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

Thursday, 13th June, 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 13th June 2019 **Minutes of the previous meeting and matters arising**	Item No **5**

OUTLINE

Attached please find the draft minutes of the held on 8th April 2019.

MATTERS ARISING from November meeting

Action at 8.7

ACTION:	*Chief Executive of HUHFT to meet with Chief Executive of Barts Health Trust and the Chair of Tower Hamlets CCG to explore a common approach to implementing these regulations for charging overseas visitors and to report back to the Commission.*

The CE of HUHFT will update on this aspect of the issue at this meeting.

MATTERS ARISING from April meeting

Action at item 4.11

ACTION:	*Chair to write to Transport for London on the proposed reductions to the 242 bus route and lobbying that they be reversed because of the hardships they will cause adding that the closure of the GP Practice has increased the need for transport solutions particularly for the frail and elderly.*

This related in particular to the closure of the Sorsby GP Practice item and TfL has already been lobbied on this by the Cabinet.

Action at item 4.11

ACTION:	*CCG Primary Care Team to provide a further update the Commission on the progress of the dispersal of the patient list from Sorsby.*

A future update will be scheduled on this.

Action at 5.5

ACTION:	*Adult Services to provide update on ILDS in March 2020.*

This has been added to the work programme.

Action at 7.19

ACTION:	*MD of CCG to provide the implementation plan in the run up to the 13 May go live date for The NHS App in City & Hackney.*

This is attached.

Action at 7.24

ACTION:	*DH to provide information on the governance structure and the members of the governing bodies overseeing The NHS App work.*

This has been provided and will be reflected in the report of the scrutiny review. The reply to the matter arising above also relates.

Action at 8.5

ACTION:	*MV to liaise with O&S officer on timing for a possible scrutiny event on the St Leonard's site.*

This has been done and it has been provisionally pencilled in for October.

ACTION

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

The NHS App has been available for all patients to download with the basic symptom checker function for a number of months. However, it was only from February 2019 that it began being connected to GP practice clinical systems in order to enable the key functionality of appointment booking, repeat prescription ordering and viewing medical records. This process has been phased; City and Hackney practices were connected to the App simultaneously with other INEL CCGs on 13th May 2019.

The roll out of the App has been principally led by NHS Digital (D) and digital leads at NHS England (E). They have made a toolkit available to practices which sets out the recommended steps to be undertaken by practices in preparation for connection. It should be noted that the key functionality of the App, previously collectively referred to as Patient Online services, have been available to all registered patients in City and Hackney since 2014/15 via EMIS Patient Access website or a variety of other apps such as Evergreen-Life. The NHS App simply provides a new common user interface for these existing services, adds the new symptom checker, and enables patients to register preferences around organ donation and personal data.

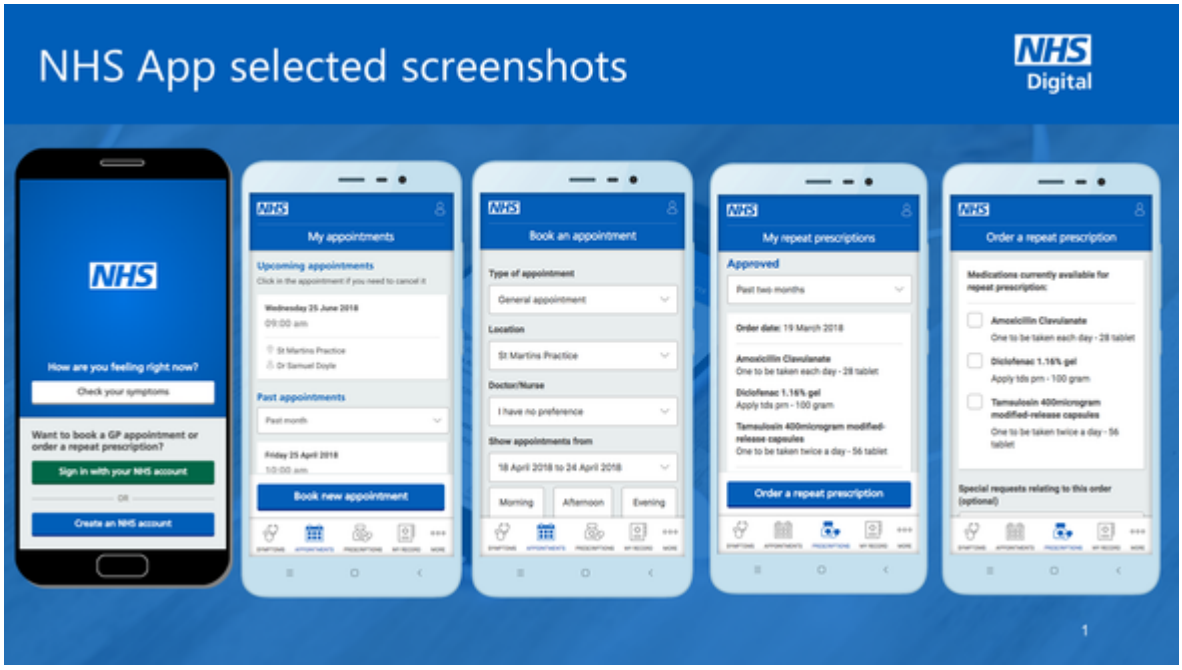
The main drive of the toolkit prepared by NHSD has been to encourage practices to address known issues with Patient Online services; for example, reviewing the naming of online appointment slots available to ensure that they are booked appropriately or ensuring that their staff are familiar with IG issues around granting more convenient online access to the medical records. Although the toolkit does encourage practices to promote the App, NHSE are planning a significant public facing marketing campaign for Q3 19/20 by which time they expect any teething problems from the launch to be resolved. The CCG will expect local practices to take part in this campaign, as appropriate.

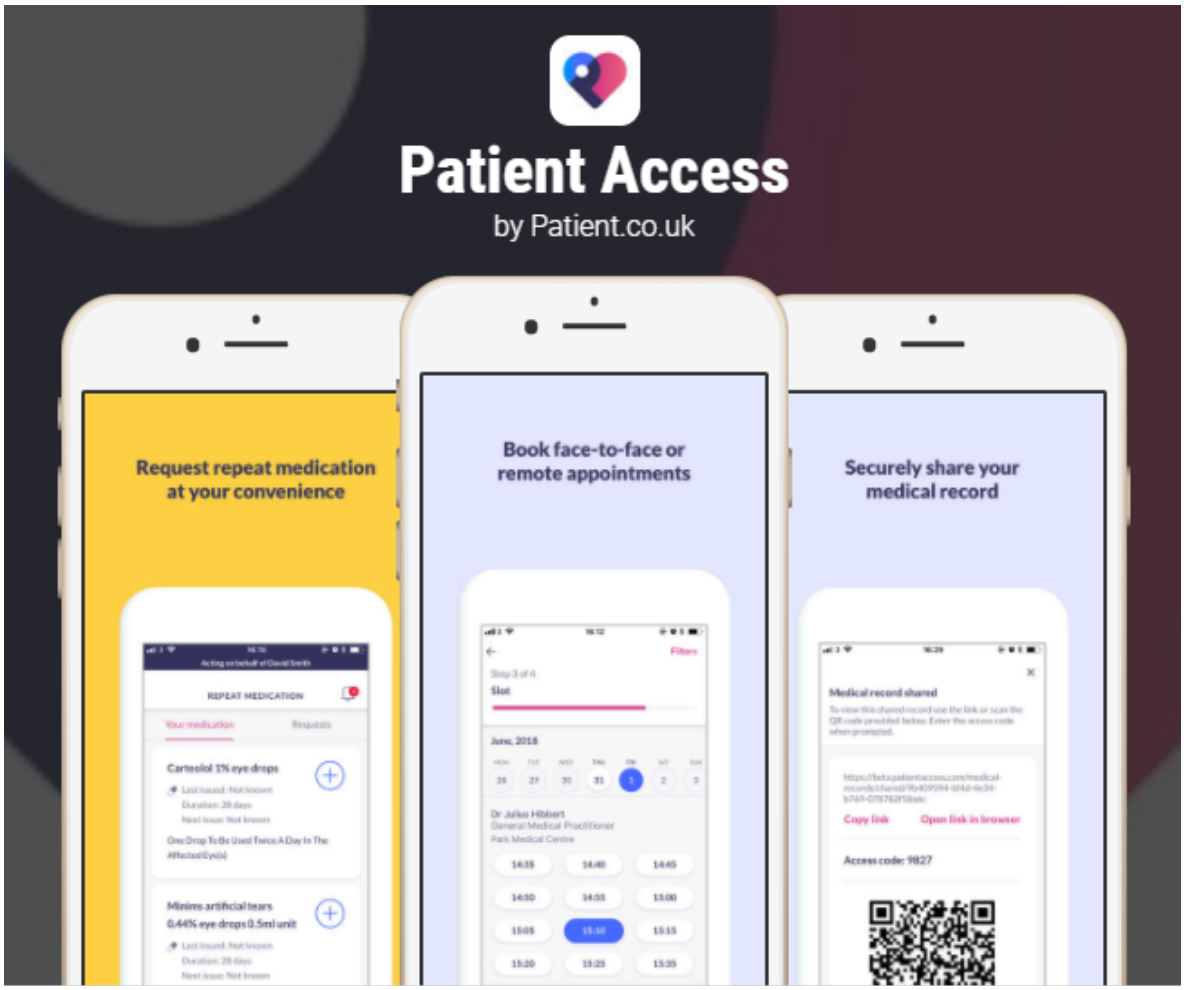
Locally, the CCG has liaised with colleagues from NHSE and neighbouring CCGs on communications to practices commencing six weeks prior to connection on 13th May to ensure that they were taking the necessary steps to prepare. This was supplemented by the creation and promotion of a page on the CCG GP website linking to a number of resources on the App, but also technical information on how to effectively configure EMIS for Patient Online services.

Through the CCG's monthly GPIT Steering Group and May's Clinical Commissioning Forum we have been engaging with practice managers and GPs to raise awareness and report practice level statistics for utilisation of online services. A practice facilitator working under the CCG commissioned GP IT support service also works closely with the local Practice Managers Forum to run training sessions on the App and online services. One of the key issues raised by practices has been how to facilitate patient access to medical records online, as under the GDPR this sometime requires redaction of third party references or sensitive conditions. The CCG is working with a local practice manager to produce some guidance.

Patient Online services more generally are promoted by practices through their websites and internally in practice waiting rooms and at reception desks as these have been in place for several years. Some practices are known to engage more readily with these services as a method of managing administrative demand for appointment booking and repeat prescriptions which ordinarily would have resulted in walk-ins and telephone calls. For example, several local practices have adopted an appointment model which actively directs patients to book an initial telephone consultation on line.

City and Hackney currently has approximately 28% of registered patient enabled to use Patient Online services. Enablement is a pre-requisite to accessing these services via the NHS App.


NHS App selected screenshots
NHS Digital
How are you feeling right now?
Check your symptoms
Want to book a GP appointment or order a repeat prescription?
Sign in with your NHS account
Create an NHS account
My appointments
Upcoming appointments
Past appointments
Book new appointment
Book an appointment
Type of appointment
General appointment
Location
St Martins Practice
Doctor/Nurse
I have no preference
Show appointments from
Morning
Afternoon
Evening
My repeat prescriptions
Approved
Order a repeat prescription
Order a repeat prescription
Medications currently available for repeat prescription:
Amoxicillin Clavulanate
Diclofenac 1.16% gel
Apply tds prn - 100 gram
Tamsulosin 400microgram modified-release capsules
Special requests relating to this order (optional)
1


Patient Access
by Patient.co.uk
Request repeat medication at your convenience
REPEAT MEDICATION
Carteolol 1% eye drops
Minims artificial tears 0.44% eye drops 0.5ml unit
Book face-to-face or remote appointments
Slot
Securely share your medical record
Medical record shared
Copy link
Open link in browser
Access code: 9827

Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Monday, 8th April 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) and Cllr Patrick Spence**
Apologies:	**Cllr Deniz Oguzkanli and Cllr Emma Plouviez**
Officers In Attendance	**Anne Canning (Group Director, Children, Adults and Community Health), Tessa Cole (Head of Strategic Programmes and Governance), Penny Heron (Joint Strategic Commissioner Learning Disabilities) and Ann McGale (Head of Integrated Learning Disabilities Service)**
Other People in Attendance	**Richard Bull (Programme Director Primary Care, CCG), Siobhan Harper (Workstream Director, Integrated Commissioning, CCG/LBH/CoL)), David Maher (Managing Director, CCG), Dr Mark Rickets (Chair, CCG), Kirit Shah (City & Hackney Local Pharmaceutical Committee), Michael Vidal (Public Rep on Planned Care Workstream), Andrew Carter (SRO Planned Care Workstream and Director at CoL) and David Hodnett (Programme Delivery Lead The NHS App, NHS Digital), Tristan Stanton, (Implementation Lead – NHS App, NHS England), Dr Phil Kozan, NHS England)**
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 were received from Cllrs Plouviez and Oguzkanli.

1.2 Apologies were also received from Cllr Demirci and Dr Sue Milner.

2 Urgent Items / Order of Business

2.1 There were no urgent items and the order of business was as on the agenda.

3 Declarations of Interest

3.1 Cllr Maxwell stated that she was a member of the Council of Governors of Homerton University Hospital NHS Foundation Trust.

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

4 Minutes of the Previous Meeting and Matters Arising

4.1 Consideration was given to the minutes and matters arising from the meeting held on 12 March.

RESOLVED:	**That the minutes of the meeting held on 12 March 2019 be agreed as a correct record and that the matters arising be noted.**

CLOSURE OF SORSBY MEDICAL PRACTICE

4.2 The Chair stated that further to the AOB item on the closure of Sorsby GP Practice at the previous meeting he had submitted a number of follow up questions to the CCG as Members had some ongoing concerns about the issue.

4.3 Members gave consideration to the following email responses received from the CCG:

---

1) Which neighbouring Practices are taking up the Sorsby patients and can you demonstrate that they have the capacity to cope? He would like to see a map to indicate the distance patients will have to travel.

Since 11th April 484 out of 4200 patients have already registered with a new practice. 37% have gone to Lower Clapton Surgery; 26% to Wick Surgery; 13% to Lea Surgery. The nearest practices confirmed that between them they have capacity to take on over 10,000 extra patients (Sorsby has 4,200). The CCG is providing financial support to surrounding practices to help them cope with the spike in new registrations. At point the CCG's assessment is that practices can cope. Based on the current trend only two practices appear to have more patients registering than they said they could cope with – Nightingale is forecast to receive 52 patients (an increase on its current list size of <0.5%) and Athena is forecast to receive 364 patients and has capacity to take on 300 patients. Based on current numbers about 3% of patients may have to register with their second choice of practice. The CCG is monitoring the numbers on a weekly basis. If patients register at the current rate then the list should be fully dispersed before the end of June. About 15% of the Sorsby list live outside of Hackney or live outside of the Clapton Park Estate.

2) What happens to those requiring home visits?. Members are well aware that this Practice is in the most deprived corner of the borough and the patient cohort is

particularly vulnerable with a lot of older people and people with complex needs. Transport provision is not good in this area and transport for those who are elderly or with limited mobility to the other Practices IS a problem. There is one bus. Are there plans therefore to increase the number of home visits to accommodate these patients and if not why not?

There are 52 patients on the current Sorsby home visiting list. Receiving practices will be required to carry out home visits where clinically indicated as part of their contractual duties.

3) Members also have concerns that the consultation was inadequate in that the meetings were held during the day and for a proper engagement some should have been held in the evening so those working full time could attend. Complaints have been made to Members about this.

This was engagement rather than consultation and all patients were written to.

4) Has the meeting with King's Park Ward Cllrs happened yet and if so what was the outcome of it? Is there an action list?

Yes – Mark Rickets and myself met with Councillors Demirci, Patrick and Rennison on 4th April, 8am, at the Town Hall.

It was agreed that I would contact Paul Williams, Operations at Clapton Park Management Organisation regarding additional local communications; that I would write to TfL regarding the proposed reduction in the 242 bus route and that I would provide the Councillors with monthly reports on the numbers of patients re-registering. First report sent last Friday. Next report due 2/5/19.

Richard Bull
Programme Director – Primary Care, City & Hackney CCG

4.4 The Chair added that Dr Mark Rickets (MR) (Chair, CCG) and Richard Bull (RB) (Programme Director for Primary Care) were joining the meeting to answer some further questions and he also welcomed 2 residents affected by the closure who had asked to contribute to the discussion.

4.5 A resident stated that her 83 year old mother-in-law had been a patient at Sorsby for 45 years and she was aware of a number of other elderly patients who were also very concerned about the impact of the closure on them. She detailed the difficulty of a bus journey to the alternative practices especially in winter for someone who was elderly and frail. There was only one bus route and the buses were overcrowded, with school children in particular, and she would have a walk at either end. She added that in her view the surgery had been deliberately run down over a number of years and had been providing a bad service. She stated that there was always difficulty trying to get through on the phone, then 10 minute appointments which were not sufficient for elderly people. She added that this area of the borough badly needed more doctors.

4.6 The Chair asked whether additional home visits would now be offered for these elderly and vulnerable patients. He added that Members had heard a lot about the new Neighbourhoods Model and had that taken into account addressing what needs to be done when there is a loss of GP capacity.

4.7 MR replied that it had been very disappointing that they had been unable to find a GP partner to take on the practice despite great efforts over the past few years. Lower Clapton Medical Practice had run it on an interim basis but no longer wanted to do so. There was no deliberate running down of the service. The premises was owned by NHS Property Services and the CCG had been trying to engage them on improving the facilities for many years. As regards Home Visits this was part of the Core Contract for GPs and would be provided when requested. In addition the CCG had increased capacity for supporting older and vulnerable patients by enhancing the basic offer with proactive visits up to 4 times a year to frail and elderly patients. The offer on home visits in Hackney was far better than in other CCG areas. He re-iterated that if elderly patients were unable to get to the surgery they could phone to request a home visit.

4.8 The resident replied that officers needed to understand that change was very difficult for elderly people and that the communications on the closure of the practice must be better tailored for elderly and vulnerable patients in future. Her mother in law was finding it difficult to negotiate the processes she already had to contend with and yet people like her, wished to retain their independence. The letter to residents in November was bland and implied there would be no issues and they heard nothing until they were told the practice would be closing and she had to take a day off work to accompany her mother in law to the practice to try and sort things out. Her mother in law had not registered with the new practice yet as she didn't know what to do. She asked why Lower Clapton Medical Centre did not wish to continue at Sorsby. The Chair added that there was a strong requirement here for link person in the surgery to help with vulnerable patients who were struggling.

4.9 RB replied that Lower Clapton had run the practice for 9 years and spent their own money on it. They could not get GPs to work there and this had nothing to do with the patients but was mainly because of the poor condition of the premises. 10 nearby practices had been identified where patients on the Sorsby list could be moved to. He said the CCG had been very proactive in identifying those who needed additional support through the transfer and registration process and additional resources had already been allocated to the receiving Practices to ease this transition.

4.10 A Member stated that the Commission should consider a future review on "Service Change and Transport" because this issue had come up fairly regularly over the years. Members agreed.

4.11 The Chair asked that officers, outside of the meeting, provide direct advice to the residents who had attended. He also stated that he would also write to Transport for London lobbying on the proposed reductions to the 242 bus route as the closure of Sorsby illustrated yet again the hardship that change would cause in a deprived neighbourhood and to lobby them to re-instate it in full.

ACTION:	**Chair to write to Transport for London on the proposed reductions to the 242 bus route and lobbying that they be reversed because of the hardships they will cause adding that the closure of the GP Practice has increased the need for transport solutions particularly for the frail**

	and elderly.

ACTION:	**CCG Primary Care Team to provide a further update the Commission on the progress of the dispersal of the patient list from Sorsby.**

5 Integrated Learning Disabilities Service - update on new model

5.1 The Chair stated that this was the third in a series of updates on the review of the Integrated Learning Disabilities Service which the Commission had requested, the last one being in September 2018.

5.2 Members gave consideration to the update report and the Chair welcomed for the item

Anne Canning (AC), Group Director CACH
Ann McGale (AM), Head of Integrated Learning Disabilities Service
Tessa Cole (TC), Head of Strategic Programmes and Governance
Penny Heron (PH), Joint Strategic Commissioner – Learning Disabilities

5.3 In introducing the report TC stated that this was the third update and the new model was in place and the service now had a 2-provider model with ELFT and LBH. One of the big challenges was to recruit permanent staff and much progress had been made with 6 new social workers and a new permanent Head of Service in place.

5.4 AM added that there had been extensive consultation on a redesign of the service and they now had a much more joined-up offer. The focus was much more on achieving independent outcomes. She described the 4 new pathways which were being rolled out: *Preparing for Adulthood; Referral and Review; Intensive Support; Ongoing Support*. The Intensive Support model would focus on dual diagnosis patients (mental health and learning disability) for example. Multi disciplinary teams were working to prevent crisis and with an increased focus on preventions. The Referral Pathway would focus for example on those who were new in the area or whose needs had changed and on reviews against the set Performance Indicators. The Ongoing Support pathway had a focus on social care for health. Officers had been asked to report back specifically on out of borough cases and she explained that this was a complex area. Many were historic and had been out of borough for 20 or 30 years. These were given a chance to return and ensure if they did they are properly linked into local services and in receipt of the advocacy they needed.

5.5 Members asked about staffing. AM replied that the staffing establishment remained the same and the service worked in multidisciplinary teams to avoid duplication. There were 48 FT and PT and 6 new permanent social workers would help reduce the dependence on agency staff. This issue was a national one.

5.6 Members commended the co-production approach and the user forums and commented that forums might not always be representative and asked how people got appointed on to them. They also asked what was being done to ensure outreach to groups such as the elderly, BME and LGBT groups.

5.7 AM replied that many had been on the forums for a long time but much work was going on to attract new members. The new Supported Living organisations in the system were also represented and the health staff were also bringing in new people via the programmes such as those on healthy living, movement, dance, dieting etc. They were also reaching out to young people still in education and generally focused on being more outward facing.

5.8 The Chair asked about the ongoing and serious budget pressures in the service and if there was no reduction in staff and no diminution of service how could the savings be made.

5.8 AC replied that one of the key challenges was that the SEN pressures were already feeding through into ILDS as those young people reached maturity. AM replied that there were two elements to the cost savings challenge: rising demand and cost pressures on the budget because of increased costs for nursing care/support in the community/daycare and these cost pressures were national. So, needs were going up and providers' costs were also going up. In response they were looking a possibilities such as more local provision and at better advance planning by looking at projections of the numbers that would be coming through for the schools etc. Generally there was a need to move away from high cost residential accommodation.

5.9 The Chair asked how the new strategy would ease the cost pressures?

5.10 AC replied that the main reason for the redesign was to come up with a better and more fit-for-purpose model rather than simply cost savings. They looked at more appropriate local accommodation for example but central to the approach was to be clearer on the principles underlying the assessments. The Group Director for Finance and Resources and his officers were working very closely with the service on responding to the cost pressures. Also if additional monies came through from savings as a result of integrated commissioning, she added, this is where it would be directed. The key point was that this was a statutory service and structurally it was not funded at the level it needed to be and this was a national issue.

5.11 Members asked why it was so difficult to recruit staff.

5.12 AM replied that there was a national crisis in recruitment of social workers and so it was necessary to consider the full offer to these workers. The focus therefore was to ensure that support for mentoring newly qualified staff was in place as well as ongoing support.

5.13 The Chair asked whether with the 130 out of borough placements if they did decide to return they would be able to do so.

5.14 AM replied absolutely yes, it was their choice and obviously a whole number of issues would need to be considered such as the mental capacity of the patient and the ability to deliver the correct care to them. All out of borough placements had been reviewed and most wanted to stay put because they had lost links with the borough etc. The challenge was to ensure proper step-down care in assisted living for example was in place for them where they were. AC added that moving them back would not necessarily produce any significant

savings. In most cases however it had the advantage of putting them closer to home and with a provider that the Council knew well and it would be easier to ensure there were no gaps in their provision.

5.5 The Chair thanked officers for the report stating that it was clear that the new pathways were now more intuitive and sensitive. He stated that if in the next year there had to be any diminution of the service that this be explained to the Commission and if officers could return in a year with an update.

ACTION:	**Adult Services to provide update on ILDS in March 2020.**

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

6 Integrated Commissioning PLANNED CARE Workstream - regular update

6.1 The Chair stated that this was the latest in the rolling programme of updates from each of the Workstreams in Integrated Commissioning. This time it was the Planned Care Workstream and Members gave consideration to the detailed report.

6.2 The Chair welcomed:

Siobhan Harper (SH), Workstream Director – Planned Care, CCG-CoL-CCG
Andrew Carter (AC), Senior Responsible Officer for Planned Care Workstream and Director of Community and Children's Services, City of London Corporation.
David Maher (DM), Managing Director, City and Hackney CCG

6.3 SH took Members through the report in detail. She stated that Andrew Carter from City of London was the new SRO for the Workstream having taken over from Simon Cribbens. On outpatient transformation she stated that they were looking at ways in which care was delivered and described examples such as the 'virtual fracture clinic' and the dermatology service where the use of digital photo submissions was transforming the approach and avoiding patients having to come in for minor consultations face to face. On the issue of the over performance in elective care at the Homerton she started that the CCG had been able to mitigate it and there had been an external audit of the data to better understand the pathways and what the drivers were. A full audit was expected at the end of Q1 and then appropriate financial adjustment were expected. She added that in relation to the over spend in ILDS it would not be possible to commission ones way out of the financial pressures. By using joint funding arrangements they were trying to establish the level of health need and match it to the level of care need that was not being served. They was also some non-recurrent funding which was being used to alleviate the financial challenge. She stated that they had been successful in their bid to the Prioritisation and Investment Committee of the CCG to secure funding for the 'Housing First' programme and this was now out to procurement. This was a health integration model which would provide benefit to the whole system. On the issue of Continuing Health Care things were looking much better. Great progress had been made in ensuring the clients were assessed within 28 days and more was being done on arranging for assessments to take place out of hospital and in either the home or in the care home. On Cancer performance the data remained hugely disappointing. The system was capturing more

people at Stage 1 and Stage 2 which was good but screening remained a problem and so people were not being diagnosed early enough. Work was going on to drive up screening and detection rates. Bowel cancer which was very treatable still had rates which were too high and there was targeted work going on about that.

6.4 Members asked about the over spend in elective care. What were the drivers and whether this would result in a backlog and longer waiting times. Members also asked if this problem had just emerged in the past year.

6.5 SH replied that there wasn't a concern about waiting times in this context. The 18 week targets were good and one might have expected longer waiting times but this had so far not occurred. The problem was that the partners involved could not mutually agree what the drivers of the problem were and so an external audit was carried out to try and resolve it. She added that it was monitored closely and after the issue emerging at Q1 last year it was reported regularly to ICB. It varied every year but this change was not found to be statistically significant there was no issue about GP referrals for example. DM added that it was necessary to distinguish between a plan and how it was executed. A plan is always based on historical data as a starting point. The issue now was whether this was a new normal and there would be a need to adjust future plans. Discussions were ongoing with HUHFT on how to structure the contract better for the next year.

6.6 A resident, Mr Sills, described his experience of prostate cancer diagnosis and added that it was vital that early detection rates go up.

6.7 The Chair added that the figures on cancer were a concern. The Commission had heard in the past year or more about poor performance on cervical and breast screening and asked whether it would be better if both of those were devolved more locally. He added that detection, referral and conversion rates traditionally varied considerably between GP Practices and asked what was being done to tackle this.

6.8 SH replied that the CCG had an experienced GP dedicated to this one day a week and he was visiting Practices, examining their data and the literature etc that they were distributing to patients. An App had been developed for Hackney clinicians to assist them with this work. Generally the CCG and the Confederation was looking at what they could put in place to support GPs and a Clinical Practice event on it would take place on 1 May to look at what additionality could be put in place. Within Integrated Commissioning they were driving the 'Make Every Contact Count (MECC)' initiative and trying to employ a system based approach. Much more educating needed to be done about the importance of screening. The Chair commented that he had noticed that on the digital first primary care review that Tower Hamlets CCG had dedicated a GP 3 days a week to that urgent issue and asked whether there was scope to put more dedicated clinical resource onto this problem.

6.9 AC commented that it was not just about increasing clinical capacity there was also a role here for Local Authorities on public health messaging. There was a very high prevalence of certain cancers among Black Men and while some success had been achieved by the use of community champions etc there was an urgent need to do more on driving up screening.

6.10 The Chair stated the Cabinet Member Cllr Williams had been campaigning on the issue of rare and uncommon cancers and had 35 GPs attend a seminar on the issue the previous week. This had been a great success and she was keen to replicate this model and would be having talks with Cllr Demirci and health partners to develop this.

6.11 The Chair thanked the officers for their detailed update and for their attendance.

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

7 REVIEW on Digital First Primary Care... - evidence from NHS Digital on The NHS App

7.1 The Chair stated that this was the final evidence session at committee for the Commission's review on 'Digital first primary care and the implications for GP Practices'. He welcomed to the Commission:

David Hodnett (DH), Programme Delivery Lead – The NHS App, NHS Digital
Tristan Stanton (TS), Implementation Manager, NHS England
Dr Phil Kozan (PK), NHS England

7.2 The Chair added that Members had been sent the links to the background information about The App from the NHSE website and had been encouraged to download it in advance of this discussion.

7.3 DH stated that beginning in 2016 NHSE had centralised the planning for an App for primary care functions. It was now in a national roll-out phase. A new system for 'Log In' was in place requiring the applicant to submit a photo from their phone and a photo of their passport to assist with confirmation of ID. This was for those who don't already have an online account with their own GP. 15.3 million people now had an online account. The App would allow patients using a smartphone or tablet to: check symptoms, find out what to do when they need help urgently; book and manage appointments with their GP; order repeat prescriptions; securely view their GP medical report; register to be an organ donor and choose how the NHS uses their data. He added that the test programme had 3000 users on it and the majority never had an online account. There was a large procurement exercise around the App and 4 platforms had been selected to progress the work: EMIS, TPP, Vision and Microtest. They were on track for the 1 July date for full roll out.

7.4 The Chair asked how the App would integrate with all the various local systems for online triage that they had been looking at as part of the review.

7.5 DH explained that on the first version of the App had no online triage at the front end. They were working on this functionality now and had started with one of the providers E-consult and would proceed to the next three, they would not be locking any provider out but had to start somewhere. They had 32 applications, whittled it down to 7 and were now working with EMIS, TPP, Vision and Microtest. What they were currently saying to patients was that if appointment booking was not currently on the App for their GP they could

always proceed outside of the app and book online in the normal way using the various platforms which GPs are using such as Patient Access or Evergreen Life etc. This was like 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 for now the focus was very much on primary care.

7.6 PK and TS explained that another key part of the mix was the NHS Log-in which would make accessing all of this easier. The reach of the App so far has been great with 15m signed up most of whom had never accessed the NHS digitally before. There were 40m to go. The big difference with this was that an individual, once signed up, would use it throughout the various stages of 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 systems and the NHS App would function as part of a vibrant market.

7.7 In response to a Member who stated his Practice was not yet signed up TS stated that this was a staged roll out. They wanted to take the time to engage and organised it around a staged roll out in different geographical areas. City and Hackney would go live on 13 May. He added that there would be a large national advertising campaign from September to raise public awareness of it. This was held off until most of the country would be live and to give the new system a chance to bed-in.

7.8 Members stated that some would obviously benefit much more than others from this and what was being done to maximise take up.

7.9 TS stated that they were working on a number of approaches directed at target groups such as the homeless and those who with a low educational background who were digitally excluded. He undertook to share a link to their pathfinders programme which included the “Empower the Person” programme. He added that it should be considered that if appointments were freed up by digital this released resources to provide more support to those who could not use digital methods. PK added that as part of this they were working to how to engage service providers to make better use of the advantages that would come from the App. The Chair commented that the challenge was to get them to meaningfully engage. DH replied that 12000 names for the different clinical interactions had been identified and there would be a need for clinical interactions and appointment types to be renamed and standardised so that the system operate better. Pharmacists were also very important to the App and they were working with them using an iterative approach on the business change needed.

7.10 Michael Vidal, a resident, asked why all this functionality could not be added to the existing Patient Access system and what was being done for those who have neither a smartphone nor a tablet.

7.11 PK responded that this change could not be a bolt-on. NHS Trusts and CCGs had been engaging their own providers on a range of digital tools for patients. There was a need for a national App and to try and integrate and build on what had been developed by the 4 leading platform providers and there had been an extensive period of learning before they started. As regards accessibility standards in the NHS these were the highest possible and the NHS App had

received the highest rating from the Government Service which rates all Apps which are used on public projects. They also want to get the public to go on using a wide range of services. On the issue of access by digitally excluded patients there were a number of approaches. Patients could use iPads at GP Practices and in Libraries and there was also a system for proxy access for example for the elderly living at home whereby a family member or care could log-on on their behalf. DH added that a programme for those on offline pathways was being developed. Pharmacists were also going to set up the ID element of the App also and a web version of the App would follow. They were not charging Practices for any of this.

7.12 Members asked about parents logging on for children or elderly relatives.

7.13 DH replied that they were working on the system for carers to log on for adults and parents and guardians to log on for children. There were significant safeguarding issues in relation to children which had to be taken into consideration. 13 year olds and over can use the App. 13-16 year olds must have id verified in the Practice and only over 16s could use NHS log in.

7.14 Chair asked about the problems with the algorithm and public being annoyed by lots of questions on these systems when they're trying to do something simple quickly.

7.15 DH replied that for online triage this was totally under control of the individual Practices. Some GPs (or CCGs encourage their GPs) to open their whole appointment calendar to online requests, others offered a limited selection and some locked it down. The design of the online triage element can be tailor made. Under new GP Contract a minimum number of online appointments will have to be offered by all GPs however. TS added that some contacts will require that the digital provision is of a sufficient quality.

7.16 A Members stated that as with the shift to electronic banking they were stripping out the bulk of direct face to face contact and this had implications for quality and also meant lots of receptionists potentially being made redundant.

7.17 PK replied that this was true but the reality was that General Practice was not coping with its current workload so something had to be done. The days of being on the phone for 20 minutes at 8.00 am trying to get through had to end, there was no effective triage it was luck of the draw in getting through. In relation to staffing he did not foresee any reductions in staff instead there would be different roles for receptionists within Practices. Some people will of course insist on seeing a doctor face to face and this will need to be managed.

7.18 The Chair asked DM what training was being planned for GPs in City & Hackney in the run up to 13 May and how would it be advertised to patients.

7.19 DM replied that this was being led by Niall Canavan in the IT Implementation Group and by the GP Confederation and he undertook to provide members with the implementation plan.

