Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2023/24
Date of Meeting Thursday 12 January 2023

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 Deniz Oguzkanli, Cllr Kam Adams, Cllr Eluzer Goldberg and Cllr Sharon Patrick (Vice-Chair)**
Apologies:	
Officers In Attendance	**Chris Lovitt (Deputy Director of Public Health) and Helen Woodland (Group Director Adults, Health & Integration)**
Other People in Attendance	**Sally Beaven (Healthwatch Hackney), Dr Kirsten Brown (Primary Care Clinical Lead for City and Hackney), Richard Bull (CCG) and Councillor Christopher Kennedy**
Members of the Public	
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence (19.00)

1.1 Apologies for absence were received from Dr Sandra Husbands, Janet McMillan and Cllr Maxwell (Cabinet Advisor for Older People).

2 Urgent Items / Order of Business (19.02)

2.1 There was none.

3 Declarations of Interest (19.03)

3.1 Cllr Samatar stated she was a Wellbeing Network Peer Coordinator for Mind in City and Hackney.

4 Local GP services - Access and Quality (19.05)

4.1 The Chair stated that Members have been raising a number of concerns about GP access and quality and these are summarised on pp.12-14 of the agenda pack, and NHS NEL was invited to the meeting to address these.

4.2 He welcomed: Dr Kirsten Brown (KB), GP partner at Spring Hill Practice and The Lawson Practice and Primary Care Clinical Lead for City and Hackney, NHS NEl and Richard Bull (RB), Commissioner for Primary Care at NHS NEL, formerly at City and Hackney CCG

4.3 Members gave consideration to 2 reports: Local GP Services - access and quality' and Patient feedback from Care Opinion, both from NHS NEL Primary Care Commissioning.

4.3 KB took members through the report. She focused on workforce issues and the crisis in General Practice adding that the complexity of presentations at GPs was now much greater and that people were now living longer with Long Term Conditions, there were more mental health issues and high levels of deprivation such that people don't know where to turn for help. She noted how heart disease and diabetes for example wee now looked after in General Practice whereas they used to be in hospitals. In addition A&E was bursting at the seams and so there was a knock-on effect on primary care. She explained how Hackney had one of the highest GPs-Patient ratios in London. She explained that a key part of their response to this challenge was the recruiting of Additional Roles so that she now works as part of a multi disciplinary team, rather than a sole practitioner, which she found much better. On Patient Experience data, Hackney performs very highly vis a vis London and England and there were more GP consultations and Hackney has one of the highest rates of Face to Face appointments. On telephone triage there is no perfect system but they work continually to improve it. City and Hackney has very low levels of calls to NHS 111 within standard GP practice hours which is testament to high performance. She explained the Duty Doctor contract which is not universally available but a major part of the mix in Hackney.

4.4 Members asked Questions and the following was noted in the responses:

KB explained that Triage refers to all patients contacting primary care and the need to direct them to the right service. 'Duty Doctor' relates to urgent on-the-same-day care. Patients get called back within 2 hours as do paramedics or other professionals who require quick responses.

RB explained that the Duty Doctor was funded through the GP Confederation and they get extra money to ensure they can employ additional doctors to fulfil that role.

KB explained that there is a need to increase the understanding and awareness in the community about these additional roles and a need to continue to work with patients to make things as easy as possible.

RB explained that another indicator of high performance was not having any closures as a result of CQC inspections (unlike elsewhere) and additional investment has been put into PCNs and more communications were needed with the general public to help them understand the new model of care which is wider than just seeing a GP. The Chair commented that GPs in C&H have been able to receive up to 40% more funding on top of their core contract because of additional local investment.

RB explained about the Patient Volunteers Pilot (Together Better) run with Volunteer Centre Hackney which integrates Practices more into the community.

Cllr Adams detailed his personal experience with a local GP Practice where the performance on transferring him to a new Practice and on registration and on repeat prescriptions had been very poor. KB expressed regret about this but added that there would alway be a degree of variability in the way Practices are run and the important thing was for them to learn from each other.

On the prescription problems, KB explained that all GP Practices are now required to have Clinical Pharmacists working within them so there is no reason why there should have been problems with medication.

