Hackney

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

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair), Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	
Officers In Attendance	**Anne Canning (Group Director, Children, Adults and Community Health)**
Other People in Attendance	**Richard Bull (Programme Director Primary Care, C&H CCG), Mark Rickets (Chair, C&H CCG, Dr Fiona Sanders (Chair, City & Hackney LMC), Kirit Shah (City & Hackney Local Pharmaceutical Committee), Laura Sharpe (Chief Executive, C&H GP Confederation), Sunil Thakker (CFO, C&HCCG), Jon Williams (Director, Healthwatch Hackney), Paul Bate (Director NHS Services, Babylon Health/ GP at Hand) and Dan Burningham (Programme Director, C&H CCG)**
Members of the Public	**10**
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Cllr. Snell gave apologies stating that he would have to leave early to attend another meeting.

2 Urgent Items / Order of Business

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

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

2.2 Members gave consideration to 3 tabled documents:

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

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

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

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

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

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

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

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

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

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

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

3 Declarations of Interest

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

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

4 Minutes of the Previous Meeting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.1 Members noted the following background reports for the review:

1.) *NHS Digital data update on GP at Hand/ Lillie Rd Practice* from City and Hackney CCG/LBH/CoL Public Health Intelligence Team
2.) NHS UK website note on '*Patient choice of GP Practices'* and the change in the law which enabled this
3.) NHS UK website note on '*Seeing same doctor every time reduces risk of death'*
4.) FT article on "*High profile health app under scrutiny after doctors' complaints"* on the controversy around the AI algorithm which is used.
5.) Review from British Journal of General Practice by a professor of Primary Care Health on recent book on '*Challenging perspectives on organizational change in health care'*
6.) Louis Peters, Geve Greenfield, Azeem Majeed, Benedict Hayhoe, Imperial College London *The impact of private online video consulting in primary care,* in Journal of Royal Society of Medicine, Vol 111, Issue 5, 2018
7.) Greenhalgh T, Vijayaraghavan S, Wherton J, et al *Virtual online consultations: advantages and limitations (VOCAL)* study British Medical Journal Open 2016; bmjopen-2015-009388

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

8 2018/19 Work Programme

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

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

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

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

9 Any Other Business

9.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm