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 November, 2019

7.00 pm

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

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ 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, Cllr Patrick Spence and Cllr Tom Rahilly**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

Access and Information

Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

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

Public Involvement and Recording

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at http://www.hackney.gov.uk/l-gm-constitution.htm or by contacting Governance Services (020 8356 3503)

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital

and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

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

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

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

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

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

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

Providing oral commentary during a meeting is not permitted.

Hackney

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

OUTLINE

Attached please find the draft minutes of the meeting held on 12th September 2019.

MATTERS ARISING

There were two actions under items of Any Other Business raised by Mrs Murgraff and agreed by the Commission:

ACTION:	*The Deputy Mayor is requested to provide a brief update on the current status of the feasibility study on the future options for the Median Rd Resource Centre site.*

A reply is awaited.

ACTION:	*The Cabinet Member for Finance and Housing Needs to respond to the request regarding the issue of ensuring that entitlement for pension credit is more fully publicised by the Council so that the estimated pot of £26m in unclaimed pension credit is claimed.*

This is attached.

ACTION

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

This page is intentionally left blank

Meeting of HiH on 4 November 2019 – Item 4 Matter Arising

Response from Revenues and Benefits Service

Unclaimed Pension Credit- Briefing for Health in Hackney scrutiny commission

We recognise and value the role independent advice organisations play in supporting residents in realising their rights. That's why we have protected our advice grant budget from cuts and why we are working proactively with the advice sector to respond to the increasingly challenging environment.

The overarching principle of funded advice services is understanding what matters to residents in context and not just focusing on the presenting issue. This would include helping to identify unclaimed benefits or tax credits and helping people to claim. For example if a person approached a service about debt, organisations would explore other ways to support them which may include how to maximise their income. More information on the approach can be found in the Advice grant framework

Advice is provided in health and community settings to reach people who may not go to traditional advice settings.

The funding for Hackney's advice sector remains the same as in previous years and is approximately £770k. A further £120k is also available to support the advice sector based in GP surgeries.

The Council has also protected its wider voluntary sector grants programme of £2.6m

With regard to the specific details relating to pension credit take up in the area it is very difficult to concur with the numbers quoted in the Independent Age report as there are only 20,394 people over the age of 65 in 2017, living in Hackney and a recent exercise which looked at all households where we hold information relating to Housing Benefit customers only identified 830 households that are potentially eligible to claim Pension Credits but are not doing so as at the end of July and of those around 100 are from mixed age couples for whom that entitlement no longer applies.

Having said this, we do recognise that there is a significant number of households that are not claiming pension credits (this is likely to exceed those currently claiming Housing Benefit or Council Tax Support) when they are eligible and we fully understand the consequences of this. That is why over the last few months we have:-

- Undertaken an exercise to try and personally contact 100 mixed age couple cases in advance of the 13th August deadline and advised them to make a claim for Pension Credit.
- Worked with AGE UK East London to provide signposting support for claimants needing assistance
- Had regular contact with the Department for Work & Pensions to highlight issues we know claimants have encountered with the Pension Service application process

- On the 28th September we have written to 741 households across Hackney and advised them to make a claim for Pension Credit, providing guidance on how to make the claim and again signposting support that is available from AgeUK East London.
- In a few cases where we have identified income shortfalls in households we have attempted to make telephone contact and we will be following this up with personal visits.
- We have shared information with colleagues in Council Tax and Housing Services in order that they are aware of these cases and can provide a more targeted support when delivering their own campaigns for collection of rent and Council tax.
- We will be writing to all Members of the Council advising them of this campaign and providing details of the number of cases we have contacted in each of their areas.

The Council is committed to maximising the income of Hackney's disadvantaged residents and has a range of processes across many departments to deliver this. Where officers are engaged with government departments such as DWP and MHCLG they will continue to lobby against welfare reform and austerity, reminding central government of its responsibility to ensure all benefit take up is maximised.

Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Thursday, 12th September, 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 and Cllr Patrick Spence**
Apologies:	**Cllr Emma Plouviez and Cllr Tom Rahilly**
Officers In Attendance	**John Binding (Head of Safeguarding Adults), Anne Canning (Group Director, Children, Adults and Community Health), Simon Galczynski (Director - Adult Services) and Joe Okelue (Legal Services)**
Other People in Attendance	**Nick Bailey (Hackney KONP), Councillor Feryal Clark (Deputy Mayor and Cabinet Member for Health, Social Care, Leisure and Parks), Amanda Elliot (Healthwatch Hackney), Nina Griffith (Workstream Director Unplanned Care, CCG-CoL-LBH), David Maher (MD, City & Hackney CCG), Dr Nick Mann (Local GP and Member Keep Our NHS Public), Dr Mark Rickets (Chair, City and Hackney CCG), Laura Sharpe (Chief Executive, City & Hackney GP Confederation), Michael Vidal (Public Rep on Planned Care Workstream, CCG-CoL-LBH) and Jon Williams (Director, Healthwatch Hackney)**
Members of the Public	**4**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllrs Plouviez and Rahilly.

1.2 Cllr Snell, Dr Mark Rickets and David Maher also stated they would have to leave early for other meetings.

1.3 Apologies were received from: Dr Sue Milner, Kirit Shah, Carol Ackroyd and Richard Bull.

2 Urgent Items / Order of Business

2.1 The Chair stated that item 9 would be taken after item 6.

3 Declarations of Interest

3.1 Cllr Maxwell stated that she was a member of the Council of Governors of HUHFT.

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

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the minutes of the meeting held on 10 July 2019.

4.2 The matters arising were noted.

RESOLVED:	**(a) That the minutes of the meeting held on 10 July be agreed as a correct record.** **(b) That the matters arising be noted.**

5 City & Hackney system's summary response to NHS Long Term Plan

5.1 Members gave consideration to a report on the draft City and Hackney response to the NHS Long Term Plan.

5.2 The Chair welcomed for this item:

David Maher (DM), Managing Director, City and Hackney CCG
Dr Mark Rickets (MR), Chair, City and Hackney CCG
Nina Griffiths (NG), Workstream Director – Unplanned Care, LBH-CoL-CCG

5.3 Introducing the report, DM stated that the content of the response had been through a number of forums. The Long Term Plan was the plan for the next 10 years for the NHS and followed on from the Five Year Forward View. One of the key challenges in north east London was the increase in population and the plan helped tackle that. It will lead to £2.3bn more in investment in primary and community health services in NEL. City and Hackney was in a good place and had achieved a number of successes since the last plan including reductions in obesity in the working age population. The opportunities presented by the LTP were significant. Going back 5 years, he said, mortality rates in mental health in NEL were the worst in the country and as of this year that mortality curve had been inverted for those living with severe mental illness. The challenge now was how to use the LTP going forward and one of the key aspects would be the Primary Care Networks which were being delivered in C&H via the Neighbourhoods Programme. There was also now a well-established Integrated Commissioning Board and it put Marmot principles on wider

determinants of ill-health at the forefront of its thinking. Significant inroads were being made in the CYP&M Workstream, an example being the fact the recent measles outbreak had now been contained and over 1000 vaccinations had been delivered. The ICB had been in place for 2 years and administered £50-£60m in contracts and the ambition was to go much further with this. The presence of elected members on the ICB gave it significant levels of accountability. Work was ongoing on having Providers join the ICB and a planning forum was being run to look at the whole architecture of the workstreams. There was also a need to include the VCS even more in the workstreams. A key focus was to reduce the pressure on acute beds and going forward on improving digital access to primary care.

5.4 Members asked about recent media coverage that London had the lowest vaccination rates in the country. DM replied that this was still correct, for all the reasons covered at the Commission's meeting on this, but nevertheless, solid progress was being made locally and a serious outbreak had now been successfully contained and they would be able to build on this.

5.5 Members asked if there was a more detailed data document underlying the response paper and DM replied that there was.

5.6 Members commented that, often with these changes, Secondary Care absorbed the bulk of the money and how is it possible in this context to safeguard primary and community care funding. DM replied that primary care funding was locked into contracts for Primary Care Networks and likewise for example in mental health and so it was protected to that extent. Hackney and Newham would benefit from new money flowing into the system under the LTP.

5.6 Members commented that the LTP contains a vision for thriving hospitals but asked if the reduction in the scale of the Path Lab at HUHFT a contradiction of this. MR replied that histology tests (i.e tissue) already went to Barts and HUHFT would always retain capacity for blood testing and that none of this would impact on, for example, the early diagnosis of cancer. A business case on the future of pathology services at HUHFT was being developed but he had not yet had sight of it. The Chair stated it would not be helpful to continue this issue without the presence of a senior representative from HUHFT and the CE had come to the Commission to discuss this on a number of occasions already.

5.7 Healthwatch representative enquired about what Equality Impact Assessment if any had been done by the ELHCP. DM replied that he was not aware of the detail on this and he would take the issue back for a response.

5.8 NG commented that the LTP response reflected C&Hs strategic priorities such as the Neighbourhoods Programme, the Make Every Contact Count programme and all of these were developed within an integrated system. The Plan preserved innovation in integration such as the 'Prevention Investment Standard'. She also described how resident input was always sought by the workstreams in all its service development.

5.9 Members asked about next steps and whether the C&H plan was going to be merged into a single document covering the three ICS areas. DM replied that it would go to Cabinet and CCG Governing Body. By the end of the Sept the ELHCP would have to submit activity plans on finances and on workforce to

NHSE. The narrative document would then go to NHSE in Oct and a final version would be resubmitted in mid November following any changes. DM clarified that the response comprised a standalone C&H Plan and a separate document where it is weaved into the overall plan for NEL. The amended draft Response would come back to Cabinet also on 16 Oct and it was of course also being discussed at INEL JHOSC on 19 September.

RESOLVED:	**That the draft Response to the NHS Long Term Plan be noted.**

6 Future of North East London CCGs

6.1 Members gave consideration to a report from Hackney Keep Our NHS Public and the chair welcomed for this item:

Dr Nick Mann (NM), Local GP and Member of KONP
Nick Bailey (NB), Member of KONP

Dr Mark Rickets (MR), Chair, CHCCG
David Maher (DM), Managing Director, CHCCG
Nina Griffith (NG), Workstream Director, CHCCG-CoL-LBH
Michael Vidal (MV), Public Representative on Planned Care Workstream, CHCCG-CoL-LBH

6.2 The Chair asked DM to respond to the concern about possible 'merging' of CCGs. DM replied that the national expectation was that ICSs cover a population area of 2 million people. At the other end of the spectrum Primary Care Networks, which are delivered locally as part of the Neighbourhoods Programme, work to a population of 30-50k. The idea with the Long Term Plan was to modernise community care and to modernise the whole commissioning architecture. The expectation in the Plan was that the restructures should aim to deliver a necessary cost saving of 20% to the system. Commissioners such as CCGs are not providers and he drew Members' attention to the system diagram on p.29. City and Hackney already operated as an integrated system with increased possibility for accountability. Further transparency would be added with Providers joining the ICB and they will sit with commissioners in planning local services. The NHS is looking to CCGs working in this integrated model by 2021 so by April 2020 a new structure needed to be worked up. As part of this the local system will be able to set out 'Asks' for what it wants to commission locally. 15% of CCG activities are already commissioned already at ELHCP (i.e. STP) level. Certain areas such as mental health bed planning or cancer pathways need to be delivered at sub regional level to be effective. The aim was to reduce costs in the system.

6.3 The Chair invited Hackney Keep Our NHS Public (KONP) to respond. Dr Nick Mann (NM) replied that it was becoming clear that City and Hackney would not survive as a small entity and with all the transfer of funding being tied into a requirement of expected behaviours this would prove troubling. He cited the example of the Path Lab at the Homerton, stating that pathologists there did not support the changes. In his view HUHFT would lose it all. There were a lot of issues and they wouldn't be debated if the decision making was escalated higher. He stated that it was his understanding that the mergers would mean

that patients with schizophrenia would have to travel long distances for treatment, that mental health beds would move to Mile End Hospital and specialist care for Older People would move to King George's and the result would be less accountability overall. The ICS would be making all the decisions and you can't have local decision making within a sub-regional model, he stated. He stated that these trends were worrying and recently Virgin Health had been contracted in Waltham Forest and warned the same could occur in Hackney. He asked where was the document which explained the process of the merger and the legal basis for it. If the merger went agenda C&HCCG would be folded and Hackney would lose accountability and control. The Chair stated that for this item he would steer Members from discussions of the Path Lab or Estates as both had been discussed at length.

6.4 MV opened the response on behalf of the CCG by stating that the Communications and Engagement team at the CCG had met with all the public and patient reps and they had set up a working group to plan a programme of engagement around this issue. His understanding was that, thus far, the CCG was not minded to opt for formal consultation but instead would roll out an engagement programme. DM added that this work would commence in October.

6.5 The Chair asked when for clarity on when a formal decision would be made. DM replied that a Case for Change was being developed and should be shared in October and then each CCG would have to consult with its constituent members – its GPs. There was still 18 months to the 2021 date and any proposals would also have to be agreed by each CCG Governing Body. The Chair stated that the extent of any objection by councillors and the public would depend on the detail of where the decision making on commissioning will lie in future. DM replied that it was important to wait for the Case for Change in the first instance.

6.6 MR stated that north east London had secured additional time to April 2021 to consider this proposal and this had been secured by Chief Accountable Officer of the ELHCP.

6.7 The Chair took issue with the plans stating that Scrutiny had been in a similar position before regarding engagement vs consultation over the Transforming Services Together (TST) programme, where they had been "informal engagement" at INEL JHOSC over a few years only then to be told that that had constituted a public consultation and the NHS was proceeding with the plan, therefore, Members had reasons to be sceptical. He stated that the suggestion that this didn't warrant a full public consultation was preposterous considering that the plans envisioned that the balance of 85% of commissioning budgets would now be moved upwards. He asked whether there would be separate engagement and consultation exercises.

6.8 MR replied that this would partly be driven by the outcome of any Judicial Reviews as per the Lewisham document. DM added that there was a chance here for City and Hackney to collectively drive through the change it wanted to see and this should be embraced. MR added that it was important for City and Hackney to keep getting on with the excellent work which was being done locally and this would demonstrate the local system's ability to build and develop excellent services.

6.9 Members asked what the risks were with the move and what would the benefits be. DM replied that there was an opportunity to build more accountability with the addition of the Provider partners. The ICB as it currently stands was highly accountable with elected members sitting on it and the CCG Governing Body comprised clinical reps, patient reps and elected GPs on it. The Governing Body would need to carefully examine the proposals coming out of ELHCP.

6.10 Members commented that these decisions were just being taken by GPs and it appeared like they were being taken behind closed doors and this was profoundly undemocratic.

6.11 MR replied that NHSE makes the final decision and if it was unhappy with what C&HCCG did it could put it "under directions". The Governing Body was governed by statute. It was constituted in a different way to local authorities. It comprised: 4 GPs, 3 lay members, 1 independent nurse, 1 independent consultant, the Chief Accountable Officer and the Chief Financial Officer. It met in public and local GPs voted on and appointed the CCG Chair.

6.12 Members stated that it was important that a proper public consultation take place on these changes rather than merely engagement. The public needed to have their say and there needed to be a proper fully publicised timetable for this activity.

6.13 MV replied that he agreed and the consultation and engagement working group would come up with a concrete plan for this. He added that his preference was for engagement rather than consultation. Engagement involved 2 way discussions and jointly working up proposals whereas formal consultation involved mostly just answering questions on a formal questionnaire and the response might be low or might not very representative. DM added that this was not about particular service changes and MR added that they had already had 1200 contacts since early spring on the Long Term Plan which was a lot.

6.14 The Chair re-iterated that this had to depend on the detail. If 85% of the budget was moving elsewhere it was not credible to say that this process wasn't about "service re-configuration". He also took issue with the point that this was more accountable because there were 3 elected members on the ICB or that Provider organisations were now participating. He added that making savings on administration did not trump the loss of local accountability which these changes would incur. City and Hackney had done very well in how it had adapted to the Lansley changes (in the 2012 Act) and had to be commended for that but this now represented a new and significant change.

6.15 The Deputy Mayor added that the ICB was both transparent and accountable, for example, through the elected members who sit on it. She stated that, nevertheless, councillors have concerns about the future of NEL CCGs and she and the Mayor had arranged to meet the Chief Accountable Officer of ELHCP to discuss these.

6.16 The Chair thanked the officers for their input and noted that they would be returning to this issue.

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

7 Briefing on Intermediate Care beds

7.1 Members gave consideration to a report on Intermediate Care Beds which they had requested.

7.2 The Chair welcomed for this item

Simon Galczynski (SG), Director, Adult Services
Nina Griffith (NG), Workstream Director – Unplanned Care, CCG-CoL-LBH

7.3 NG took Members through the report in detail. It was noted that as the demand for intermediate care beds had been reduced because of the establishment of a successful Integrated Independence Team (IIT), there was now a requirement for only 2 to 4 step-up or step-down beds and this volume would not justify establishing a separate new residential unit within the borough. They had spent the underspend on intermediate care beds on the Discharge to Assess work and they were working closely with the IIT in the lead up to that contract having to be renewed in November 2020. They were linked in to Community Care and they continued to spot purchase beds, as required, in St Pancras or Bridges wards which are in Camden and Islington respectively.

7.4 The Chair asked for clarification on the bed numbers in 4.1 ('GFD' section) and the table at 4.2 which seemed to be contradictory. NG explained the difference between "number of bed days" and "number of beds" and that the length of stay was generally quite short.

7.5 Shirley Murgraff, a resident, stated that she did not agree with the assessment this it was a good service because in her view there was an absence of patient choice. She stated that she had personally been a service user of the intermediate care beds at the St Pancras facility, out of borough. She stated that City and Hackney could not say that it had unfettered access to these beds because St Pancras could refuse for three reasons: the facility was full; priority was given to Camden and Islington residents or they did not agree with the assessment of the patient. They could therefore veto a request for a bed. She also stated that she did not consider these to be proper intermediate care beds but rather this was a 'sub-acute' ward which had patients in it who had complex conditions and so could not get out of bed. She stated that the possibilities for a more permanent solution using the previous Median Rd site had not been properly explored before it had been closed and that that site could have had income generation possibilities.

7.6 SG replied that the St Pancras facility was fully registered for Intermediate Care and they provided intensive multi-disciplinary care and this was different from respite. As with every facility it had a 'pipeline' for admissions and there may, on occasion, be a capacity issue but no cases had been escalated to him as Director regarding patients who could not be found a bed when they needed it. He did not agree with the assertion that there were quality issues at St Pancras. He stated that they did have access to step-down beds there but not to 'step-up' beds. They currently did not have bed based provision for 'step-up' and this was resolved by use of more intensive home based support for 'step-up', than people would have received in the past. He added IIT also provided 2 hr rapid response into A&E if required. This was a much faster response than

previously and the focus was on getting the right support at the right time. He added that while the St Pancras facility was bed based the setting was very homely and non-institutional. NG added that they also provided 'Same Day Emergency Care' where patients could be discharged home afterwards. The Ambulatory Care Unit at HUHFT was also assisting them with providing a 'whole-system' hospital response with community services coming into A&E to plan both care and discharge. UCLH NHS Trust was running a similar model she added.

7.7 Members asked who the budget holder was. NG replied that the IIT was jointly commissioned as part of the Integrated Commissioning system and the budget came from the Better Care Fund. Within their allocation IIT were given funding to spot-purchase beds at St Pancras if required and this was held by the IIT as part of the integrated care service. The CCG held the budget for any other beds outside of this arrangement.

7.8 The Deputy Mayor stated that she and the Mayor took a keen interest in exploring the development of Intermediate Care and a business case was being developed to look at long term options within the borough.

7.9 Shirley Murgraff, a resident, asked what had happened to the options appraisal on the future of the Median Rd site and re-iterated that in her view its closure had removed the element of patient choice. She added that that commissioners must be more up front with patients. She questioned that spot purchasing must be more expensive in the long term. She added that while she was grateful to receive intermediate care at St Pancras, options such as physiotherapy were not available there.

7.10 The Chair thanked officers for their report and for their attendance.

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

8 Annual Report of City & Hackney Safeguarding Adults Board

8.1 Members gave consideration to the 2018/19 Annual Report of the City and Hackney Safeguarding Adults Board and a covering report. The Chair stated that the Commission considered this each year and he added that this time the Chair, Dr Adi Cooper, had had to give her apologies. He welcomed to the meeting:

Anne Canning (AC), Group Director CACH
Simon Galczynski (SG), Director – Adult Services
John Binding (JB), Head of Service – Safeguarding Adults

8.2 SG took Members through the report. It was noted that 34% of concerns went on to become safety investigations and this had been in line with national averages. Officers would like to hear more from people about the outcome of safeguarding investigations he added. He stated that the research had shown that most of the patient outcomes were 'positively met'. He stated that there had been two Safeguarding Adults Reviews (SARs) in 2018/19 relating to Ms Q

and Ms F. He explained that 14 more 'Safeguarding Champions' had been trained up over the year.

8.2 JB took Members through the 'areas for development' section of the report and explained how they were working on how to get more feedback from those who had used the service and to this end they were developing a Service Users' Engagement Network. He also explained the campaigning they were doing on tackling modern slavery with a campaign being launched on 18 October and the work they were doing on chronic rough sleeping. He explained that at last year's Annual Report item they had been encouraged to have greater service user involvement in the training of the Safeguarding Champions and this was now taking place.

8.3 AC stated that the CHSAB had made a significant contribution too to the work of the Integrated Commissioning Board particularly in its work with the CHSCB (safeguarding childrens' board) on transitional safeguarding which was aimed at ensuring that vulnerable adolescents are properly supported and do not lose out during the transition to adult services.

8.4 Members asked why there wasn't an SAR relating to the case of the homeless man who had recently died in Stoke Newington, which had received much media coverage. JB replied that it was after the cut off point for the report and a decision on whether there would be an SAR couldn't be taken until after consideration of the Coroner's Report, which was still awaited. SG added that he would expect there to be an SAR in that case as there were definite lessons to be learned around managing mental capacity issues affecting those who are street homeless. Members commented that many members of the public were upset and angry about that case that there was generally a public lack of awareness about safeguarding issues.

8.5 A Healthwatch representative asked why the case of the 32 year old who had died of scabies infection wasn't included. JB replied that it happened after the 2018/19 cut off and would be included in next year's report.

8.6 Christopher Sills, a resident, stated that more needed to be done to provide support earlier to street homeless as their mental health declines rapidly as does their ability to help themselves.

8.7 Members asked about the SAR regarding 'Ms Q' and asked whether the service could be faster in publishing preliminary findings from SARs and cascading these down more promptly so that key issues can be attended to urgently. SG stated that SARs didn't happen in chronological sequence because it depended on the complexity of the events involved. AC replied that there definitely was a mechanism in place to internally expedite learning when issues needed to be addressed quickly and gave an example of a recent issue relating to housing. She stated that officers did not wait for the conclusion of the whole process before acting on key issues which could be tackled quickly.

8.8 Members stated that the full report had had a number of technical terms such as DoLS which needed to be explained more clearly to a lay reader. Officers undertook to take this on board for next year's report and welcomed the feedback.

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

9 REVIEW on 'Digital first primary care and implications for GP Practices' - draft report

9.1 Members gave consideration to the draft report of its review on 'Digital first primary care and the implications for GP Practices'. The Chair stated that this was being presented for comment before it would be presented for formal agreement at the next meeting.

9.2 Dr Mark Rickets (MR), Chair of City and Hackney CCG, stated that they had already fed back on the draft recommendations. It was important to note that the CCG did not employ GPs and so could not direct them, which he felt was the inference in Recommendations 1 and 2. The Chair responded that this merely illustrated the point that nobody appeared to be holding the ring on this issue in the STP area.

9.3 MR stated that if you drove up access there would be resource implications. He added that NHSE was also currently consulting on the patient registration funding and contracting rules.

9.4 A Member took issue with why this was being discussed. It was up to the Commission to make its own recommendations and the NHS would then would have an opportunity to respond afterwards he said.

9.5 Laura Sharpe, Chief Executive, City and Hackney GP Confederation, stated that she had pointed out that directing Recs 1 and 2 to them was inappropriate as they were just the provider. If someone wanted to commission them to expand this work they would do their best to do so but the Confederation only had 4 staff. The system in NEL did not dictate to GP Practices on digital transformation. She acknowledged that there needed to be a serious response to GP at Hand but Practices can respond how they see fit. MR added that part of the reason why they had not been responding sufficiently on this drive for digital first was that they were so busy doing the day job.

9.6 Members commented that perhaps the findings of the review would assist the CCG and the Confederation in making the case for a system response on digital first primary care. Private operators were moving into digital primary care and the situation must be responded to, they added. MR asked what response they should make. Members replied that there was no single solution but there was a need to ensure that the local system responds adequately in a way which ensures that GP Practices survive and thrive.

9.7 Dr Nick Mann (NM) commented that there was, in his view, extreme pressure coming from NHSE on digital and larger forces were at work here, giving the example of the push for a London wide electronic patient record.

9.8 The Chair stated that Members would consider whether any amendment to the wording of the two Recommendations was required and to bring it back for agreement.

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

10 Health in Hackney Scrutiny Commission- 2019/20 Work Programme

10.1 Members gave consideration to the updated work programme.

RESOLVED:	**That the updated Work Programme for the Commission be noted.**

11 Any Other Business

11.1 Christopher Sills, a resident, raised the issue of a young woman who had been terminally ill but had recovered and who whose subsequent treatment by the health service had been lacking, in his view. The Chair cautioned that this was case work and the Commission could not get involved with individual cases. He asked Mr Sills that if there were systemic issues which merited the Commission's attention they would give them consideration and requested that he email him with these.

11.2 Shirley Murgraff, a resident, asked about the status of the feasibility study on the future of the former Median Road Resource Centre. The Chair agreed to request a note on this from the Deputy Mayor/Cabinet Member.

ACTION:	**The Deputy Mayor is requested to provide a brief update on the current status of the feasibility study on the future options for the Median Rd Resource Centre site.**

11.3 Shirley Murgraff, a resident, stated that she had written to the Commission asking for its assistance regarding the issue of the poor take-up of pension credits in Hackney. Recent reports from Independent Age and Age UK had highlighted that there was c. £26m in unclaimed pension credit in the borough and she asked what the Council was doing to ensure that every single pensioner and pension age couple in the borough knows about their entitlement and are encouraged to apply for it. The Chair replied that he would ask the Cabinet Member for Finance and Housing Needs to respond.

ACTION:	**The Cabinet Member for Finance and Housing Needs to respond to Mrs Murgraff's request about ensuring that entitlement for pension credit is more fully publicised by the Council so that the estimated pot of £26m in unclaimed pension credit is claimed.**

Duration of the meeting: 7.00 - 9.00 pm

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **Children, Young People and Maternity Workstream of Integrated Commissioning – annual update** **Joint item with CYP Scrutiny Commission**	Item No **5**

OUTLINE

Health in Hackney receives a rolling programme of updates, in turn, from each of 4 Workstreams under the Integrated Commissioning Board. The Board integrates the health and social care commissioning of Hackney Council, City & Hackney CCG and Corporation of City of London.

To avoid this item being repeated at two Commissions the CYP&M Workstream update is always taken jointly with members of the Children and Young People Scrutiny Commission.

Here is a link to the discussions at last year's joint item on this:
http://mginternet.hackney.gov.uk/mgAi.aspx?ID=32919

Attending for this item will be:

Anne Canning	Group Director CACH	Senior Responsible Officer for CYP&M Workstream
Amy Wilkinson	Workstream Director	CYP&M Workstream, LBH-CCG-CoL

Members of CYP Scrutiny Commission will attend to ask questions.

ACTION

Members are requested to give consideration to the report.

This page is intentionally left blank

Integrated Commissioning: Children, Young People Maternity and Families Workstream

Update to Health and Hackney and CYPS Joint Overview and Scrutiny Committee 4th November 2019

1.0 Introduction

The Children, Young People, Maternity and Families (CYPMF) Workstream has been working to deliver an integrated system for children, young people and their families across City and Hackney since October 2017. The overarching aim is to coordinate, optimise and transform the delivery, and subsequently the health outcomes of our residents.

The top 3 deliverables linked to our transformations plans for 2018/19 were:

1) **Improving emotional and mental health for children and young people**: Delivering the CAMHS transformation, developing an evidence base to support integrated work on exclusions; and drafting an integrated emotional health and wellbeing strategy

2) **Improving the health of our vulnerable groups**: Transforming pathways for children with SEND in line with recommendations from inspections, commissioning a new health offer for our Looked After Children; and beginning the development of an integrated Speech and Language Therapy service

3) **Improving care at maternity and early years**: Continuing to support improvements in quality of maternity services at HUFT, repatriating many of births we have out of area, and addressing a measles outbreak, supported by the implementation of a two year action plan.

During 2018/19, the workstream consolidated structures to support delivery of both business as usual, and transformation. Clinical and Practitioner lead roles continue to support leadership and drive forward integration for Maternity, Children, and CYP mental health and wellbeing alongside our clinical leads for Long Term conditions, Maternity Early years and SEND / wider children's pathways. The workstream delivers CCG business as usual for Maternity and Families and Public Health business as usual for Children and Families alongside system wide transformation.

2.0 Context: Plans and progress 2019/20

The workstream has made good progress on delivery of the 4 functions outlined in the delivery framework ('How we are working') that support both the development of the workstream and the delivery of the CYPMF integration and transformation agenda as detailed in the delivery framework (Appendix 1). Additionally:

- The NHS Long Term Plan contextualises our work, placing a strong focus on prevention, and on giving our population the 'Best Start in Life' through continued delivery of maternity and CAMHS transformation, and a new focus on maximising our use of digital, implementing pathways for 0-25s and improving transition and strengthening services for those with SEND and autism. A new national transformation programme for children and young people will be rolled out during 2020/21.

- The workstream is well positioned in 2019/20 to deliver on the Long Term Plan transformation priorities, as detailed below, and through the structural mechanisms of the Integrated Care System / Partnership, the new Provider Alliance working on community health services, and the City and Hackney Primary Care Networks and Neighbourhood frameworks.

- The workstream is developing a system wide approach to raising awareness and reducing the impact of Adverse Childhood Experiences (ACE's) which underpins all of our work, and links across the other three workstreams as well as the wider system. A needs analysis, strategy and action plan are being developed (due January 2020), which will include delivery of specific workstrands to support and strengthen workforce, improve the offer of early support and parenting and to develop a digital resource portal to support professionals and carers to be more trauma-informed in their approaches.

- Close alignment with the other workstreams is a priority in 19/20 and we will continue to focus on improving uptake of immunisations, Speech and Language Therapies and the consolidation of pooled resources, improving the health of Looked After Children, Maternity and early years provision and ongoing improvements to support the emotional wellbeing and mental health of children and young people.

- Proposals are being explored to take forward an integrated 0-25s commissioning approach which would seek to align the commissioning of a range of CYP services including (but not limited to) Health Visiting, School Based Health and the Young People's Clinical Health and Wellbeing Service (CHYPS Plus). This integrated approach will seek to maximise opportunities to improve outcomes through joint-working and to reduce transactional costs associated with holding several contracts with external/internal providers. Potential synergies between the children's centre clusters and the proposed Joint Commissioning neighbourhoods and developing children's centres into opportunity hubs, offering support to families with children of all ages are some of the changes being considered as part of the Early Help review.

3.0 Impact

While we are seeing improved health outcomes across a number of measures for children and families (see table 6.0 below), and improvements in measured quality of services, we are consciously looking at how we demonstrate impact more tangibly through our workstream Outcomes Framework, Logic Model and ongoing evaluation with Cordis Bright partners. We are aware of ongoing challenges in specific areas including uptake of immunisations, childhood obesity (linked to Prevention workstream), women's experience of maternity services, health outcomes for our more vulnerable groups (ie. Looked After Children, those with SEND) and experience of transition between services.

4.0 Alignment with London and the East London Health and Care Partnership ('the North East London STP')

There are several areas of alignment with the East London Health and Care Partnership, and our close neighbours, including maternity, vulnerable children at risk of sexual exploitation and assault, CAMHS transformation and asthma. STP level work will look at urgent care for children and young people throughout 2020. City and Hackney is a key player in the North East London Children and Young People's Steering Group, and we are now a member of the London Children and Young People Clinical and Leadership Group driving implementation of the new CYP national transformation plans.

