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, 8th July, 2021

7.00 pm

Until further Notice, all Council meetings will be held remotely

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 Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Kofo David, Cllr Kam Adams and Cllr Michelle Gregory**

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.

This page is intentionally left blank

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, 8 July 2021 at 7.00 pm

Council Chamber
Hackney Town Hall, Mare St, E8 1EA

The press and public are welcome to join this meeting remotely via this link: https://youtu.be/Z4cenv9CqwI

If you wish to attend otherwise, you will need to give notice and to note the guidance below.

Contact: Jarlath O'Connell, Overview & Scrutiny Officer
☎ *0771 3628561/ 020 8356 3309* ✉ jarlath.oconnell@hackney.gov.uk

Ian Williams
Acting Chief Executive, London Borough of Hackney

MEMBERS: **Cllr Ben Hayhurst (Chair)**
Cllr Peter Snell (Vice Chair)
Cllr Kam Adams
Cllr Kofo David
Cllr Michelle Gregory
Cllr Deniz Oguzkanli
Cllr Emma Plouviez

VACANT: **2 Labour, 1 Opposition**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**Apologies for absence**	**19.00**
2	**Urgent items/ Order of business**	**19.01**

1

3	**Declarations of interest**	**19.01**
4	**Covid-19 – update from Public Health and CCG**	**19.02**
5	**Homerton University Hospital NHS Foundation Trust Quality Account 2020/21**	**19.35**
6	**Future plans for St Leonard's site – verbal update**	**20.00**
7	**Healthwatch Hackney Annual Report 2020/21**	**20.15**
8	**Secondary use of GP patient identifiable data – verbal update**	**20.35**
9	**Minutes of the previous meeting**	**20.50**
10	**Work programme for the Commission for 2021/21**	**20.51**
11	**Any other business**	**20.55**

Guidance on public attendance during Covid-19 pandemic

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)

The Town Hall is not presently open to the general public, and there is limited capacity within the meeting rooms. However, the High Court has ruled that where meetings are required to be 'open to the public' or 'held in public' then members of the public are entitled to have access by way of physical attendance at the meeting. The Council will need to ensure that access by the public is in line with any Covid-19 restrictions that may be in force from time to time and also in line with public health advice.

Those members of the public who wish to observe a meeting are still encouraged to make use of the live-stream facility in the first instance. You can find the link on the agenda front sheet.

Members of the public who would ordinarily attend a meeting to ask a question, make a deputation or present a petition will be able to attend if they wish. They may also let the relevant committee support officer know that they would like the Chair of the meeting to ask the question, make the deputation or present the petition on their behalf (in line with current Constitutional arrangements).

In the case of the Planning Sub-Committee, those wishing to make representations at the meeting should attend in person where possible.

Regardless of why a member of the public wishes to attend a meeting, they will need to advise the relevant committee support officer of their intention in advance of the meeting date. You can find contact details for the committee support officer on the agenda front page. This is to support track and trace. The committee support officer will be able to confirm whether the proposed attendance can be accommodated with the room capacities that exist to ensure that the meeting is covid-secure.

As there will be a maximum capacity in each meeting room, priority will be given to those who are attending to participate in a meeting rather than observe.

Members of the public who are attending a meeting for a specific purpose, rather than general observation, are encouraged to leave the meeting at the end of the item for which they are present. This is particularly important in the case of the Planning Sub-Committee, as it may have a number of items on the agenda involving public representation.

Before attending the meeting

The public, staff and councillors are asked to review the information below as this is important in minimising the risk for everyone.

If you are experiencing covid symptoms, you should follow government guidance. Under no circumstances should you attend a meeting if you are experiencing covid symptoms.

Anyone experiencing symptoms of Coronavirus is eligible to book a swab test to find out if they have the virus. You can register for a test after checking your symptoms through the NHS website. If you do not have access to the internet, or have difficulty with the digital portals, you are able to call the 119 service to book a test.

If you're an essential worker and you are experiencing Coronavirus symptoms, you can apply for priority testing through GOV.UK by following the guidance for essential workers. You can also get tested through this route if you have symptoms of coronavirus and live with an essential worker.

Availability of home testing in the case of people with symptoms is limited, so please use testing centres where you can.

Even if you are not experiencing covid symptoms, you are requested to take an asymptomatic test (lateral flow test) in the 24 hours before attending the meeting.

You can do so by visiting any lateral flow test centre; details of the rapid testing sites in Hackney can be found here. Alternatively, you can obtain home testing kits from pharmacies or order them here.

You must not attend a lateral flow test site if you have Coronavirus symptoms; rather you must book a test appointment at your nearest walk-through or drive-through centre.

Lateral flow tests take around 30 minutes to deliver a result, so please factor the time it will take to administer the test and then wait for the result when deciding when to take the test.

If your lateral flow test returns a positive result then you must follow Government guidance; self-isolate and make arrangements for a PCR test. Under no circumstances should you attend the meeting.

Attending the Town Hall for meetings

To make our buildings Covid-safe, it is very important that you observe the rules and guidance on social distancing, one-way systems, hand washing, and the wearing of masks (unless you are exempt from doing so). You must follow all the signage and measures that have been put in place. They are there to keep you and others safe.

To minimise risk, we ask that Councillors arrive fifteen minutes before the meeting starts and leave the meeting room immediately after the meeting has concluded. The public will be invited into the room five minutes before the meeting starts.

Members of the public will be permitted to enter the building via the front entrance of the Town Hall no earlier than ten minutes before the meeting is scheduled to start.

They will be required to sign in and have their temperature checked as they enter the building. Security will direct them to the Chamber or Committee Room as appropriate.

Seats will be allocated, and people must remain in the seat that has been allocated to them. Refreshments will not be provided, so it is recommended that you bring a bottle of water with you.

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.

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

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Covid-19 – update from Public Health and CCG**	Item No **4**

OUTLINE

The roll out of the vaccinations programme for Covid-19 is dominating the work of the local NHS bodies and we receive detailed updates at each meeting. At the last meeting we asked for a further update from Public Health/Vaccinations Steering Group.

This is a fast-moving situation and to ensure that the briefing is as up to date as possible for 8th July officers will submit it to members on the 7th and it will be included in the published document folder and TABLED on the night.

Attending for this item will be:

Dr Sandra Husbands, Director of Public Health
Siobhan Harper, Director of CCG Transition for C&H and SRO for the Vaccinations Steering Group

ACTION

The Commission is requested to give consideration to the briefing.

This page is intentionally left blank

City and Hackney COVID 19 Vaccination Programme

Briefing to Health in Hackney overview and scrutiny committee

8 July 2021

Update on the local vaccination roll-out

1. For cohorts 1-12, 156k (59%) 1st & 90k (34%) 2nd dose vaccinations have been undertaken (as of 6th July).
2. Although there has been 3% increase in vaccination uptake for 1st doses across Cohorts 1-9 (i.e aged over 50) since the last meeting, 25k residents remain unvaccinated
3. Although there has been a 3% in vaccination uptake for 1st doses across cohorts 1-6 (i.e aged 65 and over and at risk of Covid), 16k residents remain unvaccinated
4. All vaccine delivery sites and outreach events in C&H now offer booked and walk-in appointments
5. Pfizer and Moderna now recommended for all those under 40 years of age
6. All those 18 years old and over now eligible to book their vaccine in addition to cohorts 1-9, however we are seeing demand slowing down
7. Vaccinating Pharmacies and local vaccination centres now delivering Pfizer or Moderna as well as AstraZeneca (AZ), with two new pharmacies going live in the week commencing 5th July
8. Outreach work continues through to provide support to specific communities and areas with local outbreaks with variants of concern
9. PCN clinics specifically for 2nd dose AZ (Springfield PCN, Shoreditch Park and City PCN, Hackney Downs PCN, Lower Clapton surgery)

Key actions in the next two weeks

- On track to deliver a mass vaccination event at the Hackney Service Centre this weekend aiming for 4,000 doses to be delivered
- Targeted communications to each of the unvaccinated cohorts (i.e. invited, declined, no contact coded)
- Range of activities to increase uptake of vaccination by wider social care workforce and carers (see slide 6)
- Community outreach targeted in five LSOA clusters where uptake is low from the most high risk cohorts (four in Hackney, one in the City) (see slide 8)
- Centralised call and recall team to target unvaccinated population, including writing to patients; to go live week commencing 12th July
- Continued use of social media to encourage walk-in and maximise use of available capacity

C&H vaccination snapshot by cohort (as of 6th July)

Cohort	Cohort Description	Cohort Size	First Vaccination	% Vaccinated	Fully vaccinated	% Second Vaccination	WoW Change 1st doses (%)	WoW Change 1st doses (#)	WoW Change 2nd doses (%)	WoW Change 2nd doses (#)
1	Older adult residents in a care home	321	293	91%	279	87%	-1%	-3	-1%	- 2
2	80 years of age and over	5,169	4,327	84%	4,102	79%	0%	0	0%	14
3	75 years of age and over	3,981	3,351	84%	3,221	81%	0%	9	1%	18
4	70 years of age and CEV	20,961	16,342	78%	15,004	72%	0%	38	1%	144
5	65 years of age and over	7,102	5,730	81%	5,445	77%	0%	4	1%	40
6	16-64 years of age and at risk of COVID	26,555	17,973	68%	15,625	59%	1%	125	2%	262
7	60 years of age and over	6,669	4,880	73%	4,496	67%	0%	20	1%	64
8	55 years of age and over	10,324	7,275	70%	6,506	63%	1%	53	2%	129
9	50 years of age and over	12,797	8,889	69%	7,762	61%	1%	50	3%	199
10	40 - 49 years of age	39,617	23,231	59%	12,485	32%	1%	250	41%	3,612
11	30-39 years of age	73,636	38,857	53%	10,343	14%	3%	1,078	23%	1,950
12	18-29 years of age	58,576	24,867	42%	5,208	9%	17%	3,602	12%	539
	Totals Cohort 1-6	64,089	48,016	75%	43,676	68%	0%	173	1%	476
	Totals Cohort 1-9	93,879	69,060	74%	62,440	67%	0%	299	1%	868
	Totals Cohort 1-12	265,708	156,015	59%	90,476	34%	3%	5,226	8%	6,969

Source: NEL Covid vaccination dashboard: Invite & uptake coded in Primary care

Note; Average decline rate 4% (or 10,005) across all cohorts: no contact coded 13% (34,159). Targeted work taking place to address.

Week on week change in 1st doses = 5226 (+3%), wow change in 2nd doses = 6969 (+8%). WoW change from CEG dashboard 6.07 vs. 29.06

How we are putting on capacity to meet the challenge

	21st June	28th June	5th July	12th July	
LVS	6,282	8,406	9340	9,340	
GP / PCN dispersed	480	755	755	500	
St Leonards	800	300	300	300	
Small pop up events	183	300	480	300	
Larger pop up events	0	0	2000		
Community Pharmacy	10,532	10,532	12,512	12,512	
10/11th Surge event	0	0	4,000		
Total planned capacity:	18,277	20,293	29,387	22,952	**90,909**
Target to deliver 90% uptake:*	25,393	25,393	25,393	25,393	101,573*
Gap between target and plan:	7,116	5,100	(3,994)	2441	**10,664**

This is total planned optimal capacity, including:

- Hackney Service Centre surge event on 10/11th July (AZ & Pfi)
- North MSOA large pop-up on 11th July (AZ)
- Community AZ events in LSOA clusters
- Practice-based and PCN events
- Walk-ins

- Across NEL we are seeing a slowing rate of uptake especially for 1st dose Pfizer
- NEL review of communication plan for 18-39 taken place and actions being implemented

Note: Capacity required assumes (1) 20% of 1st and 2nd dose activity required over the next 4 weeks goes to mass vax sites (2) a DNA rate of 15% (3) 90% of eligible City and Hackney residents will be vaccinated with 1st dose and 2nd doses will continue as per JCVI guidance

Care home (a) residents and (b) staff and carers vaccination data uptake Hackney

(a)

	Total number of residents	Number of eligible residents reported to be vaccinated with at least one dose	% of eligible residents reported to be vaccinated with at least one dose	Number of eligible residents reported to be vaccinated with a 2nd dose	% of eligible residents reported to be vaccinated with a 2nd dose
Older adult care homes (65+)	187	172	92%	167	89%
Younger adult care homes	97	88	91%	83	86%
Total	**284**	**260**	**91%**	**250**	**87%**

(b)

	Total number of staff	Number of eligible staff reported to be vaccinated with at least one dose	% of eligible staff reported to be vaccinated with at least one dose	Number of eligible staff reported to be vaccinated with a 2nd dose	% of eligible staff reported to be vaccinated with a 2nd dose
Domiciliary Carers	1,646	1075	65%	643	39%
Younger adult care homes	124	112	90%	106	85%
Older adult care homes	276	215	77%	201	73%
Non- registered settings & all other frontline social care	2,841	1,340	47%	695	24%
Total	**4,887**	**2,742**	**56%**	**1,645**	**34%**

Source: Figures extracted from Department of Health and Social Care Capacity Tracker

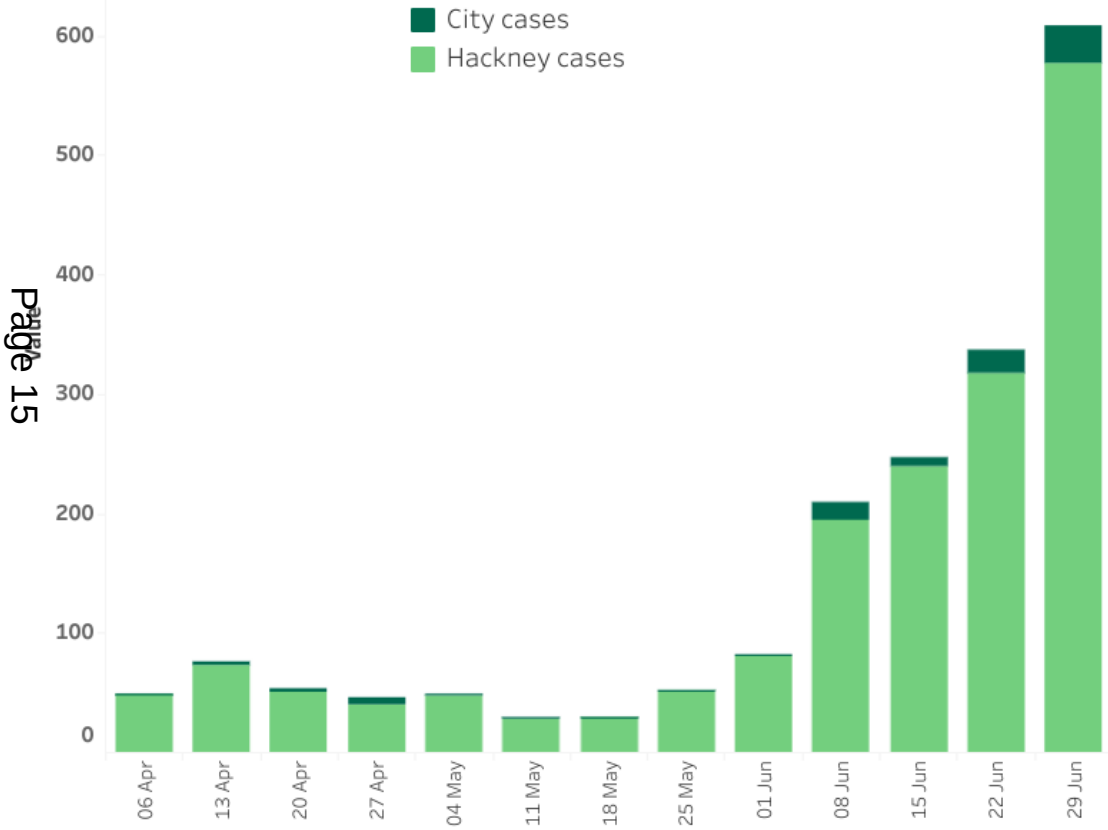
Period: 6th July 2021

Update on work to improve vaccination uptake in Care Homes

1. **Data validation -** ensuring self-reported vaccine uptake from care providers is reflected within Capacity Tracker, twice weekly vaccine uptake reports for Homecare data is reported via MIT Adaas into Capacity Tracker
2. **Management Action Plans –** case-by-case approach to increase vaccination take-up within each Care Home for staff and residents (in line with SAGE compliance)
3. **Engagement Session 6th July -** Q&A session between clinical experts and staff in Care Homes, offering resources/ support/ 1:1 individual sessions
4. **Direct Engagement -** between residents in Care Homes and Public Health / GP clinical leads to help address individual concerns
5. **Community Champions -** have been trained by a Clinical Expert to help support conversations with staff working in Care settings
6. **Fast track access to vaccinations** - pop in clinics across the borough for care staff (staff ID)
7. **Financial incentive -** offered to all care staff to help increase uptake

COVID-19 Cases Weekly Trend

Cases have been increasing steeply in City and Hackney, since late May

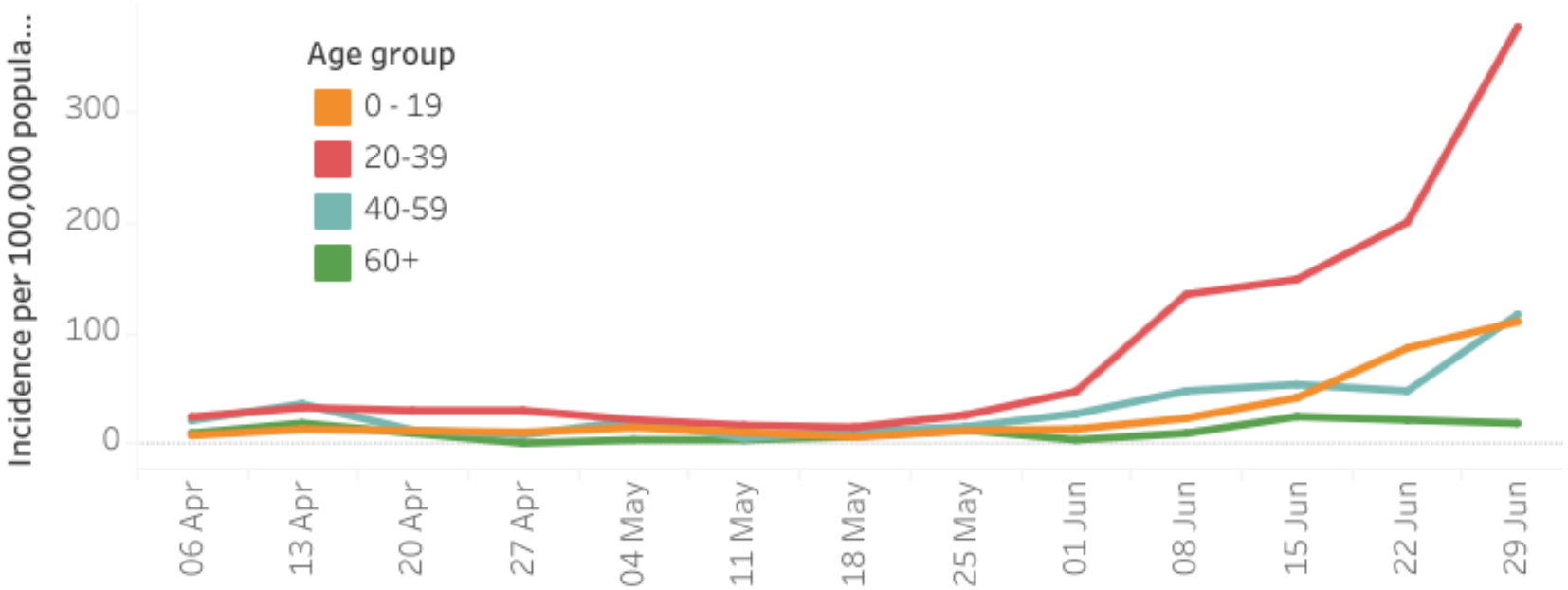


Data from **Public Health England (PHE)**. Last updated **5 July 2021**. Next update **8 July 2021**.
Note: In line with recent PHE guidance, both cases identified by lateral flow testing and PCR are included.

- Cases have been rising exponentially in London, as well as locally
- Rates have increased by as much as 80% week on week
- Current incidence rate is over 230/100,000 population in Hackney

Weekly Cases by Age and Sex

Majority of cases in young adults

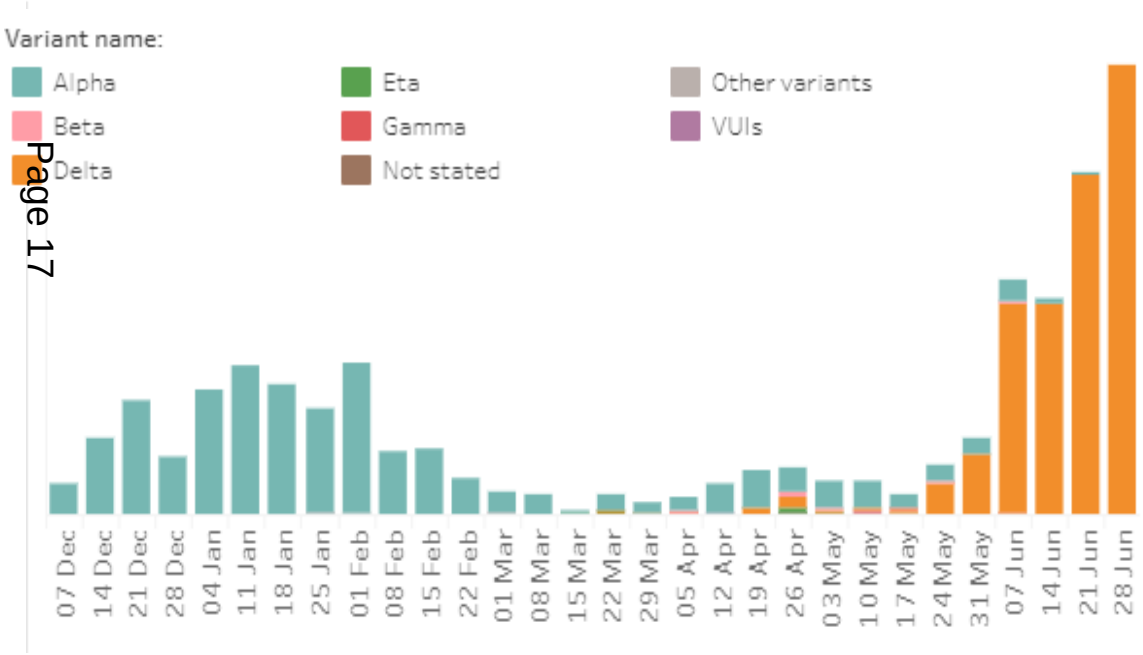


- Most cases are occurring in young people
- The highest proportion of cases occur in young, working-age adults and there is also the steepest rise in this group
- Young people (0 -18) and older working age adults also saw increases over the past 5 - 6 weeks

Update on variants of concern (VOC) and variants of interest

Combined Alpha and Delta variants account for 98% of all of the variants detected in City and Hackney starting December 2020 onward

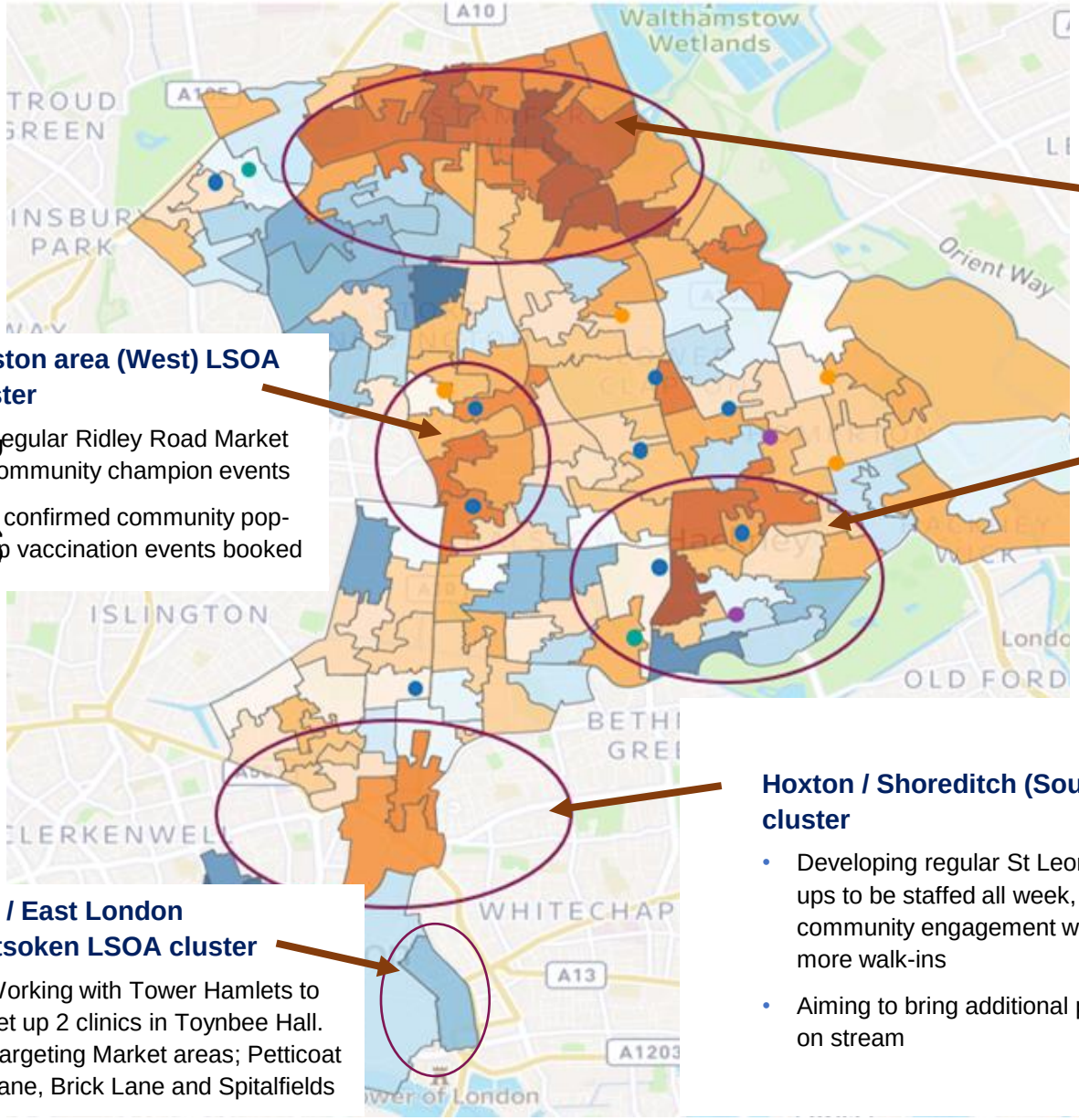
Number of VOC and VUI cases by week and type, Hackney and the City of London



- The Alpha variant (Kent) has been the dominant variant in City and Hackney from December 2020 until about the end April 2021, when a new variant emerged
- The new variant, Delta (India), has since become the dominant variant accounting for about half of all the COVID-19 cases in the last week of available data (up to 28 of June 2021)

Data source: Public Health England.

Targeted local outreach and community action in five LSOA clusters



All clusters include:

- On-street engagement using community champions
- Grant-funded events with VCSE sector

Springfield / Cazenove (North) LSOA cluster

- PCN surge event in w/c 12th July
- Using Council Charedi networks
- 4 confirmed community pop-up vaccination events booked

Dalston area (West) LSOA cluster

- Regular Ridley Road Market community champion events
- 2 confirmed community pop-up vaccination events booked

Homerton / Victoria (East) LSOA cluster

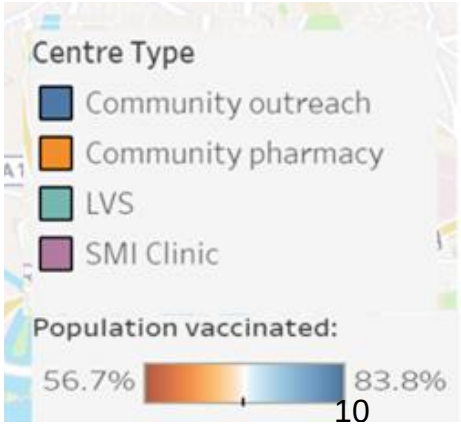
- Town Hall Service Centre mass event 10th/11th July
- 6 confirmed community pop-up vaccination events booked

Hoxton / Shoreditch (South) LSOA cluster

- Developing regular St Leonards pop-ups to be staffed all week, allowing community engagement work to direct more walk-ins
- Aiming to bring additional pharmacies on stream

City / East London Portsoken LSOA cluster

- Working with Tower Hamlets to set up 2 clinics in Toynbee Hall. Targeting Market areas; Petticoat Lane, Brick Lane and Spitalfields



Source: *LBH PH Tableau data, 23rd June 2021*

Communications – key actions in the next two weeks

- **Continued widespread comms** using **all** system partner channels/ networks – social, local publications (Hackney Life 21st July), influencers, targeted ads/ posters, community champions etc.
  - Encourage vaccination uptake amongst all adults
  - To encourage uptake of the second dose of COVID-19 vaccination and
  - To highlight over 50s having their second dose bought forward
  - Addressing vaccine concerns throughout messaging
  - Amplifying national messaging and campaigns/ events

- **Targeted messaging/ activity** for following groups:
  - **Younger adults (18-25 years old)**
    - Steering group established to look at ways to reach these audiences/ communities through relevant channels/ clinics
    - Planning for vaccination clinics at local colleges
    - Young Hackney vaccine toolkit to be shared across system/ all workforce
    - Targeted social media campaign
    - Behavioural insights project (with LBH Change Support Team) to test different messages about vaccines with younger cohorts
  - **Pregnant women**
    - Support CYPFM with maternity specific online event on 14th July
  - **Orthodox Jewish community through local publications**

- **Continued comms support for local outreach events/ clinics**

➢ Halkevi Community Centre Dalston Lane E8 3DF – Wednesday 7 July 10.30am-2.30pm

➢ Hindle House Community Centre Arcola Street E8 2DZ – Saturday 10 July 12-4pm

➢ Hackney Service Centre – 1 Hillman Street E8 1DY – Saturday 10 and Sunday 11 July 9am-7pm

➢ Spring Hill Practice, 57 Stamford Hill - Sunday 11 July, 11am-3pm

➢ Ridley Road Market Ridley Road E8 2NH – Wednesday 14 July 10am-2pm

➢ St Thomas Moore Church 9 Henry Road N4 2LH – Friday 16 July, 10am-2pm and Tuesday 20 July 10am-2pm

➢ Woodberry Down , N4 1SN – Wednesday 21 July 10am-2pm

➢ Clissold Park House Church Street N16 9HJ – Saturday 24 July 11am-3pm

➢ Uprising Community The Ark Suite, Cricketfield Road E5 8NS – Monday 26 July 11am-3pm

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Homerton University Hospital NHS Foundation Trust Quality Account 2020/21**	Item No **5**

OUTLINE

Each year NHS Trusts are required to submit a Quality Account to NHSE/NHSI. This is part of their standard reporting requirements and is completed according to an NHS mandated template. As part of the process they are required to seek comments from their local Overview and Scrutiny Committee for health.

Each year the Commission is sent a draft before it is submitted to NHSE and the Chair on behalf of the Commission submits a response. We then invite the Chief Nurse and Director of Governance from HUHFT to come and discuss any issues raised. The item is used as a chance to reflect on the past year for the Trust.

Attached please find:

a) The Commissions letter of response dated 28 June
b) HUHFT Quality Account for 2021 as submitted to NHSE on 30 June

Attending for this item will be:

Catherine Pelley, Chief Nurse and Director of Governance, HUHFT
Claire Hogg, Director of Strategic Implementation and Partnership, HUHFT

ACTION

The Commission is requested to give consideration to the briefing.

This page is intentionally left blank

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

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

28 June 2021

Ms. Catherine Pelley MBE
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 Homerton University Hospital NHS Foundation Trust's draft Quality Account for 2020/21

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2020/21. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The impact of the Covid-19 pandemic continues to be deeply felt by all the local health and care providers. We note that last year because of the unprecedented pressures on the NHS this process was completed in Sept and you attended our Oct meeting and responded in further detail in November. This letter therefore will pick up on issues since then and we note that this year's report is more truncated than usual.

We've been grateful to your Chief Executive for her engagement with our work especially now in her new role as Integrated Care Partnership (ICP) Lead for City and Hackney. In Sept she took part in a discussion panel on the plans for the ICS, in Nov in another panel on Covid-19 and Care Homes and in January she participated in an item on the vaccinations programme roll-out. In March she presented the new governance structure for the City and Hackney ICP.

We do appreciate the Quality Account exercise as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services. The Commission Members take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We commend the Trust for the role it played during the pandemic and in particular for the drive to vaccinate the adult population particularly staff of other local health and care providers (ambulance service, social care staff, cleaners, drivers etc). On a personal note, congratulations on your much deserved MBE.

We note that the usual reporting of your performance on many national audits has been delayed as patient care was given priority over such exercises during the pandemic. We also note that as a result of the pandemic the contractual arrangements for 2020/21 with NHS foundation trusts were modified to a block payments approach (as opposed to PBR) which will remain in place for the first half of 21/22. This also means there is also no reporting on CQINs which usually gives us an indicator of overall performance. We also note that during this exceptional year most clinical research activity (which HUHFT normally excels at) was paused to concentrate resources on the pandemic, although you still managed to engage a significant number of patients with Covid in important clinical studies.

We are pleased that despite the pandemic you delivered a comparably strong performance against the suite of core national standards (p.62) when performances of Trusts nationally have deteriorated because of Covid.

With respect to page 30 please can you outline what measures you have taken to improve the shortcomings around the completeness of ethnicity data recording, considering that patients from ethnic minority groups often have poorer outcomes and are disproportionately affected by Covid.

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 Christopher Kennedy, Cabinet Member for Health, Social Care and Leisure
Dr Sandra Husbands, Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

Homerton University Hospital NHS Foundation Trust Quality Report; reporting period 2020/21

INTRODUCTION

The aim of this report is to provide a review of the quality of the care and the services that are delivered by the Homerton University Hospital NHS Foundation Trust. The Trust acknowledges that the content and wording used within this document may appear bureaucratic, but it is written in a manner that complies with our statutory duty under the Health Act 2009 and the National Health Service Regulations.

The reporting period covered within this quality account report is for the 2020/21financial year.

The Trust welcomes this opportunity to communicate our progress and commitment to key elements of quality; -

- Patient Safety,
- Clinical Effectiveness, and
- Patient Experience.

1.0 PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE NHS FOUNDATION TRUST

Welcome to our 2020/21 Quality Account.

2020/21 was far from normal because of the COVID-19 pandemic. The year started a week after the first national lockdown and as the first wave reached its peak. It ended as the second and larger wave subsided, the vaccination programme reached full speed, and the country took its initial steps out of the third lockdown.

The pandemic had a dramatic impact on the range of services we were able to offer, the way we cared for patients, the way our operations were financed and the way we worked with the wider NHS and with other public services. Some of those changes, for example the shift of many outpatient appointments from clinic to phone or video, are likely to persist.