ACTION:	**MD of CCG to provide the implementation plan in the run up to the 13 May go live date for The NHS App in City & Hackney.**

7.20 TS added on training that there was an extensive progamme of online training for GPs including webinars, toolkits, social media campaigns, posters and any practices which might struggle were being identified. A lot was happening locally in each CCG area. Waltham Forest was taking the lead as the Accelerator Site for this work in North East London.

7.21 Kirit Shah (Local Pharmaceutical Committee) asked about training for Pharmacists on this.

7.22 DH replied that the toolkit currently was for NHS clinicians but that community pharmacists provided a really valuable component of primary care and were being part of the plans. Work was going on to develop a triage system with pharmacists for example. PK added that this was about system change and so not just about GPs.

7.23 A member asked who was on the governance bodies overseeing the development of this.

7.24 DH replied that there was a board in NHS Digital which in turn was overseen by a governing board in NHSE and above that by DHSC.

ACTION:	**DH to provide information on the governance structure and the members of the governing bodies overseeing The NHS App work.**

DH added that part of what they oversaw was Security Penetration Testing and Technical Reassurance. Every time they released an updated version of the app there was a significant number of governance tests that had to be gone through to ensure security was maintained.

7.25 The Chair thanked the officers for coming from Leeds to contribute to the review and thanked them for their time.

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

8 Inner North East London Joint Health Overview and Scrutiny Committee - verbal update

8.1 The Chair gave a verbal update on the meeting of INEL JHOSC held on 3 April. He stated that there were two substantive items the NEL Estates Strategy and the 10 year NHS Long Term Plan. He added that while the funding bids from ELHCP (the NEL STP) had failed the bid to Cabinet Office for some seed funding to work up proposals for the options for redeveloping the St Leonard's site, as part of the 'One Public Estate' pilot, had been successful. One of the issues to be considered was when the time would be right to run an engagement event in the community.

8.2 A resident (Mr Sills) added that as a borough Hackney needed to decide what it wanted to do with the site and there was some urgency here.

8.3 The Chair stated that his preference was to organise a Scrutiny Engagement event on the future of St Leonard's which could involve a public meeting with a panel from CCG, HUHFT, ELFT, LBH. A member stated that he was confused what had happened to the London Devolution Pilot and whether this had been superseded by the ELHCP. The Chair added that there was a need to hear from the local NHS about: St Leonard's, the possible transfer of mental health beds from HUHFT to Mile End (Barts Health) and plans for GP re-configuration. He added that there was a view that there was a trade-off being made between increased elective capacity and mental health beds.

8.4 David Maher (MD of C&HCCG) replied that the Neighbourhood Model was key here. The development of St Leonards as part of One Public Estate provided key opportunities for the borough. The issue in relation to the move of mental health beds was not about an exchange. He was the mental health lead for ELHCP and what was envisaged was similar to what been achieved successfully for stroke and cancer services i.e a vision for a mental health centre of excellence which would drive up outcomes for the local population. The Chair replied that there would be a degree of political unhappiness if different aspects appeared to be traded off against each other and this would require careful handling and appropriate engagement and consultation.

8.5 Michael Vidal stated that he as a public rep on the Planned Care Workstream and was involved in initial work on the St Leonard's issue and he undertook to liaise with the O&S Officer on the more appropriate timing for holding a possible engagement event. The Chair thanked him for this.

ACTION:	**MV to liaise with O&S officer on timing for a possible scrutiny event on the St Leonard's site.**

8.6 The Chair reported that the items for the next two INEL JHOSC meetings would be as follows:

19 June 2019:

- Waltham Forest formally welcomed into the INEL JHOSC family
- NELCA /ELHCP Accountable Officer update
- Early Diagnostic Centre for Cancer at Mile End
- INEL System Transformation Board

18 September 2019 joint meeting with Outer North East London JHOSC:

- NELCA /ELHCP Accountable Officer update
- NHS Long Term Plan and Workforce
- Estates Strategy update
- Moorfields Eye Hospital

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

9 Work Programme for the Commission for 2019/20

9.1 Members gave consideration to the work programme for the Commission.

9.2 The Chair stated that the final part of the evidence gathering for the 'Digital first primary care' review would comprise focus groups with were being run by Hackney Matters and which would feed into the review.

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

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00 - 9.15 pm

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **Response to draft Quality Account from St Joseph's Hospice**	Item No **6**

OUTLINE

NHS Trusts are required to submit an annual Quality Account to NHS Improvement and as part of this process are required to invite the local health scrutiny Committee to comment on their draft submission. The Commission does this every year.

The Commission has invited the Chief Executive and the Director of Clinical Services at St Joseph's to the meeting to discuss the issues raised in their draft report.

Attached is a copy of the draft report. The Chair's letter of response on behalf of the Commission will be tabled and will form the basis for the discussion.

Attending for this item will be:

Tony McLean, Chief Executive
Jane Naismith, Director of Clinical Services

ACTION

Members are requested to give consideration to the draft Quality Account.

This page is intentionally left blank

Quality Account 2018/19

St Joseph's Hospice,
Mare Street, Hackney,
London E8 4SA

T: 020 8525 6000
E: info@stjh.org.uk
www.stjh.org.uk

St Joseph's Hospice

Founded in 1905 under the care of the Religious Sisters of Charity. Registered Charity No. 1113125

Part 1: Chief Executive's Statement

CEO Statement for 2018/19 Quality Account

This year's Quality Account illustrates the progress we have continued to make in striving to achieve outstanding care across our services. During this year, we celebrated our 114th anniversary of delivering services from our site in Hackney, we have again managed to achieve a great deal despite the prevailing financial climate.

It gives me great pleasure to introduce this report as the relatively new CEO of the Hospice, having taken on the role on the 1st November 2018. I hopefully bring to the organisation a great deal of experience and expertise having been in healthcare for 38 years and being a registered nurse and health visitor for most of that time as I still retain my registrations for my 3 professional qualifications. My experience as a CEO in the public, private and now not-for-profit sectors over the last 20 years are what brought me to St Joseph's as the Trustees believed that all of this experience, knowledge and skill will enable the Hospice to continue to evolve as an organisation.

St Joseph's Hospice continues to deliver specialist palliative care, end of life care, and respite care for people with progressive and life-threatening illnesses, as well as supporting their families and carers. We are very focused on looking after people with complex or multiple needs and providing specialist support and expertise at end of life.

In addition, we provide specialist advice and support to other professionals in palliative and end of life care, offering specialised education and training and undertaking targeted research. We also ensure that we continue to explore other ways of extending the care pathway for our patients through the continuous development of our community projects and services such as Compassionate Neighbours, Namaste, Islington Bereavement Service and many more, some of which are award-winning programmes.

Underpinning all our work is our mission statement, which evolved from the words of Religious Sisters of Charity founder, Mary Aikenhead, which is to ensure “the poor could be given, for love, what the rich could obtain with money”. “We have been caring for and supporting people affected by complex and terminal illness, as well as their families, ever since the five Sisters arrived in Hackney and established the Hospice in 1905.

This year has had its financial challenges in keeping with many others in our specialist sector, as well as changes in senior management. We have a substantive Director of Clinical Services and Registered Manager with extensive knowledge and expertise in the sector who has ensured that our standards of care and the governance that underpins this is robust and gives assurance to the Trustees and me as CEO.

Around half of our funding comes from our NHS Block contract for the three principle boroughs we serve; City and Hackney, Newham and Tower Hamlets, covering a population of approximately 2.2 million. In addition, we also deliver services to Islington, Waltham Forest, Haringey and specific services for residents of some of the surrounding London boroughs, which extends our population catchment to around 4 million. The remainder of our funding comes from charitable legacies, donations and other fundraising, which is due to the generosity and goodwill of our local communities. We also recognise that we cannot do this without the support of many partner organisations. We work closely with local NHS providers and with many other voluntary sector care providers to deliver better integrated services and care models across our pathway of care.

2018/19 has been a year of continued change and challenge, but we have managed this without detriment to the delivery of care to our patients across our services, as you will see within the body of the report.

Some key achievements have been:

- To set out a budget plan that ensures we achieve a balanced budget over the next two years so that predictable income and expenditure are in balance.
- Completion of the refurbishment of Lourdes ward to be able to provide a state of the art fit, for the care services we deliver now and in the future. We are raising funds to achieve these same improvements to our second ward and hope to start this work in 2019/20.
- We are improving our communication mechanisms to ensure that Board to Ward and Ward to Board messages are transmitted up and down the

organisation in ways that are meaningful and timely so good practice can be cascaded around the organisation.

- We have just launched Vision 2024 which sets out the strategy for the next 5 years in light of the NHS Long Term Plan, and the plans we have developed to stabilise our income and give longevity to some of our existing projects.
- We are continuing to invest in our volunteers and are taking steps to better acknowledge their value across all aspects of our care pathway and services.

Once you have digested the report, I trust you will be encouraged by the progress that has already been made, despite the prevailing financial climate in the sector.

To the best of my knowledge, the information reported in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by our Hospice.

Tony McLean,
Chief Executive

We welcome your comments and feedback on this Quality Account, which you can do via email, letter or telephone to Jane Naismith, Director of Clinical Services, may be contacted by telephone on 020 8525 3009, or by email (j.naismith@stjh.org.uk). Please address correspondence to Ms J Naismith, Director of Clinical Services, St Joseph's Hospice, Mare Street, London E8 4SA.

If you know of someone who may need a translator, we can arrange this via our Advocacy and Interpreter services.

Organisational Context

In 2019 we launch Vision 2024 – our plan that sets out the direction for St Joseph's Hospice for the next five years and which reflects the recently published long-term NHS strategy. Vision 2024 comprises five pillars that cover all aspects of St Joseph's operations and services:

1. **Patients' strategy**: We aim to improve services to all patients whether at home, in the Hospice, in the community, or by caring for others who give care.

2. **Enterprise strategy**: We are establishing a new Enterprise pillar that augments existing revenue channels to generate a predictable income flow.

3. **Estates strategy**: Our Estates strategy focuses on development of the main Hospice site, and includes plans for the acquisition of retail and clinic/day care facilities in the boroughs.

4. **Funding** and fundraising strategy: New fundraising initiatives will make up the continuing shortfall in funding from the NHS.

5. **Human resources strategy**: We aim to make St Joseph's a place that gives staff – and volunteers – the opportunity, whatever their background, to fulfil our Mission, develop their careers and earn a reasonable income in an environment of mutual support and care.

Over the next five years, staff, volunteers and members of our wider community will actively contribute to St Joseph's unique identity. We will be at the forefront of delivering care tailored to individual needs and continue to develop and share best practice.

Our strategy will reinforce St Joseph's role as a place where patients can expect care, compassion and specialist clinical support, whether in the tranquil surroundings of the Hospice, in people's homes or in the wider community.

We will work closely with other institutions locally, and where necessary, nationally, so that together, we meet patients' medical, social and spiritual needs. Care will be tailored to the individual irrespective of their faith, no faith and background.

We will continue to build our reputation as a centre of excellence for specialist palliative care, working closely with primary care and local hospitals.
St Joseph's services will include in-patient, out-patient, day care, respite care, advice and support in the individual's home or care home, and bereavement support. Much of this will be available 24/7.

Staff will be committed to caring for patients and their families. In turn, we will help staff meet their objectives for professional practice and personal development.

St Joseph's will support the Hospice services through legacies, fundraising from trusts and personal donations, commissioning from the NHS and we will establish enterprise initiatives that will bring a sustained income to the Hospice.

We need to explore new sources of funding to augment the income we currently receive from the NHS and charitable donations, and look to increase income from different enterprises that are in keeping with our overall ethos.

As part of all of these developments, we will ensure we manage our information in ways that protect those we care for and their families, as well as use information on our services to influence those who commission our services.

Part 2: Priorities for Improvement 2019-20

Priority 1- Care Closer to Home

In line with the NHS plan and St Joseph's Hospice five year vision we are committed to bring care closer to the patient's locality be that their own home, care home or homeless hostel.

We are currently working collaboratively with Newham CCG to improve earlier recognition of people who may be coming towards the last months of life to ensure that appropriate care plans are in place. To achieve this, we are attending monthly multidisciplinary team meetings (MDT's) and our nurse specialists are building stronger links with the care home staff.

We are already working closely with St Mungo's homeless hostels in City and Hackney. Having provided education and holding regular cause for concern MDT's, this has led to an increase in referrals to the community palliative care team and more people from hostels dying in the Hospice if that is their preferred place of care. We are participating in an action research project with two hostels in Tower Hamlets and will transfer what we learn to support patients in Newham. We also accept referrals for patients with no recourse to public funds to our community and inpatient service.

Having reviewed our community service, we are aware that not all patients need to be seen in their own homes. The number of referrals to our community team has increased by 23 % in the past year. To meet this increased capacity we have set up nurse-led outpatient clinics. This enables us to see more patients in a timely manner and is less of an intrusion for the patient. However, we are aware that for some patients this means travelling some distance, therefore we plan to set up outpatient clinics in each of our core boroughs.

Priority 2 Expansion of Day Services

Following our review of day services including Day Hospice last year, it is our intention to expand our day services offer from three to five days per week. We are aware our day services play an important part in supporting people to manage their symptoms be they physical or psychological to maximise their wellbeing and remain in their own homes.

Our day services also have an important role in reducing social isolation and loneliness, which are factors that increase the potential of hospital admission in people with long-term health conditions or life-limiting illness.

As part of this expansion, we are exploring having different sessions for specific disease groups or populations such as neurological conditions or younger people.

Priority 3- Increased User Involvement

St Joseph's Hospice has always placed the recipients of it services at the heart of its work. As such, its commitment to continually improving services remains an organisational priority. The Hospice uses a variety of approaches to improve quality, and it is particularly interested in engaging service users to ensure that it always considers an outward, external perspective as it builds and develops into the future.

The Hospice has a long tradition of seeking the views of service users via specific surveys carried out throughout the year, through formal complaints and through letters offering compliments and praise. More recently it has started issuing " I Want Great Care" cards to service users and their relatives, giving them the opportunity to feedback their views about the care they, or their loved one, have received.

In January 2019, the Hospice set up a new service user group as part of its overall planned user engagement strategy. This new group focuses on helping the Hospice to understand what actual service users think of the services available, and it explores how these people would like to see services improved and developed in the future. It involves members of the group becoming actively engaged in on-going face-to-face dialogue over time. The process is two-way in the sense that it enables the Hospice to test its ideas for future plans and developments directly with actual service users, whilst at the same time allowing this same cohort to express its views about the issues that they consider to be important in relation to end of life care.

The aim and function of the user group is

- To engage service users in face-to-face discussions concerning issues around dying, death and bereavement, and specifically about their experience of using our services
- Extending knowledge regarding hospice and end of life care, death, dying and bereavement
- The group meets monthly, discussing a planned programme of topics throughout the year. Topics are partly determined by the group members themselves, and partly by the Senior Management Team at St Joseph's.

Priority 4- Increased utilisation of Quality Improvement Methodology

The Hospice has always strived to maintain and improve the quality of the care delivered. To support our efforts, in October 2018 we reviewed our current governance structure and created a Quality improvement (QI) and Clinical Governance post. The aim of this post is not only to ensure our clinical governance systems work effectively, but also to educate staff and promote the application of Quality Improvement (QI) methodology to any projects or service reviews or improvements across the Hospice.

We intend also look at all patient incidents, complaints and concerns through a QI lens, ensuring that learning is identified and shared not only with the relevant care team but also across the organisation as a whole.

In 2019/20 we plan to:

- Train 60% of all clinical staff in QI methodology
- Create QI champions in each clinical area
- Hold bi-annual shared learning events.

Priority 5 – To become a Dementia-Friendly Community

Building on our very successful Namaste programme, in 2018/19 we introduced Namaste volunteers to our wards. They visit the wards daily and use the principles of Namaste therapy to all patients in our in-patient areas. This has been scored highly in our I Want Great Care feedback.

We are aware that there are an increasing number of individuals in the communities we serve living with dementia, and our aim is to become a dementia-friendly community,

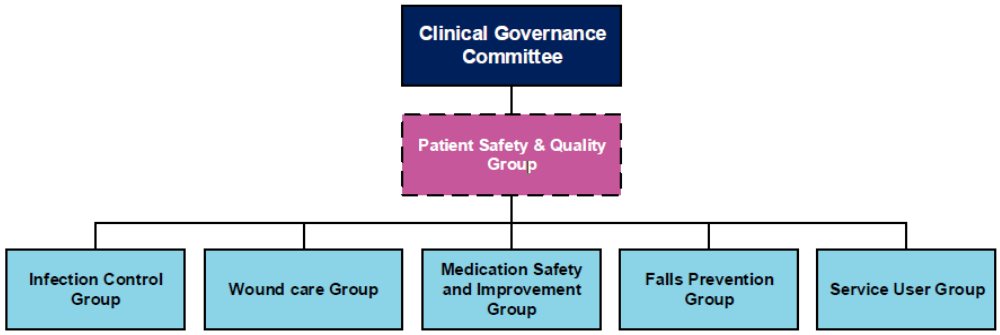
Dementia Friendly Community: Alzheimer's Society's Dementia Friends programme is a national initiative to change people's perceptions of dementia. It aims to transform the way the nation thinks, acts and talks about the condition. St Joseph's is working towards recognition as a 'Dementia Friendly Community' by meeting the DFC Foundation criteria. This includes having dementia-friendly staff, champions, services and environments. Our ward environments and toilets in public areas meet dementia-friendly standards, and we are working towards ensuring the remainder of our patient environment meets these standards. All our healthcare support workers have had dementia training and we will be introducing dementia champions on our ward areas. We recently made 'Dementia Friends' training mandatory for all staff and are aiming to achieve >95% compliance by September 2019. The current compliance rate is 62%. We are also member of City and Hackney Dementia Alliance.

Part 3: Review of Quality of Service in 2018/19

We regularly measure our performance against national, local and internal performance standards, as well as benchmarking ourselves against other UK hospices. We also welcome quality-monitoring visits from external organisations. These objective measurements demonstrate that we meet both external and internal standards, and demonstrate that St Joseph's Hospice continues to provide safe and effective specialist palliative care.

3:1 Quality Assurance

Reporting Structure



3:2 Quality Monitoring Visits

We have not had any quality-monitoring visits in 2018/19. However, we do have quarterly contract and quality assurance monitoring meetings with our commissioners at which we review all our incidents, complaints and concerns.

3:3 National Quality Indicators

NHS trusts are required to report performance against core indicator using nationally held data. Hospices do not submit this data, but we have measured our performance against the indicators that apply to the healthcare we provide. Hospice UK benchmarks performance data which enables St Joseph's Hospice to compare its quality to other hospices.

Indicator	Performance
Inpatient falls	Total number of falls were 59, affecting a total of 49 patients. 42 resulted in No Harm, 15 Low Harm, and 2 falls resulted in Moderate Harm (both patients attended A & E but only minor injury was seen). This represented 6.6 per 1000 Occupied Bed Days. Hospice UK's benchmark for similar sized inpatient units is 10.3 %. An increase in Quarter 4 was a result of 3 patients falling more than once.

	To manage and reduce the risks :- • The Falls Group meets monthly to review all falls and actions taken • Staff awareness is ongoing with a Falls Prevention and Management day planned for September • 1:1/observation protocol includes 4 levels of the assessed observation required • Safe staffing and escalation processes is in place • Post Falls Protocol is being reviewed and updated • A NICE Quality Standard audit is in progress
Pressure Ulcers	Total number of new/ hospice acquired pressure ulcers in the year was 44 affecting 35 patients. We continue to report all new hospice acquired pressure ulcers; six categories from I to Unstageable. In this year, there were 7 Category I, 27 Category II, 6 Category II deteriorated to III at End of Life, 2 Deep Tissue Injuries and 2 Unstageable ulcers. We record the patients' phases of illness and AKPS. All ulcers were assessed as unavoidable. This represented.4.9.per 1000 occupied bed days. Hospice UK reintroduced this benchmark after a 2 year break, following work carried out by NHS Improvement (June 2018) The Hospice UK average is 17.3%. Hospice UK also included revised definitions and measurements. For example since April 2019, we now include moisture lesions, medical device damage and removal of the category of unavoidable. To reduce the incidence of pressure damage within the inpatient unit we take the following actions:- • Wound care group which meets monthly • Monthly Matrons ward rounds • 2 weekly panel to review all new Category III and above PU's • All patients are assessed on admission for risk of developing pressure damage using a validated tool and Route Cause Analysis for new PU's • Six wound care champions have cascaded RGNs • All HCAs are being trained to use the React to Red tools over the next 6 months • Equipment is reviewed and updated as required • A NICE Quality Standard Audit will take place in the next 6 months
Medication	Total medication errors in the year were 78. All the errors were graded as No or Low Harm. This represents 8.8 per 1000 Occupied Bed Days. The Hospice UK benchmarking data average per 100 bed days is 8.0 %, which makes us slightly above average. We have implemented the following action plan to reduce errors/incidents and improve our medication safety: • Monthly medication, safety and pharmacy meetings • Monthly bulletins highlighting trends and actions to be taken • An identified increase in prescribing errors in Quarter 4, has been followed up by the medical team and staff have been encouraged to challenge poor prescribing practices

	• Robust education, support and assessments have been implemented by the pharmacist • All RGNs attend a full morning Clinical Day and yearly assessment including calculations • Staff have been trained to understand documentation and how to double check balances for discrepancies • Deep dives initiated when themes are identified to get to the root cause of the issues
Venous Thromboembolism	Our management in treating Venous Thromboembolism (VTE) risk was 100%. We have developed VTE guidelines in accordance with national recommendations. All medical staff are aware of the revised guidelines, which are now incorporated into everyday practice.
Mortality	A hospice will have a higher mortality rate than other care settings with many individuals choosing a hospice as their preferred place of care and death. The consultants review all deaths - there have been no cases due to suboptimal care. We have begun MDT 'Learning from Deaths' meetings where we focus on more complex deaths where there have been identified unmet physical, psychosocial or spiritual symptoms, despite maximum intervention. This has allowed staff to examine the circumstances surrounding the complexities of death, express their feelings and identify any learning points or suggested changes to practice.

3:4 Clinical Audits Completed since April 2018

During the year, we have completed a number of audits in order to access our compliance and effectiveness in relation to national, local and good practice guidance.

These audits are monitored through our Patient Quality & Safety group and shared with the Clinical Governance Committee who report to the Board.

An annual plan is scheduled at the beginning of each year and additional audits are included as identified from our monitoring and review processes linked to patients' quality and safety**.**

Statutory audits	
Infection Control: Compliance with hand washing	Good compliance overall with best practice & infection prevention guidance Hand Hygiene awareness day held December 2018 **Improvement plan:** Will be following the 'High impact interventions' (1)
Infection Control: Sharps – July 2018	100% scored on last audit

Infection Control: Vascular Access	No infections noted, good documentation found in records. **Improvement plan:** Will be following the 'High impact interventions' (1) initiative.
Infection Control: Catheter Care	Audits have indicated good compliance with local guidelines. There has been slight increase in E Coli over the last 2 years. **Improvement plan:** To address this, the Hospice will be carrying out a more robust audit, working with the education department to disseminate training in personal hygiene and catheter care. Will be following the 'High impact interventions' (1) initiative.
NHS Cleaning Standards	Housekeeping staff carry out monthly audits. Matron meets housekeeping supervisors monthly to review findings. Compliance with national standards for cleanliness in healthcare organisations is being met in all clinical areas. **Improvement plan:** From May 2019, the ward manager will be included in the monthly cleanliness audits on the wards. UV will be used for cleanliness audits (2)
Blood Transfusion	Audits have shown documentation of some parts of the process can be missed by both doctors and nurses, e.g. last cold chain and transfusion process audit showed consent section of prescription chart not completed or end time of transfusion not recorded in prescription chart. No major concerns when auditing practice. Staff follow procedure, it is just documentation that is occasionally lacking.
Medication: Quarterly Controlled Drugs	Overall good compliance with standards across all wards The way in which documentation errors were corrected in the CD register was noted to need improving. **Improvement plan:** The pharmacist carried out training with staff during the nursing training day and on an individual basis.

Ad hoc audits	
End of Life Documentation	Audit of IPU practice against NICE care of the dying adult in last days of life – a multi-centre pilot study involving St Joseph's, St Francis Hospice and The Margaret Centre. **Improvement plan:** The findings showed wide variability in the quality of documentation and this has been addressed with the medical team. Medics are working on producing patient and carers leaflets to address some areas.
IPU Admission Times	The target set was for 90% of out of hours and weekend admissions to be 'urgent' admissions. The findings were that 82% were 'urgent' admissions. The causes of non-urgent patients being admitted out of hours were described, e.g. transport delays. **Improvement plan:** Actions such as requesting transport earlier in the day will be followed up.

Falls NICE Quality Standard	Admission falls assessment and completion of falls care plans fell below pre-audit target of 100%. In cases where a falls care plan was not completed, there was a higher rate of falls i.e. it appears that completion of a care plan reduces the risk of falls. **Improvement plan:** Medical team to write a hospice falls policy and to roll this out alongside education sessions to medical and nursing colleagues and then to re-audit.

References

(1) https://www.nursingtimes.net/clinical-archive/infection-control/using-high-impact-interventions-to-reduce-infection-risk-by-standardising-good-practice/5004045.article

(2) https://www.infectioncontroltoday.com/environmental-hygiene/hospitals-using-uv-light-check-efficacy-its-cleaning-efforts

Quality Improvement (QI) Projects

The following QI projects are underway in the Hospice.

Quality Improvement Project	Start date	Project Lead
For therapies to receive all appropriate referrals from First Contact Team	Jan-19	Therapies team
To check the best method of administering medicines on the IPU.	Mar-19	Debbie Pegram, Matron
For patients and families to have a greater understanding of physiological changes at the end of life.	Mar-19	Charlotte Bryan, Nesar Gilani, junior doctors
To see if children attending the Day Hospice enhances the patient experience	May -19	Amy Outingdyke, Day Hospice manager
For outcome measures to be used to benefit patients	In discussion	Gary Murphy/Kate Crossland, ANP and doctor

3:5 Education in End of Life Care

Creating a skilled and competent workforce is essential to deliver high quality care. As a Specialist palliative care provider, educating the wider workforce is a key priority.

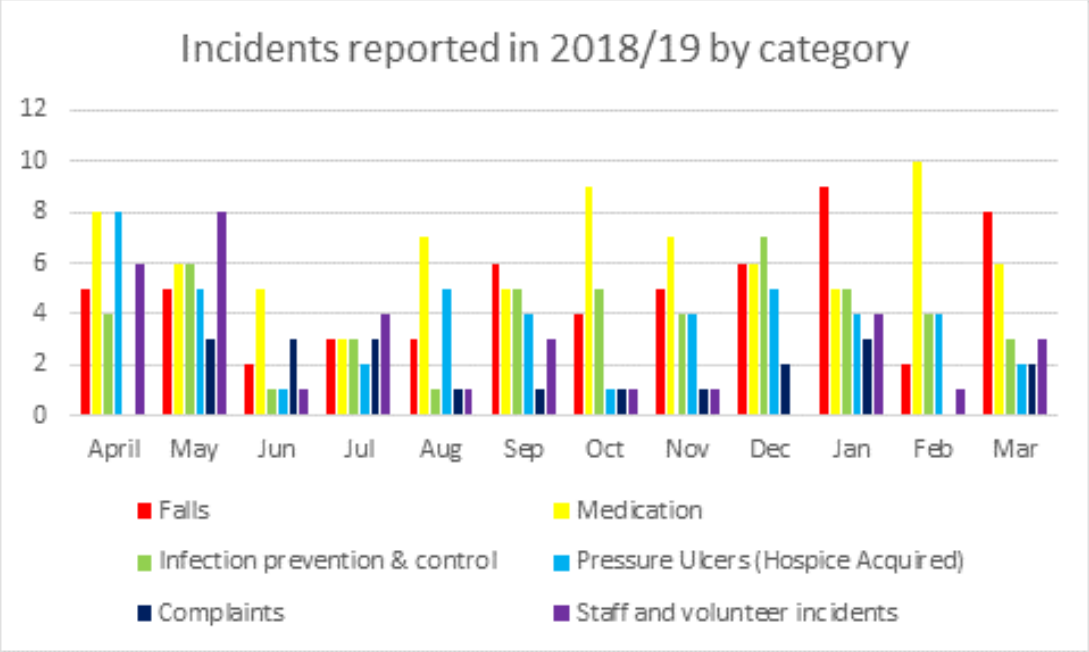
Training completed 2018/19

Professional staff who undertook external clinical courses	80
Support staff undertaking nationally accredited vocational courses	5
Staff undertaking leadership and management training	49

Staff and volunteers who attended STJH workshops in different aspects of EOLC*	147
External staff Staff who undertook our workshops in different aspects of EOLC*	126
Students supported on placements at St Joseph's Hospice Nursing, including returning to practice	28
Nursing, including returning to practice (Plus others attending for a day or less).	31
Medical (placements varied from part day to several weeks	487

3:6 Incidents

Reviewed monthly by the groups that feed into our patient safety and quality group. The table below shows the incidents reported in 2018/19. None of the incidents resulted in serious harm and all incidents were of low harm. As an organisation that strives to improve, we use the reported incidents to improve our quality of care through learning.



3:7 Formal Complaints and Concerns

In 2018/19, we received 12 complaints and 3 concerns. Of these, 3 concerned the quality of communication between staff and service users, 2 were about staff attitude, 7 raised issues about the need for staff to be clear about the service offered so patients can be clear what they can expect, 1 was about noise on the ward and 2 were about breaches of confidentiality.

We see complaints as an opportunity to learn, develop and improve our services. Over the past year, we have made the following changes because of complaints we have received:

- We increased the coordination between FCT and CPCT so that patients with urgent needs were allocated an appointment immediately.
- We clarified our referral criteria to GPs to remove any delay caused by a referral being sent to us inappropriately.
- We set limits on the time after which children would not allowed to be in the corridors on the wards.
- We offer training in handling difficult conversations, advanced communication skills and conflict management. Any staff/ volunteers who have concerns raised about their communication skills or attitude are registered on the relevant training and their performance is monitored via supervision.
- Each complaint or concern is followed up with a team reflection session, to learn from the complaint and prevent a recurrence.

3.8 Commissioning for Quality and Innovation

Service users offered the opportunity to participate in advance care planning conversation by the 3rd contact	Target 100% Achieved 98.25 %
Ethnicity recorded	Target 100% Achieved 89.75%

Referred patients ethnicity

White	BME	No stated
44%	52%	4%

Preferred place of death

	Achieved	Target
PPD achievement	74.25 %	70 %

Diagnosis at time of referral

Cancer Diagnosis	No Cancer Diagnosis	Non Cancer Target
62%	38%	35%

3:9 Information Governance Toolkit

NHS Data Security and Protection Toolkit: The DSPT is a published self-assessment which measures organisational compliance with the National Data Guardian's data security standards.

St Joseph's has completed and submitted the toolkit for 2019/20 and the standards are fully met (70/70 mandatory evidence items provided and 38/38 assertions confirmed). The toolkit content was reviewed by the St Joseph's Data Protection Officer prior to submission.

4:1 Care Quality Commission (CQC)

Periodic reviews by the CQC

St Joseph's Hospice was subject to an announced CQC inspection between July and August 2016. The inspection report was published in October 2016 and is available on the Hospice's website.

The CQC rated the quality of care provided by St Josephs as "Good" overall. The table below is how the rated the hospice in each of the five questions the CQC asks during an inspection.

CQC Question	Rating
Is the service safe	Good
Is the service effective	Good
Is the service caring	Good
Is the service responsive	Good
Is the service well led	Requires Improvement
Overall	**Good**

We are an organisation that places great value on staff, and we are working to ensure staff feel safe and secure at work.

Reviews and investigations by CQC
St Joseph's Hospice did not participate in any special reviews or investigation by the CQC during 2018/19.

Part 4: Improvements in Progress

St Joseph's Hospice set out the following priorities or improvement in 2018/19. We have made the following progress.

Priority 1: Implementation of a Care Strategy

Many of our strategic priorities for 2015-2018 remain relevant to delivering hospice services and will continue to be part of our strategy going forward. We have created a Care Strategy which continues to focus on providing care closer to home, reaching hard to reach groups, developing our workforce, strengthening community engagement and a clearer referral and discharge criteria, with a focus on episodic care which will enable the Hospice to meet increased demand for its services.

In particular, we will continue to strive to improve equitable access to palliative and end of life care, providing education, training and support to partners, providing care to people at the end of life, and professionals requiring advice on managing complex symptoms.

We have also focused on the support we give to our carers and launched our carer's service last autumn as a community based project with trained volunteers offering emotional, practical and respite support to carers at home. This approach promotes the 'Compassionate Communities' model and encourages communities to support each other. The service has had 48 referral and 55 respite visits giving 120 hours of free care. We have also established satellite peer-support group in Newham.

The project has attracted £30,000 in funding from St James Place Foundation and has been accepting referrals since October 2018.

Our vision for 2019/20 will focus on sustainability, by building and strengthening our volunteer base. We are improving skills and development opportunities for our volunteers to attract more individuals to the service, while working collaboratively in community outreach with other projects at the Hospice, promoting our Compassionate Communities model.

Priority 2: Well-Led and Employee Engagement

St Joseph's Hospice places a high value on our staff team; we recognise that they are critical to the continued high standard of care experiences by our patients in the community and in the inpatient wards. Employee engagement has continued to be a high profile activity for the Hospice.

We have continued to provide opportunities for reflective practice via the Schwartz Rounds, which are well attended. The next stage of development for this piece of work is to gain CPD accreditation for them. We have established a number of working groups to look at specific issues of importance in the Hospice. This year we have commenced consultative work to develop our values into a framework that can be used to inform how we set standards for knowledge, skills and behaviour in employment measured at key points during the employee life cycle, for example at recruitment and on boarding, during supervision at appraisal etc.

We have adopted a different approach to staff surveys working with a company called Survey Initiative, and have surveyed all our staff. We received the top line results and

are aware that more needs to be done to demonstrate leadership in the organisation and also to co-create the action plan arising from the survey results to dig deeper into the employee experience. We selected the Survey Initiative because of the data slicing and benchmarking service that they offer as standard which means we will be able to action plan on a pan hospice and service specific level which is not a facility we have previously had. The success of the action plan will be measured in the next staff survey and so on into the future.

We also plan to re vamp our representative staff forum this year to give it a new focus and new work plan.

Finally, we have introduced a "staff love" programme that enables us to celebrate specific special events in the calendar such as St. Valentine's Day, Easter and Christmas. St Joseph's Day is a day of celebration that includes the presentation of the long service awards and we have been delighted to present a 40-year service award to one of our nurses. We have long service awards planned for our Volunteers in the summer.

Priority 3: Day Services Review

Our Day Hospice is a weekday service offering activities, therapy and support for up to 20 patients each day. Patients are at the Hospice as outpatients from 10:30am to 3pm on Tuesdays, Wednesdays or Thursdays, for monitoring and treatment of their physical, emotional, spiritual and social needs. Patients now attend for a 12 week placement. At the beginning of the placement they set goals and aims which support them to maximise the resources they have around them and live as independently as possible.

We have completed a review of our Day Hospice and have seen the number of attendances rise in the past few months. We continue to recognise the value of offering alternative care settings for patients receiving palliative care treatment in the community and to achieve this we have expanded Physiotherapy, nurse outpatients, and have a new dietetic/ speech and language clinic

Priority 4: User Feedback

Service user feedback is essential in our quality improvement journey as it is vital to be able to monitor what we do well and what we need to do differently. We now use I Want Great Care.

'I Want Great Care' is now being used across the Hospice and the feedback remains consistently positive. The teams are being encouraged to collect sufficient forms for the data to be statistically significant. The process of recruiting a volunteer to support patients to complete the surveys on the wards is underway.

The surveys are completed independently by patients, or with assistance from family or staff, or, in some cases, by administrative staff during follow up phone conversations with patients and they are collected monthly by the Clinical Governance Lead. Feedback is disseminated to teams. Any member of staff who is specifically mentioned is sent the compliment via an email, copied to their line manager.

The results will be circulated as part of the monthly Dashboard Reports, with clear actions around improving the areas we are not doing so well in, and celebrating those where we are.

In addition to this, Matron now does a monthly ward round seeking information from patients and their families or friends about their care and how if they have been treated with dignity and respect throughout their stay.

We continue to carry out in-depth questionnaires quarterly on specific issues such as food and ward cleanliness and staff attitudes.

Priority 5: Information, Systems and Processes

In 2017/18, we continued to improve our information systems which we bring through to 2018/19 by strengthening the infrastructure. We have rolled out Microsoft 365, which will ensure that we have greater email security, and will facilitate easier remote access for all staff. We have improved our network, also bringing on line new servers and storing more data in the cloud. We have sourced funding which has enabled us to equip our community nurse specialist team with laptops which means they will can now access our clinical information system and the Health Information Exchange in real-time when with patients in their homes. This will lead to safer more efficient care.

We are still seeking a solution which will enable our clinical systems to talk to other clinical systems, and are working with Homerton NHS Trust to identify a solution.

Part 5: Statements of Assurance from the Board

The following are a series of statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers.

Referrals

In 2018/19, we had 2469 referrals and accepted 2136. The reasons for service users not being accepted are; service user declined service, service user not eligible for service, service user offered services from another hospice, and service user too unwell to transfer.

1.1 Review of services

During 2018/19 St Joseph's Hospice provided six key service areas for the NHS. These were as follows:

- Inpatient
- Day Hospice
- Community Palliative Care
- Bereavement and Psychological Therapies
- Social work
- Physical Therapies including speech, language and dietetics

We also provide the following services:

- Compassionate Neighbours
- Empowered Living
- Namaste Care (for people with advanced dementia)
- Education and training for health and social care professionals
- The Macmillan Information, Support and Advice Service. (This service will end on the 30th of August 2019.)

We have reviewed all the data available to us on the quality of care in all of our services.

1.2 Income Generated

The income generated from the NHS represents approximately half of the overall cost of running the Hospice services. The rest comes from the generosity and goodwill of our local communities, businesses, Individuals, trusts and foundations who support us.

1.3 Eligibility to Participate in National Confidential Enquiries

During this period, we were not eligible to participate in any national confidential enquiries.

As we were ineligible to participate in any national clinical audits and national confidential enquiries there is no list or number of cases submitted to any audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

1.4 Research

We are a research active hospice, including developing and undertaking hospice-initiated research and building in the capacity for linking with academic institutions.

- Homelessness Intervention (UCL)

  This is an action research project involving two Clinical Nurse Specialists and two hostels in Tower Hamlets. The nurses have received 2 days bespoke training around recognising and supporting people at end of life in a hostel setting training. They will now spend 2 days per month in this partner hostel providing formal, informal education and support. The impact of this intervention and its ability to improve the care people with end of life care receive will be evaluated by the research team.

2.0 Quality Improvement and Innovation Goals Agreed with our Commissioners

In 2018/19 St Joseph's Hospice did not have set commissioning for Quality and Innovation and Quality (CQUIN) goals. However, the Commissioner requested that we improve on our recording of ethnicity to ensure that we are caring for all ethnic groups in our community.

3.0 Data Quality

We continually strive to improve data quality through:

- Recording and monitoring data in line with information governance regulations
- Implementation of regular data audits
- Providing readily available support and training for all staff utilising our clinical records systems
- Regular work to maintain a culture practising accurate data capture, with good understanding of its use and application across the organisation
- Operation in accordance with the Data Protection Act

4.0 Governance Toolkit Attainment Levels

NHS Data Security and Protection Toolkit: We have completed and submitted the toolkit for 2019/20 and the standards are fully met (70/70 mandatory evidence items provided and 38/38 assertions confirmed). The toolkit content was reviewed by St Joseph's Data Protection Officer prior to submission.

5.0 Clinical Coding Error Rate

St Joseph's Hospice was not subject to a payment by results clinical coding audit by the Audit Commission during this period.

Part 6: GLOSSARY

Care Quality Commission
The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Visit: www.cqc.org.uk

Clinical Audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups (CCGS) are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population's health.

Overview and Scrutiny Committees
Since January 2003, every local authority with responsibilities for social services (150 in all) have had the power to scrutinise local health services. Overview and scrutiny committees take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Hospice UK
Hospice UK is the national charity for hospice care, supporting over 200 hospices in the UK.

Registration
From April 2009, every NHS trust that provides healthcare directly to patients must be registered with the Care Quality Commission (CQC).

Regulations
Regulations are a type of secondary legislation made by an executive authority under powers given to them by primary legislation in order to implement and administer the requirements of that primary legislation.

Schwartz Rounds
Schwartz Rounds offer healthcare providers a regularly scheduled time to openly and honestly discuss social and emotional issues that arise in caring for patients. The focus is on the human dimension of caring. Caregivers have an opportunity to share their experiences, thoughts and feelings on thought-provoking topics drawn from actual patient cases. The premise is that caregivers are better able to make personal connections with patients and colleagues when they have greater insight into their own responses and feelings.

Appendix 1 – MDS Data

This year, we were not required to send the National Minimum Dataset (MDS) to the National Council for Palliative Care (NCPC) due to changes in reporting requirements. We have, however, continued to collect the MDS data for internal purposes. This data is also shared with our three local CCGs (Newham, Tower Hamlets and City & Hackney) on a quarterly basis. We have provided these national figures as a comparison to our data over a 3-year period.

In Patient Unit

	18/19	17/18	16/17
% Bed Occupancy	78.25%	78%	74%
% Diagnosis – non cancer	25%	25%	26%
% Ethnicity – BAME	43%	42%	36%
% Patients returning home from an IP stay	42%	42%	43%
Average length of stay	17 days	15.8 days	18.7 days

Community Palliative Care Team – CPCT

	18/19	17/18	16/17
% Non-cancer patients	32%	36%	36%
% Ethnicity – BAME	54%	51%	40%
% Homecare patients who died at home/hospice	73%	81%	70%
Average length of care	103 days	129 days	107.6 days

Day Hospice

	18/19	17/18	16/17
% Diagnosis non cancer	37%	41%	36%
% Ethnicity –	50%	36%	33%

Appendix 2 – Audit Schedule for 2018/19

Title	Aims	Aspect of service delivery
Compliance with hand washing	Compliance with best practice & infection prevention guidance	Are we safe?
Sharps audit –	Ensure sharps are safely managed within the organisation	Are we safe?
NHS cleaning standards -2007 monthly audits	Compliance with national standards for cleanliness in healthcare organisations	Are we safe?
Quarterly controlled drug audit	Compliance with Medicines Act 1968 and Misuse of Drugs (Safe Custody) Regulations 1973 Department of Health Safer Management of Controlled Drugs – A guide to good practice in secondary care (England) October 2007 NMC standards for medicines management	Are we safe?
Re-audit of the core nutritional assessment on the inpatient unit	The aim of the re-audit is to review whether there has been any change in practice in this area, in particular in view of the recent move to an electronic record system.	Are we effective?
Patient led assessment environment PLACE	Ensure environment meets service users expectations – using national NHS audit tool	Are we responsive to needs?
Clinical handover from hospital teams	Re-audit of notes of patients who attended 25 hospital/day centre reviews	Are we effective?
End of life documentation audit	To evaluate the use of the new forms in end of life care, which will inform the end of life care group of necessary changes to be made to the current (interim) documentation	Are we responsive to needs?
Pressure ulcer - best practice compliance	Compliance with the recommendations from RCN & NICE relating to pressure ulcer prevention & management	Are we safe?
Are antibiotics prescribed in line with the antimicrobial stewardship guidance? Quarterly.	Compliance with hospice policy/guidelines √ Care Standards Commission NICE/ Department of Health & Public Health England Essence of Care / NSF International Patient/Carer instigated Professional concerns	Are we responsive?
Audit on omitted doses of medication	This audit aimed to capture baseline data for omitted medicine doses at St Joseph's Hospice, and to implement changes if necessary to improve medicines administration and documentation.	Are we safe?

Medical gases audit – using Hospice UK audit tool	Meet the requirements of the Medicines Act (1968), H&S at Work Act (1974), Misuse of Drugs Regulations (2001) and The Health Act (2006)	Are we well led?
Audit of resuscitation decisions and documentation in IPU	To assess if the patients' resuscitation status, and the discussions that took place are documented clearly	Are we safe?
Audit of care delivered compared to NICE Quality standard [QS144]	To assess if the care delivered met the NICE Quality Standard QS144. This standard This quality standard covers the clinical care of adults (aged 18 and over) who are dying, during the last 2 to 3 days of life.	Are we effective?

END

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **Response from HUHFT re Quality Account**	Item No **7**

OUTLINE

NHS Trusts are required to submit an annual Quality Account to NHS Improvement and as part of this process are required to invite the local health scrutiny Committee to comment on their draft submission. The Commission does this every year.

Attached is the letter which the Commission submitted in response to the Homerton's request as well as the final version of the Quality Account report.

The Commission has invited the Chief Executive and the Chief Nurse and Director of Governance to the meeting to respond to the points raised in the Commission's letter and to provide an update on current key issues affecting the Trust.

Here also is a link to the discussion on last year's Quality Account
http://mginternet.hackney.gov.uk/mgAi.aspx?ID=31616

Attending for this item will be:

Tracey Fletcher, Chief Executive, HUHFT
Catherine Pelley, Chief Nurse and Director of Governance, HUHFT

ACTION

Members are requested to give consideration to the discussion.

This page is intentionally left blank

Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

8 May 2019

Ms. Catherine Pelley
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Trust Offices
Education Centre
Homerton Row, E9 6SR

Email to: c.pelley@nhs.net

Dear Catherine

Response to HUHFT's draft Quality Account for 2018/19

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2018-19. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The Commission Members take a great interest in the performance of our key local acute trust and were pleased to learn about some of your key achievements over the past year. Your overall '*Good*' rating in May 2018 from the CQC across all services and the '*Outstanding*' ratings for Medical Care and for Urgent and Emergency Services is to be commended. We note also the additional new Improvement Priorities you have set for 2019/20.

During the past year we have continued to enjoy a good working relationship with the Trust and we greatly appreciate the willingness of the Trust's representatives' to attend our Commission meetings and contribute to our work.

Your Chief Executive attended our June and September meetings where we discussed a range of issues including the proposals for reconfiguring the pathology service. Local residents and GPs continue to have concerns about the Path Lab consolidation and the proposed revised structure across the NEL area, therefore we will continue to pursue this with you over the coming year.

In September your CE also took part in a high level discussion item on the Estates Strategy for North East London with senior executives from the CCG, the Council and ELFT and she also contributed to the debates at the Inner North East London JHOSC on both the NEL Estates Strategy and the implications for east London of the NHS Long Term Plan. We will continue to

pursue these discussions with you this year as hopefully outline proposals will emerge in particular for the St Leonard's site. We hope to organise an engagement event on this later in the year.

In November your CE took part in a discussion on the implementation of the Overseas Visitor Charging Regulations after the impact of these on vulnerable migrants was raised with us by Hackney Migrant Centre and local GPs. We have since had a response to our letter to the Secretary of State. The Health Minister has made clear that these rules must be implemented sensitively and sensibly and we would ask therefore that, while there is no direction on you to monitor these impacts, that you do so, because of the level of local concern about their impact.

We are also grateful to your Director of IT and Systems who has also contributed to our own review on '*Digital first primary care'* in his capacity as the lead officer for City and Hackney Integrated Commissioning IT Enabler Group.

We wish to make the following specific comments on your draft Quality Account noting that it is an early draft:

a) Re p.15 again this year there is an absence of data relating to the new requirement to report on 'Learning from Deaths'. How is this being rectified?

b) Re p.16 on 'Seven Day Services' you say that because the numbers are low it has been a challenge to develop appropriate Consultant rotas across the surgical specialities. One presumes the numbers are low because this is just starting? You also say that having a 12 hr Consultant presence is sufficient yet this is not in compliance with this particular NHS priority clinical standard.

c) Re p.16 you describe the two new 'Freedom to Speak Up Guardians' to support whistleblowers, but give no evidence about how busy they have been? Is this policy working?

d) There has been a lot of media coverage this year nationally of junior doctors experiencing bullying and working for dangerously long periods. On p.16 you describe the 'Guardian of Safe Working' which you now have in place in response to the new junior doctors' contract. Can you give us examples of how often s/he might have intervened on issues regarding your rota gaps?

e) The Trust is to be commended for your significant progress in reducing the C-Difficile rates to just 3 in 2018/19 and for being one of the best performing Trusts nationally on this indicator.

f) You are to be commended for making steady progress on End of Life Care issues but, re p.32, why have only 70% of cases had 'End of Life

Care Plans' or 'Treatment Escalation Plans' during 2018/19. What are the barriers here and how are you addressing them?

g) Re p.35 on the "improving first impressions" indicator why has there been such poor uptake of training by receptionists and surely this should be mandatory?

h) Your reporting on Priority 9 on seamless discharge makes no reference to the 'Discharge to Assess' pilot which we've been informed about by the Integrated Commissioning Unplanned Care Workstream. Why is this?

i) Re p.36 the series of missed post-natal discharges was serious and resulted in mothers and babies having delayed home visits and follow up. You implemented a new failsafe system. Is there now 100% compliance on this?

j) The Trust's improvement on IAPT waiting time targets is to be commended.

We look forward to taking up these issues with you over the next year on the Scrutiny Commission.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Tracey Fletcher, Chief Executive, HUHFT
Cllr Feryal Demirci, Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks
Dr Sue Milner, Interim Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

2018-19 Quality Account

CONTENTS

PART 1: STATEMENT ON QUALITY

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to present our Quality Accounts for 2018-19, which detail the Homerton University Hospital NHS Foundation Trust's position on quality over the last year, and which provides assurance that we continue to strive to provide the highest quality clinical care. We are proud to continue to perform well against our key performance and regulatory requirements while delivering high quality care for our patients and service users. The ongoing focus given to the quality improvement work is key to these achievements.

Our Improving Quality programme has continued to lead and support improvement projects throughout the year. This approach has increasingly been applied to improvement work within the Trust and it also influences the approach to change across the wider system, particularly within Hackney and The City. The Trust continues to be key partner in the work associated with the establishment and development of Neighbourhoods, enhancing the opportunity for multi-disciplinary working. The strong partnership approach also positively impacts on the management of urgent and emergency patients within the system, with all partners contributing to the success seen in the performance management of these pathways.

The internal quality transformation work has once again explored the benefits of technological and system advancements and considered how these could improve the way we are able to offer care and share information effectively. This has resulted in a shift to a paperless outpatients service with pathways managed entirely through the use of digital technology and enhancements to health systems, from referral to communication back to the GP. Our next area of focus now needs to result in ensuring such opportunities are available to patients.

The Trust also remains high performing in key areas of quality measures:

- A&E 4 hr waits – one of the best performing Trusts nationally
- Standardised Hospital Mortality Index (SHMI) –.one of the lowest in the country
- Referral to treatment (waiting times) – 96.7% of patients wait <18 weeks
- Diagnostic waiting times - 99.8% of patients wait < 6 weeks for diagnostic procedures
- Improving Access to Psychological Therapies (IAPT) -– 99.5% of patients wait <18 weeks to begin treatment
- Homerton attributable C Diff levels significantly below the national threshold set for the trust – 3 cases against a threshold of 10

We have also welcomed the Care Quality Commission during the past year when they carried out inspection visits to the acute services based on the hospital site. Four service areas were reviewed as part of this inspection and three of the four ratings were improved. Urgent & Emergency Services retained the Outstanding rating. Medical Care, including older people's care also received an Outstanding rating. Maternity and Surgery both improved and were rated Good. Overall the Acute services were rated as Good, combined with the previous inspections for Community services and Mary Seacole Nursing Home, the Trust overall was rated as Good. This is a significant achievement and recognition for all staff across the Trust, reflecting the quality of service they provide to patients and their families on a daily basis.

There are many examples of innovative and quality improvement examples that were successfully implemented in 2018/19 and these include:

- The Acute Pain Team was recognised as the Team of the Year by the National Acute Pain Symposium. The award is just the beginning for the service with further developments planned for the future including the development of pain link nurse roles, developing nurse led telephone clinics and growing and expanding the team further with the addition of two new trainee clinical nurse specialists.
- A range of new technological innovations have been introduced in outpatients aimed at improving quality, safety and efficiency. A new voice recognition system using Dragon, aids the information entry in electronic notes and letter production. Doctors now also able to access cardiology, endoscopy and radiology images directly from EPR via a new image archive, whilst a new app allows clinicians to safely take a clinical photograph with a smart phone. After scanning the QR code, the photo is directly uploaded into the appropriate record and then automatically deleted thus maintaining patient confidentiality.
- A newest part of the Trust's network of sexual health clinics opened at 80 Leadenhall in the heart of the City of London. The centre provides a range of services including testing for sexually transmitted diseases (STIs) and administering post-exposure prophylaxis preventing HIV infection (PEP). The clinic welcomed over 4,000 client visits in the first four months of opening.
- An innovative team of advisers from Redthread Youth Violence intervention Programme were introduced into the emergency department to offer support and counselling to young people who have or might be victims of violence.
- The Trust retained its Planet Mark accreditation for a second year by showing good practice in sustainability including achieving a 9.6% total carbon footprint reduction in 12 months and decreasing carbon emissions from buildings by 9.7%.
- The Trust dismantled its remaining smoking shelters and replaced them with additional bike racks.
- The Elderly Care Unit welcomed animal friends to patients. The "Pets As Therapy" scheme increases a person's level of interaction and can reduce agitation, something that can be particularly helpful for people with dementia who can show symptoms of distress and agitation when in hospital.
- The Care Certificate programme was expanded over the year with 104 members of staff completing the programme.
- The Trust introduced a scheme to provide employment experience opportunities to people with learning disabilities.
- The Trust has signed a commitment to supporting members of the armed forces as they seek new employment opportunities on leaving the services. The Armed Services Covenant ensures that Homerton pledges to recognise the value serving personnel, reservists, veterans and military families bring to the organisation as well as ensuring that no member of the Armed Services Community should face disadvantage.
- Homerton has joined other local public service leaders in signing a No Smoking pledge. The pledge has been designed by the Smokefree Action Coalition and is endorsed by NMHs England, Public Health England and Health Ministers.
- Talking Mats have been introduced by the speech therapy team. The mats are a tool which is used as a visual communication tool that is used with children and adults with a wide range of communication difficulties.
- New developments have improved the environment of Mary Seacole Nursing Home. The gardens were completely refurbished and new door pictures for wards were installed with old photographs reflecting local landmarks in Hackney.
- Lloyd Ward has been completely refurbished complete with a new reception area for visitors.

- We continue to actively participate as a member of NHS QUEST. This is a network of trusts and foundation trusts, working collaboratively to reduce avoidable harms in hospital, to stimulate innovation and to improve staff satisfaction.

We continue to share our examples of good practice both within Homerton at our Quality Sharing Days, Simulation Training Day and the annual Research & Development Day, all with attendance from local stakeholders and partner organisations. Additionally, a range of individuals, services and innovations have been recognised by reaching the final shortlists of several national awards.

Sharing learning in this way is not only a vital part of maintaining and improving our quality standards, but helps to inform our future aspirations. Our Quality Priorities set out areas of focus for the coming year, drawing on both local experience and requirements agreed with our commissioners, and national programmes of work.

Whilst every effort has been made to reflect accurately the position of the Trust against the measures reported on, there are a number of inherent limitations in doing this which may affect the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgment about individual cases, where another clinician might have reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Board of Directors have sought to take all reasonable steps and to exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

As always, the Trust's key strategic quality priorities remain the focus of our goals and ambitions for the quality of care we deliver.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Tracey Fletcher
Chief Executive
Homerton University Hospital NHS Foundation Trust

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT DURING 2019/20

We have agreed our annual priorities for 2019/20 which support our Organisational Strategy and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, City and Hackney Clinical Commissioning Group and Healthwatch. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by 31 March 2020 and progress to achieve them is to be monitored by our Trust Management Board.

Patient Safety (Safe)

Priority 1	To reduce the number of community and hospital attributed pressure ulcers – carried forward from 2018/19
Rationale	The Trust is unlikely to have achieved this priority in 2018/19 therefore has agreed to continue with this priority in 2019/20. The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures. There is continued national focus on the need to reduce the number of pressure ulcers. Work to reduce the rate of community acquired pressure ulcers link to the wider development of neighbourhoods in City and Hackney.
Monitoring	Improving Patient Safety Committee
Reporting	Total number of avoidable community and hospital acquired pressure ulcers at grade 2 and grade 3+ Numbers of pressure ulcer free days.

Priority 2	Appropriate identification and management of deteriorating patients - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the deteriorating patient group to build upon the work established in 2018/19. This priority will also include the timely identification and treatment of patients with sepsis.
Monitoring	Critical Care Committee, Improving Clinical Effectiveness Committee
Reporting	Implementation and measures established through the deteriorating patient group. Sepsis measures to mirror sepsis CQUIN.

Priority 3	Reducing physical violence and aggression towards patients and staff – New priority
Rationale	The most recent national staff survey shows that more than 15% of NHS employees have experienced violence from patients, their relatives or the public. Implementation of the NHS Violence Reduction Strategy is to be a priority for the Trust to reduce the impact on staff and patients through improved training and prompt mental health support for staff.
Monitoring	Health and Safety Committee
Reporting	Local implementation of the national strategy.

Clinical Effectiveness (Effective)

Priority 4	Improving management of end of life patients for adults - carried forward from 2018/19
Rationale	The Trust has agreed to continue with this important priority through the End of Life Board to build upon the work established in 2018/19 and the implementation of the End of Life Strategy 2018-21. The key elements of the strategy being personalised end of life care, supporting our staff, improving environment and communication & information. This will include the wider partnerships the trust has with community organisations including the local hospice.
Monitoring	End of Life Board
Reporting	Implementation and measures of strategy to be established through the end of life board.

Priority 5	Making Every Contact Count – New priority
Rationale	Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly. Making every contact count (MECC) is an approach to behaviour change that utilises the day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. Implementing MECC means providing their staff with the leadership, environment, training and information so that staff have the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them. Initially being implemented in maternity then the wider Trust. The delivery of MECC in the trust will contribute the wider prevention work stream priority across City and Hackney
Monitoring	Improving Quality Board
Reporting	Metrics based upon implementation programme.

Priority 6	Learning from complaints, incidents, claims and compliments – New priority
Rationale	It is fundamental that we listen to our patients and learn from their experiences. We will carry out an in depth review of complaints, incidents, claims and compliments to better develop actions to ensure learning is captured and fedback to staff and shared across the organisation and practice is changed to prevent recurrence.
Monitoring	Patient Safety Committee
Reporting	Metrics to be established.

Patient Experience

Priority 7	Improving the first impression and experience of the Trust for all patients and visitors - carried forward from 2018/19
Rationale	Creating positive first impressions of the Trust for patients and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients and visitors and therefore play a pivotal role in this. We will continue to develop a range of measures to support receptionists and their managers create a positive first impression for every service user and visitor to the Trust at every visit.
Monitoring	Patient Experience Committee
Reporting	Metrics based upon results of 2018/19 priority outcome - to include training and compliance with first impression standards.

Priority 8	Getting Patients Moving – New Priority
Rationale	Move, groove and improve – Trust wide implementation of the 2018 national *EndPJParalysis* campaign. The campaign focuses on encouraging patients in hospitals, where possible, to stop wearing their pyjamas or hospital gown when they don't need to. This is because wearing pyjamas for many patients reinforces the 'sick role' and can prevent a speedier recovery. Obviously the patient and their condition need to be taken into consideration and this principle cannot apply to every single in-patient, however for many, it's a matter of enabling them to get up, get dressed and get moving.
Monitoring	Patient Experience Committee
Reporting	Metrics to be established.

Priority 9	Improvements in staff health and wellbeing – New priority
Rationale	Aiming to create a working environment which is beneficial to the health and wellbeing of our staff. All staff will be supported to maintain and improve their health and wellbeing and are encouraged to take reasonable steps to improve their own health and wellbeing. The goal is to inspire our staff to take a greater interest in their own health and wellbeing.
Monitoring	Workforce Committee
Reporting	Metrics to be established.

2.2 Statements of Assurance from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

2.2.1 Review of Services

During 2018/19 Homerton Hospital NHS Foundation Trust (HUHFT) provided and/or sub-contracted 68 relevant health services.

Homerton Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2018/19.

2.2.2 Participation in clinical audit

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

The Trust participates in relevant national audits and confidential enquiries programmes as listed through the HQIP. All the programmes listed were assessed for relevance in 2018/19.

During 2018/19, 37 national clinical audits and five national confidential enquiries covered relevant health services that Homerton provides.

During that period HUHFT participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and confidential enquiries that the Homerton was eligible to participate in during 2018/19 are listed in **Appendix A.**

The national clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2018/19, are listed in appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 15 National Clinical Audits were reviewed by us in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 1: Examples of changes from a national audit

Audit	Trust Actions
National Joint Registry (NJR)	Low consent rates documented for NJR data collection. Consent for NJR data collection now routinely collected at time of consent for surgery and consent rates audited locally. A British Orthopaedic Association review of arthroplasty during the last year was supportive of the department's current clinical practice.
National Lung Cancer Audit (NLCA)	All relevant clinicians contacted to ensure completion of spirometry and Eastern Cooperative Oncology Group (ECOG) performance score (using voice recognition template provided when possible). Continue to refer patients urgently to the relevant clinical teams for chemotherapy and radiotherapy. Ensuring regular presence of Thoracic Surgeon at Homerton "Diagnostic MDT" Discussions under way to obtain cover for Diagnostic MDT in the absence of the Chest specialist Radiologist
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Homerton neonatal unit overall performance is comparable or above national average in most areas investigated. Homerton performance is below national average in two areas measured: Lower admission temperature of babies born very preterm (less than 32 weeks gestation). Action taken - Education and awareness of maintaining normal temperature at induction and regular teaching. Monthly admission temperature tracking and discussion at clinical governance Follow-up at two years of age: around 45% of eligible babies were reviewed at two years of age (National average is 61%). Action taken - Business case to be submitted for a dedicated follow-up co-ordinator to ensure babies attend clinic follow-up at correct age.
Falls and Fragility Fractures Audit programme (FFFAP)	2018 Best Practice Tariff achievement is 58.3% - a significant increase from 2017 which was 46.5%. Key actions being taken are: • Ensuring completion of Abbreviated Mental Test Score in the Emergency Department before surgery. • Ensuring completion of the rapid assessment test for delirium in 7 days post-op with translators being used if there is a language barrier. • Reducing time to get to surgery. • Ensuring physiotherapy reviews for patients admitted on the weekend. • Reducing inpatient falls and improving after care, including prompt X-rays and diagnosis. • Reducing incidence of pressure ulcers.
MBRRACE-UK Saving Lives, Improving Mothers' Care	Action being taken includes the Venous Thrombo-Embolism audit being added to the 2019-20 audit plan for maternity services
Major Trauma Audit (TARN)	The following actions are being taken as result of the major trauma audit: Review and improvements in the Trust governance around major Trauma through the Trauma Operational Group Training and education including online competencies for nurses, Trauma Intermediate Life Support (TILs) training, Trauma Team Leaders education and Resuscitative Interventions Procedure training.

National Audit of Dementia	The following actions are being taken as result of the National Audit of Dementia: • Creation of 'delirium champions' on surgical wards with the wider hospital in phase II • Care plan to be made available electronically. • Offer multiple Dementia awareness training sessions – including the dementia and delirium study day – several sessions arranged for 2018 • Monthly audits to assess completion of the Disability Assessment for Dementia and fed back to the governance meeting. • Discussions with Ward Sisters and Heads of Nursing, Lead Therapists for advice around dementia and delirium care bundles being available in on the Electronic Patient Record. • Patient and carer information to be incorporated into dementia care support worker role. • Visual Identifier to be incorporated into 'care bundle' proposal for patients to have access to food throughout the day and night offered regularly. • Ongoing work with transport regarding delays to ensure that patients are discharged in the early part of the day.
NCEPOD Acute Heart Failure	The following actions are being taken as a result of the audit: • Provision of heart failure rehabilitation is provided where appropriate and when available • The aim is for information relating to correct diagnosis, cause of heart failure, current medications and need for monitoring is on the discharge summary. • The inpatient heart failure nurse gives the patient additional information regarding self-management, and liaises with the medical staff and community heart failure staff with regards to discharge planning • This criteria is met for all heart failure patients ascertained by the inpatient surveillance mechanism and in whom heart failure team advice is followed • The cardiology department aims to provide an echocardiogram on all inpatients within 48 hours of the request being made during weekdays

Local clinical audit

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe, evidence based and meets agreed standards. All staff are encouraged to complete clinical audits or other similar projects to monitor and then improve services.

The reports of 158 local clinical audits were reviewed by us in 2018/19. A selection of these audits is outlined in the following table and the Trust intends to take the following actions to improve the quality of health care provided.

Table 2: Examples of actions that the Trust intends to take or has taken following local clinical audit recommendations

Audit title	Key actions following the audit
Maternity booking summaries – are they present in all antenatal notes?	Continue 100% compliance with booking summaries in antenatal notes. Ensure all booking summaries are placed behind the Antenatal Care tab in antenatal notes. Report printer issues as soon as possible to ensure summaries can be printed. If printing not possible, gain consent from woman to post summary to her home address (checking address details are correct) for her to add to her antenatal notes.
Audit of Referrals to Bariatric Assessment Clinic	Ensure vetting referral pathway is clear with all members of the team (bookings and bariatrics). Continue ongoing work of encouraging electronic referrals to the bariatric service.
An audit of *Molluscum contagiosum* against the UK BASHH guidance	Add *Molluscum contagiosum* guideline in to the HSHS guideline booklet
Audit of C&H wheelchairs currently in use in local nursing homes	Nursing Home managers to be informed regarding wheelchair service criteria for future reference. An Information sheet has been provided to Nursing Home managers.
Audit of GP Ultrasound referrals	Encourage addressing of clinical query on conclusion/summary. To develop an information sheet for GP's to ensure that referrals are improved with specific queries.
An Audit of VTE prophylaxis	Introduce a VTE score as part of standard 26 week midwife appointment. Update of midwifery guidelines
Postnatal readmission for hypertension audit	Send reminder to all GPs regarding community treatment of hypertension. Information to be added to CCG newsletter update
Review of the powered wheelchair assessment pathway	Wheelchair Service team agreement regarding the Powered Pathway. Implementation of the Powered Pathway
Perinatal mental health audit	Formalise discussion of medication in mental health with women of childbearing age. Incorporate a tick box into the mental health review template indicating discussion about medication with women of childbearing age.
Audit of nutrition screening in adult medical admissions 2016-2018: Re-audit after initial intervention and subsequent Quality Improvement Project Plan	Formalise training for nursing staff. Rewrite compulsory nursing training e-learning module on nutrition to emphasise the importance of getting an accurate weight for all patients
Women's Health Physiotherapy Documentation Audit	Gestation and expected date of delivery (EDD) documentation. Changed new paperwork to "Gestation/Post-Partum" and "EDD/Baby DOB" to accommodate post-natal patients too.
Speech and language therapy stammering Pathway for under 8 year olds in mainstream primary schools in Hackney	Raising awareness about stammering; its potential impact and the importance of referring a child to SLT early. Stammering advice leaflet and poster developed and distributed in team

Diabetic foot amputations	Education of A&E staff. Review of standard operating procedure for diabetic foot complications
Evaluating incidence of pain in Post Anaesthetic Care Unit (PACU)	Establish working group with anaesthetic department and PACU. Develop standardised recovery documentation
Audit of clinical practice at Homerton postnatal echo technician clinics	Parents' information leaflet. Design a leaflet with information on the procedure, discussion on results and medical follow up. Modify the neonatal clinic referral to highlight babies scheduled for outpatient echo.

2.2.3 Research

Clinical research remains high on the Government agenda with continued funding to Clinical Research Networks (CRN) ring-fenced for the promotion of research within the NHS. Research is written into the NHS Constitution and this has recently been reinforced through the CQC inspection process. In September 2018 the Care Quality Commission (CQC) signed off the incorporation of clinical research into its Well Led Framework (NHS Trusts)[1]. This formally recognises clinical research activity in the NHS as a key component of best patient care. Thus, clinical research is no longer perceived as just a 'nice to do' exercise in the NHS - it is now a key part of improving patient care. Furthermore, the government reflect this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England, stated that 'Research is central to the NHS… We need evidence from research to deliver better care. Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence. We can only correct that with research.'[2] Homerton is committed to this path growing research capacity year on year. During 2018 between 130 and 150 studies were recruiting at any given time, with a total of 222 studies recruiting patients during 2018.

We aim to open studies that are particularly relevant to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that studies are in line with local clinical practice. During the lifecycle of each study the R&D team ensure that all governance and regulatory processes are approved and adhered to; recruit patients who are eligible for the trial; collect and maintain necessary data and accurately record the data; and finally confirm secure archiving of all necessary trial related documentation at the end of the study.

Participation in research remains important to patients with over 94% of a national consumer poll indicating that it is important for the NHS to carry out clinical research, with a similar number saying it was important so that new treatments could be offered by healthcare professionals[3].

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 3078.

This increase in recruitment has led to a consequential increase in the number of personnel in the research team. In 2018 we were fortunate to be able to support an apprentice as well as research nurses, research practitioners and administrative staff.

