

# 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

**Tuesday 13 June 2023**

**7.00 pm**

**Council Chamber, Hackney Town Hall, Mare Street, London E8 1EA**

The press and public are welcome to join this meeting remotely via this link:  
<https://www.youtube.com/watch?v=RvEKFRmh0n8>

Back up live stream link: <https://www.youtube.com/watch?v=5Ku111v0ODM>

If you wish to attend please give notice and note the guidance below.

Contact:

Jarlath O'Connell

☎ 020 8356 3309

✉ [jarlath.oconnell@hackney.gov.uk](mailto:jarlath.oconnell@hackney.gov.uk)

**Mark Carroll**

**Chief Executive, London Borough of Hackney**

**Members:** Cllr Ben Hayhurst (Chair), Cllr Kam Adams, Cllr Grace Adebayo, Cllr Frank Baffour, Cllr Eluzer Goldberg, Cllr Sharon Patrick (Vice-Chair), Cllr Ifraax Samatar, Cllr Claudia Turbet-Delof and Cllr Humaira Garasia plus 1 vacancy (Conservative)

## Agenda

**ALL MEETINGS ARE OPEN TO THE PUBLIC**

- 1 To note appointment of Chair and Vice Chair for 2023-24 (19.00)**
- 2 Apologies for Absence (19.01)**
- 3 Urgent Items / Order of Business (19.01)**
- 4 Declarations of Interest (19.02)**

<b>5</b>	<b>Appointments to INEL JHOSC (19.03)</b>	(Pages 9 - 12)
<b>6</b>	<b>Air Quality Action Plan 21-25 implementation update (19.05)</b>	(Pages 13 - 28)
<b>7</b>	<b>Local GP services - Access and Quality - update (19.50)</b>	(Pages 29 - 50)
<b>8</b>	<b>St Joseph's Hospice Quality Account 22-23 (20.30)</b>	(Pages 51 - 88)
<b>9</b>	<b>Minutes of the Previous Meeting (20.50)</b>	(Pages 89 - 102)
<b>10</b>	<b>Health in Hackney Scrutiny Commission Work Programme (20.51)</b>	(Pages 103 - 108)
<b>11</b>	<b>Any Other Business (20.59)</b>	

## ACCESS AND INFORMATION

### Public Involvement and Recording

#### Public Attendance at the Town Hall for Meetings

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 <https://hackney.gov.uk/council-business> or by contacting Governance Services (020 8356 3503)

Following the lifting of all Covid-19 restrictions by the Government and the Council updating its assessment of access to its buildings, the Town Hall is now open to the public and members of the public may attend meetings of the Council.

We recognise, however, that you may find it more convenient to observe the meeting via the live-stream facility, the link for which appears on the agenda front sheet.

We would ask that if you have either tested positive for Covid-19 or have any symptoms that you do not attend the meeting, but rather use the livestream facility. If this applies and you are attending the meeting to ask a question, make a deputation or present a petition then you may contact the Officer named at the beginning of the agenda and they will be able to make arrangements for the Chair of the meeting to ask the question, make the deputation or present the petition on your behalf.

The Council will continue to ensure that access to our meetings 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. The latest general advice can be found here - <https://hackney.gov.uk/coronavirus-support>

#### 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. 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.

## Advice to Members on Declaring Interests

### Advice to Members on Declaring Interests

Hackney Council's Code of Conduct applies to all Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- Director of Legal, Democratic and Electoral Services
- the Legal Adviser to the Committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

#### **You will have a disclosable pecuniary interest in a matter if it:**

- i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;
- ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or
- iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

#### **If you have a disclosable pecuniary interest in an item on the agenda you must:**

- i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).
- ii. You must leave the meeting when the item in which you have an interest is being discussed. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.
- iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the meeting and participate in the

meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

**Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?**

You will have 'other non-pecuniary interest' in a matter if:

- i. It relates to an external body that you have been appointed to as a Member or in another capacity; or
- ii. It relates to an organisation or individual which you have actively engaged in supporting.

**If you have other non-pecuniary interest in an item on the agenda you must:**

- i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.
- ii. You may remain in the meeting, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.
- iii. If you have an interest in a contractual, financial, consent, permission, or licence matter under consideration, you must leave the meeting unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the meeting. Once you have finished making your representation, you must leave the meeting whilst the matter is being discussed.
- iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non-pecuniary interest.

**Further Information**

Advice can be obtained from Dawn Carter-McDonald, Director of Legal, Democratic and Electoral Services via email [dawn.carter-mcdonald@hackney.gov.uk](mailto:dawn.carter-mcdonald@hackney.gov.uk)

## 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')

[Health in Hackney Scrutiny Commission](#)



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## REPORT OF DIRECTOR FOR LEGAL, DEMOCRATIC AND ELECTORAL SERVICES

### APPOINTMENT TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Health in Hackney Scrutiny Commission  
13 June 2023

Classification

Public

Ward(s) affected

All

Enclosures  
None

AGENDA ITEM No

# 5

### 1. INTRODUCTION

- 1.1 This report invites the Health in Hackney Scrutiny Commission to agree the appointment of **3** Members to the Inner North East London Joint Health Overview and Scrutiny Committee for 2022/23. The Committee comprises one member from the City of London Corporation, and three each from the London Boroughs of Hackney, Newham, Tower Hamlets and Waltham Forest.

### 2. RECOMMENDATIONS

- 2.1 **To appoint 3 Members as Hackney’s representatives on the Inner North East London Joint Health Overview and Scrutiny Committee for 2023/24.**

### 3. FINANCIAL CONSIDERATIONS

- 3.1 The recommendations to appoint new members to these Committees to deal with the issues specified in the report will not result in any significant additional cost to the Council. Any costs arising from the hosting of or attendance at meetings of the Joint Committee will be met from existing budgets.

### 4. LEGAL CONSIDERATIONS

- 4.1 Sections 190 and 191 of the Health and Social Care Act 2012 (“HSCA 2012”) made various changes to the system of review and scrutiny of the health service. Under the HSCA 2012 health scrutiny functions were conferred upon the Council itself. Health scrutiny became a statutory function of the Council (as opposed to an overview and scrutiny Committee of the local authority). Health scrutiny functions are not functions of the executive under executive arrangements. Under section 244 of the NHS Act 2006, local authorities were no longer required to have a Health Overview and Scrutiny Committee to discharge health functions. The Council chose to continue its existing Health

Overview and Scrutiny Commission as set out in the report to Full Council on 20 March 2013 upon the setting up of the Health and Wellbeing Board.

- 4.2 Article 11.4 of Article 11 of the Constitution provides that the “Council may be required to form a joint Health Scrutiny Committee with other boroughs being consulted by local health providers that are planning changes to the way they deliver services which could be considered to be a substantial and arrange for the Joint Health Scrutiny Committee to review and scrutinise matters relating to the health services and make reports and recommendations on such matters”.
- 4.3 By virtue of Article 7 of the Constitution, Health in Hackney Overview and Scrutiny Commission has been delegated the Council's statutory functions in accordance with section 244 of the National Health Service Act 2006 and associated regulations to set up a Joint Health Overview and Scrutiny Commission and appoint members from within the membership of the Committee to any Joint Overview and Scrutiny Commission with other local authorities, as directed under the NHS Act 2006.
- 4.4 The arrangements for the Joint Health Overview and Scrutiny Committee must comply with the relevant provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Joint Health Overview and Scrutiny Commission is established under Regulation 30(1), which enables two or more local authorities to appoint a joint overview and scrutiny committee and arrange for health scrutiny functions to be exercisable by the joint committee, subject to such terms and conditions as the authorities consider appropriate. Under Regulation 30(6) the Joint Health and Overview and Scrutiny Commission may not discharge any functions other than health scrutiny (relevant functions) in accordance with Regulation 30.

## 5. DETAIL

- 5.1 INEL JHOSC and ONEL (Outer North East London) JHOSC emerged from the then pan-London JHOSCs formed to scrutinise heart and stroke services and the Darzi reforms c. 2008. INEL JHOSC has met formally 4 times during 2022/23 in virtual or hybrid meetings. The main focus of its work is to scrutinise the NHS North East London (NHS NEL), our Integrated Care System, which fully came into being on 1 July 2023 under the Health and Care Act 2022. The NHS NEL footprint crosses 8 boroughs and replaces the 7 previous CCGs in north east London, including City and Hackney CCG.
- 5.2 An Integrated Care Board (ICB) – has been established to be known as **NHS North East London**. NEL Integrated Care System is the collective term for: *the Integrated Care Board, Integrated Care Partnership, place-based partnerships and provider collaboratives*. The ICB has taken on the NHS commissioning functions of CCGs as well as some of NHS England's commissioning functions. It is responsible for the NHS budget and performance within the system.
- 5.3 In terms of cross-borough scrutiny of NHS services, the North East London patch has, for historical reasons, had two joint health scrutiny committees covering it. **Outer North East London (ONEL)** comprising Havering, Barking and Dagenham, and Redbridge and **INEL** which comprises Waltham Forest, Tower Hamlets, Newham, City and Hackney. Waltham Forest is also an Observer on ONEL and Redbridge is an Observer on INEL.

- 5.4 The custom has been that the Chair of the Committee rotates among the boroughs every two years as agreed by the majority vote of the Committee. Hackney held the Chair from 2014-2016 and again from 2021-2023 (Cllr Ben Hayhurst) and, from June, it moves on to Waltham Forest who will also host the Secretariat. The Hackney Secretariat has been working with Waltham Forest on the handover.
- 5.5 Over the past year the Committee has considered the following items. The 25 July 2022 meeting considered:
- a) Implementation of NEL ICS
  - b) Health updates (Trust updates; continuing healthcare proposals, community diagnostic hubs, Operose and primary care issues, Whipps Cross redevelopment)
  - c) Proposed changes to access to fertility treatment
  - d) Update from Chair of Whipps Cross JHOSC
- 5.6 The 19 October 2022 meeting considered:
- a) Health Updates (Trust performance, winter planning and resilience, vaccinations updates on mpox and polio)
  - b) Developing ICS Strategy
  - c) Acute Provider Collaborative - developing plans
  - d) Update from Chair of Whipps Cross JHOSC
- 5.7 The 15 December 2022 meeting considered:
- a) NEL Integrated Care Strategy - development
  - b) Health Updates (Trust updates)
  - c) What are we doing to improve access, outcomes and experience and equity for children, young people and young adults mental health
  - d) Update from Chair of Whipps Cross JHOSC
- 5.8 The 28 February 2022 meeting considered:
- a) Understanding ICS staffing at Place level
  - b) Health Updates (Trust updates)
  - c) Additional hospital discharge funding in NE London
  - d) NEL Research and Engagement Network funding
  - e) Update from Chair of Whipps Cross JHOSC
- 5.9 In 2023/24 the Committee will meet on 12 July, 1 Nov, 23 Jan and 24 April. The Membership for 2022/23 was:
- City of London:** Common Councilman David Sales  
**Hackney:** Cllrs Ben Hayhurst, Kam Adams, Sharon Patrick  
**Newham:** Cllrs Susan Masters, Anthony McAlmont, Harvinder Singh Virdee  
**Tower Hamlets:** Cllrs Ahmodur Rahman Khan, Ahmodul Kabir, Abdul Malik  
**Waltham Forest:** Cllrs Richard Sweden, Catherine Deakin, Afzal Akram  
Observer Member: Cllr Beverley Brewer (LB Redbridge)

Please note that memberships will change after the May AGMs in each borough.

5.10 Hackney Members have played an active role in the Committee and ensured that there isn't duplication in the work programmes of INEL JHOSC and Health in Hackney SC.

**Dawn Carter-McDonald**  
**Director Legal, Democratic and Electoral Services**

Report Originating Officer: Jarlath O'Connell ☐020-8356 3309

Legal Comments: Louise Humphreys ☐020-8356 4817

**Background papers:**

The following documents were used in the preparation of this report:  
- Local Government Act 1972 (as amended) - Access to Information

**For reference:**



<p><b>Health in Hackney Scrutiny Commission</b></p> <p>13th June 2023</p> <p><b>Air Quality Action Plan 2021-25 - implementation update</b></p>	<p>Item No</p> <p><b>6</b></p>
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### PURPOSE OF ITEM

To receive an update on the implementation of the *Air Quality Action Plan* and a review of the latest pollution monitoring data together with emerging evidence on links between air pollution and health.

### OUTLINE

At our meeting on 29 June '22 we had a lengthy item on '*The science on the health impacts of poor air quality*' which began with an expert briefing from Dr Ian Mudway (Faculty of Medicine, Imperial College) exploring the health impacts of poor air quality both indoor and outdoor and we discussed with Environmental Services and with Public Health the progress being made in implementing Hackney's own [Air Quality Action Plan 2021-25](#). The Chair asked for an update on this important work and on the 'Annual Status Report', containing the most up to date monitoring data, as it's been compiled.

Attached please find an update briefing entitled ***Health impacts of air pollution - progress update*** from Public Health and Environmental Services.

You can view the June 2022 discussion here:

<https://www.youtube.com/watch?v=SWCfoSgfJME>

and the minutes of it are here:

<https://hackney.moderngov.co.uk/mgAi.aspx?ID=40279>

### ***Note on Air pollution***

Air pollution is ubiquitous, but in urban and especially highly trafficked areas, exposures can be high. Numerous research studies, replicated across the world agree that breathing air of poor quality impacts on people's health. Exposure to poor air quality is associated with both ill health and premature death. It affects everyone, but in particular children, older people 65+ and

those with CVD/respiratory disease. People may be affected by poor air quality even if they never experience any noticeable pollution related health effects such as breathing problems. Air pollution can cause short term (nearly immediate) symptoms and long term (chronic disease) effects. Most of the air pollution in London is produced by traffic, heating, and burning of solid fuels. Over 40% per cent of the NO<sub>2</sub> in London comes from road transport so this is why the highest concentrations of NO<sub>2</sub> are recorded at busy roadside locations.

Presenting this item will be:

**Dave Trew**, Land Air Water Manager, Sustainability and Environmental Services, Climate Homes and Economy

**Tom Richardson**, Environment Projects Officer - Sustainability, Climate Homes and Economy

**Suhana Begum**, Senior Public Health Specialist, Adults Health and Integration

Also present will be:

*Cllr Chris Kennedy*, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture

*Dr Sandra Husbands*, Director of Public Health for City and Hackney

*Jayne Taylor*, Consultant in Public Health, Adults Health and Integration

*Sam Kirk*, Head of Sustainability & Environment, Sustainability & Environmental Services and Public Realm, Climate Homes & Economy

## **ACTION**

Members are requested to give consideration to the report and the discussion.

