Overview & Scrutiny

Health in Hackney Scrutiny Commission

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

Monday, 7th January, 2019

7.00 pm

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

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Tim Shields
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair), Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**Apologies for Absence (19.00)**	
2	**Urgent Items / Order of Business (19.00)**	(Pages 1 - 88)
3	**Declarations of Interest (19.01)**	
4	**Minutes of the Previous Meeting (19.01)**	(Pages 89 - 102)
5	**Review on 'Digital Primary Care and its implications for GP Practices' - agree Terms of Reference (19.03)**	(Pages 103 - 118)
6	**Review on 'Digital primary care and its implications for GP Practices' - briefings from GP at Hand, CCG, GP Confed, ELHCP, H&F CCG (19.10)**	(Pages 119 - 194)
7	**Review on 'Digital primary care and implications for GP Practices' - background reading (20.55)**	(Pages 195 - 218)
8	**2018/19 Work Programme (20.55)**	(Pages 219 - 228)

Hackney

9 Any Other Business (21.00)

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Health in Hackney Scrutiny Commission

Meeting on Mon 7 January 2019

ADDITIONAL PAPERS

URGENT ITEM – Health Based Places of Safety in North and East London

No.	*Title*	*Author*
1	Health Based Places of Safety in North and East London	Dan Burningham, Mental Health Programme Director, City and Hackney CCG and Rory McMahon AD Transformation NE London Commissioning Support Unit for East London Health and Care Partnership
2	London's Mental Health Crisis Care Programme – Stakeholder Engagement Summary July 2018	Healthy London Partnership
3	Executive Summary of Mental Health Crisis Care for Londoners HBPoS Business Case DRAFT March 2018	Healthy London Partnership

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East London Health & Care Partnership

LB Hackney - Health and Social Care Scrutiny Committee

Health Based Places of Safety in North and East London

Subject Heading:	East London Health Care Partnership (North East London STP) Health Based Places of Safety (HBPoS)
Report Author and contact details:	Dan Burningham, Mental Health Programme Director, City and Hackney CCG dan.burningham@nhs.net Rory McMahon, Assistant Director of Transformation, North East London Commissioning Support Unit Rory.McMahon1@nhs.net
Policy context:	In 2017, the government formally announced changes to section 136 of the Mental Health Act 1983 (s136 MHA) through the Policing and Crime Act 2017. These came into effect on 11 December 2017. Under these amendments, CCGs must ensure plans for the designation, and appropriate staffing of CCG-commissioned health-based places of safety. In May 2018 HLP produced a pan-London business case for few better quality HBPoS.

SUMMARY

A Health-Based Place of Safety (HBPoS) is a space where people can be detained under Section 136 of the Mental Health Act and assessed. Patients are typically detained under the Mental Health act under Section 136 by Police, then transported to a Section 136 Suite to be assessed.

Since 2015, Healthy London Partnership (HLP) has worked in partnership with London's health and care system to develop a Pan-London business case to inform a specification for a new model of care for individuals detained under Section 136.

The HLP business case proposes that the 20 existing dedicated HBPoS sites across London are reduced to nine hubs, each with better facilities and immediately available 24/7 staffing on site. This includes hubs within North East London.

The aim is to deliver:

- Better, quality, built environments that offer patients who are vulnerable or acutely unwell, the safety, privacy and dignity they deserve.
- Improved capacity with more rooms being added to fewer sites, to ensure blue light services are turned away less often.
- Trained and experienced dedicated staffing to improve the quality and efficiency of assessments and the relationships between services.

The HLP business case has been subject to a North East London STP options appraisal which was conducted by the STP Workstream 3, with stakeholders from each of the sites.

This paper details the options and recommendations arrived at as the result of this options appraisal, and the subsequent engagement process required for the reconfiguration of Health Based Places of Safety and Section 136 detentions, Pan-London and within the North East London STP.

RECOMMENDATIONS

It is recommended that The North East London STP proceed with **Option 5,** a three site HBPoS option in the short term, located with three rooms each at Sunflower Court and Homerton Hospital, and one at the Newham Centre for Mental Health. This option is in line with the Transition Phase recommended in the HLP business case.

After a year of operation, the option will be assessed and a view taken on whether to keep the Newham HBPoS, or whether to re-divert the flows and move to a two site solution: Homerton and Sunflower Court.

REPORT DETAIL

Context

Section 136 detainments give the police the power to remove a person from a public place when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety, where they can be assessed by relevant healthcare professionals. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.

London's crisis care system is under significant pressure and does not have the services or infrastructure to ensure people experiencing a mental health crisis under a section 136 detainment receive timely, high-quality care that respects individual needs.

The Pan-London change and engagement process

An HBPoS options appraisal in conjunction with an extensive engagement process, was undertaken by the Healthy London Partnership to identify how London's HBPoS sites could meet the developed specification. Over 400 Londoners with lived experience of Mental Health crisis and carers have been involved in developing the new model of care through an extensive engagement process.

Workshops, online surveys, and patient statements have been used in order to inform the Options Appraisal and recommendations.

The options appraisal identified several delivery options, with the aim of deciding on an optimal Pan-London place of safety configuration including:

- the required number of sites;
- optimal capacity; and
- optimal locations across London.

The output of this process was a nine-site model. This wider, pan-London process has then informed the development of a business case for HBPoS service change across the NEL STP.

Current Provision of Health-Based Places of Safety (HBPoS) in North East London

There are currently four HBPoS sites operating in North East London:

- Sunflower Court, in Redbridge, provided by NELFT (2 assessment rooms)
- Newham Centre for Mental Health, in Newham provided by ELFT (one assessment room)
- Homerton Hospital, in Hackney provided by ELFT (one assessment room)

- Royal London, in Tower Hamlets, provided by ELFT (one assessment room)

Figure 1 – Health Based Places of Safety within the North East London STP

Key issues within the case for change can be summarised as follows:

- The HBPoS at the Royal London Hospital within Tower Hamlets is situated in a busy Accident and Emergency department, potentially compromising patient safety, privacy and dignity. The unit is also situated one mile away from mental health teams and wards, making an immediate transfer to patients problematic and drawing on staff support from mental health teams difficult. For these reasons the RLH is not considered an appropriate environment by CQC and HLP.
- The HBPoS at Royal London, Homerton and Newham have no dedicated staff and use staff from the wards. This makes it hard to ensure staff with sufficient experience and training are available. It therefore does not comply with the recommendations of HLP's business case that staff from wards are not used and that all staff are trained and experienced.
- The HBPoS at Homerton is situated in a rather public space and is not easily accessible.

Options for Service Delivery

The following options for delivery of a new model of Health Based Places of Safety within the North East London STP were considered.

Option 1: Do nothing - Sunflower Court, Homerton, Royal London, Newham General all remain open.

Option 2: Develop an alternative HBPoS to Royal London at Mile End hospital; Homerton, Newham and Sunflower Court remain open.

Option 3: Two Sites - Sunflower Court & Homerton and Newham General HBPoS).

Option 4: Two Sites remain open - Newham and Sunflower Court.

Option 5: Three Sites remain - Homerton, Newham and Sunflower Court.

Based on the case for change and the options appraisal alongside an analysis of revenue costs, it is recommended that ELHCP proceed **with option 5**, a three site HBPoS option in the short term:

- **Sunflower Court** (3 rooms) with a dedicated core staff team
- **Homerton Hospital** (3 rooms) and re-located to offer better patient privacy and dignity and staffed with a dedicated core staff team
- **Newham Centre for Mental Health** (1 room).

Figure 2 Option 5, HBPoS Three-Site Option

This option expands the Homerton site's capacity to absorb the potential re-directed s136 flows from the Royal London.

Furthermore, the use of option 5 has the following advantages:

- More flexible facilities in terms of capacity in the short-term ,and allows time for further planning for a future two-site model if appropriate.

- Means reduced travel distances compared to Option 3.
- Enables experienced, qualified staff to be immediately available 24/7 on all sites.
- Incorporates capacity close to the City of London, which has a high number of section 136s.
- Facilitates better care for children and young people with two co-located CAMHS sites.
- Is in keeping with HLPs 13 site transition phase.

Option 4 (HLP's recommended final configuration), was rejected in the short-term because it was considered that re-directing flows from two sites at once was too risky. It was agreed that it would be better to close one site, map the flow, and then assess the case for closing a second site.

It was also agreed that Option 4 would be difficult to deliver in the short-term due to the higher revenue and capital cost implications. This could delay the re-diversion of flows from Royal London which does not meet standards of patient safety, privacy and dignity.

IMPLICATIONS AND RISKS

Financial and Activity implications and risks:

a) Financial Implications

- The Department of Health has funded a £388,200 capital development at Homerton (2-3 rooms) and £349,000 at Sunflower court (3 rooms). This element is thus cost-neutral to the local healthcare economy. Revenue costs are currently under negotiation with local CCGs.

b) Activity:

- The model predicts that the additional capacity from the closure of the Royal London site will be absorbed by the Homerton; any additional demand will be mitigated by the increased use of Street Triage and home treatment teams.

c) Legal implications and risks: Not applicable to this report**.**

d) Human Resources implications and risks: Not applicable to this report.

e) **Equalities implications and risks**: The preferred option is likely to improve the safety, privacy, and dignity of all service users through improved built environments and dedicated staffing teams. Older adults and people with disabilities may benefit from closer adjacencies to the wards. A dedicated and trained and qualified staff team is

also more likely to have a better understanding of the needs of BME and LGBT patients and share this in good working relationships with the police.

Appendices

London's Mental Health Crisis Care Programme, Stakeholder Engagement Summary, July 2018, Healthy London Partnership
Mental Health Crisis Care for Londoners, HBPoS Business Case, March 2018, Healthy London Partnership

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Mental Health Crisis Care for Londoners

HBPoS Business Case - DRAFT

March 2018

Supported by and delivering for London's NHS, Public Health England and the Mayor of London

Contents

1 Executive Summary ... 3
2 Introduction ... 28
2.1 Introduction and purpose of document ... 29
3 Strategic case ... 34
3.1 Mental health crisis care in London ... 36
3.2 Case for change ... 38
3.3 Vision and objectives ... 49
4 Clinical case ... 52
4.1 Existing clinical challenges ... 53
4.2 Clinical benefits of the preferred option ... 57
5 Economic case ... 61
5.1 Options assessment ... 63
5.2 Indicative economic costs and benefits ... 74
6 Financial case ... 91
6.1 Baseline 'do nothing' pathway costs ... 94
6.2 Preferred option pathway costs ... 106
6.3 Variance in pathway costs ... 115
6.4 Transition costs ... 122
6.5 Capital costs ... 123
6.6 Summary and funding arrangements ... 124
6.7 Risks to financial assessment ... 126
7 Management case ... 128
7.1 Transitional phase ... 129
7.2 Implementation ... 133
7.3 Post implementation ... 143
8 Commercial case ... 146
8.1 Commercial strategy ... 147
8.2 Synergy with the wider crisis care system ... 149
9 Workforce case ... 151
9.1 Current staffing arrangements ... 152
9.2 Future staffing arrangements ... 157
Appendix A ... 167

DRAFT

1 Executive Summary

1.1.1 Introduction

The purpose of this document is to provide a business case to support implementation of London's section 136 (s136) new model of care and the proposed reconfiguration of Health Based Place of Safety (HBPoS) sites. This is to improve the efficiency and effectiveness of treatment and quality of care for people experiencing mental health crisis along the s136 pathway and the broader crisis care system.

To implement this innovative new model of care, bold action needs to be taken by London's crisis care system. Strong collaboration and new ways of working across healthcare, social care, police and third sector organisations are imperative, including breaking down the silos that exist between organisations and barriers between physical and mental healthcare. Whilst there must be an increased focus on local action to prevent crises occurring, when a crisis does happen, people experiencing mental health crisis need to have timely, high quality care, which respects individual needs, wherever they are in London.

The voice of people with mental health problems must be at the heart of the changes. Londoners say over and over again that their care whilst in crisis does not meet the basics of dignity, respect and high quality compassionate care. Services are often not delivered in the right environment to help people recover. Londoners are often denied access to HBPoS sites and Emergency Departments (EDs), left in the back of police cars and ambulances, or transferred unnecessarily between EDs and HBPoS sites due to a lack of appropriate and co-ordinated care. There is still not parity of esteem for mental health; as is clearly reflected in the disparity of care for people with mental health issues as opposed to physical ones. People with mental health problems and clinicians have recognised the opportunity to address a forgotten service and make s136 an active part of the crisis pathway.

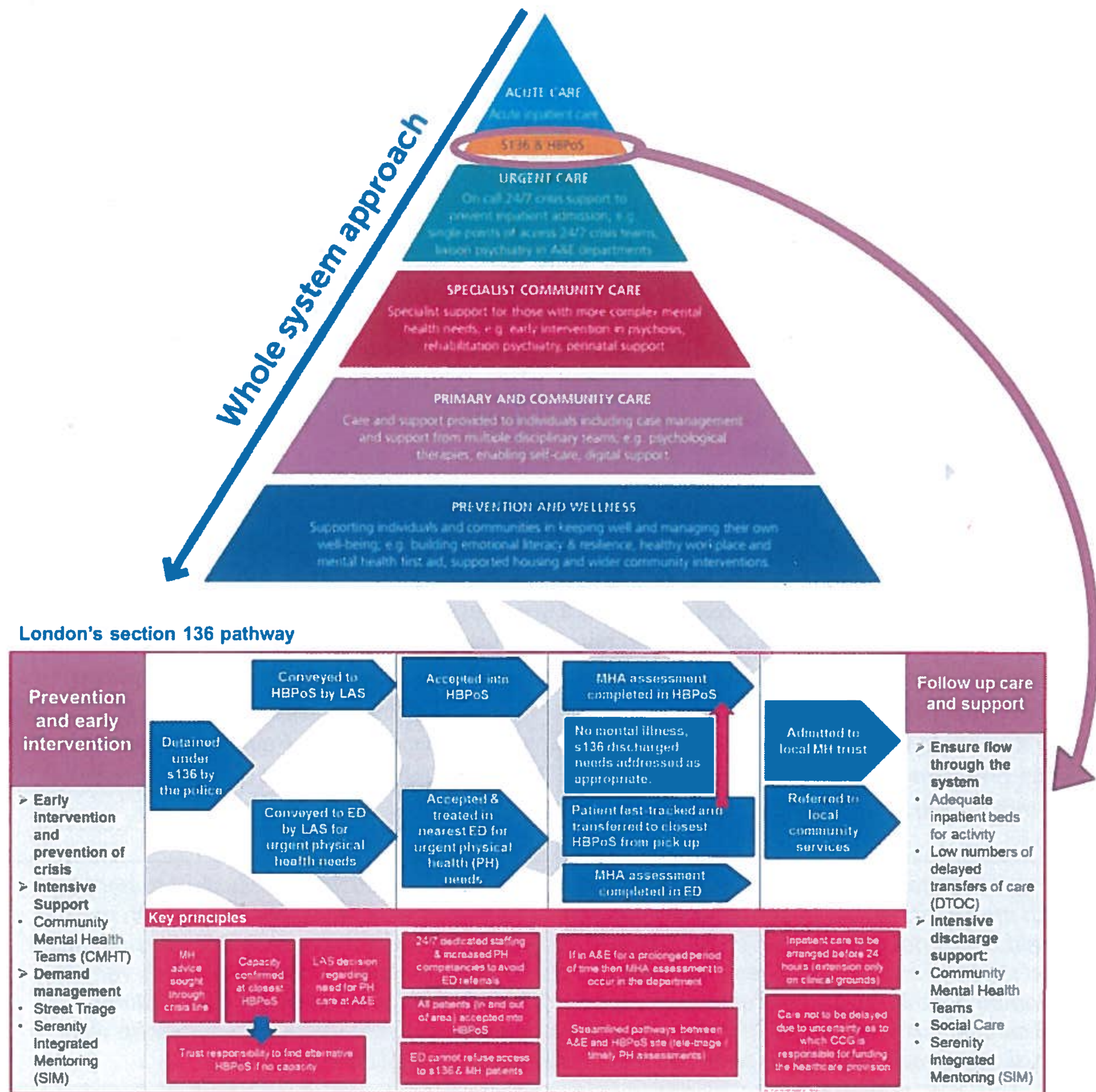
> *"There is a stark disparity in the response from the health and social care system to people with mental health vs. physical health problems and this is unacceptable. People with mental health crisis needs are often denied access to care by the NHS in a way that is discriminatory and may have to be conveyed over many hours to multiple points of care in a police vehicle or ambulance in deeply distressing circumstances - sometimes even ending up detained in a police cell. It is unthinkable that this would be tolerated for a vulnerable individual who was physically in need of urgent care."* Mental health service user (2017)

Whilst the new model of care will have positive impacts on the crisis care system as a whole, it is also important to recognise that in order for it to be sustainable, all parts of the wider system need to be functioning well including: preventative initiatives which assist in demand management (such as Street Triage and Serenity Integrated Mentoring (SIM)), adequate flow through inpatient services including reduced delayed transfers of care (DTOC), well-resourced and responsive community crisis response, and aftercare teams to support on discharge. The ideal pathway for a person in mental health crisis will involve positive, coordinated interactions with more than one of a range of services that will support them.

The optimal pathway for an individual detained under s136 is detailed below. The diagram shows the pathway is one element of the wider crisis care system; preventative and early

intervention services must be in place to prevent people from reaching crisis point as well as adequate follow up pathways once assessed at the HBPoS site.

Figure 1: The pan-London's section 136 pathway



This business case sets out the rationale for improving London's s136 pathway and for the HBPoS site reconfiguration to proceed, subject to completion of all recommendations herein and obtaining regulatory approval and funding.

1.1.2 Strategic Case

London is currently facing significant challenges across the crisis care system owing to rising levels of mental ill health and challenges with current service provision. It is anticipated that services will be required to change to address these challenges and become sustainable in the medium term.

- **The vision is to provide safety and high quality care and treatment to people detained under s136** by delivering the following six strategic objectives:
  - Enable the improvement in s136 patient outcomes
  - Facilitate access to 24/7 services
  - Ensure appropriate service provision for all ages
  - Concentrate staff expertise to enable a service suitable to patient needs
  - Ensure synergy with the wider crisis care system
  - Deliver value for money
- **Delays in accessing support and on-going treatment negatively impacts patient experience and outcomes.**
- **The new model of care provides the opportunity to achieve improved access and patients outcomes, higher levels of patient satisfaction, positive benefits to staff, deliver 24/7 services, reduce inequality and realise efficiencies** across the local health and care economy and wider society.
- **There is a continued drive for high quality sustainable care in the NHS**. People with mental health problems, carers, clinicians and regulatory bodies have highlighted that there is too much variation in both quality and access across different services.
- **Increasing financial and operational pressures** are being placed on mental health Trusts due to demand for services is increasing. Funding does not meet requirements to maintain standards of care; there is a need for all NHS organisations to engage in wider transformational change and service reconfiguration with other agencies towards highly responsive, effective and personalised services for people with urgent physical and mental health needs.
- **South London and Maudsley Mental Health Trust (SLAM) has piloted the new model of care at their centralised HBPoS site.**

- An average of 15% more admissions are accepted.
- Having a 24/7 dedicated team has meant there has been only one closure over the last year; sites were closed 279 times previously over a 12 month period;
- The number of individuals taken to an ED before going to the centralised site has reduced;
- 96% of individuals detained are being admitted to the HBPoS within 30 minutes of arrival;
- The new purpose built facility provides a physical environment which is much more conducive to recovery;
- 76% of service users provided positive feedback, finding the service more respectful and responsive;
- The rate of admission to an inpatient bed has fallen by 13%.

Mental health crisis care in London

London's mental health crisis care system is under significant pressure and simply does not have the services and infrastructure to ensure that people experiencing mental health crisis receive timely, high quality care that respects their individual needs. Across London's s136 pathway there are 20 designated HBPoS sites which vary in capacity, facilities, workforce and services. Most of the facilities are not fit-for-purpose and cannot handle current and future patient activity along the s136 pathway, let alone high quality, effective care.

There is a requirement for delivery of a new model which ensures that people experiencing a mental health crisis have the right care delivered at the right location, at the right time, by staff with the right skillset and in suitable facilities.

Moreover, the potential gains are clear for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care and integrating the care of people's mental and physical health. In addition to the moral imperative and the clear clinical and individual benefits, it is important to recognise that there is a financial necessity to manage the challenges of the years ahead.

The proposal is in line with wider policy goals relating to health and social care and particularly mental health care provision in England. Providing a better service to those detained under s136 will contribute to the aims and objectives outlined in the Crisis Care Concordat and the NHS Five Year Forward View. It also aligns to Mental Health and Urgent and Emergency Care (UEC) deliverables within London's STP plans and ensures the *pan-London s136 pathway and Health Based Place of Safety specification* (endorsed by all key stakeholders and launched by the Mayor of London in late 2016) is met.

Issues across the s136 pathway and current HBPoS configuration

There are six key issues across London's s136 pathway and the current HBPoS configuration, which all play a role in affecting the experience of those in mental health crisis.

- **Inconsistent quality of care:** The care on offer at London's HBPoS sites can vary due to differing levels of staff training and skillsets of the staff allocated to HBPoS sites. London's service users and clinical staff have indicated the current 'ad-hoc' staffing model, where staff are pulled off wards when a person detained under s136 arrives, is not conducive to good patient care, both to those detained under s136 but also those on the ward where staffing numbers are depleted for a 12-24 hour period. Some sites across London also indicated that nursing and medical staff were not trained in de-escalation, which is recommended for managing those with disturbed behaviour.

- **Inappropriate provision for Children and Young People (CYP):** Patients who are under 18 require appropriate facilities and specialised staff that can respond to their specific needs. However, at present many of London's HBPoS sites have local protocols that restrict children and adolescents from the site. EDs are regularly used as the default position when HBPoS sites are unable to manage CYP detained under s136. When this occurs children can be in the ED for a 24-72 hour period due to lack of appropriate staffing but also the lack of Child and Adolescent Mental Health Services (CAMHS) beds available in London.

- **Delayed and unreliable access to care:** London's three police forces, the London Ambulance Service (LAS) and NHS Trusts continuously struggle to find capacity at HBPoS sites. This is primarily due to sites not having sufficient capacity to meet demand and because the absence of 24/7 staffing prevents effective patient flow, both in and out of hours. As the number of s136 detentions increase, this adds additional pressure to London's EDs and increases the length of time people are detained due to waiting in the back of a police van, ambulance vehicle or in ED.

  A typical Emergency Department sees on average 300 patients a day who are in the department for an average of 2.5 hours. When an individual detained under s136 is in the department they spend on average 12 hours due to their complex health and social needs. This means that the care for one person detained under s136 is the equivalent of being able to treat ten other patients, based on the time s136 patient spend in department being five times that of other patients and requiring twice as much resource.

  Treating a s136 patient in A&E takes on average the same resource as treating 10 physically ill patients and patients are significantly more likely to breach the A&E 4 hour standard and 12 hour standard. In an average A&E department, seeing 300 non-s136 patients a week, 10 patients equates to 3.3% of standard daily activity and therefore by treating s136 patients in a more appropriate environment frees up A&E resource and would positively impact on performance against the A&E standards.

  Clinical staff have noted that delays in accessing support and on-going treatment negatively impacts patient experience and outcomes. Staff have stated that those who experience poor treatment at the start of the pathway are less likely to engage with health services, co-produced crisis plans are jeopardised and a lot of the trust between clinicians and the patient is lost.[1] This is illustrated by the fact that in 2015/2016 there were approximately 320 Londoner's who were detained again under s136 within two days.[2]

- **Challenging treatment environments:** A number of HBPoS sites were deemed not fit-for-purpose by the Care Quality Commission (CQC). It is important that during a mental health crisis, the treatment environment supports a good experience for those detained, staff efficiency and protects safety including that of staff. This problem in London is intensified by the fact that four of the designated HBPoS sites are EDs; whilst in some instances it is necessary for mental health crisis patients to attend an ED due to specific physical health needs e.g. overdose or self-harm, it is recognised that a busy ED is not always the most suitable environment for the care of patients in mental health crisis.

- **Funding issues:** Current funding arrangements do not promote Trusts to accept people into HBPoS sites based on need but rather a number of people are accepted and assessed based on their home address or registered GP. This causes delays and inconsistent and variable care across London; patients are denied access to urgent mental health care - something that does not happen to Londoner's who require urgent physical healthcare.

[1] NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

[2] NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

- **Inpatient bed availability**: The lack of inpatient beds in London impacts on the s136 pathway increasing the length of time patients spend at HBPoS sites. In line with the Mental Health Act, Approved Mental Health Professionals (AMHPs) cannot complete the Mental Health Act assessment until a bed is found. The lack of inpatient beds causes a delay in completing the assessment and there is now additional pressure given the recent changes to the Mental Health Act[3]. Currently, the London average is approximately 41% of those detained under s136 are admitted to an inpatient ward following assessment.

Evidence from elsewhere in the UK and in London (e.g. Birmingham and South London and Maudsley Mental Health Trust) suggests that confronting these issues can lead to improvements in patient experience and outcomes, reduced inpatient admissions and decreased readmissions. It is important that the rest of London follows suit.

Pilot of London's s136 new model of care

South London and Maudsley Mental Health Trust is the first Trust in London to fully implement the London s136 pathway guidance and HBPoS specification to provide a 24/7 staffed place of safety for adults and children detained under s136. Healthy London Partnership with stakeholders from across the crisis care system have evaluated the new model of care which has received overwhelmingly positive feedback from service users as well as significant improvements in the pressure often experienced by the police, paramedics, EDs and the sites themselves. The key findings include:

- The site accepts on average 15% more admissions than previously across the four sites in that area. The activity increase represents the amount of patients turned away at previous single occupancy sites located in Croydon, Lambeth, Lewisham and Southwark;
- Having a dedicated team at the centralised site has meant that it has only been closed once over the past year - a stark improvement - sites were closed 279 times previously over a 12 month period;
- The number of individuals detained under s136 that have had to be taken to an ED before going to the centralised site has reduced - partly due to the fact that the staff based at the pilot site are better trained to address physical health issues;
- Individuals detained under section 136 are being admitted to the sites quicker, with 96% of cases being admitted within 30 minutes of arrival;
- The physical environment has been transformed through the new purpose built facility which is much more conducive to recovery;
- Service user's satisfaction with the centralised site has significantly improved with 76% of service users providing positive feedback;
- The rate of admission to an inpatient bed has fallen by 13% under the new model following comprehensive assessment by dedicated staff; and
- Improving flow will be important to reduce the time patients are detained at the suite in light of new legislation.

The feedback from service users is that they received a more respectful, more responsive and less fragmented experience from all agencies involved; from the police and ambulance services, to ED and social and mental health services.

[3] Revisions to the MHA (1983) changed the length of time an individual can be detained under s136 from 72 to 24 hours.

DRAFT

1.1.3 Clinical Case

London's mental health crisis system is facing a number of clinical challenges that have been identified through significant engagement with people with lived experience of mental health crisis, the LAS and clinical staff at both HBPoS sites and EDs and corroborated by the CQC, most recently in a report published in July 2017.

The new model of care will contribute significantly to improving these challenges and help deliver better outcomes to Londoners:

1. **Improve the quality of care** by enabling more capacity across the system, better environment conditions and suitably trained and dedicated staff teams, enable the delivery of a consistent level of care for all, which support reduced inpatient admissions and readmissions.
2. **Improve the provision of care for CYP** by increasing the capacity of appropriate facilities for CYP with suitably trained staff.
3. **Improve access to care** by being better placed to accommodate capacity and demand, supporting reduced ED admissions, providing dedicated staffing 24/7, reducing conveyance time and enabling patients to be assessed and treated holistically and comprehensively.
4. **Improve the environment in which care is provided** by ensuring patients are treated with respect, comfort and dignity and feel safe at all times, in fit-for-purpose facilities.

Implementation will be carried out with strong clinical engagement and leadership to ensure clinical quality is maintained and improved at all sites throughout the transformation.

In the existing system, there are a number of clinical challenges along the s136 pathway which affect patient experiences and outcomes. These include:

- **Inconsistent quality of care** - Only 14% of people with experience of mental health crisis interviewed said that they had the support they needed in a crisis.[4] Issues within the crisis care system, such as the delays and unsuitable environments discussed above, contribute to potentially harmful patient experiences. Patients have also shown a clear preference for 24/7, dedicated crisis services even if that means travelling marginally further to access care. Patient experiences also vary due to differing levels of staff training and skillsets at the HBPoS sites and EDs. Staff who are not dedicated to treating mental health crisis patients feel less confident in their ability to contribute to mental health assessments;

- **Inappropriate provision for CYP** - In a survey by the Royal College of Psychiatrists, 79.1% of respondents reported safeguarding concerns while CYP waited for an inpatient bed; 61.9% reported young people being held in inappropriate settings such as paediatric and adult wards, police cells, and EDs.[5] The use of adult wards and EDs for managing

[4] Healthy London Partnership (2015) UEC Programme: 'I' statements
[5] Survey of in-patient admissions for children and young people with mental health problems. RCPsych, Faculty Report CAP/01

CYP has been described as problematic by stakeholders due to the perceived lack of staff expertise together with inappropriate facilities to care for CYP;

- **Delayed and unreliable access to care** - In 2015, over 100 issues related to HBPoS capacity and access across the s136 pathway were reported by frontline police officers.[6] This number increased in 2016 and 2017, with some instances of police officers and paramedics recording waits of over seven hours in accessing care, despite it being clear that without prompt intervention, a patient's mental health condition can deteriorate. A poor experience at the beginning of the s136 pathway can have traumatising effects for individuals, leading to worse clinical outcomes and a reluctance to seek professional help in the early stages of any future deterioration in mental health; and

- **Unsuitable treatment environments** - London's treatment environments for people experiencing mental health crisis vary, but often fail to provide a therapeutic setting for patients. In their most recent reports from 2016 and 2017, the CQC rated two London HBPoS sites as 'requires improvement' and one as 'inadequate'. The feedback is even worse for those that are transferred to Emergency Departments due to capacity issues; only 12% of those assessed in an ED thought their assessment rooms were pleasant, comfortable and welcoming.

The reconfiguration of HBPoS sites seeks to address these challenges through:

- Reducing delays throughout the pathway including improving the access to care, approximately 45% and 23% reduction in average police and ambulance conveyance times respectively and a 29% reduction in time spent at the HBPoS;
- Improving the treatment environment and staff expertise in both mental and physical health to support improved patient experience and outcomes.
- Reducing approximately 531 unnecessary ED attendances due to improved access and improved physical health competencies of HBPoS staff; this equates to resources for 5310 additional patients or 12,744 extra hours of patient care, which would become available to treat other patients.
- Each person detained under s136 attending ED accounts for 3.3 percentage points of activity (equivalent of 10 other patients) which if not seen will directly impact on performance against the four hour and twelve hour standard.
- Decreasing the overall rates of inpatient admissions and readmissions, 20% (1061 admissions) and 48% (2547 readmissions) respectively.
- Reduction in LAS handover time; LAS estimate a nine minute improvement in the handover of s136 patients, it is clear that this will have a positive impact on the majority of waiting and handover times across London.

These benefits have been demonstrated by models both nationally and in London that have made changes that reflect the new model of care.

[6] Metropolitan Police Mental Health Escalation Log (2015)

1.1.4 Economic Case

The current configuration of HBPoS sites in London is not conducive to meeting the standards outlined in the pan-London s136 pathway and HBPoS specification.

HBPoS sites are historically located where space has been available; however, capacity issues, a lack of dedicated, skilled resource (both in and out of hours) and lack of access predicated on geographic location of need are all drivers for a change of the current configuration.

- A robust options appraisal has demonstrated a reconfiguration of HBPoS sites is required to meet the new model of care. The options appraisal showed a preference of moving to:
    - **Nine site model for adults** with a combined workforce model *(further details on the workforce model is detailed in the workforce chapter)*; and
    - **Five sites (one in each STP) within the nine site model that provide an all-age service.**
- The options appraisal represented the best option to address the mental health crisis care problems across London, bringing sustainable improvements and lasting benefits for patients, as well as driving improvements in the wider health economy.
- This option is the preferred state for London's future HBPoS site configuration; however a **transitional 13 site phase** has been developed following STP programme leads engaging locally on proposed configurations.
- The **indicative benefits** of the reconfiguration based on nine sites have been quantified by estimating the NHS financial savings as well as measuring the social impact of nine key outcomes.
    - NHS financial savings total £14,384k
        - £795k cashable / £13,589k non-cashable
    - Social impact savings (non-cashable) measured at £5,572k
- The **total baseline pathway cost is c. £20,632k p.a. (excluding activity growth).**
- The **total estimated cost of the reconfiguration is £23,744k** which includes the following:
    - Pathway cost £20,494k p.a.
    - Transition costs £1,000k
    - Capital costs £2,250k
- The **indicative net present benefit** of the reconfiguration over the five year period FY17/18 to FY21/22 is £73,927k which includes;
    - Net present value of non-cashable benefits (excluding non-pay costs) £66,174k
    - Net present value of the preferred option £7,753k

Overview

A detailed options appraisal has been carried out in order to arrive at the preferred option, the 'consolidated model' of nine HBPoS sites. Within the nine site model the outcome of the options appraisal was that within each STP, one of the HBPoS sites should provide an all-age service with the appropriate facilities. This is to ensure those that are under 18 receive care in a suitable HBPoS site with adequate facilities and that EDs are not used.

Following the options appraisal, further engagement led by programme STP leads took place across the system on the preferred option. The engagement process resulted in some STPs confirming sites that would be included in a pan-London nine site model whilst others required more time to develop local plans, reflecting on other crisis care services and further understanding the impact of patient flow across local systems. This is particularly the case (but to varying degrees) in North West London (NWL), North East London (NEL) and South East London (SEL).

This resulted in a transitional stage of 13 HBPoS sites across London (including five sites that provide an all-age service). The 13 site transitional stage is referenced throughout the following chapters with further detail in the management case.

Options appraisal

The options appraisal process comprised of three phases:

- Phase 1a: Site agnostic appraisal
- Phase 1b: Site specific appraisal
- Phase 2: Pan – London site configuration assessment
- Phase 3: Preferred option

At each phase, a set of criteria was used to reduce the millions of potential configurations to one preferred model. These criteria included quality, access to care, deliverability, strategic coherence and value for money. Figure 2 provides a map of the preferred 9 site configuration following the options appraisal as well as additional sites in the transitional phase (faded circles)[7].

[7] City and Hackney Centre for Mental Health received a marginally higher options appraisal score than Newham Centre for Mental Health. For this business case, the former is considered the preferred site, however as implementation plans progress the preferred site may change.

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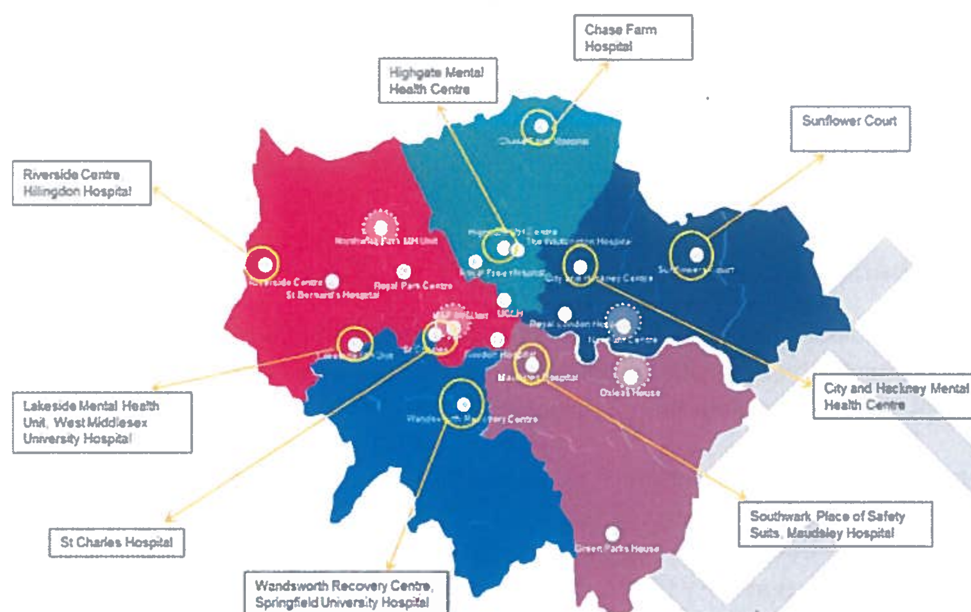
Figure 2: Pan-London consolidated HBPoS site model



All sites within the 9 and 13 site model are suited for adult provision, with one site per STP providing an all-age service. The preferred CYP sites in the transitional 9 and 13 site model are: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL), and St. Charles (NWL). Newham Centre for Mental Health (NEL) is the preferred all-age site in the 13 site model; however, on transition to the 9 site model, the all-age provision will need to be reassessed as the Newham Centre is not included.

Some of the key attributes of the consolidated model are:

- The location is spread evenly across London, ensuring equity of inner and outer London, but also at an STP level. The consolidated approach, with dedicated staffing, also ensures that capacity is adequate to deal with fluctuations in demand at peak hours;

- Eight of the nine sites are within 0.5 miles[8] of an ED, ensuring that urgent physical care can be accessed if required;

- 100% of the sites are within 0.5 miles of an inpatient mental health bed (both adult and CYP);

- 88.5% of the s136 cohort will be 45mins[9] or less away from an HBPoS site. For the remainder of those detained under s136, the average time would be 53 minutes, with a range of 48 – 56 minutes. If patients were to be conveyed by blue light (only when suffering a life threatening clinical condition), 100% would be 45mins or less away; and

[8] 0.5 miles was agreed by service users, carers and operational staff to be the maximum distance HBPoS sites should be from inpatient and physical health services.
[9] 45 minutes travel time aligns to the timeframes used for London's stroke and trauma reconfiguration and is consistent with national and international good practice.

- The utilisation of facilities and staff will significantly improve, with an expected capacity utilisation of 58% and workforce utilisation of 62% across the nine sites. Based on 5,307 s136 patients equating to 58% utilisation, this would provide a range of 5,307-9,150 at peak capacity (100% utilisation), providing headroom to allow HBPoS sites to better manage peaks and troughs in activity.

- Furthermore, the experience from SLAM's centralised HBPoS illustrates that quieter periods give time for on-site training and for adequate breaks and reflection in what is on other occasions a high intensity environment; this has a positive impact on staff wellbeing and contributes to high retention rates.

Economic costs and benefits

The Economic Case also outlines the indicative economic costs and benefits of the nine site model. This chapter focuses on the nine site model; further information on costs and benefits for the 13 site transitional phase is outlined in the management case.

The total estimated pathway cost of the preferred option is £20,494k p.a. giving a £138k saving on the baseline pathway cost of £20,632 p.a. (excluding impact of activity growth). In addition, the preferred option assumes transition and capital costs of £1,000k and £2,250k respectively will to be incurred through FY17/18 and FY18/19. In particular, the consolidation of HBPoS sites will require an increase in capacity for the majority of sites within the preferred option, for example through an increase in the number of assessment rooms, thereby necessitating capital investment. These costs are discussed in more detail in the financial case.

A range of benefits, which are designed to specifically enhance patient experience along the s136 pathway, include the financial, economic and social values which will be realised as a result of implementing the new model of care which includes the consolidation of HBPoS sites.

Table 1 below sets out the financial benefits totalling £14,384k which are estimated to be delivered, £795k of which is assumed to be cashable, £13,589k non-cashable. In addition, a further £5,572k social impact savings have been identified as part of the nine site option analysis. Table 2 sets out the indicative benefits per STP / HBPoS, both cashable and non-cashable, with the allocation calculated on a capitation basis; this will require further review and analysis at next business case stage.

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Table 1: Benefits overview

No.	Outcome	Financial (cashable) benefit Value p.a (£000)	Financial (non-cashable) benefit Value p.a (£000)	Benefit of measuring social impact (non-cashable) - Value p.a (£000)	Total Value p.a (£000)
1a[10]	Reduced conveyance time (ambulance and police vehicle)	£498	-	£14	£512
2	Reduced ED admissions	£297	-	£60	£357
3	Reduced length of stay at HBPoS	-	-	£87	£87
4	Improved staff expertise	NA	-	NA	Qualitative
5	Improved HBPoS environment	-	-	£335	£335
6	Reduced non-pay costs	-	£5,542*	-	£5,542
7	Reduced inpatient admissions	-	£7,918**	£4,606	£12,524
8	Reduced HBPoS readmissions	-	£129**	£470	£598
9	Improving the wider crisis care system	NA	NA	NA	Qualitative
	Total	**£795***	**£13,589**	**£5,572****	**£19,956**

**Financial benefits figures included in the preferred pathway costing analysis in section 5 of this business case*

***Total non-cashable benefits figure (£13,619k combined) included in indicative net benefits calculation in subsection 4.2.5 of this business case*

Table 2: Benefits overview by STP / HBPoS

	STP	NCL		NWL			NEL		SEL	SWL	
	HBPoS	Chase Farm H	Highgate MHC	Lakeside MHU	Riverside C	St Charles	City & Hackney MHC	Sunflower Ct	Southwark	Wandsworth	
No.	Outcome	Indicative preferred option benefits (£'000s)									Total £'000s
1	Reduced conveyance time (ambulance vs. police vehicle)	£106		£103			£142		£111	£50	£512
2	Reduced ED admissions	£74		£72			£99		£78	£35	£357
3	Reduced length of stay at HBPoS	£5	£13	£9	£2	£6	£16	£8	£19	£8	£87
5	Reduced non-pay costs	£20	£50	£35	£9	£24	£61	£32	£73	£33	£335
6	Reduced inpatient admissions	£326	£824	£575	£141	£396	£1,014	£521	£1,205	£540	£5,542
7	Reduced HBPoS readmissions	£736	£1,862	£1,300	£319	£894	£2,292	£1,178	£2,723	£1,220	£12,524
8	Improving the wider crisis care system	£35	£89	£62	£15	£43	£109	£56	£130	£58	£598
	Total	**£1,303**	**£2,838**	**£2,156**	**£486**	**£1,363**	**£3,733**	**£1,795**	**£4,339**	**£1,944**	**£19,956**

In total, after considering financial and non-financial savings, the indicative net present value of the preferred option over the five year period FY17/18 to FY21/22 is estimated at approximately £70,931k which includes:

- Net present value of non-cashable benefits (excluding non-pay costs) £66,174k; and
- Net present value of the preferred option £4,757k.