5.0 Delivery of Local Transformation

Transformation is progressing as part of our quality improvement through Business as Usual, and also where areas are identified as specific priorities for transformation. Developments are detailed in the following table:

6.0 Delivering Transformation: Highlight Report

This demonstrates delivery across our three identified priority areas, and incorporates elements of business as usual grouped into priority area:

Deliverables:	**Outcome ambitions:**	**Highlights**
Priority 1: Improving Children and Young People's Emotional Health and Wellbeing across the system		
Ensure the development of a clear prevention offer, with an emphasis on wellbeing, and young people getting support where needed. Includes: ● Implementation of the CAMHS transformation plans, including schools work ● Re-design of service system ● Investigating the increase in self- harm presentation, and ● Identify key trends / issues and making recommendations to address ● Improving access to support for children and young people in the City of London	Improved offer of, and access to CAMHS, demonstrated through: ● Increased diagnosis (linked to increased investment) ● clearer pathways for residents and non-residents ● Improved access to support for crisis ● CAMHS support in all schools by 2020 ● Improved outcomes for those transitioning to adult mental health services through a pilot 18-25 yr. service ● Reduced waiting times to entering treatment within 6 weeks by Q3, 18/19 ● Extended hours of Paediatric Psychiatric liaison in A&E to 10pm ● Enhanced eating disorders service ● Improved neurodevelopmental pathways including increase funding for Autism diagnosis and aftercare	● **CAMHS Transformation** plan is fully operational with a recurring investment addressing gaps identified and in alignment with Future in Mind. The plan is now in Phase 3. City and Hackney CAMHS Alliance is due to publish its implementation plan for 2019-20 which includes 18 transformation work streams. ● Some highlights include the new 16-25 transition service, reach and resilience project expansion with the launch of a 'cool down' cafe on the Pembury estate and online counselling offer as well as the establishment of a 24/7 crisis line and crisis pathway for C&YP. ● The **Well-Being and Mental Health in Schools** (WAMHS) project re-launched in June 2019 with phase one having been rolled out in half of the state maintained schools in Hackney with rollout to the remaining schools to enable all schools to have WAMHS from 20/21. ● City and Hackney have been successful in securing funding to deliver **Mental Health Support Teams** in schools as of September 2019. This is £1.8million of investment (over 2 years) to provide direct clinical interventions in schools, building on the WAMHS strategic work. ● Based on locally collected data, end of year CYP MH **access rate** is predicted to be c40% meaning we are likely to be one of the highest performing CCGs in the region. ● Funding has been secured by CAMHS and VCS partners (CAMHS Alliance) to deliver work to **improve the mental health of Black African and Caribbean heritage young people** at key transition points (up to age 25). ● The **Trusted Relationships project** is at the end of year one of a 2-4 year funded project working on capacity building in community settings around education, awareness of support, reducing harm and increasing access to mental health pathways. ● An Integrated Emotional Health and Wellbeing **Strategy** (2019-2024) is in first draft and will be out for consultation by December 2019.

Priority 2: Strengthening our health and wellbeing offer for vulnerable groups		
Improve the health offer for Looked After Children: Re-design and procure integrated HLAC provision Oversight of the health elements of the SEND offer and targeted joint work. Includes: ● Pathway development, particularly around the offer at early years ● Early health input mechanisms embedded into EHCPs (Education, Health and Care Plans) ● Support at key transition points ● Further development / use of personal health budgets ● work with partners including the OJ community to support access to provision ● explore improving the health and wellbeing of boys with autism specifically for City of London Support work with children to manage Long Term conditions. Includes: ● STP Integrated Asthma provision work ● Epilepsy and Asthma specialist nurses ● Develop local offer around allergy and dermatology ● Explore increasing access to therapies for groups with	More effective pathways for LAC through health, particularly for those CYP with complex health needs, mental health needs and challenging behaviour needs through newly commissioned service ● Increased early health support for children with SEND, as evidenced through input to EHCPS ● Increased numbers of children and their families utilising Personal Health budgets and making effective transitions to adult services ● Increased representation of specific communities accessing SEND heath support More families supported to manage long term conditions in the community, and through a closer relationship with Primary Care	● The collaborative re-design and commissioning process for the **new health of Looked After Children's** service successfully delivered a new service, launched on September 1st 2019 and is on track to transfer to the Hackney Ark by January 2020. Young people and foster carers were involved in the design of the service. It is now being delivered by HUFT. ● The LAC health annual report 2018/2019 documents positive early indicators of progress including partnership working, the recruitment of a Named Nurse and the presence of a CAMHS practitioner at the LAC clinic. ● An Integrated arrangement for delivery of **Speech and Language therapies**, including for pooled budgets will be in place by 2020. A similar joint review for Occupational Therapy is due to be initiated and will explore and review commissioning of Learning Disability across the partnership in line with STP priorities around reviewing therapies. ● The local campaign response to tackle the **measles outbreak** was nominated for a parliamentary award. This included additional clinics being set up and over 1000 **immunisations** being delivered. The partnership has agreed a draft action plan and a task group has developed a public health campaign aligning closely with the priorities of the NE networks ● Interventions included utilising the developing neighbourhood and PCN structures to pilot work to increase uptake of immunisations, delivery of a public health communications campaign and commissioning Hatzola (volunteer ambulance service highly trusted in the Jewish Orthodox community) to promote the management of childhood illness in the community. ● All children with continuing healthcare needs now transferred to **personal health budgets**, and all those eligible now transferred from statements to EHCPs. Funding secured for implementation of recommendations arising from the CoL and LBH **SEND** inspections, which will include a system wide review of, and recommendations for funding protocols and pathways. Implementation of SEND inspection recommendations ongoing. Joint funding has been agreed for a number of children via monthly case management meeting between CCG, HLT and HUHT. ● Joint work (with Planned Care and across system partners) have begun to develop City and Hackney protocol and process to deliver '**Care, Education and Treatment Reviews**' in line with LTP drive on autism and LD. Includes development of a register. ● '**Reducing Exclusions'** work supported by the workstream completed a

barriers to access, and specifically for City of London children ● Develop clear Primary Care pathways for children with unexplained medical symptoms (in conjunction with the Paediatric liaison service), and work with CAMHS on the Autism pathway Scope potential for joint work across the CSE, harmful sexual behaviours and CSA agenda, and deliver on STP proposals for development of CSA hub Support integration and groups with disparities in health outcomes and higher levels of coming into contact with the Youth Justice system, alongside work to Explore links to reducing exclusions Improve the health and wellbeing offer for the most vulnerable groups of City of London children and young people	Further integration of social care and health, resulting in better identification and support for those at risk of sexual exploitation, and better and faster access to support for those who have experience sexual assault. Less disproportionate representation of specific vulnerable groups accessing health and wellbeing services Closer working across education, health and social care to support the most vulnerable young people to stay in school	detailed analysis of the 41 Primary and Secondary school exclusions in 2017/18 which showed trends and provides the evidence to support the strategic integrated work. Work will now go on to look at pathways through early help services for this cohort. ● The new integrated **School Based Health service model**, which includes the safeguarding school based health element, went live in January, 2019. Each school has a named school nurse, with the nurse attending each school at least once a fortnight. The addition of mobile device technology further allows nurses to spend more time working at their schools. ● **Family Nurse Partnership** had 55 clients enrolled at the end of Q1 including 1 enrolled from the Jewish Orthodox community with a further one in recruitment. A Key Skills and Knowledge Exchange Programme started in September 2019 and will run until April 2020 covering the teenage brain, attachment, communication skills and engaging marginalised clients. ● A system wide approach to raising awareness and reducing the impact of **Adverse Childhood Experiences** is in development and aims to strengthen workforce, improve the offer of early support and parenting and to develop of a digital resource portal to support professionals and carers. An ACE's workshop on 22nd August 2019 and the first phase of training rolled out with GP's on 17th October 2019 and were both well received. The strategy for this work will be completed by December 2019.

Priority 3: Improving the offer of care at maternity and early years		
Support improvement in quality of local maternity services and perinatal care. Includes: ● Explore and propose work to reduce rates of infant mortality ● Explore and evaluate data around re-admissions and identify action plan ● Reduce rates of smoking in pregnancy (Embed HUFT maternal smoking pathway and explore UCL pathway) ● Support work to improve rates of immunisations (including antenatal flu and pertussis). Explore potential effectiveness of devolved commissioning. ● Support work on choice of maternity care and perinatal mental health (with STP partners) ● Clarify pathways for women following birth and discharge Support work to improve rates of immunisations at 1 and 2 years, including exploring options for a devolved commissioning role Improve access to breastfeeding support	Reduction in the rate of stillbirths, neonatal and maternal deaths, supported by: ● Increased early booking by 10 weeks of pregnancy, and improve continuity of care from their midwife ● Improved pregnancy outcomes, specifically for women who have Long Term Conditions (LTCs) or other specific medical needs through our GP Early Years Contract, and targeted pre-conceptual care ● An increase in numbers of women taking folic acid, aspirin and healthy start vitamins for a healthy pregnancy and healthy growth and development of the child ● Increased numbers of women who receive Pertussis and Flu jabs during their pregnancy ● Increased referral of women early to local services when social or psychological risks are identified ● Improved pregnancy outcomes for socially vulnerable women targeted support for women who may be socially vulnerable ● Clearer pathways through services for women with a high Body Mass Index (BMI) ● Ensure pregnant women, partners and parents have the opportunity to provide feedback	● Continued focus on delivering key areas in the NHS Long Term Plan, including building on our 28.9% of women booked on **Continuity of Carer pathway** in March 2019 – exceeding national ambition of 20%, and reducing stillbirths and neonatal deaths. ● Implementation of **digital solutions** for Maternity which are in the planning stage will support better working with patients in antenatal care with a clear focus on improving women's experiences of antenatal care through responses to input from service users through the Maternity Voices project. ● Increase in deliveries in 2018/19 and sustaining improvements in quality performance of midwifery services at the Homerton, verified through **CQC** inspection August 2018 (moved from 'needs improvement' to **'good'**). HUFT received 4x Chief Midwifery Officer for England **awards** June 2019. ● **Peri-natal mental health** services have been expanded in line with 2019/20 targets and work with primary care and VCS partners is focussed on early support and a clear pathway for the most vulnerable women in pregnancy. ● A 'Weigh and Play' pilot at Linden Children's Centre is in the process of being evaluated to find out whether the change in the play based health visiting clinic environment means parents feel more supported around their emotional needs, whether parent and baby relationships are enhanced in the setting. ● **Health Visiting services** have been delivering a new integrated model from September 2018 and will be re-commissioned for 20/21. Work to explore the possibility of joining the 0-25's public health, community nursing services (health visiting, family nurse partnership, school based health and CHYPS) into **one joint commissioned service** to start in 2021/22. ● Health visiting is meeting or exceeding all KPIs with the exception of antenatal contact. Senior Health Visitor Jane Horsfall won the Community Midwife award, in part due to the development of a Downs Syndrome pathway ● Work with the Prevention workstream is focussing on implementing the new **smoking in pregnancy pathway** and supporting the development of the Making Every Contact Count programme through a pilot in maternity. ● The senior health visiting team continue to work closely with Midwifery to develop the referral pathway for targeted antenatal contact. ● An Early Help Position statement clarifying how things are now has been drafted and highlights the complexity of the service provision has been completed. An **Early Help** review in December 2019 will consider the effectiveness and accessibilities of pathways into early help and how well they

Explore options for development of a 'supporting parents' pathway, linked to substance misuse. This includes exploring work with Fathers. Ensure the needs of families and young children are built into the new 'Neighbourhoods' model (above), and the interface with children's centres is effective	on their experience of using maternity services • Increased identification of, and access to support for women around mental health in the perinatal period (alongside our STP partners)	meet the needs of those who need them. This will begin to look at the role of health and how this can be maximised.

7.0 Delivering Transformation: Risks and Challenges

Key risks are managed through workstream governance structures, with high level risks reporting through to the Integrated Commissioning Board. Ongoing and upcoming risk and challenges are outlined here:

Issues, risks and challenges:	Progress/ Actions being taken to address:
School exclusion and self-harm remain high. Hackney has higher numbers of children in specialist education provision and demand for CAMHS continues to increase by 15-18% per year. Gaps in 18-25 services remain.	The CAMHS transformation plan is tackling these challenges with strong partnerships in place. Funding has been secured for WAHMS and mental health support in schools, increased support for Black African and Caribbean heritage young people and a 16-25 transition service has been piloted.
Maternity deliveries with complications and comorbidities are increasing year on year at HU going from 54% in 2017/18 - 63% in Sept 2018. Increasing caesarean rates are an area of concern A recent audit of C2C outpatient paediatric activity found that 50% were found to be incorrectly coded.	An independent coding audit has confirmed changes in coding practices during 2017/18 leading to significant financial impacts and a full audit is due to be completed by December 2019. This is being monitored and an action plan developed.
Figures from the **LAC health** annual report for Q1, 2 and 4 of 2018/19 show that 64% of Initial Health Assessments were completed within 20 days which was mostly due to late notification and reduced clinic capacity. A high number of LAC children were also found to be refusing a second LAC review and dental and immunisation take up by LAC children and young people was found to have gone down.	The transfer of services from WH to HUFT and implementation of the new service has been completed safely. A policy/ pathway is in place to address the refusal of reviews with input from young care leavers.
City and Hackney's recent measles outbreak is now over, however risk remains due to **low uptake of immunisations** in specific areas of Hackney, exacerbated by complications of centralised commissioning arrangements and lack of clarity centrally on outbreak funding arrangements.	A quick response to the measles outbreak was commissioned by the CCG for 8 weeks with over 1000 immunisations delivered. The local partnership 'improving immunisations' action plan and targeted public health campaign went live in June 2019 and CCG commissioned targeted service offer for NE practices along with NHSE commissioned call and recall pilot for NW Hackney, will help inform network plans for 20/20.The two year partnership action plan to increase uptake of immunisations sits across all age groups, and progress against this reports directly to ICB.

The Long Term plan outlines Care Education and Treatment Review (CETRs) processes that are the responsibility of the CCG are not yet fully embedded. These cross -agency arrangements are intended to prevent avoidable admissions to long stay specialist hospitals for children and adults with **LD and / or autism** who are displaying challenging behaviour. The coordination and chairing of children's CETRs, no baseline of activity levels whilst robust dynamic risk register is developed with partners)	Work across the CYPMF and planned care workstream with LBH, City and education colleagues to establish a dynamic risk register and CETR arrangements is progressing well. Lay Board Member has offered leadership to the early children's CETRs, supporting the agreement of governance processes and raising the profile of this Agenda. NEL Sector Programme support and learning from STP CCGs and adults' processes. Engaged partnership working to draft governance protocols.
Financial pressures on funding of Special Education Needs and Disabilities across the system.	Current PIC funded pilot work is supporting looking at how we implement integrated funding arrangements across health education and social care. This is a national issue, but it is flagged in terms of local impact.

7.0 Primary Care: working through and with primary care networks and neighbourhoods

The workstream is keen to develop a stronger offer for children and families aligned to the delivery of services through neighbourhoods allowing for targeted, collaborative and localised approaches to target the highest need. We are exploring this through our CYPMF Neighbourhood coordination group, piloting neighbourhood work on immunisations and paediatric psych liaison initially. We will begin work to implement CYP and Families Multi-Disciplinary arrangements across each neighbourhood during 19/20. We will strengthen joint working between community paediatrics and primary care, specifically in the transfer of two community baby clinics to two practices in NE Hackney with very high child lists. We will also be piloting the move to an 8 week baby check that includes immunisations.

8.0 Quality and Safeguarding

Quality continues to be monitored at contract and service level, through a number of KPIs and wider indicators, with the support of the CCG quality function. Further detail on Quality of local children's and maternity services is available but generally Homerton acute and community services are rated "good" by CQC and mental health services for children are rated "good" or "outstanding" at ELFT. All local GP practices are rated "good" or "outstanding.

We have had two generally positive SEND (Special Educational Needs and Disability) Inspections (Hackney Dec 2017 and CoL March 2018). Health services for this cohort were found to be good, and Maternity services rated were rated by HUFT as 'Good' in the August 2018 CQC report.

City and Hackney are currently implementing new arrangements in adherence with the recently published safeguarding guidance: 'Working together to Safeguard Children 2018'. The 3 main changes required are:

1) Local safeguarding children boards will be replaced by Safeguarding Partnerships comprising 3 statutory partners: the CCG, the local authority and the police who will work together with local relevant agencies to safeguard and promote the welfare of children including identifying and responding to their needs. The new Partnership is being put in place currently.
2) Changes to the Child Death review process which transfers to DOH from DfE with child death review partners, the LA and CCG arranging collective thematic reviews of child deaths in their area and agreeing locally how this will be funded.
3) Changes to the Serious Case Review Process involving the setting up of a national panel to oversee the review of serious child safeguarding cases which raise issues that are complex or of national importance. These will be commissioning and overseen by the safeguarding partners.

9.0 Co-production & Engagement

An Engagement Strategy developed by the workstream is in place which will be finalised in consultation with young people during 2020. The strategy outlines a wide range of groups with which we will engage going forward. The Young Parents Advisory Group is currently being refreshed and feeds into the workstream as part of a public rep role, and also meet to design and deliver their involvement in workstream priorities. There has been a strong co-production and engagement plan supporting the re-design of the new Health of LAC service, led by Public Health and Young Hackney. Key input from a range of children, young people (including those in care), foster carers and professionals features in the new design. Stakeholder involvement and co-production are key elements of the design of the new Integrated Speech and Language Therapy service.

Our Young Parents Advisory Group will be refreshed over the coming months, and they have begun to think about how they would like to take co-production forward across maternity (specifically the campaign to attract births back to HUFT - alongside the Maternity Voices Partnership), CAMHS (as part of evaluating delivery of transformation plans), and they have been part of designing our new health offer for Looked After Children. Our two public representatives (parents of very young and adolescent children) alongside our two VCS representatives (from Interlink and the Black Parents Forum) represent our more specific communities. A review in the coming months will look at how we engage with children and families in line with the LBH Young Futures initiatives.

A Co-production meeting held with the Neaman practice regarding SEND arrangements in the City. The City Parent Carer Forum, CCG, CoL Principal Educational Psychologist and SEND Advisor agreed greater joint review of complex cases and closer working on literature and pathway review. The CCG contributed to the review of the City Carers' Strategy and this will be reviewed via the City SEND co production working group

Following request from parents we are exploring a Personal Health Budget peer support session / forum for families in receipt of a continuing care PHB's.

Appendix 1

Delivery Framework: 'How' we are working

Deliverable	Progress to Nov 2019	19/20 Plans
Consolidating and streamlining of workstream budgets	Work progressing. Budgets collated across LBH, CCG, CoL and HLT and recommendations drafted for pooling / aligning. A mapping of services commissioned by the City of London has been carried out. Plans for pooling of funding arrangements for Speech and Language Therapies developed	Ongoing, in line with wider integrated programme discussions Next steps for the City of London will be discussions on prioritisation and KPI's. Alternative arrangements for the pooling of Speech and Language Therapies budgets will be in place by 2020.
Refreshing children's health governance across the system	Work complete. New streamlined workstream - based governance structure being implemented.	New structures in place. Review will take place in Winter 2019
Improvement and oversight of Business as usual	BAU being managed through BPOG (as below). Integrated management of BAU functioning well.	Continue integrated oversight and management of BAU. Services are continuing to improve with most children and families services commissioned by the CCG and Public health being good or outstanding. Key areas of focus for 2020 will be around strengthening services for children with SEND and Autism in line with the long-term plan, and improving the experience of transition for 16-25 year olds.
Identification and delivery of transformation priorities	Priorities agreed, early plans drafted and structures for delivery emerging.	Delivery of transformation priorities progressing. See above for details.

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **Consolidating dementia and challenging behaviours mental health in-patient wards in east London – proposal from ELFT**	Item No **6**

OUTLINE

East London NHS Foundation Trust is proposing to locate all older adult in-patients with behavioural and complex psychiatric symptoms of dementia, across East London into one site at Sally Sherman Ward at East Ham Care Centre.

The plan envisages that the future care of mental health in-patients currently in Thames Ward at Mile End Hospital be consolidated within Sally Sherman Ward at East Ham Care Centre.

This proposal builds on previous consolidations which the Commission endorsed such as:

- Dementia beds from 3 CCGs to Columbia Ward at Mile End (2012)
- Functional Older Adult beds from 3 CCG's within Leadenhall Ward at Mile End (2015)
- Functional Older Adults beds from Cedar Lodge in Hackney into Thames Ward at Mile End (2018)

Attached please find the full 'case for change' proposal from ELFT and the CCG. This proposal relates to the 4 Inner North East London boroughs and is being brought to HiH as it will impact the Hackney patients involved.

Attending for this item will be:

Eugene Jones	Director of Strategic Service Transformation	ELFT
Dan Burningham	Programme Director – Mental Health	City & Hackney CCG

ACTION

Members are requested to ENDORSE the proposal.

This page is intentionally left blank

East London NHS
NHS Foundation Trust

Health in Hackney Overview and Scrutiny Committee

4th November 2019

Centre of Excellence Model

Consolidating Dementia and Challenging Behaviour Inpatient Wards

1. Summary

1.1 The purpose of this document is to outline the next stages of the Trust's proposed continued strategy and commitment to improve the care and outcomes for Older Adults within East London.

1.2 It is proposed that the future care of Thames Ward patients (Mile End Hospital), will be consolidated within Sally Sherman Ward (East Ham Care Centre), this proposal will build upon and compliment previous successful Older Persons ward consolidations such as

- Consolidation Dementia Assessment for the 3 CCG's within Columbia Ward (2012)
- Consolidation Functional Assessment for the 3 CCG's within Leadenhall Ward (2015)
- Consolidation of Cedar Lodge into Thames Ward (2018)

1.3 Sally Sherman is a 19 bedded ward with the provision to flex to 23 beds, it provides holistic care for older adults serving Newham CCG, the service supports people with cognitive impairment (specifically dementia), who require specialist nursing care to support their complex and challenging behaviour.

1.4 Thames Ward is an 18 bedded ward providing holistic care for older adults serving Tower Hamlets and City & Hackney CCG, the service supports people with cognitive impairment (specifically dementia), who require specialist nursing care to support their complex and challenging behaviour.

1.5 In total are 37 (including flex beds 41) complex and challenging behaviour beds for Newham, City & Hackney and Tower Hamlets.

1.6 A run chart (Table 1) identifies Sally Sherman ward occupancy from January 2017. When looking at the last 12 months, from Sept 18, 59.8% through to (peak of 71.8% July 19) Sept 19, 63.2%, the ward has been carrying significant bed vacancies for considerable time.

1.7 A run chart (Table 1) identifies Thames ward occupancy from January 2017. When looking at the last 12 months, from Aug 18, 11.3% through to Aug 19, 32.9% the ward has been carrying significant bed vacancies for considerable time. This is despite the closure of Cedar Lodge and the consolidation of that service within Thames ward from April 2018.

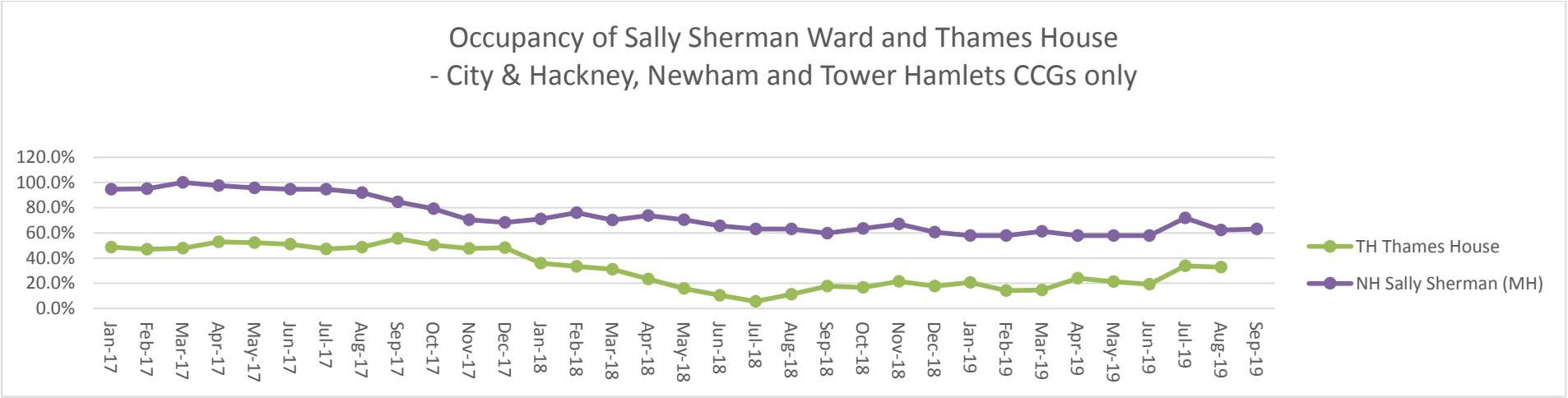


Table 1- Sally Sherman and Thames Ward occupancy as a % Jan 2017 – Sept 2019

1.8 A run chart identifies the available bed days (vacant beds) from January 2017 for both wards (Table 2)

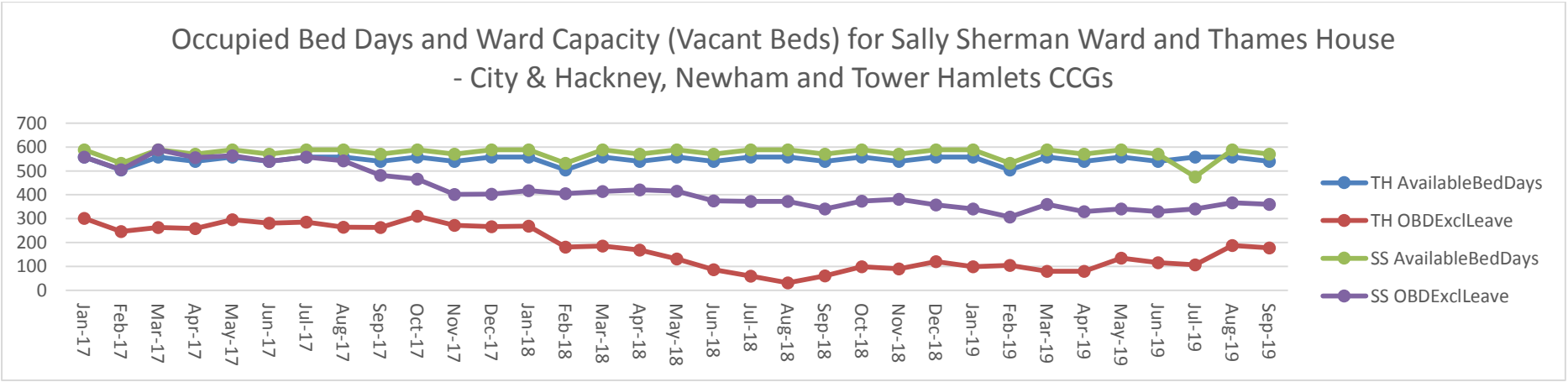


Table 2 – Sally Sherman and Thames Ward occupied bed days against capacity Jan 2017 – Sept 2019

1.9 Locating the complex care and challenging behaviour services together at East Ham Care Centre will provide a vast

improvement to the environment currently provided in Thames Ward, with improved lighting and access to natural light through a central atrium, an environment using effective colour and design with dementia patients in mind, a feeling of space, clear lines of sight, with provision for privacy and dignity. Clinically this will improve access to a wide range of healthcare services, activities and support, and a more joined up approach to care delivery maximising the benefits the adjacency of other services configured for Older Persons on site.

1.10 The clinical scoping of these changes suggests this proposal could take place and be implemented incrementally, providing a safe and planned transition to Sally Sherman ward from November through to early December 2019.

TASK	Sept - 19	Oct - 19	Nov - 19	Dec - 19	Jan -20
Agreement of Business Case with CCG's					
Quality Impact Assessment					
Local Stakeholder Events					
Staff Consultation					
Further Engagement with individual patients and carers					
Transfer of patients out of ward					
Closure of Ward					

2. Background

2.1 Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. **The prevalence of dementia increases with age and is estimated to be approximately 7 per cent in those over 65.**

2.2 The risk of dementia, Alzheimer's type rises incrementally with age, the prevalence is higher in women than in men due to the longer lifespan of women.

2.3 The configuration of Older Adult complex care and challenging behaviour services is not currently optimised; the activity and bed occupancy is underutilised within Thames and Sally Sherman wards.

2.4 The opportunity to build on previous successful consolidations within Older Adult Mental Health would not only improve the quality of patient care, and reduce variation it would also provide better value and use of the available estate and resources.

2 National Guidance

3.1 ***NHS Long Term Plan*** - NHS will need to make better use of capital investment and its existing assets to drive transformation, as well as maximising productivity through improving utilisation of clinical space, and as an enabler to support transformation. This proposal in consolidating the available estate resource in one place rather than across 2 wards responds to this key driver.

3.2 ***Royal College of Psychiatrists*** - The Quality Network for Older Adults Mental Health Services (formally known as AIMS-OP) works with inpatient services to improve the quality of the care that they provide through peer review and accreditation processes. The ELFT Older Adult service has undertaken an initial review of the standards and deemed it would be difficult to reach compliance within Thames ward as a number of the criteria are environment related. Sally Sherman ward however provides a much-improved environment and the service would wish to register and apply for accreditation of the new consolidated service. **(Appendix 2 pictures of environment)**

3.3 The ***Prime Minister's Challenge on Dementia 2020*** - Highlights the need to ensure that every person diagnosed with dementia receives meaningful care and recommends that care settings ensure consistency of access, care and standards and reduce variation. The environment within Sally Sherman ward is far superior to Thames ward in terms of design and flow, use of space, colour, lighting and sound. The consolidation of Thames ward will respond to these issues and also reduce variation in what is a specialist area of psychiatry, supporting very complex inpatient Mental Health care. **(Appendix 2 pictures of environment)**

3.4 ***NHS England's Dementia: Good Care Planning (2017)*** further highlights the need for a standardised approach: "reducing unwarranted local variation in process or outcomes, promoting equality and tackling health inequalities, ensuring alignment with relevant cross condition care plans such as diabetes; and drawing on examples of good practice around the country". Sally Sherman ward has the benefit of having hospital status and is also located in the heart of the community, having direct and easy access to the full range of community services, Health and Social Care.

3.5 The Kings Fund ***Enhancing the Healing Environment*** Programme highlights the importance of providing visual clues and prompts, including accent colours and artworks, to help dementia patients find their way around a ward. Sally Sherman ward has won a number of awards and acknowledgments for its design, artwork and overall environment, related to Dementia provision. **(Appendix 2 pictures**

of environment)

4.0 Service Proposal

4.1 It is proposed to locate all older adult inpatients with behavioural and complex psychiatric symptoms of dementia, across East London consolidated into one site, Sally Sherman Ward, East Ham Care Centre. An analysis of the options has been considered, **(Appendix 1)**

4.2 This represents a comparatively small-scale service change; this proposal would see the transfer of 7 inpatients. However, the benefits in terms of improved quality are significant.

4.3 There are currently 7 patients on Thames Ward (Table 3) who have been clinically assessed as suitable for transfer to Sally Sherman Ward. Sally Sherman Ward has 8 vacancies

Borough	Male	Suitability for Sally Sherman	Female	Suitability for Sally Sherman	Total
City & Hackney	3	Yes	1	Yes	4
Tower Hamlets	0	N/A	3	Yes	3
Total	3		4		7

Table 3– Thames Ward Occupancy & Gender Mix – (Sept 2019)

5.0 Benefits

5.1 The East London NHS Foundation NHS Trust and working with local Commissioners are committed to ensuring ongoing access to high quality care, the merger of Thames Ward and Sally Sherman is part of this process of improvement and will deliver a number of quality benefits.

5.2 East Ham Care Centre is purpose-built, patients would be accommodated in a dementia-friendly unit, which has recently been refurbished, designed specifically for the older adult population and provides the full range of holistic care to older adult patients including the following wards and services:

- **Sally Sherman Ward** – 19 bed ward, providing specialist and continuing care for people with cognitive impairment and challenging behaviour

- **Fothergill Ward** - 27 bed intermediate care ward, providing, rehabilitation and end of life care

- **Day Hospital incorporating the Falls Prevention Clinic (FPC)** – providing intervention from two or more health specialists to help support chronic or long-term condition, FPC a multidisciplinary service including Occupational and Physiotherapy working together to investigate the causes of falls, reduce incidence and minimise injury following falling.

- **Activity Centre** - includes weekly music therapy sessions; a music therapist has recently commenced working at East Ham Care Centre. Patients also have access to faith and fellowship services, including multi-faith prayer meetings each week, and a sensory room

- **Cazaboun Ward** – 23 bed vacant wad

5.3 The co-location of the different streams of the older adult inpatient pathway allows for a smooth transition between them for a patient group for whom change can be unsettling and also creates a critical mass of expertise, resources and support in the care of the elderly and frail at this location. Patients can transition from the day hospital to our continuing care ward and if required, transition to our end of life ward providing seamless care.

5.4 Sally Sherman Ward operates a treatment model based on delivering person-centred care, as recommended by the Alzheimer's Society:

- Treating the person with dignity and respect
- Understanding their history, lifestyle, culture and preferences, including their likes, dislikes, hobbies and interests
- Looking at situations from the point of view of the person with dementia
- Providing opportunities for the person to have conversations and relationships with other people
- Ensuring the person has the chance to try new things or take part in activities they enjoy.
- Family, carers and the person with dementia (where possible) should always be involved in developing a care plan based on person-centred care.
- Their knowledge and understanding of the person is extremely valuable to make sure the care plan is right for them.

5.5 The ward is dementia-friendly, providing a bright spacious environment for patients. Every bedroom has en-suite facilities and are spacious enough to be equipped to support patients with disabilities. The ward is built around a central atrium, which not only renders an abundance of space and natural light it also provides a dementia-friendly natural loop, which patients can move around when they want to take some exercise but in a safe environment where they cannot get lost. There is seating

areas spaced around this loop where service users can sit, to relax or rest if they get tired.

5.6 The ward maintains exceptional levels of cleanliness, is pleasant, friendly and inviting.

5.7 East Ham Care Centre also benefits from lovely gardens, which are used frequently by service users. Every service user has a tailored activity programme and is allocated an activity worker. The Activity Centre runs from Monday to Friday every week and includes weekly music therapy sessions; a music therapist has recently commenced working at East Ham Care Centre. Patients also have access to faith and fellowship services, including multi-faith prayer meetings each week, and a sensory room.

