community Matrons. Evidence from CMC suggests that those patients who have an ACP are more likely to die in their preferred place of death and to avoid unnecessary hospital admissions. The service aims to reduce the number of emergency admission at end of life, to reduce the length of stays in hospital at end of life and to increase the proportion of patients dying in their preferred place of death. Practices were asked to actively identify those patients who may be in the last year of life (using the Supportive & Palliative Care Indicators Tool, known as SPICT) as well as by other means. GPs were to offer patients information about their disease trajectory (if appropriate), and offer them the opportunity to create an ACP which as a minimum should include the following:

- Preferred place of care;
- Preferred place of death;
- A discussion about resuscitation and the circumstances in which the patient and/or the health care professional feel it would not be appropriate. This could result in a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form on CMC;
- Any other patient wishes

5.4.10 We learned that GPs have active oversight of the patients on the palliative care register, they are discussed at the monthly practice Multi-Disciplinary Team (MDTS) meeting which are ideally attended by the Adult Community Nursing teams and the Palliative Care Clinical Nurse Specialist, they are visited regularly or as necessary and their carers' and/or family are consulted and engaged.

5.4.11 Advance Care Planning is key to making the patient's and carers' experience be as good as it can be in the circumstances. ACPs involve having those difficult conversations with the patient and their carer (if appropriate and relevant) and, crucially, sharing this information with other care providers, such as the hospital, the community nursing teams and other health care professionals who are involved in the patient's care.

5.4.12 The GP Confederation stressed to us that good advance care planning happens when all those involved in the patient's care are able to *speak* to each other so that the patient's changing needs are understood in real time. As they pointed out Health IT systems do not lend themselves to being able to *speak* to each other. GPs in Hackney use *EMIS*, whilst the hospital uses *Cerner* and the District nurses use *RIO*. CMC offers a solution, whereby, information recorded by the GP on the CMC care plan, can be viewed, and if necessary, updated, by other health care professionals who may have seen the patient in another setting, such as the hospital, or at home by the district nurse. The aim is to ensure that all patients on the end of life register have a CMC care plan. We learned that further IT developments are required to have this system fully operational at all levels, but it is expected that this will be achieved within the next year.

5.4.13 We learned that since the linking of CMC to the wider GP Confederation's End of Life contract, Hackney has steadily progressed in the national CMC league tables[19]: City & Hackney is now 14th in the national rankings, has added 195 more patients to CMC in September 2016 and has been the top performing CCG each month from June 2016. This is as a result of GP practices consistently creating care plans on CMC for those patients who have consented.

5.4.14 We learnt too that the Confederation has instigated quarterly MDT training sessions where they use a case study to aid learning. We would encourage more of this and all attempts to engage all the stakeholders (acute, primary, social care, voluntary sector) in these sessions.

5.4.15 While we acknowledge that CMC is an excellent innovation we did come across some instances of poor awareness of it and we'd ask the Confederation to focus on these. HUHFT described how patients often are going on their own Treatment Escalation Plans too late e.g. when too ill or lacking capacity, so there is a need to stress the importance of people thinking of End of Life Care issues while still able. GPs also need to encourage more Advance Care Plans and Do Not Attempt CPR plans among their patients where appropriate. The Commission also heard concerns from Richard House Children's Hospice about why children were not included in CMC.

[19] End of life care report to HiH meeting on 29 November 2016 from City & Hackney GP Confederation

Recommendation Two
The Commission requests the GP Confederation, as operators of the Coordinate My Care system, to:

(a) Ensure all health partners are active in ensuring that there is greater uptake of CMC
(b) Ensure that all relevant health and care providers can and do access CMC records for patients in their care
(c) Report back on the pilot whereby social workers were given access to a GP Practice's EMIS system and the viability of extending this.
(d) Explain why patients of children's hospices are not currently included in CMC.

5.5 CARE AND QUALITY OF SERVICE

5.5.1 We heard some concerns about instances of poor care for frail and elderly patients at HUHFT particularly around hydration and help with feeding and washing. Our research is not quantitative and claims we hear are anecdotal but they nevertheless do raise concerns that a successful Trust like the Homerton must address confidently. When discussing this with the Chief Nurse she agreed that this was about the general standard of good nursing care and not about any specialist treatment and we acknowledge this response. We do acknowledge too the challenges of providing care for frail and confused elderly patients in a general acute setting but would ask that there is a need for the Homerton to keep a focus on training of nurses and Health Care Assistants (HCAs) and to be more responsive to claims of insufficient nursing care when these do occur. In January 2017 the CQC has published national ratings on its CQC inpatient survey and we noted with some concern that the Homerton came out with the lowest scores in England for two questions: *Did you have confidence and trust in the nurses treating you?* And *Overall, did you feel you were treated with respect and dignity while you were in the hospital*?'[20]

5.5.2 How to improve and better align nurse training across the acute, nursing home and care home sectors became an issue in our review. There are 4 nursing homes in Hackney with a total of 226 beds: Acorn Lodge Care Centre (98), Beis Pinchas (44), St Anne's Home (34) and Mary Seacole (50). For this review we made site visits to two: Acorn Lodge and Beis Pinchas. We learned that while there is some joint training taking place however we want to encourage more initial and continuing training for nurses and HCAs with both care homes and hospices. Care Home managers expressed criticism of the condition of frail elderly people who had been returned to them from acute hospitals. It was suggested to us that Homerton's nurses, like all in acute hospitals had a relative lack of experience of washing and feeding very frail elderly people. We acknowledge the pressures on general nursing staff and all the other training calls on them and the fact that nursing home staff too

[20] Quarter 2 Quality Report to CCG Governing Body meeting 27 Jan 2017 reporting on results of CQC Inpatient Survey 2015. Agenda pp 127-132.

have the benefit of working in a specialist sphere, but we would suggest that the professional silos that appear to have built up between acute providers and nursing homes need to be surmounted in the interests of delivering higher standards for patients.

Recommendation Three
The Commission requests the Chief Nurse of HUHFT to explore how, as part of their initial and continuing training, the Homerton's nurses and Health Care Assistants could learn from going on secondments to Hackney's care homes to share best practice in caring for frail elderly people e.g. in washing, feeding and hydration.
The Commission would also like to be advised how the training modules for geriatric and palliative care have developed of late and what scope there is for increasing joint training with care homes.

5.5.3 We heard concerns from a local care home about recurring issues relating to the protocols of London Ambulance Service in transferring frail, elderly patients to A&E at the request of family members. There were concerns about the attitude of staff and derogatory comments made by LAS staff about care homes in the presence of the family members who instigated the calls. As the Care Home Manager said to us "*A & E also does not question the transfer and by admitting the resident the perception of the family is that the Home did not deliver adequate care".*

5.5.4 We acknowledge that dealing with anxious family members at the end of life stage is a significant problem for all care providers but we would argue there appears to be a lack of leadership in evidence here. If a care home manager feels strongly that the case for transferring a very frail elderly person to an acute hospital is not justified surely that needs to be made strongly to the GP who is the Responsible Individual here and the various parties then need to abide by the GPs judgement call and respect the decision made and not communicate mixed messages to anxious families. Instead, distressed or anxious family members force a situation, which is not ideal for the patient, because of a poor spirit of partnership working between the care home, the ambulance service, the acute hospital and the GP.

5.5.5 Allied to this problem is that when such frail elderly people then arrive in A&E, because of the current pressures on these services, they can often be required to wait for long periods where their condition will deteriorate. By the time they are seen they are dehydrated, with criticism falling back on the care home, when the reason the patient is dehydrated is because they have been waiting to be admitted. It is obvious to all that a busy acute setting is not the best place for a very frail elderly and confused patient, unless there is a major medical emergency, therefore the question arises - why is such a patient in an A&E in the first place and who is making the decision? It is challenges like these that we hope will be alleviated by the new integrated care system and we would hope when we revisit our recommendations after six months that there will be some tangible evidence of improvement.

Recommendation Four

The Commission recommends that the new Unplanned Care Board work with the City and Hackney EOLC Board to examine how outcomes for frail elderly patients at end of life might be improved if a better co-ordinated system of controlling movement between care homes and acute settings was instigated and care home staff were supported to access advice from other sources where appropriate. Furthermore, we request London Ambulance Service to examine their Clinical Triage Process on responding to calls from families of very frail elderly people at end of life stage in care homes where families want the patient transferred to acute care. What are the guidelines here and who do the LAS staff take direction from? Are Paradoc always called out? LAS also to be mindful that advance care plans/CMC records may be in place and these would need to be consulted.

5.5.6 The issue for carers of how to manage large volumes of medications in End of Life Care to ensure sufficient quantities are available out of hours, known as anticipatory prescribing, is a growing problem. Poorly controlled symptoms can lead to considerable distress for the dying person and an individualised approach to anticipatory prescribing should ensure that the drugs prescribed are appropriate to the anticipated needs of the dying person, and prevent distressing hospital admissions and waste of medicines. We observed a key stakeholder meeting on the issue which arose because the CCG's Prescribing Board had received concerns from some GPs.

5.5.7 The meeting involving all the key stakeholders included some very useful input from carers/patient advocates, those with direct experience of dealing with pain management crisis with loved ones often in the middle of the night and at weekends. The NHS appears to have gone from low levels of anticipatory prescribing 10 year ago to a situation now where there is too much waste of expensive medications and hence the concern. We learned that GP Out of Hours providers (in Hackney CHUHSE) can no longer keep controlled drugs and this has led to the need for more anticipatory prescribing for end of life care patients.

5.5.8 In addition the Dr Harold Shipman case has also led to new national regulations which prevent medical staff from removing unused controlled drugs from a deceased person's home and families often do not appreciate this. This has to be done in a special procedure under a Home Office licence. We also learned that Pharmacists generally no longer have space to keep large stocks of controlled drugs and furthermore they are not reimbursed for loss of out of date medicines, which makes them less likely to keep stocks high. Could they be commissioned to keep approved lists of medicines in stock, we wondered? Also is there a need to give some patients a safe for controlled drugs if they have a family member in the home who has a drug misuse problem? Could there be an Out of Hours pharmacist for dispensing controlled drugs in each of the 4 new Quadrants is another issue? It became clear that so many of the issues here would be alleviated by better take up of the Co-ordinate My Care System and progress being made by the new Unplanned Care Board.

5.6 COMMUNICATION WITH PATIENTS AND FAMILIES

5.6.1 The effectiveness of communication with patients and families is key to improving the quality of end of life care. It comes out in every discussion but we first looked at what the NHS was doing formally about this issue.

5.6.2 The CCG described how the key issues coming out of the various Patient and Public Involvement groups over the past two years were:

- Informed consent
- Shared decision making and involving patients in care planning
- Need for clear information
- Consideration for patients' individual circumstances and the importance of patient choice
- Involving carers and family in discussions and decisions
- Ensuring that patients with no carers or family members have access to other support.
- Ensuring sufficient training for clinicians

5.6.3 The CCG has commissioned Healthwatch to run the *NHS Community Voice* which is a series of monthly discussions on health related topics. Recommendations, questions and comments from these meetings are collated and shared with relevant services and commissioners who are asked to respond accordingly. We learned that their meeting on End of Life Care raised the following:

- Services should devise a mechanism to monitor effective and timely information sharing between health professionals.
- Carers should be included in planning and decision making.
- Need for better information about different services including One Hackney and City; extended appointments with GPs; the role of GPs as the holders of a person's medical information and advanced decision making support through *My Life My Decision*.
- Clear information for carers and advocates on where people can go if they want to challenge decisions made about their needs assessment when at end of life.
- Provision to be made for advocates/befrienders/community champions for people without family who are approaching end of life. Patients felt that there is a lot of focus on family but where is the support for those without family?
- Where do those who choose not to follow medical advice around their condition go for support?

5.6.4 In response to these we noted that the CCG explained that additional support including additional appointments with GPs were available under the existing End of Life Care contract. Where families want to challenge the decisions that their family member has made they are encouraged in the first instance to speak with the services concerned or to contact the PALS service which offer confidential advice and support. We acknowledged that this is a very challenging area.

5.6.5 The CCG also highlighted the following initiatives as key:

- *Compassionate Neighbours*: via St Joseph's Hospice. About 50 volunteers already trained and matched with clients in the community to

offer support on end of life issues. Patients referred in by GPs and care providers
- *VOICES survey*: carried out locally (see 5.3.8 above)
- *Dying Well Charter*: Hackney was chosen as 1 of 9 national pathfinders and the only one in London. This was focused on improving communication, coordination and joint responsibility and the previous CEO of St Joseph's led on this.
- *Project by St Joseph's* to engage communities which access less hospice care than others.

5.6.6 The CCGs own Patient and Public Involvement Committee is a formal sub-committee of the CCG's Governing Body. Membership of it comprises patient and service user representatives, Healthwatch, representatives of local community and voluntary sector groups as well as patient experience teams within the providers. They focused on Coordinate My Care in their recent discussions on EOLC but also on developing a CQUIN on 'shared decision making'.

5.6.7 The CCG's 'Planned Care Programme Board', 'Patient and Public Involvement' team and the Homerton Hospital developed a patient experience CQUIN (Commissioning for Quality and Innovation) to ensure that shared decision making is embedded within the relevant treatment pathways at end of life care. CQUINs are incentives which are built in to the various treatment pathways as part of the contract between the CCG/NHSE and the provider. Reaching the target then delivers financial rewards to the provider. The CCG told us that in their discussions on developing this incentive the following interesting issues arose:

- What is the role of carers if the patient is not deemed to have the capacity? (Doctor makes the decision but always in consultation with carers and family members)
- The importance of having discussions about Treatment Escalation Plans while acknowledging that it takes a long time to change people's behaviour and mind set
- Was there a potential role for community and voluntary sector organisations around facilitating some of these discussions with people? Could representatives of community and voluntary sector be trained to have these discussions?

We noted the last point with interest and develop this further in 5.9 below.

5.6.8 On Coordinate My Care the CCG's PPI committee noted that the current patient groups were chosen as they were most likely to be admitted to hospital unexpectedly and it is thought that patients with complex needs would benefit most from staff having access to their care planning records. The Committee explored what happens if patient hasn't got the capacity to give consent? Who can act of patients' behalf? Can they be pressurised into making decisions they don't want to make or decisions that have implications they can't understand? And were cultural considerations taken into account?

5.6.9 We noted with interest the key co-ordination issues which are being discussed in the 4 Quadrant Multi-Disciplinary Teams such as the Duty Doctor system being available in each GP practice, having District Nurses based in GP practices again, having the Charedi Jewish ambulance service added to CMC or the need to align different IT systems, noting that Elsdale GP Practice for example was piloting giving social workers access to EMIS (the GP Practices' patient records system). The latter roll-out to other GP Practices may be prevented, we learned, because of concerns about information governance rules, which all GPs must comply with. This issue needs resolving.

5.6.10 The Commission found that while each partner has well developed End of Life Care plans, there is a lack of alignment which can sometimes lead to a lack of leadership. The Homerton's Treatment Escalation Plans, though excellent, appeared very internally focused. We do appreciate however that TEPs are shared with GPs when a patient is in their Elderly Care Unit. A key issue was who needs to take the initiative and responsibility for having difficult conversations with patients and families and then making key decisions at the End of Life Care when someone is being cared for in the community, a care home or an acute setting. While we appreciate that is it the GP in the former two and the lead hospital clinician in the latter, lines of responsibility are often not clear enough to families. There are two issues here: How the Homerton can better support GPs about which patients might best benefit from an ACP and then ensuring that families and carers understand what is going on.

Recommendation Five
The Commission's recommends the CCG's EOLC Board to consider how lines of responsibility can be better communicated to families of EOLC patients so that it is clear to them who is taking responsibility at each stage of the process

5.6.11 Training in 'difficult conversations' around death and dying remains limited as does the overall limited amount of time which clinicians and staff spend on learning how to talk to and support end of life care patients and their families. The current staff pressures in the NHS also make it much more difficult for nurses and doctors to be spared from the front line for the repeated and necessary training calls that are on them. We would therefore argue that initial training is probably the best time to get these messages across.

Recommendation Six
The Commission requests the Chief Nurse of HUHFT and the Chair of the CCG's EOLC Board to report back on how training of clinicians in having difficult conversations around End of Life Care issues could be improved. This should include the need for Advance Care Planning, Advance Decision to Refuse Treatment, Do Not Attempt CPR plans and the need to get more patients onto systems such as 'Co-ordinate My Care'.

5.7 RAISING THE PROFILE

5.7.1 We heard a range of views about the ongoing communications challenge of increasing the profile of hospice services generally and the need to improve signposting of residents to the range of support which is currently available locally in end of life care. This is an ongoing challenge for the Hospice sector. We think there is a need to link in this work with what could be developed in Connect Hackney and the local VCS as well as to build on the GP Confederation's work on ensuring that GPs get better at referring appropriate patients to St Joseph's earlier.

5.7.2 The borough is lucky to have a long established centre of excellence in hospice care, St Joseph's, located here and we commend the breadth of work they do. They care for and support people affected by life-limiting conditions and terminal illness providing nursing and medical care, emotional support, practical advice, physical and psychological therapies, spiritual care as well as social and creative activities. At the hospice on Mare St they provide in-patient wards, respite wards, day hospice, out-patients clinic and a very well used community space. In the community they provide care in patient's homes, in care home and in other residential settings. They have c.300 staff, 400 volunteers and provides 42 beds across three wards. We were somewhat surprised on our visit however to note spare in-patient capacity, considering the complaints we hear from every section of the NHS about overcrowding pressures. We would seek assurance from St Joseph's that this is because their Community Palliative Care Team and the Community Nursing Service are successfully dealing with lower acuity patients in a community setting. We heard that those being admitted were increasingly of higher acuity, which would fit this pattern.

5.7.3 The range of support both to patients and their families and carers is impressive but the ongoing challenge is getting the message out to the community that it is there and tackling the stigma which unfortunately still persists around hospices. On our visit we spoke to some in-patients and the issue of general support for carers came up. We noted the diverse range of support which St Joseph's provide including: information and support, complementary therapies, physiotherapy, occupational therapy, dietetics, speech and language therapy, psychological therapies, social work services, welfare and benefits support and spiritual care and support. Complementary Services are crucial part of the mix but sadly receive no statutory funding and so have to be funded totally from their charitable side. On top of this they have a Live Well Information and Support Service which is specifically for those affected by a life-limiting but not necessarily terminal condition. We also learned about more specialist services such as Namaste care for people with dementia.

Recommendation Seven
The Commission requests St Joseph's to work with the CCG's End of Life Care Board on increasing awareness of St Joseph's services locally, including working towards equality of access for different communities in the borough and to better signpost other EOLC support in the borough. In particular there needs to be an emphasis on reaching and supporting carers. The plan should also consider how more specialist services such as St Joseph's Namaste care, for example, can be promoted.

5.7.4 The need for a community development approach to death and dying became more apparent to us as we proceeded with the review. While there is much that the statutory sector can do there are limits in terms of how they can begin to change behaviours and attitudes. Likewise in the community it is often down to community and voluntary sector to deliver the support and advice to improve end of life care. Key players here are Age UK and Marie Curie, both of whom we spoke to.

5.7.5 Age UK East London told us about their *My Life My Decision* programme which was delivered by them locally and funded from 2014-16 by the Big Lottery Fund. The aim was to support people aged over 50 to think about and plan their care in advance and help to ensure they have the death that is right for them. Age UK's national research revealed that while 82% of people have strong views about what treatment they would want or refuse to accept at end of life, only 4% of adults have made Advanced Care Plans or Lasting Power of Attorney for Health and Welfare[21]. The programme tested new ways of engaging people and communities, they developed person centred support, delivered one-to-one support and improved models of partnership between health services and voluntary organisations allowing healthcare professionals to refer patients to the programme to plan for their own care. The programme also provided training and awareness raising for professionals. The programme claimed a return on investment of 1:2.24, calculated on savings in unnecessary future hospital admissions or treatment and they made a strong case for such a programme to be replicated more widely to save more for the public purse.

5.7.6 We also heard from the Conscious Ageing Trust about a project they were running in Bridport in Devon on working with one locality to support them to develop what that called a Compassionate Community Hub. This comprised a Caring Network Forum, peer support groups and a range of community engagement activities including the 'Before I Die Wall', a 'mourning café and a social media platform. These 'Dialog Compassionate Community Hubs' as they are called use an approach which they term "grassroots up participatory development" i.e. citizen led participation in developing a community response to end of life care.

5.7.7 Closer to home we found a thriving example of this with the phenomenon of the 'Death Cafés. These community gatherings which invite people to tea

[21] Extract from *Summary learning from My Life, My Decision*, Agenda for Commission meeting 29 Nov 2016 p.121

parties where there are informal discussions about death and dying have spread all over the world (already 3,600 in 37 countries) and we met with their founder Jon Underwood, who is based in Hackney. We also took the opportunity to visit one which was held in St Joseph's. This attracted a packed crowd of over 100 people and combined a panel of interesting opening speakers who provided very useful information for participants, with a focus group like discussion (about 10 tables x 10) which was not moderated. These discussions then evolved organically and with the audience being a mix of interested local residents, the recently bereaved and some professionals, they provided a useful space for people to unburden and share experiences. A signature feature of Death Cafés is that the never direct people to any course of action and are always respectful of different attitudes to death and dying. Written guidelines are provided on how to set them up but they are not centrally controlled. They do not apply for funding as they do not collect data on those who attend which of course would be a requirement.

5.7.8 The National Council for Palliative Care and Hospice UK produced a key report entitled '*Each Community is Prepared to Help – Community Development in End of Life Care*' which outlined a public health approach to end of life care. The aim was to build on the National End of Life Care Strategy 2008 and in particular Ambition Six ('each community is prepared to help') of the *Ambitions for End of Life Care 2015-2020.* The approaches outlined are based on the principle that care at end of life should be done with and not to people and that death, dying, loss and care are complex social events of which the medical component is only one aspect. Solutions to the problems facing people such as social isolation, carer fatigue, stigma and fear are not the sole responsibility of professionals, it argues. Everyone has a role to play and these issues will only be truly tackled if a whole community approach is taken. One typical concern for example is about the over-medicalisation of the process of dying and Advance Care Planning may help health and social care partners to resist the reflex recourse to hospitalisation and people may therefore choose non-hospital deaths more often.

5.7.9 Building on the NCPC's *Each Community is Prepared to Help* report, Age UK's '*My Life My Decision'* project (the funding for which ended in 2016) and examples such as the 'Dialog Compassionate Community Hubs' in Devon, the Commission is asking the End of Life Care Board to examine the feasibility of developing something similar in Hackney.

Recommendation Eight
The Commission recommends to the End of Life Care Board to work towards making City and Hackney a 'Compassionate Community' as per Devon's 'Compassionate Community Hub' and report back on how the issues raised in the NCPC report could be taken forward locally. This would involve close working with HCVS, Age UK East London, Older People's Reference Group and Connect Hackney. The Hub would bring together a Caring Network Forum, Peer Support Groups and community engagement activities.

5.8 SUPPORTING VOLUNTARY AND COMMUNITY SECTOR

5.8.1 As we learned with Age UK East London and Marie Curie for example the community and voluntary sector has a key role in developing and improving end of life care working with providers and commissioners and the statutory sector. We learned about Connect Hackney which is a project led by older people, for older people in Hackney. It is managed by HCVS and has won a five-year funding package from the Big Lottery Fund's *Ageing Better* programme, which aims to prevent and reduce social isolation among older people.

5.8.2 Connect Hackney's primary focus obviously is in organising a programme of activities which help reduce social isolation for elderly people and we commend the work they've been doing and the principles of co-production which drives their activity. As they are dealing with older people we would consider them an important vehicle for reaching this group with messages about thinking ahead and perhaps making plans for end of life care. They could be instrumental for example in helping to break down the stigma that exists in talking about these issues and, as part of the general support they provide this age group, they would be a perfect vehicle for increasing the awareness of what help is available for those caring for partners at end of life and what support is available for the bereaved.

5.8.3 To this end we are asking the Connect Hackney Steering Group and its partners in HCVS to consider taking forward the Compassionate Community Hub concept locally. As is done elsewhere such activity could explore what options are currently available to families and carers, the importance of hospices and the need for Advance Care Plans, making a will, funeral planning, plans for care of pets after death, digital legacy, organ donation etc. We would like to request Connect Hackney if it might consider establishing event(s) which would combine the best elements from Age UK seminars on end of life care with the 'Death Café' events i.e. combining practical support/information with a discussion on people's emotional responses to death and dying.

Recommendation Nine
The Commission requests Connect Hackney to consider using part of its funding to increase awareness about End of Life Care issues for older people. This could focus on what is the current local offer and how it might be improved.

5.8.4 In addition we would also like to echo the suggestions which emerged from the CCG's Patient and Public Involvement Committee on whether there might be a role for the wider community and voluntary sector organisations around facilitating discussion with people at End of Life stage. Could representatives of the relevant local community and voluntary organisations be trained to have these discussions? This might be particularly fruitful within BME communities where the take up of hospice services is poor.

5.8.5 We learned from St Joseph's about their excellent Compassionate Neighbours programme. This is a free community-led support for anyone living with or caring for a person with a serious, long-term or terminal illness, or a person who is frail and/or isolated. Compassionate Neighbours are a network of trained volunteers who are willing to offer their time, companionship and support to people living in their own community. The scheme is growing rapidly and has been highly commended as an example of best practice for others to follow.

5.8.6 Our suggestion about encouraging volunteers in local VCS organisations to facilitate (most likely group) discussions on end of life would be separate from but complement Compassionate Neighbours. It would focus on helping people with the practicalities of end of life care planning (the basics of Advance Care Planning) rather than the more one-to-one befriending support which Compassionate Neighbours provides. It was clear from the large numbers attending the Death Café for example that there is a demand in the community for a space to talk but also a place to go and hear what you need to be doing, should you have dying relative or friend.

Recommendation Ten
The Commission requests HCVS and in particular Connect Hackney and Age UK East London to examine how there might be a greater role for the sector locally in facilitating discussions with patients at End of Life stage. This could focus on the desire to die at home, the need for ACPs, the need for a will, the need to consider lasting power of attorney for health and welfare decisions etc. This builds on the work of St Joseph's 'Compassionate Neighbours' volunteers but would have a focus on end of life care planning rather than general support and befriending.

5.8.7 We learned that a key issue for the volunteers who work in St Joseph's Compassionate Neighbours scheme is that they can often get heavily involved in attempting to sort out their client's welfare rights issues. Often problems are far too acute for a Compassionate Neighbours volunteer to manage. We also learned that the potential of the scheme was perhaps not as fully appreciated as it could be within Adult Social Care. We'd like to suggest that there is scope therefore for St Joseph's and Adult Services in the Council to liaise here to their mutual benefit.

Recommendation Eleven
The Commission requests the Council's Adult Services and the Compassionate Neighbours Co-ordinator at St Joseph's to explore how the Compassionate Neighbour volunteers can better signpost clients into council advice and support services and on the other hand how social workers might be able to refer possible clients who are socially isolated into the Compassionate Neighbours scheme, therefore maximising take-up of it.

5.9 CULTURAL SENSITIVITY

5.9.1 End of life care issues are very much linked to culture and traditions. These vary between communities and we acknowledge how challenging it is for the Homerton or St Joseph's to tailor their services to suit a highly diverse borough such as Hackney. We heard from the local Charedi community and we visited their key nursing home Beis Pinchas in Stamford Hill. In our discussions with community representatives we heard about instances whereby Charedi families appeared to be reticent to raise legitimate complaints about treatment of their loved one during end of life at the Homerton Hospital because they felt that the complaint might trigger post mortems or autopsies to which they have specific cultural objections. They therefore worried that a complaint from them could lead to the body of a loved one not being released for burial immediately after death, which is a key religious requirement for them.

5.9.2 Interlink Foundation has been very active in progressing these issues with local providers. They have already recommended in various forums and committees that Palliative Care Teams need to be trained in Charedi ethical principles around end of life care and Charedi patients should be advised to seek advocacy support when admitted to mainstream services. They recommend that Palliative Care Teams have a good dialogue with experts in Jewish law and the clinical aspects of end of life. They also argue that the 'Duty of Care' has to cover basic care needs of nutrition, hydration and medication. They explained that according to Jewish law, a number of factors would be taken into account including how seriously ill a patient was and momentary pain versus long term pain. They also talked to us about the need for greater sensitivity in conveying information to patients' where there is a terminal prognosis.

5.9.3 We were contacted by Interlink North West in Salford where they have developed a project called "Chayim Aruchim"[22] (Hebrew for long life) which comprised a team of 10 Rabbis, 2 retired GPs and legal advisors. The project developed a bespoke advance directive amongst the core team so they could better support Jewish families with end of life or crisis care. Again they pushed for 'Care advocates' to support families in case meetings so as to lower tensions. They also described how they got their Community Nursing Team to provide subcutaneous drips to their patients, including with glucose added, which they say has significantly reduced the need for hospitalisations for these people at end of life.

5.9.4 We noted a report they produced in October 2014 for Healthwatch Hackney and the CCG entitled *Community Insight Report – Patient Centred Care* which contained some specific recommendation on End of Life Care. Here again they raised concerns about disclosing a terminal prognosis arguing that they "put a great emphasis on the sanctity of human life and conveying positive

[22] *Chayim Aruchim – 7 key points to know when caring for Orthodox Jewish Palliative or Hospice Care Patients*, Interlink North West, 2016.

message to inspire hope and recovery"[23]. They add that "*there is a culture within the NHS and social care of openness and sharing of information with patients which does not sit comfortably with Charedi culture. Often relatives may request that the patient should either not be told or be protected from the full impact of the diagnosis, which is often disregarded by clinicians. Family wishes are disregarded in the name of the protocol"*[24] they argued. They object to the words 'hospice' or 'end of life care' being used in the presence of the dying patient and to staff providing a prognosis with explicit timelines of life expectancy. Whilst we appreciate there are cultural sensitivities here, as a Commission we support the current NHS guidance that a patients' right to know and to make their own decisions supersedes the rights of their family in these situations.

5.9.5 Interlink also made some useful recommendations on better flexibility in use of allocated care hours (to accommodate cultural factors) and they asked if greater thought could be given to the importance of commissioning specific Charedi provision alongside general provision.

Recommendation Twelve
Whilst the Commission supports the current NHS guidance that a patients' right to know and to make their own decisions supersedes the rights of their family, the Commission would like HUHFT and St Joseph's to explain what work they are doing with the Charedi community to address that community's concerns about what they consider as a lack of culturally appropriate end of life care. The Commission also requests St Joseph's to report on progress being made in driving up the use of the hospice by other BME communities where there may be other cultural sensitivities.

5.10 CHILDREN'S PALLIATIVE CARE

5.10.1 We visited Richard House in Beckton which is London's first children's hospice, supporting families whose children (babies, children, young adults) are life limited, life threatened or have complex health conditions. The majority of their patients have congenital or genetic conditions e.g. muscular dystrophy, Duchene syndrome, congenital heart conditions, brain injuries (accident or premature birth). They deal with few oncology cases as these require urgent treatment in specialist cancer centres. Their focus is primarily respite care rather than long stay and their work is more akin to Long Term Conditions treatment. They look after families and also provide ante-natal care. They currently have 4 beds and 2 family flats. They provide holiday short breaks (respite for families) and step down care from hospital and they work closely with Children's Community Nurses to put in place a package of care

[23] *Community Insight Report – Patient Centred Care*, Oct 2014, Interlink Foundation for Healthwatch and CCG, p.17.

[24] ibid

5.10.2 We learned from them about the recent national survey of children's palliative care[25] which found that:

- The number of babies, children and young people with life-limiting or life threatening conditions is increasing and the demand for services is growing
- Statutory funding for children's palliative care charities in England is declining and is patchy
- Short breaks are essential to families and local authorities have a duty to make sure they are provided to disabled children, yet many have cut funding for children's palliative care charities
- Over half of charities would have to cut services if the children's hospice grant was removed
- There is a need for parity with adult services for seriously ill children all over the UK, (they also argue that Scotland appears to have got the balance right).

5.10.3 Richard House made the case to us that specialist care for children ideally needs to be planned on a larger footprint than is currently the case and this is because there is too much disparity between funding and commissioning arrangements across neighbouring boroughs. They are therefore fully supportive of any moves which the NEL STP might make in redesigning support for children's palliative care around a larger footprint. Similarly they asked us if any reviews of Urgent Care and GP Out-of-Hours Services could also encompass acute and community care of children at end of life, so as to get more children out of acute hospitals sooner.

5.10.4 They also reminded us that it is important to challenge thinking that a hospice is seen as 'giving up'. A typical scenario would be that a patient receiving children's palliative care would be likely to pass away in c.3 years, so the focus would be what can be done in the interim to enhance the quality of the time they have left.

Recommendation Thirteen
The Commission recommends the Cabinet Member of Health Social Care and Devolution include the concerns of the children's palliative care sector when considering the reconfiguration proposals underway as part of the NEL STP. This also applies to reconfiguration of Urgent Care and Out of Hours Services. Children's palliative care would benefit from being planned across a larger footprint than is currently the case. Variations in funding and structure of support available across borough boundaries makes it difficult for Children's Hospices to plan their services.

[25] *On the brink: a crisis in children's palliative care funding and commissioning in England 2015/16*, Together for Short Lives, November 2016. www.togetherforshortlives.org.uk

CONCLUSION

6.1 The recent local VOICES survey of bereaved relatives and carers in City and Hackney[26] found that end of life care in Hackney was generally rated 'very good' or 'good' across all providers. We always need to learn however from those who felt that care could be better and these respondents expressed a desire for better communication and coordination between services, more compassion from healthcare staff and easier access to out of hours services, as well as better pain control, in particular for patients receiving care at home. After our review we would echo all these points and ask local commissioners and providers to look more closely at these aspects.

6.2 It was interesting to note that while two thirds of the respondents to the local VOICES survey wished their family member to die at home yet only half actually did. There are a number of possible reasons for this. Firstly 42% of the aged 65+ population in Hackney are in single person households[27] and this is rising. There are also links between the proportion dying in hospital and general levels of deprivation (see Appendix 2) with poorer wards having higher rates of hospital deaths. The reason here is that poorer people are more likely not to have the level of support at home which could sustain them throughout a lengthy period of decline and death.

6.3 The review caused us to question whether there are unreal expectations about the nature of death and dying mixed in with the current drive by acute providers to ensure more people die at home. It became clear to us that if rates of dying at home are to be increased there needs to be in place a range of provision so that care can be escalated when needed. Dying at home can be messy and painful for both the patient and carer, who are often old and frail themselves. It is also protracted and needs will escalate and alter. There is a need to plan for these changes so that there are no sudden admissions to hospital when a carer is simply no longer able to cope. This brings us to the long term problem of patients being moved to hospices at too late a stage.