Initially we plunged into an emergency response to the unprecedented wave of illness and hospitalisations. In the space of a very few days, our hospital and community services had to be transformed both to provide for the rush of admissions of COVID-19 patients and to protect staff and patients from infection. Across the NHS, non-urgent admissions and surgery and most outpatient appointments and clinics were cancelled and our main theatres were reconfigured to provide critical care beds for patients requiring ventilation. In the community, services were reorganised to provide care by telephone and video, as well as at home, in a way which protected the vulnerable and our staff. With many staff having to isolate themselves for a period to limit infection, many staff had to work outside their normal services. At the same time, we joined others in the NHS and universities in building a better understanding of the disease and in developing and testing new treatments for it.

From June, as the levels of infection and hospitalisation fell and the lockdown was lifted, the Trust resumed a full range of services and began to tackle the backlog of elective cases. But in the autumn infection levels rose again leading to renewed restrictions in the community and another surge in hospitalisations at Christmas and the New Year. North East London was one of the areas hardest hit in

this second wave and the numbers of COVID patients in Homerton were almost twice as high as in the first wave. Alongside dealing with the covid infection, the Trust played its part in the drive to vaccinate the adult population particularly by vaccinating our own staff and the staff of related organisations including the ambulance service, social care staff, and cleaners, drivers and other staff employed by our contractors.

Partly as a result of the lessons from the earlier surge we and our partners were able to maintain a wider range of services for other patients through the second surge but we know that many have had to wait longer for care or have been discouraged from seeking clinical help. The key priorities for the Homerton in the coming months are to do all we can in collaboration with our neighbouring Trusts, with primary care and with our local authorities to tackle this unmet need, to address the inequalities in health outcomes that the pandemic brought out so starkly and to build a more integrated care system for the people of City and Hackney.

We pay tribute again to staff throughout the Trust for their dedication to do the best for our patients and our communities despite the risks. The public spotlight was on the nurses and others caring directly for covid patients in acute wards and critical care. We applaud their work including the commitment of many staff from other parts of the Trust who switched to work in these most pressured areas. But we also applaud the work of others in the hospital and the community, in the frontline of care and in management or support roles, for their work and dedication which was also necessary to deal with the unprecedented demands. We also mourn again the deaths associated with the pandemic of many patients and of three members of our staff – Abdul Chowdhury, Michael Allieu and Sophie Fagan.

Although the pandemic reshaped our service and our year, we would note some other developments and achievements during the year.

The safety and quality of care is our first responsibility. This depends of course on the quality of the frontline clinical teams who deal directly with patients. But it also depends on the supporting services for example from pharmacy, pathology, procurement and estates.

We measure ourselves by our patient feedback in regular surveys and by monitoring our performance on waiting times and a range of other quality indicators against other similar trusts. We also have a structured process to learn from serious incidents and from complaints. Subject to the disruption during the two pandemic surges, we maintained low waiting times in our Emergency Department and for outpatients and for surgery. We maintained a good performance on infection control (including nosocomial infections of covid -19)

There remain areas in which we want to improve but we are pleased that on many of the objective measures we have continued to do well compared with our peers. like all NHS trusts we are subject to examination by the Care Quality Commission (CQC) which inspected the hospital services early in 2020. Their report, which was published last summer, revised up their rating for the Trust's acute services from "Good" to "Outstanding" which was a great tribute to the excellent work of all our staff. We have every expectation that the CQC will extend this to the whole Trust including the community services and Mary Seacole when they revise their wider ratings.

The Trust's objective is to build with our partners a truly integrated care and health system in City and Hackney while playing an effective and sustainable role in the provision of acute services across our wider region of north east London.

We saw progress in 2020/21 towards establishing an Integrated Care Partnership in City and Hackney to bring together the local authorities, primary care, community services and the acute services of

Homerton and the East London Foundation Trust (which provides mental health services). The boards combining providers and commissioners are expected to be launched in the summer. At executive level the Neighbourhood Health and Care Board will be led by our Chief Executive and will build on the experience of the Strategic Operational Command Group which was formed during the pandemic to ensure all the services pooled their information and collaborated effectively.

Closer collaboration in eight "neighbourhoods" is already leading to more integrated care pathways. One notable development has been the restructuring and strengthening of our adult community nursing service to work on the neighbourhood basis alongside the new Primary Care Networks and local authority services.

There have also been important developments in North East London more widely where an Integrated Care System (ICS, previously STP) has been established. In the crisis it has taken on a leadership role in coordinating the North East London (NEL) emergency response and now the recovery programme. It remains committed to integrating care and health across the region including through an Integrated Care Partnership for City and Hackney. At the end of the year, the seven NEL Clinical Commissioning Groups agreed to merge into a single Clinical Commissioning Group (CCG) for the whole of NEL in anticipation of becoming formally part of the ICS in 2022 following legislation which will also put the ICS and its partnership with local authorities on a statutory basis.

None of what we have achieved would have been possible without the commitment and quality of all our staff and the support of the organisations with which we work. We are both very conscious of and grateful for this.

Finally, in recognition of the importance of our community services and our work with partners to provide integrated care, the Board, Governors and Members agreed to change the Trust's name to Homerton Healthcare NHS Foundation Trust. This will come into effect in 2021.

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

2.1 PRIORITIES FOR IMPROVEMENT

The Trust is required annually to set challenging priorities to improve the quality of care provided to our patients. Previously the Trust quality priorities would be agreed following a consultation with staff and stakeholders; including Governors, City and Hackney Clinical Commissioning Group and Hackney Healthwatch. However, the impact and the pressures of responding to Covid as meant that pace of implementing the priorities was slower than anticipated. As such the Trust has agreed to carry forward the priorities identified in 2020/21 into 2021/22 financial year.

Going forward the quality priorities will be monitored by the relevant oversight committees and reported to the Trust Management Board.

The table 1 below summarises the review outcome of each quality priority, see section 3.1 of this report for a detailed overview of the progress made during 2020/21;

Domain	Priority	Priority Title	Carried forward (2019/20)	New Priority (2020/21)	2020/21 Progress	Oversight Committee
Safe	1	To reduce the number of community and hospital attributed pressure ulcers	✓		↑	IPSC
	2	Improve the safe management of medicines within the organization		✓	↑	IPSC
	3	Reducing physical violence and aggression towards patients and staff	✓		↑	IPSC
	4	Improve falls management and individualised management plans of inpatients and the support given to both patients and staff post fall.		✓	↑	IPSC
Effective	5	Learning from complaints, incidents, claims and compliments	✓		↑	IPSC and ICEC
	6	Appropriate identification and management of deteriorating patients to support maternity and CSDO	✓		↑	ICEC
	7	Making Every Contact Count	✓		↑	ICEC and IPEC
Patient Experience	8	Improving the first impression and experience of the Trust for all patients and visitors	✓		↑	IPEC
	9	Improvements in staff health and wellbeing	✓		↑	IPEC
	10	Getting Patients Moving (End PJ Paralysis)	✓		★	IPEC

★Target exceeded ✓Target fully achieved ↑Progress towards target achieved *Minimal (possible no) progress towards target achieved

Table 1: Quality priorities for 2020-21

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD

NHS foundation trusts are required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. Therefore, the exact structure and content of these statements as specified by the regulations are common across all NHS Quality Accounts.

2.2.1 REVIEW OF SERVICES

During 2020/21 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2020/21.

2.2.2 NATIONAL AND LOCAL 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 HQIP. All programmes listed were assessed for relevance in 2020/21 and covered both account and community services.
During 2020/21, 53 national clinical audits and 3 national confidential enquiries covered relevant health services that Homerton provide.

Due to the delays in the publication of national audit reports and the redirection of services to support the Trust's Covid response the total number of national clinical audits that HUHFT participated is currently not available. However the Trust participated in 100% of eligible national confidential enquiries
National clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2020/21, are listed in table 2 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.

Due to the pandemic HQIP specified that patient care was a priority and national audits were put on hold. The reporting for audits undertaken has also been delayed and at point of reporting not available for the quality accounts

National Audits reviewed 2020/2021

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
Antenatal and new-born national audit protocol 2019 to 2022	√	√	*TBC
Case Mix Programme (CMP);Intensive Care National Audit and Research Centre (ICNARC)	√	√	*TBC
Child Health Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) -Long-term ventilation in children, young people and young adults-	√	√	100% - national report with leads
Elective Surgery - National PROMs; Programme NHS Digital	√	√	*Surgery suspended due to pandemic
Endocrine and Thyroid National Audit; British Association of Endocrine and Thyroid Surgeons (BAETS)	√	√	*Surgery suspended due to pandemic
Emergency Medicine QIPs - Fractured Neck of Femur (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Emergency Medicine QIPs - Homelessness inclusion health (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Y	Y	*Audit delayed – data currently being collected
Falls and Fragility Fractures Audit programme (FFFAP); Royal College of Physicians (RCP)	√	√	*TBC
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	√	√	Check website
Learning Disabilities Mortality Review Programme (LeDeR)	√	√	100%
Major Trauma Audit; Trauma Audit Research Network (TARN)	√	√	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection Public Health England (PHE)	√	√	*TBC

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
Maternal, New-born and Infant Clinical Outcome Review Programme: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	√	√	100%
Medical and Surgical Clinical Outcome Review Programme 1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD)- Physical Health in Mental Health Hospitals	√	√	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP); Royal College of Physicians (RCP)	√	√	100%
National Audit of Breast Cancer in Older People (NABCOP); Royal College of Surgeons (RCS)	√	√	*Surgery suspended due to pandemic
National Audit of Cardiac Rehabilitation (NACR) University of York	√	√	*TBC
National Audit of Care at the End of Life (NACEL); NHS Benchmarking Network	√	√	100% - Report with leads
National Audit of Dementia (Care in general hospitals); Royal College of Psychiatrists (RCPsych)	√	√	100% - Report with leads
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12); Royal College of Paediatrics and Child Health (RCPCH)	√	√	100%
National Bariatric Surgery Registry (NBSR); British Obesity and Metabolic Surgery Society (BOMSS)	√	√	*Surgery delayed due to the Pandemic
National Cardiac Arrest Audit (NCAA) Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK National Cardiac Audit Programme (NCAP); Barts Health NHS Trust	√	√	100%
National Cardiac Audit Programme (NCAP) NICOR-Myocardial Ischaemia National Audit Project (MINAP)	√	√	100%
National Diabetes Audit – Adults ;NHS Digital	√	√	100% Core and retinal check
National Early Inflammatory Arthritis Audit (NEIAA); British Society for Rheumatology (BSR)	√	√	*TBC Services have resumed following Covid

AUDIT TITLE	ELIGIBLE FOR PARTICIPATING	PARTICIPATED	PERCENTAGE OF CASES SUBMITTED
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists (RCOA)	√	√	100%
National Gastro-intestinal Cancer Programme; NHS Digital	√	√	*TBC
National Joint Registry (NJR);Healthcare Quality Improvement Partnership (HQIP)	√	√	* Surgery suspended due to pandemic
National Lung Cancer Audit (NLCA); Royal College of Physicians (RCP)	√	√	100%
National Maternity and Perinatal Audit (NMPA); Royal College of Paediatrics and Child Health (RCPCH)	√	√	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	√	√	*TBC
NHS provider interventions with suspected/confirmed carbpenease producing Gram negative colonisations / infections (PHE)	√	√	Suspended until 2021-22
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	√	√	*TBC Ambulance Service audit
Sentinel Stroke National Audit programme (SSNAP); King's College London	√	√	*TBC
Serious Hazards of Transfusion: UK National Haemovigilance Scheme - Serious Hazards of Transfusion (SHOT)	√	√	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) Society for Acute Medicine (SAM)	√	√	100%
Surgical Site Infection Surveillance Service Public Health England (PHE)	√	√	*TBC
National Child Mortality Database	√	√	100%

Table 2: National clinical audits applicable to the Trust - source internal Trust records

It should be noted that the publication of several national audit reports was delayed during 2020/21, as the programmes were suspended due to the impact of Covid pandemic. We will continue to review our participation rates when the national audit reports are published (these are indicated by * in the table 2) and these will be reported to the Improving Clinical Effectiveness Committee.

There were 42 national clinical audits that were not applicable to the Trust, see table 3.

AUDIT TITLE	REASON
BAUS Urology Audit - Bladder Outflow Obstruction Audit	This is not carried out at Homerton
BAUS Urology Audits - BAUS Cytoreductive Radical Nephrectomy Audit	This is not carried out at Homerton

AUDIT TITLE	REASON
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	This is not carried out at Homerton
BAUS Urology Audit – Radical Prostatectomy	This is not carried out at Homerton
BAUS Urology Audit - Cystectomy British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Nephrectomy 2 British Association of Urological Surgeons (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Percutaneous Nephrolithotomy 2 British Association of Urological Surgeons (BAUS) BAUS Urology	This is not carried out at Homerton
BAUS Urology Audit –Renal Colic (BAUS)	This is not carried out at Homerton
BAUS Urology Audit - Urethroplasty	This is not carried out at Homerton
British Spine Registry	This is not carried out at Homerton
Child Health Outcome Review - Young People's Mental Health	This is related to Mental Health Trusts
Cleft Registration Audit Network (CRANE)	This is not carried out at Homerton
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database / Vertebral Fracture Sprint Audit	This is not carried out at Homerton
Mental Health Clinical Outcome Review Programme 1 National Confidential Inquiry into Suicide by children and young people in England (CYP)	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme 1 National Confidential Inquiry into Suicide and Homicide	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme 1 The assessment of risk and safety in mental health services	This is related to Mental Health Trusts
Mental Health Clinical Outcome Review Programme – Suicide by middle aged men	This is related to Mental Health Trusts
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Asthma (Adult and paediatric) and COPD Primary care - Wales only	This relates to Primary Care and is for Wales only
National Audit of Pulmonary Hypertension (NAPH) NHS Digital	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This is not carried out at Homerton
National Cardiac Audit Programme (NCAP - National Congenital Heart Disease (CHD)	This is not carried out at Homerton
National Clinical Audit of Anxiety and Depression (NCAAD) - Core audit	This is related to Mental Health Trusts
National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight	This is related to Mental Health Trusts
National Clinical Audit of Psychosis - EIP audit 2019/2020	This is related to Mental Health Trusts

AUDIT TITLE	REASON
National Ophthalmology Audit (NOD) 1, 2 Royal College of Ophthalmologists (RCOphth) - Adult Cataract surgery	This is not carried out at Homerton
National Paediatric Diabetes Audit (NPDA) 1 Royal College of Paediatrics and Child Health (RCPCH)	This is not carried out at Homerton
National Prostate Cancer Audit 1, 2 Royal College of Surgeons (RCS)	This is not carried out at Homerton
National Vascular Registry 1, 2 Royal College of Surgeons (RCS)	This is not carried out at Homerton
Neurosurgical National Audit Programme 2 Society of British Neurological Surgeons	This is not carried out at Homerton
Paediatric Intensive Care Audit Network (PICANet) 1, 2 University of Leeds / University of Leicester	This is not carried out at Homerton
Perioperative Quality Improvement Programme (PQIP) Royal College of Anaesthetists	The programme is not in-line with Homerton Services
Prescribing Observatory for Mental Health (POMH-UK) 3 Royal College of Psychiatrists (RCPsych) - Monitoring of patients prescribed lithium	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Prescribing Clozapine	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Use of depot/LAI antipsychotics for relapse prevention	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK - Assessment of side effects of depot and LAI antipsychotic medication	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Antipsychotic prescribing in people with a learning disability	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing valproate	This is related to Mental Health Trusts
Prescribing Observatory for Mental Health (POMH-UK) - Prescribing for depression in adult mental health services	This is related to Mental Health Trusts
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	This is not carried out at Homerton
UK Renal Registry National Acute Kidney Injury programme -UK Renal Registry	This is not carried out at Homerton

Table 3; National audits not applicable to the Trust – source internal Trust records

Implementation of actions implemented following the publication of the national audit 2020/21

Examples of actions that the Trust intends to take or has taken following the review of the 17 national audit reports published during the financial year 2020/21, there consists of 5 audits from 2018-19, 6 audits from 2019-20 and 6 audits from 2020-21. 4 reports have action plans assigned and these are summarized in table 4 below. 13 of these reports are currently being reviewed by the project lead at the time of reporting.

However, it should be noted that due to a reporting lag the data referenced in national clinical audit reports could have been collated during previous financial reporting years.

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
National Emergency Laparotomy Audit (NELA)	• There has been improvement noted in Preoperative documented risk • Cases with clinical access to theatres within timescales • High risk cases with surgeon/anaesthetists in theatre • High risk cases admitted to critical care postoperatively • Risk adjusted 30 day mortality • Positive performance against Best Practice Tariff	• Reduced case ascertainment (both nationally and locally) from previous year and action put in place to improve case ascertainment rate. • Consultant review of CT scans prior to surgery above national average (71%), but below 80% target. Related to audit tool not including outsourced reviews as completed by a consultant. All NELA radiology data is reviewed and audited to identify any discrepancies between reports and operative findings.	• Cases audited have now risen as a result of actions put in place • Improvements in theatres times have also been made • Overall performance during COVID period has shown that despite the decrease in number of Laparotomies overall, the level of care provided to emergency laparotomy patients were mostly maintained .
National Early Inflammatory Arthritis Audit (NEIAA)	• Early arthritis clinics are available in 77% of departments • Annual review almost universal. Audit data not representative • Self-management encouraged. • Talks to GPs and GP trainees delivered. Education via advice and guidance service • Talks delivered to physiotherapists. • Dedicated psychology service • All referrals triaged by consultant • Close liaison with MSK services • Telephone clinics embedded • Urgent referrals vetted and prioritised.	• Consider expanding education material and introducing monitoring 'app' to improve patient experience. • Patient 'follow-up' capacity issues (one year remission rate) to be reassessed after COVID disruption • Annual review of patients almost universal; Audit data fully not representative due to collection methodology. • Consider the introduction of a proforma to standardise annual review data	• Provision of education and monitoring • Ensure that follow up cases are resumed following Covid • identify further data collection outside the parameters of national audit

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
BTS Pneumonia National Audit	• Results show that the Trust has designated NIV area/s • Compliant in many recommendations	• Not all cases had smoking status recorded • Time between admission and first antibiotic in minutes not always recorded	• To explore the feasibility of the mandatory recording of smoking status • Education on staff of the importance of recording data timely
Learning Disability Mortality Review Programme (LeDeR) (COPD) Secondary Care	• Trust Lead is part of the Steering group which is led by CCG • Training sessions scheduled following an event around patient who died 2 years ago. • Trust working disability group; representative's includes service users, advocates. • Sharing of the learning; review A&E attendances and putting in place some support for the service users. • Active review of cases – audit progress notes to identify lapse in care and what went well so that we can share learning such as use of passport • Work with the community team but we refer people to the learning disability team if appropriate • Review DNRs and any other decisions are appropriate and that reasons are recorded • Training on the deterioration for patient with learning disabilities; including recognising pain and asking questions in a different way.	• Develop working with End of Life Care Team to identify appropriate and timely referrals	• Training available to identify the signs of patient approaching end of life.

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
	• Care plan to be available on EPR which is currently being tested to assess pain and reasonable adjustments with service users. • NEWS scores -family and cares are included in the discussion so that staff what is known as 'normal'.		

Table 4; actions identified from national audit reports

Local Audits reviewed 2020/2021

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 improve services. There were 143 local audits registered during 2020-21. The reports of 80 local clinical audits were reviewed by us in 2020/2021 A selection of these audits is outlined in table 5 and the Trust intends to take the following actions to improve the quality of health care provided.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Service evaluation of Child protection medical examinations	CSDO/ Safeguarding	• Consideration of a trainee in the VCC to speed referrals being seen • To ensure awareness is raised • To ensure smooth transfer of services practice to inform specialty team of Senior doctors should ensure that all essential parts of the spider form is checked which will indicate completion of ED clerking, drug chart, senior review and specialty referral. • Only a senior doctor plus the NIC can make the decision to spider a patient to the ward. Both names should be indicated on the spider form. • The SOP should be updated before or during March 2020. • Ward nurses to contact specialty teams if the patient still has not been seen within the recommended timeframe	• Consideration of staffing in the VCC to improve speed of neglect referrals • Present findings to paediatric department – acute and community • Continue staffing levels to ensure physical abuse cases are assessed in a timely fashion • Review of pathways for very young children to ease transition between acute and community setting.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on suitable milk provision on the Neonatal Unit (NNU)	CSDO/ Neonatal	• Increased incident reporting when error noted • Discussion with sister in charge how to communicate any errors found • Addition of milk to daily nursing check list • Presentation of findings at the Grand Round • Potential of new training sessions for experienced nurses • Additional reference materials on the NNU	• Official incident reporting of any babies on the wrong milk. Staff have been reminded of the need and importance of reporting and evidenced by incident reporting. • Identify appropriate method to communicate errors to staff • Discussion with practice development team about suitability/ development of phrases for the daily nursing check list • Planned presentation of audit findings in relation to the new Enteral feeding guidelines • Training days for band 5-7 staff • Share practice development nurses updated enteral feeding guidelines with appendix of updated flow chart for trolley showing SMA range • Previously developed information sheet to be displayed in the milk kitchen
Audit of the Camish operational guidance for information sharing for safeguarding young people U18	CSDO/ Camish	• Providers are able to evidence that safeguarding list/temporary record system (Brook) has been checked prior to patients being seen for consultation • The guidance is embedded in new staff inductions and safeguarding training updates in each organisation • Deputy arrangements are put in place during staff absences. • Safeguarding leads to review system and strengthen it where necessary	• Each provider reviews recording system to ensure it is fit for purpose • The audit results and recommendations are fed back to staff at network clinics by the safeguarding leads. • All staff are advised to familiarise themselves with the guidance, which is kept on each providers shared network drive along with their organisational safeguarding policies and procedures • All staff are reminded of their role and specific tasks in following the guidance and of accurate and timely documentation • The safeguarding leads review their deputy arrangements

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			and agree a system with their deputies to help remind them to follow the process during their absence. • The safeguarding leads review their system and strengthen it where necessary.
Summary - Point Prevalence Audit of Antimicrobial Prescribing Hospital "	CSDO/ Pharmacy	• New review date after 48h evaluation of IV antibiotics not being documented on prescription • Documentation of antibiotic indication not documented well in the notes. • Documentation of oral antibiotic duration not documented well in the notes and incorrectly prescribed on the drug chart. When completing a course of antibiotics, the total duration is made up by both IV and oral administration of antibiotics and should not exceed number of days as recommended in the micro guide (unless clinically indicated). • Slight increase in the prescribing and Meropenem, may be explained by increase in amount of prescriptions than last audit. • Documentation of antibiotic indication not documented well in the notes. • Increased use of Meropenem	• Train staff to ensure correct documentation • Indications to be documented on both the drug chart and in the notes for all antibiotics. • Duration of antibiotics need to be documented on both the drug chart and in the notes for all antibiotics, particularly oral medication. • The total course length should not exceed the recommendation in microguide. This can be done through increasing prescriber awareness of amending review/stop dates of antibiotics on electronic drug charts and encourage pharmacists to highlight old dates to prescribers. • Continue to monitor usage of all antibiotics and work hard in reducing the amount of restricted and broad spectrum antibiotics prescribed. Encourage appropriate step down of antibiotics once causative organism is known. Increased inappropriate use does not benefit patients, elevating the risk of C. difficile and candida infections and encouraging the development of resistant bacteria. • Monitor use of Meropenem and encourage early review of iv antibiotics
Inequality for the high-risk Foot: The INFO clinical audit into foot	IMRS/ Podiatry	• Workshops on the implementation of RA foot management guidelines • Series of educational workshops for podiatrists in rheumatology foot	• Workshops to be developed • Specialist Workshops to be developed • Proforma to be developed

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
health management standards of rheumatoid arthritis compared to foot health management standards of diabetes mellitus in North-East London		health and its association with the high-risk foot. • Creation of a pro-forma to be used during initial assessment of people who present with a rheumatology (not RA specific) foot/ankle issue. • Creation of a specialist rheumatology podiatrist or lead podiatrist for people who present with a high-risk foot and have a rheumatology disorder to act as a liaison between podiatry and rheumatology.	• To create a specialist post for rheumatology podiatry
Radiographer Commenting And Preliminary Clinical Evaluation Audit	CSDO/ Radiology	• Staff should be made aware that use of the red dot and sticky note is not optional, but mandatory and the policy should be enforced more. This would help avoid missed abnormalities in the future. • Staff to be given extra training with image interpretation sessions at lunchtime or when the department is quiet. This would help staff improve their skills and knowledge and make them feel more involved with the patient's diagnosis rather than just producing the images.	• To present the findings to staff and ensure staff are guided to the policy • To provide training sessions on the red dot system
Management in the delivery room audit	CSDO/ Neonatal	• Transfer more babies on CPAP from the delivery room to the neonatal unit if the clinical condition allows. • Need to order consumables, train staff and implement Less Invasive Surfactant Administration technique at the Home	• Share audit with colleagues • To order more consumables • To train staff on CPAP and ensure competencies
Lyme's Disease	IMRS/ED	• Clinician education to update on Lyme disease diagnosis and when to select laboratory testing • Clearly accessible resource for choice of antibiotic, dosage and duration for clinicians • Clinicians to check for pregnancy in all women of child bearing age • SOP of the week final stage on process map of Lyme disease management to include giving patient education and information leaflet • Patient information leaflet added to EPR for printing on completing discharge summaries	• Reminder message on Microguide to indicate no testing required if has matching history with typical erythema migrans rash • New Microguide page (adults and paediatrics) for Lyme disease • Include section on pregnancy on Microguide

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		• Distribute amongst ED, PUCC and microbiology staff email. • Clinicians to provide adequate education and information at point of patient discharge • Share the results of this audit	
COVID VTE Audit	IMRS/ Respiratory	• Presented a summary of the audit and key learning points at the Medical Mortality and Morbidity meeting (19/06/20). The medical unit was reminded of the new VTE guidelines with particular focus on ensuring that patients receive a D-dimer when deemed medically fit for discharge to allow complete assessment. • An email reminder of the guidelines was distributed • An additional checklist column was added to the weekend discharge list as a reminder to check the D-dimer on discharge for patients with COVID-19 (19/06/20). • Posters were put up in key areas such as ACU and wards designated for COVID admissions (20/06/20). At the time these were Lloyd / ECU South / Lamb / Edith Cavell / Thomas Audley	• Present findings to reminded staff of new guidelines • Email reminder to be sent to Staff • add additional column to weekend discharge list • Posters to be put up on wards
Outcomes of the X-PERT Diabetes Structured Education Program delivered at the Hackney Diabetes Centre	IMRS/ Diabetes	• Provide additional visual materials for X-PERT programs for different ethnic groups (Asian, Caribbean, African) adapted to their needs about dietary habits and meal ideas. • World Carbs & Cals book have the photos and portion sizes of the South Asian, African and Caribbean meals. • Involve the participants and adopt their visual materials (such as the food labels) which can be used for the X-PERT programs. • Re-design the post - program questionnaires to evaluate the relevance of the program for the minority ethnic groups and reflect their specific needs	• To tailor the teaching materials to the needs of the participants from the group. • There is a specific session in the X-PERT program about the food labels. Ask the participants to bring their own food labels which they are using on an everyday basis and discuss those labels with them; or arrange a grocery store tour with a couple of participants to gather some labels • Add to the existing questionnaire the questions about the food, to find out if the cultural diets/dietary habits of that specific group were covered at the session

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on Diagnosis of Chronic Heart Failure	IMRS/ Cardiology	• To ensure that correct procedures are followed such as: NT-proBNP levels should be measured in people with suspected heart failure, Patients with suspected heart failure and a NT-proBNP level above 2,000 ng/L to have a specialist assessment and transthoracic echocardiography within 2 weeks urgently, Patients with suspected heart failure and an NT-proBNP level between 400 and 2,000 ng/L should have a specialist assessment and transthoracic echocardiography within 6 weeks.	• To improve awareness of guidelines by sharing these results with colleagues and GPs; via audit presentation day and GP session • Improvement in record keeping by emphasizing the importance during the audit presentation • Possible mandatory entries of ECHO and NT-proBNP in the EPR – discussion to take place with EPR lead on feasibility • Improve the access for cardiac ECHO – discussion with lead on referral process and timeframes in line with guidance • Possible mandatory entries of ECHO and NT-proBNP in the EPR – discussion to take place with EPR lead on feasibility
Clinical Audit on the appropriateness of IV paracetamol use across surgical wards.	CSDO/ Pharmacy	• To document clearly the indication for the IV paracetamol in the medical notes/drug chart, as it should be reserved for those patients who are unable to tolerate oral intake. • All IV paracetamol prescriptions should be reviewed within 24 hours of initiation, and continued every 24 hours until patient is able to tolerate oral intake, with a view to switch to the oral route as soon as possible.	• Email to the surgical team leads, highlighting audit findings and recommendations and rational. • Ward pharmacists to proactively review all patients on IV paracetamol on their wards with a view to advising prescribers to step-down to oral as appropriate.
ANNUAL RPA AUDIT	CSDO/ Radiology	• The Trust's radiation protection policy should be reviewed as it is now overdue. Please ensure that references to IRMER2000 and IRR99 are updated with the new regulations in mind. • The staff declaration form should be signed by all relevant staff to evidence that they have read and understood the IRMER procedures that apply to them. • The list of clinicians who may refer patients identified in IRMER5 should include references to the GPs who are permitted to refer patients to the department. Whilst they need not be	• Update policies • Ensure staff are made aware of the guidelines • List of referrers to be updated • To incorporate guidance into procedures • To ensure training completed every two years • New format local rules are provided with this report. These should be reviewed upon receipt by the RPS and annually, thereafter. All previous versions should be removed from circulation.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		identified individually in the IRMER procedures, reference to the relevant electronic lists should be made. • The latest copy of the IRMER18 procedure for dealing with radiation incidents arising from medical exposure is available via the RPC dropbox. The new procedure includes the latest guidance and reporting thresholds issued by CQC earlier this year and should be incorporated into your framework of procedures • Please be aware that RPC provide online radiation protection update training for radiographers. This should be completed at least once every 2 years. Individual passwords required to access this training can be provided by RPC. • New format local rules are provided with this report. These should be reviewed upon receipt by the RPS and annually, thereafter. All previous versions should be removed from circulation. • IRR17 requires employers of staff who work with ionizing radiation at multiple sites to share personal dose information in order to ensure that dose limits are not exceeded. A pro-forma letter that can be edited locally and sent to the other employers of the gastro consultants is provided with this report. • The same principal should be applied to all staff who work at multiple employer sites including radiologists and any other staff groups	• To ensure that dose information is shared
The Cappuccini Test: An audit of supervision	SWSH/ Anaesthetics	• The name of the supervisory consultant anaesthetist should be observable on the anaesthetic rota	• The mentee needs to clearly document on the anaesthetic chart for each case the name and location of their mentoring consultant. - this was shared at the local CG meeting • On the day, the mentee should approach their

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			assigned mentor to confirm they are being supervised and to highlight and potential issues on their list.- this was shared at the local CG meeting • Any omission of a NCG not being assigned a mentor should be highlighted at the earliest opportunity to the rota-coordinator such that this can be rectified on the anaesthetic rota as soon as possible - this was shared at the local CG meeting
Traceability Audit	SWSH/ Fertility	• For all IUI-H and D, template must be selected by the person preparing sperm sample • For all verification for patients, a template must be added • to check feasibility of moving traceability to RI	• Staff training • To arrange a session with RI
Morbidity and Mortality Documentation	SWSH/ General Surgery	• Medical Certificate of Cause of Death (MCCD) Note • Morbidity and Mortality Meeting Note	• Template has been devised and needs to be added to EPR • Present at M&M/governance meeting
What proportion of Semen Analysis (SA) results are still emailed, and why?	SWSH/ Fertility	• Proactive engagement of CIS/Pathology and GP electronic personnel • TPAs with errors that will expire soon • TPAs with errors that will not expire soon • TPAs not getting a lay perspective or a dedicated Quality perspective.	• Liaise with (CIS), (Pathology) • Highlighted on Q-pulse, will be addressed when renewed • Email contacts to amend TPA • All new and renewed TPA now go through both Lab Director and Quality Manager
Audit of suboptimal x-ray images	SWSH/ Radiology	• To identify whether the suboptimal images are performed in or out of hours. • Audit of Ankle, Knee and Facial Bones examinations. • Continually address individual image quality • Informal departmental CPD talks • More consistent use of Sticky Notes	• A new field on the suboptimal images folder to select in or out of hours. • Ankle audit currently being undertaken. Ask for volunteers for knee and facial bones audit • Currently being done on an on-going basis. • To be discussed – COVID-19 considerations allowing. • Audit recently completed, reminders communicated regularly.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Consent of emergency general surgery patients for COVID 19 risk during pandemic	SWSH/ General Surgery	• All patients undergoing emergency surgery need COVID risk documented on either standard yellow consent form or the new consent specific consent form. • Swab testing to be discussed at the time of team brief as per the suggestions from the audience • All patients going to theatre should be COVID tested either in AE or on ward	• Findings to be discussed with teams and emailed
Cholecystectomy in gallstone pancreatitis	SWSH/ General Surgery	• Patients admitted with Gallstone pancreatitis who do not have an index admission laparoscopic cholecystectomy with no further investigations pending should be booked for laparoscopic cholecystectomy on discharge and this should be booked urgently within the 6-8 week timeframe. Ideally they should get a date for their operation before going home • Any pending investigations as an outpatient (such as MRCP/repeat bloods) should be booked urgently with a timely follow up of results (e.g. paper clinic) and then, if appropriate, laparoscopic cholecystectomy booked urgently within the 6-8 week window from initial discharge • A further longer term project ideally should be initiated to work out feasible plan to increase laparoscopic cholecystectomy during index admission for gallstone pancreatitis (as well as “hot” laparoscopic cholecystectomy for cholecystitis) • Use Glasgow scoring as clinically appropriate, as well as ABG results, to guide discussion with critical care outreach and HDU/ITU teams.	• Team to book patients for urgent OP cholecystectomy at or before discharge • Team to book investigations as stated • Complex pathway which will need significant planning and implementation. • On call teams updated at the Audit meeting and to make clinical decisions as deemed appropriate
Covid patient experience of Home treatment	SWSH/HANS	• Improvement to Pathway • To update SOP	• Flow chart to be devised • Information on HANS website such as diagrams • Provide Peer support • Update SOP

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
Audit on VTE prophylaxis in lower limb injuries seen in out-patient clinics	IMRS/ED	• To standardise care • To ensure that all lower limb injured patients receive prophylaxis if appropriate • Documentation to be improved • To review/devise Protocol or highlight Sop with staff	• Flow chart to be completed and shared with staff • Posters on display in clinics • SOP for VTE in limb injuries to be followed, • risk assessment as per EPR VTE form • Autotexts in clinic letter template • SOP to be presented at departmental audit meeting
Review of practice: management of fever in 1-3 month old infants	CSDO/ Paediatrics	• Clarify with microbiology the choice of antibiotics for suspected sepsis in the Microguide • Discuss the findings with the General Paediatrics department and recap NICE guidelines for the management of fever in 1-3 month olds	• To check if guidelines at Homerton contain recent NICE guidance published 07/11/2019– if not this needs to be updated • Findings presented 03/09/2020 to 15 members of the department (grades: senior house officers, registrars, consultants and senior nurse)
COVID VTE Audit Cycle 2	IMRS/ED	• To raise awareness of standards • An order set of bloods can be created on admission for suspected COVID patients, which includes a D-dimer level. This ensures that this is done straightaway and may require liaising with the A+E department to ensure this is done.	• Presentation of the results of this audit at a suitable forum to create greater awareness on this topic. • Further teaching sessions on COVID VTE assessment and prescribing with junior doctors. This was something that was hard to implement during the pandemic due to stricter social distancing rules in the hospital. However, there appears to be many more established mediums, such as Microsoft Teams, which this could take place • Poster to be displayed on expectations • Liaison with the A&E Department on D-dimer level blood tests
An audit of VTE assessment/ prophylaxis	SWSH/ Maternity	• Educate midwifery staff on the need to complete VTE assessment at 26/40 • VTE assessment as part of SBAR during handovers/Accurate	• To be presented in a community midwife education session

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
		prescribing and documentation of VTE assessment and treatment plan on the discharge summary • Review of VTE assessment flowchart to remove ambiguity • Accurate prescribing and documentation of VTE assessment and treatment plan on the discharge summary	• Update of midwifery guidelines • Postgraduate midwifery training • Re-circulate this as the tip of the fortnight and ensure it is part of the induction process. • Liaise with EPR for mandatory filling to access records • To be considered during guideline review • To be part of SHO's induction training • Incorporate into the discharge package/documentation on EPR as a compulsory action to address the poor compliant and improve documentation.
Patient satisfaction survey - Outpatient hysteroscopic surgery (true clear)	SWSH/Gynae	• Improve communication • Post procedure leaflet • Pain relief during the procedure	• Email , text and letter about patient leaflet and pain relief. • Await BSGE video for patients – To overcome language barrier. • Review current leaflet and create a post procedure plan / give letter print out • Consistent with use of local anaesthesia , entonox, conscious sedation , PR Diclofena
What do we offer to women at their first attendance with urinary incontinence"? Do we meet the standards	SWSH/Obs and Gynae	• To amend practice • To raise awareness • New leaflet • Incorporate Urogynaecology Proforma on EPR	• Improve documentation, with the incorporation of the urogynaecology Proforma on EPR • Raise staff Awareness – present findings to staff • Design new leaflet
Saving Babies' Lives SGA/FGR Audit	SWSH/ Maternity	• SFH Chart education, audit and compliance • Documentation changes for identification of risk • Consideration of future scanning pathways	• Organise action plan • Educational support • On-going compliance monitoring • Changes to EPR to record risk factors and guide staff to care plan guidance. The creation of a MTD sheet outlining additional scan criteria.