The team provide both an excellent and efficient service and Homerton performs consistently well and once again is top for value for money when compared to other mid-sized acute trusts in North Thames.

[1] Well Led Research in NHS Trusts: A Briefing for Clinical Research Network Staff about outputs from the work to establish research markers in CQC inspection

[2] Excerpt from video Enhancing patient care through research

[3] Results of Censuswide consumer poll of people in England in September 2014

R&D department is committed to growing research both locally and nationally and the department supports novice researchers setting out on an academic pathway. Currently there are three researchers, all in allied health professions, who are being funded through NIHR grants to achieve ether an MSc or PhD. Additionally four members of staff are being funded for PhD studies through research income. We also offer support and advice for those seeking funding for projects. Successful grants in 2018 include £500k for a fertility study under Dr Priya Bhide, and £1m for a study in neonatology under Dr Narendra Aladangady.

We further promote, develop and support researchers at the annual conference offering the opportunity to share research findings and hear the experiences of veteran researchers. The 2018 conference covered many topics and introduced us to our keynote speaker: Dr Chris Turner, University Hospitals Coventry & Warwickshire; who spoke about "Why Civility Counts in a Complex World" a salient and important discussion.

Patient involvement in research

Both nationally and locally we seek to gain opinions and views of patients involved in all aspects of research. We encourage researchers to involve patients/lay members of the public in the design of their research thus enhancing the acceptability of the research to service users. We also host a stall in the reception area of the Trust to engage and inform members of the public in the research being undertaken locally. Nevertheless, in our 2018 survey only 26% of our respondents were aware that Homerton were involved in research activity prior to being recruited to a study.

A taste of research activity at Homerton

STOPPIT 2 - Prematurity is thought to account for over 70% of twin neonatal deaths and adversely affects fetal survivors, with increased risks of future respiratory problems, motor and sensory impairment, learning difficulties and social and behavioural difficulties. Twins alone account for over 20% of neonatal unit cot stays, a significant excess given they comprise only 2% of all births. Together, the complications of preterm birth result in an estimated annual cost of £2.9 billion to the public purse in England and Wales (2006 prices).

There is a clear expressed need for innovative interventions to reduce preterm birth in both high-income and low-income countries. The 2011 National Institute for Health and Care Excellence (NICE) Multiple Pregnancy Guideline Group noted that bed rest at home or in hospital, progesterone, cervical cerclage and oral tocolytics are all ineffective at preventing preterm birth in twins, concluding that alternative effective interventions are urgently required.

STOPPIT-2 is a multicentre open-label randomised controlled trial of the Arabin pessary (CE marked device) versus standard treatment in women with twin pregnancy recruited from NHS antenatal clinics. The study is in two phases: a screening phase, in which women with a short cervix (cervical length of ≤35 mm) are identified, and a treatment phase, in which women with a short cervix will be randomised to either treatment with Arabin pessary or standard treatment.

The primary objective of this study is to test the hypothesis that the Arabin cervical pessary reduces spontaneous preterm birth in women with a twin pregnancy and a short cervix (≤35 mm).

The study, which commenced in January 2016, has consented 72 patients and has randomised 26 patients at Homerton. Homerton is the sixth recruiting site out of 56 participating Trusts nationwide and has played a key role in the achievement of the national target of 500 randomised patients.

Microbial Colonisation and Immune Responses in Preterm Babies - Necrotising Enterocolitis (NEC) and septicaemia disproportionately affect infants with extreme prematurity or low birthweight. Both carry high rates of mortality and morbidity and can impact significantly on neurodevelopmental outcomes in survivors. A number of previous studies have shown that the preterm microbiome is different from the microbiome of term babies with typically more potentially pathogenic bacteria seen.

There have been some studies that suggest these abnormal pathogenic bacteria are associated with an increased risk of NEC and septicaemia. Little is known about how the immune system develops in preterm babies and what factors alter immune responses. This local study looked at the relationship between the developing immune system and the preterm intestinal microbiome.

Babies admitted to the Homerton NICU and born between 23+0 to 31+6 weeks gestation were recruited with written informed consent. Stool samples were collected every day and weekly gastric aspirates were collected and stored to evaluate intestinal colonisation. Blood samples were also taken weekly and when babies were being evaluated for suspected infection to assess the immune responses. 143 babies and more than 6000 biological samples were collected during the study. To date, outputs from this study have been presented at: The European Federation of Microbiology (Valencia Spain); The Neonatal Society (Dublin, Ireland); The London Microbiome Meeting (GSST, London); The Pediatric Academic Society Meeting (Toronto, Canada) and the British Society of Immunology (London).

Discover Study - The DISCOVER study is a clinical trial of PrEP to test whether a combination of emtricitabine and tenofovir alafenamide (F/TAF) is as safe and effective as Truvada® (emtricitabine and tenofovir disoproxil fumarate, F/TDF) at reducing the risk of HIV infection when used as PrEP. F/TAF was recently approved for HIV treatment, but it is not yet known whether it is effective as PrEP

This international multi-site study is a double blind randomised controlled trial where participants in the study are randomly allocated to get either active Truvada® and placebo F/TAF or active F/TAF and placebo Truvada®. Neither the participants nor the study clinicians will know which drug the participant is taking until the end of the study. Participants are followed up three monthly for two years and are told which drug they were getting at the end of study follow up.

The eligible population for this study is men who have sex with men and transgender women who have sex with men. This study is funded by Gilead Sciences and enrolled 5000 patients at 92 study sites across the United States, Canada and Western Europe. Homerton recruited 49 patients in to this study and currently everyone in follow up.

APPIPRA - Rheumatoid arthritis (RA) is a chronic autoimmune disease and can affect any racial group with a higher rate in women. It causes painful, stiff and swollen joints that if left untreated can lead to deformity of synovial joints and significant disability.

There is no cure for RA but Professor Andrew P Cope and his team at Kings College London are trying to determine if it can be prevented with their trial 'Arthritis Prevention in the Pre-Clinical Phase of RA with Abatacept' (APIPPRA).

APIPPRA is one of 11 studies that Homerton is currently running within the Rheumatology Department. It is a randomised, multicentre, placebo controlled, double-blind clinical trial of abatacept. APIPPRA closed to recruitment earlier this year having met the target of 206 subjects, five of whom who were recruited here at Homerton.

Abatacept is a new drug in the class of 'selective costimulation modulators' and is already licenced for the treatment of RA. Participants were eligible if they have the presence of arthralgia and are positive for rheumatoid antibodies but do not yet have joint swelling. They were given a year's course of either a placebo or abatacept.

We are now in the follow-up phase of this trial and meet with each participant every three months for a further year. We are collecting data including DNA samples, routine bloods, x-rays, joint ultrasounds, Disease Activity Scores, clinical assessments and quality of life questionnaires.

Patients benefit from being seen by their clinicians at three monthly intervals and from the potential to receive a medication that is not routinely available to those with pre-clinical RA. Their participation will

help to determine the feasibility, efficacy and acceptability of abatacept for RA prevention for future patients in a similar position to themselves.

2.2.4 Goals agreed with Commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by the Trust.

During 2018/19 the Trust continued to work with the Commissioning for Quality and Innovation (CQUIN) scheme to drive quality improvements across the organisation.

A proportion of the Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/

The monetary total for income in 2018/19 conditional on achieving quality improvement and innovation goals was £6.146m and the monetary total for the associated payment in 2017/18 was £5.464m.

In 2018/19, the Trust continued to hold three major contracts that encompassed a number of CQUIN schemes; the acute services contract, the community health services contract and the NHSE contract (which encompasses specialised services, public health services and acute dental services). However in 2017/18 last year, there was a significant change to the way CQUINS were delivered. For the first time, NHSE published a programme of two year CQUIN schemes. The purpose was to provide more certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives. The current CQUIN programme runs from 2017-2019.

Appendix B provides details of the Trust's 2018/19 CQUINs.

2.2.5 What others say about Homerton

Care Quality Commission (CQC)

Homerton University Hospital NHS Foundation Trust is required to register with the Care Quality Commission. Its current registration status is 'registered with the CQC' with no conditions attached to registration.'

The Care Quality Commission has not taken any enforcement actions against Homerton University Hospital NHS Foundation Trust during the reporting period 2018/19.

There were no special CQC reviews or investigations during the reporting period for the Trust to participate in.

CQC Inspection of acute services.

An inspection of Homerton acute services was carried out by the CQC during April 2018, followed by a 'well-led' inspection in May 2018. The four core services inspected were Urgent and Emergency Care; Medical Care; Surgery; and Maternity care. The CQC took into account the current ratings of the other four services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the Trust achieving an overall rating of 'Good'. The core services of Urgent and Emergency Care and Medical Care, including older people's care each received the highest rating of 'Outstanding' overall.

The CQC found areas of 'Outstanding' practice across all the core services inspected which are highlighted in the inspection report. Examples of this include

Urgent and Emergency Care

- There was an active quality improvement programme in place which was monitored by two consultants
- The service performed consistently better than the England average for patients admitted, transferred or discharged within four hours between February 2017 and March 2018
- 95% of patients between March 2017 and February 2018 would recommend the service to friends and family
- There were good protocols in place for the recognition and management of sepsis

Medical Care

- The division that managed medical services also included the delivery of local community services which facilitated the integrated delivery of care for patients on their transfer from inpatient to community teams
- Flow through the medical wards was excellent, facilitated by effective streaming of patients through the assessment unit and on to the speciality wards. Despite a busy winter period, patient flow was well managed enough to not need to use the hospital escalation ward
- The Trust had one of the highest rates of referral for patients with sickle cell anaemia and thalassaemia in the UK. The Medical Day Unit provided specialised and targeted health promotion, diagnosis, treatment and follow up (as well as crisis support) for patients
- Medical wards had access to a number of clinical nurse specialists to meet the needs of local patients. This included access to a dementia support team, mental health liaison, critical care outreach and various oncology nurse specialists

The CQC highlighted a number of areas for improvement. These included:

- The need to improve the capacity and sustainability of the adult safeguarding team to ensure timely completion of safeguarding referrals and Deprivation of Liberty Safeguards (DoLS) assessments, monitor incidents, provide engagement with other agencies, and ensure the consistent delivery of training for staff
- Increase the mandatory training completion rates for medical staff in Surgery and Maternity to meet the Trust target of 90% and for nursing staff in Surgery who did not meet Trust targets for most mandatory training modules
- Eliminate the inconsistent hand hygiene practices carried out by doctors and midwives in maternity services
- Reduce the varying understanding and gaps in the compliance of the WHO surgical safety checklist and its use among staff in maternity services

An action plan has been developed to address the CQC's recommendations. Good progress is being made against the actions which are monitored and reported on, through divisional and Trust-wide committees.

2.2.6 NHS number and General Medical Practice Code Validity

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

Homerton submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data for **April 18 – Mar19**:

- which included the patient's valid NHS number was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.0%	98.3%	99.5%		
Outpatients	99.7%	98.5%	99.6%		
A&E	94.7%	94.8%	97.6%		

- which included the patient's valid General Medical Practice Code was:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	100.0%	99.9%	99.9%		
Outpatients	100.0%	99.9%	99.8%		
A&E	99.9%	99.2%	99.3%		

The Trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

2.2.7 Information Governance (IG)

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and presents them in one place as a set of Information Governance requirements.

The Trust submitted evidence in support of all the mandatory elements of the new Data Security and Protection Toolkit in March 2019. The Trust did not meet the 95% mandatory IG training compliance standard and an improvement plan has been agreed with NHS Digital.

2.2.8 Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

Clinical coders collect, collate and code clinical information, relating to the diagnosis and operations for the patients admitted to the hospital. This data is essential for the effective management of the Trust, and also forms the basis for clinical audit, clinical governance reporting and payment.

Homerton was not subject to the Payment by Results (PbR) clinical coding audit during 2018/19 by the Audit Commission. The Audit Commission has closed.

The Clinical Coding department supports patients' care by providing ICD-10 DIAGNOSTIC codes and OPCS procedure codes that are used for a variety of purposes, including payment and Hospital Standardised Mortality Ratios. The department codes around 70,000 admitted spells (approx. 93,000 FCEs) a year across a wide range of specialities.

The Trust has an internal Clinical Coding Audit post that is responsible for auditing the accuracy of the Trust's clinical coding on a monthly basis. This is further supported through specific external audits undertaken by independent coding auditors to ensure that the accuracy of the Trust's coding is of a sufficient standard. In 2018/19, an external audit was undertaken in Trauma & Orthopaedics the results of which are set out below. The aims of these audits were to focus on improving the quality of our data and focus on providing a high quality, accurate coding service.

- Primary diagnosis correct 95.2%
- Secondary diagnosis correct 80.2%
- Primary procedures correct 85.1%
- Secondary procedures correct 83.9%

The results should not be extrapolated further than the actual sample audited. 167 FCEs were sampled.

2.2.9 Actions to improve data quality

Accurate and timely data is essential to provide robust intelligence and allow sound clinical and strategic decisions to be made. The Trust continues to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

A Data Quality Committee chaired by the Chief Operating Officer met four times last year. Through the use of data quality indicators for both acute and community services the committee is a vehicle for data quality improvement and awareness within the Trust. The committee promotes and maintains robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality.

The Trust will be taking the following additional actions to improve data quality in 2019/20.

- Engage in relevant national conferences and workshops in relation to clinical coding standards.
- Develop further new data quality indicators.
- Provide staff with any additional training and developmental support required or identified to maintain skills, knowledge and data management.
- Implement a formal internal rolling programme of audit.
- Maintain close working relationships with clinical services.
- Continue to use benchmarking data to enable the Trust to identify areas of opportunity i.e. where the Trust is benchmarked as being a negative outlier.
- Develop internal programme of quality improvement to ensure the availability of clinical information is enhanced, thus ensuring clinical coders have easy and quick access to all relevant clinical information.
- Engage an external auditor to undertake a comprehensive independent review of the Trust's clinical coding.

2.2.10 Learning from deaths

This is section of the Quality Report that NHS Trusts are required to include was introduced in 2017/18. In March 2017 the National Quality Board published a document called 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

All deaths are reviewed by the primary clinical team and also discussed at a multi-professional forum to learn from every death.

During 2018/19, 387 patients died at Homerton Hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 91 in the first quarter
- 79 in the second quarter
- 112 in the third quarter
- 105 in the fourth quarter

By 31 March 2019, 296 case record reviews and 10 investigations have been carried out in relation to 387 of the deaths during 2018/19

In 11 cases a death was subjected to both a case record review and an investigation.

The total number of deaths reviewed was 296. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 75 in the first quarter
- 64 in the second quarter
- 98 in the third quarter

- 59 in the fourth quarter (as of 30th April 2019)

7 of the 387 (1.8%) of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 3 of the 75 deaths (4%) reviewed for the first quarter
- 1 of the 64 deaths (1.6%) reviewed for the second quarter
- 1 of the 98 deaths (1%) for the third quarter
- 2 of the 105 deaths (1.9%) for the fourth quarter (as of 30th April 2019)

2 representing 1.3% of the patient deaths during quarter 4 of 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been achieved using the CESDI score methodology supported by the learning from deaths guidance.

Please see below a summary of some of the learning identified following case record reviews and investigations for 2018/19:

- Lack of focus on advanced care planning in oncology patients
- Delayed transfers of care.
- Difficulty starting individualised end of life care plan when family may not agree
- Good palliative care input.
- Delays in transfers to Nursing Homes may add to risk of decline.
- Difficulty establishing preferred place of death/appropriate discharge location
- Death certification information/discharge letters not on EPR.
- Appropriateness of ITU interventions.
- Delays in discharge preventing meeting Preferred Place of Death (PPD).
- Communication with family as well as with professional teams.
- Delay in appropriately focused diagnosis and/or treatment.

Please see below a summary of the actions which the Trust has taken in 2018/19 and actions it proposes to take following the reporting period as a result of the learning.

- Implementation of an online mortality review tool.
- Developed a formal checklist for blood gases to ensure entire sample is reviewed in a systematic manner.
- Audit of NEWS scores
- Developed a Poster detailing all the vascular access mid lines and long lines utilised in the trust to be displayed in the CT control room.
- Review by Thrombosis Committee of the two thrombolytic agents in use in the Trust.
- Staff to receive training on pain in delirium.
- Review of written consent process in gynaecology
- Raised awareness about aortic dissection.

Please see below a summary of the impact of actions taken in 2018/19

Deteriorating Patients

It was recognised that there were a number of issues with the management of deteriorating patients, including delays in escalation to ITU, lack of or slow escalation, tolerance of abnormal physiology and poor handover. As a result, the Deteriorating Patients task and finish group was relaunched at the request of the Medical Director in September 2018, with a remit to look at education, NEWS 2

implementation, to review the hospital at night model and to develop guidelines for escalation and referral to critical care.

There have been a number of key achievements:

- Improved nursing escalation – from August to December 2018, the number of patients with a NEWS score of 5 or over who were escalated appropriately increased from 53% to 73%. The documentation is significantly better, and the changed assessment in EPR has also helped.
- There has been a reduction in delayed ITU referrals, reduction in inadequate medical team response and delayed nursing response, and fewer incidents recorded of staff tolerating patients with high oxygen requirements.
- Reduced number of bleeps going to the wrong place at night time.

The Group is led by the Medical Director, Chief Nurse and Clinical Lead for the Acute Care Unit, with support and input from the Chief Registrars, ITU, ED, IT, surgery, the Critical Care Outreach Team, the Simulation Lead, Education and Training and the Patient Safety Team.

Online Mortality Review Tool

The Trust ability to track and report on mortality reviews has improved since the introduction of the mortality review tool and additionally the number of reviews is increasing and all deaths are being reviewed in a multidisciplinary forum to facilitate learning.

Over the last year, the Trust has been developing an online Mortality Review Tool. The tool has been developed under the guidance and leadership of the Medical Director and the Specialty Mortality leads, who have played a crucial role in ensuring the tool is fit for purpose. The tool is a live web-based system, linked to EPR, which is designed to help clinicians review deaths in a systematic and consistent way. It is based on the existing paper-based tool, and is accessible to all staff involved in the mortality review process.

There are a number of advantages over the existing paper based system, including:

- Ability to identify and track themes and areas of good practice.
- Ability to record family concerns so that they can be linked to the review process
- Automatic link to EPR, so that teams can more easily identify the patient deaths requiring a mortality review
- Area to record details of SI investigations to better link up learning.
- Improved reporting so that data, themes and learning can be more easily identified, and so that reminders can be sent where reviews are overdue.

Following implementation of our online mortality review tool in October 2018 we have been better able to draw together more comprehensive learning and aim to strengthen the way we share learning. This will have the net effect of providing clarity around themes which may not have been joined up across the organisation previously.

The impact of the implementation of the online tool will in time allow identification of high impact communication streams and projects as a consequence of thematic learning as well as consolidating the existing newsletter process.

Coordinate My Care

The Trust collaborates actively with City and Hackney primary care colleagues to allow system wide participation in Coordinate My Care (CMC). CMC is used as the shared urgent care plan to improve patient care. A CMC care plan supports a patient if they have an urgent care need. Health care professionals should be more informed about the patient they are attending to and better able to provide care in accordance with the patient's needs and wishes. A CMC care plan should help to

avoid unnecessary hospital admissions as well as improving coordination of care for patients at the end of life by giving professionals the information they need at the first point of contact with a patient in an urgent care situation.

CMC has been adopted in City and Hackney for the following groups of patients:

- End of Life Care Register
- Proactive Care Practice Based Register (including High Intensity Users)
- Proactive Care Home Visiting Register
- C&H Nursing Home Patients
- Patients with Dementia under the Diagnostic Memory Service (ELFT)

The first phase has achieved the creation of care plans and work is continuing to ensure there is access to those care plans by the wider urgent care system and that the care plans are of sufficient quality to be fit for purpose.

2.2.11 Seven day services

NHS trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven day hospital services. Ten clinical standards for seven day services in hospitals were developed in 2013. These standards define what seven day services should achieve, no matter when or where patients are admitted. Four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Homerton made good progress with implementation of the four standards and has met both standards five and six.

Two main challenges exist with regard to standard two. Firstly given the relatively low numbers of patients developing appropriate consultant rotas across surgical specialities has been a challenge. Following recent work undertaken the Trust would expect performance to improve in future. Secondly the challenge exists with regards to overnight admissions in terms of prioritising the review of acutely unwell patients against chronological review of all admissions on the morning post take ward round. It is important to stress that those patients not reviewed within 14 hours missed the expected timely review by a short margin.

With regard to standard eight the Trust's current model is to have 12 hour consultant presence on the Acute Care Unit seven days a week. This means all admissions during this period are reviewed in real time and critically unwell patients are reviewed as regularly as necessary. This model ensures the daily review of over 90% of emergency admissions, however it doesn't cater for two structured ward rounds as stated in the standard. There is no current evidence that this leads to any detriment in patient care or missed opportunities for early recognition of deteriorating patients.

2.2.12 Speak up Safely

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising

concerns. The Trust Board of Directors receives a six monthly Raising Concerns at Work report which includes content from the Freedom to Speak Up Guardians as well as additional information on live/closed formal cases that have occurred in the reporting period.

In addition there are two Freedom to Speak up Guardians in the Trust to promote the need for staff to speak up where issues of concern arise as well as support them in doing so. In addition there are two designated Board Leads one Executive Director and one Non-Executive Director.

2.2.13 Rota gaps.

Homerton has had a Guardian of Safe Working in place since the implementation of the new junior doctors' contract in 2016. Their role is to monitor the exception reports that come in and ensure any issues are addressed in a timely manner. Currently we have a 92% fill rate across medical and dental. Any vacancies in rota's are filled on a temporary basis by bank or agency doctors, whilst the post is advertised and a substantive/fixed term doctor is appointed. In the last six months we have advertised on 50 occasions for junior or senior clinical fellow posts. The Trust Board of Directors receives reports from the Guardian of Safe Working which includes details on fill rate and actions taken across the trust to support junior doctors.

2.3 Reporting against core indicators

All NHS foundation trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. Where the required data is made available by NHS Digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS Digital website and may not reflect the Trust's current position (please note that the data period refers to the full financial year unless indicated). All data provided is governed by standard national definitions.

All Trusts are also required to include formal narrative outlining the reasons why the data is as described and any actions to improve.

1. Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care

The SHMI reports on mortality at trust level across the NHS in England. SHMI is the ratio between the number of patients that die following hospitalisation and the number of patients expected to die based on the national average and on the particular characteristics such as comorbidities of our patients.

It reports on all deaths of patients who were admitted to hospital and either died whilst in hospital or within 30 days of discharge. The Standardised Hospital Mortality Indicator is unaffected by palliative care coding.

SHMI has three bandings: higher than expected, as expected as and lower than expected. If the number of deaths falls outside the 'as expected' range, then the Trust will be considered to have either a higher or lower SHMI than expected. A 'higher than expected' SHMI should not automatically be viewed as bad performance, but rather should be viewed as a 'smoke alarm', which requires further investigation. Conversely, a 'lower than expected' SHMI does not necessarily indicate good performance.

If you would like to know more about how these ranges are calculated, then please refer to the NHS Digital website at: https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Table 3: Summary Hospital Level Mortality Indicator data

Indicator	Reporting Period	Homerton Performance	National Average	Highest Performing Trust	Lowest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct 2016 – Sept 2017	Value: 0.87 Banding: 3	Value: 1.01	Value: 1.25 Banding: 1	Value: 0.73 Banding: 3
	Oct 2017 – Sept 2018	Value: 0.69 Banding: 3	Value: 1.00	Value: 1.27 Banding: 1	Value: 0.69 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Oct 2016 – Sept 2017	45.4%	31.6%	11.5%	59.8%
	Oct 2017 – Sept 2018	43.6%	33.8%	14.3%	59.5%
	Jan 2018 – Dec 2018	46%	34%	15%	60%

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

The data is produced using a recognised national agency and adheres to a documented and consistent methodology. The Trust recognises and is assured by its benchmarked position as having one of the lowest SHMI in the country.

The Trust intends to take the following actions to sustain and improve the SHMI, and so the quality of its services:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths.
- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

2. Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMS) is a tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. It covers four clinical procedures:

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)
- Groin hernia
- Varicose vein (Homerton Hospital does not participate in this PROM as we do not provide this type of operation)

A patient will complete two questionnaires: one prior to surgery and one six months after surgery. These questionnaires ask patients about their health and quality of life (as well as the effectiveness of the operation) before and after surgery.

Completion of these questionnaires is voluntary and the patient's consent to participate must be granted in order for the data to be used.

Table 4: Average adjusted health gain for hip replacement, knee replacement and groin hernia surgery.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Hip Replacement Surgery	Apr 2016 – Mar 2017	**0.467**	0.437	0.329	0.533
	Apr 2017 – Mar 2018	**0.476**	0.458	0.357	0.550
Total Knee Replacement Surgery	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.391
	Apr 2017 – Mar 2018	**0.332**	0.337	0.254	0.406
Groin Hernia Surgery	Apr 2016 – Mar 2017	**0.048**	0.086	0.006	0.135
	Apr 2017 – Mar 2018	**No data***			

Data source: Latest figures available on NHS Digital

*PROMs data was collected on groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Finalised data for groin hernia procedures up until September 2017 has been published. Submission figures of less than 30 do not allow calculation of the adjusted health gain. HUHFT submitted 25 groin hernia records between April and Sept 2017.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre and postoperative questionnaires.
- There has been sustained improvement in outcomes for total hip and total knee replacements. This is consistent with data collected by the trust for improvement projects, such as the opening of the ring fenced elective orthopaedic ward, and patient feedback questionnaires.

The Trust intends to take the following actions to sustain and improve the PROMS, and so the quality of its services.

- Review of how we collect PROMS data. We are currently trialling an electronic system to collect PROMS. It is anticipated this will allow for a fuller dataset, i.e. increased six month PROMS completion and allow the service to be more responsive to patient feedback.
- Review of Enhanced Recovery Protocol to improve the patient's immediate post op recovery.
- Reviewing PROMs data and findings and discussing these within relevant departments.
- Reviewing PROMS data on a bimonthly basis through the Improving Clinical Effectiveness Committee.

3. 28 day emergency readmission rate

This indicator on the NHS Digital portal was last updated in December 2013 for the 2011/12 reporting period. Due to their 'statistical method' in continuous inpatient spell (CIP) construction, we are unable to replicate the data produced by NHS digital (the national standardisation process involves external data sources that we do not have access to). However, the information provided below is based on our internal dataset and NHS digital methodology without the standardisation applied.

Table 5: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over.

Indicator	Reporting Period	Homerton Performance
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	2016/17	3.63%
	2017/18	4.66%
	2018/19	4.36%
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	2016/17	12.7%
	2017/18	11.95%
	2018/19	12.60%

Data source: Latest figures available on NHS Digital

The Trust is unable to provide national comparative data for this measure due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust has a robust clinical coding and data quality assurance process, and readmission data is monitored through the Trust Management Board on a monthly basis.

The Trust intends to take the following actions to sustain and improve the 28 day readmission rate, and so the quality of its services.

- Working together with partners across Hackney to develop the concept of 'neighbourhoods' which will allow better coordination and integration of geographically

based community services. A key metric for neighbourhoods will be to readmissions, as the aspiration is that better coordinated and integrated services should allow patients to be discharged more safely and cared for at home to prevent the requirement for readmission.

- We will work with the new Head of Information to develop our information capacity and systems, so that local services can drill down seamlessly from Trust wide through divisional to local level in order to permit more real time tracking and interventions to reduce readmissions.

4. Responsiveness to personal needs of patients.

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Table 6: responsiveness to the personal needs of patients

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The Trusts responsiveness to the personal needs of its patients during the reporting period.	2016/17	**66.3**	68.1	60.0	85.2
	2017/18	**68.1**	68.6	60.5	85.0

Data source: National Inpatient Survey

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust uses an approved contractor, Picker Institute to collect the required data which follows the methodology set out by the CQC.

Whilst we have improved since 2016/17 we have performed just below the national average for our responsiveness to the personal needs of our patients in 2017/18.

The Trust intends to take the following actions to sustain and improve the responsiveness to personal needs of patients, and so the quality of its services by:

- Improving communications between ward and community services to improve discharge planning
- Implementing improvements in the care of patients with dementia
- Implementing Learning Disability awareness training for staff
- Implementing actions in relation to nutrition and hydration overseen by the Nutrition Steering Group
- Implementing the 'Hearing the voice of the child' project on Starlight Ward
- Launching the trust End of Life care strategy

5. Staff recommending the Trust as a place to work or receive treatment to Family and Friends.

The National NHS Staff Survey provides the opportunity for organisations to survey their staff in a consistent and systematic way on an annual basis and benchmark their results against each other.

Obtaining feedback from staff, and taking into account their views and priorities is vital for driving real service improvements across the NHS.

Table 7: Staff recommending the Trust to family and friends.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	2017	**73.4**	70.2	48.0	89.3
	2018	**75.1**	69.9	49.2	90.3

Data source: National Staff Survey

Assurance Statements

The Trust considers that this data is as described for the following reasons:

- The Picker Institute conducted the survey on behalf of the Trust and all full and part time staff employed by the organisation on the 1st September 2018 (with certain specific exclusions) had the opportunity to complete the survey electronically between September to December 2018. The Trust achieved a return rate of 52.4%, which represented a 2.4% point increase from 2017 (50%).
- We have performed above the national average for staff recommending friends and family as a place to be treated with the score improving by more than one percent since 2017.

The Trust intends to take the following actions to sustain and improve the percentage of staff recommending the Trust to their friends and family, and so the quality of its services.

We will act on this information responsively to drive further improvements in engagement levels by:

- Ensuring the organisation acts fairly: career progression.
- Reviewing the Staff Engagement Action Plan in light of the 2018 Staff Survey results (key features of the plan including those areas where results were not so positive when benchmarked against comparator).
- Responding to our latest staff survey under the themes of equality and diversity; career progression and recognition; leadership strategy; staff health and wellbeing; reward and recognition; and Trust values.

6. Patients recommending the Trust to Family and Friends

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism

to highlight both good and poor patient experience. This kind of feedback is considered vital in transforming NHS services and supporting patient choice.

Table 8: Patients recommending the Trust to family and friends.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Percentage of patients who would recommend the Trust to their family and friends. (inpatient)	2017/18	94.5%	95.6%	54.5%	100%
	2018/19	93.7%			
Percentage of patients who would recommend the Trust to their family and friends. (A&E)	2017/18	93.0%	86.4%	59.2%	98.3%
	2018/19	92.7%			

The Trust is unable to provide national comparative data for this measure in 2018/19 due to data not being available on the NHS Digital website.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust follows the guidance and methodology as set out by the Department of Health in the provision of data to Optimum Healthcare.
- A process is in place to ensure that data is quality assured prior to being uploaded onto the national reporting system UNIFY.

The Trust intends to take the following actions to sustain and improve the percentage of patients recommending the Trust to their friends and family, and so the quality of its services.

- Review of how data on Friends and Family is collected and utilised. This will be overseen by the Improving Patient Experience Committee.
- Use Perfect Ward and Chief Nurse Rounding to ensure that feedback is provided in clinical areas to patients on actions taken as a result of feedback.
- Triangulate FFT date with wider patient experience data to agree areas for further improvement.

7. Rate of admissions assessed for VTE

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill-health problems – many of which are avoidable. 1 in 20 people will have a VTE at some time in their life and the risk increases with age. It is estimated that as many as half of all cases of VTE are associated with hospitalisation for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognised as a clinical priority for the NHS in England.

Table 9: Rate of admissions assessed for VTE

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2016/17 (full year)	**96.2**	95.6	79.1	100
	April-June 2017/18	**97.0**	95.2	51.4	100
	July-Sept 2017/18	**96.7**	95.3	71.9	100
	Oct-Dec 2017/18	**97.4**	95.4	76.1	100
	Jan-Mar 2017/18	**96.6**	95.2	67	100

Data source: Latest figures available on NHS Digital

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton has consistently met or exceeded the national average for patients admitted who received a documented risk assessment for VTE. This is through an on-going programme for education, training and user prompts on the hospital-wide electronic medical record under the regular review of the Trust Thrombosis Committee.

The Trust intends to take the following actions to sustain and improve the percentage of patients risk assessed for VTE, and so the quality of its services.

- All hospital acquired VTEs are recorded on Datix and investigated through the incident review process.
- Trust Thrombosis Committee (TTC) reviews serious incidents and hospital acquired thrombosis to look for any systematic issues.
- Working with the GP Confederation that has been commissioned to provide a community anticoagulation service for Hackney to ensure patients receive an integrated service.

8. *Clostridium difficile* rate (*C. difficile*)

Acute hospitals in England are required to report all C.difficile toxin positive stool samples in those patients over two years of age. During the 2018/19 reporting period we have had three Homerton Hospital attributable cases against our national threshold of no more than 10 cases. This is significantly less than the 10 Homerton Hospital attributable cases in 2017/18. In addition the hospital has admitted patients who acquired *C.difficile* prior to admission. The Trust continues to report low number of cases when compared to other trusts across England. Review of these cases is still in progress by the Trust's clinical commissioning group. Patient management issues arising from the Root Cause investigations included the time from start of symptoms to taking a stool specimen & thus commencement of appropriate precautions. The *C.difficile* rate per 100,000 days as shown is sourced from the DH website and is up to end July 2018. It represents the latest published comparable data available. It shows a slight increase in our rates from the previous year. However we compared favourably to other London trusts and we are significantly below the national average.

Table 10: The rate per 100,000 bed days of cases of *C.difficile* infection.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust

The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2016/17	**3.3**	14.9	66.0	0.0
	2017/18	**8.9**	13.7	82.7	0.0

Data source: Latest figures available from Public Health England data collection

Table 11: The total number of cases of *C.difficile* infection.