[10] Combined benefit for LAS and Police

Improving the wider crisis care system

The new model of care and reconfiguration of HBPoS sites across London will not only have a direct impact on the s136 pathway; it will have wider implications for the entire crisis care system in the capital:

- The first notable benefit is that the new model will future proof services. The reconfigured sites allow capacity to be utilised in a more sustainable manner, ensuring that infrastructure can better cope with volatility in demand and potential growth in coming years;

- Successful implementation of a pan-London model with improved facilities and a high quality standard of care will raise the profile of crisis care as a whole and is likely to encourage future service improvement in crisis care services, including potential expansion of other services and training;

- In addition, the new model of care will promote greater synergies between crisis care services and other physical and health services within the NHS and well as local demand management schemes that are emerging (e.g. Street Triage and the Serenity Integrated Mentoring (SIM) model). The specialised 24/7 staffed sites will lead to focal points for crisis care activity, providing the opportunity for a solid network of supporting services to be developed around the sites and bringing transparency and recognition to an often forgotten and 'ad hoc' service;

- The investment will support the broader objective of closing the financial gap between physical and mental health care funding. There are direct financial benefits to the reconfigured pathway as detailed in Section 5. Furthermore, the new model of care will provide a platform from which performance and trends can be appraised across the system, establishing the potential for further cost efficiencies; and

- The new model of care proposes a standardised, consistent s136 pathway across London. This presents an opportunity to collect and appraise standardised crisis care data. Using this as an initial platform to expand data collection across crisis care, will ensure that performance of the whole crisis care system can be effectively evaluated; this will support identification and sharing of best practice and identification of opportunities for wider service improvement and cost efficiencies.

1.1.5 Financial Case

The current configuration of HBPoS sites in London, with a lack of dedicated, specialty skilled resource, results in a cost pressure for most MH Trusts, with staff diverted from other roles (often from inpatient facilities) to attend to s136 patients.

The preferred **nine site option is estimated to cost c. £20.5m p.a.** compared to the baseline pathway cost of c. £20.6m p.a. (excluding impact of activity growth), a decrease of £0.1m

The interim stage of transition to the preferred option will involve a total of **13 sites at an estimated cost of c. £23.2m p.a.**

Over the five year period FY18/19 to FY22/23 total costs of the reconfiguration are estimated at c. £106.8m, compared to £111.7m per the baseline pathway. This gives a net savings of £4.9m, with a NPV of £4.8m.

The current plan is predicated on the following assumptions:

- Preferred option is implemented in FY19/20
- **Net activity growth** of 16.5% (allow for demographic growth and growth from recent statutory changes)
- Successful delivery of £6.3m financial savings (of which £795k are **cashable cost savings)**
- **£1m transition costs**; however, this is only an estimate and it is acknowledged that further analysis and refinement is required
- **£2.3m capital expenditure**; however, this is only an estimate and it is acknowledged that further analysis will be required during implementation planning, with capital requirements per site defined with local estates team. A transitional stage of 13 sites would require £450k less capital funding
- £3.3m funding being made available from CCGs / pooling of budgets across STP footprints

Risks inherent to the financial analysis of the s136 pathway and HBPoS specification include:

- Gaps in data collection
- Robustness of data
- Access to data

Financial costs

To understand the financial implications of the HBPoS reconfiguration, it is necessary to cost each step of the s136 pathway and determine the potential impact of the new model. However, there are a number of complications with trying to estimate a baseline cost for the s136 pathway, including inconsistent pathway practices and a lack of available data.

Nevertheless, pathway costs have been estimated by utilising existing secondary data sources provided by the LAS, Police and the NHS; supplemented through a series of data collection audits and surveys. The analysis considered the costs of conveyance, HBPoS sites and EDs

and determined a total saving of £138k per annum. This saving is primarily a result of non-pay savings, which result from a reduction in sites. Table 3 below summarises the annual variances.

Table 3: Summary of cost variances

Reference	Stakeholders	Baseline	Preferred Option	Variance
1a[11]	Police	£203k	£112k	(£91k)
1b[11]	Police (with LAS)	£435k	£333k	(£102k)
2[12]	LAS	£1,310k	£1,004k	(£306k)
3	ED	£297k	£0k	(£297k)
4	AMHPs	£1,118k	£1,175k	£57k
5	Independent s12 Doctor	£378k	£302k	(£76k)
6	HBPoS: workforce	£5,417k	£11,636k	£6,219k
7	HBPoS: non-pay	£11,473k	£5,931k	(£5,542k)
	Total	**£20,632k**	**£20,494k**	**(£138k)**

Transition costs

The reconfiguration of HBPoS sites across London will be a complex undertaking and as such, resources will be required to support in the transition.

It is proposed that implementation will be led locally and coordinated at an STP level. To this regard and with detailed implementation planning still to be undertaken, subject to the progression of this business case, it is difficult to provide a firm estimate of the level of resource required. However, it is acknowledged that resource will be required at both a local level and at a pan-London level to support the transition requirements.

For the purpose of the wider costing exercise it is proposed that £100k will be required per STP to support the transition. This establishes a total cost of £500k p.a. in FY18/19 and FY19/20 to support the transition. This is however, a high-level estimate and will require further refinement.

Capital costs

The consolidation of HBPoS sites will require an increase in capacity for the majority of sites which are incorporated within the preferred option. As such, to support this increase in capacity, capital investment will be required at many HBPoS sites.

[11] 1a the cost of conveyance to police when conveying alone and 1b when conveying with LAS.
[12] The cost to LAS when they convey (always with police).

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Aside from the increase in the number of assessment rooms, the degree to which an existing site can accommodate a larger HBPoS will vary. While analysis has been undertaken as part of the options appraisal process that considered the percentage of estates that are currently utilised for non-clinical purposes, further analysis is required during implementation planning to effectively deduce capital requirements per site in collaboration with local estate teams.

For the purpose of this financial analysis, an assumed capital cost of £150k is utilised per extra bed required. This figure is drawn from the Policing and Crime Bill – Amend Police Powers under the Mental Health Act 1983, which provides an indicative view of what may be required across London. This establishes that an assumed total level of capital investment required across London to support the configuration is £2.3m.

Funding

At this early stage of the project, the exact funding arrangements for the costs outlined above have not been finalised and agreed. However, initial expectations about funding arrangements can be summarised as follows:

- It is likely that variances to pathway costs will be borne by the relevant stakeholders i.e. police forces, LAS, Mental Health Trusts;
- The pan-London transformation work programme has thus far been led by the Healthy London Partnership (HLP) in partnership with key stakeholders across London's crisis care system. Going forward, implementation and transition costs will require funding from local systems;
- Transition costs will likely be incurred by the CCGs within the relevant STPs as they transform the services at their HBPoS sites. It is important that additional funding is made available for this transition as there will be no equivalent income mechanism to support them; and
- The capital costs required to increase capacity at relevant HBPoS sites will likely be borne by the local STPs, however national capital funding available through bidding processes should be exploited.

Pooling budgets across CCGs within the relevant STPs, combining spending power, is expected to provide funding support for the new model of care.

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1.1.6 Management Case

Current reconfiguration planning is based on a completion date of 2019/20, subject to agreement on financial support and regulatory and Board approvals. To reach the 9 site option the following measures are proposed:

- **A 13 site transitional phase has been supported by STPs in the shorter term as an interim measure to reach the preferred nine site option.**
- **A highly collaborative approach and governance structure, with robust governance arrangements** will be adopted to manage the reconfiguration and plan for the future implementation; key requirements have been identified.
- **A plan to continue engagement with key stakeholders including people with lived experience of mental health crisis and their carers** will be developed to ensure the transition into the new reconfiguration of HBPoS sites is successful.
- **A plan for proposed governance structure post implementation and performance management arrangements** will be developed; principles for governance have been identified and a suggested multi-agency group structure. Group roles and governance benefits have been identified.
- **A comprehensive risk assessment, escalation and mitigation process** will be developed and in place to support the reconfiguration, with risks identified both at a local and system wide level. Implementation risks will be identified and assessed using a four tiered matrix. Risks will be discussed during implementation and post implementation governance forums

The implementation of a material reconfiguration of any clinical service must be undertaken in a robust and sensitive manner. As such, a number of priorities/principles have been proposed that should be adhered to during the course of implementation, ensuring that the process meets its objectives. These include:

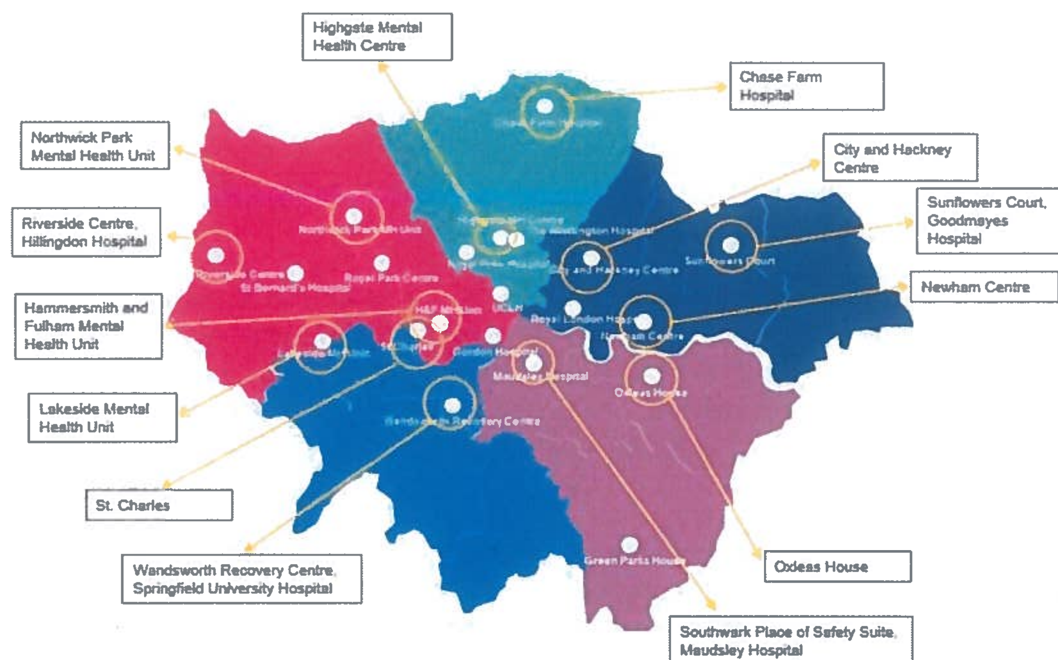
- Ensuring patient safety;
- Profiling implementation and developing detailed implementation plans;
- Ratifying key protocols prior to go-live;
- Engaging with stakeholders;
- Aligning with wider crisis care transformation and;
- Maintaining clinical leadership.

Transition phase

As previously mentioned programme STP leads tested the nine site configuration locally through significant engagement across the system. From this it was recognised that the changes required for the nine site model would not be achievable locally in the short to medium term.

In light of this, the 13 site model is considered a transition stage to support STPs to implement the nine site preferred configuration. The resultant 13 site transition phase is shown below in Figure 3.

Figure 3: HBPoS locations in the 13 site transition phase



All sites within the 9 and 13 site model are suited for adult provision, with one site per STP providing an all-age service. The preferred CYP sites in the transitional 9 and 13 site model are: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL), and St. Charles (NWL). Newham Centre for Mental Health (NEL) is the preferred all-age site in the 13 site model; however, on transition to the 9 site model, the all-age provision will need to be reassessed as the Newham Centre is not included.

The total estimated benefits of the transitional phase are marginally higher than the nine site model due to decreased travel times. This equates to an additional financial benefit to LAS and Police of c. £134k p.a. and an additional £3k p.a. social benefit (non-cashable) accruing to the patient due to a reduced travel time.

The overall costs however are more expensive with 13 sites largely due to 24/7 dedicated staffing at each site. The 13 site configuration is estimated to cost c. £23.2m p.a. compared to the baseline pathway cost of c. £20.6m p.a. and the nine site configuration of c. £20.5m p.a. (excluding impact of activity growth). Of the additional four sites not included in the nine site configuration, only two sites need additional capital funding to meet capacity requirements of an additional assessment room at each site. This capital investment will total c. £1.8m for the 13 site configuration, £450k less than the preferred nine site model.

The timelines for this transition are due to fall within the proposed two year process to move to the nine site model. As a result there no additional transition costs expected in addition to the £1.0m included as part of the preferred nine site option.

Structures in place for implementation

The programme recognises the need for establishing robust governance procedures, risk management and a benefits realisation framework prior to implementation. This is to help manage key risks and issues that may arise, these include:

- Diversion and delays from the implementation plan;
- Lack of buy-in, scepticism and resistance to change;
- Impact on broader health and crisis care services;
- The requirement for formal new ways of working; and
- Availability of both capital and revenue funds.

Specific examples of implementation structures to consider for the next stage, in order to address the key risks and issues outlined above, will include establishing formal arrangements for AMHPs working outside of local authority boundaries, reaching an understanding on cross-charging arrangements for out of area patients, and understanding how this work interacts with other key mental health initiatives, such as ensuring adequate inpatient capacity and delayed transfers of care (DTOC).

During and post implementation, a local multi-agency group led by the provider trust providing each of the HBPoS sites should exist and should be overseen by the respective UEC network in each STP. In addition, a post programme evaluation should be carried out. Due consideration should also be given to the pan-London position during implementation as it is important to ensure that there is pan-London oversight.

Post-implementation, in order to assess the impact of the programme at a pan-London level, a programme evaluation should take place. Appropriate key performance indicators (KPIs), which align with the objectives for the new model of care, would need to be established and agreed upon by stakeholders across the crisis care system.

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1.1.7 Commercial Case

The new model of care and reconfiguring HBPoS sites across London is the most effective option to address current issues across the s136 pathway.

The new model will bring sustainable improvements and lasting benefits for patients, whilst in the medium to long term resulting in a local health economy that is both clinically and financially sustainable, delivering improved access, with 24/7 services and patient improved outcomes and provision of care.

The reconfiguration will present an opportunity for broader transformation of the crisis care system, including a range of services; a robust commercial process is therefore required.

- **With the complex network of stakeholders** involved in the reconfiguration, oversight of the commercial process is critical to the success of the new model of care
- Whilst it is early in the process to establish the exact service requirements, the **expectation is that services will be required for construction, programme support/implementation, recruitment and training**
- A commercial strategy supporting the reconfiguration will be developed in conjunction with proposed transformation plans on a STP basis

The requirement to develop a robust commercial strategy is particularly important for this transformation programme due to the breadth of stakeholders and delivering a pan-London model of care. At this early stage in the programme, it is difficult to predict which services will be required as part of the scheme. However, it is expected that services will be required for construction, programme support/implementation, recruitment and training.

A set of objectives have been developed which must be adhered to through development of procurement approach. This includes providing optimum value for money, the procurement is managed and governed in an open and transparent manner and there is careful planning and timing of procurement process.

In addition, the commercial strategy must recognise the opportunities related to synergies in the wider crisis care system. These involve joint investment, shared infrastructure and system wide data.

1.1.8 Workforce Case

Very few London HBPoS sites have dedicated trained staff and staffing levels are minimal out of hours; this is despite over 75% of s136 detentions occurring outside of regular working hours. Key components of the workforce model in each HBPoS site are:

- **Providing adequate, dedicated staffing 24/7 teams that are suitably skilled in both mental and physical health** at all HBPoS sites is expected to significantly improve patient experience and outcomes, staff experience and reduce cost pressures currently experienced from having to pull staff of inpatient wards.
- **Two dedicated specialty workforce models have been proposed: a combined staffing model** where the HBPoS is co-located with a crisis assessment unit or Psychiatric Decision Unit (as seen at South West London St. Georges Mental Health Trust), and a **stand-alone workforce model** (as seen at SLAM)
- **Three possible options have been identified to deliver AMHP services** following the reconfiguration of sites learning from different models across London; however, a more rigorous assessment is required to ensure challenges encountered by AMHPs are addressed and an efficient model is created.
- Greater transparency is needed to ensure **appropriate training standards have been met in relation to independent s12 doctors and** improved payment and administration protocols.
- The future operating model is expected to **minimise the number of ED presentations** due to capacity issues and improved physical healthcare provision in the HBPoS sites, both of which will reduce the strain currently experienced by London's Emergency Departments.
- **Development of a clear strategic direction and purpose** will facilitate transformation of the workforce model as well as a robust workforce strategy that includes staff engagement throughout implementation, robust workforce planning including network approaches across STPs, values based management and leadership and consistent London standards.

At present, staff across the crisis care system face a number of issues when it comes to the s136 pathway. The roles of the police and LAS, HBPoS staff, AMPHs, s12 doctors and ED staff are all affected by operational inconsistencies and efficiencies:

- **Conveyance staff**: London's police forces and LAS are hampered by delays in accessing HBPoS facilities, poor communication protocols between their staff and staff at HBPoS sites and Emergency Departments and lack of knowledge and clarity regarding the roles and responsibilities of each stakeholder group;
- **HBPoS staff**: Non-dedicated staffing can cause a number of issues for clinical staff and individuals undergoing Mental Health Act assessments at HBPoS sites. It detracts nurses and doctors from their substantive posts and leads to varying levels of competencies when treating s136 patients. It also leads to low staff satisfaction due to staff being pulled off wards and not feeling part of a dedicated, specialised team. A further important impact of a lack of dedicated staffing is that on downstream inpatient wards. When staff are brought in from other areas to staff the HBPoS, a reduction in staff in those clinical

areas will impact on quality of care for patients there, which effects patient experience and outcomes;

- **AMHP services**: Limited capacity, particularly out-of-hour AMHP availability, and inconsistent protocols across boroughs can delay mental health assessments. These issues are often amplified for out-of-borough presentations;

- **S12 doctor**: The lack of standardised processes for recruitment, administration and payment requirements can often delay independent s12 doctors, create a lack of transparency in the system, and lead to insufficient capacity and variable quality of assessments; and

- **ED staff**: Unclear policies and responsibilities for liaising and communicating with police and HBPoS staff, as well as lack of clarity of the role of EDs in the s136 pathway, can exacerbate delays to treatment. In addition, the limitations faced when accessing patient notes due to incompatible systems between Acute and Mental Health Trusts are challenging for good quality care.

The pan-London s136 pathway and HBPoS specification outlines key criteria that the future workforce model needs to meet. Once met the new model of care will have significant positive implications for staff in terms of safety, efficiency, utilisation and new ways of working. In addition, the improvements in staff training, communication protocols and multi-agency working that are expected will help to engage staff members from all parts of the pathway to help ensure successful implementation of the new model.

Workforce model for HBPoS sites

During the options appraisal two staffing models were considered, a stand-alone workforce model (as seen at South London and Maudsley Mental Health Trust) or a combined workforce model where staff cover both an HBPoS and PDU (e.g. Psychiatric Decision Unit, seen at South West London St. Georges Mental Health Trust). In both models, the creation of a dedicated team has significant benefits through addressing some of the challenges related to access and quality of care. The dedicated, specialty trained workforce model is innovative and provides an opportunity to build a specialised workforce for this largely forgotten service, promoting the s136 pathway to an active part of the crisis care system.

The introduction of dedicated 24/7 staffing as part of the reconfiguration of the HBPoS sites will address current pressures experienced due to inadequate staffing and facilitate improved quality of assessments and resulting patient outcomes. The dedicated team will be able to work more closely with patients to understand their needs and identify the best course of action, with any plans developed handed over to the next team member on shift. At SLAM's centralised place of safety, which has piloted the new s136 model of care for London, the rate of admission has fallen by 13% following implementation of the new model. This has been attributed in large part to improved practice following the introduction of the dedicated staff team, together with a close working with the Trust's Acute Referral Centre.

The concept of the combined unit is to have a psychiatric decision unit and HBPoS co-located; this enables a joint workforce that can flex between the decision unit and the HBPoS increasing the utilisation of staff and benefitting from a model that provides a broader service to a wider range of patients (e.g. the assessment unit receives mental health crisis patients from liaison

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psychiatry, crisis teams and street triage to carry out an informed, collaborative assessment in an appropriate mental health assessment facility). As noted above for SLAM however, periods of lower utilisation can have positive impacts on staff wellbeing and retention. Each area would need to consider the case for each model within their area.

The benefits of both models are a dedicated 24/7 specialised workforce and whilst it may be tempting to create an HBPoS team who have additional roles as supernumerary staff in other mental health teams, in the climate of overall low mental health workforce numbers, there is a real danger of reliance on these staff members thereby creating the situation where their immediate availability for a s136 patient is reduced, or those other areas of care are affected; this would mark a return to one of the key issues of the current model of care.

Costing the 24/7 model

It is estimated that the preferred 9 site option with 24/7 dedicated workforce would cost £11.6m per year. The workforce model that is proposed is based on safe levels of staffing at the HBPoS.

Whilst the cost associated with providing dedicated 24/7 staffing with the new model of care at c. £11.6m p.a., is significantly higher than the staffing cost with the current 20 site model at £5.4m p.a., the cost associated with the preferred 9 site model is much more favourable than maintaining the current 20 site configuration and introducing 24/7 staffing at a cost of c. £14.7m p.a. (an additional £3.1m compared to the preferred option).

HBPoS staff training and competencies

Irrespective of which workforce model, healthcare staff who work in an HBPoS should be sufficiently trained in mental and physical health to safely and effectively perform their role. The provision of a dedicated team allows for s136 specific training to be delivered to a dedicated workforce and for the on-going assessment of skills and training needs; this will improve the quality of care for individuals detained under s136.

As well as improving team skills and expertise, training initiatives for dedicated staff teams have a clear role in staff development and career progression. This will have positive impacts on recruitment and retention, both important issues to address across mental health, as highlighted in the Health Education England (HEE) Mental Health workforce plan[13].

Furthermore, a dedicated workforce will allow development of relationships across the ED/Mental Health interface, leading to sharing of expertise, improved handover and the opportunity to develop novel approaches in partnership to support integrated mental and physical healthcare. It is anticipated that adherence to the physical health competencies set out in the pan-London guidance will reduce the need for physical health assessments or treatment in an ED prior to or during assessment at the HBPoS site. This will reduce the burden on EDs, improve the timeliness of assessments and reduce the use of further conveyance by LAS or police between HBPoS sites and EDs.

[13] Stepping Forward to 2020/21: Mental Health Workforce Place for England (2017). Health Education England. Available at: https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/mental-health-workforce-plan

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1.1.9 Recommendation and next steps

This business case sets out the rationale for a new model of care and consolidating HBPoS sites across London. The proposal contained herein demonstrates that such a reconfiguration can improve outcomes for patients, facilitate the availability of a 24/7 service, concentrate and enhance staff expertise, achieve value for money and ensure effective synergies between the s136 pathway and broader crisis care.

However, it is acknowledged that such an undertaking would be delivered in a complex, multi-stakeholder environment. Furthermore, it also requires an investment of resource, both in terms of finance and time. Therefore the steps that should be taken post the conclusion of this business case should be considered judiciously, ensuring that due diligence is taken in the commitment of further resource.

It is recommended that the proposal contained within this business case is progressed towards implementation, augmented with the following steps:

- Appropriate consultation is undertaken with key stakeholders as necessary;
- Each respective STP determines precise capital requirements particular to the sites within their jurisdiction;
- Sources of funding are determined, with relevant submissions made to secure such funding; and,
- The proposals contained within the Management Case are progressed; most notably, the establishment of effective implementation governance and the development of detailed implementation planning.

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2 Introduction

This section sets out the context of the business case. It details the scope and purpose of the change and introduces the reader to the baseline pathway and preferred option. This section is structured as follows:

- Purpose of document
- Overview
- Mental Health Crisis Care for Londoners
- Current s136 pathway

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London’s Mental Health Crisis Care Programme

Stakeholder Engagement Summary

July 2018

Supported by and delivering for London’s NHS, London Councils, Public Health England and the Mayor of London

About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About this document

Since 2015, Healthy London Partnership (HLP) has worked in partnership with London's health and care system to develop a pan-London new model of care for individuals detained under Section 136 (s136). Continuous system wide engagement has been integral to the development of the new model of care. This document summarises the engagement in terms of activities undertaken, the stakeholders involved and how this has fed into the development of the new model of care. For further information on the proposed pan-London model of care for s136, please refer to the public engagement document.

Contents

Overview of the engagement process ... 4
Key documents and dissemination ... 6
Committees and boards ... 10
Service user engagement ... 11
Key presentations and meetings ... 23
Events and workshops ... 36
Marketing and media ... 41

Overview of the engagement process

It has long been recognised across London that mental health crisis care services often fall short in providing effective access, care and treatment for people who are among the most vulnerable in our society. London's crisis care system is under significant pressure and does not have the services or infrastructure to ensure people experiencing a mental health (MH) crisis receive timely, high-quality care that respects individual needs.

In 2015, HLP worked with stakeholders, including service users and carers, from across London's mental health crisis care system to identify key issues across the pathway and to develop a strong case for change.

A multi-agency group including service users, carers, frontline staff, MH and acute trusts, the London Ambulance Service, the three London police services and local authorities led the development of *London's s136 Pathway and HBPoS Specification*, which outlines the minimum standard of care for HBPoS sites and the roles and responsibilities of all professionals in the pathway. Extensive engagement led to all partners formally endorsing this guidance, which was launched by the Mayor of London in December 2016.

The new model of care was developed from the principles laid out in the guidance. It was recognised across the system that in order to meet the specification standards, significant changes were needed to the current provision of services.

A HBPoS options appraisal was undertaken to identify how London's place of safety sites could meet the specification. The options appraisal identified the optimal pan-London place of safety configuration including the required number of sites, capacity and optimal locations across London. The output of this was a 9 site model with 5 of these sites as all-age provision. This then informed the development of a business case for service change.

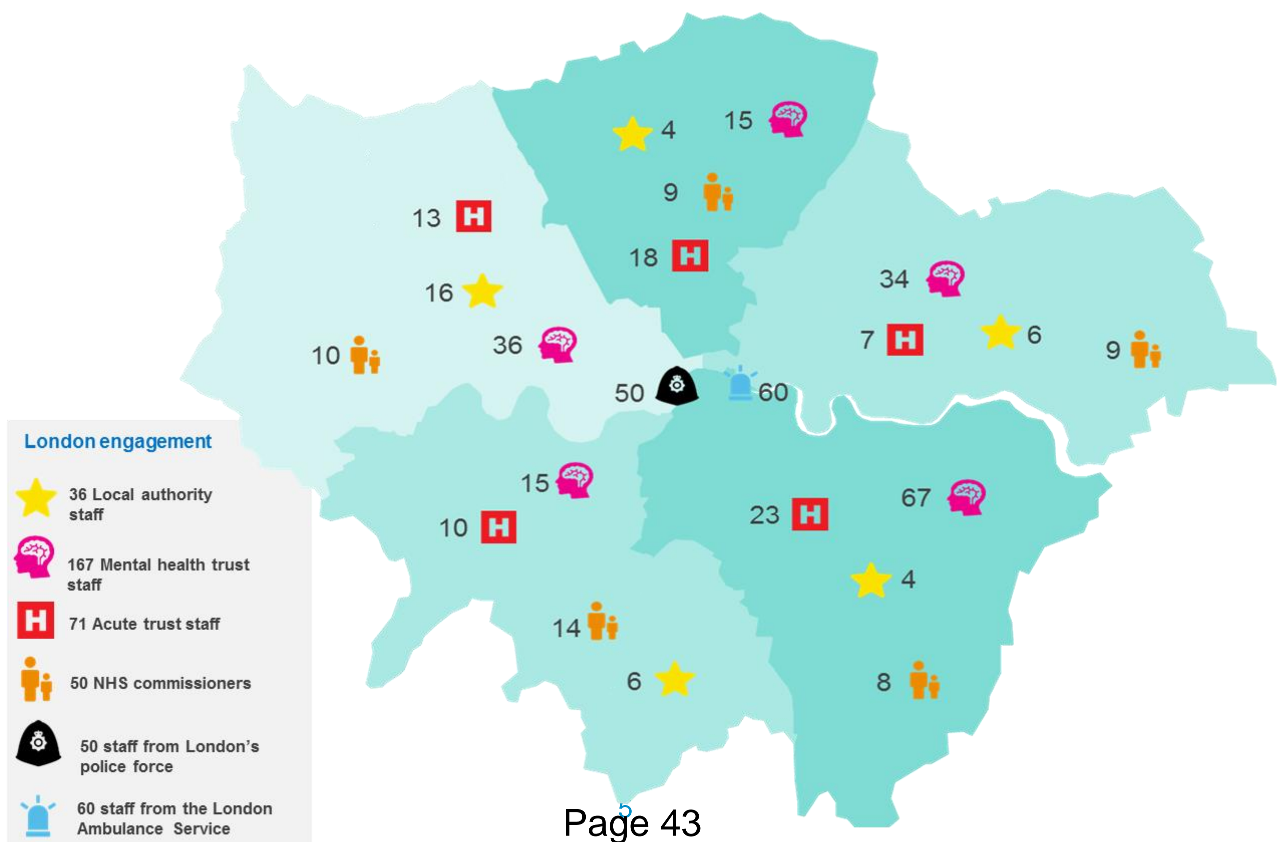
HLP is now working with London's crisis care system and service users to support implementation of the model of care across London. Next steps include the development of business plans in each Sustainability and Transformation Partnership (STP) and for these to be taken through local decision making forums in order to progress implementation. As part of this process there will be further public engagement as further consideration is given at the STP level regarding plans for future HBPoS provision.

The voice of people with mental health problems has been at the heart of the programme. A section of this document has been dedicated to engagement with service users and carers, describing how they have been involved and how their experiences and views have shaped the development of the programme and the pan-London s136 model of care.

Figure 1 below includes the amount of engagement that has taken place throughout the life of the programme. Figure 2 provides an overview of staff that have been actively engaged more recently since the pan-London guidance has been developed. This includes those involved in specific activities to support implementation of the guidance throughout 2017 and 2018. Individual STP maps are available in appendix 1.

Figure 1: Summary of engagement throughout the programme

Figure 2: London engagement to implement the guidance throughout 2017 and 2018



Key documents and dissemination

- London's s136 pathway and HBPoS specification (December 2016)
- Evaluation of South London and Maudsley NHS Foundation Trust's Centralised HBPoS (December 2017)
- The business case for service change (April 2018)
- S136 new model of care public engagement document

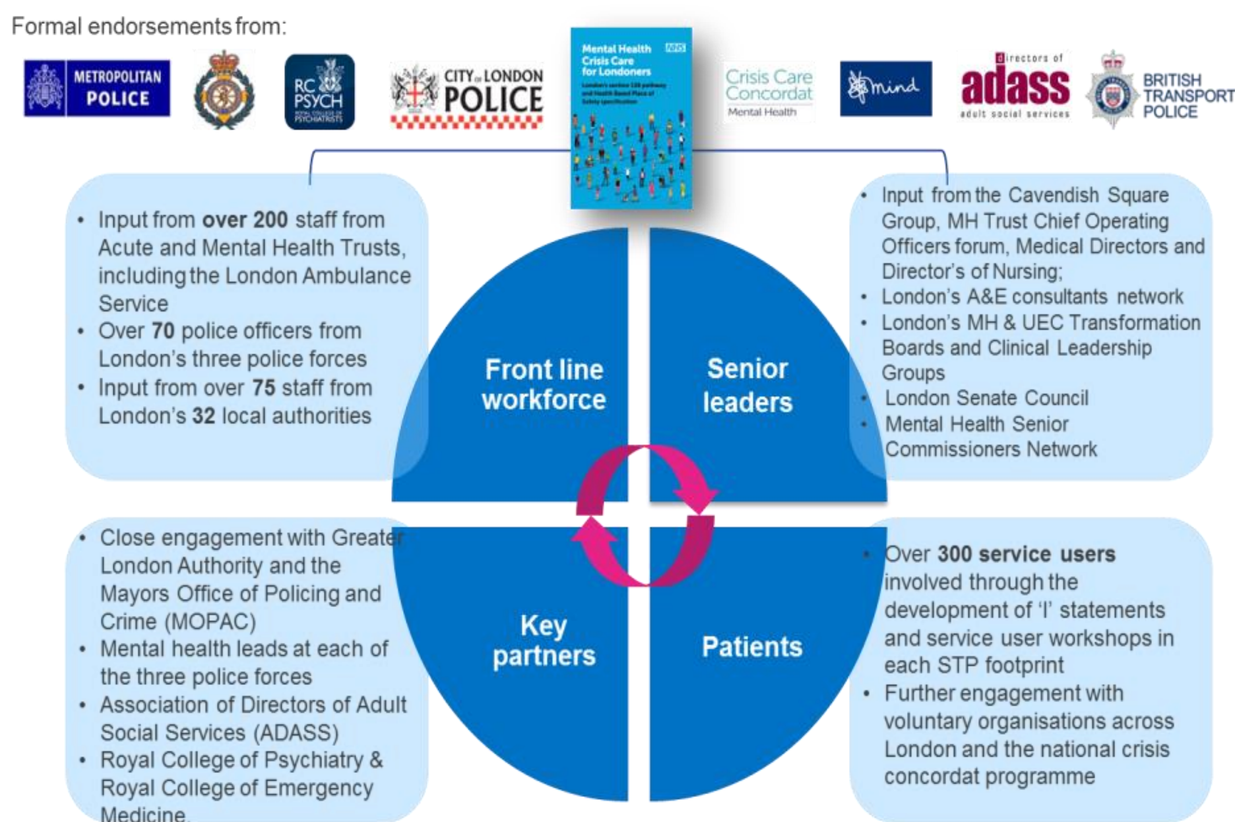
1. London's s136 pathway and HBPoS specification

Since 2015, Healthy London Partnership has worked with London's health and care system to develop a pan-London, new model of care for individuals detained under s136. Significant engagement at the outset of London's mental health crisis care (MHCC) programme determined that the s136 pathway was best focussed on at a pan-London level and that this would complement other local crisis care service development.

The pan-London s136 pathway and Health Based Place of Safety (HBPoS) specification, which outlines the minimum standard of care for HBPoS sites and the responsibilities of staff within the pathway, was developed through extensive engagement with London's crisis care system, including over 300 service users and carers and over 300 frontline staff from London Ambulance Service, London's police forces, mental health and acute trusts. Draft guidance was circulated to over 150 stakeholders for feedback prior to the final version being developed. An outline of the engagement is displayed in the figure below.

The pathway and specification was also formally endorsed by all NHS stakeholder organisations and pan-London forums, London's three Police forces, London Ambulance Service, the Royal College of Psychiatry, Mind and the National Crisis Care Concordat Initiative.

Figure 3: Summary of engagement for development of London's s136 pathway and HBPoS specification.



On the 12th of December 2016, Mayor of London Sadiq Khan launched London's s136 pathway and HBPoS Specification at an event at City Hall (see Events section for more details).

The document was uploaded to the HLP website in order to broaden its reach with 1863 page views since publication in October 2017. HLP also targeted specific stakeholders for distribution including:

- Metropolitan Police
- British Transport Police
- City of London Police
- London Ambulance Service
- Mental Health Trusts
- Local authorities, including London's AMHP services

- Acute Trusts
- Service users

2. Evaluation of South London and Maudsley NHS Foundation Trust's Centralised HBPoS

To understand the impact of SLaM's new centralised place of safety, piloting the pan-London s136 pathway and HBPoS specification, Healthy London Partnership worked with service users, SLaM staff, the police, the London Ambulance Service and AMHPs to evaluate the new service.

The evaluation report was circulated in November 2017 to stakeholders across London. Information and a link to the report was also included in the End of Year crisis care programme update distributed to over 450 stakeholders and in a news item on the HLP website. The evaluation itself has also been available on the HLP website since November 2017, where so far it has had over 500 page views.

Since its launch, information from the evaluation has been included in numerous presentations and to share learning on the potential impacts of the pan-London new model of care. Crucially, the findings from the evaluation, including the service user and frontline staff feedback, were used to develop the business case for service case.

3. Business case for service change

The Business case for service change has been disseminated to a broad range of stakeholders via emails, events and meetings including:

- All 5 of London's Sustainable Transformation Partnerships (STPs): North Central London, North East London, North West London, South West London and South East London.
- London's Mental Health Trusts
- London's Acute Trusts
- Approved Mental Health Professional (AMHP)
- Local Authorities (LA)
- Clinical Commissioning Groups (CCGs)
- NHS England (London region)
- NHS Improvement (NHSI)

- Greater London Authority (GLA)
- London Ambulance Service (LAS)
- All 3 London police services (Metropolitan Police Service, British Transport Police and City of London Police)
- Mind charity
- Service users

The Business case for service change was presented to London's Crisis Care Implementation Steering Group for comment in mid-February 2018 and circulated for comment to the group members. This included feedback from service users and Mind. It was then taken to London's Mental Health Transformation Board and the Urgent and Emergency Care Transformation and Delivery Board for consideration in late March 2018 and the NHSE (London) Parity of Esteem Delivery Group in April 2018.

The Business case for service change was uploaded to the HLP website where it has had 157 page views since publication. A link to the document was provided in the April 2018 programme update distributed to over 450 stakeholders.

4. Other documents and resources developed and disseminated via the HLP website and targeted emails to specific stakeholders include:

- Regular Programme updates, including a 2017 End of Year crisis care programme Report.
- The Voluntary Handover Form (April 2018): A process to support the safe and effective handover of patients attending emergency departments (EDs) accompanied by police.
- The Mental Health Crisis Care Toolkit (December 2017): Training slides developed by an independent legal expert support local training regarding the roles and responsibilities for s136 of the Mental Health Act, including legislation changes in which came into effect in December 2017.
- Posters detailing the roles and responsibilities of each agency involved in the s136 pathway as outlined in the new pan-London guidance developed by HLP. These were provided on request to MH Trusts, Acute Trusts, LAS and Police (December 2017)
- Posters from the 12 December 2016 launch event for the new London s136 pathway and HBPoS Specification (December 2016)

- London s136 pathway: key principles (December 2016)
- S136 pathway service user scenarios (December 2016)
- Crisis care sustainability and transformation presentations (December 2016)
- Improving care for children and young people with mental health crisis in London (October 2016)
- The launch of London's s136 pathway learning report (December 2016)
- Improving care for children and young people in mental health crisis in London: Recommendations for transformation of services (November 2015)

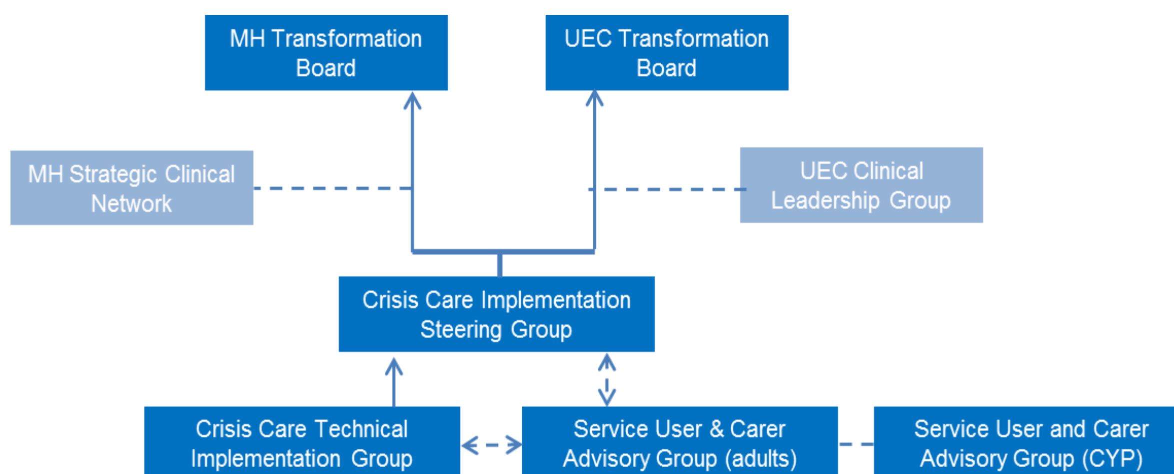
Committees and boards

The following committees provide stewardship of the programme and expert input into the development of the s136 new model of care through various engagement activities including regular meetings and programme updates. The groups are made up of a range of key stakeholders from London's health and care system including mental health and acute trust staff, service users, representatives from all five STP areas, the police, LAS, local authorities and senior representatives from all partner organisations.