Members expressed concern about what having a Named Doctor actually means, and whether it was just a notional concept. KB explained that all Practices do it and the patient should also be informed of the name. Members' pursued if there was an issue about patient expectations here that needed closer attention. KB explained that she was passionate about continuity of care and while an individual won't necessarily see their Named Doctor at every consultation this process still has value. She also added that while she had initially been sceptical about the new roles in GP Practices she has been totally won over and sees they are now making a great contribution.

Members asked if GP:Patient ratio data could be seen by ward. RB replied that they could map wards on top of PCN boundaries and you could get a sense of GP-Patient differentials across areas.

Cllr Goldberg expressed a concern that the data in the report was not reflective of what they were experiencing on the ground in the north east of the borough. The rush to get through at 8.00 am, children taken to A&E because they couldn't get a GP appointment for simple things and now the influx of 15 new private GPs moving into the area, illustrated this. The Chair asked why performance in Stamford Hill consistently rated worst across the indicators in the report and was there a particular issue in the NE in terms of Access. RB replied that GPs in Stamford Hill would admit they were struggling and this was also reflected in the survey responses. Improvement plans were in place and the GP Confed had a Resilience and Sustainability Fund to help Practices at times of need e.g. with recruitment problems. He added the variabilities in performance are normal and the majority were on an even keel. In that area they were under a lot of pressure from patient demographics. The number of children per family was high. The GP funding formula does not deal with the reality of large families (additional baby checks, immunisations etc). He added that additional money was going in.

The Chair commented how digital solutions had helped improve accessibility at Lower Clapton Practice and asked whether the responsiveness of same day callback was the same across online and phone requests. Cllr Goldberg added that most in Stamford Hill would not have digital access. KB responded that you need both and the key thing is to encourage those who can access digitally to do so which would free up phone lines for those who don't. She also said that Practices need to improve their telephone system to better monitor data and regretted the influx of new private GPs.

The Chair asked how they were analysing the 8.00 am call data. RB replied that use of electronic monitoring tools was common. Demand is generally largely predictable and they have commissioned expertise to help them to understand demand and

capacity and respond accordingly, a recent challenge had been a huge increase in, for example, respiratory disease and in those circumstances some Practices will inevitably struggle.

Members asked about how information is made accessible to the very diverse communities in the borough where there are c. 86 languages. RB explained the approach and illustrated work such as the Volunteers in Primary Care Project which was up and running in 7 of the 8 Pilot Practices and will shortly be in 16. Delivered by Volunteer Centre Hackney it uses volunteers to lead support programmes in the Practices working with residents on such things as cooking or exercise programmes which ties them into practical health promotion activity.

The Chair asked whether they have a strategic plan on culture and language barriers. KG explained that the GP Enabler Group had met the previous day to discuss this issue and in particular actions to improve health literacy, so it was in hand.

Members commented that it's about more than language because diverse communities have different needs and will need assistance for example in understanding their health records. KB replied that online access is just one aspect and the aim is to use that to free up the practitioners to work with those who might struggle.

Members asked what more is being done on Prevention and on supporting newly arrived migrants. KB explained the Proactive Care Contracts via the GP Confederation. Patients are called for proactive appointments mainly face to face or have home visits e.g. for the housebound and also the work of health and wellbeing coaches helping with exercise, diet, improved social contact etc.

Sally Beavan (Healthwatch Hackney) commented that the trend in GP access is slowly and steadily improving. RB detailed the work they did with Healthwatch and how appreciative they are of their input.

The Chair asked if there was a standard hold message across all 41 Practices or some IT support for patients who might just need a little assistance to get up and running using digital channels. Cllr Kennedy explained that the Practitioner Forum he'd just attended had announced the appointment of a new Digital Inclusion Specialist to focus on this aspect.

Members asked about surveying patients and a need for psychotherapy support in GP Practices. RB explains how GP patients are surveyed nationally and locally and the use of the 'Friends and Families survey' and 'Care Opinion' adding that there are a whole range of methods of collecting patients' views. On the issue of wrapping more mental health support around GP Practices, KB explained that there are mental health workers now in all PCNs, not psychotherapists but other mental health workers and they also form part of Neighbourhoods Teams.

Members asked how central govt policies were helping/hindering the current pressures; about the impact of Brexit on GP recruitment, and on GPs now dealing with issues previously dealt with in Acutes. RB commented that there were no real new policy solutions coming downstream from central government that would immediately ease current pressures and added that he envisaged perhaps another top down restructure. KB explained that since Brexit, the schemes for overseas doctors require Practices to jump through even more hoops.