# Health in Hackney Scrutiny Commission

Health Impacts of Air Pollution: Progress update

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**Suhana Begum** - Senior Public Health Specialist

**Dave Trew** - Land, Water, Air Manager

**Tom Richardson** - Environmental Projects Officer

# Health in Hackney Scrutiny Commission

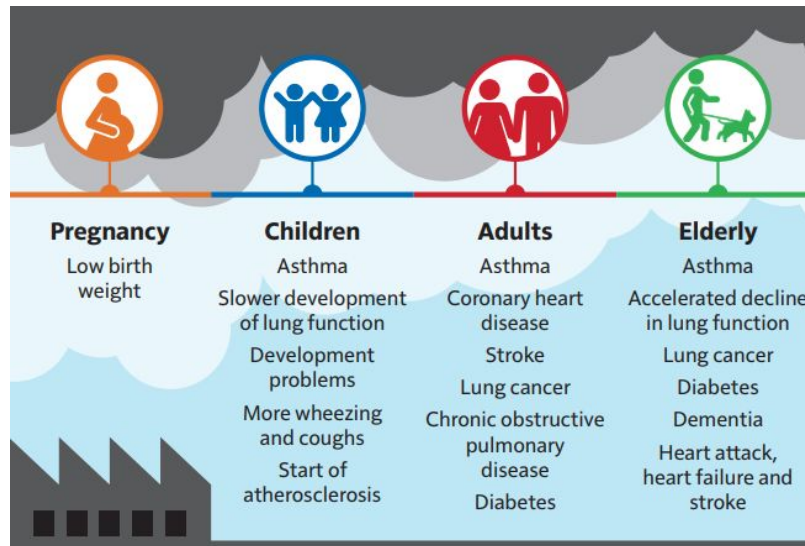
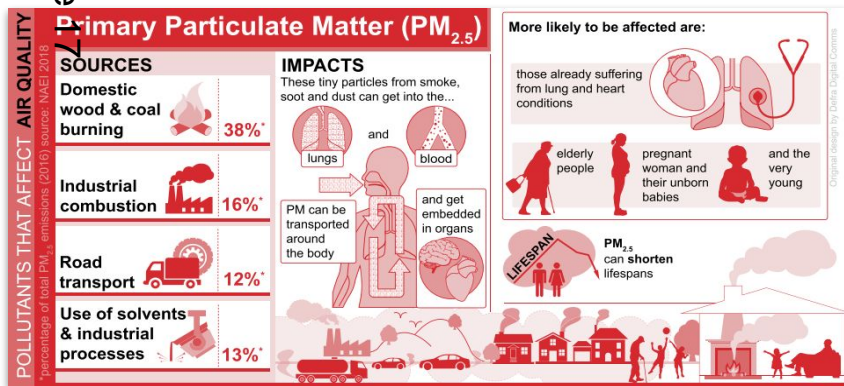
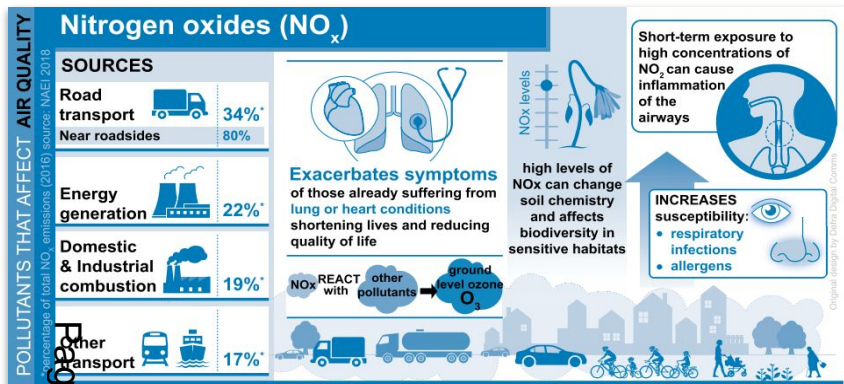
## Health Impacts of Air Pollution: Evidence and Responses

### Contents

- Recap - Health in Hackney Scrutiny Commission 2022
- Health impacts of air pollution - new evidence
- Air quality in Hackney - how did 2022 compare?
- Changes in UK Legislation and Guidance
- Hackney's Air Quality Action Plan 2021-2025 - achievements
- PHE evidence review and NICE guidance - what are we doing?
- Expansion of air quality monitoring and assessment of traffic schemes
- Web-based tool to reduce exposure to air pollution
- Quality of the environment JSNA and updated factsheet
- Conclusions



# Health impacts of air pollution

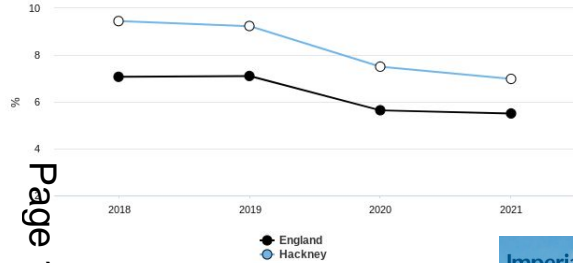


Chief Medical Officer's Annual Report 2022: Air pollution.  
Adapted from Public Health England

# Health impacts of air pollution

Fraction of mortality attributable to particulate air pollution (new method)

[Show confidence intervals](#) [Show 99.8% CI values](#)



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Public Health Outcomes Framework,  
Office for Health Improvements &  
Disparities

There is **no safe threshold** of exposure to PM2.5

Sources and Effects of PM2.5, Defra



Children living in London are at risk of developing **lifelong conditions** including poorly developed lungs, asthma, high blood pressure, inattention and hyperactivity and mental illness (Fuller, Friedman and Mudway, 2023)

A recent study looked at air pollution across European cities. They found that complying with WHO guidelines in reducing PM2.5 levels could **prevent over 50,000 deaths** and reducing NO2 could **prevent almost 80,000 deaths** per year (Khomenko et al., 2021)

Data is emerging that suggests being exposed to high levels of air pollution can **adversely affect cognitive function** (Delgado-Soborit et al., 2021)

## WHO guideline values

- Hackney's commitment to meet WHO guideline values for NO<sub>2</sub>, PM<sub>10</sub> and PM<sub>2.5</sub> by 2030
- WHO revised down guidelines in light of new evidence of health effects
- WHO guidelines include **interim targets** feeding into policy/target setting

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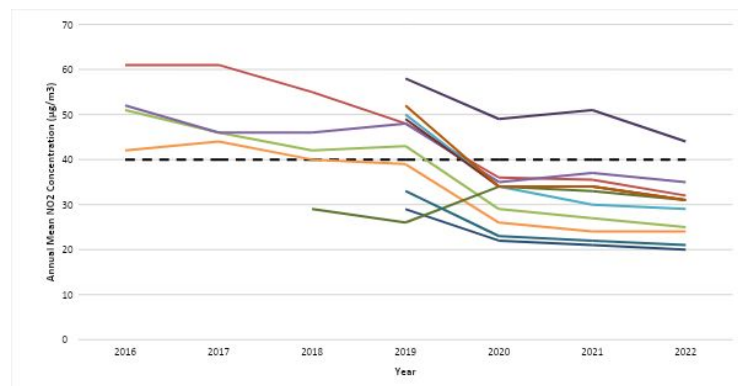
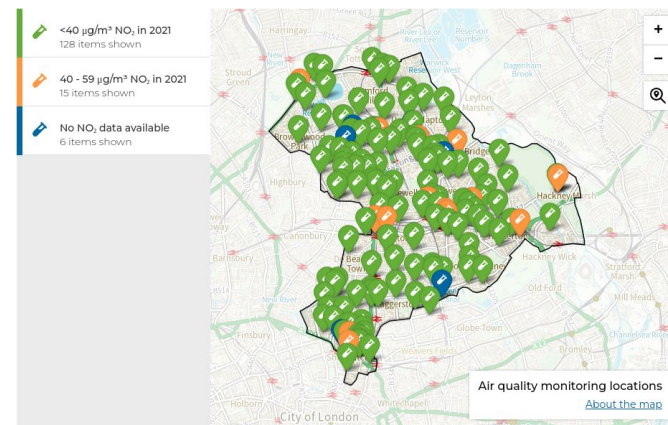


Recommended 2021 AQG levels compared to 2005 air quality guidelines

Pollutant	Averaging Time	2005 AQGs	2021 AQGs
PM <sub>2.5</sub> , µg/m <sup>3</sup>	Annual	10	5
	24-hour <sup>a</sup>	25	15
PM <sub>10</sub> , µg/m <sup>3</sup>	Annual	20	15
	24-hour <sup>a</sup>	50	45
O <sub>3</sub> , µg/m <sup>3</sup>	Peak season <sup>b</sup>	-	60
	8-hour <sup>a</sup>	100	100
NO <sub>2</sub> , µg/m <sup>3</sup>	Annual	40	10
	24-hour <sup>a</sup>	-	25
SO <sub>2</sub> , µg/m <sup>3</sup>	24-hour <sup>a</sup>	20	40
CO, mg/m <sup>3</sup>	24-hour <sup>a</sup>	-	4

## Air quality in Hackney - how did 2022 compare?

- Trends in air quality over time - improving
- Almost all monitoring sites showed **steady or reducing** levels of NO<sub>2</sub> between 2021 and 2022, despite easing of lockdown restrictions
- Only **one** site exceeded NO<sub>2</sub> air quality objective in 2022
- PM10 at four sites **at or slightly above** (20-22 µg/m<sup>3</sup>) the adopted WHO guideline value, to be met by 2030
- PM2.5 at the Old Street monitor was **just below** (9 µg/m<sup>3</sup>) the adopted WHO guideline value



Example of trends in roadside NO<sub>2</sub> from our 2022 AQ Annual Status Report

## Government legislative and guidance updates

### Environment Act 2021

- Legal requirement to set new PM2.5 targets
- Consultation - Hackney's response questioned the ambition & **timeframe**
- Feasibility of the **exposure reduction target**
- October deadline was missed

### Environmental Targets Regulations 2022

- Annual mean concentration of PM2.5 - 10  $\mu\text{g}/\text{m}^3$  by 2040
- Population exposure reduction target of 35% by 2040 (2018 baseline)

### Air Quality Strategy: Framework for Local Authority Delivery

- Published April 2023 following very short consultation (11th - 21st April)
- Lack of detail
- Commitments to strengthen **Smoke Control** regulations and improved communication channels
- **Indoor air quality** considerations



# Hackney's Air Quality Action Plan (AQAP) 2021-2025 - Achievements

1



Commitment to WHO guidelines for particulate matter by 2030

4



Reducing solid fuel burning by raising awareness during cold weather and visiting suppliers

7



51 street signs installed to discourage engine idling

10



42 permanent School Streets in place and a further six being trialled

2



Five new automatic air quality monitoring stations installed

5



Launched a new cargo bike sharing scheme

8



Increased parking spaces for cycles and scooters on streets and in schools

3



New online air quality map available

6



Pavements widened and trees planted in new Low Emission Neighbourhood

9



New entrance to Hackney Central station to improve access for passengers

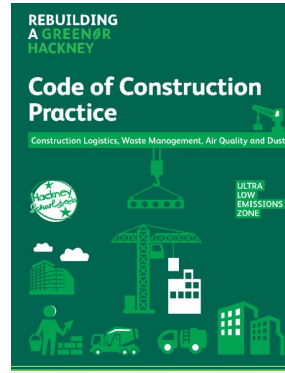
# Public Health England (PHE) evidence review and NICE guidance

## NICE Guidance NG70 and PHE evidence review of interventions to improve outdoor air pollution

Some examples



**‘Develop infrastructure and support active travel’**



Hackney

**‘Consider Air Quality in plans for new developments’**

Figure 1: Air pollution intervention hierarchy



**‘Implement targeted interventions to address specific local issues’**

# Expansion of AQ monitoring and assessment of LTNs/LENs



- Increased number of PM<sub>10</sub> and NO<sub>x</sub> monitors
- Automatic monitoring - data on website
- Assessment of impacts within and outside LTNs - [modelled data](#)



- Modelling carried out of impacts of Stoke Newington LEN
- Analysis of monitoring data around LTNs



# Development of web-based tool to reduce exposure to air pollution

- Over £300k funding awarded by DEFRA
- Recruitment of volunteers and workshops held

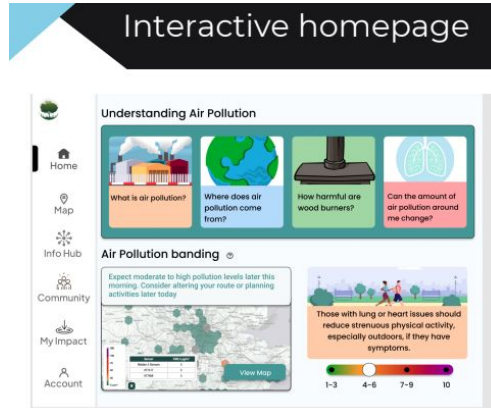
## Survey of residents

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In November 2022, GAP surveyed 256 residents across Hackney, Newham, Tower Hamlets & City of London councils

## Web Tool Prototype



## Training of Champions



## Environment JSNA and creation of factsheet

- The [Quality of the Local Environment JSNA](#) is published on Hackney and the City of London's [Health and Wellbeing Website](#). This was written in 2019 and based on older data/evidence.  
A new factsheet will be produced in summer 2023, which will include updated data on key indicators relating to outdoor air quality.

## Next Steps

- Overall - continue delivery of the Air Quality Action Plan
- Annual Status Report for 2022 - address comments and feedback from GLA and publish once approved
- Publish an air quality update factsheet to complement the JSNA, with new data and evidence relating to air quality.
- Defra project - launch information tool and train cohort of volunteers
- Ensure air quality integrated into streetscene projects, including establishing new permanent AQ monitors to assess impacts

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<p><b>Health in Hackney Scrutiny Commission</b></p> <p>13th June 2023</p> <p><b>Local GP services - access and quality</b></p>	<p>Item No</p> <p><b>7</b></p>
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#### **PURPOSE OF ITEM**

To receive an update on the work being done to drive up access to and quality of local GP services.

#### **OUTLINE**

At our 12 January '23 meeting Members considered reports from local Primary Care leaders on issues around registration and access to local GP Services and quality more generally. This was partly driven by issues raised with Members at their ward surgeries. The Chair asked NHS colleagues to return in 6 months with an update on progress to include if possible an update on particular challenges being felt in the NE of the borough.