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Number of Clostridium Difficile (C-diff) cases.	10	3	10	4

Data source: Latest figures available from Public Health England data collection

Assurance Statements

The Trust considers that this data is as described for the following reasons:

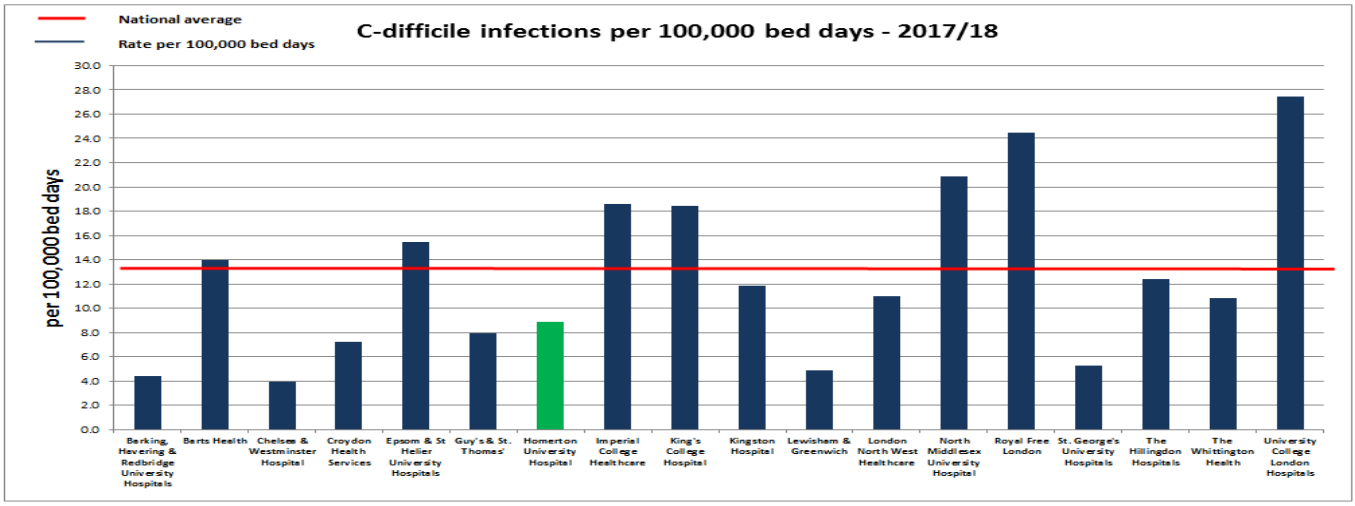
The data has been sourced from the Department of Health website and validated against the Trust's internal data derived from the pathology laboratory and inputted onto the Public Health England mandatory surveillance system. There is a defined process for checking data at a number of levels which include daily reports from the laboratory, reporting of cases as incidents with a post infection review and monthly sign off by the Director of Infection Prevention and Control.

The Trust continues to work hard at reducing the risk of C-difficile infection to our patients including continuously improving our already embedded processes for risk reduction by antimicrobial stewardship, prompt identification of possible cases and laboratory testing processes.

The Trust intends to take the following actions to sustain and improve the rate of *C-difficile* infection, and so the quality of its services.

- Raised profile of *C.difficile* mandatory induction & update training.
- Focus on timely isolation of all ward patients with diarrhoea whilst awaiting results.
- Focus on timely sample testing of all diarrhoeal stools enabling prompt identification of *C-difficile* positive cases.
- Environmental decontamination by deep cleaning and going forward hydrogen peroxide vapourisation (HPV).
- Focus on clutter reduction in ward environments to enable high standards of cleaning.
- Regular audits to ensure compliance with national and local guidelines.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.
- Root Cause Analysis investigation of every case to identify lessons to be learnt and feedback to the multidisciplinary teams and into the governance structure to ensure learning across the Trust.

Figure 1: *C.difficile* rate in London NHS Trusts 2017/18



9. Patient safety incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe. Patients should be treated in a safe environment and protected from avoidable harm.

Homerton actively encourages its staff to report all adverse incidents that have either caused harm or have the potential to cause harm during their care at the Trust. This is to ensure an open and transparent culture and promote organisational learning from safety incidents with the intention of preventing similar incidents from reoccurring in the future. Like NHS England, the Trust considers its high reporting culture as a 'positive indicator of its healthy safety culture, giving organisations the chance to learn and improve'.

Table 12: Reported Patient Safety Incidents

Indicator	Reporting Period	Homerton Performance	National Average*	Lowest Performing Trust*	Highest Performing Trust*
Number of patient safety incidents	Apr – Sept 2017	**2951**	5226	1133	15228
Rate of patient safety incidents (per 1000 bed days)		**52.9**	42.8	23.5	111.7
Number (%) of patient safety incidents resulting in severe harm or death		**11 (0.37)**	18	0 (0)	121 (1.97)
Number of patient safety incidents	Oct 2017 – March 2018	**3151**	5449	1311	19897
Rate of patient safety incidents (per 1000 bed days)		**56.9**	42.6	24.2	124.0
Number (%) of patient safety incidents resulting in severe harm or death		**4 (0.13)**	19	0 (0)	99 (1.56)

Data source: Latest figures available on NHS Digital
*based upon all the Acute (non-specialist) Trusts

Assurance statements

The Trust considers that this data is as described for the following reasons:

- The Trust has reported more incidents in the second reporting period above in comparison with the first reporting period.

- The Trust has a much higher rate of incidents reported per 1000 bed days than the national average.
- The Trust has a lower rate of serious harm and death incidents than the national average.
- The Trust aims to promote a just culture to ensure that staff feel confident to report incidents and this is reflected in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

In addition:

- The Trust has a robust process to ensure rigorous incident management. All incidents are reviewed at weekly divisional or corporate CLIP (Complaints, Litigation, Incidents and PALS) meetings and themes and trends reviewed at monthly divisional governance meetings. Trust Management Board receives quarterly updates from the Divisions.
- During 2018/19, the Trust has worked to improve the electronic incident reporting system (Datix) so that staff can report and investigate incidents more effectively. This has included training and engagement sessions with teams and individuals across the Trust.
- The Trust has strengthened its processes around Serious Incident (SI) and internal root cause analysis investigations, to ensure that reports are completed by appropriately trained investigators within agreed timescales.
- An Assurance Panel has been established to quality assure and approve all SI and RCA investigation reports. This is chaired by the Chief Nurse and attended by the Divisional Leads to ensure a robust approval process.

The Trust intends to take the following actions to sustain and improve this indicator further, and so the quality of its services.

- We continue to consider ways to improve our incident reporting processes through induction training and raising staff awareness to ensure staff feel confident and able to report incidents.
- Undertaking a full review of the incident reporting system (Datix) to identify areas for improvement across all the modules.
- In addition to induction training for new starters on incident reporting, the Quality and Patient Safety team will be delivering training on Datix and incident reporting to staff in both the acute and community settings. The aim is to further develop staff capacity and capability as well as confidence in reporting patient safety-related incidents.
- Further work to provide feedback to staff who report incidents, so that they can realise the benefits or improvements to patient safety and care that have resulted from the incident(s) they reported.
- Improving the ways in which learning from investigations is shared across the organisation, using better and more consistent use of existing channels including divisional and team meetings. The aim is to also look at other ways of sharing learning and promoting change, including closer working with the Quality Improvement team and the Training and Development teams.
- Continuing to build closer links with the legal, complaints and PALS teams to ensure that information is shared in a more useful and timely fashion, and so that themes that cut across complaints / incidents / claims etc can be identified.
- Ensuring that actions and lessons learned from investigations are followed up in a consistent and systematic way so that there is assurance across the Trust that actions have been completed.

PART 3: OTHER INFORMATION

This section of the Quality Account provides information on our quality performance during 2018/19. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Risk Assessment Framework and Single Oversight Framework are outlined. We are also proud of a number of initiatives which contribute to strengthening quality improvement systems. An update on progress to embed these initiatives is also included in this section.

3.1. REVIEW OF QUALITY PERFORMANCE

Performance against priorities identified for improvement in 2018/19

We agreed a number of priorities for improvement in 2018/19 published in last year's Quality Account. These were selected in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1 - To prevent the number of community and hospital attributed pressure ulcers. – Partially Achieved

Background

The development of a pressure ulcer can cause significant long term harm both physically and mentally to a patient. This coupled with the impact of the resultant extended inpatient/community care provision can create avoidable financial pressures.

Our target was to reduce the number of avoidable grade 3 and 4 pressure ulcers in both the hospital and community by 10% and to reduce the number of avoidable grade 2 pressure ulcers in both the hospital and community by 5%

Our success measures have been

For the full year there has been a quarter on quarter reduction in the number of grade 3/4 community and hospital acquired pressure ulcers. However the reported numbers remain high and the target of a 10% reduction in ulcers was met for hospital acquired but not community acquired.

For grade 2 attributable pressure ulcers there has also a reduction quarter on quarter however the target of a 5% reduction has been met for community acquired ulcers but not for hospital acquired.

What did we achieve to date?

The format of the Pressure Ulcer Scrutiny Committee (PUSC) has been revised and relaunched in January 2019 with the aim being to provide a more structured opportunity for shared learning, identification of contributing factors and how these can be addressed to aid reduction.

The Trusts processes for the identification and management of pressure ulcers has been reviewed and updated in line with the publication of the NHSI – Pressure ulcers: revised definition and measurement framework.

We can evidence progress through

- Revised terms of reference for PUSC
- Minutes of meetings held

- Revised guidance.

What will we do in 2019/20 to continue improvements?

- Continue with this important priority in 2019/20.
- Review of the effectiveness of the revised PUSC
- Development of a pressure ulcer dashboard on Datix
- Provision of information at ward and team level to support the strategic information currently provided
- Quarterly thematic review of contributing factors identified in PUSC to ascertain what worked and any further action required.

Priority 2 - Improve patients by appropriate management of their nutritional needs. – Partially Achieved

Background

Nutrition and hydration are key factors influencing the health and well-being of patients across all healthcare settings and the Trust's policy for the treatment of malnutrition in adults is based upon the NICE clinical guideline 32: nutritional support in adults; which states that "All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened. Screening should be repeated weekly for inpatients and when there is clinical concern for outpatients".

Our target was to ensure that patients have MUST score assessed and appropriate nutritional management based on the result of the MUST score.

Our success measures have been

The MUST audit completed on the Acute Care Unit in May 2018 indicated 55% of patients were screened within 24hrs of admission against a target of 95). This is a decrease from results of a large audit completed in February 2018 which indicated a 70% uptake and 82% uptake in November 2017.

A subsequent MUST audit undertaken in August 2018 across 8 wards (80 patients) indicated a 73% record of MUST. MUST score is therefore not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately.

The most recent MUST audit undertaken in April 2019 across 10 wards (219 patients) indicated a 75% recording of MUST.

Whilst improvements have been achieved since May 2018 MUST score is not routinely being accurately recorded on the inpatients wards and work is continuing in collaboration with nursing staff to ensure this measure is assessed and recorded accurately and acted upon appropriately.

What did we achieve to date?

A number of actions have been achieved such as:

- A standardised audit tool was produced in collaboration with nursing staff across 8 wards.
- Liaison has taken place with Practice Development Nurse's and training provision enhanced to include:
  - HCA (care certificate) training and essential skills training,
  - Mandatory Nutrition training for nurses increased to 60mins from 30mins

- New MUST training for Band 5 & 6 nurses lasting 1 hour
- Mandatory Nutrition training for nurses training length increased to 60mins
- Online Elsiver training has been established but low uptake as staff prefer face to face training

- The Nutrition Steering Group (NSG) has been re-established - this provides a forum for discussing and recording adherence to quality standards, such as MUST Electronic Recording of MUST - Change request submitted to EPR to indicate if weight recorded is estimated/self-reported or accurate.

We can evidence progress through

- Six monthly audits
- Nutrition steering group bi monthly Meetings

What will we do in 2019/20 to continue improvements?

- MUST 'snapshot' audits to be undertaken twice yearly, including Mary Seacole.
- Nutrition Steering Group to meet bimonthly
- Development of automated MUST Audit reporting per ward via EPR.
- MUST Quality Improvement (QI) projects to be undertaken with support from the QI Team to identifying the barriers and potential solutions to facilitate the improvement of MUST screening and recording.

Priority 3 - To improve identification and response to acutely deteriorating patients. Partially Achieved

Background

Severe sepsis and septic shock have a mortality of 25-35% with approximately 44000 deaths per year in UK (2014/2015 data). Improvement in outcomes of patients suffering from severe sepsis and septic shock can be attributed to timely early management, namely prompt assessment and senior review, initial treatment (sepsis 6) and source search and control.

We need to ensure we have robust systems in place to ensure that we consistently identify deterioration in inpatients in a timely way no matter the cause and ensure an appropriate rapid response. We strive to ensure we are continually reviewing our progress in this area and are committed to continuous quality improvement.

Our targets were:

- To establish a deteriorating patient task and finish group
- Ensure timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Timely treatment of sepsis in emergency departments and acute inpatient settings
- Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours
- Reduction in antibiotic consumption per 1,000 admissions.

Our success measures have been

A multi-professional deteriorating patient task and finish group has been established reviewing the models and resources available to enhance the detection of, and response to, deterioration in adult medical and surgical inpatients out of hours.

Sepsis screening - The results April 18 to January 19 for both acute and emergency demonstrate that 98% of all patients that met the criteria for sepsis screening were screened for sepsis showing continuous improvement from last year. Year end results confirm the target was met.

Timely treatment – Whilst not achieved throughout the year there have been improvements in Q4 and the target was met with a performance of 92%. The likely reason for the drop in performance in Q2 and Q3 was a change in staff, both with new doctors starting in August and also the departure of the sepsis nurse. A new sepsis nurse has now been in post since December 2018.

Assessment of clinical antibiotic review - There has been a steady improvement in compliance with antibiotic review criteria over the financial year. Targets for the year have all been met.

Reduction in antibiotic consumption - Total consumption increased in Quarter 3 of this financial year, in comparison to Quarter 1 and 2, as is to be expected over the winter period. Overall however we met the target to achieve our 1% reduction in total antibiotic consumption in 2018/19 in comparison to 2017/18 total consumption.

What did we achieve to date?

The Deteriorating Patient Group has multi-professional representation from across all services involved in the detection and response to deterioration including Critical care, Surgery and Medicine. So far the group has:

- Completed a review of clinical incidents related to deterioration
- Completed regular audit of the escalation and response to abnormal National Early warning scores in adult inpatients
- Completed two detailed thematic analyses of case reviews of patients admitted as an emergency to critical care from adult inpatient wards.
- Used this data to inform an updated education plan around deterioration including in-situ simulation, seminars with all clinical departments and updated nurse study days
- Review of the workload and competences of all members of staff involved in providing care to inpatients in the hospital at night
- Options appraisal for different suggested staffing and models of care overnight
- Completed roll-out of the NEWS 2 system of physiological monitoring in January 2019 Completion and roll-out of new guidelines for escalation of deterioration and for referral to critical care

There has been continuous work and training around sepsis recognition and treatment.

A new sepsis nurse has now been in post since December 2018 and the effect of that is evident in the improvement in performance in the last quarter. There are a number of interventions undertaken to improve sepsis awareness including teaching on mandatory training for nurses and doctors, training sessions on wards, close work with PDNs and resus officer to facilitate sepsis training.

The microbiology team continues to monitor use of all antibiotics where indicated and works with pharmacy to provide an education and awareness raising programme, support the Antimicrobial Stewardship Virtual Ward Round, as well as providing feedback to clinical teams regarding progress. There has been a steady improvement in compliance with antibiotic review criteria over the financial year.

We can evidence progress through:

Progress for the deteriorating patient group can be evidenced by the rollout of new teaching sessions, minutes of the meeting of the group and the rollout of the new escalation pathways

What will we do in 2019/20 to continue improvements?

The Trust intends to continue with this important priority in 2019/20.

The deteriorating patient Group will continue to focus on regular data collection looking at escalation and response to deterioration.

Once a new model for hospital at night cover for adult inpatients has been agreed the team will focus on its rollout and reviewing its efficacy

The sepsis nurse role has shown to be invaluable as evidenced by the drop in our performance when the post was vacant. For 2019/20 we will continue with a number of interventions currently in place to increase sepsis awareness. Other future plans include, continuing to provide regular training to both doctors and nurses in ED; in ward SIM training; and raising awareness throughout the hospital with posters on all wards.

We will continue to provide educational initiatives and develop our Trust strategy via antimicrobial management group regarding antimicrobial stewardship, including daily antimicrobial stewardship ward rounds and use of carbapenem-sparing agents where appropriate. We will focus on the promotion of electronic tools (e.g. Medicine Powerplans for Sepsis) to improve antimicrobial stewardship and adherence to guidelines with incorporation of such tools for example into simulation training sessions on acutely deteriorating patients where relevant.

Clinical Effectiveness (Effective)

Priority 4 - To achieve the Quest best employer accreditation. - Not Achieved

Background

NHS Quest, of which Homerton is a member, has decided to add to its core role as a quality improvement network by developing an Employment Brand.

NHS Quest were initially attempting to support the ‘Best Employer Brand’ by developing an accreditation regime designed to assure employers they were focussing on the right things that would ensure they featured in the top 20% NHS trusts to work by 2020 as measured by the NHS staff survey.

Our success measures have been

This work has not progressed as envisaged and subsequently QUEST is currently reflecting on next steps in respect of how to effect quality improvements in this key area for member organisations. Homerton continues to be involved where appropriate.

What did we achieve to date?

2018 Staff Survey feedback indicates that Homerton broadly managed to continue with its previous ratings which indicate that it remains in the top 20% of NHS Trust to work for.

Specifically the 2018 Staff Survey indicates that 70% of staff would recommend the organisation as a place to work and 76% would be happy with the standard of care if a friend or relative needed treatment.

We can evidence progress through

- Staff Engagement Meetings and Action Plan.
- Equality & Diversity Meetings and Action Plan.
- Healthy Homerton Meetings.
- Staff survey completion and results

What will we do in 2019/20 to continue improvements?

The Trust is currently formulating an action plan to generate improvement at corporate and local levels with the aim of achieving an overall improvement in Trust ratings across a range of areas. Significantly priorities at corporate level have been identified as follows:

- Harassment and Bullying of Staff by Patients and Carers
- Equality, Diversity and Inclusion in employment
- Staff Health and Well Being
- Trust Values and Culture
- Appraisal rates consistently high across the organisation.

The Trust plans to include a priority related to staff health and wellbeing in 2019/20.

Priority 5 - Improving services for people with mental health needs who present to A&E – Achieved.

Background

It is widely recognised and accepted that people with mental health problems are up to three times more likely to present to an ED than the general population; and are also up to five times more likely to be admitted to an acute hospital. ‘Frequent Attenders’ to an ED continue to be a ‘growing health concern’ with research suggesting that each of these ED attendances are not always beneficial for the patient, yet are resource-intense both in terms of clinical time and financially. As such, clinicians in acute settings need to be adequately equipped to recognise urgent mental health needs as well as identifying underlying mental health conditions.

Our aim was to maintain a 20% reduction in attendances to ED for patients within a selected cohort of frequent attenders in 2017/18 and identify a new cohort of frequent attenders to ED during 2017/18 that could benefit from interventions to reduce by 20% their attendances to ED in 2018/19.

Our success measures have been

Maintain 20% reduction in attendances to A&E for patients within the selected cohort of frequent attenders identified in Year 1 (2017/18) – the Trust achieved an 80% reduction.

Identify a new cohort of frequent attenders to A&E during 2017/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19 – the Trust achieved a 60% reduction.

What did we achieve to date?

A summary of the achievements to date is set out below:

- Identify subsets of patients who would benefit from assessment, review and care planning with specialist mental health staff
- Produce care plans for each patient in the cohort, engaging with local partner agencies
- Establish joint governance arrangements
- Establish local data collections to support the evaluation of the CQUIN project
- Provide assurance on EPR recording/coding for patients presenting with MH complaints
- Ensure a system is in place to identify new FA
- Continue to develop and embed service development plans to support sustained reduction in attendances for people with MH needs
- Identify whether the presentations of the patient cohort were recorded/coded correctly on the electronic patient record system
- Agree service development plan to support sustained reduction in attendances for people with MH needs

We can evidence progress through

- CQUIN updates
- Operational Meetings
- Steering Group meetings (HUH and ELFT)
- Urgent Care Quality Meeting
- ED attendance data

What will we do in 2019/20 to continue improvements?

- To continue to monitor, review and analyse frequent attenders and adopt a multi-disciplinary approach to managing this patient cohort.
- To continue developing our understanding on this cohort of patients and their health needs.
- To improve individualised care planning for identified frequent attenders.
- To ensure robust governance systems between acute and community settings and maintain information sharing mechanisms.
- To learn and share experiences on individual case management.

Priority 6 - Improving the management of end of life care for adults. - Achieved.

Background

This priority relates to the need that when a patient is dying that they and their family receive the best possible care. This involves ensuring they do not receive unnecessary medical interventions and that care is delivered in line with the 5 priorities of care identified by The Leadership Alliance for The Care of Dying People (One Chance to Get it Right June 2014).

Our targets were to ensure our patients who die within the hospital have an end of life care plan and a treatment escalation plan.

Our success measures have been.

Completion of an individualised end of life care plan ensures individualised needs are identified, regularly reviewed and any nursing interventions evaluated in a timely way. It ensures that the needs of the family are considered and met. This has been achieved in over 70% of cases over 2018/19.

Completing a Treatment Escalation Plan enables the documentation of communication with patients and families around recognition of dying, appropriate treatment options at this time, identification of preferred place of care and death and other priorities for the dying person and their family. With the TEP there is an End of Life Review completed, again ensuring psychological, spiritual and social needs have been considered. This has been achieved in over 70% of cases over 2018/19.

What did we achieve to date?

- In 2018 the Trust launched a revised end of life care strategy for 2018-2021.
- The Trust applied and was granted funding from Macmillan for a two year end of life facilitator post to take forward the strands of the strategy.
- The end of life care plan has been revised to better reflect the needs of the dying patient and their family. The Trust will be introducing a programme of teaching in relation to the new care plan. This went live on EPR in 2019.
- Following consultation with the ward staff, a two hour communication training programme for ward nurses and health care assistants has been delivered to staff on ECU and Edith Cavell.
- An End of Life Care Facilitator started in 2018 and has been establishing and promoting this new post and the Strategy throughout the Trust (inpatient and community).
- In December 2018 we started giving out a bereavement feedback survey to the next of kin of all adult patients that have died in the hospital.

We can evidence progress through

- Maintaining records of training done, attendance numbers and evaluations including doctors training, nurse's band study days, annual update training, ward based training and Simulation training.
- Audits demonstrating a continued increase each quarter in the number of patients at end of life with a TEP (and EOL Review) and nursing end of life care plan.
- Feedback received in the bereavement surveys.

What will we do in 2019/20 to continue improvements?

The Trust is taking forward the aims of the End of Life Strategy 2018-21. These are:

- Personalised End of Life Care
- Supporting our staff
- Improving environment
- Communication and Information.

We will deliver ward teaching re changes to the End of Life Care plan.

Conversations with patients and families about dying have been included in simulation training for nurses and health care assistants and this will continue and be developed for medical staff too.

Patient Experience

Priority 7 - Ensuring staff are actively hearing the Voice of the Child and this is integral to care. – Achieved.

Background

Two key drivers for ensuring that the voice of children and young people is heard, listened to and shape the way in in which Homerton provides services for them are:

In 2015 the CQC published a report which reviewed 50 inspection reports and concluded that the 'voice of the child' was deafeningly silent.

One of the guiding principles that the Trust has signed up to as member of the City and Hackney Safeguarding Children Board is developing a culture which ensures that children and young people are heard through professionals taking the time to listen to what children and young people are saying, putting themselves in the child or young person's shoes and thinking deeply about what their life might truly be like.

Our targets were to ensure; that the voice of the child is included in health visitors safeguarding supervision; children feel involved in decisions about their care; children feel safe as in-patients and staff attend me first training.

Our success measures have been

- 100% Health Visitors have the voice of the child documented on RIO as part of their supervision.
- Over 90% of children sampled felt involved in their care.
- A how safe do you feel pilot questionnaire has been developed.
- Over 30% of relevant staff have attended Me first training

What did we achieve to date?

- Standard Operating Procedure developed for documenting safeguarding supervision on RIO which includes guidance on documenting the voice of the child.
- 24 Safeguarding children supervision records were audited in Q's 3 & 4.
- HV participated in a Voice of the child audit. Report completed and findings have been used to form the basis of a workshop scheduled for 12th April 2019.
- Parents and children on Starlight Ward continue to be asked to complete the patient satisfaction survey using Optimum Technology.
- How safe do you feel questionnaire has been developed and piloted with 36 children aged 8-15 years (the denominator was not established), who were in patients on Starlight ward. The momentum for this work slipped in quarter 3 when the trust quality improvement lead left the organisation.
- Staff (nursing and medical) attended Me first Masterclass

We can evidence progress through

- Dip sample audits of supervision records
- In patient satisfaction feedback report
- 'How safe do you feel' questionnaire developed and piloted.

What will we do in 2019/20 to continue improvements?

Continue work on embedding the voice of the child in clinical practice as an objective in the Safeguarding Children 2019/20 work plan which will be monitored by the Safeguarding Children Operational Forum.

Priority 8 - Improving the first impression and experience of the Trust for all patients and visitors – Not Achieved.

Background

Creating positive first impressions of the Trust for patients, service users and visitors who are visiting the Trust is important in building trust and confidence in our staff and services. Receptionists are on the front line in meeting and greeting patients, service users and visitors and therefore play a pivotal role in this. We will develop a range of measures to support receptionists and their managers create a positive first impression for every patient, service user and visitor to the Trust at every visit.

Our targets were to initiate a quality improvement project with non-clinical outpatient staff, increase the numbers of staff attending the effective receptionist course and developing first impressions standards.

Our success measures have been

A Quality Improvement project has been established looking at measuring ourselves against best practice, identifying expected behaviours and barriers and enablers to delivering this and measures to support delivery.

There is an action plan for the First Impressions project and it included the need for 50% of the receptionist staff to undertake the Effective Receptionist training. The uptake of training was not fully taken up.

A draft set of first impression standards has been produced aiming to create a positive first impression which will help to provide consistency across the Trust.

What did we achieve to date?

First Impressions Workshop Sept 2018 attended by 20 receptionists from a range of teams including reception managers, Head of Learning and Head of Patient Experience. The session explored three questions to help inform an action plan.

- What does the Trust need to put in place to ensure that ‘first impression’ standards can flourish?
- What are the things that currently get in the way and prevent us from delivering a positive first impression?
- What are the factors that will help you deliver a positive first impression?

A draft First Impressions Standard was proposed and a number of areas agreed to support its delivery including recruiting staff with the right attitude, competencies and training, supporting staff to consistently exhibit behaviours.

We can evidence progress through

A draft set of First impression Standards has been developed including code of behaviours. An action plan has been created which will form the basis of the work plan for the first impression steering group to deliver. Additional Effective Receptionist courses have been commissioned for 2018/19.

What will we do in 2019/20 to continue improvements?

Refresh the action plan, meeting membership and key priorities. Review the Effective Receptionist training to ensure it is tailored to the new standards. The initiative will be project managed in line with the QI principles. A new OPD Manager has been appointed and will give the initiative a refreshed launch.

Priority 9 - For patients who on discharge are receiving one or more community services for their discharge to be seamless and communication between all services enhanced. – Achieved.

Background

Improving discharge from hospital is a key priority for the trust. This has previously been shown to be an area that could be improved on and that affects both patients and the effective operational performance of the hospital. While considerable work was done in 2017/18 with hospital services including wards and multi-disciplinary teams to better facilitate discharge, greater focus has now turned to enhancing the community-facing services involved in supporting discharge.

Our targets were to develop a patient information leaflet in relation to discharge services offered; implement a discharge to assess pilot; ensure continuing care assessments are completed in the community and ensure continuing care assessments are completed within 28 days.

Our success measures have been

A discharge patient information leaflet has been developed and is awaiting approval.

What did we achieve to date?

A patient information leaflet has been produced describing the range of the discharge related services.

The discharge to assess pilot has been implemented and assessed.

We have achieved our target of 85% continuing healthcare (CHC) assessments complete in the community, unless exempt by agreement.

We have achieved our target of 95% CHC assessments to be completed within 28 days.

We can evidence progress through

Minutes or action logs of meetings including Medical Productivity Group, CQUIN Board, Integrated Discharge Steering Group and Unplanned Care Board.

What will we do in 2019/20 to continue improvements?

- To ratify patient information leaflet
- To seek data for other D2A services as a comparator
- To maintain delivery of local CHC CQUIN
- To ensure on-going attendance and effective functioning of various groups identified above.

Priority 10 - To implement a complete electronic postnatal discharge process with a failsafe element to ensure timely and appropriate delivery of postnatal care to mothers and babies once transferred from hospital into the community setting. - Achieved.

Background

Datix incident reports identified a trend in 'missed' postnatal discharges from inpatient areas to community care to Homerton and out of areas (16 missed discharges in January 2018). This resulted in mothers and babies having delayed home visits and therefore the schedule of postnatal care in the community not being followed. This was of serious patient safety concern as mothers and babies were having essential care and screening tests delayed, which in turn has the potential for harm.

Following review it was identified that the missed discharges were occurring in both the transfers of care to Homerton's community services and out of Homerton area community services. It was also identified that the missed discharges were coming from all inpatient areas that process Incorrect Homerton community zone/out of area hospital identified by midwife to be notified of discharge.

There were a number of reasons why discharges were not reaching appropriate community teams, it was decided that a new process was to be implemented to cut out the manual process of paper notification and minimise the number of individuals involved in the process to reduce the risk of errors being made.

Our targets were to ensure postnatal discharges are sent electronically, daily failsafe checks were being made and missed discharges were reported on Datix – with the aim of having 0 missed discharges by March 2019.

Our success measures have been

As part of the new process, sending of the discharges electronically is mandatory as there is now no provision for paper copies to be collected. This has been successful with 100% compliance.

The daily failsafe check is completed by two different teams; Community complete the failsafe to check they have received all of the Homerton community discharges, and Delivery Suite complete the failsafe to check all of the out of Homerton community area have been sent. There was a decline in the compliance with this in Quarter 2, which was identified when missed discharge incidents were being reported. Both the Delivery Suite and Community leads have identified the issues which lead to not achieving 100% compliance with the daily failsafe.

Although the target of 0 missed was achieved in March 2019, prior to this there were low levels of incidents monthly. It is however evident that there has been a clear reduction since the implementation of the new process and failsafe.

The main reasons for discharges being missed were;

- Discharge not sent on day of discharge, and failsafe not done therefore missed discharge not identified
- Discharge sent to incorrect out of area hospital – no notification from other hospital or notification not acted upon due to the failsafe not being done

The missed discharges are generally identified by families calling the maternity helpline to inform them that they have not had their expected visit, or the health visitor informing us. All missed

discharges would be identified at the latest by the national Northgate Newborn Blood Spot (NBBS) failsafe system which would identify a delayed NBBS sample. All are logged via Datix and reviewed and actioned by the line manager of the area that the client was discharged from.

What did we achieve to date?

- Standard Operating Procedure implemented for new discharge process
- Datix reporting and investigation of any missed discharges
- Staff support in implementing the new process including training, discussion at team meetings, written feedback
- Monitoring of incident trends via the maternity trends report with feedback to staff
- Updates at team meetings
- Focus on ensuring failsafe completed daily, including further training
- Putting processes into place to ensure failsafe is completed when core members of the administration team are not working

In late Quarter 4, implementing the London-wide map to support ensuring discharges are sent to the correct hospital.

We can evidence progress through

Gradual reduction in missed discharges and maintenance of lower level of incidents. There is a continued focus on discharge incidents. In March 2019, we achieved the aim of 0 missed discharges.

What will we do in 2019/20 to continue improvements?

- Further work with administration teams to work towards the aim of 100% compliance with the daily failsafe, including further training and audit.
- Continued reporting via Datix of any missed discharge to identify any training or system issues.
- Continue to embed the use of the London-wide electronic map to support the staff to select the correct hospital for discharge.

3.2. Review National Performance Indicators

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016. Please note Summary Hospital-level Mortality Indicator (SHMI) Clostridium difficile and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Homerton endeavours to meet all national targets and priorities. Below is a summary of the national targets and indicators.

Cancer Waits

Table 13: 62 day cancer waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Cancer: 62 day wait for first treatment (from urgent GP referral for suspected cancer)	85%	87.70%	81.70%	83.90%
Cancer: 62-day wait for first treatment (from NHS Cancer Screening Service referral)	90%	66.67%	100.00%	100.00%

Data source: Somerset Cancer database

The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and is a significant improvement against last year's performance. The Trust continues to place significant focus on the delivery of this standard via its fortnightly Cancer Access Board. It should be noted that the improved performance has coincided with the appointment of a new Head of Access. With regard to the screening target, it should be noted that although the performance is below the 90% standard, this relates to a total of three treatments, of which one treatment was recorded as a breach.

Referral to Treatment Time

Table 14: Referral to treatment time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Referral to treatment time (incomplete pathway) - within 18 weeks	92%	96.71%	96.18%	95.30%

Data source: Homerton EPR/RIO

The Trust has continued to perform strongly against the 92% standard and has met the standard for every month of 2018/19, despite increase demand for its outpatient services. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Accident and Emergency (A&E)

Table 15: A&E waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
A&E - total time in A&E under 4 hours (from arrival to admission/transfer/discharge)	95%	94.34%	94.73%	94.10%

Data source: Homerton EPR

The Trust has seen an improvement in its overall performance against the total time in A&E standard in 2018/19, although overall the Trust has not delivered the 95% standard. However, it is of note that the standard has been delivered in five months over the course of the year.

Diagnostic procedures

Table 16: Diagnostic procedure waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Maximum 6 week wait for diagnostic procedures	99%	99.77%	99.97%	N/A

Data source: Homerton EPR

The Trust has consistently performed strongly against the six week wait standard for diagnostic tests despite on-going increases in demand. Whilst performance has been compliant overall on a monthly basis, there have been some instances where the standard has not been met within individual modalities. Performance is monitored on a fortnightly basis as the Trust's Elective Access Board.

Improved Access to Psychological Therapy (IAPT)

Table 17: IAPT waiting time performance

Indicator	Target 2018/19	2018/19	2017/18	2016/17
Proportion of people completing treatment who move to recovery (from IAPT* database)	50%	60.45%	56.65%	N/A
Waiting time to begin treatment (from IAPT minimum dataset) within 6 weeks	75%	96.50%	93.87%	84.4%
Waiting time to begin treatment (from IAPT minimum dataset) within 18 weeks	95%	99.52%	99.42%	99.1%

Data source: Patient Case Management Information System

The Trust has continued to deliver its core IAPT targets throughout 2018/19 and performance has improved compared to 2017/18 across the three core standards.

3.3. Quality Improvement at Homerton

'Quality Improvement' (QI) can be defined as an approach to improving service quality, efficiency and morale simultaneously, using improvement science. It is part of a broad range of activities known collectively as 'improving quality'. QI uses systematic methods to involve those closest to the quality issues in developing solutions to a complex problem. The systematic method used at the Trust is the Institute for Healthcare Improvement (IHI) Model for Improvement.

Building and fostering QI knowledge and skills

During 2018/19 the QI team priority has been building QI knowledge and skills in staff (clinical and non-clinical) whatever the service they deliver or the role they play. QI has been incorporated into the organisational development activities aimed at fostering an 'improvement mindset'. We have introduced a QI session into the induction of staff that have managerial or supervisory duties because we want every team to be empowered and supported to use QI to improve the care provided.