- London's Mental Health Transformation Board
- London's Urgent and Emergency Care Transformation & Delivery Board
- NHSE (London) Parity of Esteem Delivery Group
- Service User and Carer Advisory Group
- London's Crisis Care Implementation Steering Group
- London's Crisis Care Technical Implementation Group
- London s136 Commissioning and Payments Task & Finish Group
- London's Urgent & Emergency Care Clinical Leadership Group
- London's Mental Health Strategic Clinical Network

The governance structure for the programme is outlined in the figure below.

Figure 4: Programme governance structure for London's Mental Health Crisis Care programme



Service user engagement

Over 400 Londoners with lived experience of MH crisis and carers have been involved in developing the new model of care through an extensive engagement process. Below we outline who we involved and why, how service users were involved, what we learned from our conversations and how this influenced the programme development. There are approximately 5000 s136 detentions in London per year; this includes multiple detentions for the same individuals.

Who was involved and why

Over 400 Londoners have been involved in London's Mental Health crisis care programme, the majority of whom have lived experience of mental health crisis as a service user or carer. This has included those with specific experience of the s136 pathway, and those with experience of the wider crisis care in London. Representatives were sought from all areas of London, with black and ethnic minority communities and Children and Young people (CYP) also represented.

Through this, the programme endeavoured to include the input of both a large number of service users and to capture the experience in different areas of London and for particular groups. Where demographic information was asked for and provided, the proportion of white (65%) and BME (35%) represented in the service user engagement, reflects the proportion of these groups who are detained under s136 in London. A summary of service user and carer engagement and demographics for key events in development and implementation of London's s136 pathway and HBPoS specification is shown in the table below. Note that demographic information was not asked for in all cases.

Table 1: Service user demographics

	White	BME	Information not given
Online survey and focus group	70	23	61
CYP Focus Group for I statements	0	0	3
CYP Online survey for I statements	24	5	33
Crisis Care Summit	0	0	25
Mental Health Trust focus groups	5	10	32
Harrow in Mind (Somali group)	0	17	3
CYP workshop	2	0	0
Service user and carer advisory group			11
S136 Launch			10
Evaluation of SLAM's centralised place of safety			45
Technical Implementation Group and Implementation Steering Group			4
Mental Health Act Multiagency Training			8
London Ambulance Service patient forum			10

Patient and public network meeting	4
Total	**405**

How service users have been involved

Engagement with service users and carers has taken place at each stage of the process from developing the case for change through to implementation.

Workshops

Five workshops with over 50 service users and carers were held in each STP in London to look at a number of areas of the s136 pathway and HBPoS specification in more detail to ensure service user needs and expectations were met. Specific ideas were also tested with service users to support the implementation process. London's diverse population has been represented through these workshops including all ages and a range of ethnic groups, specific workshops were held for children and young people and individuals from BME communities.

Online survey

In 2016, Healthy London Partnership's Mental Health Crisis Care programme undertook engagement with service-users and carers to further understand the experiences of people who have experienced a mental health crisis in London and find out what is important to them when they are in crisis.

Part of this work involved the charity, Mind, supporting the programme in developing an online survey, which focussed on the experiences of those whose crisis led to:

- attending an ED or
- being detained under section 135 or 136 of the Mental Health Act by the police

The survey was live online from 18 January to 24 February 2016 and was promoted by HLP, Mind, National Survivor User Network, Young Minds and other partners on social media. We received 104 responses by 29 January (the point at which HLP did the analysis to inform the I-statements) and 154 by 24 February when it closed. All except 6 people (29 January) rising to 10 (24 February) were from across London.

The service users and carers who took part in the online survey told us about their recent experiences of crisis care, including those in EDs and HBPoS sites. Service users told us what was good and what could have been better. They also told us what was most important to service users when helping to prevent a crisis, during a crisis and following a crisis.

The information gathered has been used to steer the development of London's new model of care to ensure that it meets the needs of service users.

Demographic information for those who took part in the survey can be found in Appendix 2.

I statements – focus group and online consultation

A key output from the service user and carer involvement was the development of 'I statements'. These are first person statements setting out the expectations of how Londoner's wish to be treated before, during and after a MH crisis. Over 200 service users co-produced a set of 'I' statements through online surveys and focus groups facilitated by Mind and YoungMinds. They were then refined through further online consultation (see appendix 3).

Further engagement was also undertaken with children and young people to better understand where their experiences and needs might differ from those of adults. HLP created an online survey to enable more children and young people to feed back on the draft 'I' statements. The survey was actively promoted on social media and featured on the YoungMinds online blog, which reaches thousands of young people across their network.

The survey was launched on 6th April 2016 and more than 60 young people completed it. Their responses were used to redraft the statements to ensure they reflect what is most important to Londoners who experience a mental health crisis as a young person. The CYP 'I' statements (see appendix 4) are to be read alongside and not instead of the other statements, which apply to Londoners of all ages.

The 'I' statements reflect service user needs and expectations of London's mental health crisis care and were used in the development of a case for change. The statements directly informed London's s136 pathway and HBPoS specification and the new model of care and will be crucial to the evaluation of the programme.

BME service user experience

As part of HLP's continued service user engagement, in July 2016 a workshop was specifically arranged for members of BME communities to ensure that the needs of service users from BME communities were well represented within the new model of care. The workshop was co-facilitated by Mind and HLP. This was in addition to BME service users already represented in the other forums relating to the programme.

Expert by experience videos and stories

In spring 2016, HLP filmed with a number of experts by experience to talk about their story and experience of being cared for under s136. In 2017, service user experiences were included on the Healthy London Partnership website, a Rethink blog and were presented at MHCC summit in February 2016 as well. These

accounts of crisis care in London have been vital to inform the case for change and provide on-going drive for the programme.

London's crisis care summit

London's crisis care summit was held in February 2016 and over 12% of delegates were service users from across London with experience of London's crisis care services. Service users were also involved in the event through presentations and co-facilitating workshops with clinical staff and key partners. The presentations from the service users highlighted examples of substandard crisis care while demonstrating an appetite to work together to improve the pathway for Londoners.

Pan-London s136 pathway launch

On the 12th of December 2016, Mayor of London Sadiq Khan launched London's s136 pathway and HBPoS Specification at an event at City Hall. Over 10% of attendees were crisis care service users.

Place of safety options appraisal process

Service users in each STP were engaged in the options appraisal to determine the best way to deliver crisis care services across London in order to meet the standards set out in London's s136 pathway and HBPoS specification.

Evaluation of SLAM's centralised place of safety

The new model of care was piloted in South London and Maudsley NHS Foundation Trust (SLAM) in 2017, through the consolidation of 4 sites into 1 purpose built site with 24/7 dedicated staffing. The new purpose built facility was co-designed with service users to support delivery of safe, dignified care in a therapeutic setting and staff reported being able to use the facilities flexibly to better manage risk and respond to the changing needs of the individual in their care.

Service user surveys were carried out both before and after the centralised HBPoS opened. Under the new model, 76% of those surveys were positive about the support they received and 64% felt safe (compared with 36% in previous surveys of Londoner's). Furthermore, 79% of service users reported being treated with respect and dignity by staff, 63% felt listened to by staff and 94% felt that they understood the next steps prior to leaving the unit.

Figure 5. Service user perceptions SLAM's centralised place of safety 2017

Service User and Carer Advisory Group / committee representation

Two service User and Carer Advisory Groups were formed (one for adults and one for CYP) to help ensure that service users had meaningful input into the stewardship of the programme. In addition to this service users also sit on London's Crisis Care Implementation Steering Group and the Crisis Care Technical Implementation Group.

Other meetings:

*London Ambulance Service (LAS) patient forum (August 2017):*Service users involved in the LAS patient forum were gathered to hear more about the London mental health crisis care programme and to provide feedback on the implementation plans across London.

Urgent and emergency care patient and public network meeting (April 2018): Programme updates were provided to members of London's patient and public care networks. Their role is to ensure there is patient input into London's wider UEC programme and ensure effective feedback links between local patient groups into London-wide work.

Programme updates

Regular programme updates every x month? have emailed to service users throughout the development of the new model to help keep them engaged and informed and to give them an opportunity to feedback to the programme team.

London's crisis care mailbox:

The crisis care programme team set up a dedicated email address which is widely available and advertised on the Healthy London Partnership website and on programme updates to allow access to information directly from the programme team and to allow all stakeholders, including service users to provide feedback.

What was learned from the conversations

A number of issues came out strongly from the surveys, focus group and online consultation when respondents were asked about their recent experiences in London's EDs and HBPoS sites.

These issues can be grouped under the follow themes: access and timeliness of care, attitudes and skills of staff, environment, and continuity of care.

We asked people what the most important thing to them was. The following were the most commonly identified areas of importance across the comments left by service users:

- being treated with compassion
- feeling safe
- being listened to

A number of respondents explicitly associated feeling safe with the appropriateness of the surroundings and the attitude of staff.

A significant number of respondents also raised the importance of being taken seriously, feeling respected and being able to access care quickly.

The following areas were identified through the engagement process as particularly important in the delivery of crisis care. The survey responses and focus group have helped to identify both the current problems across these areas and how service users think improvements could be achieved.

- **Access to the right help** – less than half of survey respondents knew how to access advice and support to get the help they needed when in crisis
- **Timeliness of care** – nearly 70% of survey respondents felt there were missed opportunities to prevent their mental health deteriorating to crisis point
- **Compassion** – only 34% who attended an ED and 27% who attended a place of safety agreed that staff had treated them with compassion
- **Choice and Involvement –** only 30% felt involved in discussions about their mental health problems

- **Staff attitudes and knowledge –** only 36% of those who attended an ED felt listened to and that their concerns were taken seriously
- **Environment** – 93% of respondents feel that being in an environment that suits their needs when in crisis is either important of very important
- **Continuity of care** – Over 95% said that receiving appropriate follow-up care after their crisis was either important of very important

Key messages from BME workshop

- Service users said that HBPoS staff were often not very welcoming. It could seem like they were 'preparing for war', treating the individual as dangerous and showing fear of the individual in crisis. This demonstrated a lack of training and the stigma that currently exists.
- Service users often felt that there was not enough joined up thinking for the benefit of the individual in crisis.
- Staff should be mindful of the individuals' cultural and spiritual beliefs and do their best to provide culturally appropriate care.
- Those detained under s136 should be provided with a clear explanation of what is happening in their own language.
- Consideration should be given to ensure that those detained can be assessed by someone of their own gender if requested.
- Onward care plans should give consideration to an individual's social care needs, such as housing and employment, as well as addressing their mental health need.
- More information is needed on the voluntary and community services available including face-to-face and online support. Where possible, efforts should be made to find support groups that align with the individuals cultural and spiritual beliefs. Socialising is an important part of support and access to support groups and peer-support is needed.

Key messages from expert by experience videos

- ED can be distressing and manic for an individual in crisis. ED members of staff do not always understand an individual's mental health need or treat it with the same importance as those with a physical health need.

- Individuals with mental health needs don't want to end up in ED but if they do they want to know physical and mental health staff are working together to coordinate their care.
- Waiting for long periods of time to access care or get a mental health assessment makes a crisis worse. They want to be seen quickly by skilled staff that can care for their mental and physical health needs.
- Individuals don't always know what is happening and members of staff don't always treat them with compassion. They want to be seen by skilled staff that understand mental health and listen to their needs.
- Suitable follow-up care not always available for individuals when they need it. Individuals want to know about all the services they can turn to in their community.
- A bad experience with the NHS means individuals can lose trust in health services and stop engaging in their care. They can then be extremely reluctant to seek help from the NHS when they need it.
- People are extremely hopeful things are going to change and it's a positive step that everyone has been working together to improve the care for patients detained under s136.

Key messages from the options appraisal process

Service users involved in the optional appraisal process (service user and carer advisory groups and reps on the boards) were key to determining the criteria used in the process. The figure below shows the priorities for all age service users and CYP.

Figure 6: Adult and CYP priorities for the pan-London S136 model of care.

Adult priorities		Young people priorities
1	Staffing and care: Ensuring specialised skilled staff available to care for patients 24 hours a day.	1
2	Environment: Ensuring the Health Based Place of Safety environment promotes dignity, recovery, comfort and confidentiality for the patient. It offers a therapeutic environment that is safe, well maintained with good access to facilities e.g. washing and toilet.	1
3	Effective pathway with reduced delays: To have an effective pathway from the point of detention to acceptance in a place of safety meaning patients are not waiting in back of police cars or ambulances as well as a timely assessment once at the site.	1
4	Proximity to other health services (24/7 physical healthcare): The site is located close to an A&E to enable easy access to physical health care if required.	2
5	Proximity to other health services (mental health services): The site is located close to mental health services provided within a mental health trusts e.g. inpatient services or other mental health specialist services (not community mental health services).	2
6	The distance from pick up to the site where assessments take place: A close distance between where a service user is detained and where the mental health assessment takes place as well as proximity from the site to the patients place of residence to enable a short journey home following discharge.	3

How feedback and involvement influenced programme development

We were told: People need timely access to care and effective pathways to reduce delays.

What is in progress and what has been done:

London's s136 pathway and HBPoS specification provides an effective pathway which aims to reduce delays. Key standards that promote timely access to care include:

- Individuals detained under s136 must be taken to the closest HBPoS to the site of detention, regardless of where they are resident.
- If there is no capacity at the local HBPoS, it is that site's responsibility to ensure that the individual is received into a suitable place of safety.
- When the HBPoS states that it has capacity, this means it is able to receive the detained individual as soon as they arrive on site.
- When an individual under s136 presents to an ED, the ED cannot refuse access unless a formal escalation action has been enacted.

- The mental health assessment should be completed within 4 hours of the individual arriving at the HBPoS unless there are clinical grounds for delay.

Under the proposed London model, 88.5% of patients will be 45 minutes or less from an HBPoS which is able to provide specialist care through a 24/7 dedicated staffing team. Though the reconfiguration will mean that there are a smaller number of sites, those sites will have a higher capacity.

It is expected that access to care on arrival at the site will be quicker, with fewer incidences of individuals waiting outside HBPoS sites whilst staff are brought in from other areas of the trust to staff the unit. Furthermore, there will be fewer site closures and instances of individuals being transported from one trust to another due to insufficient capacity at an individual site.

By providing sufficient capacity at the HBPoS sites, the proposed option for the new model of care will reduce the average journey time from 64 minutes to 22 minutes for police vehicles and 24 minutes to 22 minutes for ambulance vehicles. This will ensure that patients receive emergency clinical care more quickly. Patient experience will improve as delays are minimised and they can be seen faster by clinical staff trained to care for their needs.

We were told: Specialised skilled staff must be available to care for patients 24 hours a day, and not pulled off inpatient wards

What is in progress and what has been done:

A key feature of London's s136 pathway and HBPoS specification is that all sites should have 24/7 dedicated staff teams to ensure that delays do not occur as staff are sought from other areas of the trust. Furthermore, there are clear expectation for the mental health and physical health competencies for all staff at the HBPoS.

The roles and responsibilities of all non-HBPoS staff e.g. police, paramedics, ED staff etc. are specified in the guidance to ensure clarity as to the expectation for all professionals involved in the pathway.

Under the proposed new model of care, the number of sites () will be reduce to 9 centres of excellence (however overall capacity will not change), this allows the 24/7 dedicated staffing to be feasible at all sites.

Multiagency training has taken place in all mental health trusts and for the London ambulance service in order to ensure that professionals involved in the s136 pathway are clear on their responsibilities under the guidance and the Mental Health Act legislation. Further training sessions will take place throughout 2018/19 with the focus on ED clinical and operational staff.

Furthermore, the programme has supported four of London's mental health trusts with existing dedicated staffing to secure funding from Health Education England and to begin setting up rotational nursing programmes to allow mental health nurses to develop physical health skills in EDs and ED nurses to develop mental health skills by spending time in the HBPoS. These programmes are on-going and hope to be implemented pan-London as centres of excellence develop.

We were told: The HBPoS environment must promote dignity, recovery, comfort and confidentiality for the patient.

What is in progress and what has been done:

This is achieved both through the physical design of an HBPoS site and staff factors: the training of the staff to use the environment effectively, the compassion and dignity afforded to patients by staff and the relationships within the staff team and with other professionals.

London's s136 pathway and HBPoS specification outlines the requirements for the facilities at an HBPoS. Where HBPoS environments have been co-designed with patients, this can ensure that the environment meets patient, as well as staff, needs. The guidance advises that there is significant service user and carer involvement in the governance and monitoring of HBPoS sites.

The crisis care programme has also supported London trusts to apply for capital funding to ensure facilities developed under the new model of care are fit for purpose with the right capacity.

We were told: Proximity to other health services is important, including mental health services and EDs to enable access to physical health care if required.

What is in progress and what has been done:

Whilst no EDs are dedicated HBPoS sites under the proposed pan-London s136 new model of care (under guidance from the Royal College of Psychiatry and the Royal College of Emergency Medicine) the options appraisal process ensured that close proximity to both mental health inpatient beds and 24/7 urgent physical care were key criteria points to determine the preferred location of sites in London.

We were told: Individuals with mental health problems do not want to end up in ED and if they do, but if they do they want to know ED and mental health staff are working together to coordinate their care.

What is in progress and what has been done:

Under the proposed pan-London s136 new model of care, no EDs are designated HBPoS sites (under guidance from the Royal College of Psychiatry and the Royal College of Emergency Medicine). In addition, London's s136 pathway and HBPoS

specification outlines physical health competencies for HBPoS staff to ensure that there are no unnecessary transfers to EDs for minor physical health problems. There is also a clear protocol to ensure that individuals under the influence of alcohol are not automatically transferred to ED including closer working with paramedics.

The rotational nursing programme and ED training sessions described above will support mental health and ED staff to work together and ED staff to clearly understand their role in the s136 pathway.

How will London's crisis care programme engage with service users and carers in future?

The input of service users and their carers into the London's crisis care programme is vital for its future success and implementation of the pan-London new model of care. Service users continue to be valued members of the Crisis Care Implementation Steering Group and Technical Implementation Group. The London programme will continue to circulate programme updates and upload material to the crisis care pages on www.healthylondon.org.

Whilst Healthy London Partnership continues to support the crisis care system on a pan-London basis, following the business case for service change outlining the proposed pan-London HBPoS configuration, STPs are taking ownership of planning and delivery at a local level. This will involve public engagement on local plans and taking these through decision making forum within the STP footprint.

London's crisis care programme has initiated work to develop a plan for evaluating the changes resulting from implementation of the new model of care and to collect baseline data for this evaluation. Service users and carers will have an important role, both by providing insight into current care through focus groups, and through input into the design of the evaluation.

Key presentations and meetings

Throughout the programme information and updates have been given at a number of forums across London. These have been an opportunity to develop plans and receive feedback from a wide variety of stakeholders.

In the table below, a large number of small meetings (1-3 attendees), teleconferences and email exchanges have not been included as it is not practicable to detail such a significant number of interactions with senior stakeholders and frontline staff from police, LAS and NHS trusts.

Meeting	Date	Audience	Purpose
London's Urgent and Emergency care Clinical Leadership Group	Monthly	Urgent and emergency care clinical leads from London	Regular updates on the MHCC programme and securing feedback/ clinical input into the development of the s136 pathway and pan-London model of care; an opportunity to increase support and engagement for the programme to support implementation, particularly around ED issues.
Mental Health London Transformation Board	Regular attendance	Senior London Mental health care stakeholders	Formal reporting updates provided as this is a pan-London Board within HLP governance. This included the presentation of the final business case for endorsement. Feedback and input from the group sought to inform and steer development of the programme.
London's Urgent and Emergency Care Transformation and Delivery board	Regular attendance	Senior London urgent and emergency care stakeholders	Formal reporting updates provided as this is a pan-London Board within HLP governance. This included the presentation of the final business case for endorsement. Feedback and input from the group sought to inform and steer development of the programme.

London Learning Disability and Mental Health Commissioners Network Meeting	June 2018, February 2017	London Learning Disability and Mental Health Commissioners	General update on the MHCC programme ensuring links with MH and LD commissioning and increasing engagement efforts across London. Recent presentation of the business case and proposed London model of care. Feedback sought as well as understanding of any local issues to help inform development/ implementation.
Association of Adult Directors of Social Services Meeting	June 2018 and June 2016	Adult directors of social care London	The London ADASS lead has presented to ADASS colleagues on the MHCC programme over the past couple of years outlining new guidance and London proposals, the engagement with AMHPs and ensuring comments, feedback and potential challenges are fed into the programme.
London Health Board	June 2018, October 2017	The Mayor of London, leaders of London local authorities (LA) and senior representatives from the Health Sector in the capital.	Outline of MHCC programme implementation progress and a request for both the Board's and Mayor's continued support and input into the programme.
NHSE (London) Parity of Esteem Delivery Group	April 2018, September 2017		An overview of the case for change and pan-London model of care

			including the business case for service change. An opportunity to increase engagement and support from NHS London and to align the work with the PoE agenda/ discuss issues relating to this.
MiCapacity workshop	March 2018	MHCC stakeholders including MH Trust staff, the police, LAS and service users.	Linking the London s136 pathway with advances in the MiDOS MiCapacity tool which is looking at a pan-London live capacity tool for place of safety sites/ exploring synergies between the two programmes and opportunities for alignment.
Health Education England - Delivering the Five Year Forward View: Caring for patients at the right time and in the right place	March 2018	Various London NHS staff	An overview of the MHCC work to date with particular emphasis on the development of a rotational nursing programme between HBPoS and EDs; raising awareness of the work and an opportunity to hear feedback and explore synergies with other relevant projects at the event.
London Security Management Specialists Managers Forum	January 2018	Hospital security managers from across London	An introduction to pan-London transformation programmes, specifically what is happening in crisis care to increase understanding of the roles and responsibilities

			of all staff; understanding local issues relating to security and garnering support for and input into the implementation of the s136 pathway across London with these in mind.
Approved Mental Health Professional (AMHP) London Leads Meeting	Various dates- January 2018, March 2017, November 2016, May 2016, April 2016	London AMHP leads	Updates on the development of the MHCC programme with support from AMHP leads involved in the programme; an opportunity for AMHP feedback/ input into development of the pathway and implementation of the new model as well as to understand local issues/ barriers to implementation.
London's Urgent and Emergency Care Improvement Collaborative Event	December 2017	London's urgent and emergency care system stakeholders, including service users.	Workshop at the event dedicated to detailing the London guidance with a specific emphasis on mental health crisis care in ED's. Presentation included input from MHA legal expert. Aim was to understand issues and potential barriers to implementation and to increase awareness and support.
London's Mental Health Trust Chairs meeting	November 2017	Mental Health Trust chairs from across London	An update on the MHCC Programme of work to date; an opportunity to gain input/ feedback to

			inform delivery and to increase /sustain engagement, momentum & support for the work.
Mind London CEO Network meeting	November 2017	Mind charity CEOs London	Overview of the programme provided as well as asking for feedback and support to increase third sector and service user involvement in local implementation of the new model of care.
London's Mental Health Trust Chief Operating Officers	Various dates 2017	Mental Health Trust Chief Operating Officers	Regular updates provided to the London MH Trust COOs on the programmes' progress. Updates provided an opportunity to ask for feedback and continue engagement with senior leaders to ensure continued momentum and support.
London Mental Health Trust Cavendish Square Group	Various dates- November 2017, May 2017	Senior representatives from London's MH Trusts	Regular updates provided to the London MH Trust CEs on the programmes progress. Updates provided an opportunity to ask for expert feedback and continue engagement with senior leaders to ensure momentum and support.
Meetings with CAMHS clinical leads at each MH trust	August 2017	CAMHS clinical leads at each MH trust in London	Meetings to test possible options for CYP HBPoS provision. Feedback from these meetings steered programme towards having CYP HBPoS

			provision in each STP footprint
London Clinical Senate Council Meeting	May 2017, July 2017	Nominated representatives of the Patient & Public Voice, London's Clinical Commissioning Council, Academic Health Science Networks, Local Education and Training Boards, and Directors of Public Health Network and Social Care, and appointed senior health professionals.	Intro to HLP and the MHCC programme, an overview of the work undertaken to date and a request for specific advice and feedback from senate members around next steps in implementation incl. barrier and enablers such as financial challenges, buy-in at both a local and pan-London level.
Metropolitan Police Service Mental Health Liaison Officers meeting	May 2017	Metropolitan Police Service Mental Health Liaison Officers	An overview of the MHCC programme to date; opportunity to increase engagement, ask the officers for feedback/ input into the multi-agency training agenda and uncover local issues/ potential barriers to implementation.
London's Mental Health Trust Directors of Nursing meeting	May 2017	London's Mental Health Trust Directors of Nursing	An overview of the MHCC programme to date with particular emphasis on options appraisal & Pan-London configuration criteria; an opportunity to seek feedback, increase engagement/ support from the nurses and to understand if anything additional needs to be considered during

			development/ implementation.
London's Mental Health Trust Medical Directors meeting	May 2017; May 2016, May 2015	London's Mental Health Trust Medical Directors	An overview of the MHCC programme to date with particular emphasis on options appraisal & Pan-London configuration criteria; opportunity to increase engagement/ garner support from the MDs and their clinicians to ensure clinical input.
London ED Consultants Network meeting	May 2017	London ED consultants	An overview of the MHCC programme to date with a particular emphasis on the changes in legislation; opportunity to seek feedback and info on ED related issues/ potential barriers to implementation.
London Care Quality Commission Mental Health Team meeting	May 2017	Care Quality Commission London mental health team (30 attendees)	An overview of the MHCC programme to date with particular emphasis on comparison between RCPsych guidance and the London specification; a call for feedback /input to direct development and a call for support from the CQC.
London Mental Health Senior Commissioners meeting	Various dates- April 2017, February 2017	London's Mental Health senior commissioners	Regular updates on the progress of the MHCC programme and opportunity for feedback/ input from a commissioning perspective as well as support (e.g. explore

			local governance & nominate a member to join the MHCC Implementation Steering Group).
London Clinical Commissioning Group Chief Officers meeting	April 2017, July 2017	Chief officers London	Update on the progress of the MHCC programme; opportunity for feedback to inform development and a consultation on how the group would like to be engaged with /updated going forward.
London Mental Health Clinical Network Leadership Group	Various dates 2016		Regular updates and opportunities for feedback on the programme ensuring clinical input into the development of the s136 pathway and pan-London model of care. Also an opportunity to increase support/ engagement for the programme to support implementation
London Directors of Nursing meeting (acute and mental health trusts)	October 2016	Directors of nursing (45 attendees)	An update on the MHCC Programme to date and an opportunity to gain input/ feedback to inform deliver, increase engagement & support amongst nursing and to understand any issues pertaining to this group / potential barriers to implementation.
Westminster briefing	October 2016	25 attendees	Presentation on London's s136 pathway by Briony Sloper (LAS) and Dan

			Thorpe (Metropolitan police) to raise awareness and gain feedback.
NHSE (London) Sustainability and Transformation Executive	October 2016	Pan-London	An update on the MHCC programme and London's new model of care to raise awareness and gain feedback from NHSEL executives to inform implementation.
S136 pathway scenario testing workshop	September 2016	Multiagency s136 pathway stakeholders (14 attendees)	Testing of s136 patient scenario pathways with stakeholders to understand issues, barriers to implementation and to inform delivery of the programme.
BEH Inter-Agency Mental Health Law Monitoring Group	June 2016	Multi-agency stakeholders involved in MH law within BEH trust	An update on the MHCC programme to date and an opportunity to gain input, understand issues and increase engagement / support amongst this group.
London Mental Health Partnership Board meetings	Oct 2015; Jan & Apr 2016	Senior mental health crisis care stakeholders	An introduction to the pan-London MHCC programme including the scope of the programme and what it is proposed to cover in regards to s136, ensuring strong links and alignment with work that was being led by the Partnership Board.
Mental Health	Various (May,	London urgent and	The MHCC subgroup

Crisis Care Subgroup meetings	Jul, Sep, Nov Dec 2015; Jan; Mar, May, Jun 2016)	emergency care and MH crisis care stakeholders	was a precursor to the Implementation steering group (see below). Meetings were held to inform and progress the development of the case for change, as well as the scope, content and direction of the MHCC programme.
London Nursing Leadership forum	June 2016	Acute and mental health trust nurses (40 attendees)	An update on the MHCC Programme progress and an opportunity to gain input/ feedback to inform direction, hear about issues/ potential barriers and to increase engagement & support.
London AMHP workshop discussing staffing models for AMHP options	June 2016	London borough of Newham AMHPs (12 attendees)	Workshop facilitated by Simon Pearce (London ADASS lead) to discuss alternative staffing models for AMHPs to support implementation of the new model of care and to hear about challenges faced by this group that may hinder implementation as well as possible solutions.
London borough Mental Health Officers meetings	June 2016	Metropolitan police borough mental health officers (50 attendees)	Update provided to London's borough MH officers assigned to each Trust outlining details of the London pathway, asking for feedback and information on issues experienced / barriers faced as well as expectations from officers

			and other staff groups to inform development of the programme.
St. Mary's Psychiatric Liaison team meeting	April 2016	Psychiatric Liaison Team (8 attendees)	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
ED mental health subgroup meeting (St. Mary's hospital)	April 2016	ED staff members	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
St. Thomas' ED Psychiatric Liaison team	April 2016	Psychiatric Liaison Team (8 attendees)	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
Camden and Islington MH Trust acute divisional meeting	April 2016	Camden and Islington MH Trust Staff members	Engagement and feedback on the s136 pathway and HBPoS specification; understanding local issues and sharing the pathway development to date; call for input/ feedback to shape development.

London Chief Executive Officers (CEO) Mental Health Trusts (Individual meetings)	Various meetings throughout 2016	Individual meetings between programme team and each MH trust CEO in London	An update on the MHCC Programme progress; an opportunity to gain input / feedback to inform development and increase /sustain engagement, momentum & support. To explore local challenges and plans with the CEO.
Implementing the Urgent and Emergency Care Vision in London	November 2015	Broad range of London urgent and emergency care stakeholders	An update on the MHCC Programme progress; an opportunity to gain input / feedback to inform development and increase /sustain engagement, momentum & support.
NHS England National Mental Health Team	July 2015	NHS England national MH team members	An update on the MHCC Programme progress and a call for feedback; an opportunity to define the input & support this group has to offer in terms of informing development.
South London and the Maudsley NHS Foundation Trust induction day	May 2015	HBPoS new staff members	Supporting pilot site induction and its alignment with London's s136 pathway; helping staff understand what they are piloting and the expectations around the project.
London Police Force s136 workshop	May 2015	Police officers from all three of London's police forces (40 attendees)	Workshop lead by Chief Inspector from the Met Police to understand issues faced by front-line officers and to ensure

			they are addressed in the London s136 pathway guidance.

Events and workshops

This section outlines additional specific activities associated with programme stages

London's Mental Health Crisis Care Summit

London's first Mental Health Crisis Care Summit was held at the KIA Oval on 25th February 2016 to share learning and best practice in crisis care and explore the changes required in order to meet the needs and expectations of Londoners facing a mental health crisis. The summit brought together multi-agency partners including local crisis concordat groups, the Urgent & Emergency Care networks and key partners such as the Police and London Ambulance Service, to promote partnership working and strategic alignment across national, London and local initiatives. The day comprised of three sessions that allowed delegates to hear from national and London mental health leaders, receive updates on different crisis care programmes and participate in 'share and learn' workshops that focussed on good practice and innovation.

200 delegates attended the day from numerous agencies across all five of London's UEC Networks. There was strong representation from commissioners, providers, clinicians, managers, local authorities and service users.

Feedback on the event received from delegates via evaluation forms and feedback cards was overall positive. Comments highlighted the multiple opportunities to learn from others and hear from service users, while suggestions for improvement included covering less content in the agenda and further involving service users in the design and delivery of the event.

Feedback and discussions from the event was used to inform the development of the programme.

London's s136 pathway and HBPoS specification development

Over 50 meetings, workshops and pan-London forums took place to inform the case for change and the development of London's s136 pathway and HBPoS Specification, including:

- Service user and carer engagement (as outlined in separate section).

- Establishment of CYP working group (including CAMHS and commissioners)
- Site visits and meetings with pan London organisations including the London Ambulance Service and London's three police forces
- Engagement with acute trust and mental health trust staff including liaison psychiatry staff.
- MH liaison officer workshop
- Police frontline officer workshop
- Scenario testing workshop

London's s136 pathway and HBPoS specification launch event

On the 12th of December 2016, Mayor of London Sadiq Khan launched *London's s136 pathway and HBPoS Specification* at an event at City Hall. The event brought together over 100 delegates from across London's crisis care system to recognise the significant partnership work undertaken and to build momentum to ensure the collaboration continued to implement the guidance. There was significant representation from service users, frontline and senior staff from Acute and Mental Health Trusts, commissioners, London's police forces, London Ambulance Service, Local Authorities and the voluntary sector. Over 10% of attendees were service users and all organisations that formally endorsed the guidance were present at the event.

The event offered a chance to hear from service users and leaders across London's crisis care system, and to provide facilitated multi-agency discussions to familiarise delegates with the new guidance, identify current blockers in the system and understand the further work required to ensure its successful implementation.

The event included presentations from an expert by experience and representative of the NSUN voluntary organisation, Sadiq Kahn (Mayor of London), John Brouder (Chief Executive of North East London Foundation Trust), Fionna Moore (former Chief Executive of London Ambulance Service) and Commander Christine Jones (Metropolitan Police and National Lead for Mental Health). Feedback and discussions from the event were used to inform the crisis care delivery plan to implement the guidance across London.

173 unique Twitter users used the event hash tag #crisiscare16 in 400 posts. These tweets were delivered to over 3 million users and to almost 20 million Twitter streams. The launch of the new guidance was picked up by BBC London News and featured on both the lunchtime and evening programmes. The item featured service user Pat Kenny and Dr Mary Docherty, a psychiatrist from SLaM involved in the

development of the guidance. Dr Marilyn Plant, clinical lead for the programme, was interviewed for BBC Radio London.

Options appraisal workshops

In order to provide a viable solution to the existing issues, it was necessary to consider the full range of alternative delivery models for the s136 pathway and HBPoS specification. As such, a structured process made up of several steps was required to examine the options in order to identify the most desirable alternative to the status quo.

At each stage, a set of criteria was used to measure the different reconfiguration options in terms of patient experience and outcomes as well as efficiency improvements to the wider system. Before progressing to the next stage of the options appraisal process, the criteria was approved by the Crisis Care Implementation Steering Group, a group including members from the police, London ambulance service, mental health trusts, acute trusts and experts by experience.

Service user groups provided valuable input into the development of criteria and the options appraisal process, as described in the service user section. Frontline staff also had strong input into the options appraisal process, including outlining their priorities for a 'good' staff experience of the s136 pathway; this is shown in the figure below.

Specifically, in May 2017, an options appraisal evaluation workshop was held with senior staff from the different stakeholder groups as well as staff from London's mental health and acute trusts, and service users. At the workshop, pan-London configuration options were reviewed to provide recommendations for the optimal HBPoS configuration for London. The workshop representatives were able to use their experience and expertise to review and critique the options, and share opinions on the impact each option may have on patient experience, outcomes and the wider mental health and acute system. Recommended configuration options were then taken to a focussed testing workshop with mental health and urgent and emergency care clinical leads in June 2017.

At the multi-agency evaluation workshop, it was agreed that the assessment regarding CYP HBPoS sites should be completed in a more focussed session with Children and Adult Mental Health Services (CAMHS) clinicians and commissioners and needed to incorporate wider developments occurring across the CAMHS system. Therefore, a separate CYP options appraisal workshop was held in June 2017 which explored the HBPoS site configuration for CYP in the context of other CAMHS programmes in London. This workshop was supplemented by further engagement with CAMHS clinical leads from each Mental Health Trust which led to the notion that there should be one dedicated CYP HBPoS site in each STP to align

with local pathways; this was incorporated into the final proposed preferred pan-London configuration.

Figure 7: Staff priorities

- Staff are **part of a dedicated, skilled team** that have capacity to appropriately manage the service and able to deliver high quality care to those in crisis. Staff are able to maximise their skills due to enough throughput of activity through the site.
- Staff feel **supported in their role** and have access to the right tools and resources to carry out their responsibilities to deliver effective patient care.
- Staff have a **clear understanding of their roles and responsibilities** within the s136 pathway including the powers under the mental health act.
- The **physical environment** is pleasant, well equipped with good facilities and arranged in a way that supports staff to undertake their role.
- Staff **feel safe whilst carrying out their work** and should be supported by clear organisational procedures to reduce risk, and ensure appropriate response.
- Staff are **appropriately trained** to confidently carry out their role, e.g. training in the mental health act and de-escalation, and are provided with opportunity to learn and develop through their work.
- Staff have **positive working relationships** across the multi-agency pathway to allow effective cooperation and to improve morale.
- There are **clear, effective and timely escalation protocols** in place that ensure staff feel able to call on senior staff when necessary to provide additional support.
- There are **clear governance processes in place** for staff to feedback on the service and effectively manage quality, performance and risk.

Following the options appraisal workshops, a dedicated STP implementation workshop took place in mid-July 2017, with leads from each footprint. London's STP leads involved in the programme attended the workshop to discuss how to align outputs from the London-wide HBPoS options appraisal with local implementation and decision making processes. It was agreed at this workshop that more extensive testing with stakeholders would take place, as well as taking local Health Based Place of Safety configuration proposals through appropriate governance boards and forums. With the range of representatives in the room from different London STPs,

the group was able to define what needed to happen locally in order to get to the proposed configuration for HBPoS sites, including engagement methods and timeframes for implementation.

Programme STP leads tested the proposed short list of configuration options locally in late 2017 / early 2018, this included significant engagement with commissioners, Trust representatives, service users, Directors of Adult Social Services and Approved Mental Health Professionals as well as the London Ambulance Service and London's three police forces.

AMHP workshop

An AMHP workshop was held in June 2017 led by Simon Pearce (Association of Directors of Adult Social Services (ADASS)), with representatives covering all nine of London's MH trusts; this group discussed the challenges that the current AMHP service could face with changes in the configuration of HBPoS sites across London. The group acknowledged that these challenges could be worked through, and proposed options for achieving this, including a pan-London agreement for cross-borough working and dedicated AMHPs to each HBPoS site.

Physical health competencies workshop

A workshop was held in November 2017 between HLP and Health Education England (HEE) to scope existing opportunities to improve the physical health competencies of HBPoS staff. Discussions highlighted a particular interest in the development of rotational nursing programmes between EDs and HBPoS sites out of which came the HEE funded HBPoS/ED Rotational Nursing Programme (RNP). Twenty-four representatives from seven mental health trusts, four acute trusts (ED representatives), the Royal College of Nursing, Health Education England and the London Ambulance Service attended the workshop.

Mental Health Act Multi-agency training

Engagement with frontline staff involved in the crisis care pathway was further strengthened by multiagency training developed by HLP. This training was facilitated by an independent legal expert and aimed to inform staff on their roles and responsibilities under the new guidance.

It was also designed to ensure awareness of the Mental Health Act legislation changes and provide an opportunity to discuss with professions from other agencies the challenges for the s136 pathway. They also provided the opportunity to distribute supporting material for the guidance e.g. roles and responsibility posters for displaying in workplaces.

Over 300 delegates attended the sessions including service users, and frontline staff from MH trusts, LAS, police and local authorities. A training toolkit was developed to

allow further training to take place locally. Further training sessions will take place in 2018, focussing on the ED role in crisis care.

Marketing and media

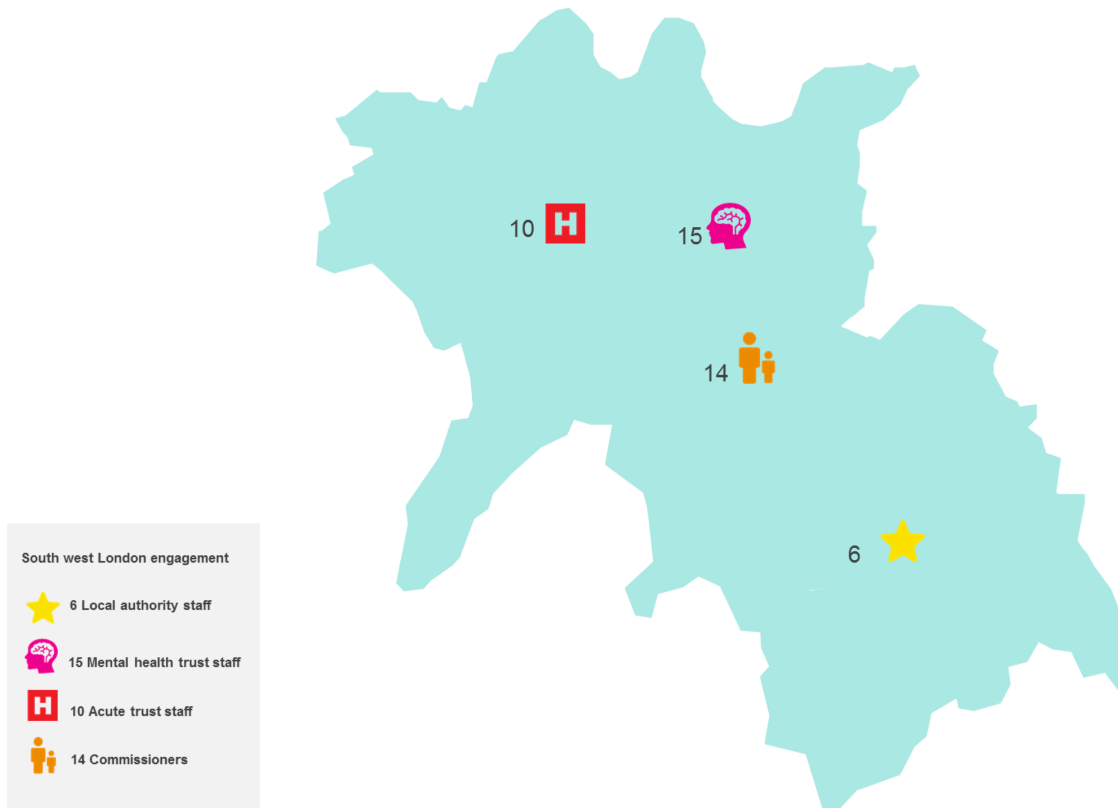
To increase engagement in the development of the s136 new model of care HLP undertook a range of marketing activities including:

- Social media activity e.g. Twitter (50 HLP Tweets from January 2016 – May 2018)
- Blogs e.g. Mental Health Today; HSJ; Rethink; and Taking the crisis out of mental health crisis care on the HLP site
- An improving crisis care for Londoners video outlining the success of the SLAM pilot evaluation (December 2017)
- In focus briefing - Healthy London Partnership London's s136 Pathway and HBPoS Specification (December 2017)
- Online news piece on new funding available to support crisis care (October 2017)
- Online news piece - Successful multiagency training for London's mental health crisis care professionals (July 2017)
- In focus briefing - Treat as One: Bridging the gap between mental and physical healthcare in general hospitals (April 2017)
- Online news piece - Specialist A&E mental health support around the clock 24/7 (April 2017)
- Award entries: Shortlisted for the Patient Safety Awards 2018; entered the HSJ awards 2017 and 2018; shortlisted for the Healthcare Transformation Awards 2018.

