Haringey CCG Engagement Network Meeting
Tuesday 18 December 2018, 2.30-4.30pm
Meeting notes

Members present: Cathy Herman (Lay member and Vice Chair, HCCG); Bola Aworinde (Ms) (Erada UK); Esther Myerson (Central Haringey CHIN); Faridoon Madon (East Haringey CHIN); Rev. Gita Bond (Christ Church); Gordon Peters (Frailty Steering Group of CCG & Haringey Over 50s); Ivy Ansell (South east Haringey CHIN); Lauritz Hansen-Bay (Haringey Over 50s); Lourdes Keever (Trustee of CAH); Peter Richards (Haringey Over 50s); Ricardo Johnson (Rockstone Bike Alley); Robel Tesfazion (CARIS Haringey); Rod Wells (Haringey Keep Our NHS Public - HKONP); Viv Sharma (CCG Patient rep); Geoffrey Ocen (CEO, Bridge Renewal Trust);

In attendance: Paul Allen (Head of Integrated Care and Frailty, HCCG); Priyal Shah (Senior Commissioning Manager, HCCG); Delia O'Rourke (Head of Planned Care, Haringey CCG); Seonaid Henderson (HCCG); Yewande Sangowawa (HCCG); Robert Good (HCCG); Deborah Jenkins (Haringey Public Health, HCCG); Diane Doody (Care Navigator, West Haringey CHIN); Joanne Stewart (Care Navigation Co-ordinator, Central Haringey CHIN); Lilian Kaluma (Care Navigator, West Haringey CHIN); Farid Akhtar (Care Navigator, East Haringey CHIN).

1. Welcome introduction (Item 1)

Cathy Herman welcomed members to the meeting and the usual round of introductions was undertaken.

Cathy explained the agenda for the afternoon and extended appreciation to members for their time and their invaluable feedback.

2. Care Closer to Home Integrated Networks (CHINs) (Item 2)

Care Closer to Home Integrated Networks (CHINs) are multi-disciplinary models of care based around GP practices. Haringey currently has three CHINs, which support people with diabetes (East networks) and people with moderate frailty (Central and West networks). Delia O'Rouke (Head of Planned Care, HCCG) and Paul Allen (Head of Integrated Care and Frailty, HCCG) provided an update on the CHINs' progress and highlighted how previous feedback from the Network had been used to shape the current CHINs (see below table). They also asked the Network to feedback on further proposed developments of the service model.

Table – how we have used previous feedback on CHINs

You said	We did
How CHINs can better support people in diverse communities, e.g. whose first language is not English?	CHINs have recruited bi-lingual members of staff, including staff who speak Turkish and Bengali, to deliver the care navigation service. There are also health education programmes available for patients with long-term conditions whose first language isn't English.
Could CHINs offer more social prescribing?	We will be increasing investment in community navigation, which will signpost patients to local social activities that will benefit them.
Increase the number of referral sources into CHINs	We will be looking at broadening referral sources into CHINs.
How can CHINs be funded and sustained in the longer-term?	We plan to increase investment in community navigation and will continue to invest in primary care development.

CHINS table discussions - feedback

- The group noted that they agreed with the general direction of the CHIN models for both frailty and diabetes.
- The attendees suggested that the referral resource be expanded to include a Trusted Referrer. This could be a carer or possibly a family member of the patient.
- The group noted that some elderly people were not inclined to visit their local GP or even fully discuss some of the issues they are experiencing. In these cases, a trusted referrer would be very beneficial.
- The group noted that a lot of the various ethnic communities in the local area have their own support groups which could possibly offer translation services for CHINs.
- The group noted that it would be useful to have visual/picture/audio information regarding both the diabetes and frailty CHINs on the website for people who have reading/literacy difficulties, language barriers or are hearing impaired.
- Health checks for over 60s are only available for residents in the east of the borough. There is inequity of service. It would be good to understand how CHINs are enabling a more preventative approach (such as health checks).
- Community groups and non-health organisations may have an impact on health and wellbeing (housing associations, coffee groups). One possibility would be to have a health professional, or a trained volunteer deliver education to community groups. It is essential that these people are adequately trained for their role.

