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, 4th February, 2019

7.00 pm

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

Contact:
Jarlath O'Connell
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✉ jarlath.oconnell@hackney.gov.uk

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

Hackney

10 Any Other Business (21.00)

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Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app') http://www.hackney.gov.uk/individual-scrutiny-commissions-health-in-hackney.htm

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Providing oral commentary during a meeting is not permitted.

Hackney

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

OUTLINE

Attached please find the draft minutes of the held on 7th January 2019.

MATTERS ARISING from November meeting

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 has been chased.

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.

MATTERS ARISING from January meeting

Action at 2.9

ACTION:	*The Chair requested that if in future a further proposal came forward to move to two HBPoS sites in the NEL patch, that officers should return to Scrutiny with that case for change.*

CCG Programme Director for Mental Health has noted this.

ACTION

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

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting Monday, 7th January 2019

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), Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	
Officers In Attendance	**Anne Canning (Group Director, Children, Adults and Community Health)**
Other People in Attendance	**Richard Bull (Programme Director Primary Care, C&H CCG), Mark Rickets (Chair, C&H CCG, Dr Fiona Sanders (Chair, City & Hackney LMC), Kirit Shah (City & Hackney Local Pharmaceutical Committee), Laura Sharpe (Chief Executive, C&H GP Confederation), Sunil Thakker (CFO, C&HCCG), Jon Williams (Director, Healthwatch Hackney), Paul Bate (Director NHS Services, Babylon Health/ GP at Hand) and Dan Burningham (Programme Director, C&H CCG)**
Members of the Public	**10**
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 Cllr. Snell gave apologies stating that he would have to leave early to attend another meeting.

2 Urgent Items / Order of Business

2.1 The Chair stated that he had accepted a request from City and Hackney CCG and the ELHCP for an urgent item relating to a proposal for changes to the system of Health Based Places of Safety and he welcomed to the meeting:

Dan Burningham (DB), Mental Health Programme Director, City and Hackney CCG

2.2 Members gave consideration to 3 tabled documents:

a) Cover report *Health Based Places of Safety in North and East London* from East London Health and Care Partnership
b) Executive Summary of *Mental Health Crisis Care for Londoners HBPoS Business Case Draft* from Healthy London Partnership
c) *London's Mental Health Crisis Care Programme Stakeholder Engagement* Report from Healthy London Partnership

2.3 Introducing the report Dan Burningham stated that Health Based Place of Safety provision across London was very uneven. The space currently used at the Royal London Hospital was not fit for purpose and would fail a CQC inspection. The Homerton's space was also fronting onto their busy A&E. There was an issue about dedicated staffing and all had to pull staff off their wards when required for this purpose. This London wide report addressed these issues by rationalising the number of sites and introducing dedicated staffing. The preferred option was Option 3 (p.5 of report) which involved a reduction from 4 sites to 3 (Sunflower Court in Redbridge, Homerton Hospital and Newham General) with the site at Royal London in Tower Hamlets being discontinued. He added that it was important to reassure Members that there was already a high level of Street Triage in place in City and Hackney (the Crisis Café, the Crisis Line etc) which provided the community support necessary to align with the HBPoS provision.

2.4 Members asked if police cells had ever been used locally for Section 136 cases whether there was sufficient capacity in the system, what was in place for 14-16 year olds and what work was being done with the police to better identify individuals in crisis.

2.5 DB replied that there were no records of police cells having been used. Staffing was a challenge as 3 members of staff were required at HBPoS sites to ensure proper and safe assessments. No children would be seen in these sites. Talk were ongoing with police on dedicated staff on their part for these functions.

2.6 Members commented that the issue was surely the ability to respond quickly in these cases rather than the numberof available sites. DB replied that this was correct and this cohort wold not be taken to a police station. That category was outside the scope of this proposal. He added the City of London accounted for half of Section 136 cases and police there had mental health workers with them. There were dedicated nurses to ensure patients didn't self-harm. By having a dedicated staff as a result of these changes the processing times for these cases would be much quicker.

2.7 Members' asked about the subset of this group who may have committed a criminal offence and how the system copes with this cohort and whether there was diversion pre-charge. DB replied that this cohort would be dealt with by the Liaison Diversion Service which was another service. He reiterated that the focus with this report was the cohort in Tower Hamlets, City and Hackney who come through the S.136 process only. This cohort has not committed any criminal act, for example they had not assaulted anyone or caused a disturbance during their distress.

2.8 Members expressed concern about the reference that following this change a further reduction to 2 sites in the NEL area might be contemplated. DB replied that

Newham wanted to keep their site open and the issues was whether economies of scale here might dictate whether they had to divert their patient flows. Individual CCGs still had the autonomy to make final decisions here and the issue would be kept under review. Members' asked which sites would remain should a future decision be made to reduce to 2 sites and drew attention to an error in p.5 of the report which stated that Option 2 comprised Newham and Sunflower Court when it was actually Homerton and Sunflower Court. DB replied that this was a transition process and if a decision were to be made to reduce to two sites those sites would be the Homerton and Sunflower Court and that Newham and Sunflower Court would be a most unlikely option because, the Homerton was close to the City which had the highest numbers of S.316 cases.

2.9 Carol Ackroyd (Hackney KONP) asked how this service change related to the overall NEL Estates Strategy and the proposals to move mental health beds from the Homerton to Mile End Hospital. DB explained that that was a higher level proposal which had still not been agreed and if such a move were to occur it would not be for some years. He added that in relation to this specific proposal they could not wait for 6 or 7 years to make the change to fit in with that larger plan. The site for HBPoS at Royal London was a risk and there were no other easy alternatives in Tower Hamlets. If in the future mental health beds did move from the Homerton to Mile End there would be an expectation that some provision for S136 beds would have to be retained at the Homerton.

RESOLVED:	**That the proposal Option 3 as set out in the paper be endorsed.**

ACTION:	**The Chair requested that if in future a further proposal came forward to move to two HBPoS sites in the NEL patch, that officers should return to Scrutiny with that case for change.**

3 Declarations of Interest

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

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

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the draft minutes of the meeting held on 19 November and noted the outstanding matters arising.

4.2 With reference to minute 7.19 on the vaccinations issue, Dr Mark Rickets (Chair, City and Hackney CCG) commented that Amy Wilkinson (Workstream Director, Integrated Commissioning) has asked him to draw to Members' attention that no additional funding had actually been received from NHSE London over and above the CCG funding. He added that it takes time the effect of an immunisation drive to show up and while the rate had dipped it was now back up. The first cohort concerned here should now be fully immunised and we would see a consistent fall in cases. Laura Sharpe (Chief Executive, City & Hackney GP Confederation) added that Haringey CCG had now confirmed that it would now invest in the GP Confederation's immunisations project in South Tottenham (next to the cohort being targeted in the north of Hackney). There had been 2 new cases recently identified by NHS 111.

They were still awaiting the overall data from NHSEL. She added that NHSEL had stated it would pay £2.80 extra per immunisations at Practice level above the standard payment but the main funding for this response was coming via the two CCGs. MR added that NHSEL was only paying this for immunisations given outside the core hours. Richard Bull (C&H CCG) added that NHS 10 Year Plan published that day made reference to an overhaul of the immunisations system.

4.3 The Chair offered the Commission's support for any necessary lobbying required on this immunisation issue. He also stated that as the issue crossed NEL borders it would also be raised at INEL JHOSC and that would be meeting very shortly now that Newham had taken on the Chair. He added that he had also recently attended a London JHOSCs Forum where the issue of the poor engagement of councils with STPs generally had been discussed.

RESOLVED:	**That the minutes of the meeting held on 19 November 2018 be agreed as a correct record and that the matters arising be noted.**

5 Review on 'Digital first primary care and its implications for GP Practices' - agree Terms of Reference

5.1 Members gave consideration to the draft Terms of Reference and Scope for their review on 'Digital first primary care and its implications for GP Practice'.

RESOLVED:	**That the terms of reference for the review be agreed.**

6 Review on 'Digital first primary care and its implications for GP Practices' - briefings from GP at Hand, CCG, GP Confed, ELHCP, H&F CCG

6.1 The Chair stated that they would now begin the evidence sessions for the review and he welcomed the following to the meeting:

Paul Bate, Director of NHS Services, Babylon Health/GP at Hand
Dr Mark Rickets, Chair, City and Hackney CCG
Sunil Thakker, Chief Finance Officer, C&H CCG
Richard Bull, Programme Director – Primary Care, C&H CCG
Laura Sharpe, Chief Executive, City and Hackney GP Confederation
Dr Fiona Sanders, Chair, City and Hackney Local Medical Committee

6.2 Members gave consideration to the following papers in the agenda:

(a) Presentation from GP at Hand '*Progress to date'*
(b) Presentation from GP at Hand '*Variation on NHS payments per patient'*
And to the following papers which were tabled:
(d) Briefing from City and Hackney CCG
(e) Briefing from City and Hackney GP Confederation '*Digital solutions in City Hackney Primary Care'*
(f) Briefing from East London Health and Care Partnership '*Primary Care Digital Across NEL*'
(g) *Evaluation of GP at Hand Progress Report December 2018* from Ipsos MORI/ York Health Economics consortium report commissioned by Hammersmith and Fulham CCG and NHSE London

The Chair added that Jane Lindo from ELHCP was unable to be present but had submitted a written presentation and would come to a future meeting. The contribution from Hammersmith and Fulham CCG was via Mark Jarvis their Head of Governance and Engagement who offered further input from H&F CCG if necessary. It was noted that the Commission would await with interest the publication of the full assessment report on GP at Hand in April and it would feed into the Commission's own conclusions and recommendations. The report tabled was essentially an outline of how they were going about this high level evaluation of GP at Hand.

6.3 Introducing his reports Paul Bate (PB) outlined the history of Babylon Health which was the owner of GP at Hand. Among their other businesses was providing the NHS111 service in NW London. GP at Hand was a fully registered NHS GP Practice service. Patients were guaranteed video appointments on their smart phones within 2-3 hours of calling. 95% of their patients gave them 4 star ratings. Of their patients only 15% required follow up face to face and this was provided in 5 clinics across London including Kings Cross, Canary Wharf, Westminster and Fulham. They had 200 GPs and they reviewed 50% of all video recordings to ensure quality control. He added that it was not correct that they only targeted healthy people and that they never took on patients with complex needs. He explained that they had a Care Coordination Tem who work with those patients. He added that their second papers described what they maintain was a 6 fold differential in funding between what a 25 year old and an 85 year old received from the NHS. Their average NHS income was £91 per patient whereas for others the average was £144.

6.4 Dr Mark Rickets (MR) introduced their paper and explained that they funded the local City and Hackney GP Confederation c. £10.9 per annum to carry out various GP Practice development work. The general view was that if you improve quality you remove much of the unnecessary care. You could make significant savings which could then be used to pump prime the GP Practice development work. He stated that there was no local evidence that digital consultations reduced demand and in fact many took the view that it might increase demand. He drew Members' attention to the series of challenging questions on p.5 which they would put to GP at Hand. In particular he would like to know how much of their GPs time was taken up with discussions with Consultants which of course was a vital element of joined up primary care. He added that London CCGs including City and Hackney had been asked by NHSEL to make contributions to plug the deficit at Hammersmith and Fulham CCG as a result of destabilisation caused by GP at Hand.

6.5 Laura Sharpe (LS) stated that every practice wanted to improve access and every practice wanted to embrace new development on telephone triage and on helping patients navigate better through the care pathways. They all wanted to rise to the challenge set by new entrants to the market such as Babylon. Speeding up access for the NHS for those patients who are busy during working hours had been a key priority for some time. City and Hackney GPs were no longer offering only the traditional offer to call at 8.00 am and they all wanted to rise to the challenge of improving access combined with continuity of care. Their concern with GP at Hand would be how for example continuity of care for say a 90 year old could be met by GP at Hand, who require the local links into secondary care. She took Members through the various options on increasing access outlined in their paper.

6.6 Members asked detailed questions of the panellists and in the responses the following points were noted:

(a) Members asked about evidence in Hackney of GP at Hand attracting away younger and healthier patients the funding for whom normally cross subsidises the older and more ill patients.

RB replied that the numbers were still quite small with just 1500-2000 so it was still too small for Practices to notice any big difference. City and Hackney also already had a very big churn of patients. Patients are worried however about the general threat.

(b) Members stated that GPs know their patients and the local care pathways and have built up good relationships with other providers. Hackney was also very diverse and how would GP at Hand cope with the many patients for whom English was a second language and also how it would cope with patients who were not computer or technology literate.

PB replied that in the national surveys of GP patients' only 50% of respondents stated that they valued an ongoing relationship with a single GP and of those 50% of them didn't have it. 50% didn't think such continuity was more important than more ready access. This meant that ready access to the same GP is actually not the norm anymore. He added that their offer was obviously only attractive to certain people. They had done full Equality Impact Assessments which were more than what was required of standard GPs and for each of the protected characteristics GP at Hand had been found to be as least as good. They also found that their service was particularly attractive to patients with mobility issues and when those patients were surveyed they found GP at Hand as good as if not better than traditional Practices. This research was done by North West London CCGs Group. Members' queried this response saying that Protected Characteristics did not take into account age or language ability and having continuity of care with a GP was important for those with complex needs. PB replied that he agreed and it took time and energy to build up effective relationships. They provide ongoing coordination over and above basic appointments and for many patients they were able to better negotiate care pathways using digital methods.

(c) In response to questions about the company's origin and structure PB replied that each employee was a shareholder and they had five or six large institutional investors. He went through the medical credentials of their senior staff including their Medical Director. Their head office had GPs and Clinical AI doctors. They also had non-medical teams such as post-Doctoral scientists and engineers.

(d) Members expressed concern about how they would handle patient churn.

PB replied that GP at Hand had only been operating 14 months and the churn levels varied over the year but had reduced significantly. The majority had remained with them and their average churn across the capital was 15%. Many who had left GP at Hand to return to their previous practice had subsequently come back to them. He added that Hammersmith and Fulham CCG commissioned report would provide more data on this when it was completed.

(e) Members asked about the issue of commercial confidentiality being used to withhold information on their operations.

PB replied that GP at Hand provided more data than traditional practices, they had a statutory duty to produce various data schedules and for example 75% of their

patients are 25-40 years so the churn rate for this cohort would be of particular concern to them.

(f) Members asked about the challenges to commissioning of having a widely dispersed list and how GP at Hand could respond to this. MR added that GP at Hand made no reference for example about outreach to Children's Social Services for example. He also took issue with the point on p.40 of the agenda that of the 4000 patients only 50 were being managed by the Care Co-ordination Team. This was very low in proportion of the number of patients registered.

PB replied that this was small nationally but this was because the largest proportion of their patients were 20-40 year olds. The purpose of the Care Co-ordination team was to make links into Safeguarding Teams and Community Mental Health Teams etc.

(g) Members asked what the business plan was in terms of growth and stated that their model undercut GP Practice and cherry picked the healthy and the worried well therefore leaving standard GPs with the old and the chronically ill. One Member stated that this was potentially letting rip a system which would totally undermine the basis for funding primary care.

PB replied that he could not share numbers from the growth plan but that they continually worked hard to understand their patient profile. From the outset they had planned for upscaling so as not to be focused on the first 40,000 for example. They were focussed on increasing their business outside London and NHSE has cleared them for operation now in Birmingham. One of the issues there was how they would interface with national NHSE led screening programmes where you need to be near your centre of treatment. On the issue of destabilisation he stated that a review of the whole Carr-Hill funding formula for primary care was now necessary. No weighted formula is ever perfect but it needed to be improved. What they were looking at was what level of service they could provide at the same price point as other practices.