The minutes of that item are here:

<https://hackney.moderngov.co.uk/mgAi.aspx?ID=41353>

Attached please find a briefing note entitled **GP Access** from NHS NEL Primary Care Commissioning.

The Chair has also invited to this meeting the new Chair of the City and Hackney GP Confederation and the Exec Director of Healthwatch Hackney.

#### ***Background information - The Fuller Report***

In previous discussions on primary care, the then CE of the local GP Confederation recommended that Members, when considering this topic, be guided by the influential Fuller Report, published in May 22, which was a stocktake for integrated primary care, and was commissioned by NHSE. A copy of that is here:

<https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/>

Since then the national NHS Confederation has just published a useful summary and have drawn together the responses of different parts of the system to the Fuller report recommendations. A copy of that is here:

<https://www.nhsconfed.org/publications/next-steps-integrating-primary-care>

Attending for this item will be:

**Dr Kirsten Brown**, GP Partner at Spring Hill Practice and The Lawson Practice and Primary Care Clinical Lead for City and Hackney, NHS NEL

**Richard Bull**, Commissioner for Primary Care, NHS NEL

**Andreas Lambrianou**, Chief Executive, City and Hackney GP Confederation

**Sally Beaven**, Interim Executive Director, Healthwatch Hackney

## **ACTION**

Members are requested to give consideration to the report and discussion.



North East London

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# GP Access

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Briefing for the Health in Hackney Scrutiny Committee, 13<sup>th</sup> June 2023

City & Hackney PBP



North East London

# GP workforce and access

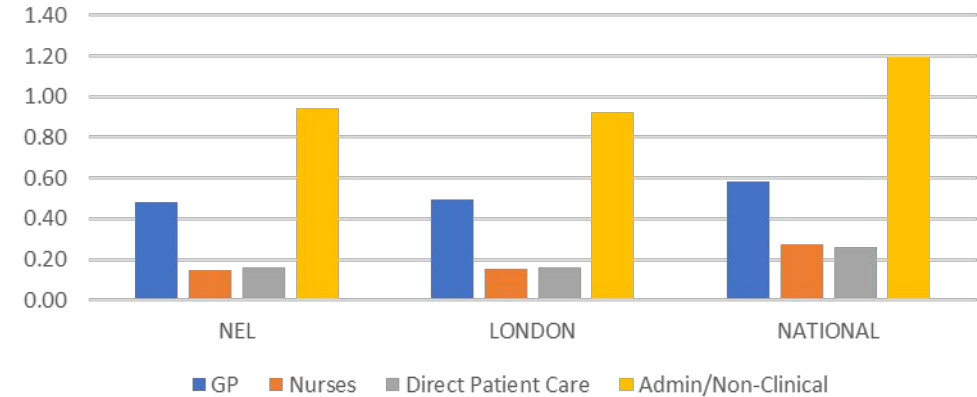
Data update – Oct-22 to Mar-23



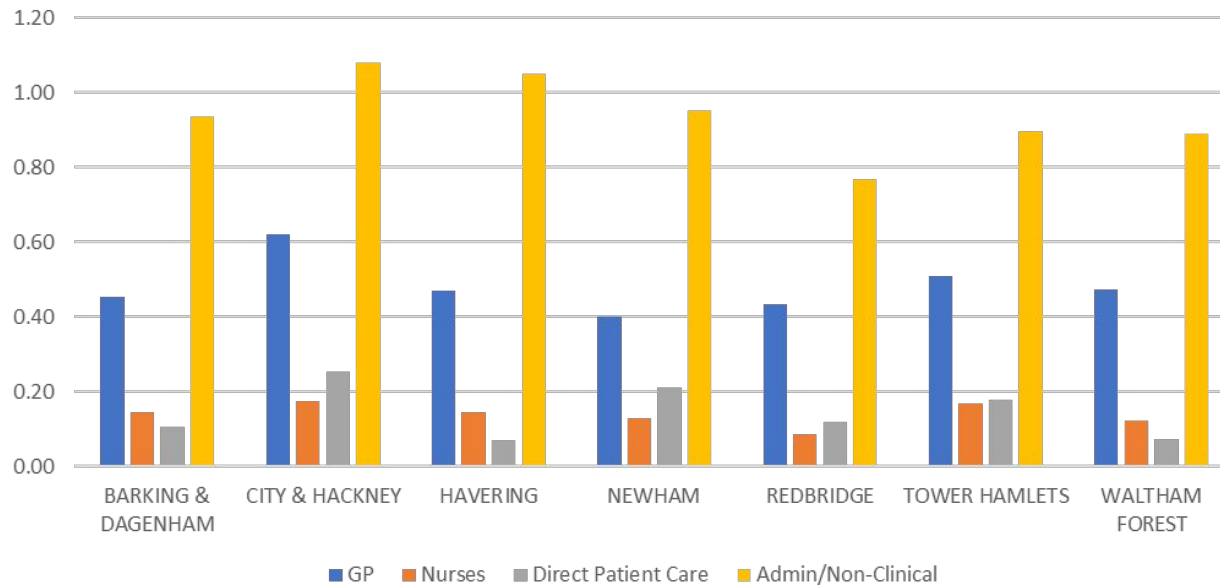
# GP workforce – staff type, FTE per 1000 patients

- On average, NEL has fewer staff per 1000 patients than the national average in all categories
- The difference equates to 17% fewer GPs and 44% fewer nurses
- NEL is broadly comparable to the rest of London

Staff type, FTE per 1000 patients, Mar-23



Staff type, FTE per 1000 patients, Mar-23

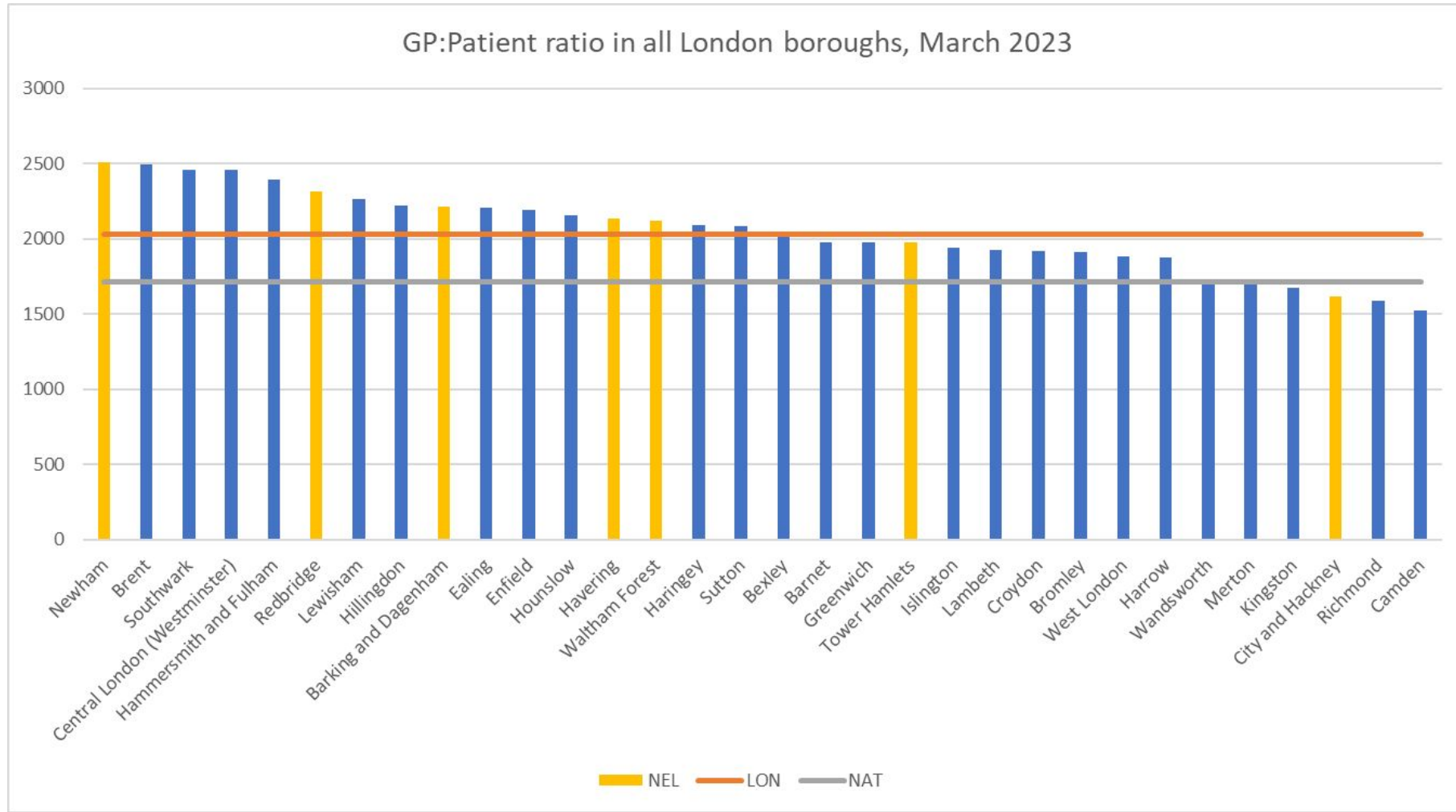


- Taken alone, staff numbers per 1000 patients in City & Hackney are more comparable to national averages and even slightly higher in relation to GPs - and is high relative to other London Boroughs (see next slide)

Source:

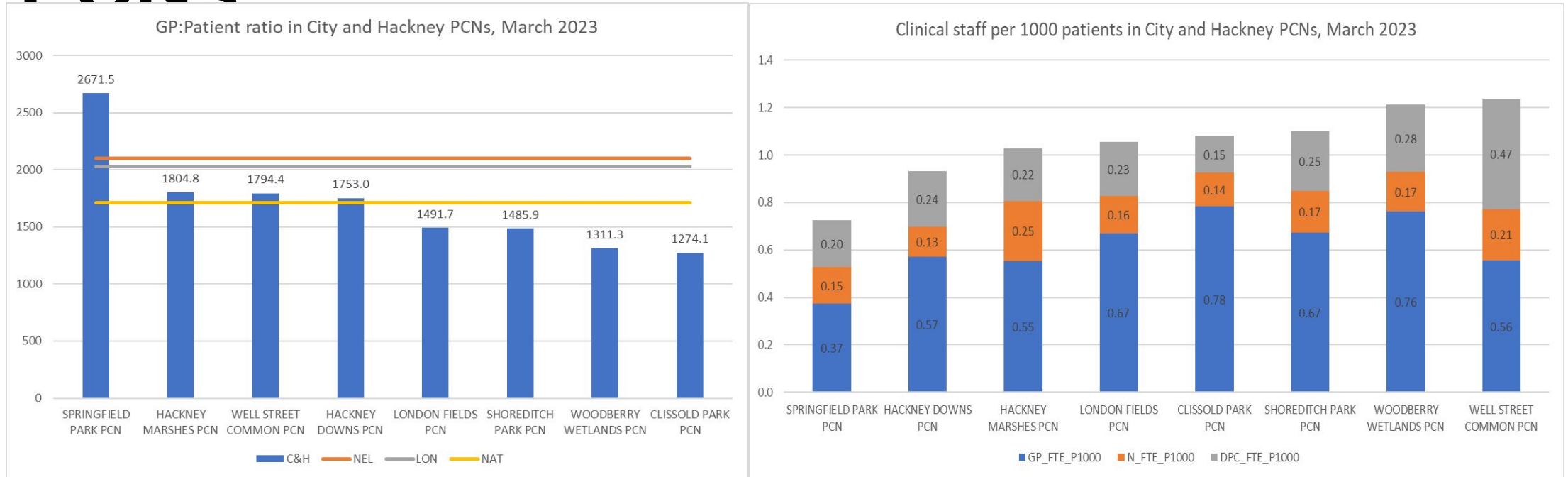
<https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-march-2023>

# GP workforce – GP:Patient ratio, London



Source: <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-march-2023>

# GP workforce – City and Hackney PCNs

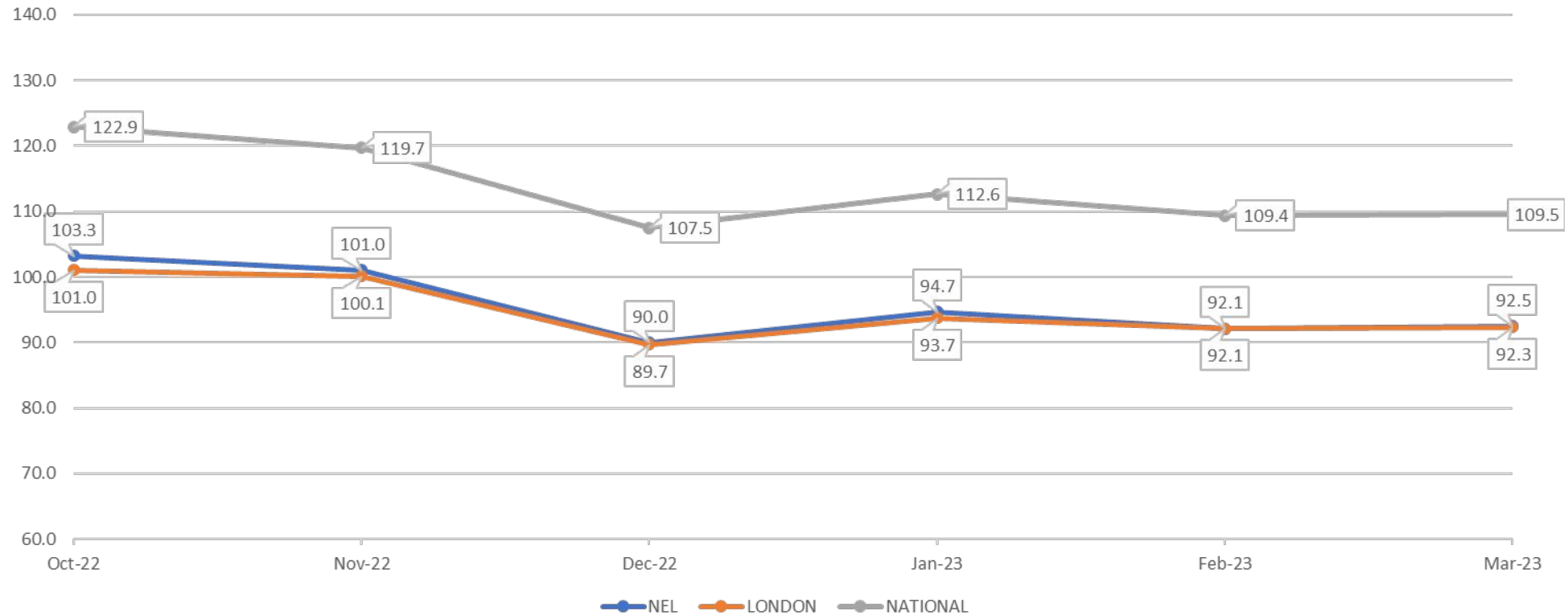


- These charts show primary care workforce at the eight City and Hackney PCNs
- On the left is GP:Patient ratios for each PCN. Seven PCNs have fewer patient per GP FTE than the London and NEL averages, with four below the national average. The exception is Springfield Park PCN, which has more patients per GP than the NEL average
- The chart on the right shows clinical staff (by group – GP, nurse, direct patient care) per 1000 registered patient. Clissold Park PCN has the highest number of GPs but lower number of other clinical staff groups. Well Street Common PCN has the most clinical staff per 1000 patients but third lowest number of GPs
- This data set does not indicate where practices are carrying GP vacancies that they are unable to fill.