- How can CHINs help screen out non-medical issues so that GP time is used for clinical matters.
- There should be more support for self-management and education and helping people understand their medical condition and symptoms and help them to self-monitor.
- People need to have information on what support, services and activities are out there and how they can access this. A directory of services may be one way of providing this information. Written information does go out of date and needs to be updated regularly. This information may be linked to self-management training.
- We should put a greater focus on children and support patients. There should be a focus on eating well and wellbeing for children. The CHIN models would work well for under 5s.
- There should be more inter-agency working with the London Fire Brigade and the Metropolitan Police as they often identify vulnerable patients.
- CHINs should consider offering support with Lasting Power of Attorney and Advance Care Planning for older people.
- There should be training for family carers so that they are able to care for their loved ones better. This may be linked to self-management training and support. There should be more support for carers.
- Share the message of frailty and diabetes in the hard to reach communities more. More targeted approach (Mosques, Community services etc…) encouraging more face to face discussions on the topic.

<u>Specific Diabetes CHINs feedback</u>

- The group noted that if the diabetes CHINs model proves successful then it would be good to extend it to other areas. It was noted that if the model is extended then the ethnic demographic in these new areas need to be considered and sufficient support needs to be available for those languages.
- The group noted that having mobile diabetes test sites could prove beneficial to capturing people who are too busy to attend GP surgeries or have health checks.
- The group noted that there needs to be more advertisements surrounding diabetes in the local area (such as at bus stops etc).
- The group noted that educating children in schools about diabetes would also be beneficial, especially as a number of children who have moved from a different country into the area have stronger English skills than their parents.
- There should be a greater emphasis on pre-diabetes work, more education and subsidies to encourage healthier living. Sports/ activities could be available at a discount. More teaching in schools.
- 80% of people newly diagnosed with diabetes do not attend the educational courses. The education structure is partly to blame. Sessions aren't flexible

and can take up an entire day. People who work or have other obligations cannot attend. Perhaps evening or Saturday sessions could be piloted.
- Language barrier is also a barrier to attending self-management courses. People who can't speak English (or have a limited grasp of English) feel isolated in generic Diabetes meetings. If there are Turkish Diabetes meetings,
- then people with a limited grasp of English will be helped out by people in their own community attending.
- Interest on the table in low carb diets which can reverse diabetes for newly diagnosed Type 2 patients
- Processed foods and lack of exercise were seen as key drivers in increasing diabetes
- Recommendation to "prescribe" resistance and weights training for diabetic patients to manage blood glucose levels
- Council to promote use of park by schools, fitness groups and sports groups as a way of preventing more obesity
- Raise public awareness of subtle signs of diabetes so patients actively ask for screening
- Patients expect more than a one-off visit from the care navigator because they have more issues to discuss or have built a rapport with them.
- Patients who are registered in Haringey but live out of borough, particularly Enfield, can't access local services because they have a higher threshold for access and a smaller range of services are available

Specific Frailty CHINs feedback

- The Frailty CHIN service is going well and is well received
- Difficulty getting a GP referral to the gym. Referral process could be easier/ improved.
- Eligibility criteria in central Haringey CHIN of having to be over 75, on 10 or more medications is too high. Suggested that the age criteria is reduced.

CHINs questions and answers

Question: Is Haringey CCG measuring the impact of CHINs?

Answer: Yes - we will agree a set of outcome measures for CHINs for measurement in 2019/20.

Question: Do the current CHINs support young people?

Answer: No – Almost all children and young people who have diabetes have type 1 diabetes which required Insulin management. Because of the level of complexity of managing children they are cared for by hospital and paediatric services.

Question: Does the CHINs which focus on moderate frailty only support older people?

Answer: It will predominantly support older people but the much smaller number of individuals with frailty who are, for example, under 65 can also receive support.

Question: What impact will Brexit have on the availability of medicines?

Answer: There are national arrangements being made by NHS England, in preparation for Brexit, to ensure that the medicines' supply is managed effectively so that patient care is not affected.

Question: There is often a lack of coordination between medical care and carers (home care). How can CHINs help improve this?

Answer: This is an issue that the longer-term development of a local care network, in which clinical and care professionals (such as nurses and doctors, social workers and home care staff) work more closely to coordinate planning and support for individuals, will address. The function that CHINs will undertake in 2019/20 should form part of this network of care in the future. We will look at ways to improve joint planning and delivery arrangements across health and care in the interim.

3. Developing a Frailty Strategy for Haringey (Item 3)

Haringey CCG and Council are planning to develop a joint frailty strategy for the borough. Paul Allen (Head of Integrated Care and Frailty, HCCG) delivered a presentation on the planned Frailty strategy and asked attendees to discuss and provide feedback on priorities.

The Engagement Network was asked to consider other ways in which the strategy for frailty could be implemented, which at this initial stage, may not have yet been considered.