(h) Michael Vidal, a resident, asked the GP Confederation why some Practices were not using any new access improvement system and whether discussions were under way with those. He also asked GP at Hand why they did not include their CQC ratings in their report.

(i) Jon Williams (Director Healthwatch Hackney) asked about the legal case GP at Hand took against the CQC and also about how they were planning for growth

(j) Dr Nick Mann (local GP) stated that what Babylon was offering was being imposed by the NHS rather than something that the NHS patients actually need. He stated that there was no external validation for Babylon Health's Symptom Checkers and it was in his view being marketed on false premises. The Medical Healthcare Regulation Authority which licenced medical devices had stated that there was no need for certification because what Babylon was offering was standalone software but Babylon needed to be regulated under Class 2 because it actually offered patients advice, so Babylon as an interface hadn't, in his view, been externally validated. He referred to cases where Babylon had allegedly misdiagnosed patients and had seriously underestimated their conditions.

PB replied that Babylon and GP at Hand were fully regulated by the CQC. The latter would not receive a rating until April 2019. Lillie Rd Practice had been rated as 'Good' and the previous 'Requires Improvement' rating dated back to 2016. They would be

welcoming CQCs next inspections. On the issue of the Symptom Checker Babylon didn't claim to provide standalone diagnoses. GP at Hand and Babylon were different services and were being confused he added. In terms of validation re GP at Hand, Hammersmith & Fulham CCG's Primary Care Committee and NHSEL had raised 3 clinical safety cases but these had subsequently been cleared as safe. On the Class 1 declaration not being a validation this was correct but they also believe that when a provider can and does self-certify this also has some value as they have to be sure they reach a high standard.

(k) Members stated that GP at Hand could experience exponential growth and asked how Hackney's primary care system was going to respond to it? Was there a case for some kind of one-stop-shop in Hackney for all the latest innovations and how were GPs working together on this.

MR replied that there were significant costs involved in getting a universal video consultation offer up and running. A lot of work had been done in ensuring local Practices all took up the EMIS clinical notes system for example. The challenge was how to find time in GPs working day to fit in this development work. There was a capacity issue and a need to take stock. He added that video consultation did have its place but the consequences would have to be managed and that the plans envisaged in the *NHS Long Term Plan* out that day, on digital, would have to be studied carefully. He added that Tower Hamlets Primary Care was further ahead on this. RB added that the IT Enabler Group and the Estates Group locally were keen for greater investment to be leveraged in here.

(l) Members stated that developments like these would destroy the current model of General Practice and stated that equality and access issues needed to be at the fore front of planning these changes.

LS replied that the Confederation was indeed taking these developments very seriously and the danger was that local GPs would be left only with the elderly and those with complex needs. The whole of the NHS was a public insurance system and this disrupted the whole model. Dr Fiona Sanders (LMC Chair) added that cross subsidy was vital to the whole system and the CCG needed to focus on development which can benefit everyone in the community not just a subset. PB replied that there was a challenge to be addresses about the small number of people who don't have smart phones and he clarified that GP at Hand will also do home visits if required.

(m) MR drew Members' attention to p.64 and took issue with GP at Hand's analysis and stated that it was incomplete. He stated that Practices always got extra payments for the first year of a new registration and this and other variables weren't properly reflected in GP at Hand's stated calculations and so they were not comparing like with like. PB replied that the Year 1 benefit had been included as well as age-sex adjustments which they don't benefit from. As per p.64 they argued that payment was deliberately linked to resource utilisation and the Carr-Hill formula included a 6 fold variation in global sum funding for patients of different ages and sexes. There also had to be consideration given to the level of list turnover. He concluded that a separate piece of work needed to be done on the Carr-Hill formula to feed in to the consultation on the renegotiation of the formula in 2020. MR replied that perhaps the Ipsos MORI study on the situation in Hammersmith and Fulham would provide much needed clarification on this.

6.7 The Chair thanked all the contributors for their papers and for their attendance.

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

7 Review on 'Digital first primary care and implications for GP Practices' - background reading

7.1 Members noted the following background reports for the review:

1.) *NHS Digital data update on GP at Hand/ Lillie Rd Practice* from City and Hackney CCG/LBH/CoL Public Health Intelligence Team
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'*
6.) Louis Peters, Geve Greenfield, Azeem Majeed, Benedict Hayhoe, Imperial College London *The impact of private online video consulting in primary care,* in Journal of Royal Society of Medicine, Vol 111, Issue 5, 2018
7.) Greenhalgh T, Vijayaraghavan S, Wherton J, et al *Virtual online consultations: advantages and limitations (VOCAL)* study British Medical Journal Open 2016; bmjopen-2015-009388

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

8 2018/19 Work Programme

8.1 Members gave consideration to the latest draft of the Work Programme for the year.

8.2 The Chair added that the NEL Estates Strategy would be taken forward at the INEL JHOSC which he hoped would schedule a meeting in early February. He was also asking for the Single Financial Officer for ELHCP also be on the agenda.

8.3 Carol Ackroyd (Hackney Keep Our NHS Public) asked if the Commission could have a future item looking at *The NHS Long Term Plan* which had just been published that day. She stated that the Commission needed to pay particular attention to the proposals in it for legislative change to usher in Integrated Care Systems. The Chair agreed.

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

9 Any Other Business

9.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

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Hackney

Health in Hackney Scrutiny Commission 4th February 2019 **CQC Inspection report on Council's Housing with Care**	Item No **5**

OUTLINE

On 14 January the Care Quality Commission published an inspection report on the Council's in house Housing With Care service and rated it as 'Inadequate' and issued four warning notices. The service has 6 months to remedy the situation and will then be re-inspected.

The Chair has asked officers to present the full Action Plan in response to the inspection as the next available meeting of the Commission however in the interim he has asked for a verbal update on the actions which the Council is immediately taking.

Attached please find

a) The CQC's Inspection repot
b) Note from Adult Services on the Council's initial response, as published on website

Attending to provide a verbal update will be:

Anne Canning, Group Director CACH
Ilona Sarulakis, Principal Head of Adult Social Care

ACTION

The Commission is requested to give consideration to the report and response.

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London Borough of Hackney

London Borough of Hackney, Housing with Care

Inspection report

Hackney Service Centre
1 Hillman Street, Hackney
London
E8 1DY

Tel: 02083564864
Website: www.hackney.gov.uk

Date of inspection visit:
23 November 2018
29 November 2018
03 December 2018
05 December 2018

Date of publication:
14 January 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place between 23 November and 5 December 2018 and was announced. The service was last inspected in February 2016 when it was rated 'Good.' In February 2016 we made a recommendation about how medicines were disposed of. We followed up on this recommendation at this inspection.

The London Borough of Hackney, Housing with Care provides care and support to people living in 14 'supported living' settings, so they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The 14 schemes were all located in the London Borough of Hackney and ranged in size from eight to 40 self-contained flats. Most of the schemes were designed to meet the needs of older adults, although some were specialised for particular groups including adults with learning disabilities aged over 50 and people living with a particular type of dementia.

There was one registered manager who was responsible for seven of the schemes. A second manager had applied to register with us who was responsible for the other seven schemes. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff were able to describe the support they provided to ensure people were safe. However, care plans and risk assessments were poor quality, lacked details and were not personalised.

Risks faced by people in the receipt of care had not been appropriately identified and measures in place to mitigate risks were not clear or robust. There was insufficient information about people's medicines to ensure they were managed safely and records did not show people had been supported to take medicines in a safe way. Although staff had a sound understanding of safeguarding and incident reporting, the systems in place to monitor and respond to incidents and allegations of abuse were piecemeal and there was a risk that trends and themes were not identified.

People did not feel involved in developing their care plans and did not always feel they had been offered choice about their care provider. Care plans had not been developed in line with best practice and guidance for meeting people's specific needs. There was insufficient information about people's healthcare needs, dietary requirements, cultural background and sexual and gender identity. We made a recommendation about ensuring the provider was able to offer appropriate support about people's sexual and gender identity. There was a risk that people's preferences and needs would not be met because these were not recorded.

People gave us mixed feedback about the staffing levels in the service and the impact this had on their

experience of care. While some people felt there were enough staff who had time to chat, others found staff rushed and busy. Staff were recruited in a way that ensured they were suitable to work in a care setting. Some of the schemes had very high agency use, with half of their shifts being covered by agency workers. Staff received regular supervisions, but the records did not demonstrate they had received the training they needed to perform their roles.

People did not always know how to make complaints, but were confident that if they had cause to make a complaint their feedback would be responded to appropriately. Records showed complaints were responded to in line with the provider's policy. The systems in place for learning from complaints were not operating effectively.

People told us they liked living in the schemes and would be happy to stay there until the end of their lives. Information about people's end of life wishes was not captured and the provider was not following their end of life policy.

Staff at the registered location did not have access to all of the documentation about people's care, which showed a lack of good governance at the service. We also identified shortfalls in how information was recorded and the reliability of the IT systems in use. The quality assurance and audit systems were not operating effectively. They had not identified or addressed issues with the quality and safety of the service. A range of audits were completed by managers at different levels but there was no central oversight or action plan. Actions to improve the quality of the service were not embedded or sustained.

The management structure of the service was new, and the managers were committed to improving the service. Staff felt supported in their roles. Staff worked closely with other organisations to ensure people were able to be active in their communities and attend a range of activities if they wished.

We found breaches of four regulations relating to person centred care, safe care and treatment, staffing and good governance. Full information about our regulatory response is added to reports when all appeals have been exhausted.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed in a safe way and information about people's medicines was insufficient.

Risks to people were not appropriately identified or mitigated against.

Incidents and concerns about abuse were appropriately identified and escalated. It was not clear how the schemes ensured lessons were learnt and shared.

Feedback about staffing levels was mixed, and some schemes had high agency use.

Staff knew how to keep people safe by the prevention and control of infection.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not assessed in line with best practice and guidance. Care plans were generic and did not inform staff how to support people to achieve their goals.

Records did not show staff had received appropriate training for their role. Staff received regular, supportive supervisions from their managers.

Care plans did not contain sufficient information to ensure people's healthcare and dietary needs were met.

The schemes worked closely with other organisations, particularly housing providers, to ensure people's needs were met.

Staff understood and applied the principles of the Mental Capacity Act 2005 but records did not always show the MCA had been applied.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us care workers were kind and had a caring attitude, although some people found staff were too rushed to spend time with them.

Staff spoke about people they supported with kindness and compassion.

People's cultural identity and personal history were not always considered as part of care planning.

The service did not always ensure they provided a safe environment for people to disclose their gender or sexual identity.

Is the service responsive?

Requires Improvement

The service was not always effective.

People did not remember being offered a choice about how they received their care. Care plans lacked detail and were not personalised.

The provider worked with other organisations to ensure a wide range of activities were available to people who wished to engage with them.

People told us they would be happy to receive end of life care from the service, but the provider was not following their own policy about end of life care.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems had not operated effectively to identify and address issues with the quality and safety of the service.

The audits in place did not ensure improvements were sustained.

The systems in place did not always facilitate the management of the service or sharing of information.

People and staff spoke highly of the managers who were

committed to making improvements to the service.

Staff meetings took place regularly and gave staff the opportunity to be involved in developing their schemes.

London Borough of Hackney, Housing with Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place between 23 November and 5 December 2018. The provider was given 48 hours' notice of the inspection activity as the service provides care across a wide range of sites and we needed to be sure the information we needed would be available during the inspection.

The inspection was completed by three inspectors. The inspectors spent two days in the office and visited five housing schemes over two days.

Before the inspection we considered the information we had received from the service in the form of notifications they had submitted to us. Notifications are information about events and incidents that providers are required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 15 people and 26 members of staff including the service manager, a registered manager and a manager who had also applied to register with us, two administrators, five scheme managers, six team leaders and ten care workers. We reviewed the care files for ten people who used the service including care plans, risk assessments, medicines records and records of care delivered. We looked at eight staff files including recruitment, supervision and appraisal records. We reviewed various other documents, meeting records, policies and audits relevant to the management of the service.

After the inspection we required the provider to send us an action plan to address some serious concerns we

found during the inspection. The action plan they sent us demonstrated they understood the extent and range of our concerns.

Inadequate

Is the service safe?

Our findings

People told us the staff supported them to take their medicines. One person said, "I do my own tablets at the moment, but they would help me if I needed. I rattle like a pharmacy so it's nice to know they would help if it got too much." Another person said, "They make sure I've taken my tablets." Staff described checking the medicines containers supplied by the pharmacy and the medicine administration records (MAR) when supporting people to take medicines.

The provider did not have effective systems in place to ensure the safe management of medicines. All ten of the people whose files we reviewed needed staff to support them to take their medicines. None of the care files contained information about what medicines they were prescribed, any risks associated with these medicines or details of the support they needed to take their medicines. The only information available to staff was contained in the MAR and this was insufficient to ensure people were supported to take their medicines safely.

People had been prescribed medicines on a 'take as needed' basis. There were no guidelines to inform staff when to offer and administer these medicines. Some medicines prescribed on an 'as needed' basis should not be taken together. For example, co-codamol should not be taken at the same time as other products containing paracetamol as it contains paracetamol and this means there is a risk of overdose and liver damage. One person's MAR showed staff had recorded they had administered both these medicines on 18 occasions in a six week period. This meant this person was exposed to the risk of harm and overdose. Staff had also used codes that were not explained on the MAR and therefore it was not possible to tell medicines had been administered safely. The provider told us they would take action to ensure staff knew how to record and administer medicines properly.

Risks faced by people had not been properly identified or mitigated against. One person had been prescribed medicine for seizures. Their care plan contained no information about their seizures. The registered manager confirmed this person had a history of seizures. This exposed this person to the risk of harm as staff did not have any information about how to identify seizures or respond when they happened. Other health related risks, such as diabetes and other long term health conditions had not been appropriately mitigated. There was no information for staff to identify the symptoms of high or low blood sugar levels for people living with diabetes or guidance on how to respond to these conditions.

One person's care file stated they had a history of suicide attempts. Their risk assessment stated staff should monitor their mood and report to the GP if they thought they had become depressed or anxious. There was no information to describe how to identify depression or anxiety in this person. Another person had a history of self harm and there was no guidance about how to identify and mitigate concerns about their mental health.

Three people's care files referred to them requiring treatment from medical professionals for wound care. There was no guidance for staff about how to mitigate the risk of harm by ensuring treatment plans were followed to encourage these wounds to heal. One person's care plan made repeated references to pressure

wounds from 2016. The manager confirmed they did not currently have any pressure wounds but their care plan had not been updated to reflect the change in their circumstances.

The above issues with the lack of clear identification and mitigation of risk and management of medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with staff. One person said, "I feel safe, the staff are always very kind." Staff were able to identify the different types of abuse people might be vulnerable to. Staff knew how to report and escalate concerns they had in line with local safeguarding and whistleblowing procedures. Records showed scheme managers completed incident forms and raised concerns about allegations of abuse appropriately to their managers. Where appropriate safeguarding alerts were raised and investigations were completed. Staff meeting records showed staff were reminded about recording incidents and safeguarding concerns regularly. However, there was no record that staff were supported to reflect on learning from incidents and safeguardings through these meetings.

The provider had systems in place to ensure suitable staff were employed. Applications were reviewed and applicants had been interviewed by management panels who applied the provider's policy to ensure equality of opportunity in recruitment processes. Applicants' knowledge and skills were assessed through a standardised interview process. After successful interviews the service carried out checks of staff right to work, identity and character through references and criminal records checks. It was not clear that the provider established the relationship between the applicant and the referee so it was not always possible to see if the reference was a professional or character reference.