# GPAD – National, regional and NEL

- Chart below shows the rate of booked appointments per 1000 registered patients per week in each month from Oct-22 to Mar-23
- Nationally, the weekly rate of appointments was 19% higher on average than NEL during this period
- Rate of appointments in NEL is very slightly higher than the rest of London

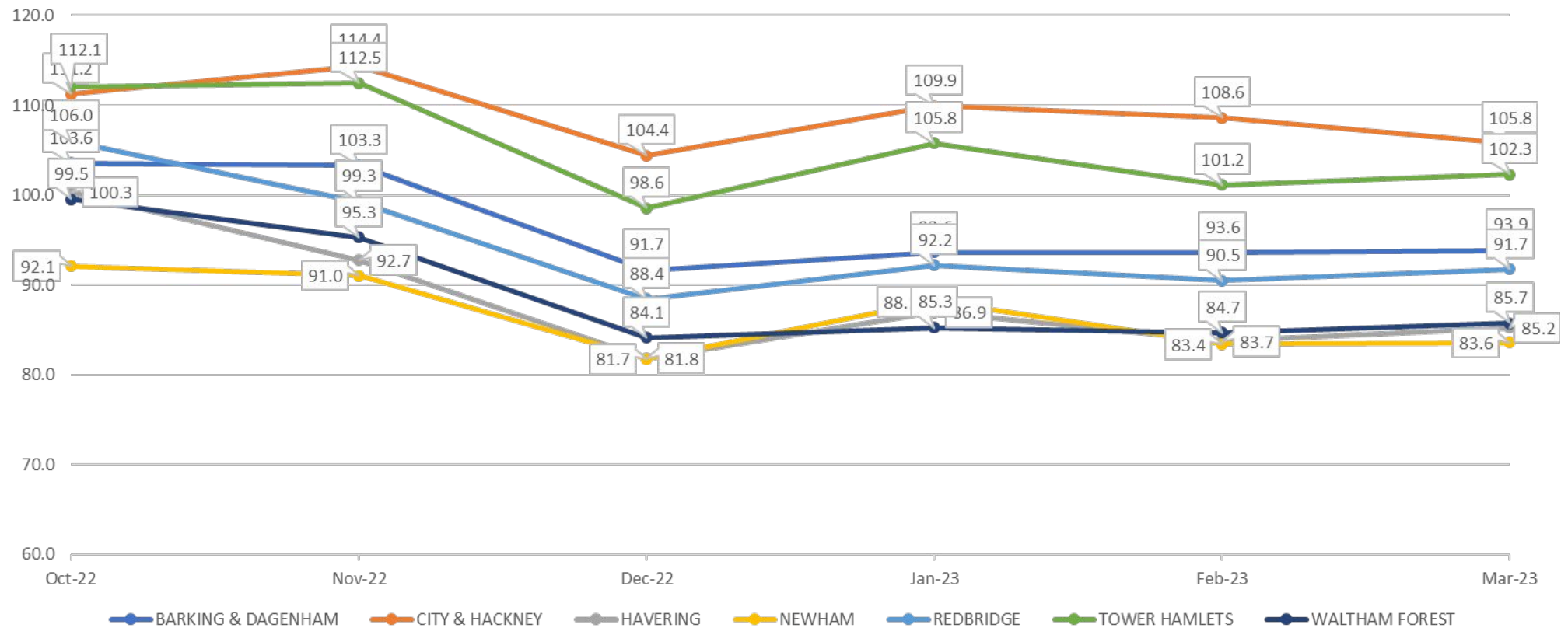
Weekly total appointment rate per 1000 patients, Oct-22 to Mar-23



# NEL GPAD place/borough level

- Chart below shows the same metric as the previous slide but at place level within NEL
- In City & Hackney, the weekly rate of appointments was 14% higher on average than NEL during this period but 4% lower than the national average

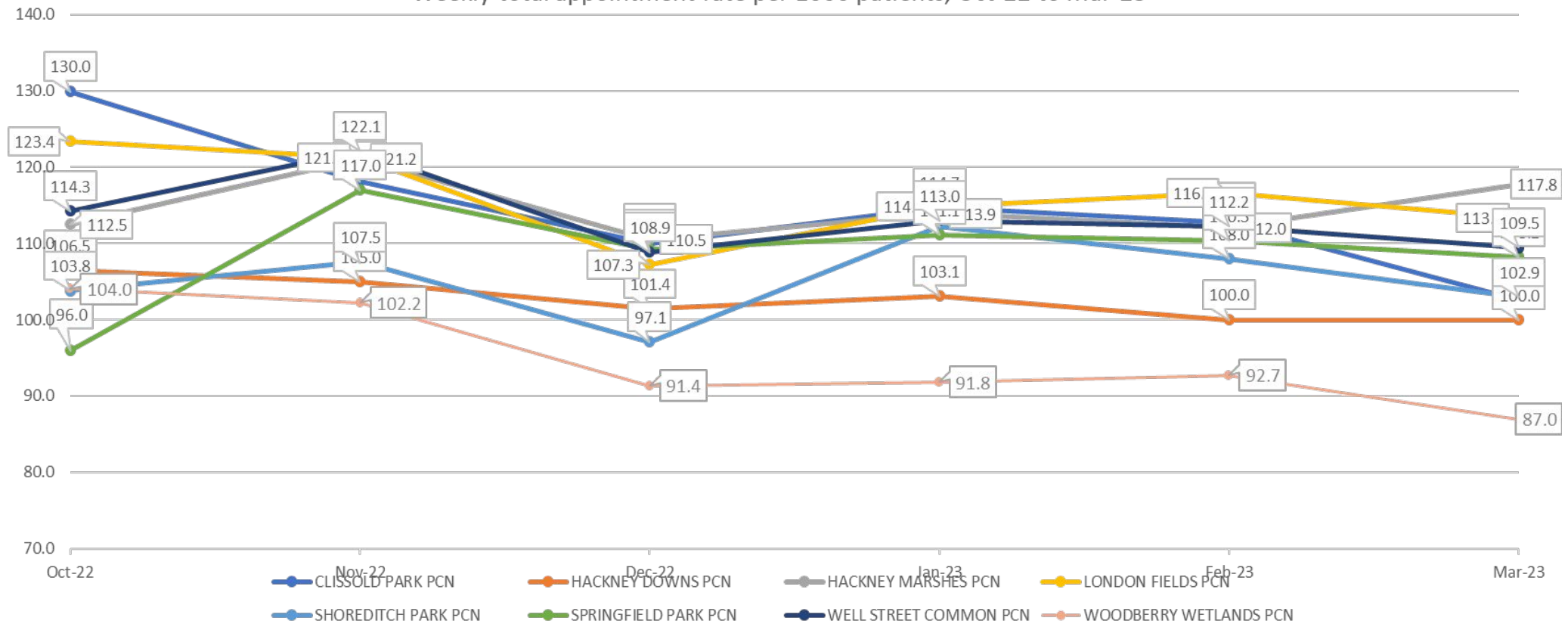
Weekly total appointment rate per 1000 patients, Oct-22 to Mar-23



# GPAD – City and Hackney PCNs

- The chart below shows the same metric as the two previous slides for City and Hackney PCNs
- All eight PCNs have an average weekly consultation rate that is similar to or higher than London, seven are higher than the NEL average and three are higher than the national average

Weekly total appointment rate per 1000 patients, Oct-22 to Mar-23



# “GP Appointment Data” (GPAD) - appointment mode

PCN	Face-to-Face	Home Visit	Telephone
BARKING & DAGENHAM	73.9%	0.3%	24.7%
CITY & HACKNEY	75.6%	0.4%	23.9%
HAVERING	73.4%	1.2%	25.3%
NEWHAM	61.0%	0.2%	38.8%
REDBRIDGE	68.0%	0.4%	31.0%
TOWER HAMLETS	59.4%	0.5%	40.1%
WALTHAM FOREST	55.3%	0.4%	42.8%

- City & Hackney has a higher proportion of face to face appointment than the NEL (66%), London (65%) and national (70%) averages.

PCN	Face-to-Face	Home Visit	Telephone
CLISSOLD PARK PCN	69.6%	0.9%	29.5%
HACKNEY DOWNS PCN	77.1%	0.4%	22.5%
HACKNEY MARSHES PCN	77.5%	0.6%	22.0%
LONDON FIELDS PCN	77.3%	0.2%	22.5%
SHOREDITCH PARK PCN	79.3%	0.0%	20.7%
SPRINGFIELD PARK PCN	66.5%	0.2%	33.3%
WELL STREET COMMON PCN	79.6%	0.3%	20.1%
WOODBERRY WETLANDS PCN	75.9%	1.5%	22.6%

- Only Clissold Park and Spring Park PCNs have a lower proportion of face to face appointments than the City and Hackney average.

# GPAD – time between booking and appt

Place	Same Day	1 Day	2 to 7 Days	8 to 14 Days	15 to 21 Days	22 to 28 Days	More than 28 Days	Unknown / Data Issue
BARKING & DAGENHAM	40.49%	9.12%	25.06%	14.02%	6.55%	2.75%	1.83%	0.18%
CITY & HACKNEY	53.30%	10.69%	19.37%	9.50%	4.06%	1.71%	1.32%	0.05%
HAVERING	36.84%	8.20%	19.44%	14.13%	9.16%	5.60%	5.82%	0.82%
NEWHAM	35.94%	12.53%	29.36%	12.36%	5.38%	2.53%	1.54%	0.36%
REDBRIDGE	45.86%	10.29%	24.37%	11.42%	4.60%	2.01%	1.37%	0.09%
TOWER HAMLETS	41.36%	11.43%	24.96%	12.33%	5.24%	2.52%	1.68%	0.48%
WALTHAM FOREST	47.03%	9.80%	21.01%	12.98%	5.34%	2.23%	1.16%	0.47%

- Over half of C&H appointments take place on the same day they were booked, with 93% taking place within two weeks
- These are the highest proportions in NEL and are higher than the averages for London (44% same day, 89% within 2w) and England (43% same day, 83% within 2w)

PCN	Same Day	1 Day	2 to 7 Days	8 to 14 Days	15 to 21 Days	22 to 28 Days	More than 28 Days	Unknown / Data Issue
CLISSOLD PARK PCN	44.91%	12.73%	22.24%	11.37%	6.02%	1.72%	0.99%	0.03%
HACKNEY DOWNS PCN	57.66%	7.96%	17.77%	9.05%	4.59%	1.72%	1.25%	0.01%
HACKNEY MARSHES PCN	55.67%	10.24%	17.94%	8.83%	3.33%	1.82%	2.09%	0.09%
LONDON FIELDS PCN	59.27%	13.08%	17.59%	6.12%	2.08%	0.95%	0.80%	0.11%
SHOREDITCH PARK PCN	50.78%	11.28%	21.40%	8.85%	3.96%	2.07%	1.65%	0.01%
SPRINGFIELD PARK PCN	62.13%	11.04%	15.77%	6.79%	2.02%	1.13%	1.11%	0.01%
WELL STREET COMMON PCN	47.19%	9.38%	21.91%	12.87%	5.23%	2.07%	1.30%	0.06%
WOODBERRY WETLANDS PCN	44.40%	8.01%	21.00%	15.43%	7.16%	2.57%	1.39%	0.03%

- Springfield Park PCN have the highest proportion of appointments taking place on the same day they were booked
- Over 90% of appointments at seven PCNs take place within two weeks of booking. The only exception is Woodberry Wetlands with 89% taking place within two weeks

Data source: <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice> - Data shown for Oct-22 to Mar-23



# Duty Doctor

- The higher proportion of same day appointments in C&H is in part due to the Duty Doctor service. Audit data for each quarter in 22/23 is shown in the table below
- The average number of calls from patients during the audit weeks constitutes approximately 10% of the average weekly same day appointment activity at C&H practices