Frailty strategy table discussions - feedback

- The frailty strategy should not be exclusive to old people e.g. it's not just 65+ that have moderate frailty. Young people and those with long term/ complex health needs should also be included.
- The strategy needs to recognise that care for the elderly/ those who are frail needs to be personalised. It's not a one size fits all - people need to be engaged on a personal level and on a case by case basis.
- The group noted that integrated and collaborative working between health and social care will be key to the success of the frailty strategy.
- The group noted that it is key that people feel like they have a purpose and understand what they may be giving up when they make certain choices about their care/support.
- The group noted that housing will be important in supporting the frailty strategy as it needs to be ensured that the accommodation that patients are returning to is suitable and will allow them to continue living independently

- People need purpose to motivate them to take responsibility for their own wellbeing – this needs to be considered on the strategy.
- The importance of faith needs to be in the strategy
- Patients need to be the focus of the strategy – so that they can be supported to live well with frailty and long term conditions.
- There is a lack of coordination between social services, NHS acute, NHS community, mental health and voluntary sector etc. They all need to be much more integrated. There needs to be a coordinated process and how this will work needs to be written in the strategy.
- The strategy needs to address the complications that patients registered with Haringey GPs, but who live in a different London boroughs, face.
- The strategy needs to take into account the outcomes of the North East Tottenham pilot.
- GPs need to be involved and trained up
- The strategy needs to state who the named person ultimately responsible for the frail person - doesn't have to be the GP. Could be psychology graduates?
- Care plans need to be developed with care navigators
- The priority needs to be early identification, diagnosis and intervention.

- Inspiration/ Drive to motivate people to a healthier lifestyle. People need to be stimulated and empowered.
- The frailty strategy needs to be developed as soon as possible as there is a need for it. It needs to be a long-term plan, not just for a year then stop.

<u>Other comments on frailty</u>

- People on lower incomes are unable to buy befriending services like Buddy Hut so rely on community groups and renting community centre space. E.g. men's domino groups. As the number of community centres reduce these groups are unable to afford more expensive meeting places
- Long waiting times for "free" services which are not means tested
- There is a perceived stigma with wealthy residents in admitting being frail or being labelled frail therefore don't always access services.
- Some patients are not eligible for services until they are frail by which time they are too frail to attend e.g. taxi services
- Older people may be too scared to go out particularly after a fall, because pavements are uneven or afraid to use public transport because bus drivers brake aggressively.
- Encourage easy exercise to improve core stability e.g. Yoga, Tai Chi, balance classes
- Rehab classes after a fall twice weekly for a shorter period as opposed to once a week for longer period. Patients who are afraid to fall don't practice exercises at home. Twice weekly classes encourage muscle development faster and exercise technique is reinforced.
- Students on fitness training courses need practical experience and could provide one to one support for people to exercise at home or community-based classes
- Promote joining of social groups before people become frail
- Recognise local resources as social groups to reduce isolation e.g. men meeting at the barber shops as a social event.

- Services need to consider people's backgrounds and what they have been doing all their lives up to the point they become frail and need support and services.
- Patients and their relatives need a named individual who works across all the services that they need. This person may need to advocate for the patient across services

Frailty questions and answers

Question: What consultation has been done in developing the strategy and this model? How many patients and relatives have been involved?

Answer: Haringey CCG and Council are very much in the early stages of developing a frailty strategy for the borough. We are currently gathering initial thoughts and feedback on what the strategy's priorities and areas of focus should be. We will continue to engage and involve a range of stakeholders, including patients and carers, as the work progresses.

General comments

- End of life is a difficult subject to talk about.
- Concerns that the east gets more support than the west.
- More service signposting in all GP Practices.
- Carers need to be acknowledged more for what they do.
- Social services/ care services are only interested in people on benefits.
- Staff appear to be working for money as opposed to actually wanting to help people. People feel like they are being treated as a statistic/ name rather than an individual and become disenfranchised.
- More flexibility for people and carers to spend money on the care they need. Give more budget control. Give people the choice on services however it appears the services are reluctant.
- Patients need more choice in the staff who deliver their care e.g. support workers. When complaints are raised about staff nothing is done about it.
- Text message appointment reminders is a good thing to remind people of their appointments, possibly follow up with another text if people miss their appointments.
- More updates need to be provided on progress to introduce more joined up working between services / professionals.
- There should also be stronger links with community organisations, voluntary groups, faith groups and social groups.