Records of recruitment processes were difficult to access during the inspection. The provider's systems required the documents to be scanned and uploaded to their online filing system. However, this had not been consistently done by the previous registered manager. Administration staff were able to access hard copy records from a locked cabinet, but this required the administrators to go through boxes of records that had not been clearly sorted or archived.

People gave us mixed feedback about whether they felt there were enough staff on duty to meet their needs. At some schemes people told us there were plenty of staff available to them when they needed. One person said, "I don't have to wait for staff." Another person said, "They're never short on coming here, they come on time." However, other people told us there were not always enough staff. One person said, "There could be more staff. If I pull the cord they will get here as quickly as they can." Another person said, "They help me when they have the time."

Rotas showed some schemes were covering half of the shifts with agency workers. Staff at some of the schemes told us they felt rushed at busy times of the day. All the staff told us absences were covered, either by agency staff or by team leaders providing additional support to people. The schemes had established links with named agency workers who were known to the people who lived in the schemes. Agency staff attended staff meetings and received supervisions in the same way permeant staff did which minimised the impact of unfamiliar faces.

Staff described maintaining appropriate hygiene to ensure people were protected by the prevention and control of infection. We saw personal protective equipment was available to staff from the offices in the schemes. We noted that one person was particularly at risk of infection due to an underlying health condition. Their care plan referred staff to guidance documents, but these were generic guidelines and did not clarify for staff what individual actions were required to ensure effective infection prevention and control or what the risks were to this person and others. Staff were able to describe the risks in conversation.

Inadequate

Is the service effective?

Our findings

The registered manager told us they met with people to plan their care based on the commissioning referral received from people's social workers. People confirmed they had meetings about their needs before moving into the supported housing schemes. However, the service did not have a set needs assessment and did not keep records of the assessment process.

The care plans produced were generic and did not reflect best practice in terms of people's individual needs. For example, one of the schemes specialised in supporting people with learning disabilities but people's care plans did not reflect how their needs may be different from those in an older adults' scheme. Care plans for people with long term, enduring mental health conditions did not reflect best practice in ensuring people's mental health was supported. For example, one person's profile described that they continued to live with residual symptoms of psychosis but did not inform staff how to support or respond to the person in relation to these symptoms.

People told us staff supported them to access healthcare services when they needed. One person said, "They [staff] would notice if I wasn't feeling too clever. They'll call the GP for me." Another person told us, "They will get the ambulance if you need it." Care plans contained information about people's medical history, however this was limited to the health concerns that led to their moving into the schemes. There was no information about what people's diagnoses meant in terms of their wellbeing or care preferences. For example, one person's profile described the findings of a brain scan in detail, but did not explain what that meant for the person and their needs.

It is well established as best practice in supporting adults with learning disabilities with their healthcare needs that people should be supported to have health action plans and attend annual health checks. Health action plans are documents that ensure that all the information about a person's health conditions and appointments are held in one place that is available to the person and all relevant healthcare professionals. We reviewed two files for adults with learning disabilities and their files did not contain health action plans and did not include information about annual health checks. One of these people spoke to us about the health appointments they attended, but the support they needed to book and attend the appointments and follow the advice of the healthcare professionals was not recorded.

People receiving care were living with a range of long term health conditions including diabetes, dementia, mental health conditions and other age and lifestyle related conditions that affected their wellbeing. Care plans did not explain the impact of people's health conditions on their support needs and preferences. For example, one person was diagnosed with high blood pressure and diabetes. Their plan regarding physical health stated they needed glasses to read and described facilitating GP appointments "when necessary" and informing healthcare professionals of "any changes." There was no guidance about how to identify changes in health or how to support this person to maintain their health.

Another person's medical history included high blood pressure and having a pace-maker fitted. The health section of their care plan referred to their need to wear glasses and attend optician appointments. There

was no information or guidance about the support they needed to manage their blood pressure or to ensure their heart health. This person told us they attended regular hospital appointments but the support they needed with this was not recorded. This meant there was a risk that people did not receive the support they needed to maintain their health and liaise with healthcare professionals as this support was not described.

People told us staff helped them prepare their meals. One person said, "They help with my meals, it depends what I've got in." In some of the schemes staff prepared communal meals, but this was not possible in other schemes due to the nature of the buildings. Staff told us some people preferred to cook from scratch while others had microwave meals delivered. Staff told us they offered people choices about their meals. Care plans did not include information about people's dietary needs and preferences, and did not contain information about whether or not people had meals delivered or required support to prepare them. Although staff were knowledgeable there was a risk that new, or unfamiliar staff may not provide people with the support they needed as this was not captured in the care plans.

The above issues with the assessments and lack of detail in care plans are a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received regular, supportive supervisions from their line managers. The provider's system required line mangers to upload supervision records to an online filing system. We found that this was only done when prompted by the registered manager following an audit. This meant records available were out of date although scheme managers uploaded records after being requested as part of the inspection. Records showed staff received regular supervisions that followed the provider's format which included discussions of individuals receiving care as well as service issues.

Although some staff told us they received the training they needed to perform their roles, this was not consistent across the service. Staff who wrote care plans and risk assessments told us they had not received training in writing personalised care plans since the service was established in 2014. This had affected the quality of the care planning across the service, where we found shortfalls in the levels of personalisation in care plans. The training records submitted by the provider were not clear and did not show staff had received the training they needed to perform their roles. For example, only three staff out of 212 had ever received training in diabetes care. Staff working in the schemes which specialised in providing care to specific groups such as learning disabilities, dementia or mental health had not received training in these areas. Records did not show staff had received training in responding to behaviour which might be challenging despite providing care to people who behaved in this way. In some schemes there was no record any staff had received training in safeguarding adults, despite this being an annual requirement of the provider.

The above issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At each of the schemes the relevant housing association provided housing related support and some activities for people living in the schemes who also received care from the provider. At some of the schemes the housing provider also had an office base. We saw staff from the different organisations liaised to ensure people's needs were met. For example, care staff would liaise with maintenance teams to ensure repairs were completed. We also saw housing staff would share concerns about people's care if these were raised. At several of the schemes there were joint meetings with the provider and housing association to discuss services on offer to people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In community settings this is through applications to the Court of Protection.

We checked whether the service was working within the principles of the MCA, and whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Staff demonstrated a sound understanding of the MCA and understood that people's capacity to make decisions may vary depending on the circumstances. For example, staff told us they would not ask people to make complex decisions when they were under the influence of alcohol as that may have affected their capacity to make decisions. Records did not always support staff understanding of people's capacity to make decisions or provide guidance on how to facilitate decision making. For example, one person's care plan described how a relative managed their finances. However, there was no record that the family member had the appropriate legal authority to manage finances on their behalf. The team leader told us they would seek confirmation and appropriate records about this matter. A meeting record also showed a relative had put in place restrictions on their family members liberty without following proper processes and without any record of them having legal authority to make decisions on behalf of their family member. The registered manager established that the scheme manager had taken immediate action to remove this restriction.

Requires Improvement

Is the service caring?

Our findings

Across all the schemes we visited we saw staff interacted with people in a kind and positive way. Staff knocked on people's flat doors and enquired after their wellbeing in a polite and considerate way. People told us the staff were kind. One person said, "The staff chat to me, they are friendly and caring." Another person told us, "The staff are very respectful to me. They know I am very particular about how I like things and do not want them to interfere with certain areas. They respect my boundaries."

Although the interactions were positive, some staff told us they did not always have time to spend with people outside of providing care. One staff member said, "There could be more staff on the ground [this would help] provide a compassionate service, people would benefit from more time and hours, as well as staff wellbeing. We manage to do it, but it's at a push." One person told us, "They [staff] are busy. They can't sit around chatting all day."

Care plans explained that some people needed emotional support, particularly those with mental health needs. However, the care plans did not describe how to identify this need or what the support would entail. Staff described sitting and talking with people, and offering them reassurances.
Staff spoke with compassion about how they would support people who may be embarrassed or upset by their support needs. They described offering reassurances and taking their time to ensure people were at ease during the receipt of care.

People told us they were able to maintain their important relationships, or that staff would help them to do so if they wished. One person said, "I see my [relative] regularly but if I needed the staff to phone them they would." Staff told us they supported people to keep in touch with family members. One care worker explained how they supported one person to visit their relative who lived in a care home. Care files did not include details of people's significant relationships. Family members were referred to but only if they were involved in making decisions or if there were risks associated with their contact.

Information about people's lives before they received a service was extremely limited and usually only referred to their circumstances immediately before moving into the schemes. This meant it was not always clear the service was considering people's background, culture and values when developing support plans. For example, we visited one person in their flat and they had flags and artwork on display relating to their heritage. In conversation they were proud of the culture and described how it influenced their preferences. Their ethnicity in their care plan did not match the cultural heritage they told us about. Another person told us they did not like some staff to help them with meal preparation as they did not know how to prepare meals in line with their cultural requirements. We have explored in the effective domain that people's dietary preferences were not clearly described.

Care plans contained a section where people's sexuality could be recorded. We found that in some care plans rather than a sexual orientation staff had recorded the person's gender. In other files this was blank. Staff told us they did not support anyone who identified as lesbian, gay, bisexual or transgender. This was despite the service supporting over 200 people. Staff told us, "No one ever mentioned it [sexual orientation

and gender identity]." Though they acknowledged they would know if someone had previously been in a heterosexual partnership. This meant there was a risk that people who identified as lesbian, gay bisexual and transgender may not feel that the service offered a safe space for them to disclose their identity.

The provider information return stated staff had attended LGBT training. Despite the training matrix supplied by the provider showing they offered 3 different courses relating to equality and diversity, and a further seven courses relating to sexuality and sexual needs only 33% of staff had completed training any diversity training, and 41% had completed training in sexuality and sexual needs. Some of the course dates were from 2013, before the service was registered. Furthermore in three of the schemes no staff had received any training in equality, diversity or sexuality.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring the service is providing appropriate support to people regarding their sexual and gender identity.

People told us they valued their independence and staff supported them to maintain it. People described how staff supported them to keep their homes clean which helped them stay independent, or reminded them to use equipment to reduce the risks of falling and losing their independence. Staff told us they encouraged people to be as independent as possible. One staff member said, "If they can do something independently we won't interfere in that. We'll make sure we're available but that is all."

Requires Improvement

Is the service responsive?

Our findings

We saw care plans were signed as being updated every six months, or following incidents where people's needs had changed. However, care plans were not personalised and did not describe how to support people's individual needs. People we spoke with told us they could tell the scheme managers and team leaders if they felt things needed to change with their care, but did not recall having meetings about their care. No one we spoke with recalled being offered a choice about who provided their care. One person said, "It's just the ones [care workers] that come. I didn't choose who they are."

Across all the care plans reviewed the provider had taken an outcome based approach. Although the goals of support were included, the details of what a positive outcome would look like, and how to support the person to achieve it was not. For example, one person's wishes regarding their personal care were recorded as being, "Requires staff support with shaving every morning and prompt to choose clean clothes." The planned outcomes were, "To promote independence, to promote choice of what to wear, to maintain a good standard of care, to ensure one member of staff assist to wash / shower and shave." There was no information about this person's preferences or details of how care should be delivered. Other care plans referred to staff providing encouragement, prompts and assistance but this was not described.

One person's risk assessment referred to them having a hearing impairment. However, this was not mentioned in their care plan and there was no information or guidance for staff about how to communicate effectively with this person to ensure their needs were met. Another person's risk assessment described them as experiencing confusion due to dementia. There was no guidance in their care file about how to support them to be more orientated or how to respond if they became confused or distressed.

The above issues are a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were offered a range of activities by both the service and their housing providers. There were three welfare and activities coordinators who worked across the 14 schemes to facilitate a range of activities to suit people's tastes. Records showed people were offered group activities including coffee mornings, bingo, film club as well as trips to the theatre. People were supported to attend day centres and external activities with the combined support the provider and housing schemes.

Some people told us they liked the activities and we saw people engaging with a range of sessions that were taking place at the schemes we visited. For example, one person enjoyed playing cards, and at another scheme bingo. However, other people told us they knew activities were on offer, but did not feel they were suitable for them. One person said, "The activities don't really interest me. I've made my own arrangements with friends from outside." Records of tenants meetings showed activities were discussed and housing providers gave feedback to the provider based on what people said at these meetings.

Records of care showed people received support with their personal care, medicines and meal preparation as required. We noted the level of detail was limited, for example, staff did not record what meals people

were supported to prepare and eat, and rarely recorded any information about people's mood or presentation. This was despite care plans stating staff should be monitoring people's wellbeing. This meant there was a risk that changes in people's presentation may not be identified from the records.

Although not all the people we spoke with knew how to complain, they were all confident any concerns they had would be responded to appropriately. One person said, "I don't know how [to make a complaint] I've not had cause to. I'm sure [team leader] would sort it out if something came up." Other people told us they knew how to make complaints. One person said, "I know how to make complaints. I'd tell [scheme manager]."

The provider's complaints policy covered only complaints that required a written response; complaints made verbally and resolved within 24 hours were considered out of the scope of the policy. We reviewed the provider's responses to complaints made over the last year and saw they completed investigations as described in the policy. However, the audits completed did not include any lessons learned for the service, and complaints were not discussed in staff meetings. This meant there was a risk that lessons from complaints were not shared and issues could recur. There was no thematic analysis of complaints which meant themes to complaints were not identified and opportunities for learning were missed.

Care plans did not specifically address people's wishes for care should they reach the last stages of their life. However, people told us they would choose to remain within the schemes if they reached the last stages of life. One person told us, "I'd stay here to my last days. I trust them all to take good care of me." Staff told us they worked with the local hospice when people were approaching the end of their life. One care worker explained, "We work with [hospice]. They will send the nurses, or sometimes people will go and stay there if it's what they want." The provider's policy for supporting people at the end of their lives referred to best practice guidance and ensuring people were able to express their preferences and have these acted upon. The policy stated all staff working in the service should have training in end of life care. However, only 63% of staff had completed this training.

Inadequate

Is the service well-led?

Our findings

The management of the service had recently changed. The previous registered manager had left, and the plan for the service recognised the large scope of the role of managing 14 schemes. The provider had decided the role would be shared across two managers, one of whom had completed the registration process and the other was going through the processes at the time of our inspection. Each of these managers was responsible for seven supported housing schemes. Although only one was currently registered they shared responsibility and are referred to as 'the managers' throughout this section of the report. The management structures were clear, with scheme managers in place and team leaders for each shift. Some scheme managers worked across two sites depending on the size and nature of the needs of people living in the schemes.

The location address was the head office of the local authority. For a location to be correctly registered the regulated activity must be managed from the location address. We identified concerns about whether the office location was truly where the regulated activity was managed from. This was because information about people and staff was not available at this office. While the information relating to staff should have been uploaded to the online filing systems, it was not the usual practice for information about people to be available in the office as this was all kept at the schemes. For the regulated activity of personal care to be correct people must be able to choose their care provider, and their housing tenancy and care support must be separate agreements. People did not recall being able to choose their provider at several schemes and people did not have contracts or agreements regarding care provision. The provider took action during the inspection to make records available and has committed to reviewing their registration to ensure it is correct.

The managers told us a new system for online record keeping had been introduced and this was difficult for scheme managers to use, and often stopped working. We saw during the inspection that as the managers opened documents for us to review, the system would slow down and stop. On one occasion the managers had to contact their support desk to unlock the system and this took half an hour to resolve. The managers explained this led to scheme managers failing to update the online systems as it was a time consuming task that often did not work effectively. Staff supervisions were meant to be uploaded to this system, but the most recent records were six months old. One of the managers explained, "We have to chase the scheme managers to do these things [upload the documents]. We last did an audit of the staffing records six months ago and found the records had not been uploaded. They uploaded them, but the next audit is due which would have found the same thing." The managers recognised they needed to follow up on whether actions from audits had been sustained.