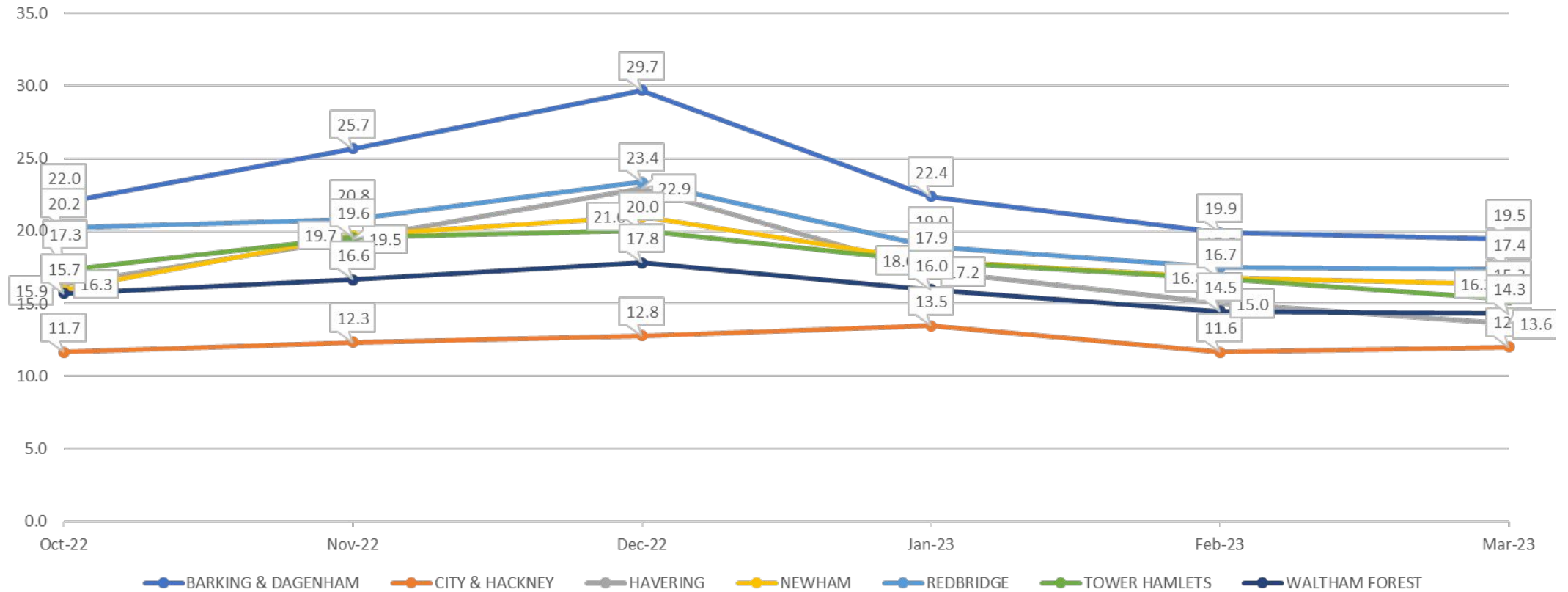
Period	PATIENTS			PROFESSIONALS		
	Total number of Duty Doctor calls received from PATIENTS during audit week	Number of PATIENT calls audited for adherence to response times	Number of PATIENT calls responded to (%) within the KPI response time	Total number of Duty Doctor calls received from PROFESSIONALS during audit week	Number of PROFESSIONAL calls audited for adherence to response times	Number of PROFESSIONAL calls responded to (%) within the KPI response time
Q1 April – June 2022	1,613	655	655 (100%)	192	181	181 (100%)
Q2 July – September 2022	1,835	601	600 (99.8%)	165	156	165 (100%)
Q3 October – December 2022	1,917	623	621 (99.7%)	167	153	153 (100%)
Q4 January - March 2023	2,054	614	613 (100%)	212	193	193 (100%)
Average total per audit week	1,855			184		

# Duty Doctor and impact on NHS111 calls

- Chart below shows the rate of calls per 1000 patients to NHS111 during core GP hours from Oct-22 to Mar-23
- The rate for City and Hackney practices is approximately 30% lower each month than the NEL average

Calls to NHS111 during core GP hours rate per 1000 patients, Oct-22 to Mar-23

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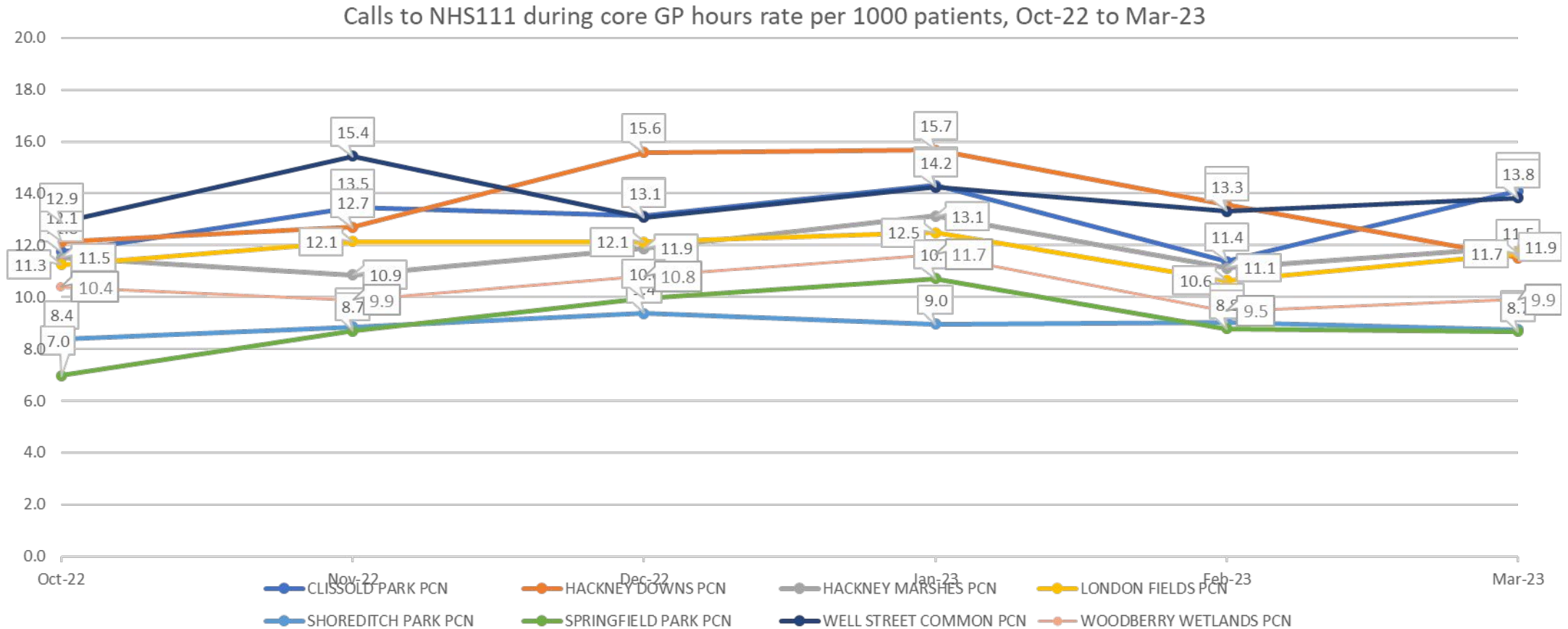


Data source: PRM data Oct-22 to Mar-23

# Call to NHS111 – City and Hackney PCN

- Chart below shows the same metric as the previous slide but for City and Hackney PCNs
- All eight PCNs are below the NEL average in each month between Oct-22 and Mar-23

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Data source: PRM data Oct-22 to Mar-23



North East London

# GP Contract 2023/24

Access requirements of GPs and PCNs for the coming year

# GP contract changes 2023/24

The focus for contractual arrangements for 2023/24 is on **supporting teams** and **improving patient access and experience**

This is the last year of the five year GP contract reform framework, [Investment and Evolution](#) (2019), which was introduced to deliver the commitments set out in the [NHS Long Term Plan](#).

**The headline changes to the 2023/24 contract are:**

- Improving **patient experience and satisfaction of access** – offer of assessment or signposting at first contact with practice, all routine appts within two weeks, mandated use of Cloud based telephony
- A **streamlined approach to:**
  - **The Impact and Investment Fund (IIF)** – Five priority clinical indicators retained relating to flu vaccs, LD health checks, early cancer diagnosis and two week access. Introduction of Capacity and Access Payment to allow PCNs to focus on improvements to help manage demand and improve patient experience of access (see slide 3)
  - **Quality and Outcomes (QOF)** where there is a focus on staff wellbeing in the Quality Improvement (QI) module (see slide 4)
- Taking on board feedback from general practice:
  - expanding flexibility of the **Additional Roles Reimbursement Scheme (ARRS)** and
  - changes to **childhood immunisations**
- Freeing up **workforce capacity through reducing targets**
- Updates to **vaccinations and immunisations**

**In recognition of the current workload pressures in general practice, no additional requirements have been added to the PCN service specifications in 2023/24, with only minor changes. These include guidance on suggested best practice for PCNs.**

# Capacity and Access Payments (CAP)

- Repurposes £246m (80%) of PCN Improvement and Investment Fund (IIF) monies to allow practices and PCNs to focus on improvements to access and patient experience
- Aim of this new indicator is to provide space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so improvement work can be data-led.
- 70% paid in monthly instalments to PCN in proportion to list size as capacity and access support payments (CASP)
- 30% capacity and access improvement payment (CAIP) subject to delivery of improvement plan

## 1. Capacity and Access support payment (CASP):

The PCN payment should be used to complete local improvement work including but not limited to:

- Consider, plan and implement local processes to ensure:
  - Patients offered an assessment of need signposted to an appropriate service, at 1<sup>st</sup> contact with the practice
  - Routine patient appointments are held within two weeks where appropriate
  - Prospective (future) record access is provided to patients by 31<sup>st</sup> October 2023
- Improved local use of data, & training (e.g. care navigation)
- Support achievement of the Access Recovery Plan

## 2. Capacity and Access Improvement Payment (CAIP):

- Will be made in respect of improvements in the 3 key areas outlined within the [guidance](#): i) patient experience of contact; ii) ease of access & demand management; and iii) accuracy of recording in appointment books
- By 12<sup>th</sup> May 2023, each PCN should have considered their baseline position and held an initial conversation with their commissioner about their approach to local access improvements – ***initial meetings between local PC team and PCNs already taken place***
- An *Access Improvement Plan (AIP)* should be finalised and agreed 30<sup>th</sup> June 2023

# QI QOF

Quality Outcomes Framework in 23/24 contains two QI modules focused on access:

1. Optimising use of staff capacity and reducing avoidable appointments;
2. Workforce and wellbeing - Improving wellbeing, resilience, and risk of burnout for the GP workforce

# Delivery plan for recovering PC access

NHSE published on 9<sup>th</sup> May, seeking to tie together a number of existing and new workstreams relating to access. It seeks to support recovery by focusing this year on four areas:

- **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.
- **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.
  1. better digital telephony – all practices to migrate to cloud systems with call queueing, auto call back, call routing
  2. simpler online requests
  3. faster navigation, assessment and response – along the lines of total triage models adopted during the pandemic
- **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
  1. larger multidisciplinary teams
  2. more new doctors
  3. retention and return of experienced GPs
  4. higher priority for primary care in housing developments
- **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

Full plan available at link below:

<https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/>



# Delivery plan for recovering PC access

Commitment	Detail	Planned national enablers
<p><b>Empower patients</b></p> <p><i>Tools for patients to manage own health using NHS App and community pharmacy expansion</i></p>	<ul style="list-style-type: none"> <li>Patients can see records &amp; practice messages, book appointments and order repeat prescriptions via NHS app (90% practices <a href="#">by Mar 24</a>)</li> <li>ICBs to expand self-referral pathways (<a href="#">Sept 23</a>)<sup>1</sup></li> <li>Expand pharmacy oral contraception and blood pressure services</li> <li>Launch Pharmacy First – supply prescription only medicines for 7 common conditions (<a href="#">Dec 23</a>)</li> </ul>	<ul style="list-style-type: none"> <li>Expand NHS.uk content</li> <li>Planned changes to VAT, flexibilities around supervision, dispensing</li> <li>Focus on interoperable digital solutions</li> <li>From 2026 updated training standards will ensure all newly qualified pharmacists are independent prescribers</li> </ul>
<p><b>Implement ‘Modern General Practice Access’</b></p> <p><i>Tackle 8am rush - Patients know on the day how request will be handled, respecting appointment type preferences</i></p>	<ul style="list-style-type: none"> <li>Support all practices on analogue lines to move to digital telephony, if they <a href="#">sign up by July 2023</a> - Transition all who sign up by <a href="#">Mar 24</a>; All remaining practices must transition by <a href="#">Dec 25</a></li> <li>Provide all practices with the digital tools, care navigation training &amp; fund transition cover for those that commit to Modern General Practice Access <a href="#">before March 2025</a>.</li> <li>Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme (GPIP).</li> </ul>	<ul style="list-style-type: none"> <li>Financial and procurement support for digital telephony</li> <li>Fund uplifted framework tools for online consultation, messaging, self-monitoring, and appointment booking tools</li> <li>Care navigation training – every practice and PCN allowed to nominate one member of staff to undertake training</li> <li>ICBs invited to nominate and support practice take up <a href="#">GPIP</a> offers, funding TBC</li> </ul>
<p><b>Build capacity</b></p> <p><i>Practices can offer more appointments &amp; add flexibility to the types of staff recruited and how they are deployed</i></p>	<ul style="list-style-type: none"> <li>Employ 26,000 more direct patient care staff and deliver 50 million more appointments <a href="#">by March 2024</a></li> <li>Expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England.</li> <li>Retain experienced staff through pension reforms and simpler routes back to practice for recently retired.</li> <li>Raise the priority of primary care facilities when allocating funds from new housing developments (LA planning guidance)</li> </ul>	<ul style="list-style-type: none"> <li>Increase flex. by including apprentice physician associates and Advanced Clinical Practitioners Nurses</li> <li>Long Term Workforce Plan and additional ARRS support resources (to be published)</li> <li>Care navigator &amp; digital &amp; transformation staff training</li> <li>Campaign for GPs to return to general practice</li> </ul>
<p><b>Cut bureaucracy</b></p> <p><i>Reduce workload across interface between primary and secondary care &amp; medical evidence requests, so there is more time to focus on patients’ clinical needs</i></p>	<ul style="list-style-type: none"> <li>Reduce time spent liaising with hospitals</li> <li>Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat.</li> <li>Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.</li> </ul>	<ul style="list-style-type: none"> <li>Streamlined the IIF from 36 to 5 indicators and repurposing funding as part of the Capacity &amp; Access Payment</li> </ul>

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<p><b>Health in Hackney Scrutiny Commission</b></p> <p>13th June 2023</p> <p><b>St Joseph’s Hospice - Quality Account 2022-23</b></p>	<p>Item No</p> <p><b>8</b></p>
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**PURPOSE OF ITEM**

To consider the annual quality account for St Joseph’s Hospice for 2022-23.

**OUTLINE**

In June each year the Commission is asked to submit a response to the draft Quality Account which local NHS Trusts must submit to NHSE covering the previous financial year. The reports follow a nationally mandated template.

It is customary to invite senior officers to discuss their Report and, depending on the timing, our letter of response to it. The Trust submits our letter as an appendix to their Report to NHSE.

Please find attached the draft of St Joseph’s Hospice Quality Account 2022-23. Our letter of response to St Joseph’s Hospice’s Quality Account will be tabled.

Please note that as St Joseph’s is not an NHS Trust but provides services to the NHS it is not formally required to submit a report but does so as part of its own Quality Assurance process.

Attending for this item will be:

**Jane Naismith**, Director of Clinical Services and Joint CEO, St Joseph’s Hospice

**ACTION**

Members are requested to give consideration to the report and the discussion.