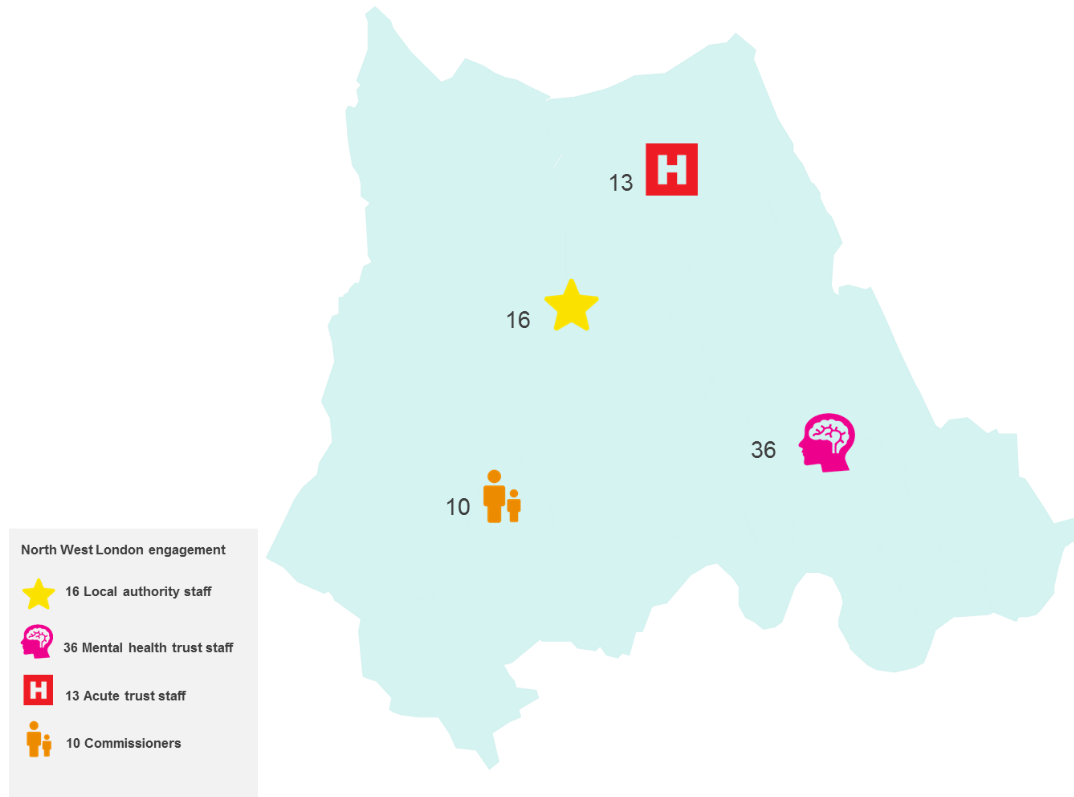
London's crisis care programme would like to thank all those involved in the programme thus far and going forward for their hard work and support.

Appendix 1: STP Engagement Maps

Individual STP maps to show engagement that has taken place more recently since the pan-London guidance has been developed, including activities to support implementation through 2017 and 2018.

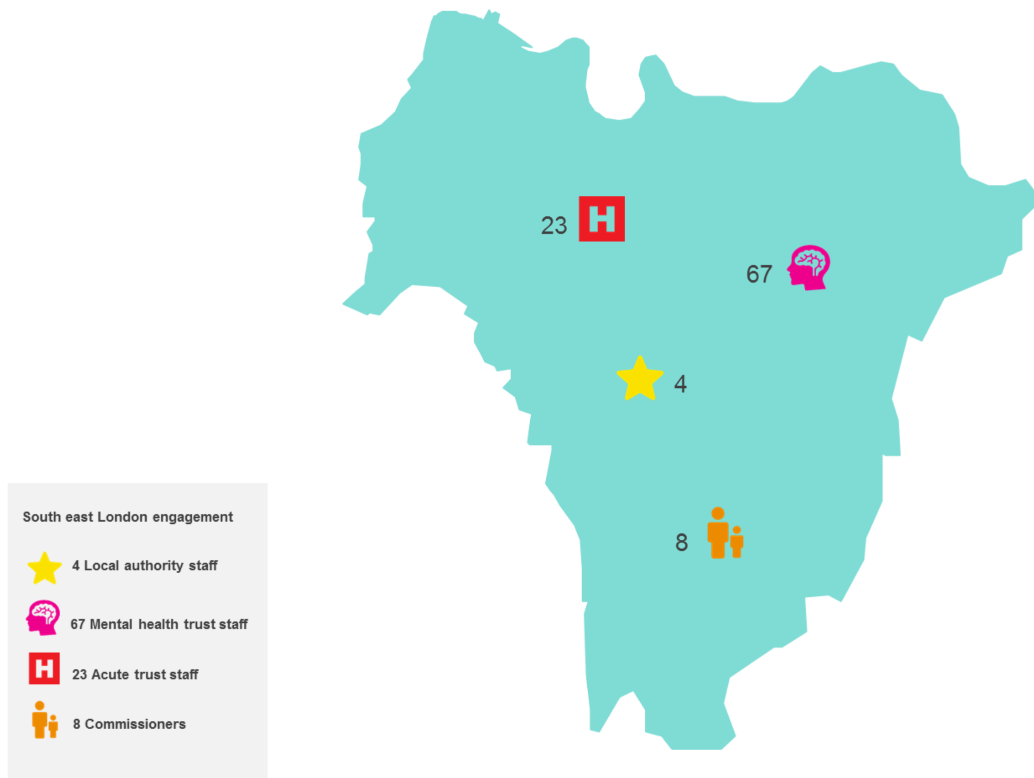


North West London

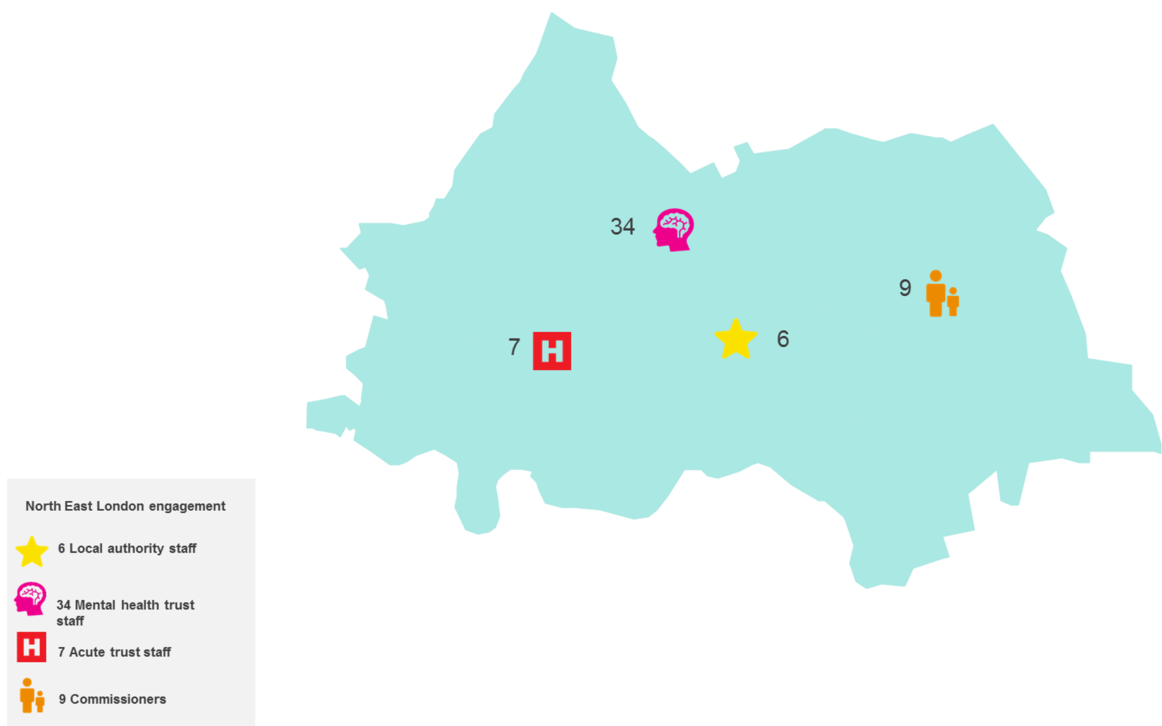


North Central London STP

South East London STP



North East London STP



Appendix 2: Online survey 2016 demographic information

The information below was collected at two points:

- 29th January – the point at which responses were analyses in order to develop initial drafts of the 'I' statements
- 24th February – the survey closure date

Characteristic	Online survey at 29/1/16 (104 responses)		Online survey when closed 24/2/16 (154 responses)	
Age				
12-17			3	3
18-24	7	11	12	13
25-34	14	22	16	17
35-44	10	16	17	18
45-54	23	36	31	33
55-64	9	14	12	13
65-74	1	1.5	2	2
75-84			-	-
85 and over			1	1
Gender				
Male	16	25	27	29
Female	48	75	66	70
Other			1	1
Transgender				
Yes	0	0	1	1
No	62	100	88	99
Sexuality				
Bisexual	10	16	13	14
Gay	3	5	4	4

Heterosexual/straight	45	73	65	72
Lesbian	1	2	3	3
Other	3	5	5	6
Religion				
No religion	**26**	**41**	**33**	**36**
Christian	**28**	**44**	**43**	**47**
Buddhist	**1**	**2**	**2**	**2**
Hindu	**2**	**3**	**3**	**3**
Jewish	**0**	**0**	**2**	**2**
Muslim	**0**	**0**	**0**	**0**
Sikh	**1**	**2**	**2**	**2**
Other	**5**	**8**	**7**	**8**
Long term health condition or disability				
Physical or sensory	**12**	**28**	**13**	**22**
Learning or developmental	**3**	**7**	**4**	**7**
Other (mainly mental health problems, also mental health problems with physical disability; diabetes; COPD; stroke survivor; chronic fatigue; asthma; vitamin and iron deficiency)	**28**	**65**	**43**	**72**
Ethnic group (only groups represented are listed)				
Asian or Asian British - Indian	**4**	**6**	**7**	**8**
Asian or Asian British – other Asian	**1**	**2**	**1**	**1**
Black or Black British - African	**1**	**2**	**4**	**4**
Mixed – White & Asian	**1**	**2**	**1**	**1**

Mixed – White & Black African	**2**	**3**	**2**	**2**
Mixed – White & Black Caribbean	**1**	**2**	**1**	**1**
Mixed – another mixed	**1**	**2**	**1**	**1**
White – White British	**43**	**69**	**61**	**66**
White – White Irish	**1**	**2**	**1**	**1**
White – another white background	**5**	**8**	**8**	**9**
Other ethnic group - Arab	**0**	**0**	**1**	**1**
Other ethnic group – another ethnic background	**3**	**5**	**5**	**5**

Appendix 3: Service User 'I' statements

Appendix 4: CYP 'I' statement

***Staff believe what I am saying and take my opinion seriously**. My voice is not ignored just because I have an adult with me and I am not spoken over or about just because I am young.*

*Those caring for me **involve me** in discussions about my care and listen to what I think works well.*

*Wherever possible **I am given options** in my care that recognise that I am an individual and that every situation is different*

***I am never left waiting on my own without knowing what is going on** and I am always involved in making plans for what happens next.*

*Those involved in my care are **always honest with me**. They support me to gain confidence in them when I am feeling vulnerable.*

*Those involved in my care **make the effort to get to know me**. They understand that although I may be an adult legally, I may not always feel like one.*

***I am supported to achieve my aspirations** for other areas of my life such as education, hobbies and relationships.*

*As far as possible **my confidentiality is respected** and only the friends, family and carers that I choose are involved in my care.*

***I am prepared for the changes which are coming up** and not left feeling I am going into the unknown.*

*Those caring for me **take the time to find out about my fears.** They take them seriously and reassure me.*

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Health in Hackney Scrutiny Commission 7th January 2019 **Minutes of the previous meeting and matters arising**	Item No **4**

OUTLINE

Attached please find the draft minutes of the held on 19th November 2018.

MATTERS ARISING

Action at 5.8

ACTION:	*Head of Screening NHSEL to provide data on how many women in Hackney were affected by the recent national serious incident relating to notifications about cervical cancer screenings as well as a note to clarify what was put in place locally to mitigate the damage caused.*

This is awaited.

Action at 8.7

ACTION:	*Chief Executive of HUHFT to meet with Chief Executive of Barts Health Trust and the Chair of Tower Hamlets CCG to explore a common approach to implementing these regulations for charging overseas visitors and to report back to the Commission.*

An update on this from CE of HUHFT is awaited.

Action at 8.10

ACTION:	*The Commission to meet with Hackney Migrant Centre to draft a letter/submission to DoH detailing the negative impacts of the Overseas Visitors Charging Regulations locally.*

This took place and Members are considering a draft text of lobbying letter to Secretary of State.

ACTION

The Commission is requested to agree the minutes and note the matters arising.

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London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Monday, 19th November 2018

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair) and Cllr Patrick Spence**
Apologies:	**Cllr Deniz Oguzkanli and Cllr Emma Plouviez**
Officers In Attendance	**Dr Penny Bevan CBE (Director of Public Health), Martin Bradford (Overview and Scrutiny Officer) and Amy Wilkinson (CYP&M Workstream Director)**
Other People in Attendance	**Councillor Sophie Conway (Chair, CYP Scrutiny Commission), Councillor Feryal Demirci (Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks), Councillor Clare Potter (CYP Commission Member) , Shuja Shaikh (North London Muslim Association CYP Co-optee), Ernell Watson (CYP Commission Co-optee), Councillor Caroline Woodley (CYP Commission Member), Mary Clarke (City and Hackney GP Confederation), Amanda Elliott (Healthwatch Hackney), Dr Rhiannon England (City and Hackney CCG), Tracey Fletcher (Homerton University Hospital NHS Foundation Trust), David Maher (NHS City & Hackney Clinical Commissioning Group), Laura Sharpe (City & Hackney GP Confederation), Rehana Ahmed (NHS England London), Dr Miriam Beeks (Hackney Migrant Centre), Kathie Binysh (NHS England London), Sarah Darcy (City and Hackney CCG/LBH), Steven Davies (Royal Free NHS Foundation Trust), Dr Simrit Degun (City & Hackney CCG), Rayah Feldman (Hackney Migrant Centre), Debbie Green (NHS England London), Catherine Heffernan (NHS England London), Maggie Luck (NHS England London), Councillor Gilbert Smyth, Kim Stoddart (Royal Free NHS Foundation Trust), Tamara Suaris (Central and East London Breast Screening Service), William Teh (Royal Free NHS Foundation Trust) and Daf Viney (Hackney Migrant Centre)**
Members of the Public	**4**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 🖂 jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllrs Plouviez and Oguzkanli and from Anne Canning, Dean Henderson and Kirit Shah.

1.2 The Chair welcomed the following Members of the Children and Young People Scrutiny Commission who were present for item 6: Cllr Sophie Conway (Chair); Cllr Caroline Woodley, Cllr Clare Potter, Ernell Watson (coptee) and Shuja Shaikh (coptee).

1.3 Apologies were also received from Cllr Margaret Gordon, Cllr Humeria Garacia and Jo MacLeod (coptee) from CYP Scrutiny Commission.

2 Urgent Items / Order of Business

2.1 The Chair stated that item 8 would be taken as the first substantive item.

3 Declarations of Interest

3.1 Cllr Snell stated that he was the Chair of Trustees of the disability charity DABD UK.

3.2 Cllr Maxwell stated that she was a Member of the Council of Governors of the Homerton University Hospital NHS Foundation Trust.

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the draft minutes of the meeting held on 26 September 2018 and noted the matters arising.

RESOLVED:	**That the minutes of the meeting held on 26 September 2018 be agreed as a correct record and that the matters arising be noted.**

5 Update on changes to breast screening services in Hackney

5.1 Members gave consideration to a briefing providing an update from NHS England (London) on the recovery plan for breast screening services in Hackney, following a period of poor performance. At the previous meeting Members had noted a response from NHSEL to a letter from the Chair raising concerns about the volume of cancelled appointments and the displacement of sessions in Hackney. Members had issues with that response and so representatives of NHSEL were invited to this meeting to answer further

questions. They were accompanied by representatives of Royal Free London NHS FT which is now the sub-regional provider for central and east London.

5.2 The Chair welcomed the following:

Dr Kathie Binysh, Head of Screening, NHS England (London) (**KB**)
Maggie Luck, Deputy Head: Adult & Cancer Screening, NHS England (London) (**ML**)
William Teh, Overall Director of Breast Screening Services, Royal Free Hospital NHS Foundation Trust (**WT**)
Tamara Suaris. Director of Screening CELBSS (**TS**)
Kim Stoddard, Senior Operations Manager, Royal Free Hospital NHS Foundation Trust (**KS**)
Steven Davies, Operational Manager, Royal Free Hospital NHS Foundation Trust (**SD**)

5.3 KB took Members through the briefing and it was noted that an agreed recovery plan was in place. There was an issue about wheelchair access in static sites and this was being looked in to.

5.4 The Chair stated that he had been contacted by a Hackney Resident who is a wheelchair user who had a complaint about her personal treatment when she attended for a screening at the Barts site and had been made to stand, which had been very painful for her. Officers had referred her to Steven Davies, the Operational Manager at the Royal Free, now the provider, who would be responding to her. The Chair added that while the Commission could not get into an individual case providers had a legal duty to ensure that wheelchair users were not discriminated in any way in terms of their ability to access screenings or in their treatment during screenings and asked that officers ensure that the resident was given a full response. Officers replied that they would.

5.5 Members asked what was being done about the shortage of mammographers. SD replied that NHSEL was fully aware of this in the Central and East London Breast Screening Service (CELBSS) there should be 15 in place but they currently had half that amount covering up to 6 sites across the patch. The time between calls for screening was running at 40 weeks and they were required to keep that below 42 weeks. A new training programme was up and running at St George's also. In Hackney they had increased the numbers screened at the Homerton site. KS added that they had regular meetings with the Superintendant of Mammography to address the London wide shortfall. Many of the staff will for example take career breaks which will affect numbers she added. They also moved staff around London to plug any gaps and they were pleased that the new apprentice scheme, which commences in January, will help address the shortfall.

5.6 The Chair asked for clarification on the reference to screenings "stopping" at the Homerton in April. KS explained that this was not a cut but an actual routine temporary planned pause as part of how they approach achieving full coverage across the patch. Screenings would continue there at a lower level for a time and then increase in the next phase.

5.7 The Chair commented that the shortfall in Q3 where there were just 5.8 FTE employees instead of the target of 11.8 was quite dramatic and must have an impact on the numbers of women screened. He added that the Royal College of Radiologists had expressed concern at how services were struggling and how this was a problem even before the removal of the training bursary. KS replied that many practitioners were now reaching retirement age. Plans were afoot for Assistant Practitioners but there was a need for continued focus on recruitment. Some Trusts offered golden handshakes but this was problematic as it would just have the effect of destabilising other areas.

5.8 Cllr Demirci (Cabinet Member) asked whether the NHSEL officers could comment on a related matter. She asked what impact there had been on the Hackney population of the recent controversial national incident regarding the failure to accurately issue letters to women being called for cervical cancer screenings. KB replied that this was a national incident and was being investigated at the highest level. She stated that reassurances could be given because there was a fail-safe mechanism in place so that the system did not rely totally on those letters. There was also a direct referral between the laboratory involved and the service which ordered tests. The Chair asked if NHSEL could provide data on how many women in Hackney were affected and to clarify what local mitigation had been put in place. KB undertook to pursue this.

ACTION:	**Head of Screening NHSEL to provide data on how many women in Hackney were affected by the recent national serious incident relating to notifications about cervical cancer screenings as well as a note to clarify what was put in place locally to mitigate the damage caused.**

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

6 Update on Integrated Commissioning - Children Young People and Maternity Workstream (JOINT WITH CYP SCRUTINY COMMISSION)

6.1 The Chair stated that this was the latest in the rolling programme of regular updates from the 4 Integrated Commissioning Workstreams. This item was joint with Members of the Children and Young People Scrutiny Commission as it related to the Children Young People and Maternity Workstream.

6.2 Members gave consideration to the update report and the Chair welcomed:

Amy Wilkinson, CYP&M Workstream Director (**AW**)
Sarah Darcy, CYP Strategic Lead, CYP&M Workstream (**SD**)

6.3 AW took Members through the report and highlighted that CAMHS, SEND and maternity were the current key areas of focus for the workstream. She reported that Angela Scattergood had left the Council and the new Senior Responsible Officer for this Workstream was Anne Canning. She added that since the last report in March there had been two highly rated SEND inspections and Homerton's maternity service was also now rated 'good' by the CQC. Work

had also commenced on the re commissioning of the Looked After Children Service.

6.4 Members asked about the 'deep dive' work on exclusions and AW described the work being led by the Director of Education and the Improving Exclusions Board on carrying out a "deep dive" into the databases available to look at children who might be vulnerable with a view to offering earlier intervention.

6.5 Dr Miriam Beeks, a local GP, asked what the Council was doing to tackle holiday hunger, extending free school meals and on free school meals for children of families who have No Recourse to Public Funds. AW undertook to take this back. MB commented that North East London Migrant Centres had collated a lot of evidence on the impacts. Cllr Demirci subsequently clarified that the Council had committed to pay for free school meals for children of parents who have No Recourse to Public Funds.

6.6 Members asked what was being done to tackle obesity and diabetes in children. SD replied that there was a multi-agency approach under Integrated Commissioning and as part of this the GP Confederation had a contract to improve support children with Long Term Conditions. Every child was invited to see a nurse and there were checks with families to ensure they had everything they needed. There was such a system in place also for children with asthma. The challenge with diabetes was greater at present though.

6.7 Members asked about out of borough placements for children with SEND. AW detailed the work with the CCG on the finance pathways here in order to improve the situation. SD detailed how the SEND Partnership Board oversaw the partnership working on this. They were working with the Education team on the offer to children with SEND and among the principles underlying this work was the need to ensure in-borough support.

6.8 Members asked about the engagement with the Charedi community. SD explained that this was mainly done via the organisation Interlink who has, for example, very active Members who they work with on access to speech and language therapies. There were co-morbidity issues and gaps in services and they worked closely with them on many issues. They also worked with them on Looked After Children.

6.9 A member of the public asked about the numbers of children brought into the City during the working day and the impact supporting them would have on demand for services in City and Hackney. SD replied that Hackney's CYP service worked very closely with City colleagues and one of the things they were doing was to provide clarity specifically on the health offer to children in the City.

6.10 The Chair stated that any Member, who like himself, had served on the Corporate Parenting Board would be aware of the challenges around supporting the boroughs Looked after Children. The health services for these children were provided by the Homerton but are now provided by the Whittington. AW replied that provision of services to Looked after Children was a vital issue and they were measured across a range of statutory indicators for this. Looked after Children must have annual health reviews. AW stated that managers were satisfied that there weren't any current risks in the system and

in terms of current performance, progress needed to be made on a number of indicators. Performance was improving in the move to the Whittington service and it was providing an opportunity to take forward the work on ensuring a more joined up approach to supporting these children. Members asked if the monitoring approach was too much of a tick-box exercise and a more proactive approach to prevention would be preferable to support of these children and young people. AW agreed and stated that particular pressure points were in relation to sexual health services and mental health support. A Member asked if in re-procuring these services thought had been given to bringing them in-house. AW replied that with health services in particular there was no value in the Council employing people directly.

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

7 Vaccine preventable disease and 0-5 childhood immunisations

7.1 The Chair stated that the Commission had agreed at the start of the year to devote a whole meeting to this, which it had not been able to achieve but they had requested the following updates as there had been another recent increase in cases of measles (50 in the last four weeks across Hackney, Haringey and Newham) and rising concern about the issue. The Commission had last examined the issue in 2016 and concerns remained. They had agreed to focus here on 0-5 year immunisations as this was where the challenge was and there would be three elements to this item:

a) Briefing from NHSE London who commission GP Practices to deliver vaccinations
b) Briefing from City and Hackney GP Confederation who run a supplementary vaccination programme funded by the CCG
c) Update from Integrated Commissioning on the issue as it is currently rated as a risk item in the CYP&M Workstream

7.2 Members gave consideration to papers from NHSEL and from the GP Confederation and the Chair welcomed for this item:

Dr Catherine Heffernan, Principal Advisor for Commissioning CHIS, Immunisations and Vaccination Services, NHS England London (**CH**)
Debbie Green, Commissioner, NHSE London (**DG**)
Rehana Ahmed, Immunisation Commissioning Manager, NHSEL (**RA**)
Dr Mary Clarke, Director of Workforce, City and Hackney GP Confederation (**MC**)
Laura Sharpe, Chief Executive, City & Hackney GP Confederation (**LS**)
Dr Simrit Degun, City and Hackney GP Confederation (**SD**)
Amy Wilkinson, Integrated Commissioning Workstream Director - Children, Young People and Maternity (**AW**)
Sarah Darcy, Children and Young People Strategic Lead, Integrated Commissioning CYP&M Workstream (**SD**)
Dr Rhiannon England, City and Hackney CCG (**RE**)
David Maher, Managing Director, City and Hackney CCG (**DM**)

Dr Penny Bevan, Director of Public Health, City and Hackney (**PB**)

7.3 CH took Members through NHSEL's paper. She stated that she was from Public Health England but was currently embedded in NHSEL. She added that it was regrettable that no PHE colleagues were present who could better answer on the current outbreak in north and east London. Hackney's performance was poor but one of the key challenges here was that while children within the reported figures appeared to be unvaccinated it would turn out that many actually had been and this was a recurring pattern. The main challenge to the record keeping was the mobility of the population. One of the key tasks was to simplify the reporting and information systems and they had reduced 19 different systems to 4. CCGs were now on just 3 data systems in London. One of the characteristics of the Hackney population was that children were being vaccinated later e.g. at aged 2. She detailed the wider pan London plans on increasing vaccination and the work being delivered by the London Immunisation Partnership.

7.4 DG stated that there was now a national initiative on revalidation of data and a national 'movers and removers' process was being added and by June 2019 the NHS would be in a much better place in relation to live data on immunisations.

7.5 LS explained that City & Hackney GP Confederation was an umbrella body to support general practice locally. Local GP performance was one of the top nationally in terms of clinical measures. The CCG had given the GP Confederation some non-recurrent funding to tackle the urgency of the situation on the low immunisation rates. She stated that local GPs knew full well that immunisation was the best evidence based intervention which could be made on children's health but driving uptake takes time and GP practices were hard pressed. Improving the overall level of uptake would always be a slow steady process. The Confederation produced monthly performance dashboards on immunisation uptake and it had gone from being almost all red to having significant amounts of green. The challenge was to get Practices to think of immunisations in the same way as they think about tackling hypertension and diabetes. As part of the specific project Mary Clarke had established a programme to add capacity and more weekend access. They would also use nurses who were engaged in wound dressing rotas to work on vaccinations. A key challenge was 'Call and Recall' systems. Each Practice has responsibility for phoning each patient to get them in for vaccinations. The system was reliant on vaccinations being done in core hours in General Practice. This was proving an inconsistent approach and when Practices were short of Receptionists, as was happening, it was proving difficult. NHSEL commissioned the Confederation to carry out a pilot project, which they decided to hold in North West Hackney, which was closest to the 95% 'herd immunity' target, to examine over 12 months what actions could be taken to have the greatest impact. Having access to live data on immunisations remained the "holy grail" of prevention work here, she added.

7.6 MC detailed that 5 extra clinics (evenings and weekends) which were being provided. Initial uptake had not been good but more work was underway with the communities in NW Hackney. They were aiming to move from 8 week checks to 6 week checks and were working with both health and maternity services and with the Ann Taylor and Lubavitch Children's Centres in particular.

7.7 Members asked why the pilot was running not in the worst performing area but in the second worst. LS explained that this was deliberate because to attempt to do it in the worst area would be difficult as the baseline would be too low to be an effective pilot study.

7.8 Members asked about the challenge for large families of ensuring every child was fully vaccinated. RE replied that this was a huge challenge in the North East. While there was some cultural opposition in ultra-orthodox families this was not significant. Much work needed to be done on improving access. Recent measles outbreaks in Israel and New York were also a factor because of the links with the community in Stamford Hill.

7.9 Cllr Demirci (Cabinet Member) commented that a one-size-fits-all approach to commissioning across London was not helping Hackney with this situation and the Chair asked further if this could be commissioned at a CCG level.

7.10 CH replied that there were common issues across London and the UK so Hackney was not unique. Data was a key problem and they were finding data on 5 year olds who should have been vaccinated 3 years previously. It is now possible to see the update by Practice monthly. Immunisation was a huge endeavour and it was a partnership. There was a need to make it far easier for parents. Hackney was making great progress because of a keen partnership approach. DG described the development of an electronic version of the 'Red Book' whereby parents would get prompts from antenatal stage onwards. This was being piloted in Kingston.

7.11 Members expressed the concern that a digital solution such as this would be of no use to the Charedi community in Stamford Hill. LS stated that there were three large practices in the NE but they did not have the capacity to cope with the volume of vaccinations needed in that area, the community model therefore was not working in this context. With Public Health England, NHSE London, CCG and the GMS contracts all involved it was proving too complex. There was a need for a debate on whether every child, for example, should be immunised before nursery. She added that childhood Immunisations did not have the focus and attention at very senior levels that breast screening, for example, has.

7.12 A Member of CYP Scrutiny Commission asked what follow up was considered for babies who were being taken abroad on holidays. CH replied that it depended on the length of the holiday. Taking babies abroad before 2 months always posed a risk if there were not vaccinated. She added that the recent measles outbreaks were in young adults who should have been vaccinated but weren't because of the MMR scare during 1999-2000 and who had picked it up abroad.

7.13 A Member of CYP Scrutiny Commission asked about the use of Children's Centres. MC replied that immunisations were no longer offered but advice and guidance was. They were in discussions with Lubavitch and Ann Taylor about instigating them again and would be carrying out a pilot in Ann Taylor Centre in January. There were challenges for many e.g. Tyssen and Woodberry Down as the environment there was not appropriate for running immunisation sessions.

7.14 Members asked what the ideal community model for delivering immunisations would be. One Member commented that what was taking place constituted contract failure and the variations between Practices were unacceptable and asked why sanctions hadn't been put in place.

7.15 RE replied that she understood Members' frustrations about this situation. In the NE specifically Stamford Hill Practice was running 4 baby clinics a week but it wasn't enough as the baby population had exploded and they also had inadequate space. There were a lot of mitigating circumstances but it would be unfair to characterise the GPs involved as not trying to tackle this problem. She stated that it was unfortunate that Health Visitors had been stopped from delivering vaccinations and up until recently many GPs had been dependent on that system. The Call and Recall system was inadequate and the under 5s population had exploded.

7.16 A resident asked about how Gateshead was performing as it had a similar Charedi population. She also asked how much the electronic screens in GP waiting rooms were being used to promote immunisation uptake.

7.17 LS replied that Cranwich Rd Practice for example had a video on immunisations on a loop in Reception. Some Practices such as Barton House were doing very well and it was vital to understand why. She would like to see Practices receive mini accreditation for best practice on childhood immunisations as a way to drive up performance. RE stated that ongoing sustained partnership working was required and no one player could tackle it alone.

7.18 The Chair asked for the latest on the recent outbreak.

7.19 AW stated that the situation was fluid but as of the meeting there had been 50 new cases across Hackney, Newham and Haringey. 35 cases in Hackney and 6 unconfirmed. NHSE was providing additional funding to tackle a local outbreak response to meet the sharp increase in the demand for vaccines from the community. NHSEL and PHE had also called for bids on a call-recall pilot. Locally the GP Confederation was leading on an excellent response. One of the challenges was that Haringey did not have a GP Confederation which could mobilise GPs in the same way as in Hackney but City and Hackney CCG had now offered to put a response in place for them.

7.20 The Chair asked if someone at NHSEL was on top of the Haringey situation and added that the lesson to be learned from the Francis Report was that when 4 or 5 organisations were holding the ring there was a greater chance of things going wrong.

7.21 CH replied that they were and the health protection teams had been notified of the situation in Haringey. She added that the recent incident was a contained outbreak and there had been a similar one recently in SE London. The outbreak was predominantly related to an older group returning from abroad. PHE would be focused on containing the spread and there would be mobilisation in schools etc.

7.22 MC stated that prior to the recent outbreak the uptake had been 21% in the NE it was now 94% and 316 children had been immunised up to Oct 22. 6 clinics were running that week in addition to some immunisations at home. 261 additional appointments had been added over and above what they had planned and they had opened up a third clinic in Stamford Hill on Sunday. They also had an immunisation phone line open 7 days 9.00am-6.00pm.

7.23 Members asked whether funding for immunisations could be delegated to the CCG. CH replied that it could not legally be delegated. DM added that the health community ignored at its peril the need to consolidate the commissioning arrangements for immunisations. He added that a contained outbreak would not be contained for long and there was a greater need for co-commissioning.

7.24 Dr Miriam Beeks, a local GP, asked what NHSEL would do about children not registered with GPs considering that half of London was born abroad. RE replied that when immunisation was offered is was offered to all.

7.25 The Chair asked for clarification on whether it was a “contained outbreak” of measles. AW replied that Public Health England had informed Public Health in the Council that it was an outbreak. CH took issue with this stating that NHSEL had not been informed of this by Public Health England. AW added that NHSEL had undertaken to pay the top-up tariff.

9.26 The Chair thanked all the officers for their papers and their attendance and that the Commission would keep a watching eye on this.

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

8 Implementing the Overseas Visitors Charging Regulations

8.1 The Chair stated that this issue was first raised with the Commission over the summer as part of local concerns about the government’s broader ‘hostile environment’ approach to illegal migrants. He had written to Homerton University Hospital (HUHFT) for a response and the reply was included in the agenda papers. It was raised again by Members at the September meeting and he therefore invited Tracey Fletcher (Chief Executive, HUHFT) to attend to answer questions on the Trust’s approach.

8.2 The Chair noted that also present for this item were:

Dr Miriam Beeks (a local GP, active in Hackney Migrant Centre) (**MB**)
Rayah Feldman (Chair, Hackney Migrant Centre) (**RF**)
Daf Viney (Centre Manager, Hackney Migrant Centre) (**DV**)

8.3 Members’ gave consideration to the briefing from the Chief Nurse to the Chair, which had outlined the process at the Homerton in relation to charging Overseas Visitors who are not entitled to free NHS services, and to a subsequent presentation titled ‘Overseas Patients’ which the Director of Finance had recently given to HUHFT’s Council of Governors.

8.4 Tracey Fletcher (**TF**) stated that HUHFT, like all NHS Trusts, had obligations to comply with the government's regulations on charging overseas visitors once it was established they were not eligible to free NHS services. The initial 'pre-attendance questionnaires' which had been used had caused concerns and so had been withdrawn in favour of a process which is now used at 'check in' at the hospital where they are required to establish a patient's eligibility for free treatment. The Trust was required to provide the Home Office with information on overseas patients who have outstanding debts with the NHS. The Trust also provided information to the CCG on overseas patients who are being treated as part of the UK's reciprocal health agreements with fellow EU countries.

8.5 In response to a question from the Chair, TF confirmed that the Trust was obliged to share data with the Home Office in the case of outstanding debts but not otherwise.

8.6 MB asked whether HUHFT would be prepared to agree with other Trusts to refuse to make these charges. The initial letters were issued widely and according to how patients replied to them some were charged. These charges were mostly being levied on people who were destitute and vulnerable. She stated that a recent Evening Standard Freedom of Information request had revealed that of 9000 people sent invoices only 0.5% turned out to be chargeable and nationally only 0.3% of these NHS charges were actually recoupable. In her view this charging was not about increasing income opportunities it was about deterring the most vulnerable patients, including pregnant women and many with PTSD. They would lead to more costs in the longer term because people in this situation were being deterred from seeking medical help and thus would become more ill. She highlighted the recent case of a TB patient who had a form of the illness which was difficult to diagnose. The Chair commented that the use of the words "income opportunities" in the Homerton's paper had come from NHSI and not from HUHFT itself. She continued that Tower Hamlets CCG was encouraging Barts Health NHS Trust to stop charging. Overall this policy was potentially disastrous in relation to immunisations, infectious diseases and supporting pregnant women, she added.

8.7 TF replied that it was DoH who had characterised this as "income opportunity" and Dr Beeks' sentiments were widely shared among members of the Council of Governors. She added that she would be interested to hear the views of Alwyn Williams (Chief Executive, Barts Health NHS Trust) and Dr Sir Sam Everington (Chair, Tower Hamlets CCG) and would meet them to discuss how these issues might be resolved. NHS Trusts had been set quite clear guidance on this by DoH but she acknowledged the point about the difference between what was chargeable and what could be recouped. A Member added that the local NHS Trusts needed to challenge this on the basis of how much time was spent on invoicing and trying to recoup this money.

ACTION:	**Chief Executive of HUHFT to meet with Chief Executive of Barts Health Trust and the Chair of Tower Hamlets CCG to explore a common approach to implementing these regulations for charging overseas visitors and to report back to the**

	Commission.

8.9 DV gave a number of examples of recent cases including a woman who had been sent a bill for £96k for a liver transplant, a bill for £86k to a cancer patient who was street homeless and a bill for £14k sent to someone for treatment they had not yet received. He asked if TF could guarantee that these charges, which were ludicrous in his view, would not be applied. RF asked further if HUHFT could examine the degree of deterrence and what the health impacts were. TF replied that it would be very difficult for the Trust to examine the second element i.e. how, once patients had been charged and dropped out of the system, what had become of them.

8.10 The Chair suggested a meeting with Hackney Migrant Centre to draft a submission from the Commission to DoH on the local impacts and Members agreed.

ACTION:	**The Commission to meet with Hackney Migrant Centre to draft a letter/submission to DoH detailing the negative impacts of the Overseas Visitors Charging Regulations locally.**

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

9 Health in Hackney Scrutiny Commission- 2018/19 Work Programme

9.1 Members noted the updated Work Programme for the Commission.

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

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

Health in Hackney Scrutiny Commission 7th January 2019 **Review on 'Digital first primary care and its implications for GP Practices' – SCOPE ANDTERMS OF REFERENCE**	Item No **5**

OUTLINE

Attached is a draft scoping document and Terms of Reference for the Commission's next review on 'Digital first primary care and its implications for GP Practices'

ACTION

The Commission is requested to agree the terms of reference for the review.

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<u>DRAFT</u> Proposal for a scrutiny review by Health in Hackney Scrutiny Commission

<u>Review title</u>: **Digital first primary care and its implications for GP Practices**

<u>Municipal year</u>: **2018/2019**

Definition: ***Digital first primary care*** *refers to delivery models through which a patient can receive the advice and treatment they need from their home or place of work via online symptom checking and remote consultation. This means that a patient's first point of contact with a GP is usually though a digital channel*

1. Background & context

1.1 This paper sets out the scope for a scrutiny review on '*Digital first primary care and its implications for GP Practices'*. It will look primarily at how **virtual consultations via smartphones** with clinicians will transform how we interact with GPs and will also address the related issue of **online access** by patients to patient systems.

1.2 Online access for patients has been identified as a key aspect of a modern primary care system and digital tools can help to improve the quality of care and also support patients interested in self-care. *Patient Online* is the generic term used for online access systems. They use apps or web browser access to a GP Practice provided by the GP's system suppliers. These systems all have their own proprietary names and operate on computers, tablets and smartphones. With *Patient Online* patients can book and cancel appointments and order repeat prescriptions i.e. 'transactional services'. Practices can offer patients online access to the detailed coded information in their records, now a contractual requirement in England. They can also enable patients to view their consultation notes and clinical correspondence. Patients can use record access to prepare for consultations, collaborate fully in person-centred models of care and improve their self-management of their long-term conditions. We will look at the systems currently used or being planned to be used in Hackney.