Members asked about funding flows and about patients having little confidence in using digital channels. KB replied that care closer to home is the right approach but waiting times for procedures for out patients are up. Locally she stated that the Homerton was performing well compared to other trusts but those pressures have no doubt had an impact on GP Practices as they have to help patients on waiting lists manage pain and manage conditions for longer.

The Chair asked if there was in effect a levelling down since the ICB, also if the GP Confederation was at risk and could PCNs backfill the work of the GP Confed. He asked further what staffing would Primary Care commissioning receive under the new structure. RB replied that GP Confeds do continue to have a future and NHS NEL would likely commission more directly from them in future adding that there still remains a space for Confeds working jointly with the PCNs. The Chair added that he would like this to be a future item on the work programme.

KB added that residents do require better education/information on where, when, and from whom to seek care at any time. She reiterated her optimism about the greater opportunities that the newly created roles in GP Practices will provide.

4.5 The Chair stated that the data on NHS 111 calls and the patient survey analyses are testament to the excellent GPs Practices we have in Hackney and he thanked KB and RB for their excellent and detailed report and for their attendance. He added that he would like the Commission to revisit the issue of how PCNs are bedding down and how we can continue to protect the model we've got.

ACTION:
To return to the issues of GP Access challenges specifically in the NE of the borough as well as the PCN-GP Confederation alignment at a future meeting.

RESOLVED:
That the report and discussion be noted.

5 Cabinet Member Question Time: Cllr Kennedy (19.55)

5.1 The Chair welcomed Cllr Chris Kennedy (CK), Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture, adding that this is an annual item where all Cabinet Members are required to attend their relevant Commission. There is no written report but three topic areas are sent to the Cabinet Member in advance so that the discussion can be focused. The three questions are:

Q1) How to protect a local voice for Hackney and to retain a meaningful element of local commissioning, fed by local knowledge, within the ICS

Q2) How to develop and expand Homecare and intermediate solutions (e.g. Housing with Care, step down flats) to reduce the growing need for Care Home places

Q3) How PCNs are working for the community and improving access to primary care

Cllr Kennedy gave a detailed verbal response on the three topic areas and in the questioning the following was noted.

5.2 In a comment on the previous item CK reminded Members that England had lost 4000 EU national GPs post Brexit

5.3 In answer to Q1 Cllr Kennedy explained the NEL and City and Hackney Place Based Structures. There were now just 42 ICSs in the country with 5 in London. The main NEL ICB meets 4 times a year and the ICPB (above it) has about 40 members on it comprising all cabinet members for health, directors of adult and children services etc from the 8 authorities as well as VCS representatives and others. He explained the local end of the ICS is the City and Hackney Health and Care Board which is our local Place Based Partnership. At the main decision making ICB level there is 1 LA rep for inner NEL and it's on a rotating three year basis and the current rep is Mayor Glanville from Hackney. He is also on the important Treasury Sub Cttee of ICB so Hackney has a strong voice. In addition Dr Mark Rickets, our former CCG Chair, is one of two Primary Care reps for all of NEL on the NEL ICB.

5.4 The 4 core priorities of C&H HCB are: Babies, children and young people; Long Term Conditions; mental health; and employment and the workforce. ICB and ICPB are public meetings and papers are available. They do want to move to in-person and they want to encourage public attendance and public questions. Our old CCG got rated outstanding many times and it is very clear, he added, that the extra funding spent then is now reflected in the better outcomes for patients. Our worry is how to protect this level of quality, adding that the argument he makes is to remind people what happens to an acute hospital's performance when you invest in what happens outside of it in the wider community.

5.5 CK highlighted how the recent statistics on residency of patients presenting at the Emergency Department at the Homerton had shown that the percentage of City and Hackney residents had declined from 75% to 66% due to Homerton's mutual aid to neighbouring hospitals. His argument would be that you level up and give PCNs across NEL the same level of funding and that will greatly relieve stress in acute departments.

5.6 The Chair asked about what NHS NEL staffing would remain at Place Based Level i.e. in City and Hackney. CK replied that it was still unclear. The structure they had settled on in NEL was different from that in other ICSs. He described how City and Hackney had fought to retain the Director of Integration joint role and that the Place Based Leader be a Trust CE. Others had gone for an MD type role for the whole system.