5.8 Staff on Sally Sherman Ward encourage orientation and involvement of the service users. Annual celebrations and events are marked and service users are involved in art projects to create decoration for the ward at key points of the year, e.g. Easter, Christmas.

5.9 Staff work with the service users to create a 'memory book' features photographs of their family, items from their childhood or people and places that have a special meaning to them. These books are regularly shown to and discussed with service users and this can help with orientation and reduce stress in isolation.

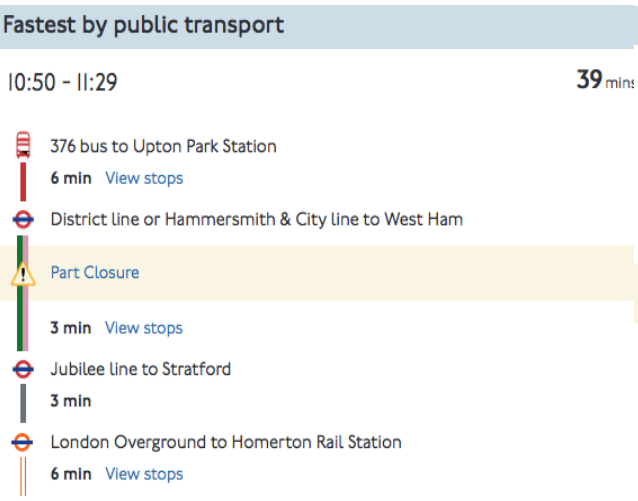
5.10 The ward encourages the use of small tables at mealtimes to create conversation and interaction between service users and staff, to minimise any distractions and to ensure that service users aren't sat in one place all day and are stimulated by a change of scenery.

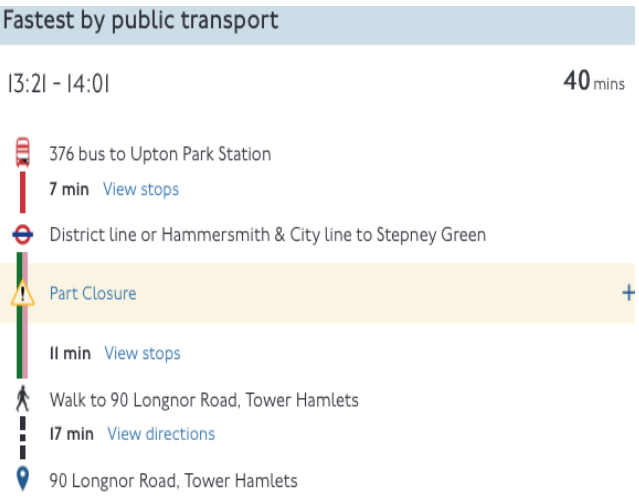
5.11 Patients based at Sally Sherman Ward also benefit from a wide range of health care and treatment approaches which are either based on site or visit the site on a regular basis, as follows:

Speech & language therapists	Physiotherapists	Diabetic nurses	Dieticians	Tissue viability nurses
Falls clinic	Podiatry	Optician	Dental service (provided by local practice)	Hairdresser on site
Liaison with local Bereavement Service	Sensory Room	Welfare Team	Physical health nurses	Therapy Room
Therapeutic Gardens	Mental Health Nurses	Medical Psychiatry and General Physicians	Activity Centre	Restaurant

5.12 East Ham Care Centre has good transport connections for families and carers visiting patients based at Sally Sherman Ward, as follows:

- Car park with visitor parking
- Cycle bays
- East Ham tube station is a 10-minute walk away on the District and Hammersmith & City lines
- Nearby bus stop in Shrewsbury Road offering access (376) to public transport routes to Hackney and Tower Hamlets.





5.13 Service users, families, carers and other visitors have access to an on-site canteen at East Ham Care Centre. A good support mechanism is also in place for relatives, with a designated area where families and carers can chat and offer informal support to each other. The multi-disciplinary team works closely with families and carers who are engaged at every step of their loved one's journey.

A relative recently wrote: "The level of care that patients receive here is extraordinary. Compassion, commitment and dedication are the order of the day. The staff bring hope and happiness to those in need. The atmosphere is calm and relaxed and promotes a much better quality of life than many had before. The confidence and contentment I had a as relative was priceless."

5.14 Sally Sherman Ward has participated in and achieved the following:

- Successful QI Project to reduce violence & aggression on continuing care wards
- Older Peoples Positive Mental Health (positive practice improvement). Ward shortlisted for QI Project on including carers in the care of older adults
- Oral health QI Project about to commence with aim of improving oral hygiene and responding early to dental decay and associated problems
- Won Nursing Times award for their work on reducing violence by 50%; sickness levels also reduced as a consequence of this
- The ward reached the final three in the Older People's National Awards in Bristol and although they did not win the award, they were 'highly commended' and received a certificate for the excellent work they undertake with Carers.
- Strategies to reduce antipsychotic and benzodiazepine
- Carers took part in a charity Memory Walk in Olympic Park
- Ward Housekeeper won Ancillary Leader of the Year at the National Unsung Hero Awards for her work around patient nutrition and developing diet plans
- Ward nominated for Improvement Team of the Year at ELFT Staff Awards
- As part of an International Quality Conference, the ward was visited by health staff from a number of countries around the world, including Canada, Australia, Scotland, Sweden, Norway and other parts of the UK, who all gave very positive feedback about Sally Sherman and said that they would be happy to have their family members placed in such a facility.

5.15 Sally Sherman successfully secured funding through the Prime Minister's Challenge on Dementia used the funds to make changes to the ward, including the décor, lighting, flooring and colours. The team also created lots of seating areas around the ward, including one particular alcove transformed from a dull unused area into a bright, inviting area, now used by many service users and their families. The alcove seating blends beautifully with a lovely view overlooking the beautiful gardens.

5.16 Staff on Sally Sherman Ward have undertaken a number of particularly successful interventions with challenging patients **(Appendix 3).**

6. Current, Future Activity and Demand

6.1 The demand capacity forecasting of Dementia diagnosis over the next 10 years has been based upon the baselines and profile of the ageing population within the Boroughs. All 4 Boroughs are regarded as young in terms of the population age range in comparison to the rest of the country and indeed London.

6.2 The number of people with Dementia in 2013 according to Local Authorities

CITY of LONDON – 86

HACKNEY – 1293

TOWER HAMLETS – 1209

NEWHAM - 1540

6.3 Life expectancy for older people is increasing, older people are most at risk of suffering dementia, the largest increases in the number of people with dementia will occur in those areas with oldest age groups within their population (see Table 4), this risk rises incrementally with increasing age.

Table A: The consensus estimates of the population prevalence (%) of late-onset dementia

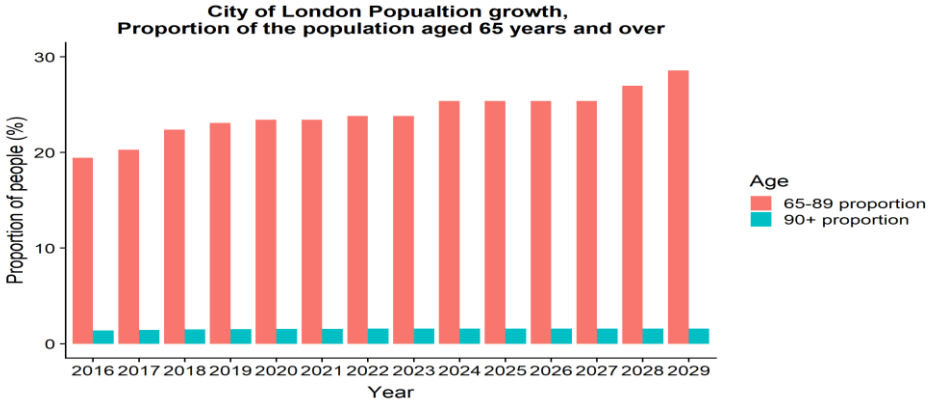
	Previous estimates (Dementia UK 2007)			Current estimates (Dementia UK 2014)		
Age in years	Female	Male	Total	Female	Male	Total
60–64	(0.1)*	(0.2)*	(0.2)*	0.9	0.9	0.9
65–69	1.0	1.5	1.3	1.8	1.5	1.7
70–74	2.4	3.1	2.9	3.0	3.1	3.0
75–79	6.5	5.1	5.9	6.6	5.3	6.0
80–84	13.3	10.2	12.2	11.7	10.3	11.1
85–89	22.2	16.7	20.3	20.2	15.1	18.3
90–94	29.6	27.5	28.6	33.0	22.6	29.9
95+	34.4	30.0	32.5	44.2	28.8	41.1

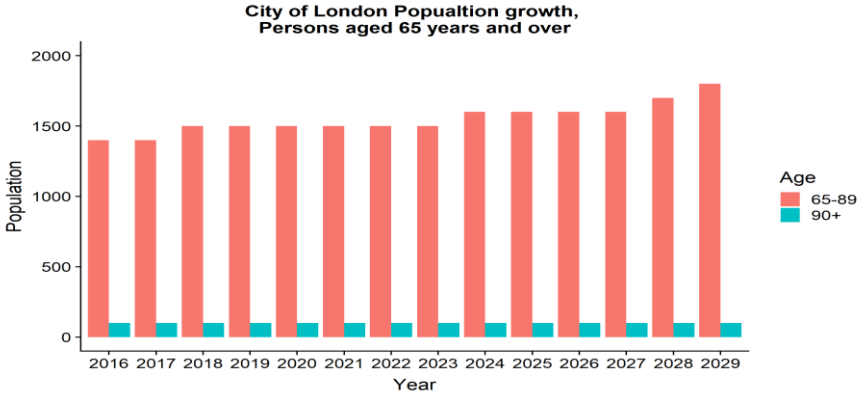
Table 4 – Population prevalence of late onset dementia

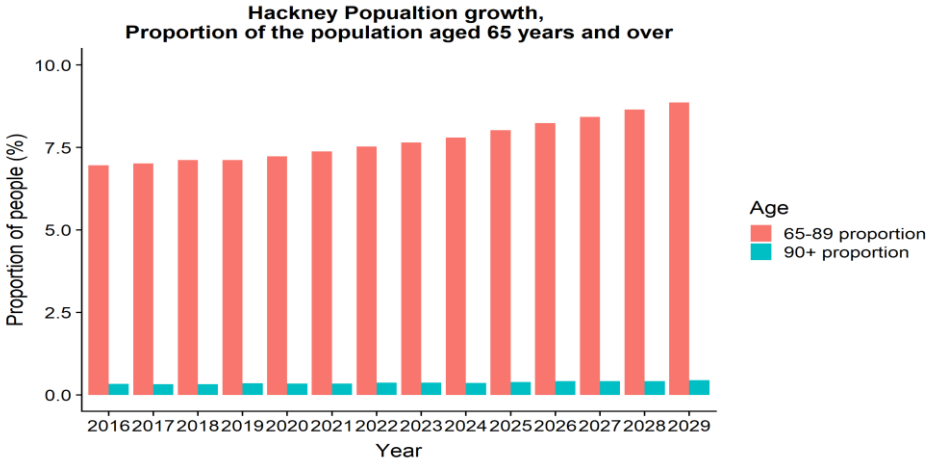
6.4 The tables below provide the forecast in terms of the general population age profile for the 4 Boroughs over the next 10 years.

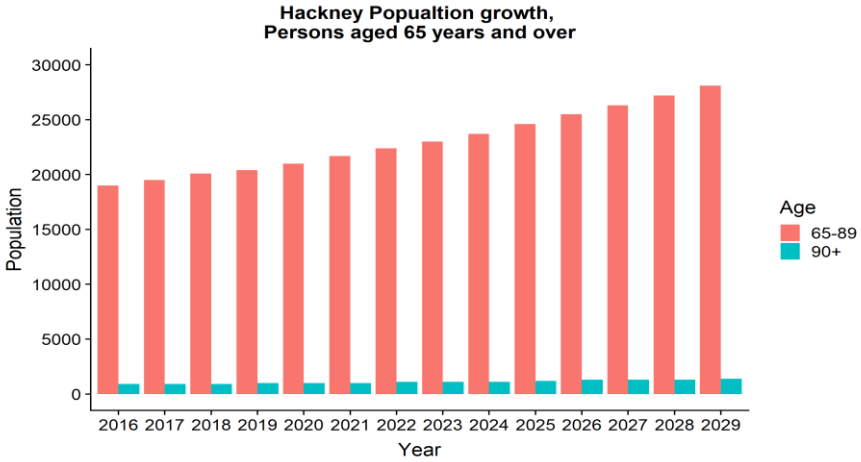
6.5 Using the population profile as a means to assess future demand and capacity requirements for Dementia we can establish that

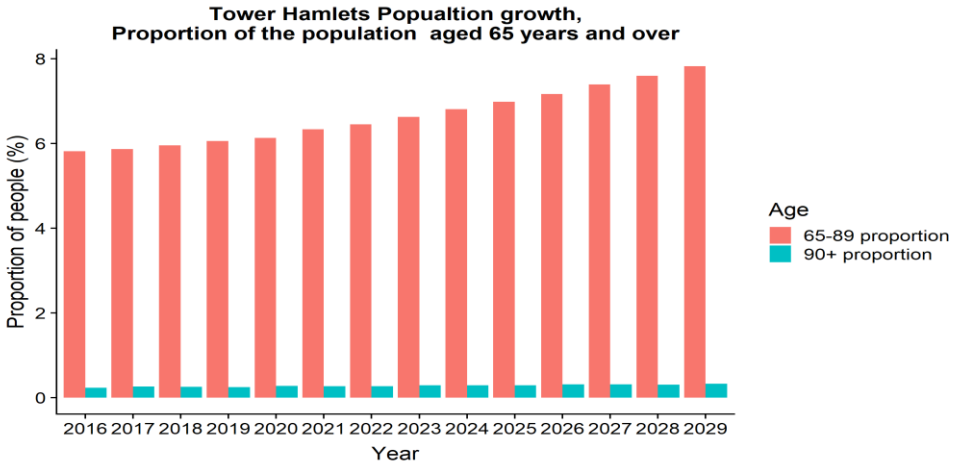
increasing age, increases risk, those people who are in the 90+ age group remains largely static within the Boroughs (life expectancy is lower than UK national average), whereas the 65 – 89 age range increases.
profile increases within each of the Boroughs.

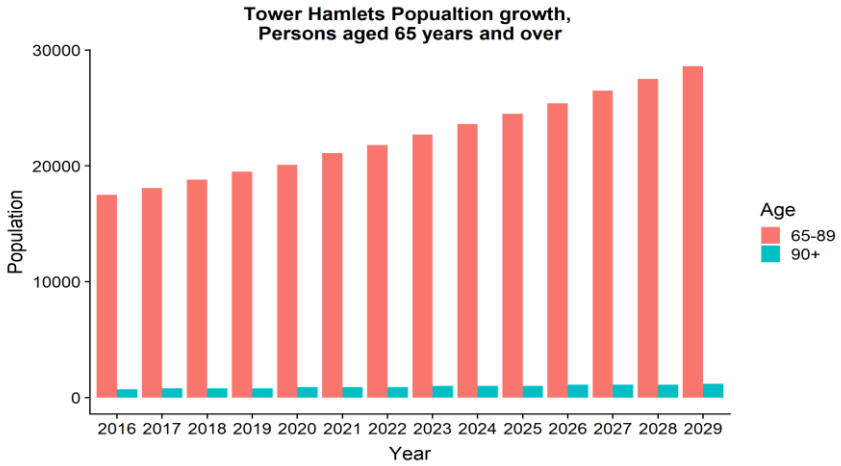


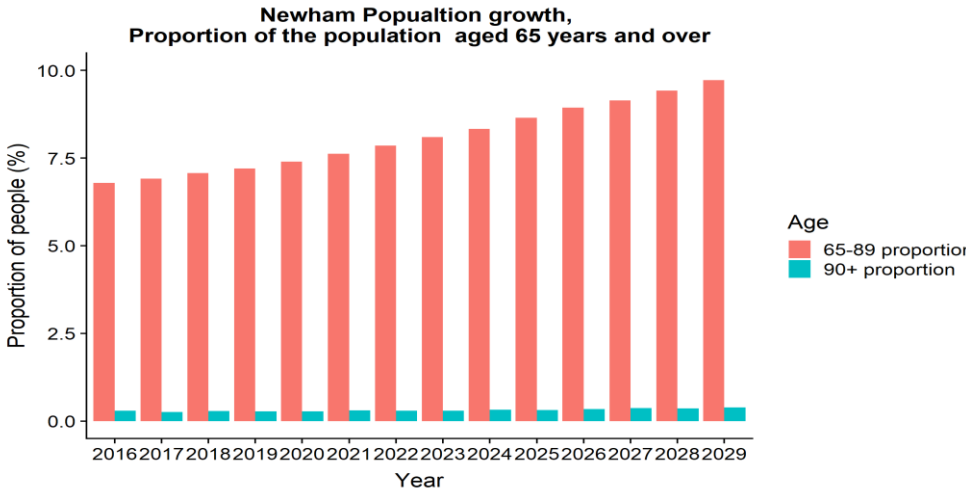


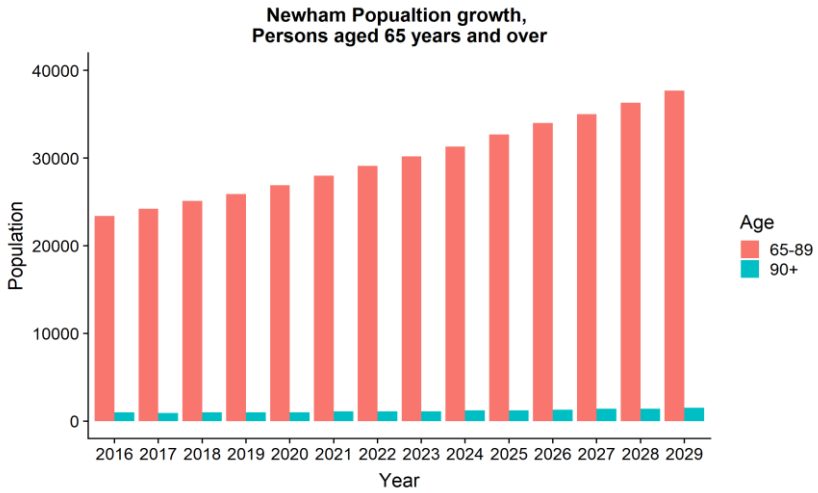












6.6 In terms of inpatient bed requirements for those with complex care and/or challenging behaviour the following growth assumptions have been made using the formula, current population and age profile 65 – 89 and 90+, compared with current usage of Inpatients beds as an % of that population segment. Projecting forward the forecast Inpatient need based on the increased growth of those aged 65 and over within the Boroughs. (Table 5 below)

Area	Measure	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
City of London	OBD 65 years and over	164.1	164.1	164.1	164.1	164.1	174.3	174.3	174.3	174.3	184.6	194.8
Hackney	OBD 65 years and over	2194.4	2255.9	2327.7	2409.7	2471.2	2543.0	2645.5	2748.1	2830.1	2922.4	3024.9
Newham	OBD 65 years and over	2758.3	2860.9	2983.9	3096.7	3209.5	3332.6	3476.1	3619.7	3732.5	3865.8	4019.6
Tower Hamlets	OBD 65 years and over	2081.6	2153.3	2255.9	2327.7	2430.2	2522.5	2614.8	2717.3	2830.1	2932.7	3055.7
City of London	Occupancy 65 years and over (%)	1.2%	1.2%	1.2%	1.2%	1.2%	1.3%	1.3%	1.3%	1.3%	1.4%	1.4%
Hackney	Occupancy 65 years and over (%)	16.2%	16.7%	17.2%	17.8%	18.3%	18.8%	19.6%	20.3%	21.0%	21.6%	22.4%
Newham	Occupancy 65 years and over (%)	20.4%	21.2%	22.1%	22.9%	23.8%	24.7%	25.7%	26.8%	27.6%	28.6%	29.8%
Tower Hamlets	Occupancy 65 years and over (%)	15.4%	15.9%	16.7%	17.2%	18.0%	18.7%	19.4%	20.1%	21.0%	21.7%	22.6%

Table 5 – Projected bed requirements forecast over next 10 years

6.7 In term of future forecasting and capacity from our bed modelling the capacity within Sally Sherman ward will meet future demand over the next 4 years, in 2024 demand will begin to outstrip bed availability.

6.8 In order to effectively plan for this forecasting and mitigate demand pressures we will be investing as phase 2 of this development in community orientated, upstream interventions to support more effective support and upskill the sector, developing increased expertise within nursing homes to help manage greater degrees of complexity, educational and supportive in reach for carers.

7.0 Staffing

7.1 It is proposed that all staff on Thames House are met with and redeployment plans are agreed and put into place in advance of patient transfer and ward closure.

7.2 Suitable Trust-wide vacancies have now been frozen and will be used to redeploy Thames House.

Medical Cover Current

7.3 Thames House is currently allocated 3 PAs of older adult consultant psychiatry input per week, Junior doctor cover to supplement the medical care is currently provided as required.

7.4 G.P input is provided by a local practice, to which all the patients would be temporarily registered whilst they are an inpatient

7.5 Sally Sherman is currently allocated 2 PAs of older adult consultant psychiatry input per week; only one of these is funded, the unfunded PA to be supported through this consolidation.

7.6 There is nominal duty doctor cover

7.7 G.P cover is one session per week; however, it is limited in its scope.

Medical Cover New Model

7.8 Sherman Ward consultant psychiatry sessions increased to 4 PAs per week. The current Sally Sherman consultant has the capacity to accommodate this increase and a new job description will be developed for this role. In addition, a middle grade doctor will provide cover for the Sally Sherman consultant's leave and other absence, providing much needed continuity of care and senior medical oversight.

7.9 The GP model (Thames House) will be replicated at Sally Sherman Ward to address current limitations.

8.0 Impact of Changes for City & Hackney and Tower Hamlets Service Users

8.1 It is recognised that that the move to Sally Sherman ward will be unsettling for the individual patients, who would transfer from

Thames Ward, Mile End Hospital, and for their families. In each of these cases the Consultant Psychiatrist and nursing staff, who know and are currently caring for the patients, will work closely with them and their family to re-assess their specific needs, agree individualised transfer plans and prepare them for the move. Family and carers will also be given the opportunity to visit Sally Sherman prior to change taking place.

8.2 The Trust recognises the importance in providing accessible services for Family & Carers to care and support older people in hospital of being able to be visited regularly by their family and carers. Therefore, additional travel assistance will be offered to carers where the journey to Sally Sherman is significantly more complex than the journey would have been to the Thames Ward. In coming to this determination the care co-ordinators will take into account:

- Mobility issues.
- Journey time.
- Number of transport changes needed to complete the journey.
- Physical, sensory or mental health problems that make travelling by public transport difficult.
- Personal safety considerations, including travelling after dark.

8.3 In situations where a journey is agreed as significantly more complex, **a total journey time of 45 minutes or more the** care co-coordinator will determine with the carer how the Trust might support the individual to maintain their visiting arrangements to Sally Sherman ward. This might include the provision of taxis, payment towards parking costs or provision of hospital transport. The transport arrangements will be reviewed regularly by the ward team and the carer throughout the patients stay.

8.4 Appraisals of travel times (Table 6) for Tower Hamlets and (Table 7) City & Hackney residents to East Ham Care Centre have shown that the potential impact on patient and carer travel time would not be excessive as there are a number of public transport routes. There are specific locations where the journey time is in excess of 45 minutes marked in red. An analysis undertaken shows the following differences in travel times for Tower Hamlets and Hackney residents.

Table 6 Tower Hamlets travel to Mile End/ East Ham Care Centre

Tower Hamlets	Current Travel to Mile End Hospital **Driving**	Current Travel to Mile End Hospital **Public Transport**	Future Travel to East Ham C.C **Driving**	Future Travel to East Ham C.C **Public Transport**
Stouts Place	13 mins	24 mins	34 mins	41 mins
St. Katherines Dock	16 mins	24 mins	32 mins	38 mins
Docklands	15 mins	36 mins	28 mins	56 mins
Island	13 mins	37 mins	25 mins	52 mins
Aberfeldy	14 mins	30 mins	24 mins	36 mins
Strudley Walk	12 mins	16 mins	21 mins	25 mins
Ruston Street	10 mins	23 mins	27 mins	37 mins
Spitalfields	12 mins	17 mins	43 mins	33 mins

Table 7 Hackney travel to Mile End/ East Ham Care Centre

Hackney	Current Travel to Mile End Hospital **Driving**	Current Travel to Mile End Hospital **Public Transport**	Future Travel to East Ham C.C **Driving**	Future Travel to East Ham C.C **Public Transport**
Abney House	25 mins	45 mins	38 mins	60mins
Green Lanes	32 mins	50 mins	45 mins	60mins
Southgate Road	19 mins	40mins	50 mins	55 mins
Half Moon Court	25 mins	30 mins	40 mins	52 mins
Broadway Market	12 mins	30 mins	36 mins	48 mins
Lower Clapton Road	23 mins	40 mins	31 mins	60 mins
Wick Road	15 mins	40 mins	30 mins	49 mins
Mandeville Street	31 mins	49 mins	35 mins	64 mins
Egerton Road	30 mins	45 mins	43 mins	57 mins

9.0 Financial costs and Value for Money

9.1 It is not financially viable to run wards with such significant bed vacancies over a long period of time. The staffing costs remain disproportionate with the ratio of patients, the consolidation of the wards will address these financial imbalances whilst providing the opportunity to achieve greater value for money and use of resources.

9.2 This scheme will enhance the current inpatient service through a remodelled and full multi-disciplinary team and support through reinvestment further improvements in the community pathway for Older Adults, including greater accessibility, early intervention and in reach to nursing home providers.

10. New Service Monitoring and Governance

10.1 In order to understand the impact of the change and mitigate/respond to any unintended consequences we propose to use the following measures to understand over time

- Length of Stay (Trend)
- Staff turnover (monthly – 12 month rolling)
- Staff absence rate (monthly)
- Incidents number and themes (trend)
- Patient experience & F&F responses
- Staff experience
- Eligibility for travel assistance identified vs's Travel assistance provided

11. Conclusion & Recommendations

- Sally Sherman is a modern, purpose built Older Person's ward located within East Ham Care Centre with sufficient capacity to meet the future requirements of complex and challenging behaviour for Older People from Tower Hamlets, City & Hackney and Newham.

- Family and carers of City and Hackney and Tower Hamlets residents in Thames Ward will be able to access assistance where travel time is an issue to enable them to regularly visit the ward in East Ham.

- The City & Hackney Health and Social Care Committee are therefore asked to support this proposal to merge Thames Ward with Sally Sherman, and in so doing deliver more cost effective, higher quality inpatient care, and improve the overall utilisation of estates at both East Ham Care Centre and Mile End Hospital enabling further exploration of various options to repurpose the future use of Thames Ward.

12. Horizon scanning and future plans

12.1 We are about to embark on a review of the Older Persons Organic Inpatient Assessment service (Columbia Ward 21 beds) which is currently located at Mile End Hospital, Columbia provides a function on behalf of all 3 CCG's. There is opportunity to utilise further the available space and accommodation at East Ham Care Centre to greater effect, as there is a vacant ward (Cazaboun 23 beds) which will
provide sufficient bed mass for the relocation of Columbia ward.

12.2 Discussions are at a very early stage, but we feel it important to signal at this stage this exciting opportunity to bring together all of the frail elderly and Dementia wards together on one site to provide a Centre of Excellence for this care group.

APPENDIX 1

No	Option Description	Positive Impact	Negative Impact
1	Do nothing; Trust provides two separate Continuing Care Wards: Thames House and Sally Sherman Ward	Service users do not have to be moved	Service users will not benefit from being located in the best possible environment and what this enhancement will mean to their daily lives
		Staff do not have to be redeployed	The Trust is not offering good value for money in operating two wards which are underutilised.
		Families and carers who are residents of the City of London, Hackney and Tower Hamlets will not need to source alternative travel to visit loved ones.	Thames House is not a fully dementia-friendly ward and does not offer the same level of environment as Sally Sherman Ward, e.g. large ensuite bedrooms, colour, light and space
2	Consolidate the location of all older adult inpatients with behavioural and complex psychiatric symptoms of dementia into one site, Sally Sherman Ward, East Ham Care Centre.	Service users will benefit from being located in the best possible environment. This will enhance their daily lives, as highlighted above.	Service users will need to be moved; continuing care service users sometimes find change difficult
		Sally Sherman Ward has led on many exciting projects, including violence reduction, involving families and carers and implementing innovative ways of working with service users	Families and carers who are residents of the City of London, Hackney and Tower Hamlets will need to travel further to visit loved ones. However, Trust can provide free transport for this where required
		The Trust will provide a high quality service to <u>all</u> Continuing Care residents of the East London boroughs it serves. There is currently inequity in the service provided for people with behavioural and complex psychiatric symptoms of dementia	Staff will need to be redeployed. However, the Trust has identified a number of suitable vacancies and Sally Sherman Ward will also need to be enhanced when operating at full capacity
		The Trust will be able to generate an efficiency saving of £900k as a result of creating a consolidated unit and will therefore offer better value for money	

No	Option Description	Positive Impact	Negative Impact
3	Close Thames House and replace with an enhanced community Continuing Care Service	Service users can be managed in their own home or in alternative community settings	Service users will need to be moved; service users sometimes find change difficult
		Care closer to home where possible is considered to be best practice	Staff will need to be redeployed
			This service user group, patients with behavioural and complex psychiatric symptoms of dementia are not deemed suitable to be managed in the community; most display challenging behaviour and many require 1:1 care

APPENDIX 2

Sally Sherman Environment

APPENDIX 3

Sally Sherman Patient Stories

A service user was placed in eight different care homes but did not settle; staff were unable to manage her care and she was subsequently readmitted to Columbia Ward at Mile End Hospital. She exhibited challenging and often aggressive behaviour. She was then transferred to Sally Sherman and the team used their person-centred care model to great effect, getting to know her over the long-term. She did not have any family visiting her and so ward staff set up a befriending system. They also arranged for her to leave the ward a couple of times a week and this opportunity enhanced her experience and reduced her aggressive behaviour.

Another challenging man had refused to leave the ward for many years, even refusing to go downstairs to the garden. Sally Sherman's Housekeeper developed a relationship with him and managed to get him out of the ward, into a taxi and took him shopping. This significantly reduced his aggression. This led to staff considering every service user on the ward, why they were aggressive and what we could do for them and was developed into a very successful QI Project.

Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **Housing with Care – improvement plan update**	Item No **7**

OUTLINE

In January the Council's in-house Housing with Care service was rated 'Inadequate' after an inspection by the Care Quality Commission. In February and March the Commission questioned the senior officers on how they were responding and considered the Action Plan which was immediately put in place. Here is a link to the discussion at the March meeting: http://mginternet.hackney.gov.uk/mgAi.aspx?ID=33641

At the same time Healthwatch Hackney carried out 6 Enter and View inspections and provided input to the Council's improvement work by supporting the work on engaging with the services user and families.

The CQC came to re-inspect in July and they published their re-inspection report in September. This upgraded the rating to 'Requires Improvement'. The Commission agreed to invite officers back in Sept to provide an update on the progress being made with the improvement plan and the lessons learned but this was postponed to this meeting so that the re-inspection report from the CQC could be considered.

Attached please find:

a) Cover report from Adult Services
b) The CQC re-inspection report from September
c) Healthwatch Hackney's report on the service from August

Attending for this item will be:

Anne Canning	Group Director CACH	LBH
Simon Galczynski	Director – Adult Services	LBH
Ilona Sarulakis	Principal Head of Adult Social Care	LBH
Jon Williams	Director	Hackney Healthwatch

ACTION

Members are requested to give consideration to the report and make any recommendations as appropriate.

This page is intentionally left blank

Report title:	Housing with Care improvement plan update - Oct 2019
Meeting:	Health in Hackney Scrutiny Commission
Report owner:	Anne Canning – Group Director, Children, Adults & Community Health Services Simon Galczynski – Director, Adult Services
Report author:	Ilona Sarulakis - Principal Head of Adult Social Care Leanne Crook - Project Manager, Adult Services
Date:	4th November 2019

Contents		**Page no**

1. Executive Summary

1.1. Housing with Care (HwC) is an in-house provided service in Adult Services at the London Borough of Hackney which currently supports 222 people in 14 schemes located across the borough. These schemes provide care and support to people in 'supported living,' so they can live in their own homes as independently as possible. While people in HwC hold tenancies for their accommodation, the care element of HwC is a regulated service and subject to inspections by the Care Quality Commission (CQC).

1.2. HwC was inspected by the CQC in Nov-Dec 2018, and was rated as 'inadequate'. A thorough action plan was developed in response, and the CQC requested that LB Hackney demonstrate that the improvements identified the plan were in place by 8th March 2019.

1.3. Delivery of the action plan was closely monitored, and additional resources were brought into support its delivery. LB Hackney sent a detailed progress report to the CQC on the 8th March.

1.4. Following the submission of the progress report to the CQC, a longer-term improvement plan was implemented and continues to be closely monitored. The priorities are; completion of any outstanding personalised care plans (completed) and risk assessments with service users, quality assurance, embedding the improvements made and making sure they are sustained, reducing the use of agency staff, ensuring all staff are well supported and trained to deliver the updated practices, and improving communication and engagement with service users and relatives.