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			Consideration on strategies on how additional scans are booked • Ethnic background, social factors and language barriers – consideration of an offer of additional scanning with one or a combination of these factors. • Future consideration of universal offer
Clinical audit of currently existing reflex serum triglyceride testing in lipaemic blood samples	CSDO/ Pathology	• Reflex TG testing in lipaemic samples in A & E patient is useful and will continue • Clinical alignment with this policy of reflex TG testing in A & E patients with high LI ,by Bart's and Lewisham & Greenwich Hospital	• Clinical biochemistry IT specialist and co-auditor to complete the IT change form to remove reflex testing in GP and outpatients • Bart's Health and Lewisham & Greenwich Hospital to consider aligning with this protocol – to liaise with them around feasibility
The Safe Transfer of Women from Hospital to a Community Setting	SWSH/ Maternity	• Improve failsafe measures • Remind staff that missed/delayed visits should be datixed • Generalise failsafe measures for all areas of maternity • Re-evaluate how discharges are delegated and received by community teams at HUH. • Review discharge email addresses • Datix training	• Add a column in the discharge diary to be signed by the clerk when the failsafe has been completed. Write instruction at the top of each page indicating 'Please sign once correct hospital and email checked'. This will ensure the failsafe is followed when bank staff clerk in the ward. • Send all maternity staff an email and ensure they are aware that if they identify a missed visit this should be escalated appropriately and datixed to ensure appropriate analysis and audit can be undertaken in future. • Ensure when women are discharged from delivery suite/birth centre that they are written in the postnatal diary in Templar so that the failsafe can be performed. • For discussion with community clerks to review how they ensure all emails received from HUH discharge

AUDIT TITLE	DIRECTORATE / SERVICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
			email are dealt with in a timely manner. • Review the list of outward postnatal discharges. Ensure that each area of maternity has an up to date summary of all surrounding hospitals community discharge emails. • Consider implementing some additional training surrounding incident reporting so that common themes can be easier identified in subsequent audits.
Shoulder dystocia re-audit 2019	SWSH/ Maternity	• Send e-mail to maternity staff to • address areas of improvement • (syntocinon infusion, all fours) and praise the team • SD training	• Tips of fortnight • Simulations and workshops on SD, to continue with monthly PROMPT teaching
Bereavement Care in Maternity Services:	SWSH/ Maternity	• Improve completion of the bereavement checklist. • Improve intrapartum documentation (e.g. birth plan discussion). • Improve communication between teams	• Bereavement midwives to continue to monitor completion and provide feedback to staff. Bereavement midwives to complete where possible • Meet with K2 midwife to develop 'Bereavement' section in 'notes' in K2. • To inform community teams/referring hospitals/GPs of any loss.
Covid Consent Audit	SWSH/ Fertility	• Simplifying form • Extending clinic times • Staff training	• Assess to see what information can be down sized; speak with doctors/admin etc. • Ensuring that scan times are no shorter than 15 minutes • Staff training to be organised after modification of forms

Table 5: actions implemented following the review of national audit recommendations

2.2.3 PARTICIPATION IN CLINICAL 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 reflects this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England until September 2019, 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] This remains particularly pertinent in light of today's pandemic and the health crisis the population is encountering.
The Trust is committed to this path, growing research capacity year on year. However, during this exceptional year most research activity was paused to concentrate resources to COVID 19, opening studies focusing on the treatment of patients infected with virus. Nevertheless, the target of 2000 recruits per year was missed by just 89.

Our vision remains to ensure that research is an integral part of the functioning of the Trust, working with staff and patients to improve the health of our community. We aim to ensure that staff patients and families understand the importance of research and research is seen and a benefit and not a compromise to NHS clinical activity. We value those involved in research by offering support and training.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 1909. This was out of a total of 2318 patients who were deemed eligible and were screened for inclusion. A total of 1229 of these were patients diagnosed with COVID19

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 Research & Innovation (R&I) 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. Additional approvals were sought during this pandemic from the Clinical Review Group to ensure a balance between gathering vital information and ensuring our patients continued to receive optimal clinical care.

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 professionals3.
The R&I team engaged in a number of high profile COVID 19 Urgent Public Health Studies The end of this reporting period saw the Covid19 pandemic. The research team was responsive to the crisis initially by supporting the clinical teams within midwifery and then quickly refocusing the remaining team towards recruitment to the Urgent Public Health studies. These included the high profile RECOVERY and REMAP-CAP studies that identified the positive effect of dexamethasone when included in the COVID 19 patients' pharmaceuticals. Other studies included Clinical Characterisation Protocol for Severe Emerging Infection (CCPSE), UKOSS- a maternal prevalence study, GenOMICC, a study looking at the genomic make up of patients becoming critically ill with COVID19 and CAPTURE- a trial looking at a near patient testing device. The Clarity study is investigating the impact of biologic therapy on COVID 19, and MERMAIDS is a study designed to investigate why people react so differently to the virus.

As the year drew to a close the department once again refocused to reopening closed studies and sourcing new studies that would be relevant to the patients and staff of the trust.

[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

2.2.4 GOALS AGREED WITH COMMISSIONERS

As a result of the Covid pandemic the contractual arrangements for 2020/21 with NHS foundation trusts were modified to a block payments approach.

The block payments approach for arrangements between NHS commissioners and NHS providers in England will now remain in place for the first half of the 2021/22 financial year. Block payments to NHS providers are deemed to include CQUIN, and there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage.

2.2.5 WHAT OTHERS SAY ABOUT THE 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 2020/21.

We did not participate in any special reviews or investigation carried out by the CQC during 2021/21.

Homerton University Hospital was last inspected by the CQC in January 2020, covering three core services; older people's services in medical care, maternity services and end of life care. The CQC took into account the current ratings of the other services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the acute hospital site achieving an overall rating of 'Outstanding'. The rating remained unchanged in 2020/21. The figure below outlines the current CQC hospital rating against the five key lines of enquiry.

Overall rating for this hospital	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Figure 1: CQC ratings – overall summary; report published 2nd July 2020

Action plans have 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.

Mary Seacole Nursing Home has been identified for use as a designated care setting for people discharged from hospital with a positive Covid-19 status. To ensure that the service was compliant with infection control and prevention measures, the CQC undertook a focussed inspection at Mary Seacole Nursing Home in December 2020. The CQC is assured that the care home has safe infection control and prevention systems in place. The rating of the care home remains at 'Good' across all five key lines of enquiry.

2.2.6 NHS NUMBER AND GMC 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 University Hospital NHS Foundation Trust submitted records during 2020/21 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 20 – Mar21**:

- which included the patient's valid NHS number was

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.1%	98.9%	99.5%		
Outpatients	99.7%	99.1%	99.7%		
A&E	98.0%	97.2%	98.6%		

Table 6: Valid NHS numbers

- 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%	99.8%		
Outpatients	100.0%	99.9%	99.7%		
A&E	99.9%	99.7%	99.6%		

Table 7: Valid GMP code

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.

The Acute and Community Services Data Quality Committees continue to take place bi-monthly. During the height of the COVID pandemic the committees did not take place but they reconvened in August 2020.

Locally agreed core DQ Acute and Community indicators continue to be monitored and discussed during committee meetings. Figures from the Data Quality Maturity Index (a monthly publication intended to raise the profile and significance of data quality in the NHS) are also presented to the committees and the Trust's data quality performance is discussed. The DQMI mainly focuses on the completeness and validity of the data the Trust submits.

The committees are a vehicle for data quality improvement and awareness within the Trust. They continue to promote and maintain 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 Data Quality department do carry out audits at agreed frequency to check the consistency of the key SUS data items for admitted patients and outpatients between SUS submitted data, Data warehouse tables and front end of EPR (Cerner Patient Administration System).

New data quality indicators will be monitored as and when identified and deemed necessary by the committees. They will be vehicle through which new issues are raised, analysed to identify cause, impact and manage resolution. This will continue to be the platform through which strategies, policies and standards are monitored to ensure they align with operational requirements.

There are numerous DQ reports which are sent to services at regular frequency to improve the data completeness on clinical systems. There are on-going DQ checks, updates and staff training as and when new errors come to light.

2.2.7 INFORMATION GOVERNANCE ASSESSMENT REPORT

The Trust uses the Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

Due to Covid19, NHS Digital has deferred the submission date of the annual DSPT to 30.06.2021; the trust has decided to plan its submission for this date. So the current status of the Trust's DSPT remains 'Standards Not Fully Met (Plan Agreed) at least until the above date.

2.2.8 CLINICAL CODING

Homerton University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.
Homerton University Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Maintain its internal clinical coding audit programme
- Commission external clinical coding audits where deemed necessary
- Monitor a range of data quality issues via its Data Quality Committee

2.2.9 ACTIONS TO IMPROVE DATA QUALITY

The six dimensions of data quality: Completeness, consistency, accuracy, timeliness, uniqueness and validity are monitored on regular basis in order to provide intelligence for clinical and strategic decision making. 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.

The Acute and Community Data Quality (DQ) Committees reconvened in August 2020 having stopped during the height of the COVID pandemic. The committees continue to provide a focused space to review and discuss the DQ issues and steps to improve them. The committee meets every month alternating between acute and community services. The Data Quality committee is chaired by Head of Information Services. The committee reviews both local and national indicators including the Data Quality Maturity Index which looks at the validity and completeness of the data the Trust submits. 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.

Deep-dive audits are periodically conducted within specific areas with reports produced of current state and key recommendations. Regular daily, weekly and monthly processes are in place to monitor key areas such as the recording of patient demographics, the timely production of discharge summaries, and the correct recording and coding of clinical events.

The Information team have regular meetings with Clinical Systems team to review and resolve the current technical and reporting issues within main clinical systems.

The Data Quality team has regular meetings with Clinical Systems team to review and improve existing correction processes and to discuss emerging issues and ways to create a correction work flow.

A Data Quality Bulletin is presented to the Informatics committee which provides a summary of the Trust's local indicators as well as the benchmarked data for key indicators against London and National figures.

Homerton University Hospital NHS Foundation Trust are taking the following additional actions to improve data quality:

- The Data Quality Team are currently working on the improvement of ethnicity data completeness. Using the ethnicity from the Discovery Data Service, the team are updating the ethnicity on EPR for patients with upcoming outpatient appointments. By taking this action we expect there will be an improvement in the Trust's ethnicity completeness submissions.

- The Data Quality Team are also currently working on the clean-up of potential duplicates on the Health Information Exchange. This is a critical piece of work ensuring that Homerton holds one record for every patient who can be viewed by other Trusts and organisation's to ensure safe and effective clinical care.

- Improve our completeness in the Data Quality Maturity Index by incorporating low performing completeness datasets into our Data Quality dashboards. By reviewing these data sets in the DQ committees we are developing a dialogue to push improvement forward. For the Community Services Data Set this will include Language code, Ethnic category and Consultant Medium. For the Acute data sets this will include Ethnic Category and Decided to admit date.

2.2.10 LEARNING FROM DEATHS

During 2020/21, 680 of the Homerton University Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Reporting quarter 2019/20	Number of deaths	Number of completed MDT reviews
Quarter 1	189	149
Quarter 2	76	73
Quarter 3	143	142
Quarter 4	271	247

*Table 8: mortality reviews completed per quarter -*includes Covid-19 deaths*

Part of the mortality review process includes assigning likelihood that there were issues in the level of care that may have attributed to the death of the patient. These scores are estimated using the CESDI (Confidential Enquiry into Stillbirth and Deaths in Infancy) methodology which is defined as;

- CESDI 0 - No suboptimal care
- CESDI 1 - Suboptimal care, but different management would not have made a difference to the outcome
- CESDI 2 - Suboptimal Care – different care might have made a difference
- CESDI 3 - different care would reasonably be expected to have made a difference.

Following the reviews 9 patients (2%) of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient (CESDI 2).

At the Homerton, the CESDI score is agreed by the responsible Consultant and medical team and findings are documented on an electronic tool and shared through the governance process. The majority of all cases (as above) were reviewed either in a multidisciplinary forum or by a second independent reviewer who was not involved in the care of the patient.

If a CESDI score 1 or above is obtained the case will be discussed in a multidisciplinary forum which includes identifying areas of good practice as well as opportunities for improvement. Themes are extracted and presented in the quarterly Board report and discussed in the Mortality Leads meetings and where appropriate actions are attached and completed.

To provide assurance of the review process, a minimum of 50% of reviews scored as CESDI 0s are audited independently. However, many teams choose to review all of their cases by an independent assessor or in a multidisciplinary forum.

All reviews scored as CESDI 2's and above are investigated via the Trust's Serious Incident review process. For the purpose of this report the learning of all CESDI reviews that scored 2s are below;

(note there were no CESDI 3 reviews)

Overall deaths numbers are higher than in previous years in keeping with an increased mortality from COVID.

From April 2020 – March 2021 a total of 680 adult deaths occurred.

Overall 379 deaths occurred with COVID recorded on the MCCD (Medical Certificate of cause of death) as part 1 or part **2** from April 2020 – March 2021.

- Quarter 1: 124 out of 189 deaths,
- Quarter 2: 5 deaths out of 76 deaths,
- Quarter 3: 47 out of 144 deaths,
- Quarter 4: 203 out of 271 deaths.

For comparison in the year 2018/19 a total of 387 patients died of **all causes**, 2019/20 a total of 421 deaths of **all causes**.

Background information:

- Counted are both COVID swab positive deaths (which make up >90% of all COVID deaths) and a small number of COVID swab negative deaths ("clinical COVID", e.g. based on clinical presentation, imaging, supportive blood tests, lack of a better alternative diagnosis). Note: these are not routinely followed up by Post mortem results.

- All deaths with positive and negative swabs are reported to CPNS (COVID 19 patient notification system) by the Trust. A change regarding reporting regulations happened on 24.04.20 regarding swab negative deaths, which means that these are now included in CPNS data. ONS (Office for National Statistics) data however is based on MCCD information only which used to cause two different total of COVID deaths numbers. The Trust has reported all COVID deaths including swab negative deaths to CPNS from the beginning and an audit and reconciliation exercise happened in May 2020 and all but 1 death were reported as per the regulations to CPNS.

Key achievements made in 2020/21:

1) **COVID specific arrangement for deaths reviews and learning:**

Despite the time pressures of the Pandemic, the well-established mortality review process continued as evidenced by ongoing very high numbers of Consultant and MDT reviews:

Quarter 1: Consultant review in 100% of cases, MDT discussion in 79% of cases documented (more took place but were not captured on the tool).

Quarter 2: Consultant review in 100% of cases, MDT discussion in 96% of cases.

Quarter 3: Consultant review in 99% of cases, MDT discussion in 99% of cases.

Quarter 4: Consultant review in 98%of cases, MDT discussion in 91% of cases (some still pending as there is usually a time lag between death and mortality discussion).

For both waves of the Pandemic there was enhanced focus on multidisciplinary assessment of cases with ITU and some other Medical Speciality cases being additionally independently reviewed by a body of General Medical Consultants who were not directly involved in care of the patient in addition to the parent team in order to strengthen the review process. This was felt to be beneficial on both accounts and helped share learning more widely.

Both the ACU as well as the ITU mortality meetings were used as fora for wider Trust relevant learning of significant cases that stimulated debate and shared learning.

In addition some teams have put on shared learning events like academic afternoons or hosted a Medical Unit Meeting with the express wish to facilitate wider system learning, e.g. with regards to Continuous Positive Airway Pressure (CPAP) on the wards and escalation planning.

This work has build on other work that was already being conducted like the establishment of CPAP daily meetings and new guidance on escalation pathways for COVID.

2) End of life care / palliative care:

One theme from MDT mortality discussions that has been flagged by different members of the multidisciplinary team on several occasions was concerns about when and how to conduct end of life discussions.

An end of life SIM has been established as an action from it with the aim to improve staff skills in recognising the dying phase of a terminal illness, manage symptoms in dying patients appropriately and manage end of life care conversations with patient and relatives.

The end of life facilitator has also done work with different staff groups and the Palliative care team has also in a pilot expanded its working hours to a 6 day on site service to help facilitate face to face reviews which was well perceived (additional Consultant Palliative Care input is available at all other times on the phone).

There was a small but noticeable increase in the number of patients from wave 1 to wave 2 who were correctly identified as approaching the end of life where palliative care were able to assist in addressing symptoms and provide support for patients, their families as well where appropriate for staff members.

3) Independent scrutiny:

The Medical Examiner System was introduced nationally as part of the Department of Health and Social Care's death certification reforms programme for England and Wales.

The aim of the system is to address 3 key questions:

- What did the person die from?
- Does the death need to be reported to a Coroner?
- Are there any clinical governance concerns?

The system is designed to provide bereaved families with greater transparency and opportunities to raise concerns.

3 Medical Examiners have scrutinised cases since July 2020 (in an incremental way in keeping with guidance from the National Medical Examiner), with a fourth Medical Examiner recently having joined the team.

The Medical Examiners are accountable to the Regional Medical Examiner.

4) Structured Judgement reviews:

The Royal College of Physicians' structured judgement review (SJR) methodology is part of a whole range of measures intended for review of deaths for specific adult inpatients.

The Structured Judgement review is a validated research methodology which blends traditional clinical judgement based review methods with a standard format. The benefit is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care.

This requires the reviewer to make safety and quality judgements over phases of care. This is done by making explicit written statements about care for each phase of the hospital admission and to score each phase. The aim is to look at strengths and weaknesses of the caring process, to obtain information about what can be learnt about systems where care goes well and identify gaps or problems in the care process.

The AHSN (Academic Health Science Network) "Implementing Structured Judgement Reviews for Improvement" based on The National Quality Board Guidance 2017 suggests that each Trust should have mechanisms to review deaths of people;

1. With a Learning Disability
2. With a Serious Mental Health Illness
3. Those aged under 18 years

A pilot has so far run and a Standard Operating Procedure has been developed which recommends for completed structured judgement reviews to be reviewed in the 2 monthly Mortality Leads meeting and at this point fed back to the parent team and it is suggested that this is then included in the local mortality review process and that the electronic mortality tool is updated as appropriate. If an overall care score of 1 or 2 (poor or very poor care) is reached then this is referred to the Trust Incident reviewing process. These cases are also fed into the departmental governance structure.

2.2.11 SEVEN DAY 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

In July 2019 The Trust repeated the case note review exercise reviewing 100 patients admitted to the hospital.

Standard 2: Standard 2 – Time to first consultant review

87% of patients received a review within 14hrs. Considerable improvement was noted in those who received a review within that timeframe at the weekend (96%).

Clinical Standard 8: Once/ Twice daily Consultant reviews as appropriate

We met this standard for once-daily and twice-daily review patients admitted both during the week and weekend. This was the case in the last round of reviews as well. The decision of whether a patient requires twice daily review or once daily was based on the clinical needs of the patient using the standards set out in the national 7 day services guidance.

This exercise has not been repeated since that time because of the COVID pandemic. There has been no expectation from NHS England that board level assurance has been needed in the form of these case reviews since the first wave of the pandemic.

We continue to provide twice daily consultant reviews as per patient need as set out in standard 8.

For standard 2 we ensured we retained the same level of consultant review by increasing consultant presence during covid with doubled up consultant rotas during the surges and additional weekend working especially in January 2021 to meet the needs of the expanded medical inpatient population with a significantly higher acuity than normal.

The Trust continues to meet standards 5 and 6.

Future Plans – Seven Day Services

We will be guided by the national ask in this area with regard to what audits and notes reviews we undertake. We will continue to review incident reports and root cause analyses where there is any suggestion that there was a delay in consultant review.

2.2.12 SPEAK UP SAFELY

Speaking up and ensuring a culture of staff speaking up is at the heart of the Trust's refreshed People Plan; 'Our Homerton People'.
The Trust has two Freedom to Speak up Guardians in the Trust who have dedicated time to promote speaking up and support staff who speak up. In line with national regulations, the Trust has an executive lead (Director of People) and a named Non-Executive Director with responsibility for speaking up (Dr Michael Gill).

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. Following the Covid-19 pandemic and in line with national guidance, the Trust will submit data to the National Guardian Office on a quarterly basis, and will continue to present a six-monthly report to the Trust Board, is presented in person by the Freedom to Speak Up Guardians. This report includes details of live/closed formal cases that have occurred in the reporting period, actions taken and feedback received.

In addition the Trust has developed a number of staff networks that have widespread staff membership and provide further routes through which staff can raise concerns.
The Trust is also supportive of Trade Unions and actively supports staff to raise concerns via the local trade union representatives.

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 88% fill rate across medical and dental posts. 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 66 occasions. There has been an increase in recruitment activity due to during the last six months, which is likely attributed to a reduction in advertising during the peaks of the pandemic, and a "back log" created.

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 and the exact form of each of these statements is specified by the quality accounts regulations.

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; NHSI Quality indicator ref 12

Data for 2020/2021 has been impacted by the Sars – CoV2- Pandemic. Additional caution needs to be taken when interpreting SHMI data.

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

The data in table 9 below describes the SHMI has been sourced from HED, Trust benchmarking tool. The data period is from Jan'20 to Dec'20. Our Trust SHMI score is 85.16 which equates to NHS Digital Band 3 (lower than expected deaths when compared to the national baseline).

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest 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
	Jan 2019 – Dec 2019	Value:0.77 Banding: 3	Value: 1.004	Value:1.1999 Banding: 1	Value: 0.6889 Banding: 3
	Jan 2020 – Dec 2020	Value:0.85 Banding: 3	Value: 1.0016	Value:1.1845 Banding: 1	Value: 0.7030 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	45.40%	31.60%	11.50%	59.80%
	Oct 2017 – Sept 2018	43.60%	33.80%	14.30%	59.50%
	Jan 2018 – Dec 2018	46%	34%	15%	60%
	Jan 2019 – Dec 2019	48%	36%	10%	60%
	Mar 2019 – Feb 2020	51%	37%	10%	59%
	Jan 2020– Dec 2020	47%	37%	8%	61%

Table 9: SHMI scores since 2016 to 2020(NHS Digital)

Assurance Statements

Data for 2020/2021 has been impacted by the Sars – CoV2- Pandemic. Additional caution needs to be taken when interpreting SHMI data.

The data for SHMI has been sourced from HED, Trust benchmarking tool. The data period is January 2020 – December 2020 which includes wave 1 of the Sars CoV 2 Pandemic and in part wave 2 of the Pandemic. The SHMI is not designed for this type of Pandemic activity. Our Trust SHMI score is 0.85 and banding is a NHS Digital Band 3 (lower than expected deaths when compared to national baseline) which is a trend which has continued from previous years.

How is Homerton University Hospital NHS Foundation Trust doing?

1) The electronic mortality review tool has been in use since October 2018. It continues to have very high levels of engagement (for the year 2020/21 the following an MDT or second independent senior reviews of deaths took place for each Quarter: Quarter 1: 79%, Quarter 2: 96%, Quarter 3: 99%, Quarter 4: 93%. The high levels of ongoing engagement with the learning from death mortality review process pre Pandemic have continued throughout the Pandemic (with a short period during the height of each wave when reviews were delayed and then picked up again). New ways of supporting other teams have been established through a process

where an independent second Consultant Assessor from a different speciality has supported this process for certain areas with particularly high clinical workload which has added additional rigour to the process.

2) The Palliative Care team has worked in additional and close direct liaison with individual clinical teams during this period and has provided additional support for patients close to or at the end of life with individualised care plans and support. This has been possible through an expansion of the hours worked on site which has included additional weekend (Sunday) cover. Training on recognition of the End of life has been ongoing with different staff groups and a new SIM has been developed for recognition and communication of end of life scenarios to help build staff confidence.

2. Patient Reported Outcome Measures (PROMS) – NHSI Quality indicator ref 18

Patient Reported Outcome Measures (PROMS) is a questionnaire based tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. All patients are asked to participate in the scheme which 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.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Hip Replacement Surgery	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient records to calculate data (23 but 30 needed to report, n= 110 surgeries)			
	Apr 2018-Mar 2019	**0.546**	0.500	0.360	0.550
	Apr 2017 – Mar 2018	**0.478**	0.458	0.357	0.550
	Apr 2016 – Mar 2017	**0.467**	0.437	0.329	0.533

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
Total Knee Replacement Surgery	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient records to calculate data (24 but 30 needed to report, n=94 surgeries)			
	Apr 2018-Mar 2019	**0.339**	0.300	0.250	0.400
	Apr 2017 – Mar 2018	**0.332**	0.337	0.254	0.406
	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.391
Groin Hernia Surgery	April 2020-Mar 2021	**Not available at time of publication**			
	Apr 2019-Mar 2020	Insufficient numbers to be included			
	Apr 2018-Mar 2019	**No data***	Insufficient numbers to be included		
	Apr 2017 – Mar 2018	**No data***	Insufficient numbers to be included		
	Apr 2016 – Mar 2017	**0.048**	0.086	0.006	0.135

Table 10: PROMS data for hip, knee and hernia surgery.

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.
- Reviewing PROMs data and findings and discussing these within relevant departments.
- Reviewing PROMS data on a regular basis through the Improving Clinical Effectiveness Committee.

3. 28 day emergency readmission rate - NHSI Quality indicator ref 19

Every acute Trust submits their admitted patient activity to Secondary Uses Services (SUS) as per the mandated timetable. Every month the submitted SUS data is cleansed by HES (Hospital Episodes Statistics). This dataset is provided to authorised organisations like HED.

The readmissions data is based on PbR (Payment By Results) logic.

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	2019/20	4.97% (National average 10.02%)
	2018/19	4.36%
	2017/18	4.66%
	2016/17	3.63%
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	2019/20	9.12% (National average 8.30%)
	2018/19	12.60%
	2017/18	11.95%
	2016/17	12.7%

Table 11: 28 day readmission rates for patients aged 0 – 15 and aged 16 and over. Source is HED benchmarking tool.

Assurance statements

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

The Trust uses the 30 day readmission standard rather than 28 day readmission.

The Trust has a robust clinical coding and data quality assurance process, and 30 day readmission data is monitored through the Trust Management Board on a monthly basis. The Trust board readmission rates have agreed local exclusions applied over and above the PbR logic.

The Trust has the following to support regular monitoring and take actions as required

- Information team has developed an electronic readmissions report that enables local services to drill down seamlessly from Trust wide through divisional to local level and identify possible causes of the increased readmission rates.

- The utilisation of the readmission report has been discussed within the Trust's Improving Clinical Effectiveness Committee with a view that the Divisional Leadership teams will oversee the specialties in the real time tracking and interventions to reduce readmission.

4. Responsiveness to personal needs of patients – NHSI Quality Indicator 20

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.

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.	2019/20	64.7	67.1	60.0	84.2
	2018/19	63.4	67.2	58.9	85.0
	2017/18	68.1	68.6	60.5	85.0
	2016/17	66.3	68.1	60.0	85.2

Table 12; responsiveness to personal needs – source NHS Digital; NHS Outcomes framework

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.

With the increase in demand for our services, we continue to report a high number of patient satisfactions. The Trust acknowledges that sometimes it may not be as responsive as it would like to, especially when the system is under pressure.

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

- The Trust actively supports staff completing quality improvement projects to ensure that care is tailored to individual needs.
- The review of learning from the communications team developed through the pandemic to shape ongoing work on patient experience
- The training of staff in communicating in PPE
- The continued focus on first impressions and work to improve this area of experience
- The ongoing implementation of Swan Scheme on all wards has seen staff more aware, sensitive and respect for the dying. End of Life patients receive personalised care.
- Service specific user engagements guarantee patients have the opportunity to discuss their views and concerns on what really matters to them to/with the right people.

5. Staff recommending the Trust as a place to work or receive treatment to Family and Friends. – NHSI quality indicator 21

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.

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	2020	**77.0**	74.3	49.6	91.7
	2019	**76.2**	69.0	N/A	N/A
	2018	**75.1**	69.9	49.2	90.3
	2017	**73.4**	70.2	48.0	89.3

Table 13: Staff survey response – "happy with standard of care" (Picker)

Assurance statements

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

- The survey was conducted on behalf of the Trust by Picker Institute, an approved provider by NHS England. All full and part time staff employed by the organisation on the 1st September 2020 (with certain specific exclusions) had the opportunity to complete the survey electronically between October and November 2020. The Trust achieved a return rate of 47.6%, which represented decrease of 8.5% from 2019.
- We have performed above the national average for staff recommending friends and family as a place to be treated with the score improving by nearly 4% since 2020.

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:

- Implementing 'Our Homerton People' plan - The plans and projects that will deliver the improvement in our people's experience be made of the following key elements:
    - People matter at Homerton Healthcare
    - Achieving equality and inclusion for our people
    - Creating a values-led organisation for all our people
    - Supporting the health and wellbeing of our people
    - Developing our people's potential

6. Rate of admissions risk assessed for VTE - NHSI Quality Indicator 23

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill-health problems – many of which are avoidable. It is estimated that as many as half of all cases of VTE are associated with hospitalization for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognized as a clinical priority for the NHS in England**.**

During the 2019/20 the trust continued to ensure that more than 95% of patients admitted to hospital had a VTE risk assessment completed as per NICE guidance. Over the course of that year we focused on

improving the quality of these assessments. Findings from previous Root cause Analyses performed for patients who had developed VTE associated with a hospital stay showed that sometimes the process of completing the risk assessment is not directly tied to the prescription of appropriate VTE prophylaxis.

To respond to this in March 2020 we launched a redesigned VTE risk assessment form as part of our electronic patient record which provided enhanced clinical information such as relevant blood test results within the form and which contained the prescription embedded within it. This ensured that the quality of the risk assessment process remains consistently high and that the actions of risk assessment and responding to that risk with the appropriate prescription of thromboprophylaxis remain linked in each case.

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.	2020/21	Q1	**88.9**	N/A	N/A	N/A
		Q2	**86.3**	N/A	N/A	N/A
		Q3	**85.7**	N/A	N/A	N/A
		Q4	**88.5**	N/A	N/A	N/A
	2019/20	Q1	**95.6**	95.6	69.8	100
		Q2	**95.9**	95.5	71.7	100
		Q3	**96.2**	95.3	71.6	100
		Q4	**93.6**	*	*	*
	2018/19	Q1	**95.5**	95.6	75.8	100
		Q2	**97**	95.5	68.7	100
		Q3	**96.9**	95.7	54.9	100
		Q4	**96.2**	95.7	74.3	100
	2017/18	Q1	**97**	95.2	51.8	100
		Q2	**96.7**	95.3	71.9	100
		Q3	**97.4**	95.4	76.1	100
		Q4	**96.6**	95.2	67	100

*Table 14: VTE risk assessment data (NHS Digital); *Q4 publication delayed due to Covid*

Following this change there was unfortunately a drop off in VTE performance. The new VTE process is clinically safer for patients who have it completed (because it links the VTE risk assessment directly to

the prescription of prophylaxis and has far more data relevant to decision making displayed within the form). However despite this improvement in quality of assessment there was a fall in % completion.

This was quickly picked up as an issue and is discussed on a monthly basis by the trust board.

The reasons for this fall in performance include:

1) Changes in the alert that a VTE risk was not completed- previously these forced a decision before all the relevant information was available but in response to the concerns described above these have been changed to regular reminder pop ups.

2) As activity has moved around the hospital there may be some issues with data quality especially in surgical specialties where some patients not admitted to hospital may have been counted in totals

3) The upsurges of covid and associated redeployment of staff

Assurance statements

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

There is a clear plan in each division to tackle the fall in VTE performance. The Associate Medical Directors in association with the Divisional Governance Leads review performance weekly and report to the Medical Director on their improvement plans.

In order to address this issue an icon flag has been added to the inpatient view on EPR which provides a pictorial summary for all alerts for all inpatients which clearly shows who has an outstanding VTE assessment.

The acute admitting wards; ACU and Lloyd, have appointed “VTE champions”-and weekly performance is feedback to the junior doctors; this has led to a real improvement in completion of forms for medical admissions with IMRS performance in March of > 90%.

The SWISH team are working with the Quality improvement team to understand both the data quality and clinical performance issues to develop a full range of interventions to improve performance for patients admitted under surgical specialties. We would expect this approach to lead to the same performance improvements seen in IMRS.

It was important to address the safety concerns we have identified in previous years. VTE risk assessment is a surrogate marker for a complex process of risk assessment and decision making that needs to be patient centred and seamless.