6.4 The Safeguarding Adult Review case of Mr GH demonstrated that he was referred to St Joseph's too late. It also underlined the importance for patients, particularly single people living alone, of having a champion who can navigate the complex matrix of health, social care, community nursing, sheltered housing support which the person is receiving and apply pressure when it is needed. "Who owns the case" became the conclusion of that case review and we understand it is a common theme in others. The answers to this are too often not satisfactory.

6.5 Hackney is fortunate to have a major, highly regarded, hospice like St Joseph's at our doorstep and they are rightly commended for the diverse range services they provide. How to drive up use of the hospice and how to tackle the stigma that still surrounds hospices is an ongoing challenge

[26] VOICES Survey – City and Hackney 2015-16, City and Hackney CCG/ Homerton University Hospital/ St Joseph's Hospice, November 2016

[27] Briefing from HUHFT to HiH on 10 Oct 2016

however. While they are making great strides in attracting referrals from people from our local BME communities there is always more to be done. We hope that expansion of the Compassionate Neighbours scheme will be a conduit for driving up use of the hospice in the future.

6.6 We learned how St Joseph's, Age UK East London and other providers suffer from the fact that their funding tends to be short term and fragmented and this proves a real hindrance to their ability to plan and grow. They are not alone in this. A typical scenario is that they receive pump priming for an important new initiative which is being trailed, they put in the investment, start it up, and then funding ends and initiatives can't be sustained, but soon along comes another new but slightly amended variation of the same thing. This short termism wastes both time and money and it is unfortunate for example at Age UK's very useful *My Life My Decision* project has ended.

6.7 Both the care homes we visited had an interesting and persuasive perspective on promoting the concept of dying at home. From their point of view they seek to create a 'home' for their residents where these people live and die with the medical support they need around them. They argue that we need to remain more open-minded and flexible in considering what constitutes "home".

6.8 Poor communication with patients, carers and families and the struggle to ensure there is sufficient take up of the necessary training for clinicians and health care workers remains a problem. At its simplest the choice of words is key when communicating with patients about end of life care and it is vital to ensure that patients do not feel abandoned or feel that care is being withdrawn. Knowing when to have the "difficult conversation" with patients, their families and carers and crucially, feeling confident in holding these conversations, is key and more efforts need to be made by bodies such as Health Education North Central and East London (HENCEL) to expand learning opportunities for these "soft skills". On the flip side of that there is the need too for medical staff to avoid unnecessary or unwanted escalations of care because of a lack of confidence in dealing with anxious families.

6.9 As with all our reviews we came across the problems arising from the fragmentation of health and social care as it gets more complex. As budget pressures get more severe there is a need prevent cost shunting across the health and social care partners and a need to prevent a culture of blame from emerging. This can be inevitable when everyone at each stage of the pathway is feeling under pressure but tackling this must be a priority for the new the new integrated care model under the Hackney Devolution Pilot.

6.10 Looking to the future it is clear that GPs, the Homerton, St Joseph's and Adult Social Care will be fully engaged in improving this area of care. GPs in particular via Co-ordinate My Care have taken on the IT challenge of creating shared care plans. The journey to fully integrated care plans shared across all sectors is not yet achieved and may take some time to be fully implemented, but in the meantime, the CMC platform is acknowledged as the best option available to improving communication amongst health care professionals

involved in end of life care and so improving the care provided to patients at the end of life.

7. CONTRIBUTORS, MEETINGS AND SITE VISITS

7.1 The review's dedicated webpage includes links to the terms of reference, findings, final report and once agreed, the corporate response. This can be found at http://www.hackney.gov.uk/end-of-life-care-review

7.2 Evidence was gathered at the following meetings:

1.) Site visit to NHS Community Voices event 'Dying well in City & Hackney' at CLR James Library on 20 October 2015
Attending: Cllrs Sales and Snell

2.) **Site visit to DEATH CAFÉ held at St Joseph's Hospice on 11 May 2016**
Attending: Cllrs Munn, Patrick, Peters, Potter, Sales, Snell

3.) Site visit to ST JOSEPH'S HOSPICE – 22 September 2016
Attending: Cllrs Munn, Patrick, Peters, Potter, Sales, Snell

Met with: Mary Flatley (Lead Nurse, In-patient Unit), Beverley John (Information and Support Service Assistant), Micaela Loveridge (Clinical Governance Lead), Carly Attridge (Volunteer Services Manager), Ann Hines (Volunteer), Libby Fry and Sarah Mooniamah Salem (Compassionate Neighbours Volunteers), Sally Muylders (Compassionate Neighbours Programme Manager), Dr Libby Sallnow (Palliative Care Specialist), Marianne Mestern (Community Nursing Lead), Ruth Bradley (Interim Chief Executive), Linda McEnhill (Interim Director of Care), Diane Laverty (Nurse Consultant Respite Care) and Dr Sam Edward (Medical Lead and Consultant in Palliative Medicine).

4.) Site visit to CITY AND HACKNEY CCG/Dr Max Mackay-James/Jon Underwood (founder of 'Death Cafes') on 5 October 2016 at CCG office.
Attending: Cllrs Munn, Hayhurst, Patrick, Peters, Potter, Sales, Snell

Met with: Dr Meena Krishnamurthy (Lead GP for End of Life Care, CCG), Jan Annan (Head of Outcomes and Evaluation, CCG), Dr Max Mackay-James (Conscious Ageing Trust), Jon Underwood (founder Death Cafés). Apology from Jennifer Walker (Programme Director, One Hackney and City), input added via Jan Annan.

5.) Site visit to ACORN LODGE CARE CENTRE on 6 October 2016
Attending: Cllrs Munn, Patrick, Peters, Potter, Sales, Snell

Met with: Diane Jureiden (Home Manager) and Julie Cornish (Administration Manager)

6.) Site visit to BEIS PINCHAS NURSING HOME on 6 October 2016
Attending: Cllrs Munn, Patrick, Peters, Potter, Sales, Snell

Met with: Mrs Ita Symons and other staff

7.) Commission Meeting on 10 October 2017.
Attending: Cllrs Munn, Hayhurst, Patrick, Peters, Potter, Sales, Snell

Evidence from: Sheila Adam (Chief Nurse and Director of Governance and Honorary Professor of Nursing Leadership, Homerton University Hospital NHS Foundation Trust (HUHFT)), Dr Martin Kuper (Medical Director, HUHFT), Dr David Feuer (Consultant, HUHFT), Linda Athey (Lead Nurse Cancer and Palliative Care, HUHFT), Leanne James (Lead Nurse Cancer and Palliative Care, HUHFT), Margaret Howat (User Engagement Forum, HUHFT), Genette Laws (AD Commissioning, Adult Social Care, Hackney Council), Alexis Howsam (Divisional Business and Service Development Manager, Marie Curie Care/Pan London End of Life Alliance) and Rachael Chapman (Service Innovation and Improvement Lead, Marie Curie Care/ Pan London End of Life Alliance)

8.) Site visit to RICHARD HOUSE CHILDREN'S HOSPICE 28 Nov 2016
Attending: Cllrs Munn, Potter and Sales.

Met with: Caroline O'Connor (Director of Finance) and Hazel Ryan (Statutory Partnerships Manager). Also input from Peter Ellis (Chief Executive).

9.) Commission Meeting on 29 November 2016
Attending: Cllrs Munn, Hayhurst, Patrick, Peters, Potter, Sales, Snell

Evidence from Amaia Portelli (Practice Support Manager, GP Confederation), Dr Stephanie Coughlin (Board Member and local GP, GP Confederation), Deborah Hayes (Director of Individual Services, Age UK East London), Philip Adams (Project Co-ordinator, Age UK East London), Shirley Murgraff (Chair, Older People's Reference Group), Sarah Weiss (Interlink Foundation), Ita Symons (Agudas Israel Housing/Beis Pinchas Nursing Home)

Also attended:

10.) Older People's Reference Group at CCG on 10 June 2016
O&S Officer attended on behalf of the Chair. Observed meeting of the Advisory Group of the Older People's Reference Group (i.e. its Executive Committee) chaired by Cynthia White. Group comprises about a dozen Hackney residents.

11.) Managing Medicines at End of Life held at CCG on 10 November 2016 O&S Officer attended to observe, on behalf of the Chair, a stakeholder review meeting on 'Anticipatory Prescribing and End of Life Care'. This meeting arose because the CCCs Prescribing Board had received concerns about this issue from various GPs. This is on-going performance improvement work led by the CCG and involving all the key partners.

8. MEMBERS OF THE SCRUTINY COMMISSION

8.1 The following served on the Commission during this review

Councillor Ann Munn (Chair)
Councillor Ben Hayhurst (Vice Chair)
Councillor Sharon Patrick
Councillor James Peters
Councillor Clare Potter
Councillor Rosemary Sales
Councillor Peter Snell

Overview and Scrutiny Officer:	Jarlath O'Connell ☎ 020 8356 3309
Legal Comments:	Dawn Carter McDonald ☎ 020 8356 4817
Financial Comments:	Mizanur Rahman ☎020 8356 4223
For this review:	
Lead Group Director:	Anne Canning, Group Director - Children, Adults and Community Health
CCG Lead:	Paul Haigh, Chief Officer
Lead Cabinet Member:	Cllr. Jonathan McShane, Cabinet Member for Health, Social Care and Devolution

9. FURTHER READING

9.1 The agenda pages for the Commission meetings on 10 October 2016, 29 November 2016 and 16 January 2017 on the Hackney Council website contain minutes of the evidence sessions, background briefings/papers submitted and notes on the site visits.

9.2 The following documents have also been relied upon in the research:

National:

- *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020*
- *Transforming end of life care in acute hospitals: The route to success 'how to' guide (NHSE Dec 2015)*
- *NICE guideline on care of dying adults in the last days of life*
- *Actions for End of Life Care 2014/16, NHS England*
- *One Chance to Get it Right: the Leadership Alliance for the Care of Dying People, June 2014*
- *More Care, Less Pathway: A review of the Liverpool Care Pathway 2013*
- *Dying without Dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life*
- *End of Life Care - House of Commons Health Committee report 2015*.
- *End of Life Care Audit – Dying in Hospital*, *an national report for England* (Royal College of Physicians/Marie Curie; 2016

Note: The National Palliative and End of Life Care Partnership's *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020* is aimed at local health and social care and community leaders. It builds on the Department of Health's 2008 *Strategy for End of Life Care* and responds to an increased emphasis on local decision making in the delivery of palliative and end of life care services since the introduction of the Health and Social Care Act 2012

Local/ sub-regional:

- Draft Hackney Health and Wellbeing Strategy 2015-18
- City and Hackney Health and Wellbeing Profile: Our Joint Strategic Needs Assessment, 2011/12, updated 2016. Hackney Council and City of London
- End of Life Care in London, Report of London Assembly's Health Committee, February 2016

9.3 The following web resources are also useful.

e-ELCA e-learning for end-of-life care
End of Life Care for All (e-ELCA) is an e-learning project for the NHS, commissioned by the Department of Health and delivered by e-Learning for Healthcare (e-LfH) in partnership with the Association for Palliative Medicine of Great Britain and Ireland. It was developed to support the implementation of the Department of Health's national End of Life Care Strategy.
www.elfh.org.uk/projects/end-of-life-care

Gold Standards Framework for Community Palliative Care
Offers primary healthcare teams an evidence-based programme with the tools and resources to help improve the planning of palliative care for their patients in the community. The National Gold Standards Framework (GSF) Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life. www.goldstandardsframework.org.uk

General Medical Council (GMC)
Treatment and Care Toward the End of Life: good practice in decision-making; 2010. www.gmcuk.org/guidance/ethical_guidance/end_of_life_care.asp

NICE: End of Life Care Quality Standard
This NICE quality standard defines clinical best practice within this topic area. It provides specific, concise quality statements, measures and audience descriptors to provide the public, health and social care professionals, commissioners and service providers with definitions of high-quality care. http://guidance.nice.org.uk/QS13

Palliative Care Matters
Palliative Care Matters is a website intended for health-care professionals working in palliative care or related fields. It includes the Palliative Care Handbook. www.pallcare.info

RCGP End of Life Care Resources
This provides useful information and links to resources on end of life care www.rcgp.org.uk/end_of_life_care/home.aspx

Charitable organisations

Macmillan Cancer Support
Offer practical advice and support for patients and families affected by cancer. www.macmillan.org.uk

Marie Curie Cancer Care
Offer practical advice and support for patients and families affected by cancer. www.mariecurie.org.uk

Hospice UK
Champions and supports the work of member organisations, which provide hospice care across the UK, so that they can deliver the highest quality of care to people with terminal or life limiting conditions, and support their families. www.hospiceuk.org

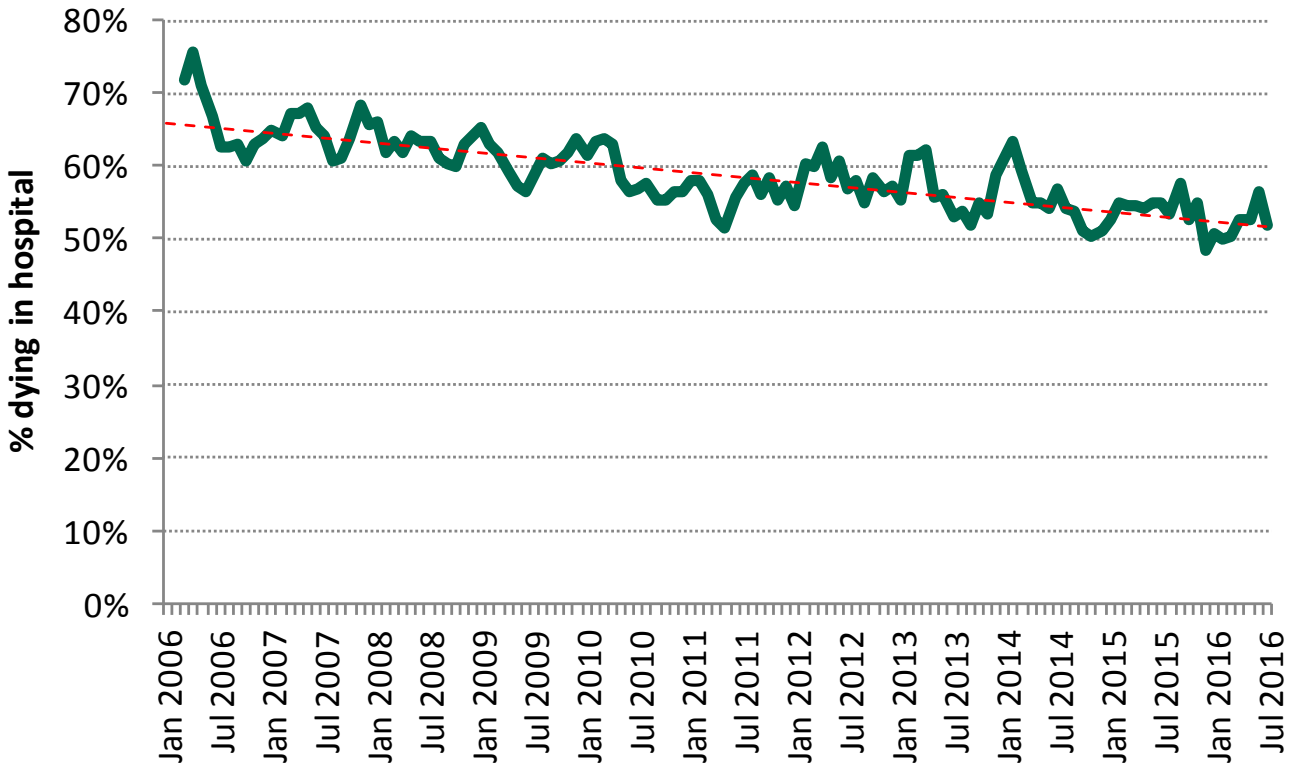
10. GLOSSARY

Acorn Lodge	Is a 98 bed nursing care home in Clapton which is also able to accommodate residential, respite and palliative care needs. It is one of 4 homes which are part of the Lukka Homes Group.
Advance Care Plan	Advance Care Planning is a voluntary process of discussion and review to help an individual who has the capacity to anticipate how their condition may affect them in the future. If the person wishes to they can set on record choices about their care and treatment (known as Advanced Statement) and/or an Advance Decision to Refuse a treatment in specific circumstances. These choices can then be referred to by those responsible for care and treatment (whether professional staff or family carers) in the event that the person loses capacity to decide once their illness progresses.
Advanced Decision to Refuse Treatment	This is a legally binding refusal of medical treatment in advance of a time that you lose capacity.
Advance Statement	This allows you to write down your wishes and preferences in case you become unwell and need care or medical treatment.
C&H CCG	NHS City and Hackney Clinical Commissioning Group
Beis Pinchas Nursing Home	Is a nursing home in Stamford Hill for the Charedi community which is part of Agudas Israel Housing Association. They have 43 residents in sheltered housing and 43 in nursing care as well as some respite beds.
CHSAB	City & Hackney Safeguarding Adults Board
CHUHSE	City and Hackney Urgent Healthcare Social Enterprise is the organisation which has the contract for providing GP Out of Hours Services
City and Hackney Together	This is a consortium run by HCVS focusing on helping local third sector organisation, which lack the capacity, to win contracts on their own. It also encourages joint bids as joint working becomes more central to tendering.
CMC	An online care planning platform for frail elderly patients and those patients at the end of their lives. It is commissioned by the CCG and run by the GP Confederation.
CNS	Clinical Nurse Specialist
Compassionate Neighbours	Compassionate Neighbours is free community-led support for anyone living with or caring for a person with a serious, long-term or terminal illness, or a person who is frail and/or isolated. They are a network of trained volunteers who are willing to offer their time, companionship and support to people living in their community.
Connect Hackney	Connect Hackney is a project led by older people, for older people in Hackney. It is managed by HCVS and has won a five-year funding package from the Big Lottery Fund's *Ageing Better* programme, which aims to prevent and reduce social isolation among older people.
CQUIN	CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. CQUINs sets an agreed target against which the health provider achieves rewards on reaching an agreed set of outcomes. These are used in the NHS to drive up performance.
Death Café	Death Cafes are informal, facilitated conversations around death and dying using a tea party format.
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
GP Confederation	City and Hackney GP Confederation is made up of a membership of all 43 City & Hackney GP practices The Confederation provides true population coverage, mitigating against uneven service provision. In other words, the Confederation works with practices to provide help and support as well as direction, to ensure