1.5. The CQC reinspected HwC between the 3rd-8th July. The inspector and the team observed that significant improvements had been made, and the overall rating for the service improved to '**requires improvement**', **and is therefore no longer in 'special measures'.** A breakdown of the ratings for each domain can be seen in the table below. The inspection report and outcome was published online on 18th September 2019.

No	Domain	September 2019 rating
1.	Is the service **safe**?	Requires improvement
2.	Is the service **effective**?	Requires improvement
3.	Is the service **caring**?	Requires improvement
4.	Is the service **responsive** to people's needs?	Good
5.	Is the service **well-led**?	Requires improvement

1.6. A communications plan was implemented immediately following publication of the report. The priorities were informing service users, relatives, staff and also all key stakeholders, including holding forums attended by Healthwatch Hackney.

1.7. The ongoing improvement plan is being reviewed in light of the findings in the inspection report, and all required actions are being incorporated

2. Background

2.1. In Hackney there are 14 HwC schemes, with the capacity to provide care and support to up to 280 people in 'supported living,' so they can live in their own homes as independently as possible. There are currently 222 service users

within Housing with Care. There are two Registered Managers, who manage seven schemes each.

2.2. The 14 schemes range in size from 8 to 41 self-contained flats in each scheme. It is mainly for people over the age of 55 and they hold individual tenancies with a social landlord. Some schemes specialise in helping people with similar needs, for example people with learning disabilities, memory problems or brain injury.

2.3. There are separate contracts for care and housing. Housing support is provided to service users by the social landlord and includes a housing support worker to help with tenancies, such as arranging repairs. Personal care and support is provided by the LB of Hackney.

2.4. HwC is a regulated service and is subject to inspection by the CQC. The CQC does not regulate accommodation used for supported living. The CQC inspect the personal care and support provided by LB Hackney's in-house service only.

3. Summary of inspection & outcome (Dec 2018 / Jan 2019)

3.1. The CQC carried out an inspection of HwC between 23rd November - 5th December 2018.

3.2. The service was rated as **'inadequate'** overall and in "special measures".

3.3. During this inspection the CQC identified a number of concerns, which they judged to be serious enough to issue a warning notice that more serious regulatory action will be taken if improvements aren't made, which could lead to the service losing its registration. This means that the service is in 'special measures.' The CQC asked LB Hackney to ensure that the improvements they identified were in place by 8th March 2019.

4. Action taken since inspection (January - present)

4.1. In response to the warning notices and inspection report, an action plan was immediately developed by Adult Services, and additional resources were obtained to support the delivery of the plan. The progress against this action plan was carefully monitored by a core group led by the Director of Adult Services. The group met weekly to ensure sufficient progress was made by the 8th March 2019.

1.1. The Council's Provider Concerns process was also initiated, led by the Head of Commissioning for Adult Services. As part of this process, it was agreed that the in-house care provision on new placements to HwC were to be suspended until the Head of Commissioning is assured that sufficient progress has been made to improve the quality and safety of the service.

Following the latest inspection outcome and improved rating, The Head of Commissioning has decided to lift the suspension of placements into HwC, and therefore new referrals are now being accepted.

4.2. Following the inspection outcome, a detailed communications plan was implemented to ensure all service users, staff and stakeholders had all required information. This included Housing with Care forums with service users and relatives and attended by Healthwatch Hackney, and regular progress updates sent to the CQC.

4.3. In addition to attendance at the forums, Healthwatch Hackney visited four schemes in June and July 2019 to collect the views of service users, relatives and staff and published a report of their findings. LB Hackney welcomed the recommendations from Healthwatch Hackney as useful input into the ongoing service improvements being made. The report and LB Hackney's response to the recommendations can be found at: http://www.healthwatchhackney.co.uk/wp-content/uploads/2019/09/Housing-with-Care-September-2019.pdf

4.4. A full report of the progress made against the action plan was submitted to the CQC on the 8th March.

4.5. Following the submission to the CQC on the 8th March 2019, the outstanding tasks were reviewed along with; the statutory requirements from the CQC; the areas outlined in the warning notices and CQC inspection report; feedback from service users, their families and staff; the recommendations from Healthwatch Hackney; and the feedback from the Health in Hackney Scrutiny Commission. This informed the development of an ongoing improvement plan.

The table below outlines the priorities of the improvement plan, the progress made to date, and what this means for service users.

Priority	**Summary of progress made**	**What this means for service users**
To complete all outstanding personalised care plans and risk assessments	• All service users in Housing with Care now have updated, personalised care plans. • The majority of new risk assessments have been completed with service users, with the final outstanding documents	• Personalised care planning empowers individuals, promotes independence and ensures people are involved in decisions about their care. It centres on listening to individuals,their family and friends, finding out what matters to them and what support they

	expected to be completed by the end of Oct 2019.	need. ● Service user's care plans now reflect them as individuals, and capture all required information about how they would like staff to support them to remain independent as possible. ● Service users have been involved in conversations about their individual needs, areas of risk, and now clear plans in place to keep them safe. This reduces their risk of harm, whilst supporting their independence.
To embed the improved internal quality assurance processes	● A new quality assurance framework describing the updated internal quality assurance processes has been developed. ● Recruitment for a Quality Assurance Manager is in progress. This post will lead on embedding the new quality assurance processes. ● Quality checks of all updated care plans is ongoing, and is a key priority.	● Service users and relatives should see faster action in response to concerns raised. ● As there is now a process to share and embed lessons learnt between staff from all schemes, service users will benefit from learnings that have informed changes in other schemes, as well as from their specific scheme. This will help provide a more consistent quality of care across the schemes. ● The Quality Assurance Manager will ensure service user and relatives feedback informs service monitoring and improvement on an ongoing basis. ● Checking and improving the quality of the updated care plans will mean all service users will have a high-quality care plan that accurately reflects them, ensuring the support they receive is person centred.

To support staff to embed new practices	● Staff continue to attend regular training, as part of the updated training programme. ● A new 'embedding best practice' programme has been rolled out. This includes workshops for all HwC staff focussing on specific areas of practice. The last topic focussed on person centred care and medication.	● Service users will see a more consistent and improved quality of care as a result of staff attending significantly more training. ● Staff will be more confident in all areas of care delivery, and better able to support service users and relatives in a range of ways, improving their experience of living in Housing with Care.
To reduce the use of agency staff	● A recruitment campaign took place throughout July and August. 17 permanent staff were recruited. ● 16 existing part-time staff are being made full-time, based on expressions of interest. ● A second round of recruitment started in October 2019, to recruit further permanent staff.	● By recruiting more permanent staff and increasing the hours of existing staff, the consistency and continuity of care will improve for service users. ● Reducing the use of agency staff means service users will see more of the same staff more regularly, helping to build relationships and familiarity.
To continue the Provider Concerns process to oversee improvements and quality of the service	● Regular meetings have continued. ● Quality Assurance Officers conducted visits in all schemes, and their findings have fed into service improvements. ● The suspension of placements to HwC has been lifted.	● The purpose of this process is to monitor and improve the quality of the service, prioritising service user safety. ● This process has resulted in changes to practice that have improved the care service users receive. ● Not accepting any new placements into Housing with Care for a period of time meant staff were able to prioritise making the required improvements for existing service users.
To improve communication and engagement with service users and relatives	● Housing with Care forums have been established. These have taken place in July and October 2019, and the next will be in January 2020.	● Service users and relatives are better informed about improvements being made in HwC. ● Service users and relatives have a choice about how to

	Healthwatch Hackney are invited to attend all forums. ● A co-production group is being planned. An introductory meeting about this is happening in early November. ● Written updates about the progress being made in HwC have been sent to service users and relatives at key times, and in accessible formats. ● Updated care plans have been developed in partnership between the service users, their relatives, and staff.	engage with the service. ● Service user and relatives can give feedback and shape services to ensure their views are incorporated and reflected in the actions taken. ● The service received is improved as a result of the input and partnership working with service users and relatives as 'experts by experience'. ● Care plans are more holistic and personalised.

The improvement plan is being updated in light of the latest CQC inspection report findings, and will continue to be overseen by a core group led by the Director of Adult Services.

5. Summary of re-inspection and outcome (July 2019)

5.1. The CQC announced on the 1st July 2019 that they would be returning to re-inspect the service starting from the 3rd July 2019.

5.2. A comprehensive inspection took place between 3rd - 8th July 2019.

5.3. Four schemes were visited across over the course of the inspection, and the inspector reviewed files from the registered location (Hackney Service Centre) over two days. The inspectors spoke to a number of service users, relatives and staff.

5.4. A feedback meeting took place on 8th July with the inspector, the Director of Adult Services (who is also the Nominated Individual for the service), the Registered Managers, the Principal Head of Adult Social Care, and the Service Manager.

5.5. The Nominated Individual and the Registered Managers were informed of the outcome of the inspection and sent a draft report on the 4th September 2019.

5.6. The full report was published online on 18th September 2019, following LB Hackney completing a factual accuracy check of the contents. The overall rating of HwC is now **'requires improvement'.** The report commented on the

significant amount of improvement that has been made, whilst recognising more time was needed to fully embed all of the improvements.

5.7. The table below shows the current rating for each domain, compared the rating the service received after the previous inspection in January 2019.

No	Domain	January 2019 rating	September 2019 rating
1.	Is the service **safe**?	*Inadequate*	Requires improvement
2.	Is the service **effective**?	*Inadequate*	Requires improvement
3.	Is the service **caring**?	*Requires improvement*	Requires improvement
4.	Is the service **responsive** to people's needs?	*Requires improvement*	Good
5.	Is the service **well-led**?	*Inadequate*	Requires improvement

5.8. The table below summarises the findings identified in the report for each domain, and the action the service is taking to address any areas of improvement identified.

Summary of findings and areas of improvement identified in the report	Actions
Domain: Safe **Rating:** Requires improvement	
The service was found to no longer be in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines management systems had improved, and risk assessments and management plans were thorough. A few gaps in MAR charts were identified, and some PRN protocols were found to be unclear. These were addressed during the inspection. The report stated that staff understood where people required support to reduce the risk of	Quality assurance checks of all care plans and medication management plans are in progress, and are an ongoing priority. Missing staff files are being collected and recorded - expected completion end of Oct 2019. Work is underway with HR to ensure recruitment policies and practices are compliant with CQC requirements. A recruitment campaign took place this summer and 14 permanent staff were

avoidable harm, and service users provided positive feedback about how staff support them to manage medication. Staff understood the importance of reporting and acting on any concerns of abuse, and adopted good infection control practices. Some gaps in staff files, such as in employment history and reasons for leaving previous employment, were identified. There is a high level of agency staff use.	recruited. 16 permanent part-time staff are also increasing their hours. A second recruitment campaign started in October 2019, aiming to recruit more permanent staff, further reducing the use of agency staff.
Domain: Effective **Rating:** Requires improvement	
The service was found to no longer be in breach of regulation 9 (3) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Whilst most care plans were found to be written in a person-centred way and were much improved from the previous inspection, further work is required to ensure this is applied to all care plans. Staff were found to support service users to ensure they maintain a balanced diet in a personalised way, and staff knowledge of service users needs and how they work in partnership with other agencies to ensure they are met was recognised. Staff showed they understood the importance of asking consent and giving choice. *The service was found to no longer be in breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.* Some gaps in supervision records were identified. The training on offer for staff has improved.	Quality assurance checks of all care plans and medication management plans are in progress and are an ongoing priority. Gaps in staff supervision were addressed immediately, and Registered Managers are overseeing frequency and recording of supervisions completed by Managers closely.
Domain: Caring **Rating:** Requires improvement	
Staff understood the importance of treating people equally, and care plans now included information on sexual and gender preferences and people's cultural and religious needs. Relatives and service users provided positive	All new personalised care plans were developed with service users and their relatives. This will continue, including during reviews of the care plans and any decisions about the person's care.

feedback about staff's caring nature. People and relatives told CQC that staff treated them with dignity and respect, and CQC found that staff encouraged service users' independence. There was mixed feedback from service users and relatives about how involved they felt in the care planning process. Whilst some people felt involved in developing their plan of care, others did not.	A co-production group is being developed that will enable service users, relatives and staff to work together to prioritise and deliver further service improvements. Through feedback at the Housing with Care forums, we know having simplified summaries of care plans may be beneficial. Co-producing these will be one of the areas of work the co-production group will be involved in.
Domain: Responsive **Rating:** Good	
Care plans were personalised and detailed enough instructions for staff to provide personalised care, and relatives provided positive feedback about staff understanding of service users' individual needs. Service users also said that staff understood their communication needs. Staff support service users to ensure they are not socially isolated. The system for managing complaints and discussing them at team meetings was recognised, as was how end of life wishes are discussed as part of care planning. Some schemes' care plans included the details of people's communication needs, but others had not recorded this information. Therefore further work is required to ensure *all* care plans record people's communication needs.	Ensuring people's communication needs are recorded in care plans will be addressed during the ongoing quality checks of care plans.
Domain: Well-led **Rating:** Requires improvement	
The service was found to be no longer in breach of regulation 17 (1)(2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were involved and committed to improving the quality of care and embedding good practice in their work, and were being supported by managers to do so. Service users and relatives said the service was well managed, and said they would recommend Housing with Care.	In addition to the ongoing quality checks of care plans and improving the recruitment processes and policies, the service will explore digital options related to management of service user and staff records, following the recommendation made by the CQC.

Staff work in partnership with others to make improvements to the service. Gaps in records related to staff recruitment and care records related to people who used the service were identified (also mentioned under 'safe' and 'effective').	

5.9. Overall, the report provided a lot of positive feedback. It is an encouraging outcome showing that the CQC observed that the improvements underway are progressing well and on the right track. Continuation of these improvements, as well as ensuring all areas of improvement identified in this inspection report,and by Healthwatch Hackney remain a priority for the service.

5.10. The full report can be found: www.cqc.org.uk/directory/1-136277108

6. Communications

6.1. A communications plan was prepared in advance, and implemented immediately following the publication of the inspection report. Service users, family, staff and stakeholders will be informed of the outcome, what is happening in response, and what it means for them, in a timely way.

6.2. The latest Housing with Care forum was in October 2019, where all service users and relatives were invited to hear more detail about the inspection outcome and speak to Healthwatch Hackney, following the letters sent immediately after the publication.

7. Next steps and conclusion

7.1. The improvement plan is being reviewed and updated to incorporate the areas of improvement identified in the latest inspection report, whilst continuing to embed the changes already underway. Progress will continue to be monitored by a core group, who will now meet monthly.

7.2. The recruitment of a new Quality Assurance Manager will support the work to continue improving and embedding the new quality assurance processes, and making sure the service is responsive to the latest regulations and best practice on an ongoing and sustainable basis.

7.3. A second recruitment campaign started in October 2019, aiming to further reduce the use of agency staff within HwC.

7.4. Greater engagement with service users and relatives to make improvements to the service is a key priority moving forward. Quarterly Housing with Care forums will continue, and a co-production group is being established.

7.5. Whilst this outcome demonstrates that the significant work to improve the service is progressing in the right direction, the service remains committed to continuing to embed the improvements already underway and to make the further improvements identified by the CQC.

7.6. Progress will continue to be monitored closely to ensure all changes made are done so in a sustainable way, and that all actions following the latest CQC inspection are delivered.

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:
03 July 2019
04 July 2019
05 July 2019
08 July 2019

Date of publication:
18 September 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
London Borough of Hackney Housing with Care provides care and support to 223 people living in self-contained flats across 14 schemes located in the London Borough of Hackney. The schemes provide a 'supported living' setting which enables people to receive care and continue to live independently in their own homes. CQC does not regulate premises used for supported living; this inspection looked at the personal care provided the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
New systems for monitoring the quality of the service were being implemented. The service improvement plan was detailed and documented the provider's commitment to continuously improve the quality of the service. The provider had made several improvements since our last inspection in November 2018, however, some of these changes had yet to be fully embedded. We found some gaps in staff records and care records for people who used the service. We made recommendations related to the management of records for staff and care records related to people who used the service.

People's needs were jointly assessed by the housing provider and the service. Relatives told us they were involved in the assessment process. Choice in which care provider people were able to use varied across schemes, whilst some people had care provided by an external agency, most people used the care provided by housing with care as part of the accommodation tenancy.

People and relatives said they felt safe. Systems were in place to protect people from abuse and staff understood their role and responsibility in reporting and acting on abuse. Staff were aware of the procedure to report their concerns to external authorities. Staff followed safe infection control practices when caring for people. Where things went wrong the service held a lessons learnt meeting to improve the service provided to people.

People were cared for by staff who felt supported and well trained to effectively carry out their roles. People's nutritional needs were met, and their likes and dislikes for food were respected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were treated with dignity and respect and said staff were caring and kind. Most people and relatives felt involved in the care provided by the service.
People received personalised care tailored to their needs. Systems were in place for dealing and acting on complaints, people and relatives felt able to approach senior management with their concerns. People had their end of life wishes considered and recorded in their plan of care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 14 January 2019) and there were multiple breaches of Regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.
This service has been in Special Measures since January 2019. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

London Borough of Hackney, Housing with Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors and three Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The service provides care and housing support to people living in purpose-built housing.
The care and housing are provided under separate contractual agreements. 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.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are

required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed information sent to us by Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 16 people who used the service and 21 relatives about their experience of the care provided. We spoke with 24 members of staff including, the principle head of adult social care, service manager, two registered managers, three scheme managers, three team leaders, two welfare and activities workers, 11 care support workers and the director of adult services who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed records related to people who used the service. This included care plans, risk assessments and medicine administration records charts. We looked at records for nine staff members related to recruitment, training and supervision and a variety of records related to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the registered managers to validate evidence found. We looked at training information, newly introduced documents since our last inspection, staff rotas and quality assurance monitoring.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement.

This meant some aspects of the service were not always safe and improvements to the service required additional time to be embedded.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.
Systems for the management of medicines had improved. The service had developed a medicine support plan detailing people's prescribed medicines and information on any associated risks. MAR charts reviewed showed most had been completed correctly. However, we found a few gaps in MAR charts and some PRN protocols unclear. PRN is medicine prescribed to be taken when the person needs it, rather than on a schedule. The team leader took immediate action to address the situation during our visit to the service. We saw evidence that the registered managers had addressed medicine gaps, and this was an area they were aware of.

- Risk assessments provided more detail about risks. For example, for one person at risk of falls, the risk assessment stated for care staff to ensure that the person always had their walking stick close by and ensure their home is clutter free to prevent the risk of trip hazards.
- Risks management plans covered areas such as risk of falls, epilepsy, diabetes, continence care, developing pressure sores and bruising.
- Staff understood where people required support to reduce the risk of avoidable harm. Care plans contained basic explanations of the control measures for staff to follow to keep people safe.
- Where medicine support was provided, people and their relatives told us staff were good at assisting them with their medicine needs. Comments included, "[Care staff] give the medicines and this works well," "[Staff] are very good on medicines and always locked away and on time," and "[Staff] check that she has taken them which is the major part of her care."

Staffing and recruitment

- Recruitment practices were not always followed to ensure staff were suitable to support people. Records reviewed showed checks had been carried out such as, criminal record checks to ensure the applicant was safe to work with people and reference checks. However, we found some gaps for example, in employment history and reasons for leaving previous employment and interview records, this was not in line with the

provider's recruitment policy and procedure. We informed the provider of our findings during the inspection. The registered managers told us recruitment was managed by the provider's human resources team and they were working with their human resources team to update and ensure the necessary documentation was up to date. Following our inspection, we received a letter from the nominated individual outlining their plans to address this issue.

We recommend the service seeks advice from a reputable source regarding good practice in recruitment and maintaining staff records.

● People and staff told us staffing levels could be improved. There was a high use of agency staff at some schemes within the service. One staff member told us, "There is not enough staff, but there are a lot of agency staff. They are now recruiting for support workers." Rosters reviewed confirmed this.
● We received mixed feedback from people and their relatives in relation to staff attendance times. Whilst most people said staff did not miss an appointment, a few people told us that staff were often late. Comments from people and their relatives included, "[Staff] are often late and no one informs my [relative], "Carers are always on time. They are never late and are kind to me," "Carers turn up on time, I have never seen one running late, they are truthful," "Often very late, they are supposed to be there by 09:30am and sometimes aren't there by 11:00am, and [relative] needs to be washed and dressed and given breakfast."
● The registered managers told us they had introduced a 'homecare information line' where people were able to report missed or late care worker visits, not staying for the agreed time, not being treated with dignity and respect and any other concerns about the quality of the care received. We observed this was displayed on the communal notice board at the schemes visited.
● We reviewed the rosters sent to us by the registered manager and this showed agency staff had been frequently used. The registered managers old us they used the same agency staff members who were familiar with people who used the service. This was confirmed by permanent staff. This meant the service was able to provide continuity of care.

Systems and processes to safeguard people from the risk of abuse
●People and relatives provided mixed views about how safe they felt using the service. Comments included, "I trust his care to [care staff] without reserve," "He has a hoist and they are perfectly safe," "Yes with some and no with others, I don't think they go in to check often enough," and "[Relative] has a lot of needs and sometimes I am not sure."
●Staff understood the importance of reporting and acting on any concerns of abuse. One staff member told us they would, "Report [any concerns] to the manager and write up the incident. If nothing happens I will contact local authority Safeguarding and CQC."

Preventing and controlling infection
●Staff received infection control training and provided good infection control practises.
A relative told us, "If they help my mother go to the toilet, I've seen them wear protective clothing."
Learning lessons when things go wrong
● Regular lessons learnt meetings took place whereby staff reflected on incidents and made changes to the way they worked

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement.

This meant the effectiveness of people's care, treatment and support was sometimes inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 9 (3) (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- Following our last inspection, the service implemented a new person-centred care plan. 'My personalised care and support plan' included information such as orientation, communication, personal care, physical health, mobility, nutrition and hydration needs, meal preparations, medication, socialisation, relationships and wellbeing, cultural and religious needs and mental and emotional wellbeing.
- We noted that the registered managers and staff had worked hard to improve the quality of the care plans and saw that there had been significant changes. Whilst most care plans were written in a person-centred way, further work was required to ensure this was applied to all care plans. The registered managers told us this work was in progress and required time for this to be fully embedded. Care plans reviewed confirmed this.
- Prior to joining the service people's needs were jointly assessed by the local authority's adult social care team and housing with care, before people were signed up to use the service. At the time of our inspection no one new had recently joined the service.
- Relatives told us people's needs were assessed before using the service. Comments from relatives included, "[Relative] was interviewed before she moved in and her needs were discussed," "Most of the care staff treat [relative] as an individual, and she was assessed with the manager and a social worker."

Staff support: induction, training, skills and experience

At our last inspection staff had not received the training they needed to perform their roles. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of

regulation 18.

● Staff told us they had received a lot of training since the last inspection in November 2018. Staff received mandatory training in areas such as health and safety, manual handling, infection control and prevention, emergency first aid, MCA and DoLS, caring for a person with dementia and learning disabilities. Specialist and targeted training included behaviours that challenged the service, epilepsy, dysphagia and diabetes awareness and fire safety.
● Staff completed an induction when joining the service, this covered areas such as infection control, health and safety, medicine administration, safeguarding and basic first aid.
● Staff told us training had been useful in helping them to provide effective care to people who used the service. They reported a noticeable improvement in training since our inspection in November 2018. A staff member commented, "Training in dysphagia gave me an eye opener, I know what to look for."
● People felt staff were skilled and qualified to provide care. Comments from people included, "Undoubtedly; [staff] have skills. I can see it by the way they do things [care for people]," and "I see kindness as a skill and they're very kind; it's something you have or haven't. They treat me well."
● Staff received supervision and felt supported in their role. Staff told us they received regular supervision, however, this was in contrast with records reviewed during our inspection. We reviewed a supervision matrix sent by the registered manager and this showed there were gaps in frequency and not all staff received supervision in line with the provider's supervision policy. The registered managers told us the provider no longer completed appraisals, this had been replaced with a new system. This included looking at staff goals, feedback, learning and development, achievements and performance. Records reviewed confirmed this.
●Staff said they felt supported by the registered managers and found them approachable. Staff comments included, "My team leader and manager are really supportive," "My manager is very good, once in three months my manager wants to know if training has been effective. It makes me see my weaknesses and strengths."
● Staff worked as a team to deliver quality care. A staff member told us, "We do team working. We have to try our best, everyone is different. We are here to work for the service user, in order to get the work done you have to work well with your colleagues."

Supporting people to eat and drink enough to maintain a balanced diet
● People who required support with eating were provided with the support they needed. Comments from people included, "I get enough to eat and drink. My [relative] does the shopping for me and brings it every two weeks; and I keep all I need in the fridge," and "They cook my food and they give me a choice of what I want."
● People with special dietary requirements had this documented in their care plan. This included their likes and dislikes for food. Staff knew what people liked and where this was required prepared meals of their choice. People also had meals of their choice provided by relatives involved in their care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other health and care professionals to meet people's health needs. Records confirmed this. Files contained details of appointments with dentist and hospital,
● Staff had knowledge about the health needs of the people they cared for and contacted relevant professionals as needed. For example, they liaised with speech and language therapists for people experiencing swallowing difficulties, GPs, district nurse team, physiotherapist and occupational therapist. Daily communication records reviewed confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's capacity was assessed, and staff understood the importance of giving choices and asking people for their consent before providing care. The service worked closely with the local authority to ensure people were appropriately assessed. Records reviewed confirmed this.
● Staff understood the importance of asking consent and giving people choice. Comments from staff included, "Always ask people are you ready to have your personal care, if they say not yet, come back in half hour," and "If I go into a tenant to give personal care I would ask would you like a wash or shower. It's personalised care. That's his choice."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people did not always feel involved in their care.

Ensuring people are well treated and supported; respecting equality and diversity

At our last inspection we recommended the provider 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. The provider had made improvements.

- Care plans had been reviewed to include people's sexual and gender preferences. During our inspection we observed notice boards at the schemes visited provided information related to events in May 2019 for lesbian, gay bisexual and transgender people.
- Staff understood the importance of treating people equally and said they would not discriminate. A staff told us, "People's sexuality or colour should not affect any service provided to them. We treat everybody equally." Another staff member said, "There is no difference between any human being, [people from the LGBT community] would be treated just the same as all service users, there is no difference."

- Most people and relatives told us staff were caring and kind and treated them well. Comments from relatives included, "Yes, they are respectful, and they always ask if [relative] wants to go out to coffee or the lunch club," "They are really polite and make sure he is turned out well for going out when they take him shopping or socialising."
- People's cultural and religious needs were documented in their care plan. For example, in one care plan it stated that the person enjoyed listening to religious songs on the television. Other people attended their place of worship with their relative or through transport arranged by the Church.
- Staff were aware of people's cultural and religious needs. People were supported to attend their place of worship. Care plans documented people's religious and cultural needs for care.

Supporting people to express their views and be involved in making decisions about their care

- People did not always feel involved in the care planning process. We received mixed views about people being involved in the care planning process or decisions about their care. Whilst some people felt involved in developing their plan of care others did not. Comments from people included, "Yes, we have been involved every step of the way," "Yes, I was involved in the care plan and I have seen the new one, much more complex assessment," and "Yes, we were involved with the care plan, but I don't think the carers all read it. I don't know about the new one."
- The registered managers told us they worked with people and their relatives to develop people's care plans, but the changes made required more time for this to be embedded across the schemes where care

was provided.

Respecting and promoting people's privacy, dignity and independence

● People and relatives told us staff treated them with dignity and respect. One person told us, "Definitely, they knock on the door before coming, greet me with a smile and ask about me." During our visit to one scheme, we observed staff knocked on people's doors and called out the person's name before entering their home, this was confirmed by people who used the service.

● Staff encouraged people's independence. For example, a staff member told us when providing personal care they encouraged the person to wash themselves by, "Handing them the flannel and encourage to wash face or body, not to take her independence away."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection the rating has improved to Good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans were personalised and detailed enough instructions for staff to provide personalised care and covered areas such as communication, personal care, nutrition and hydration, medication, mental and emotional wellbeing, night care, finance management and end of life care. People's history and background, their likes and dislikes were recorded in their care plan.

● Relatives told us staff understood people's needs and provided care that met their individual needs. One relative told us, "It is totally individual, they do a good job." Another relative told us, "They seem to look on [relative] as family, chatting to her about all sorts."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were discussed when developing the care plan. Some care plans provided information on people's different communication needs. For example, in one care plan it stated the person had a hearing impairment and tended to lip-read when staff or people spoke with them. The person required staff to speak to them slowly, face to face without covering their mouth, using simple words and sentences. Whilst at some schemes care plans had been completed with people's communication needs, others had not, therefore further work was required to ensure all care plans recorded people's communication needs.

● People told us staff understood their communication needs. One person told us, "[Care staff] acknowledge my deafness and stand in front of me to speak to me so that I can understand."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to maintain relationships with friends and family to avoid social isolation. Each scheme provided activities in the communal area of the building and people had the choice to participate in these. Care plans documented people's socialisation, relationships and wellbeing needs. In one care plan it stated the person received visits from their relative who took them out for dinner. Another care plan stated the person did not wish to participate in activities at the scheme and was able to verbalise their preferences.

● The registered managers told us each scheme provided separate activities available to people who used the service. We spoke with the welfare and activities coordinators who told us that they provided activities in the communal area and people were given the choice to participate. Where possible people were supported to take part in activities of their choice. Daily records confirmed people had taken part in some activities. Welfare and activities staff responsible for organising activities encouraged people to take part in communal events to minimise isolation.
● Relatives told us their family member participated in activities of their choice. A relative told us, "[Relative] gets taken out; they do things like trips to the seaside, coffee mornings, exercise and sometimes there's other little functions. [Relative] is not left in her flat all day long; most times I turn up she's in the communal room."

Improving care quality in response to complaints or concerns
● Systems were in place for dealing with complaints. People and relatives told us they knew how to make a complaint. However, some relatives felt their complaint was not always heard. Comments included, "I have made complaints and they have all been dealt with really well," "I make my views known and they take notice, very approachable and the problem gets sorted," and "I frequently bring issues to their attention and I feel I am fobbed off, nothing has changed," "I complain all the time as well as makes helpful suggestions but they take no notice."
● Services visited had a copy of the complaints policy displayed on the notice board. This provided information on how and who to make a complaint to. We reviewed complaints held by the service and noted that these had been dealt with promptly. Records showed formal and informal complaints were logged on a spreadsheet and the outcome recorded.
● Records showed complaints were discussed at staff team meetings and were a standing item whereby staff made suggestions for improving the service. The registered managers told us they had introduced a system for logging and acting on informal complaints, this includes action taken and the outcome. This helped them to monitor and analyse reasons for complaints to improve the quality of the service. Records confirmed this.

End of life care and support
● People's wishes and preferences for end of life care were taken into account when developing their care plan. The provider had an end of life policy in place, this provided guidance for staff on how to care for people during their end of life. Records showed people were asked their end of life wishes when developing their care plan. At the time of our inspection no one using the service was receiving palliative or end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure systems and processes operated effectively to identify and address issues with the quality and safety of the service. This was a breach of regulation 17 (1)(2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. However, further improvements were required to ensure these improvements were fully embedded into service delivery.

● We found gaps in records related to staff recruitment and care records related to people who used the service. For example, gaps in employment history were not explored and care plans were not always written in a person-centred manner. Although audits were carried out the registered managers told us they had not yet fully implemented their newly developed quality assurance framework. We noted this was documented in the provider's service improvement and action plan. We recommend the provider seeks advice from a reputable source regarding maintaining and managing records related to staff and delivery of care.
● Staff were involved and committed to improving the quality of care and embedding good practice in their work. The registered managers held learning sessions with staff to reflect on the quality of care. This involved reflecting on the findings from the last CQC inspection, best practice in personalised care planning and medication management and refresher in report writing. Staff told us the changes implemented since our last visit had been positive for staff and people using the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People and relatives told us the service was well managed. Relatives commented, "I think [the service] is well managed. I can't think of any reason it isn't; it always seems very professional. I would approach the manager and I know who the manager is, contact isn't an issue," and "Yes, it's well managed. I have no complaints, I would talk to the office if I had a problem."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
●The registered managers were aware of their responsibility in reporting and being transparent when things went wrong. Staff told us the registered managers were approachable and listened to concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were asked their views about the service and this was encouraged by the service.
● Quarterly Housing with Care forums had been implemented by the registered managers. The first will be taking place in July 2019. This would enable people to give their views about how things could be done better and learn more about the work happening to improve the service.
● The registered managers told us they regularly obtained people's views about the service. We noted that an annual survey was sent out to everyone using the service.
● People told us they were asked their views about the quality of care provided by the service. Relatives were also asked their views about the quality of care provided by the service.
People and relatives told us they would recommend the service. One person commented, "I would definitely recommend this service to friends. The carers are good." A relative told us, "I would but they do need to make some improvements, to do with supervising the carers."

We noted that the service had organised a forum for people who used the service and their family and friends for July 2019.

Continuous learning and improving care
●Staff told us the changes made since our inspection in November had been good. A staff member told us the changes made to the new care plan had encouraged staff to be more proactive in their job and put more emphasis on people who used the service.
● The registered managers had introduced lessons learnt meetings to enable them to learn from errors and improve their practice. Records reviewed confirmed this.