Staff told us the activities and welfare officers carried out quality assurance visits and sought feedback from people about their experience of care. We asked if there were action plans in place to address issues raised by people during these visits. Scheme managers told us they received emails about any issues and addressed these one by one. This meant there was no systematic or service wide analysis of the quality of support received by people, and no way of identifying if themes were scheme-specific or more general in nature.

The managers completed quality assurance visits and checks to the schemes. The scheme managers also completed audits of medicines records, signed off care plans and risk assessments and completed spot checks at night. However, there was no analysis of audits or related action plans for any of the schemes. The mangers explained that where they identified issues they would receive feedback from scheme managers that issues had been addressed. However, there was no clear audit trail and it was not captured that issues were followed up on future occasions to ensure they were addressed. Due to the nature of the way audits were captured it was not possible to see if issues were recurring or different issues were identified at each visit.

The provider sent us a record of audits completed and this showed there was no pattern or routine to the audits. For example, medicines were checked at one scheme in August 2017. The next medicines audit did not take place until June 2018. A night spot check was carried out in January 2018 where actions were identified, but the next night spot check did not take place until November 2018. At another scheme there had been an audit of "all mandatory documents" in July 2017, the next recorded audit was of medicines in September 2018.

The audit systems in place were not operating effectively to identify and address issues with the quality and safety of the service. They had not identified the poor quality of care plans and risk assessments. They had also not identified that medicines records were incorrect and that medicines practice had not been updated to reflect the guidance issued by the National Institute of Clinical Excellence (NICE) in March 2017, about medicines in home care. The provider submitted an audit of complaints, there were no lessons learnt recorded for any of the complaints audited. Scheme managers sent records of incidents, accidents and safeguarding records to the managers for review. We saw the managers reviewed these, and asked for appropriate follow up action to be taken. However, there was no overall audit or analysis so no themes could identified. This meant there was a risk that patterns to incidents, accidents and allegations of abuse may be missed as each was dealt with on an individual basis.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found the managers supportive. One care worker said, "I think the team works well and the managers are all supportive. I've got a good team leader, then [manager] covers a group of the units, and [name] is the scheme manager. I like their approach. Very straightforward." Another staff member said, "[Manager] does a really good job and is approachable and helpful. I've never felt she hasn't been there. She is an absolute diamond." Both the managers demonstrated their commitment and dedication to the services during the inspection and expressed a clear desire to improve the quality and safety of the service. They were both relatively new to their current role and recognised there had been a steep learning curve.

Staff told us, and records confirmed each scheme had regular staff meetings. Although these varied depending on which scheme they took place in, we saw staff discussed people they supported and their needs in detail. All staff meetings included discussions around health and safety, infection control, record keeping, incident recording, safeguarding as well as activities taking place in the local community. Staff meetings records also showed staff were given opportunities to discuss the running of the service, as rotas, workloads and holiday planning were discussed.

The welfare and activities coordinators worked with staff from the schemes to ensure people were supported to engage with their local communities. We saw information about activities and events in the local community were on display throughout the schemes and people were able to get involved if they wished. The schemes worked with other organisations in their local area, including day services, theatres,

cinemas as well as supporting people to engage with events offered by their housing providers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not assessed in line with guidance and care plans were not personalised. Regulation 9(1)(3)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training they needed to perform their roles. Regulation 18(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not appropriately identified or mitigated. Medicines were not managed in a safe way. Regulation 12(1)(2)

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant by March 2019.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)(2)

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant by March 2019

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Housing with care CQC inspection: what we're doing to improve the service

- **Housing with care CQC inspection: what we're doing to improve the service**

We take the Care Quality Commission's (CQC) rating of 'inadequate' very seriously. The safety of the service users that we support is extremely important to us and making immediate improvements to the service is our highest priority.

An improvement plan and extra resources have been put in place to fully address the issues as quickly as possible, and our quality assurance team is monitoring all service improvements regularly to ensure they are sustained long-term.

We are working closely with CQC to ensure full compliance with the necessary regulations.

What we're doing to improve the service

CQC said: Medication was not managed in a safe way, and records for medication were incomplete

We did:

- we have reviewed how we assess risks related to medication for our service users, and we are implementing a more thorough risk assessment process that ensures the safety of service users
- we have developed a new medication support plan template and process that records what each individual service user requires in order to take their medications safely, improving the care and support they receive to do so
- all staff will be briefed and trained on a new approach to managing and recording medication safely

CQC said: We need to do more to make sure that lessons are learnt and shared if an incident is raised within schemes

We did:

- staff will be receiving refresher training on the complaints and incident reporting processes
- we will be working with the complaints officer to ensure any complaints and issues raised are not only responded to in that instance, but that lessons are learnt and changes made are sustained
- we will be doing this by implementing regular analysis of all complaints to find the key themes. Improvement plans will then be developed and implemented to address themes identified, and communicated to all staff
- this will ensure that service users, friends and families' input will help to improve the services

CQC said: The processes and paperwork for identifying and mitigating risks, and assessing service users needs, were inadequate

We did:

- we are developing new ways of carrying out risk assessments and recording mitigating actions taken by staff to address those risks. Paperwork and record keeping will reflect this improved approach
- service users can expect more detailed conversations about their individual needs, areas of risk, and clear plans of what will be put in place to keep them safe. All will be communicated and documented
- staff will be trained on how to carry out the improved needs and risk assessments

CQC said: There is a high agency staff use

We did:

- by using agency staff we are able to quickly adjust the amount of care available to service users as their needs change
- we also cover the absences of permanent members of staff who are on leave with agency staff to ensure we maintain the correct ratios of staff to support and provide care for service users
- we will continue to ensure staffing is adequate across all schemes to enable the delivery of good quality care to all service users

CQC said: Service users' care plans need to be more detailed and personalised

We did:

- we will be ensuring a full picture of our service users is evidenced in their care plans, through training staff on how to have detailed conversations with service users as individuals, as well as looking at their healthcare needs
- a more personalised care plan template has been developed. This includes recording information about service users' dietary requirements, cultural background, sexual and gender identity, support networks and other relevant information that enables staff to offer personalised care and support

CQC said: The training programme for staff needs to be improved, and implemented more consistently

We did:

- making sure staff have the knowledge and skills to deliver high quality care to service users is the foundation to achieving and sustaining the improvements needed
- learning and development specialists are reviewing the current training offer. A new training strategy is being introduced to clarify all mandatory staff training, and how often staff are required to attend
- we are also introducing an improved way of tracking and recording staff attendance at training
- training on writing personalised care plans will be included in the new training strategy, and a priority is ensuring safeguarding training is attended by all staff

CQC said: The quality assurance systems were not being operated effectively to identify and address issues with the quality and safety of the service. The audits of schemes were not resulting in sustained improvements

We did:

- quality assurance processes within schemes are being reviewed, to ensure any issues with quality of care are identified and improved quickly
- clear guidance on the process for implementing improvements in response to issues identified during audits is being developed. Findings and associated action that is taken as a response to audits will be discussed at monthly managers' meetings, and then communicated with all staff
- this will ensure that any issues discovered during audits are addressed, lessons are learnt and applied through all schemes

CQC said: Staff did not always fully apply some relevant legislation and policies in their practice

We did:

- all staff will attend further training on the Mental Capacity Act (MCA) (2005), with a focus on practical application and documentation
- all staff will also attend refresher training on end of life, complaints, and whistleblowing policies

Contacts

If you would like to know more about the full improvement plan, please contact:

- Lina Banionyte - Locality Manager: lina.banionyte@hackney.gov.uk
- Frances Harve - Locality Manager: frances.harve@hackney.gov.uk

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Hackney

Health in Hackney Scrutiny Commission 4th February 2019 **Obesity Strategic Partnership**	Item No **6**

OUTLINE

When setting the work programme for the year Members requested a briefing on what the Council was doing to tackle obesity.

Attached is a briefing on the work of Hackney's *Obesity Strategic Partnership* which is a whole system approach to tackling obesity and which is chaired by the Chief Executive.

Attending for this item will be

Tim Shields, Chief Executive, Hackney Council
Jayne Taylor, Consultant in Public Health, Hackney Council

ACTION

The Commission is requested to give consideration to the report.

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Obesity Strategic Partnership – a 'whole systems' approach to obesity for Health in Hackney Scrutiny Commission

Item No:		**Date:**	4th February 2019
Subject:	Obesity Strategic Partnership - a 'whole systems' approach to obesity		
Report From:	Tim Shields, Chief Executive, London Borough of Hackney (LBH) Jayne Taylor, Consultant in Public Health/Prevention Workstream Director, LBH Jack Gooding, Public Health Strategist, LBH		
Presented by:	As above		
Summary:	This report gives an overview of the current state of obesity in Hackney, and the 'whole-systems' response that the Council has been leading since February 2016, via the Obesity Strategic Partnership (OSP). The report discusses the impact of the work of the OSP to date, and how success will be measured in future.		
Recommendations:	To note the information in the report, and to endorse the whole-system approach to obesity that the Council is taking with partners.		
Contact(s):	Jack Gooding Public Health Strategist Jack.gooding@hackney.gov.uk 0208 356 7475		

1. Obesity in Hackney - the evidence

1.1 Obesity has significant health, social and economic impacts. The national economic costs of obesity are significant, £27 billion in total. People who are obese have a shorter life expectancy, are less likely to be employed, and are much higher users of social care and health services.

1.2 Overweight and obesity are commonly calculated by body mass index (BMI).[1] Being overweight or obese is linked to a wide range of diseases, most commonly type 2 diabetes, hypertension, some cancers, heart disease, stroke, and liver disease. Obesity can also be associated with poor psychological and emotional health, and poor sleep. Obese individuals may also be more likely to suffer from stigma, which may impact on their self-esteem.

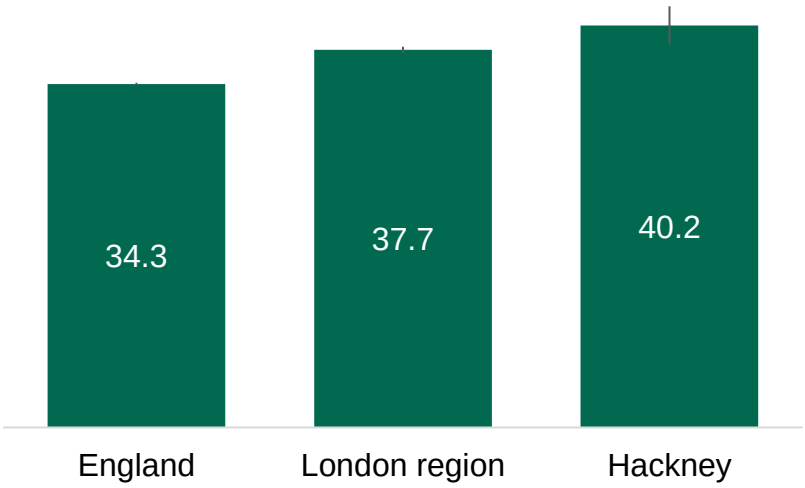
1.3 The latest National Child Measurement Programme (NCMP) results from 2017/18 show that in City and Hackney 24.6% of 4-5 year olds had excess weight (obese or overweight). In year 6 in 2017/18, 40.2 % of 10-11 year olds had excess weight (overweight or obese) locally. Values across all age ranges are above regional and national averages (see figures 1 and 2 below).[2]

Figure 1: *Excess weight (overweight and obesity) in Reception Year (age 4-5) children in City and Hackney, London and England (2017/18 NCMP)*

Source: Fingertips PHE

[1] Overweight and obesity – the most common method of measuring obesity is using BMI. An adult BMI of between 25 and 29.9 is classified as overweight and a BMI of 30 or over is classified as obese.
[2]Results for City and Hackney NCMP are combined. Due to the small numbers in the City, the patterns shown primarily reflect the picture in Hackney.

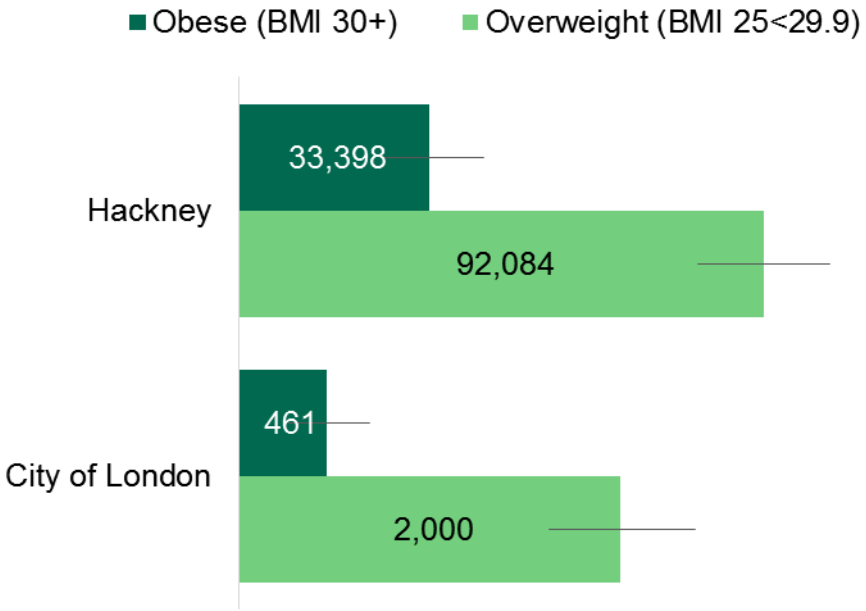
Figure 2: *Excess weight (overweight and obesity) in Year 6 (age 10-11) children in City and Hackney, London and England (2017/18 NCMP)*



Source: Fingertips PHE

1.4 Based on GP practice records in Hackney, 59% of adults are estimated to have a BMI in the 'overweight' or 'obese' range. Applying these prevalence figures to the total resident population, just over 92,000 adults are estimated to be overweight and around 33,400 are estimated to be obese in Hackney (see Figure 3 below).