Whilst the challenge of reduced form completion rates is being taken very seriously and this package of interventions along with the safer redesigned form will lead to a higher quality process for each patient moving forward will be reviewed regularly going forward; performance will be reported within the Trust’s governance framework

7. Clostridium difficile rate - NHSI Quality Indicator 24

In the financial year 2020-2021, there were 10 Trust-attributable C.difficile toxin positive cases against Public Health England's very low target for the Trust of 12 cases. This was despite the extraordinary pressures put on the staff at the Trust by the COVID pandemic including the higher than usual use of broad spectrum antibiotics to cover for possible secondary bacterial chest infections in COVID patients. This demonstrates the educational work performed by the Antimicrobial Stewardship Team to ensure that inappropriate antibiotic use was minimised and the commitment by the ward teams to follow that advice closely in very pressurised circumstances and should be formally recognised.

Of the 10 Trust-attributable C.difficile toxin positive cases, 1 was defined as 'community onset healthcare associated' (COHA). COHA cases are those occurring in the community/within 2 days of admission when the patient has been an inpatient in the reporting Trust in the previous 4 weeks. The other 9 were defined as 'hospital onset healthcare associated' (HOHA). HOHA cases are those detected in the reporting Trust two or more days after admission. Although the formal 'Post Infection Review' root cause analyses are still in progress for a number of the cases due to the backlog of reports as a result of the pressures of the COVID pandemic, the 'lapse of care' findings on preliminary review are as follows:

Month	Lapse of care issues	Category of case
April-20	Delay in side room isolation	COHA
Nov 20	Delay in sending of stool sample & side room isolation	HOHA
Dec 20	Delay in consideration of C.diff infection/Delay in sending of stool sample & Side room isolation	HOHA
Dec 20	Delay in sending of stool sample & side room isolation	HOHA
Dec 20	Delay in sending of stool sample & side room isolation	HOHA
Jan 20	Delay in sending of stool sample & side room isolation	HOHA
Feb 20	Delay in side room isolation	HOHA
Feb 20	Delay in consideration of C.diff infection/Delay in sending of stool sample & Side room isolation	HOHA
Feb 20	Nil	HOHA
Mar 21	Delay in sending of stool sample & side room isolation	HOHA

Table 15: Lapses of care identified

Assurance statements

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

In the 10 Trust-attributable cases, there were no 'lapse of care' issues related to cross-transmission or inappropriate antibiotic use. Only 4 cases were in long-term inpatients and only 7 cases were in patients over 65 years of age, indicating good adherence to the Trust's antimicrobial policy. Two cases were admitted with diarrhoea and their C.difficile infection, from a clinical perspective, was community-onset. However, due to delay in recognition of the possible diagnosis and therefore sending of the stool sample, from the PHE perspective these were HOHA cases. The main theme form review of the cases was the delay in sending stool sample once the patient met the criteria for C.difficile testing and the delay in side room isolation. It is probable that this was, at least in part, due to the pressures of caring for a large number of patients with COVID and therefore a decrease in awareness of other infection issues.

The Trust remains committed to minimising the risk of any avoidable C.Difficile case and 'Post Infection Review' root cause analyses are performed on all trust-attributable cases where there are possible 'lapse of care' issues so that the learning from these reports can be shared across all stakeholder groups.

8. Patient Safety Indicators – NHSI Quality Indicator 25

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'.

Indicator	Reporting Period	Homerton Performance		National Average*	Lowest Performing Trust*	Highest Performing Trust*
Number of patient safety incidents	Oct 2019 – March 2020	**2502**		6502	1271	22,340
Rate of patient safety incidents (per 1000 bed days)		**56.65**		50.66	15.7	110.2
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**3 (0.12%)**	14 (0.24%)	0 (0.0%)	91 (0.8%)
		Death	**0 (0%)**	5 (0.10%)	0 (0.0%)	22 (0.6)
Number of patient safety incidents	Apr 2019 – Sept 2019	**2772**		6276	1392	21,685
Rate of patient safety incidents (per 1000 bed days)		**65.39**		50	26.3	103.8
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**4(0.1)**	14.6 (0.0018%)	0 (0%)	76(0.4%)
		Death	**0(0%)**	4.8 (0.0005%)	0 (0%)	24(0.7)
Number of patient safety incidents	Oct 2018-March 2019	**2917**		5841	1278	22,048
Rate of patient safety incidents (per 1000 bed days)		**64.82**		46	16.9	95.94
Number (%) of patient safety incidents resulting in severe harm or death		Severe	**6(0.2%)**	13.7(0.00185)	0 (0%)	62(0.3%)
		Death	**3(0.15)**	5.1(0.00075)	0 (0%)	23(0.3%)
Number of patient safety incidents		**3151**		5449	1311	19897

Rate of patient safety incidents (per 1000 bed days)	Oct 2017 – March 2018	**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)

Table 16: reported patient safety incident data uploaded to NRLS; (NHS Digital)

Assurance statements

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

The Trust submits all eligible incidents to the National Reporting and Learning System. The latest information available from NRLS (October 2019 – March 2020) does not cover this reporting period (2020/21). For this period, Homerton was noted as a relatively high reporting Trust when compared nationally (see figure 2 below).

Figure 2: reporting to the NRLS October 2019 – March 2020

During this period, there were 56.65 incidents reported per 1000 bed days, a decrease from 64.82 incidents per 1000 bed days over the same period in 2018/19. It should be noted that these figures relate to when incidents are uploaded into the NRLS system rather than when they occur or are reported within the Trust. Work has been going on throughout 2020/21 to improve the internal incident approval process and thereby improve the timeliness of reporting to NRLS.

A number of broad areas of work will be prioritised during 2021/22, including:

- Implementation of the Patient Safety Strategy, and in particular ensuring the Trust is fully prepared for the introduction of the new Patient Safety Incident Response Framework, which will replace the SI Framework during 2021/22. This will require a significant programme of work involving staff across the whole organisation. The Head of Patient Safety has been identified as the Trust's Patient Safety Specialist, and will be linking into a national network of people in the same role to ensure the Trust is linked into all relevant national programmes of work.

- Continuing the Datix improvement project,which during 2020/21 has focused on developing and improving the complaints, claims and risk register modules. During 2021/22, the dashboards module more widely across the organisation.

- Further strengthening the way in which learning from incidents and investigations is shared and in particular working more effectively with the legal, complaints and PALS teams to ensure that information is shared in a useful and timely fashion, and so that themes that cut across complaints / incidents / claims etc can be identified. A new Quality and Patient Safety Manager has been appointed to lead on this work.

- We will undertake a review of the way in which patients and their families are involved in the investigation process, including looking at the Duty of Candour process and the ways in which investigation reports are shared with the family. This objective has been carried over from last year's plan.

- Working to develop a more comprehensive training programme for staff around different aspects of patient safety, including Duty of Candour, human factors and investigation techniques. This will link into the national patient safety syllabus which has been developed as part of the Patient Safety Strategy.

Ensuring that the team remains flexible and responsive so it can respond to any future challenges presented by COVID-19 and continue to support the rest of the organisation as required

9. Patient Experience: Friends and Family Test

Since 2013/14, providers of NHS healthcare have been asked to consider reporting on the patient element of the Friends and Family Test in the quality accounts (as part of the letter referred to on page 4 of this document). As this is not a statutory requirement, the patient element of the Friends and Family Test it is not reported in the same way as the indicators above.

Homerton Hospital works hard to ensure that our patients and their families have the best possible experience of our treatment and care.
Receiving feedback is vital in improving our services and supporting patient choice and to support this, alongside our existing feedback collection methods, we are exploring alternative means of participation in all of our patient experience work, to offer greater options for service users to provide feedback on their experience of care.

We strive to improve patient experience and has successfully maintained a high rating and work continues to guarantee that patient experience on the care delivered meets the expectation of those who use our services.

During the pandemic the collection of Friends and Family data was suspended and so the trust is not able to report any data for the full year. Data collection has recommenced and this will be reported on a regular basis to the Board and in the 2021/22 Quality Account.

3.0 Part 3: Other information

3.1 Overview of the progress with the Trust's 2019/20 quality priorities

The following summary slides describe the progress of each quality priority, the actions taken to drive the priorities and the key risks identified going forward;

1. To reduce the number of community and hospital attributed pressure ulcers

Back ground

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 preventable financial pressures.
There is continued national focus on the need to reduce the number of pressure ulcers both hospital and community acquired. The new neighbourhoods model that will be operating in our community will aim to improve collaborative multi-agency work and reduce pressure ulcer incidence.

Metrics

- Number of preventable hospital acquired pressure ulcers category 3 and above
- Number of preventable community acquired pressure ulcers category 3and above
- Number of preventable hospital acquired pressure ulcers category 2
- Number of preventable community acquired pressure ulcers category 2

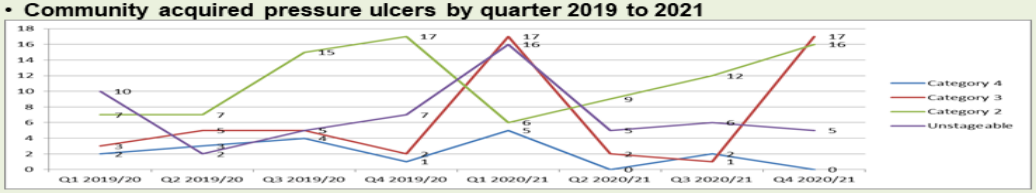
Updated:
June 2021

Position update

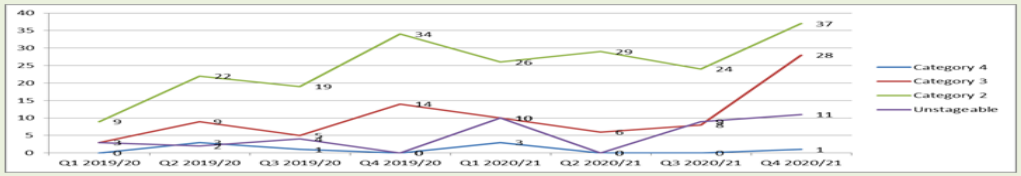
Aim of priority when originally launched

- Reduce the number of category 3 and above pressure ulcers by 10%
- Reduce the number of category 2 pressure ulcers by 5%

- Review methodology of reporting pressure ulcers
- The pressure Ulcer Scrutiny Committee (PUSC) continues to meet with Therapy and Dietetics now attending
- A Thematic analysis of all category 2 and above pressure ulcers HUH recorded from 1st April 2020 till 31st March 2021, identified the similar themes for the acute and community:
  - Skin inspection, Lapses in the implementation of PU prevention/management interventions and Lapses in documentation
- **Community acquired pressure ulcers by quarter 2019 to 2021**



- **Homerton Hospital acquired pressure ulcers by quarter 2019 to 2021**



- Worldwide there has been an increase in the incidence of the pressure ulcers in patients who are severely unwell with Covid 19 and this is likely due to the hypercoagulability, which affects the microcirculation, and subsequently leads to ischaemia (NPIAP, 2021). The pandemic has also led to an unprecedented bed occupancy/high turnover of patients, workforce challenges among others, which has had an impact in following all the actions that the Trust had initially planned for (for e.g. regular auditing, thorough skin inspection within 6h of admission etc.)
- Following the 1st Covid wave, a Covid 19 Contigency plan was developed and actioned during the 2nd Wave (Winter) which showed to be effective and led to a reduction of 19% of incidence of PUs in ITU setting.
- In the community setting, Wound Multidisciplinary Team meetings, including Foot Health, TVN and Community nurses have been taking place each month since September 2020.
- Pando app has been implemented, which allows staff to share photos of the wounds (with patients' consent) and get support from the TVN team as required
- Tissue Viability team participate in the Worldwide "Stop the Pressure Ulcer Day"

Actions to sustain

- Complete QIP
- Action plan to improve the assessment of patient's skin in accordance to national guidance, ensuring the assessment is correct and escalation is appropriate.
- Ward managers are already auditing pressure ulcer care as part of the Perfect Ward.
- Covid-19 contingency plan
- To continue with Wound MDT meetings in the community

Key risks going forward

- Mini-rcas not always being completed in a timely matter.
- Improvements to reports generated from Datix
- Replacement of the monthly national Safety Thermometer audit tool.
- Timely completion of root cause analysis

Outcome

Carried forward from 2018/19 on 2 year cycle.

Continued oversight to be provided by the Improving Patient Safety Committee

2. Improve the safe management of medicines within the organization

Back ground

New priority for 2020/21

Stakeholder survey identified a need to support and improve the safe and secure handling of medicines, learning from medication incidents and embedding best practice.

Missed/omitted doses can impact upon patient physical and mental wellbeing, delayed discharges, bed management and staff morale.

Metrics

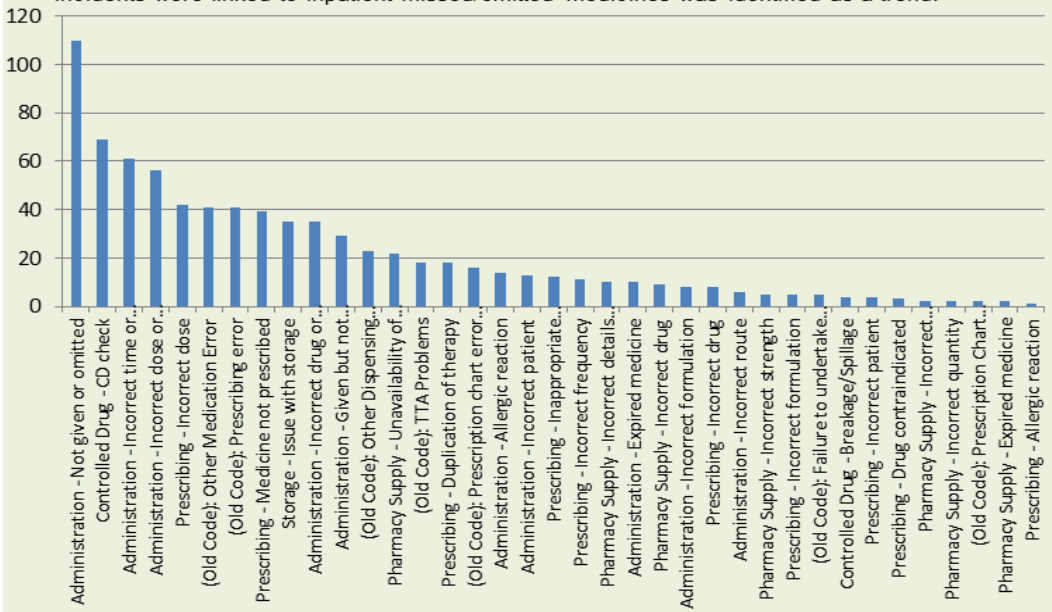
To be agreed by Working Group

- Number of missed/omitted doses for inpatient medication recorded on Datix
- Further metrics to be identified by T&F Group

Updated:
May 2021

Position update

- Established working group for quality priority
- Review of the medication incident data on Datix for 2019 identified 13% of all medication incidents were linked to inpatient missed/omitted medicines was identified as a trend.



- Omitted medicines audit completed March 2021,reviewed EPR records for 7476 omitted or delayed administration during November 2020;
  - 40% patient refusal, 21% reason not documented, 20% various clinical reasons, 9% medication unavailable, 6% incorrect route (NBM or no IV access)
  - Templar ward identified over 300 incidents of missed medication due to medications that was meant to be discontinued after delivery but was not discontinued on EPR; linked to non documentation for reason of non-administration
  - Common medications refused were analgesics and laxatives.
  - Prescription of STAT medications not communicated to nursing teams

Actions to sustain

- Implement action plan to reduce missed/omitted medication based on audit
- Link with NICU medication QIP
- Develop links to Medication Safety Strategy and relevant re-audits;
  - Develop local critical medicines list
  - Introduce regular missed medications report
  - Improve training of IV medication
  - Trust wide annual safe & secure handling of medicines audit
  - Medicine administration chart (MAR) audit on MSNH, HTNRU & community services

Key risks going forward

- Impact on resources of Covid-19.
- Launching new quality priority
- Nurse training for IV access
- Linking to NICU medication QIP

Comments

New priority 2021/22

Oversight to be provided by the Improving Patient Safety Committee

3. Reducing physical violence and aggression towards patients and staff

Back ground

Carried forward from 2018/19 and then into 2020/21

The most recent national 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.

Metrics

- Number of V&A incidents recorded on Datix
- Feedback following NHS Staff survey
- Number of Red/yellow cards issued to patient/visitors (28 yellow cards and 1 red card)
- Local implementation of the national strategy

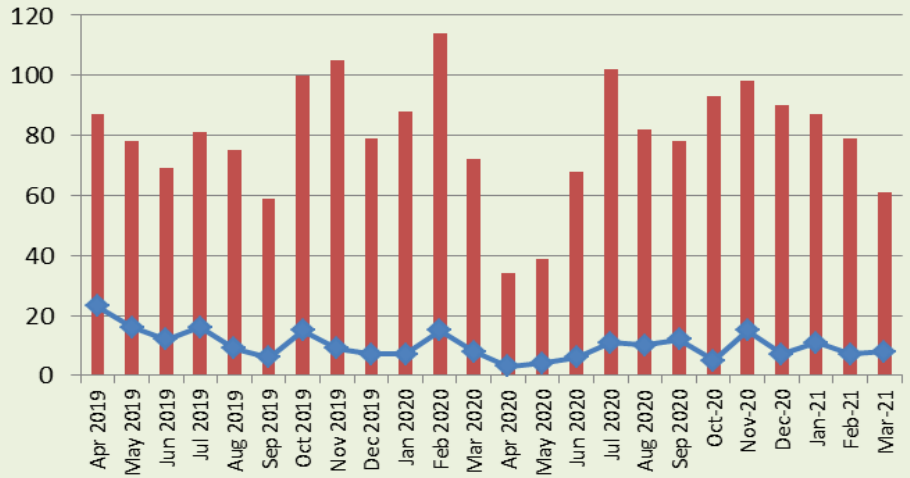
Updated:

May 2021

Position update

- Reduction of physical assaults on staff by 43% for 2019-2020 FY
- Reduction of physical assaults on staff by 31% in 2020-2021 FY
- Improved reporting of violence and aggression continues as the number of total violence and aggression increased each year but reduction in physical assault is a positive result.
- Increased number of yellow and red cards issued (31 yellow & 4 red)
- Continued partnership with Met Police on Operation Cavell, 4 police community protection notice issued (CPW).
- Increased number of reported crimes to police which shows staff are more confident in escalating incident with police as there is better support and result.
- Increased number of convictions and fines resulting from offenders being arrested by the police for V&A incidents.

Actual physical assaults (blue line) versus V&A incidents reported (red columns)on Datix



Actions to sustain

- Further reduce physical assaults on staff
- Restart the Enhanced Maybo Conflict Resolution Training for staff to give them better knowledge and skills to deal with violence and aggression and deescalate situations.
- Continue raising awareness and improve reporting on Datix
- V&A champions in each areas to support staff
- Staff not to tolerate violence and aggression and seek sanctions through yellow and red card
- Support community services with better police support from issuing CPW and support in joint risk assessments for high risk home visits
- Effective roll out of new lone worker device solution to support staff working alone.
- Quarterly review by Health & Safety Committee

Key risks going forward

- Raised awareness of the issue may result in an increase in the number of incidents reported by staff on Datix.
- Embedding the use lone worker devices
- Delivering Maybo training on-going

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Safety Committee

4. Improve multidisciplinary falls assessments and individualised management plans of inpatients and the support given to both patients and staff post fall

Back ground

New priority for 2020/21

CQC survey identified a need to Improve multidisciplinary falls assessments and individualised management plans of inpatients and the support given to both patients and staff post fall.

Metrics (Proposed)

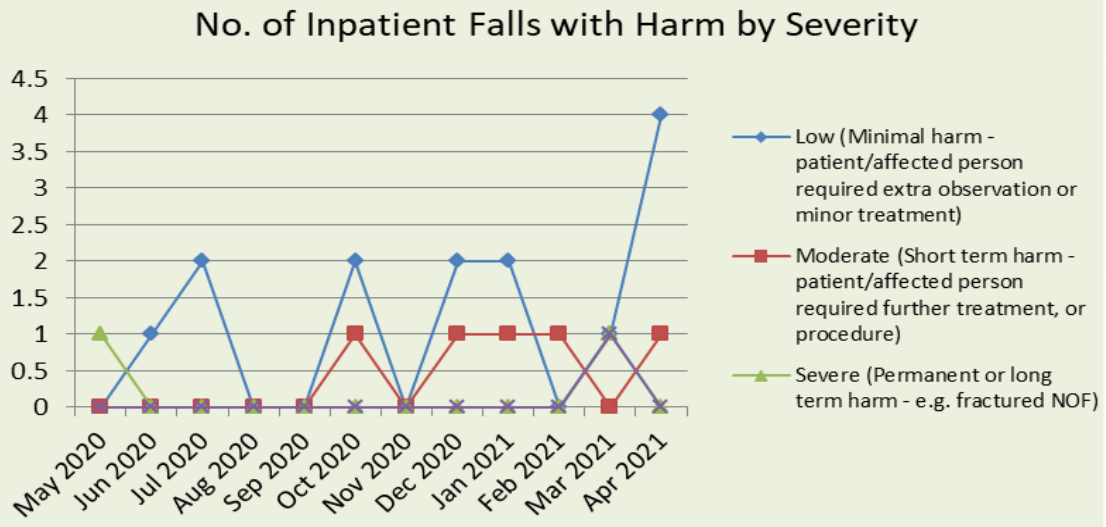
Metrics to agreed by working group.

- the number of patients with documented MDT individualised falls management plan
- Inpatient Falls Per 1000 Bed days
- Number of inpatient falls with harm

Update:
May 2021

Position update

- Quality priority to be progressed by Strategic Falls Group and the Falls Working Group
- Ward based training on personalised care planning for band 5 & 6 Nurse's completed in April. A 2 week mini audit and, spot check and micro teaching planned for every 2 weeks until the end of June.
- Started focused MDT project on ECU – progress limited due to wave 2
  - Project registered with QI team
  - Based on learning from Falls care plan audit
  - Audit of therapies manual handling assessments and use of mobility charts
  - Aiming to improve individualised falls care plan documented in nursing care plan
  - In planning stage of PDSA – will liaise with QI team for support
- Initial focus on ECU – then plan to share learning and consider what change ideas could have impact across the trust
- Post fall support for patients and staff will continue into 2021/22
- Continued audit of falls reported on Datix to identify themes and trends



Actions to sustain

- Integrate quality priority into Strategic Falls Group Action Plan Work Streams
- QI project on ECU
- Implement actions of Falls care plan audit
  - Improve completion of falls assessments
  - Improve completion of falls management plans
- Follow up on the Therapies manual handling and mobility chart audit
- Yearly falls awareness week to be held in October
- Yearly Audit of falls with Harm
- Staff feedback on managing patients who have fallen
- Review of priority progress and aims

Key risks going forward

- New quality priority
- Continuation of audits during Covid

Outcome

Continue priority for 2021/2022

Continued oversight to be provided by the Improving Patient Safety Committee

5. Learning from complaints, incidents, claims and compliments

Back ground

Carried forward from 2019/20

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 feedback to staff and shared across the organisation and practice is changed to prevent recurrence..

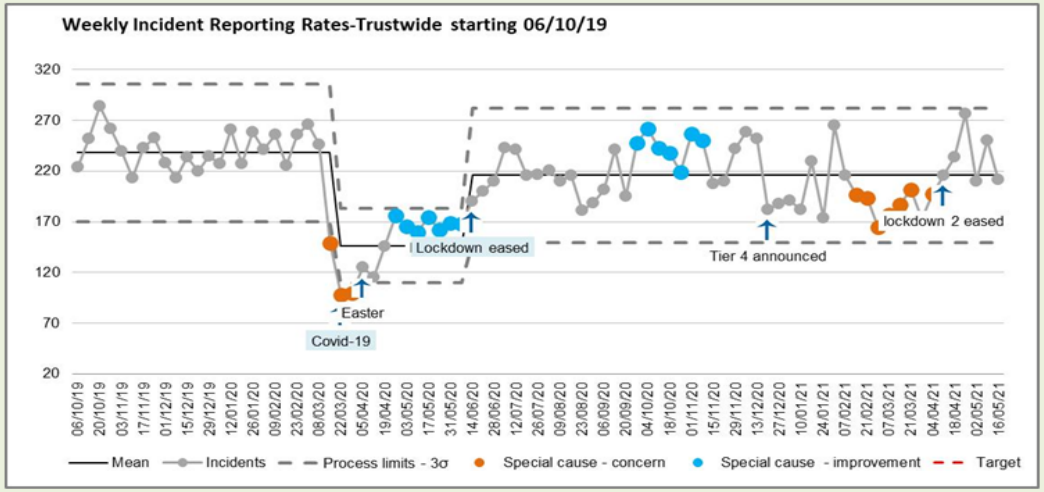
Metrics

- Evidence of sharing the learning from incidents with patients (Duty of Candour audits)
- Evidence of learning from Serious Incidents shared with staff
- The number of incidents reported on Datix
- Patient feedback from PALS and Complaints
- Number of incidents open beyond agreed timeframe (20 days)

Update:
May 2021

Position update

- Updated Datix incident categories and reporting forms, easier to extract themes and learning – resulted in increased reporting
- Resumed training to specific departments on claims, inquests and advisory work including department specific statistics on claims and also themes of claims.
- Migrated all claims and inquest management onto Datix web to ensure that data can be analysed efficiently and develop further links with the complaints and incidents work streams
- Establish closer links with the Patient Safety and Complaints team to review wording in SI/RCA's and complaint responses to ensure they adequately reflect the facts of the case and ensure that any claim related concerns are raised early.
- Ensure effective communication internally to ensure that once a claim or inquest has concluded, that all learning is shared and any actions are completed.
- Attending SIR meetings to identify areas of care that may require further investigation to enable a more rounded analysis and give an indication of weaknesses in a potential claim.
- Working closely with NHSR to improve the relationship with the Early Notification Scheme leaders and to learn from themes and trends in maternity care.
- Completed recruitment into Patient Experience team
- Completed recruitment of trust wide Q&PS Manager dedicated to developing actions plans and sharing the earning from SI's
- Statistical Process Control charts for incident data include in Governance reports.



Actions to sustain

- Finalise process to disseminate learning to staff outside of formal meetings (SI learning alert)
- Develop support from QI Team
- Introduciton of Datix dashboards for incidents, complaints and claims
- Review of Datix modules for claims and complaints
- Scoping exercise with Patient Experience and Claims
- Robust mortality review process.
- Support the timely closure of incidents based on agreed metrics
- Implement Patient Safety Strategy

Key risks going forward

- Further development of after action review process required
- Launch of post serious incident learning
- Covid-19
- Datix development

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Safety Committee and Improving Clinical Excellence Committee

6. Appropriate identification and management of deteriorating patients extended to maternity and neonates

Back ground

The Deteriorating Patient Group (DPG) to build upon the work established in 2018/19.

The DPG will continue to support the adult work stream.

This priority will be extended to initially include maternity and then neonates.

Metrics

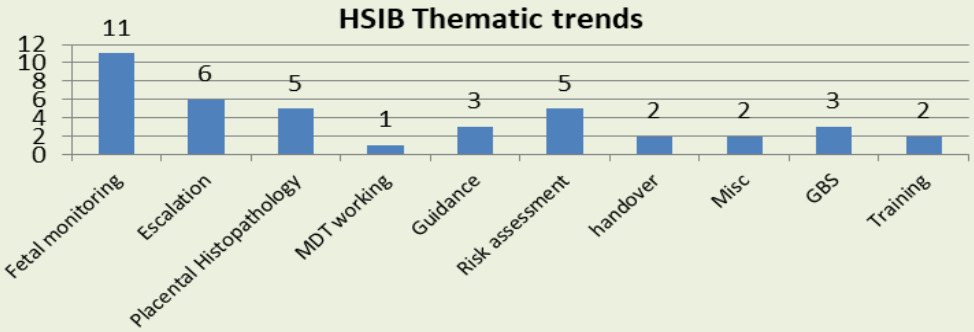
Metrics to be agreed by working group based upon:

- Appropriate escalation of Neonatal Early Warning Triggers(NEWTT) score
- Appropriate escalation of Cardiotocography (CTG)
- Audits of patient notes- recording escalations and actions taken

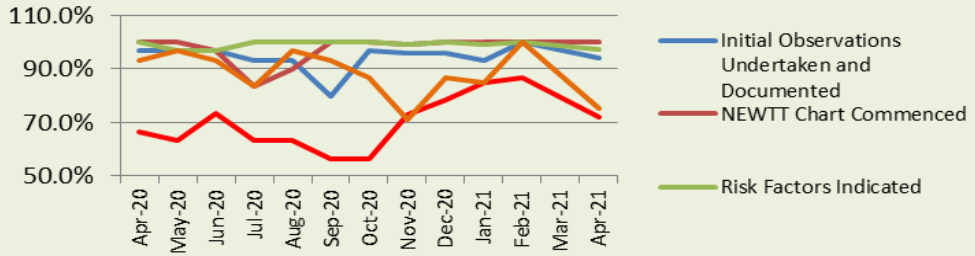
Update:
May 2021

Position update

- Identified key staff to patriciate in maternity style Deteriorating Patient Group
- Thematical analysis of the outcome of maternal investigations completed by the Healthcare Safety Investigation Branch (HSIB



- NEWTT refresher training on the principles of NEWTT scoring undertaken and training slides shared with staff
- Utilise staff working remotely to complete real-time reviews of NEWTT score
- Increase the number of computers to enable to timely recording of observations
- Exception reporting at MRMR meetings
- Audit monthly of NEWTT compliance and metrics identified, opportunities to improve identified



- Support from QI Team to identify approach to further embed progress
- Identified community based improvements for deteriorating children to include policies, review mechanisms, training of school based staff, reporting metrics and establish membership of T&F group.
- Explore outcome of nation pilot scheme to plan next steps for deteriorating children on the acute site

Actions to sustain

- Establish 'maternal deteriorating patient' Task and Finish group
- Categorise CTG's to establish normal, suspicious and pathological (when escalation is needed)
- Expand timeframe for continuing priority into 2021/22
- Continue NEWTT audit – introduce SPC analysis
- QI Team support to meet compliance targets
- Launch Maternity Oversight Group
- Develop service improvement plan with support from Deteriorating Patient Group
- Introduce priority into CSDO for appropriate paediatric work streams and metrics in the community and on the acute hospital site

Key risks going forward

New/extended quality priority

- Establishing Task & Finish group
- Impact of Covid-19
- Introduce priority into CSDO for deteriorating children on both community and acute settings

Outcome

Priority modified to support maternity and paediatric services during 2021/22.

DPG will support and advise working groups. Progress to be reported to the Improving Clinical Effectiveness Committee.

7. Making Every Contact Count (MECC)

Back ground

Carried forward form 2019/20

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.
Implementing MECC in partnership with the Commissioners 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.

Metrics

- Friends and Family Test
- NHS patient Survey
- PALS and complaints

Further metrics to be advised by task and finish group

Update:
May 2021

Position update

- Hackney council-funded MECC training delayed during 2020 due to Covid-19, but restarted in February 2021
  a) experiencing health and social inequalities
  b) training delivered virtually and added to Maternity Mandatory Training week - to be repeated annually. 95 midwives trained to date
  c) Discussions on-going to continue training after funding ends in August 2021

- MECC steering group

Members of the steering group are from key partners across Hackney and the City and will act as MECC champions, coordinating actions on behalf of their organisation and help to unblock operational and strategic barriers to implementation.

- Triangulate learning from interactions implemented following the first Covid wave. After Action Reviews completed by QI team have been collated and reported to the Trust Management Board.
- Extend work stream beyond maternity, starting with therapies
  - Therapies MECC working party established during 2020.
  - Musculoskeletal Physios from the Locomotor service and Homerton MSK team attended a virtual MECC training in September 2020.
  - Online teaching session was recorded and remains available along with the slides for staff to view on the MSK MS Teams channel
  - Incorporate health promotion and signposting to the find support services on the Trust's internet web page, into the new online self-referral to Physiotherapy service
  - Therapies team supported the 'Getting Patient Moving' quality priority

- Oversight to be shared with Improving Clinical Effectiveness Committee from February 2021

Actions to sustain

- Training recommenced during February 2021
- Therapies MECC working party established
- Improved oversight - shared with ICEC
- Identify learning from Covid-19; for example
  - Patient admission lifestyle questionnaires – smoking
  - Nutrition support post Covid-19

Key risks going forward

- Availability of staff to complete training
- Covid-19
- Extending work steam to other clinical services
- Changes to divisional leadership team

Outcome

Priority carried forward into 2021/22

Oversight to be shared with Improving Clinical Effectiveness Committee and Improving Patient Experience Committee

8. Improving the first impression and experience of the Trust for all patients and visitors

Back ground

Carried forward from 2019/20

The First Impressions project aims to create a culture where patients, visitors and staff experience a positive and helpful first impression(s) when they visit our services.

Metrics

Currently begin refreshed due to changes in project leadership. Previously identified metrics were:

- Metrics from survey and client experience feedback
- Length of outpatient clinics
- Percentage of staff completing customer care training

Update:
January 2021

Position update

The First Impressions Group has continued to prior to the pandemic, nominating two governors as members. There is a work plan and agreed standards which was piloted in CSDO with a view to transfer the approach throughout the Trust.

- Posters to ensure that the patients and visitors were aware of our standards, to be produced post Covid-19 pandemic.
- At the end of the financial year 100% of the CSDO administrative staff members had undertaken Customer Care Training. Training to be rolled out to the rest of the trust later in 2020/21 - delayed due to Covid-19.
- Training sessions to be rebooked once it is safe to do so, as the course dates were nearly at capacity following recommendations from colleagues.
- The course has received high praise and staff have fed-back that they feel more confident when dealing with patients who are angry or frustrated, understand when they should escalate issues and to whom.
- "Hello My Name is…" yellow badges ordered for staff with several teams already wearing the badges.
- Uniforms provided to clearly identify admin/clerical and volunteers
- Reception signage when areas are temporarily unstaffed
- Hospital signage for areas not frequented by patients; e.g. blood clinics
- Signage and disability access monitored by Improving Patient Experience

Actions to sustain

- Update on progress to be reported to divisional governance meetings by the Associate Chief Nurse for CSDO
- Staff training programme to relaunch post Covid-19
- Review hospital and reception signage
- Review original action plans and evidence
- QI projects ongoing
  1. To improve the number of completed client experience feedback collected by 10% within the next 3 months, at all contacts.
  2. To reduce the average time clinics in outpatients overrun from 1hr 30 mins to 45 mins by November 2019.

Key risks going forward

- Roll out of associated staff training programme
- Consider disability access requirements.
- Changes to CSDO Divisional leadership team
- Impact of Covid on patient feedback programme

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Experience Committee

9. Improvements in staff health and wellbeing

Back ground

Carried forward from 2019/20

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.