Working in partnership with others
● The service worked in partnership with health and care professionals to make the necessary improvements required to improve the quality of the service. This included the local authority MCA assessor who completed assessments of people's capacity for people who used the service, and the occupational therapist worked with staff to develop and implement manual handling assessments.
● The registered managers had attended various forums and conferences to learn and share ideas with other providers' of health and care services and develop the service. This meant the service was up to date with best practice in areas such as, delivering personalised care and medication management.

This page is intentionally left blank

Report on Housing with Care services in Hackney

August 2019

Liz McKeon House, one of Hackney's 14 Housing with care schemes

1. Background

In November 2018, the Care Quality Commission (CQC) inspected Hackney's Housing with Care service that provides care to around 230-50 people across 14 units. CQC inspectors rated the service as inadequate, placing it in special measures. *

Healthwatch Hackney attended six residents' meetings arranged by the service provider, Hackney Council, following the report's publication. In March 2019, we published a report with recommendations, based on feedback from the meetings. On 12 March we presented the report to Health in Hackney scrutiny commission.

Healthwatch Hackney was keen to find out if the council had implemented recommendations from our March 2019 report and from the CQC inspection. Health in Hackney scrutiny commission also requested Healthwatch Hackney provided an updated report on the service.

We used our powers of Enter and View to visit four Hackney housing with care schemes over June and July 2019. During these visits, our authorised representatives collected residents' views and interviewed staff. We attended two 'family and friends' forum on 16 July organised by London Borough of Hackney.

2. Purpose of our visits

We visited six housing with care schemes to:

- Collect feedback from residents, staff, family, and friends on five main recommendation areas established in our report in March 2019. These areas were:
    1. Communication
    2. Quality of care
    3. Level of care provided
    4. Social isolation
    5. Housing/care interface

- Visit housing with care schemes to observe the facilities overall, atmosphere, and staff-resident interaction
- Identify good practice and areas for improvement
- Make recommendations to Hackney council on how to improve the service to residents
- Share our findings with the CQC and Health in Hackney scrutiny committee

** The CQC re-inspected the service on 3 July 2019.* Their subsequent report of 19 September *found some improvements and rated the service 'requires improvement' taking the service out of 'special measures'*

3. Methodology

Ahead of our visits we:

- Informed each scheme of our plan to visit a week prior to the visit (a poster, letter, Enter and View guidance)
- Created a list of prompt questions to guide interviewers
- Sought advice from Alzheimer's Society and Independent Age on developing questions for older residents

We invited the council to provide a formal response to our report. Item 15 (page 11) sets out our recommendations and the council's response.

How visits were structured

Our visit comprised at least one staff member and one authorised Enter and View representative. Numbers varied from two to four people, depending on the size and scope of the unit. The format was:

- Meeting with management
- Tour of facilities
- Talk to residents in communal areas
- Visits to residents' rooms with their consent

Many residents we spoke to had various forms of dementia. Our volunteers, all trained authorised representatives, were sensitive in their approach to all residents.

Item 16 (page 16) of this report sets out residents' feedback.

Family and Friends forums, 16 July 2019

Around 30 people attended the 2pm forum meeting including residents, family members and residents' friends. Four people attended the 6pm meeting.

Staff had taken on board feedback from the February meetings. All agendas and handouts were in an easy read, large font format. Refreshments included healthy fruit options as well as biscuits.

4. Schemes we visited

We selected the schemes to represent the range of different sized facilities within the Hackney Housing with Care service. Visits lasted between two to four hours.

Housing with care unit	Size	Care staffing levels
Century Court 72 Warwick Road E5 9FF	40 flats	6 morning 5 afternoon 2 overnight
Liz McKeon House 3 Bridport Place, Mintern Street, N1 5LW	8 flats	1 staff member on duty at any one time
Leander Court 63 Balcorne Street, E9 7AY	33 flats	4 morning 4 afternoon 2-3 overnight
Rose Court 57 Holly Street E8 3XL	41 flats	2 morning (on each floor) 2 evening (on each floor) 2 overnight (whole building)

5. Disclaimer

This report is not representative of all residents in housing with care schemes in Hackney. It only represents the views of residents and staff able to contribute within the restricted time available and our observations during each visit.

6. Acknowledgements

Healthwatch Hackney would like to thank the scheme managers and staff for making us welcome. We wish to thank residents for participating in our interviews. We are grateful to our volunteer authorised representatives for taking part in the visit.

7. General observations

We were pleased to note all residents appeared physically well cared for and that all the schemes we visited were clean, tidy and well decorated. Residents can choose how to arrange or decorate their own flats. However, common areas were somewhat institutional in feel, lacking displays or pictures to reflect residents' personalities.

We had most concerns about the social aspects of residents' lives in the housing with care schemes. In some instances, this felt very close to 'warehousing' people with support needs. Some residents did not get out as much as they wished.

Several key themes emerged from our observations and interviews with residents and from the family and friends forums. We have grouped our comments according to these themes (rather than by the scheme) to protect residents' confidentiality.

8. Care plans

The CQC report was critical of the generic nature of residents' care plans, highlighting that people's needs were not assessed in line with best practice and guidance and that the plans failed to advise staff how to support people to achieve their goals.

Speaking to staff it was clear that, following the inspection, much effort had gone into producing more personalised care plans to reflect residents' individual needs.

Previously there were often blank spaces in care plans. Staff told us they now try to make sure all areas are completed. Staff complete these after talking informally to residents about their likes and preferences.

Staff at one scheme said that any changes to care plans came from staff recommendations and that families were informed of changes by phone, email or, if the changes were significant, in a face to face meeting.

Nevertheless, when interviewing residents, most were unaware of what was in their care plan, and a summary of their care plans did not appear to be available in in their flats. Not one resident we interviewed said they had a care plan in their flat.

Family and friends who attended the forums did not feel as though care plans had improved and there was ambiguity about who was in charge of updating plans and how residents and family members were involved in updates.

Families raised concerns about the lengthy nature of care plans that meant care workers did not have time to read them thoroughly and therefore missed people's important information and preferences.

Families felt mangers should disseminate important information in the care plans clearly and easily to workers, especially agency care staff. Families also wanted a summary of care plans in the residents' room, posted somewhere easy to read/access.

One person suggested creating a list of 'six key things' all workers should know about the resident. Staff could type up the list in a large font and post it near the entrance to their flat.

9. Food

Few residents were able to cook for themselves and relied on staff to cook food for them. Staff told us they heated frozen meals bought by families or ordered by staff and residents.

We asked the Alzheimer's Society for guidance on whether these were a good option. They told us, in principle, frozen food is more nutritious than fresh food but that general supermarket frozen meals do not meet the nutritional needs of older residents and therefore living on these might lead to nutritional deficiencies. Frozen meals do have the advantage of offering each resident an individual choice of meal.

Many residents order meals from the Wiltshire Farm foods catalogue that arenutritionally balanced and labelled. They meet older people's specific dietary requirements including pureed meals for residents who have swallowing problems. The Enter and View Representatives felt that the options in the Wiltshire Farm Foods catalogue were not exciting to be eating every day.

All schemes have communal kitchens where staff can prepare food in. Staff at one scheme mentioned that they made the effort to put the ready meals in the oven rather than in the microwave as this improved the flavour. In all schemes, residents have the choice of eating meals in their rooms or in communal dining areas.

10. Social isolation

Some residents appeared socially isolated. Their interaction with staff was limited to practical issues such as what they wanted to eat. There was no time to chat.

The lift at Rose Court was broken on the day of our visit, and although there was a chair lift, people need assistance to use this, thus limiting residents' ability to move from floor to floor.

We did not see any communal areas used fully. The exception was a scheme we visited where an afternoon birthday celebration was taking place. The timing of our other visits in the morning might have been a factor.

Staff told us many residents were not interested in participating in activities. Staff at one scheme said if someone was persistently isolated, they took a *'personalised approach'* to try to lessen their isolation. One scheme told us Hackney social services provided a befriending service to take residents shopping and for a walk.

11. Organised activities

Poorly managed noticeboard

Three Welfare and Activity officers work across all 14 housing with care schemes to organise outings. This has the benefit of increasing outing options for residents.

Activities are publicised on notice boards. We noted that not all posters or display board were up-to-date. Display boards were somewhat chaotic which made them difficult to read and find items of interest.

Rose Court uses a folder system in the lounge area on each floor. These folders contain details of activities. Content was variable, with some folders providing more information than others.

Staff at one scheme told us some residents go to lunch clubs such as the Salvation Army. Other residents attend church services. These residents were probably among the most independent.

Some residents commented positively on provided activities such as bingo, listening to music and dancing. Others said they would like more activities like darts and support to go for a walk.

Staff at one scheme told us most residents needed assistance to go out. This restricted their ability to access activities outside of the unit. Staff had limited time to accompany people to places so residents rarely left the building. Staff said they would like more funds for transport and additional staff so that residents could be part of the local community. Staff recognised this was important for residents' mental health.

The council does not always lay on transport for community activities. Care staff said this was an issue. Not having proper transportation makes residents more reluctant to go because it costs more money to get a taxi, etc. Families are often in charge of getting taxi cards for residents.

12. Involving family and friends

Staff spoke about reaching out to family members to arrange specific support for residents, such as GP appointments or hospital visits. They said contact took place face-to-face when families visited or over the phone or by post.

The first Family and Friends forum meetings held since the CQC report took place on 16 July 2019. At this meeting it was announced that future forums will be held quarterly.

13. Housing

Family members told us that care workers needed to know part of their job was to check the physical environment to ensure it was good/healthy for the residents

Some relatives expressed concern that care staff were not liaising with housing about repairs when residents were unable to do this themselves.

Staff reported that the relationship with the housing providers in general could be improved, with better communication and faster response times to repair request

14. Staff

From speaking to staff and managers at each scheme, it was clear the poor CQC outcome negatively affected staff morale. However, staff showed a strong desire to make the required improvements.

We were told the service used lots of agency staff at one particular scheme due to a shortage of full-time permanent employees. Families agreed that agency staff were worse at taking the time to get to know the resident and that the quality of care provided by those workers was not adequate

Families said some permanent staff were reliable and knew their relatives and their care plan well.

Some family and residents wanted greater clarity about who care workers were and who was working with which resident regularly, reflecting a perfectly reasonable desire for their vulnerable loved ones to be receive care from familiar people. This would eliminate confusion when relatives need to contact care workers about their loved ones.

Staff have a tough job at times. Some patients can be physically and verbally abusive. One BME staff member told how she was subject to racist abuse from a resident who had dementia and mental health problems. She talked to us about how she felt had to accept the abuse because of his health problems.

We witnessed staff speaking respectfully about and to residents, for example referring to them as Miss X or MR Y. Many residents spoke warmly of the staff and their kindness and helpfulness. Residents said some staff were better than others. Some staff could be *'patronising'.*

It was clear staff were under increased pressure due to the additional work required to address the issues identified by the CQC. This work included completing more than 19 forms for each resident, including new-style care plans.

Staff spoke about the difficulty in completing work within the tight timeframe while trying to do more with the same level of resources. They felt rushed trying to meet deadlines and clearly needed more staff to help complete the paperwork.

Staff talked about wanting to be valued more. They felt management did not always support them, for example by failing to tackle staff who arrive late for shifts, making their coworkers late with their handover. Hackney Council told us performance issues are dealt individual and confidential, other staff would not unaware of actions taken.

Staff told us the insurance did not cover them past the end of their shift creating a risk. Hackney Council told us that this is incorrect: insure covers care staff at all times when they carrying out the agreed council work and cover is not time-limited.

Staff said they sometimes worked 9 to 10 hour shifts to get their work done and they reported often feeling stressed and tired. The council told us all staff were encouraged to claim overtime or take back time in lieu for extra hours worked while the improvements were made, and staff have exercised their right to this.

One manager became tearful talking about the stress she was working under She talked about working unpaid overtime and at weekends.

In one of the smaller schemes, only one worker was on duty at any time. This means that there is no cover available for them to take a break. This worker would typically start at 7am and finish at 3pm, and their colleague might come at 2pm.

Staff said residents are sometimes afraid to ask for things because of the perception, and reality, that care workers are always busy. Staff recognised it was important to empower residents to speak up so that they can get what they want to ensure a higher quality of care. Staff said had developed a more in-depth understanding of each resident and their needs since the CQC report.

15. Recommendations and council responses

Area	Recommendation	Service response
Care plans	• All residents and their families given a copy of their care plan • A care plan summary put in each residents' room, in a prominent accessible place • Consideration to be given to the production of a '6 key things about me' poster, for each resident	We have now ensured all service users have a copy of their care plan. We are also informing all relatives of this. The idea of a '6 key things about me' summary was raised by a relative at the HwC forums. We were pleased to hear this suggestion and agree it could be a valuable activity. We are in the process of establishing a co-production group with service users and relatives. The group will be asked if they would like to co-produce a '6 key things about me' template, that will then be completed with all service users and displayed on the front of care plans.
Food	• Where possible freshly cooked rather than frozen ready meals food made available for residents. • This could either be through care staff cooking for a group of residents joint meal from fresh ingredients, and involving residents where practical, in tasks such as peeling vegetables	Part of supporting service users to be independent in their own homes includes service users exercising choice related to what they eat, how they source it, and when/where they eat. Each service users' needs are assessed under the Care Act, and support plans are devised to

		reflect this. Care plans also include details of what food the service user likes/dislikes. Whilst many service users do choose to have ready meal provision, a number of service users choose to collectively have takeaways on Fridays, and in some schemes service users choose to have freshly cooked communal meals at the weekends, that staff cook. In some schemes, this no longer happens, as this was the choice of the service users. Staff support service users to access their meals, in line with their choices.
Social isolation	• More effort to be put into recruiting volunteers as be-frienders to visit residents and accompany them on walks • Care plans to include adequate provision for support to access the community • Make sure the lift at Rose Court is fixed so residents can easily visit each other, no matter what floor they live on	Care plans document people's socialisation, relationships and wellbeing needs. Service users are supported to maintain relationships with friends and family to avoid social isolation. Each scheme provides activities in the communal area of the building and service users have the choice to participate in these. Hackney Council commissions a befriending service, and this is offered to service users in Housing with Care, some of

		which have chosen to have befrienders. We will continue to raise awareness of this to service users, and if required we will work with the provider to increase the numbers of befrienders within the schemes. We raised the concern about the broken lift to the Landlords and will continue to monitor any maintenance issues and escalate as needed.
Activities	• Notice boards, and activity folders need to be kept up to date • More reserved residents encouraged through more one to one activities that meet their interests and needs e.g. reading together. • Residents consulted on the activities they want. • More accessible and easy to organise transport to enable less mobile residents to participate in community activities • Increase in funding for transport	Welfare and Activity Officers and Scheme Managers will be instructed to keep activity folders and notice boards up to date, and in an appropriate and easy to read format. When planning activities with service users, activities on a one to one basis will be considered and discussed with the service user and their relative. Each service user is consulted about the activities they are interested in, and this is reflected within their care plans. The activities scheduled are informed by service user's choices, and they are supported to access these.

		The service does not directly provide and pay for transport, as this is not part of a Housing with Care service. Instead Housing with Care staff support service users to be able to access transport to reach activities of their choice in the community, such as Dial-a-Ride, use of the taxi-card scheme when eligible, or privately purchased transportation i.e. mini-cabs.
Involving family and friends	• Quarterly meetings should be organized to enable family and friends to meet staff and feedback	Our Housing with Care forums are now held quarterly - the first was in July 2019 and the next is in October. We will continue to run these and will invite Healthwatch Hackney to attend.
Housing	• Staff to take the initiative to contact housing regarding repairs rather than relying on family	Staff have been instructed to raise any repair and maintenance issues with Housing colleagues on behalf of service users and do so frequently. A new Housing with Care leaflet is being produced that will clarify the roles of care staff and housing staff, and who to contact and how for different issues. We hope this will also make it easier for service users and relatives to contact housing when needed.
Staff	• Staffing levels reviewed so that no staff feel pressured to work unpaid overtime • Staffing organised so staff are able to take lunch and rest breaks • Staffing increased so that they have time to chat more	We are confident that staffing levels are sufficient to meet the needs of service users. All staff were encouraged to claim overtime or take back time in lieu for extra hours worked

	with residents rather than being totally task- orientated • System of staff reward and recognition put in place • Recruitment of additional permanent staff to reduce reliance on agency staff	whilst the improvements were made, and staff have exercised their right to this. Staff rotas are organised to ensure staff can take sufficient lunch and rest breaks. To recognise and reward the valuable work of care staff, the annual Hackney Care Awards started in 2017, and includes a category especially for Housing with Care staff. A recruitment campaign took place over the summer, and 15 additional permanent staff have been recruited. Another recruitment campaign is planned to start from October 2019, looking to further increase permanent staff and reduce the use of agency staff. 16 existing permanent staff will also be increasing the hours they are contracted to work, following expressions of interest, further reducing the use of agency staff and increasing continuity of care.

16. Residents' feedback

To preserve residents' confidentiality and prevent identifying people, we have not linked residents' comments with their home address.

Resident 1 said they liked living in this scheme and mentioned a range activities including bingo, going to the park, listening to music, enjoying coffee, and even dancing. They were clearly one of the more independent residents who goes shopping once a week. She is sociable and she will visit other flats in the building when she can. She described staff as '*very nice and helpful',* both on the care and housing side. She was very aware of her care plan and feels she could easily contribute to her own plan by talking to staff, but beyond that they knew very little about other areas of interest and how they were handled such as personal finances, costs of living, bills, etc.

Resident 2 reports communication with staff to be fine, most of the time. '*We all have bad days.'* Overall, she feels staff listen and when a request can't be accommodated, they explain why. She is aware she has a care plan, although she has not seen it in a while. She said her care was *'fine'*. If it wasn't, she felt confident to say this and *'ask for help'*. She can talk in confidence to her carer as *'she is the best'*. She feels safe and secure at the scheme. The resident feels there is a good variety of activities and activities and likes computer, crosswords, seated exercise and watching films. It is very important to her to go for a walk but she can only do that with support because her mobility is poor (uses a stick). She says she manages to go out two or three times a week. She would like to go on more walks if possible. She reports having felt lonely occasionally but has decided not to tell staff as she knows they are unable do anything about it.

Resident 3 feels communication with staff can sometimes be *'difficult'*. She needs to take medication at regular times including during the night and sometimes has had to wait for help come. When she pulls the call cord, carers often take a long time to show up or do not show up at all. She feels the paid carers often assume that something would be fine for her, but they do nor double check directly. Sometimes she might not be open about things she is unhappy about as she fears being seen as a troublemaker. Her main care worker used to be her key worker. She did not feel respected by her when she was her key worker. In particular, she mentions episodes when some personal belongings were thrown away (e.g. current issue of a magazine she enjoys reading). Overall, she felt the key worker wasn't very nice. Her relative present asked her quantify her care out of 100. She said it's probably 60% good and 40% not so good**.**

Resident 4 has lived in the scheme for about eight years. He found staff easy to talk to, kind and respectful. He likes to play and listen to piano and drums. Sometimes people come on Fridays. He does not know what is in his care plan. The manager buys groceries every week including things he likes and staff cook for him. His brother and sister come to visit often. He has a care plan but is not sure what is in it.

Resident 5 said staff have hit him. Complained the water is contaminated. Said there were no activities. (Note: we were told this resident suffers from schizophrenia and dementia).

Resident 6 said the place looks damp and complained there was not enough heating, and no heating in the corridor. This resident is independent, cooks and cleans for herself. She goes to church once a week on a Saturday.

Resident 7 says care staff are easy to talk with. She has severe mobility issues, and uses her pendant alarm if she needs anything. Care workers arrive promptly when she uses it. One regular staff carer is '*perfect'* for her and very kind. She knows she has a care plan but did not know where it is. She gets regular support from visiting family. She only stays in her flat. She used to walk a lot and misses being mobile. She lost her mobility a year ago after she was bed-bound for two months in hospital. This resident now needs lifting with a hoist and uses a wheelchair. She does not like to be in the wheelchair as she fell out a couple of times and is scared it might happen again.

Resident 8 has been living at the scheme for a few years. She says staff are *'nice and lovely'*. Family visit daily and support her. They help with personal care, shopping and cooking. It was difficult to gauge how much support she gets from staff as the family is heavily involved in her care. The resident does not join activities with other residents. Her family could take her to the communal area but she does not want to go there as she is happy in her flat.

Resident 9 reports communication with staff is good. He is aware he has a care plan, although he is unsure where to find it and thinks it might be close to the door. He says staff are good. *'They are there for us'*. He gets support with washing, medication and shopping. He prepares the shopping list and care workers buy what he needs. He can choose his clothes and get dressed. Overall, he is happy with how it all works. This resident feels safe at the scheme. Staff come in promptly when he uses the call cord. He feels he could with more prompting to take part in activities. This resident stays indoor most of the time. He would like to go out more often, even if just for a quick walk. He misses the day trips that used to be organised. He would like to do games such as dart balls but appreciates it might not be appropriate for the setting and thinks he might enjoy dance classes/activities and board games like Ludo. No family visits him and he reports feeling lonely at times.

Resident 10 now has a walker following a fall in his flat. During the fall, he could not reach the call cord. Family and friends visit but rarely. Staff help him shower and shop. He says his health has worsened since living here. *'Staff are alright'.* He is aware of his care plan, but said: *'Ask Jxxx about it*'. He was unsure of the details or where the plan is kept. His social worker visits once a year. He is not interested in activities. He would like to play darts. His daughters take him out in the wheelchair occasionally, but he would like to walk in the fresh air more often. He does not have conversations with staff, they just come in and do their job then leave, and ask him routine questions like *'what do you want for breakfast?'* He feels lonely and isolated sometimes. He has a friend in a flat on another floor in the scheme but has not seen them in many months due to mobility issues.

Resident 11 reports some staff are easy to talk to but others are not as friendly. She does not have a copy of the care plan, as far as she knows. She enjoyes it when young people from a nearby community group come to chat to residents. She does not participate in many centre activities. She feels safe and enjoys the staff. She has decorated her own flat to make it feel more like a home. She can choose where to eat meals but likes to eat in her flat in the afternoon and in the communal areas in the evening. The optician collects her for appointments at Morefield's Eye Hospital.

Resident 12 had a haircut recently and a few months ago went to the barber. Someone comes to shave his beard every so often. He feels safe and likes the staff. He says they all do 'care' a little differently. Sometimes staff will listen and hear what the residents need, but not always at every hour of the day. He has been *'a bit depressed recently'*. He had not been out much and would like to go out more. He broke his hip 3-4 weeks ago and injured his knees, which limits his mobility further. His brother lives in a Jewish residential home nearby, but he has not seen him in a while because they cannot get to each other easily. He does not know what a care plan is or who would be in charge of it.

Resident 13 initially felt she made the *'wrong decision'* moving to the unit. She has now settled and enjoys living there. '*Most staff are good and they help out a lot. They are very helpful.'* Staff help her to stand, wash, with her bathroom needs and getting in and out of bed. The catering *'isn't great'*, mainly frozen foods and lacks variety. She prefers it when her family bring her home cooked meals at weekends. A couple of staff *had 'a poor attitude'*. They spoke to residents in a poor tone of voice and were patronising at times. She knows how to complain and has in the past but did not receive follow-up or feedback. She does not like to participate in social activities. She goes to movie club and monthly residents meeting. She was involved in her care planning, however she does not agree with certain aspects and has refused to sign it. She does not have a copy. She knows about 'independent advocates' but would like more information. She finds the flats small but she is very happy living here.

Resident 14 *'Very happy living here and they treat me very well, I feel respected by the staff and they help me out a lot. They book my appointments and they take me shopping once a week*.'

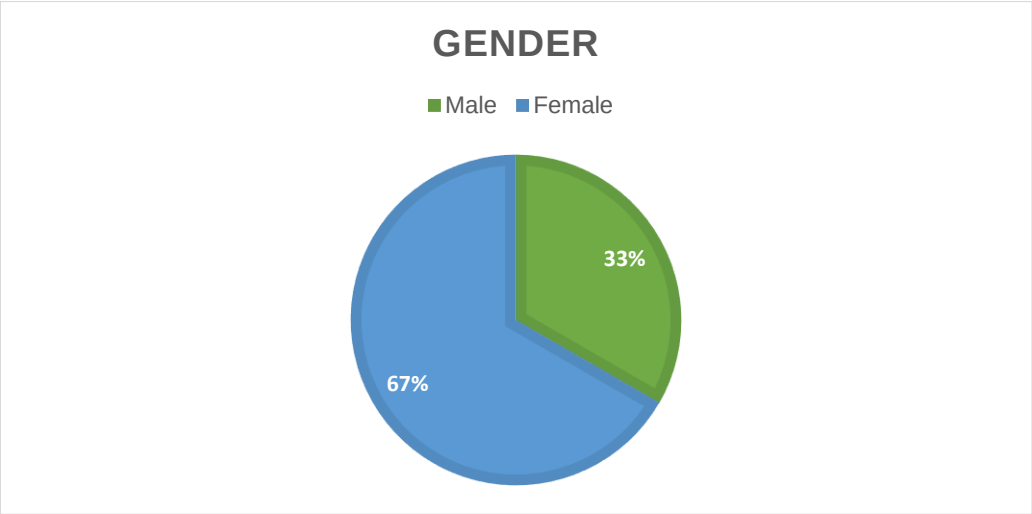
Resident 15 does not go out alone, only with family. '*I am very content living here and I have made some friends'*. He reports some staff are *'very good'* but not all. Would like more personalised care. He does not have copy of his care plan. If he needs to complain, he feels that it better for his family to intercede on his behalf. Has had to wait a long time for repairs as there is water in the ceiling. It was reported but has taken over 5 weeks. He does not feel secure and feels scared to leave the home alone in case of losing his bearings.

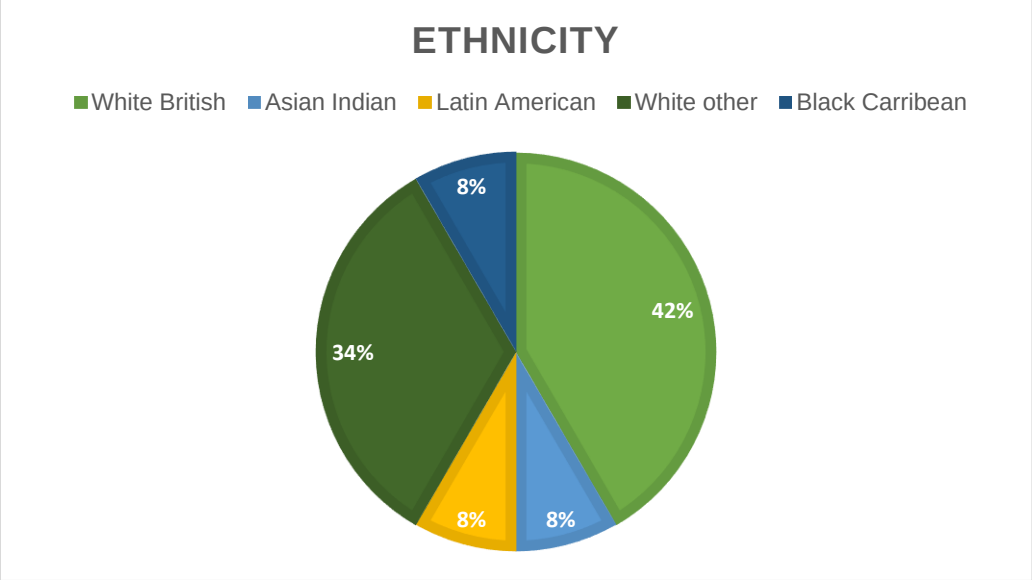
Resident 16 enjoys living in scheme and finds it quiet. Staff treat her well. She struggles to get in and out of the building at times. She feels isolated but she has made friends in the scheme. She does not take part in activities. She is aware of care plans but does not know much about them. She has complained in the past and feels they dealt with her complaint adequately.

Good care, in parts

The sister of one resident said the service improved after the CQC visited but the service had never offered a family meeting since her sister moved in more than four years ago. Her sister was upset she received no notification of our visit nor the recent CQC inspections. She only found out from another resident. Her new key worker is '*more respectful'* but some communication problems persist. Her sister told us she had seen the care plan and it *'looks alright'* but she is unsure how much staff actually implement. '*The care plan doesn't get to the nitty gritty of what is needed. Often it is more a box ticking exercise and it is not reviewed or followed up.'* Staff handled her sister's recent complex medical problems *'quite well'* and appropriately dealt with a safeguarding alert when someone outside the unit was financially abusing her. Her sister '*doesn't have much food in her fridge'* and needs regular support with both shopping and cooking but only gets sporadic help. She has hairs on her chin and her new key worker agreed to attend to these but nothing happened. Her sister was upset when care staff shaved her chin rather than use hair removal cream. She is concerned care staff are not helping her sister use her prescribed compression tights because they are unhappy with the applicator provided by the lymphoedema service. Staff ignored her suggestion to call the nurse for advice and now she has to put them on her sister. She feels staff are not proactive at finding solutions and thinks they do not have enough training supporting residents with learning difficulties, even though the scheme specializes in this*. 'It's great to focus on residents' independence but sometimes the need for support is missed.'*

17. Demographics of residents interviewed





Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **Sexual and Reproductive Health Services in GP Practices**	Item No **8**

OUTLINE

The Commission received a request from the Local Medical Committee to examine the issue of the impact of new commissioning arrangements for sexual and reproductive health services on local GPs.

Specifically they asked:
LMC also raised concerns regarding a proposed new GP Sexual Health Services contract by LBH for non-GMS services. In context of C+H's highly transient and diverse population, the expectations of the contract appear unrealistic. There is a feeling that the contract is underfunded for the large amount of work required; that KPIs are set too high: 75% of all new registrants must accept an HIV test; 95% of all women 16-49yrs must be offered Long Acting Reversible Contraception (eg coils), and these must be fitted within five days of a request; that 95%of all women must be offered STI testing and that 90% of positive STI test results must be notified to patients within 10 days of the test date; that moves to online requesting for self-tests may prejudice opportunities for individual counselling of patients potentially at risk (eg sexual assault, safeguarding and relationship issues); that responsibility for contact tracing is delegated to GPs via an app; that the time required for effective Sexual Health consultations is not available in General Practice. Typically in secondary care and community clinics, patients have 20-30 minute appointments for consultation, testing, and counselling patients. It is also unclear how the GP SH service contract is planned to fit in the wider provision of SH services across the Borough. The degree of shift of SH from secondary care and community services onto GPs is unclear. We do not know if this SH contract is intended to permit closure or downgrading of existing SH services and clinics provided elsewhere. LMC would welcome some enquiry as to the overview of SH service provision envisaged, and whether the budget allocations, contract demands and KPI requirements are appropriate for the demands of the contract on GPs

Attached is a briefing from Public Health.

The services are commissioned by Public Health and managed by the GP Confederation.

Attending for this item will be:

Dr Sandra Husbands	Director of Public Health	City and Hackney
Dr Andy Liggins	Consultant in Public Health	City of London (lead commissioner for C&H)
Shivangi Medhi	Public Health Strategist	LBH

Dr Deborah Colvin	Chair	City & Hackney GP Confederation
Laura Sharpe	Chief Executive	City & Hackney GP Confederation
Dr Fiona Sanders	Chair	Local Medical Committee
Dr Nick Mann	Member	Local Medical Committee

ACTION

Members are requested to give consideration to the report and make any recommendations as appropriate.

Sexual and Reproductive Health Services in GP practices
Update from Public Health for Health in Hackney Scrutiny Committee - 4 November 2019

Background

Sexual and reproductive health is a broad term covering multiple and often interlinking topics (see Appendix A). The World Health Organisation has identified eight overarching themes:

- Antenatal, intrapartum and postnatal care
- Comprehensive education and information
- Contraception counselling and provision
- Gender-based violence prevention, support and care
- Fertility care
- Prevention and control of HIV and other sexually transmissible infections (STIs)
- Safe abortion care
- Sexual function and psychosexual counselling

The provision of sexual and reproductive health is complex and falls under the responsibilities of local authorities, Clinical Commissioning Groups (CCGs) and NHS England (NHSE).

Local authorities must, by law (Health and Social Care Act 2012), provide open-access sexual health services for everyone in their area, to control and prevent outbreaks of sexually-transmitted infections and reduce unwanted pregnancies. They are responsible for commissioning:

- Comprehensive sexual health services, including most contraceptive services (excluding GP additionally-provided contraception under the General Medical Service (GMS) contract)
- STI testing and treatment (including HIV testing but not treatment)
- Specialist services, including young people's sexual health, HIV prevention and sexual health promotion

Sexual and reproductive health services in Hackney

Hackney Council is part of the London Sexual Health programme, which is a partnership of 29 London local authorities. Through this programme, a new commissioning model has been implemented, transforming the way sexual health services are provided in London. In addition to integrated (covering both sexual and reproductive health services) local clinics, residents from most London local authorities are now able to access an online service called Sexual Health London (SHL) to order test kits for STI and HIV testing. In 2018/19, over 8,500 Hackney residents were registered on SHL and 99% rated the service as 3+ stars (out of 5). London wide figures have also shown that around 20% of SHL users had never visited a sexual health clinic, which indicates SHL is increasing access and take-up of STI testing.