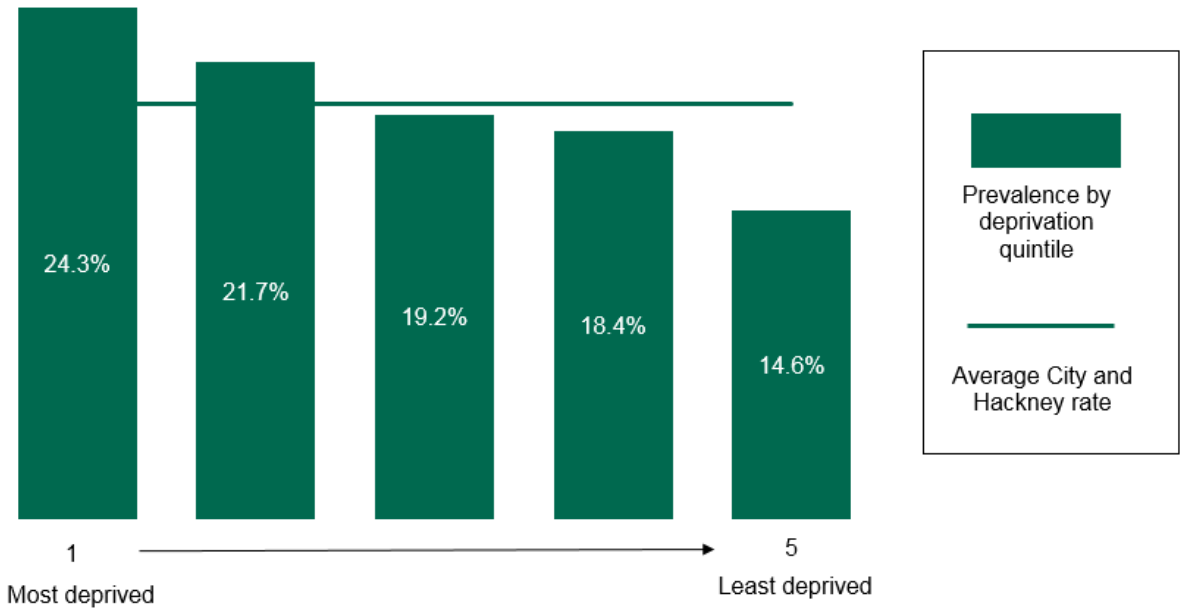
Figure 3: *Estimated number of Hackney and the City residents who are overweight or obese (age 18+, 2016/17)*



Source: City and Hackney Joint Strategic Needs Assessment

1.5 There are substantial social inequalities in relation to obesity, where those from the most deprived backgrounds are significantly more likely to be obese than those from the least deprived backgrounds. Figure 4 below shows that 24.3% of adults living in the most deprived areas in Hackney are obese, compared to 14.6% in the least deprived. Similar inequalities related to obesity are seen in children. For example in England in 2017/8 at reception age, 26.5% of children from the most deprived 'decile' were overweight or obese, compared to 17.0% of children from the least deprived decile (a similar pattern is observed in Year 6).[3]

Figure 4: *Percentage of Hackney and the City residents who are recorded as obese (BMI 30+) by their GP, by deprivation quintile (age 18+, 2017)[4]*



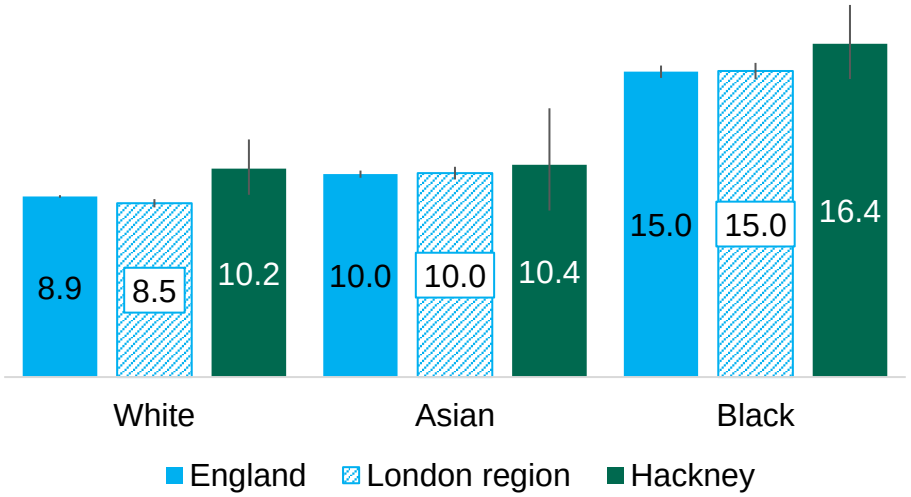
Source: City and Hackney Joint Strategic Needs Assessment.
Note: Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).
Note: Only includes GP patients with BMI recorded.

1.6 There also significant differences in obesity prevalence between different ethnic groups. For example, combined five year NCMP data shows the highest rates of obesity are found in Black ethnicity pupils for both Reception and in Year 6 (see figures 5 and 6 below). Similarly, Black adults are the most likely to be recorded as obese by their GP (33.6% in 2017) and White adults the least likely (15.1%).

[3] Deprivation deciles are defined using the Index of Multiple Deprivation 2015. They are created by ranking lower super output areas (LSOA) in England from most to least deprived and dividing these into ten categories with approximately equal numbers of LSOAs in each. Further information can be found in Public Health England's 'Assigning Deprivation Categories' technical guide.

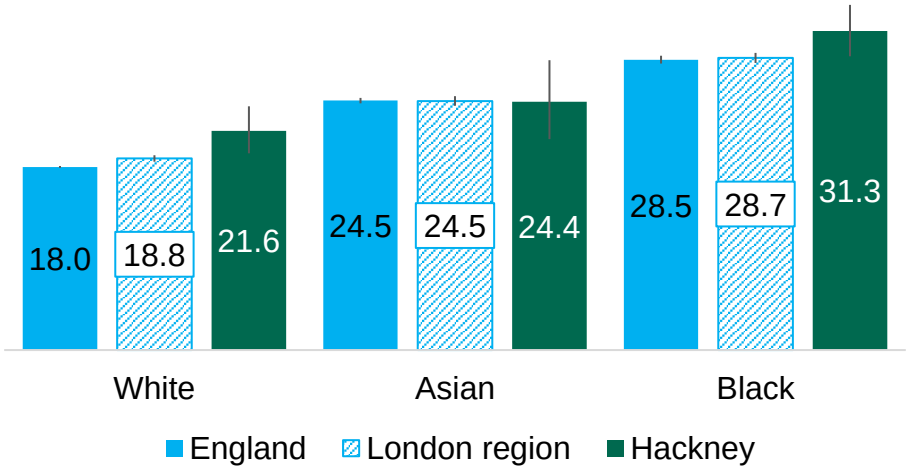
[4] These figures are taken from City and Hackney Joint Strategic Needs Assessment, where the results for the two local authority areas are combined. Due to the small numbers in the City, the patterns shown primarily reflect the picture in Hackney.

Figure 5: *Obesity (including severe obesity) in Reception in City and Hackney, by ethnicity, 5-years of combined NCMP data (2013/14-2017/18)*



Source: Fingertips PHE

Figure 6: *Obesity (including severe obesity) in Year 6 in City and Hackney, by ethnicity, 5-years of combined NCMP data (2013/14 – 2017/18)*



Source: Fingertips PHE

1.7 Differences in obesity prevalence are also observed by gender locally, but the picture is more complex. For example, a higher proportion of boys were overweight/obese than girls (22.5% and 21.1% in Reception, and 40.3% and 35.0% in Year 6, respectively, in 2017/18). However, among adults, GP recorded obesity rates are higher amongst women (22.7%) than men (16.4%) (CEG 2017).

Box 1: Ethnicity adjustments to child obesity prevalence estimates

Research has shown that BMI cut-off points used to identify obesity in the UK tend to under-estimate obesity in South Asian children and over-estimate obesity in Black children.[5]

When local NCMP-recorded BMI is adjusted for ethnicity, the overall prevalence of obesity (reception and year 6 combined) is on average 2% lower. This is because Hackney has a relatively higher proportion of primary school children from Black ethnic groups and a relatively lower proportion of children from South Asian groups. However, in Hackney neighbourhoods with a higher concentration of South Asian residents, prevalence accordingly increases following this adjustment.

This new analysis will help orient future work that we do with specific communities on obesity and healthy weight in Hackney. However, it is important to note that the absolute *numbers* (not just % prevalence) of children affected will also inform the work. While the percentage of Black children who are obese decreases following these adjustments, there are still a large number of children classified obese within these communities.

2. A 'whole system' response - a strategic approach to obesity

2.1 The 2007 Foresight report on obesity took a forward look at how the UK can respond sustainably to rising levels of obesity.[6] It brought together evidence and expertise from across a wide range of disciplines and from professionals and interested organisations both inside and outside government.

2.2 The report describes an 'obesogenic' environment, where obesity is seen as a 'normal' response to an 'abnormal' environment and set of circumstances, where it is easier for people to be unhealthy than healthy. The causes of obesity were demonstrated to be complex, and not solely based on individual actions; we are strongly influenced by the circumstances and environment in which we live – often described under three headings (a simplified version of the Foresight systems map is presented in Figure7):

- the 'food environment' – examples include the relative price and availability of unhealthy vs. healthy food, marketing and promotion, portion sizes, and the formulation/content of convenience food;

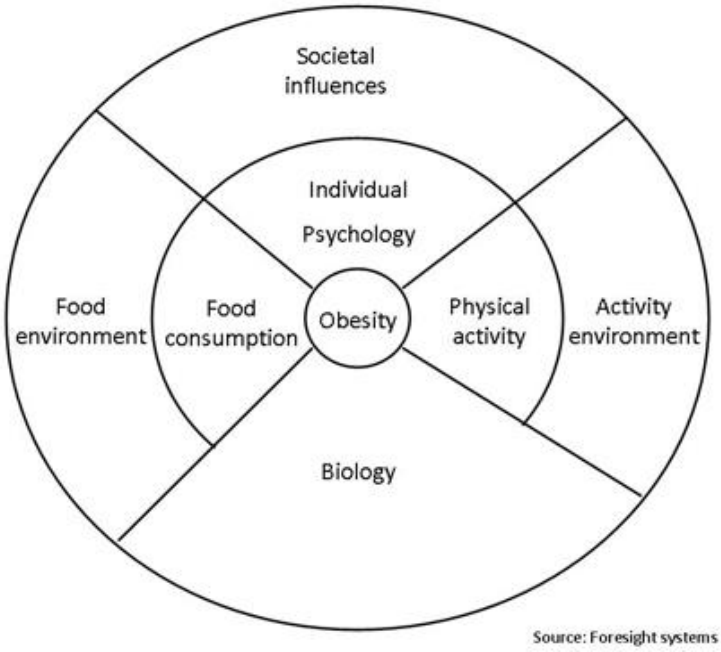
- the 'physical activity environment' – examples include local transport options, safety issues, technology and labour-saving devices, sedentary jobs, and the availability of PE in schools; and

[5] Patterns of body size and adiposity among UK children of South Asian, black African–Caribbean and white European origin: Child Heart And health Study in England (CHASE Study)

[6] Foresight Tackling Obesities: Future Choices – Project Report 2nd Edition (Government Office for Science, 2007) https://www.gov.uk/government/publications/reducing-obesity-future-choices

- the ‘social environment’ – advertising, education, social acceptability of overweight and/or obesity, peer pressure, family/social norms, and cultural practices.

Figure 7: *Simplified Foresight obesity systems map*



2.3 This means that responding to obesity is complex. It requires a coordinated response across the local obesity ‘system’ by organisations, communities and individuals. The report advised that there is **no single effective measure to reduce obesity, and that only by taking cumulative coordinated action against all the drivers of obesity will we see the level of change required to effectively reduce obesity** levels and overturn the current trends.

2.4 Led by the **Obesity Strategic Partnership** (OSP), since February 2016 Hackney has been working to implement a new local system response to obesity reduction and create a borough where everyone can achieve a healthy weight.

2.5 The OSP brings together senior partners from across key council services - transport, parks, business and regeneration, education, housing, children and adult services, regulatory services and environmental health, planning, public health, communications – as well as City and Hackney CCG.

2.6 The OSP has concentrated on delivering a small number of actions in each year, making the most of levers available to the partnership to tackle the various and complex local drivers of obesity (as described above). These actions have been based around the following themes:

- working with businesses to improve the food environment, through roll-out of the Healthier Catering Commitment (with a particular focus on hot food takeaways);
- getting people active as part of their everyday lives, including exploring how we can best connect Hackney's green spaces and improve estate permeability;
- behavioural insight and influence, including the co-production of an affordable healthy recipe pack and commissioning an ethnographic research project with the most affected communities;
- workplace interventions to get staff active, happy, and healthy, including offering weight management services for council staff on-site;
- school-based activities, including implementing the Hackney Daily Mile in 29 primary schools in the borough; and,
- supporting people at high risk of obesity-related harm to access appropriate information, resources and services (see appendix 2 for an overview of local obesity care pathways).

2.7 The current local Healthy Weight Strategy ends in 2019. The main focus of the OSP over the past 12 months has been to build a social movement for change around healthy weight, to inform the development of a new shared vision and action plan, working together with a broad partnership of local organisations, communities, and individuals.

2.8 This has been initiated through a number of engagement events that have expanded participation in shaping the local response to obesity, to include the voluntary and community sector, businesses, schools, the housing sector, health and care professionals, and residents (including children and young people). A whole day collaborative strategy design workshop is scheduled for 7 March 2019, and will include representatives from the groups described above, with the first draft of a new strategy scheduled to be completed and ready for consultation by the end of May 2019 (see table 1 below for a timetable of events). The new long-term strategy will guide our work for up to ten years.

Table 1: *Key engagement groups and dates for the development of the new healthy weight strategy*

Area/group	Engagement dates
Children and young people	October – December 2018
Housing	September 2018 – January 2019
Insight with key communities	October – December 2018
Residents, in partnership with Prevention workstream, and neighbourhoods programme	November 2018
Voluntary and community sector	November 2018
Collaborative strategy design workshop	March 2019

3. Measuring the success of local action to reduce obesity

3.1 Taking a 'whole systems' approach to reducing obesity requires us to think differently about how we measure the impact of our work (see Box 2).

3.2 The work of the OSP has developed organically since its inception, taking an approach of 'getting things done', trying things out, being curious and learning. We did this by selecting up to five priority actions to concentrate on each year, and reflecting on and adjusting our plans as we went along. As a result, the OSP has made some significant strides over the past three years in implementing various actions and interventions at all levels of the local obesity 'system' (see the accompanying infographic in appendix 1 for an example of some of our successes).

3.3 In order to better understand what is working and where we should continue to focus our efforts, we recognise that we need a more systematic approach to monitoring and measuring impact. In keeping with the innovation and learning approach adopted by the OSP to date, we are exploring novel approaches to evaluating the impact of our work, for example using Revaluation methodology.

3.4 This method was developed in order to measure the full value of activity in complex systems. It is a new approach, developed in the context of NHS Change Day 2015, a grassroots social movement for improving patient experience. Revaluation is centrally concerned with revealing the value of an activity in a complex system. Rather than asking "what works", its first question is "what is going on?" For this and other reasons, Revaluation has been described as "a paradigm shift in evaluation". It's currently being used in the Greater Manchester Moving programme, and a range of other regional national evaluations including family nursing, and work on the natural environment.

4. Next steps

4.1 As mentioned above, a collaborative design workshop with partners, residents and other key stakeholders will take place on 7 March 2019. The workshop will aim to define a set of principles and a shared vision on how to promote healthy weight and reduce obesity-related harm in Hackney. Included in the workshop will be a discussion of how we can measure success in achieving our aims by taking forward the agreed actions.

Box 2: Evaluating complex whole system change – a different approach

Moving the focus away from 'outcomes'
The main outcome measures for child obesity are Reception and Year 6 prevalence, based on data collected as part of the NCMP. However, as described in this paper, obesity is a complex issue and there is no single intervention or organisation that can solve it, with many influences playing out at national (or even international) level. An effective and lasting response relies on sustained and focused partnership work to generate meaningful change. Consequently, our local actions are unlikely to result in a significant shift in NCMP outcome indicators over the short-term. Instead, we need to focus on understanding the short and medium term impacts of our work in influencing different levels of the obesity system (not at the expense of, but as a complement to, monitoring formal outcome measures).

Considering direct and indirect impacts
The impact of some of our work to date is relatively easy to evidence and 'count' (for example, the number of schools and pupils participating in the Hackney Daily Mile). Other actions have directly led to tangible change, but are less easy to quantify (for example, influencing the Corporate Sponsorship Policy to restrict promotion of sugar sweetened drinks at council events targeted specifically at children).