Metrics

Metrics to be based upon

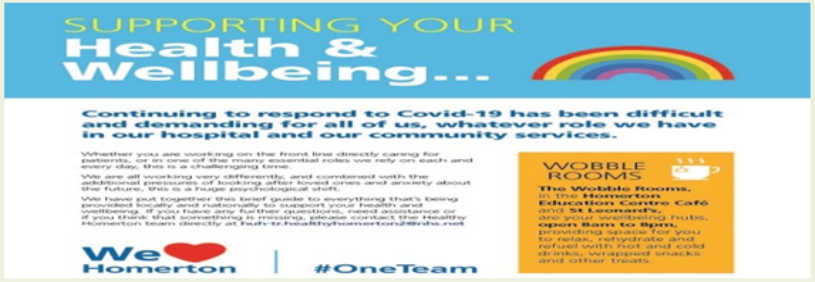
- "Health and wellbeing" theme (National Staff Survey)
- Recommendation as a place to work (National Staff Survey and Friends & Family Test)
- Long-term and short-term sickness (ESR)
- Turnover (ESR)

Update:
May 2021

Position update

Progress achieved to date:

- Improvement in "Health and Wellbeing" theme as measured through the National Staff Survey 2020; up from 5.5 to 5.8
- From September 2020, BollyX , Pilates, Yoga and Barr Fit were moved online
- Homerton Choir online
- Health Assured (Trust's Employee Assistance Programme) – offering online counselling, webinars
- Wobble Room, ran throughout both waves and investment for Community wobble rooms to be developed.
- Feel Good Trollies roll-out across the wards, to bring, information, support and welfare to ward based staff.
- Regular staff briefings, which always feature health and well-being, intranet pages update to date with all information for staff.
- Executive team webinars
- Going home check lists, support for shielding staff
- Various information sheets for staff e.g. sleep, diet, exercise
- Promotion of well-being apps and offers from NHSI/E (NHS People)
- Talk Changes Psychological support for staff
- Support for staff with children via First Steps, including dedicated email address, webinars and 1-1 support.
- General wellness offers around childcare support / parking/ travel/ accommodation/ cycle to work.
- Schwartz rounds offering a safe space to share stories
- Supporting Menopause Awareness day, holding HUH's first menopause café
- Improve communications around health and well-being, via weekly email newsletters.
- Visit from Dexter the Met Policies Therapy dog
- Project Wingman – Wellbeing bus visited for 2 weeks, offering staff first class lounge experience from Aircrew
- Memorial service for staff to reflect, remember and come together
- Throughout October 2020 over 5,000 breakfasts were given out to staff as a thank you
- Thank you cards for all staff from the Chief Executive
- Well-being day – additional annual leave day given to substantive staff as a thank you.



Actions to sustain

- Embed wellbeing support across the Trust, including ensuring sustainable psychological support and developing our leaders to support staff health and wellbeing
- Establish clear pathways and signposting for staff to access appropriate care
- Deliver refurbishment programme to update and upgrade staff areas; three areas identified and a further three being scoped
- Embed health and wellbeing in the wider Trust strategy
- Utilise funding from early 2020 to deliver Mindfulness and Mental Health first aiders
- Project Wingman revisiting in September 2021

Key risks going forward

- Staff engagement & NHS staff survey completion rates
- Impact of Covid

Outcome

Priority carried forward into 2021/22

Continued oversight to be provided by the Improving Patient Experience Committee and will link with new 'People and Culture Group'.

10. Getting Patients Moving (End PJ Paralysis) - CLOSED

Back ground

Carried forward from 2019/20

During hospital admission it has been widely publicised that patient can have a dramatic decrease in their functional ability which can lead to hospital acquired disabilities (HAD), prolonged hospital stays, increased dependency on discharge, poor patient experience, and subsequently increased cost.

Is a global social movement embraced by nurses, therapists, and medical colleagues. It's aim: "*to value patients' time and help more people to live the richest, fullest lives possible by reducing immobility, muscle deconditioning, and dependency at the same time as protecting cognitive function, social interaction and dignity.*"

Anecdotally it is believed that patient activity while residing at HUH was limited and furthermore that the majority of their time was spent in bed in hospital gowns.

Trust priority was set in 2019/20 to get patients moving.

Update:
November 2020

Position update

The overall aim of the ~~whole~~ QI project; in order to meet the Trust priority, was to have a 20% increase of all eligible patients sitting out in a chair by midday across the acute inpatient wards.

Final position statement – October 2020

Results:

- GSU (baseline 36.4% up to 84.6%) = **48.2% improvement**
- ECU – (baseline 50% up to 71.3%) = **21.3% improvement**
- ITU – The mean (average) = **97% compliance.**
- ACU – (baseline 15% up to 48%) = **33% improvement**
  - On review ACU had not sustained this achievement. The unit showed a 6% sustained change of practice
- Cardiology – (baseline 34.6% up to 68%) = **33.4% improvement**
- Lamb – (baseline 30% up to 74%) = **44% improvement**
- Lloyd – (baseline 61% up to 81%) = **20% improvement**
- OMU – (baseline 39.1% up to 87.8%) = **48.7% improvement**
- TA – (baseline 46.1% up to 74.4%) = **28.3% improvement**
- Edith Cavell (baseline 24% up to 53%) = **29% improvement**
  - On review EC had not sustained this change and reverted back to a baseline mean (average) of 24%

Pre-project understanding

35% not heard of HADs

30% did not know what caused them or how to prevent them

Post-project understanding

100% understanding on both questions

Lessons & Limitations

- The importance of co-production in projects of this type and that better results can be achieved through collaborative working
- Including patients in the co-production phase
- Speaking with teams from similar hospitals, incorporated the data from a prior project within HUH and used the resources available from the #EndPJparalysis campaign – not to duplicate work or re-invent the wheel
- While the same QI methodology can be applied, change ideas might need to be adapted according to the needs of different wards and disciplines
- The time taken to understand the wards, the faculty roles, responsibilities, barriers and enablers
- During the co-production phase, it was important to face up to challenges as they arose
- Acknowledge that a proportion of patients, who, no matter how much positive persuasion were provided by staff, would simply refuse to get out of bed
- Many of the frailest patients in the sample also experienced incontinence may have had only one or few sets of clothes and there were limited washing facilities

Actions to sustain

1. Making early mobilisation of eligible patients a topic of conversation on a daily basis during all staff handover and whiteboards
2. There needs to be clear ownership and accountability, which really needs to be ward-driven
3. Advocates or champions could be allocated for each ward to continue the positive progress that has been made and keep it as a focus
4. Using the relevant questions on the 'Perfect Ward' and seeing them as important as the other elements
5. A relevant senior executive could be responsible for ensuring the senior leadership team is engaged with the initiative and provided with relevant information on progress

Key risks going forward

1. Impact of Covid-19 on ward staff and patients
2. Reverting to older practice during times of increased pressure
3. Failure to embed changes within daily practice and use the perfect ward app as a measurement tool
4. Engagement of patients and families to participate with "get up, get dressed, get moving".
5. Not agreeing on sustainability objective recommendations

Outcome

The QI project demonstrated that improvements can be achieved.

The focus should now be on embedding this practice across all inpatient wards.

FOR CLOSING

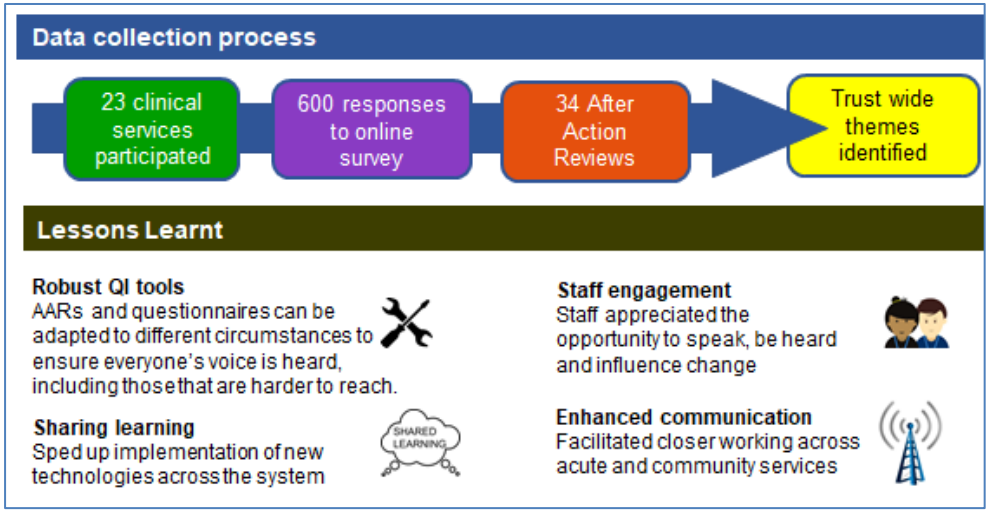
Final update presented to Improving Patient Experience Committee

3.2 Quality Improvement at the Homerton

The QI approach at Homerton aims to foster an improvement mindset in staff across all the Trust services. We recognise that ideas for improving services come from staff and our patients from the 'bottom up'. Our challenge is to give staff the permission, time and the tools to test out ideas for changes in service delivery and measure whether changes really are an improvement. The small central Homerton QI team deliver training and coaching to staff on QI methods, blending the IHI Model for Improvement with Kaizen Lean tools. Staff are encouraged to put this knowledge into practice by working on a QI project in their area. This 'learning by doing' approach means that over 50% of the staff undertaking QI training then register and work on a QI project. In 2020/2021, 125 staff completed basic QI training, despite the disruption to all services and teams (including the QI team) caused by COVID. 76 projects were registered - 11 of which were completed and 65 are ongoing.

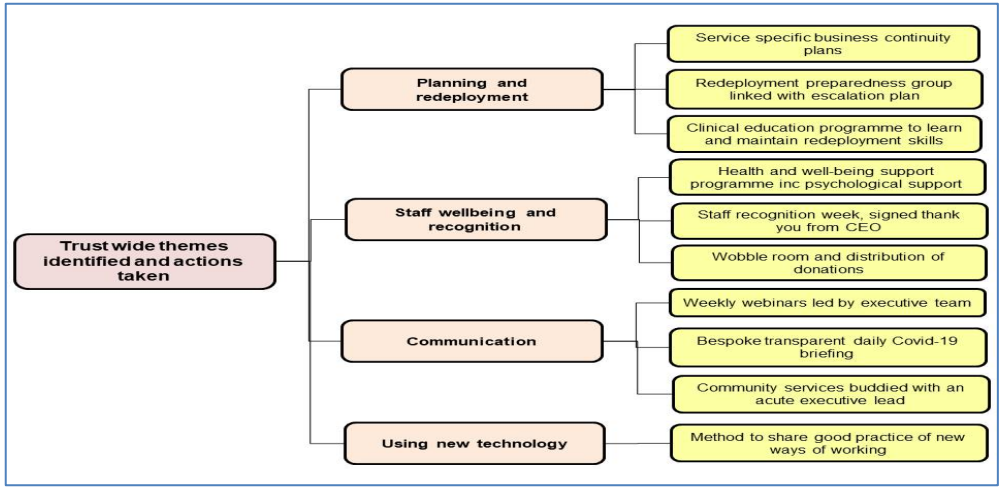
Capturing learning from COVID

A key focus of the Homerton QI team during 2020 was to devise and deliver a programme to capture learning from the first wave of Coronavirus-19 infections. We used techniques such as After Action Reviews (AAR) and anonymous online surveys to collect the views and experiences of a wide range of staff working in the hospital and community services. The diagrams below show the data collected, the themes identified and changes made as a result.



Showcasing innovations developed in responses to COVID

In October 2020 we showcased innovations developed in response to COVID – all of which used QI approaches:



- Acute Kidney Injury (AKI) in COVID Patients – 25% of COVID patients develop AKI. This project developed interventions to improve the awareness and confidence of Doctors in identifying and treating AKI in these patients.
- Improving the pathway of newborn babies being discharged home with a heart murmur – QI tools such as process mapping were used to streamline the pathway, reduce long waits for diagnosis and treatment, improving patient and staff experience.
- Improving discharge processes - The surge in COVID patients meant it was imperative that health, social care and voluntary services (third sector) work together ensuring that patients were discharged home in a safe, coordinated and efficient manner.
- Post COVID Recovery: Development of Patient Information Pack – This presentation detailed the development of an information pack for patients with 'Long-COVID'. The pack has been shared nationally and is a model of collaborative working.

- Developing Virtual Consultation and Digital Resources across Allied Health Professional (AHP) Services – Iterative development of virtual exercise classes in the 'Locomotor' service. Classes, live and pre-recorded, were developed for clients unable to attend group sessions due to social distancing requirements.
- Children's Therapies response to COVID – with schools, health and children's centres closed in the first wave of COVID, children's therapies services developed innovative ways to support children and their families. Examples included interactive virtual telehealth sessions. Hackney children's Speech and Language Therapy was featured on ITV news and Twitter, raising awareness and reaching over 4 million viewers.

What matters to you?
In the second wave of COVID, the 'Ward Communication Team' was set up and trained through joint working between a QI Lead in the Homerton QI team and the Lead Nurse for Cancer and Palliative Care. The team provided COVID patients with support to connect with their loved ones and the opportunity for a 'what matters to you' conversation. This work has elicited excellent patient and family feedback as well as improved staff experience.

This service wasn't available when I was in hospital last year and I felt very lost and lonely, and I didn't have things that I needed like my phone charger and toiletries. I think this service is so valuable to patients

The 'what matters to you' approach continues to grow with Homerton QI staff coaching Homerton staff as part of the North East London cancer collaborative and cancer services.

Quest network Improvement Science for Leaders
Homerton is proud to be a member of the Quest network – the first member convened network for NHS Trusts, who focus relentlessly on improving quality and safety. With support from the Homerton QI team, staff from the maternity service and the cancer programme continue to participate in the Improvement Science for Leaders course during 2020/21. The course provides rigorous training in improvement science. Graduates from the course have not only delivered improvements in care but will continue to bolster a network of QI advocates and champions at Homerton.

First Annual QI Awards - Spreading improvements and awareness of QI
In December 2020, we held our first QI Awards to celebrate the Homerton culture of QI. QI projects delivered sustained improvements in:

- End of life care
- Staff experience and wellbeing in the sexual health service
- Management of lacerations in children in the Emergency Department
- Oxygen therapies in medical inpatients
- Managing iron deficiency in patients undergoing major gynaecology surgery

As the Trust Chairman, Sir John Gieve, said *'This is one of my favourite afternoons of the year. Again today it has shown in a vivid way how staff, senior and junior, can take the initiative, work out how to improve Trust services and patients' lives'*

3.3 Performance against national indicators

During 2020/21, as a consequence of Covid, the Trust's actual performance against national operational standards suffered (along with the rest of the country). However, given the circumstances, the Trust delivered a comparably strong operation performance against the suite of core standards. It should be noted that due to the Covid pandemic.

The following table sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all NHS trusts, were required to report to NHS on a range of measures monthly and/or quarterly.

Key Performance Indicators	2020/21 Target	2020/21 Performance	2019/20 Performance
A&E patients discharged < 4hrs	**95%**	**93.00%**	**93.75%**
Cancer			
2 Week Wait	**93%**	**96.16%**	**97.86%**
31 Day Target	**96%**	**98.43%**	**99.30%**
62 Day Target	**85%**	**84.60%**	**86.93%**
Infection Control			
MRSA	**0**	**5**	**1**
***Clostridium difficile* (*C.diff*)**	**12**	**10**	**8**
18 Week RTT Indicator			
Incomplete Pathways	**92%**	**74.08%**	**95.13%**
IAPT Indicators			
6 week target	**75%**	**98.02%**	**96.81%**
18 week target	**95%**	**99.68%**	**99.60%**

Table 17: national indicators

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month. Details of performance against key quality indicators that were prioritised throughout 2020/21 are presented in the Quality Account which will be published later this year.

Annex

1.0 Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

1.1 Commissioners Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Commissioners Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

NHS North East London Clinical Commissioning Group is the lead commissioner responsible for commissioning health services from Homerton University Hospital NHS Foundation Trust on behalf of the population of east London.

Thank you for asking us to provide a statement on the Trust's 2020/21 Quality Account and priorities for 2021/22.

Last year we asked that the Quality Account provide greater emphasis on our City and Hackney plans for greater integration with our Local Authority and other partners and the development of our neighbourhood model. We are pleased to see this included and celebrated in this year's Quality Account.

We recognise the immense challenge the Trust faced during the year to respond to the SARS- CoV-2 pandemic. Locally we saw strong leadership from the Trust, mutual support and closer working with partners in City and Hackney and north east London to deliver services as safely and effectively as possible. The Quality Account provides a clear and compelling picture of the strengths of the Trust and its staff to maintain quality of services in such difficult circumstances and the selfless devotion to patient care that staff delivered. We are acutely aware of the sacrifices staff made and are deeply grateful.

Going forward we know there is much work to be done to meet the needs of our residents and to design clinical pathways so that these can be delivered remotely where it is safe, effective and patient-centered. We welcome the opportunity to work with colleague in developing neighbourhood teams and primary care networks, moving towards closer integration with primary care, mental health and social care partners in the City and Hackney Integrated Care Partnership. We anticipate a richer partnership with the voluntary sector, patients, carers and citizens so that we can co-produce local services that meet local needs.

Last year we congratulated the Trust on receiving an Outstanding rating by the CQC and we applaud the Trust for its journey to being Outstanding in every area of its work.
The Quality Account outlines a wide range of quality improvement projects and programmes and, as always, a strong focus on participating in national audits, research and quality improvement initiatives.

The Trust's quality priorities show progress and ambition and we welcome the two new priorities for 2021/22.

Of note is the impressive and comprehensive programme of work relating to learning from deaths in the Trust, the use of Consultant and multi-disciplinary review of cases and General Medical Consultants who were not directly involved in care of the patient. We think this work could be shared more widely and is exceptional. We also applaud the work and expansion of the end of life team and the learning from phase one of the pandemic that enabled the service to provide exceptional care throughout and for phase two.

We note the Trust is reporting medical staffing rota gaps and can see there have been considerable efforts made to advertise and fill these: we hope these will reduce over the coming year as the Trust has an impressive reputation for staff wellbeing and quality of care.

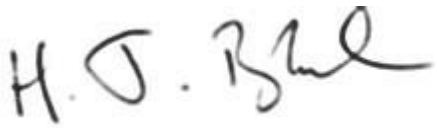
We are pleased to see unplanned readmissions being addressed directly by relevant teams. As always the Trust performs very well on staff feedback and we hope to see exceptional performance in relation to patient and carer feedback as services are restarted and staff are able to recover. We wish to offer all our support to initiatives that enable staff to reflect, recover and receive the support they need.

The "what matters to you" project is a brilliant example of how a new approach can deliver fundamental change for both staff and patients and carers; we hope this will be expanded beyond cancer services and be used in neighbourhood partnerships.

Patient safety data is reassuring and we agree that the Trust's data shows a good reporting culture. The new Patient Safety strategy will be a challenge to implement for the NHS and we offer our support to embedding the various elements over the next few years including changes to the serious incident process and Medical Examiner's role.

We confirm that we have reviewed the information contained within the Account, and checked this against data sources where these are available to us and we have no concerns about accuracy or completeness whilst recognising that the publication of several national audit reports has been delayed as programs were suspended due to the impact of Covid.

Overall we are welcome the 2020/21 quality account, we offer our deepest thanks to the Trust and staff during the past year for their devotion to high quality and compassionate services and we look forward to another year working together to improve the quality of services for the population we serve.



Henry Black

Acting Accountable Officer, NHS North East London CCG

1.2 Healthwatch Hackney Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Catherine Pelley

Chief Nurse

Homerton University Hospital Foundation Trust

Homerton Row,

E9 6SR

25th June 2021

Dear Catherine,

Draft Quality Account

Thank you for sending us the draft Quality Account (QA) for review and comment. We very much appreciate Homerton Hospital seeking views on its QA given the challenges of the coronavirus pandemic and its aftermath, which places the NHS under considerable on-going pressure. We know this has been a very difficult time and that Homerton staff have risen to this challenge admirably. We express our deep sorrow at the loss of patients and staff in this pandemic. It is important there is local public recognition of these losses and contribution of health (and social care) staff to support and treat people during the pandemic. We further welcome the Homerton's work developing a Long COVID clinic, this is a very important initiative given that the extent of Long COVID is now unfolding.

We note the tighter timescale to produce this QA. Ironically, this undermines the intention to demonstrate quality and a commitment to it. We appreciate the Homerton's efforts to produce a QA are the result of decisions by the Dept. of Health and Social Care and NHS England; their approach risks focusing on the appearance of quality rather than a commitment to effectively resource quality outcomes.

We know from our research the Homerton is a locally respected institution and recognised for the quality of its services. We believe the Homerton demonstrates a clear ability to respond to local need. In this context we welcome the moves by the Homerton to actively seek control of the St Leonards Hospital site, from NHS Property Services Limited, and work with local health and care leaders, to shape the services at the hospital to meet local need and to co-produce future developments at St Leonards together with local people. We will actively support this with the development of the People's Plan for St Leonard's, which we are coproducing with residents and our partner in this work, Healthwatch City of London.

We note within the Northeast London Integrated Care System, the closer working of acute providers, BART's Health and Barking, Havering and Redbridge University Trust. We are concerned this could impact on the independence of the Homerton and has the potential, with the planned Government health legislation, to focus on developing one acute hospital for all of Northeast London. This would make acute services more distant from those they serve and undermine the approach in Hackney (and the City of London) of services being locally based.

We found the Quality Account interesting and informative. There are some areas where we feel clarification is required and where we have made suggestions and recommendations.

1) It is a long and complex document and as recommended for the last QA, a short form should be produced for Homerton members, patients and staff. The short form should demonstrate how patients have influenced the QA.

2) HUH has done outstanding work in vaccinating its own staff and staff in primary care, e.g. dentists, GPs, pharmacists and opticians.

3) We welcome the increased focus on the HUH's community services, which have like the acute services been exemplary during the pandemic.

4) The number of patients and staff (including contracted staff) who were infected and died at the Homerton from Covid are recorded in the report and the HUH should create a public memorial for those who died. It would be useful for the HUH to record where the deaths occurred, e.g. are deaths included where the patient was receiving NHS CHC from Homerton community staff?

5) The ethnicity of patients and staff (including contracted staff) who were infected, and those who have died of covid, should be published by the HUH to enhance knowledge of the impact of ethnicity on infection, morbidity and mortality.

6) The Homerton should publish details of the number of infected people transferred to care homes, the outcomes, e.g. in relation to deaths, and the learning from these very difficult situations.

7) Priorities for Improvement: Page 4 summary table and detailed support section 3.1. The progress set out in the table is unclear and gives an impression of sustained progress with this symbol:  . However, it is difficult to assess progress as there is no clear baseline set out in the supporting section 3.1. For example, in section 9 'Improvements in staff health and well-being' under the 'progress achieved to date' section states bullets point Dermatology Clinic and Gynaecology Clinic. It is unclear what the progress is here. Across section 3.1 it is difficult to assess the meaning of the symbol  on page 4 and the level of improvement set out in section 3.1.

8) The Patient Safety Committee and the Assurance Committee continue to carry out outstanding work and continue improve year on year. However, the HUH should share with patients/carers the outcome of serious incident and complaints investigations to demonstrate how these investigations enhance the quality and safety of patient care. The quality of this work was maintained during the pandemic.

9) HUH has stopped communicating with it's members on a regular basis and has stopped active recruitment. Pandemics are times to develop a shared understanding of the pressure that the Homerton and people in the community are under, not to shut down. Our research in 2020 on the impact on the pandemic on residents told us there is increasing public mistrust of their national *and local* institutions. In this context we strongly urge the Homerton to improve its communications with its members and continues to promote membership

10) We are very pleased that the Homerton achieved outstanding from the CQC. We are disappointed that community services and Mary Seacole House have not been similarly acclaimed. The Action Plans should be published so that HW can better monitor HUH progress with achieving goals set by the CQC.

11) In relation to Mary Seacole House we would like to see evidence that all staff and visiting staff (GPs, social workers etc) are regularly training in the implementation of DOLS.

12) Whilst the objective of creating a truly integrated health and care system is highly valued, we believe that the objectives for this aspiration need to be clearly laid out in terms of service redevelopment and specific benefits for patients.

13) The establishment of an integrated care partnership and Neighbourhood Health and Care Board are high level attempts to better integrate service for the benefit of patients. But to patients the aspirations are obscure and should be clearly explained. Will they benefit patients or just create a more powerful and distant bureaucracy?

14) People in the local community are mostly not aware of the existence of PCNs and Neighbourhood and their benefits in relation to joint work with the HUH should be explained.

15) Change of Name: We hope that the change of name of the HUH will lead to 'parity of esteem' between community and acute services and between the needs of patients using both sectors.

16) Participation in Local and Nationals Surveys: There has been a very impressive level of participation, but we are not sure in some cases whether there is evidence of consequent service improvement. E.g.
    - Telephone Clinics have been embedded in the system, but we don't know if they have or will improve or worsen services for patients. Neither do we know if patients have a choice whether they will receive care face to face or by phone.
    - Learning Disabilities Mortality Review – it is not clear whether the actions have been implemented or are proposed actions.

17) Patient Verification- details of the process to prevent patients receiving the wrong treatment or wrong diagnostic tests should be published in the QA.

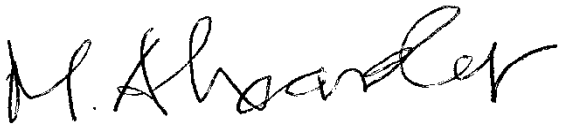
18) Learning from deaths: we found this section confusing. Does it refer to all patients or only to CESDI – stillbirths and deaths in infancy?

19) Independent scrutiny of deaths: We would like to see more information about the HUH's learning from deaths and the outcomes of recommendations made to the HUH by Coroners, including feedback from bereaved families.

20) Freedom to Speak Up Guardians: We would like the QA to give assurance that all staff have easy access to the guardians including front line staff contracted by the HUH.

21) We were disappointed to see the results of the 'Responsiveness to personal needs of patients – NHSI Quality Indicator 20 which suggests that the HUH is performing below the national average and is showing little improvement over recent years. We would strongly recommend joint work with Healthwatch Hackney to ensure that the patients and carers voice is heard more loudly and has real impact on service improvement. This also connects to the need for the Trust to listen to HUH members ideas and proposals and demonstrate how they follow through patient led recommendation for quality and safety.

Yours sincerely,



Malcolm Alexander
Chair, Healthwatch Hackney

Healthwatch Hackney announcement of its key recommendations for the Homerton Hospital Quality Account 2021/22

Healthwatch Hackney - KEY RECOMMENDATIONS

1. We strongly **RECOMMEND** the Homerton to continue to actively seek control of the St Leonard's Hospital site, from NHS Property Services Limited. We are pleased with the positive role the HUH has taken to work with local health and care leaders, to shape the services at St Leonard's hospital to meet local needs, and to co-produce future developments at St Leonard's together with local people.

2. We **RECOMMEND** that a short form of the QA be made available for the Annual Trust Board meeting and for HUH Members and the public. This would aid the public appreciation of the Homerton and its work. Evidence of improvement needs to be set out clearly so the public can understand were the Homerton has achieved improvements, the extent of those improvements and where there is need for work to be done.

3. We **RECOMMEND** publication by the Trust of ways in which patients can contribute to their doctor's annual appraisal for Revalidation in line with GMC guidance, so patients have knowledge of the process that allows them to both compliment and criticize medical practice. Despite several requests to the HUH, they have been unable to explain how they meet their statutory duty to enable patients to contribute to doctor's revalidation.

4. We **RECOMMEND** details of all recommendations made by Coroners to the HUH (Coroner's Regulations 28 (Prevention of Future Death Reports)) for the relevant period are placed in this QA, and that actions taken by the HUH in response to Coroner's recommendations, and evidence of implementation are also be placed in the QA.

5. We **RECOMMEND** patients should be advised about the purpose and content of their Coordinate My Care (CMC) plan. They should also be advised how to initiate a CMC if they believe this would be useful for themselves or family members during a medical emergency.

6. We **RECOMMEND** that evidence of enduring improvement to access, safety and quality of services, and advances made in learning from incidents, complaints and investigations, are publicised more widely to patients using services at the HUH and to their families.

7. We **RECOMMEND** HUH works with Healthwatch Hackney to ensure effective use of patient feedback to improve patient experience. This would involve (a) Healthwatch establishing a patient group to review and making recommendations to improve the HUH Complaints, PALS and Compliments services, and (b) Homerton and Healthwatch agree feedback areas where Healthwatch can provide the Homerton with patient feedback through its enhanced online feedback centre to be launched in the autumn.

1.3 Overview & Scrutiny Statement for Homerton University NHS Foundation Trust 2020/21 Quality Account

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Town Hall
Mare St,
London E8 1EA
Reply to: jarlath.oconnell@hackney.gov.uk

28 June 2021

Ms. Catherine Pelley MBE
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 Homerton University Hospital NHS Foundation Trust's draft Quality Account for 2020/21

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2020/21. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

The impact of the Covid-19 pandemic continues to be deeply felt by all the local health and care providers. We note that last year because of the unprecedented pressures on the NHS this process was completed in Sept and you attended our Oct meeting and responded in further detail in November. This letter therefore will pick up on issues since then and we note that this year's report is more truncated than usual.

We've been grateful to your Chief Executive for her engagement with our work especially now in her new role as Integrated Care Partnership (ICP) Lead for City and Hackney. In Sept she took part in a discussion panel on the plans for the ICS, in Nov in another panel on Covid-19 and Care Homes and in January she participated in an item on the vaccinations programme roll-out. In March she presented the new governance structure for the City and Hackney ICP.

We do appreciate the Quality Account exercise as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services. The Commission Members take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We commend the Trust for the role it played during the pandemic and in particular for the drive to vaccinate the adult population particularly staff of other local health and care providers (ambulance service, social care staff, cleaners, drivers etc). On a personal note, congratulations on your much deserved MBE.

We note that the usual reporting of your performance on many national audits has been delayed as patient care was given priority over such exercises during the pandemic. We also note that as a result of the pandemic the contractual arrangements for 2020/21 with NHS foundation trusts were modified to a block payments approach (as opposed to PBR) which will remain in place for the first half of 21/22. This also means there is also no reporting on CQINs which usually gives us an indicator of overall performance. We also note that during this exceptional year most clinical research activity (which HUHFT normally excels at) was paused to concentrate resources on the pandemic, although you still managed to engage a significant number of patients with Covid in important clinical studies.

We are pleased that despite the pandemic you delivered a comparably strong performance against the suite of core national standards (p.62) when performances of Trusts nationally have deteriorated because of Covid.

With respect to page 30 please can you outline what measures you have taken to improve the shortcomings around the completeness of ethnicity data recording, considering that patients from ethnic minority groups often have poorer outcomes and are disproportionately affected by Covid.

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 Christopher Kennedy, Cabinet Member for Health, Social Care and Leisure
Dr Sandra Husbands, Director of Public Health, City and Hackney
Jon Williams, Director, Healthwatch Hackney

2.0 Statement of directors' responsibilities for the quality report

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 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20.* No specific guidance was issued for 20/21.

• 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 2020 to March2021

– papers relating to quality reported to the board over the period April 2020 to March 2021

– feedback from commissioners emailed on 22nd June 2021

– feedback from governors following meeting on 17th June 2021

– feedback from local Healthwatch organisations dated

– feedback from overview and scrutiny committee dated

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2020 (20/21 report not yet finalised)

– the latest national patient survey completed during July 2019 (2020 survey delayed due to Covid)

– the latest national staff survey published March 2021

– the Head of Internal Audit's annual opinion of the trust's control environment dated 24/05/2021

– CQC inspection report dated 02/07/2020

• 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

.....Date.....Chairman

.....Date.....Chief Executive

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Future plans for St Leonard's site – verbal update**	Item No **6**

OUTLINE

The future plans for the re-development of the St Leonard's Hospital site has been a key local issue for the healthcare economy for some time.

The building is not in a good state of repair yet provides residents with a range of important and excellent services nonetheless. Prior to the pandemic discussions had been taking place between the CCG, the Council and NHS PropCo on possible options and funding had been secured to carry out a feasibility study. The site is also part of the wider NEL CCG Estates Strategy.

Healthwatch Hackney (together with Healthwatch City) is also working to develop a 'Peoples' Plan' to inspire local thinking about how this site could enhance currently provided NHS services, and develop new services needed by residents and is holding a public meeting on this on 13 July.

Healthwatch and others argue that this is a very important opportunity to build a community hospital that meets local needs and they are pushing for strong public involvement throughout its planning and development stages.

The following NHS services are currently provided at St Leonards by Homerton University Hospital and others: Dietetics; Dentistry; Learning disability services; Orthopaedics; Physiotherapy; Podiatry services; Rehabilitation care services; Sexual health services; Wheelchair services and 'Talk Changes' (the NHS IAPT (Improve Access to Psychological Therapies) service for City & Hackney).

Members have asked for a verbal briefing on the progress which has been made and what is being done to pick up this work post pandemic. Invited for this item is:

Claire Hogg, Director of Strategic Implementation and Partnership, HUHFT

ACTION

The Commission is requested to give consideration to the briefing.

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Healthwatch Hackney Annual Report 2020/21**	Item No **7**

OUTLINE

Each year Healthwatch Hackney presents its Annual Report to the Commission at the time it submits it to Healthwatch England. For the Commission it is an opportunity to reflect on the progress of the organisation over the past year and to ask about future plans.

Attached please find:

a) Briefing note from Healthwatch
b) Healthwatch Hackney Annual Report 20/21

Attending for this item will be:

Malcolm Alexander, Chair, Healthwatch Hackney
Jon Williams, Executive Director, Healthwatch Hackney

ACTION

The Commission is requested to give consideration to the briefing.