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**St Joseph's  
Hospice**  
Serving East London  
and the City



# Quality Account 2022/2023

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

**020 8525 6000** [info@stjh.org.uk](mailto:info@stjh.org.uk)

**stjh.org.uk** [@stjohospice](#)

**Advocacy** **Compassion** **Justice** **Quality** **Respect**

Charity No. 1113125

## Part 1: Chief Executive's Statement



## Part 1: Chief Executive's Statement

This is the fifth Quality Account I have been involved with but my first as Joint CEO, with Jane Naismith joining me as Joint CEO in November 2022. We are delighted to confirm that we have continued to make progress against our strategic plan, Vision 2024, despite the challenges the year has thrown at us.

This year's Quality Account reflects our progress as we have emerged from the restrictions caused by the pandemic. However it is important to be mindful that for our patient group, who are extremely vulnerable, the pandemic and the current cost of living crisis still has a significant impact - similarly for staff and our communities at large.

We have continued to deliver our plans and strategies for continuous progressive improvement in our services, and you will see detailed in these reports real, everyday examples of this, in terms of reduction in incidents of avoidable harm and developments in many other areas.

As you will be aware, underpinning all of our work is our Mission, which evolved from the words of Religious Sisters of Charity founder Mary Aikenhead, "to give to the poor what the rich can buy with money". We have been caring for and supporting people affected by complex and terminal illness, as well as their families, ever since the five Sisters arrived in Hackney and established the Hospice in 1905, 118 years ago.

I am pleased to report here that St Joseph's Hospice Hackney continues to deliver and develop the highest quality specialist palliative and end of life care for people with progressive and life-threatening illnesses, as well as supporting their families and carers on an ongoing basis. We do this in both our inpatient and community services, across our day hospice, and the wide range of family support services we provide.

We have also managed to continue to provide specialist advice and support to other professionals in palliative and end of life care, despite the direct and indirect impact of the pandemic over the past three years. Our benefits team continue to support families and have successfully enabled claims up to a staggering £651,232 in unclaimed benefits to ease hardship within those families supporting loved ones with life limiting illness or recently bereaved. This has been more important since we entered the cost of living crisis as the impact of this added to the loss or impending loss of a loved one can be catastrophic.

We recently upgraded facilities in our education centre to be able to provide more remote training opportunities by the introduction of smart technology into our meeting and training rooms to facilitate a mixed economy of in-person and remote training

opportunities or a blend of the two when most appropriate. This has proven to be a real benefit to our users both internally and externally.

We have continued to look at ways to improve our communications across all of our diverse groups and you will see this in our continuing priorities for the coming year where we aim to gain the FREDIE award (Fairness, Respect, Equality, Diversity, Inclusion and Engagement) and we will seek Level 2 Disability Confident accreditation. This will reinforce systems to enable us to be as inclusive to our staff and the communities we serve, as we can be.

We have also continued to explore different care pathways that are responsive to the changing needs of our population, either from the longer term impacts of the pandemic or the changes in needs of society more widely. These changes will seek to build upon or be complementary to our award-winning Compassionate Neighbours, Empowered Living Team and Namaste services.

We could not have done any of this work without the continued dedication and commitment of our workforce including our dedicated volunteers who give 47,000 hours of time - from our reception team who greeted visitors and checked compliance with our current restrictions, through to housekeeping and facilities, to our therapists, administrators, counsellors, and of course our doctors and nurses. They have continued to work tirelessly to support our patients, their families and their colleagues.

I would also like to highlight the continued support we have had from our local communities and donors who have enabled us to maintain the services we provide and without whose support we could not deliver the range and scope of services we do. This support continues in times of financial pressure for us all so is all the more impressive of late.

This year has been another financially challenging period for many across the hospice sector, but for St Joseph's our continued financial stability has allowed us to once again navigate the year successfully. Our established Senior Management Team have again delivered our change agenda and ensured our standards of care and the governance that underpins our practice remains robust. This continues to give assurance to our Board of Trustees and us as Joint CEOs and Accountable Officers.

It would be remiss of us not to once again highlight to those reading this report that a little over half of our funding comes from our NHS block contract for the three principal boroughs we serve - City & Hackney, Newham and Tower Hamlets, which collectively cover a population of approximately 1.2 million. In addition, we deliver services to Waltham Forest, Islington and Haringey, as well as specific services for residents of some of the surrounding London boroughs. The remainder of our funding comes from charitable legacies, donations and other fundraising, which is due to the generosity and goodwill of our local communities and our corporate partners. We recognise that we cannot do this without the support of many partner organisations. We work closely with local NHS providers, primary care colleagues and with many voluntary sector care providers to deliver better integrated services and care models across our pathway of care.

2022/23 has been the fifth year of change, and we have continued to deliver improvements without detriment to the delivery of care to our patient services.

Some of our key achievements have been:

- Continued investment to futureproof the site as well as make it more sustainable in order to improve our green credentials. We have done this through adding solar



panels to the roof spaces and installation of more efficient and greener boiler systems across our estate.

- Improved fundraising for the services and the planned redevelopment of St Michael's ward to match the improvements we achieved for Lourdes ward in 2019, delayed as a consequence of the pandemic but now to be commenced and completed in 2023/24 fiscal year.
- To continue to have offered additional bed capacity to our Commissioners by keeping open our third ward - St Anne's - and adding capacity to our existing wards should it have been needed.
- To once again implement a budget plan that has ensured we achieve a balanced budget in the 2023/24 fiscal year so that income and expenditure are in balance. This is despite the impact of a cost of living crisis with increased costs almost across the board and resulting impact on the way our services are provided.
- Continued success in improving our ability to generate income from our enterprise initiatives in order to offset the reductions in fundraising due to the cost of living crisis and increasing costs for utilities and to lessen our dependence on legacy income.

I hope in reading this report you too will be reassured by the continued progress that has been made, despite the prevailing uncertain climate in the healthcare sector due to the current economic disruption, which is further complicated by conflict in other parts of the world.

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

Tony McLean  
**Joint Chief Executive**

Jane Naismith  
**Joint Chief Executive**

We welcome your comments and feedback on this Quality Account, which you can do via email, letter or telephone to Jane Naismith, Director of Clinical Services. She may be contacted by telephone on 020 8525 3007, or by email at [j.naismith@stjh.org.uk](mailto:j.naismith@stjh.org.uk). Please address correspondence to Ms J Naismith, Director of Clinical Services, St Joseph's Hospice, Mare Street, London E8 4SA.

A translator is available on request via our Advocacy and Interpreter services.

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## Organisational Context

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

1. Patients' strategy: We aim to improve services to all patients whether at home, in the Hospice, in the community, or by caring for others who give care.
2. Enterprise strategy: We have established an Enterprise pillar that augments existing revenue channels to generate a predictable income flow.
3. Estates strategy: Our focus is on development of the main Hospice site, and includes plans for the acquisition of retail and clinic facilities in the boroughs we serve.
4. Funding and fundraising strategy: New fundraising initiatives will make up the continuing shortfall in funding from the NHS.
5. Human resources strategy: We aim to give our workforce the opportunity, whatever their background, to fulfil our Mission, develop their careers and earn a reasonable income in an environment of mutual support and care.

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

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

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

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

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

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

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

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

## **Part 2: Priorities for Improvement 2023-24**

### **Priority 1– Easy read Project**

At St Joseph's Hospice we have always had very good links with our colleagues in health and social care who support people with learning disabilities. We have always provided direct support to individuals either in the own home or in our inpatient unit working in collaboration with the individuals usual care team and family to ensure our care and support is tailored to meet the preferences of the individuals and support those they live with. To support this we have 'Learning disabilities friends' in the inpatient and day hospice. Our learning disabilities friends are staff members who have had additional training and often lived experience of supporting a family member with a learning disability and they act as support to other team members.

However the COVID pandemic significantly changed the way we delivered care to this group. Rather than being able to provide face-to-face support and advice, families and group care settings began shielding, and no longer wanted face-to-face contact. We were able to adapt and use technology such as video calls and MDT discussion with their primary care team as our main means of discussion.

During this time we identified that obtaining and retaining information for this group of people was a challenge and that there was a huge gap in easy read information on death and dying. To fill this gap, we collaborated with our colleagues from the learning disability team at East London Foundation trust and we produced our first easy read leaflet 'In the last few days of life'.

Reflecting on this experience and reviewing the other information the Hospice provides we are aware that one leaflet is just the start. Therefore, we have launched our 'easy read project' which aims to create a suite of accessible information for people with learning disabilities. To achieve this we will be co-creating the materials with support from Empowering Voices based at the Creative Hub in Tower Hamlets.

In 22/23 we completed the 15 step challenge. Overall the results were very positive, however the team completing the review highlighted that some of our signage was unclear or confusing particularly to those with learning difficulties or cognitive impairments. Therefore we also plan to have a working group to review and replace the signage throughout the hospice.

### **Priority 2 – Increase access and community support individuals with non –cancer diagnosis**

At St Joseph's Hospice we work hard to try to widen access to palliative care services and we are pleased that our non-cancer referrals have been increasing year on year. For many members of the public and some health and social care professionals, the words hospice and cancer go synonymously together with little thought being given to the positive impact that a palliative care approach can give to a range of progressive long-term conditions such as end stage heart failure or Lung disease.

The preconception that hospices are for cancer patient means that, when a patient with a non-malignant diagnosis is referred, the patient will often decline the referrals, particularly when they are referred earlier in their disease pathway.

We are aware that for the majority of these patients breathlessness will be the symptom that will have the greatest impact on their quality of life and is the symptom that they are most likely to call an ambulance for or to seek support from a hospital.

To support improved access and take up of palliative care services we propose to commence a specific breathlessness support service. This service aims to provide a 'Toolkit' that patients can use to manage their breathlessness. This toolkit will be tailored to each patient but will include information for them and their family around beneficial interventions, and practical tools they can

use such as specific breathing techniques, hand held fans alongside face-to-face appointments. The service will also work on a consultative basis offering support, advice and education to other health and social care professionals.

We are also aware that health professionals can struggle to recognise how hospice care could benefit their patient and when would be the right time to refer them. To support identification of patients who may benefit from support from the hospice we hope to be able to join MDT with the interstitial lung respiratory and cardiac secondary care teams.

### **Priority 3. Improvement to the hospice environment**

We have had to carry over our ward refurbishment project from last year.

We had hoped to start the build in 2022/23 but the Ukrainian crisis appeared to cause a shortage of building material leading to costs to rise by 30%. This coupled with the increase in fuel bills meant we had a funding gap of approximately four hundred thousand pounds, which meant we had to delay to raise more funds, we have now raised the majority of this funding and are committed to start mid-2023.

We have taken this time to carefully consider how we want our new ward to look now and anticipate any changes in our care pathways in the future. Our vision for the new ward is to have an area that promotes orientation, enablement and wellbeing. The design will focus on a calm, safe and welcoming environment whilst promoting meaningful interaction between our patients, staff and families.

Whilst the majority of our patients on the inpatient ward we refurbished in 2018/2019 really appreciate our simple modern ward design, the uniformity of the design can make it difficult for individuals with dementia to orientate themselves to their environment. Therefore, we plan to create a more dementia friendly environment using colour and visual symbols to help support people navigate the environment

We have decided to decommission the 2 four bed bays and build bays which are flexible enough to accommodate one or two beds. We have also re-thought our patient communal areas, redesigning them so they can be used for dining, family meetings, or therapy and we will include an area when patients can make their own drinks and snacks.

As part of the ward refurbishment work we will also be running a seating project to review and improve patient and visitor seating on each ward and a project to improve ventilation throughout our inpatient areas.

We have also been considering how welcoming the rest of the hospice environment is as we have been aware that for many children who come to visit a loved one, the environment can seem very daunting and adult centric. We already have our 'elephant kits' which we give to our children and young people. These kits are tailored to include age appropriate activities for the child or young person and resources to support the parent to support the child. This year we will embark on a new project led by one of our child psychologists and our Matron. The project's aim will be to improve the environment in the hub and in our inpatient ward and to create a range of resources and activity boxes for the wards which will help to support the children and young people who visit the Hospice.

### **Priority 4 Implement the new NHS Patient Safety Incident Response Framework (PSIRF)**

As you would expect as an organisation we are committed to continuous quality improvement and patient safety. Over the past few years we have introduced a number of initiatives to improve and make our clinical governance processes more robust. In 2021 we reviewed our clinical governance lead role, changing its focus from recording, counting and measuring the

impact of incidents, to a role that focused on patient experience and quality improvement. This change of emphasis has led to many changes in practice including the way we assess and manage patients who are at risk of falling, pressure ulcer management and the implementation of an electronic prescribing and medicines administration system.

While we would have always described the hospice as a learning organisation we have significantly strengthened our approach to this and have a bi-weekly key learning and safety huddle meeting on the wards and produce a '*Learning from..*' bulletin which highlights the human factors that contributed to incidents and clinical services wide shared learning events. We have published bulletins on *Learning from...* incidents, complaints, and medication incidents.

By September 23 in agreement with North East London Integrated Care Board (ICB) we will complete the transition to the new Patient safety Incident Response Framework (PSIRF) implementing the new framework across the hospice. The approach to patient safety that we have already developed aligns strongly with PSIRF. We welcome the emphasis the framework brings to address incident themes and clusters to ensure learning is acquired and improvement in patient safety is delivered. We hope using the framework will bring about a deepening of our approach, which has already been in action in recent years. The framework also facilitates more easily inter-organisational working on common patient safety themes, which will support the sharing of best practice.

We currently collate and interrogate our patient safety data on a monthly basis, but we will utilise the transition to PSIRF phase to review 24 months of patient safety incident data. This will enable us to quantify further and to allow us to survey for underlining themes or signals, which may have escaped our scrutiny at this point. We will share this learning with the wider team and look at what systems we can put in place to reduce incidents that cause harm.