The Trust Leadership Level 2 programme 2018 for the first time included QI tools and approaches with bespoke teaching from the QI team as well as one to one coaching for each of the participants. The nurse preceptors also benefitted from QI teaching and support. Staff in both of these programmes completed high quality QI projects, produced posters and presentations sharing their findings widely through the QI Forum, audit days and Research and Development conferences. These projects delivered improvements in the efficiency of systems and processes reducing the time patients wait for care, decreasing the time taken to administer or dispense medication, improve patient and staff confidence and levels of feedback as well as safety through better reviews and assessments of patients.

The QI Forum was launched in June 2018 as a place for staff to share QI project activities with colleagues from across the Trust. Presentations and discussion highlight issues, findings and solutions that are transferable. As a regular participant fedback 'I like the learning – there's always something to take away'. The Improving Quality Board, co-chaired by the Medical Director and the Director for Organisational Transformation, is responsible for a strategic overview of the broad range of improvement activities from mortality reviews to themes from patient feedback and patient safety and effectiveness which shape QI project priorities.

Lessons from the QI team's work with preceptor nurses, as well as the 'Improving Trust and Confidence in Nurses' workstream, is being used to develop a Chief Nurse QI Fellow programme, specifically for Band 5 nurses. This will run from April 2019. Staff groups such as Allied Health Professionals and doctors in training are already in the forefront of putting QI into practice. The team provide teaching and advice to these groups as part of their induction, learning and development programmes. All staff undertaking QI projects are encouraged to align their projects with Trust and service priorities and to include patients/clients and service users as key partners.

Working in partnership

Partnerships are crucial to the Trust's QI approach. Homerton is part of UCLPartners (Academic Health Science Network) and shares QI projects using the LIFE collaboration and data analysis platform. The Trust subscription to the IHI also provides staff with access to e-learning and to international QI cases studies and resources.

Homerton is also an active participant in the QUEST network of 16 NHS organisations which are committed to focussing on improving quality and patient safety. The Trust contributes to the QUEST 'Best Employer Brand' initiative because we recognise that high levels of staff engagement improve the quality of patient care.

Homerton QI in the City and Hackney health economy and beyond

The QI team ethos is to bring QI support to wherever teams are based. For example, we have built on the 'lunch and learn' QI sessions for Adult Community Nursing teams and practice nurses in the south west of City and Hackney to improve communication between practitioners to provide seamless care to clients. The QI team is part of a project using Experience Based Co-Design principles and methods to develop and deliver better services and solutions with and for patients. This is an exciting opportunity to use QI principles in 'Neighbourhoods' or place based models of care.

One of three 'transformation' projects ongoing during 2018/19 related to mobile working in community service teams. This project took a holistic approach to examining how the benefits of mobile working could be realised in three services which included different care models e.g. adults and children's services and therapy and nursing teams. 'Time in motion' studies were conducted using validated tools together with assessing staff and patient/client experience and attitudes to the use of technology. Recommendations for action are informing the development of IT systems and place based 'Neighbourhood' care models. This work aligns with the North East London Sustainability and Transformation Plan: investment in and development of technology and delivering paper-free care at the point of use.

Homerton has a track record of developing technology enabled healthcare, such as electronic patient records and sharing information efficiently and securely across health organisations via the Health Information Exchange (HIE). In July 2018, Homerton organised and hosted an event for NHS partners in the Quest network focussing on this theme. Homerton Experience Day included immersive sessions for participants to see the HIE in action in the hospital and try out Voice Recognition software to produce clinic letters. We showcased the latest thinking from Homerton staff harnessing the power of wearable technologies to help patients manage long-term conditions and the proposed use of Artificial Intelligence to screen and triage referrals. The event included insights from Dr Simon Eccles, Chief Clinical Information Officer for Health and Care, the Northern Care Alliance (a Global Digital Exemplar) as well as an opportunity to explore the positives and pitfalls of technology in healthcare through a lively debate.

The Surgical Transformation Programme aims to increase efficiency and productivity in surgical services. Staff used skills developed in the Quest Improvement Science for Leaders (IS4L) to improve the percentage of patients undergoing gallbladder removal to go home safely on the day of the procedure. Theatres team members also took part in the 'Improving Theatre Safety Collaborative' which used a clinical communities model to drive and sustain improvements in outcomes.

Homerton has again been successful in winning a place on the IS4L programme in 2018/19. The team project is called 'Mind the Gap' and is focussed on decreasing the late diagnoses of speech, language and communication needs in children and young people living in Hackney.

QI Futures 2019/2020

Homerton's QI activities in 2019/2020 aim to support the Trust's ambition to be a provider of 'Outstanding' care. The QI approach is in line with the Care Quality Commission (CQC) guidance on trusts with a maturing QI function. Key priorities will be to develop and embed better use of data and qualitative information, improve how we work in partnership with patients and service users, sustain and spread successful QI projects and communicate and raise awareness of QI in innovative and compelling ways.

APPENDIX A. LIST OF NATIONAL AUDITS AND CONFIDENTIAL ENQUIRIES 2018/19

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
Adult Community Acquired Pneumonia (BTS)	✓	✓	-	73	-
Case Mix Programme (CMP)	✓	✓	578	578	100%
NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults	✓	✓	-	4	-
Elective Surgery (National PROMs Programme)	✓	✓	294	375	78%
Falls and Fragility Fractures Audit programme (FFFAP)*	✓	✓	96	96	100%
Feverish Children (care in emergency department)	✓	✓	120	120	100%
Inflammatory Bowel Disease (IBD) programme	✓	✓	982	982	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	3	3	100%
Major Trauma Audit	✓	✓	136	-	-
Mandatory Surveillance of bloodstream infections and *Clostridium difficile* infection	✓	✓	54	54	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme(MBRRACE)	✓	✓	53	53	100%
NCEPOD - Medical and surgical clinical outcome review programme - Perioperative diabetes	✓	✓	3	4	75%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism	✓	✓	-	-	100%
NCEPOD - Medical and Surgical Clinical Outcome review programme - Acute Bowel Obstruction	✓	✓	7	7	100%
NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Acute Heart Failure	✓	✓	3	5	60%
Myocardial ischaemia National Audit Project (MINAP) *National Cardiac Audit Programme (NCAP)*	✓	✓	278	278	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)* *Secondary care*	✓	✓	90	90	100%
National Audit of Breast Cancer in Older People (NABCOP)	✓	x	-	-	-
National Audit of Cardiac Rehabilitation	✓	✓	224	420	53%
National Audit of Care at the End of Life (NACEL)	✓	✓	28	28	100%
National Audit of Dementia (in General Hospitals)	✓	✓	56	50	100%
National Audit of Intermediate Care (NAIC)	✓	✓	73	73	100%
National Audit of Seizures and Epilepsies in Children and Young People	✓	✓	36	49	73%
National Bariatric Surgery Registry (NBSR)	✓	✓	193	193	100%
National Bowel Cancer (NBOCA)	✓	✓	90	90	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	17	17	100%
National Clinical Audit for Rhematoid and Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	16	29	55%
National Comparative Audit of Blood Transfusion programme*	✓	✓	11	30	36%

Audit Title	Eligible for participation	Did Homerton participate?	Number of cases submitted	Number of cases required	% of cases submitted
National Diabetes Audit*	✓	✓	13958	13958	100%
National Emergency Laparotomy Audit (NELA)	✓	✓	63	63	100%
National Heart Failure Audit (NCAP)	✓	✓	301	301	100%
National Joint Registry (NJR)	✓	✓	198	198	100%
National Lung Cancer Audit (NLCA)	✓	✓	144	144	100%
National Neonatal Audit Programme (NNAP)	✓	✓	1395	1466	95%
National Oesophago-gastric Cancer (NAOGC)	✓	✓	47	47	100%
Non- invasive ventilation Adults (NIV) (BTS)	✓	✓	-	3	-
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	✓	✓	6537	6537	100%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	152	153	99%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance scheme	✓	✓	7	7	100%
Surgical Site Infection Surveillance Service	✓	✓	1	1	100%
Vital Signs in Adults (care in emergency departments)	✓	✓	122	120	100%
VTE risk in lower limb immobilisation (care in emergency departments)	✓	✓	150	150	100%

*Multiple work streams

1. *Adult Community Acquired Pneumonia. We are submitting data with a deadline of 31/05/2019. 100% data submission is anticipated.*
2. *NCEPOD - Child Health Clinical Outcome Review Programme Long term ventilation on children, young people and young adults- we are awaiting individual patient questionnaires. 100% data submission is anticipated.*
3. *Major Trauma: the expected number of cases is based on HES and EPR data and may not always reflect the true number of cases that are eligible for the audit. Therefore, it may appear that not enough cases were submitted for the audit. As we are a level 1 trauma centre, the majority of trauma cases would go elsewhere and would be captured through the Major Trauma data at tertiary centres. 100% data submission is anticipated for cases identified.*
4. *National Audit of Breast Cancer in Older People – The Trust did not submit the required data by the deadline.*
5. *NCEPOD - Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism – Only organisation questionnaire required and was submitted.*
6. *Non- invasive ventilation Adults (NIV) We are submitting data with a deadline of 31/06/2019. 100% data submission is anticipated.*
7. *LeDeR audit became mandatory on the 1st of March 2017 and we have had no patients who met the criteria to date.*
8. *National Comparative Audit of Blood Transfusion programme. Despite the numbers of eligible patients not all patients will have received either FFP or massive transfusions and therefore will not have required an audit response. All patients who met the criteria in the period were audited.*

APPENDIX B. 2018/19 CQUINS

No.	National Indicator	Description of Indicator	Indicator weighting acute & community £
1a	**Improvement of health and wellbeing of NHS staff**	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.	127,754
1b	**Healthy food for NHS staff, visitors and patients**	Maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 and introducing 3 new changes	127,754
1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	Year 1 – Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2- Achieving an uptake of flu vaccinations by frontline clinical staff of 75%	127,754
2a	**Timely identification of patients with sepsis in emergency departments and acute inpatient settings**	The percentage of patients who met the criteria for sepsis screening and were screened for sepsis	75,935
2b	**Timely treatment of sepsis in emergency departments and acute inpatient settings**	The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.	75,935
2c	**Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours following the review criteria**	Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours following the review criteria	75,935
2d	**Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both in- patients and out-patients) within the Access AWaRe category.**	1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions	75,935
4	**Improving services for people with mental health needs who present to A&E**	For 2018/19: 1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. 2. Identify a new cohort of frequent attenders to A&E during 17/18 that could benefit from psychosocial interventions and work to reduce by 20%, their attendances to A&E during 2018/19. In year 2, it is expected that the cohort will include groups who experience particular inequalities in access to mental health care (see below for further detail). Ensure that mental health attendances to A&E are recorded and submitted to the Emergency Care Dataset.	300,530
5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).	79,521
6	**Advice & Guidance**	The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.	300,742
9a	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening**	Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.	15,187

9b	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**	Percentage of unique patients who smoke AND are given very brief advice	60,748
9c	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication**	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	75,935
9d	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	75,935
9e	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral	75,935
10	**Improving the assessment of wounds**	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	106,028
11	**Personalised care and support planning**	Embedding personalised care and support planning for people with long-term conditions.	106,028
LOCAL	**Continuing Healthcare Assessments, reviews and best practice management**	This CQUIN aims to improve the care and support provided to people in receipt of continuing health care funded by City and Hackney CCG.	106,028

No.	NHSE Indicator	Description of Indicator	Indicator weighting - 2%
GE2	**GE2: Activation System for Patients with LTC**	To ensure patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition)	£42,875 0.31%
B13	**B13 – Automated Exchange Transfusion for Sickle Cell Care**	Patients with sickle cell disease require exchange transfusions to manage their condition. This can be done manually or using automated exchange. This CQUIN scheme aims to incentivise the use of automated exchange by specified specialist centres in order to improve patient experience and use of clinical resources.	£316,314.93 1.18%
B14	**B14 - Sickle Cell ODN**	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	£77,738.42 0.29%
	Neuro-Rehab	• Reduce unnecessary duplicate referrals and the time spent in waiting for assessment • Reduce the number of 'rejected' referrals rejected simply because the information is not complete. • Improve patient experience data at a unit level • Bring Level 1/2a neuro-rehabilitation services more fully into a 'system' of care in each STP in the London.	£58,973.97 0.22%

	CQUIN – DENTAL		Indicator weighting 2%
	Activity reporting by Referral to Treatment (RTT) for each dental specialty	Collection and submission of data for dental pathways using the CQUIN RTT dashboard.	£32,388

	Acute Dental Systems Resilience Group	Participate in the Acute Dental Systems Resilience Group (SRG), including supporting data requests to contribute to a Pan London approach to demand and capacity modelling.	£32,388
	Use of the acute dental portal	Develop a central storage system for all documents/ correspondence relating to acute dental activity and data	£32,388
			£97,164

No.	**Public Health Indicator**	**Description of Indicator**	**Indicator weighting DESP 2.5% , Bowel 2%**
DESP	**Improve outcomes and reduce risk of complications for patients with diabetes through implementation of Making Every Contact Count (MECC) project with patients attending for diabetic eye screening.**	London DES services to implement tailored MECC projects that will contribute to improved health and wellbeing of service users and support uptake of approved Diabetes Structured Education programmes, through facilitating referral of patients with diabetes. To include: • Development and implementation of CQUIN project plan in collaboration with and in alignment with STP Diabetes programme priorities. • Service protocol to include defined target patients • MECC training to support staff interventions with patients and evaluation. • Mechanisms to track MECC interventions and numbers of referrals • End of project evaluation	£76,792
	Bowel Scope Patient Experience Survey	Improve patient experience of Bowel Scope through conduct of Patient Feedback Survey and Focus group for all those who attend bowel scope at North East London screening site. Results from surveys will feed into local screening service improvement plans	£56,019

No.	**STP Indicator**	**Description of Indicator**	**Indicator weighting acute & community £**
STP	**STP CQUIN**	This CQUIN seeks to engage providers within the ELHCP in order to play a full part in the development and implementation of the productivity, efficiency and quality improvement schemes as well as supporting the development of the ELCHP and wider system management. A number of specific indicators have been set out with milestones for achievement, however, there are pre-conditions requirements that need to be met first	£1.8m

APPENDIX C: GLOSSARY OF TERMS AND ABBREVIATIONS

CCG	Clinical Commissioning Group
C-Diff	Clostridium Difficile
CEO	Chief Executive Officer
CESDI	Confidential Enquiry into Stillbirths and Deaths in Infancy grading system
CLIP	Complains, litigations, Incidents Pals meeting
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission – The independent regulator of health and social care in England
CQUIN	Commissioning for Quality and Innovation
DNA	Did Not Attend
DH	Department of Health
ED	Emergency Department
EoL	End of Life
EoLC	End of Life Care
EPR	Electric Patient Record
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement Partnership
HUHFT	Homerton University Hospital Foundation Trust
IAPT	Improving Access to Psychological Therapies
ICEC	Improving Clinical Effectiveness Committee
IG	Information Governance
IGT	Information Governance Toolkit
IHI	Institute for Healthcare Improvement
ITU	Intensive care unit
MDT	Multidisciplinary Team
MSK	Musculoskeletal
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Scores
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PbR	Payment by Results
PE	Pulmonary Embolism
PrEP	Pre-exposure Prophylaxis
PROMS	Patient Reported Outcome Measures
PUSC	Pressure Ulcer Scrutiny Committee
QI	Quality Improvement
R&D	Research & Development
RA	Rheumatoid arthritis

RCA	Root Cause Analysis
RiO	RiO (Community EPR*) - RiO is a secure, Electronic Patient Record (EPR) which is used by Homerton's Community Services in Hackney and the City as their primary clinical system
Sepsis	A life-threatening illness caused by the body's response to an infection. 'Red Flag Sepsis' is one or more criteria identified using the UK Sepsis Trust Sepsis Risk Stratification
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SLT	Speech and Language Therapy
SOP	Standardised Operating Procedure
TTC	The Trust Thrombosis Committee
VTE	Venous Thromboembolism

ANNEX 1: STATEMENTS FROM CLINICAL COMMISSIONERS, LOCAL HEALTHWATCH AND OVERVIEW AND SCRUTINY COMMITTEES

The Trust is grateful to all our scrutiny committees including our commissioners for their work in reviewing and responding to our quality account 2018/19 report. As part of 2019/20 quality improvement work, we will consider the points raised with the purpose of making continuous improvements to the care we provide to our patients.

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Room 118, Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

8 May 2019

Ms. Catherine Pelley
Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust
Trust Offices
Education Centre
Homerton Row, E9 6SR

Email to: c.pelley@nhs.net

Dear Catherine

Response to HUHFT's draft Quality Account for 2018/19

Thank you for inviting us to submit comments on the Quality Account for your Trust for 2018-19. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The Commission Members take a great interest in the performance of our key local acute trust and were pleased to learn about some of your key achievements over the past year. Your overall '*Good*' rating in May 2018 from the CQC across all services and the '*Outstanding*' ratings for Medical Care and for Urgent and Emergency Services is to be commended. We note also the additional new Improvement Priorities you have set for 2019/20.

During the past year we have continued to enjoy a good working relationship with the Trust and we greatly appreciate the willingness of the Trust's representatives' to attend our Commission meetings and contribute to our work.

Your Chief Executive attended our June and September meetings where we discussed a range of issues including the proposals for reconfiguring the pathology service. Local residents and GPs continue to have concerns about the Path Lab consolidation and the proposed revised structure across the NEL area, therefore we will continue to pursue this with you over the coming year.

In September your CE also took part in a high level discussion item on the Estates Strategy for North East London with senior executives from the CCG, the Council and ELFT and she also contributed to the debates at the Inner North East London JHOSC on both the NEL Estates Strategy and the implications for east London of the NHS Long Term Plan. We will continue to

pursue these discussions with you this year as hopefully outline proposals will emerge in particular for the St Leonard's site. We hope to organise an engagement event on this later in the year.

In November your CE took part in a discussion on the implementation of the Overseas Visitor Charging Regulations after the impact of these on vulnerable migrants was raised with us by Hackney Migrant Centre and local GPs. We have since had a response to our letter to the Secretary of State. The Health Minister has made clear that these rules must be implemented sensitively and sensibly and we would ask therefore that, while there is no direction on you to monitor these impacts, that you do so, because of the level of local concern about their impact.

We are also grateful to your Director of IT and Systems who has also contributed to our own review on '*Digital first primary care'* in his capacity as the lead officer for City and Hackney Integrated Commissioning IT Enabler Group.

We wish to make the following specific comments on your draft Quality Account noting that it is an early draft:

a) Re p.15 again this year there is an absence of data relating to the new requirement to report on 'Learning from Deaths'. How is this being rectified?

b) Re p.16 on 'Seven Day Services' you say that because the numbers are low it has been a challenge to develop appropriate Consultant rotas across the surgical specialities. One presumes the numbers are low because this is just starting? You also say that having a 12 hr Consultant presence is sufficient yet this is not in compliance with this particular NHS priority clinical standard.

c) Re p.16 you describe the two new 'Freedom to Speak Up Guardians' to support whistleblowers, but give no evidence about how busy they have been? Is this policy working?

d) There has been a lot of media coverage this year nationally of junior doctors experiencing bullying and working for dangerously long periods. On p.16 you describe the 'Guardian of Safe Working' which you now have in place in response to the new junior doctors' contract. Can you give us examples of how often s/he might have intervened on issues regarding your rota gaps?

e) The Trust is to be commended for your significant progress in reducing the C-Difficile rates to just 3 in 2018/19 and for being one of the best performing Trusts nationally on this indicator.

f) You are to be commended for making steady progress on End of Life Care issues but, re p.32, why have only 70% of cases had 'End of Life

Care Plans' or 'Treatment Escalation Plans' during 2018/19. What are the barriers here and how are you addressing them?

a) Re p.35 on the "improving first impressions" indicator why has there been such poor uptake of training by receptionists and surely this should be mandatory?

b) Your reporting on Priority 9 on seamless discharge makes no reference to the 'Discharge to Assess' pilot which we've been informed about by the Integrated Commissioning Unplanned Care Workstream. Why is this?

c) Re p.36 the series of missed post-natal discharges was serious and resulted in mothers and babies having delayed home visits and follow up. You implemented a new failsafe system. Is there now 100% compliance on this?

d) The Trust's improvement on IAPT waiting time targets is to be commended.

We look forward to taking up these issues with you over the next year on the Scrutiny Commission.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Members of Health in Hackney Scrutiny Commission
Tracey Fletcher, Chief Executive, HUHFT
Cllr Feryal Demirci, Deputy Mayor and Cabinet Member for Health, Social Care, Transport and Parks Dr Sue Milner, Interim Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

healthwatch Hackney

May 15th 2019

Dear Catherine,

Healthwatch Hackney contribution to the Homerton Hospital Quality Account 18-19

Thank you for sending us the draft Quality Account for review. Please find below our response to the Homerton University Hospital's Quality Account for 2018-19.

Co-production of Service Improvements for Patients

We would welcome a new approach to our engagement with your annual Quality Account. It seems under the current system we contribute each year to the Account, yet there is no clear feedback on how our proposals and recommendations are taken on board and influence service improvement for patients. As you know Healthwatch has the following statutory responsibilities, which require both submission of our proposals for service improvement and evidence that these have been acted on or reasons provided for not doing so:

a) promoting and supporting the involvement of local people in the provision and scrutiny of local care services;

b) enabling local people to monitor the standard of provision of local care services and whether and how local care services could and ought to be improved;

c) obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known;

d) making reports and recommendations about how local care services could or ought to be improved. These should be directed to providers of care services, and people responsible for managing or scrutinising local care services;

e) formulating views on the standard of provision and whether and how the local care services could and ought to be improved.

1) Presentation of the Quality Account

We would like to see a more accessible Quality Account, the Account from 16-17 was outstanding: interesting, an enjoyable read, well presented and accessible. This year's report and last year's has returned to previous style which is much less

The Adiaha Antigha Centre, 24-30 Dalston Lane, E8 3AZ
www.healthwatchhackney.co.uk Main Number: 020 7923 8188
Limited Company No: 08457463

comprehensible and would be difficult to understand for people in the community without a clinical background. It is too long, and segmented in a way that prevents the easy access to the many achievements that you record.

It is not clear who the report is intended for, but it is written as an internal technical document for staff and to satisfy the requirements of NHS Improvement. We strongly believe the report should be written in a way that is accessible to local people, celebrates your achievements and identifies areas for improvement and the means of achieving those aspirations.

Our key areas for service improvements are as follows:

1) **Pressure ulcers** – we recommend that in the community, any signs or symptoms of early development of ulcers identified by care workers, is placed in nursing notes kept in the patients' residence, or shared with health professionals using a process agreed between care worker agencies and the HUH or primary care. Information for families about the identification of early signs of pressure ulcers in the community would be valuable.

2) **Deteriorating patients** – this terminology may be very distressing to patients and their families/carers. We recommend that other terminology is used in any documentation visible to patients/family and that information about this condition is provided in a ways that is accessible, understandable and meaningful to patients, families and carers.

3) **Sepsis** – it would be useful if the QA could report on HUH's progress with implementation of NEWS 2 and how this has so far impacted on the incidence of sepsis, including reported deaths from sepsis on the past three years.

4) **End of Life Care** – the use of the term End of Life Board sound strange. Adults are mentioned but not children our young people. Supporting family is not mentioned. Access to minutes of the Board meeting for Healthwatch would be useful to give us greater insight into the developing work being carried out.

5) **Making Every Contact Count** – great idea, but implementation and developing appropriate metrics would seem to be a difficult aspiration to achieve.

6) **Learning from Complaints** – we are concerned about the effectiveness of PALS and impact of joining this service to complaints. A certain amount of independence is needed for PALS to be effective. We welcome a more effective process to demonstrate how complaints can result in enduring improvements in patient care and treatment. Feeding this information back to

1) patients is also very important. This need to know that their contribution has had a real impact on services. HWH will be testing the system using a mystery shopper exercise. We would welcome participation in the learning from complaints process.

Other issues:

a) The research section 2.2.3. is very interesting but not accessible to public. Improvements to the layout and language could be make this section much more accessible. There should be evidence that patients participating in trials are given feedback about the impact and outcomes of trials.
b) Section 2.2.4. is not about enhanced quality arising from the CQUINS, but about payments for achievement of CQUINS.
c) Patient safety incidents charts on pages 24/25 appear to have data presented in reverse.
d) Discharge planning – in relation to patients with dual diagnosis of mental and physical health problems does discharge planning start when the patient is admitted to a HUH ward and what is the process to ensure post discharge support in relation to both physical and mental health?
e) Dissemination of Complaints Charter and Poster to all clinical spaces, e.g. wards, OPD, front desk, waiting areas.
f) Accountability for ensuring prescription of appropriate medicines. Is it possible for a doctor to diagnose a patients condition, e.g. a VTE, record this in the patient's notes but not take action to ensure that appropriate medication is prescribed and provided to the patient. This accountability gap needs to be removed.

Additional Recommendations from HWH

1) **Access to Community Equipment.**
Problems with access to equipment for some people in the community who require equipment for mobility, access and to ensure their safety, is causing delays due to problems with the supplier (Millbrook). Delays in access to equipment can result in poor discharge arrangements and have resulted in patients developing pressure ulcers. In some cases the wrong equipment has been provided. The contract is held by Hackney Council and the City of London.

HWH recommends to joint approach between HUH and HWH to both Health and Wellbeing Board to get their support to ensure proper governance of the Millbrook contract and consequently the enhancement of service quality for patients.

The Adiaha Antigha Centre, 24-30 Dalston Lane, E8 3AZ
www.healthwatchhackney.co.uk Main Number: 020 7923 8188
Limited Company No: 08457463

2) **Clinical Follow-Up in the Care of Young People in the Fracture Clinic**
The system for following up young people who are referred to the fracture clinic needs to be reviewed. If a young person is referred to the fracture clinic and fails to attend, there is no certainty that the person will be followed up through the parents and GP causing potential harm.

HWH recommends that the non-attendance of a young person at a fracture clinic, should be subject to positive action to ensure that the person has either been treated elsewhere or that the parents and GP are aware of the importance of attending for the referral appointment.

3) **Mental Health – Delayed Transfers**
In the 2018 Quality Account, we asked for evidence of urgent plans to stop extended waits for patients requiring psychiatric care. This issue was raised because of unacceptable delays in the transfer of some patients, because the person's home CCG has not agreed to spot purchasing of an ELFT bed, or a failure of locate a bed in the person's home borough. Such delays are a clear breach of the duty of 'parity of esteem'. Unfortunately, this problem continues, e.g. a patient recently waited in Homerton A&E for at least 15 hours for transfer to a bed in Lewisham Hospital.

HWH recommends that HUH and ELFT jointly agree that no patient requiring an urgent mental health will be left to wait in A&E as this is a potential source of harm to a person in a mental health crisis.

4) **Ensuring Implementation of Ward Round Decisions**
During ward rounds the consultant may request the junior doctor to implement decisions regarding prescriptions for drugs and other forms of treatment. The junior doctor is expected to implement decisions 'on the run' and may not be able to do so because of the pressure of ward round or demands on the doctor's time immediately after the ward round.

HWH recommends that doctors have protected time after a ward round to ensure that patients get the medication and aids that they needs, and that doctors are provided with IPADs (or similar) to enable them to quickly requests prescribed medications.

We hope you find our contribution and comments helpful.

Yours sincerely

Jon Williams

Executive Director

CC: Malcolm Alexander (HWH Board member)

The Adiaha Antigha Centre, 24-30 Dalston Lane, E8 3AZ
www.healthwatchhackney.co.uk Main Number: 020 7923 8188
Limited Company No: 08457463

NHS
City and Hackney
Clinical Commissioning Group

Commissioners Statement for Homerton University Hospital NHS Foundation Trust 2018/19 Quality Account

NHS City and Hackney Clinical Commissioning Group (CCG) is the lead commissioner responsible for commissioning health services from Homerton University Hospital NHS Foundation Trust on behalf of the population of the City of London and the London Borough of Hackney.

Thank you for asking us to provide a statement on the Trust's 2018/19 draft Quality Account and priorities for 2019/20.

The Trust set itself ten challenging quality priorities for 2018/19. We note progress for the majority of these priorities and congratulate the Trust for aiming high. We support the Trust's work to develop metrics for the 2019/20 priorities to enable the Trust to celebrate success at the end of this year.

We congratulate the Trust on consulting with patients, staff and stakeholders on the 2019/20 priorities.

The Trust's recent CQC inspection illustrated the outstanding work taking place to improve quality of care with an overall rating of Good and improved ratings for maternity services and medical care, the latter now rated as Outstanding along with emergency care. We congratulate the Trust on their journey to move from Good to Outstanding and hope to support and contribute to this achievement going forward.

We are very pleased to see sustained improvement to patient experience scores as measured by the CQC National Inpatient survey linked to the work undertaken over the last few years to improve nurse communication skills and patient centered care. The Trust has performed strongly against the 62 Day Cancer standard in 2018/19 and there has been a significant improvement against last year's performance. The Trust has continued to deliver its core psychological therapies targets in 2018/19 and again performance has improved compared to 2017/18. We congratulate the Trust again for their performance in relation to the four hour A&E target. The Trust's approach to the new mortality review requirements is exemplary and a high percentage of unexpected deaths are investigated so that learning can take place.

The Trust has expanded research activity and increased the number of patients who are invited to take part and there is an impressive account of world class research activities taking place.

We commend the Trust on their focus on staff wellbeing and being responsive to staff feedback and once again the Trust has been very highly rated by staff on the care they provide and working at the Trust.

Last year we asked that the 2018/19 Quality Account provide greater emphasis on our City and Hackney plans for greater integration with our Local Authority partners and the development of our neighbourhood model. We are pleased to see references to wider system work throughout the document and are keen to see these developments progress further over 2019/20.

We are delighted to see further progress made by the Trust to embed quality improvement (QI) and the work of the QI team in the Trust, particularly the new QI programme for Band

NHS
City and Hackney
Clinical Commissioning Group

nurses and work being undertaken in surgical specialities. We encourage the Trust to make quality improvement everyone's business and to equip front line staff with the skills and capacity to develop this in 2019/20.

We confirm that we have reviewed the information contained within the Account, and checked this against and data sources where these are available to us, and it is accurate.

Overall we welcome the 2018/19 quality account and are excited at the prospect of another year working together to improve the quality of services for the population we serve.

Dr Mark Rickets

Chair, NHS City and Hackney Clinical Commissioning Group

Ms Jane Milligan

Accountable Officer, NHS City and Hackney Clinical Commissioning Group

Mr David Maher

Managing Director, NHS City and Hackney Clinical Commissioning Group

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to [the date of this statement]
  - papers relating to quality reported to the board over the period April 2018 to 20/05/2019
  - feedback from commissioners received 17/05/2019
  - feedback from governors dated 30/04/2019
  - feedback from local Healthwatch organisations dated 15/05/2019
  - feedback from overview and scrutiny committee dated 08/05/2019
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/10/2018
  - the national patient survey 01/06/2018
  - the national staff survey 26/02/2019
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 24/5/2019
  - CQC inspection report dated 10/05/2018
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

24.5.19 Date ..... Chairman

24.5.19 Date ..... Chief Executive

ANNEX 3: LIMITED ASSURANCE STATEMENT FROM EXTERNAL AUDITORS

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **Overseas Visitors Charging Regulations**	Item No **8**

OUTLINE

At its meeting on 19 November the Commission considered the issue of the impact of the government's *Overseas Visitor Charging Regulations* which it was requiring all acute trusts to implement in full. Concerns about the impact of these processes at the Homerton Hospital were brought to the Commission by councillors, local GPs and the Hackney Migrant Centre. Concerns focused in particular on the impact on vulnerable migrants including asylum seekers and about the unwell being driven away with, at the very least, public health consequences. The requirements for acute trusts to report debts for medical expenses to the Home Office was another major concern.

Following the discussions, which involved the Chief Executive of HUHFT and the MD of the CCG, the Chair wrote to lobby the Secretary of State on the issue. We have since received a response from the Minister of State Baroness Blackwood. The letter and response are attached.

Attending for this item will be:

Tracey Fletcher, Chief Executive, HUHFT
Catherine Pelley, Chief Nurse and Director of Governance, HUHFT
Rayah Feldman, Chair of Hackney Migrant Centre
Daf Viney, Centre Manager, Hackney Migrant Centre

ACTION

The Commission is requested to give consideration to the response and agree next steps.

This page is intentionally left blank

Overview & Scrutiny

Health in Hackney Scrutiny Commission

Hackney Council
Room 118
Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

28 February 2019

The Rt. Hon. Matthew Hancock MP
Secretary of State
Department of Health and Social Care
39 Victoria St
London SW1H 0EU

By email to matt.hancock.mp@parliament.uk

Dear Secretary of State

Impact of Overseas Visitor Charging Regulations for NHS services on vulnerable migrants

I am Chair of Hackney Council's Health Scrutiny Committee and following representations from residents, GPs and local third sector organisations about the use of Pre Attendance Forms for overseas visitors at our local acute trust, Homerton University Hospital (HUHFT), we recently held a meeting on the issue, where we heard major concerns, which I would now like to share with you.

We understand that the Pre-Attendance forms used at the Homerton have since been withdrawn but that all Trusts are still required to pursue all those who don't qualify for free NHS services and more importantly to report non-payment to the Home Office or UK Border Agency.

The issue here is that we've learned from the local Hackney Migrant Centre and others that the bulk of those being pursued are destitute and so are in no position to pay these very significant charges. Many have 'No Recourse to Public Funds', although if they have children the Council still has statutory responsibilities to them, and some of course are homeless. The Council may also have responsibilities to some of these adults under The Care Act.

We heard from Hackney Migrant Centre about cases such as:

- A woman sent a bill for £96k for a liver transplant
- A bill for £86k sent to a cancer patient who was street homeless
- A bill for £14k sent for a treatment not yet delivered

The key issue is the degree of deterrence and what the health impacts are. Often, when patients disappear from the system, their health subsequently deteriorates to the point where they are then admitted by emergency services.

Although maternity cases and cases involving infectious diseases (such as TB) are excluded from charging, most of these people do not understand this fact and are fearful of coming into contact with officialdom. Maternity care is classed as 'immediately necessary' care and therefore cannot be delayed for any reason, including any reason related to charging, however, it is still chargeable and the patients are billed after the event, with charges typically starting at around £4000.

The implications of this for their personal health not to mention wider public health are obvious. In the case of one homeless patient we heard about, it was only when he subsequently contracted TB that he was effectively saved by the system.

Our questions to you are:

1.) Are you auditing how much Acute Trusts are paying to administer these overseas visitor charges and whether the income being generated from them is covering the cost of administering the system? The Homerton (our local hospital) now has a whole team engaged in pursuing these charges.