In addition to SHL, Hackney Council commissions the following sexual and reproductive health services:

- Homerton Sexual Health Services – providing open access integrated sexual and reproductive health services. There are three clinics based within Hackney.
- Condom Distribution Scheme (provider: Brook) – provides sexual health information and free condoms to targets groups (such as under 25 year olds).
- HIV prevention and support services (providers: Positive East; Body and Soul) – supporting people, and their families who are affected by HIV
- Sexual and reproductive health provision in GP practices (see below)
- Community pharmacy sexual and reproductive health provision – provides access to advice, free condoms, emergency hormonal contraception and chlamydia screening.
- Sex workers support (provider: Open Doors) – provides clinical and non-clinical case management and outreach service for sex workers.
- City and Hackney Young People's Services Plus (provider: Homerton), known as CHYPS Plus – providing clinical health and wellbeing services to young people, including one-to-one sexual and reproductive services
- Young Hackney Health and Wellbeing Service (provider: London Borough of Hackney) – providing Personal, Social and Health Education (PSHE) drop-ins sessions in schools, youth hubs and other settings. They cover a range of health and wellbeing issues, including those related to sexual and reproductive health.

Sexual and reproductive health services in GP practices

When statutory sexual health functions transferred to local authorities in 2013[1], Hackney Council inherited individual contracts with GP practices, which included sexual and reproductive health services. Although some GP practices were committed to providing a range of services, activity has remained stagnant and, in some cases, had decreased. T

he rate of GP prescribed long-acting reversible contraception (LARC) has been in decline over the past five years and is significantly lower than both the national and London rates. This contrasts with total LARC prescribed rate (combining GP and Sexual and Reproductive Health LARC activity) which has increased and is higher than the London rate, but still lower than the England rate. This indicates a need to improve availability of LARC within GP practices, to enable better and consistent access for residents across Hackney.

Since April 2019, Hackney Council has commissioned the City and Hackney GP Confederation to implement and manage sexual and reproductive health services delivered by City and Hackney GP practices. This arrangement replaces the need for individual contracts with GP practices and enables a more coordinated approach to manage activity.

[1] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

The vision for this provision is to:

> ***"complement the existing integrated sexual health services in the City of London and Hackney by offering confidential, non-judgemental and accessible sexual and reproductive health services within local GP practices, to help increase long acting reversible contraception (LARC) uptake and improve service health outcomes"***

The service objectives are to:

- Ensure sexual and reproductive health services are accessible to City and Hackney GP patients, particularly for those who are at a higher risk of unplanned pregnancies and poorer sexual health outcomes,
- Provide a LARC service that is widely promoted and easily accessible, providing convenient and timely appointments to encourage take-up,
- Provides services for the prevention, detection and management of STIs,
- Provide Chlamydia screening in line with the National Chlamydia Screening Programme.

The service contributes to the following outcomes:

- improved patients' knowledge of sexual and reproductive health,
- increase the availability of local sexual and reproductive health services in City and Hackney,
- increase the uptake of LARC,
- increase the uptake of HIV testing,
- increase the proportion of young people screened for Chlamydia,
- reduce the prevalence of STIs in City and Hackney,
- reduce the number of unplanned pregnancies.

Links to Corporate Priorities

This GP-led sexual and reproductive health provision fits the Mayor of Hackney's priorities of:

- ***'a campaigning Council that speaks up for Hackney and actively intervenes to protect and promote the well-being of the borough and its citizens***' and
- '***connecting with Hackney's communities; a visible engaging, and listening Council, working in partnership with local people to shape services, and promoting community cohesion***'.

It also fits within the Council's Community Strategy theme of '***a borough with healthy, active and independent residents***'.

Concerns highlighted by the LMC

In responding to a request from the Health in Hackney Scrutiny Committee for work programme items, City and Hackney Local Medical Committee (LMC) have raised concerns regarding this GP Sexual Health Services contract for non-GMS services, as follows:

"In the context of City & Hackney's highly transient and diverse population, the expectations of the contract appear unrealistic. There is a feeling that the contract is underfunded for the large amount of work required and that the Key Performance Indicators (KPIs) are set too high."

Specific KPIs and other issues causing concern to the LMC were listed and these will be addressed individually:

LMC concern: "75% of all new registrants must accept an HIV test";

KPI: % of newly registered patients, aged between 15-59 years, offered and accept an HIV test within three months of their registration (target – offered 95%, accepted: 75%)

The rationale behind this KPI is in line with NICE Quality Standard (QS157) HIV testing: encouraging uptake, which recommends that young people and adults in areas of high and extremely high HIV prevalence are offered an HIV test by their GP practice when registering. In addition, as there is still a stigma associated with HIV, the provision of universal testing for newly registered patients could help to address this stigma and normalise HIV testing as part of improving a person's sexual health and wellbeing.

LMC concern: "95% of all women 16-49yrs must be offered Long Acting Reversible Contraception (e.g. coils), and these must be fitted within five days of a request";

KPI: % of 16 to 49 year old women offered and accepting a LARC method (target – offered 95%, accepted: to be baselined in year 1) & % of patients choosing LARC methods offered an appointment within 5 working days of choice or at next eligible point in cycle (target: 95%)

The rationale behind these KPIs is in line with NICE Clinical Guidance (CG30), which states that the uptake of LARC is low but expert opinion is that such methods may have a wider role in contraception and their increased uptake could help to reduce unintended pregnancies. This guidance also recommends for contraceptive service providers who do not provide LARC within their own practice to have an agreed mechanism in place for referring women for LARC.

LMC concern: "that 95% of all women must be offered STI testing and that 90% of positive STI test results must be notified to patients within 10 days of the test date";

KPI: *% of all STI results notified to the patients within 10 working days from the test date (target 90%)*

There is no target for '95% of all women being offered STI testing', although increasing the availability of testing for STIs is to be encouraged and there is a KPI to measure the percentage of 15 to 59 year old patients who are offered and accept a STI test. This is in line with NICE Quality Standard (QS178) Sexual Health, which highlights the need to discuss prevention and testing for people who are at risk of STIs.

With regards to the KPI on notifying patients of their results, it is accepted that timely diagnosis and reporting of results can help prevent patients passing on STIs. The equivalent KPI for Homerton Sexual Services is that 80% of positive test results must be notified to patients within 2 days and 95% within 5 days.

LMC concern: "that moves to online requesting for self-tests may prejudice opportunities for individual counselling of patients potentially at risk (e.g. sexual assault, safeguarding and relationship issues)";

The online service has been set up to reduce unnecessary clinic or primary care attendances by focusing on asymptomatic patients requiring testing only. Should a person have symptoms or another reason for attending a clinical appointment, this is the correct pathway to follow. In terms of sexual assault or potential exploitation, the online system includes various triggers to identify potential safeguarding issues, with call back from the clinical team as appropriate (see SHL FAQ).

LMC concern: "that responsibility for contact tracing is delegated to GPs via an app";

A consistent contact tracing or partner notification system is an essential element of any sexual health service, reducing transmission, and new diagnoses, of STIs. Such procedures should be in place to provide support to contact, test and treat partners of patients diagnosed with an STI, with support being tailored to meet the patient's needs. The SXT tool (https://sxt.org.uk/pn/about) is designed to support primary care in fulfilling this element of their contract service specification but is not the only possible approach. Partner notification should be carried out when a patient is informed of their positive diagnosis, preferably in a face to face consultation. If there are issues with the online tools or other notification system, these should be discussed with commissioners.

LMC concern: "the time required for effective Sexual Health consultations is not available in General Practice. Typically, in secondary care and community clinics, patients have 20-30 minute appointments for consultation, testing, and counselling patients."

Whilst recognising that pressures within health services are a real issue, it is important to note that general practices are not being asked to undertake the same role as that fulfilled within a specialist sexual and reproductive health clinic, where there is a broader range of sexual health services available.

LMC concern: "It is also unclear how the GP SH service contract is planned to fit in the wider provision of SH services across the Borough. The degree of shift of SH from secondary care and community services onto GPs is unclear. We do not know if this SH contract is intended to permit closure or downgrading of existing SH services and clinics provided elsewhere."

The service delivered by GP practices complements the existing integrated sexual and reproductive health services, as highlighted in the Background section of this report. As part of the contract, the GP Confederation is required to participate in the City and Hackney Sexual Health forum meetings, which are facilitated by Homerton Sexual Health Services.

As is the case for any topic or diagnosis-based pathway, each element of the system is important, as is the need for each element of the system to understand its role, those of other parts of the system and how and when patients move through the pathway. It is equally important for patients to be informed about how to access appropriate services.

There have been no closures of sexual health clinics in Hackney and none are planned. The contract with Homerton covers a five-year period (plus the option of extensions thereafter).

LMC concern: "LMC would welcome some enquiry as to the overview of SH service provision envisaged, and whether the budget allocations, contract demands and KPI requirements are appropriate for the demands of the contract on GPs."

As part of the contract with the GP Confederation, regular monitoring of activity and financial expenditure is required. During the implementation phase, the GP Confederation has been engaging with GP practices and at date 37 GP practices have signed up to deliver one or more of the key sexual and reproductive services. A training needs audit is currently being conducted and the condom distribution scheme is being phased into the 29 practices that have signed up to provide this service, via a co-designed workshop with Brook.

One of the key objectives of this contract is to improve LARC activity and the tariffs for the fitting of coils and implant have been increased. Data for Quarter 1 19/20 has already shown an increase in LARC activity when compared to the same period in 18/19. The City and Hackney Public Health Team will continue to monitor activity and spend through routine contract monitoring procedures and the KPIs will be reviewed after year one of the contract.

Appendix A

Framework for operationalising sexual health and its linkages to reproductive health

Source: (World Health Organisation, 2017, p5)

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **Draft report of review on 'Digital first primary care and the implications for GP practices'**	Item No **9**

OUTLINE

Attached is the revised draft report of the Commission's own review into 'Digital first primary care and the implications for GP Practices'. This was first considered at the previous meeting in September.

ACTION

Members are requested to AGREE the report.

This page is intentionally left blank

Hackney

REPORT OF THE HEALTH IN HACKNEY SCRUTINY COMMISSION		
Digital First Primary Care and the implications for GP Practices **Health in Hackney Scrutiny Commission** **4th November 2019**	**Classification** Public	**Enclosures** Appendices 1-3

FOREWORD

What is the best model for GP access in 2019?

Those who are willing and enabled to be able to book appointments online and, if appropriate, undertake initial consultations over the phone or online, at the same time as ensuring other patients can still access their GP by visiting or calling reception with the availability of speedy face to face appointments?

Hackney, like many other places in the country, has a long way to go in offering its residents a smooth journey for accessing its GP's online.

With private providers entering the space and disrupting the conventional GP model, there is a clear need for the NHS family in Hackney, and further afield, to have a clear strategic and co-indicated plan in place or order to both take advantages of technological advancements but also meet patient expectations.

There are clear movements in this direction with the NHS app being developed and rolled out, but the pace of change has been slow.

Hackney is no island and must work alongside colleagues both regionally and nationally but there are things that can be done locally to drive up online access for the cohort of residents who wish to engage with their GP in this way.

Cllr Ben Hayhurst
Chair – Health in Hackney Scrutiny Commission

CONTENTS

1. Why do the review now and Core Questions?

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

1.2 The issue of improving access to primary care in Hackney has been a continuing one for the Commission and in 2013 we carried out a full review on Improving GP appointment systems. Since then there has been a whole range of digital solutions offered to patients to make it easier for them to access their GP or manage their health. There are now, for example, 37 private providers registered with the CQC to provide online consultations in England[1] and some of these are now looking to access the NHS funding on offer, by partnering with NHS GP Practices. Hackney with its large young population of digitally savvy and often time-poor population has been a target for these companies.

1.3 The issue came to a head in 2018 with the controversy over '*GP at Hand'*. Babylon, the company behind this service, is a subscription health service provider that enables users to have virtual consultations with doctors and health care professionals via text and video messaging through a mobile app 24 hrs a day. They rolled out their 'GP at Hand' app offering NHS GP consultations whereas previously this was just for private patients.

1.4 GPAH attracted a lot of media attention and the Health Secretary stated that he was an admirer and user of the service[2]. It was described as a market 'disrupter' like Uber, however this was soon contested by others who would argue that there is no real 'market' and instead a parallel economy was being created by NHSE. This, they argued, favoured private providers who were then "siphoning off" NHS funding so that more money would go to private providers of these Apps for the same work, while leaving the basic system itself struggling with decreasing funding and increasing demand. These innovations now challenge the whole basis on which primary care is funded and the system has just started to respond with NHSE consulting on transforming the payments structure.

1.5 As well as potentially losing the younger and healthier patients (who are more digitally savvy), to the new system, models like GPAH are drawing younger GPs to work for them, attracted by more flexible hours and work locations and all this is happening at a time when there is a general crisis in GP recruitment.

1.6 A key driver for the review is the publication of the *NHS Long Term Plan*[3] which makes explicit reference to the need to urgently embrace technology to: *Improve urgent care online; resolve more issues without patients resorting to A&E; develop more online appointment booking for hospital appointments;*

---

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

[2] https://www.telegraph.co.uk/news/2018/09/12/hancock-attacks-nhs-block-progress-says-patients-should-able/

[3] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

increase use of digital solutions to handle patient medical information and greater use of Apps to help people manage their own health.

1.7 The review also took place as the East London Health and Care Partnership was working on Enabling Online Consultation, introducing Patient Access to Information (GP online), improving sharing information and the 'Discovery Project' which links data sets to improve health population. Locally the GP Confederation is piloting some new digital primary care approaches and the review was to provide some input to these discussions.

1.8 Our review set out to answer the following questions:

CORE QUESTIONS

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

2. EXECUTIVE SUMMARY

2.1 Our review set out to gain an understanding of the pace and scale of transformation which digital changes will bring to our GP practices over the next few years. We wanted reassurance that City and Hackney was not on the back foot on these developments and how they will facilitate better outcomes for patients.

2.2 We took evidence from local commissioners and providers at both the STP and local CCG level and our local GP Confederation who are pivotal to driving forward this programme. We heard from the developers of The NHS App and from some of the providers of the new platforms for digital access who are working with our local GP Practices. We looked at developments next door in Tower Hamlets and within the broader North East London area. We heard from Babylon-GP at Hand who have been the main 'disrupter' in primary care in London over the past two years. We visited a GP Practice trialling a new system and we had a focus group with a group of local residents to hear their views. We also heard from Hackney and Tower Hamlets' Local Medical Committees representing GPs on the ground.

2.3 Our recommendations encompass suggestions drive up access, to improve communications, to better align with pharmacies and to encourage steps to drive 'digital first' at the North East London level where most change is now managed.

2.4 In our conclusions we point to the need for a more standardised approach across the East London Health and Care Partnership when it comes to mobilising the roll out of online/digital systems in primary care. We also ask for more leadership to be shown in order to ensure more clinical and managerial buy-in to these new ways of working.

2.5 We argue that there is a significant communications job to be done also in selling the many benefits of digital approaches and addressing the fears of some that these developments are about saving money or cutting jobs.

2.6 Genuine concerns about surveillance and data capture by the commercial companies involved, or about the overall risk of destabilisation of the system by 'disruptors' from the private sector or about safety concerns once carefully planned local care pathways are severed or, about misleading advertising of services, must all be faced head-on if 'digital first primary care' is to be a success.

2.7 Finally we would stress that there will always be a cohort who will, for various reasons, be unable to fully utilise digital approaches and they must not be disadvantaged by these changes.

3. LIST OF RECOMMENDTIONS

Recommendation One The **ELHCP/CCG/GP Confederation** is requested to set out the **strategy and timeline** for ensuring that all City and Hackney GP Practices are seeking to drive up access to digital consultation including The NHS App and what specific measures are being deployed to support patients who are still reluctant to use digital channels or who will be unable to do so.
Recommendation Two **The ELHCP/CCG/GP Confederation** is requested to set out what is being done to **encourage patients** who are having difficulty to register for both online consultation and to sign up for the NHS App and what **extra support** the Confederation can give individual Practices in order to fulfil this strategy. This might include training and mentoring of Practice staff as well as practical on-site support to patients.
Recommendation Three **GP Confederation** is requested to work with VCS groups such as Hackney Stream and Age UK East London on **encouraging those elderly people** who have the ability to get more confident in engaging digitally with services.
Recommendation Four **C&H CCG** is requested to consider replicating Tower Hamlets CCG's **information leaflets** about the consequences for the individual of being de-registered from your local practice if you decide to switch to private providers. These need to be distributed widely at GP Practices and other settings.
Recommendation Five The **ELHCP** is requested to ensure that its constituent local NHS bodies co-operate on a **communications campaign** to proactively promote the benefits of digital first approaches.
Recommendation Six The convenience of online ordering of repeat prescriptions either locally or by mail has proven very popular and in itself is a driver of change in encouraging the take-up of digital approaches. The **GP Confederation** is requested to ensure that the **Local Pharmaceutical Committee is fully included** in the work to roll-out more digital consultations locally.
Recommendation Seven The issue of how you meet different patient priorities within a single GP primary care system is a difficult one. The Commission requests **ELHCP** to report back on whether patients could be given a choice of online triage at a neighbourhood level e.g with a familiar GP or a local GP or for those who prioritise speedy responses over retaining the personal link, to have some online triage delivered at a sub-regional level, similar to NHS 111. The Commission would be interested to hear about how this issue will be addressed in the context of the requirements of the NHS Long Term Plan.

Recommendation Eight The work of City and Hackney's IT Enabler Group in Integrated Commissioning has been very much focused on secondary care and patient records. **IT Enabler Group** of ICB is requested to detail how they intend to give greater focus to driving up access to digital primary care and align this work with their efforts on digital interactivity in secondary care e.g. hospital follow-up appointments at Barts via video calls. They are requested to detail what current planning there has been on the **streamlining of digital pathways from primary through to secondary care**.
Recommendation Nine **ELHCP** is requested to report on how it is providing both **Clinical and Managerial leadership and coordination on this across the ELHCP area**. Is there sufficient resource for the GPs who are Digital Leads in each of the 3 CCG group areas (BHR,WEL,C&H) to drive the Digital First agenda in order to share knowledge and learning and how closely are they working with IT Steering Groups in each of the 7 CCGs.
Recommendation Ten The **Chief Clinical Information Officers** in the 3 group CCG areas to provide updates to scrutiny on the work being done on the **Online Registration project across North East London** which would allow patients to register at any practice.

4. FINANCIAL COMMENTS

4.1 There are no direct financial implications for the Council arising from the recommendations outlined in the report at this stage.

5. LEGAL COMMENTS

5.1 The Director of Legal has been consulted on the preparation of this review report and has considered the contents and confirms that it reflects the position of the law.

5.2 The Health in Hackney Scrutiny Commission's remit is to scrutinise local health and social care services, and make recommendations to NHS bodies and the Council in order to improve services. This is in line with the functions conferred on the Overview and Scrutiny committees by section 244 of the National Health Service Act 2006.

5.3 This report raises no specific legal issues, but Legal Services will be in a position to assist in providing advice, should specific issues arise in relation to the proposed healthcare delivery models.

FINDINGS

Note: Evidence for this review was gathered during 4 commission meetings, 2 site visits and a focus group. The Commission received detailed briefings from the commissioners and service providers who are involved and we will not repeat that information in detail here but it can be found online in the agenda papers for the meetings on 7 January, 4 February, 12 March and 8 April. **Instead we will draw out the main themes of our findings and the basis for our recommendations.**

6.1 Background and context to the review

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

6.2 Our review set out to look at online consultations but also how virtual consultations via smartphones with clinicians are set to transform how we interact with GPs in the future. The review also touched on the related issue of online access by patients to patient systems. Another element of this transformation is the growth of digital tools for symptom checking and self-management of health conditions which we have not touched on as this would require a separate review in itself.

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

6.4 At present London STPs have procured a range of online consultation solutions for online access to primary care. These lend themselves to a range of varying functionalities for the users of those systems. In the North East London STP area (now called the *East London Health and Care Partnership*) and comprising the 7 north east London CCGs, 57% of GP Practices were live

with online consultation solutions as of June 2019 and this is by far the highest in London. North Central London STP area by contrast is at just 4%[4].

The main drivers for online access are the various NHS Strategic Mandates and these include:

- 100% online consultation roll- out as a target in the *NHS Long Term Plan*;
- NHS Planning guidance that 100% of Practices offer online consultation solution by March 2020
- 100% of Practices are technically enabled with the *NHS App* by July 2019. (this was achieved in City and Hackney)
- The revised national *GP Contract* also requires all Practices to provide at least **25%** of appointments online by July 2019
- All Practices to offer video consultancy by April 2021
- All Practices offer electronic ordering of repeat prescriptions by April 2019.

6.5 The NHS in North East London is using four suppliers for Online Consultation systems: eConsult; Egton (part of EMIS); AskmyGP and ATMedics. Within NEL eConsult was the overall favourite however in Hackney it was Egton and in Newham they rolled out all four. Unlike in our neighbours City and Hackney has not mandated any one system allowing Practices to choose what is best for them. The GP Confederation has been contracted to manage the development work for this and to support the Practices.

6.6 At the ELHCP level, system plans are being developed to mobilise digital first primary care across the 7 CCGs. All practices are encouraged to provide some online consultation services by 2021. GP Federations in each area required to review the potential to improve and develop online consultation system and the service models supporting them. The target of 2018/19 was 30% of patients to be enabled for GP online services which was a challenge.

6.7 At the NEL level most of the digital focus has been on ensuring that all practices in Inner North East London are connected to the London Patient Record thus allowing them to see a range of patient level health and social care information. As part of a wider 'One London' INEL's shared record system will be connected to the 5 other STP areas in London. The other major initiative of ELHCP has been the *Discovery Project* linking data sets to improve population health. This is described in more detail in section 10.

6.8 Separately, ***The NHS App*** went live in ELHCP area on 13 May with connectivity across all Practices in City and Hackney and all using the EMIS platform. Nationally 4 platforms were procured to provide the service and EMIS totally dominates as the key platform provider. The NHS App allows patients to: *check symptoms, find out what to do when you need help urgently; book and mange appointments at your GP surgery, order repeat prescriptions, securely view your GP medical report, register to be an organ donor and choose how the NHS uses your data*. It can be easily downloaded and a rapid

[4] London Digital Transformation Team presentation to the Healthy London Partnership's Pan London Online Consultation Task and Finish Group on 26 June 2019

programme of connecting GP Practices to the app has taken place over this summer. The App has to link into a platform used by the GP Practice.

6.9 The number of registered users of the App across London remains very small but this will change with the roll out of a national marketing and communication campaign in autumn-winter 2019. You register for the App by either using a code provided to you by your GP Practice or by using your phone to photograph yourself and then your passport ID page to prove identity as part of the sign-up process. Currently if you experience difficult with the App you can still go to your GPs website and avail of Online Consultation.

6.10 For the patient these issues around providers, platforms and Apps are largely irrelevant. The challenge is simply whether the system works for them when they visit their own GPs website or try to start using the NHS App. The focus of this review therefore was to look at these issues from the perspective of the patient and how to ensure access (or suitable alternatives) for those who will struggle with the technology. It is also necessary to consider that *Access* is just part of the picture in Primary Care and it has to be balanced carefully with the two other key elements: *Quality of Care* and provision of sufficient *Resources*.

7. City and Hackney General Practice Development Programme

7.1 Locally, City and Hackney CCG via the City and Hackney GP Confederation is working on **General Practice Development Programme** which includes 10 "high impact actions" to release more time for care in General Practice. Their focus is on new communication methods for some consultations such as smart phone and email as well as improving continuity of care and convenience for the patient and reducing the clinical contact time. There are a plethora of patient management systems including G*P First, Patient First, Patient Online, Patient Partner* as well as the system for urgent care as part of the national *NHS 111* system and delivered in Hackney and east London by London Ambulance Service. We learned that as of 31 Oct 75,986 City and Hackney patients were enabled for one or more GP Online service and that to meet the 30% target a further 20,000 needed to be added by end of March 2019.

7.2 When looking at each offer it was necessary for the GP Confederation to consider how they met the following criteria:

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

7.3 Throughout the review we heard about the GP Confederation's work and they facilitated a site visit for us to Lower Clapton Practice to view the askmyGP system in operation. The Confederation told us that only 80% of practices in City & Hackney had engaged with digital systems up to the summer of 2019 and we noted their view that while Practices might sign up for a particular GP Online system for example this did not necessarily mean that they were maximising the opportunities being presented to them as part of the new system. This challenge in mobilising the roll out of digital primary care was echoed by the Healthy London Partnership. We note however that the creation of Primary Care Networks (PCNs) as part of the Neighbourhoods Development Programme will also see PCNs play an essential role in supporting practices and other partners to deliver a comprehensive digital offer for their patients and in integrating these services across a local area.

8 NHSE consultation on digital first and the LMC responses

8.1 NHSE London has been driving digital take up while local CCGs have often appeared somewhat less enthusiastic. Some have argued that CCGs have been caught on the back foot by the likes of companies like GP at Hand who have entered the market as disrupters and whose offer is examined in section 8. Initial frustration and annoyance about newcomers such as GP at Hand has had to be replaced, at the system level, by a more cautious approach and GP Practices have had to acknowledge that they have to rise to the challenge and that merely calling for GPAH to be more strictly regulated than they are or challenging their ability to secure premises is no longer viable. At the end of the day GP at Hand is another primary care provider and is bound by the same regulations as everyone one else.

8.2 Last summer NHSE launched a consultation[5] on the implication for of digital first primary care on the system of GP practice payments as a first step in trying to figure out how to safely integrate the new technology into primary care pathways whilst not unfairly destabilising the existing services. They stated that the outcome of this engagement would inform GP contract negotiations for 2019-2020 between NHS England and the General Practitioners Committee of the British Medical Association. We are awaiting the outcome of those negotiations.

8.3 This summer they have consulted[6] again this time on patient registration, funding and contracting rules. Because of the boom in out of area registrations (not only because of GP at Hand) they are specifically proposing that when the number of patients registering out-of-area reaches a certain size, it should trigger those patients to be automatically transferred to a new separate local practice list, that can be better connected with local Primary Care Networks and health and care services in their area. We await with interest the outcome of this consultation.

[5] https://www.engage.england.nhs.uk/survey/digital-first-primary-care/

[6] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

8.4 Regionally the organisation 'Londonwide LMCs' responded to NHSE's consultation[7] on how to implement greater digital first provision in general practice. They summarised their response as follows:

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

9. Digital solutions in City and Hackney Primary Care

9.1 Digital first developments in primary care in Hackney take place in the context of a system which is generally considered to be high performing, certainly compared to London comparators. There are 40 practices in C&H, the average list is 7681 and the average number of FTE GPs per practice is 4.5. Primary care in C&H is considered productive with 1.6m consultations per annum. Practices in Hackney perform well on all quality measures with the CCG ranked 1st or 2nd out of 194 in England. Unlike in many other CCGs areas C&H Practices do collaborate closely with each other and at scale and this has been achieved through the efforts of the GP Confederation. Through the Confederation the CCG invests in extra services from the Practices, last year to a value of £10.9m. Part of the funding for the local trials on electronic consultations (£1.5m) had been secured by the CCG from the national Estate and Technology Transformation Fund.

9.2 Hackney faces the same pressures as all CCGs in the UK namely:

- A shift of activity from hospitals (secondary care) to primary care
- People living longer with more long term conditions, thus creating increasing complexity
- Changing patient expectations
- In addition C&H patients have a higher consultation rate at 5 per year than the STP average of 4 per year.

Digital solutions are therefore vital and in terms of online consultation, the two main platforms initially were E-Consult and askmyGP with Egton emerging

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

since our review started as the preferred platform provider. These are detailed further down.

9.3 We also learned from the Confederation about some other local initiatives. ***Patient Partner*** is a software that integrates with a practice's existing telephone system and the EMIS appointment system, to enable patients to book, cancel or check an existing appointment via the telephone, 24/7, without speaking to the reception staff. 5 practices were offering it and were very keen on it as it helps patients who do not wish to access the practice via a computer/website/online route and it was very easy to use.

9.4 We heard from Dr Gopal Mehta at Richmond Rd Medical Centre about the system which he had developed and which was being adopted widely in the borough. This is called ***Patient First*** and it is an access/appointments system which combines the use of digital initiatives, reception navigation and collaborative triaging. The model enables patients to arrange telephone appointments with a GP or member of the administrative team 24 hours in advance without having to call the surgery. On the day the telephone appointment has been booked, the patient receives a call-back within 15 minutes of their chosen time slot from the healthcare professional with whom they have pre-booked who will discuss the patient's health concern and manage their needs accordingly (i.e. offer face to face appointment/complete referral/order investigation etc.). If patients aren't able to access online services they can call the main surgery telephone number at 8am and ask to make a telephone appointment with the GP; who will then call the patient back within a 3 hour window.

9.5 'Reception Navigation' is the other key element of Patient First and admin teams are trained to screen all calls that have been booked online, ensure they have been booked for the appropriate healthcare professional, and re-navigate them if required. They also navigate the patients who call in to the surgery to ensure they are directed to the most appropriate healthcare professional for their needs. As part of navigation, Patient First also incorporates non-clinical members of the team in delivery of QOF/long-term conditions outcomes (i.e. booking in the relevant health reviews if required) to ensure this process becomes a core element of initial navigation and every patient contact counts. We learnt that 8 Practices had implemented it and 7 more had expressed interest.

9.6 We also learned about the ***City & Hackney Health App/Directory of Services*** This piece of work began under the banner of "demand management" and was initially funded by the CCG, but this has now grown and is a central plank of the work being done under the Neighbourhood Model. The plan is to have a single live Directory of Services and supporting App so that residents, patients and professionals all know what is available and where across health, social care and VCS services.

10. *GP at Hand*

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

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

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

10.4 The service has had a number of teething problems. Earlier in the year Babylon was de-listed from the 'NHS Apps' library with NHS Digital claiming they didn't want the promotion of the private services on an NHS platform, however Babylon provides separate private and NHS services and clearly markets itself as providing NHS GP services. The company also took legal action against the CQC regarding what they perceived to be an unfair rating. They have since received a 'Good'[8] rating. A CCG in Birmingham initially blocked their expansion plans in that city citing arguments about patient safety but this has been over ruled and they are now providing services there.

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

10.6 Critics have pointed out a number of shortcomings however. They argue that GP at Hand's stringent eligibility criteria are unfair i.e. that they essentially "cherry pick" healthy patients. GP at Hand deny this. Patients who sign up to

[8] CQC inspection report on GP at Hand home practice May 2019

use the service are de-registered from their current GP practice and the consequences of this aren't always immediately apparent and GP at Hand has been heavily criticised for not doing enough to make these consequences clearer to patients. The current number of locations for face to face consultations is limited which means that patients often want to re-register with their previous GP practice again; this adds to practice churn which is already high in Hackney, for example, and further adds to Practice workload. Some argue that a lack of new locations for face to face consultations might lead to patients being referred to A&Es for example, thus putting undue pressure on local hospital services and on other CCG budgets outside its home CCG. We learned from Tower Hamlets GPs that a key problem for GP at Hand was where do patients go who require follow up appointments to have their dressings changed. GPAH didn't have the resource to have a nurse practitioner in each hub and this caused delays and frustrations, they added. Another key concern about GPAH was about their GPs being more risk averse (because the patients are unfamiliar to them) and as a consequence more likely to over prescribe e.g. anti biotics. On the other hand GP at Hand recently was rated by the CQC as 'Good' and the independent evaluation report on them (see 8.17) found very high levels of patient satisfaction.

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

10.8 When this issue first arose in 2018 City & Hackney CCG pointed out that there was an opportunity for GP Practices in Hackney to match or better the GP at Hand offer because City and Hackney already offers same day access. They gave examples of the CCG 'Duty Doctor' contract via Primary Care Hubs (open 8.00 am-8.00pm on Saturday and Sunday), or Hubs which are open from 6.30 pm to 8.00 pm. They also argue all Practices now offer some kind of extended opening either through locally or nationally commissioned services. They also stated that patients can message their Practices directly or consult with their Practice online. The Chair of City and Hackney CCG took exception to the analysis on patient data which GP at Hand presented to us stating that practices always get 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. Both agreed that the national Carr-Hill formula (governing funding allocations to GP Practices) was overdue a revision and this might resolve some of these issue.

10.9 City and Hackney Public Health Intelligence Team has been monitoring quarterly the local impact on our GP Practices of GP at Hand for over a year now. We considered the January and April data during our evidence gathering and the key points were:

- Continued rise in the number of patients at GP at Hand from 2500 in July 2017 to 48,935 in April 2019 and **57,248** in July 2019.
- As of July, 2863 patients are from Hackney and 5238 from Tower Hamlets. City has proportionately the highest number of residents registered with GP at Hand
- As of July 0.9% of GP registered Hackney residents were registered with them. 3.5% for City.
- While 42% of patients registered with GPs in City and Hackney are aged 20-39 GP at Hand has 84% in this group. Nationally there are only 28% of patients in this age group.
- Only 9% of patients registered at GP at Hand are Hammersmith & Fulham residents

Appendix One contains the latest quarterly update in full.

10.10 As a consequence of *GP at Hand* Hammersmith & Fulham CCG had a sudden and immediate in-year budget deficit because the service was significantly increasing H&F's patient population without any equivalent increase in their commissioning budget. As our Local Medical Committee pointed out NHS GP Practices rely on risk pooling and the cross subsidy that the capitation free for younger fitter patients (who consult less often) provides to care for the more complex patients and the elderly. Operating models like GP at Hand, they argue, threatens the system and risks diverting resources away from those who need them most to those who need them least.