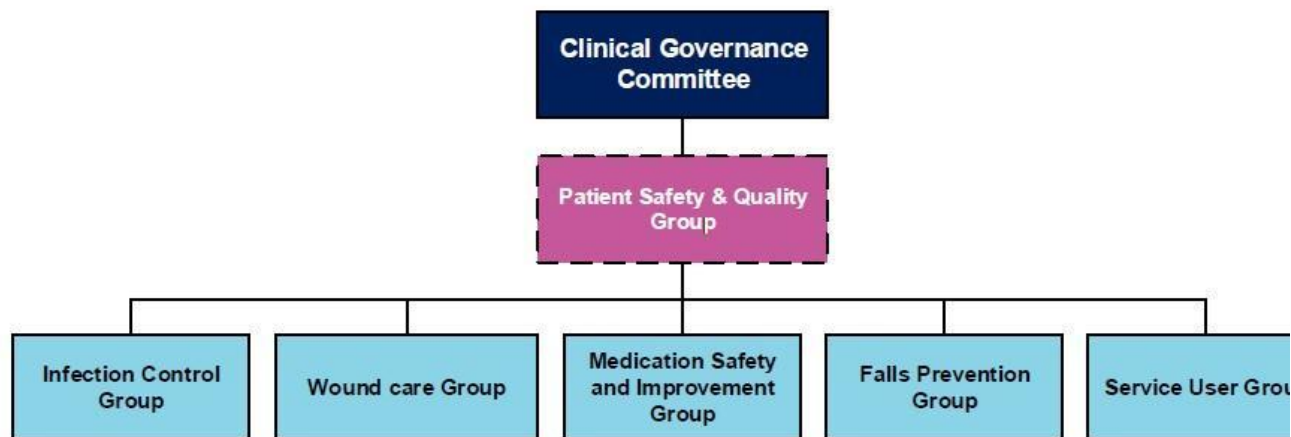
To successfully implement PSIRF we will ensure all clinical staff are trained about the requirements of this framework including the importance of a just culture. We already give consideration to how Human Factors may contribute to an incident but feel that for many staff understanding of Human Factors that contribute to incidents is a knowledge gap therefore we will focus on Human Factors training.

## Part 3: Review of Quality of Service in 2022/23

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

### 3:1 Quality Assurance

#### Reporting Structure



#### 3:2 Quality Monitoring Visits

Due to the COVID-19 pandemic, we have not had any quality visits in the past year. We have however had regular engagement and monitoring calls with our CQC inspector as well as our CCG colleagues. This has given us an opportunity to discuss issues and provide assurance around our standards. During this period, they conducted a transitional monitoring assurance desktop review and were satisfied with our performance. We also continued to produce and disseminate our quarterly quality report.

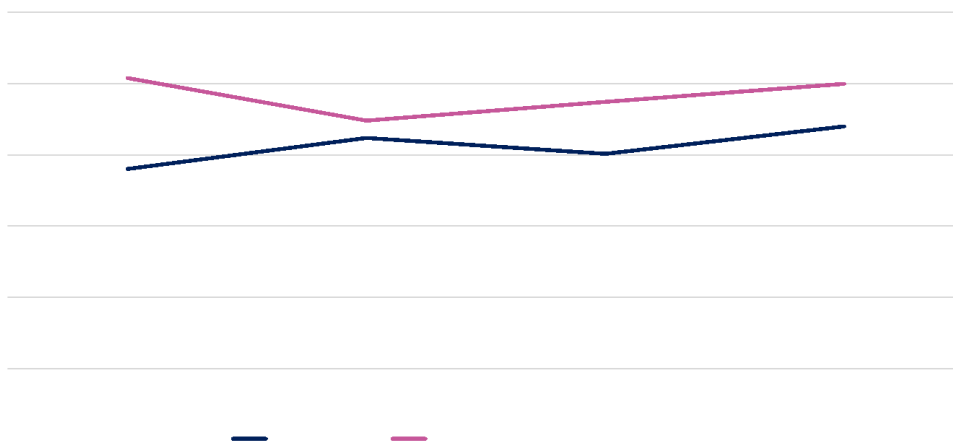
#### 3:3 National Quality Indicators

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



Indicator	Performance															
<p data-bbox="177 405 371 439"><b>Inpatient falls</b></p>	<div data-bbox="395 416 1393 792" style="text-align: center;"> <p><b>Falls Benchmarking Q1-4 2022/23</b></p> <table border="1" style="margin: auto;"> <caption>Falls Benchmarking Data (per 1000 occupied bed days)</caption> <thead> <tr> <th>Quarter</th> <th>STJH</th> <th>Adult Hospice Average UK</th> </tr> </thead> <tbody> <tr> <td>Q1 22-23</td> <td>10.0</td> <td>8.9</td> </tr> <tr> <td>Q2 22-23</td> <td>8.8</td> <td>8.9</td> </tr> <tr> <td>Q3 22-23</td> <td>5.5</td> <td>8.9</td> </tr> <tr> <td>Q4 22-23</td> <td>5.8</td> <td>8.9</td> </tr> </tbody> </table> </div> <p data-bbox="400 797 1372 958">           There were 55 falls on the inpatient wards affecting 49 patients. 27 falls resulted in no harm, 7 low harm, 1 fall resulted in moderate harm this patient fell and required sutures to a head wound which the patient attended A&amp;E for and included an assessment of a head injury returned to STJH the same day. Six patients fell more than once.         </p> <p data-bbox="400 987 1329 1155">           There has been a slight decrease in falls over the year 2022-2023 The falls on the inpatient wards represent an average of <b>7.3</b> per 1000 occupied bed days. Hospice UK's benchmark for similar sized inpatient units is <b>8.9</b> and for all hospices <b>8.9</b> per 1000 occupied bed days, so we remain below average.         </p> <p data-bbox="400 1189 829 1223">           To manage and reduce the risks:         </p> <ul data-bbox="400 1256 1372 1659" style="list-style-type: none"> <li>● The Falls Multidisciplinary Group meet monthly, all falls are reviewed individual case studies are presented by the teams to ensure any learning is identified</li> <li>● Equipment has been reviewed over the year including low beds, alarmed mattresses/beds and seating to help to reduce falls risks</li> <li>● Ongoing training, throughout the year with regular updates, workshops and reminders regarding post fall management. The documentation reveals robust post falls management is consistently undertaken</li> <li>● We have trained staff in the use of our Hoverjack - a piece of equipment to safely move patients after a fall which reduces the risk of any further harm for both the patient and staff. This was identified as a requirement following the 2022 National Falls Audit</li> </ul>	Quarter	STJH	Adult Hospice Average UK	Q1 22-23	10.0	8.9	Q2 22-23	8.8	8.9	Q3 22-23	5.5	8.9	Q4 22-23	5.8	8.9
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## Pressure Ulcers



The total number of new/hospice acquired pressure ulcers in the year was 31 affecting 24 patients. This number includes Moisture Associated Skin Damage (MASD) and damage from Medical Devices which are not reportable this then equates to a total number is 21 hospice acquired ulcers.

We continue to report all new hospice acquired pressure ulcers; categories from I-IV, Unstageable, Deep Tissue Injury (DTI), Moisture Associated Skin Damage (MASD) and those acquired from a medical device.

In this year, there were three Category I, nine Category II, seven Category III (these deteriorated from a Category II), two Deep Tissue Injuries. (There were eight MASD and two Medical Device Pressure Ulcers).

We record the patients' Phases of Illness and AKPS (performance status) for context. All ulcers were assessed as unavoidable.

In respect of hospice acquired Pressure Ulcer benchmarking, this represented an average of **4.4** per 1000 occupied bed days. The Hospice UK average is **7.4** for a hospice of our size and **9.7** for all hospices per 1000 occupied bed days; we are below average compared to all other hospices.

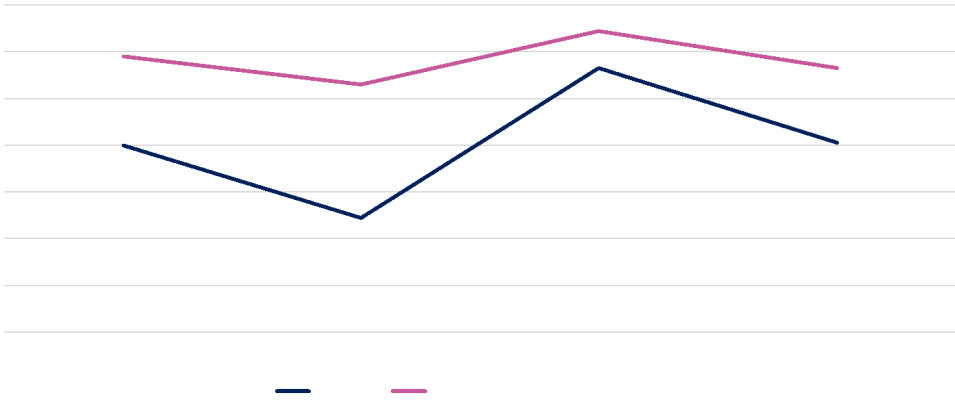
The benchmarking for all pressure ulcers including those present on admission was on average **15.6** per 1000 occupied bed days, compared to all hospices of a similar size where the average was **18.6** per 1000 occupied bed days, making us below average.

60 patients were admitted with a total of 75 pressure ulcers excluding MASD and Medical Device damage which we capture and report but are not counted in the Hospice Benchmarking data. We have continued to monitor patients admitted from home during the ongoing pandemic due to reduced services in the community the safeguarding teams have been informed.

To reduce the incidence of pressure damage within the inpatient unit we take the following actions:

- Ongoing Education with workshops, drop ins and on the job teaching

	<ul style="list-style-type: none"> <li>● Bi-weekly bitesize training and safety sessions which include PU management are held on the wards</li> <li>● Monthly Wound Care Meeting with an MDT approach and any learning cascaded</li> <li>● Champions on the wards who have access to HUH practitioner days</li> <li>● A monthly Matron's ward rounds focus's on assessments &amp; Care planning</li> <li>● Bi-weekly panel to review all new Category III and above pressure ulcers</li> <li>● All patients are assessed on admission for risk of developing pressure damage, using a validated tool</li> <li>● Ongoing improvements in the use of documentation and reporting</li> <li>● Equipment has been reviewed &amp; purchased including profiling beds, mattresses, in-situ slings, four-way glide sheets and we now have two bariatric profiling beds, mattresses &amp; reclining chairs which have full pressure relief.</li> </ul>
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<p><b>Medication</b></p>	 <p>The total medication errors in the year amounted to 39.</p> <p>The level of harm for all errors were categorised Level 0 - no harm (incident prevented) Level 1 - no harm incident (not prevented) Level 2 Low Harm. There were 13 incidents with no harm (incident prevented) and 25 incidents were no harm (incident not prevented) and 1 low harm.</p> <p>We identified a small trend of overages and underage and a task and finish group worked to reduce the risk of anomalies. From this work a new measuring system and calculation of liquids was introduced to also include equipment.</p> <p>Incident occurrence represents on average <b>8.1</b> per 1000 occupied bed days. The Hospice UK benchmarking data average per 1000 bed days is <b>9.2 for a hospice of a similar size and 11.5 for all hospices</b>, which makes us below average for a hospice of a similar size.</p> <p>To manage and reduce the risk of incidents or errors we:</p> <ul style="list-style-type: none"> <li>● Consistently monitor and review of all incidents by a team prior to Drugs and Pharmacy Meeting where all incidents are discussed and any learning revealed.</li> <li>● Robust process following incidents errors where nurse are supported to learn from any mistakes and human factors investigated</li> </ul>
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	<ul style="list-style-type: none"> <li>• The monthly <i>Learning from ...</i> series is used to highlight learning from medication incidents</li> <li>• Successful introduction of e works and electronic system which is now embedded and a continual update of a robust Standard Operating System Monthly Bulletins are produced following discussions with the teams following errors bulletins highlighting incident trends and actions to be taken</li> <li>• All nurses have completed a yearly assessment, competency CD e learning and practical assessment which , includes drug calculations tests</li> <li>• Bitesize sessions are facilitated to improve understanding and knowledge following any incidents highlighted as a learning opportunity</li> <li>• A morning is dedicated on a Clinical Day for all nurses which includes input from the pharmacy teams</li> <li>• Monthly Matron's ward round to observe practice, including auditing of controlled drug documentation e administration reports</li> </ul>
<p><b>Venous Thromboembolism</b></p>	<p>Our management in treating Venous Thromboembolism (VTE) risk was 100%.</p> <p>We follow VTE guidelines in accordance with national recommendations specifically NICE Guideline 89 (section 1.4.13). We consider pharmacological VTE prophylaxis, taking into account temporary increases in thrombotic risk factors, risk of bleeding, likely life expectancy and the views of the person and their family members or carers. When appropriate, we use Low Molecular Weight Heparin as a first-line treatment and monitor daily. We do not offer VTE prophylaxis to people in the last days of life.</p>
<p><b>Mortality</b></p>	<p>A hospice will have a higher mortality rate than other care settings with many individuals choosing a hospice as their preferred place of care and death.</p> <p>We have had a change of how we Learn from deaths. Prior to January 2023 we used the NHS 'Learning From Death' methodology. All deaths had a case review at our multi-disciplinary team meeting, and a second more in-depth review takes place if the patient's family has any concerns or questions. A sample of all deaths also have a second review using PRISM* for quality monitoring.</p> <p>Since January 2023 all our deaths have been reviewed by the medical examiner service at Homerton University Hospital Foundation Trust.</p> <p>In 2022/23, there were no episodes of suboptimal care that contributed to or hastened patients' deaths.</p> <p>*<a href="https://improvement.nhs.uk/documents/1423/PRISM_2_Manual_V2_Jan_14.pdf">https://improvement.nhs.uk/documents/1423/PRISM_2_Manual_V2_Jan_14.pdf</a></p>

<b>Regular audits</b> <b>Title/Frequency</b>	<b>Findings</b>
Infection Prevention and Control (IPC) - handwashing (Monthly)	<b>Findings</b> All audits showed excellent results, any anomalies are addressed at the time of audit – cross-ward auditing is taking place and the team at Homerton carry out twice-yearly audits in these areas.
IPC – Bare Below Elbows (BBE) (Monthly)	We have had very low levels of infections and no hospice acquired infections in the year MRSA 1, C.Difficile 1, (present on admission)
IPC – Catheters (Monthly)	Pseudomonas Aeruginosa 6 and Klebsiella 2 across the year. There were 10 cases of e-coli spread evenly across the year.
IPC - Invasive devices (Monthly)	<p>IPC – Bare Below Elbows audit normally shows some lack of compliance with the arrival of new doctors to the hospice but with early reminders at inductions and education this was not the case.</p> <p>The IPC Catheter audit has been improved in line with NICE standard, documentation of catheter being in-situ, the catheter size and date of change. now includes reason for catheter, date of bag change            IPC - Invasive devices audit tests for the dressing being dated, and the date of change being documented. Across the year, the dressing date has rarely been missing. The use of invasive devices has decreased.</p>
Sharps Annually in August	<p>Carried out internally in August 2022 and repeated in January 2023 following some failures due to inappropriate use, gauze present and one bin not closed appropriately. Marked improvements in 01/2023 100%. External Auditor did not attend due to COVID. So we carried out cross ward auditing.</p> <p>Action plan devised, disseminated and implemented.</p>
Cleanliness audits (Monthly)	<p><b>Findings</b>            Compliance with National Standards of Healthcare Cleanliness are being met in all areas.</p> <p>The national Cleanliness Standard 2021 was introduced in 2022 and has been successfully embedded in all areas to include increased auditing, a star rating, and a commitment to the Cleanliness Charter.</p> <p><b>Improvement plan</b>            Matron meets housekeeping supervisors monthly to review findings ward staff and housekeepers are working alongside each other to carry out the audits twice a month. We hold a 5 star rating food hygiene rating.</p>