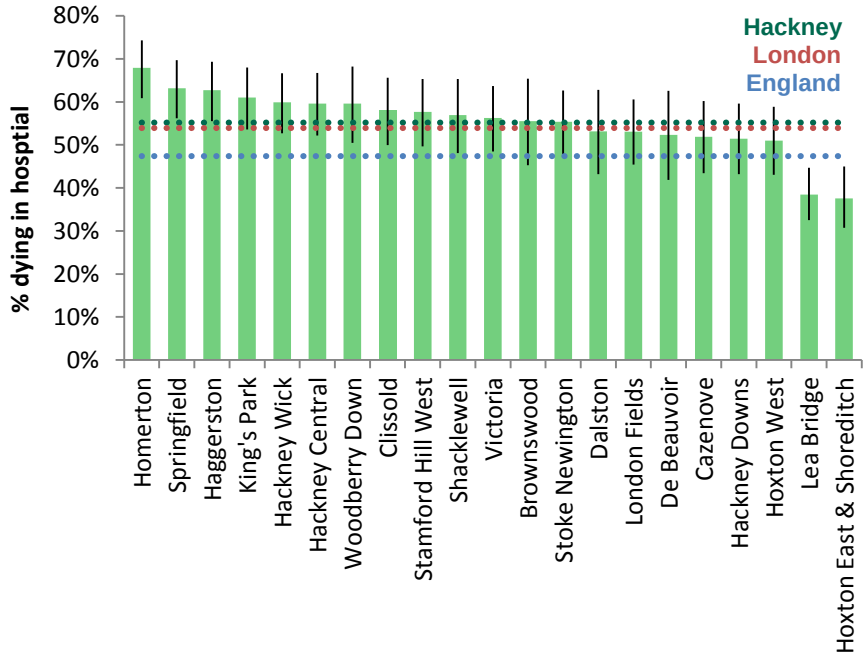
	that all practices deliver care and services of equal high quality.
HENCEL	Health Education England (HEE) is the national NHS organisation responsible for the education and training of all current and future NHS employees. HEE exists for one reason: to improve the quality of care delivered to patients. Health Education North Central and East London (HENCEL) is one of 13 local committees of HEE known as a Local Education and Training Boards (LETBs). HENCEL is responsible for ensuring that high quality education and training is provided to all health professionals including the next generation of doctors, dentists and nurses in North Central and East London.
HUHFT	Homerton University Hospital NHS Foundation Trust
Lasting Power of Attorney	LPAs give someone your trust the legal power to make decisions on your behalf in case you later become unable to make the decisions for yourself. They are registered with the Ministry of Justice's OPG. There are two types: LPA for Property and Financial Affairs LPA for Health and Welfare
Namaste Care	Namaste Care™ is a program designed to improve the quality of life for people with advanced dementia. Namaste, is a Hindu term meaning "to honour the spirit within" and was selected to describe a program that brings honour to people who can no longer tell us who they are or who they were or care for themselves without assistance.
NEL STP	North East London Sustainability and Transformation Plan is one of 33 national plans to reconfigure the NHS. Its footprint covers the CCG areas of: City and Hackney, Tower Hamlets, Newham, Waltham Forest, Barking & Dagenham, Redbridge and Havering.
One Hackney and City	One Hackney and City was a pilot to provide more co-ordinated services for the most vulnerable, high risk patients in City and Hackney. Integrated Care Teams, provided care that crossed the boundaries between primary, community, voluntary, acute and social care services.
OOH	Out of Hours. Used in context of GP Out of Hours services.
Richard House	Richard House in Beckton is London's first children's hospice, supporting families whose children (babies, children, young adults) are life limited, life threatened or have complex health conditions.
St Joseph's	St Joseph's Hospice cares for and supports people affected by life-limiting conditions and terminal illness. They provide nursing and medical care, emotional support, practical advice, physical and psychological therapies, spiritual care as well as social and creative activities. At the hospice on Mare St they provide in-patient wards, respite wards, day hospice, out-patients clinic and a community space. In the community they provide care in patient's homes, in care home and in other residential settings. It has 300 staff, 400 volunteers and provides 42 beds in three wards.
Unplanned Care Board	One of the new bodies under the Integrated Commissioning Board, the others will cover Planned Care, Prevention, Early Years & Children. This takes on the work of the One Hackney and City Pilot which has come to an end.

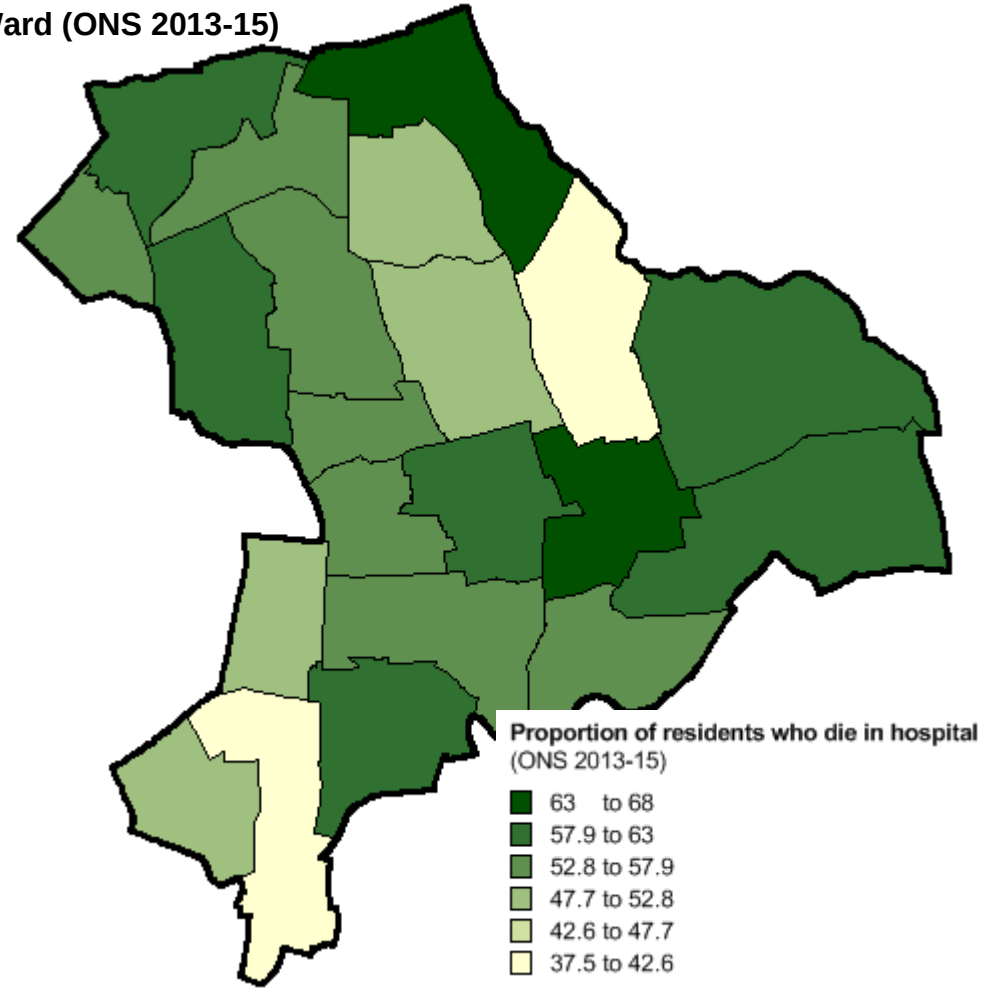
11. APPENDICES

Appendix 1: Proportion of City & Hackney residents who die in hospital – 3 month rolling averages, January 2006 to July 2016 (ONS)

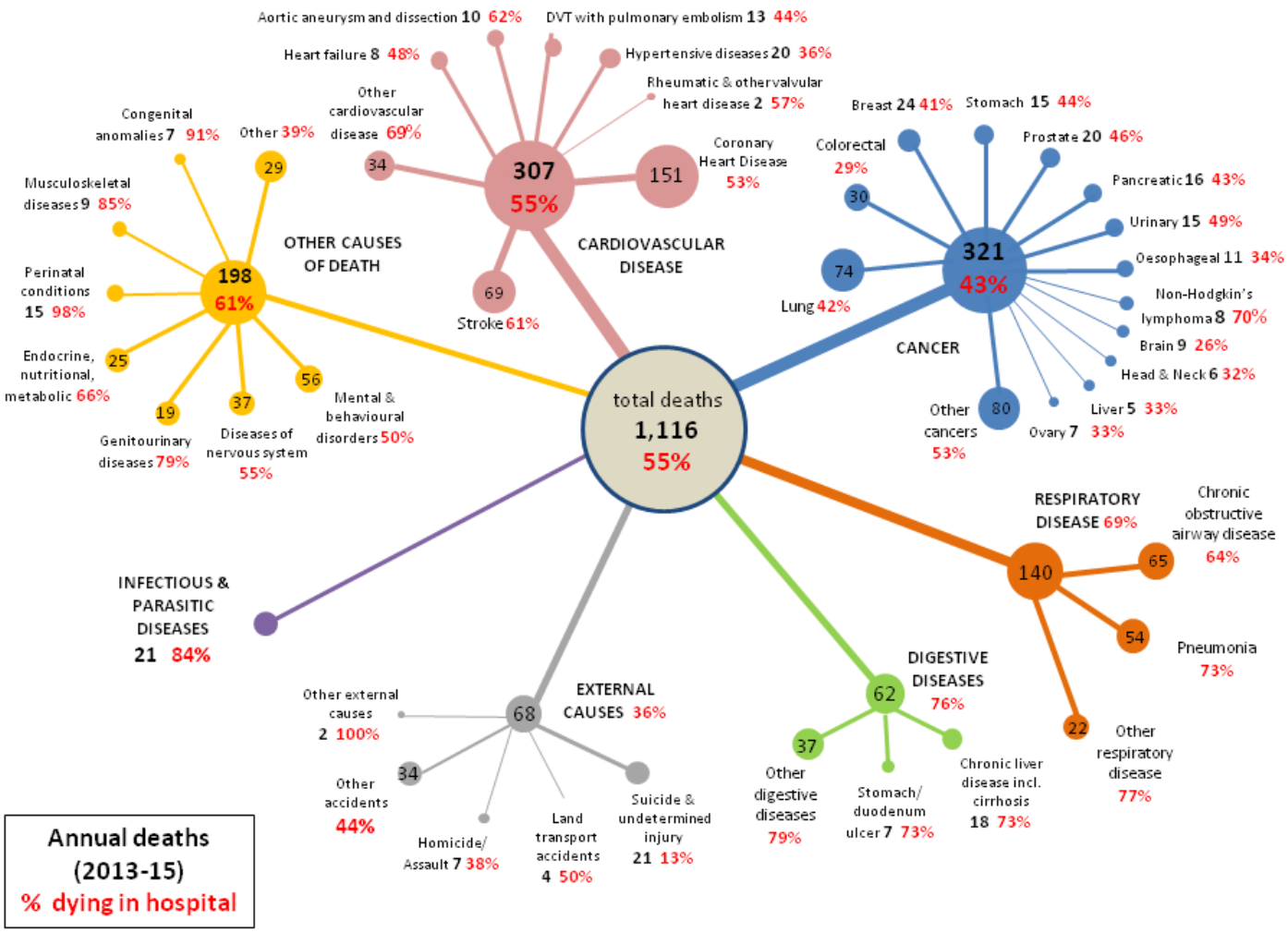


Appendix 2: Proportion of residents who die in hospital, by Ward (ONS 2013-15)





Appendix 3: Proportion of City & Hackney resident deaths in hospital by cause of death (ONS 2013-15)



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Cabinet Response to the Health in Hackney Scrutiny Commission Review into End of Life Care	
CABINET MEETING DATE **24 July 2017**	**CLASSIFICATION** **Open**
WARD(S) AFFECTED **All Wards**	
CABINET MEMBER **Cllr Jonathan McShane** **Health, Social Care and Devolution**	
KEY DECISION **No**	
GROUP DIRECTOR **Anne Canning** **Children, Adults, Community Health**	

1. Introduction

1.1. It has been one of the great ambitions of public health in Hackney to improve the end of life care that is provided in our borough, and to have a service that supports those at such a difficult and challenging time to make informed choices, surrounded by those who care for them, and supported by professionals who are sympathetic and empathetic to their individuals needs and requirements.

1.2. The Commission's review, and the responses from some of our partners, indicates the seriousness with which end of life care is taken, and that it is fully recognised that ensuring our residents, and those who care for them, are able to take control provides a level of dignity and freedom in the final stages of life that can ease pain and provide comfort.

1.3. However recent reports indicate that there is much more to be done across all sectors to truly deliver the levels and type of care that we would all expect and want for our loved ones, and ourselves. It is my hope that this timely report from the Scrutiny Commission provides the necessary clarity to help us realise the ambition we have for Hackney.

1.4. I commend this report to Cabinet.

2. Recommendation

2.1. The Cabinet is asked to approve the content of this response.

3. Executive Response to the Scrutiny Recommendations

Recommendation One The Commission recommends that the new Unplanned Care Board use the new Quadrant work stream to ensure that processes for communication with patients at end of life and coordination between agencies are firmly in place, that they continue to be adhered to and that work is undertaken to improve them.	The City and Hackney Clinical Commissioning Group (CCG) Unplanned Care Workstream have confirmed that they are currently in the process of developing their work plan and are using data analysis to drive the development of a business case for the revised 'quadrant model'. Data analysis is expected to be completed over the summer, meaning that full implementation of the revised model will start later in 2017, or early 2018. An update can be provided for the Scrutiny Commission.

Recommendation Two The Commission requests the GP Confederation, as operators of the Coordinate My Care system, to: (a) Ensure all health partners are active in ensuring that there is greater uptake of CMC . (b) Ensure that all relevant health and care providers can and do access CMC records for patients in their care (c) To report back on the pilot whereby social workers were given access to a GP Practice's EMIS system and the viability of extending this. (d) Explain why patients of children's hospices are not currently included in CMC.	Coordinate My Care (CMC) is an NHS clinical service currently available across London and funded by the 32 Clinical Commissioning Groups (CCGs). It is designed to empower patients to have choices about the care they receive and to make those choices known to those who care for them. In Hackney, CMC is under the governance of the Integrated Care Programme Board, which comprises the City and Hackney CCG, the London Borough of Hackney, The City of London Corporation, East London NHS Foundation Trust, Homerton University Hospital, One Hackney and the City, and the City and Hackney GP Confederation. The Programme Board is working to ensure uptake is maximised amongst all relevant partners. In part this will be done through the wide use of the EMIS Web, a

	clinical system that allows our health partners to record, share, and use vital patient information in order to provide better and more efficient care. Within that system all patients with CMC care plans created under the end of life care contract and frail home visiting contract are flagged. The Integrated Care Programme Board has agreed that CMC will be used as the shared urgent care plan for end of life care patients and frail elderly patients across as many care settings as possible. Implementation will be staggered to make sure it's embedded properly, that staff are fully trained, and that it integrates with our existing systems. With that being successfully delivered this year the roll out will be widened to include other patients, including children. The widening process will include bringing on relevant partners. An update on the roll-out of CMC can be provided to the Scrutiny Commission when complete.

Recommendation Three The Commission requests the Chief Nurse of HUHFT to explore how, as part of their initial and continuing training, the Homerton's nurses and Health Care Assistants could learn from going on secondments to Hackney's care homes to share best practice in caring for frail elderly people e.g. in washing, feeding and hydration. The Commission would also like to be advised how the training modules for geriatric and palliative care have developed of late and what scope there is for increasing joint training with care homes.	Our partners at Homerton University Hospital Foundation Trust have confirmed that all doctors and nurses directly employed receive mandatory annual training in both the care of the dying, and palliative care by the Hospital's own palliative care nurses. In addition there is a consultant on call and a clinical specialist on site to provide direct support for all staff. The hospital has developed a multi-professional end of life training session for higher trainees,

	nurses, operational therapy workers, physiotherapists, and social workers. It is designed to help health professionals to; • better consider ways to meet patient and family needs and preferences; • examine the benefits of shared, informed decision making and learn about the priority of timing in the context of the patient journey; • explore and interact with the patient to apply clinical knowledge and non-technical skills; • improve clinical decision making skills and application of knowledge; • develop an awareness of the dilemmas faced by healthcare professionals when acting as an advocate; • understand the implications for patients', their families and healthcare professionals when making difficult decisions such as DNR or withdrawal of treatment. The Homerton End of Life Care Board reviews training to ensure that they are providing the level and quality required to ensure the highest levels of service and assistance for patients and their families.