1.3 The issue of improving access to primary care in Hackney has been a continuing one for the Commission and in 2013 we carried out a full review on Improving GP appointment systems. Since then there has been a whole range of digital solutions offered to patients to make it easier for them to access their GP or manage their health. There are now, for example, 37 private providers registered with the CQC to

provide online consultations in England[1] and some of these are now looking to access the NHS funding on offer, by partnering with NHS GP Practices. Hackney with its large young population of digitally savvy and often time-poor people has been a target for these companies.

1.4 The issue came to a head earlier this year with the controversy over '*GP at Hand'*. Babylon, the company behind this service, is a subscription health service provider that enables users to have **virtual consultations with doctors** and health care professionals via text and video messaging through a mobile 'App' 24 hrs a day. They recently rolled out their 'GP at Hand' app offering NHS GP consultations, previously it was just for private patients.

1.5 It has attracted a lot of media attention and the new Health Secretary is an admirer (and user) of the service[2]. It is described as a market 'disrupter' like Uber, however this is contested by others who would argue that there is no 'market' and instead a parallel economy is being created by NHSE. This, they argue, favours private providers who are "siphoning off" NHS funding so that more money is going to "private providers" of these Apps for the same work, while leaving the basic system itself struggling with decreasing funding and increasing demand. These innovations now challenge the whole basis on which primary care is funded.

1.6 As well as potentially losing the younger and healthier patients, who are more digitally savvy, to the new system, these models are drawing younger GPs to work for digital providers, attracted by more flexible hours and work locations and this is happening at a time when there is a general crisis in GP recruitment.

1.7 Primary Care however is not just about processing patients through a system, it is also about empathy and the relational aspect between the patient and the doctor and some would argue that this could be eroded by digital consultations unless they are handled sensitively. Doctors have described the concept of the "one last thing" question as the worried patient stands at the door, expressing what might be the real reason they came. How effective can video consultations be in allowing clinicians to pick up on these, often, non-verbal cues?

2. City and Hackney CCGs General Practice Development Programme

2.1 City and Hackney CCG is working on General Practice Development Programme which includes 10 "high impact actions" to release more time for care in General Practice. Their focus is on new communication methods for some consultations such as phone and email as well as improving continuity of care and convenience for the

[1] http://www.pulsetoday.co.uk/news/gp-topics/it/the-online-providers-disrupting-the-market/20037376.article
[2] https://www.telegraph.co.uk/news/2018/09/12/hancock-attacks-nhs-block-progress-says-patients-should-able/

patient and reducing the clinical contact time. We will look at their proposals and consider primary care vs non-primary care consultations and how these compare

2.2 We will look at new ways of booking appointments and how phone triage is operating and impacting on treatment. We will look at *GP First??, Patient First??, Patient Online, Patient Partner??* and *NHS 111* and how they impact on GPs practices. NEED TO CHECK

2.3 We will look at on-line consultation: *E-consult* (see 5 below) and *Ask My GP* which are being trialled locally as well as Skype based platforms such as *GP at Hand* and we will look at areas of innovation such as Tower Hamlets.

2.4 When looking at each offer we will consider how they meet the following criteria:

- Equity
- Continuity
- Satisfaction
- Will this help to manage demand/produce efficiencies/release more time for care?
- System wide impacts and implications
- Risks (safety, data protection, destabilisation, safeguarding)

3. 'GP at Hand'

3.1 The most high profile disrupter of GP appointment systems of late has been 'GP at Hand'. This service is provided out of a host GP practice in Lillie Rd in Hammersmith and operates on a standard GMS Contract managed by Hammersmith and Fulham CCG's Primary Care Commissioning Committee. It is marketed to attract patients who want speed of access to GP advice over continuity of service with the same GP and these patients do tend to be fitter and younger and with non-urgent problems. For many, current waiting times for GP appointments across London are too long and/or GP Practices are perceived as being too inflexible, particularly for those with little time. Initial contact is via Skype where, GP at Hand maintain, a number of problems can be dealt with there and then.

3.2 Where a patient does need to be seen e.g. for a physical examination, GP at Hand has a small number of sites across London where the patient would be referred. These sites would technically be branches of the H&F practice. GP at Hand also appears to be going into partnership with existing GP Practices (e.g. Newby Place Health and Wellbeing Centre in Poplar) to provide a site for any necessary face to face consultations.

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3.3 GP at Hand is extensively marketed which is highly novel in the NHS; routine General Practice does not generally market itself beyond declaring that it is open to register new patients. GP at Hand however has also recently had some adverts banned by the Advertising Standards Authority for not making it clear to patients that they would be giving up their existing GP practice registration when they register with them.

3.4 The service has had a number of teething problems. Earlier in the year Babylon was de-listed from the 'NHS Apps' library with NHS Digital claiming they didn't want the promotion of the private services on an NHS platform, however Babylon provides separate private and NHS services and clearly markets itself as providing NHS GP services. The company also took legal action against the CQC regarding what they perceived to be an unfair rating. A CCG in Birmingham has also blocked their expansion plans in that city citing arguments about patient safety.

3.5 The advantages of the model to patients are that it offers near instant access, which routine GP practices struggles to offer, they also appeal to a younger demographic who are digitally minded, with little time and they also argue that they relieve pressure on the NHS

3.6 Critics have pointed out a number of shortcomings however. They argue that GP at Hand's stringent eligibility criteria are unfair i.e. that they essentially "cherry pick" healthy patients. GP at Hand deny this. Patients who sign up to use the service are de-registered from their current GP practice and the consequences of this aren't always immediately apparent and GP at Hand has been heavily criticised for not doing enough to make these consequences clearer to patients. The current number of locations for face to face consultations is limited which means that patients often want to re-register with their previous GP practice again; this adds to practice churn which is already high in Hackney, for example, and further adds to Practice workload. Some argue that a lack of new locations for face to face consultations might lead to patients being referred to A&Es for example, thus putting undue pressure on local hospital services and on other CCG budgets outside its home CCG.

3.7 The service is looking to open additional local branches for face to face consultations but generally CCGs have been slow to support them because the risks to sustainable Primary Care funding (and by implication CCGs own commissioning budgets) from services like this are, as yet, not fully known. The fear is that unless the system is changed Apps like GP at Hand could lead to destabilisation of Core Primary Care and thwart ambitions, already in place within many CCGs, for their own place based contracting of services e.g. Hackney's own Neighbourhood Model.

3.8 When this issue first arose back in March City & Hackney CCG pointed out that there is an **opportunity for GP Practices in Hackney to match or better the GP at Hand offer** because City and Hackney already offers same day access. They do this via the CCG 'Duty Doctor' contract, via Primary Care Hubs (open 8.00 am-8.00pm on Saturday and Sunday), or Hubs which are open from 6.30 pm to 8.00 pm. They also argue all Practices now offer some kind of extended opening either through locally or nationally commissioned services. They also stated that patients can message their Practices directly through software (Ask My GP) or consult with their practice online (eConsult software) and that they have commissioned the GP Confederation to develop a local messaging app (e.g. to support the Duty Doc service).

3.9 As a consequence of *GP at Hand* Hammersmith & Fulham CCG had a sudden and immediate in-year budget deficit because the service was significantly increasing H&F's patient population without any equivalent increase in their commissioning budget. More broadly however all CCGs are currently experiencing population growth. One of the fundamental challenges too is that GP at Hand is seen to cherry pick the younger, healthier patients and in doing so poses a threat to the whole funding model for routine primary care. Local City and Hackney GP practices have received complaints about the de-registering of their patients. In response to this, one local Practice has communicated with its existing patients to inform them of the sign up process and voice their concern.

3.10 An article in the GP's newspaper *Pulse* stated that "The Drum, a website for the advertising and marketing industries, said Babylon's media agency PHD Media had looked at which of the capital's boroughs outside west London would be best to target 20- to 39-year-olds – it chose Hackney and Southwark"[3].

4 NHSE consultation and an intermediate approach

4.1 While CCGs appear keen to contain the impact of GP at Hand, NHSE London has been much more supportive of the trend. There is a view that CCGs have been caught on the back foot with it. This consultation, which closed on 31 Aug, is NHSE's attempt to square the circle and figure out how to safely integrate the new technology into health and care pathways whilst not unfairly destabilising existing services. NHSE has stated that the outcome of this engagement will inform GP contract negotiations for 2019-2020 between NHS England and the General Practitioners Committee of the British Medical Association.

[3] http://www.pulsetoday.co.uk/news/gp-topics/it/the-online-providers-disrupting-the-market/20037376.article

4.2 Londonwide LMCs responded to the consultation[4] and summarised their response follows:

How to implement greater digital first provision in general practice

- Online access and consulting could reduce the need for attendance at GP practices and appointments in the long-term. How to apply the technology in ways which actually do this needs to be established by rigorous evaluation, rather than the belief that rolling out more online services will somehow inherently reduce workload.
- To create a reliable online service the NHS needs to fund user research (both patient and clinical), significant IT infrastructure investment and improvements in practices, software development and/or procurement, training and roll-out support.
- In order for investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so.
- Money should not be diverted from elsewhere in general practice to pay for new digital services.

4.3 A new dimension has been added by *Now Healthcare Group*[5] who are offering to provide practices with its technology for “free” through its *Now Patient* app, which will allow patients to book appointments with their own GP and take part in a video consultation. In return, Now Healthcare Group will be able to use its app to ‘communicate’ to customers about its repeat medicine delivery service. This gives GPs the opportunity to continue to see their patients – rather than losing them to other practices offering online consultation services and at the same time provides Now Healthcare Group with access to more customers for its services. Its website boasts how it already serves 15 million chronic care NHS patients in the UK. Some GPs have criticised this ‘free offer’ stating it would allow another provider to come between them and their patients. They have also dismissed it as no more than a Skype consultation but using independent software which then allows the provider to make use of valuable patient data.

5. E-Consult and other innovative Apps

5.1 We will look at some of the innovative Apps that are being used in Hackney or comparator boroughs to enhance primary health care.

5.2 The *Health Touch* app which is used by Bromley By Bow Health Centre in Tower Hamlets is an example of a tele-health application, which contributes to the innovation of health care using mobile technology. Health Touch brings together Health Care Professions and patients via any mobile phone or tablet. The app monitors patients’ health, allowing them to be fully involved in their care. It also enables HCP’s to have improved visibility of patient’s medical data, so they can accurately track progress.

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[4] https://www.lmc.org.uk/visageimages/2018%20Londonwide%20Newsletters/September/Londonwide%20LMCs%27%20Digital%20First%20response%20for%20publication.pdf

[5] https://www.nowhealthcaregroup.com/

5.3 The Hurley Group of GP Practices (which operates Allerton Rd GP Surgery) ran a pilot funded by Tower Hamlets CCG which utilised **eConsult** app using 133,000 patients across 20 practices across 10 boroughs. eConsult provides an online portal where patients can self-check their symptoms, and receive on the spot medical advice 24/7. Helping to relieve pressure on GPs by giving patients access to round-the-clock support and alternative treatment providers. They claim it allows patients to gain better access to instant medical care and advice while empowering GPs to run their practices more efficiently. The app is licensed to a surgery and the cost is proportional to the number of registered patients. They provide personalised training on the system to the Practices and it bolts on the existing Practice website without the need to invest in any software. They ask that the eConsult banner is highly visible, ideally on the home page and they provide full assistance on marketing it. They argue that GP Practices are likely to see a reduction in the number of patients coming through their doors, and a decline in the amount of patients phoning up for an appointment, as more and more switch to using the platform.

6 Use of Virtual Clinics for out-patients

6.1 Accessing your GP via digital channels is just one part of a wider transformation of health and social care which is now taking place. Digital innovations are also impacting on access to both secondary care and to social care with digital transformation continuing through the care pathway. We will explore some of these trends in our review.

6.2 Clinicians and those driving transformation programmes have argued for some time that traditional models of outpatient care are not always aligned to the needs of patients and can be difficult for them to access. This has led to high rates of non-attendance at out-patient appointments and poor patient engagement, resulting in poor health outcomes and greater use of emergency care, plus rising costs. With increasing multi-morbidity, people living longer with complications and care being more multi-disciplinary, care models need to be more flexible and responsive. Research has shown that using remote video outpatient consultations rather than face-to-face review with patients in hospital has the potential to address some of these issues, however, implementing such services within routine practice in the NHS is challenging.

6.3 Barts Health NHS Trust has been exploring the use of video consultations via Skype, and the impact on patient attendance rates, patient satisfaction and efficiency savings. Last year the Health Foundation awarded Barts Health £3.5 million from its *Scaling Up Improvement* programme to take Newham Hospital's previous success in this area and mainstream it. That hospital (part of Barts Health) had cut the number of missed diabetes appointments from 30-50% to just

11-13%. From this project Barts Health has developed significant expertise in the area and have produced standard operating procedures, information governance and technical guidance documents, and protocols for setting up and running virtual clinics. This pilot was led by Barts Health NHS Trust has been in partnership with the Nuffield Department of Primary Care Health Sciences at the University of Oxford, East London and City (WELC) Clinical Commissioning Groups; Oxford University Hospitals NHS Foundation Trust, NHS England and Microsoft

7. Why do the review now?

7.1 Some argue that CCGs, including City and Hackney have been caught on the back foot with digital primary care and now need to get up to speed as providers such as Babylon are moving in and have the support of NHSE and the Secretary of State. While they attract a lot of media attention it is not clear that their solutions could be presented at scale and this is one of the key issues to explore.

7.2 The *NHS Five Year Forward View* makes explicit reference to the need to urgently embrace technology to:

- *Improve Urgent care online*
- *Resolve more issues without patients resorting to A&E*
- *Develop more online appointment booking for hospital appointments*
- *Increase use of digital solutions to handle patient medical information*
- *Greater use of Apps to help people manage their own health*.

7.3 The borough has a growing young population who will be very responsive to digital primary care solutions and some practices are already seeing a draining away of younger patients.

7.4 The GP Confederation is piloting some new digital primary care approaches and the review would provide an opportunity to feed into the discussions on these proposals.

7.5 The review takes place as the East London Health and Care Partnership is introducing '*one London'* which aims to be an exemplar of local health and care records and "to raise the bar" around NHS and partners sharing data to deliver better care. We will look at how this digital transformation of care records interacts with other digital initiatives such as virtual consultations or patient online systems.

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8. Core Questions

8.1 Overall, the review seeks to answer the following **Core Questions**:

a) How can the NHS safely integrate digital approaches to primary care with existing health and care pathways whilst not unfairly destabilising existing GP services?
b) How can digital developments facilitate better outcomes for patients?
c) How can they ensure better access and better outcomes for ALL equality groups and how can digital solutions improve how demand is managed and how unmet demand is assessed?
d) Digital solutions cannot be silo and how can they fit within a 'whole system' approach and how can they help the development of more 'whole system' approaches?
e) How can digital solutions deal with safeguarding issues in relation to vulnerable patients?
f) How might digital enable the development of a more Systems Approach to improving primary care across health, social care and third sector providers?
g) What is the demand for primary care and what is the unmet demand and can digital primary care approaches perhaps assist with the latter?
h) This has had a degree of success as the numbers are small and it is in London only. If this is scaled up nationally where will all the additional doctor time come from?

9. Key Stakeholders

Sector / organisation	**Stakeholder**
The key stakeholders	Local GPs Providers of digital primary care services in Hackney and NE London City and Hackney GP Confederation Local Medical Committee Healthwatch Hackney District/Community nurses Social workers Carers
Local commissioners	City and Hackney CCG NHS England London
Statutory sector providers	City and Hackney GP Confederation GP Out of Hours/ NHS 111 providers (London Ambulance Service)
Key Third Sector providers	Hackney CVS
Regional and national bodies	NHS 111 Royal College of General Practitioners

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10. Methodology

10.1 The evidence gathered will be collated and published in the Commission's agenda papers. Desk research will be undertaken initially and throughout the review to provide background information on national policy and local findings.

10.2 Evidence will be collected at both commission meetings and during site visits and notes of these will appear in the agenda packs.

10.3 With the collaboration of the Council's Consultation Team the review will use the Council's online engagement portal **Hackney Matters** to get residents views of and personal experiences with digital primary care. This will provide some useful primary research to inform the review.

11. Timetable

11.1 The table below provides a schedule of when different corporate aspects of the review are likely to be completed.

Task	Envisaged Timetable
Draft Terms of Reference, desktop research, consulting experts, confirming Executive Link Officer/Members	Dec 2018
Agreement of scope and terms of reference	7 Jan 2019
Site visits	Jan to March
Formal committee meetings	7 Jan, 4 Feb, 12 Mar, 4 April
Recommendation areas discussion	4 April 2019
Consult Executive Link Officer/Members on draft findings and recommendations	April
Report drafting	April
Schedule for Legal/Finance comments	May
Draft report published in Agenda for June HiH	June (date tbc)
Commission agrees Report	June
Cabinet response and report considered at Cabinet	Sept 2019

11.2 Below is a **provisional list** of which topics will be considered at each meeting, and who we will ask to contribute.

N.B. These are NOT CONFIRMED and subject to change depending on availability of individuals.

7 Jan 2019 *(note 2 other items on agenda)*	
Stakeholder and topic	*Responsible Officer/Partner*
Agree Terms of Reference	Scrutiny Officer
Case study: Overview of **GP at Hand's** impact across London and lessons to be learned.	Paul Bate, Director of NHS Services, Babylon Health
East London Health and Care Partnership (STP) – **Commissioner's view**	Jane Lindo **TBC** Primary Care Programme Director NEL STP Primary Care Transformation Team
City and Hackney CCG's **– Commissioner's view**	Richard Bull, Programme Director – Primary Care, City and Hackney CCG Dr Mark Rickets, Chair, City & Hackney CCG
City & Hackney GP Confederation's **local pilot on digital primary care**	Laura Sharpe, Chief Exec, GP Confederation Peter Shields, GP Confederation
Experience of local commissioner of 'GP at Hand'. Destabilisation of existing model, impact on A&E etc	Deborah Parkin, Hammersmith and Fulham CCG Primary Care Board **TBC**
4 Feb 2019 *(note 2 other items on agenda)*	
Stakeholder and topic	*Responsible Officer/Partner* **All TBC**
Local Medical Committees and Healthwatches responses to 'GP at Hand' and similar in Hackney and Tower Hamlets	Dr Fiona Sanders, Chair of City & Hackney LMC Dr Jackie Applebee, Chair of Tower Hamlets LMC **TBC** Jon Williams, Healthwatch Hackney and/or Tower Hamlets
Use of **eConsult** app in GP Practices	Rep of The Hurley Group/ Allerton Rd surgery **TBC**
Update in Integrated Commissioning's **IT Enabler Group** and implications for primary care	Tracey Fletcher and Niall Canavan, City and Hackney Integrated Commissioning's IT Enabler Group (Tracey also CE of HUHFT)
NHSE London TBC	TBC
12 Mar 2019 *(note 3 other items on agenda)*	

Stakeholder and topic	*Responsible Officer/Partner* **All TBC**
Virtual out-patients clinic at Barts Health – Health Foundation pilot project OR VIA SITE EARLIER VISIT	Dr Sir Sam Everington (Chair of Tower Hamlets CCG, Project Team member) **TBC** Project Manager, Barts Health
Virtual outpatient clinics in Hackney (experience from the renal clinic)	Siobhan Harper, City and Hackney Integrated Commissioning Workstream Director
TBC	TBC
8 April 2019 *(note 2 other items on agenda)*	
Draft Recommendations Discussion	Members
X June 2019 date tbc	
To agree final report. *Commission does not meet in May.*	Scrutiny Officer

11.3 In addition, Members will look at benchmarking data and make **Site Visits** to:

- Observing new innovations being used in a Hackney GP surgeries
- Observing the Virtual Consultations system at Barts Health
- Bromley by Bow Centre OR OTHER (Tower Hamlets CCG) pilot on video consultations and use of Apps or similar **TBC**
- Others TBC

11.4 Members will also **observe** and or attend the following:

TBC

12. Background papers/websites

12.1 The following will be consulted as background reading for the review. The list is not exhaustive.

National:

https://www.gpathand.nhs.uk/
http://www.pulsetoday.co.uk/news/gp-topics/it/the-online-providers-disrupting-the-market/20037376.article
https://www.bartshealth.nhs.uk/virtual-consultations
https://www.bbbc.org.uk/health-centres/health-touch

NHSEL Consultation on Digital First Primary Care July 2018
NHSEL Five Year Forward View

RCGP Patient Online Getting Started Checklist
http://www.rcgp.org.uk/clinical-and-research/our-programmes/patient-online.aspx

file:///C:/Users/joconnell/Downloads/RCGP%20Patient%20Online%20Getting%20Started%20Checklist%20v02%20%20interim.pdf

More to be added

Local:
City and Hackney CCG Primary Care Committee documents on..

Draft Hackney Health and Wellbeing Strategy 2015-18
City and Hackney Health and Wellbeing Profile: Our Joint Strategic Needs Assessment, 2016 update. Hackney Council and City of London
More to be added

13. Executive Links and Response

13.1 The following corporate stakeholders within the Council have been consulted on this Terms of Reference:

Contributor	How have they been consulted on proposal
CCG/GP Confed and Council lead officers	David Maher/Laura Sharpe/Anne Canning
Cabinet Member	Cllr Feryal Demirci Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks

Contact
Jarlath O'Connell, Overview and Scrutiny Officer
Telephone: 020 8356 3309
E-mail:jarlath.oconnell@hackney.gov.uk

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Health in Hackney Scrutiny Commission 7th January 2019 **Review on 'Digital first primary care and its implications for GP Practices' - EVIDENCE SESSION 1**	Item No **6**

OUTLINE

For this first evidence session for its review the Commission has invited the following:

Invitee	*Organisation*	*Topic*
Paul Bate, Director of NHS Services	Babylon Health	Provider of the 'GP at Hand' digital primary care service
Richard Bull Prog. Dir,, Primary Care **Dr Mark Rickets**, Chair	City & Hackney Clinical Commissioning Group	A local commissioner's perspective
Laura Sharpe Chief Exec **Peter Shields**	City & Hackney GP Confederation	Local pilots on digital primary care
Deborah Parkin TBC Dir of Primary Care	Hammersmith & Fulham CCG	The commissioner of GP at Hand's base service.

Attached please find:

1) **Presentation from GP at Hand 'Progress to date'**
2) **Presentation from GP at Hand 'Variation on NHS payments per patient'**

TO FOLLOW

3) **Briefing from City and Hackney GP Confederation**
4) **Briefing from East London Health and Care Partnership Primary Care Programme Director**

ACTION

The Commission is requested to give consideration to the briefings and the discussion.

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GP at hand
Progress to date

November 2018

Executive summary

What is GP at hand?

- The leading digital-first NHS GP practice, powered by Babylon technology
- Over 35,000 registered members, with over 1,000 joining each week
- Digital-first approach significantly improves the value to people using the service, as well as to the NHS

What makes it a high-quality service?

- GP at hand brings together Babylon's artificial intelligence and clinical expertise to provide a service that is safe, clinically effective and highly accessible – 24/7/365
- Unlike traditional general practice, the default is to cater for each individual's needs digitally, with in-person consultations only where necessary

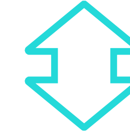
How does Babylon's technology work?

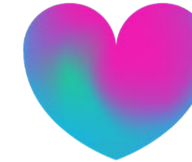
- Babylon's AI provides a safe, accurate and immediate symptom checking service, alongside a full AI Healthcheck to predict future disease risk and coaching to stay as healthy as possible
- The GP portal streamlines consultations and reduces clinician paperwork – allowing them to focus on patient care

GP at hand is the leading digital-first NHS primary care service

- NHS GP appointments available on phone within 2 hours, 24/7 – free at the point of need
- Members switch to GP at hand, automatically de-registering from their existing practice
- Payment follows the patient, largely based on age/sex adjusted capitation
- GP at hand holds a GMS contract with the NHS, and has a technology partnership with Babylon

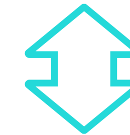
Commissioners





babylon
GP at hand

NHS GP Partnership



babylon

Provides technology and clinical services

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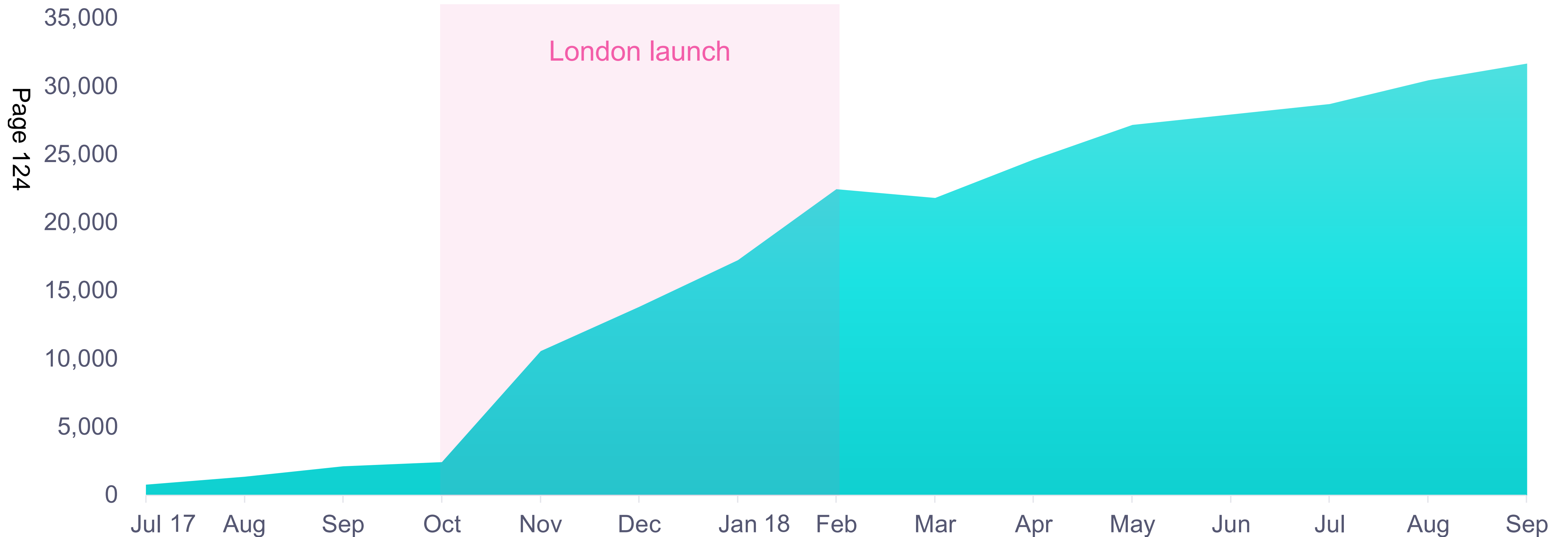
GP at hand now has more than 35,000 registered members and continues to grow quickly



Page 124

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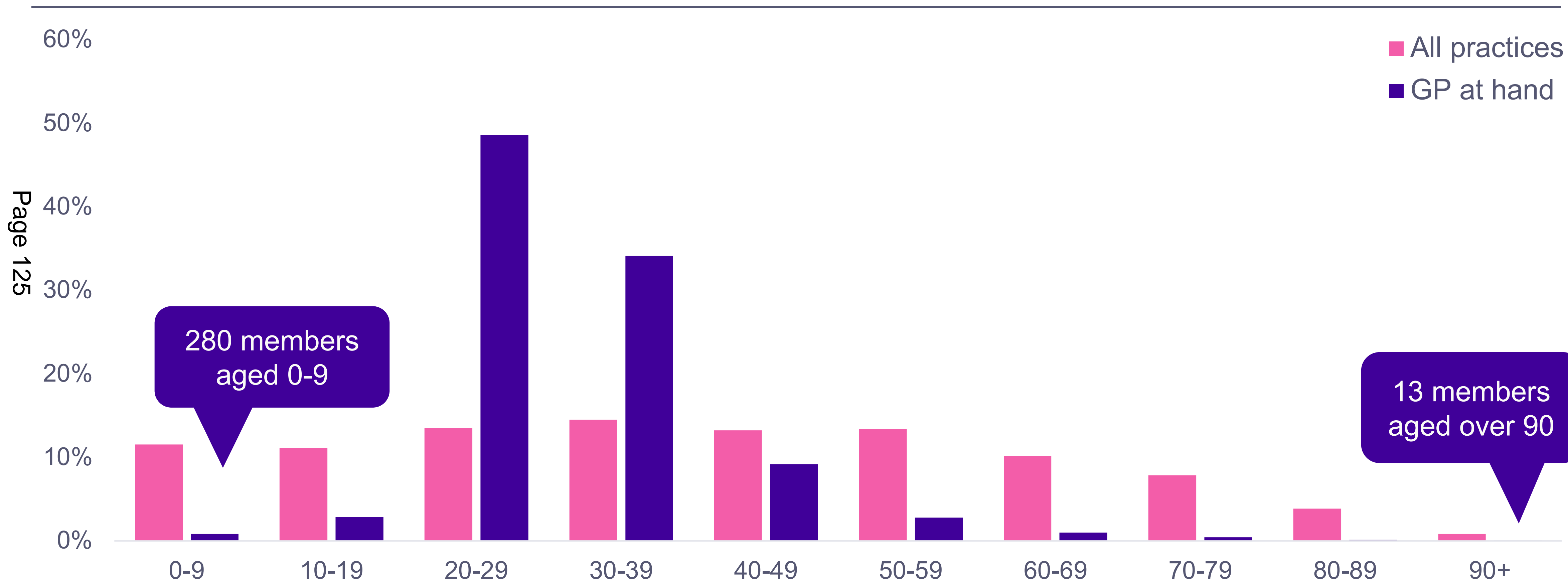
GP at hand is available to people of all ages, currently most popular with people aged 20–40



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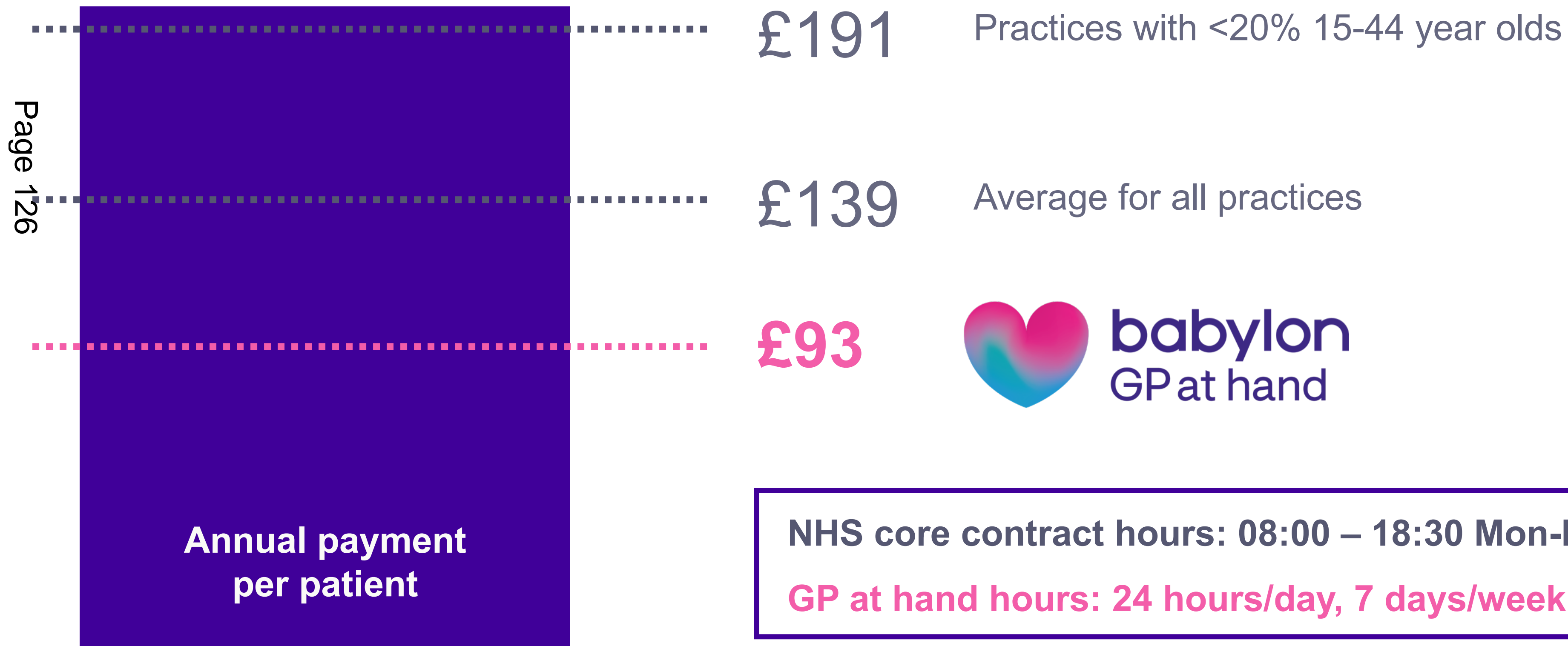
Age/sex capitation means Babylon GP at hand receives 33% less funding per member than average practices, while offering >3x the contracted hours



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Safe: Well-trained clinical teams, technology, and an open and empowered culture

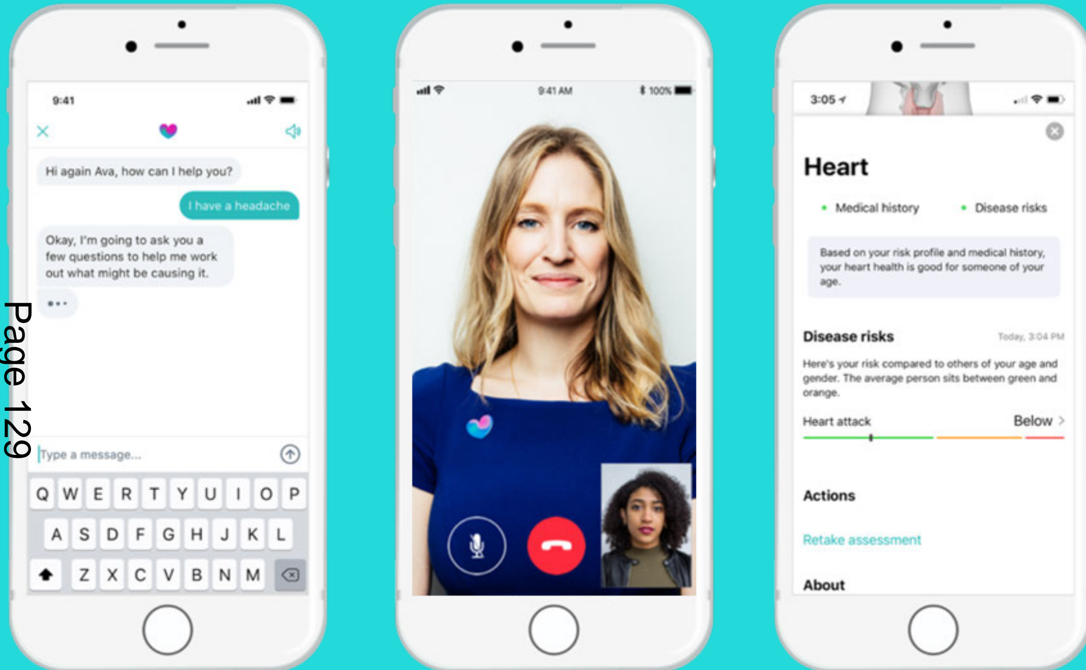
- **Well-trained:** GPs undergo specialist training in virtual consultation, with ongoing peer-review of consultations
- **Technology-assisted:** Verbatim recordings support ongoing clinical audit, and workflow tools to standardise pathways and proactively alert where follow-up needed
- **Transparent:** Members and clinicians able to review every chatbot and virtual consultation in full – no "he said, she said" debates
- **Empowered:** Safety-first environment in which clinical teams are encouraged to raise concerns

Safe: Multi-disciplinary teams coordinate care for the most complex members

- Our dedicated, multi-disciplinary teams provide inter-consultation continuity and care coordination for people with complex needs
- Led by a medically qualified full-time Complex Care Coordinator, plus 4 GPs, a nurse, and admin support staff
- Currently >50 patients managed by this team, with patients being identified by GPs, notes summarisers, and patients themselves

Case study 1: Complex mental health
Mr M is a 39 year old man with bipolar disorder and borderline personality disorder, who registered with GP at hand in 2017. His care had previously been compromised as he was unable to leave the house due to anxiety, and subsequently was lost to follow-up by local mental health services for failing to attend appointments. Our care coordinator is able to liaise frequently with local teams and is facilitating a domiciliary assessment by his local CMHT.

Case study 2: Drug dependence
Mr Z is a 40 year old man with a history of opioid dependence. He is under the care of his local addiction team and using buprenorphine maintenance therapy. When he registered with GP at hand in Jan 2018, he had also begun misusing clonazepam, obtained illicitly. Our teams have worked with his addiction team to agree a benzodiazepine reduction plan and continuation of his buprenorphine therapy.



Page 129

Effective: Full suite of Babylon technology supports clinical teams to provide consistent, high quality care

- **AI Triage and Symptom Checker**
  Asks questions and interprets symptoms via a chatbot interface to recommend the most appropriate service
- **GP Consultations**
  Video appointments – fast and convenient with full ability to diagnose, prescribe and refer for NHS tests or specialist care. In-person consultations available at clinics across London
- **Health Assessment**
  Accurately assesses a person's current health and predicts future risk for 20 of the most common diseases

Hi Alex, how can I help?

I've got a really bad headache and I don't know what to do...