2.) Are you requiring Acute Trusts to monitor and report on the deterrent effect these charges have? Are they required to report on the numbers of ‘no shows’ for follow-up appointments? We learned that patients are fearful that any debt they might accrue with the NHS, of whatever size, would mean that any future applications by them for Leave to Remain would be automatically refused.

3.) Is it correct that you will not pursue a patient once they agree a Repayment Plan and therefore their case would then not be reported to the Home Office? Are you therefore issuing guidance to Acute Trusts on how they can make better use their discretion to waive these charges when collection would be unlikely? We learned of one destitute person with a debt of £96k agreeing to repay £5 per week. This would take 400 years to repay.

4.) We also understand that the current guidance states that “writing off the debt for accounting purposes does not waive nor extinguish it” and therefore the data on those whose debts have been written off are not necessarily protected from being reported to the Home Office. Would it not be reasonable to consider rescinding this punitive regulation?

5.) Are you reminding Acute Trusts that they already have responsibilities in terms of need to treat vulnerable patients (e.g. homeless and destitute) with sensitivity and that guidance on this already exists but is obviously not being adhered to in many cases?

6.) We also have concerns about the complaints mechanism and the mechanisms for patients to challenge charging decisions. Third sector organisation who work with these patients tell us these systems are inadequate and we would ask that this be looked at because so many of the cases here are or become complex?

We look forward to hearing from you.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Diane Abbott MP, Member of Parliament for Hackney North and Stoke Newington
Meg Hillier MP, Member of Parliament for Hackney South and Shoreditch
Mayor Philip Glanville, Mayor of Hackney
Cllr Feryal Demirci, Deputy Mayor and Cabinet Member for Health, Social Care, Transport & Parks
Tim Shields, Chief Executive, Hackney Council
Anne Canning, Group Director CACH, Hackney Council
David Maher, Managing Director, NHS City and Hackney CCG
Tracey Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust
Alwyn Williams, Chief Executive, Barts Health NHS Trust
Rayah Feldman, Chair, Hackney Migrant Centre
Health in Hackney Scrutiny Commission Members

This page is intentionally left blank

Department of Health & Social Care

From the Baroness Blackwood
Parliamentary Under Secretary of State for Innovation

39 Victoria Street
London
SW1H 0EU

020 7210 4850

PO-1168913

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission
By email to: jarlath.oconnell@hackney.gov.uk

02 MAY 2019

Dear Cllr Hayhurst

Thank you for your correspondence of 28 February to Matt Hancock about NHS services for overseas visitors. Please accept my apologies for the delay in replying.

I appreciate your concerns about the impact of overseas visitor charging regulations on vulnerable migrants and I am grateful to you for taking the time to raise this matter.

The NHS has operated as a residency-based healthcare system since its inception. Entitlement to NHS-funded hospital treatment is principally based on being 'ordinarily resident' in the UK at the time of treatment. It is not dependent on the payment of UK taxes or National Insurance contributions, or on nationality.

Providers of NHS secondary care are legally obliged to establish whether an overseas visitor must pay charges for treatment and, if so, to recover the charge from them. The Government remains committed to ensuring that overseas visitors and migrants are charged for using NHS services during their stay in the UK where appropriate. However, it also recognises that it is important to ensure that patients receive free NHS care if entitled to it, and that treatment that clinicians consider urgent or immediately necessary is never withheld due to lack of payment.

The Department does not audit how much trusts are paying to administer overseas visitor charging or how much income is received. NHS Improvement supports trusts in operating their charging regimes effectively and efficiently.

There is no direct requirement for trusts to monitor or report the effectiveness of charges as a deterrent, nor are they required to report on the number of 'no shows' for

follow-up appointments. Patients may decide not to proceed with treatment for a number of reasons, such as deciding to wait until they return home to have it. However, the Government fully recognises the importance of ensuring that anyone in need of NHS services is not deterred from seeking them. The Home Office also takes individual circumstances into account when making a decision on any future immigration applications.

Patients who have reasonable repayment plans with NHS providers, and who are adhering to that agreement, do not have details of their debt shared with the Home Office. Guidance for trusts sets out that a reasonable repayment plan is one that allows for the debt to be repaid within a realistic timeframe. The financial circumstances of the patient must also be taken into account, and agreement on the terms of the repayment plan reached between them and the organisation. NHS staff are also advised to bear in mind that some patients will be unable to pay; for example, destitute undocumented migrants for whom a repayment plan may not be appropriate or cost-effective. Trusts will have their own policy on debts that are written off.

As you will be aware, writing off a debt does not waive or extinguish the debt, but instead means that it is not being actively pursued and the trust will not be accounting for the income. NHS services have still been provided to a patient who is unable to pay for them, and the NHS must subsidise this from elsewhere within its funding. A debt may not be pursued for a number of reasons, such as the whereabouts of the patient being unknown or the patient's inability to pay. It would therefore be inappropriate not to inform the Home Office of written-off debts, since applying an immigration sanction may result in payment of a debt by someone who was previously untraceable or whose financial circumstances have changed.

The *Guidance on implementing the overseas visitor charging regulations* and the *Upfront charging operational framework* have recently been updated, in line with commitments made in December following a review of the regulations. The main change we have made is to emphasise that the longer a patient is expected to remain in the UK, the more likely they are to require urgent care, which is not subject to upfront charging. Therefore, visitors who are in the UK for a longer period of time will be more likely to receive treatment that does not require upfront charges. A number of case studies have been added to the framework to demonstrate this.

The Government continues to work with NHS Improvement to ensure providers are applying the regulations properly and fairly, to promote awareness of the important exemption categories and safeguards that are in place for vulnerable patients, and to ensure that all patients receive the care they need. It is also working on developing guidance that is more focused on vulnerable patients, their families and advocates.

With regard to mechanisms for patients to complain and to challenge charging decisions, the guidance relating to this has also recently been amended. This can be found at www.gov.uk by searching for 'overseas NHS visitors implementing the charging regulations'.

I hope this reply is helpful.

Best wish

Nicola

NICOLA BLACKWOOD

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **NHS consultation on 'Aligning commissioning policies across north east London'**	Item No **9**

OUTLINE

The NHS in the East London Health and Care Partnership area are currently engaged in a stakeholder consultation on aligning commissioning policies across north east London. This is their introduction to the consultation documents:

Across north east London, CCGs have been working together to look at how to make sure that people, wherever they live, are able to have the same treatments and procedures. At the moment, this can be different from borough to borough, which isn't fair for people and is confusing for people working in the NHS.

As part of this work, GPs have said that there are a number of procedures that they feel could benefit from clearly defined criteria so that they are clear about treatment options for their patients – things like which tests are best to carry out or which treatments or medicines to use first.

In order to do this in a consistent way across north east London, CCGs want to make changes to what is known as a commissioning policy. This lists all the treatments, procedures and interventions the NHS funds, and who is eligible to have them. They want to merge the different commissioning policies (currently there are different ones for Barking and Dagenham, Havering and Redbridge; City and Hackney; Newham; Tower Hamlets and Waltham Forest) to create one.

By doing this, it would mean that:

- *all patients living in north east London would have access to the same type of care*
- *the care patients would receive would be in line with the latest clinical guidance*
- *hospitals and GPs would be clear about what policy to refer to, reducing confusion*
- *patients would not have treatments that don't work or aren't the best option for them.*
- *NHS funds would be spent paying for procedures that people need, and that would give them a better quality of life.*

GPs from all the CCGs have been working together, looking at what currently happens in each commissioning policy, at clinical evidence and guidance and at work done by NHS England. They have also asked hospital consultants for advice. After lots of discussion, they have come up with what they think needs to change to create a new commissioning policy for north east London.

They now want to know what you think.

This consultation closes on 3 July.

Following local concerns raised via Healthwatch the Chair has invited the Chair and MD of the local CCG to give a Hackney clinical perspective on these proposals.

Attached is a copy of the main consultation document. The full suite of documents can be found here:
http://www.cityandhackneyccg.nhs.uk/about-us/oncefornelondon

This issue will also be discussed at a sub-regional level at INEL JHOSC however the Chair is keen for there to be a local discussion in the first instance.

Attending for this item will be:

David Maher, Managing Director, City and Hackney CCG

ACTION

The Commission is requested to give consideration to the consultation document and the discussion and make any recommendations as necessary.

Aligning commissioning policies across north east London

Creating a single commissioning policy for Barking and Dagenham, City and Hackney, Havering, Newham, Tower Hamlets, Redbridge and Waltham Forest

City and Hackney, Newham, Tower Hamlets and Waltham Forest

Tell us what you think by 5pm, 3 July 2019

Introduction

Across north east London, clinical commissioning groups (CCGs) have been working together to look at how to make sure that people, wherever they live, are able to have the same treatments and procedures. At the moment, this is different from borough to borough, which isn't fair for people and is confusing for people working in the NHS.

As part of this work, GPs have said that there are a number of procedures that they feel could benefit from clearly defined criteria so that they are clear about treatment options for their patients – things like which tests are best to carry out or which treatments or medicines to use first.

In order to do this in a consistent way across north east London, CCGs want to make changes to what is known as their commissioning policy. This lists specific treatments, procedures and interventions the NHS funds, and who is eligible to have them. They want to merge the different commissioning policies (currently there are different ones for Barking and Dagenham, Havering and Redbridge; City and Hackney; Newham; Tower Hamlets and Waltham Forest) to create one.

Clinical commissioning groups (CCGs) are led by local GPs who plan and commission (buy) health care services for the residents of their local area.

Commissioning is about deciding what services are needed, and making sure that they are provided well, and getting the best possible health outcomes for local people by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals.

By doing this, it would mean that:

- all patients living in north east London would have access to the same types of care
- the care patients would receive would be in line with the latest clinical guidance
- hospitals and GPs would be clear about what policy to refer to, reducing confusion
- patients would not have treatments that don't work or aren't the best option for them.
- NHS funds would be spent paying for procedures that people need, and that would give them a better quality of life.

GPs from all the CCGs have been working together, looking at what currently happens in each commissioning policy, at clinical evidence and guidance and at work done by NHS England. They have also asked hospital consultants for advice. After lots of discussion, they have come up with what they think needs to change in order to create a new commissioning policy for north east London. They now want to know what you think.

The new commissioning policy is based on making sure that the right people get the right care, at the right time. This document explains what the current situation is, what we believe needs to change and why.

What we want to do

We have developed new policies for:

1. Chalazia removal (lumps on the eyelid)
2. Shoulder decompression surgery
3. Interventional treatments for back pain (without sciatica)
4. Haemorrhoidectomy
5. Cataract surgery
6. Hip replacement
7. Knee replacement
8. Spinal surgery
9. Functional electrical stimulation for foot drop
10. Abdominal wall hernia management and repair
11. Weight loss surgery

At the moment, there are no formal policies in place, and our GPs felt it was important to formalise existing good clinical practice by developing policies that clearly set out who can have these procedures.

Listening to feedback from our GPs, we want to change and make clearer the eligibility criteria for:

1. Ear surgery
2. Nose surgery
3. Dupuytren's contracture release
4. Female breast reduction
5. Grommets for glue ear in children
6. Trigger finger treatment

This is so that only people who are likely to benefit from these types of surgery can have it.

We also think that we should no longer routinely fund the following treatments:

1. Injections for non-specific low back pain
2. Surgical interventions for snoring
3. Laser surgery for short sightedness

This is because there is limited evidence that these procedures work, and/or they are not a good use of limited NHS resources. We believe the NHS should only be funding procedures to deal with medical conditions and symptoms, for people who will benefit clinically from having the treatment. This means that people won't have unnecessary treatment and the NHS won't waste money.

What we're proposing would mean that the only way you could have these three procedures funded by the NHS is to demonstrate what is known as 'clinical exceptionality'. This means that a doctor believes their patient is clearly different to other patients with the same condition or their patient might significantly benefit from the treatment in a different way to an average patient with the same condition. If the doctor does not believe this, the patient could not have this treatment.

In order to demonstrate clinical exceptionality, evidence would have to be provided about why the patient should have this treatment, over and above other people with the same condition, which would then be then considered by a panel of clinicians who decide if funding should be granted.

Note: The changes we're proposing would not apply to:

- Patients diagnosed with cancer or suspected of having cancer
- Patients that have survived cancer e.g. breast reconstruction post cancer
- Children (aged under 18) unless otherwise stated within the individual policy
- People receiving emergency or urgent care
- Where NHS England is responsible for commissioning the care.

Financial impact

The main reason for aligning commissioning policies across north east London is to make sure that people, wherever they live, are able to have the same treatments and procedures, and that these treatments and procedures would be of benefit to them.

Making the changes we're proposing would save some money – we estimate an annual saving of around £1.7 million across north east London – which works out at approximately 0.044% of our total commissioning budget of £3.8 billion.

So while money is a factor in this piece of work, it isn't the main reason for doing it. It's about making sure we are making the most effective use of public money to commission the most appropriate healthcare services for local people. Any money we save would be re-invested in other health services.

About this document

This document sets out what we'd like to do and why. We've tried to explain this as simply as possible, but sometimes it is hard to avoid using technical language. There's more information on our websites, including an easy read document and background to this piece of work. If you're a nurse, doctor or someone with a clinical background, there is a document with more technical detail there too.

Please go online and fill in our questionnaire about these proposals.

www.cityandhackneyccg.nhs.uk/oncefornelondon
www.newhamccg.nhs.uk/oncefornelondon
www.towerhamletsccg.nhs.uk/oncefornelondon
www.walthamforestccg.nhs.uk/oncefornelondon

Over the next six weeks (until 3 July 2019) we will be talking to local people about what we're proposing and encouraging them to respond to our questionnaire. All responses will inform a report, which will go to our governing bodies to consider and make a decision. We will put that report and details of whatever decisions are made on our websites.

We want to know what you think

- How might these proposals affect you or your family?
- Could we do things differently?
- Are there any circumstances where these proposed changes should not apply?

Please fill out our questionnaire by 5pm on 3 July 2019

Developing new policies for certain treatments and procedures

For some procedures there hasn't been a consistent process in place for to make sure that everyone gets the right treatment at the right time, with no formal policies in place about who can have these treatments.

While our providers tell us they make sure that only people who would benefit from the treatment have it, they also tell us it would be helpful to have a formal policy agreed. Our GPs also felt it was important to formalise existing good clinical practice by developing policies that clearly set out who can have these procedures. We'd expect that as a result of this, fewer people would have these procedures.

These are:

1. Chalazia removal
2. Shoulder decompression surgery
3. Interventional treatments for back pain (without sciatica)
4. Haemorrhoidectomy
5. Cataract surgery
6. Hip replacement
7. Knee replacement
8. Spinal surgery
9. Functional electrical stimulation for foot drop
10. Abdominal wall hernia management and repair
11. Weight loss surgery

1. Chalazia removal

Chalazia are benign (non-cancerous) lumps on the eyelid that happen due to oil glands becoming blocked and swelling. Most are harmless and disappear within six months if you regularly apply warm compresses to the eye and massage the lump. A small number of chalazia are persistent, very large, or can cause problems such as making it hard to see. In these cases surgery is needed, which involves cutting into the lesion and scraping away the contents.

We want to introduce the following policy:

NEL CCGs will fund treatment of chalazia (incision and curettage or triamcinolone injection if appropriate) when one of the following criteria is met:

1. A chalazion has been present for more than six months and has been managed conservatively with warm compresses, lid cleaning and massage for four weeks

OR

2. Interferes significantly with vision

OR

3. Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

OR

4. Is a source of infection that has required medical attention twice or more within a six month time frame

OR

5. Is a source of infection causing an abscess which requires drainage

OR

6. Cancer is suspected

Number of procedures in 2018/19	Cost
328	£174,073

2. Shoulder decompression surgery

Shoulder decompression surgery involves taking out small pieces of bone and soft tissue (like tendons) from inside the shoulder by keyhole surgery.

We want to introduce the following policy:

NEL CCGs will fund shoulder decompression surgery when:

1. The surgery is for pure subacromial shoulder impingement

This means surgery is only for subacromial pain (associated with any of the structures that sit within the space between the ball and socket joint of the shoulder) and is not for pain caused by other conditions such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy because it isn't clinically effective for these conditions.

Before surgery, physiotherapy and exercise programmes should be considered. If pain continues or gets worse, surgery should be considered.

Number of procedures in 2018/19	Cost
85	£411,238

3. Interventional treatment for back pain (without sciatica)

Back pain can take many forms – from short term to chronic, long-term pain – and it is important that we give patients the tools to manage their pain and improve their quality of life. For many patients, specialist treatments only come after a period of time managing pain with their GP, and after seeing specialist musculoskeletal services.

GPs have identified a number of back pain treatments that they think could benefit from a clear policy on who can have this treatment. These are:

a) Epidurals
b) Spinal decompression
c) Discectomy
d) Epidurolysis

An epidural is an injection in the back to stop you feeling pain in part of your body. Epidurals are best known for being used for pain relief when a woman is in labour and we do not intend to limit the use of epidurals for this. This applies to epidurals for back pain only.

We want to introduce the following policy:

NEL CCGs will fund epidurals for back pain without sciatica when:

1. The patient has radicular pain consistent with the level of spinal involvement
AND
2. The patient has moderate-severe symptoms that have lasted for 12 weeks or more

AND either one of the following:

3(a). The patient has severe pain and has been given advice, reassurance, pain relief and physical therapy through the community musculoskeletal (MSK) service.
AND/OR
3(b). The MRI scan confirms the clinical diagnosis.

A maximum of three epidural injections, within a 12-month period would be funded.

Spinal decompression refers to removal of pressure from the nervous structures within the spinal column.

We want to introduce the following policy:

NEL CCGs will fund interventions for spinal decompression when:

1. The patient has radicular/claudicant leg pain consistent with the level of spinal involvement
   AND
2. The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is consistent with the clinical diagnosis
   AND
3. The patient has shown no sign of improvement despite conventional therapy such as physical therapy for one year.

Discectomy is the surgical removal of abnormal disc material that presses on a nerve root or the spinal cord. It involves removing a portion of an intervertebral disc, which causes pain, weakness or numbness by stressing the spinal cord or radiating nerves.

We want to introduce the following policy:

NEL CCGs will fund interventions for discectomy when:

1. The patient has radicular pain consistent with the level of spinal involvement
   AND
2. The patient has shown no sign of improvement despite conventional therapy for 12 weeks

Epidurolysis is minor surgery used to treat people with low back and leg pain caused by epidural adhesions (type of scar tissue in the spine). Affected nerve roots are identified and separated from scar tissue.

We want to introduce the following policy:

NEL CCGs will fund interventions for epidurolysis when:

1. The patient has late onset radiculopathy post spinal surgery
   AND
2. MRI Gadolinium-enhanced or dynamic epidurogram (unless contraindicated) findings show adhesive radiculopathy
   AND
3. Conservative management and epidural injections have failed

This would not apply to:

- People with sciatica
- Children (aged under 18)
- Patients thought to have/who have cancer
- Patients with nerve damage, fracture or infection

GPs have also identified a number of treatments that because there is limited clinical evidence that they are effective for people with back pain, they believe the NHS should not routinely fund. These are:

Therapeutic spinal injections (including facet joint injections, intradiscal therapy, prolotherapy, trigger point injections) – which reduce inflammation and are said to lessen or resolve pain.

Spinal fusion surgery for non-radicular back pain (also called spondylodesis or spondylosyndesis) is a surgical technique that joins two or more vertebrae which prevents any movement between the fused vertebrae.

Lumbar disc replacement surgery which involves replacing problematic discs in the lower spine with an artificial disk made of medical-grade metal and/or plastic.

Acupuncture - complementary medicine in which fine needles are inserted into the skin at specific points along lines of energy.

Ozone discectomy - an injection of gas inside the intervertebral disc

Number of interventional treatments in 2018/19	Cost
2397	£2,156,760

4. Haemorrhoidectomy

Haemorrhoids, also known as piles, are swellings containing enlarged blood vessels found inside or around the bottom. Often haemorrhoids (especially at an early stage) can be treated by simple measures such as eating more fibre or drinking more water. If these are unsuccessful many patients will respond to other treatments before surgery is needed.

We want to introduce the following policy:

NEL CCGs will fund haemorrhoidectomy when one of the following criteria has been met:

1. Do not respond to non-operative measures
   OR if the haemorrhoids are more severe
2. Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding
   OR
3. Irreducible and large external haemorrhoids

Number of procedures in 2018/19	Cost
251	£292,834

5. Cataract surgery

A cataract is cloudiness of the lens, the normally clear structure in your eye which focuses the light. They can develop in one or both eyes. The cloudiness can become worse over time, causing vision to become increasingly blurry, hazy or cloudy. Minor cloudiness of the lens is a normal part of ageing.

Significant cloudiness, or cataracts, generally get slowly worse over time and surgery whereby the natural lens is replaced by an implant is the only way to make it easier to see. However, you don't need to have surgery if your vision is not significantly affected and you don't have any difficulties carrying out everyday tasks such as reading or driving.

New glasses, brighter lighting, anti-glare sunglasses and magnifying lenses help reduce the impact of cataracts.

Surgery should only be offered if you have cataracts that are affecting your ability to carry out daily activities.

Visual acuity describes how well you see detail. This is usually measured using a chart with rows of letters that start with one big one at the top and get smaller row by row. During a routine eye test, you sit 6 metres from the chart. If glasses or contact lenses are worn, these should be used for the test. Each eye is tested while the other one is covered.

The rows of letters correspond to the minimum size of letter that could be seen by someone with normal vision from 6m up to 60m. The first number is the distance the chart is viewed from. 6/6 is normal vision (what used to be known as 20/20 vision, when distance was measured in feet not metres) In order to legally drive a car, you must have a visual acuity of 6/12 or less.

If you can only read the big letters on the top line, that's recorded as 6/60 – you can see at 6m what can normally be seen from 60m with normal vision. This would mean that you would be considered severely sight impaired, or legally blind.

We want to introduce the following policy:

NEL CCGs will fund cataract surgery when:

1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye **AND**
2. The cataract is affecting the patient's ability to carry out day to day activities and increasing the risk of falls.

Note: The policy would not apply to:

- Patients with confirmed or suspected cancer
- Patients with acute trauma or suspected infection
- Children under the age of 18

Number of procedures in 2018/19	Cost
2118	£1,663,462

Osteoarthritis

Osteoarthritis is the most common form of arthritis in the United Kingdom and can cause joint pain and stiffness. The severity of symptoms can vary greatly from person to person, and between different affected joints.

For some people, the symptoms can be mild and may come and go. Other people can experience more continuous and severe problems which make it difficult to carry out everyday activities.

Often Osteoarthritis affects the hip or knee, requiring surgery to replace these joints.

The policies proposed for hip replacement and knee replacement which follow only apply to people with osteoarthritis.

6. Hip replacement

Also known as hip arthroplasty this is a common type of surgery where a hip joint is replaced with an artificial one (known as a prosthesis).

GPs looked at guidance from the National Institute of Health and Care Excellence, the Royal College of Surgeons and the British Orthopaedic Association to develop a draft policy.

We want to introduce the following policy:

NEL CCGs will fund hip replacement surgery when all of the following criteria are met:

1. The patient has osteoarthritis with joint symptoms (pain, stiffness and reduced function) that have a substantial impact on quality of life as agreed with the patient and / or the patient's representative, referring clinicians and surgeons

AND

2. The symptoms resist non-surgical treatment (including pain relief, exercise, physiotherapy and weight loss, where appropriate)

AND

3. The patient's symptoms are consistent with degenerative disease, and before surgery there is radiological confirmation of this

AND

4. The patient has been involved in making decisions about their treatment options.

Number of procedures in 2018/19	Cost
336	£2,361,274

This policy would not apply to:

- Children (aged under 18)
- Patients with confirmed or suspected cancer, acute trauma, suspected infection or inflammatory arthropathy
- Patients with underlying disease (such as haemophilia or sickle cell) related hip disease
- Young adults (18 to 25) with abnormal hip anatomy

7. Knee replacement

Also known as knee arthroplasty, this is the most common type of surgery performed for osteoarthritis. Depending on the extent of osteoarthritis in the joint, a knee replacement can be either partial (one compartment is replaced) or total (the whole joint is replaced).

We want to introduce the following policy:

NEL CCGs will fund total or partial knee replacement surgery when all of the following criteria are met:

1. Osteoarthritis with joint symptoms (pain, stiffness, reduced function, joint instability) that have a substantial impact on quality of life as agreed with the patient and/or the patient's representative, referring clinicians and surgeons
   AND
2. The symptoms resist to non-surgical treatment (including pain relief, exercise, physiotherapy and weight loss where appropriate)
   AND
3. The patient's symptoms are consistent with degenerative disease, and before surgery there is radiological confirmation of this
   AND
4. The patient has been involved in making decisions about their treatment options.

This policy would not apply to:

- Patients with joint failure from causes other than degenerative disease / osteoarthritis
- Patients with confirmed or suspected cancer, acute trauma or suspected infection
- Patients with inflammatory arthropathies
- Children under the age of 18

Number of procedures in 2018/19	Cost
570	£4,180,632.

8. Spinal surgery

Our proposed spinal surgery policy focuses on a surgical procedure called discectomy which involves releasing the pressure on spinal nerves caused by a bulging or slipped disc by removing a section of the damaged disc. Discectomy carries risks and should be considered only after other options such as pain relief and physical therapy have been tried.

We want to introduce the following policy:

NEL CCGs will fund spinal surgery (discectomy) when the following criteria is met:

1. Patient is >18 years, and has MRI disc herniation at level and side corresponding to clinical symptoms

   AND either of the following:
   2(a). Demonstrable neurological deficit
   OR
   2(b). Radicular pain despite conservative therapy under the care of a specialist back pain MDT for at least six weeks

Number of procedures in 2018/19	Cost
205	£221,626

9. Functional electrical stimulation for foot drop

Functional electrical stimulation (FES) is a treatment that applies small electrical charges to a muscle that has become paralysed or weakened, due to damage in the brain or spinal cord. The electrical charge stimulates the muscle to make its usual movement. FES can be used as a treatment for foot drop, where disruptions in the nerve pathways between the legs and brain mean the front of your foot cannot be lifted to the correct angle when walking.

We want to introduce the following policy:

NEL CCGs will fund treatment when one of the following criteria are met:

Initiation

1. Foot drop makes it difficult to walk and evidence that this is not satisfactorily controlled using ankle-foot orthosis

OR

Continuation

2. Gait improvement from its use

Because of the way data is currently logged, there is not recent dfata on numbers of patients or costs.

10. Abdominal wall hernia management and repair

A hernia is when an organ or fat protrudes through the wall of muscle around it, looking like a lump or bulge beneath the skin. Abdominal wall hernias occur around the belly. There are two main types of surgical hernia repair; open surgery, where the surgeon make a small incision into the groin, and then pushes the protruding tissue back into the abdomen and minimally invasive surgery using small incisions in the abdomen and inserting a camera to guide the surgeon.

We want to introduce the following policy:

NEL CCGs will fund abdominal wall hernia management and repair when one of the following hernias are diagnosed:

1. Symptomatic hernias (i.e. hernias causing pain)
2. Irreducible hernias
3. All femoral hernias
4. Spigelian hernias
5. Inguinal hernias extending to scrotum
6. Incisional hernias with small defects
7. Hernias at risk of strangulation
8. Symptomatic umbilical hernias

Number of procedures in 2018/19	Cost
886	£1,541,786

11. Weight loss surgery

This is an operation that helps you lose weight by making changes to your digestive system. It may be an option if you are severely obese (very fat) and have not been able to lose weight or keep from gaining back any weight you lost.

We want to introduce the following policy:

NEL CCGs will fund weight loss surgery when all of the following criteria are met:

1. The patient has a BMI of 40 kg/m2 or more **OR** between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight
2. **AND**
   All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss
3. **AND**
   The person has been receiving or will receive intensive management in a tier 3 service (specialist support for obese people)
4. **AND**
   The person is generally fit for anaesthesia and surgery
5. **AND**
   The person commits to the need for long term follow up

Number of procedures in 2018/19	Cost
106	£714,600

Procedures where we want to change the clinical criteria

We are proposing changing the eligibility criteria for the following procedures:

1. Ear surgery
2. Nose surgery
3. Dupuytren's contracture release
4. Female breast reduction
5. Grommets for glue ear in children
6. Trigger finger treatment

We want to make these changes to make it clearer who should have these treatments.

1. Ear surgery

This is an operation to correct ears that stick out. The surgery is performed by cutting behind the ear and is carried out under general anaesthetic.

Current policy	Proposed new policy
Patient must have 'significant ear deformity'	Significant ear deformity is defined as having 'prominence measuring >30mm'.
Patient must be between 5-18 years old	Patient must be under 18

We want to introduce the following policy:

NEL CCGs will fund ear surgery when all of the following criteria are met:

1. The patient is under the age of 18 at the time of referral for significant prominent or bat ears
   AND
2. Where the prominence measures >30mm

Number of procedures in 2018/19	Cost
No data held	No data held

2. Nose surgery

When funded by the NHS, rhinoplasty involves reconstructing the nose by repairing nasal fractures, modifying nasal cartilages and bones, or adding tissue. Septoplasty is an operation on the partition inside the nose. Rhinoseptoplasty is for patients with a nasal obstruction. It removes any internal obstructions and stabilises structures inside the nose that may be stopping you breathing through your nose. **Note: NEL CCGs will not fund any type of nose surgery for cosmetic reasons.**

Current policy	Proposed new policy
Unclear if policy includes septoplasty and rhinoseptoplasty	Policy includes septoplasty and rhinoseptoplasty
Treatments need to be tried for at least three months	Treatments need to have been tried (no time limit) This allows for flexibility if all conservative treatments are tried in less than three months, but also for treatments to be tried for longer based on clinical judgement about what is appropriate.

Significant symptoms to be confirmed by an ENT consultant as resulting from nasal obstruction	Documented evidence of medical problems caused by an obstruction of the nasal airway is required

We want to introduce the following policy:

NEL CCGs will fund this treatment only when the following criteria is met:

1. Documented medical problems caused by obstruction of the nasal airway (continual impairment of sleep and/or breathing) **AND** all conservative treatments have been exhausted.
   OR
2. Correction of complex congenital conditions e.g. Cleft lip and palate

Number of procedures in 2018/19	Cost
146	£344,880

3. Dupuytren's contracture release

Dupuytren's contracture draws the finger(/s) and sometimes the thumb into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient's life, but are not permanent cures.

Current policy	Proposed new policy
Treatment will be funded if patient has a loss of finger extension of 30 degrees or more at the proximal interphalangeal joint (knuckle).	Treatment will be funded if patient has a loss of finger extension of 20 degrees or more at the proximal interphalangeal joint.

We want to introduce the following policy:

NEL CCGs will fund intervention/treatment when one of the following criteria are met:

1. Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint

   OR
2. Severe thumb contractures which interfere with hand function

NEL CCGs will fund collagenase for Dupuytren's contracture when

1. The patient is a participants in an ongoing clinical trial
   OR
2. Patient has visible tissue/veins if:
   (a) there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints
   AND
   (b) needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon.

Number of procedures in 2018/19	Cost
69	£186,173

4. Female breast reduction

Breast reduction surgery is for women whose breasts are large enough to cause problems like back and shoulder pain, skin inflammation and poor quality of life. **The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. backache).**

We have developed two policies for female breast reduction – one for both breasts, and one for one breast, which is the treatment available when a woman has very uneven breasts.

Note: this does not apply to women who have had cancer.

Surgical reduction of both breasts

Current policy	Proposed new policy
Eligible women must have a cup size of H or larger	Removed so patients with a smaller cup size can have breast reduction surgery
Breast reduction must remove at least 500gms or at least 3 cup sizes from each breast	Breast reduction planned should remove 500gms or more or at least 4 cup sizes from each breast.
The patient must have documented that they have has a body mass index (BMI) equal to or below 27 kg/m2 for at least two years	The patient must have had a BMI below 27 kg/m2 for at least 12 months.
Evidence must be submitted to demonstrate the patient is still in pain despite six months of therapeutic measures	Removed

We want to introduce the following policy:

NEL CCGs will fund breast reduction of both breasts when all of the following criteria are met:

1. The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain

AND

2. In cases of back and shoulder pain, a physiotherapy assessment has been provided

AND

3. Breast size results in functional symptoms that require other treatments/interventions (e.g. skin rashes, upper back pain, a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps)

AND

4. Breast reduction planned to be 500gms or more per breast or at least four cup sizes

AND

5. Body mass index (BMI) is <27 and stable for at least 12 months

AND

6. Women must be provided with written information to allow them to balance the risks and benefits of breast surgery

AND

7. Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking

AND

8. Women should be informed that breast reduction surgery can mean they are unable to breastfeed.

Reduction of one breast (treatment for uneven breasts)

Current policy	Proposed new policy
There must be gross asymmetry, defined as a minimum of three cup sizes difference between breasts.	Gross asymmetry is defined as a difference of 150 - 200gms size as measured by a specialist. This ensures the measurement is carried out by a specialist.
The patient must show she can't maintain a normal breast shape using non-surgical methods (such as a padded bra)	Not required
Breasts must be fully developed, with no change in the size of either breast in the past 18 months.	Not required
	Body mass index (BMI) to be <27 and stable for at least 12 months has been added. This promotes a healthy weight before surgery and encourages maintenance of a healthy weight.

This treatment is considered for uneven breasts instead of breast enlargement if there is an impact on the woman's health. Surgery will not be funded for cosmetic reasons.

We want to introduce the following policy:

NEL CCGs will fund breast reduction of one breast when all of the following criteria are met:

1. A difference of 150 - 200gms size as measured by a specialist

AND

2. Body mass index (BMI) is <27 and stable for at least 12 months

Number of procedures in 2018/19	Cost
46	£92,326

5. Grommets for glue ear in children

This is a surgical procedure to insert tiny tubes (known as grommets) into the eardrum as a treatment for fluid build-up (glue ear) when it is affecting hearing in children.

Glue ear is a very common childhood problem (four out of five children will have had glue ear by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and difficulty hearing. When the hearing loss is affecting both ears it can cause language, educational and behavioural problems. In most cases glue ear will improve by itself without surgery.

Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.

Current policy	Proposed new policy
The child should be aged between three and twelve.	No age restriction
The child must have documented persistent hearing loss on two occasions at intervals of three months or more	The child must have one episode of persistent hearing loss of at least three consecutive months documented
Funded if the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma	This criterion has been removed, to make sure that the cholesteatoma is treated before a new grommet is fitted.

Funded if the child has five or more episodes of acute otitis media.	Requirement removed
	All children must have had a specialist audiology and ENT assessment.