Recommendation Four The Commission recommends that the new Unplanned Care Board work with the City and Hackney EOLC Board to examine how outcomes for frail elderly patients at end of life might be improved if a better co-ordinated system of controlling movement between care homes and acute settings was instigated and care home staff were supported to access advice	The City and Hackney Clinical Commissioning Group (CCG) Unplanned Care Workstream are in the process of developing formal governance structures and reporting lines for their sub-boards, including those for the City and Hackney End of Life Care (EOLC) Board.

from other sources where appropriate. Furthermore we request London Ambulance Service to examine their Clinical Triage Process on responding to calls from families of very frail elderly people at end of life stage in care homes where families want the patient transferred to acute care. What are the guidelines here and who do the LAS staff take direction from? Are Paradoc always called out? LAS also to be mindful that advance care plans/CMC records may be in place and these would need to be consulted.	Work with care homes is included in the EOLC Board work plan, as part of the expansion of the St. Joseph's Hospice Community Nurse Specialist team, with work due to start in late summer when the recruitment process is complete. Discussions have begun about the Unplanned Care Workstream taking on responsibility for this work area. Separately the London Ambulance Service have indicated that they will feed into this process.

Recommendation Five The Commission's recommends the CCG's EOLC Board to consider how lines of responsibility can be better communicated to families of EOLC patients so that it is clear to them who is taking responsibility at each stage of the process	This issue will be discussed at the next Clinical Commissioning End of Life Care (EOLC) Board in late July to discuss how Hackney's GPs can better communicate to patients the range of services available to them as support, and that responsibility for their care remains with their GP.

Recommendation Six The Commission requests the Chief Nurse of HUHFT and the Chair of the CCG's EOLC Board to report back on how training of clinicians in having difficult conversations around End of Life Care issues could be improved. This should include the need for Advance Care Planning, Advance Decision to Refuse Treatment, Do Not Attempt CPR plans and the need to get more patients onto systems such as 'Co-ordinate My Care'.	A training event on better identifying people at the end of their life, having difficult conversations with patients, and recording these effectively on a care plan is happening later in the summer. This is ostensibly aimed at GPs but will be expanded to include a session prior to the training module to encourage all staff who provide end of life care to be aware of the range of services, support, and tools available to improve early identification and having conversations with patients. Ongoing training provided via a number of routes, including via St.

	Joseph's Hospice, CCG masterclasses, and external training, to a number of staff groups, and the impact of these along with learning about format and delivery are talked about repeatedly at City and Hackney End of Life Care Board and Homerton End of Life Care Board to ensure that they are both providing the level of training required to ensure the highest levels of service and assistance for patients and their families.

Recommendation Seven The Commission requests St Joseph's to work with the CCG's End of Life Care Board on increasing awareness of St Joseph's services locally, including working towards equality of access for different communities in the borough and to better signpost other EOLC support in the borough. In particular there needs to be an emphasis on reaching and supporting carers. The plan should also consider how more specialist services, such as St Joseph's Namaste care, for example, can be promoted.	Agreed. Our partners will continue to work together to ensure that our residents are made aware of all the end of life services available in our borough. This will include reaching out to Hackney's carers and better communicating the work of specialist services.

Recommendation Eight The Commission recommends to the End of Life Care Board to work towards making City and Hackney a 'Compassionate Community' as per Devon's 'Compassionate Community Hub' and report back on how the issues raised in the NCPC report could be taken forward locally. This would involve close working with HCVS, Age UK East London, Older People's Reference Group and Connect Hackney. The Hub would bring together a Caring Network Forum, Peer Support Groups and community engagement activities.	The National Council for Palliative Care's 'Dying Matters' Compassionate Community programme, which advocates a whole systems approach and reaches out beyond public health providers, is rightly seen as the model approach for a local community to take. Hackney's public health partners are examining the results of the work that has been underway in Devon and has committed to working towards making Hackney and the City of London a

	compassionate community. This would represent the next step of the work already underway to better bring together the different organisations who already deal with end of life care.

Recommendation Nine The Commission requests Connect Hackney to consider using part of its funding to increase awareness about End of Life Care issues for older people. This could focus on what is the current local offer and how it might be improved	Connect Hackney is a project led by older people, for older people, principally focused on issues relating to social isolation. Connect Hackney would be keen to support people at risk of social isolation to cope with significant life changes such as diagnosis of an illness and currently helps support St. Joseph's Hospice's Compassionate Neighbours project. As a result of both the nature of the organisation, and existing commitments, Connect Hackney must focus on programmes that aim to assist with reducing social isolation. However Connect Hackney will take the Scrutiny Commission's recommendations into consideration as they review their programme model over the summer. This process is due for completion by September.

Recommendation Ten The Commission requests HCVS and in particular Connect Hackney and Age UK East London to examine how there might be a greater role for the sector locally in facilitating discussions with patients at End of Life stage. This could focus on the desire to die at home, the need for ACPs, the need for a will, the need to consider lasting power of attorney for health and welfare decisions etc. This builds on the work	Hackney's community and voluntary sector are aware supportive of the importance and value of ensuring our residents receive the end of life care that they require and choose. This can be seen in the support already provided projects such as Compassionate Neighbours. There is, however, a recognition,

of St Joseph's 'Compassionate Neighbours' volunteers but would have a focus on end of life care planning rather than general support and befriending.	as there is amongst all organisations involved in this area, that more can be done. Especially in relation to some of the areas that the review highlighted, including the need to prepare people to create wills, or mechanisms relating to power of attorney decisions. So both this scrutiny review and this recommendation will be fully considered.

Recommendation Eleven The Commission requests the Council's Adult Services and the Compassionate Neighbours Co-ordinator at St Joseph's to explore how the Compassionate Neighbour volunteers can better signpost clients into council advice and support services and on the other hand how social workers might be able to refer possible clients who are socially isolated into the Compassionate Neighbours scheme, therefore maximising take-up of it.	Saint Joseph's Hospice's Compassionate Neighbours service is a volunteer-led project which aims to decrease the social isolation experienced by people who are at the end of their lives. The project matches volunteers who support people locally with those who require their help and support, including those who care for friends and family members nearing the end of their life. The volunteers are recruited to the project via a programme of outreach to people from communities in East London who might not traditionally access formal hospice services. The project has support from organisations such as Connect Hackney because of its focus on people who are at risk of social isolation, either as a result of their own health, or the health of those they are caring for. As part of the project the volunteers undergo 8 weeks of training, and are asked not just to offer companionship and support, and help to stay in contact with friends and the community, but are also explicitly tasked with directing individuals to other support

	services. These services include those provided by the Council and other community and voluntary sector organisations. In addition the Council's Adult Services department are prepared and able to refer individuals to the Compassionate Neighbours project who may not initially present themselves as individuals having to deal with end of life care issues, but who officers are concerned may face social isolation as a result of them.

Recommendation Twelve Whilst the Commission supports the current NHS guidance that a patients' right to know and to make their own decisions supersedes the rights of their family, the Commission would like HUHFT and St Joseph's to explain what work they are doing with the Charedi community to address that community's concerns about what they consider as a lack of culturally appropriate end of life care. The Commission also requests St Joseph's to report on progress being made in driving up the use of the hospice by other BME communities where there may be other cultural sensitivities.	Public Health England (PHE) have prepared guidance for our public health partners to better understand the needs of patients from some of Hackney's communities. This includes papers such as PHE's 'Faith at end of life' which aim to educate clinicians of specific faith based needs. Work is underway with the Charedi community to ensure that our partners are dealing with them in a way that ensures full respect, whilst also reflecting the need to focus on the specific requirements of individual patients. In service of this training has been in place to help public health workers to identify if the person they care for ascribes to a particular religion, and whether they expect this to have a bearing on their end of life care, and to expressly ask whether they have particular spiritual needs related to the end of life, listen to and record these needs. This includes consultation with families, where requested and appropriate. In order to ensure that the services and facilities provided by St.

	Joseph's Hospice are fully known and understood, the hospice, though projects such as Compassionate Neighbours, aims to recruit volunteers via a programme of outreach to people from communities who might not traditionally access formal hospice services. This includes those whose particular culture or faith means they have specific requirements in the run up to and aftermath of death, but are not certain a hospice will be able to fulfil them. St Joseph's are also focusing on other communities who use of the hospice perhaps do not reflect their numbers in the borough.

Recommendation Thirteen The Commission recommends the Cabinet Member of Health Social Care and Devolution include the concerns of the children's palliative care sector when considering the reconfiguration proposals underway as part of the NEL STP. This also applies to reconfiguration of Urgent Care and Out of Hours Services. Children's palliative care would benefit from being planned across a larger footprint than is currently the case. Variations in funding and structure of support available across borough boundaries makes it difficult for Children's Hospices to plan their services.	I will work with Cabinet Members from our neighbouring boroughs to ensure that as the STP process continues we advocate for a plan that alleviates the concerns raised by this review.

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Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

21 July 2017

Cllr Jonathan McShane
Cabinet Member for Health, Social Care and Devolution

Dear Jonathan

Executive Response to HiH's Scrutiny Review on 'End of life care'

At last night's meeting of Health in Hackney Scrutiny Commission we tabled your response to our report of our review on 'End of life care'.

While we are grateful to you for acknowledging the importance of this issue, the response from the various partners to this very cross cutting review falls very short of what we had hoped, in terms of taking on board the issues we exposed in the review. The general view of Members last night was that the responses are inadequate and don't demonstrate what changes might take place or give us confidence that any change will take place.

As you know the process is that we wait for 6 months for the update on implementation but if the issues aren't taken on board now we are not confident that a response in 6 months would be any clearer.

Whilst partners are fully entitled to disagree with us, if they choose not to implement what we recommend they do need to give reasons rather than a bland lukewarm response to the recommendations that we so carefully drafted. Members commented that the tone was too defensive and that it was not a helpful response overall. The report makes clear that End of Life Care issues are everyone's responsibility (not just hospices), but the response demonstrates just the silo thinking we were suggesting needed to be avoided here. Progress can only be made here by taking imaginative initiatives, particularly in the work with the third sector, and there is no evidence of that being understood.

On the specifics we would make the following comments:

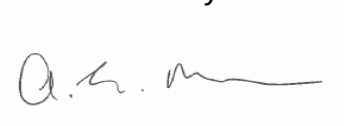
On response to Rec 1 When we receive a briefing on the Unplanned Care workstream of the Integrated Commissioning process we will expect more detail on specific plans for improving End of Life Care.
On response to Rec 2 We will expect the 6 month update to demonstrate clearly that use of CMC

has increased considerably across all care settings not “as many as possible”.
On response to Rec 3 The response says this training is for “all doctors and nurses directly employed”. What we asked for is “nurses and Health Care Assistants” as this is where the problems arose and it does not address ‘secondments’ at care homes which is what we asked.
On response to Rec 4 This does not address the key issue which was with the behavior of LAS staff when transferring people from care homes to the Homerton.
On the response to Rec 5 Good response
On the response to Rec 6 Good response.
On the response to Rec 7 We will need to see evidence.
On the response to Rec 8 Good response.
On the response to Rec 9 Connect Hackney exists and it is good that Hackney has it. It is best placed to make inroads on this problem, it also has a ‘Connecting Carers’ strand. This Recommendation is about getting older people to engage with Advanced Care Planning well before they or their partner hits crisis point. It is a positive step. It seems a wasted opportunity not to embrace this. It was suggested at the Commission meeting last night that the Big Lottery Fund’s restrictions on their type of activity might prevent this. This needs to be investigated. If Connect Hackney can’t do this who within HCVS might take this on? The third sector is vital here if more people are to be encouraged to make Advanced Care Plans.
On the response to Rec 10 The response recognises that this is an issue, but does not say what actions will be taken. The recommendation is about the responsibility of many organisations in End of Life Care discussions and not just the local hospice.
On the response to Rec 11 Good response
On the response to Rec 12 The recommendation is quite specific, whereas the response is very general. As part of our review, we spoke to the Charedi community. We would like to know that their specific concerns are being addressed.

On the response to Rec 13 Good response.

We look forward to hearing from you.

Yours sincerely



Councillor Ann Munn
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Anne Canning

Report to Hackney Health and Wellbeing Board

Item No:		**Date:**	**10 January 2018**
Subject:		**Update on East London Health & Care Partnership**	
Report From:		**Ian Tompkins, Director of Communications & Engagement, East London Health & Care Partnership and NEL STP**	
Summary:		This report provides a further update to the Board on the development of the East London Health & Care Partnership and the draft NEL Sustainability and Transformation Plan (STP). On 21 October 2016 we submitted a draft updated narrative, updated summary and delivery plans to address our local priorities to NHS England. Further work is continuing to develop the plan in more detail; additional updates will be presented to the Board as they become available. For more information go to www.eastlondonhcp.nhs.uk or email: enquiries@eastlondonhcp.nhs.uk	
Recommendations:		The Health and Wellbeing Board is recommended to: Note the verbal update on the East London Health & Care Partnership and draft NEL STP	
Contacts:		**Ian Tompkins** Director of Communications & Engagement, East London Health & Care Partnership office: 020 8221 9052 or 07879 335180 E-mail address: ian.tompkins@nhs.net	

1 Financial Considerations

The East London Health & Care Partnership's draft NEL STP includes activities to address current financial challenges. There is a clear emphasis on reconciliation of activity and finance between organisations. Implications for estates and workforce are being considered as part of the development of the draft STP.

2 Legal Considerations

The East London Health & Care Partnership Board developed a draft plan as stipulated by the NHS England guidance.

3 Equality Impact Assessment

An equality screening has been completed to consider the potential equality impact of the proposals set out in the draft STP. This can be viewed at http://www.eastlondonhcp.nhs.uk and includes:

- An overview of all the initiatives included in the draft STP narrative to determine at which level equality analyses should be undertaken i.e. East London Health & Care Partnership level, local area level, CCG/borough level or London-wide level.

- An initial assessment of the draft STP overarching 'Framework for better care and wellbeing'.

- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the draft STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

4 Attachments

Background papers

Appendix 1: ELHCP general update for Hackney Health & Wellbeing Board January 2018

Appendix 2: ELHCP Better Care & Wellbeing in East London

Appendix 3: ELHCP Our goal and highlights of 2017

Appendix 4: ELHCP Current governance structure

Comments of the Corporate Director of Finance and Resources	N/A
Comments of the Corporate Director of Legal, HR and Regulatory Services	N/A

East London Health & Care Partnership

Appendix 1: East London Health & Care Partnership General Update January 2018

1. Introduction

The East London Health & Care Partnership brings the 12 local NHS organisations and eight borough councils together to protect and improve health and care services.

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most, supported by the right team of staff from across health and social care, with the right resources, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

'Barrier busters'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

The Partnership is not seeking to take away local control of services. It recognises that while east London faces some common problems – such as the high rate of preventable illness and a shortage of clinicians and care staff – the local make up and characteristics of the area vary considerably and services must be tailored and managed accordingly.

The Partnership is therefore shaping the way it tackles its priorities around five local areas, bringing together the councils and NHS organisations together within them as local care partnerships to ensure the people living there get high standards of care designed around their needs:

- Barking, Havering and Redbridge
- City of London & Hackney
- Newham
- Tower Hamlets
- Waltham Forest

The wider Partnership will drive forward the things that can only be achieved by all of the councils and NHS organisations across east London working together. This includes:

- good quality urgent and emergency care for east London
- the availability of specialist clinical treatments
- a better use of buildings and facilities;
- the recruitment and retention of doctors, nurses and other health and care professionals
- an increased use of digital technology to speed up the diagnosis and treatment of illness
- ways of working that will put a stop to duplication and unnecessary expense

The involvement of councils is also enabling the provision of health and care services to be aligned with the development of housing, employment and education, all of which can have a big influence.

But the biggest single factor in the long term is to prevent ill health and deaths caused by the effects of lifestyle choices such as diet, lack of exercise and smoking.

2. What the Partnership is doing and the Sustainability & Transformation Plan (STP)

The development of a Sustainability & Transformation Plan (STP) was the original reason for the East London & Health Care Partnership came together. However, it is now just one of many things the Partnership can and wants to do.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the STP was submitted in draft form to NHS England (NHSE) and NHS Improvement (NHSI) on 21 October 2016.

It sets out how local health and care services will transform and become sustainable over the following five years, building and strengthening local relationships and ultimately delivering the vision of the NHS *Five Year Forward View*.

The plan describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap

The plan officially remains as submitted, in draft form, but things have moved on considerably since then, as the various organisations and other interested parties have come together to develop shared ideas and solutions. They have created a series of transformation workstreams to focus on the following:

- Prevention
- Urgent & Emergency Care
- Primary Care Services
- Mental Health
- Cancer
- Maternity
- Medication
- Digital and Online Services
- Workforce
- Estates

All of the workstreams have set out what they want to do and what it will mean for local people (see *Appendix 2 Better Care and Wellbeing in East London)*. Their ambitions are now being developed further in terms of how they can be achieved and when.

Some of the ideas are dependent on additional 'transformation' funding, and the Partnership is currently bidding for this from NHS England and other sources.

Once plans have been sufficiently developed, and any necessary funding is in place, the Partnership will engage fully with stakeholders, so they can contribute their views and ideas. This includes the wider public, as appropriate.

However, many improvements are already being made. Some examples are shown in *Appendix 3*.

3. Partnership Governance

The organisations behind the East London Health & Care Partnership member organisations:

NHS

Clinical Commissioning Groups

Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts

Barking, Havering and Redbridge University Hospitals Trust; Barts Health

NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS; Foundation Trust; North East London NHS Foundation Trust

Councils

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

The Partnership itself is not a statutory body, so it cannot make any formal decisions. These are made by the member organisations, through their existing governing bodies or systems.

The Partnership does, however, have a governance structure for its activities. The existing one is attached as Appendix 4, but this is currently being reviewed and streamlined, following feedback from the member organisations. More information on this will be available in early 2018.