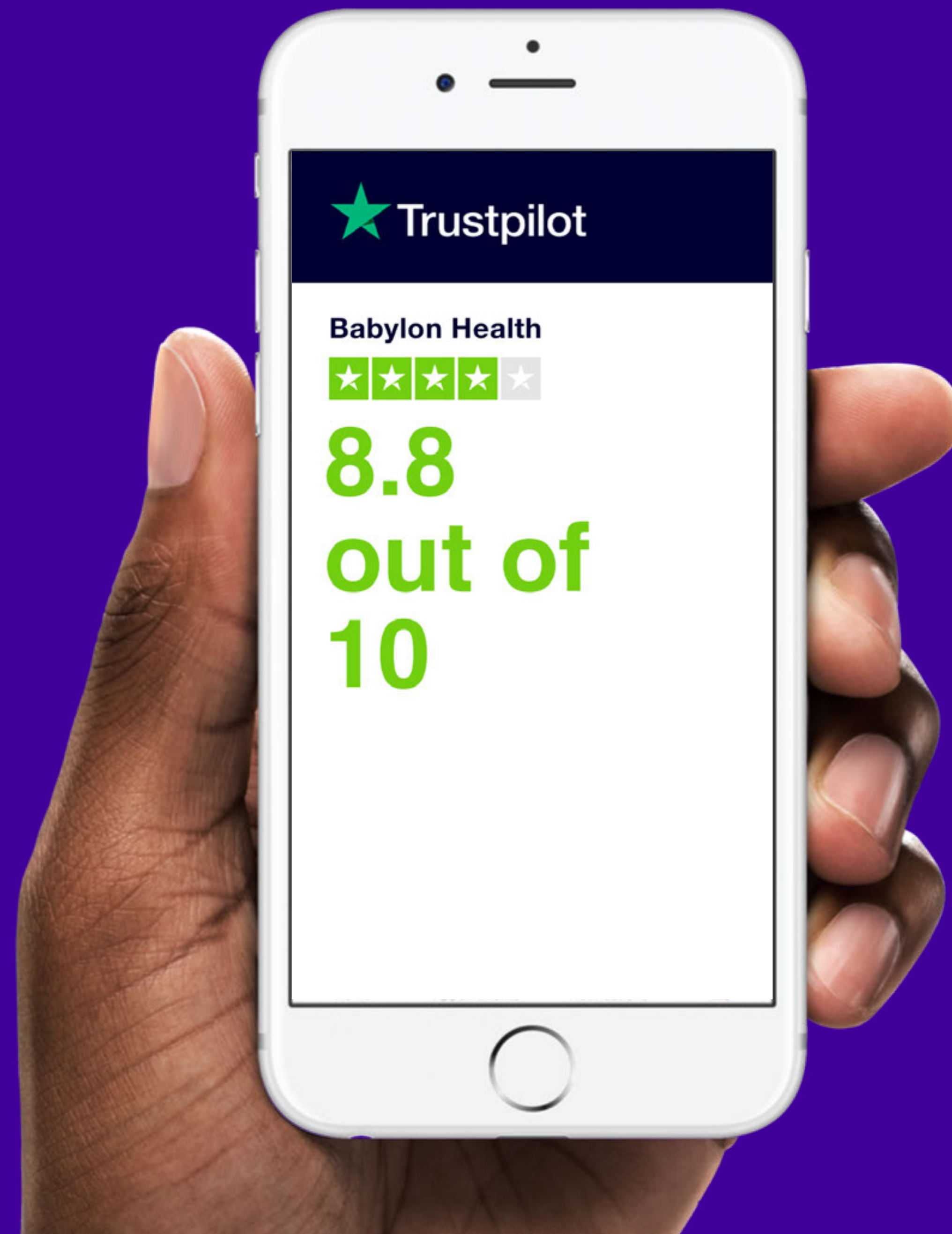
No problem, let me ask you a few questions

Effective: Digital-first approach significantly reduces the cost to serve

- AI triage reduces unnecessary consultations
- Operating at scale increases clinical and support team productivity
- Healthcheck feature encourages healthy behaviours to improve long-term health
- Continuous development of technology e.g., automated, coded note-taking through natural language processing

Caring: Feedback is extremely positive, and acted on quickly to improve the service

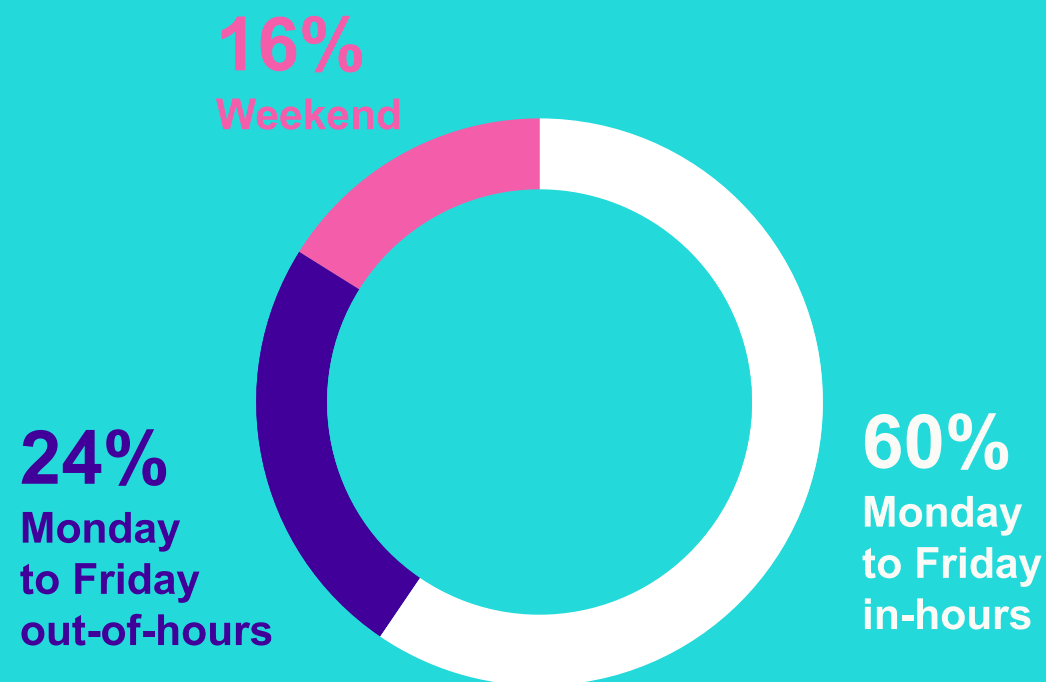
- Regular, comprehensive feedback after every interaction enables us to continually improve the service
- 95% of Babylon appointments are rated as 4 or 5 stars out of 5
- Independently validated feedback from Trustpilot



Responsive: The service is highly accessible as well as inclusive

- **Quick access:** GP appointments are usually available within 2 hours
- **Exceptional availability:** The service is available 24 hours a day, 365 days a year
- **Accessible for all:** A recent equalities assessment concluded that GP at hand better addresses GP access barriers for groups with protected characteristics than traditional practices

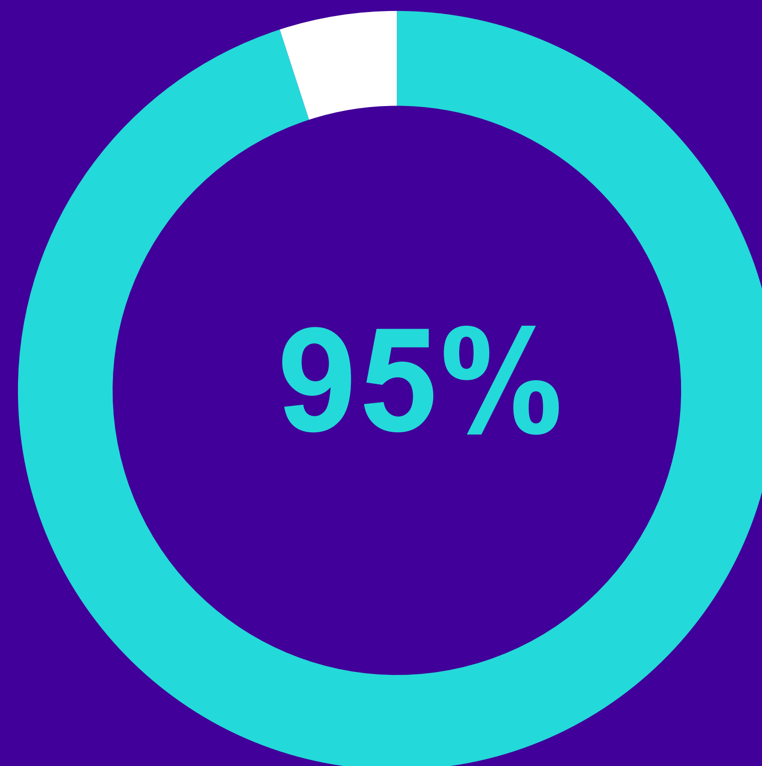
40% of virtual consultations are conducted outside of traditional opening hours

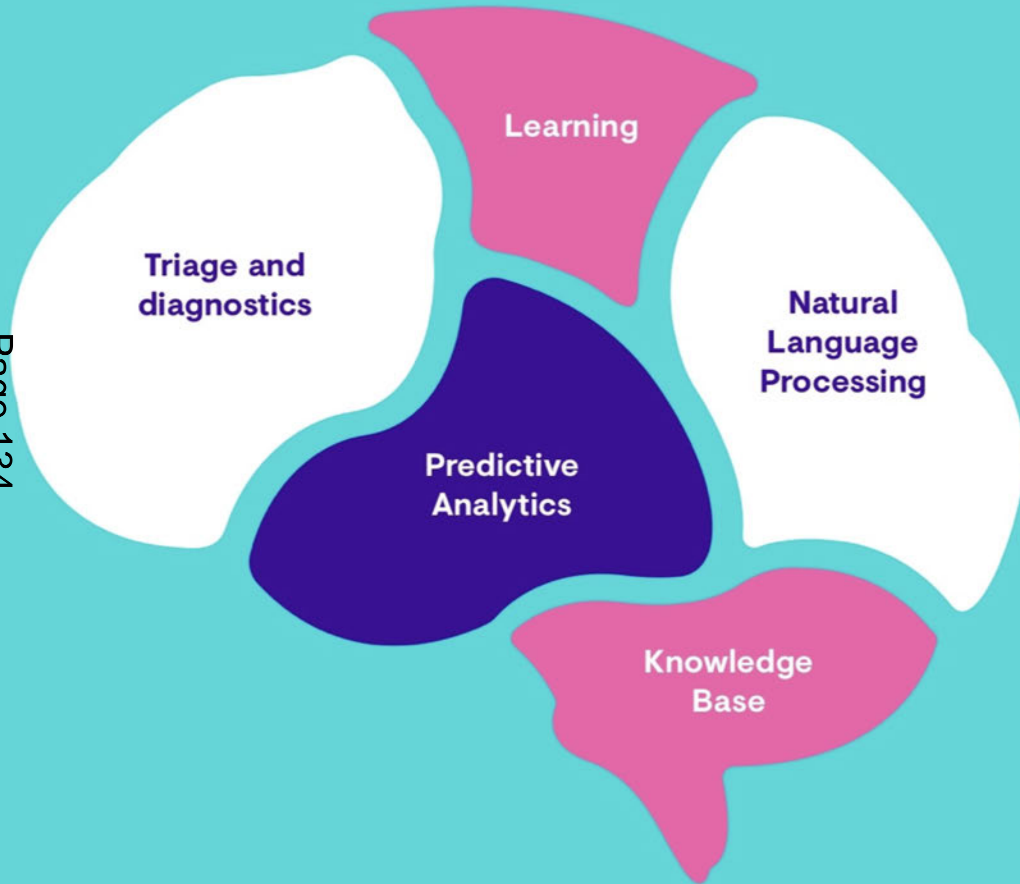


Well-led: Our doctors report much greater ability to manage workloads than other NHS GPs

- **Manageable workload:**
  - 95% of Babylon doctors say that they can manage the amount of work well
  - Compared with a BMA survey that showed that 84% of NHS GPs reported “unmanageable” or “excessive” workloads
- **Clear ambition:** Our >200 doctors and clinical support staff are united behind a common ambition to provide safe, effective, digital-first healthcare to the NHS

“Usually, I can manage my amount of work well”





Babylon provides AI that is built to mimic a doctor’s brain.

It has software equivalent to 10 years of medical training, and decades of practical experience, all accessible in seconds

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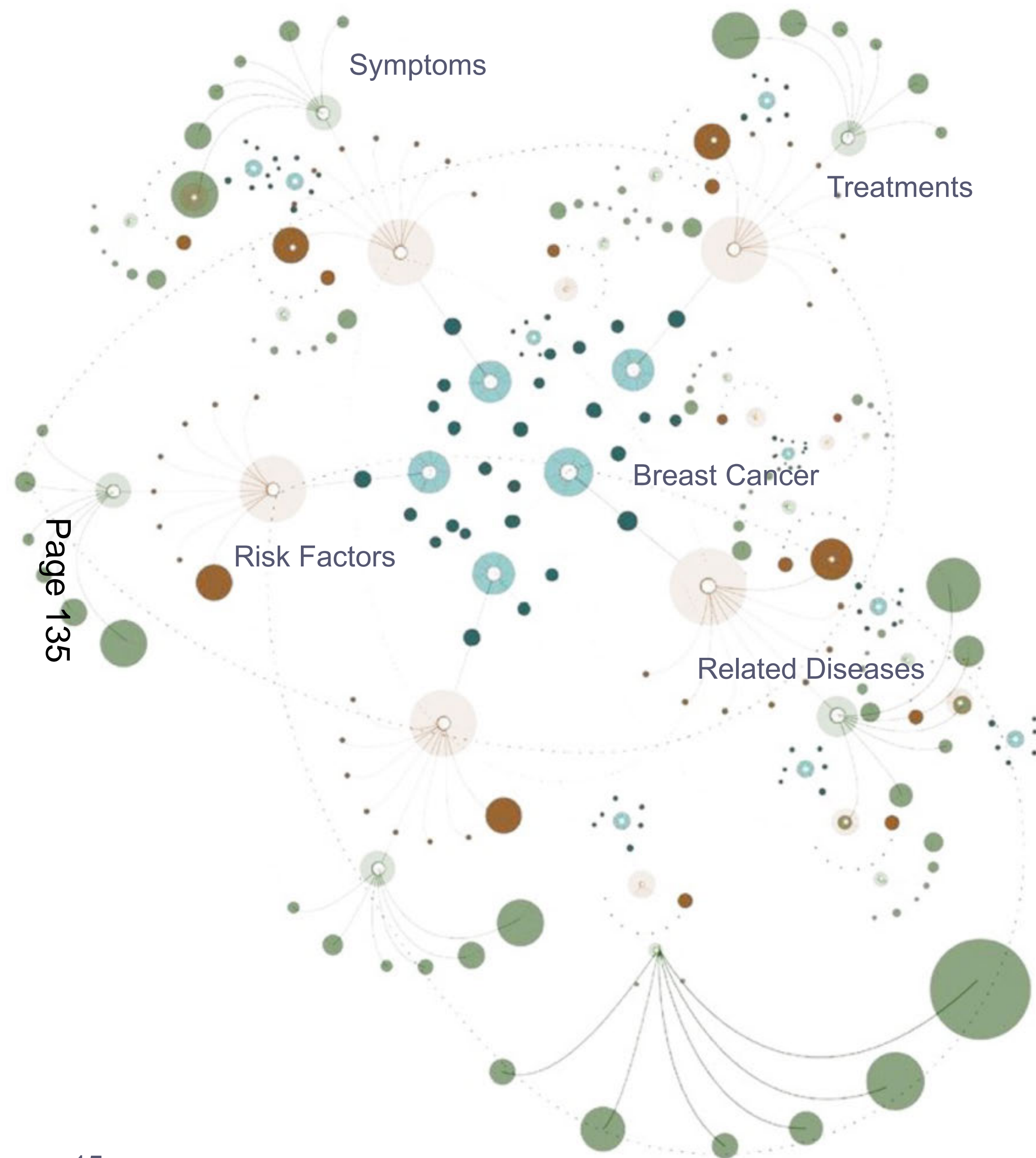


Page 135

One of the world's largest machine readable medical knowledge bases

- The foundation of the Babylon brain is the vast pool of knowledge in our knowledge graph, drawn from multiple sources and continuously updated
- Built through advances in semantic web, knowledge representation, NLP and deep learning technologies, it empowers the rest of our AI platform to deliver accurate medical decisions
- Our medical knowledge base, encompassing 530+ million medical facts which continues to evolve

Precise medical natural language processing

- Babylon has built from the ground up natural language understanding and natural language generation capabilities, unparalleled in the healthcare domain
- Babylon NLU and NLG services are based on a unique combination of traditional linguistic and the more modern statistical/deep learning methods
- They are significantly faster, and more accurate than existing best-of-breed systems

Made with

SYMPTOMS

I have pain: *yes*

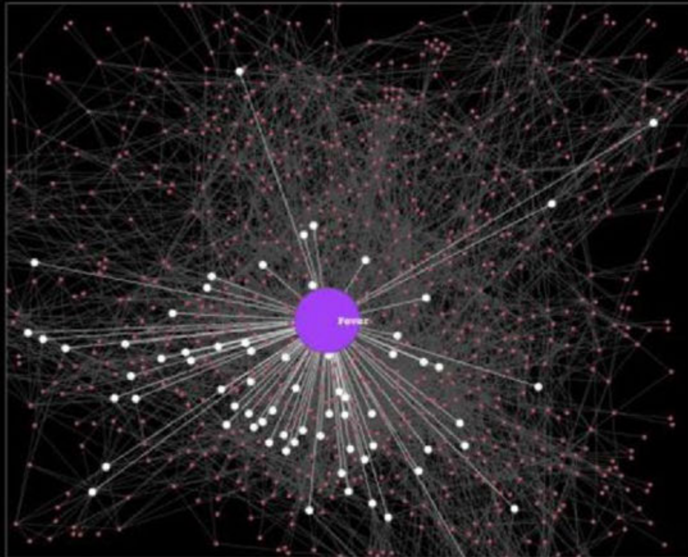
My pain is severe; it's the worst pain I have ever had: *yes*

I feel sick, like I may vomit: *yes*

~~I have vomited~~: *no*

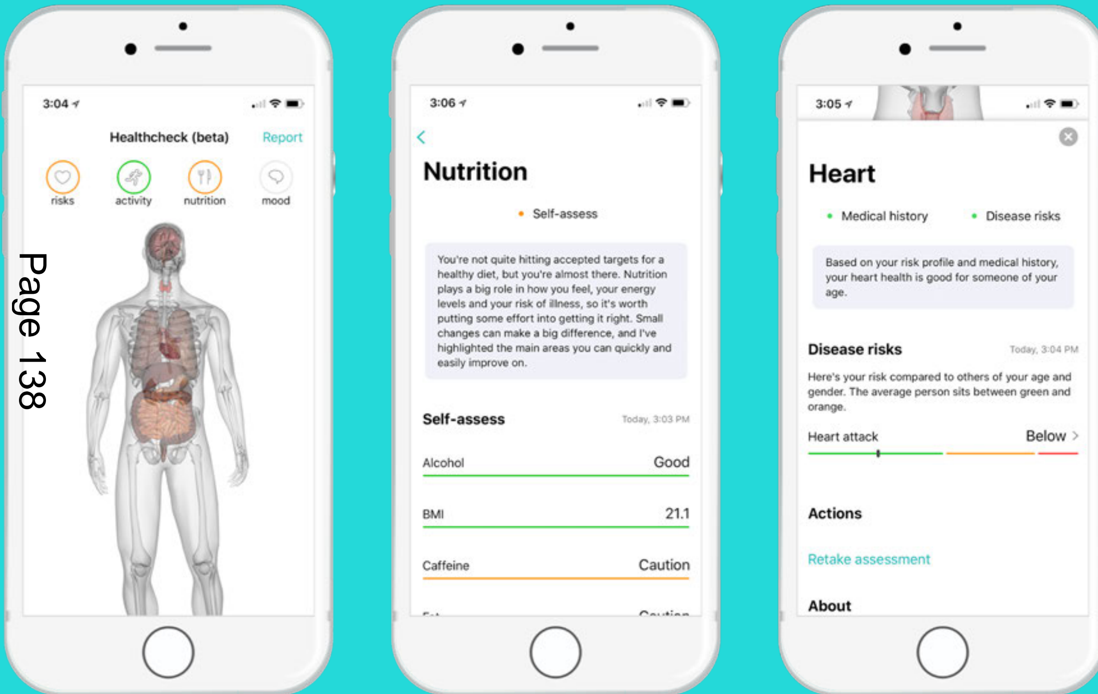
I have a temperature: *Not sure*

GRAPH



One of the world's largest probabilistic inference models

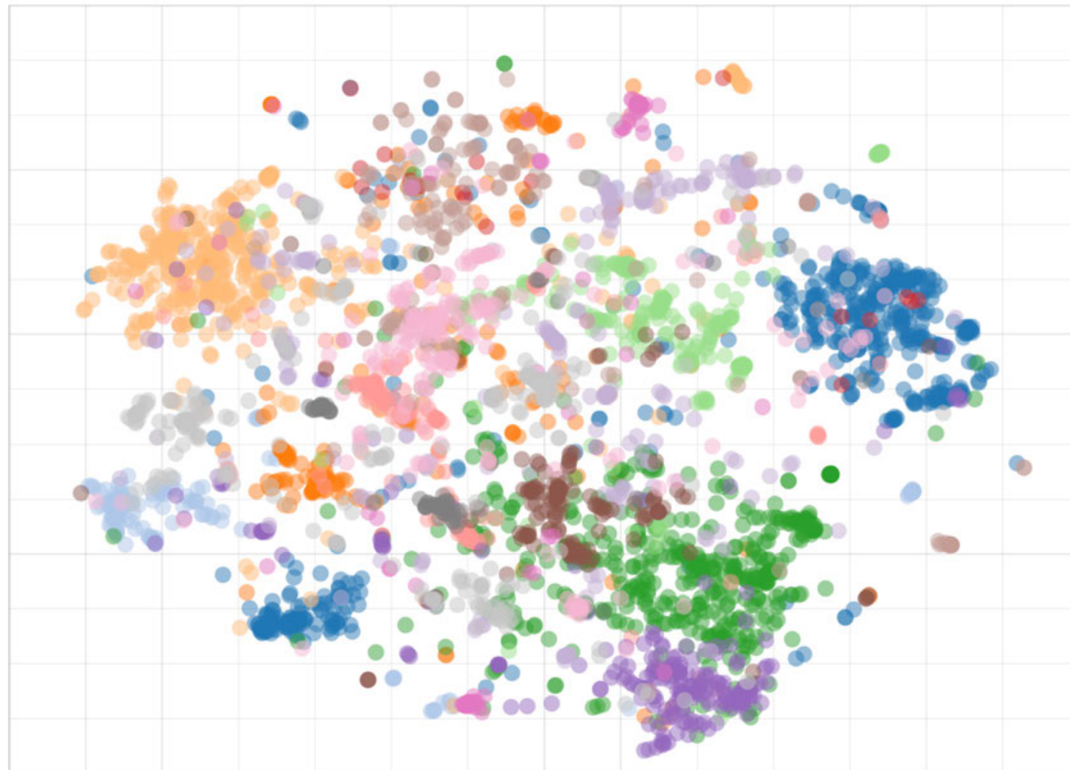
- Our probabilistic inference model can triage and diagnose patients based on personalised knowledge of diseases, symptoms and risk factors
- This technology forms the basis of our triage system used by the UK NHS in a population of 2mn, in what we believe to be the largest deployment of AI in medicine worldwide
- The AI brain can already diagnose the most common conditions in primary care and will soon be available publicly as a powerful aid to consumers and professionals alike

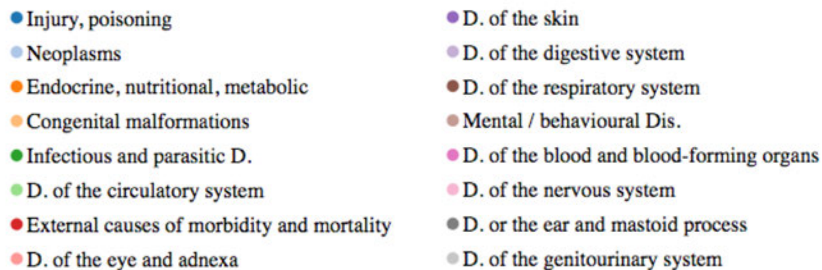


Page 138

Predictive analytics

- In addition to diagnosis, doctors learn to make a prognosis. Similarly, the Babylon brain learns to predict a patient's individual disease risk based on the data in our knowledge base, in combination with their medical history, lifestyle data, test results and genetic profile
- In the case of cardiovascular disease, our predictive engine has demonstrated over 90% accuracy when tested against the longitudinal records of over 60,000 patients
- This forecasting capability allows for early intervention, preventing disease progression well in advance of the need for treatment





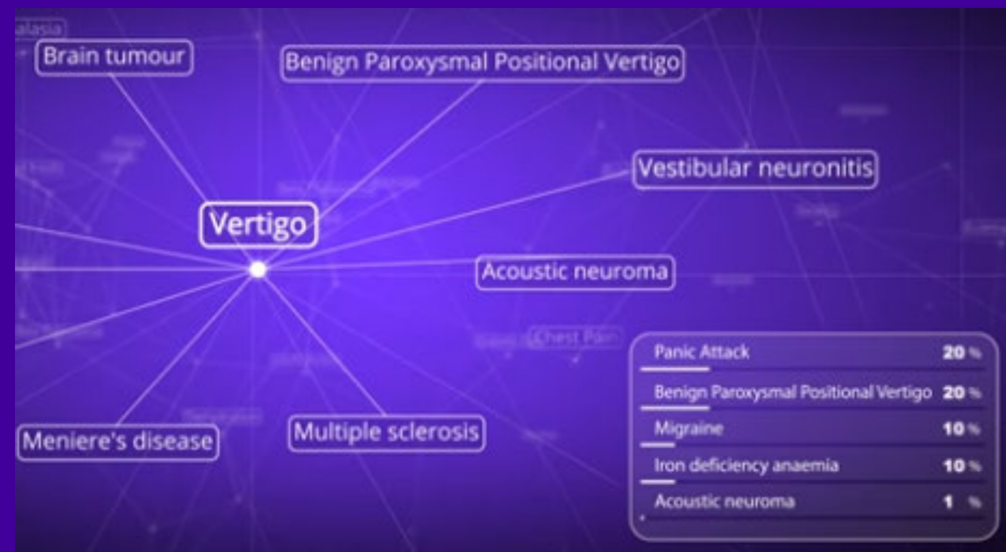
Page 139

Sophisticated deep learning capabilities

- We use deep machine learning to train our AI, just like doctors learn through experience and recognise when a new case is similar to previous cases that they have encountered
- We use deep-learning techniques to capture a doctor’s intuition and improve our models, based on data from our knowledge base and anonymised patient encounters
- Our GPU-based, cloud-based learning and inference platform allows us to process vast volumes of data to ensure our conclusions are clinically valid

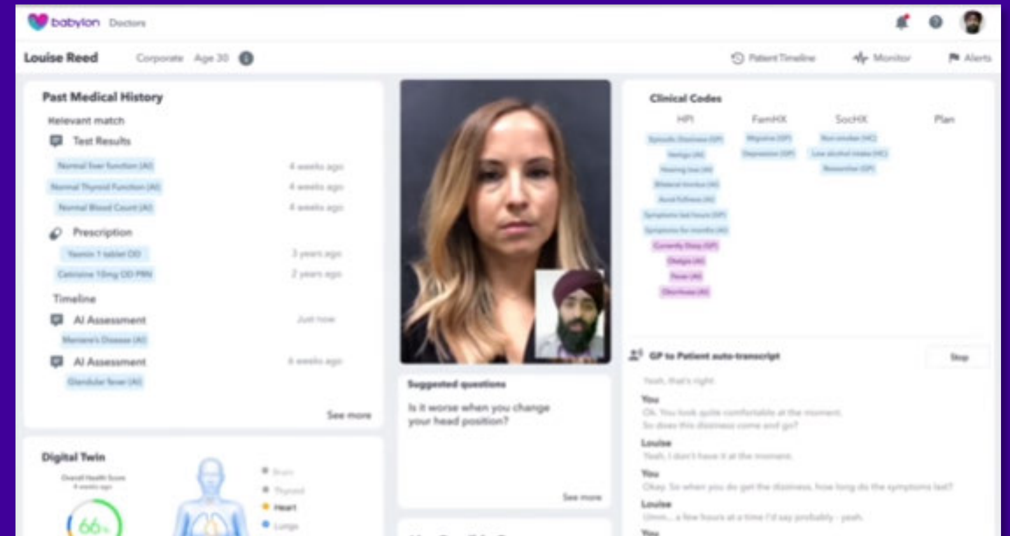
Babylon provides technology to improve the experience for members…

- Users can easily check their symptoms in our AI chatbot
- Our Probabilistic Graphical Model (PGM) is built from over 500M medical facts
- Click here to see it in action



…and streamlines consultations for clinicians

- Clinicians can see the outcome of the AI symptom checking in-consultation
- Voice interface removes the need for typing during consultation
- Click here to see it in action



Through our operations in Rwanda, as well as the NHS, we have clear evidence demonstrating the benefits of digital-first care

Page 142

We are the sole provider of digital health in Rwanda

15%

Of adults in Rwanda have registered with Babylon

153%

Growth in Rwandan users in the last 12 months

2,000

Patients a day

NHS
Providing NHS services

Get well ~~soon~~ now

Page 143

Free NHS GP appointments in minutes on mobile 24/7, and at our clinics in London*

Download the Babylon app

*To register you will need to switch from your current GP practice. A registration period will apply before you are able to access the service. Available for people living or working within 40 minutes of one of our clinic locations. Download app or see website for details.

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How does primary care funding vary per patient?

April 2018

“Two practices with the same count of registered patients may have very different populations with very different needs; this is partially reflected in the weighted patient numbers. These practices, while apparently similar in terms of list size, may thus receive very different levels of funding.”

- NHS Digital

Source: [NHS Payment to General Practice – England, 2016/17]

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NHS Digital published data
has been analysed to show the extent of the variation

Two NHS Digital data sets were combined:

1. Payments data at practice level: NHS Payments to General Practice, England, 2016/17

2. Age structure data at practice level: Numbers of Patients Registered at a GP Practice (practice level, 5 year age groups)

GMS practices were selected (as Global Sum payments are not available for PMS and APMS practices) – total of 5,301 practices, and £5.4bn of expenditure. For comparison the total 2016/17 NHS payments to General Practices was £8.1bn

Data was cleaned to only include practices where the Global Sum per patient was over £0 and up to £300 (removes 3% of practices) – which leaves a total of 5,134 practices in our analysis, and £5.3bn spend

Payment per registered patient was calculated for each practice, and each practice allocated to an age band according to the percentage of 15-44 year olds on the registered list. As this involves combining data from the two listed datasets, an additional 220 GP practices that cannot be matched between datasets were excluded from the analysis, leaving a total of 4,914 (total spend remains at £5.3bn).

An average payment per patient for all practices within each age band was then constructed through summing the average payments per patient at each practice in the age band and dividing by the number of practices in the age band.

Total payment per registered patient uses the data set for "Total NHS payments to General Practice minus deductions (for Pensions, Levies and Prescription Charge Income)."

QOF and Global Sum payments are taken directly from the NHS Digital payments data fields for these items

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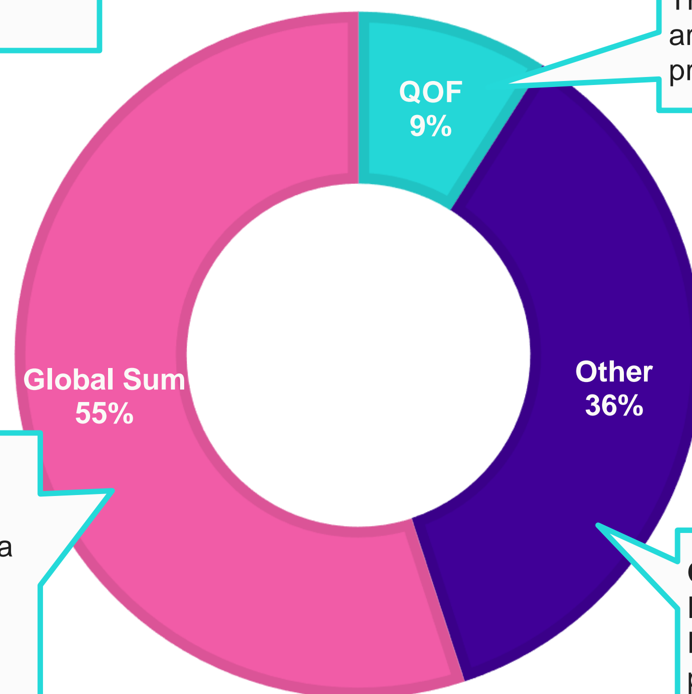
Practice payments have several components, so variation is considered for total payment and individual elements

£5.3bn total payment to GMS practices (analysed on slide 5)
Combination of all the payments made to GMS practices, after cleaning the dataset as set out on slide 3.

Page 148



Quality and Outcomes Framework (analysed on slide 7)
The objective of the QOF is to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients.

Global sum (analysed on slide 6)
The main payment to practices - based upon each practice's registered patient list, adjusted according to the Carr-Hill Formula to produce a "weighted patient list" for payment. The weighted patient list takes into consideration the age and sex of the patients, as well as any in nursing or residential care, additional patient need due to medical conditions, patient turnover and unavoidable costs based upon rurality and staff market forces for the area.

Other elements of payment (not analysed here)
Includes National and Local Enhanced Schemes, Minimum Practice Income Guarantee, Seniority payments and prescribing payments

Source: NHS Payments to General Practice 2016/17 provides data for 5,134 GP Practices meeting the criteria set out on slide 3, with a "Total NHS spend minus deductions" of £5.3bn

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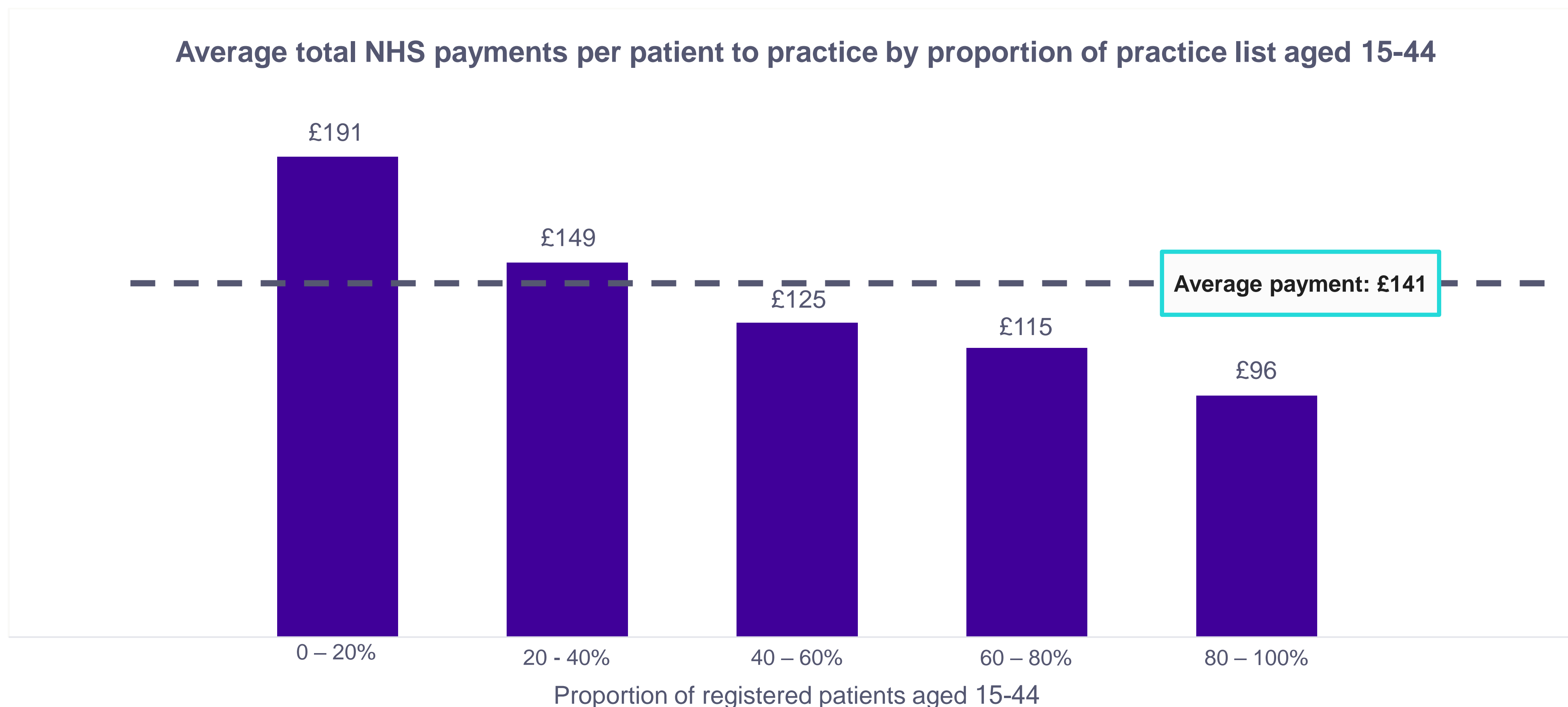
Practices with a low proportion of 15-44 year olds get twice the funding per patient as those with mostly younger patients



Source: "Total NHS payments minus deductions" field in NHS Payments to General Practice, England, 2016/17. Proportion of patients aged 15-44 taken from Numbers of Patients Registered at a GP Practice (practice level, 5 year age groups). The 15-44 year old age band was selected to reflect the age bands used in the Carr-Hill formula (see slide 8)

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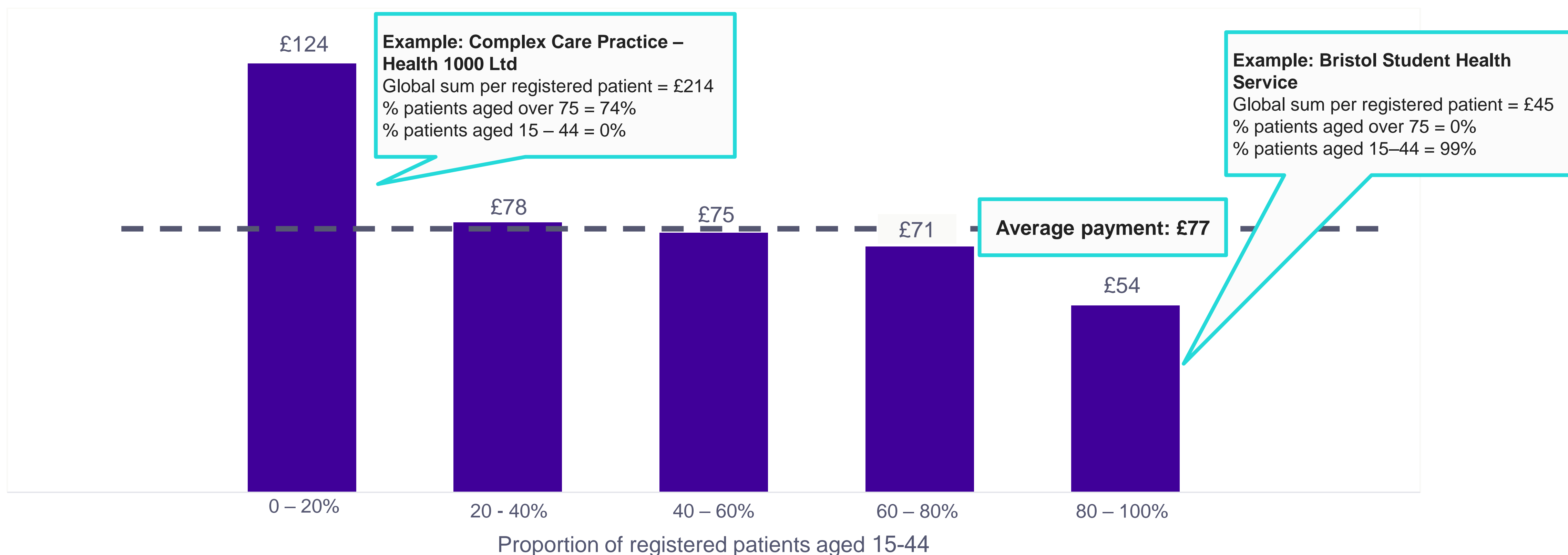
The variation in payment per patient is seen in the "capitated" (Global Sum) component of practice funding…



Source: "GlobalSum_£" field in NHS Payments to General Practice, England, 2016/17. Proportion of patients aged 15-44 taken from Numbers of Patients Registered at a GP Practice (practice level, 5 year age groups). The 15-44 year old age band was selected to reflect the age bands used in the Carr-Hill formula (see slide 8)

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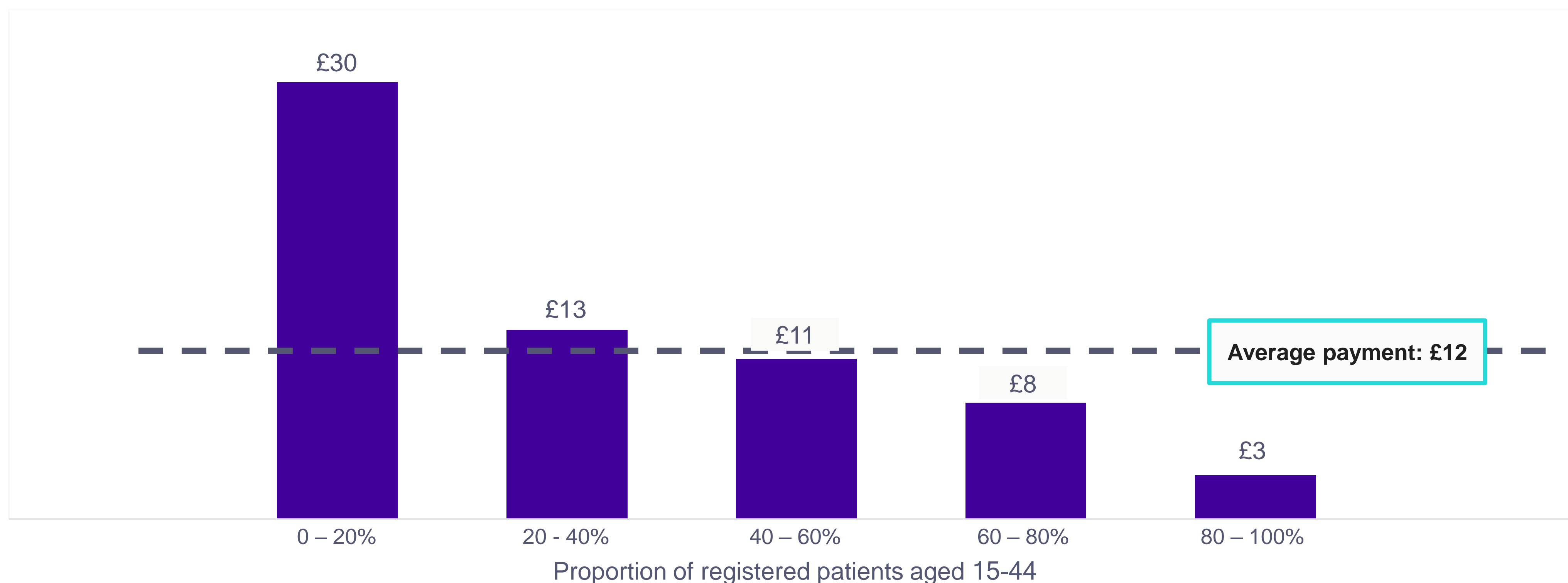
… and in non-capitated elements of funding like QOF



Note: “QOF” = Quality and Outcomes Framework
Source: “TotalQOFPayments_£” field in NHS Payments to General Practice, England, 2016/17. Proportion of patients aged 15-44 taken from Numbers of Patients Registered at a GP Practice (practice level, 5 year age groups). The 15-44 year old age band was selected to reflect the age bands used in the Carr-Hill formula (see slide 8)

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The main reason for the variation is that payment is deliberately linked to resource utilisation: The Carr-Hill formula includes a 6-fold variation in global sum funding for patients of different ages and sexes

Carr-Hill weightings*							
	0-4	**5-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**
Male	3.97	1	1.02	2.15	4.19	5.81	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

Convert to Global Sum using national population in each age-sex group, combined with national average payment of £83.64**

>6x difference

Global Sum payment per patient							
	0-4	**5-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**
Male	£ 126	£ 32	£ 32	£ 68	£ 133	£ 184	£ 199
Female	£ 115	£ 33	£ 69	£ 106	£ 155	£ 208	£ 213

* From: Table 3, NHS Employers "Carr-Hill resource allocation formula" document
** From: Annex B, "NHS England Letter: GMS Contract Changes 2018/19"

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Get in touch:

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Health in Hackney Scrutiny Commission

Meeting on Mon 7 January 2019

ADDITIONAL PAPERS

Item 6 – Review on 'Digital first primary care and its implications for GP Practices"

No.	***Title***	***Author***
1	Digital Solutions in City and Hackney Primary Care	City and Hackney GP Confederation
2	Primary Care Digital Access across NEL	East London Health and Care Partnership
3	Evaluation of GP at Hand – Progress Report	Ipsos MORI and York Health Economics Consortium and Prof Chris Salisbury for Hammersmith and Fulham CCG and NHS England
4.	Briefing from City and Hackney CCG	Richard Bull, C&H CCG

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Health in Hackney Scrutiny Commission

Review on "Digital Primary Care and its implications for GP Practices"

CCG briefing 4th Jan 2019

Primary care in City and Hackney

- There are 41 practices in LBH and 1 practice in CoL; the average list is 7681 patients; the average number of fill-time equivalent GPs per practice is 4.5
- Primary care in C&H is productive – with circa 1.6 million consultations p.a.; the ratio of face to face to phone consultations is 4:1 (with a shift towards more phone consultations over time); 70% of consultations are with a GP
- Primary care in C&H is high quality – practices perform well on quality measures e.g. local quality dashboard and the national quality and outcomes framework (QOF) (the CCG is ranked 1st or 2nd out of 194 CCGs in England in 42% of the QOF clinical attainment measures such as control of blood pressure, cholesterol, lung disease and asthma); C&H practices also perform well (relative to London) on measures of patient satisfaction
- Primary care in C&H is efficient – C&H has the lowest referral rate for a first outpatient appointment in London which means that local practices are (safely) managing patients when other practices might refer; this helps keeps the local health economy in financial balance
- Primary care in C&H is value for money – at about £35 for a face to face appointment with a GP
- Primary care in C&H is accessible – half (51%) of C&H appointments take place on the same day of booking which is the highest proportion in London (London average 43%); 80% of all C&H appointments take place within a week of being booked, compared to 75% for the STP and 74% for London; all C&H practices have a Duty Doctor service; 37/42 of C&H practices offer appointments outside the core contract hours of 8-6.30 Mon-Fri (mostly evening appointments from 6.30-8); all practices can refer their patients to weekday evening and all day (8-8) weekend primary care hubs
- Practices in C&H collaborate with each other (work at scale) – all practices are part of the local GP Confederation and all practices are part of a neighbourhood
- The CCG invests in extra services from its practices, mostly through the GP Confederation, to the tune of £10.9m p.a.; lower levels of GP referred activity and unplanned admissions, relative to NEL CCGs, are forecast to benefit City & Hackney by £11.2m in 2018/19
- Practices in C&H are under similar pressures from increasing demand as practices in the rest of London and the country – this is largely due to a combination of the following factors
  - The shift of activity from hospitals (secondary care) to primary care
  - People living longer, with more long term conditions creating increasing complexity
  - Changing patient expectations
  - Additionally C&H patients have a higher consultation rate at 5 per year than the STP average of 4 per year

Demand management in primary care

There is a national general practice development programme with 10 key actions designed to free up "time for care" (i.e., help manage demand) - C&H CCG has a programmes in place for each action. This briefing focuses on no. 2 – new consultation types:

1. Active signposting
2. *New consultation types: Introduce new communication methods for some consultations, such as phone and email, improving continuity and convenience for the patient, and reducing clinical contact time*
3. Reduce Did Not Attend
4. Develop the team
5. Productive work flows
6. Personal productivity
7. Partnership working
8. Social prescribing
9. Support self care
10. Develop QI expertise

New consultation types

- The CCG made a successful bid to the national Estate and Technology Transformation Fund for £1.55m to do a large scale local trial of electronic consultations in 2018/19 and 2019/20. This is in addition to smaller sums of national monies allocated to CCGs to trial electronic consultations.
- The CCG Commissioned the local GP Confederation to run the trail working with all local practices.
- See the Confed's briefing for the detail (which includes other elements of the contract which all contribute towards demand management).
- The volume of local e-consultations is currently low; response times by individual practices is variable with scope for improvement.
- The new Secretary of State for Health and Social Care is making it is mission to transform primary care through digital means and it will be part of the 10-year NHS plan that all practices are to routinely offer digital consultations by 2023 to 2024.
- There is currently no local evidence that digital consultations do indeed help manage (reduce) demand; there is the possibility that they increase demand by opening up a new channel of access.