Further impacts of our work are less direct and even more difficult to measure. For example, where a member of the OSP has taken a policy decision or intervention in their organisation or service area to support the aims of promoting healthy weight (or reducing obesity), where they would not have done so previously. In a recent survey, most OSP members agreed that they now have a better understanding of the role that they can play in reducing and preventing obesity, including increased confidence in suggesting policy changes that support this work.

Appendix 1: Obesity Strategic Partnership infographic

WORKPLACE

More than **300** opportunities for staff to take part in **low cost exercise classes** over the last year

A 12 week **weight management offer for Hackney Council staff**, funded by HR

Removing **500,000** cubes of **sugar** from Council buildings per year

100 staff health and wellbeing champions at Hackney Council have invested their time in workplace health

1 of 8 organisations to achieve **excellence** out of 200 applicants

The **Healthy Catering Guidelines** support staff and caterers to make healthier food and drink choices

ACTIVITY

One You sees **800** people taking part in **48000** minutes of exercise every week

2705KG Was lost last year by going to the **Healthier Together Hackney** weight management service

Affordable recipe kits designed by and sold to residents

3000 residents have cooked and eaten together in the **Community Kitchens project**

15,703 hours of walking were recorded during the Walking Campaign

69% of families who participated in the **Rose Voucher programme** are eating more meals together as a family

3100 school children are taking part in the **Daily Mile**

900 fewer sugar cubes per vending machine in leisure centres

Working with **16** schools and **5** early years settings to raise awareness and take action to reduce sugar

32 local food business operators are signed up to the **Healthier Catering Commitment**

Conversations with over **200** residents of all ages and other stakeholders about what a **healthy weight** means to individuals and communities

The Obesity Strategic Partnership

Planning – Environmental Health – Public Health – Parks and Leisure – Hackney Learning Trust – Community Safety – Streetscene – Adult Social Care – Communications – Young Hackney – Regeneration – City & Hackney Clinical Commissioning Group – Chief Executive – Housing – Children's Services –

Encouraging **active travel** by making estates easier to **walk and cycle** through, for tenants and residents

Helping to make Hackney a child friendly borough by increasing opportunities for **play**

Connecting and improving access to Hackney's **parks and green spaces**

Supporting the way that **Parks, Leisure, Planning, Environmental Health, Transport** and **Business support sectors** contribute to improving health in Hackney

Restriction of new hot food takeaways opening within a **400** metre radius of **schools** in the proposed Local Plan

Signing the Local Authority Declaration on **Sugar Reduction** and **Healthier Food**

Introducing a **Corporate Sponsorship Policy** to restrict sponsorship by sugar sweetened fizzy drinks companies, especially for events aimed at children

Making the way we buy, serve and promote food **healthier and more sustainable**

POLICY

So far, the wider group has seen people from approximately **80** organisations come together

Creating a space for:

- ✓ Innovation
- ✓ Shared ownership
- ✓ Trying new approaches
- ✓ Collective action
- ✓ Whole system approach to addressing obesity
- ✓ Building relationships

Working together for a place where everyone can achieve a healthy weight

Making obesity everybody's business

PARTNERSHIP

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Appendix 2: Healthy weight and obesity services pathway

5.1 Much of the work described in this paper is preventative, and supports the local obesity care pathways, which provide different interventions and services based on different levels of need. Figure 8 below gives an overview of the different elements of an evidence-based obesity care pathway. Table 2 shows the commissioning responsibility for each part of the pathway.

5.2 Locally there are a range of services commissioned and delivered across the health, care and voluntary sectors that contribute to promoting healthy weight, and reducing obesity.

5.3 Through the City and Hackney Integrated Care System, joint work is being taken forward by the Prevention and Planned Care workstreams to review and address existing gaps in local clinical obesity pathways. At present, there is no specialist service provision (Tier 3) commissioned to support very obese individuals with obesity related co-morbidity, who may not have responded to earlier interventions in the pathway. The service gap is evident for both adults and children. The emergence of integrated commissioning creates a new opportunity for joint work to commission across the whole pathway in Hackney to meet all levels of need in relation to obesity treatment.

Figure 8: *UK Obesity pathway for adults, Department of Health 2013*

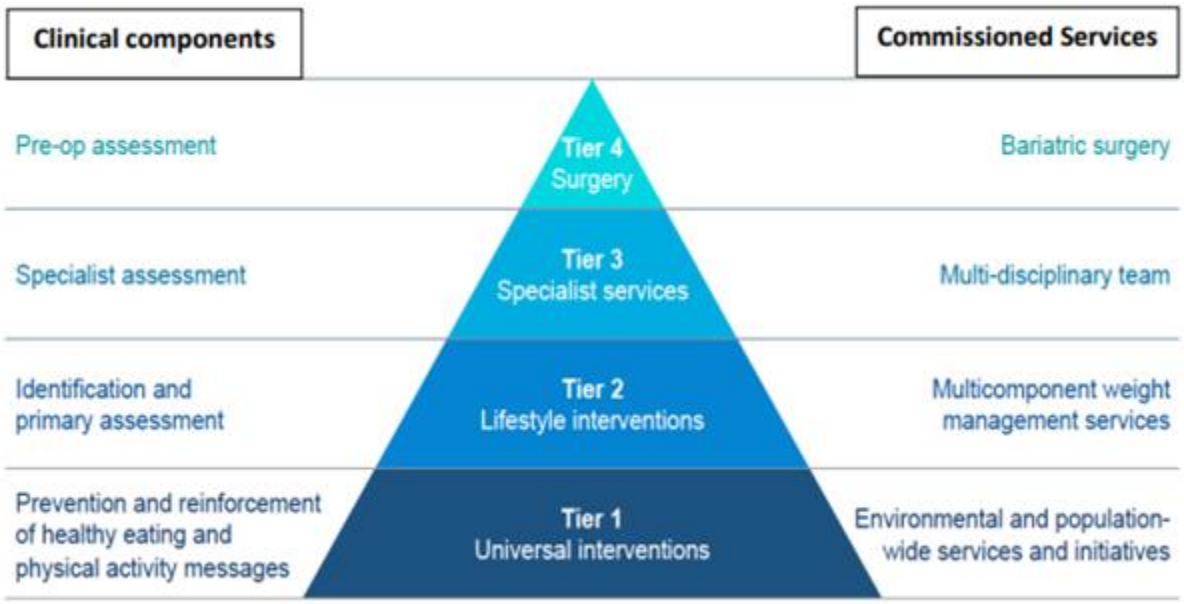

Table 4: *Pathways for obesity - adapted from 'Joined up clinical pathways for obesity: Report of the working group', NHS England, 2014*

Intervention type	Description	Commissioning lead	Referral criteria
Universal interventions	Universal interventions (prevention and reinforcement of healthy eating and physical activity messages)	Local authority	Universal
Lifestyle interventions	Lifestyle weight management services, usually in a group and time-limited	Local authority	Locally determined
Specialist services	Clinically-led multidisciplinary team (MDT), potentially including physician (including consultant or GP with a special interest), specialist nurse, dietitian, psychologist, psychiatrist, and physiotherapist	CCG	Very obese/morbidly obese
Surgical	Bariatric surgery, supported by MDT pre and post procedure	CCG (formerly NHS England)	Very obese/morbidly obese

Hackney

Health in Hackney Scrutiny Commission 4th February 2019 **Review on 'Digital first primary care and its implications for GP Practices' - EVIDENCE SESSION 2**	Item No **7**

OUTLINE

At last month's meeting the Commission heard from: Babylon Health/GP at Hand, City and Hackney CCG and City & Hackney GP Confederation.

For the second evidence session the Commission has invited the ELHCP Primary Care Leads, both Hackney and Tower Hamlets LMC Chairs and from the lead officer for the Integration Commissioning Board's IT Enabler Group.

The following will be in attendance:

Invitee	***Organisation***	***Topic***
Jane Lindo	Primary Care Lead for East London Health and Care Partnership	Future model for digital first services in NEL
Jenny Cooke	Deputy Director for Primary and Urgent Care Tower Hamlets CCG and also lead for the Primary Care New Models	New models of primary care in Tower Hamlets
Dr Fiona Sanders	Chair, City and Hackney Local Medical Committee GP at Heron Practice	Local Medical Committee
Dr Gopal Mehta	GP at Richmond Rd Medical Centre	Local GP perspective
Dr Jackie Applebee	Chair, Tower Hamlets Local Medical Committee	Tower Hamlets Local Medical Committee
Niall Canavan	Director of IT and Systems at Homerton University Hospital NHS FT but also lead officer for LBH-CoL-C&H CCG Integrated Commissioning Board's **IT Enabler Group**	Work of City and Hackney's Integrated Commissioning Board's IT Enabler Group on digital care pathways

Attached please find:

1) Briefing from ELHCP ‘Primary Care Digital Across East London’
2) Briefing from Dr Fiona Sanders City & Hackney LMC
3) Letter from Tower Hamlets LMC to Sec of State March 2018 re impact of GP at Hand
4) Letter from Tower Hamlets LMC to Sec of State Sept 2018 re impact of GP at Hand
5) Briefing from IT Enabler Group

ACTION

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

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.

Briefing notes for Fiona for 'Digital First primary care and its implications for GP Practices'

Meeting date 4 February 2019

Implementation of digital approaches without destabilising GP

- GP always at the forefront of digital innovation in NHS
- GP been utilising computer records since the 1980s (https://www.nethealth.com/a-history-of-electronic-medical-records-infographic/ -useful brief history of this)
- The issue is not with digital approaches it is with the current issue of this not being a universal offer to all patients and practices. The NHS was founded on the principle of health care equality for all citizens.

Better outcomes for patients

- Doctor-patient relationship has evolved, patients are becoming increasingly proactive in their own care. Digital developments can enable patients to safely monitor their conditions, interact with healthcare professionals to enable improved self-management of both acute and long term conditions.
- Consider a patient with an exacerbation of their asthma, digital technology through a smart phone can enable them to remotely check their pulse, respiratory rate, oxygen saturation, BP and they can add to this their PEFR. To this they can provide the GP with a structured history using one of the currently available online consulting tools and the GP or AHP would be able to assess the severity of the exacerbations, whether the patient required a F2F review, hospitalisation or could manage this by stepping up their treatment. The only thing this doesn't include is auscultation of the chest, there are apps that enable someone to use a smart phone as a stethoscope and in theory they could record this and send to the GP but this would require them understanding how to use this app correctly.
- Consider a patient with hypertension who utilising current technology can self-monitor their BP and remotely send this to the GP. With a clear plan for the patient they would be able to determine if the BP was well controlled or if they possibly required a change in treatment. This could then be achieved through either email, telephone or video consultation without the need for the patient to attend the GP surgery
- The above is currently achievable the issue is that at present these systems do not integrate with the GP clinical systems and there is a risk that important information will therefore not be recorded in the patient's health record

Equality and demand management

- GPs are currently struggling under the ever-increasing demand
- Digital technology has the potential to reduce the demand on F2F GP appointments enabling the GP and their teams to focus during the F2F appointments on patients who require direct contact.
- The concern is that by increasing availability your increase demand. This will only be successful if the increase in demand is at least meet by the increase in self-management. This will take a shift in public expectations that has occurred over the past generation. Regarding patients who are normally fit and healthy but have developed an acute illness. As a generalisation, significant numbers of patients currently attend their GP as soon as they

develop any illness. We seem to have lost the support networks that people use to have to enable them to receive some basic suggestions and trial appropriate self-management. The

- hope is that developing AI will be able to provide this group of patients with appropriate advice to enable them to self-manage prior to seeking advice from a healthcare professional. If they then require advice it would help triage them to the most appropriate healthcare professional and not necessarily the GP.
- The worry in this is that vulnerable patients and those who are not technologically savvy, do not receive the same level of care. We need to ensure that we have methods of identifying these groups of patients and either enabling them to have direct access to healthcare professionals or advocates so that they can access and receive the digital healthcare systems.

Digital as part of a whole system approach

- Risk of adding digital 'solutions' as an addition to current systems and not offering them as part of a whole system
- Need a clear well communicated vision that the public understand and agree with regarding the development of healthcare.
- If we are moving to a digital first system, this will become the entry point into healthcare for the majority of patients. It would then become part of the whole system
- The worry is that digital solutions will be offered as another option for patients. This would risk causing further confusion for patients on how they access healthcare and unfairly benefiting those who are tech savvy who may have 'wants' at the expense of other patients who have clinically more concerning 'needs'

Safeguarding vulnerable patients

- Repeatedly in public enquires following a case of harm to a vulnerable patient, the issue of lack of communication between different agencies is highlighted as a key issue
- Enabling access to a single record could help prevent these events by enabling trends to be spotted earlier. Often in such cases, there are smaller issues that occur which taken individually would not suggest a risk to a patient but taken in totality can identify a vulnerable individual or one being put at risk.

System Approach

- We commonly talk about holistic care, yet the system is designed with numerous artificial barriers. We have the separation of primary and secondary care. Add to this how all the secondary care services appear to work in individual silos. This results in patients physically having to travel to the different parts of the system to receive their care. Digital solutions enable patients to be cared for without the need for them to physically travel the system
- An example of this is the NEL virtual CKD clinics. These enable a patient with renal impairment to be referred by their GP to a nephrologist, who is then able to review the patient's notes and investigations to provide advice regarding the ongoing care. Any changes to treatment can then be communicated to the patient or the patient is able to remotely access their own record and read the advice themselves. There is no need for the patient to attend either the GP practice or the hospital.

Demand on primary care

- Primary care is under increase demand. This is due to the increase in average number of consultations per patient per year, increasing population numbers and decreasing numbers of WTE GPs at a time when practices are under financial constraints meaning they may not be able to extend the primary care team.
- Unmet need is the concept that there is a cohort of patients with health needs that do not consult a healthcare professional. There are numerous reasons for this, one of which is access to healthcare but also includes things such as language, understanding of the healthcare system, cultural reasons, embarrassment, a symptom of the patient's condition/health.
- The hope for utilising digital technology is that it will enable patients to appropriately selfcare, for those that selfcare is inappropriate it will enable improved triaging so that they are booked with the most appropriate member of the primary care team in an appropriate timeframe for their symptoms rather than just on a first come basis. The worry is that it won't assist with the current demand but will unearth a further demand for patients who may not have consulted for very minor problems, consult ,as access becomes much simpler. Consider how email has increased the amount of correspondence compared to when there was a more complex process in writing and delivering a letter -the worry is that opening up digital avenues to patients will have the equivalent result.

Upscaling current models

- Any of the current digital offers that are significantly reliant on a GP consultation are limited. This is due to the falling numbers of WTE GPs. To upscale these models, we will need development of the AI systems so that minor self-limiting illness which only requires advice and OTC treatments are safely diagnosed and managed without the need for a direct GP appointment (F2F, video, telephone or email). We may also wish to consider the management of long term conditions. AI could assist patients in self-management plans enabling them to safely step up/down treatment.

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Londonwide LMCs
The professional voice of London general practice

Please find the following letter sent to you by email from Tower Hamlets Local Medical Committee and Tower Hamlets Clinical Commissioning Committee

29 March 2018

For the attention of:
Mr Jeremy Hunt, MP, Secretary of State for Health
Simon Stevens, Chief Executive of NHS England

Dear Mr Hunt and Mr Simon Stevens

GP at Hand is destabilising general practice

General practice in Tower Hamlets, like everywhere else in England, is struggling to survive. As the NHS endures the most prolonged squeeze in its history the proportion of the budget allocated to general practice has fallen from 9.6% in 2005/06 to 7.9% in 2016/17.

GPs are retiring early and young doctors are not choosing general practice as a career. In November 2016 84% of GPs said that their workload was undermining their ability to provide safe patient care.
The advent of GP at Hand can only make this situation worse, if not for themselves, then for most other practices and their patients. GP at Hand is an NHS service, supported by Babylon technology. It is run by Dr Jeffries and partners of Lillie Road Medical Centre, Hammersmith, West London.