4. Development of Accountable Care Systems (ACS) and a single accountable officer

Proposals for new commissioning arrangements across east London have been approved by all seven CCG governing bodies and things have now progressed to the next stage with the appointment of the single accountable officer and the designing of new governance structures.

The aim of the new arrangements is to establish commissioning that is truly integrated around patients, putting their needs first and in line with the expectations of the NHS Five Year Forward View, and harnesses the benefits of CCGs working together and collaborating with other NHS organisations, local authorities and the voluntary sector. Providing care that is better coordinated and more joined-up

care between GPs and hospitals, physical and mental healthcare and social care will mean breaking down barriers that currently hinder this happening. Additionally, the new plans aim to ensure that discussions and decisions happen at the most appropriate level, for example, due to its scale, specialised commissioning will take place at an east London level.

The approved proposals also reflect the very strong desire to build sustainable local Accountable Care Systems (ACSs) in east London and the new arrangements are seen as a starting point for that and may evolve over time to reflect progress with implementation of local ACSs.

There is a recognition that while the borough and system focus are important in delivering the best services for local people there is also a need to work at scale across a wider patch to standardise some functions and some ways of working that are common across all east London CCGs. Good examples would be the approach to hospital payment mechanisms and around NHS111. CCGs remain accountable to their local populations and their stakeholders, including health and wellbeing boards and overview and scrutiny committees.

In September, all CCGs GBs agreed to appoint a single Accountable Office across east London. A competitive recruitment process then followed throughout October and early November and Jane Milligan was appointed to the role on 6 November. She took up the post formally on 1 December.

The recruitment process included an interview with all seven CCG chairs and a Q&A session with key stakeholders. These included local government, Healthwatch and NHS trust representatives.

In her new role, Jane will be Accountable Officer for all seven north east London CCGs and sit on their respective governing bodies, supporting them to discharge their statutory responsibilities. She will also act as the executive lead for the East London Health & Care Partnership, which includes the North East London STP.

The local arrangements that sit beneath the single Accountable Officer at CCG level are currently being worked through, along with new governance structures to support them. Jane is leading the completion of this work.

It is expected there will be a senior manager and team at each of the seven CCGs to provide strong local leadership and focus on the delivery of the plans within the local system. This includes the management of finances and engagement of partners to drive greater integration. To make sure this happens an Acting Managing Director has been appointed across all CCGs until the end of March 2018

with permanent recruitment starting in January 2018. A Director of Strategic Commissioning is also being appointed on an acting basis for 6 months through to June 2018. This is to lead the NEL planning and contracting for 2018/19, align and manage the commissioning strategies across NEL and prepare for the anticipated delegation of specialised commissioning from NHSE for 19/20.

A report to the meetings of CGG Governing Bodies in December is proposing that the NEL CFO is recruited from January 2018. However, it is important to stress that existing CFOs will remain in CCGs to make sure there is continued focus on financial issues and particularly savings programmes, as well as ensuring the robust preparation and delivery of Annual Accounts. Measures on the financial executive support in each CCG will be brought forward in January.

Governance structures are being developed to support these arrangements, with joint decision-making through CCG governing bodies acting together. This will be achieved through a joint committee responsible for the strategic functions that need to be done at an east London level, as well as committees in common, for functions where CCGs wish to collaborate at a system level, thereby supporting local accountability and sovereignty

Wider engagement with stakeholders is continuing to discuss and test the new arrangements and further reports will be taken the CCG governing bodies to agree them in due course.

The intention is to operate the arrangements in shadow form from January 2018, to ensure they are robust and effective. Full implementation will be from 1 April 2018.

5. Engagement

The Partnership has been engaging with various key stakeholders over the past year, but it has mainly been to establish relationships rather than talk about specific plans.

They include the police, fire and ambulance services; professional associations such as the BMA; housing, education and local business organisations; the voluntary and charity sector; community groups; and public and patient representatives.

The range of audiences is very diverse, with many different levels and types of interest. Keeping them engaged and involved in what we are doing is one of our biggest challenges. We need to invest considerable time and resource in it and ensure there is a regular dialogue, but it is essential if we are to achieve our goal.

A previous attempt to bring stakeholders together, through a single reference group as part of the Partnership governance structure, proved impractical due to the diversity of interests and numbers involved.

Instead, we are looking to develop smaller ones based around localities or areas of interest. Rather than create something new, we are building on existing forums and networks such as Health & Wellbeing Boards and voluntary groups. These bring many of the stakeholders together already.

Just mapping the various interests has been a challenge. While many networks are already in place, they don't always connect with each other. Many organisations we have spoken to have welcomed our efforts to do this.

It is important to get the language right, too. It's why we talk of a partnership, and people working together, rather than a plan.

A priority has been to address the poor image of STPs; the perception of secrecy and cuts; the view that they are overly ambitious and lack credibility.

People agree about the challenges facing health and care services and that something needs to happen to ensure they meet current and future demands. What they want to know is how we plan to tackle those challenges and what it will mean for them.

The detail they want, to inform the engagement we need to do, is only just starting to emerge as the Partnership comes together and develops shared ideas and solutions. Once these are agreed, and any necessary funding and resources are in place, the Partnership can then start holding meaningful conversations with people.

The information in *Appendix 2* is a starting point. A suite of other communications resources, including videos and an improved Partnership website, are also being developed, with help from stakeholders.

As already said, there are many groups we need to engage with, and we are seeking advice and guidance on how we should go about it.

We are working closely with our communications and engagement colleagues in the partner organisations to make use of their local insight and networks. We have established regular meetings with local Healthwatch organisations and are seeking help from the community voluntary

sector, not just with our communications and engagement activities but the development of ideas and plans generally.

While some of our activities are pertinent to everyone in east London – such as those around prevention, signposting of services and improvements to NHS111 – we intend to frame most of them at a local level, to give more relevance. Again, we are working closely with all the right people in doing this.

Our first major engagement event was the Partnership launch held in Stratford last July. This was well-received, and we now want to hold similar events across east London in 2018, showcasing the current and planned improvements to services and listening to people's comments and suggestions.

A roadshow style of engagement – going to where people are, rather than expecting them to come to you – is clearly the right way to reach specific communities and hard-to-reach groups. A number of existing forums and networks have expressed a desire for this.

The various festivals and events held in boroughs each year are also valuable. Our presence alongside public health, NHS and voluntary sector organisations at the Mayor's Newham Show and Waltham Forest Garden Party last summer demonstrated the effectiveness working together can have in terms of attracting public attention. Both were highly successful, pulling in lots of people, and we plan to do it again this year, joining up with the police, fire and other sectors too.

London Fire Brigade is particularly keen to work with us. It has around 100 staff involved in a school visit programme and is happy for us to piggyback it with health education information.

Our universities and colleges are also willing to help, as are business organisations like the Canary Wharf Group and East London Business Alliance. They all have access to many of the people we need to engage with.

Events like the Health & Housing Conference in October '17 are also an effective means of stakeholder engagement, especially as they go beyond the confines of the STP. We hope to do more of these, covering topics such as workforce and prevention, and are also looking to hold events with specific interest groups, such as young people.

But one of the most important groups we must engage with is our staff. They are the eyes and ears in terms of what matters to local people and are an invaluable source of views and ideas that will help us

get it right. It is vital they feel involved in what we are doing and our internal communications will reflect this, recognising the contribution everyone makes and encouraging and valuing people's opinions and suggestions.

We intend running an interactive programme of engagement with staff over the coming months to create awareness and understanding of what the Partnership is about; what it is planning to do; what it will mean for people; and what they can do.

Keeping our many different stakeholders engaged and involved in what we are doing is one of our biggest challenges. It is essential if we are to achieve our goal.

East London Health & Care Partnership

BETTER CARE AND WELLBEING IN EAST LONDON

East London Health & Care Partnership

We are:

NHS

NHS
Barking and Dagenham Clinical Commissioning Group

NHS
Redbridge Clinical Commissioning Group

NHS
City and Hackney Clinical Commissioning Group

NHS
Tower Hamlets Clinical Commissioning Group

NHS
Havering Clinical Commissioning Group

NHS
Waltham Forest Clinical Commissioning Group

NHS
Newham Clinical Commissioning Group

East London NHS Foundation Trust

Homerton University Hospital NHS Foundation Trust

North East London NHS Foundation Trust

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

Councils

London Borough of Barking & Dagenham

City of London

Hackney

Havering London Borough

Newham London

London Borough of Redbridge

Tower Hamlets

Waltham Forest

BETTER CARE AND WELLBEING IN EAST LONDON

We can all do our bit

With an ever growing population, and more of us living longer, the challenge to keep us healthy and well has never been bigger.

As more and more people choose to live and work in east London, the demand on health and social care services is at an all-time high. Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country. Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing and using services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

We all have a part to play in this – all of those providing the services, and all of us using them. We can all do our bit.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

BETTER CARE AND WELLBEING IN EAST LONDON

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most and supported by the right team of staff from across health and social care, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

'Barrier busters'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

The Partnership's *Sustainability and Transformation Plan (STP)* sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

It describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

The plan proposes improvements across the whole of east London, such as the availability and quality of specialist clinical treatments, how buildings and facilities could best used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The involvement of councils enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence on people's health and well being.

The Partnership is committed to being transparent and engaging fully with key stakeholders and the wider public in the development of its plans.

But the biggest single factor in the long term is to prevent ill health and the time pressure and financial pressure preventable conditions put on the NHS. This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities.

Public health information and advice will be strengthened. Information and support to help us live healthier lives will be made more widely available, online and through social media. It's up to us to enjoy life to the full by doing those little things each day that help us stay healthy and fit. We can watch what ourselves and our families eat and drink and all get more active.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit and if we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it.

PREVENTION

Our aims

- **Better support to stop smoking**
- **Better screening, treatment and support for diabetes**
- **Help you look after your own general health and wellbeing**

More and more people are choosing to live, work and stay in east London.

Major regeneration of the area is creating growth and opportunity, bringing new jobs and housing, better transport, shopping and leisure facilities, making it an attractive place to call home.

But while this is improving east London as a place, and making it generally more prosperous, are we actually investing in ourselves and taking care of our personal future health and wellbeing?

Some 40 per cent of all deaths in England are preventable and are caused by the effects of lifestyle choices including diet, lack of exercise, smoking, alcohol and drugs.

Treating preventable diseases, such as heart disease and smoking-related lung cancer, costs the NHS in England £11 billion each year.

About 1.2m people in London still smoke. Of these, 280,000 live in east London and the local NHS spends £56m a year treating people for illnesses caused by it.

Type 2 diabetes is also preventable.

One in six patients in hospital in England has diabetes, 90 per cent of whom have Type 2 and it costs the NHS £1million an hour to care for them – 10 per cent of the total NHS spend.

More than half of all adults in east London are overweight or clinically obese. This is less than the national average of 63 per cent, but London has the highest rate of childhood obesity of any city of its size in the world.

If we fail to tackle preventable illnesses, not only will this situation continue, and likely get worse, the sustainability of our health and care services will be put at risk.

The East London Health & Care Partnership has three priorities to help tackle these issues:

- To help people stop smoking. We will especially target children and young people, so they fully understand how harmful and expensive smoking is – both to the individual and, in terms of treatment, to the NHS
- To reduce diabetes. We want to improve early diagnosis and provide ongoing support for those identified 'at risk'. This includes offering places on the National Diabetes Prevention Programme, where people are given a personal health and wellbeing coach to help with their diet and exercise. We also want to improve outcomes for those living with Type 1 and Type 2 diabetes, ensuring they receive regular follow ups and have access to specialist advice when needed.
- To improve workplace health. Around 24 million working days are lost in London each year because of sickness absence or injury. We will help business and public sector organisations across east London, including our own, give better health and wellbeing support to staff. We will promote healthy eating and physical activity and create support services for dealing with stress and other health issues, including those who want to stop smoking or reduce the amount of alcohol they drink.

But it's not just down to the authorities; we all have a stake in our own health. There are many things we can do in our daily lives to take better care of ourselves – such as eating more healthily, reducing alcohol intake and getting plenty of exercise.

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better support in our hospitals, mental and community health and primary care services to help people stop smoking
- Improving screening processes to better identify those at risk of contracting Type 2 diabetes, and offering courses to help those people change their lifestyles
- Making the care that people with Type 1 and Type 2 diabetes receive in GP surgeries and hospitals the same across east London
- Empowering people, through flexible self-care courses, to better look after their diabetes and avoid unnecessary trips to hospital
- Working with local schools, colleges and universities, employers, libraries and voluntary services to provide better support for young people with diabetes
- Improving workplace health across east London, starting with the NHS. Happier, healthier NHS staff means better healthcare for patients.

What does it mean for local people?

- Better support to stop smoking, with help and advice available at many health and care centres, workplaces and online
- Better screening, diagnosis, treatment and support for people with diabetes
- New services to help young people, and pregnant women, manage diabetes better
- Better opportunities and more support to stay healthy at work
- Greater consistency of healthcare opportunities and support across east London
- Help to help you take better care of yourself

What can you do?

- If you smoke, try to stop and seek help to do so
- Cut down on sugary food and drinks
- Eat smaller portions and enjoy a balanced diet, including vegetables
- Keep hydrated – plenty of water!
- If you drink alcohol, do so sensibly and watch how much you drink
- Try to do some physical exercise every day. Just taking the stairs instead of the lift once a day, or going for a quick stroll, can make a difference

And if you do these things yourself, support a family member or friend that wants to do the same!

Take an NHS Health Check

The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.

If you are in this age group without a pre-existing condition, you can expect to receive a letter from your GP or local authority inviting you for a free NHS Health Check every five years.

In the meantime, there are other ways of getting your health checked. Visit www.nhs.uk for more information on this and many other topics.

URGENT & EMERGENCY CARE

Our aims

- **Make it easier to understand the range of services available and how to access them quickly**
- **Provide more services in local communities, so they are accessible and convenient. This will also reduce the pressure on hospitals**
- **Make it easier to see a GP and bring services together**

Our hospital Accident & Emergency (A&E) Departments face some of the most intense pressures in our local health and care services, with growing numbers of people attending them each year.

Around 100 people are currently visiting the A&Es across east London every hour. But many of them do not need to be there, as they have relatively minor problems that can be treated elsewhere.

With people unsure of where to go for treatment, there is a huge demand on busy A&E services.

Some 68 per cent of patients have told us they do not know the difference between facilities such as 'Urgent Treatment Centres' and 'Minor Injury Units'. We want to change this.

An immediate priority for the East London Health & Care Partnership is to give better information on how and where we can all get the right care and treatment, including advice on ways we can look after ourselves.

There are three ways in which you can access health services and help to reduce pressure on our hospitals:

- **'Click'** - online information and support and to book urgent or routine appointments when needed.
- **'Call'** – for people who don't have access to the internet and those who need more advice or reassurance from a healthcare professional.
- **'Come in'** – where patients really need to see a healthcare professional.

...and we are improving all three.

'Click' and 'Call' – information and support online and by telephone through NHS 111

Click

Online support and information 24/7 through the NHS 111 website at **www.nhs.uk**. Here you get information on a range of health issues, and in a variety of languages, to help you decide what action to take, including what to do if you need to speak to a clinician.

Call

If you do not have access to the internet, or need further health advice after going online, you should firstly try calling your GP. If your GP is unavailable, you can call NHS 111 by simply dialing 111.

The NHS 111 telephone service is being improved from next year, enabling you to speak to a wider range of qualified healthcare professionals, including nurses, GPs and pharmacists.

Calls to NHS 111 about the very young and older people (babies under one and people over 75) will always be directed immediately to a qualified healthcare professional.

Speaking to NHS 111 will ensure you are getting the right level of advice and support. If you need to be seen by someone, you will be booked an appointment at the most appropriate place, such as with your own GP or at an Urgent Treatment Centre close to where you live.

Staff from care homes and community health staff are also now using NHS 111 for clinical advice. It is helping many people avoid the need to go to hospital and be treated and cared for at home instead.

Come in

Where patients really need to see a healthcare professional because it is an emergency.

GP Practices

We don't just want to make it easier to book an appointment with a GP. We also want to offer them at a more convenient time.

It's now possible to book appointments online at many surgeries. An increasing number are extending their opening hours to cover evenings and weekends.

In some instances you may not need to visit a surgery at all. You could have the appointment with a doctor, or nurse, by a video link from your smartphone instead.

We are also looking to free GPs, and other healthcare professionals in local surgeries, from paperwork so they can spend more time with their patients, especially those with complex conditions.

Improvements to information systems, and the links between surgeries, hospitals and specialist services, will give doctors and other clinical specialists quicker access to records and test results, enabling them to plan and give better care to patients.

Community

A priority is to provide care closer to, or in, people's homes. It's why we are bringing all the relevant services together in local neighbourhoods.

GPs, community nurses and other NHS specialists will be based alongside council care teams in centres across east London, within easy reach of the main residential areas, to provide comprehensive treatment and support – not just in the centres themselves, but also in the surrounding homes.

Bringing expertise together in this way will do more than just streamline services. With more staff than traditional GP practices, and equipped with the latest facilities and technology, the centres will be able to stay open longer and offer a greater range of services – from 8am to 8pm, seven days a week.

Urgent Treatment Centres

If your need cannot be treated by a GP, you may be directed or booked for an appointment at your nearest Urgent Treatment Centre.

Located across east London, Urgent Treatment Centres give treatment for minor injuries including: sprains, strains and broken bones; injuries to the back shoulders and chest; minor head and eye injuries; minor burns and scalds; insect and animal bites; and wound infections.