GP at Hand

Meanwhile GP at Hand has become a market leader on digital consultations with wider implications for the way that mainstream general practice is currently funded. Some suggested quality related key lines of inquiry for these type of services are:

- Use of consultant advice services to obviate the need for a referral - how is this achieved by clinicians working remotely for patients registered at Lillie Road? (C&H practices are supported to make full use of consultant advice services which contributes to its low referral rate).
- How is practice informed by locally agreed pathways of care? (C&H practices are supported to follow 50+ local care pathways).
- What is the practice's patient churn? How long do patients choose to stay registered with the service and what is the rate at which the service deregisters patients?
- What are the challenges to place-based commissioning from having a widely dispersed list? For any registered patient the commissioning budget goes to Hammersmith and Fulham CCG and the patient care budget goes to the Lillie Road Practice.
- What are the other impacts on the wider healthcare system?

Hammersmith and Fulham CCG (H&F) have requested all London CCGs make a financial contribution towards the secondary care costs associated with treating Lillie Road patients who register in-year (on the basis that H&F CCG is funded to treat these patients). C&H's share is currently £285k. This has been agreed at the London-level but is being widely challenged.

Appended is a paper produced by LBH's public health dept. giving an update on GP at Hand's Lillie Road Practice. At Oct 2017, 1523 Hackney residents were registered with Lillie Road.

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City & Hackney
GP Confederation
A community interest company

Digital Solutions in City and Hackney Primary Care – December 2018

As described in the paper submitted by Dr Mark Rickets and Richard Bull, City and Hackney GP Confederation has been commissioned by the CCG to explore a range of tools which might support practices to manage patient need more efficiently by using online/digital/phone systems. At present we are exploring with practices the following areas:

1 Online Consultation Platforms

1.1 eConsult Online Consultation Platform

eConsult is a web based patient triage platform, developed by the Hurley Group of doctors. Hackney has one practice run by this organisation – Allerton Road surgery. eConsult provides for a consistent online offering for practice websites (via GP Web Solutions), which allows them to retain their existing practice website address. Alternatively a practice can create a link to eConsult from their existing practice website. Patients use eConsult to ask for advice about their condition online.

1.1.1 A new, one year contract (1st August 2018 to 31st July 2019) has recently been signed for 13 practices, ten of which are renewals and three of which are new adopters of the platform.

- Cedar Practice
- Dalston*
- Elsdale Street
- Gadhvi*
- Latimer Health Centre
- Queensbridge Group Practice
- Richmond Practice
- Shoreditch Park Surgery*
- Somerford
- Sorsby Practice
- Spring Hill Practice
- Statham Grove Practice
- The Heron Practice
- The Hoxton Practice

*new practices added

1.1.2 Practices have mixed views about whether this actually helps them or patients. Some practices really rate this platform, others say that it is “clunky” and requires patients to input a lot of information about their need and so there is a high rate of patients abandoning the eConsult process. However, we are discovering that, like most things, the practice has to really own the concept and support it and patients in order to get the most out of it.

1.1.3 We aim to work with practices to drive up the use of eConsult. A meeting is booked with the account manager in January to plan a relaunch of the platform and to discuss increasing the quality of management data.

1.2 askmyGP

askmyGP is an online access and GP digital triage system created by a GP called Dr Harry Longman. askmyGP assesses patients when they initially contact their practice to make a GP appointment. The online algorithm is then read by the GP who can process the patient onto the appropriate health professional within the practice, such as a practice nurse or pharmacist, if not relevant for the GP. The GP will respond to the patient by phone or email (depending upon the patient's submitted preference) and, depending upon the presentation, can offer a consultation by telephone, video or face to face.

1.2.1 The following five practices in City and Hackney have signed up to the initial Pathfinder programme which helps practices to understand and reflect upon their demand, capacity, service and efficiency through the GP Navigator suite.

i. Spring Hill Practice
ii. Nightingale Practice
iii. Barton House Group Practice
iv. De Beauvoir Surgery
v. The Lawson Practice

Once completed, practices can then decide whether or not they wish to proceed and embark upon the Transform programme which provides access to the askmyGP online consultation platform. Thus far, only one practice has completed the Pathfinder programme. This is a fairly new initiative in Hackney so we will watch with interest.

2 Patient Partner

Patient Partner is software that integrates with a practice's existing telephone system and the EMIS appointment system, to enable patients to book, cancel or check an existing appointment via the telephone, 24/7, without speaking to the reception staff.

2.1 The following five GP practices in City and Hackney are currently offering Patient Partner:

i. Cranwich Road Surgery
ii. Hoxton Surgery
iii. Lawson Practice
iv. Lower Clapton Health Centre
v. Stamford Hill

The following eleven practices have placed an order for it to be installed:

i. Beechwood Medical Centre
ii. Clapton Surgery
iii. De Beauvoir Surgery
iv. Elm Practice
v. Gadhvi Practice
vi. Nightingale Practice
vii. Rosewood Practice
viii. Sorsby Health Centre

ix. Spring Hill Medical Centre
x. Well Street Surgery
xi. Wick Health Centre

The following seven practices have been visited by the supplier and provided quotes:

i. Abney House Medical Centre
ii. Allerton Road Surgery
iii. Cedar Practice
iv. Dalston Practice
v. Elsdale Street Surgery
vi. Heron Practice
vii. Southgate Rd MC & Whiston Rd Surgery

A further ten practices have arranged demo visits with the supplier:

i. Barretts Grove Surgery
ii. Greenhouse Health Centre
iii. Healy Medical Centre
iv. Lea Surgery
v. Neaman Practice
vi. Riverside Practice
vii. Shoreditch Park Surgery
viii. Somerford Grove Health Centre
ix. Statham Grove Surgery
x. Trowbridge Practice

Practices which have taken on Patient Partner are very keen on it – it helps patients who do not wish to access the practice via a computer/website/online route and is very easy to use.

3 Patient First

Patient First is an access/appointments system developed by one of our own C&H practices – by Richmond Road Medical Centre, winner of Practice of the Year in 2017 and GP of the Year (Highly Commended) in 2018 for Dr Gopal Mehta. It combines the use of digital initiatives, reception navigation and collaborative triaging and is the particular expertise of Dr Mehta.

3.1 Online Access

Through the use of patient online services, the model enables patients to arrange telephone appointments with a GP or member of the administrative team 24 hours in advance without having to call the surgery. On the day the telephone appointment has been booked, the patient receives a call-back within 15 minutes of their chosen time slot from the healthcare professional with whom they have pre-booked (GP/Pharmacist/Admin etc.) who will discuss the patient's health concern and manage their needs accordingly (i.e. offer face to face appointment/complete referral/order investigation etc.). If patients aren't able to access online services they can call the main surgery telephone number at 8am and ask to make a telephone appointment with the GP; who will then call the patient back within a 3 hour window.

3.2 Reception Navigation

Administrative teams are trained to screen all calls that have been booked online, ensure they have been booked for the appropriate healthcare professional, and re-navigate them if required. Administrative Teams are also trained to navigate the patients who call in to the surgery to ensure they are directed to the most appropriate healthcare professional/member of staff for their needs. As part of navigation, PatientFirst also incorporates non-clinical members of the team in delivery of QOF/long-term conditions outcomes (i.e. booking in the relevant health reviews if required) to ensure this process becomes a core element of initial navigation and every patient contact counts.

3.3 One Team

A large element of teaching and training during implementation of PatientFirst is focused on working with practices to create 'one team' – a team that work together and deliver together.

3.4 The following five practices in City and Hackney are now using Patient First:

i. Barton House Health Centre
ii. Lawson Practice
iii. Lower Clapton Health Centre
iv. Richmond Road Medical Centre
v. Springhill Practice

Three practices are in the process of implementing it:

I. Healy
II. Stamford Hill Group Practice
III. Queensbridge

A further seven have expressed an interest in it:

i. Athena Medical Centre
ii. Beechwood Medical Centre
iii. Hoxton Surgery
iv. Neaman Practice
v. Nightingale Practice
vi. Well Street Surgery

4 EMIS Online Triage

The GP Confederation have arranged for the provider to do a presentation and demonstration of EMIS Online Triage to a small group, in January 2019. This platform has reportedly improved significantly and therefore could be provide a third option for practices to choose from, in terms of online consultation platforms.

5 City and Hackney Health App/Director of Services

This piece of work began under the banner of "demand management" and was initially funded by the CCG, but this has now grown and is a central plan of our whole-system work around Neighbourhoods. Essentially, we aspire across the health, social care, voluntary etc system to have a single live Directory of Services and supporting app so that residents, patients and professionals all know what is available and where. This is at the very early

stages of development but might be something that Councillors would like to learn more about.

6 Evaluation

We now need to develop a model of evaluation of all of these initiatives. We are talking to the Clinical Effectiveness Group (part of the Department of Primary Care at Queen Mary) to see if they feel they can work with us on evaluation.

5. Conclusion

This short paper seeks to give an overview of what we are doing around Digital services in primary care at the moment. We would love to do more!

Laura Sharpe, Chief Executive Officer, City and Hackney GP Confederation
Peter Sheils, Programme Manager, City and Hackney GP Confederation

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East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

Primary Care Digital Across NEL

January 2019 Briefing For City and Hackney

Areas Covered

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

1. Enabling Online Consultations
2. Patient Access To Information – GP Online
3. Sharing Information
4. Discovery Project Linking Data-Sets To Improve Population Health

Enabling Online Consultations

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

1. Systems being put in place across all CCGs over the course of 2018-19 enabling patients to interact with GP services using the internet.

2. All practices will be encouraged to provide some online consultation services by 2021.

3. Federations will review the potential to improve and develop online consultation systems and the service models supporting them.

4. This approach will minimise negative impacts of potentially disruptive technologies such as “GP at Hand”.

Patient Access To Information – GP Online

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

1. During 2018-19 30% of patients will be enabled to use GP Online services (any of; access to their primary care record or requesting repeat prescriptions or booking / cancelling appointments) via the internet or an App

2. The system will also support self-management if patients review their detailed record. As at 31st October 2018, 75,986 patients in City & Hackney are enabled for one or more of these GP Online services.

3. To meet the 30% target, approximately 20,000 additional patients will need access by 31st March 2019.

Sharing Information

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

1. The east London Patient Record (HIE) is in place in Inner East London with all practices connected. It will be expanded to BHR practices during 2019.
2. This will enable all practices to see a range of patient-level health and social care information.
3. LB Hackney is already connected along with Homerton, ELFT, Barts Health and St Joseph's Hospice.
4. C&H GPs now view the shared record around 10000 times a month with Homerton clinicians viewing it around 14000 times per month.
5. City of London Corporation are expected to connect in Q4 2018/19.
6. As part of the One London LHCRE programme, our shared record system will be connected to 5 others across London.

Discovery Project Linking Data-sets To Improve Population Health

East London Health & Care Partnership
Primary Care Transformation Team
Helping the people of East London live healthy and independent lives

1. All practices are providing data to the Discovery project, which will support pathway improvements through data sharing across all health and care organisations.
2. It will enable proactive approaches to population health via the new primary care-led networks.
3. An additional benefit will be real-time flagging of key information to practices to help decision-making for individual patients.
4. The first utility using Discovery in now live, enabling frail patients calling 111 to be passed through immediately to a clinician rather than undergoing a lengthy triage with a call handler.
5. In the first 21 days of operation 863 potentially frail patients flagged.

Ipsos MORI
Social Research Institute

December 2018

Evaluation of GP at Hand

Progress Report

Ipsos MORI and York Health Economics Consortium with Prof. Chris Salisbury

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Contents

1 Summary 3

1.1 Purpose of this progress report 3

1.2 Summary 3

2 Evaluation overview 5

2.1 Introduction to the evaluation 5

2.2 Evaluation questions 5

2.3 Fit with wider evaluative work 7

3 Evaluation approach and progress 8

3.1 Quantitative assessment of patient experience 8

3.2 Case studies to explore experience and outcomes 9

3.3 Wider qualitative work 12

3.4 Economic evaluation 13

3.5 Secondary data analysis 14

4 Evaluation governance and timings 16

4.1 Evaluation governance 16

4.2 Evaluation timings 16

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1 Summary

Ipsos MORI, working with York Health Economics Consortium (YHEC) and Professor Chris Salisbury[1] were commissioned in May 2018 to conduct an independent evaluation of babylon GP at Hand[2].

1.1 Purpose of this progress report

The aim of the progress report is to provide the Primary Care Commissioning Committee for NHS Hammersmith and Fulham Clinical Commissioning Group (CCG) with a:

- summary of the final evaluation approach following the evaluation scoping stage; and,
- an update on progress in delivering the agreed evaluation approach.

This progress report is structured as follows:

- **Chapter 2, Evaluation overview.** Evaluation aims and evaluation questions.
- **Chapter 3, Evaluation approach and progress.** Proposed evaluation methods and progress to date.
- **Chapter 4, Evaluation governance and timings.** Evaluation governance arrangements, and timings for the remainder of the evaluation.

1.2 Summary

1.2.1 Evaluation approach

The final evaluation approach, arrived at following completion of the scoping phase involves five key strands as set out in the table below.

Table 1.1: Summary of evaluation approach

Strand	Details
Quantitative assessment of patient experience	• Online survey of babylon GP at Hand patients to understand experience. • Comparative analysis against GP Patient Survey data to assess **impact** of babylon GP at Hand.
Qualitative practice-based case studies	• GP practice-based case studies at babylon GP at Hand and two other models of digital primary care. • Qualitative interviews with patients and staff to understand experience, and perceptions of impact on safety, effectiveness and outcomes.
Wider qualitative work	• Qualitative interviews with individuals/organisations to assess wider policy questions.
Economic evaluation	• Assessment of patient and system-level impact of babylon GP at Hand through analysis of routine datasets.
Secondary data analysis	• Synthesis and analysis of NHS England analytical work. • Analysis of available workforce data to understand impact on.

1.2.2 Progress to date

Progress of the evaluation to date has involved:

[1] Professor Salisbury is Professor in Primary Health Care, University of Bristol.

[2] The practice was initially known as 'GP at Hand' but was relaunched as babylon GP at Hand in October 2018.

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- completion of the scoping phase (June – September 2018);
- agreement of the final evaluation approach with the Evaluation Steering Group;
- design and initial implementation of the patient experience survey;
- initial qualitative visit to two babylon GP at Hand locations; and,
- refinement of the approach to economic evaluation and negotiation of data access.

1.2.3 Timings

The evaluation is ongoing until March 2019, at which point a final evaluation report will be provided to Hammersmith and Fulham CCG and NHS England. (Further detail on timings is provided in chapter 5).

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2 Evaluation overview

2.1 Introduction to the evaluation

Babylon GP at Hand is a primary care practice that incorporated a digital first service model into an existing practice in 2017. The practice operates in North West London, commissioned through a General Medical Services (GMS) contract through NHS Hammersmith and Fulham[3]. The practice now offers a 'digital-first' model of primary care, primarily through use of a mobile app and video consultations provided by their subcontractor, Babylon Health.[4]

NHS Hammersmith and Fulham CCG and NHS England are undertaking a programme of evaluative activities to understand the babylon GP at Hand practice and its impact on a range of audiences. As part of this Hammersmith and Fulham CCG and NHS England have commissioned an evaluation team, led by Ipsos MORI, working in partnership with York Health Economics Consortium (YHEC), and with advisory input from Prof. Chris Salisbury (University of Bristol) to undertake an independent evaluation of babylon GP at Hand.

This evaluation is a key component in a wider programme of work to evaluate the effectiveness and impact of babylon GP at Hand (see 2.3). This evaluation consists of 5 key strands. This report provides details of the approach, and progress to date, for each strand (see chapter 3).

The key strands are:

1. Quantitative assessment of patient experience.
2. Qualitative practice-based case studies.
3. Wider qualitative work.
4. Economic evaluation.
5. Secondary data analysis.

2.2 Evaluation questions

Babylon GP at Hand represents a significant departure from the 'usual' model of care within primary care settings, and could have implications across the health system, given the potential for future national roll-out. The ongoing debate has highlighted a range of potential issues that this evaluation seeks to help unpick. These fall under three broad areas:

- What is the impact of babylon GP at Hand on **registered patients**? Including considering the impacts on experience; cost and efficiency; equity; and as far as possible, safety and effectiveness.
- What is the impact of babylon GP at Hand on the **wider health system**? Building on work being undertaken by NHSE, consider the impacts on: other practices and their patients; CCG finances; referral pathways; overall demand and costs; productivity, efficiency and value.
- What is the impact of babylon GP at Hand on the **workforce**? To consider the potential effects of Babylon GP at Hand on staff, including: job satisfaction; pay; training, retention/recruitment/working patterns; workload; the patient/doctor interaction; and the wider primary care workforce.

It is also important that in considering the impact of babylon GP at Hand the evaluation does not focus solely on the digital-first nature of the model but also the implications of the way in which this operates under the GP Choice Policy. This means exploring each element of the model, as far as is possible within the resource and timeframe of the evaluation, to try to understand each element and its contribution to the outcomes observed:

[3] babylon GP at Hand is the name of a GMS contract-holding general practice providing Primary Medical Services under the GMS Regulations 2015 in North West London, previously known as Dr Jeffries and Partners.

[4] NHS England, *GP at Hand Fact Sheet,* 2017. Online at: https://www.england.nhs.uk/london/our-work/gp-at-hand-fact-sheet/

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- the digital-first 'offer' of babylon GP at Hand;
- the rapid access to primary care offered by babylon GP at Hand (within 2 hours, 24/7);
- the active marketing of babylon GP at Hand; and,
- the employment model and working arrangements for the babylon GP at Hand workforce.

The introduction of babylon GP at Hand also raises a range of wider policy questions which NHS England is exploring. While these are not the explicit focus of this evaluation, in designing the evaluation approach we have sought to be sensitive to these and ensure that any evidence generated that could contribute to answering these is recorded and fed back.

Based on initial internal analysis and exploratory work Hammersmith and Fulham CCG and NHS England identified a range of possible evaluation questions. During the scoping phase of this evaluation, these have been refined, and the key areas of investigation are outlined below.

A. Questions relating to activities and impacts

- A1. Who is accessing the service and what attracted them?
- A2. To what extent do users understand the service, and its implications?
- A3. How does the Babylon GP at Hand model work and what are the patterns of usage by patients?
- A4. How is this digital first model of primary care delivered and what are the resource implications of this?

B. Questions relating to outcomes and impacts:

- B1. What are the levels of satisfaction with Babylon GP at Hand?
- B2. What evidence can the evaluation provide regarding potential differences in clinical outcomes for babylon GP at hand patients compared to 'usual' GP services?
- B3. Why do patients de-register from the practice?
- B4. What changes (if any) are there to patients' use of health and social care services?
- B5. What are the workforce issues?
- B6. What evidence can the evaluation gather (or could be gathered in the future) to inform an assessment of the financial implications of a digital first primary care model such as Babylon GP at Hand?

C. Wider policy questions

- C1. How does this fit with wider NHS policy, now and in the future?
- C2. What options do NHSE/ CCGs have to effect change?
- C3. How might this model change in the future?
- C4. What other models are there for delivering a digital-first service?

2.2.1 Scope and limitations of the evaluation

The scoping phase has highlighted the difficulty of answering some of the evaluation questions. While the evaluation team have designed an approach that will seek to gather as much evidence against as many of the evaluation questions as is practically possible within the resource available, there will be some limitations to this. In particular, it is important to note that:

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- The evaluation does not include a comprehensive assessment of the safety and effectiveness of the babylon symptom checker ('Artificial Intelligence' triage tool). It will explore patient use of the tool, and perceptions around the quality of advice given.
- The evaluation will only be able to provide **qualitative evidence** as to the safety and effectiveness of the babylon GP at Hand service, and therefore will be limited in the robustness of the conclusions that can be drawn in this area.

Beyond these limitations to the scope of the evaluations, the success of the evaluation in being able to answer some of the evaluation questions will depend on the ability to secure access to the necessary data and individuals (patients and staff).

2.3 Fit with wider evaluative work

There are three parallel strands of evaluative work focussing on babylon GP at Hand.

1. **Independent external evaluation.** This evaluation focuses on providing a robust and independent analysis of the outcomes and impacts of babylon GP at Hand.
2. **NHS England internal analysis.** Led by NHS England's Operational Research and Evaluation Unit, this work focuses on understanding the patient population, and service usage, as well as exploring other aspects (such as prescribing patterns).
3. **Ongoing clinical assurance.** Led by the Hammersmith and Fulham CCG clinical review team, an ongoing process of clinical assurance seeks to ensure that the service provided by babylon GP at Hand is safe, meeting contractual requirements and is addressing issues raised in initial clinical review.

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3 Evaluation approach and progress

In this section we provide an overview of the approach for each strand of the evaluation and a summary of progress to date.

This approach has been developed from that put forward in the original proposal to undertake this evaluation following a scoping phase for the evaluation. This phase, commencing in June 2018 saw the evaluation team undertake a range of scoping activities including familiarisation discussions, and rapid review of evidence, literature and data, to refine the evaluation approach. The revised approach was presented to, and agreed with, the Evaluation Steering Group in September 2018.

3.1 Quantitative assessment of patient experience

3.1.1 Approach

An **online patient experience survey** of babylon GP at Hand patients has been designed to enable the evaluation team to:

- quantitatively assess the experience of babylon GP at Hand patients; and,
- compare this experience to that which would be expected from a similar patient cohort.

The survey covers experience of key aspects of the babylon GP at Hand model and includes questions designed to allow a comparison to wider primary care via the GP Patient Survey[5]. It also includes wider questions to understand the nature of the babylon GP at Hand patient population.

Questionnaire

The questionnaire covers the following topics:

- the registration process;
- overview of services (e.g. ease of accessing information);
- making an appointment;
- experience of most recent appointment;
- overall experience;
- future intentions;
- wider NHS service use;
- smartphone usage; and,
- demographics.

Consent (and contact details) for recontact are also being collected to allow the evaluation team to conduct qualitative interviews with a sub-sample of patients (see 3.2).

Survey administration

Information Governance restrictions mean that it would not be possible for the evaluation team to be provided with patient contact details to administer survey invitations. Babylon GP at Hand are therefore acting as 'gatekeepers' and sending out invitations to take part in the patient experience survey on behalf of the evaluation team.

As the invitation method is reliant on babylon GP at Hand administering the invitation, it is necessary to use an SMS approach. The evaluation team worked with babylon GP at Hand to explore other possibilities for sampling and inviting patients to participate in the survey, but the systems in place mean that it was not feasible to restrict an

[5] https://www.gp-patient.co.uk/

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email invitation to only babylon GP at Hand patients. As a result, an SMS approach was considered the best way to reach currently registered babylon GP at Hand patients.

A single SMS invitation will be sent out, including a unique survey link for each patient. The SMS invitation will be sent out to all currently registered patients of babylon GP at Hand aged 16 and over (a 'census approach')[6].

Proposed analysis approach

The proposed approach to analysing responses to the patient experience survey is set out below. The final analysis approach cannot be designed until the level of response received to the patient survey is known, and this will be agreed with Hammersmith and Fulham CCG and NHS England, with input from the evaluation scrutiny panel.

- **Assessment of overall patient experience (across key metrics) within babylon GP at Hand**. This will allow exploration of the patient experience within the practice, including analysis by sub-group. This analysis will be based on all currently registered patients completing the survey.
- **Assessment of the variation in patient experience by key patient groups**. Dependent on achieved sample size we will undertake analysis of variations in patient experience across different groups of patients (e.g. age, sex, ethnicity, long-term condition, distance from clinic(s)).
- **Comparison of babylon GP at Hand patient experience to expected patient experience.** We intend to create a matched-sample[7] of non-babylon GP at Hand patients from the most recent GPPS dataset. This analysis will be based on all currently registered babylon GP at Hand patients who have been registered for six months or more (at the time of sampling).[8]

A key challenge in conducting any comparative analysis will be adequately accounting for differences between patients using babylon GP at Hand and wider patients. Initial analysis will assess how robust any such analysis will be and inform decisions about the final analytical approach.

3.1.2 Progress to date

At the time of writing this report, progress on this strand of the evaluation can be summarised as follows:

- The patient experience survey has been designed and implemented by the evaluation team.
- The evaluation team have been working with babylon GP at Hand since September to agree the process and timings for inviting patients to take part in the survey.
- The evaluation team are currently working with babylon GP at Hand to launch the survey as soon as possible. This work has included a series of 'soft launches'[9] to test the process which are still underway.
- Alongside this the evaluation team is currently negotiating the necessary Information Governance processes to secure access to the person-level dataset for GP Patient Survey (2018) from NHS England.
- Initial data analysis and refinement of the analysis plan will take place in early 2019.

3.2 Case studies to explore experience and outcomes

The second primary research strand of the evaluation is a series of case studies.

---

[6] At the time of writing the intention was to send the survey invitation to around 34,000 currently registered patients. Given the changing nature of the babylon GP at Hand population, the exact sample size will be determined at the point at which the survey is launched.

[7] Using a Propensity Score Matching approach.

[8] This is important to ensure the comparability of the sample with GPPS.

[9]This involves sending out survey invitations to small subs-samples of patients to test the invitation and survey process, ironing out any issues prior to a full launch.

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3.2.1 Approach

The case studies have been designed to gather evidence to answer key evaluation questions that it is not possible to answer using quantitative data, and to provide supplementary evidence to help understand data collected as part of the patient experience survey and the economic evaluation. The evaluation team will conduct three case studies, as set out in table 3.1.

Table 3.1: Overview of case studies

<table>
<tr><th>Case study</th><th>Overview</th><th>Approach</th></tr>
<tr><td>babylon GP at Hand</td><td>• Core case study at babylon GP at Hand to understand how the model works, the experience of patients, and staff, and explore perceptions of the impact of the model on various aspects of importance to the evaluation.</td><td>• Site visit to two babylon GP at Hand locations (clinic and GP hub), including discussions with several key audiences:
  o Practice manager
  o Staff interview (nurse and GPs)
  o Patient interviews
• Additional qualitative in-depth interviews with:
  o GPs.
  o Current patients[10]
  o Deregistered patients
• Additional patient interviews to be agreed to explore particular groups or issues of interest.[11]
• Follow-up analysis of available data (e.g. patient experience, workforce).</td></tr>
<tr><td>Online triage approach</td><td>• Case study at a practice using an online triage-only approach alongside 'usual' general practice delivery.
• To allow comparison to another 'technology enabled' primary care model.</td><td rowspan="2">• Desk research and exploration of available data to understand background to practice and refine key lines of investigation for interviews.
• Will include understanding local practice context (current digital offer/list-size and mix etc).
• Day-long site visit to practice by one researcher.
• Discussions with several key audiences:
  o GP Partner
  o Practice manager
  o Paired-depths/triads/mini-groups with staff
  o Patient interviews
• Follow-up interviews with additional patients ().
• Follow-up analysis of available data (e.g. patient experience, workforce).</td></tr>
<tr><td>Blended approach (triage + virtual consultations)</td><td>• Case study at a practice using an online consultation approach alongside 'usual' general practice delivery.
• To allow comparison to another model of digital primary care using online consultations.</td></tr>
</table>

Interviews will vary in length but last up to one hour, and will use semi-structured discussion guides focussed on collecting evidence relating to the evaluation questions.

[10] Patient interviews, across all three case studies, will be conducted either by telephone or in-person, depending on the preferences of individual patients.

[11] The evaluation includes additional resource that will be used to conduct further qualitative research at babylon GP at Hand, for example to explore issues with any particular groups of patients emerging from initial qualitative work or the analysis of responses to the patient survey.

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Selection of interview participants

The identification and selection of patients and staff to participate in the qualitative interviews is crucial to the success of the evaluation. The approach will vary across the case studies and is summarised below.

Babylon GP at Hand

- **Patients:** Patients will be recruited in two ways:
  - *Pragmatic* selection of patients attending face-to-face appointments during the evaluation team visit to the clinic.
  - *Purposive sampling* of patients following the patient experience survey. Quotas will be put in place to ensure a spread of patients with different characteristics: Demographics (age, gender, employment status); Distance from closest clinic; Utilisation rate (high; medium; low); Ongoing health conditions (no long-term health conditions; patients with one specific ongoing health need requiring regular consultations; patients with mental health problems ; patients with multimorbidity); nature of service use (face-to-face vs digital only).[12]
- **Staff:** As with patients, there will be a pragmatic element to the recruitment of staff, with the evaluation team interviewing those working in both the clinic and GP hub during the visit. In addition, a purposive sample of other GPs will be targeted for interviews. Babylon GP at Hand will act as gatekeepers to secure the participation of GPs. The sampling approach will be agreed with Hammersmith and Fulham CCG and NHS England following discussion of workforce information with babylon GP at Hand. At this stage, we anticipate sampling will be focussed on the following methods: length of time working as GP; working patterns (hours/week); working shifts; working location.
- **De-registered patients:** Given the rate at which patients are de-registering from babylon GP at Hand, it is anticipated that a number of patients invited to take part in the patient experience survey may have deregistered or stopped using the babylon GP at Hand service by the time they complete the survey. The survey is, therefore, the preferred approach for identifying and recruiting deregistered patients for the evaluation and has been designed with this in mind. If, following review of the patient experience survey data, this is not feasible, the evaluation team will work with babylon GP at Hand, Hammersmith and Fulham CCG and NHS England to find an alternative approach.

Other models

- **Arranging site visit.** Once participating practices have been agreed, the evaluation team will work with the designated contact (practice manager, lead GP) to arrange the visit. For on-site interviews, selection must be pragmatic and will be based on those staff who are available to speak with the researcher on the day. Ensuring a broad range of views and experiences are collected will factor into agreeing a date for the visit.
- **Patients:** As with the babylon GP at Hand case study, interviews with patients during the visit will be dependent on those with appointments during the site visit. We also anticipate using similar criteria for the recruitment of patients for follow-up interviews, although with a narrower focus given the smaller number of patients.

3.2.2 Progress to date

The following progress has been made on the case study strand of the evaluation, following agreement of the approach with the Evaluation Steering Group in September.

[12] In addition to those criteria to be used for recruitment the evaluation team will also monitor the spread of patients recruited across the following characteristics: Ethnicity; Use of digital services (e.g. banking etc); Reasons for registering with babylon GP at Hand/using the other model; and, Level of contact with health services in past 12 months.

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Babylon GP at Hand case study

- The evaluation team conducted two half-day site visits:
  - to one of babylon GP at Hand's clinics (King's Cross BUPA Health Centre), and,
  - to the 'GP hub', a co-working space where doctors can carry out digital consultations and other administrative work.

  During these visits the evaluation team conducted interviews with GPs, patients and a nurse.
- The evaluation team have also agreed the sampling criteria and approach for recruiting additional patients and GPs. Following the launch of the patient experience survey, the evaluation team will begin to recruit patients (and former patients) who have 'opted in' to the qualitative research. We will also work with babylon GP at Hand to identify and invite GPs to take part in the additional GP interviews.

Wider models

- The evaluation team have been working with NHS England, Hammersmith and Fulham CCG and the Evaluation Steering Group to identify the most suitable alternative models to be included in the evaluation.
- Following agreement of the approach by the Evaluation Steering Group, NHS England have been supporting the evaluation team in making initial contact with the providers of alternative models. Agreement in principle to support the evaluation has been obtained and discussions about involvement and timings are ongoing. In particular, the evaluation team are currently establishing the 'maturity'[13] of other models to inform final selection of practices.

3.3 Wider qualitative work

3.3.1 Approach

The scoping work highlighted the importance of some wider evaluation questions related to informing policy and future developments of digital primary care. As such, the scoping report presented to the Evaluation Steering Group in September 2018 set out our approach to exploring these issues.

A series of qualitative interviews with a range of organisations to help NHSE analysts and policymakers shape the research questions for future internal and/or commissioned work to more fully answer these questions.

We plan to conduct a relatively small number (15) of telephone consultations[14] across five key groups[15]. Table 3.2 sets out the groups it is suggested are included in this work, and the contributions we anticipate that consulting these groups would make. These consultations will take place at a later stage in the evaluation once babylon GP at Hand is a more mature practice and the longer-term developments and implications may be becoming more apparent.

For example, it may be more beneficial to the evaluation to include organisations representing a wide range of groups who may have a lower propensity to access usual GP services or face other barriers to accessing healthcare (e.g. homeless, refugees, undocumented migrants).

Table 3.2: Suggested groups for inclusion in wider qualitative work

Group	Key contributions
Regulators, national	Understand regulator opinion on the safety and efficacy of key features

[13] To provide useful evidence for the evaluation it will be necessary for the other models to have been up and running for sufficient time that the evaluation team can recruit patients who have experience of using the service.
[14] Consultations would be based on a high-level discussion guide focussed on the implications of models like babylon GP at Hand.
[15] These audiences are to be agreed following consideration of the emerging findings from the evaluation, and it may be more beneficial to the evaluation to include organisations representing a wide range of groups who may have a lower propensity to access usual GP services or face barriers to healthcare (e.g. homeless, refugees, undocumented migrants).

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bodies/services	of the service.
Providers and provider representatives	Understand workforce impacts. Understand perceptions of system impact. Understand likelihood of wider adoption of babylon GP at Hand model.
Commissioners and commissioner representatives	Understand perceptions of system impact. Understand implications for place-based commissioning. Understand likelihood of wider adoption of babylon GP at Hand mode.
Technology companies	Understand other models for delivering a digital-first service. Understand how other models might adapt as a result of Babylon GP at Hand.
Others	Understand perceived impact on recruitment and retention. Understand perceived impact on GP training. Understand impact on indemnity, risk taking and mistakes by GPs. Understand perceived impact on patients.

3.3.2 Progress to date

This strand of the evaluation is not scheduled to be conducted until early 2019 to feed into the final analysis and reporting stages of the evaluation. As such, efforts to date have focussed on agreeing the broad approach and audiences to be included.

The evaluation team will be working with Hammersmith and Fulham CCG and NHS England during late 2018 to refine the audiences to be included in this strand and begin approaching them.

3.4 Economic evaluation

Seeking to understand the economic impact of the babylon GP at Hand model is a key component of this evaluation.

3.4.1 Approach

The approach to assessing the economic impact of babylon GP at Hand is proposed at two levels: patient level and system level.

Patient-level

A cost minimisation analysis is planned to analyse the cost and efficiency of babylon GP at Hand (cost per patient adjusted for needs). This will involve analysing data on the use of primary care by those patients who have signed up to babylon GP at Hand and comparing use with comparator data, either using administrative data from a control group, literature or clinical best practice. The use of a control group will provide the most robust approach but whether this is feasible in the time and with the data available will need to be explored. Alternatives to the use of a control group would be the generation of assumptions from a rapid review of literature and/or opinion on clinical best practice.

Evaluating the cost-effectiveness of the service for users is more challenging because the babylon GP at Hand cohort are most likely to be episodic users of primary care and may not have any underlying health conditions. There will be no measurement of health-related quality of life (e.g. EQ-5D) so cost-utility analysis will not be possible. Instead a wider cost-minimisation analysis is planned using proxy metrics such as use of hospital (e.g. A and E) and 111 services to understand the patterns of usage between the cohort using babylon GP at Hand and a comparator group (as above, using either a control group or assumptions from data/opinion).

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System-level

Evaluation of the impact of babylon GP at Hand on the wider health system needs to consider the potential changes in demand, pathways and overall system costs. An interrupted time series approach is planned to examine key metrics such as changes in demand for consultations over time. Any bias in the numbers will be controlled by using regression to predict likely changes in demand over time. Data gathered from the survey and case studies may also be used to understand the extent to which the babylon GP at Hand service impacts on patient pathways. The aim is to model both the results of the time series analysis and an understanding of the changed pathways to estimate the likely impact on 'usual' primary care services, as well as other urgent and emergency care services. Nationally available data on costs will be used to value the outputs and outcomes from the economic analysis (e.g. Payment by Results Tariff, NHS Reference costs, PSSRU Unit costs of Health and Social Care).

As far as evidence allows, the evaluation also plans to assess the impact of patients switching to babylon GP at Hand on capitation funding, including the impact on other GP practices and their sustainability, and the costs of patients registering and de-registering.

3.4.2 Progress to date

The ability of the economic evaluation to effectively assess the impact (both observed to date and potential) of babylon GP at Hand depends on the ability to successfully negotiate access to key datasets. This is currently being negotiated with NHS England.

An evaluation with limited access to data and covering a short time period will not be able to provide definitive conclusions on whether babylon GP at Hand is cost-effective or provides value for money but it will be able to provide information for decision makers to help them understand the impact of babylon GP at Hand. The quality of that information will depend upon the granularity of the data available for analysis.

Given the above, efforts to date have been focussed on refining the proposed approach to conducting an economic evaluation, and on negotiating access to necessary datasets.

- A proposed economic evaluation plan has been produced and is being reviewed and discussed with Hammersmith and Fulham CCG, NHS England analytical colleagues and the Evaluation Steering Group.
- Advisory input is also being provided by the Improvement Analytics Unit[16].
- Discussions are ongoing with babylon health and babylon GP at Hand with regard to what data on the use of primary care resources by babylon GP at Hand patients may be available to feed into the evaluation. We have asked for individual patient data, anonymised or pseudonymised, detailing all contacts with babylon GP at Hand (and outcomes of contacts) broken down by different types, and linked to demographic data such as CCG of origin, age etc.
- The evaluation team are also currently negotiating access to wider health system data NHS England and the CCG. Discussions with the NHS England Information Governance team are currently ongoing

3.5 Secondary data analysis

3.5.1 Approach

In addition to the primary data generated through the evaluation, the analysis of routine datasets and service-specific datasets that will be conducted as part of the economic evaluation (see 3.4), and the analysis of GP Patient Survey data, the evaluation will also include two other kinds of secondary data analysis. This consists of:

- **NHSE analytical outputs.** The NHS England Operational Research and Evaluation Unit is conducting ongoing analysis of babylon GP at Hand using nationally-held routine datasets. The evaluation team will have continued access to the outputs of this analysis and will work to synthesise these findings into the overall

[16] The Improvement Analytics Unit is a partnership between the Health Foundation and NHS England to provide rapid feedback and evaluation for local health care projects in England. More information can be found online: https://www.health.org.uk/programmes/projects/improvement-analytics-unit

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evaluation (and use them to inform lines of investigation for qualitative work). This will minimise the amount of duplication between the different programmes of evaluative work that is ongoing.