5.4 The Chair asked if we were advocating that more staff should reside at Place. CK replied that it was yet unclear but they were trying to keep the staff who know about our 'Place' adding that our integrated teams have proven very successful e.g. the Integrated Independence Team (on learning disability) and we were pushing to scope out more joint commissioning arrangements at the local level. The Chair explained to Members that the change from commissioning more locally and knowing the local ecosystem and the 41 GP Practices, for example, to one of commissioning from above was key. It was not enough to say that 80% of funds will still come down to Place level if you don't have people here with the requisite local knowledge. Staff

resources were fundamental to 'Place' being a meaningful concept, he added. CK commented that the sudden and new Dame Patricia Hewitt report on ICSs for DoH was likely to confirm what a separate IFS study also found which was the admin costs have actually gone up 12% under ICSs, and while there was an argument to be made that this would level out after the initial stage of building up the new regime, it was not a good statistic.

5.5 The Chair asked what scope there would be for local innovation if all commissioning ended up being more centralised. CK replied that it would be where you genuinely do things at Neighbourhood or PCN level such as work on prevention or anticipatory care. The Together Better project between GP surgeries and Volunteer Centre Hackney using volunteers in GP surgeries and running such things as walking clubs or cooking clubs was a great example.

5.6 Members asked about aligning local needs to the objectives of NHS NEL. CK replied that there were two parts to it, firstly being bold enough to be really specific in each neighbourhood, which is what these projects in the Health Inequalities Summit exemplified. Also building further on the Covid Community Champions work would be key. These are now serving as Health Advocates engaged in peer mentoring of parents and people with health conditions. The other aspect of this was that you should be able to afford more local projects because you have availed of economies of scale at higher levels by becoming an ICS. With this you might have to make longer journeys for acute treatments but the things that will keep you healthier longer will be available closer to home, he added.

5.7 Members asked if there was a health emergency re GPs access should be declared in the North East of the borough. CK replied that without having a lot more information in front of him he would not advocate doing this and he would need to see much more detail on the help that is available to the surgeries which are currently struggling. He said it was good that they had admitted they were challenged and that there was some comfort that there is a Resilience and Sustainability Fund in place to provide initial support. He added that he understood Members' concerns and that the variations in performance in the NE needed closer attention.

5.8 Members asked how to improve messaging in diverse communities. CK replied that one of the best approaches was the Community Champions who are living proof that lifestyle change can lead to health improvements. People will always copy actions from those they trust and admire and therefore Peer Mentoring absolutely works.

5.9 Members asked what was the formula to allocate resources to Place Based Systems. CK replied that the full details on exactly what funding is available and how it will be distributed but that for example the first funding from the government's Hospital Discharge Fund (previously called 'winter pressures') was out and City and Hackney had received £2m. Half of that is distributed on an age based formula and the full breakdown of that is in the papers which went to the 9 Jan Health and Care Board. The Chair added that the recent INEL JHOSC papers detailed that outer NEL boroughs with older populations were receiving extra top up support over more demographically deprived but younger-aged boroughs.

5.10 Members asked what more could we have done to retain the doctors lost due to Brexit. CK replied that leaving the EU was the reason for this exodus and a total lack of confidence about their security and freedom of movement to move back and

forth and visit families was the main cause for the doctors' departure. A significant number felt they had been left with no choice but to go back to their home countries and this was a great loss to our health system.

5.11 CK responded in detail to Q2 'How to develop and expand Homecare and intermediate care solutions to reduce need for care home places'. He stated that this question mirrored the Manifesto Pledge 193. The point here is that it is not a binary home vs care home decision. Currently 1250 people receive Homecare with 210 in Housing with Care schemes and then 550 residents are placed in Residential Care Homes and two thirds of these have to be placed out of the borough. Most people do not want to end up in residential care, he added, and it was vital therefore to reduce the numbers and provide better and earlier alternatives. For this reason the Council was recommissioning Homecare services later this year. He added that although Housing with Care had been insourced, the Council does not own the 14 buildings involved which are split between four RSLs. The Council therefore is looking at better and more innovative solutions and working closely with RSLs.