10.11 Hammersmith and Fulham CCG having taken a significant financial hit (which had to be remedied by a London wide bail out), got together with NHSE to commission Ipsos MORI and York Health Economics Consortium to carry out a detailed '**Evaluation of Babylon GP at Hand**[9]'. Their extensive report, published in May, made a number of recommendations covering: *how the GP at Hand model works and is used by patients; about the patient characteristics; about the GP at Hand workforce characteristics; patient experience; deregistered patients; workforce experience; GP at Hand outcomes and the impact on the wider system.* That conclusions on the latter are attached at **Appendix Two**.

10.12 The Hammersmith and Fulham Primary Care Commissioning Committee in considering their response to the report at their 16 July 2019 meeting headlined the conclusions of the evaluation report as follows[10]:

- The sustained growth in list size shows an appetite for 'something' that was not being met by traditional general practice
- Satisfaction is high for most Babylon GP at Hand patients and more so than a matched sample of other patients with their own practices
- These patients have chosen a model on the basis of access and convenience; i.e. 24 hours a day within 2 hours

[9] https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf

[10] https://www.hammersmithfulhamccg.nhs.uk/media/160021/PCCC-16-July-Item-7-Coversheet-Babylon-GP-at-hand-Evaluation-july-2019.pdf

- GPs working for Babylon GP at Hand stated a consistent set of motivating factors for doing so; primarily they were attracted by the potential of a better work-life balance
- These GPs were also positive about the support and development opportunities provided

H&F CGG's paper responding to the valuation then concluded[11]:

The evaluation was not able to fully address whether the current BGPaH model is affordable and sustainable. To sustain the enhanced access benefits of the BGPaH model requires considerable numbers of GPs and an embedded IT infrastructure. Even if a system is sustainable and affordable, the evaluation concludes that this may only be achievable alongside on-going health system reform, and the scale of the redesign needed 'should not be underestimated'. It should be noted that the outcomes of the NHSE consultation currently underway, 'DigitalFirst' (June 2019) may have a significant impact on the way that the practice contract arrangements work in the future. The CCG will continue to work with both the practice and the Primary Care Network to monitor its impact and ensure evolution and development of services to the registered patients.

10.13 Our main take away from this interesting and detailed analysis was that for the digital first model to be sustainable across the whole system it requires a considerably greater number of GPs than we have currently have and we are currently, of course, in the midst of a crisis in GP recruitment and retention. On the conclusion that GP at Hand would have minimal impact on any single practice, we would argue that the system impact however remains very significant indeed as NHSEL found out when it had to backfill the gap in Hammersmith and Fulham's budget caused by the sudden arrival of GP at Hand. In short, the current funding system is no longer fit for purpose.

10.14 Locally, City and Hackney GP practices have received complaints about the de-registering of their patients when they didn't understand that this was a consequence of transferring to GP at Hand. In response to this, one local Practice communicated with its existing patients to inform them of the sign up process and to voice their concern. Similarly, Tower Hamlets CCG published leaflets warning patients about the implications of de-registration. There are limitations on these actions however because such information campaigns unless carefully worded will contravene the strict rules about Patient Choice. We learned about a Hackney GP who wrote an online letter warning his patients about the risks of registering with digital services and received an immediate response from GP-at Hand calling for the letter to be moderated.

10.15 Both City and Hackney and Tower Hamlets LMCs argued strongly to us that an essential part of excellent care is working in tight local teams who adhere to well-prepared, locally shard, care guidelines and referral pathways and that all of this is at risk were the GP at Hand model to be expanded. How can a

[11] https://www.hammersmithfulhamccg.nhs.uk/media/160024/PCCC-16-July-Item-7-GP-at-hand-Evaluation-PCCC-paper-jul-2019.pdf

remote GP practice hope to be able to work collaboratively and within local guidelines is their key question.

10.16 The LMC representatives we heard from underlined that their issue is not with digital approaches in themselves but with these not being a universal offer to all patients and practices. The NHS was founded on the principle of health care equality for all citizens they reminded us. They raised concerns about these new systems not being integrated with the GP clinical system and there being a risk that important information would not be recorded in a patient's health record. Likewise they cautioned that by increasing availability you also increase demand and this would only be successful if the increase in demand was met by an increase in self-management. They also had concerns that the system for identifying vulnerable patients was not robust enough and so those who are not digitally savvy would be even more likely to not receive the same level of care. They reiterated that digital solutions can't be add-on and must be part of a 'whole system' approach and they pointed out that repeated inquiries following cases of harm to a vulnerable patient ALL raise the issue of lack of communication between different agencies. For this reason they argue digital transformation must address equalities aspects and not contribute to a deterioration of services to the wider public.

10.17 City and Hackney CCG raised a number of key questions which GP at Hand and similar providers must address, namely:

- How can GP at Hand, with patients from all over, replicate the local system in City and Hackney for Consultant Advice Services[12]which obviate the need for a referral?
- How could the work of such a practice be informed by locally agreed pathways of care (of which there are over 50 in C&H) when they are remote?
- What is GP at Hand's patient churn and what are the implications of this?
- How can having a dispersed list contribute to the wider drive in the NHS for 'Place Based Commissioning' e.g. our own Neighbourhood Model
- What will the other impacts be on the wider healthcare system?

As GP at Hand and its imitators expand their geographical reach these issues will become more pronounced is the warning from local CCGs.

We now look at the 3 main platforms for online triage in the North East London STP area:

11. Ask My GP

11.1 One of the more innovative national approaches to digital first primary care is askmyGP provided by the company GP Access Ltd. We corresponded with the founder Dr Harry Longman, based in Leeds, and heard from their Senior Training Partner at committee.

[12] Arrangements where hospital Consultants provide advice to GPs

11.2 We also observed this system in operation at Lower Clapton Practice. Under this system askmyGP is dominant on the Practice's home page and it immediately offers patients electronic triage to progress their enquiry. Face to face appointments are no longer booked over the phone at 8.00 am in the old style and instead the slots are made available on the website the day before and patients can book initially a telephone slot with a GP for the following morning. GPs return the call if face to face is required and the patient is called in otherwise the matter is dealt with online or the patient is referred to a nurse or other practitioner at the practice, as appropriate. Very little is purely message managed and the system allows for a mix of approaches. The initial response was polarised with the young preferring it and the old uncomfortable with the change. They still allow vulnerable patients to come into the surgery and make appointments in the old way. At the time of our evidence gathering 6 of the 7 practices who had used askmyGP switched to Egton but Lower Clapton decided to stick with it so as not to confuse their patients. The young GP partner we met was a great champion for the new digital first approach.

11.3 GP Access, which provides askmyGP was incorporated in October 2011 and was originally devoted to the introduction of telephone triage into GP surgeries. Their view has been that clinical judgment is at the heart of the triage process, consequently they're providing a clinical triage system operated via a secure portal and not just an appointments system and they do not use artificial intelligence (AI) software that diverts patients. Online booking has an immediate attraction, they argue, but it carries the significant disadvantage that it is another way for unfiltered demand to get an appointment, often resulting in patients with more serious needs unable to get an appointment and a high proportion of DNAs. Equally, they proudly state they are not a software vendor and there is no software for Practices to download. In addition, the latest version goes well beyond simple triage facilitated by modern technology as they are now a complete workflow solution for the management of patient need, regardless of list size, demographic or practice structure. They are fully compliant with all regulatory standards and GP indemnity is unaffected. In all, they support consistent triage and clinical decisions via a single workflow which is accessible via any web browser.

11.4 Because they work with existing practices bringing the benefits of digital first standards, they argue that their approach does not destabilise systems. Their approach does not interfere with the operation of clinics, for example, and it allows Practices to stand back, reassess how they operate and embrace a new way of working. Their approach means that the online requests were not additional activity, but activity displaced from telephone and walk-ins. The segmentation of demand meant that the response was more appropriate to the needs inherent in each request.

11.5 GP Access argue that while the pressure to use online services is coming from Government, the reality is that it can actually make the lives of patients and GPs better if it is carefully adopted. But online access of itself will change nothing, they argue, and only if demand is managed through a workflow approach and that approach is supported by the segmentation of demand will the full benefit to patients and practices be realised.

12. Egton

12.1 We also looked closely at the offer by Egton which during the course of our evidence gathering appeared to become the most popular system among Hackney GPs. It is also widely adopted in Newham and the case studies we heard about were from there e.g. Stratford Village Surgery.

12.2 Egton Medical Information Systems (EMIS) was founded by two clinicians in Yorkshire in the 80s to give clinicians access to complete and shared medical records, no matter where patients present for care. What followed was the development of a clinical IT system and a plan to make more information instantly available at the point of care.

12.3 EMIS then went on to create 'Patient Access' which is a website and mobile app which gives the patient access to a range of GP services online, as well as access to their health records. It can be used to book GP appointments, order repeat prescriptions and access medical records and is one of the most widely used platforms nationally for these basic functions.

12.4 We heard from Egton's Services Development Manager about their online triage system. This is a web based platform operated from a cloud and there is no downloading of software and crucially no patient data is held by them. Their system starts with an electronic form which the patient fills in. The two entry points are online or via an EMIS web app and the patient is signposted appropriately. They described how for example the Practices they worked with in Newham had reduced their number of Do Not Attends (DNAs) by 50% and only 25% of those who completed forms i.e. used the system, needed to see a GP in the end. Waiting times went down from 4 weeks to 1 or 2 days. A case study of the GP Practices using their system produced the following results:

Case study – headline results

- *Approximately 75% of patients who fill in the forms do not need a physical appointment with the GP.*
- *33% reduction in daily face-to-face consultations.*
- *Average waiting times down from 2 weeks to 1-2 days.*
- *50% reduction in DNA rates in the first month alone.*
- *20% reduction in phone calls to the surgery.*
- *22% increase in resolved patient requests per day,*
- *For the first time, the surgery is able to meet 100% of enquiries on the day they're made.*
- *30 patient queries dealt with in a session which previously dealt with 18 face-to-face consultations.*
- *Some online forms are resolved within minutes and all are complete within 48 hours.*

12.5 On the issue of workloads and staff and patient satisfaction, case studies of their practices showed that GP workloads were more manageable because unnecessary appointments had been reduced and staff were now only seeing patients that needed to come into the practice. Receptionists were happier

with the system because they no longer had to turn patients away. They could send patients a direct link to the Online Triage system and advise them that the GP would respond to their request. Patients were, in some cases, initially unhappy with the system because they were used to being able to get an appointment straight away, however, they were now less likely to be told there were no appointments and so overall satisfaction rates had increased.

12.6 When challenged on equalities and access both Egton and askmyGP detailed how those experiencing difficulty with digital access would be fully supported and vulnerable patients would be carefully flagged in the system. They stated that their practices still allow walk-ins and they help patients to get appointments and use the system so they would be treated the same as those who successfully used it online. Egton gave an example of a practice of theirs in Plaistow, in a highly diverse and economically deprived area, where they already had 80% of patients using online in some way. We continue to have concerns about the initial form filling aspect, particularly of Egton's system, as this constitutes a barrier for those who are not fully literate or who do not have English as a first language.

13. eConsult

13.1 The GP Confederation told us about the local use of the eConsult platform. This is a web based patient triage platform, developed by the Hurley Group of GP Practices, who also run the Allerton Road surgery in Hackney. eConsult provides for a consistent online offering for the practice websites (via GP Web Solutions), which allows them to retain their existing practice website address. Alternatively a practice can create a link to eConsult from their existing practice website. Patients use eConsult to ask for advice about their condition online. Patients can self- check their symptoms and receive on the spot medical advice 24/7. This helps to relieve pressure on GPs by giving patients access to round the clock support and alternative treatment providers. They claim it allows patients to gain better access to instant medical care and advice while empowering GPs to run their practices more efficiently. Their App is licenced to a surgery and the cost is proportional to the number of registered patients. They provide personalised training on the system and support with marketing and it bolts on to the exiting Practice website without the need to invest in any software. The E-Consult banner is required to be highly visible on the home page of the Practice

13.2 We heard at our first session that 13 practices signed up for the new one year trial, ten of which were renewals and three of which were new adopters of the platform. Practices had mixed views about whether this actually helped them or patients. Some practices really rated this platform, others said that it is "clunky" and required patients to input a lot of information about their need and so there was a high rate of patients abandoning the eConsult process. The GP Confederation concluded that like most innovations, the Practice has to really own the concept and support it and the patients in order to get the most out of it. The GP Confed was working with practices to drive up the use of eConsult.

14. The NHS App

14.1 For some years now most people who wanted to have been able to achieve a basic level on online access to their GP Practices via the practice's website. GP Practices have adopted systems such as EMIS' Patient Access or Evergreen Life to provide this access for their patients. As the technology developed we are now moving towards online chats and video consultations, the latter pushed by providers such as GP at Hand. There are also a number of national online Pharmacists such as Pharmacy2U who connect with your GP to provide repeat prescriptions to patients which are then sent out by mail making it much easier for busy patients to get their medication. Separately to this NHS England has been trying to find a way to draw these various stands together and The NHS App is one way they have gone about it.

14.2 Nationally 4 platforms were procured by NHS England to provide the NHS App and EMIS totally dominated as the key platform provider. It went live in North East London on 13 May with connectivity across all 42 Practices in City and Hackney, all using the EMIS platform to connect with the App.

14.3 The NHS App allows patients to:

- check symptoms
- find out what to do when you need help urgently
- book and mange appointments at your GP surgery
- order repeat prescriptions
- securely view your GP medical report
- register to be an organ donor
- choose how the NHS uses your data.

It can be easily downloaded and a rapid programme of connecting GP Practices to the app has taken place over this summer.

14.4 The number of registered users of the App across London remains very small but NHSE is confident this will change rapidly with the roll out of a national marketing and communication campaign in autumn-winter 2019. You register for the App by either using a code provided to you by your GP Practice or by using your phone to photograph yourself and then your passport ID page to prove identity as part of the sign-up process. Currently if you experience difficult with the App you can still go to your GPs website and avail of Online Consultation.

14.5 We heard directly from the Leeds based national Programme Delivery team for the NHS App at NHS England. They clarified that the first version of the App will have no online triage at the front end. They began by working with E-Consult but would not be locking any providers out. It would be a modular system whereby various pieces would be added on as they become ready. They were also working on electronic referral systems and enhancements such as electronic prescriptions but the focus was very much on the primary

care. 15m people had already signed up for the App and so there was another 40m to go. The ambition for the NHS Log-In (required for the App) was that once signed up an individual would use it throughout their life. They were also working with social care providers on e-referrals. This was not about putting other offers out of business and they were not replicating other system, instead the NHS App would function as part of what they hoped would be a vibrant market.

14.6 We learned how they were working on a number of approaches e.g. 'Empower the Person', to target groups such as those with low educational background or those who are homeless and who might therefore be digitally excluded. They were working on ensuring that patients could use iPads at GP Practices or in Libraries for example and there were also a system for proxy access, for example, for the elderly living at home, whereby a family member of carer could log-on on their behalf. There were similar plans for accommodating parents and guardians of children. You had to be over 16 to use the App and 13-16 years olds must have ID verified at their GP Practice. There were significant safeguarding issues for children's access which we were reassured were being taken on board.

14.7 A key challenge in developing the App was to standardise the naming of all clinical interactions and appointment types so that the system will work efficiently. Pharmacists were very important to the App they said and they were working with them on using an iterative approach on the business change which will be needed. They also hoped to develop a similar triage system for pharmacists.

14.8 The central point of Digital Frist they stressed was that when appointments were freed up by use of digital methods this released resources to provide more support to those who cannot easily use those digital methods. General Practice was not currently coping at all well with its workloads, the developers said, and part of the answer was transforming the triage systems. They also stated that the role of the GP Receptionist would not be lost but rather the role would change over time.

15. Focus Group with Hackney Residents

15.1 As well as hearing from designers and commissioners of 'digital first' systems we also decided to hear directly the views of some local residents. We did this via the Council's *Hackney Matters* engagement panel and we are grateful to the Hackney Matters team for their support in setting this up. Panel members who are all Hackney residents and are representative of the population are invited to express interest in the subject under consideration and are then usually invited to take part in online moderated discussions. In our case however we were able to invite the panel members in for a Focus Group. We had 6 participants joining members' for the discussion.

15.2 We explored the following questions with them:

- How much digital interaction you've had with your local GP if any

- Whether or not you'd switch GP to another who provided more services digitally
- Your views on the GP at Hand, if you're aware of it. (they promise a video consultation via a smartphone app within 2 hours but means you would have to de-register from your existing GP)
- Your views on how your digital GP is linked up with local services and any concerns you might have here on use of your data
- Whether you'd be comfortable with video consultations and in what circumstances
- What you need from your local GP Practice to make it easier for you and your family to interact with it

15.3 There were obviously a range of views depending on how familiar people were but the majority were very welcoming of digital first approaches and wished to embrace them. Appendix Three lists comments recorded in response to the initial questions used to generate discussion.

15.4 A number of panel members complained about the difficulty in getting electronic access and it was obvious that they had needed greater support to register, while others were already using the 'Patient Access' app and ordering repeat prescriptions online. Some were apprehensive that moves to digital might mean fewer face to face channels and that some access might disappear. There were criticisms of those whom they felt abused the system by going to GPs with minor ailments which could be resolved elsewhere. There was a general consensus in the group that the trade-off between confidentiality and convenience was worthwhile in that allowing others to access records to enable more efficient use of the system was worth it. Similar views were expressed about the potential for video consultations which were generally welcomed. There was an acknowledgement that it would help manage workloads but was not appropriate in all situations as there would always be a need for some face-to-face appointments and physical examinations. It would depend on the nature of the medical problem concerned and the quality of the phone reception was vital they said.

15.5 Panel Members put a premium on being able to see the same doctor each time or at least most of the time. Some had heard of GP at Hand but when explained to them all said they would be wary of being de-registered by their local Practice if they used GP at Hand and all agreed that this fact needed to be communicated much more clearly to patients. There was an acceptance that GP at Hand would be more attractive to and useful for young people. There was concerns that those with special needs for example could not be expected to effectively use video phone consultations. Panel Members mentioned how some of their surgeries have Advocates to assist for example with those who do not speak English and there was a view that similar support needed to be provided to encourage greater take-up of digital approaches.

AREAS FOR ACTION

We decided to focus our recommendations in four key areas:

- Driving Up Access
- Improve Communications
- Alignment with Pharmacy
- Driving up 'digital first' at the NEL level

As well as making some general conclusions in section 11 which we hope will inform progress in this area.

16. Driving Up Access

16.1 Our main finding was that there is now an urgent need for a streamlined gateway process for both Online Consultation and for use of the NHS App for all local GPs, one that is accessible and which works better. While we noted the efforts at ELHCP level on enabling online consultations and on Patient Access to Information and driving up the sharing of information, the links with individual efforts at CCG level did not appear sufficiently strong to give the momentum that is needed here.

16.2 Locally we learned about the work of *IT Enabler Group* that has been operating within Integrated Commissioning in City and Hackney for just over three years. Its focus was more on secondary care than primary care but they were working on improving care pathways through the whole system. The first stage of their work had been concentrated on all partners maintaining consistent digital records and the second stage was focused on better sharing of these records e.g. between a GP and secondary care providers. The main concern about GP at Hand from the Group was that it would take patients out of the local systems of support and patients didn't fully grasp this nor was it made sufficiently clear in the publicity. The next phases of their work will go beyond record sharing to such things as 'alerts' and patients having access to their own records. Because of the way data was stored avoiding multiple portals for things like booking appointments was difficult. The aim was to have a single digital identify for people across health and social care and to tie all services to this. We noted that this was partially achieved with the 'Co-ordinate My Care' the pan London personalised care plan for end of life/frail patients typically aged 75 and which we learned about during our own scrutiny review on 'End of Life Care'.

16.3 The IT Enabler Group was also proceeding with work on electronic test results management, electronic referrals, electronic referrals to a social prescribing hub, advanced patient analytics, a Skype pilot for managing appointments of young people with diabetes and digital therapy such as online Cognitive Behavioural Therapy including a Mindfulness App. The CCG drew our attention also to one notable challenge on the records work namely that GP Practices currently do not have the resources to remove all Third Party References from current patient records which would be a requirement before

access to them could be widened. This would be a significant administrative burden.

Recommendation One
The **ELHCP/CCG/GP Confederation** is requested to set out the **strategy and timeline** for ensuring that all City and Hackney GP Practices are seeking to drive up access to digital consultation including The NHS App and what specific measures are being deployed to support patients who are still reluctant to use digital channels or who will be unable to do so.

16.4 The key to driving up access of course is to have more direct support for those cohorts who are not adept with technology. These include but are not limed to some elderly people, the homeless, those who are financially and therefore digitally excluded and those who had a difficult educational background and so may be struggling with literacy and or using technology.

16.5 There are some disadvantaged groups however where the promise of digital might be liberating in some ways for example the house bound and this also needs to be emphasised. This is not just physically disabled or frail elderly but those with mental health issues e.g. agoraphobia, anxiety etc. Investment here would pay off as more people would eventually become digitally enabled and fewer would insist on face to face interactions every time. It was important to note that the elderly and those with Long Term Conditions will always require a higher proportion of face to face interactions, so for them digital is not a replacement but an enhancement.

Recommendation Two
The ELHCP/CCG/GP Confederation is requested to set out what is being done to **encourage patients** who are having difficulty to register for both online consultation and to sign up for the NHS App and what **extra support** the Confederation can give individual Practices to in order to fulfil this strategy. This might include training and mentoring of Practice staff as well as practical on-site support to patients.

16.6 Being digitally adept is key and achieving confidence in using online services will open up opportunities for many. We would urge the GP Confederation locally and the ELHCP in the region to develop plans for how they will work with for example libraries and VCS groups who work with the elderly to provide support and training in using digital tools. Is there potential to work more closely with groups like Hackney Stream for example who provide practical assistance to elderly people on getting digitally confident. Use of health services increases with age and therefore spending more on supporting and mentoring the elderly to engage with digital channels will pay off in the long term.

Recommendation Three
GP Confederation is requested to work with VCS groups such as Hackney Stream and Age UK East London on **encouraging those elderly people** who have the ability to get more confident in engaging digitally with services.

17. Improve Communications

17.1 The challenge of GP at Hand in Tower Hamlets was confronted there by the production of leaflets which were widely distributed locally to explain the consequences of de-registration. As Hackney residents use of services such as GP at Hand continues to increase we suggest that City and Hackney CCG might consider a similar approach, noting that it has to be within the confines of 'Patient Choice' rules.

Recommendation Four
C&H CCG is requested to consider replicating Tower Hamlets CCG's **information leaflets** about the consequences for the individual of being de-registered from your local practice if you decide to switch to GP at Hand for example. These need to be distributed widely at GP Practices and other settings.

17.2 It was interesting to note that much of the concern about digital primary care comes from campaigners, e.g. Hackney Keep Our NHS Public (who made a submission to the review)[13] who have fears about any developments which appear to reduce face to face contacts or alter current arrangements and care pathways. They have concerns about surveillance and data capture by corporates, risk of destabilisation from a private sector provider, misleading advertising and safety concerns. There are concerns about staffing with fears that GP Receptionist posts will be lost and some argue that technology is being used by those in charge of the NHS to replace staff and the level of human face to face contact. Many of these fears are tied up with wider issues in society about the rapid pace of automation and of job displacement. We would argue that the NHS needs to be much more on the front foot with its communication strategies if it is to allay these legitimate concerns. It must point out the benefits and promote the many advantages of a digital first approach overall.

Recommendation Five
The **ELHCP** is requested to ensure that its constituent local NHS bodies co-operate on a **communications campaign** to proactively promote the benefits of digital first approaches.

18. Alignment with Pharmacy

18.1 The LMC pointed out to us that all the current digital offers that are significantly reliant on a GP consultation have a major limitation, which is the declining number of GPs. To upscale any of these digital models there needs to be a digital system that allows minor or self-limiting illness which only requires advice and Over the Counter treatments to be safely diagnosed and managed without the need for a direct GP appointment, so typically at a local pharmacy. There is also a need to look at the pathways for managing long term conditions and how pharmacies could assist with this. Digital innovations

[13] Hackney KONP submission to 12 March 2019 mtg

can of course also assist patients in self-management plans by enabling them to safely step up or step down treatment and again this would take further pressure off the need for direct contact with GPs. We note that whenever transformation of primary care is discussed by the NHS, they always cite the need for a more significant role for community pharmacies. There is a financial imperative here as pharmacy consultations which divert patients from A&E or GPs will generate significant savings. To this end NHS England has been funding local *Minor Ailment Schemes* and *Medicines Optimisation Services*, in Hackney these were branded under the name '*Pharmacy First'*. However, NHSE recently proposed to cut these schemes, deeming them inefficient and out of date and the C&H CCG has been engaged in a struggle with NHSEL (which the Commission has supported) to at least secure funding for suitable replacements. This is an example of where the rhetoric about the importance of 'Pharmacy First' does not match the action and the Commission continues to support the CCG and LMC in lobbying of NHSE London to maintain support for 'Pharmacy First'.

Recommendation Six
The convenience of online ordering of repeat prescriptions either locally or by mail has proven very popular and in itself is a driver of change in encouraging the take-up of digital approaches. The **GP Confederation** is requested to ensure that the **Local Pharmaceutical Committee is fully included** in the work to roll-out more digital consultations locally.

19. Driving Digital first at ELHCP level

19.1 Having spoken to commissioners and providers at the local sub regional and national level our last set of recommendations are aimed at encouraging system level change at the North East London level or the ELHCP as our local STP is called. While our local CCG has been proactive in the issue by commissioning our local GP Confederation to drive progress here the bulk of Transformation work and funding is being driven at the ELHCP level. There is a duty to respond at the ELHCP level to the requirements in the *NHS Long Term Plan* and this will impact on all our residents.

19.2 One area which we would suggest merits some attention is the issue of whether having some GP triage delivered at a sub-regional level might generate some savings and/or make the system more effective. Noting that Tower Hamlets CCG, having taken over from Waltham Forest as NHSE's "accelerator" for digital first, is now trialling a hub based approach to online consultation, we would ask ELHCP to report back on whether having digital first GP triage delivered at a more sub regional level would improve the overall effectiveness and responsiveness of the system**.** We learnt of GPs concerns that they feel they know their patients best and patients are loyal to a 'family doctor'. On the other hand there is continued pressure for greater access arising from a rising population together with rapidly falling numbers of GPs. The Commission asks therefore whether part of the initial online triage could be better be done at a sub-regional or hub level and whether local delivery, at all times and in all circumstances, is still the preferred model Doesn't the

existence of GPAH demonstrate that for a younger cohort 'the family doctor' concept no longer holds the sway that it once did and that it is not a reality for most people in London. We noted that for sub regional triage to work the GPs involved would have to be enabled to read all patient notes across the STP patch. Currently for example with 'NHS 111' services this is not the case.

Recommendation Seven
The issue of how you meet different patient priorities within a single GP primary care system is a difficult one. The Commission requests **ELHCP** to report back on whether patients could be given a **choice of online triage** at a neighbourhood level e.g with a familiar GP or a local GP or for those who prioritise speedy responses over retaining the personal link to have some online triage delivered at a sub-regional level, similar to NHS 111. The Commission would be interested to hear about how this issue will be addressed in the context of the requirements of the NHS Long Term Plan.

19.3 Primary Care of course does not exist in isolation and is inextricably tied up with secondary and tertiary care. In the time available to use we could not look at the parallel changes taking place in driving digital first in secondary care. We noted however the progress being made the IT Enabler Group of our Integrated Commissioning Board and we look forward to hearing how their work will streamline digital pathways more from primary though to secondary care.

Recommendation Eight
The work of City and Hackney's IT Enabler Group in Integrated Commissioning has been very much focused on secondary care and patient records. **IT Enabler Group** of ICB is requested to detail how they intend to give greater focus to driving up access to digital primary care and align this work with their efforts on digital interactivity in secondary care e.g. hospital follow-up appointments at Barts via video calls. They are requested to detail what current planning there has been on the **streamlining of digital pathways from primary through to secondary care**.

19.4 We noted in our conversations with GPs that having time to provide leadership and co-ordination at CCG and now additionally at STP level is a major challenge for front line GPs. Our main observation about the mobilisation of digital first platforms across NEL is just how fragmented and piece-meal it has been. While other boroughs' CCGs have taken a much more prescriptive approach about what systems or platforms their GP practices should use, City and Hackney has gone for a more laissez faire approach. This has both advantages and disadvantages and we are unconvinced that the speed of progress which is needed here, to respond to system disrupters such as GP at Hand, can be achieved without more dedicated and coordinated support at the level of clinical leadership.

Recommendation Nine
ELHCP is requested to report on how it is providing both **Clinical and Managerial leadership and coordination on this across the ELHCP area**. Is there sufficient resource for the GPs who are Digital Leads in each of the 3 CCG group areas (BHR,WEL,C&H) to drive the Digital First agenda in order to share knowledge and learning and how closely are they working with IT Steering Groups in each of the 7 CCGs.

19.5 Finally, one area where we look forward to hearing about progress is with the Online Registration project.

Recommendation Ten
The **Chief Clinical Information Officers** in the 3 group CCG areas to provide updates to scrutiny on the work being done on the **Online Registration project across North East London** which would allow patients to register at any practice

20. Aligning with Digital First approaches in Secondary Care

20.1 Accessing your GP via digital channels is just one part of a wider transformation of health and social care which is now taking place. Digital innovations are also impacting on access to both secondary care and to social care with digital transformation continuing through the care pathway.

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

20.3 Barts Health NHS Trust has been exploring the use of video consultations via Skype, and the impact on patient attendance rates, patient satisfaction and efficiency savings. Last year the Health Foundation awarded Barts Health £3.5 million from its *Scaling up Improvement* programme to take Newham Hospital's previous success in this area and mainstream it. That hospital (part of Barts Health) had cut the number of missed diabetes appointments from 30-50% to just 11-13%. From this project Barts Health has developed significant expertise in the area and have produced standard operating procedures, information governance and technical guidance documents, and protocols for setting up and running virtual clinics.

21. Planning for Digital at the ELHCP level

21.1 We learned from ELHCP about '**Discovery East London'** which is a clinical partnership programme, first established in 2016, to create a linked dataset of real-time health records across five boroughs: City of London, Hackney, Newham, Tower Hamlets and Waltham Forest. The initiative was designed to share patient records seamlessly, improving the quality of the care experience across an area that has 20 per cent patient turnover each year, and a high rate of hospital-based care needs. Discovery also provides a way to understand the wider population health patterns in some of the most deprived parts of the country.

21.2 We learned that 95% of GPs in the five boroughs have now signed-up to the scheme, covering 1.2 million patients. GP records can be seen by staff in mental health services and hospitals. Doctors and other clinicians, can see summarised records of medications, diagnosis, investigations and other key information. Tower Hamlets is piloting data sharing with approved pharmacies. Clinical performance against chronic disease indicators is now amongst the best in the country.

21.3 We also learned about the NEL wide plans to introduce digital technology to allow doctors and healthcare professionals to provide more care in local communities, something that they hope will also reduce the pressure on hospitals. They are also looking at digital devices, such as those that can monitor patients' heart via a smartphone, which would enable a patient to care for themselves in their own home yet remain in constant touch with expert help and support, should it be needed. Work is also going on to introduce digital outpatient services – virtual clinics that allow a consultant to assess a patient's records to decide if they actually need to visit hospital, or if the GP can take the required action.

22. CONCLUSION

22.1 The aim of our review was to gain an understanding of the pace and scale of transformation which digital changes will bring to primary care over the next few years. We wanted reassurance that City and Hackney was not on the back foot on these developments.

22.2 Our impression has been that there is a lack of sufficient clinical and managerial 'buy in' to 'digital first' combined with a poor articulation to GPs and the general public of the benefits of using online consultation. Locally we learned that 80% of practices in Hackney are engaged with an online consultation system which means that 20% still think this isn't a priority. We heard that while practices might sign up they're not fully maximising the opportunities open to them. It was suggested the there is a need for experts/mentors to work within Practices once they've signed up to ensure they are embracing the change fully. The key issue for us therefore is what proportion of patients within each Practice is actually using digital first as opposed to just being enabled to do so.

22.3 There also appears to be a lack of trust from some quarters and a feeling, even among supporters of digital approaches, that digital first primary care is yet another attempt to simplify a process using technology rather than full on system change. In our view askmyGP, in particular, take this problem beyond tech solutions and represent a genuine attempt to bring about whole system transformation in how GP surgeries deliver their services. Needless to say the crisis in GP recruitment and ongoing primary care funding challenges are likely to act as a major catalyst and perhaps lead to rush for more digital solutions sooner rather than later.

22.4 We noted that there have been some challenges with the mobilisation of the roll out of both online consultation, Apps and video consultations. There seems to be little standardisation of approaches when it comes to the mobilisation of online systems in the STP area with the result that there is great uncertainty about what is being deployed and a confusion caused by the sheer number of suppliers operating in the system and about how they are supposed to interact. It is probably not surprising therefore that many GPs are less than enthusiastic.

22.5 We don't yet see accurate local mechanisms to report on the impact of online consultation solutions including their impact on levels of patient demand and patient redirection. Obviously, it is early days, but these need to be more transparent and more systematic, if the public is to be convinced.

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

on these, often, non-verbal cues? The effectiveness of these is still a matter of contention in academia and there appears to be great deal of polarisation in how these research findings are reported in publications such as *Pulse* and in the wider media.

22.7 There is a danger too in forgetting that **Access** (which 'digital first' is primarily concerned with) is just part of the picture in Primary Care and it has to be balanced with **Quality of Care** and provision of sufficient **Resources** for the system to work. In addition there will always be a cohort who will always find it hard to access digital approaches and they should not be disadvantaged by the moves to digital first.