- **Workforce data.** At this stage we anticipate using two types of workforce data.
  - NHS Digital data on the primary care workforce will be used to provide contextual information to support the analysis emerging from the case studies in terms of the composition of the babylon GP at Hand workforce (and how this compares to usual primary care), and the potential impacts on recruitment and retention of GPs.
  - Data on the babylon GP at Hand primary care workforce would have to be provided by babylon GP at Hand, to understand the composition of the workforce and allow comparative analysis against the wider primary care workforce.

3.5.2 Progress to date

- To date, the evaluation has focussed on, negotiating Information Governance processes for the wider service-use datasets required.
- Discussions with babylon GP at Hand regarding workforce data are ongoing.

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4 Evaluation governance and timings

4.1 Evaluation governance

The evaluation team report to Hammersmith and Fulham CCG and NHS England on a weekly basis. Wider evaluation governance arrangements are as follows:

- **Evaluation Scrutiny Panel:** A 'scrutiny panel' consisting of two academics (with primary care and health economics expertise) and a Patient and Public Involvement representative plays a role in reviewing and challenging the design and key outputs of the evaluation before submission to Hammersmith and Fulham CCG and NHS England.
- **Evaluation Steering Group:** The evaluation team are ultimately responsible to the Steering Group, who make all key decisions on the scope and direction of the evaluation. The Steering Group consists of representatives of Hammersmith and Fulham CCG, NHS England (Operational Research and Evaluation team, National Primary Care team) and NHS England London Region. The evaluation team reports to the Evaluation Steering Group monthly.

4.2 Evaluation timings

The evaluation is scheduled to run until the end of March 2019. Analysis of evidence within individual strands of the evaluation, and synthesis across strands, will be conducted on an ongoing basis between December 2018 and March 2019.

A final evaluation report will be provided to Hammersmith and Fulham CCG and NHS England in **March 2019.** This final report will present an assessment of the impact of babylon GP at Hand on the various audiences of interest based on a synthesis and triangulation of all evidence collected as part of the evaluation, and triangulation with findings from the other evaluative work being undertaken (NHS England analysis, ongoing clinical assurance process).

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About Ipsos MORI's Social Research Institute

The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methods and communications expertise, helps ensure that our research makes a difference for decision makers and communities.

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Health in Hackney Scrutiny Commission 7th January 2019 **Review on 'Digital first primary care and its implications for GP Practices' background reading FOR NOTING ONLY**	Item No **7**

OUTLINE

The report of the review will have a full bibliography but here FOR INFORMATION ONLY are some recent articles which explore the issues at the core of this review:

1.) NHS Digital data update on GP at Hand/ Lillie Rd Practice from City and Hackney Public Health Intelligence
2.) NHS UK website note on '*Patient choice of GP Practices'* and the change in the law which enabled this
3.) NHS UK website note on '*Seeing same doctor every time reduces risk of death'*
4.) FT article on "*High profile health app under scrutiny after doctors' complaints"* on the controversy around the AI algorithm which is used.
5.) Review from British Journal of General Practice by a professor of Primary Care Health on recent book on '*Challenging perspectives on organizational change in health care'*

And here are links to two research papers on the advantages and limitations of video consultations
https://journals.sagepub.com/doi/full/10.1177/0141076818761383

https://bmjopen.bmj.com/content/6/1/e009388?utm_source=TrendMD&utm_medium=cpc&utm_campaign=BMJOp_TrendMD-0

ACTION

The Commission is requested to note the information.

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GP at Hand / Lillie Road practice

October 2018 data update. City & Hackney Public Health Intelligence

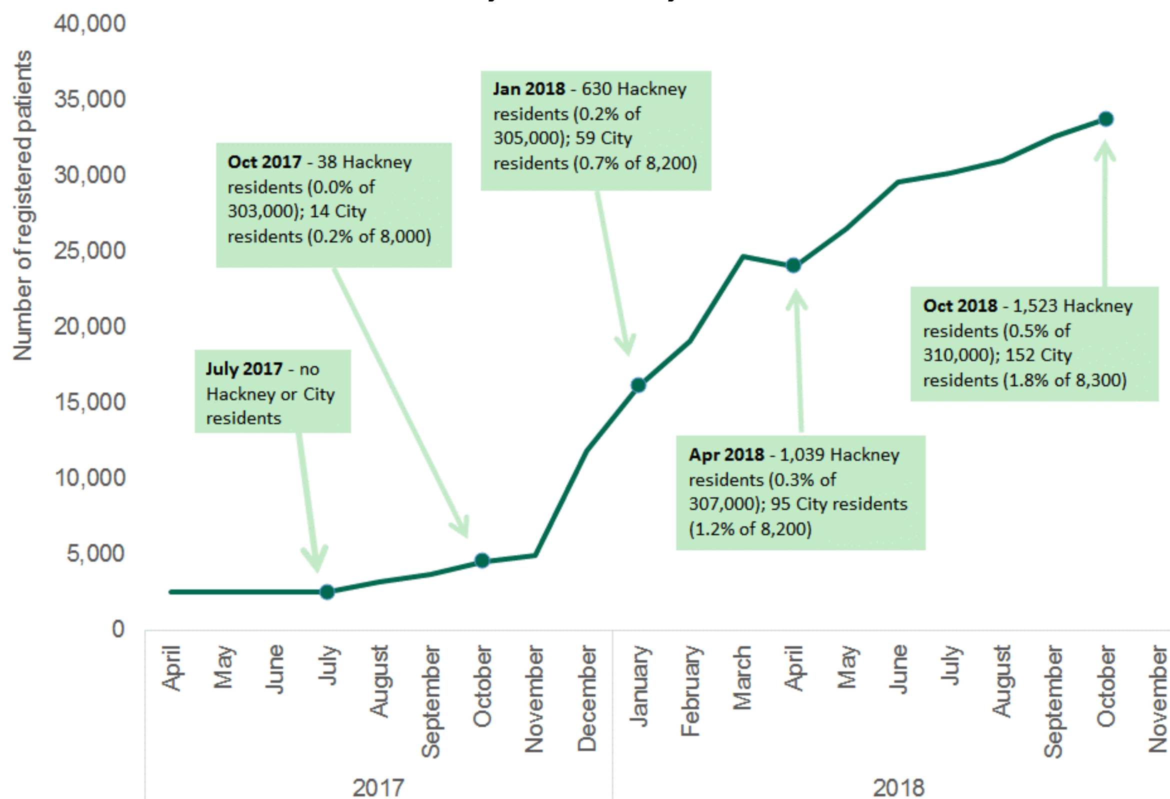
- NHS Digital currently release overall numbers of registered patients by GP practice every month, with a full geographical breakdown every quarter in January, April, July, October. This report includes figures published on 16 October 2018.
- These figures show a continued rise in the number registered at Lillie Road Health Centre (practice ref E85124) from 2,500 in July 2017 to 33,720 in October 2018 - see Figure 2
- In October 2018, 0.5% of registered Hackney residents were registered at Lillie Road, and 1.8% of City of London residents – see Figure 2
- Data form April 2018 show that nationally, 28% of patients are of younger working age (20-39). In City & Hackney 42% of registered patients are in this age group, reflecting the local demographics. Patients registered with Lillie Road have an even higher proportion in this age group – 80% – see Table 1 and Figure 3.
- In April 2018, 50% of patients registered with City & Hackney GPs were male. At Lillie Road, patients were 54% male – see Table 1 and Figure 3
- In October 2018, 12% of patients registered at Lillie Road were resident in Hammersmith and Fulham, 83% elsewhere in London, and 5% outside London. Hackney residents were the 8th highest number at the practice and made up 5% of the practice list – see Figure 4

Figure 1a: GP at Hand website (accessed April 2018)

Figure 2b: Little Road Health Centre

Source: Google Street View (accessed April 2018)

Figure 3: Number of patients registered at Lillie Road Health Centre over time, with the number of residents of Hackney and the City of London.

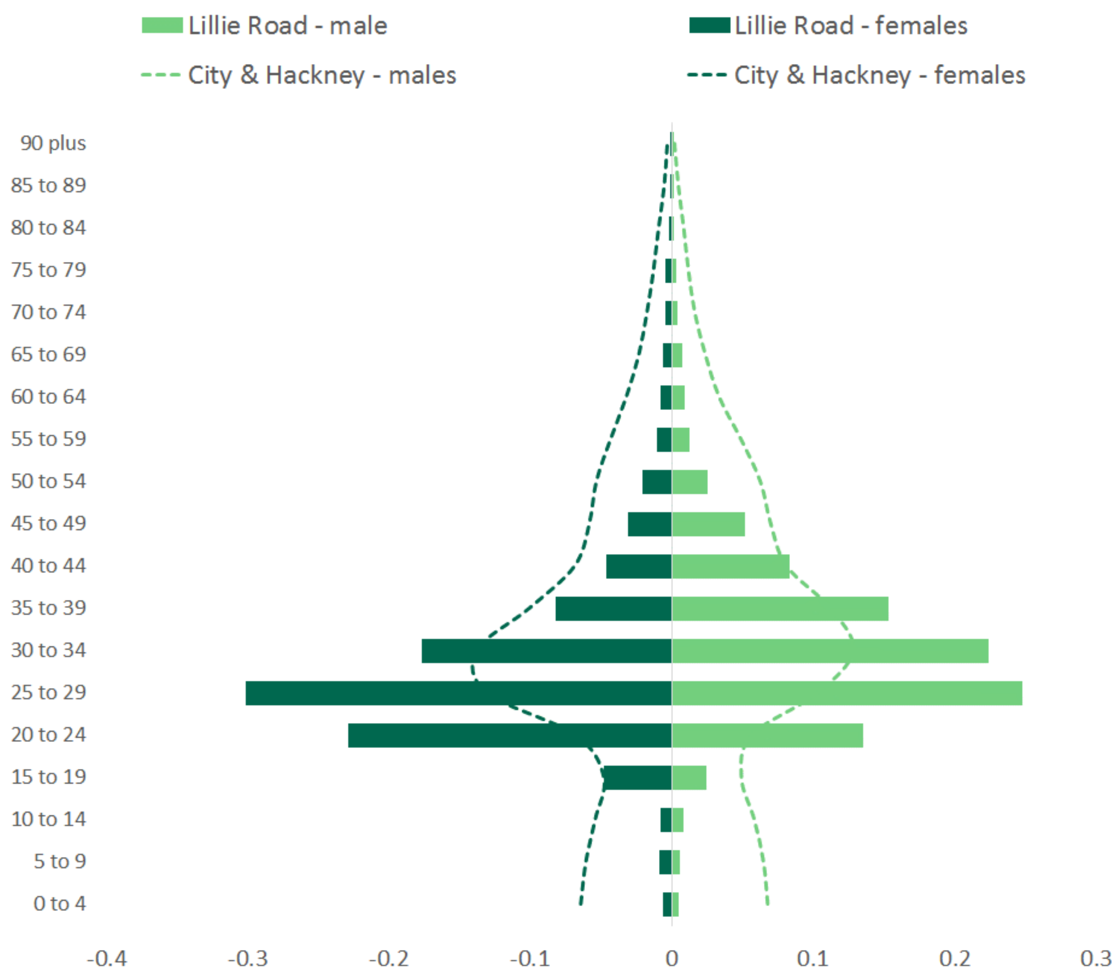


Data source: NHS Digital https://digital.nhs.uk/article/4197/Primary-care-services

Table 1: Number of patients in City & Hackney and Lillie Road by gender and age profile (April 2018)

	England	City & Hackney	Lillie Road
Total registered	59,039,595	318,787	23,997
% Male	49.9%	49.6%	54.3%
% Aged 20 to 39	28.0%	42.0%	80.4%

Figure 4: Age and gender of patients registered at Lillie Road Health Centre compared with City & Hackney CCG registered patients (April 2018)



Data source: NHS Digital https://digital.nhs.uk/article/4197/Primary-care-services

Figure 5: Patients registered at Lillie Road Health Centre by local authority of residence (October 2018)

Data source: NHS Digital https://digital.nhs.uk/article/4197/Primary-care-services

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Patient choice of GP practices

Since 2015, all GP practices in England have been free to register new patients who live outside their practice boundary area.

This means you can **register with a GP practice** (https://www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/) somewhere that's more convenient for you, such as a practice near your work or closer to your children's schools. This will give you greater choice and aims to improve the quality of access to GP services. Use the **Services near you facility** (https://www.nhs.uk/Service-Search/GP/LocationSearch/4) to find out what people say about a GP practice.

These arrangements are voluntary for GP practices. If the practice has no capacity at the time, or feels it is not clinically appropriate or practical for you to be registered so far away from home, they can still refuse registration. The practice should explain to you their reason for refusing your registration.

How to register with a GP practice further away

You may wish to join a GP near work or re-register with your old GP following a move. The new arrangements make this possible; however, there are a few things to consider:

- Research your options in the area you want to register with, so you choose a practice that is right for you.
- Compare GP surgeries according to facilities, services or performance before you decide. Ask friends, relatives and others you trust for their thoughts and recommendations.
- Contact the practice and ask if it is accepting registrations from out-of-area patients.

- If the practice is accepting registrations, ask for a registration form.
- The practice will decide, following a review of your completed registration form, whether to accept you as a regular patient or accept you without home visiting duties (if it is clinically appropriate and practical for you to be registered away from home).

Because of the greater distance to your home, the GP you register with is under no obligation to offer you a home visit. If you are not well enough to go to the practice yourself, then other arrangements will be made. NHS England (the body responsible for buying GP services) ensures there is access to a service either near your home or at home (if needed). When you register with a practice further away from home, you will be given information about what you should do in those circumstances.

Additionally, if you're worried about an urgent medical concern, you can call the **NHS 111** (https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/nhs-111/) service to speak to a fully trained adviser. This service is available 24 hours a day.

- **Patient information leaflet – Patient choice of GP practice (PDF, 28kb)** (https://assets.nhs.uk/prod/documents/141230-patient-information-choice-of-gp-practice.pdf)

Registering with a practice further away from home can affect decisions about **referrals for hospital tests and treatment** (https://www.nhs.uk/using-the-nhs/nhs-services/gps/referrals-for-specialist-care/), or access to **community health services** (https://www.gov.uk/government/publications/the-nhs-choice-framework). Speak to the GP about your options.

Outer practice boundaries

In 2012, all GP practices were asked to agree an outer practice boundary. Outer practice boundaries are an expansion of a GP's original catchment area. Whereas in the past you may have had to register with a new GP even after only moving a

few streets away, these outer boundaries can be a way to stay registered with your old GP.

You'll still have to speak with your GP first and, if appropriate, the GP may keep you on the register. For example, a GP may refuse to keep you on the register if you need frequent home visits but don't live close to the GP practice. If the GP covers a large area and the travel distance to your home is too long to justify regular home visits, then the GP can suggest that you register with a practice closer to your home.

However, if the GP decides you can stay registered, then you will continue to receive the full range of services, including clinically necessary home visits.

Page last reviewed: 26/11/2018
Next review due: 26/11/2021

Seeing same doctor every time 'reduces risk of death'

Friday June 29 2018

"Seeing the same doctor each time you need medical care might reduce your risk of death, research suggests," The Guardian reports.

The story was prompted by a review of data gathered by 22 previous studies to see whether continuity of care – seeing the same doctor – had any link with premature death (mortality risk).

The majority of these studies found reductions in mortality with increased continuity of care. But the findings of a review are only as good as the studies it includes.

These studies came from different countries with highly diverse health systems – most were from North America, with only 3 from the UK.

The studies were so different in their methods and how they measured continuity of care that it wasn't possible for the researchers to pool study results together.

And only around half of the doctors assessed were GPs or family doctors. It's not known how many of the doctors were treating long-term conditions such as diabetes or heart disease, or whether they were treating people in hospital.

This is the first review to look into the question of whether seeing the same doctor can reduce your risk of death, so it adds valuable insight that needs to be explored further.

But because of the differences in countries, methods and types of doctors across the studies, it's hard to draw any firm conclusions.

And on a practical note, in England it's not always possible for people to see the same GP.

Where did the study come from?

The study was conducted by researchers from the University of Exeter and the University of Manchester.

No sources of funding were received and the authors declared no conflicts of interest.

The study was published in the **peer-reviewed** (https://www.nhs.uk/news/health-news-glossary#peer-review) journal BMJ Open, which is **free to access online** (https://bmjopen.bmj.com/content/8/6/e021161).

The Guardian's and BBC News' reporting of the study was accurate.

The Mail Online took a more alarmist approach with the headline: "Seeing the same doctor every time could save your life".

Because of the limitations of the study, this dramatic suggestion is unproven.

What kind of research was this?

This **systematic review** (https://www.nhs.uk/news/health-news-glossary#systematic-review) aimed to explore whether there's a link between continuity of care with doctors and mortality.

As the researchers say, while there's been much research into the effects of improved treatment and diagnosis, the value of the doctor-patient relationship hasn't really been looked into.

Continuity of care is defined as repeated contact between an individual patient and a doctor.

This should in theory allow for a stronger relationship and better mutual understanding, and result in improved health outcomes.

Because of the differing methods used in the individual studies, the researchers were unable to carry out a **meta-analysis** (https://www.nhs.uk/news/health-news-glossary#meta-analysis) (where the results of individual studies are pooled) that you'd normally expect to see after the review.

What did the research involve?

The researchers searched medical literature databases for studies published between 1996 and 2017 that included the

words "continuity" or "continuity of care" together with terms relating to doctor, patient and mortality.

Studies had to have directly assessed some measure of continuity of care by any doctor (such as a GP or hospital doctor) and any measure of mortality. All studies were assessed for quality and risk of bias.

In total, 22 studies met the inclusion criteria. Two-thirds were retrospective studies using data provided by health insurance companies.

Only 3 studies came from the UK (England only). The others were mostly from the US and Canada, with a few from France, Israel, The Netherlands, Taiwan and South Korea.

Around half of the studies, including the UK ones, looked at contact with GPs or family doctors.

The other studies looked at any physician or hospital doctor, with even a surgeon and psychiatrist in 1 study each, and 8 of the studies looked at specific groups of patients, like those with diabetes or older adults.

Continuity of care was measured over different periods of time, from 1 month to 17 years: "Mortality was measured within different timeframes – for example, 1 study measured death rates during the length of a hospital stay, and another measured them from hospital discharge to 21 years later."

The researchers took into account **confounders** (https://www.nhs.uk/news/health-news-glossary#confounding-factor-confounder) that could have influenced the results, such as age, gender, ethnicity and socioeconomic status.

What were the basic results?

The studies were too diverse to pool the results in a meta-analysis. Overall, 18 of the 22 studies (82%) generally found that increased continuity of care was associated with significantly reduced risk of early death.

Most of this was related to all-cause mortality (death from any cause). Of the remaining studies, 3 found no link and 1 showed mixed results.

The size of the risk reduction across the studies was variable, but most often it was a fairly modest reduction in the range of about a 15 to 25% reduced mortality risk.

It's not possible to know what this meant in terms of **absolute risk reduction** (https://www.nhs.uk/news/health-news-glossary#absolute-risk) – in other words, how much of a reduction in risk a 15 to 25% drop would represent.

How did the researchers interpret the results?

The researchers concluded that, "This first systematic review reveals that increased continuity of care by doctors is associated with lower mortality rates."

They acknowledged that the evidence is observational (so it can't prove cause and effect), but say that patients appear to benefit from continuity of care with both generalist and specialist doctors.

They said: "Despite substantial successive technical advances in medicine, interpersonal factors remain important".

Conclusion

This study provides a valuable initial insight into the value of continuity of care.

The importance of good relationships between healthcare professionals and patients – with good understanding of the patient's needs, views and concerns – shouldn't be underestimated.

It seems plausible, therefore, that continuity of care could have a direct effect on improving patient outcomes and reducing mortality.

But as evidence, systematic reviews are only as good as the studies they combine, and the limitations of these studies do need to be acknowledged.

These were highly diverse studies with widely variable healthcare systems, patients, doctors, and methods of assessment. This is why the results couldn't be pooled.

And without absolute figures, it isn't possible to know how great a difference this could make.

For example, if only 4% of people died during study follow-up, a 15% reduction with better continuity of care could reduce this to 3.4%, which doesn't seem so large.

This is nevertheless an interesting review that highlights the importance of good doctor-patient relationships.

It would be useful if a similar study focusing on the UK perspective and GP care was carried out in the future.

Analysis by Bazian
Edited by NHS Website

Links to the headlines

Keeping the same doctor reduces death risk, study finds
(https://www.theguardian.com/science/2018/jun/29/keeping-the-same-doctor-reduces-death-risk-study-finds)

The Guardian, June 29 2018

Seeing the same doctor over time 'lowers death rates'
(https://www.bbc.co.uk/news/health-44643607)

BBC News, June 29 2018

Why seeing the same doctor every time could save your life: Patients are open about symptoms, trusting of medical advice and inclined prescriptions from familiar GP
(http://www.dailymail.co.uk/health/article-5898735/Why-seeing-doctor-time-save-life.html)

Mail Online, June 29 2018

Links to the science

Gray DJP, Sidaway-Lee K, White E, et al. **Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality**
(https://bmjopen.bmj.com/content/8/6/e021161)BMJ Open/
Published online June 28 2018

Digital health

High-profile health app under scrutiny after doctors' complaints

Babylon advice service faces warnings it can miss symptoms of serious illness

Babylon is one of a number of new tech products being adopted by overburdened health services

Aliya Ram and Sarah Neville JULY 13, 2018

An app that uses artificial intelligence to assess medical symptoms and boasts more than 2.5m users faces regulatory scrutiny after complaints from doctors, who warn it can miss signs of serious illness.

Babylon Health has formed partnerships with the English National Health Service as well as tech giants Samsung and Tencent, expanding rapidly since it was founded four years ago. Investors include the founders of Google's DeepMind AI unit while users include Matt Hancock, the UK's new health secretary and former culture secretary.

The UK medicines regulator asked questions about the app after one doctor complained it had failed to identify symptoms of a heart attack or deep vein thrombosis. Two other doctors told the FT they had complained about wording on the website, which has since changed, that could confuse patients.

Babylon, one of a number of new technology products being adopted by overburdened health services eager to cut costs, has two significant partnerships with the NHS. Some patients in London can register to use the app's video consultations to communicate with a doctor instead of registering with a traditional GP's surgery. Babylon also delivers a telephone advice service called NHS 111 in north London.

The complaints have shone a spotlight on a regulatory system that seems to lag far behind new innovations and classes Babylon's service alongside items such as spectacles and sticking

plasters. Uber was criticised last month for using a different health app, PushDoctor, to verify drivers' vision with video calls, a length of string and home-delivered eye charts.

Babylon said it had responded to questions from the Medicines and Healthcare products Regulatory Agency, which had confirmed the company was not under formal investigation. The MHRA said it could not comment on specific companies but added that it "regularly carries out post-market surveillance and maintains dialogue with manufacturers".

The Financial Times tested Babylon's symptom checker to understand its response to the two conditions at the centre of the first complaint. When told a 66-year-old obese male smoker was experiencing sudden chest pain and excessive sweating, Babylon suggested 9 out of 10 people with similar symptoms were likely to be having a panic attack and made no mention of the risk of a heart attack.

By contrast, the NHS website's advice page for "chest pain" contains an alert box warning people to seek medical advice and call an ambulance if the pain begins with symptoms such as sweating. "You could be having a heart attack," the box says.

Babylon said: "Variable outcomes are still possible if a different symptom is selected, as each symptom could suggest an increase or decrease in the probability of a larger number of potential diseases." Disclaimers on Babylon's symptom checker and terms and conditions say that the chatbot's responses are not diagnoses and do not constitute medical advice.

Dr Richard Body, a cardiologist and professor of emergency medicine at Manchester University, and Dr Annette Neary, a former consultant with the NHS, both expressed concerns about the results when contacted for their views. "Laypeople don't realise that 90 per cent of diagnosis is based on history," Dr Neary said.

A rheumatologist from north London, who spoke to the FT on condition of anonymity, said he had been incorrectly referred three patients through Babylon: "With standard NHS GPs, the quality is variable, but on average the quality is higher," he said.

Babylon said: "Statistically your 'consultant rheumatologist' would only expect to see one or two of these referrals, so we don't think this gives his/her perspective much credence beyond blatant self-interest . . . We regularly conduct clinical audits of our referrals, which consistently demonstrate they are of high quality and are clinically appropriate."

Another doctor, GP and medical writer Margaret McCartney, has complained to the MHRA as well as the Care Quality Commission and Advertising Standards Authority about wording on Babylon's support website. According to a screenshot she shared with the FT, the page about the NHS 111 non-emergency service "Is it safe?" used to read: "a study examining the app's safety and accuracy found that it gave safe advice in 100 per cent of the cases used in the test". "I was concerned that the app was unsafe and was being oversold," she said.

The page no longer exists in the same form. Hugo Farne, a respiratory doctor, also told the FT he had complained to the ASA about language on Babylon's website. According to screenshots shared with the FT, the website used to say Babylon's technology was certified as a medical device with the MHRA and that its video consultation service had been "comprehensively inspected by the Care Quality Commission".

Correspondence from the MHRA, seen by the FT, said Babylon would be asked to amend the wording. The ASA's website indicates that five complaints about advertising by Babylon have been informally resolved.

Babylon told the FT it constantly updates the content of its websites. "As an innovative company working at the forefront of technology and operating in an industry with many vested interests, Babylon operates under very close scrutiny," it said. It added that the complaints about its chest pain and deep vein thrombosis responses had been made by an individual with "potentially vested interests". The doctor, whose identity is known to the Financial Times, rejected the allegation.

"We go far further than traditional GPs when it comes to safety measures, as every patient interaction is recorded, encrypted and can be played back for later review," the company said.

Andrew Haldenby, director of think-tank Reform, said technologies such as Babylon had huge and widely recognised potential to speed up access to health services and enable quicker diagnoses: "The potential is so great that it is easy to get carried away . . . it's important to remember that the technology is still in its early days."

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Books

Challenging Perspectives on Organizational Change in Health Care
Louise Fitzgerald and Aoife M McDermott
Routledge/Taylor & Francis Group, 2017, HB, 220pp, £84.00, 978-1138914490

CHANGE IN THE RIGHT WAY

Innovation (as disruptive as possible) and change (radical, transformational, breakthrough) are the buzzwords of the decade. You want better health care? Then make something new and different happen. If you work in the NHS you will know that it funds a mushrooming industry of change agents, change programmes, change frameworks, and whole-system change events hosted by indefatigably smiling change facilitators. An embarrassing amount of money is passed to management consultants in the process.

Some of us make a living studying the successes and failures (of which the latter probably outnumber the former) of this transformational change industry. The statistics are apocryphal but perhaps not wildly out: it is said that around 60% of all healthcare change efforts, and 80% of those involving a new IT system, fail (with or without the input of said consultancies). Why? If I can make over my living room, why can't I introduce a new, evidence-based, and NICE-endorsed care pathway in the clinical specialty of which I am the designated lead — even when my entire team knows it is going to be performance-managed against the change and the patients and staff are already on side?

The answer, according to a new book by management academics Louise Fitzgerald and Aoife McDermott, is that achieving the kind of top-down 'transformational' change envisaged by policymakers (and promised by fast-talking consultants) is nigh-on impossible, for two main reasons. For one thing, this kind of change is inherently impossible in complex public-sector organisations (in such settings, there are mathematical and ecological reasons why incremental and adaptive change has a far better chance of succeeding). For another, the health system lacks the capacity (in terms of what Pettigrew long ago called the *'receptive context for change'*:[1] the necessary resources, knowledge, leadership, relationships, and vision within healthcare organisations and the supportive political and economic environment beyond them) to implement major transformational changes. It was ever thus, but, because of the progressive downward squeeze on budgets and the triple pressures of technological progress, rising patient expectations, and demographic shifts, it's all getting worse.

Take, for example, the repeated restructuring of healthcare commissioning in recent years (a topic dear to the hearts of the *BJGP*'s readers). Describing commissioning as *'a prime example of a complex subject where knowledge and skilled change implementation are crucial'*, Fitzgerald presents empirical evidence that a succession of governments in recent years have mandated the 'transformation' of commissioning with a view to improving efficiency, value, the patient experience, etcetera, etcetera (you can fill in the blanks). But study after study has shown that the policy vision of smooth, focused service transformation never seems to materialise — and, what is more, policymakers fail to learn from their mistakes. As Fitzgerald sums up in Chapter 5:

'Restructuring is frequently based on simplistic notions of organizational change, which do not incorporate the effects of dynamic contexts, individual responses and agency. It is therefore unlikely to produce system transformation. Empirical research on mandated change and restructuring has indicated that effective, radical organizational change requires high levels of knowledge, skill and commitment throughout the organization [...] The disruptive, negative effects of restructuring appear to have been dismissed by policymakers or become lost through government changes. The role of civil servants in preserving institutional memory and learning is important. Restructuring distracts attention from ongoing priorities and delays improvements in patient care. It also causes dislocation of relationships and the loss of organizational memory and potentially some workforce skills with each restructuring. However, the history of restructuring featured here indicates limited learning from experience and significant re-making of errors.'

Perhaps it's heartening to hear from an international expert in public-sector management that the treacle you felt you were wading through the last time you tried to help solve a local commissioning restructuring problem had a robust theoretical explanation. And the same goes for disruptive innovations more generally.

Those who know the way critical management scholars' brains work will not expect simple or universal solutions to such deep-seated problems. But the authors do offer some important recommendations (Chapter 10). First, those who trumpet the need for 'transformational' and 'disruptive' change should familiarise themselves with the substantial evidence base against this approach and learn the advantages of what they call *'accumulative change processes'* — humbler, less radical efforts that aim not to disrupt or destroy the complex infrastructure that forms the fabric of our healthcare organisations.

Second, policymakers who seek change should put substantially more effort into supporting healthcare organisations to build the capacity for change, including the ability of individual staff to seek out new knowledge and apply it adaptively to changing situations (something Sarah Fraser and I argued for 16 years ago).[2] Third, accumulative change is more likely when there is space and support for interprofessional dialogue, sensemaking, and collaborative problem-solving. And, finally, more attention needs to be paid to 'the relationship between actors and contexts' (which is academic speak for *'I'd love to have politician X shadow me for a day'*).

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2. Fraser SW, Greenhalgh T. Coping with complexity: educating for capability. *BMJ* 2001; **323(7316):** 799–803.

Health in Hackney Scrutiny Commission	Item No
7th January 2019	
Work Programme for the Commission 2018/19	**8**

OUTLINE

Attached is a copy of the updated work programme for the year. This is a working document and is constantly revised.

ACTION

The Commission is requested to consider and update the future work programme.

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Health in Hackney Scrutiny Commission

Future Work Programme: June 2018 – April 2019 (as at 19 Dec 2018)

All meetings will take place in Hackney Town Hall, unless stated otherwise on the agenda. **This is a working document and subject to change.**

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Tue 12 June 2017 Papers deadline: 1 June		Jarlath O'Connell	**Election of Chair and Vice Chair for 2018/19**	
	Legal & Democratic Services	Dawn Carter McDonald	**Appointment of reps to INEL JHOSC**	To appoint 3 reps for the year.
	HUHFT	Tracey Fletcher	**Response to Quality Account for HUHFT**	Discussion with Chief Exec of Homerton University Hospital on issues raised in the Commission's annual Quality Account letter to the Trust.
	LBH/CoL/CCG Planned Care Workstream	Simon Cribbens SRO Siobhan Harper, Workstream Director Anne Canning Dr Mark Rickets	**Integrated commissioning – PLANNED CARE Workstream**	4th in a series of updates from each of the Integrated Commissioning Workstreams
	LBH/CoL/CCG UnPlanned Care Workstreams	Nina Griffith Dr Mark Rickets	**Delayed Transfers of Care including the outcome of the 'Discharge to Assess' pilot.**	Update requested at 14 Feb meeting.

Document Number: 21014862
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Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	LBH/CoL/CCG UnPlanned Care Workstream	Nina Griffith Dr Mark Rickets	**Update on new arrangements for Integrated Urgent Care**	Presentation on the ongoing Hackney element to the new Integrated Urgent Care service which will replace CHUHSE from August and work alongside London Ambulance Service (the new pan NEL NHS 111 provider).
	MEMBERS		**WORK PROGRAMME FOR 2018/19**	To agree the outline Work Programme for 2018/19
FOR NOTING ONLY	ELHCP	Jane Milligan (for noting only)	**NHS North East London Commissioning Alliance**	To note letter from Jane Milligan (AO for the NEL LCA and Exec Lead for ELHCP) to the Chair of INEL JHOSC in response to questions regarding the new NHS structures and commissioning arrangements in north east London.
Tue 24 July 2018 Papers deadline: 16 July	CCG, GP Confed, HUH, Adult Services	Nina Griffith Dr Stephanie Coughlin	**Neighbourhood Model for Health and Social Care**	Suggested by CCG, GP Confed, Public Health.
	LBH/CoL/Prevention Workstream	Anne Canning SRO Jayne Taylor Workstream Director	**Integrated commissioning – PREVENTION Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	Healthwatch	Tara Barker Jon Williams	**Healthwatch Hackney Annual Report**	To consider the annual report of Healthwatch Hackney
FOR NOTING ONLY			**Responses to Quality Account requests**	To note responses by the Commission to requests for comments on draft Quality Accounts. Responses to:

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
				- St Joseph's Hospice - Arriva Transport Solutions
Wed 26 Sept 2018 Papers deadline: 17 Sept	Integrated Commissioning CCG/LBH/HUHFT/ ELFT	David Maher Amaka Nandi Anne Canning Tracey Fletcher Paul Calaminus	**Estates Strategy for North East London**	Update on emerging Estates Strategy at NEL level and impact on Hackney.
	HUHFT	Tracey Fletcher	**Changes to pathology services at HUHFT**	Update requested at July meeting following concerns raised by Dr Coral Jones.
	CCG, Finance & Resources, Adult Services	Sunil Thakker Ian Williams David Maher Anne Canning	**Update on pooled vs aligned budgets in Integrated Commissioning**	Requested at March meeting. To focus on implications for cost savings programmes.
	Chair of CHSAB Adult Services	Simon Galczynski John Binding	**Annual Report of City and Hackney Safeguarding Adults Board**	Annual review of SAB work. Annual item.
	Adult Services/ Planned Care Workstream	Simon Galczynski Tessa Cole	**Integrated Learning Disabilities Service**	Update on development of the new model
FOR NOTING ONLY	Adult Services Carers Centre		**Cabinet Response to review on 'Supporting Adult Carers'**	To note the Cabinet Response to the Commission's review on 'Supporting adult carers' agreed by Cabinet on 17 Sept.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Mon 19 Nov 2018 Papers deadline: Thu 8 Nov	NHSE London (commissioner) GP Confederation Public Health CCG CACH and CYP&M Workstream	Catherine Heffernan Debbie Green Rehana Ahmed Laura Sharpe Dr Mary Clarke Dr Simrit Degun Dr Penny Bevan Dr Rhiannon England Sarah Darcy Amy Wilkinson	**Vaccine preventable disease and 0-5 childhood immunisations**	Long item on Childhood Immunisations to address concerns about the borough's performance and key issues for the stakeholders engaged in trying to increase the uptake of immunisations.
Members of CYP Scrutiny Commission attended	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director	**Update on Integrated Commissioning – CYPM Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	NHSEL (commissioner) Royal Free (provider for central and east London) CELBSS	Kathie Binyish Maggie Luck Kim Stoddart Willia\m Teh Steven Davies Tamara Suaris	**Changes to Breast Screening Services in Hackney**	Follow up to response in August from NHSEL re concerns about shortage of appointments and overall performance of breast screening service for Hackney residents.
	HUHFT Hackney Migrant Centre	Tracey Fletcher Rayah Feldman Daf Viney Dr Miriam Beeks	**Implementing the overseas visitors charging regulations**	Response from HUHFT to concerns about pre attendance checks on patients attending the Homerton to establish entitlement to free NHS services.
Mon 7 Jan 2019 Papers deadline: **Tue 18 Dec** (early because of Xmas closing)	GP at Hand Hammersmith &Fulham CCG ELHCP City & Hackney CCG City & Hackney GP Confederation	Paul Bate Deborah Parkin Jane Lindo Richard Bull Dr Mark Rickets Laura Sharpe Peter Shields	**REVIEW on Digital Primary Care and the implications for GP practices – Agree Terms of Reference and Evidence gathering Session 1**	Agree ToR and commence evidence gathering with evidence from GP at Hand/Babylon Health Hammersmith & Fulham CCG City and Hackney CCG City and Hackney GP Confederation East London Health and Care Partnership

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Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
INEL JHOSC ***Late Jan early Feb*** ***In Newham***	*East London Health and Care Partnership and North East London Commissioning Alliance*		***East London Health and Care Partnership and the North East London Commissioning Alliance***	*The work of the NHS North East London Joint Commissioning Committee*
Mon 4 Feb 2019 Papers deadline: 24 Jan	Various	All TBC eConsult IT Enabler Group C&H LMC TH LMC Healthwatches Hurley Group	**REVIEW on Digital Primary Care and the implications for GP practices – Evidence gathering 2**	TBC
	Partnership Members; Public Health, Hackney Learning Trust, Children's Services, Young Hackney, Community Services, NHS partners etc	Tim Shields Jayne Taylor	**Obesity Strategic Partnership briefing**	Report from Chief Exec and Public Health on 'Obesity Strategic Partnership' a whole system approach to tackling obesity
	LBH/CoL/CCG Unplanned Care Workstream	Tracey Fletcher SRO Nina Griffith Workstream Director	**Integrated commissioning – UNPLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
Tue 12 Mar 2018 Papers deadline: 1 Mar	Various	ALL TBC Virtual outpatients pilot at Barts Health etc	**REVIEW on Digital Primary Care and the implications for GP practices – Evidence gathering 3**	Various or via site visits.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Adult Services Planned Care Workstream	Simon Galczynski Siobhan Harper	**Integrated Learning Disabilities Service**	2nd update on development of the new model
	Adult Services	Simon Galczynski	**Adult Services Local Account**	Annual item on publication of the Local Account of Adult Services
	Adult Services	Simon Galczynski	**6 month update on implementation of recommendations of 'Supporting adult Carers' review**	Including briefing on the new model for Carers Services.
Move to June?	Adult Services Oxford Brookes University researcher Camden Council rep (best practice)	Gareth Wall and Simon Galczynski Names tbc Names tbc	**Market Making in Adult Social Care**	Report on Adult Services Market Position Statement and benchmarking on how to develop the local market for social care providers.
INEL JHOSC Mar/Apr tbc	*East London Health and Care Partnership and North East London Commissioning Alliance*		***East London Health and Care Partnership and the North East London Commissioning Alliance***	*The work of the NHS North East London Joint Commissioning Committee*
Mon 8 April 2019 Papers deadline: 28 Mar	Various	Various	**REVIEW Digital Primary Care and the implications for GP practices - Evidence gathering 4 and draft**	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
			recommendations	
	LBH/CoL/CCG Planned Care Workstream	Simon Cribbens SRO Siobhan Harper, Workstream Director Anne Canning Dr Mark Rickets	**Integrated commissioning – PLANNED CARE Workstream**	4th in a series of updates from each of the Integrated Commissioning Workstreams
	Adult Services Planned Care Workstream	Simon Galczynski Siobhan Harper	**Integrated Learning Disabilities Service**	3rd update on development of the new model
			Discussion on Work Programme items for 2019/20	

20-18/19 REVIEW report will be agreed at June 2019 meeting.

Items to be scheduled

	Cabinet Member	Cllr Demirci	**Cabinet Member Question Time with Cllr Demirci**	Annual CQT Sessions
	Adult Services Oxford Brookes University researcher Camden Council rep (best practice)	Gareth Wall and Simon Galczynski Names tbc Names tbc	**Market Making in Adult Social Care**	Report on Adult Services Market Position Statement and benchmarking on how to develop the local market for social care providers.

	HCVS Connect Hackney Cabinet Member Age Concern East London? GP Confed or CCG?	Jake Ferguson Lola Akindoyin Shirley Murgraff Cllr Demirci	**Connect Hackney - Reducing social isolation in older people**	Report on work of Connect Hackney (a Big Lottery Funded project) Suggested look at work of Mendip Council in Somerset which resulted in reductions in hospital admissions.
	CCG Confed	Nina Griffith Dr Stephanie Coughlin	**Neighbourhood Model**	Revisit the progress in July 2019.
	Integrated Commissioning – Planned Care Workstream	Siobhan Harper	**Housing First pilot**	Update on this health initiative in conjunction with Housing Needs to support those with multiple and complex needs.

Other suggestions from Members this year to be considered

1. Exploring the relationship between health and well being and housing in Hackney.

2. Scrutiny of Public Health function since it transferred from the NHS 5 years ago.