5.12 CK added that there was a need to ask some difficult questions here and to interrogate, for example, our house building programme and the pledges we have made as a council to build 1000 new social homes. We need to ask where is the Supported Living in this mix? He stated that this was an area where officers were probably ahead of members on the need for an innovative approach and suggested the Scrutiny could perhaps do some further work on this. He cautioned that none of this would happen quickly however but we can improve the data we collect and do the appropriate modelling and future projections of need to help us win the argument. He added that there was greater scope for better use of assistive technology in homes to save work or the number of care visits. There was a need to look at the potential of new technology, used appropriately, and to embrace it. There was also a need to look more at cooperative models of working. He illustrated how some people are able to recover some of their mobility and hence some of their independence and we need to look closely at those in Housing with Care for example and continually reassess and support.

5.12 CK responded on Q3 'How PCNs are working for the community and improving access to primary care'. The key to this he stated was the Additional Roles Reimbursement Scheme (ARRS) in GP Practices. This encompasses such roles as pharmacists, social prescribers etc. as well as helping the Neighbourhoods to develop further. The use of multi-disciplinary teams meeting on individual cases and work on anticipatory care is key. It is important too to constantly challenge health inequalities. He shared with Members the C&H 'Health Inequalities Summit - Case Studies Brochure' from 11 Jan 2022. That detailed an incredibly impressive range of local joint working and most of these came out of PCNs. He described some of them such as: 'Uncontrolled Blood Pressure in Black People' the 'Together Better' programme (referred to earlier) expanding to 16 GP surgeries; 'Nutrition management in Sickle Cell disease in Shoreditch Park and the City'; 'Improving Immunisation at Springfield PCN'. They all produced better outcomes for a relatively small spend and were contributing to the successes illustrated by the data in the previous item on GP Access.

5.13 Cllr Adams sought reassurance that the concerns he had raised would be acted upon. CK replied that he understood the frustration but that he was confident that Dr Brown and RB would act on the points raised. He also described the commitment to support Healthwatch's 'Patient Voice' work and welcomed SBs

comments that the data on patient satisfaction levels on GP phone systems and GP access was on an upward trajectory, overall. He concluded that we will always want performance to get better and will continually look at those at the bottom of performance tables as well as those on top.

5.14 Members asked about plans to deal with increased dementia in the population. CK replied that a robust Dementia Strategy for the borough was in place which needed to be built upon. Looking to the future there was a need to rethink housing provision models and not just accept that all HRA funded building should go to straightforward residential homes. The Chair asked if there were examples in the UK of future proofing some housing with care options in new builds as part of any new HRA stock. CK replied there was and there was the potential to build much more variety into stock but there was a need to be bolder about this.

5.15 The Chair thanked Cllr Kennedy for his attendance and his insightful and helpful responses. He stated that he would explore inviting the Group Directors for Finance and Corporate Resources and for Adults Health and Integration to a future item to explore this housing aspect further because there must be an 'invest to save' element here as it would generate significant savings on residential care placements in the future. He added that the Commission would take forward the following:

Future proofing the house building/home regeneration programmes by building in a greater variety of housing stock in order to accommodate growing demand for adult social care/housing with care type support
GP Access challenges specifically in the NE of the borough
How will the future roles of the GP Confederation and PCNs align

5.16 The Chair stated that Cllr Binnie-Lubbock was unable to attend but had submitted a Question to Cllr Kennedy on whether there is a target based plan to reduce or cease commissioning health and social care from any providers still using zero hours contracts? CK responded that this would require a more detailed response than could be given at the meeting and undertook to provide a written answer.

ACTION:
Additions to the work programme:
Future proofing the house building/home regeneration programmes by building in a greater variety of housing stock in order to accommodate growing demand for adult social care/housing with care type support
GP Access challenges specifically in the NE of the borough
How will the future roles of the GP Confederation and PCNs align

RESOLVED:
That the discussion be noted.

6 Health in Hackney Scrutiny Commission Work Programme (20.45)

6.1 Members gave consideration to the draft work programme for 2022/23.

6.2 The Char outlined the planned items for the next meeting:
Work by ELFT in tackling inequalities in local mental health services
Future options for Soft Facilities Services at the Homerton
Community Diagnostic Centres - local impact (Homerton update)
New Hospital discharge funding scheme - Adult Services update

RESOLVED:
That the work programme for 2022/23 be noted.

7 Minutes of the Previous Meeting (20.47)

7.1 Members gave consideration to the draft minutes of the meetings held 5 December 2022 and the Matters Arising.

RESOLVED:
That the minutes of the meetings held on 5 December 2022 be agreed as a correct record and that the matters arising be noted.

8 Any Other Business (20.48)

8.1 There was none.

Duration of the meeting: Times Not Specified