This page is intentionally left blank

Annual Report 2020-21

Presentation to the Health in Hackney Scrutiny Commission – 8 July 2021

healthwatch Hackney

Overview of the year

- COVID re-shaped our work with residents
- Impact of COVID is still unfolding
- Satisfaction with health and care services slips further
- Integrated Care is arriving
- Healthwatch needs to be more accessible

What Healthwatch *must* do

- Promote & support people to get involved in commissioning and scrutinising local health and care services
- Enable people to monitor the quality of local health and care services and recommend improvements
- Obtain people's views on health and care services, advise on gaps and make people's views known

What we also *must* do

- **Publish reports and recommendations** on improving services and send these to health and care commissioners, providers, Healthwatch England and other scrutiny bodies
- **Provide advice and information** on how to access local health and care services
- **Formulate views on the standard local services,** on how they can be improved and share these views with Healthwatch England

What residents told us in 2020-21

- Trend of being less satisfied with local health and care services – 8% drop (52% positive) on top of 2% drop last year
- Resident felt less informed, supported and involved – 15% drop (50% positive)
- Homerton Hospital increased satisfaction by 2% (64% positive)
- GP surgeries maintain satisfaction rates (60% positive)

You also told us…

Most people get good quality, compassionate treatment and care

Increasing complaints about service access - 10% drop (56% positive)

Communication and administration key resident concerns

As your local health and care watchdog we will keep a close eye on changes and tell you about opportunities to get involved

Volunteers at Healthwatch Hackney

41 volunteers gave 2,192 hours to help improve local services

Volunteers conducted service assessments, collected feedback and sat on boards and committees

Helping you to find answers

- No face to face signposting – major limit on service
- Busiest area: contact with residents with COVID-19 focus:
  - Mental health needs increase
  - Pressure on carers,
  - Parents found home school at challenge
- Hackney Complaints Charter
  - Review
  - New versions for GPs and dentists

Giving voice to residents issues

- COVID Survey
- Temporary Accommodation
- Carers experiences
- Access to dental services
- GP Receptionists
- Information Exchange Meeting
- Healthwatch Hackney board meeting public discussions

Building future public involvement

- Coproduction
- Integrated Care
- Neighbourhoods/Primary Care Networks
- NHS Community Voice
- Resident Involvement and inequality
- Digital Divide
- St Leonard's Re-development

Our Finances

Income	2019-20 £	2019 -20 £
Funding from local authority to deliver local Healthwatch statutory activities	150,000	150,000
City of London Corporation	-	8,677
NHS clinical commissioning group projects	209,244	224,136
Other income	2,250	7,065
Total Income	361,494	389,878
Expenditure		
Operational costs (including project direct expenses)	83,443	73,281
Staff costs	251,714	282,669
Premises / office costs	15,819	17,367
Healthwatch City of London	-	11,660
Total expenditure	350,967	384,977
Balance brought forward	10,518	4,901

This page is intentionally left blank

healthwatch Hackney

Annual Report 2020-21

Contents

Message from our Chair

The past year has been painful and disturbing as a result of the COVID-19 pandemic. Many people have died, and many have suffered the pain of infection and loss. NHS and social care staff have worked tirelessly to provide care and treatment for patients in the community and hospital. Tragically some have also passed, and our hearts go out to their families.

Healthwatch Hackney has continued its work in a much-modified way, with our staff working from home and many of our usual activities put on hold. We had to stop holding meetings in public and developed online zoom meetings. This enabled us to develop an 'Information Exchange' where local residents can talk to and question services leaders, e.g. about dental services provision. We held high profile and dynamic Board meetings with Marie Gabriel, Chair of the new NE London Integrated Care System; Anne Canning, Hackney's Director for Children's services and Paul Calaminus, Chief Executive of the East London Foundation Trust.

We want to become a much more influential body in our relationship with local NHS and Council leaders. We want to see the voices of local people reflected in major decisions made by these bodies. It is not enough to be heard; we want to see far reaching changes to local services when Hackney residents find them wanting.

We are developing a new strategy, which we want to be created through coproduction and partnership with local people and local community organisations. Our priorities will focus on access, quality, safety and the effectiveness of local services. And of course, how we influence them.

We need to secure adequate longer-term funding from our statutory funder, Hackney Council, to ensure we can carry out our statutory roles effectively. We want to have visible premises in a central location fully accessible to local people.

Amongst our priorities will be a campaign with local residents to redevelop St Leonard's Hospital into a modern community hospital, to replace the very old and poorly maintained building we now have.

We want to have greater influence in the development and integration of Health and Social Care within the 8 Neighbourhoods in Hackney, and active involvement of local people in decisions about those services. We also want to make sure that no one is Hackney is denied healthcare due to problems with GP registration.

Our Enter and View programme will be re-activated, so we can systematically monitor local services and use the experience of people who use those services, to bring significant change where this is needed.

We will work more closely with mental health services by promoting the 'Wellbeing for All' agenda, to enhance access to mental health care and treatment in the context of the impact of COVID-19, with particular attention to the needs of BME and older people.

Central to our work is the need to ensure thorough coproduction with local providers of services, and the new North East London commissioning body, produces significant service improvements through the genuine involvement of people from all parts of our diverse Borough and people of all ages.

We will work closely with all of our partners in local services to promote the empowerment and health of local people and ensure the tragedy of COVID-19 does not inhibit the development of our essential work with local communities.

Thank you to our fantastic staff team, volunteers and Directors of Healthwatch Hackney.

Malcolm Alexander
Chair, Healthwatch Hackney

Message from our Executive Director

Looking ahead

This has been the year when the COVID-19 pandemic very unfortunately took its grip on our world. In Hackney we saw all communities, and particularly those from our ethnically diverse communities, badly hit by the pandemic. Existing inequalities that are in our society were brutally exposed and deepened.

I am very proud at the way our staff team responded to the pandemic, contacting our supporters hearing their concerns and making sure we could help them by telling them about the support available at this very difficult time.

This year the lockdown stopped us from being office based and we shifted to homeworking. This meant our primary way of understanding people's needs and concerns, by face-to-face work, stopped. We adapted and moved to online meetings developing our highly effective Information Exchanges Meetings. Our new chair, Malcolm Alexander, also reinvigorated our board meetings into public forums where residents can quiz local and regional health and care leaders on their work.

In the coming year our big-ticket item is our partnership with Healthwatch City of London to develop the People's Plan for the re-development of the St Leonard's Hospital. This is an important resource for our communities with well-appreciated services. It is vital it continues and builds on this role. We are hopeful as the pandemic eases we can return to face-to-face work in the borough.

We are eager to do this as we know many of those we want to hear from are on the wrong side of the digital divide. This further isolates them, they need to be at the centre of our concerns because of the challenges they face.

We will continue to see the re-shaping of health services, with the creation of a regional Clinical Commissioning Group (CCG), which will become an Integrated Care System across North East London. We have been assured we will see little change locally. We shall see; but it is important these changes are transparent and the accountability we saw in Hackney CCG continues into the new regional body. The pandemic has hit health and care services badly and waiting lists for other conditions increased. In this context, there must be no decline in the quality of services. We will monitor this carefully and speak loudly where we see service provision decline. To this end we plan to focus on making sure those who run services hear and act on the concerns and issues of Hackney residents.

This year we said farewell to staff members Chloe Macri, Jamal Wallace and Mark Drinkwater, and welcomed Sabrina Jantuah and Sally Beaven. Finally, I would like to say a big thank you to our Board, staff, volunteers and all the people of Hackney for their contributions to our work.

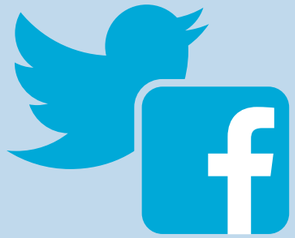
Jon Williams
Executive Director, Healthwatch Hackney

Highlights of the year

We identified 7,889 issues from 2,380 people and shared this feedback with local providers and commissioners

We produced special reports on residents' experiences of the COVID-19 pandemic, GP reception services, caring for others, living in temporary accommodation, and dental services.

41 volunteers helped us to carry out our work by providing an estimated 2,192 hours of unpaid support



Our Tweets were seen 154,000 times on Twitter, an increase of 23%. We have 1,754 followers on Twitter and 298 people follow us on Facebook.

> **"Thank you, for another informative and useful Newsletter. Due to my full-time care duties, I access your Newsletter as and when I can. I am always grateful for the articles that are essential to me, every day.**

COVID-19 response and impact

This has been a very tough year for Hackney and we are not through it yet. The longer term impact on Hackney residents is still unfolding. Our NHS Community Voice survey in the early part of the year told us how challenging people found the lockdown and their feelings of isolation. Most perturbing was the theme of distrust we found, not only of central government but also of our local authority. We know the Council put in huge extra effort to support the most vulnerable in our communities, in spite experiencing an awful cyberattack, which did not help its efforts to support people.

The distrust of institutions manifested itself in other ways too. In Hackney the structural racism many experience in health has been more clearly recognised with its impacts on increased mortality, higher levels of some long-term conditions like diabetes, higher instances of disability and mental health. Locally recognition is seen as clearly not enough, racism needs to be dealt with head on. We welcome the establishment of the City and Hackney Health Inequalities Group, led by Director of Public Health, Dr Sandra Husbands to coordinate local action on these issues. Our chair, Malcolm Alexander, attends this group, leading on resident involvement. He seeks to ensure residents are at the centre of the drive to push against inequality.

One of the issues we have heard from residents is about hesitancy towards COVID-19 vaccines. This itself is driven by distrust. So, we pushed with others, particularly Hackney Council for Voluntary Services and local community groups, to take this hesitancy seriously and with respect. People must be listened to and their concerns heard and addressed. We were very pleased how the Council worked closely with the community groups to develop local residents as Community Champions to build local confidence in the vaccine. There is still a way to go, and this is the right approach to build confidence; to listen to residents and address their issues.

Whilst it appears we are starting to get ahead of the COVID-19 virus we are not out of it yet. We are only starting to see the longer-term impacts, such as the diverse conditions that comes with long Covid. The pandemic impacted heavily on other health services and people were told not to put pressure on the NHS. But this has had the effect of increasing waiting lists, with many of those waiting suffering pain. We have also seen a massive increase in demand for mental health services, particularly for young people.

One of groups most impacted by COVID-19 were disabled people. The NE London Clinical Commissioning Group asked Healthwatches across this area to look into this, so the health and social care services could improve their response and support for disabled people. It was good hear that many disabled people felt well informed about wearing masks and social distancing, but changes in social care services could have been much better communicated. And there needs to be much better clearer information produced, including in easy-read. This is on-going work, with the aim to deliver an enduring link to disabled people and help to ensure a quicker response to their issues in future.

© London Borough of Hackney

Dr Sandra Husbands
Director of Public Health, City and Hackney

Who we are

How we make decisions

Healthwatch Hackney is a community interest company (CIC) governed by its Board of unpaid directors who live or work in the London Borough of Hackney.

The Board provides strategic direction to the organisation and ensures we meet our statutory and contractual obligations.

Decisions are made by our Board and its subcommittees, with some decisions delegated to the executive director.

How we ensure transparency

To ensure decision-making is transparent, the Board:

+ Meets in public
+ Publishes board minutes, papers and agendas
+ Widely promotes board vacancies
+ Holds formal interviews for prospective Board members
+ Holds an annual general meeting in public

Our Board

Malcolm Alexander
Chair
Lead for patient safety and St Leonards redevelopment

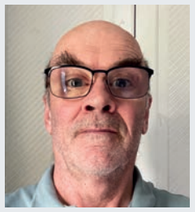
Malcolm is a former lecturer in patient and public Involvement in health and social care and patient empowerment at Westminster University. He is an active health campaigner with a special interest in emergency services, complementary medicine, mental health, health care in detention centres for asylum seekers, ethnicity and access to health care and opposes NHS privatisation.

Lloyd French
Lead for race equality and community empowerment

Lloyd has lived in Hackney for over 53 years, since arriving from the Caribbean as a child. He is a qualified structural engineer who has worked in construction, property management and community development. He has particular interests in race equality and community empowerment. He brings to Healthwatch Hackney his local knowledge, project management and finance skills and desire to improve local health service and empower patients.

Yas'ina Christopher
Vice-chair
Lead for sickle cell disorders

Yas'ina has had an extensive career as a nurse, including at Homerton Hospital, with a particular focus on accident and emergency. She is an active member of the local sickle cell group, SOLACE and has been involved in various public health programmes including Alzheimer's, sickle cell disease, cancer, heart disease and arthritis. She has lived all her life in Hackney.

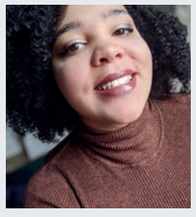


Philip Jones
Lead for mental health and adult social care (Joined September 2020)

Philip has recently retired from a mental health social work and social work management career. He has a comprehensive grasp of the issues of Integrated health and social care service delivery and the stigma and discrimination facing service users from ethnic minority communities. He has lived in Hackney for 23 years.

Anthonia Onigbode
Treasurer
Lead for financial governance of Healthwatch

Anthonia is chief executive of Hackney Co-operative Developments, a local social enterprise development organisation. She is a fellow of the Chartered Association of Certified and company secretary for a number of organisations, charities, voluntary organisations and social enterprises. Her passion is seeing businesses and individuals thrive.



Cassandra Lovelock
Lead on promoting the needs of unpaid carers within healthcare

Cassandra is a current PhD student at the London School of Economics, specialising in unpaid care and unmet needs for carers for those with mental illness and co-production with unpaid carers. She uses her experience as a young, black disabled woman and mental health carer to guide all her work. Cassandra is an ambulatory wheelchair user from a mixed background.

Sarah Oyebanjo
Lead for acute arthritic care and Healthwatch quality standards

Sarah has a degree in biomedical science and masters in public health. She has extensive experience of working with vulnerable and hard to reach groups. She volunteers with Keen London, a charity that provides one-to-one sports and fun for children with special needs. She is particularly keen to see Hackney's young people become involved Healthwatch and have their voices heard.

Saleem Siddiqui
Lead for promoting Healthwatch's influence in health and social care

Saleem was made a Freeman of the London Borough of Hackney in 2013 and served as Councillor from 1990, including as Mayor of Hackney. He is a member of the Homerton Hospital Council of Governors and is a member of the City and Hackney Older Peoples Reference Group. He has extensive links into Hackney communities.

Our staff

Jon Williams
Executive Director

Catherine Perez Phillips
Deputy Director

Lola Njoku
NHS Community Voice Manager

Liya Takie
Finance and Office Co-ordinator

Kanariya Yuseinova
Volunteer and Enter and View Co-ordinator

Sally Beaven
Engagement and Co-production Manager

Sabrina Jantuah
Neighbourhoods Community Development Manager

Healthwatch Hackney is the independent champion for people who use health and care services in the London Borough of Hackney. We make sure people's voices are heard and influence decision-makers to improve services.

Our vision

+ Health and social care services equal for all
+ Needs of all Hackney communities met
+ Residents at the heart of service design

Our mission

+ Improved health and care services
+ All people able to enjoy good health and wellbeing
+ Treatment and care provided with respect and dignity
+ Diversity valued
+ Participation and collaboration encouraged

Our priorities

+ Impact of changes and cuts to social care
+ Early rapid access to high quality mental health services
+ Shift of services out of hospital
+ Access to quality information

These key priorities guided and informed our work in 2020-21.

Our duties

+ **Promote** and support people's involvement in commissioning and scrutinising local health and care services
+ **Enable** people to monitor the quality of local health and care services and recommend improvements
+ **Obtain** people's views on using health and care services, advise on gaps and make people's views known
+ **Publish** reports and recommendations on how to improve services and direct these to health and care commissioners, providers, Healthwatch England and other scrutiny bodies
+ **Provide** advice and information on how to access local health and care services
+ **Formulate** views on the standard of provision and how it can be improved and share these with Healthwatch England
+ **Make** recommendations to Healthwatch England and advise the Care Quality Commission on special reviews or investigations
+ **Provide** Healthwatch England with the intelligence and insight it needs to perform effectively

Your views on health care

What you told us in 2020-21

The COVID-19 pandemic meant that it was not possible to run our normal face to face outreach activities. Nevertheless, by using phone calls, surveys, online meetings, focus groups, social media and our online feedback centre we were able to capture your views.

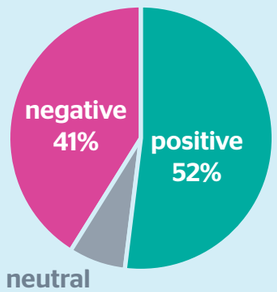
Trends and insights

In 2020-21 we identified and analysed 7,889 issues about local health and care services, based on feedback from 2,380 people.

Local residents took part in regular feedback panels, reviewing, coding and analysing your feedback with a matrix used by other local Healthwatch.

- 43% was collected from social media
- 16% was collected from our surveys
- 31% was collected from providers reports and websites

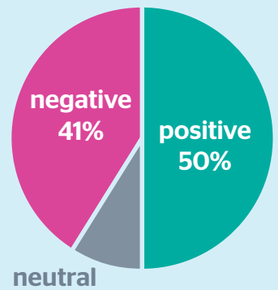
How do people feel about health and care services as a whole?



8%

Overall satisfaction has dropped by 8% this year

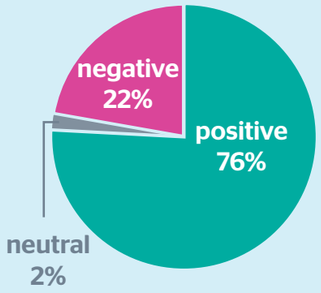
How well informed, supported and involved do people feel?



15%

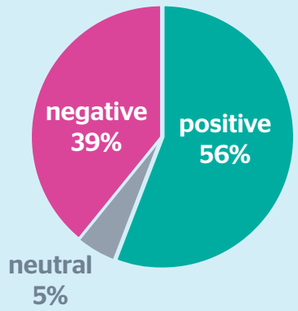
Overall satisfaction has dropped by 15% this year

Quality and empathy



Overall satisfaction has remained the same this year

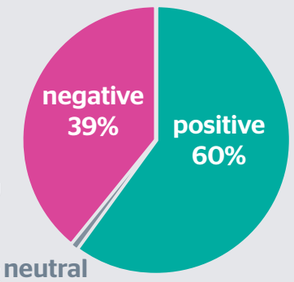
Access to services



10%

Overall satisfaction has dropped by 10% this year

General Practice



Overall satisfaction has remained the same this year

2490 issues from **473** people

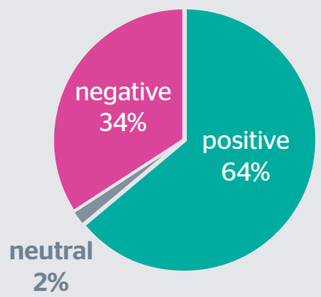
POSITIVES

- Most people receive good quality care, compassionate treatment and nursing care, with good levels of support.

NEGATIVES

- The ability to book appointments is a problem for many, with issues of telephone access and waits of days (or more) to see a clinician.
- People would like greater levels of privacy in reception.

Homerton Hospital



2%

Overall satisfaction has increased by 2% this year

1207 issues from **288** people

POSITIVES

- Feedback about A&E suggests good quality, compassionate treatment and care, with marginal satisfaction on waiting times.
- On general inpatients, outpatients and surgery, feedback is largely positive about most service aspects.

NEGATIVES

- Maternity services have recorded a 9% decline in satisfaction, with a lack of involvement and communication reported.
- Some people comment on being discharged when not feeling ready.

People's Feedback Panel (PFP)

An important part of Healthwatch's role is to scrutinise feedback, good and bad, on local health and social care services and identify issues.

Our People's Feedback Panel turns your raw experiences of health and care services into hard evidence which we then use to influence service commissioning and delivery. The People's Feedback Panel meets twice a month to look at patient feedback and decide what the issues are, coding them to enable us to identify tends. We also monitor risk to patients, equality and dignity. This makes the People's Feedback Panel a crucial part of the Healthwatch Hackney operation.

The panel is open to anyone and **no experience** in research or an understanding of the health and social care system **is needed**.

Contact us for information on how to get involved as a panel member.

Information Exchange

Our Information Exchange meetings were created as a response to our inability to meet local residents face to face, following the start of the COVID-19 pandemic.

> **I asked a question about tinnitus. Thank you for putting my questions to the audiologist and for her advice. I will contact my GP.**

Our monthly virtual public meetings to discuss important health and care related topics started in July 2020. Each meeting features a key speaker. The meetings are a great opportunity to hear the latest updates on health and care services and get answers directly from service providers.

> **Thank you for sending me the recent Information Exchange Meeting recording with subtitles, it was helpful. I will pass it onto my deaf friend who was not at the meeting.**

The meetings take place using Zoom. We strive to make the meetings as accessible as possible for all Hackney residents by using closed captions and the ability to dial in using a land line. The meetings are also recorded and published on our YouTube channel.

Some of the most popular meetings we had last year were:

- Access to Dentistry during the pandemic
- Maternity Care in Hackney during the pandemic
- Mental health services in Hackney during the pandemic
- COVID-19 vaccination rollout in Hackney

> **I have just found your email in which you have been so kind to send me all the information I missed when you had the meeting on hearing loss. I cannot thank you enough and to tell you how you made my day. It is a gesture I will never forget.**

NHS Community Voice

NHS Community Voice is a patient led project, which brings together patients and residents from all GP practices in City and Hackney to discuss things that matter to them about health. NHS Community Voice was forced to change its engagement and communication methods during the COVID-19 pandemic, as social distancing measures were imposed and some people self-isolated or shielded. All face-to-face work stopped, and the protection of vulnerable residents from the virus became a priority.

Challenges included:

- Providing targeted outreach to ensure representation of specific participant groups.
- Collating people's demographics, evaluation and feedback is difficult with online events.
- Lack of access to the internet or IT skills has made it hard to reach some groups.
- Inability to meet our communities face to face to gather people's insights.

Activities

COVID-19 survey

We wanted to capture a snapshot of the experiences and wellbeing of the Hackney and City of London community during the COVID-19 pandemic.

To ensure we reached as many people as possible, including those without internet access, we have had to be inventive and adapt our approach. Flyers were included in 1,800 food parcels that were distributed to residents by Hackney Council and 120 in the Kosher food parcels sent out to the Orthodox Jewish community, who were shielding or isolated.

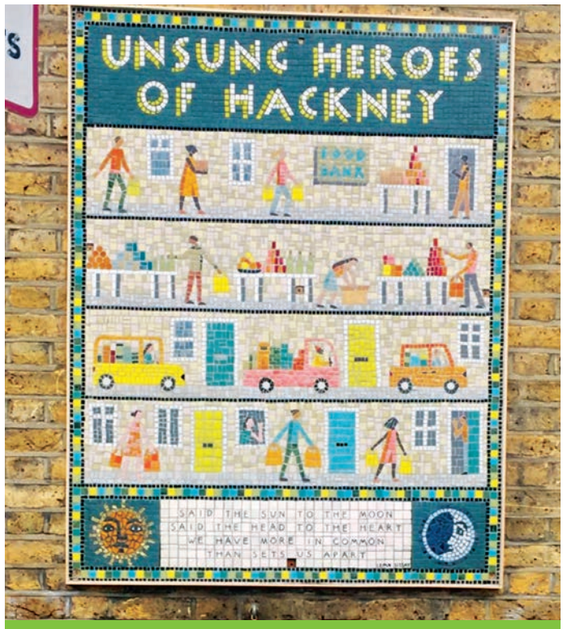
84 people completed the survey. The report highlighted the significant effect the digital divide has on residents' ability to access adequate support and information. Many people also seemed to have lost trust in public information. It also demonstrated the impact of the mental health crisis resulting from the pandemic, that is affecting all areas of the community.

NHS CV and Hackney Mosaics

We worked in partnership with Hackney Mosaics to create a plaque which is on display at Lincroft Road.

The plaque, which features a poem by Hackney resident Lemn Sissay OBE, honours the contributions of NHS staff and frontline key workers. Lemn said "Thank you Hackney Mosaic Project. This is my first landmark poem in Hackney and I love it."

The creation of the plaque involved 20 individuals, many of who were self-isolating and digitally excluded. Taking part had a positive effect on their health and wellbeing, creating connections and lessening loneliness.



Said the sun to the moon
Said the head to the heart
We have more in common
Than sets us apart

Working in partnership with Shelter to survey and run focus groups with residents in temporary housing

In late 2020, 27 households took part in a series of telephone surveys and focus groups with Healthwatch Hackney's NHS Community Voice project and Shelter London, to better understand the issues they and others face in accessing basic facilities in their accommodation and housing services.

The report highlighted the negative impact of living in temporary accommodation, with 78% reporting that it had impacted on their mental health.

Hackney Council responded positively to the report, telling us that they are rolling out free Wi-Fi to all their hostels over the next year; installing laundry facilities where possible; working on improved crisis prevention; trialling the embedding of social workers in housing needs teams; and providing hostel residents with clear and accessible accommodation guides, which outline key contacts and highlight a range of services they can access.

Self-Care Winter Event 2020

127 people attended this online event which focused on promotion of well-being activities that are free and available to the community in Hackney.

COVID-19 Conversations were held for the **Black and South Asian Communities.** The events provided a platform for discussion and the answering of questions about the vaccine, helping to address issues preventing uptake. A total of **200+ people** attended both events.

Next steps

As the lockdown starts to ease, NHS Community Voice has a key role to play in the new North East London Clinical Commissioning Group's resident involvement to feed the voices of residents into the system through the new structure of the People and Place Group.

The Involvement Alliance

For the last two years the Involvement Alliance has worked hard to raise awareness of services, working in partnership with member community organisations. Activities included the development of joint opportunities to work together on involvement and engagement to activities with seldom heard communities, training for member organisations and the sharing of strategies to reach community members. The project ended in November 2020. Members of the Alliance were surveyed and reported very positively about their experience.

70% said "the project met their expectation"

85% said "it improved information sharing"

52% said "it created opportunities for partnership working".

> **Thank you for the work carried out and shared information and inviting me to the initiative and having met with the other organisations**
>
> Turkish Cypriot Association

Although the Involvement Alliance has formally ended, it leaves a strong legacy of collaboration. Established organisational relations will enable continued exploration of joint activities to spread costs and achieve crossover between groups and service sectors, for example, bring together young people and older people for intergenerational projects.

> **We have found this a valuable vehicle for building closer working relationships with related organisations, and one well worth the extra time expended. We will try to sustain them going forward**
>
> Older People's Reference Group

The Involvement Alliance Small Grants Scheme was created to support widening engagement and organisational developmental needs. With the start of the COVID-19 pandemic it enabled organisations to better respond to the challenges of public engagement/involvement, when face to face work became impossible.

Three members of the Involvement Alliance were awarded a £1,400 grant. This included funding two postal newsletters to members of the Older People's Reference Group. The content included 'We Said – They Did' on behalf of City and Hackney Clinical Commissioning Group, as well as other useful bits of information such as. tips on self-care, useful contacts and a 'Meet the Advisory group' section. Only 140 out of 460 their members have email addresses making providing information in a paper format incredibly important.

Healthwatch investigatory reports

How can I help you? What patients tell us about Hackney GP receptionists November 2020

Receptionists in GP practices are generally the first point of contact for people seeking medical help. Making sure the service is welcoming and friendly is vital in ensuring access to healthcare is easy and straight forward.

> **I'd like to report a case of negligence from my GP practice, who have been very passive aggressively neglectful towards me, constantly forgetting to do tests, losing results, ignoring my health tickets, not replying to my call back requests, and now my physical health and illness is proceeding to get worse.**

We looked at feedback from **80 people** collected between November 2019 and July 2020 and related to patients interaction with receptionists.

POSITIVES

- Patients were generally happy with the care they receive at their GP practices.

NEGATIVES

- Problems with phone calls were one of the main issues highlighted by people trying to access GP services.
- Insensitivity and unprofessional behaviour from receptionists is experienced in multiple ways by patients across surgeries. In some cases the interaction is perceived as rude and confrontational, in others it forces patients to take drastic decisions such as changing surgeries or stopping treatment.

Complaints: Some patients felt that after they reported the behaviour of receptionists to their GP their complaint has not been fairly investigated in an open and transparent way.

Changes following our research

We signposted residents to the Hackney Health and Social Care Complaints charter and made them aware of how they can raise concerns and what they should expect from services.

> **Thank you very much for all of the information.**

> **I've been redirected to you via the NHS and Citizen's Advice websites to make a complaint about a GP in Hackney. Might you be able to let me know how to go about it?**

The experience of Hackney carers during COVID-19 pandemic March–October 2020

The COVID-19 pandemic has had a profound impact on the lives of those providing unpaid care. The closure or remote provision of services meant that many carers who previously would have had a break, had to cope without a respite.

Between August and October 2020, we spoke to **38 unpaid carers** and heard of their experience during the pandemic.

POSITIVES

- Several carers reported positive experiences – including of the increased use of remote communication (e.g. by calling, sending pictures and having virtual consultations).

NEGATIVES

- Carers have provided an increased amount of care, spent more time providing practical help and emotional support due to changes in their typical care arrangements and their restricted ability to access support services.
- They have also had extra expenses, including having to pay for extra personal care.
- The majority of respondents had not been contacted by health and social care services.
- Slow and confusing information provided.

Changes following our research

Unpaid carers were made aware of their rights to support by signposting them to City and Hackney Carers Centre and Carers First.

An investigation into dental services in Hackney during the COVID-19 pandemic September – October 2020

The COVID-19 pandemic has had a significant impact on the delivery of both routine and urgent dental services. In March 2020 all non-urgent dental care, was stopped as part of strict measures to help stop the spread of coronavirus. Urgent care would be based on telephone advice and the prescription of analgesics and/or antibiotics.

We undertook research to assess how all NHS commissioned dental practices in Hackney were operating during the COVID-19 pandemic.

What we found:

POSITIVES

- Most dentists aimed to see urgent patients on the same day or within 48 hours.
- Most of the practices were referring patients to 111 if they could not see them.

NEGATIVES

- Fewer practices were able to accept new NHS patients.
- The time-consuming infection control procedures and extra cleaning led to dentists being able to see fewer patients per day.
- Most of the practices were prioritising patients with the most urgent needs.

Changes following our report

We signposted several residents to dental surgeries in Hackney, which we identified during our research as having the capacity to accept new NHS patients.

> **This is really helpful information. Thank you very much for this. I'll enquire with the dentists you've listed and see how it goes. Fortunately, I don't have any need for emergency treatment. Thanks again for your help.**

> **I have successfully found a place at Woodberry Down Dental Practice! I have an appointment for 22/03/21. Thank you so much for your help! I was starting to lose hope.**

> **Thanks so much for that information. Really very helpful! I'll try a couple of the surgeries you mentioned.**

page 120

Enter and View report, ride-out with ParaDoc – February 2021

ParaDoc provides an assessment and treatment service for acutely unwell patients in City and Hackney, who might otherwise be admitted to Accident and Emergency. The focus is on patients who are elderly and frail and those with complex needs.

The Chair of our Board, Malcolm Alexander, had a ride-out with the ParaDoc team for three hours (5pm-8pm), which included a visit to two patients.

POSITIVES

- They are a highly impressive team of a GP and paramedic, who demonstrated outstanding clinical/medical practice in their interaction with patients, their commitment to providing the very best urgent care and keeping patients away from the A&E department.

NEGATIVES

- Services are limited to only one car. ParaDoc service should be expanded to meet the needs of patients and limit the number of referrals to the Accident and Emergency department.

Changes following our report

ParaDoc expanded their capacity and developed a connection with both the local and pan London commissioning teams for emergency care (unplanned care).

Helping you find answers

Before the COVID-19 pandemic Healthwatch Hackney was frequently out and about in the community. Directing people towards different services was an important part of this work. It became clear during the first wave of the pandemic and the introduction of social distancing, that we would have to reshape this work.

We continued to respond to general emails and calls, but also proactively contacted all our supporters to check on their welfare and collect comments on their experiences of accessing healthcare. Calls provided a vital opportunity to signposting residents to support services.

POSITIVES

- Supporters appreciated check-in calls and saw them as 'sun in a stormy day'.
- Overall, supporters found the pandemic challenging but manageable

> **Have been coping well during the lockdown. Zoom has made a real difference for me.**

> **I lost my husband a few months ago and find it difficult to cope but have been trying to keep busy.**

- NHS staff were positively regarded.
- Supporters felt safe at medical centres and the local hospital but not in transit to them.
- Virtual appointments were well received.

NEGATIVES

- Individuals who were self-isolating and the elderly needed extra care during the pandemic. Unfortunately, a small number of supporters reported having nobody to rely on.
- Physical distancing over-burdened already stressed caregivers.
- Parents were not equipped for home schooling.
- As the pandemic continued, mental health became more concerning.

Changes following our calls

We referred a number of residents to Hackney Council's Coronavirus support, food support services, prescription delivery, befriending services and carers support.

Among the main signposting destinations were NHS Independent Health and Care Advocacy Services and Hackney Council services together with GP/hospital services.

> **It was a 'breath of fresh air' speaking to you. Thank you for making time to listen to my concern regarding the poor care towards my parent at the Homerton Hospital.**

Integrated commissioning

Integrated Commissioning is about bringing together health and care services to deliver more effective care for residents. 2020 – 2021 saw many changes as the Integrated Commissioning Board prepared to become Integrated Care Partnership on 1 April 2021. Against the backdrop of a global pandemic, with remote working the norm, local councillors, health commissioners, health and care providers, voluntary and community sector and residents representing the public, prepared to come together create a truly integrated approach to governance for health and care services across Hackney and City. The integrated care partnership will allow decisions to be made by a triumvirate, made up of managers, clinicians/practitioners and the public.

Healthwatch Hackney has played a key role in the preparations of this change. We sought to ensure public representation is embedded in this new system. We faciltated communication, engagement and public representation across local health and care services. In this way we give life to the vision to the triumvirate and fully integrated care.

Care workstreams

Healthwatch Hackney has supported public representatives to sit on and contribute to each of the care workstream boards, which are planned care, unplanned care and children and young people's workstreams (the prevention workstream transformed into a COVID-19 focused group led by Public Health). This has allowed residents to bring the current patient perspective and the "common sense approach" to these decision-making boards, which are working in partnership commissioners and practitioners to generate plans for the integration of care.

Communications and Engagement group

This group is co-chaired by our executive director. The group brings together representatives from across the integrated care system, allowing London Borough of Hackney, City of London Corporation, Homerton hospital, the GP Confederation, the voluntary and community sector, East London Foundation Trust, Healthwatch City of London, patient and public representatives and many more to work together to align and agree work around communication and engagement. The group acts as a touchpoint and successfully promotes collaborative working across the system. This year the group supported:

- Communication and public engagement for the vaccine rollout and ongoing vaccine delivery, with a focus on harder to reach communities.
- Winter planning and flu engagement.
- Access to GPs for all including undocumented migrants.
- Community Champions delivering up to date accurate information about Covid and vaccines directly into communities.
- Young system influencers – a project enabling young people between 16 and 24 to engage directly with the system to promote improvements.
- The creation of the public involvement strategy for City and Hackney for the coming 12 months.
- The creation of the communication and engagement strategy for the coming 12 months.

Neighbourhoods

Neighbourhoods are part of the move towards greater joint working between different health and care teams and the wider community. Eight local Neighbourhoods have been created across the City and Hackney. By organising services such as GP practices, social care teams and community mental health support into Neighbourhoods, the aim is that they will work more effectively together, providing better support for residents. In addition to this the services and support in each Neighbourhood should better reflect the needs and priorities of local people. Here are a few highlights.

Neighbourhood Resident Involvement Group (NRIG)

Healthwatch Hackney supports the Neighbourhood Resident Involvement Group (NRIG) which is made up of 12 volunteers from across the different Neighbourhoods in City and Hackney. NRIG has been representing residents within the Neighbourhoods programme for over 2 years.

NRIG's focus in 2020-21 has been to strengthen the understanding and use of co-production within the Neighbourhoods programme. Co-production means that professionals and residents work together to develop solutions to shared challenges. This may result in new services, training, policies or communications. NRIG started a series of workshops with a consultant in January. A joint workshop with employees from the Neighbourhoods Programme will take place in May 2021, resulting in a co-production handbook. This work will also be incorporated in the review of the Hackney Co-production Charter to strengthen co-production across the borough and beyond. We anticipate this will lead to opportunities for the co-production of Community Nephrology services (kidney diseases), and aspects of mental health services.