Before heading off to one of these centres, we recommend people contact NHS 111 first so they can be directed to the right place. If you do go to an Urgent Treatment Centre and your need can be better met elsewhere you will be redirected. It's therefore best to give a 'click' or 'call' to NHS 111 first to ensure you get it right and don't waste time.

Accident & Emergency Departments

If you need to attend an Accident & Emergency Department (A&E) we want to ensure you are treated as soon as possible.

For some emergency conditions, we are setting up special areas in A&Es where people can be quickly assessed and treated so they can, when possible, go straight home without being admitted to hospital.

An example would be for a clot in the lung (pulmonary emboli) or leg (deep vein thrombosis). You will be treated by a team of specialists in a separate part of the A&E and may be able to leave the same day, with medication and a schedule of follow up treatment if needed.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 online and telephone service, with better links to other health services such as GPs, pharmacists, Urgent Treatment Centres, mental health specialists and community health professionals.
- Improving access to weekend and evening GP appointments.
- Saving some visits to the surgery by enabling patients to speak to a doctor or nurse online or via a video link from a smartphone.
- Improving information systems for GPs to free them up from paperwork, see more patients and plan and give better care.
- Bringing community nurses, GPs, other NHS specialists and social care staff under one roof in local communities.
- Creating consistency in the services available at Urgent Treatment Centres, so people understand what treatment can be given to them.
- Creating special areas in the hospital for specific emergency conditions to avoid people being admitted to hospital when there is no medical need for this.

What does it mean for local people?

- It will be easier to understand what healthcare services are available, and where.
- By calling or visiting NHS 111 online you will be able to get all the advice you need on how and where you can get the best care.
- It will be easier to book an appointment with a GP. Appointment times will be more convenient, including evenings and the weekends. In some instances you may not need to go to the surgery at all. Instead, you could speak to the doctor or nurse over the phone, online or via a video link from a smartphone.
- You will be able to see a range of health and social care professionals, quickly and conveniently in one place, close to your home.
- Wherever you live in east London, you will have access to an Urgent Treatment Centre for the treatment of minor injuries, including broken bones and minor burns.
- We will strive to give every patient the best possible care and treatment. If you need to be admitted to hospital, we want to reduce the time you have to spend there and get you safely home as soon as possible.

PRIMARY CARE SERVICES

Our aims

- **Make it easy to see your local GP or healthcare professional**
- **Improve the quality of services provided, so it is consistently good**
- **Bring services together to make them more accessible and convenient**

Primary Care services are usually the first point of contact the public has with the NHS. They include GP surgeries or practices, pharmacies and dentists.

Across east London there are examples of excellent primary care services. Many are among the best in the country, but there are also some that need improving.

We want all of our health and care services in east London to be the very best and are working with clinicians and staff in primary care to ensure they are consistently good across the area, both now and in the future.

Information on the many improvements we are making is also given elsewhere in this guide, especially in the section on Urgent and Emergency Care. This includes information about the NHS 111 service, which you can contact online or by telephone for advice and help, day and night, when you don't feel well and are unsure about what to do and where to go.

We want to make it easier to book an appointment with a GP. We also want to offer them at a more convenient time.

It's now possible to book appointments at many surgeries online. An increasing number are extending their opening hours to cover evenings and weekends.

In some instances you may not need to visit a surgery at all. You could have the appointment with a doctor, or nurse, by a video link from your smartphone instead.

We are also looking to free GPs, and other healthcare professionals in local surgeries, from paperwork so they can spend more time with their patients, especially those with complex conditions.

Improvements to information systems, and the links between surgeries, hospitals and specialist services, will give doctors and other clinical specialists quicker access to records and test results, enabling them to plan and give better care to patients.

For minor ailments it's often quicker in the first instance to visit your local pharmacy rather than GP surgery.

Pharmacists are skilled, qualified healthcare practitioners who will be able to see you immediately and offer advice and medication for a range of complaints such as hay fever, conjunctivitis and flu. They offer many other services as well, including flu vaccinations and help with stopping smoking.

An increasing number of pharmacists in east London are able to offer urgent repeat medication. NHS 111 can also help with this.

An important priority is to provide care closer to, or in, people's homes.

It's why we are bringing all the relevant services together in local neighbourhoods, in the form of hubs.

GPs, community nurses and other NHS specialists will be based alongside council care teams in centres across east London, within easy reach of the main residential areas, to provide comprehensive treatment and support – not just in the centres themselves, but also in the surrounding homes.

Bringing expertise together in this way will do more than just streamline services. With more staff than traditional GP surgeries, and equipped with the latest facilities and technology, the hubs will be able to stay open longer and offer a greater range of services – from 8am to 8pm, seven days a week.

As well as making primary care more accessible and convenient, we want to improve the quality of services so people experience the best possible treatment and care – whoever they are and wherever they live.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 online and telephone service, with better links to other health services such as GPs, pharmacists, Urgent Treatment Centres, mental health specialists and community health professionals.
- Improving access to weekend and evening GP appointments
- Saving some visits to the surgery by enabling patients to speak to a doctor or nurse online or via a video link from a smartphone.
- Improving information systems for GPs to free them up from paperwork, see more patients and plan and give better care.
- Bringing community nurses, GPs, other NHS specialists and social care staff under one roof in local communities.
- Helping GP practices improve the experience of their patients, including better staff training and development
- Helping GP practices improve services for people with long term conditions, such as diabetes
- Projecting the mix and number of GPs and other Primary Care staff that will be needed to meet the needs of the public in the future, and working hard to recruit them
- Working together to retain current staff for longer, making east London an attractive place to work for both existing and new recruits

What does it mean for local people?

- It will be easier to understand what healthcare services are available, and where.
- By calling or contacting NHS 111 online you will be able to get all the advice you need on show and where you can get the best care.
- It will be easier to book an appointment with a GP. Appointment times will be more convenient, including evenings and the weekends. In some instances you may not need to go to the surgery at all. Instead, you could speak to the doctor or nurse over the phone, online or via a video link from a smartphone.
- You will be able to see a preferred clinician if you wish and are prepared to wait longer for an appointment.
- You will be able to see a range of health and social care professionals, quickly and conveniently in one place, close to your home.
- Your overall experience of Primary Care will be better and consistent. You will feel you are treated as a person, not a number

MENTAL HEALTH

Our aims

- **Improve access to services and cut waiting times for treatment**
- **Treat mental and physical health needs as one**
- **Address the wider determinants on mental health, e.g. housing and employment**

Mental health services in east London are among the best in England, but they face tough challenges ahead.

The area's growing population is placing unprecedented demands on services, with higher numbers of people needing mental health support.

One in four of us will have problems with our mental health at some time in our lives. Whether it is a concern about a job, financial problems, a relationship, bereavement or the pace and pressures of modern life, it can happen to any of us.

- People with a serious mental health illness die on average 15 years younger than the rest of the population.
- Physical and mental health issues are intrinsically linked – 30 per cent of people with a long-term condition have a mental health problem and 46 per cent of people with a mental health problem have a long-term condition.
- Mental health service users in east London are two to three times more likely to die of cancer, circulatory or respiratory disease than the rest of the population.
- 50 per cent of lifetime mental health conditions are first experienced by the age of 14, 75 per cent by the age of 24.
- 60 per cent of people in contact with secondary care mental health services are not in employment.
- 47 per cent of people with serious mental illness smoke compared to 20 per cent of the wider population.
- 30 per cent of people with serious mental illness are obese compared to 10 per cent of the general population.

Many people with mental health problems have to rely on emergency departments (A&E) for help.

- People with mental health problems in east London attend A&E nearly three times as often as others. They are also three times more likely to be admitted to hospital in emergencies than others.
- More than 20 per cent of all emergency admissions in east London can be attributed to mental health service users, who only make up seven per cent of the overall population.

No one should experience mental illness without the right support. But with more and more people needing it, and only so many resources available, we will have to change the way our mental health services are delivered.

We are making the provision of sustainable mental health services across east London one of our top priorities, but believe we can go further.

Working in partnership, bringing the NHS and councils together, our ambition is to:

- Develop new models of care that address mental and physical health and social care needs as one.
- Provide good service user education to reduce stigma and promote resilience.
- Help people with more serious mental health problems to find and remain in employment – a key factor in their recovery.

We also want to find the right place for people to live, with the right support close by – essential in helping them get well.

Creating opportunities and providing good quality care in the community, including specialist services, is an underlying aim of the East London Health & Care Partnership. It is part and parcel of helping people live happy and independent lives, and nowhere is this more important than in mental health.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Working with partners to address the wider determinants of mental health e.g. access to accommodation, education and employment.
- Supporting the roll out of digital self-management tools such as the London Digital Mental Wellbeing Service (www.digitalwellbeing.london).
- Developing an east London-wide suicide prevention strategy.
- Supporting employers to improve staff mental health and emotional wellbeing via programmes such as Mental Health First Aid.
- Developing our talking therapies services so there are more appointments with reduced waiting times.
- Integrating mental health services into GP surgeries, A&E and general hospitals.
- Developing perinatal mental health services for expectant mums and mums of new babies.
- Improving services for people experiencing a crisis by ensuring everyone in crisis can access mental health crisis support 24/7.
- Delivering mental health treatment at home.
- Delivering specialist mental health services for children and young people closer to home.
- Developing a new Child and Adolescent Mental Health Unit Psychiatric Intensive Care Unit here in east London.

What does it mean for local people?

- Improved access to, and shorter waiting times for, psychological therapies.
- A wider range of mental health services to be accessible via your GP.
- Your mental and physical health and social care needs treated as one, wherever and whenever necessary.
- Enhanced support to access the right education, employment and accommodation opportunities for people with mental health issues.
- People in east London will have access to the same range of mental health services wherever they live.

CANCER

Our aims

- **Cut waiting times for appointments**
- **Diagnose and treat any cancer quickly, with better education and information for the public**
- **Improve care and outcomes for people**

Parts of east London compare poorly with the rest of England in helping to prevent, and treat cancer.

Local people aren't living as healthy a lifestyle as others elsewhere. The area has higher-than-average rates of smoking and obesity and fewer take part in any form of physical activity.

People are also not going for check-ups as often as they should, greatly reducing the chances of survival because a cancer hasn't been detected and treated early enough.

The facts are simple:

- More than 40 per cent of cancers diagnosed in the UK last year could have been prevented by people adopting healthier lifestyles.
- Up to 10,000 deaths in England could be avoided each year if cancer is diagnosed earlier and treatment started sooner.

But we can all do something about it.

The East London Health & Care Partnership is making the prevention of cancer, and improving outcomes for people that have it, a top priority.

We are going to improve information on screening for breast, cervical and bowel cancer and other forms of the disease. This includes better signposting on when and where you can be screened, and what you can do yourself to check for symptoms.

We especially want to reach out to those that don't have regular health checks, or who don't like seeking help.

We want to cut waiting times for appointments and ensure patients from all backgrounds have access to timely, high quality modern treatments. Working with some of the best expertise there is, we want people to live well after treatment and increase their chance of survival.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Ensuring all patients who are referred for an urgent appointment with a specialist are seen within two weeks.
- Making sure patients are receiving their tests and diagnostics on time to enhance early diagnosis and treatment and improve cancer survival.
- Enabling better communication between GPs, hospital consultants and other specialists to allow faster and more effective treatment and care.
- Encouraging patients in east London to take up their screening.
- Improving information technology and administrative processes to make sure the cancer referral pathway is effective and patient care is joined up.
- Listening to patients and carers to ensure we meet their needs and keep improving their care.
- Working with public health services to improve prevention and lifestyle choices.

What does it mean for local people?

- If you are referred urgently by your GP or another health care professional you will be seen within two weeks.
- If you have a cancer diagnosis, you will receive treatment quickly in order to improve your chances of survival.
- A number of health and social care professionals will be involved in your care to ensure your care is joined up.
- Your experience of care will be positive because we are listening to you and making improvements.
- If you take up screening when you get an appointment, you are likely to receive early detection and treatment.

What can you do?

We will do our bit to turn things round, and make sure east London does everything it can to beat cancer. But you can play your part too and take good care of yourself. It is by far and away the best thing you can do to avoid this disease.

Do yourself, your family and friends a favour and:

- stop smoking
- avoid too much alcohol
- eat well
- keep active
- check yourself over regularly
- register with a GP
- attend regular screening appointments

If your GP refers you to the hospital for a test, or to be seen, please make sure you attend the appointment.

MATERNITY

Our aims

- **Improve information and advice about pregnancy to help prevent any problems**
- **Give women greater control and more choice about how and where they give birth**
- **Make them feel safe and secure, cared for and supported**

East London has the fastest growing population in the UK and the highest birth rate.

Our health and care services must cope with this growth and continue to ensure all goes well for the mums and babies. But it's not the only challenge.

More women of child bearing age are living with a long-term health condition, such as diabetes or heart disease. This can lead to a complex birth, requiring extra care and attention. We need to help women prevent and better manage these conditions.

Our vision for maternity services in east London is for them to be safe, caring and kind. We want it to be easier for women to find out about the services, and for care to be focussed around the needs of the woman and her family.

We want all women to feel safe and secure during their pregnancy. We want them to have a choice about how and where they give birth and to feel supported throughout.

For our staff, our culture is to promote innovation and continuous learning. We want to create a working environment where they feel valued – one that will help us attract and retain the best people.

We are one of seven areas across the country taking part in the Better Births Initiative to make care safer and give women greater control and more choices during their pregnancy. It aims to reduce the number of different midwives and doctors seen during pregnancy, so a proper relationship can be built.

We will strive for continual improvement in all that we do to ensure the best, and happiest, outcome for every mum and baby.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Listening to, and working with, women in east London to understand their needs and design care around them.
- Giving women greater choice about how and where they give birth.
- Making it easier for people to get help and information and book appointments.
- Ensuring safe and high quality care for all mums and babies.
- Ensuring there are enough midwives to cope with the increasing number of births. There is currently a shortage of midwives in east London, many are retiring or moving away from the area. We need to recruit more and keep them here.
- Working together to ensure every woman gets continuity of care throughout her pregnancy and birth. We want to reduce the number of different midwives and doctors she sees, so a proper relationship can be built.

What does it mean for local people?

- You will have a greater choice about where and how you give birth.
- You will have easier and better access to help and information, including advice on how to keep well before, during and after pregnancy. You will also be able to book appointments online.
- You will likely see the same midwife throughout your pregnancy to ensure continuity of care.
- The plan for care during your pregnancy will be developed and agreed between you and your midwife or obstetrician.
- If you have a long-term condition, such as diabetes, or you are having twins or other multiples, you will be seen by your midwife and obstetrician regularly and may be referred to a specialist.
- Your overall experience of care during and after your pregnancy will be positive and of high quality. We want you to feel safe and secure, cared for and supported.

MEDICATION

Our aims

- **Ensure the right medicines are used, at the right time, for the right patients**
- **Reduce medicine waste**
- **Make it easier to get prescribed medicine when it is needed**

To be truly effective, medicines must be used properly and responsibly – from those that help get us better when we're ill, to those that keep people with long-term conditions alive.

The East London Health & Care Partnership's aim is to ensure the right people, get the right medicine at the right time. We don't want people taking medicines they don't need.

New medicines are being introduced all the time. This includes those available over the counter from pharmacists and supermarkets, as well as those only available on prescription.

GPs, pharmacists and other healthcare professionals must have a good understanding of what medicines their patients are taking and what they can and cannot do. They also need to know the side effects of the medicines and how and when they should be taken.

Evidence from the Royal Pharmaceutical Society shows there is an urgent need to get the fundamentals of medicine use right.

For example:

- Only 16 per cent of patients who are prescribed a new medicine take it as prescribed.
- At least six per cent of emergency re-admissions are caused by avoidable adverse reactions to medicines.
- It's estimated at least £300m is wasted on medicines each year across England.

The overuse of anti-biotics is also something we need to get right. It is weakening their effectiveness and making them counter-productive. The World Health Organisation says resistance to antibiotics is one of the biggest threats to global health.

We will be improving education and information about medicines and encouraging people to become less dependent on them, including antibiotics.

There are alternative and often more effective ways to treat and prevent common ailments.

Taking regular Vitamin C and Zinc supplements, for instance, can prevent colds developing. If you do have a cold, steaming your nose and mouth for up to 15 minutes, four times a day, and drinking plenty of fluids, can alleviate the symptoms.

For people with long-term conditions, alternatives to medication can include following a particular healthy eating regime and an exercise programme.

An example is for those with high cholesterol. A diet rich in plant sterols and stanols, that block the body's absorption of cholesterol, can avoid some people having to take drugs called statins. They are substances that are naturally found in small amounts in plants – in fruit, vegetables, pulses and grains. You can also buy spreads, cereals and yoghurt-style drinks which have been fortified with them. Regular exercise also helps and sometimes reduces the need for blood pressure medication.

Physical activity can also help with mental health conditions, such as depression, as can getting sufficient sleep and being more involved in communities to combat loneliness.

We also need to reduce the prescribing of medicines that are proven to have limited clinical value.

Around £3.8m is currently being spent on them every year in east London. It doesn't just represent poor value for money – which could be better spent on other health and care services – the use of such medicines is not in the best interest of patients.

It is not always necessary to go to a GP for treatment for minor ailments, or for medication that can be bought over the counter in a pharmacy or shop without a prescription. A pharmacist can give advice for problems such as coughs, colds, fevers, hay fever and eye infections.