Its selling point is that patients can be seen at their convenience for an internet consultation. They also have a small number of locations where they can provide a face to face consultation should it be necessary. One of these places is within an NHS Health Centre in Tower Hamlets, in the shadow of Canary Wharf.
Patients who register with GP at Hand are told that they will be able to book an appointment in seconds and see an NHS doctor in minutes. What is less clear to patients is that they will no longer be registered with their existing, local GP surgery and in reality, lose comprehensive local health services provided by local GPs. We know this, as we have faced complaints from patients here in Tower Hamlets when they have returned to their local GP, only to find that they have been de-registered and signed on with the practice in Lillie Road.

GP at Hand operates by utilising a clause in the GP contract, introduced in January 2015, which allows GP practices in England to register new patients who live outside their practice boundary area. The Government brought this in under its policy promoting patient choice. Some patients may find it more convenient to see a GP near to where they work rather than where they live, however the consequences of this arrangement threaten the risk-sharing on which the NHS has relied for decades. The service appeals to younger, internet-savvy patients. Registration data show that in the first two months of GP at Hand's operation 10,051 (90%) of the 11,147 patients who signed up were aged between 20 and 44 years old.

In Tower Hamlets we already have a borough-wide online consultation offer for local patients. We have streamlined our registration processes for local people and have already been working on a local service that utilises this new technology to respond to the demands of a mobile, online generation. We are not opposed to technology where it is appropriate and actively promote it where there is evidence that it is effective. However, we cannot support this initiative, which threatens to destabilise traditional general

practice, by attracting the younger, fitter patients who require infrequent, episodic care, leaving the more complex to their local GP.

Whatever the intentions of Dr Jeffries and partners there is no doubt that the consequences will be the diversion of funding from the patient's existing local practices and patients with complex needs, terminal care and disabilities, to the Lillie Road Medical Centre in Hammersmith.

We also believe that a service that disproportionately signs on the least vulnerable and frail patients is fundamentally against the founding principles of the NHS and its constitution. It amounts to indirect discrimination against the most vulnerable in our society.

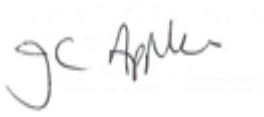
Funding will also be diverted from the CCG in which the patient lives to Hammersmith and Fulham CCG, because CCG funding, to provide NHS hospital and community services for all of us, is based on the number of patients registered with a GP in the geographical area covered by the CCG.

Tower Hamlets is one of the most deprived boroughs in the country. Despite this, we manage to provide excellent care to our patients with some of the best outcomes nationally. We have achieved this through working together across practices, having a collective ethos and a common goal to improve population health. We are renowned nationally for our work on social prescribing, integrated care and outcomes, including the best blood pressure and cholesterol control in the country in patients with heart disease and diabetes with evidence of significant reduction in heart attacks, strokes and diabetic complications. We see no evidence of GP at Hand engagement in all the local processes, training and quality improvement that has made this happen.

We rely, as do all NHS GP practices, on risk pooling and the cross subsidy that the capitation fee for younger fitter patients, who consult less often, provides to care for the more complex and elderly. Operating models like GP at Hand threaten this system and risk diverting resources away from those who need them most to those who need them least – a modern day version of Julian Tudor-Hart's Inverse Care Law.

General practice has been said by the Health Secretary to be the Jewel in the Crown of the NHS. We urge him to ensure that GP at Hand provides the same comprehensive service for patients that local general practices do and amend the out of area registration clause so that it is not able to be used to destabilise general practice thereby limiting the services available for registered patients.

Yours sincerely



Dr Jackie Applebee, Chair, Tower Hamlets Local Medical Committee
Dr Simon Brownleader, Chair, Tower Hamlets GP Care Group
Dr Sam Everington, Chair, Tower Hamlets Clinical Commissioning Group

Dear NHSE

I am writing as Chair of Tower Hamlets Local Medical Committee to express concern about the ongoing threat of GP@Hand to our local primary care health economy.

Latest figures show that Tower Hamlets CCG is the biggest financial loser of all the London boroughs as a result of GP@Hand. I know that you are aware of the precarious state of General Practice across the country. In Tower Hamlets we have managed to stave off the worst of this due to our collective, collaborative and evidence based working. We have some of the best outcomes for Childhood immunisations and chronic disease management such as hypertension and COPD in England, despite being one of the most deprived boroughs. This excellent care is delivered because we work in tight local teams, adhering to well prepared local shared care guidelines and referral pathways. All of this is at risk with the GP@Hand model. How can a remote General Practice hope to be able to work collaboratively and within local guidelines?

The arguments against the GP@Hand model are well rehearsed, the most concerning is that it provides access for those who are likely to need it least at the expense of those who are likely to need it most.

We are not against technology when it is equitable and evidence based but the GP@ Hand model is neither. The fact that there are so many exclusions means that it is inequitable, let alone the fact the only way of accessing the service is through the app so denying access to those who either cannot or do not choose to register in this way. We cannot understand why there is so much impetus to expand the model when the pilot hasn't even finished and so many reasonable concerns have been raised by so many people.

We urge NHSE to take the threat of GP@Hand to the wider health economy very seriously. It would be a travesty if the momentum behind this model allowed it to let rip only to find that those urging caution had been right all along. The NHS cannot afford yet another, very costly, ill conceived IT project.

Surely the way to develop technology and move into the world of Apps is to do so in a coordinated and properly funded way across the NHS, creating access in this way for those who wish to avail themselves of it, but as part of a menu of options for access so that no one is excluded. If the technology was available to all of General Practice and all patients there would be little need for the Out of Area Registration Scheme which GP@Hand exploits and health economies could confidently explore and develop the integrated care pathways that we all know are best for patients.

With best wishes

Dr Jackie Applebee,
Chair Tower Hamlets LMC

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1. Purpose of this paper

This paper sets out the role of the IT Enabler programme in the context of the scoping paper for the scrutiny review "Digital first primary care and its implications for GP practices".

2. Introduction

The City & Hackney IT Enabler programme has an overall aim to support better patient care through the use of technology that enables collaboration across care professionals and patients. There are three delivery phases:

- **Phase 1**: information sharing for health and social care; initiatives for the voluntary sector
- **Phase 2**: delivering the Local Digital Roadmap (LDR) – achieving paperless working by 2020:
  - Shared care records
  - Coordinate care and care planning
  - Infrastructure
  - Patient Enablement
  - Advanced System-wide analytics
- **Phase 3**: Digital initiatives for the Hackney & City transformation programme

Phase 1 is near conclusion; Phase 2 is well underway; Phase 3 is at the definition stage.

Focus to date has been on achieving robust information sharing across care providers to ensure patients can receive timely treatment and care through real-time communication of important information such as test results and care plans.

Latter stages of the programme include patient-facing tools, noting the dependencies on National initiatives for systems that ensure patient access is secure and only made available to those who should have access.

3. Digital First Primary Care

Some components of LDR are funded through external sources e.g. CCG primary care quality board, Estates and Technology Transformation Fund (ETTF) and NHS Digital funding. Nevertheless these are all important in achieving paperless working by 2020.

- Patients can access their GP record
- Patients can book appointments and order repeat prescriptions from their GP practice
- Patients can book their first outpatient appointment on-line following a GP referral
- Patients have access to Wi Fi in surgeries
- Under development: the City & Hackney Health app, to include signposting to appropriate services

4. Broader Primary Care related deliverables

The following describes how the IT enabler programme has helped improve integration of primary care with other care settings thereby providing more joined up care for the patient:

- east London Patient Record, using the Health Information Exchange (HIE) system – this enables GPs to view summary care record information from other providers the patient has been in contact with e.g. A&E attendances, community assessments and mental health care plans. Social care data will be available in Spring/Summer 2019.
- Coordinate My Care (CMC) – pan-London personalised care plan for patients. City & Hackney is implementing CMC across local healthcare providers for those patients who are approaching end of life, or are deemed to be frail or vulnerable with risk of admission, typically over 75 years of age. This means a patient's wishes can be communicated to those who need to know at the point of care including the London Ambulance Service (LAS). Plans

are mostly created by a patient's GP, and subsequently viewed and updated as appropriate by other care providers that the patient comes into contact with.

- Electronic orders and results reporting for diagnostic tests and electronic correspondence for discharge and outpatient clinics for acute, mental health and community services – sent directly to the patient's GP for information and follow up as appropriate
- Electronic referrals and advice & guidance from primary care to secondary care for all consultant led services and some nurse-led/community services
- Pilot: Social prescribing – the ability for GPs to electronically refer patients to the social prescribing hub for onward referral to the most appropriate service provider within the voluntary sector
- Under development: Advanced analytics and population health – analytics to identify areas with particular service demands to inform new service models; ability to identify areas of risk or deterioration and directly prompt care professionals for action

5. Other patient/carer facing deliverables

- Skype™ - pilot underway for young people diabetes receiving follow up appointments at Homerton Hospital
- Directory of Services (DoS) – project to set up a "master" directory of services for voluntary services in City & Hackney that other applications can link into e.g. City & Hackney app
- Active promotion of immediate access to digital therapy – on-line Cognitive Behavioural Therapy (eCBT); Mindfulness app
- Under development: City & Hackney local development of the mental health app (support for crisis, mental wellbeing and signposting to local services) -

6. The Hackney and City Transformation programme

The care work streams for the Hackney & City transformation programme have recognised opportunities that build on the IT enabler implementation to date.

Planned initiatives include:

- Systems to deliver better integration across primary care, community and voluntary sector services to support "neighbourhoods"
- Systems to better integrate urgent care services and primary care
- Electronic hospital appointment booking and correspondence for patients
- Exploiting social media to improve patient engagement with services
- Increasing mobile working capabilities
- Tools to support prevention and uphold the "Making every contact count" initiative
- Further developing advanced analytics tools e.g. to better understand the impact of mental health on physical health

7. The NHS 10 year Plan and IT Enabler

The NHS Long Term Plan has published some key milestones. City & Hackney has already started the journey towards achieving these. The deployment of the Child Protection Information Service (CP-IS) across Hackney social care and Homerton A&E will later be extended to all care setting including primary care by virtue of the latest NHS plan. The HIE implementation is a key contributor to achieving the longitudinal record across a wide geography. And the CMC deployment will be extended to meet milestones around providing patients to their own record of care.

City and Hackney remains committed to developing the digital offer to patients.

Hackney

Health in Hackney Scrutiny Commission 4th February 2019 **Integrated Commissioning – update from the UNPLANNED CARE Workstream**	Item No **8**

OUTLINE

Since the 4 Workstreams for Integrated Commissioning System commenced in May 2017 the Commission has received a rolling programme of updates in turn from each Workstream.

Attached is a briefing on the Unplanned Care Workstream.

We last heard from them on 14 Feb 2018 and the minute of that discussion is here.

Attending for this item will be:

Nina Griffith, Workstream Director for Unplanned Care, LBH-CoL-C&HCCG

ACTION

The Commission is requested to give consideration to the report and to make any recommendations as necessary.

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Integrated Commissioning: Unplanned Care Workstream Update

Health in Hackney Scrutiny Commission, 4th February 2019

1. Purpose

The purpose of this report is to update members of the Health in Hackney Scrutiny Commission on the work Unplanned Care work-stream. The workstream last reported to the commission on February 2018; this report gives an update on progress against the transformation objectives since that point and provides some background to the workstream for new members.

2. Who is part of the workstream and what are we trying to achieve

The workstream is a collaboration of health and social care providers and commissioners across City and Hackney. Membership of the board includes senior representation from the following organisations:

- Homerton University Hospital
- East London Foundation Trust
- City and Hackney GP Confederation
- City of London Corporation
- London Borough of Hackney
- Hackney Council for Voluntary Services
- Two patient representatives, recruited jointly with Healthwatch in both City and Hackney
- City and Hackney CCG
- City and Hackney Urgent Health Social Enterprise (CHUHSE)
- London Ambulance Services

We have spent some time in the workstream defining what we want to achieve for unplanned care in City and Hackney. The following describes our vision and strategic priorities. These have been informed by the Integrated commissioning board over-arching vision for the wider integrated commissioning structure.

Vision and strategic priorities for unplanned care

The unplanned care workstream is part of the wider integrated care system in City and Hackney.

Our vision is to bring together partners to create services that meet people's urgent needs and support them to stay well.

In order to achieve this -

- We will develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- We will provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- We will develop urgent care services that provide holistic, consistent, care and support people until they are settled
- We will work together to prevent avoidable emergency attendances and admissions to hospital
- We will provide timely access to urgent care services when needed, including at discharge
- We will deliver models of care that support sustainability for the City and Hackney health and care system.

The workstream is heavily clinically led, with both senior managerial and clinical representation from the Homerton, East London Foundation Trust, City and Hackney GP Confederation and City and Hackney CCG. We have three clinical/practitioner leads who lead on each of the main areas of transformation.

User representatives are represented at board level, and on each of the reference/steering groups directly below the board. We have also run a number of co-production events and taken our plans to various patient groups including the Older Peoples' Reference Group, the CCG Patient and Public Involvement Forum and the CCG Patient User Experience Group. Given the breadth of transformation required to deliver the neighbourhood model we have convened a patient panel to help us to communicate what we are doing with patients and to hold us to account to involving patients as the work progresses.

3. Plans and priorities

In order to deliver on our vision and strategic priorities, we have developed three main areas of transformation. These are: neighbourhoods, urgent care and discharge.

The following provides further detail on the ambitions and current position in relation to each of the transformation areas:

Neighbourhoods

Neighbourhoods is an ambitious programme to fundamentally change how we deliver community health and care services and how we engage with our residents in the planning and delivery of services. Eight neighbourhood areas have been created in City and Hackney with each serving a population of 30,000 to 50,000 residents. This population is small enough to provide personal care, but large enough to provide a broad range of resilient services.

At the core of a neighbourhood will be a community-centred, integrated team, working across healthcare, social care, public services, community groups and voluntary agencies. By working together, staff across different disciplines can deliver care that is joined up, community based, proactive and focused on the whole needs of a person. Neighbourhoods have sustainability as a core aim. A key principle of the programme is to deliver improved outcomes from supporting existing teams to work better together rather than to bring in significant additional resource.

The neighbourhood structure is fundamental to delivering our ambitions as an integrated care system in City and Hackney and the programme is much broader than just unplanned care. Whilst the governance and project team sit within the unplanned care workstream, the programme incorporates work from across all of the care workstream.

Summary of work to date and planned activities

The programme launched at start of April 2018. We have agreed our overall neighbourhoods strategic framework with all borough partners. This outlines where the neighbourhoods are, the core of what a neighbourhood will look like, who is involved and what we need to do to get there. We have appointed primary care leads for each neighbourhood who are leading on developing the neighbourhood identity.

We undertook a large-scale resident engagement exercise in the South-West of the borough. This was intended to understand what neighbourhoods means to resident, but also to provide a test case for effective resident engagement at a neighbourhood level. We received over 200 responses through a range of mediums which demonstrated that people are supportive of our aims to support local communities to improve their health and well being with a localised and responsive service offer.

Each of the key partners from health and social care that are central to the neighbourhood delivery model have set up a project to test new ways of working at neighbourhood level. These include a model of care for adult community nursing, adult social care and mental health. We are also developing a model of care for residents with complex and diverse needs, and a model of navigation at neighbourhood level to support residents to access the services that they need. We are also working with voluntary sector partners to develop a model for engaging with voluntary sector providers at a neighbourhood level.