Community Influencers Pilot

To meet the need for more flexible and inclusive approaches to involving residents, we have been working in partnership with Volunteer Centre Hackney's Our Place Hoxton project. Ten residents volunteered to gather insights from their friends, neighbours and family members about their local community and the things impacting their health and wellbeing. Although it has been challenging carrying out engagement activities during the pandemic, there were some interesting findings from this work. For example, social isolation and concerns about the lack of physical activity were the top impacts of COVID-19 raised by people in Hoxton. Unsurprisingly there was a lot of interest in events that bring people together and exercise groups as we emerge from the pandemic.

> **"I've learned lots from other volunteers about how they relate to their community and the training opportunities of Community Organising. I learned a lot from being in a group with diverse people, learning from people's ideas and interpretations.**

The issues raised from this work will contribute to the strategy for the local Neighbourhood Partnership Forum. The learnings from this pilot and work in the City of London later this year will be written up into a tool-kit which will be shared across the whole of the Neighbourhoods programme.

> **"It's a chance for people in the local community to feedback their thoughts and comments about what's been going on and what needs to change.**

> **"I like the collaborative aspect of things, it's fluid and participant led which I've not experienced yet. We are doing something that all Hoxton participants can relate to and it is being driven by people in the area.**

Neighbourhood Conversations and Partnership Forums

Neighbourhood meetings have been hosted by Hackney CVS to identify what the key issues are in each Neighbourhood and how different people and organisations can work together to address them. In Well Street Common Neighbourhood and Shoreditch Park and City they are developing a more formal "Partnership Forum" with their own steering groups and strategies. At both the conversations and forums there is a mixture of residents, primary care staff, voluntary and community organisations and Council staff. Resident engagement and participation within both the conversations and forums has been developing over the past year. Well Street Common was established first and has established a number of working groups to address mental health support, resident engagement, communications and inequality and inclusivity.

Our volunteers

Healthwatch Hackney cannot deliver its work without our fantastic volunteers. Many volunteers go on to paid work. Last year 43 volunteers provided 2,299 hours of unpaid support including:

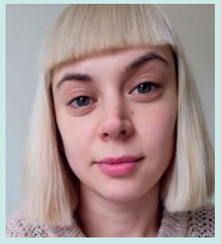
+ Board membership
+ Public representatives on key health committee and groups
+ Calling our supporters
+ Collecting public feedback
+ Event organisation and administration

Debbie

After a career as an exhibition organiser, I wanted when I retired to put something back into the community where I have lived for over 30 years. I discovered Healthwatch Hackney at a Hackney Volunteer Day. Their commitment to giving local health providers grassroots feedback appealed to me and I thought I had the kind of skills and experience they might find useful.

I enjoy the outreach activities, talking to people to get their comments. We are currently doing this on the phone due to the pandemic. We log the comments on to the Healthwatch Hackney database before they are assessed by a panel that includes some volunteers. We then create reports for our Clinical Commissioning Group to show how local services are doing against a range of criteria.

I've been volunteering for over two years now and have been trained in adult safeguarding, working with an 'enter and view' inspection team and have attended an active listening course. It is rewarding as I've had to develop new skills as well as using existing ones and the team at Healthwatch Hackney are always helpful, grateful, and supportive.



Ivana Kolar

I am a public health student and a Hackney resident for the past six years. I slowly fell in love with this vibrant borough, and it was important for me to try and give back to the community as much as I could.

Healthwatch Hackney was suggested to me through university as a great organisation to get involved with to gain insight into public health. It seemed like an amazing opportunity, but it has become so much more than I expected. I have been volunteering since February 2021. The most joyful part of volunteering is being able to connect and work with people that share the same interests as me. People who want to improve lives of their community members and people that I am able to learn so much from. Volunteering has really opened my eyes. It showed me the extent of health issues in Hackney and the importance of listening and hearing what people have to say about access and delivery of health and care services.

Volunteering during a pandemic was definitely a different experience than I expected but Healthwatch Hackney, especially my manager Kanariya, have made it a new normal. I've met and worked with so many people already, so I can't wait to see what will happen next. I look forward to meeting new people and gaining further experience while supporting the communities in Hackney.

Our finances

INCOME	2020-21 £	2019-20 £
Funding from local authority to deliver local Healthwatch statutory activities	150,000	150,000
City of London Corporation	-	8,677
NHS clinical commissioning group projects	209,244	224,136
Other income	2,250	7,065
Total Income	**361,494**	**389,878**
EXPENDITURE	**2020-21 £**	**2019-20 £**
Operational costs (including project direct expenses)	83,443	73,281
Staff costs	251,714	282,669
Premises / office costs	15,819	17,367
Healthwatch City of London	-	11,660
Total expenditure	**350,976**	**384,977**
Balance brought forward	10,518	4,901

The London Borough of Hackney funding is provided through a central government Local Reform and Community Voices 2020/21 grant and was awarded £201,335 to support Healthwatch.

Contact us

Healthwatch Hackney
1st Floor, Block A
St Leonard's Hospital
Nuttall Street
London N1 5LZ
020 3960 7454
info@healthwatchhackney.co.uk
www.healthwatchhackney.co.uk
@HWHackney @HWHackney

Please contact us if you would like this report in another format.

Front cover photo: Sabrina Jantuah. Additional photography: Chris Cross, Mark Drinkwater, Sabrina Jantuah, Sean Pollock, Jon Williams

Design and layout: www.revangeldesigns.co.uk

This report is published on our website and shared with Healthwatch England, the Care Quality Commission, NHS England, Health in Hackney scrutiny committee and North East London clinical commissioning group.

healthwatch Hackney

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Secondary use of GP patient identifiable data – verbal update**	Item No **8**

OUTLINE

The Chair has asked the CCG to provide a verbal update after concerns were raised about planned changes to how NHS medical records from every GP patient in England will be shared with third parties.

The issue has received significant media coverage nationally including for example this article in the Guardian
https://www.theguardian.com/society/2021/jun/01/gps-urged-to-refuse-to-hand-over-patient-details-to-nhs-digital

Here also is a news story on it from an industry publication which provides context and attempts to summarise both sides:
https://www.medicaldevice-network.com/features/nhs-data-grab-gpdpr/

What is the NHS 'data grab'?

By Chloe Kent 17 Jun 2021
The NHS recently delayed plans to share NHS medical records from every GP patient in England with third parties.

"The medical records of NHS England's 61 million users are set to be gathered in a new centralised database as part of a new scheme called the General Practice Data for Planning and Research (GPDPR). According to NHS Digital, the data will be used to: inform and develop health and social care policy, plan and commission health and care services, take steps to protect public health such as managing the Covid-19 pandemic, enable research, and provide individual care in exceptional cases.

The database will not include names or addresses, or any other data that could directly identify a patient like their NHS number, date of birth, or postcode. NHS Digital claims this will allow the information to remain confidential when it's accessed by third parties in the healthcare industry. It also says that the data will only be accessible to organisations with a legitimate need for it who match up to stringent criteria, and that the database will never be used for insurance or marketing purposes, promoting or selling products or services, market research or advertising.

But while the scheme was in development for three years, patients were given just over a month to be made aware of the project and opt out if they wished to do so. NHS Digital released the plans on 12 May this year and gave a deadline of 23 June for people to omit data from the GPDPR, which has since been pushed back to 25

August following pressure from the Doctors' Association UK (DAUK). If patients do not opt out by this time, they will not be able to do so in future.

The information set to be included in the database includes data about: sex, ethnicity, sexual orientation, diagnoses, symptoms, observations, test results, medications, allergies, immunisations, referrals, recalls and appointments, including information about physical, mental and sexual health. Notably, it includes details about which staff have treated patients.

Those in favour of the initiative believe the database could be a big help in advancing understanding of medical issues, but critics have described the move as an "NHS data grab". Writing into the Guardian, University of Manchester emeritus professor of medical informatics Alan Rector described the assurances of anonymity as "worthless" and that "[f]ew people realise how easy it is to identify individuals from medical records, even if obvious personal details are removed."

All 36 doctors' surgeries in Tower Hamlets, east London, have agreed to withhold patient data when the collection begins.

Patient data confidentiality

While it is worth acknowledging that "most people would be happy for the NHS to have their health data", it doesn't change the fact that the NHS has been involved in some pretty dodgy data dealings in recent years which have damaged public trust. In 2014, the Care.data initiative proved so unpopular public outcry led to the scheme being scrapped in 2016.

In 2015, the health records of NHS patients at the Royal Free London Trust were transferred, without explicit consent from patients and in a way that did not comply with the UK's Data Protection Act, to Google DeepMind. In 2019 it was revealed that international pharmaceutical companies had obtained access to NHS patient data, while the recent involvement of big data company Palantir with the NHS Covid-19 datastore has ruffled more than a few feathers."

Attending for this item will be:

Dr Mark Rickets, CCG Clinical Chair for City and Hackney
Siobhan Harper, Director of CCG Transition for City and Hackney

ACTION

The Commission is requested to give consideration to the briefing.

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Minutes of the previous meeting**	Item No **9**

OUTLINE

Attached please find draft minutes of the meeting held on 8th June 2021.

Matter Arising from 8 June

Action at 7.7

ACTION:	*TF to report back on number of first and second doses of the Covid vaccinations given to staff at HUHFT.*

This has been requested.

ACTION

The Commission is requested to agree the minutes.

This page is intentionally left blank

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Tuesday 8 June 2021 at 7.00pm

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

Chair	**Councillor Ben Hayhurst**
Councillors in attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David and Cllr Emma Plouviez.**
Councillors joining remotely	**Cllr Michelle Gregory and Cllr Deniz Oguzkanli**
Council officers in attendance	**Helen Woodland (Group Director Adults, Health and Integration)** **Chris Lovitt (Deputy Director of Public Health for City and Hackney)** **Zainab Jalil (Head of Commissioning, Adult Services)** **Alice Beard (LBH-CCG Communications Officer)**
Other people in attendance	**Cllr Christopher Kennedy (Cabinet Member-Health, Social Care Leisure)** **Cllr Yvonne Maxwell (Cabinet Adviser for Older People)** **Tracey Fletcher (Chief Executive of HUHFT/ ICP Lead City & Hackney)** **Fiona Kelly (Head of Adult Therapies, Division of Integration Medicine & Rehabilitation Services, HUHFT)** **Dr Mark Rickets (CCG Clinical Chair for City and Hackney)** **Siobhan Harper (Director of CCG Transition for City and Hackney)** **Charlotte Painter (Acting Workstream Director for Planned Care, NHSE NEL CCG for City and Hackney ICP)** **Paul Calaminus (Chief Executive, East London NHS Foundation Trust)** **Andrew Horobin (Deputy Borough Director for City & Hackney, ELFT)** **Jon Wiliams (Executive Director, Healthwatch Hackney)**
Members of the public YouTube link	42 views **The meeting can be viewed at https://youtu.be/XvXBP2SjI_E**
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Election of Chair and Vice Chair

1.1 It being the first meeting of the O&S Officer opened the meeting and invited nominations for Chair. Cllr Adams nominated Cllr Hayhurst and Cllr David

seconded. There were no other nominations. Cllr Hayhurst was elected unanimously as Chair.

1.2 Cllr Hayhurst took the Chair and invited nominations for Vice Chair. He nominated Cllr Snell and Cllr Plouviez seconded. There were no other nominations. Cllr Snell was elected unanimously as Vice Chair.

2 Apologies for Absence

2.1 Apologies were received from Dean Henderson (ELFT) and Dr Vinay Patel (LMC)

3 Urgent items/order of business

3.1 There was no urgent business and the order was as on the agenda. The Chair stated that this was the first hybrid meeting with some Members in the Council Chamber and others and all guest joining remotely.

4 Declarations of interest

4.1 There were none.

5 Confirmations of Terms of Reference

5.1 The Chair stated that as it was the first meeting of the new municipal year the Commission, as usual, noted its Terms of Reference.

RESOLVED:	**That the terms of reference and procedure rules be noted.**

6 Appointment of 3 Members to Inner North East London Joint Health Overview and Scrutiny Committee for 2021/22

6.1 The Chair drew Members' attention to the report and stated that the proposal was that he, Cllr Snell and Cllr Adams be proposed as the three representatives for the year. Members voted unanimously to accept this proposal.

RESOLVED:	**That Cllrs Hayhurst, Snell and Adams be appointed to INEL JHOSC for 2021/22.**

7 NHS East and South East London Pathology Partnership

7.1 The Chair stated that the issue of the 'path lab' at the Homerton had been discussed at previous meetings and in Jan 2020 the Chief Executive of HUHFT had undertaken to update the Commission. Since then, a new pathology partnership for East and South East London had come into being on 1 May 2021. This new organisation is jointly owned by Barts Health, the Homerton and Lewisham and Greenwich NHS Trusts.

7.2 The Chair welcomed for this item:

Tracey Fletcher (TF), CE of HUHFT and ICP Lead for City and Hackney

7.3 Members' gave consideration to a copy of Barts Health's news release announcing the partnership and a HSJ article "*Commercial partners could take over 'entirety' of planned imaging networks*" outlining NHSE's recent announcement that diagnostic imaging networks will become separate entities.

7.4 TF gave a verbal presentation describing the partnership, which went live on 1 May. It was noted that the 'GP direct access' staff element would move from the Homerton to the new hub at the Royal London in July and also that the end of 2022 would be the completion date for the associated upgrade at HUHFT.

7.5 Members asked questions, and in the responses the following points were noted:

(a) In response to a question from the Chair on the separate issue of the impact on the Homerton of the new collaborative between Barts Health and BHRUT, TF stated that in the very long term it was not clear what the impact would be. Arrangements were being made for BHRUT and Barts Health to have a joint Chair and they were trying to establish how they can work in a collaborative way to both of their advantages. She added that there was an opportunity also for HUHFT and ELFT and NELFT to think about where they all can fit in by working as 3 way or as a 5 way set of organisations for the future. There would obviously be economies of scale and savings on some elements of procurement which would be to everyone's benefit HUHFT already had clinical arrangements with Barts Health over many years. She added that the change would allow HUHFT to iron out wrinkles within their current clinical pathways to everyone's benefit. She explained that HUH did not have certain specialisms such as in-patient neurology and patients already needed to go to Barts, therefore collaborative working was already built into the system.

(b) In response to a question on job losses at HUHFT as a consequence of Pathology Partnership, she stated that there shouldn't be any but there would be some shifts in roles. She was not anticipating any losses across the three departments involved as they were all already carrying vacancies.

(c) Members' asked about local GP concerns about slow turnaround of pathology results from Barts in the past. In response to a question on why the single system hadn't been put in place before the communications network, TF replied that they had had to put a team in place first to get the components ready for the new hub and spoke system. They needed a level of expertise coming together so bringing the team together and getting them working together and establishing leadership was more helpful in subsequently establishing the transfer of services. She added too, that the building work at HUHFT would not be delaying any matters regarding the partnership.

(d) In response to a question on why the partnership was with Lewisham and Greenwich rather than with Barts and BHRUT, TF stated that BHRUT had been content with their own arrangements and the pathology network discussion had

begun three years previously and so they did not feel they needed to join the HUH-Barts-L&G arrangement.

(e) The Chair stated that the people of Hackney were proud of HUHFT and stated that any loss of independence for the Trust going forward would be met with much local resistance. He asked if there were any board level discussions at HUHFT about any possible merger of governance with Barts-BHRUT. TF replied there weren't any discussions about merging with Barts and that she would have concerns about that. Currently she added HUHFT was in very robust state but both Barts Health and BHRUT needed to resolve a number of internal issues for them and coming together was a way for them to achieve that. She added that Barts-BHRUT acknowledged that the City & Hackney system was further ahead in terms of place based care and they wanted to follow this model.

7.6 The Chair asked TF to undertake to return to the Commission if anything new was floated in terms of the future of HUHFT as they would want to scrutinise the potential local impact in good time, because Members would not be happy if changes were presented as a fait accompli. TF replied that she would and that she would also ensure that the leadership within both Barts Health and BHRUT were made fully aware of City and Hackney's views and considered them too in their deliberations.

7.7 The Chair asked if the Trust could reply to the Commission on the numbers of first and second doses of the Covid vaccination had been given to staff at the Trust.

ACTION:	**TF to report back on number of first and second doses of the Covid vaccinations given to staff at HUHFT.**

7.8 The Chair asked Dr Mark Rickets (CCG Chair) about a local press story, highlighted to him by Healthwatch, on GP Practices asking for ID before allowing people to register and what was being done about this unwarranted barrier to access. MR replied that he was not aware of the story, but the regulations were clear that you do not have to present ID to register with a GP.

8 Treatment pathways for Long Covid

8.1 The Chair stated that the Commission had asked for a briefing on Long Covid following concerns raised by residents.

8.2 Members gave consideration to a briefing report '*C&H Rehabilitation Service and HUH post-Covid Specialist Assessment Clinic'* and he welcomed to the meeting:

Dr Fiona Kelly (FK)**,** Head of Adult Therapies, Division of Integration Medicine & Rehabilitation Services, HUHFT
Charlotte Painter (CP), Acting Workstream Director for Planned Care, NHS NEL CCG for C&H Integrated Care Partnership
Dr Mark Rickets (MR), CCG Clinical Chair for City and Hackney
Siobhan Harper (SH), Director of CCG Transition for City and Hackney

Helen Woodland (HW), Group Director Adults, Health and Integration, LBH

and he added that that report contained estimated figures vs total figures and so was not fully up to date.

8.3 FK and CP took Members' through the briefing in detail, concluding that it was now necessary to treat Long Covid as a new Long Term Condition (LTC) which would stay with us. She added that the data slide contained estimates and needed updating but that there had been a spike in referrals in March arising from a rise in cases in January. She drew members' attention to slide 5 which highlighted all the resources created to help people manage their condition. FK described the clinical aspects of Long Covid and the patient pathway via GP referrals, then clinical triage and then directly to assessment in community or at HUH. She stated that they had 300 referrals to date across the service and 95 assessments in clinic and 40 in community service. A lot of out of area referrals had to be redirected. She stated that they tracked ethnicity which highlighted some gaps and so they were doing proactive case finding with the help of local VCS orgs. The symptoms of long covid were wide ranging but usually involved persistent fatigue and breathlessness which have a long terk impact. One of the risks was of people attempting to do too much too soon and getting worse. She described the diverse multi-disciplinary team across physical and psychological services at the Centre and the use of digital tech to support patients. CP stated that building a sustainable service was now the focus and that there was a need for more awareness raising and engagement and a need to monitor demand and presentations in order to better plan ahead. A Clinical Fellow post across NEL had been created to keep on top of the evaluation.

8.4 Members asked detailed questions and the following responses were noted:

(a) Chair expressed concern about people having to wait 12 weeks and asked whether the NICE guidance had got this right. FK replied that a large number of patients the condition would resolve itself in the post-acute phase therefore the focus was on getting the timing of the support right. Initially the approach was self-management by signposting to the comprehensive interactive guidance which is available. She added however that they were flexible on earlier referrals but it was very challenging to choose when the cut-off point must be.

(b) Members asked about how the Clinic worked, if at all, with those with complex medical diagnoses who had been kept in acute rather than covid hospitals and presumably this cohort would not have a 12 week wait. FK replied that there were established processes. There is clinical triage so if it is decided that a person is better supported though a known pre-existing LTC pathway and if they are already well known to those teams then they would be redirected to them. The clinical conversations take place in a Multi-Disciplinary Team. The logic in standing up some standalone capacity was essentially that this is a new LTC. If these patients had been badged in the normal way, then the system would have run the risk of being overwhelmed at a time when specialist staff were being redeployed to deal with Covid front line and so waiting times to support those with long Covid would have been even longer. It's about how we support and understand the current need while looking to

the future and how we will be able to integrate it into current range of services, she added. CP added that the team was strongly linked into the relevant specialities and can seek advice so that aspect is working well.

(c) Members asked if there had been any asymptomatic cases of Covid dealt with in the Clinic who then presented with symptoms later on. FK replied she didn't think there were. CP added that severity of initial presentation is not necessarily linked to long Covid and it's not a predictor.

(d) Members asked about two distinct cohorts: people who have been through life threatening illness in intensive care and still haven't fully recovered and others who are appearing later on with alarming symptoms, and who are often younger. FK replied that those who had a very serious illness requiring acute critical care are followed up on via a different care pathway post ICU and many of those end up in patient rehab. The other cohort is people presenting via the Single Point of Access and these are less likely to have required an acute admission but have recovered with support in the community and now have debilitating and long-term symptoms. She added that the age of this cohort is on average, 44.

(e) Members asked about how to promote healthy lifestyles to those who for various reasons haven't taken the vaccines and if this has been considered e.g. how to keep safe, having regular tests etc and on the follow-up post discharge from acute services. FK replied that across all services they make every contact count and provide information and education to make informed choices as part of recovery e.g. looking at nutrition, sleep etc. As for follow-up on hospital discharge, this is on a needs basis as they can't provide a preventive follow up for everyone regardless of need.

(f) The Chair asked about the communications strategy around this clinic/service because for those who got Covid in first wave the system was not in place then. CP replied that they were planning to do proactive contact via GP Practices to patients registered with a code of either 'Covid' or 'suspected Covid' and this speaks to the health inequalities issue about missing out on those who haven't presented. This is a large number so there will need to be a staged approach. She added that more culturally competent Communications and Engagement via community groups and VCS partners for example was very important and she would appreciate input from Members and residents on how to do this best. The Chair suggested that perhaps they needed to join up efforts with the vaccination teams as both encouraging vaccine take up and outreach on long covid are both needed at the same time. SH described the vaccination efforts using community champions and the VCS and the Chair asked if these details could be passed on to this clinic so that they can use it for outreach work.

(g) The Chair asked about education and training for GPs and CP replied that they had done a lot of it from early on. In the first wave patients were presenting and GPs were not fully sure what to do with them before this service had been set up. They had produced a resource pack with the self-management resources for the GPs to distribute to those presenting. The take up from GPs has been excellent and the process is ongoing and evolving all the time are more is being learnt.

(h) Members asked if someone presented with long covid do you do an antibody test and can you have long Covid without evidence of that in the first place. FK replied that they accept people into the service who have been clinically diagnosed as a presentation of Covid (and this was not an easy task early on in the pandemic). They were not routinely doing antibody testing but basing it on clinical assessment within primary care. MR concurred saying that it's based on clinical assessment at primary care stage and an antibody test isn't a gatekeeper.

(i) Jon Williams asked if Healthwatch can be involved in the development of the service and further about what has been done about identifying people with pre-existing disabilities, because the disabled have been one of the worst impacted groups with Covid, and whether the clinic has been in contact with Adult Social Care in terms of contacting the Homecare service users because of the high levels there. CP replied that they certainly wished to ramp up engagement work with Healthwatch. On disabilities data, she was not sure but the point on closer collaboration with ASC was well made and they would pick this up as part of their proactive searches on identifying cases. FK added that in setting up the service they did a clinical audit of all those with pre-existing LTCs to understand the issues, the need and the required configuration. They were also able to access people's clinical records who were referred to them so they would be able to easily identify those with disabilities. She stated that they would take on board the suggestion that this one of the markers in the regular stats reporting in future.

8.5 The Chair thanked the team for their excellent work and for attending the meeting. He stated that it's something that they would keep a watching brief on and would like to return to at the appropriate time.

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

9 Community Mental Health transformation and recover from Covid-19

9.1 The Chair stated that he had asked ELFT, our key mental health provider, to provide an update on the status their services as a consequence of the lockdowns and the subsequent need to redesign their crisis care pathways and adapt to a mix of face to face and remote access consultations. He welcomed for the item:

Paul Calaminus (PC), Chief Executive, East London NHS Foundation Trust
Andrew Horobin (AH), Deputy Borough Director City & Hackney, ELFT

and Members gave consideration to two papers: '*ELFT adult mental health services'* and *'Community mental health transformation'*.

9.2 AH took Members through the papers. It was noted that while initially during lockdown there had been a huge reduction in usual contacts, calls to crisis line had doubled and most were not known to mental health services. The community crisis service had continued with 100% home visits during the lockdowns. There had also been a spike in calls to Children and Young People's Services during lockdown. As regards the Transformation

Programme, the 8 x Neighbourhood Teams were now in place and fully blended teams would be operational by September. The blended teams were bigger as they included representatives from the local VCS, Turning Point, Tavistock & Portman Trust etc and so a more diverse offer could be provided. He described the role of the Community Connectors created with the VCS to help counter social isolation in the community and how they were working with Healthwatch to gather views on the temporary move of older adult mental health wards to the East Ham Care Centre. PC described the importance of the community model going forward and pointed out how the referrals predominantly related to issues also around housing and employment etc. The Chair thanked the officers and added that a general concern down the years had been about gradual reduction in bed capacity locally and Members would want to keep a closer eye on that.

9.3 Members asked questions and in the responses the following was noted:

(a) Members asked about a court ruling which now required 'hospital manager hearings' (hospital-based assessments) in mental health be done face to face instead of remotely. PC replied that all assessments were now being done face to face and they had had to contact those who had had remote assessments (in this context) and repeat them.

(b) Chair asked how ELFT saw its services evolving in post-Covid world, considering the increase in the number of crisis calls and, on the switch to video consultations when preferred and appropriate. PC replied that going forward the service would be a much more blended one. Face to face was important particularly for first assessment. They had also discovered that for certain types of therapy work remote consultations had worked really well with clients who, for example, were able to stay at home and in familiar surroundings. AH added that early interventions teams and those working with young people had really embraced digital. They had to be mindful of course about digital poverty. A lot of work had been done to devices to people and to then make sure people were able to use them. The advantages of remote services include that staff can communicate with clients much more quickly and easily but face to face will still be vital when there is a need to establish an initial rapport with the client and when staff need to see the living conditions of a client. PC added that they were working hard on re-designing the hybrid model together with service users.

(c) Members asked whether the 'pioneer sites' were coterminous with the PCNs. They asked whether 'community connectors' and 'social prescribers' were employed by ELFT and what is difference was and they asked how ELFT will take on board the importance of providing training and support to Estates Officers in Housing as so much of their work is taken up with supporting tenants with mental health problems. AH explained the timeline for putting mental health teams fully in place in the 8 PCNs which are coterminous with the 4 Neighbourhoods. The Neighbourhoods (each covering 2 PCNs) had been brought in one at a time. They also involved Community Mental Health Recovery Teams. The Community Connectors were subcontracted to the VCS and were provided by Mind who employ them. The difference with 'social prescribers' is that the 'community connectors' also do therapeutic interventions themselves and "walk beside the user" as it were, going to appointments with them if needs be. In relation to support for Estate Officers, AH agreed that social determinants

were the key and they have regular meeting with Housing who, for example, join in 'ward discharge' meetings but they have not, as yet, done direct training for them. He added that they needed to work more closely and this was something they could take forward.

(d) Members asked how the Neighbourhoods system worked with both IAPT and the Wellbeing Network. AH replied that ELFT chairs the Psychological Therapies Alliance and all the partners were on that. They are working on getting IAPT reps into the Neighbourhood meetings also. He added that it was challenging as IAPT has a different provider. The Wellbeing Network operated by Mind hosts the 'Community Connectors' so they meet with them regularly also, he added.

(e) The Chair asked about the wider discussions which have been ongoing about the Estates Strategy and previous plans to move mental health beds from HUH to create more surgical capacity there, and also the creation of a more specialist mental health hub at Mile End and asked whether the move of the older adult 'organic' mental health beads to East Ham Care Centre was part of this. PC replied that the older adults move was not related to that broader Estates work it was rather an urgent requirement for a short term move in order to make the site at Mile End Covid Secure at the height of the pandemic. The putative plan from two years ago on estates hadn't progressed since the pandemic, he added. There is a discussion that needs to take place on creating an in-patient estate that works much better for residents of Hackney and there is a need to renew the current provision and re-build because, he added, some of estate in Hackney still has, for example, shared bathrooms.

(f) A Member asked whether there were any ID access barriers to accessing mental health services (further to concerns about ID being incorrectly demanded for GP access). PC replied that there weren't.

9.4 The Chair thanked the senior officers for their detailed reports and giving their time to attend. He stated that the Commission would want to return to the broader issue around estates for mental health services in the future. He commented that the evidence base for mass consolidation was a contested one and the dynamics were actually more complicated, and he asked PC to keep the Commission updated.

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

10 Redesign of specification for the Homecare Service

10.1 The Chair stated that he had asked Adult Services for a briefing on the work being done to redesign the specification for the provision of Homecare services which, was about to be completely re-commissioned. The specification was being developed as was the plan for co-production and engagement with residents on the re-design of these services. He welcomed for this item:

Helen Woodland (HW), Group Director Adults Health and Integration

10.2 Members gave consideration to a report '*Homecare recommissioning – update report'.*

10.3 HW took Members' through the report highlighting moving to 2 or 3 areas in a Neighbourhood model would give the Providers some economy of scale combined with a geographical patch to focus on.

10.4 Members asked questions and in the responses the following was noted:

(a) Members asked what's the difference between zones, patches and neighbourhoods. HW replied that patches or zones were how you configure the service geographically around the 8 Neighbourhoods (created by the PCNs). The plan was for 2 or 3 zones/patches.

(b) The Chair asked how you might in-source this whole service and what the barriers would be to doing so. HW replied that cost was the key barrier to insourcing as to deliver homecare as an in-house service was estimated at £28.50 p/h compared to an estimate of £18 p/h when purchased externally. It would add £4-5m per year to the Adult Services budget and they would have to find that money elsewhere in efficiency targets etc. She added too that one of the duties on the Council under the Care Act was to "maintain and promote a stable market".

(c) The Chair asked what contributed to the difference because surely a private provider also had to factor in a profit margin. HW replied that it was mainly the pension obligations which add the additional £10p/h.

(d) Members asked about the cheaper costs paid by councils being supported by the private payers and wondered if the whole market in care was distorted by those who paid privately. HW replied that broadly that situation applied only to care homes but not to Homecare, where the vast majority was purchased by local authorities. The private element there was specific agencies linked to self-funders not individuals purchasing themselves.

(e) Members stated that with in-house there was likely to be greater continuity of care and a better and more secure employment model. With councils having to bail out individual providers on occasion was it not time to set up an in-house Homecare service to serve as quality barometer for the sector against which other services could be measured and which would serve as a back-up if any providers failed? HW replied that the issue of councils' role in quality was an interesting and complex one. One of reasons for moving to a zone-based model was that they'll have fewer providers to work more closely with and that it allows the council to develop stronger relationships and deliver more training and support to staff. They could, for example, work more with staff in the Providers to support them to develop Occupational Therapy Assistant qualifications, enabling them in turn to deliver over and above the current offer they provide. She added that Adult Services also wanted to work with health partners on what tasks Homecare providers could deliver which was currently being delivered by Community Nurses, in order to achieve better continuity of care. In terms of stability of employment, she added, they were signed up to the Care Charter and they worked with providers to reduce the amount of zero hours contracts. They would be better able to do that if providers were given more

consistency of work and hours and so better able to plan their workforce and offer better conditions. There were a number of ways to achieve these aims, she concluded.

(f) The Chair asked if you're signing up for 2 contractors the risk is that you don't have the multiplicity of choice you'd have with 8 contractors and what was the duration of the contracts. HW replied that the standard was 5+1+1 yrs but they can also terminate if poor quality. She added that they also have an Approved Provider list which is a back-up list of providers that meet their quality standards. Because of this, if a resident in a zone/patch doesn't want to work with either of the 2 homecare providers allocated to it, they can be offered an alternative. This gives the ASC team a group of providers they can support and develop should there be any market failure.

(g) The Chair asked whether the budget envelope for the re-commissioning was the same as the previous level of funding. HW replied that it was but that they were a demand-led service so the budget envelope had to adapt to fact that care must be provided to anyone who requests it and is eligible under the Care Act. Because of this the development of more preventative work and working with partners in Neighbourhoods was vital in order to help ASC manage that demand going forward.

10.5 The Chair thanked the Group Director for her detailed report and for her attendance.

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

11 Covid-19 update from Public Health and Vaccination Steering Group

11.1 The Chair stated that this item had been planned as 'for noting' but because of the developments he had asked if officers would answer some questions and he welcomed to the meeting:

Chris Lovitt (CL), Deputy Director of Public Health for City and Hackney
Siobhan Harper (SH), Director of CCG Transition for City and Hackney
Helen Woodland (HW), Group Director Adults Health and Integration

11.2 Members gave consideration to a tabled report *City and Hackney Covid-19 vaccination programme*

11.3 The Chair stated that the latest data was troubling because Hackney appeared to be up 200% in a week and there had been a tripling of case numbers to 43/100k.

11.4 CL took Members through the briefing in detail. He stated that the numbers were headed in the wrong direction, but this was to be expected as soon as social distancing measures were relaxed. The Delta Variant was now the most dominant and was more transmittable. The vaccination programme was rolling down the ages but in NEL overall they were 330 vaccinations behind plan, however and work was being done on surge vaccination events. A lot of

activity was taking place and the message to test was being pushed heavily. Hopefully, the planned opening on 21 June would not take place he added. London was different from elsewhere and a key concern was that there were still 70k clinically extremely vulnerable people unvaccinated. Most of the new infections were among younger age groups. If the R rate, which was now above 1, remained there they would soon see unvaccinated people presenting in the acute hospitals.

11.5 Members asked questions and in the response the following was noted:

(a) The Chair stated that whereas nationally 76% had their first dose and 53% had their second, in Hackney just 23% had both and 45% had one. We appeared to be the lowest in the country together with Tower Hamlets and we could be one of the worst hit places if there was another wave. He asked if this was too pessimistic a view? CL replied that the plan had been to vaccinate those most at risk first recognising the limits on supply. He cautioned that it was not always possible to make clean comparisons as you need instead to look in particular at how the cohorts 1-6 are faring. He added that Hackney has had lower numbers overall as our population is younger and our uptake isn't as good as it could be because of vaccine cautiousness in a number of local communities. He went on to describe the phenomenon of 'crowding out' of the vaccination slots as you opened up to younger cohorts and that this prevents getting the earlier cohorts fully covered. Because of this Hackney had run low threshold events where you can just walk up and get vaccinated. He also explained how Community Pharmacies and HUH will help with the surge vaccinations. He concluded that the headline figures can hide the real priorities and the real concern is the 17k unvaccinated who are older and Clinically Extremely Vulnerable. SH went on to describe the plans to mitigate any possible third wave and the need to give out specific advice and about trying to reduce the vulnerable cohorts. It was difficult to keep focus because, as you open up, the next thresholds and huge volumes of people then become eligible, those more vulnerable who are still not vaccinated but in higher up cohorts can get squeezed out.