We want to introduce the following policy:

NEL CCGs will fund grommets for glue ear when:

1. All children must have had specialist audiology and ENT assessment

AND

2. Persistent otitis media with effusion in both ears for at least three consecutive months

AND

3. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2 & 4kHz

OR exclusively in one of the following circumstances

4(a). The child has persistent otitis media with effusion in both ears with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

OR

4(b). The child cannot undergo standard assessment of hearing thresholds where there is clinical evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

This guidance would not apply to children with Down Syndrome or cleft palate, who may be offered grommets after a specialist multi-disciplinary team assessment.

Number of procedures in 2018/19	Cost
317	£286,938

6. Trigger finger treatment

Trigger finger occurs when the tendons which bend the thumb/finger into the palm jam, causing the finger to “lock” in the palm of the hand. Mild cases require no treatment and may resolve spontaneously. Other cases cause pain and loss and make it hard to use your hand.

Cases interfering with activities or causing pain should first be treated with:

- one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics
  OR
- splinting of the affected finger for 3-12 weeks

Current policy	Proposed new policy
Unclear if the policy applies to children	It has been made clear that this policy would not apply to children. Trigger finger surgery for children is routinely funded.
Splinting must be tried for 12 weeks or more	Splinting must be tried for between 3 and 12 weeks.
Unclear if the policy applies to diabetics	Policy applies to diabetics
	Treatment will be approved if the patient has had two other trigger digits unsuccessfully treated with non-operative methods. This will prevent patients who have already tried non-operative methods previously from having their request for trigger finger surgery rejected.

We want to introduce the following policy:

NEL CCGs will fund trigger finger surgery when one of the following criteria is met:

1. The triggering persists or recurs after one of the above measures (particularly steroid injections)
   OR
2. The finger is permanently locked in the palm
   OR
3. The patient has previously had two other trigger fingers unsuccessfully treated with appropriate non-operative methods
   OR
4. The patients has diabetes

Number of procedures in 2018/19	Cost
77	£111,082

No longer routinely funding certain procedures

GPs have identified several treatments they think should no longer be routinely funded. This is because there is limited evidence that these procedures work, and/or they are not a good use of limited NHS resources.

These procedures are:

1. Injections for non-specific low back pain

We are proposing that spinal injections of local anaesthetic and steroids should not be offered for patients with non-specific low back pain. This is because there is limited evidence that these injections work in the long term. This would mean patients with non-specific back pain could not have:

- Facet joint injections
- Therapeutic medical branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

We would instead encourage patients to consider alternative and less invasive options which have been proven to work such as exercise, behavioural therapy, and attending a specialised pain clinic, as recommended by the National Back Pain Pathway.

Note: This would not apply to people with sciatica

Number of procedures in 2018/19	Cost
160 injections	£106,152

2. Surgical interventions for snoring

Note: This would not apply to patients with obstructive sleep apnoea

Snoring is very common and is not usually a health issue, as long as it is not complicated by periods of apnoea (temporarily stopping breathing). but can be disruptive, especially to a person's partner, There are lots of reasons for snoring such as being overweight, smoking, alcohol or blockages in the nose or tonsils.

We don't think the NHS should pay for surgery to try to stop people snoring because clinical studies show surgery doesn't work in the long term and there is a risk of complications and side effects.

We would instead encourage patients to consider alternatives to surgery that can improve the symptoms of snoring, such as

- Weight loss
- Stopping smoking
- Drinking less alcohol
- Medical treatment for blocked nose
- Mouth splints to move jaw forward when sleeping

Number of procedures in 2018/19	Cost
8	£10,064

3. Laser surgery for short sightedness

Laser eye surgery involves using lasers to reshape the front surface (cornea) of your eyes so that you can focus better. Short-sightedness is a very common eye condition that causes distant objects to appear blurred, while close objects can be seen clearly.

We don't think the NHS should pay for laser eye surgery because other successful, cheaper treatments are available, such as wearing glasses or contact lenses.

We rarely fund this treatment at the moment, but on average it costs around £1000 per procedure.

Impact on people's mental health

Mental health is often a factor in patients seeking cosmetic treatment or surgery.

There are no universally accepted and objective measures of psychological distress, so it is difficult to include such factors when setting clinical thresholds for agreeing when a particular treatment is effective or needed.

We believe it is generally better to provide support, such as therapy, to treat the mental health need, but if a clinician thought there were exceptional mental health reasons why a patient needed treatment, they could apply through the individual funding request process explaining why this is an exceptional case. This is not guaranteed to be approved.

Mental health support: Talking Therapies

Talking Therapies is a free and confidential NHS service that provides support from an expert team who understand what people are going through, and who work with people to help them feel better.
Team members introduce people to effective, practical techniques specific to their needs that are proven to work. The national programme is based on evidence and all the tools and techniques used are recommended by local GPs.

The programme has already helped thousands of local people to feel better.

To find out more: search 'Talking Therapies' and the name of your borough

Questionnaire for City & Hackney, Newham, Tower Hamlets and Waltham Forest

Please complete this questionnaire on our websites:

www.cityandhackneyccg.nhs.uk/oncefornelondon
www.newhamccg.nhs.uk/oncefornelondon
www.towerhamletsccg.nhs.uk/oncefornelondon
www.walthamforestccg.nhs.uk/oncefornelondon

Or you can fill it in and post it to **FREEPOST BHR CCGs** (no stamp needed). Please make sure it reaches us by 5pm on 3 July 2019.

Tell us about you

We want to see what sorts of people are responding to our proposals. This helps us understand if our proposals might have more of an impact on some groups of people. **These questions are optional – don't answer them if you don't want to.**

Please tick as appropriate

1. Are you?

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

2. How old are you?

- ☐ Under 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years or older
- ☐ Prefer not to say

3. Do you consider yourself to have a disability?

- ☐ Yes – a physical/ mobility issue
- ☐ Yes – learning disability/mental health issue
- ☐ Yes – a visual impairment
- ☐ Yes – a hearing problems
- ☐ Yes - another issue
- ☐ No

4. Where do you live?

- ☐ City of London
- ☐ Hackney
- ☐ Newham
- ☐ Tower Hamlets
- ☐ Waltham Forest
- ☐ Other (please tell us which borough)

5. What is your ethnicity?

This is not about place of birth or citizenship. It is about the group you think you belong to in terms of culture, nationality or race.

- ☐ Any white background
- ☐ Any mixed ethnic background
- ☐ Any Asian background
- ☐ Any black background
- ☐ Any other ethnic group (please tell us what it is)
- ☐ Prefer not to say

6. **Are you an employee of the NHS?**

- ☐ Yes
- ☐ No

7. Are you responding as...?

- ☐ An individual
- ☐ A representative of an organisation or group (please tell us which)

What do you think about our proposals?

We want to understand your views about what we're proposing.

You don't have to answer the whole questionnaire if you don't want to – only answer the sections you're interested in.

Developing new policies for certain treatments and procedures

At the moment, there are no formal policies for these procedures, and our GPs felt it was important to formalise existing good clinical practice by developing policies that clearly set out who can have these procedures.

1. Please tell us what you think about our proposals by ticking the statement that best matches your views for each:

	I strongly support this proposal	I support this proposal	I am neutral about this proposal	I am against this proposal	I am strongly against this proposal
Introduce a new policy for chalazia removal					
Introduce a new policy for haemorrhoidectomy					
Introduce a new policy for shoulder decompression surgery					
Introduce a new policy for interventional treatments for back pain (without sciatica)					
Introduce a new policy for cataract surgery					
Introduce a new policy for hip replacement					
Introduce a new policy for knee replacement					
Introduce a new policy for spinal surgery (discectomy)					
Introduce a new policy for functional electrical stimulation for foot drop					
Introduce a new policy for abdominal wall hernia management and repair					
Introduce a new policy for weight loss surgery					

2. Is there anything else you want to tell us, or think we should consider, before making decisions about introducing these new policies?

Procedures where we want to change the clinical criteria

Listening to feedback from our GPs, we want to change and make clearer the eligibility criteria for a number of procedures so that only people who are likely to benefit from this surgery can have it.

3. Please tell us what you think by ticking the statement that best matches your views:

	I strongly support this proposal	I support this proposal	I am neutral about this proposal	I am against this proposal	I am strongly against this proposal
Changing the criteria for ear surgery					
Changing the criteria for nose surgery					
Changing the criteria for Dupuytren's contracture release					
Changing the criteria for female breast reduction					
Changing the criteria for grommets for glue ear in children					
Changing the criteria for trigger finger treatment					

4. Is there anything else you want to tell us, or think we should consider, before making a decision about changing the clinical criteria for these procedures?

No longer routinely funding certain procedures

Our GPs have identified several treatments they think should no longer be routinely funded. This is because there is limited evidence that these procedures work, and/or they are not a good use of NHS funding.

5. Please tell us what you think by ticking the statement that best matches your views:

	I strongly support this proposal	I support this proposal	I am neutral about this proposal	I am against this proposal	I am strongly against this proposal
The NHS should no longer routinely fund injections for non-specific low back pain					
The NHS should no longer routinely fund surgical interventions for snoring					
The NHS should no longer routinely fund laser surgery for short sightedness					

6. Is there anything else you want to tell us, or think we should consider, before making a decision about this?

General comments

7. Within the last two years have you or a member of your immediate family had any of the procedures outlined in this document funded by the NHS?

Yes	No

8. Do you have any other comments about our proposals that you'd like to make?

9. If you would like us to tell you what decisions we reach regarding these proposals, please write your name and email address in the box below. We will keep your details safe and won't share them.

Thank you for taking the time to let us know what you think.

If you're not completing this questionnaire online, please make sure you send it back to **FREEPOST BHR CCGs**.

All comments must be received by 5pm on 3 July 2019.

We want to hear from everyone

This document is about changes we want to make to some commissioning policies. We want to know what you think about this.

If you would like to know more, please email nelcsu.nelsmw@nhs.net or call 020 3688 2455 and tell us what help you need. Let us know if you need this in large print, easy read or a different format or language.

Bengali
এই দস্তাবেজটি এমন কিছু পরিবর্তন সম্পর্কে যা আমরা কিছু কমিশনিং নীতিগুলিতে করতে চাই। আমরা এই সম্পর্কে আপনি কি মনে করতে চান। আপনি যদি আরও জানতে চান তবে অনুগ্রহ করে NELCSU.NELSMW@nhs.net এ ইমেল করুন অথবা 0203 688 2455 এ কল করুন এবং আমাদের কোন সাহায্যের প্রয়োজন তা বলুন। যদি আপনি বড় মুদ্রণ, সহজ পড়া বা একটি ভিন্ন বিন্যাস বা ভাষা এই প্রয়োজন হয় আমাদের জানান।

Polish
Ten dokument dotyczy zmian, które chcemy wprowadzić w niektórych zasadach uruchamiania. Chcemy wiedzieć, co o tym myślisz.

Jeśli chcesz dowiedzieć się więcej, napisz do NELCSU.NELSMW@nhs.net lub zadzwoń pod numer 0203 688 2455 i powiedz nam, jakiej pomocy potrzebujesz. Daj nam znać, jeśli potrzebujesz tego w dużym druku, łatwym do odczytania lub innym formacie lub języku.

Romanian
Acest document este despre modificările pe care vrem să le facem la unele politici de punere în funcțiune. Vrem să știm ce credeți despre asta.

Dacă doriți să aflați mai multe, vă rugăm să ne trimiteți un e-mail la adresa NELCSU.NELSMW@nhs.net sau să sunați la numărul 0203 688 2455 și să ne spuneți ce ajutor aveți nevoie. Spuneți-ne dacă aveți nevoie de acest lucru în format mare, ușor de citit sau într-un alt format sau limbă.

Turkish
Bu belge bazı devreye alma politikalarında yapmak istediğimiz değişikliklerle ilgili. Bunun hakkında ne düşündüğünü bilmek istiyoruz.

Daha fazla bilgi edinmek istiyorsanız, lütfen NELCSU.NELSMW@nhs.net adresine e-posta gönderin veya 0203 688 2455 numaralı telefonu arayın ve ihtiyacınız olan yardımı bize bildirin. Büyük baskı, kolay okuma veya farklı bir format veya dilde ihtiyacınız varsa bize bildirin.

Urdu
یہ دستاویز ایسے تبدیلیوں کے بارے میں ہے جو ہم کچھ کمیشننگ پالیسیوں کو بنانا چاہتے ہیں. ہم یہ جاننا چاہتے ہیں کہ آپ اس بارے میں کیا سوچتے ہیں.

اگر آپ مزید جاننا چاہتے ہیں تو، براہ کرم NELCSU.NELSMW@nhs.net یا 02036882455 کو کال کریں اور ہمیں بتائیں کہ آپ کی کیا ضرورت ہے. ہمیں بتائیں کہ اگر آپ کو اسے بڑے پرنٹ، آسان پڑھنے یا مختلف شکل یا زبان میں اس کی ضرورت ہے.

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **Appointment to Joint Health Overview and Scrutiny Committee for 2019/20**	Item No **10**

OUTLINE

Attached is a report requesting the Commission to appoint its three representatives to the Inner North East London Joint Health Overview and Scrutiny Committee for 2019/20.

ACTION

The Commission is requested to agree the report and make the appointments as necessary.

This page is intentionally left blank

Hackney

REPORT OF THE DIRECTOR LEGAL

APPOINTMENT TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Classification Public	Enclosures None AGENDA ITEM No 10
Health in Hackney Scrutiny Commission **13 June 2019**	Ward(s) affected All	

1. INTRODUCTION

1.1 This report invites the Health in Hackney Scrutiny Commission to agree the appointment of **3** Members to the Inner North East London Joint Health Overview and Scrutiny Committee for 2019/20. The Committee comprises one member from the City of London Corporation, and three each from the London Boroughs of Hackney, Newham, Tower Hamlets and Waltham Forest. The latter has joined the Committee this year having previously been an observer.

2. RECOMMENDATIONS

2.1 **To appoint 3 Members as Hackney's representatives on the Inner North East London Joint Health Overview and Scrutiny Committee for 2019/20.**

3. FINANCIAL CONSIDERATIONS

3.1 The recommendations to appoint new members to these Committees to deal with the issues specified in the report will not result in any significant additional cost to the Council. Any costs arising from the hosting of or attendance at meetings of the Joint Committee will be met from existing budgets.

4. LEGAL CONSIDERATIONS

4.1 Sections 190 and 191 of the Health and Social Care Act 2012 ("HSCA 2012") made various changes to the system of review and scrutiny of the health service. Under the HSCA 2012 health scrutiny functions were conferred upon the council itself. Health scrutiny became a statutory function of the council (as opposed to an overview and scrutiny Committee of the local authority). Health scrutiny functions are not functions of the executive under executive arrangements. Under section 244 of the NHS Act 2006, local authorities were no longer required to have a Health Overview and Scrutiny Committee to

discharge health functions. The Council chose to continue its existing Health Overview and Scrutiny Commission as set out in the report to full council on 20 March 2013 upon the setting up of the Health and Wellbeing Board.

4.2 Article 11.4 of Article 11 of the Constitution provides that the council may be required to form a joint Health Scrutiny Committee with other boroughs being consulted by local health providers that are planning changes to the way they deliver services which could be considered to be a substantial and arrange for the Joint Health Scrutiny Committee to review and scrutinise matters relating to the health services and make reports and recommendations on such matters. The process by which this is established shall be agreed by the Health in Hackney Scrutiny Commission on a report from the Monitoring Officer.

4.3 By virtue of Article 11 of the Constitution, Health in Hackney Overview and Scrutiny Commission has been delegated the Council's statutory functions in accordance with section 244 of the National Health Service Act 2006 and associated regulations to set up a Joint Health Overview and Scrutiny Commission and appoint members from within the membership of the Committee to any Joint Overview and Scrutiny Commission with other local authorities, as directed under the NHS Act 2006.

4.4 The arrangements for the Joint Health Overview and Scrutiny Committee must comply with the relevant provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Joint Health Overview and Scrutiny Commission will be established under Regulation 30(1), which enables two or more local authorities to appoint a joint overview and scrutiny committee and arrange for health scrutiny functions to be exercisable by the joint committee, subject to such terms and conditions as the authorities consider appropriate. Under Regulation 30(6) the Joint Health and Overview and Scrutiny Commission may not discharge any functions other than health scrutiny (relevant functions) in accordance with Regulation 30.

5. DETAIL

5.1 INEL JHOSC has met formally 2 times during 2018/19 and has 4 meetings already scheduled for 2019/20. It generally meets 4 times a year. The main focus of its work is to scrutinise the East London Health and Care Partnership and the North East London Commissioning Alliance which is the commissioning arm of the partnership and which has a Joint Commissioning Committee. The ELHCP footprint crosses 8 boroughs and it will significantly shape the local NHS and adult care services over the next few years. The Partnership comprises 20 organisations (NHS providers, CCGs and councils) across the 7 CCGs and 8 local authority areas in north and east London. There are now effectively 3 CCG groupings across the NEL area.

5.2 The East London Health and Care Partnership sits above three integrated care systems which have now evolved. These cover:

(i) Newham, Tower Hamlets, Waltham Forest (centred on Barts Health Trust)
(ii) Barking & Dagenham, Havering, Redbridge (centred on BHRUT)
(iii) City and Hackney (centred on HUHFT)

As these have developed they have been scrutinized by both the Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC) and the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC).

5.3 The custom has been that the Chair rotates among the 4 (now 5) boroughs every two years. London Borough of Newham took its turn to chair the Committee from 2018/19, taking over from Tower Hamlets. After a delay with the establishment of the new committee, in the aftermath of the local elections, the new Committee first met on 13 February and met again on 3 April. The new leadership has added dedicated secretariat support and set up a comprehensive work programme for the coming year and the meetings have had significant attendance from the public. In 2019/20 year it will meet on: 13 June, 18 September, 27 November and 26 February. In 2020/21 provisional meetings are already pencilled in for 24 June, 30 Sept and 25 Nov.

5.4 The 13 February 2019 meeting considered the following items:

a) Election of Chair and Vice Chair
b) Agreed updates to the Terms of Reference
c) Noted revised guidance on Members' Declarations of Interest
d) Agreed INEL JHOSC protocols (clarifying what goes to a HOSC vs a JHOSC)
e) Preliminary discussion on the *NHS Long Term Plan*
f) Endorsed the plans for the introduction of medical eligibility criteria for the Non- Emergency Patient Transport System across Barth Health NHS Trust in partnership with the WEL CCGs.
g) Agreed a work plan for the following year and a half.
h) Noted the work of the Pan London JHOSC Network

5.5 The 3 April 2019 meeting considered the following:

a) *Towards Integrated Care: delivering on the NHS Long Term Plan commitments in North East London* and refreshing the East London Health and Care Partnership (ELHCP) Strategy for 2019-24.
b) North East London Strategic Estates Plan
c) INEL JHOSC work plan
d) Noting the CfPS guidance on the *NHS Long Term Plan – supporting NHS and local government relationships*
e) Noting The King's Fund paper *on London's developing health landscape: STPs, integration and population health*

5.6 The 19 June meeting will consider:

a) Accountable Officer update on work of the North East London Commissioning Alliance (NELCA) and the East London Health and Social Care Partnership (ELHCP)
b) Development of the Early Diagnostic Centre for Cancer at Mile End hospital
c) The work of the new INEL System Transformation Board

5.7 The 18 September meeting will be a joint one with the Outer East London JHOSC and will, so far, consider:

a) NELCA/ELHCP Accountable Officer update
b) North East London STPs draft response to the *NHS Long Term Plan*
c) Consultation on relocation of Moorfields Eye Hospital

5.8 The 27 November meeting will, so far, consider:

a) NELCA/ELHCP Accountable Officer update
b) Review of Non- Emergency Patient Transport Services
c) North East London Estates Strategy

5.9 The 26 February meeting will, so far, consider:

a) NELCA/ELHCP Accountable Officer update
b) NHS Workforce planning

5.10 The Membership for 2018/19 was:

City of London: Common Councilman Christopher Boden
Hackney: Cllrs Ben Hayhurst, Yvonne Maxwell, Patrick Spence
Newham: Cllrs Winston Vaughan, Anthony McAlmont, Dr Rohit Dasgupta
Tower Hamlets: Cllrs Eve McQuillan, Gabriela Salva-Macallan, Kahar Chowdhury

Please note that memberships will change after the boroughs' AGMs this month.

5.11 Cllr Munn from Hackney chaired the Committee from 2014-2016 and Cllr Clare Harrisson from Tower Hamlets chaired it from 2016-2018. The Current Chair is Cllr Winston Vaughan from Newham. Cllr Hayhurst from Hackney and Cllr McQuillan from Tower Hamlets are Vice Chairs. Hackney Members have played an active role in the Committee and ensured that there isn't duplication in the work programmes of INEL JHOSC and Health in Hackney SC.

Suki Binjal
Director Legal

Report Originating Officer: Jarlath O'Connell ☎020-8356 3309
Legal Comments: Dawn Carter McDonald ☎020-8356 4817

Background papers:

The following documents were used in the preparation of this report:
- Local Government Act 1972 (as amended) - Access to Information
- Appointment to Joint Health Overview and Scrutiny Committees – report to Health in Hackney Scrutiny Commission, 9 December 2013.
- Appointment to Joint Health Overview and Scrutiny Committees – report to Health in Hackney Scrutiny Commission, 24 June 2014.

For reference:
Papers for INEL JHOSC on 13 February 2019
Papers for INEL JHOSC on 3 April 2019

Hackney

Health in Hackney Scrutiny Commission 13th June 2019 **WORK PROGRAMME FOR 2019/20**	Item No **11**

OUTLINE

The purpose of this item is to agree an outline work programme for the coming year, for the main review and the other single items which will be considered, noting that time has to be allowed for urgent and topical items which will inevitably arise.

Attached is a copy of the first draft of the work programme which contains items which the Commission is already committed to, standard items which the Commission takes each year as part of its duties. The programme of rolling updates from each of the Integrated Commissioning Workstream Directors continues.

Every year the Chair writes to all the stakeholders inviting suggestions for topics. We wrote to Cabinet Members, Group Directors, Directors, the CCG, the GP Confederation, HCVS, Healthwatch, HUHFT, ELFT, LMC and LPC.

A note on the responses received by 13 June will be tabled.

ACTION

Members are requested to give consideration to the suggestions and to agree the outline work programme for the year.

This page is intentionally left blank

Health in Hackney Scrutiny Commission

Future Work Programme: June 2019 – April 2020 (as at 5 June 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	Tracey Fletcher Catherine Pelley	**Response to Quality Account for HUHFT**	Discussion with Chief Exec of Homerton University Hospital on issues raised in the Commission's annual Quality Account letter to the Trust.
	HUHFT Hackney Migrant Centre	Tracey Fletcher Rayah Feldman/ Daf Viney	**Overseas Visitors Charging Regulations**	To consider response received from Baroness Blackwood (Health Minister) to Commission's letter.
	All Members		**Work Programme for 2019/20**	To consider work programme suggestions received from stakeholders, Cabinet, Corporate Directors and others and to AGREE an outline work programme for the year to be sent to Scrutiny Panel's 18 July meeting for comment

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
INEL JHOSC Wed 19 June 2019 at 19.00 hrs at Old Town Hall Stratford	*East London Health and Care Partnership and North East London Commissioning Alliance*	*Robert Brown (Newham Council)*	***a) INEL System Transformation Board*** ***b) Early Diagnostic Centre for Cancer*** ***c) TBC***	
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
	CCG GP Confederation	Nina Griffith Dr Stephanie Coughlin	**Neighbourhood Model**	Revisit the progress in July 2019.
	Healthwatch Hackney	Jon Williams	**Healthwatch Hackney Annual Report**	To consider the annual report of Healthwatch Hackney
			TBC	
		Jarlath O'Connell	**REVIEW on Digital first primary care and implications for GP Practices**	Agree recommendations and report outline
Thu 12 Sept 2019 Papers deadline: 2 Sept		Jarlath O'Connell	**REVIEW on Digital first primary care and implications for GP Practices**	Agree final report.

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
	Adult Services Healthwatch Hackney	Anne Canning Jon Williams	**Update on 'Housing with Care' service post CQC inspection revisit**	Updates from both Adult Services and Healthwatch Hackney 6 months after the last item on the implementation of the Action Plan in response to the CQC inspection of the Housing with Care service
	Chair of CHSAB Adult Services	Dr Adi Cooper Simon Galczynski John Binding	**Annual Report of City and Hackney Safeguarding Adults Board**	Annual review of SAB work. Annual item.
			TBC	
			TBC	
INEL JHOSC Wed 18 Sept 2019 at 16.00 hrs Please note early start At Old Town Hall Stratford	***JOINT WITH Outer North East London JHOSC***	*Robert Brown (Newham Council)*	***a) NHS Long Term Plan*** ***b) Relocation of Moorfields Eye Hospital*** ***c) TBC***	*One meeting per year is joint with Outer East London JHOSC*
Possible separate engagement event hosted by the Commission in October 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.*

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
Mon 4 Nov 2019 Papers deadline: Thu 23 Oct			**TBC**	
Joint with Members of CYP Scrutiny Commission	LBH/CoL/CCG CYP&M Care Workstream	Amy Wilkinson Workstream Director	**Update on Integrated Commissioning – CYPM Workstream TBC**	Series of updates from each of the Integrated Commissioning Workstreams
			TBC	
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*	*Robert Brown (Newham Council)*	***a) NEL Estates Strategy*** ***b) Update on Barts Health's Non-Emergency Patient Transport Service review*** ***TBC***	
Wed 4 Dec 2019 Papers deadline: 22 Nov			**TBC**	
			TBC	
Wed 29 Jan 2020 Papers deadline: 17 Jan			**TBC**	
	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
			TBC	

Meeting	Lead Organisation /Directorate	Officer Contact	Item	Description
			TBC	
Wed 12 Feb 2020 Papers deadline: 31 Jan			**TBC**	
	Adult Services	Tessa Cole	**Adult Services Local Account**	Annual item on publication of the Local Account of Adult Services
			TBC	
			TBC	
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*	*Robert Brown (Newham Council)*	***TBC***	
Mon 30 Mar 2020 Papers deadline: 18 Mar			**TBC**	
	LBH/CoL/CCG Planned Care Workstream	Siobhan Harper, Workstream Director Andrew Carter, SRO	**Integrated commissioning – 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**	U*pdate on development of the new model
			Discussion on Work Programme items for 2020/21	

Items planned but not yet scheduled and items held over from last year

tbc	Cabinet Member	Cllr Clark	**Cabinet Member Question Time with Cllr Clark**	Annual CQT Session with the relevant Cabinet Member.
tbc	HCVS Connect Hackney Older People's Reference Group Age Concern East London GP Confed or CCG	Jake Ferguson Tony Wong	**Connect Hackney - Reducing social isolation in older people**	Report on work of Connect Hackney (a Big Lottery Funded project) Suggested look at work of Mendip Council in Somerset which resulted in reductions in hospital admissions.
tbc	Integrated Commissioning – Planned Care Workstream	Siobhan Harper	**Housing First pilot**	Update on this health initiative in conjunction with Housing Needs to support those with multiple and complex needs.
tbc	Adult Services Oxford Brookes University researcher Camden Council rep (best practice)	Gareth Wall and Simon Galczynski Names tbc Names tbc	**Market Making in Adult Social Care**	Report on Adult Services Market Position Statement and benchmarking on how to develop the local market for social care providers.
tbc	CACH Planned Care Workstream?	Anne Canning	**Update on provision of intermediate care**	Follow up from suggestion at March 2019.
Tbc	Tbc		**Impact of Service Change proposals and how they have transport implications for both patients and residents.**	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.

Health in Hackney Scrutiny Commission

Meeting on Thu 13 June 2019

Item 11 Work Programme

The Chair wrote to all the key stakeholders asking for suggestions for the work programme for 2019/20 here are the responses received as at 12 June are below:

Note: Kim Wright asked each of her directors to reply separately. 2 below.

Respondent	Suggestion
Anne Canning Group Director CACH	Suggestions from Adults Services are as follows : 1) **Assistive Technology** - service is keen to gather views of residents and potential demand in the borough. The service is planning to undertake a number of small pilots in this area and to recommission the telecare service. 2) The **implementation of the '3 Conversations' model** and moving towards a Neighbourhood, asset-based approach. The service is going to reconfigure the day care offer which will need to reflect this new model of working. Public Health, as you know from an email from Sue, have observed that the HiH topics have been very NHS focused and it would be good to look at some of the wider determinants of health and whole system approaches to key problems such as 'best start in life'.
Dr Sue Milner Interim Director of Public Health	Looking at previous work programme for this Health Scrutiny Commission its very NHS focussed with less on population health per se and what makes a population healthy (or not). It estimated that approximately 10% of population health is impacted by the NHS. We could usefully be looking at some of the wider determinants of health, such as poverty, housing, education and skills and/or **whole system approaches to specific problems e.g. best start in life, obesity** - thinking about how we draw on all our assets to tackle the problem and surfacing the overlaps with other areas of scrutiny etc. Also moving forward, this commission has the responsibility for **scrutinising the HWB** and they could be involved on work to bring that back to life.
Dr Fiona Sanders C&H LMC	1) Impact of recent **changes in the commissioning sexual health** on provision of services, access and care. 2) Impact of the ongoing downgrading of the Homerton **Pathology services** 3) Recomissioning of the **community district nursing**

	services and other community services
Dr Nick Mann Local Medical Committee member	Thank you for writing to Dr Fiona Sanders, CHLMC Chair, requesting input to the JHOSC work programme 2019-20. As LMC representative, I am replying on the Committee's behalf after discussion at LMC meeting 5th June 2019. Firstly, I would like to thank you for your engagement in the workstream of local issues including NHS Long Term Plan, NEL Estates Strategy, Digital-First Primary Care, Homerton Pathology Lab, and Overseas Visitor Charging at HUHFT. It is important to have JHOSC's oversight on these issues. It would be helpful to have updates on these issues, which remain current. Regarding the **Pathology Lab**, LMC understands that "No decision has been made" with regard to the proposed downgrading of on-site Pathology services. However, there has been some indication that HUHFT's future will be the Barts 'Hub and Spoke' model, in preference to rebuilding facilities or outsourcing services. NHSI has indicated that this is what is being planned (see London 3 in attached document), forecasting £6m saving (~10%) of service costs. Homerton Pathology lab staff have indicated that staff who have left have not been replaced. LMC welcomes JHOSC's engagement with NHS England's **national introduction of eligibility restrictions to NHS care**, and the relevance of NHSE's '17 Evidence-based Interventions' list to NEL STP's locally developed expansion of POLCV/E restrictions under the new 'Aligning Commissioning Policies' list. There are significant concerns regarding the purpose and effect of this method of **rationing** including; the removal of professional judgement in providing or referring patients for treatment; conflation within the lists of already obsolescent treatments with treatments that have a mixed evidence base; creating a structure within which mutable eligibility criteria are used to restrict entitlement to standard NHS treatments that are well established as being effective, cost-effective, and necessary for patients' health. 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 regisrants 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.** JHOSC will be aware of the very hasty development of **Primary Care Networks (PCNs)** across England. While some see this as an opportunity to strengthen GPs' position as leaders of integrated primary care systems, there is also concern regarding **the secession of GP contracts to the PCN**. GP numbers are falling while smaller Practices wither on the vine. There are concerns that, in time, PCN contracts will be subsumed by ICS/ICP/ICT contracts, and that GP GMS contracts will no longer exist. In practical terms, this may equate to GPs losing professional autonomy, national networks, and the ability to lead development of GP services for patients. There are concerns that two of the most effective components (in terms of cost-minimisation and health benefits) of GP care - continuity of care and gatekeeping usage of expensive secondary care services - may be rendered ineffectual in the larger, impersonal systems. Future funding for PCNs is likely to become leveraged by (as yet unknown) 'quality outcomes metrics'. Although currently there is partial funding specifically ringfenced for this new work, it is very unclear if it will actually enable the staff and service expansion and reorganisation that is demanded. There is not adequate funding uplift to support existing GP provision and it is doubtful that additional ancillary staff in PCNs will compensate for this lack of provision of medical care. The infrastructure to support PCN MDTs is not there: District Nurses, GPs, Health Visitors, Midwives, clinical space...It is as yet unclear what this multi-disciplinary co-working will actually look like, and what this will mean for patients accessing and receiving services. It would be very helpful to have some **oversight of PCNs as they are developed** - to explore costs, workforce and contractual implications; and evaluation of implementation and impact on patients and on General Practice. I hope these suggestions may be in line with SC workstream. Please let me know if there is anything additional you may need.
Dean Henderson Borough Director City and Hackney, ELFT	As you may be aware there are two significant service developments , one in Adult Mental Health and the other in Older Persons Mental Health Services , which come into operation later this summer : • The new **Health Based Place of Safety at Homerton Hospital** (August 2019) • The redesign of the City & Hackney **Diagnostic**

	Memory Clinic and Dementia Service Pathway (September 2019) My suggestion would be that it might be of interest to the HiH Scrutiny Commission for ELFT provide initial feedback on how well these two services are operating and what they are delivering, after each has been operating for 6 months.
James Goddard N&E (Strategic Housing Policy)	Briefly: there are currently five broad areas across Regeneration which are directly health related and which, on the face of it, would fit in with any Health Scrutiny proposals. These are: • **Smoking Cessation** • **Healthy Weight** • **Older People's Housing** • **Suicide Prevention** • Long term health outcomes of the regeneration programmes The last is an ongoing item and is covered through formal Health Impact Assessments, design and Planning etc as well as a whole range of other tools and measures (including some new health and wellbeing measures in the Inclusive Economy Strategy). We also have a number of items such as the Housing Health and Safety Rating System which are health focused but which have already undergone scrutiny by Living In Hackney. And no doubt will undergo more in the future. We are therefore focused on the first four bullet areas during this year. The key point however is that Housing/Regen are delivering these elements through both the Public Health and the Adult Commissioning functions i.e we do not lead on them. I have spoken with both the lead officers - Matt Clack and Gareth Wall - who confirm that any lead scrutiny on these areas would be via their functions but with contribution from Regeneration. They are in liaison with Scrutiny officers and chairs to establish any scope for these items. On that basis I would advise Councillor Hayhurst of the areas of focus during 2019/20 but that they are

	part of a broader and more integrated approach. I am however very happy to speak with him should he wish to consider a particular housing/regen scrutiny on any of these topics.
Aled Richards Director of Public Realm N&E	I would suggest that one item on the Health in Hackney Scrutiny Commission work programme might be **Sports development and Health**. We could prepare a paper covering the **Sport England project,** new age games and other initiatives to promote exercise amongst our residents as well as highlighting the improvements to the Council's leisure and parks facilities as well as linking in to the Public Health pilots of addressing poor health in specific areas of the borough.

This page is intentionally left blank