For those taking medication for a long-term condition, your GP will regularly review what you are taking and adjust it as and when needed. If your surgery has a practice pharmacist you can ask them to check the medication too.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Following national recommendations from NHS England, we are reviewing the prescribing of certain medicines. They are those for which there is limited evidence about their effectiveness.
- Buying some medicines from alternative better value suppliers. These are the unbranded items that do exactly the same thing, but for a lot less money. It will enable any savings to be better spent on other health and care services.
- Helping people take charge of their overall health and achieve better outcomes without a dependency on medication. Holding regular reviews with patients to identify medicines they no longer need.
- Reducing medicines waste
- Reducing resistance to antibiotics by moderating the amount and type prescribed. Educating patients and prescribers on the importance of completing courses of antibiotics when necessary.
- Ensuring we have sufficient pharmacists where they are needed. This includes clinical pharmacists within GP practices and/ or clinics in order to help ensure the right medicines are used, at the right time for the right patients.

What does it mean for local people?

- You will be able to get professional medical advice for all minor ailments in pharmacies, including out of hours pharmacies.
- Pharmacists will give you advice on the nature of medicines available to buy over the counter and what you will need a prescription for.
- You will not be prescribed medicines for which there is limited evidence about their effectiveness or where there are safer alternatives.
- You will not be prescribed antibiotics unless they are essential.
- You will be less likely to be kept in hospital waiting for medicines to be prescribed.
- The cost of prescribing medicines to you as a tax-payer will be less, meaning money can be better spent on other health and care services.

THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

Our aims

- **Ensure we have the we have right number of good quality staff to look after people, now and in the future**
- **Make services and care accessible and convenient, consistent and personal**
- **Give the best possible treatment and care by ensuring our staff have access to all information and resources they need**

THE RIGHT STAFF

There is a considerable shortage of staff to fill key roles in health and care services. It's one of the biggest challenges the sector is facing in meeting the demands of a growing and ageing population.

Not as many people want to become doctors or nurses or care workers as used to.

Doctors, nurses and care workers cannot afford to live in London because of high property prices and a chronic shortage of suitable accommodation.

People also want more flexible jobs and careers so they can manage their other responsibilities like childcare or looking after an older relative.

Many GPs are due to retire soon, and a quarter of nurses leave their profession after just five years.

Nearly 20 per cent of jobs in registered social care lie vacant.

We are having to rely heavily on temporary staff, who come at higher rates than permanent staff and are not always available.

While we are still managing to provide services safely, action is needed to tackle the shortages, both now and in the future.

Attracting staff

The regeneration of many parts of east London is making it an increasingly attractive place to live and work. We need to promote this more strongly and sell its strengths.

In future when we advertise for staff, we will not just give details about the job and organisation. We will tell people about the wider benefits of the area – its transport, shopping and restaurants; the nurseries, schools and colleges; the many leisure attractions. Most importantly, we will help find them a home and offer affordable key worker accommodation. This is the single most important factor in recruiting staff to work in London and is something we are currently working on with housing providers and developers.

But we don't just want to attract staff from outside the area. Far from it. We want to recruit 'home-grown' talent too and are working with local schools, colleges and universities to do more of this. Creating job and career opportunities in our public services for the people that already live here will always be a priority for the partnership.

When we have recruited good quality people to come and work with us, we want to keep them.

To do this we need to offer more training, research and career development opportunities, with the ability to work across different organisations.

For example, midwives in east London are now getting the chance to work in all different areas of the profession not just one – home births; deliveries in birthing centres; hospital labour wards; experience of complicated births. It's this sort of variety, and the opportunity to progress a career without having to keep moving home, that's a big factor in retaining people.

As well as offering careers, we will also be putting more emphasis on looking after the health and wellbeing of our staff, including how to manage stress. Difficulty with this is a major reason why many doctors, nurses and carers leave the profession. We want to ensure the right support is in place to help them.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Collaborating with councils and housing associations to ensure there is affordable accommodation for key workers.
- Expanding roles in GP surgeries (including physician associates, clinical pharmacists, practice healthcare assistants and care navigators) and developing an endoscopy and community nurse workforce.
- Promoting east London as a place, with all its attractions and benefits, to encourage more staff to live, work and stay here.
- Working with education and training providers to develop job and career opportunities in health and care for local residents.
- Offering more training, research and career development opportunities.
- Looking after staff so they can better look after the people of east London.

What does it mean for local people?

- More healthcare professionals likely to be taken on and retained to look after you and your family's health and care needs – now and in the future.
- A continuity of care wherever you are treated – in hospital, in the community and at home.
- More job and career opportunities in local health and care services

THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

THE RIGHT PLACE

Having staff in the right place might be a hospital, a GP surgery or even a patient's home.

Whether staff work in a hospital trauma centre or in the community, we are enabling and encouraging them to work together across the range of health and care services. We want to stop working in silos. The focus will be on following patients, not patients following us.

Where we can we are looking to put local health and care, and other public services, in the same building. This isn't just to save money, but to encourage closer working between them – and to stop the public having to go to lots of different places.

When a building is no longer required, the money recouped from the sale or rent will be reinvested locally to help improve or rebuild those we do need.

Although we have many modern facilities in the area, we also have buildings that are more than 100 years old and no longer fit for purpose. Whipps Cross Hospital in Waltham Forest definitely needs rebuilding, and we are working on this right now. We want all of our facilities to be up to date and functional, ready for future advances.

A greater use of digital technology will also help ensure services are provided in the right place. We want staff to have greater flexibility over how and where they work so they can spend more time in local communities. It also saves money on costly building space, which can be better spent on patient care.

Technology brings other benefits too.

Using a digital device to constantly monitor someone's heart, or provide a video link to a doctor or nurse, for instance, can enable a patient needing that type of care to stay in the comfort of their own home, yet remain in constant touch with expert help and support should it be needed.

It will not only make care accessible and convenient, but more consistent and personal. It's very likely you will see the same staff throughout your care rather than lots of different people.

If you are unfortunate enough to have an accident requiring major surgery, for instance, once you have been discharged from hospital the same team of physiotherapists will visit you at home to help you fully recover. As well as saving numerous trips back and forth to the hospital, it will avoid you constantly having to repeat your medical history, or details of any medication, to a number of different people.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Ensuring staff can offer a continuity of care to all patients.
- Enabling staff to work in the community – making services more accessible and convenient and saving on costly building space.
- Looking to share the buildings we do need with other public services, not just to save cost but to make things more convenient for people.
- Improving buildings and facilities in need of repair or modernising.
- Tapping into the opportunities digital technology offers to give patients better and more convenient access to services. This includes appointments via a video link and apps to monitor their own health and progress.

What does it mean for local people?

- Care will be accessible and convenient, more consistent and personal
- More care will be given to you in your home or close by, helped by digital technology
- You will more likely see the same staff throughout your care, establishing a relationship with them that generates assurance and trust
- No need to keep repeating your medical history and medicines to different health and care professionals.

THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

THE RIGHT RESOURCES

It's vital our staff have all the resources they need to do their job effectively.

As we have already said, digital technology will enable staff to spend more time in local communities. We will continue to invest in it to ensure they have easy and reliable access to all the information and data while out and about.

The right resources also means creating better links between the many different information and IT systems across health and care services.

Many of them have been developed independently of one another and, as a result, they can't 'talk' to each other. It's slowing down information exchanges between organisations and delaying the results of clinical tests. We are joining systems up to overcome these problems.

And it's not just about information technology.

To give effective treatment and care, staff need access to an array of equipment and resources, from hi-tech medical scanning systems to basic office supplies. We are working together to make sure they have it, investing in new kit and facilities where needed and joining up our buying teams to secure the best possible deals.

What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Continuing to invest in digital technology to ensure staff can work anywhere in the community with the information and data they need.
- Joining up IT systems to speed up information exchanges and the sharing of records so staff can plan, and give better treatment and care.
- Working together to ensure staff have all the modern facilities and equipment they need to do their jobs effectively

What does it mean for local people?

- More care can be given in or closer to your home as a result of staff being better equipped to work flexibly
- Your treatment and care will be planned and managed more effectively thanks to improved IT systems and the sharing of records
- Modern equipment and facilities will enable you to get the best possible treatment and care

East London Health & Care Partnership

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East London Health & Care Partnership

Appendix 3: Our goal and highlights of 2017

Our goal: To help the people of east London live healthy and independent lives

We are doing this by:

- Protecting vital services and giving the best possible treatment and care built around the needs of all local people.
- Supporting our nurses, doctors, therapists and carers to provide the best quality care to people and achieve the right outcomes.
- Improving our services, so they are easy to access and provided at a time and in a place where people want them, ideally in their homes or close by.
- Helping people to stay well. We are doing all we can to help them take good care of themselves and enjoy healthy and independent lives – now and in the future.

Highlights of 2017

Prevention

We agreed a shared ambition to reduce obesity, smoking, diabetes, high blood pressure and heart disease. We want to support people to do more physical activity, educate people around how to avoid or better manage health conditions and see more use of 'social prescriptions'.

We secured extra funding to support people with diabetes and help smokers quit.

We held a successful conference on workplace health and established a community of practice to promote it. We also launched a project with the Healthy London Partnership to improve staff health in GP practices and pharmacies.

Mental Health

We successfully bid for additional funding to increase mental health support for people in hospitals.

We were awarded more money to support children and young people in mental health crisis.

We began work to improve access to psychological therapies, local crisis services and maternal mental health services.

We increased the number of physical health checks for patients with a mental illness and are opening up more employment opportunities for people as part of their recovery.

Urgent & Emergency Care

We worked together to improve access to health services. In the New Year, patients will be able to:

- CLICK – using NHS 111 online to access information and support regarding their health.
- CALL – calling NHS 111 to access advice or reassurance from a healthcare professional
- COME IN – when patients need to be seen, because it is an emergency, we are supporting direct booking into either their own GP or appropriate service. This will also help reduce the pressures on A&E departments so that people who need to be seen there will be treated as soon as possible.

We have shared learning to improve patient flows through our hospitals, valuing our patients' time and reducing delays in transfers of care following an admission.

We implemented measures to enhance care provided in care homes and people's own homes, helping develop a skilled workforce.

Social care providers told us it is often difficult to support people who become unwell in their own home. As a result, we will shortly be launching a pilot to give domiciliary care workers increased direct access to clinical advice via NHS 111.

Primary Care

We launched a series of programmes to improve and standardise the quality of primary care across east London. This includes training plans and a common system for sharing improvement projects, with 500 free licences available to commissioners and providers.

We established business intelligence systems to collect clinical outcome data and help improve the efficiency of patient services.

We successfully set up a development framework to help our primary care providers (GP federations and networks) improve quality across local health and care systems.

We introduced a model to help us evaluate future workforce needs and a potential skill mix for multi-professional working.

We implemented a range of plans recruit to and retain our primary care workforce across east London.

Cancer

We set up three local programmes to improve cancer outcomes at a local level across east London.

We achieved cancer waiting time targets and secured more funding to help earlier diagnosis.

The one-year survival rate is continuing to improve for our local population – although there is still much to do.

Maternity

We completed and submitted (in November) our East London Maternity Transformation Plan and Funding Bid in line with the Better Births strategy to improve maternity care for our local women. We are awaiting the outcome of the bid.

We initiated joint procurement arrangements that will save money for the maternity system without impacting on services.

We became one of seven maternity 'Pioneer' sites in the country.

We finalised our East London Midwifery Workforce Programme for launching in the New Year.

We secured FIVE nominations in the Royal College of Midwives annual awards! Two of these being in the prestigious 'Team of the Year' category. Fingers Crossed!!

Learning disabilities

We have been working hard to move our patients with learning disabilities and/or autism out of long-stay hospitals and back into the community. We have so far managed to support 14 patients to go home from hospital in time for Christmas.

Medicines optimisation

Hospital providers and clinical commissioning groups are now working together to switch to medicines that do the same thing as others, but for a better price.

A national consultation on the value and cost of medicines that have a low clinical value was completed at the end of October. The results of will help steer our future decisions on this in east London.

Digital

Health and social care professionals are able to make better and safer decisions by sharing records through the east London Patient Record (eLPR) system. NELFT, LB Newham & LB Hackney have also recently connected to the system, which is now getting over 80,000 views per month – more than anywhere else in the country.

2.3m patient records are now placed in Discovery – a population health analytics platform.

Organisational development (OD)

East London Health & Care Partnership is now the pilot site for the national STP OD programme, partnering with the staff college to develop collaborative working.

Workforce recruitment

We have been working together, across the NHS and councils, to help recruit and retain essential staff for east London, such as doctors, nurses and care workers. This includes helping find them somewhere to live, and developing career opportunities.

Provider productivity

A cap on the use of medical agencies was introduced in October, thanks to an initiative we ran in conjunction with a pan-London group.

The introduction of a new procurement scheme has led to economies of scale and greater value for money in the buying of provider consumables.

Infrastructure

We established an East London Health & Care Partnership estates board – in line with the formation of a London Estates Board and the requirements of London Devolution.

We have been working together to identify opportunities to share accommodation, office and back office functions. This includes agile and new ways of working, such as shared booking systems.

We are focusing on maximising the clinical utilisation of estates, thereby supporting seven-day working while increasing efficiency and releasing savings through disposal.

We are working to complete a prioritised pipeline of sites, mapping current demand and capacity so we can ensure the right infrastructure is in place to meet future needs.

Health & Housing Conference

Developing the relationship between housing and health, and bringing the various providers and services closer together was the subject of our highly successful Health & Housing Conference in October 2017.

Delegates from across east London, with an interest in health, social care, housing and regeneration discussed a range of topics, from the provision of accommodation for key workers to how digital technology can help care for people, especially the most vulnerable, in their own home. They also talked about ways of combating homelessness and how housing services can help reduce delays in discharging people from hospital because of a lack of suitable accommodation and support.

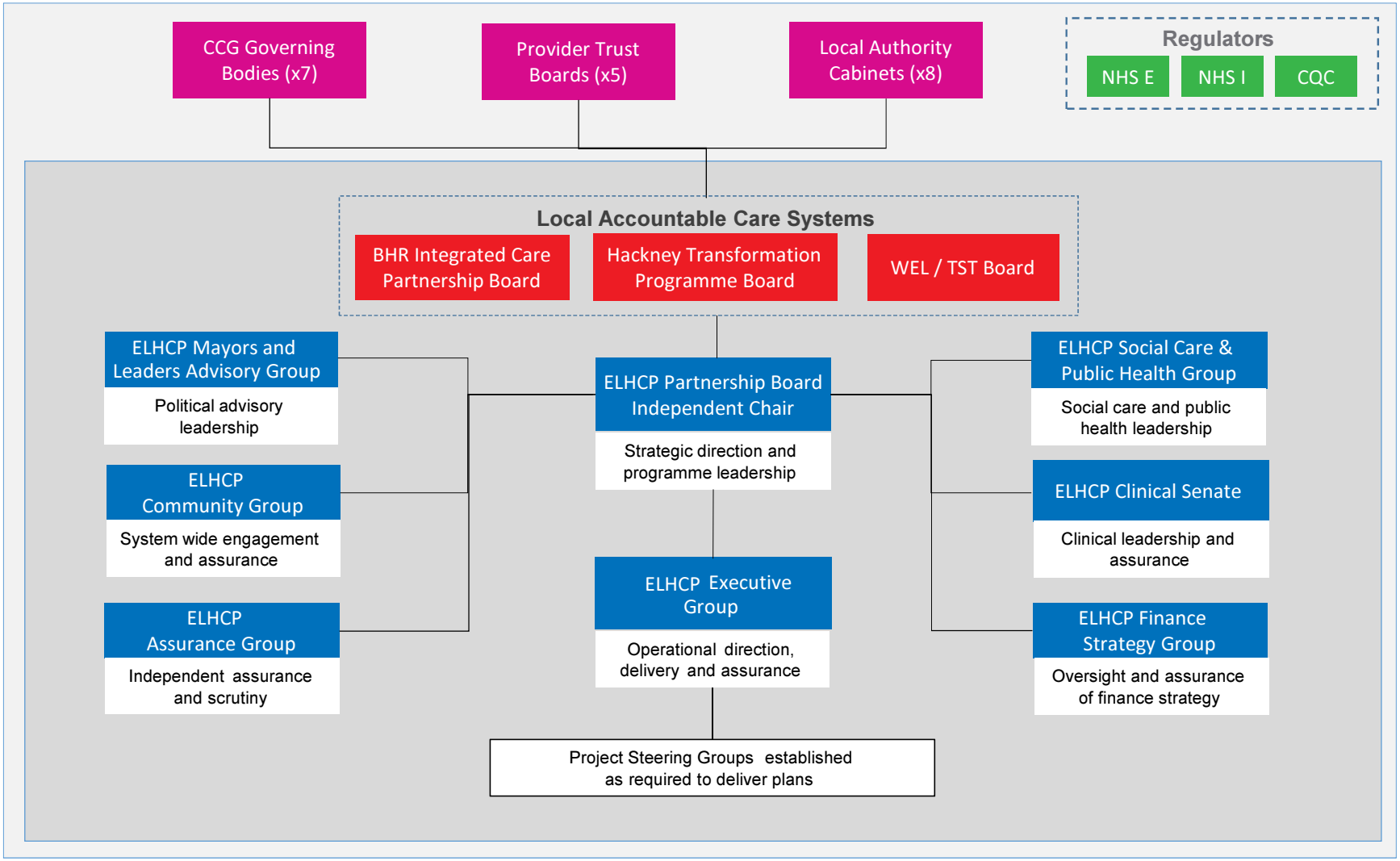
The conference was the first of its kind in east London, generating lots of ideas – many of which were simply the result of everyone coming together.

We look forward to doing more in 2018, working together with you to help the people of east London live healthy and independent lives.

Appendix 4

East London Health & Care Partnership

Current ELHCP governance structure (2017)



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