(b) Members commented that carers are possible vectors of transmission as they often can have multiple vulnerable clients. The vaccination level for domiciliary care staff was still far too low (37% one dose, 6% two). Members asked how the officers plan to target that part of the population so they too don't get lost in the rush. CL replied that domiciliary care workers were at front line and have been eligible since the beginning and sometimes the national messaging focused almost exclusively on NHS to the detriment of care. A significant element of staff were from ethnic minority groups with a high degree of vaccine cautiousness amongst them. They had been successful by taking a clear focus on older adult care homes to get vaccination rates up in those. They'd identified that they wanted to double the vaccination coverage for all care workers. There was a need to understand better where the barriers lay and potentially start incentivising the providers so they would pay from time off for staff to attend vaccination centres. He added that staff would often be younger so there was a need to make sure the Pfizer offer was available for them. There was a need to do engagement sessions with the staff and he had done Q&As with 'provider forums' as part of this. It's about taking the vaccines to these staff and making it as easy as possible for them. This work can involve more use of the Community Pharmacies and using the mobile vaccinations service. He added

that there was a lot of evidence from flu vaccination programmes that you have to keep on it, and you have to have a clear aspiration and clear metrics and to work to encourage and cajole the providers. He added that the news that the government was considering making vaccinations compulsory for care staff would not help in his regard as it played further into that narrative of an overbearing government. There was a need to improve here and they are also looking at pockets of best practice from elsewhere within NEL. HW reinforced what CL said and stated that they were very aware that Homecare is not where it should be on this. They had just employed a Project Manager specifically on it and were trying a number of different approaches. There were multiple and complex reasons why people were vaccine hesitant and it takes a lot of concerted effort.

(c) Members asked about the surge testing in Dalston and Shoreditch. CL replied that this had now concluded. He added that one of the really welcome changes was that all positive PCR tests in London were now being sequenced for variants of concern testing. He added that now that they had concluded the surge testing they were awaiting the results and for the variant of concern mapping it does take a number of weeks. In the two weeks since the Dalston testing, the delta variant had become the dominant one across the UK, so all new cases were now assumed to be delta variant. Things were moving fast and that is why they were asking for caution and hoping the planned reopening on 21 June would pushed back by at least 2 weeks. CL concluded by stressing the importance of the second dose and that it would be the key communication message in the next 10 days.

11.6 The Chair thanked the council and NHS officers for all their efforts here and for the excellent updates.

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

12 Minutes of the previous meeting

12.1 Members gave consideration to the draft minutes of the meeting held on 31 March and the Matters Arising.

RESOLVED:	**That the minutes of the meeting held on 31 March be agreed as a correct record and that the matters arising be noted.**

13 Health in Hackney Work Programme

13.1 Members gave consideration to the updated work programmes.

RESOLVED:	**That the Commission's work programmes for 21/22 and the rolling work programme for INEL JHOSC be noted.**

14 Any other business

14.1 There was none.

This page is intentionally left blank

Hackney

Health in Hackney Scrutiny Commission 8th July 2021 **Work Programme for the Commission**	Item No **10**

OUTLINE

Attached please find the latest iteration of:

HiH work programme 2021/22
INEL work programme 2021/22

These are working documents and updated regularly.

ACTION

The Commission is requested to note the updated work programmes and make any amendments as necessary.

This page is intentionally left blank

Health in Hackney SC - Rolling Work Programme for 2021-22 as at 30 June 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
8 June 2021	**New NHS East and SE London Pathology Partnership**	Update requested from Jan 2020	NEL CCG and HUHFT	ICP Lead for City & Hackney also CE of HUHFT	Tracey Fletcher	
deadline 27 May	**Treatment pathways for 'Long Covid'**	Briefing	NEL CCG	Director of CCG Transition - City & Hackney	Siobhan Harper	
			NEL CCG	CCG Clinical Chair for City and Hackney	Dr Mark Rickets	
			HUHFT	Head of Adult Therapies	Fiona Kelly	
			NEL CCG - C&H	Acting Workstream Director for Planned Care	Charlotte Painter	
	Community Mental Health Transformation and Recovery from Covid-19	Briefing	ELFT	CEO	Paul Calaminus	
			ELFT	Deputy Borough Director - City and Hackney	Andrew Horobin	
	Redesign of specification for Homecare	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
	Covid-19 update	Noting only	Public Health and CCG	Deputy Director of Public Helath	Chris Lovitt	
8 July 2021	**Covid-19 update from Public Health**	Regular update	Public Health	Director of Public Health	Dr Sandra Husbands	
deadline 29 June			NEL CCG - C&H	Director of CCG Transition - City & Hackney	Siobhan Harper	
	Healthwatch Hackney Annual Report 20/21	Annual item	Healthwatch Hackney	Executive Director	Jon Williams	
				Chair	Malcolm Alexander	
	HUHFT Quality Account 2020/21	Annual item	HUHFT	Chief Nurse and Director of Governance	Catherine Pelley	
	Future plans for St Leonard's site	Briefing	HUHFT	Director of Strategic Implementation and Partnerships	Claire Hogg	
	Secondary use of GP patient identifiable data	Briefing	NEL CCG - C&H	CCG Clinical Chair for City and Hackney	Dr Mark Rickets	
			NEL CCG - C&H	Director of CCG Transition - City & Hackney	Siobhan Harper	
11 Oct 2021	**Relocation of inpatient dementia assessment services to East Ham Care Centre**	Update requested from July 2020	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
deadline 30 Sept			CCG or NEL ICS	Programme Director Mental Health	Dan Burningham	
			Healthwatch Hackney	Executive Director	Jon Williams	
	What is Adult Social Care - overview of current provision?	Discussion	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
				Director Adult Social Work and Operations	Ann McGale	
	City & Hackney Safeguarding Adults Board Annual Report	Annual item	CHSAB	Safeguarding Adults Board Manager	Raynor Griffiths	
			CHSAB	Independent Chair	Dr Adi Cooper OBE	

	TBC					
17 Nov 2021	**Transformation Programme for Adult Social Care**	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
deadline: 8 Nov				Director Adult Social Work and Operations	Ann McGale	
	TBC					
	TBC					
9 Dec 2021	**TBC**					
deadline: 30 Nov	**TBC**					
	TBC					
	TBC					
10 Jan 2022	**Overview of capital build proposals in Adult Social Care**	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland	
deadline: 22 Dec 2021				Director Adult Social Work and Operations	Ann McGale	
	TBC					
	TBC					
9 Feb 2022						
deadline: 31 Jan						
16 March 2022						
deadline:7 March						

Note: The Local Council Elections in London take place on 5 May 2022. Purdah begins c. 20 March

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date						
TBC	**Future of virtual consultations in primary care - next steps**	Briefing requested Sept 2020	GP Confederation	Chief Executive	Laura Sharpe	
			Healthwatch Hackney	Executive Director	Jon Williams	
			NEL CCG	Primary Care Commissioner	Richard Bull	
TBC	**Extension of ISS contract for soft services at HUHFT**	Update requested from July 2020	HUHFT	Chief Executive	Tracey Fletcher	

			UNISON			
TBC	**Implementation of Ageing Well Strategy**	Update requested Dec 2019	Inclusive Economy, Policy and New Homes	Head of Policy and Strategic Delivery	Sonia Khan	
Postponed from March 2020	**Air Quality - health impacts**	**Full meeting**	King's College London	Academic	Dr Ian Mudway	
			Public Health	Public Health Consultant	Damani Goldstein	
			Environment Services Strategy Team	Head Environment Services Strategy Team	Sam Kirk	
Postponed from March 2020	**King's Park 'Moving Together' project**	Briefing	King's Park Moving Together Project Team	Project Manager for 'Moving Together' project	Lola Akindoyin	
			Public Realm	Head of Public Realm	Aled Richards	
Postponed from 1 May 2020	**Tackling Health Inequalities: the Marmot Review 10 Years On**	**SCRUTINY IN A DAY**	Public Health	Director of Public Health	Dr Sandra Husbands	
	Sub Focus on Objective 5: Create and develop healthy and sustainable communities		NEL ICS	MD City and Hackney		
			Planning	Head of Planning and Building Control	Natalie Broughton	
			Neighbourhoods and Housing	Head of Area Regeneration Team	Suzanne Johnson	
			Benchmarking other London Borough			
Postponed from July 2020	**Neighbourhoods Development Programme**	Annual Update	GP Confederation	Chief Executive	Laura Sharpe	
			GP Confederation	Neighbourhoods Programme Lead	Mark Golledge	
Postponed from July 2020	**Future use of St Leonard's Site and NEL Estates Strategy**	**Discussion Panel**				
	Follow up on planned Healthwatch Community Event wk of 12 July 2021					
	How health and care transformation plans consider transport impacts	Suggestion from Cllr Snell				
	Implications for families of genetic testing	Suggestion from Cllr Snell				
	Accessible Transport issues for elderly residents	Suggestion from Cllr Snell				

This page is intentionally left blank

INEL JHOSC Rolling Work Programme for 2020-21 as at 30 June 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
27 January 2020	**New Early Diagnosis Centre for Cancer in NEL**	Briefing	Barts Health NHS Trust	Clinical Lead	Dr Angela Wong	
			NCEL Cancer Alliance	Interim Project Manager	Karen Conway	
	Overseas Patients and Charging	Item deferred				
11 February 2020	**NHS Long Term Plan and NEL response**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			Barking & Dagenham CCG	Chair	Dr Jagan John	
			East London HCP	Director of Transformation	Simon Hall	
			East London HCP	Chief Finance Officer	Henry Black	
	New Joint Pathology Network (Barts/HUHFT/Lewisham & Greenwich)	Briefing	Barts Health NHS Trust	Director of Strategy	Ralph Coulbeck	
			Homerton University Hospital NHS FT	Chief Executive	Tracey Fletcher	
	Municipal Year 2020/21					
24 June 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Chief Executive	Alwyn Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			East London NHS Foundation Trust	COO and Dep Chief Exec	Paul Calaminus	
			Newham CCG	Chair	Dr Muhammad Naqvi	
			Waltham Forest CCG	Chair	Dr Ken Aswani	
			Tower Hamlets CCG	Chair	Dr Sir Sam Everington	
			WEL CCGs	Managing Director	Selina Douglas	
			City & Hackney CCG	Managing Director	David Maher	
	How local NEL borough Scrutiny Cttees are scrutinising Covid issues	Summary briefing FOR NOTING ONLY	O&S Officers for INEL			
30 September 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			East London HCP	Director of Trasformation	Simon Hall	
			East London HCP	Director of Finance	Henry Black	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			ELFT	COO and Deputy Chief Executive	Paul Calaminus	
			WEL CCGs	Managing Director	Selina Douglas	

			City and Hackney CCG	Managing Director	David Maher	
	Covid-19 discussion panel with the local Directors of Public Health	Discussion Panel	City and Hackney	DPH	Dr Sandra Husbands	
			Tower Hamlets	DPH	Dr Somen Bannerjee	
			Newham	DPH	Dr Jason Strelitz	
			Waltham Forest	DPH	Dr Joe McDonnell	
	Overseas Patient Charging - briefings from Barts Health and HUHFT	Briefing	Barts Health NHS Trust	Group Chief Medical Officer	Dr Alistair Chesser	
25 Nov 2020	**Covid 19 update and Winter Preparedness**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Whipps Cross Redevelopment Programme	Briefing	Barts Health NHS Trust	Whipps Cross Redevelopment Director	Alastair Finney	
			Barts Health NHS Trust	Medical Director, Whipps Cross	Dr Heather Noble	
10 Feb 2021	**Covid-19 impacts in Secondary Care in INEL boroughs**	Briefing	Barts Health NHS Trust	Group Chief Executive	Dame Alwen Williams	
	Covid-19 Strategy for roll out of vaccinations in INEL boroughs	Briefing	East London HCP	SRO	Jane Milligan	
			City and Hackney CCG	Chair	Dr Mark Rickets	
			City and Hackney CCG	MD	David Maher	
	North East London System response to NHSE consultation on ICSs	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
	Update on recruitment process for new Accountable Officer for NELCA/SRO for ELHCP	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
Municipal Year 2021/22						
23 Jun 2021	**Covid-19 vaccinations programme in NEL**	Briefing	NEL ICS	Acting AO for NEL CCG and SRO for NEL ICS	Henry Black	
			NEL CCG	Director of Transformation	Simon Hall	
			NEL CCG	Managing Director of TNW ICP	Selina Douglas	
	Implications for NEL ICS of the Health and Care White Paper	Briefing	NEL ICS	Acting AO for NEL CCG and SRO for NEL ICS	Henry Black	
			NEL ICS	Independent Chair	Marie Gabriel	
			Barts Health	Group Chief Executive	Dame Alwen Williams	
	Accountability of processes for managing future changes of ownership of GP practices	Discussion item	NEL ICS	Acting AO for NEL CCG and SRO for NEL ICS	Henry Black	

			NEL CCG	Director of Primary Care Transformation TNW ICP	William Cunningham-Davis	
			NEL CCG	Managing Director of TNW ICP	Selina Douglas	
			NEL CCG	Director of Corporate Affairs	Marie Price	
	Challenges of building back elective care post Covid pandemic	Briefing	NEL ICS	Acting AO for NEL CCG and SRO for NEL ICS	Henry Black	
			Barts Health	Consultant Cardiothoracic Surgeon and Chief of Surgery	Stephen Edmondson	
			Barts Health	Group Chief Executive	Dame Alwen Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
13 Sep 2021						
16 Dec 2021						
1 March 2022						
	Items to be scheduled/ returned to:					
	NEL Estates Strategy					
	Whipps Cross Redevelopment					
	Cancer Diagnostic Hub					
	Review of Non Emergency Patient Transport					
	Digital First delivery in NHS					
	Mental Health					
	Homelessness Strategy					

This page is intentionally left blank

Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2020/21
Date of Meeting: Thursday 8 July 2021 at 7.00pm

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

Chair	**Councillor Ben Hayhurst**
Councillors in attendance	**Cllr Kam Adams, Cllr Kofo David and Cllr Deniz Oguzkanli**
Councillors joining remotely	**Cllr Peter Snell (Vice-Chair) and Cllr Emma Plouviez.**
Council officers in attendance	**Dr Sandra Husbands (Director of Public Health for City and Hackney)**
Other people in attendance	**Catherine Pelley (Chief Nurse and Director of Governance, HUHFT)** **Dr Mark Rickets (CCG Clinical Chair for City and Hackney)** **Siobhan Harper (Director of CCG Transition for City and Hackney)** **Malcolm Alexander (Chair, Healthwatch Hackney)** **Jon Williams (Executive Director, Healthwatch Hackney)**
Members of the public YouTube link	31 views **The meeting can be viewed at** https://youtu.be/Z4cenv9CqwI
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 from Cllr Gregory and Helen Woodland.

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 There were none.

4 Covid-19 update from Public Health and CCG

4.1 The Chair welcomed for this item

Dr Sandra Husbands (Dr H), Director of Public Health, Hackney and City
Siobhan Harper (SH), Director of CCG Transition/SRO for Vaccinations Steering Group

4.2 Members gave consideration to a tabled briefing '*City and Hackney Covid-19 Vaccination Programme*". This was tabled so that more timely data could be presented.

4.3 Dr Husbands took Members through the report in detail. It covered: update on the roll-out; vaccinations snapshot by cohort; capacity issues; data on care home residents and staff; work to improve uptake in care homes; weekly trend of Covid cases; cases by age and sex; update on variants of concern and variants of interest; targeted local outreach; key communications actions in next two weeks.

4.4 SH gave an update on the specific work of the Vaccinations Steering Group and the challenges to increase capacity and to ensure all slots being offered are being filled. She described the work to ramp up the various outreach programmes and the need to engage better with young people in different settings. The booster programme was being planned to run from 5 Sept to 16 Dec, focusing the more vulnerable cohorts, and would run alongside the flu vaccine programme.

4.3 Members asked questions and in the response the following was noted:

(a) In response to a question about how long the effectiveness of the vaccines last, SH stated that it was 6 months to a year.

(b) In response to a question about a media story re 'unlicensed' plant in India producing AZ vaccine Dr Husbands clarified that the issue was that it was not approved yet by the EMA for European Economic Area countries and they haven't, as yet, approved any vaccines manufactured outside the EU.

(c) A Member asked, further, if these contentious batches had been distributed to Hackney residents. He also asked about the latest of vaccination uptake by care workers. Dr H replied that it would be difficult to know. You'd have to link the batch number back to manufacturer. EU states currently allowing UK residents to travel there. This is currently quite limited in numbers and they might treat such cohorts as if they are not vaccinated but this is not yet clear. They also require PCR tests in any case.

(d) Chair asked if there could be weekly data on uptake by domiciliary care workers as well as care workers. Dr H replied that uptake has improved thanks for the outreach work. The targets set for them have been met and they understand the barriers and have put in bespoke action plans to address these however a lot had yet to be done on Homecare. HUHFT staff vaccination rates were nearly 90%. With

home care it depended on which agency is involved. Some were doing much better than others. Catherine Pelley (HUH) added that tracking vaccination status of domiciliary care workers with different employers was a real challenge and was time consuming. Dr H added that Public Health continued to reach out to care home staff and was reaching out in person to domiciliary care staff as many will not have access to their computers during the working day. They were challenging a number of the myths which persist such as the one about the impact of the vaccine on fertility.

(e) Members asked about media reports that Hackney had the lowest pay outs for the £500 self-isolation payments. Dr H explained that the issue here was that it was proving very difficult to distribute self-isolation payments in practice because very few people actually meet the very strict national eligibility criteria and they were hamstrung by that. She added that there may also have been an issue too about ability to verify people's eligibility because of the impact of the cyber-attack.

(f) In response to a question from the Chair on the plans for vaccinating children, Dr H stated that currently it was licensed from age 16 so they could currently vaccinate 16-18 yr olds. It was not licensed on children as it hadn't been tested on them.

(g) Malcolm Alexander (Healthwatch Chair) asked about the policy for people who are immunosuppressed. Dr H replied that if they have congenital or acquired conditions which impacts on their immune system they still need to be vaccinated and these cohorts are. There was a continuing need to take precautions around these groups of people who were more vulnerable, despite being vaccinated.

(h) Chair asked what local messaging there would be for post-19 July. Dr H replied that they were working on this 'comms' plan. She added that just because the restrictions had ended this did not mean that we should stop taking precautions as the virus had not ended. So long as there is virus circulating in the rest of the world it is still not the end of the pandemic.

(i) Chair stated that given that Hackney had inbuilt structural challenges and age demographics that go against it for Covid, what the messaging would be about this and about the borough's continuing vulnerability. Dr H replied stated that the council and health partners were making very clear what our vulnerabilities were and she had done this at the London Health Committee where she had stressed that we still were vulnerable to local epidemics until vaccination rates have improved.

(j) Members asked about reopening of council offices and staff returning to the office post 19 July. Dr H replied that the position was unchanged and that they were unlikely to bring people back to council buildings on a big scale before September and there added that there would be a full review before that happened. She added that the various adaptations to make the building Covid-secure remained and would be reviewed on an ongoing basis.

4.4 The Chair thanked the officers for their report and attendance and suggested that perhaps looking more closely at internal policies could be picked up at a future meeting.

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

5 Homerton University Hospital NHS Foundation Trust Quality Account 2020/21

5.1 The Chair introduced the item reminding members that each year the Commission is asked to formally comment on a Homerton's draft Quality Account. A letter was sent and included in the report which HUHFT had then submitted to NHSE/NHSI on 30 June. The purpose of this item to was to reflect on the report and the experience of HUHFT over the past year.

5.2 Members' gave consideration to the Commission's own letter of 28 June and the final draft of the *HUHFT Quality Account 2020/21*. The Chair welcomed for this item:

Catherine Pelley (CP), Chief Nurse and Director of Governance, HUHFT

And he congratulated her on her recent MBE and HUHFT on its recent HSJ and Royal College of Nursing awards.

5.3 CP explained what the Quality Account is and the reporting requirements and that it had to be completed according to an NHS mandated template. A shorter summary version would be available for the Trust's AGM and she would respond to the Commission's letter also.

5.4 Members asked detailed questions and in the responses the following was noted:

(a) The Chair asked where HUHFT currently stood on Covid-19 patient numbers and the trends. CP stated that since Wave 2 they only had a handful of patients with Covid in the hospital. Only 1 patient in ITU currently. What they've just seen was an increasing number of patients from averages of 6-7 a day to 15-16 a day however the Community Services would be treating patients who would have Covid. She expressed concern about the possible impact of respiratory viruses on children over the coming winter.

(b) The Chair asked whether the Trust was seeing more admissions of children because the Delta variant was more transmissible by them. CP replied that an increase in number of children with respiratory illnesses was seen, mainly because they'd not been exposed to viruses over the past 18 months. They were trying to learn from the experience in Australia who are ahead of the UK with the trends.

(c) Members asked about building back elective care and the timeline for it. CP described the work at NEL level to create as much capacity as possible for elective care in order to cope.

(d) Members asked about Long Covid numbers and any change in those. CP said they were not admitting people with Long Covid. The issue was that it was something where they had relatively minor symptoms and then had longer term effects so were working with the Community Service on it. They were expecting those numbers to expand. 20-23% of people with Covid are likely to have Long Covid and it would become the new Long Term Condition to manage, she added.

(e) Jon Williams (Healthwatch) asked about staff burn-out and staff morale. CP replied that health and social care workforce was tired and exhausted. They'd done a lot of work in Trust on their wellbeing offer for staff and recognising the psychological support people needed and were doing specific interventions. Generally, people were very anxious about the third wave if vaccinations were not taken up and the virus spread widely again. They had set up a new set of awards for nursing and midwifery staff and trying to recognise good work and make sure staff feel appreciated.

(f) The Chair asked about staff feedback questionnaire and staff appraisals. CP replied that staff are still expressing concerns and there are some parts where there has definitely been improvements. They've been able to show that the culture they'd created around patient safety and quality was one of the best in London. They had struggled to get completed appraisal rates to the 80% level. They now had to implement a new quarterly 'temperature check' process rather than the old Friends and Family test and hoped with would generate more real time information.

The Chair asked why the Trust was changing its name to Homerton Healthcare. CP replied that it was a long time coming. Homerton services were not just about the hospital as it provided services across the community and into people's homes. It would also make it more of an anchor organisation within the borough.

5.5 MA reported that Stuart Maxwell (long time Governor at the Homerton) had recently passed away. The Chair expressed his sincere condolences on behalf of the Commission and stated that Mr Maxwell had been a dedicated supporter of health services locally and had long contributed to health scrutiny.

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

6 Future plans for St Leonard's Site

6.1 The Chair introduced the item stating that plans for the re-development of the St Leonard's Hospital site had been a burning local issue for the healthcare economy for some time. The building was not in a good state of repair, yet it provided residents with a range of services. Prior to the pandemic, discussions had been taking place between the CCG, the Council and NHS Property Services on possible options and funding had been secured to carry out a feasibility study and the site was also part of the wider NEL CCG Estates Strategy but Members had heard nothing about the project for some time. He welcomed to the meeting:

Claire Hogg (CH), Director of Strategic Implementation and Partnership, HUHFT

6.2 CH gave an update on St Leonard's Project Group which has been running for some time. It oversees the work that Attain was commissioned to do. The CCG had secured funding to get Attain to carry out a healthcare and demand analysis on St Leonard's. Because of Covid the process had been delayed. St

Leonard's was old and required significant investment to make it fit for purpose. The demand analysis work found that they would soon run out of space unless they took a different approach. Attain's had done some minor public engagement work and so she'd been working with Healthwatch to think about how that aspect can be expanded. The challenges was about how to create a vision for St Leonard's which the public could buy into and how to ensure that St Leonards becomes an anchor institution within City and Hackney to address both population health need and the wider social determinants of health locally. She talked about the potential for education, employment and housing uses also on the site which could form part of a plan for the site to help build a compelling business case for the re-development.

6.3 Members asked questions and the following points were noted:

(a) The Chair asked what the next steps were to unlock further funding or agreement from NHS Property Services to agree to move forward with a greater release of funding to build up a full business case. CH replied that this is the next task for the coming 6-12 months. The timescales overall would see a redevelopment by 2026 and local NHS was keen that stakeholders are all clear about this being a long-term programme of work and about the need to fully engage the public. The Chair asked if the previous funding was still on the table. CH explained that it was but in going back to One Public Estate to progress the next stage the local NHS partners would need to present a very strong and clear vision for the site and have worked up a strategy for how it would also fit with the wider system vision for NEL.

(b) Cllr Adams, in whose ward the site located, asked about non-digital promotion of the Healthwatch event and plans for consultation with local residents. CH replied they were creating an engagement plan and part of this would be to stress that this was a long-term piece of work and also to tie it in with the Neighbourhoods Programme. She undertook to meet with the Ward Cllrs to update them.

ACTION:	**CH to liaise with Cllr Adams on engagement with residents in the Ward.**

(c) Malcolm Alexander (Healthwatch Chair) asked about their People's Plan for St Leonard's and the Healthwatch event on 13 July and how they would prefer it be called St Leonard's Community Hospital. They were also going to discuss it at their AGM on 28 July and had invited Diane Abbott MP to speak at that.

(d) The Chair asked about finances of the deal and on the risks of setting unrealistic expectations locally. He asked how much of it will need to involve private sale or development on in order to fund the project. MA replied that it was essential that residents be made aware that we need to open up people's vision about what can potentially be created and what can be achieved on the site.

(e) The Chair asked about raising with the local population the need for some financial trade offs as it would have to be agreed at HM Treasury level. CH replied that they would have to do all this. The engagement event on 11th would be the start of this process. There were opportunities around housing, nurseries etc and ask the

community what they would want and this would feed into the negotiations on the financial side.

(f) The Chair asked about the structural condition of the site and whether the model used at Whipps Cross might be a template. CH replied that there were a couple of examples wider NEL (e.g. St George's in Hornchurch) that they could use when thinking about possible financial models. The site was owned by NHS Property Services and the City & Hackney system was exploring whether the asset could be transferred to a local party e.g. HUHFT, but there was a long process to go through to achieve this. It would take some time and they would have to run both processes (the engagement work and the financial modelling) in parallel for it to work out

(g) The Chair asked about the need for key worker housing for hospital staff and that that this was a real opportunity and a real selling point if it could be built in to the plan because this demographic was being priced out of the borough. Jon Williams added that the City & Hackney Coproduction Charter drives the co-production process which they were using and this would be a long term process. It was essential to have the conversation with the public and to help them understand how this process would operate. It's a potentially very exciting project he added and there was a need to focus on that rather than saying it would all be too challenging. It's a way of making people feel optimistic about things, which was needed at present, and an opportunity to show how co-production can work in the borough

6.4 The Chair thanked CH for her update. He added that when the local NHS has worked up a firm proposal it should come back to the Commission so they could discuss it with them and explore next steps.

ACTION:	**Update on St Leonard's redevelopment to be added to work programme.**

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

7 Healthwatch Hackney Annual Report 2020/21

7.1 The Chair stated that each year the Commission considered the annual report of Healthwatch Hackney before it was submitted to Healthwatch England. Members gave consideration to the report and a briefing presentation and the Chair welcomed to the meeting:

Malcolm Alexander (MA), Chair, Healthwatch Hackney
Jon Williams (JW), Executive Director, Healthwatch Hackney

7.2 In introducing the report MA reflected on past year and the struggles they had. Hearing the public particularly at this time was vital he added. He stated that they had changed the format of their Board meetings and make them more accessible, and the public can now attend and participate. They had also replaced their Enter and View visits which could not run at present with 'Information Exchanges', where they have detailed discussions e.g. on topics such as registering with GPs. They also wanted to be much more public

facing however their office was quite inaccessible and so their ambition was to secure better space where they could be seen and the public could contact them more easily. JW then took Members through a presentation containing the highlights of the report.

7.4 A Member asked what levers Healthwatch might have, with for example the GP Confederation, on the need for mystery shopping exercised when a service is inadequate. JW replied that they did do mystery shopping on dental services and on GP registrations recently. City and Hackney primary care was very strong compared to its neighbours but he would pursue the issue with the CE of the GP Confederation.

7.5 The Chair asked about the need for the Healthwatch organisations across the 8 NEL boroughs to mark the ICS across the whole NEL footprint asked what scope, plans, or financing was there to provide a Healthwatch function over the NEL ICS footprint. JW replied that they were working with NEL CCG on this and part of the solution was the Community Insight Database which had gathered data for example from 600 questionnaires from disabled people across NEL. The plan was to enhance this further and develop the next stage, known as the Platinum Model so that data can be held across the system. They were also aiming to include data from hospitals in NEL in order to establish a baseline. NEL CCG was also asking them attend very many meetings in their new structure and they had to pushback because of capacity and so they were talking to them about ways of funding such input. Healthwatches also did meet with Marie Gabriel on quarterly basis and relationships were currently very positive. They were stressing to NEL CCG that public involvement wasn't just a nice thing to have but rather it is a vital component to system transformation.

7.6 The Chair stated he would welcome Healthwatch's objective eye on planned changes in governance at the ICS e.g. the proposal that there be one Local Authority rep on the new ICB to cover 8 local authorities and the accountability gap there overall and how this could have significant ramifications depending on the situation and the demographics of the local authority where that one representative comes from. He added that Cllrs would welcome a joined up Healthwatch 'explainer' on these changes as they were going along to aid councillors understanding and ability to challenge the NHS. MA replied that there was a major funding problem for Healthwatches to work at NEL level. He stated that there was a gap between the amount of money allocated by central government to councils for Healthwatch and what was then passed on to them. The Chair replied that he was aware of this and although the Cabinet Member was not present at the meeting he would raise the issue with him.

7.7 The Chair thanked MA and JW for their hard work over this past year which had been a particularly difficult one and stated that their input was incredibly valuable to the Commission on a number of levels.

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

8 Secondary use of GP patient identifiable data

8.1 The Chair stated that the kernel of the issue here was the public giving permission to their GPs for their medical records to be passported on to the central NHS Digital database as part of a new scheme called General Practice Data for Planning and Research (GPDPR). In Tower Hamlets a number of GPs there had stated that they were refusing to pass on this data and he had asked the CCG for a verbal update.

8.2 Members noted two articles '*GPs urged to refuse to hand over patient details to NHS digita*l' from the Guardian and '*What is the NHS data grab?*' from an industry journal. He welcomed for this item:

Dr Mark Rickets (MR), Clinical Chair for City and Hackney, NEL CCG
Siobhan Harper (SH), Director of CCG Transition for City and Hackney, NEL CCG

8.3 MR explained what *General Practice Data for Planning and Research* was, how it worked and that the consultation on the change had been extended to run until 28 Aug. He explained that Dr Osman Bhatti a GP in Tower Hamlets and Clinical Lead for Digital for NEL CCG had been at the forefront of challenging the poor planning on this by NHSE.

8.5 MR stated that data was already extracted from the primary care system for all sorts of reasons and GP Practices on their websites needed to make this clear. Data was extracted on a pseudonymised basis by age, sex, medical condition etc. The government's plan was to replace that with the GDRPR which would require a new extraction arrangement. The Practices had a responsibility to explain to their patients what the data would be used for and the implications of it. They were waiting for the government to publish the data protection implications so Practices could properly counsel their patients. Practices have to switch on the data extraction process at their site and Dr Bhatti and colleagues had told their local GPs that as data controllers they each have a responsibility to inform patients how the data would be used and because that was currently unclear, they shouldn't therefore enable this data extraction. Nobody across NEL had so far turned-on data extraction because nationally there had been a huge pushback and the government then extended the deadline to 28 Aug. GPs were in a difficult position as the government had made this a contractual requirement. There weren't specific penalties, but a Practice would be breach of its contract which might have consequences. So, the data controllers could be in breach of this new GPDPR requirements and of their own GP contract. They were waiting for further information on how this data was going to be used and how it was going to be protected.

8.6 MR added that if this was done right it would be a very positive and beneficial step and it shouldn't be possible to identify any individual within it. Patients can currently complete a form and send it to their GP indicating that they wish to opt out. If thousands did this however it would create a huge volume of admin for GP Practices for which they have no additional resource. At a time

when GPs were extraordinarily busy this would add to their burden. He added that the government was promising to do more and better communications to the public, but this was awaited.

8.4 The Chair asked when this government guidance was expected and whether it would be clear about what the data might be used for? MR replied this was not clear and so it was very difficult for NEL CCG to advise GPs not to switch on the data extraction as that would constitute a breach of contract. However, the LMC itself wasn't bound by such considerations and so was campaigning against it.

8.4 The Chair asked if GPDPR was national. MR replied it was and that Dr Bhatti was well placed to advise as he'd been writing blogs and articles etc on the issue which then had been picked up by the national press who therefore had focused on the views of GPs in Tower Hamlets and east London.

8.5 A Member commented that vaccination passports were a huge driver to get people to download the NHS App and to use it more that he was worried that if people were refusing to share their data they'd lose out on that too and all the other benefits they get from the NHS App. He stressed that this needed to be sorted out quickly.

8.6 A Member asked whether you could continue to use the NHS App and refuse for your data to be uploaded? MR replied that his understanding was that when you receive your vaccine this is recorded in the Pinnacle system and within 2 or 3 days all that drops into your GP notes and it also drops into the NHS App. It doesn't have to be extracted separately from GP notes to get into the App. He reiterated that getting this data sharing right was a huge force for good in so many ways and it would be tragic to lose that opportunity by mismanaging the process.

8.7 Dr Husbands added that the vaccination system was a separate system and right now GPDPR wasn't in place and so you can still get the connection between your vaccination status and the NHS App but within the App itself you have to enable it. If you download the App you can turn on the Vaccine Passport or chose not to. MR added that there was other information in the App that comes via the Practice so if you wanted your notes or blood tests requests or prescriptions than that is all direct from your Practice and that could be affected if you don't allow data flow to the App.

8.8 In concluding, the Chair stated that government needed to publish what they're going to do re GPDPR. It would also help if Dr Bhatti could give his views then on it. The GPs then need to decide whether they will enable the data extraction and the public then need to decide whether to hand in an Opt Out form to their GP, but in doing so this will inevitably create a huge data entry burden for GP Practices. SH added that patients can opt out of the data share via the NHS App also. MR added that Dr Bhatti will be producing advice for GPs in NEL which can be shared more widely. He added that his hope was that there wouldn't be lots of opting out, as yet, because if people

turn out to be happy the revised policy, then it would be better for them to engage with the system.

8.9 The Chair thanked MR for clarifying this very complex issue and stated that Members would welcome Dr Bhatti's guidance once the government published the revised policy.

ACTION:	**MR to share with the Commission the government guidance when finally published and Dr Bhatti's response and advice.**

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

9 Minutes of the previous meeting

9.1 Members gave consideration to the draft minutes of the meeting held on 8 June and the Matters Arising.

RESOLVED:	**That the minutes of the meeting held on 8 June be agreed as a correct record and that the matters arising be noted.**

10 Health in Hackney Work Programme

10.1 Members gave consideration to the updated work programmes. The Chair stated that the next meeting in Oct would include items on the confirming of the mental health bed moves to East Ham Care Centre, on the C&H Safeguarding Adults Board Annual Report and on Maternal Mental Health disparities, which has been raised by Cllr Conway as well as an update on Covid.

RESOLVED:	**That the Commission's work programmes for 21/22 and the rolling work programme for INEL JHOSC be noted.**

11 Any other business

11.1 There was none.

This page is intentionally left blank