We have developed detailed neighbourhood level information packs which show the demographic and public health outcomes across each neighbourhood. These are being used to develop local bottom up quality improvement projects in each neighbourhood.

In year two of neighbourhoods, from April 2019, we will focus on really delivering change on the ground by testing and rolling out the new ways of working. Alongside this, we will develop a five year plan for neighbourhoods which demonstrates how they will move from transformation to sustainable delivery and lays out the expected outcomes on a multi-year basis.

Integrated Urgent Care

The overarching objective of this programme is the development of a new model of integrated urgent care services for City and Hackney and which aims to:

- Provide clear and easy pathways for patients to navigate
- Avoid fragmentation / duplication
- Manage demand away from A&E where possible

Summary of work to date and planned activities

We have been working closely with North East London colleagues to oversee the implementation of the new 111 service. There are some access issues within the clinical assessment service (CAS – the clinical telephone triage element of 111) though these are being closely monitored through the contractual levers.

We are implementing a new GP out of hours which will start in April 2019 and be delivered by the Homerton, delivering face to face GP appointments overnight at the Homerton site. GP home visiting services overnight will be provided by the Tower Hamlets GP Care Group from 1st April. The very small number of home visits each night coupled with the additional infrastructure required for home visits (drivers and vehicles) made a single borough model costly.

We are also developing specific pathways for falls, dementia and end of life that prevent crisis and support our residents better at times of crisis:

Falls: We have reviewed and enhanced our range of falls prevention and response services in the borough. We have commissioned a home based falls prevention exercise service which has been proven to prevent falls and targets those residents that cannot attend exercise classes in community venues. We have also expanded the Paradoc service to provide a falls response service, which is run by a therapist and a paramedic.

End of life: We are implementing a new Urgent End of Life Care Service which will provide a 24 hour rapid response to people in their last weeks of life. This will be run by palliative care nurses from St Joseph's hospice and will provide specialist support to patients and their carers/families with the aim of supporting people to die at home if that is their wish.

Dementia: We are implementing a new City and Hackney Dementia service which rapidly enhances the level of navigation and support that people diagnosed with dementia receive. Patients will be assigned a key/worker navigator who will support them to manage their condition and should reduce instances of dementia crisis.

Discharge

Delays to discharges can lead to adverse outcomes to patients who can lose mobility and the ability to do everyday tasks, it is also important that patients that require any rehabilitation following their hospital stay can access it as quickly as possible. The workstream is working with health and social care services to improve how we discharge people from hospital by ensuring that they have the right services in place at the point of discharge, and that that they do not sit in acute or mental health trusts for longer than is medically required.

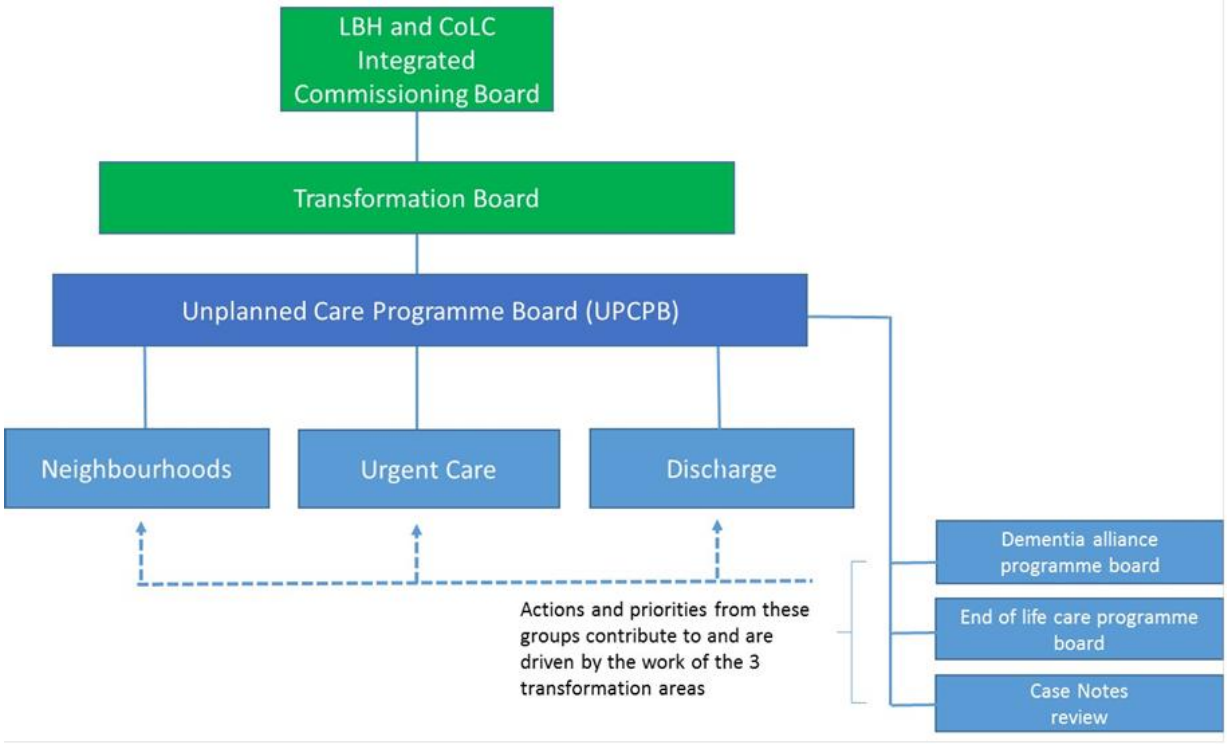
Summary of work to date and planned activities

We are piloting a new model of care known as discharge to assess, where patients receive assessments for their ongoing health and social care needs post-discharge rather than from a hospital bed. This has been running since summer 2018, and anecdotal evidence is that it has reduced length of hospital stay and improved access to step down and intermediate care. We are commissioning an external evaluation to review the success of the new service and make recommendations for the service going forward.

We undertook a multi-disciplinary case notes review of 50 delayed transfers of care. This was undertaken by colleagues working across all elements of the discharge pathway and the learning has been combined into an action plan. Actions include improved communication with patients and families earlier in the pathway about likely discharge pathways and improved communication with a range of agencies such as housing and home equipment services.

We scoped the potential for providing intermediate care beds in the borough. It was established that demand for bed based rehabilitation services was much lower than previously thought, mainly owing to the successful delivery of home based rehabilitation services by the Integrated Independence Team. This is in line with national trends of supporting people in the home where possible. The review identified a need for only 2 - 4 beds at any one time. It has therefore been challenging to identify a suitable and cost effective space for such a small service. However, we are still facing capacity challenges for interim and nursing home beds in borough, and so we are reviewing the feasibility of commissioning a larger mixed use facility including a small number of intermediate care, beds alongside interim care and nursing home beds. Any likely options will require capital investment and a considerable lead in time so this is a longer term strategic plan.

The following shows our workstream structure that is driving our work:



Integrated systems

The City and Hackney IT enabler group have overseen a programme of work to integrate patient records from a range of different systems into our 'Health Information Exchange'. This means that clinicians in primary care, secondary care and community services, who all use different systems, can access patient records from each different system. This is vital to being able to deliver integrated care. The IT enabler group sits outside of and supports all four workstreams, however, many of the improvements that unplanned care want to deliver will be reliant on the Health Information Exchange and further IT developments.

4. Finance

The workstream has a responsibility to both deliver in year financial balance, and to support long term system financial sustainability. The latter will be delivered through the transformation areas that have been described. Short term financial balance is delivered through a combination of delivery of small steps towards the larger transformation and some 'business as usual' (ie non-transformational) work to improve efficiencies in the system.

In 2018/19 we have a budget of £136m and a target to deliver £1.6m of savings to the system. We are currently projecting a £2m adverse position against this. This is driven by an increase in A&E attendances in the first half of the year at both Homerton and Barts Health and an increase in emergency admissions at Barts and an increase in ambulance conveyances. We have also seen an increase in spend of non-elective admissions at the Homerton, so whilst the activity is under plan there were a number of complex cases which drove overall commissioner spend up.

We have undertaken the following actions to mitigate the position:

- Working with London Ambulance Service and local telecare providers to utilise our local Paradoc service where appropriate instead of deploying an ambulance. Paradoc offers a GP and paramedic rapid response service that can stay with a patient for, on average, two hours and potentially therefore provide an alternative to an A&E attendance.
- Publicity to patients to use their Duty Doctor service in hours and 111 out of hours instead of going to A&E for non-critical issues.

- Increasing links between our GP practices with both Barts ED and Homerton ED. This includes introducing a re-direction service so that patients that are better served by their GP are booked into their local practices.

In 2019/20 there is a significant shift in how acute trusts get paid for all emergency activity in hospital (A&E attendances and emergency admissions, excluding maternity). A new 'blended tariff' has been mandated by NHSE to replace Payment by Results (PbR). This new arrangement comprises an agreed contract value (block contract) with a variable rate payment for activity over or under the agreed value. If activity goes over the agreed value the acute trust will only get paid 20% of the PbR tariff for that activity. If activity is lower than the agreed value then the acute trust keeps 80% of the amount by which it is lower.

This is intended to have the following benefits, which should in themselves support the overall aims of the workstream:

- An improved activity planning process between the commissioner and the trust so that both parties agree to a realistic activity plan as this forms the basis for the value of the block contract
- Incentivises the acute trust to try to reduce demand on emergency care services where they can
- Provides the system with a much better assurance that commissioner costs for emergency care will be contained

We are currently working with the Homerton and the CCG to set the agreed contract value. This should be set at a level that supports the CCG's overall affordability without de-stabilising the Homerton.

5. Performance and winter pressures

The workstream also has a responsibility to deliver on a range of performance indicators. As a workstream we have now agreed a broad range of performance and outcome indicators which we will use to track the progress of our work. However, there is national scrutiny on two main national standards within the programme. These are the four hour wait in A&E (95% of patients must be seen and treated and have left the department within four hours) and delayed transfers of care from acute and mental health settings (we must deliver the reduction in delayed transfers of care that was agreed when we submitted out Better Care Fund plans). These measures are also used as an indicator of how well the system is coping with the increased acuity and demand often seen over winter.

The Homerton are the only A&E in the borough. They have delivered excellent performance against the target. They are currently delivering 94.7% performance year to date against a North East London average of 85.93% and an England average of 88.9%. They are consistently within the top 3 performing trusts in London. The workstream oversaw a detailed winter planning exercise, and continued good performance against this indicator through winter to date demonstrates that the system is delivering well despite winter pressures.

Delayed Transfer of Care performance was within target in each month of the current year up until October. Performance from October to December deteriorated. This was due to a reduction in interim and long-term nursing home placements following a care home not meeting required quality standards. Whilst this is disappointing, system partners have responded quickly to the pressure by commissioning additional intensive home care packages where appropriate, including overnight care. Positively, the position in January is currently much better.

6. Management of risk

The table below sets outs the main risks across the workstream and the mitigation in place. The risk rating is the current risk rating

Risk	Likelihood	Impact	Score	Mitigation
Unable to deliver the required system savings to support overall sustainability of services	4	5	20	Continued work through the workstream programme board to identify the strategic direction that will deliver more long term financial sustainability Horizon scanning of evidence from other systems for interventions that have effectively delivered savings Close working between providers and commissioners to ensure current contracts deliver value for money and new contracts are developed to support overall financial sustainability.
Unable to effectively engage patients, therefore we deliver services that do not meet their needs	2	5	10	Working with healthwatch and existing patient groups to develop a model of meaningful engagement Workstream team and user representatives attended co-production training together All proposals to the workstream board must detail what level of patient engagement has happened Workstream are collating a checklist of different ways of engaging patients
Unable to deliver the large-scale transformation required within the neighbourhoods programme, which cuts across all of the workstreams	2	4	12	Programme provides resources for partner organisations to release staff to support neighbourhood design and implementation Neighbourhood governance model in place and robust and includes workstream director representation at the steering group.
Improved DToC levels are not sustained	4	3	12	Continued focus on DToCs via the discharge workstream Implementation of discharge to assess Increased provision of continuing healthcare assessments Delivery of 7 day discharge services (including social care) from the Homerton.

7. Conclusion

The unplanned care workstream has an ambitious but exciting agenda to deliver real transformation across City and Hackney. This will be delivered through strong clinical/practitioner and operational leadership, patient involvement and close collaboration between a wide range of partners.

January 2019

Hackney

Health in Hackney Scrutiny Commission 4th February 2019 **Work Programme for 2018/2019**	Item No **9**

OUTLINE

Attached is the latest version of the Work Programme for the year. This is a working document and is regularly updated.

ACTION

The Commission is requested to note the updated work programme and make any amendments as necessary.

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Health in Hackney Scrutiny Commission

Future Work Programme: June 2018 – April 2019 (as at 25 Jan 2019)

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.

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	GP at Hand City & Hackney CCG City & Hackney GP Confederation Hammersmith &Fulham	Paul Bate Richard Bull Dr Mark Rickets Laura Sharpe Written	**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

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Mon 4 Feb 2019 Papers deadline: 24 Jan	Adult Services	Anne Canning Group Director CACH Ilona Sarulakis, Principal Head of Adult Social Care	**Response to CQC Inspection on Housing with Care**	On 14 Jan 2019 a CQC Inspection Report rated Housing with Care Service as 'Inadequate'. To consider the report and the immediate response.
	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-C&HCCG Integrated Commissioning – IT Enabler Group	Niall Canavan Lead Officer for IT Enabler Group	**REVIEW on Digital Primary Care and the implications for GP practices**	Work of the IT Enabler group on digital first primary care
	ELHCP Tower Hamlets CCG	Jane Lindo, Primary Care Lead, ELHCP Jenny Cooke Deputy Director for Primary and Urgent Care	**ditto**	New digital primary care models in Tower Hamlets and in NEL.
	City and Hackney Local Medical Committee and Tower Hamlets Local Medical Committee	Dr Fiona Sanders Dr Gopal Mehta Dr Jacky Applebee	**ditto**	The view of two Local Medical Committees on the impact on the ground with GPs
	LBH/CoL/CCG Unplanned Care Workstream	Nina Griffith Workstream Director	**Integrated commissioning – UNPLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
INEL JHOSC Wed 13 Feb 2019 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	**a. Election of Chair** **b. Update from ELHCP Senior Accountable Officer** **c. Patient Transport** **d. NEL Estates Strategy** (verbal update)	
Tue 12 Mar 2019 Papers deadline: 1 Mar	Adult Services	Anne Canning Simon Galczynski Ilona Sarulakis	**Action Plan on Housing with Care service**	Action Plan in response to CQC Inspection report of 14 January which rated the service as Inadequate.
	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.
May be moved off Cttee meeting	Various	ALL TBC	**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
INEL JHOSC Wed 20 March at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	***a. NEL Estates Strategy b. NHS Long Term Plan c. Other items from NELCA tbc***	
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 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.

JHOSC Meetings in 2019/20 already scheduled

INEL JHOSC Wed 19 June at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	***TBC***	
INEL JHOSC Wed 18 Sept at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	***TBC***	
INEL JHOSC Wed 27 Nov at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	***TBC***	

Items to be scheduled for Health in Hackney

	Cabinet Member	Cllr Demirci	**Cabinet Member Question Time with Cllr Demirci**	Annual CQT Sessions
	HCVS Connect Hackney Cabinet Member	Jake Ferguson Shirley Murgraff Cllr Demirci	**Connect Hackney - Reducing social**	Report on work of Connect Hackney (a Big Lottery Funded project)

	Age Concern East London? GP Confed or CCG?		**isolation in older people**	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.
	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.

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.

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