22.8 Our CCG points out that increasing access to patient records for example will also inevitably lead to an increase in patient dissatisfaction and therefore patients will need more clinician time not less to discuss their concerns. CCGs also argue strongly that there is no evidence that opening new digital channels will reduce demand and in fact it might stimulate more. While this poses a challenge for them it is no reason, in our view, to disregard these innovations and the need to properly embrace them. Not doing so has the consequences of more patients moving to 'disruptor' services. Services such as Babylon/GP at Hand are here to stay and we note for example how they are now moving into providing services within hospital trusts. HSJ recently revealed that University Hospitals Birmingham Foundation Trust's board agreed to explore using Babylon's services, including video appointments and digital triage, to help divert pressure from its severely strained hospitals. If the deal goes ahead, it would be Babylon's first partnership with an NHS hospital.

22.9 Finally the ongoing potential for health improvement of embracing digital tools for self-monitoring (diabetes, blood pressure etc) needs to be promoted as the next step once digital access to GPs is fully off the ground. This needs to focus on the cohorts where most progress can be made initially i.e. quick wins. It is a big enough to be the subject for a separate review.

23. CONTRIBUTORS, MEETINGS AND SITE VISITS

23.1 The review's dedicated webpage includes links to the terms of reference, findings, final report and once agreed, the corporate response. This can be found at https://hackney.gov.uk/health-in-hackney-commission

232.2 Evidence was gathered at the following meetings and site visits:

No.	***Date***	***Event***	***Met with***	***Members present***
1	7 Jan	HiH meeting	**Paul Bate**, Director of NHS Services, Babylon Health/GP at Hand **Dr Mark Rickets**, Chair, City & Hackney CCG **Sunil Thakker**, Chief Finance Officer, C&HCCG **Richard Bull,** Programme Director – Primary Care, City and Hackney CCG **Laura Sharpe**, Chief Exec, GP Confederation **Dr Fiona Sanders**, Chair of C&H LMC *Plus written submissions from*: ***Jane Lindo***, Primary Care Programme Director ELHCP Primary Care Transformation Team ***Mark Jarvis***, Head of Governance and Engagement, Hammersmith and Fulham CCG re GP at Hand evaluation	All members
2	4 Feb	HiH meeting	**Dr Fiona Sanders**, Chair of City & Hackney LMC **Dr Gophal Mehta**, C&H LMC, Partner at Richmond Rd Medical Practice **Dr Jackie Applebee**, Chair of Tower Hamlets LMC **Jane Lindo**, Primary Care Programme Director ELHCP Primary Care Transformation Team **Niall Canavan**, City and Hackney Integrated Commissioning's IT Enabler Group **Dr Mark Rickets**, Chair, City & Hackney CCG	All members

3	20 Feb	Site visit Lower Clapton Medical Practice	**Dr Nick Brewer**, GP Partner at Lower Clapton Medical Practice re. use of AskMyGP	Chair Vice Chair
4	12 Mar	HiH meeting	**Ian Barratt**, Trainer Partner at GP Access (provider of AskMyGP platform) **Ifrhan Mururjani**, Development Manager, Egton **Marion Macalpine/Shirley Murgraff**, Hackney Keep Our NHS Public	All members
5	2 April	Site visit Tower Hamlets CCG	**Dr Osman Bhatti** (Lead GP for digital first for Tower Hamlets CCG and Partner at Chrisp St Medical Centre) **Arshad Takun**, Project Manager – GP Care Group, Tower Hamlets CCG	Chair
6	4 April	HiH meeting	**David Hodnett**, Programme Delivery Lead, The NHS App at NHSE **Tristan Stanton**, Implementation Lead – the NHS App, NHSE **Dr Phil Kozan**, NHS App group at NHSE	All members
7	13 May	Hackney Matters Panel Focus Group	**6 Hackney residents** who are members of the council's Hackney Matters consultation panel	Chair Cllr Snell

24. MEMBERS OF THE SCRUTINY COMMISSION

24.1 The following served on the Commission during this review

Councillor Ben Hayhurst (Chair)
Councillor Yvonne Maxwell (Vice Chair)
Councillor Deniz Oguzkanli
Councilllor Emma Plouviez
Councillor Tom Rahilly *(from May 2019)*
Councillor Peter Snell
Councillor Patrick Spence

Overview and Scrutiny Officer: Jarlath O'Connell ☎ 020 8356 3309
Legal Comments: Joe Okelue ☎ 020 8356 5208
Financial Comments: Naeem Ahmed ☎ 020 8356 7759

Lead Group Director:	Anne Canning, Group Director - Children, Adults and Community Health
CCG Lead:	David Maher, Managing Director
Lead Cabinet Member:	Cllr Feryal Clark, Deputy Mayor and Cabinet Member for Health Social Care, Leisure and Parks

25. FURTHER READING

25.1 The agenda pages for the Commission meetings on 7 Jan 4 Feb 12 Mar 8 April on the Hackney Council website contain minutes of the evidence sessions, background briefings/papers submitted and notes on the site visits.

25.2 The following (not exhaustive) was consulted as background:

National:
The NHS Long Term Plan (2019)
NHSEL Five Year Forward View
NHSEL Consultation on Digital First Primary Care July 2018
NHSE Digital First Primary Care consultation June 2019

Local:
City and Hackney CCG Primary Care Committee documents on
Draft Hackney Health and Wellbeing Strategy 2015-18
City and Hackney Health and Wellbeing Profile: Our Joint Strategic Needs Assessment, 2016 update. Hackney Council and City of London

GP at Hand:
https://www.gpathand.nhs.uk/
Pulse article on 'online providers disrupting the market'
FT article on "*High profile health app under scrutiny after doctors' complaints"* on the controversy around the AI algorithm which is used.
Evaluation of GP at Hand by ipsos MORI for H&F CCG May 2019
CQC inspection report on GP at Hand home practice May 2019

Research on advantages/limitations of virtual online consultations:
NHS UK website note on '*Patient choice of GP Practices'* and the change in the law which enabled this
NHS UK website note on '*Seeing same doctor every time reduces risk of death'*

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

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

Royal College of GPs guidelines on Patient Online:
RCGP Patient Online Getting Started Checklist

26. GLOSSARY

Alternative Provider Medical Services (APMS) contract	A contract between **NHSE and any qualifying body** including general practices, NHS trusts, voluntary and private sector providers for delivering a range of services. This allows NHSE and CCGs to commission locally flexible and innovative solutions for patients. The provider does not necessarily have to hold a registered list of patients for example when providing GP Out of Hours services.
Carr-Hill Formula	The formula used to calculate the core payments (see global sum) to GMS contracted GP practices. Payments are made according to list size of patients adjusted using the Carr-Hill formula to provide a weighted count of patients by taking in consideration a range of factors which reflect characteristics of these patients e.g. age, gender, levels of morbidity and mortality and patient list turnover
C&HCCG	NHS City & Hackney Clinical Commissioning Group
ELHCP	East London Health and Care Partnership is the Sustainability and Transformation Partnership (STP) for the 8 North East London boroughs.
Enhanced Services	Those which require an enhanced level of provision above what is required under the GMS contract. Directed Enhanced Services are those the NHSE and CCGS are required to commission. They are mostly commissioned locally and practices can choose whether or not to provide these.
General Medical Services (GMS) contract	A **nationally agreed** contract between general practices and NHS England for delivering primary medical services. The majority of practices are currently on GMS contracts.
Global sum	The basis of core funding for GMS practices since 2004. This funds a practice for delivering essential medical services to its registered list of patients.
GP Choice Policy	The Choice of GP Practice scheme was introduced in 2015 to enable patients to choose to register with a participating practice anywhere in the country. This policy was intended to, for example, allow commuters to register near work or to maintain continuity with an existing GP when a person moves house.
GP Confederation	City and Hackney GP Confederation is made up of a membership of all 40 City & Hackney GP practices The Confederation provides true population coverage, mitigating against uneven service provision.
INEL	Inner North East London covering boroughs of Newham, Tower Hamlets, Waltham Forest, Hackney and City of London.
LMC	Local Medical Committee. The BMA committee in each CCG area which represents local GPs and acts as a voice for them in negotiating with the CCG and NHS England.
NEL	Refers to the 8 boroughs of Barking & Dagenham Havering, Redbridge, Waltham Forest, Tower Hamlets, Newham, Hackney and City of London.
ONEL	Outer North East London covering boroughs of Barking & Dagenham, Havering and Redbridge,
Personal Medical Services (PMS) contract	A **locally agreed** contract between NHS England or delegated CCGs and qualifying bodies, including general practices, for delivering primary medical services. PMS contract offer local flexibility compared to the nationally negotiated GMS contract.
Quality and Outcomes Framework (QOF)	Was established in 2004 as a key component of the GMS contract. It is a pay for performance scheme which provides funding to practices on the basis of the quality of care delivered to patients as described by a set of quality indicators.

Appendix One – July 2019 data update on GP at Hand- Lillie Rd Practice
By City and Hackney Public Health Intelligence Team

July 2019 data update. City & Hackney Public Health Intelligence

- NHS Digital currently release overall numbers of registered patients by GP practice every month, with a full geographical breakdown every quarter in January, April, July, October. This report includes figures published in July 2019.

- These figures show a continued rise in the number registered at Lillie Road Health Centre, now renamed "GP at Hand", (practice ref E85124) from 2,500 in July 2017 to **57,248** in July 2019 - see Figure 2

- In July 2019, 0.9% of registered Hackney residents were registered at Lillie Road, and 3.5% of City of London residents – see Figure 2

- Data from January 2019 show that nationally, 28% of patients are of younger working age (20-39). In City & Hackney 42% of registered patients are in this age group, reflecting the local demographics. Patients registered with Lillie Road have an even higher proportion in this age group – 84% – see Table 1 and Figure 3.

- In January 2019, 50% of patients registered with City & Hackney GPs were male. 50% of patients in London and England were also male. At Lillie Road, patients were 56% male – see Table 1 and Figure 3

- More female patients were registered with the Lillie Road practice in the 20-29 age band. More male patients were registered with Little Road practice in the 30-39 age band.

- In July 2019, 9% of patients registered at Lillie Road were resident in Hammersmith and Fulham, 86% elsewhere in London, and 5% outside London. Hackney residents made up 5% of the practice list, and City of London residents 0.5% – see Figure 4

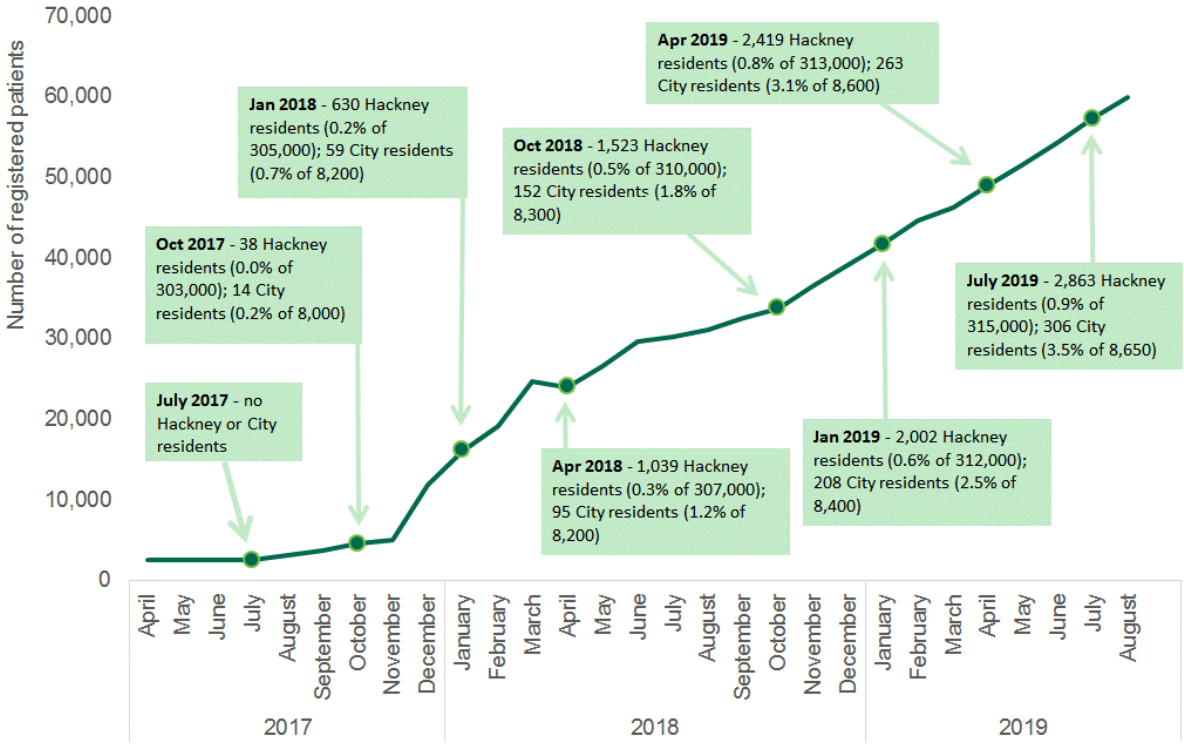
- The highest proportion of a GP registered population registered with Lillie Road are now in the City of London – 3.5% compared with 2.2% of the Hammersmith and Fulham population – see Figure 4b.

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

Figure 1b: GP at Hand / Little Road Health Centre

Source: Google Street View (accessed April 2018)

Figure 2: Number of patients registered at Lillie Road Health Centre over time, with the number of residents of Hackney and the City of London.

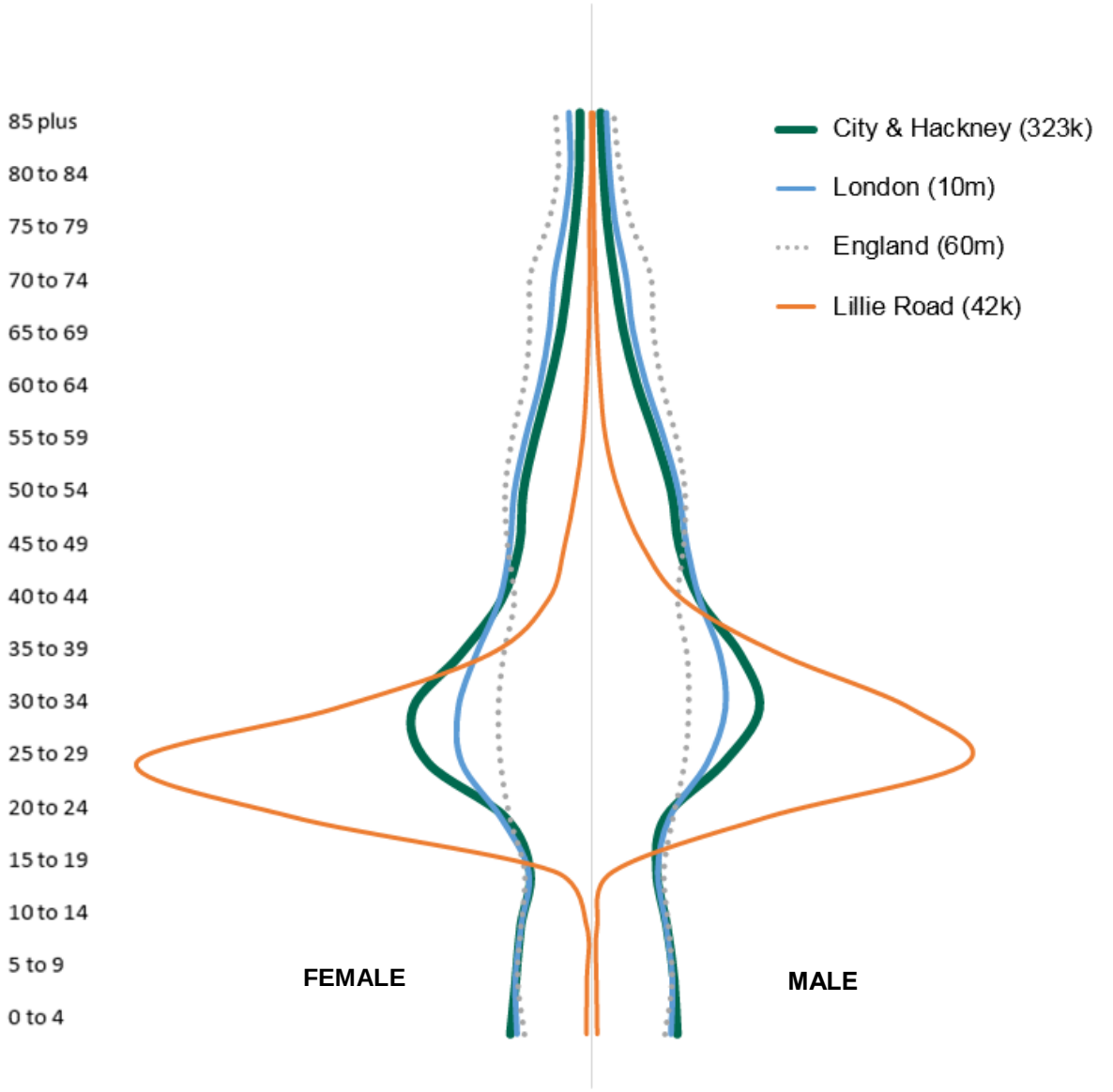


Data source: NHS Digital https://digital.nhs.uk/article/4197/Primary-care-services

Figure 3: Number of patients in City & Hackney and Lillie Road by gender and age profile (January 2019)

	England	London	City & Hackney	Lillie Road
% Male	50%	50%	50%	56%
% Aged 20 to 39	28%	36%	42%	84%

Figure 4: Age and gender of patients registered at Lillie Road Health Centre compared with City & Hackney CCG registered patients (January 2019)



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

Figure 5a: Number of patients registered at Lillie Road Health Centre by local authority of residence (July 2019)

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

Figure 5b: Percentage of patients registered at Lillie Road Health Centre by local authority of residence (July 2019)

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

Appendix Two – conclusions of evaluation report on Babylon GP at Hand

Hammersmith & Fulham CCG/ NHS England commissioned Ipsos MORI / YHEC to evaluate Babylon/GP at Hand (BGPaH). They reported in May 2019 and their conclusions on the impact of GP at Hand on the wider health system were: (our emphasis in bold)

- While the evaluation has not been able to explore the cost-effectiveness of the model, it has highlighted some useful considerations about its affordability and sustainability, if it were to be mainstreamed. To sustain the enhanced access benefits of the BGPaH model **requires considerable numbers of GPs and an embedded IT infrastructure.** While the service provides rapid access for patients, certain aspects of primary care, such as care home visits, are not provided through this model, and would need to be provided from elsewhere in the system.

- A national roll-out of digital-first models should be considered within the context of the emerging primary care landscape, including changes in the way patients experience care and supporting new ways of working for staff. In areas where digital-first models are not well established, this may need fundamental large-scale redesign of primary care services, which may **require substantial changes in the way in which primary care is funded**.

- The evidence available suggests that the **Global Sum Allocation Formula may not work well in establishing the costs** of providing GP services for patients who choose to be treated through a digital-first service and, therefore, in providing appropriate funding levels. The evaluation has shown that BGPaH patients have better health than comparable patients using traditional primary care but that they are higher users of primary care.

- BGPaH patients were previously registered at a large number of CCGs and other practices. This indicates the **impact on any singular practice or CCG would, at present, be minimal** if BGPaH patients were subsidising patient care through the Carr-Hill Formula in their old practices.

Appendix Three – Comments at Focus Group with Hackney residents

Hackney Matters Focus Group for 'Digital First Primary Care' review on 13 May 2019

What benefits and drawbacks do you feel there are by using an online digital GP service?					
BENEFITS			**DRAWBACKS**		
Immediate access to records	Don't have to phone for appointment and be on hold for ages	Can request repeat prescriptions online	The registration process is complicated.	Website must be made easy	Not sure about what services and features I can access
I can have access to my medical records	No long phone call and wait for an appointment or doctor to ring you back	Prescriptions Appointments	Initial registration?	IT assistance	Can't always find a fee appointment with the doctor I prefer
I like the idea of the live Apps	Can book when I want	Very convenient to order repeat prescriptions online	Impersonal	Having too much info online could be a problem	Don't let you book more than a few weeks ahead
Benefit is using the App often so to get used to it all	Don't need to call my GP		No one to talk to To ask questions	Patient confidentiality - accidental access may be gained by others	No good if I can't get through when I need to
I guess it's cost effective	Don't have to queue outside surgery at 8.30 am		If no access to smartphone, computer or internet then can't join	Can change or follow up if patients miss appointments	I don't think my dad could use either the app or online booking
Hopefully cuts down on wasted appointments Is easy to cancel			Older people with no IT skills find this a problem		

What are the positive and negatives aspects of online digital GP service?			
POSITIVES		**NEGATIVES**	
Smartphone apps and online services			
Sounds like a good idea for repeat prescriptions		Impact on jobs would practices close down	As long as the website is clear and one doesn't have to take too long to fill in application

Video calls via smartphone or webcam to a GP			
I think it is a good idea to have Skype talk because it would be more personal some people would like that.	Good idea in theory	Video – could be misdiagnosis if you need an examination and only going on symptoms	Difficult to converse using this form of communication – no physical exam
Great idea, speeds up.	Don't have to go to Practice could do it from work also so no need to take time off	Doctor may not understand the illness	Older folk don't like change
You can do it in your pyjamas	More immediate from own home	Prefer face to face with a GP	Depends on the skills of the doctor to create the right atmosphere
		When and where could this happen as a patient	
Online Pharmacy			
Long queues at pharmacy	Ease and speed	If online pharmacy is out of the drug you need	Pharmacy2U. If it goes wrong or there are problems it is harder to rectify as they're not based in London
Great to order prescription and don't have to collect items from my surgery. Collect medication from my local pharmacy	Convenient. Do not need to collect prescriptions.	Like the chance to see whatever medicines I can	Like to query with pharmacist if I need to
			I would like to look more online with my doctor. I don't always trust the pharmacy.

Hackney

Health in Hackney Scrutiny Commission 4th November 2019 **WORK PROGRAMME FOR 2019/20**	Item No **10**

OUTLINE

Attached please note the updated draft work programme for the year. Please note this is a working document and is updated regularly.

ACTION

Members are requested to give consideration to the work programme and agree any changes as necessary.

This page is intentionally left blank

Health in Hackney Scrutiny Commission

Future Work Programme: June 2019 – April 2020 (as at 24 Oct 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
Thu 13 June 2019 Papers deadline: 3 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.
	St Joseph's Hospice	Tony Mclean Jane Naismith	**Response to Quality Account for St Joseph's Hospice**	To comment on the draft Quality Accounts for 2018/19 from the local NHS Services who request them.
	HUHFT	Catherine Pelley	**Response to Quality Account for HUHFT**	Discussion with Chief Nurse of HUH issues raised in the Commission's annual Quality Account letter to the Trust.
	HUHFT Hackney Migrant Centre	Catherine Pelley Rayah Feldman/ Mamie Joyce	**Overseas Visitors Charging Regulations**	To consider response received from Baroness Blackwood (Health Minister) to Commission's letter.
	NELCA CCG	Alison Glynn, NELCA Siobhan Harper, Workstream Director Planned Care Dr Nikhil Katyiar (C&HCCG GB) David Maher, CCG	**Consultation on 'Aligning Commissioning Policies' across NE London**	NELCA is consulting on 'Aligning Commissioning Policies' across the NEL patch. It closes on 5 July. INEL will take this forward but the Chair has invited the CCG and NELCA to brief the Commission on these changes to eligibility for certain procedures which will no longer be routinely offered by NHS.
	All Members		**Work Programme for**	To consider work programme suggestions received from stakeholders, Cabinet, Corporate Directors and others and to

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
			2019/20	AGREE an outline work programme for the year to be sent to Scrutiny Panel's 18 July meeting for comment
Wed 10 July 2019 Papers deadline: 1 July	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
	Unplanned Care Workstream GP Confederation	Nina Griffith Laura Sharpe	**City & Hackney Neighbourhoods Development Programme**	Update requested at July 2018 meeting.
	Healthwatch Hackney	Jon Williams Rupert Tyson	**Healthwatch Hackney Annual Report**	To consider the annual report of Healthwatch Hackney
		Jarlath O'Connell	**REVIEW on 'Digital first primary care….'**	Recommendations discussion
Thu 12 Sept 2019 Papers deadline: 2 Sept		Jarlath O'Connell	**REVIEW on Digital first primary care and implications for GP Practices**	Consider draft report.
	C&H CCG	David Maher Nina Griffith Dr Mark Rickets	**The NHS Long Term Plan – draft C&H submission**	To consider a draft of the C&HCCG's formal response to NHSE on The NHS Long Term plan to be submitted by 27 Sept. This is a key consultation on the future shape of the NHS.
	C&H CCG Hackney KONP	Dr Mark Rickets David Maher Dr Nick Mann Nick Bailey	**Future of NEL CCGs**	Update from CCG on suggestions that there needs to be a public consultation on plans to merge CCGs as part of the national development of ICSs and implementation of the NHS Long Term Plan.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Chair of CHSAB Adult Services	Anne Canning Simon Galczynski John Binding	**Annual Report of City & Hackney Safeguarding Adults Board**	Annual review of SAB work. Annual item. Apologies from Dr Adi Cooper (CHSAB Chair) so presented by Anne Canning
	ASC Unplanned Care Workstream	Simon Galczynski Nina Griffith	**Intermediate Care Beds**	Follow up from suggestion at March 2019.
INEL JHOSC ***Thu 19 Sept 2019*** ***at 19.00 hrs*** ***at Old Town Hall Stratford***	*ELHCP/NELCA*	*Various*	***Moorfields Eye Hospital Relocation*** ***NHS LTP – NEL response*** ***Waltham Forest joining INEL*** ***Redbridge observer status*** ***Revised ToR and Protocols***	Update from AO of ELHCP Early Diagnostic Centre for Cancer at Mile End Hospital Update on implementation of new Non- Emergency Patient Transport system (to Barts Health sites) Work of the new **INEL System Transformation Board** Aligning Commissioning Priorities summary of response to the consultation
Mon 4 Nov 2019 Papers deadline: Thu 23 Oct	Public Health LMC	Dr Sandra Husbands Dr Andy Liggins Shivanghi Mehdi Dr Fiona Sanders (LMC Chair) Dr Nick Mann	**Sexual and Reproductive Health Services in GP Practices**	Request from LMC to examine the impact of this on primary care.
Joint with Members of CYP Scrutiny Commission	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director Anne Canning, SRO	**Update on Integrated Commissioning – CYPM Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	ELFT CCG	Eugene Jones Dan Burningham	**Consolidating dementia and challenging behaviour in-patient wards – proposal from ELFT**	A proposal involving 2 inpatient wards within East London NHS Foundation Trust by consolidating Thames Ward (Mile End Hospital) within Sally Sherman Ward (East Ham Care Centre).

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Adult Services Healthwatch Hackney	Simon Galczynski Ilona Sarulakis Jon Williams	**'Housing with Care' Improvement Plan - update**	Updates from both Adult Services and Healthwatch Hackney 8 months on about implementing the Action Plan from CQC inspection of the Housing with Care service. Re-inspection by CQC took place in July. This moved from Sept.
		Jarlath O'Connell	**REVIEW on Digital first primary care…**	Agree FINAL report. Also considered at Sept mtg.
6 Nov 2019 at 19.00 hrs At East Ham Town Hall	***JOINT WITH Members of the Outer North East London (ONEL) JHOSC***	*ELHCP Moorfields Eye Hospital*	***NHS Long Term Plan – the NEL response Relocation of Moorfields Hospital issues from consultation***	Annual joint meeting with the Outer North East London JHOSC (Barking & Dagenham, Havering Redbridge) covering items relevant to both JHOSCs.
INEL JHOSC Wed 27 Nov 2019 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Various*	**-ELHCP – AO update -NEL Estates Strategy -Overseas patients charging regulations - Feedback from Healthwatch consultation**	
Wed 4 Dec 2019 Papers deadline: 22 Nov	Integrated Commissioning Planned Care Workstream	Siobhan Harper Jonathan McShane	**Redesigning Community Services**	Suggestions from Cabinet Member and from CCG Outline briefing. Will require more detailed follow up items.
	Cabinet Member	Cllr Clark	**Cabinet Member Question Time with Cllr Clark**	Annual CQT Session with the relevant Cabinet Member.
	Policy Team	Sonia Khan Soraya Zahid	**Development of Hackney's Ageing Well Strategy**	Input to the development of this key new strategy being developed by the Council

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Not confirmed	*Adult Services*	*Simon Galczynski*	*Assistive Technology in social care*	*Suggested by Adult Services* *To explore potential demand and hear about the small pilots taking place and the plans to recommission telecare service.*
Wed 29 Jan 2020 Papers deadline: 17 Jan	LBH/CoL/CCG Unplanned Care Workstream	Nina Griffith Workstream Director Tracey Fletcher, SRO	**Integrated commissioning – UNPLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	Public Health Adult Commissioning Network providers	Anne Canning Dr Nicole Klynman Gareth Wall	**City & Hackney Wellbeing Network**	To receive update on the revised model for the Wellbeing Network being put in place following an evaluation report.
TBC	ELFT CCG Adult Services Public Health	Dean Henderson and colleagues Dan Burningham Dr Nicole Klynman David Maher	**Mental Health Updates**	Session with ELFT and CCG. List of suggestion from ELFT final items TBC.
Wed 12 Feb 2020 Papers deadline: 31 Jan	Public Health Environmental Health Clinicians	TBC	**Air Quality – health impacts**	Briefing from clinical experts/environmental health on the health impacts of poor Air Quality
	Adult Services	Tessa Cole	**Adult Services Local Account**	Annual item on publication of the Local Account of Adult Services
	Public Realm Sport England Project	Aled Richards Lola Akindoyin	**Sports development and health inc. Sport England project**	Suggested by Public Realm. Briefing on the programme of the Sport England funded project inc.the New Age games, improvements to leisure and parks facilities.
			Terms of Reference for Scrutiny in-a-day review	To agree ToR for Scrutiny in a Day review to be carried out in Feb/March

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Scrutiny in a Day on "Health inequalities' Feb daytime date tbc	Public Health Housing Housing Needs Employment Support CCG ELFT	TBC	**Health inequalities**	Intensive day of evidence gathering following site visits for mini review
INEL JHOSC Wed 26 Feb 2020 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*		**ELHCP – AO update -mental health? -digital?**	
Mon 30 Mar 2020 Papers deadline: 18 Mar		Jarlath O'Connell	**Report of Scrutiny in-a-day REVIEW**	To agree report
	LBH/CoL/CCG Planned Care Workstream	Siobhan Harper, Workstream Director Andrew Carter, SRO	**Integrated Comm. PLANNED CARE Workstream**	Series of updates from each of the Integrated Commissioning Workstreams
	Adult Services	Ann McGale Penny Heron Tessa Cole Anne Canning	**Integrated Learning Disabilities Service**	Update on development of the new model
	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.
			Discussion on Work Programme items for 2020/21	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Possible separate engagement event hosted by the Commission in Spring/Summer 2019	LBH CCG HUHFT ELFT Healthwatch	Tim Shields/ Ian Williams/ Anne Canning David Maher Tracey Fletcher Dr Navina Evans Jon Williams	**NEL Estates Plan in particular plans for St Leonard's Site**	Scrutiny will host an engagement event with the senior officers from the relevant stakeholders and the Cabinet Members to discuss the emerging plans for the St Leonard's Site.

Please note the Mayor of London and London Assembly elections take place on **Thu 7 May 2020** and the election purdah during which no meetings can take place will run from c. 1 April.

CCG suggestions

1. **CAMHS Transformation** (N.B. this is being done by CYP SC)
2. **Mental Health** (this links to ELFT's suggestions for Jan meeting).
3. **Immunisations** (follow up on item from Nov 2018)
4. **Using Neighbourhoods to address wider determinants**. (this follows on from July item on Neighbourhoods; ongoing)
5. **Tackling increasing A&E attendances including CYP** (can be covered as part of January mental health item)
6. **Estates** (being covered as part of proposed Jan/Feb scrutiny engagement event. INEL meeting on 27 Nov also covering it).

Items held over from last year but not scheduled

June 2020			**REVIEW: Digital first primary care….**	6 month update on implementation of the recommendations of the Commission's review, agreed in Nov 2019
July 2020	GP Confed Integrated Commissioning	Laura Sharpe Nina Griffith	**Neighbourhoods Development Programme**	Follow up on item at July 2019
	LMC CCG	Kirit Shah Rozalia Enti	**Pharmacy First (Minor Ailments) Scheme and Medicines**	Follow-up on previous concerns about the withdrawal of these services. Awaiting NHSEL decision on commissioning.

			Optimisation Service	
tbc	Adult Services Oxford Brookes University researcher Camden Council rep	Gareth Wall and Simon Galczynski	**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.
Tbc			**How health and care transformation plans consider transport impacts?**	Suggestion from Cllr Snell. Possible review/item to understand how much Transformation Programmes take transport impacts for patients and families into consideration and whether these can be improved.
			Implications for families of genetic testing	Suggestion from Cllr Snell. Briefing on impact on families of new technologies such as genetic testing.

Dates for INEL JHOSC in 2020/21 already scheduled:

24 June 2020
30 Sept 2020
25 Nov 2020