. Water Testing	<p><b>Findings</b> The results indicate the system is working satisfactorily.</p>
Infection Prevention & Control Audit	<p>Using the Infection Prevention Society Quality Improvement Tool covered wards, corridors and Laundry, environment, Hand Hygiene, PPE, Isolation, Equipment, ward kitchen, waster linen &amp; sharps management.</p> <p><b>Findings</b> June 22 – All areas were assessed as compliant in respect of cleanliness. There was a requirement for an increase in Single Use items, disposable BP cuffs ordered at time, fixtures and fittings which failed will be addressed in the refurbishment on STM, some waste bins needed replacing and some education was required around linen management and organisation of flow of dirty to clean in the laundry.</p> <p>November 2022 we revisited all previous areas and added the mortuary and viewing room. Each area was compliant with minor adjustments to storage and an increase in dispensers for aprons and gel.</p>
Controlled drugs audits (May/Aug/Nov/Feb)	<p>Audits carried out in the Main Pharmacy and on both wards.</p> <p><b>Findings</b></p> <ul style="list-style-type: none"> <li>● Main Pharmacy – Full compliance.</li> <li>● Lourdes Ward – Full compliance. Improvement opportunity taken: to add Methadone sugar-free and with sugar to the CD Stock list separately</li> <li>● St Michael’s Ward – Improvement opportunity taken: to add Methadone sugar-free and with sugar to the CD Stock list separately.</li> <li>● St Michael’s ward - Area requiring improvement: Standard <i>‘Each CD has only one page per drug in use and that page is clearly titled, with the drug name form and strength, and all entries are legible.’</i></li> </ul> <p><i>Finding compared to standard: Page 38, 44, 46 in the CD Record Book - the name of the medication was not written fully, no form of the drug written, and only drug name mentioned respectively.</i></p> <p><b>Improvement plan</b> Dissemination of findings. Refresh staff actions required. Monitor closely.</p>
Blood transfusion – annual site inspection (Annually)	<p>Blood transfusion inspection by external provider Homerton University Hospital (under an SLA) took place in October 2021. No report has been provided at this time. Report has been requested on numerous occasions.</p>
Blood transfusion – mock recall audit (Annually in January)	<p>Mock recall audit is an audit initiated by HUH (under SLA) and STJH respond. No initiation of audit has occurred in 2022/23.</p>

**3:4 Clinical Audits completed between April 2022 and March 2023**

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

These audits are monitored through the Clinical Governance Committee that reports to the Board for assurance at the highest level in the organisation.

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

Ad hoc audits Title	Results/Improvement plan
<p>Audit of STJH Inpatient Unit care against NICE guidelines for End of Life Care 'Care of dying adults in last days of life' (December Guidelines 2015).</p>	<ul style="list-style-type: none"> <li>● Patients (n=22) covered a wide age range and fairly equal spread of both In-Patient wards</li> <li>● 100% patients in the audit had advanced care planning discussions, DNACPR order in place and DNACPR discussion with the family.</li> <li>● 100% had subcutaneous medications prescribed in anticipation of potential need and with individualized and appropriate doses.</li> <li>● 95% had individualised EOLCP commenced before death</li> <li>● 86% had documented assessment of cultural / religious /social/spiritual needs</li> <li>● Improvement of PPD recording from 69% in 21/23 to 90% in 22/23.</li> <li>● There was inconstant recording of discussions around hydration and side effects of medication</li> </ul> <p><b>Improvement plan for hydration discussions and documentation:</b></p> <p>Medical Director led a discussion with the team, the medical team felt that in most cases introducing the topic when fluids would not be indicated caused more distress for a patient and family. It has then become a primary focus for the family causing high levels of anxiety at times and potentially a point of tension between the family and the medical team.</p> <p>The team feel very competent and confident to have the discussions and respond well when patients and families initiate the discussion. The medical team experience is that where it is on a family's agenda, those conversations go well and tend to do no harm.</p> <p>There are leaflets available on each ward, which discuss changing needs at the end of life including hydration. The multidisciplinary approach is always to check in with patients and families regularly to ask if they have any questions.</p>

<p>Steroid &amp; Antibiotic prescribing &amp; use</p>	<p>This was a re audit which examined whether there was consistent antimicrobial prescribing practice ensuring our prescribing is in accordance local/national guidelines. The results were compared with the previous audit.</p> <p>100% of prescriptions were <b>signed, dated</b> and 12.5% had an <b>indication</b> documented (this was 100% in 2021).</p> <p>25% (n=4) prescriptions had a documented duration or review date (58% in 2021).</p> <p>The switch to an electronic prescription and medicine administration system (e-Works) has contributed significantly to these reductions in compliance to the standard.</p> <p>The mandatory 'Indication' box on e-Works is only operational in the PRN (as required) context so inclusion of indication is not required in regular antimicrobial prescriptions. The same is true for the review dates. Therefore compliance to the standard depends on human memory, embedding into normal practice and handover mechanisms. These are all liable to lapse in compliance to the practice standard.</p> <p>A benefit of the electronic prescription and medicine administration system is that the 'signing' and 'dating' which in former years (pre-2021) were less than 100% will now always be 100% as the e-Works application requires them.</p> <p><b>Improvement plan:</b> A specific poster close to the prescribing stations for all doctors regarding the need to include indication for use, duration of days and review date to be written into the Additional Notes section of the prescription.</p>
<p>Speech and Language Therapy Audit: Audit the knowledge of frontline staff in recognising a swallowing or communication issue that requires a SALT referral.</p>	<p>This audit aimed to collect data on recognition of the need for referrals to Hospice SLT services for both communication &amp; swallowing difficulties. The data was analysed to look for areas requiring interventions to improve the service.</p> <p>Baseline measure of staff's knowledge and confidence in referring to SLT was collected via a short questionnaire. The audit showed that staff confidence in referral was not consistent for all diagnosis or conditions and the results suggest that people with mild speech and language difficulties were not referred until their difficulties had progressed.</p> <p>A training was delivered to improve understanding and knowledge. The confidence and knowledge questionnaire was repeated. The results showed improvement in confidence around who to refer.</p>



These audits are monitored through the Clinical Governance Committee, which reports to the Board for assurance at the highest level in the organisation.

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

## Quality Improvement (QI) Projects

The following QI projects were completed during 2022/23 or are still in progress in the Hospice.

Aim/Reason for QUIP	Baseline Measurement	Interventions/Outcomes	
<p>To ensure patients who are medically suitable have the opportunity to consider corneal tissue donation after death.</p>	<p>0% of patients had agreed to donate corneal tissue in the previous year.</p> <p>Two measures are being used to assess change which is an improvement:</p> <ol style="list-style-type: none"> <li>1) Staff confidence and competence in this area. (Questionnaire)</li> <li>2) Number of patients with an indication of 'Yes to' / 'No to' / 'Considering' donation. (via search of Electronic Patient Record)</li> </ol>	<p>The key interventions were:</p> <p>Adjusting our Electronic Patient Record (EPR) system to support capture, discussion around donation and decision. Provide education to our clinical staff to increase confidence and competence:</p> <ul style="list-style-type: none"> <li>• To identify patients who would be medically suitable</li> <li>• Conversations around donation</li> </ul> <p>This project has been successfully implemented but it is a continuous project.</p> <p>The half year figures of donations explored by the NHSBT Tissue and Eye Services was 12 resulting in 10 donations of eyes.</p>	<p><b>Completed</b></p>
<p>Increase the number of discussions and the resultant documentation of the side effects of EOLC medications with patients and/or families (in line with NICE guidelines for End of Life Care 'Care of dying adults in last days of life' (December Guidelines 2015).</p>	<p>9% of patients (n=22) had a documented discussion in the EPR.</p> <p>Measure being used to assess change which is an improvement:</p> <p>100% of all patients on the EOLC plan on the Crosscare EPR will have a documented note about the discussion of EOLC medication side effects with the patient/family as appropriate.</p>	<p><b>Interventions:</b></p> <p>- Design a pop-up prompt in Crosscare to 'nudge' the medical team to discuss and document or document why no discussion was possible or appropriate.</p> <p><b>Results in Q1 2023:</b> 7 of 12 EOLC care plans had the EOLC medication side effects documented. This is a substantial improvement.</p> <p>The Audit will be repeated in December 2023</p>	<p><b>In progress</b></p>

<p>To ensure relevant patients with a neurological diagnosis are screened for neurogenic bowel and are supported with a bowel management regime.</p>	<p>0% of patients have identification of neurogenic bowel.</p> <p>Measure being used to assess change which is an improvement:</p> <p>For 100% patients with Parkinson's, motor neurone disease, cauda equine, spinal cord compression to have an assessment of their bowel function and have the support of a bowel regime where appropriate.</p> <p>For staff to report increase in knowledge and confidence re neurogenic bowel.</p>	<p>Six months of patient data was reviewed.</p> <p>15 patients had neurological diagnosis. Neurogenic bowel was not mentioned. Average constipation score IPOS 2.5. Bowels opened on average: every 2.3 days.</p> <p>Interventions:</p> <ul style="list-style-type: none"> <li>- Training session</li> <li>- Adaptation of national Guideline to palliative care context (in progress).</li> </ul> <p>Pre and post teaching questionnaire used to obtain a measure of knowledge</p> <p>Pre-training knowledge of and confidence 16% Post training knowledge and confidence 66%</p> <p>Next steps:</p> <ul style="list-style-type: none"> <li>- Finalise guideline</li> <li>- Consider a template bowel regime care plan</li> </ul>	<p>In progress</p>

### 3:5 Education in End of Life Care

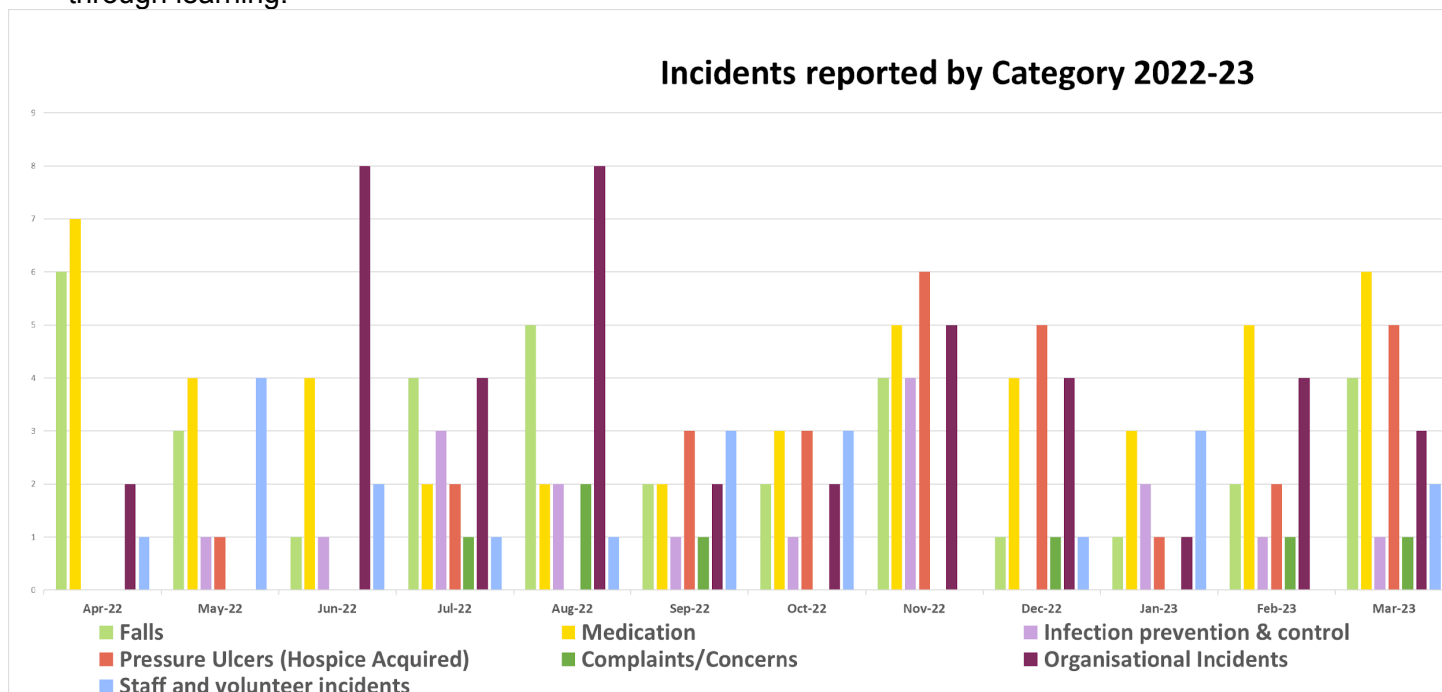
Creating a skilled and competent workforce is essential to deliver high quality care. As a specialist palliative care provider, educating the wider workforce is a key priority.

#### Training completed 2022/23

Professional staff who undertook external clinical courses	35
Support staff undertaking nationally accredited vocational courses	25
Staff undertaking leadership and management training	53
Staff and volunteers who attended STJH workshops in different aspects of End of Life Care (EOLC)	137
<b>External staff</b> Staff who undertook our workshops in different aspects of EOLC	555
<b>Students supported on placements at St Joseph's Hospice</b> Nursing, including returning to practice	26
Nursing, including returning to practice (Plus others attending for a day or less)	6
Medical (placements varied from part day to several weeks)	14

### 3:6 Incidents

The incidents are reviewed monthly by the groups that feed into our Patient Safety and Quality Group. The table below shows the incidents reported in 2022/23. Other than the Falls identified previously with moderate harm, all other incidents below were of now or low harm. As an organisation that strives to improve, we use the reported incidents to improve our quality of care through learning.



### 3:7 Formal Complaints and Concerns

In the past year, four complaints and two verbal concerns have been raised. While we strive to get things right at all times, when things don't go as expected we welcome complaints or concerns, seeing them as opportunities to learn and grow. From a governance and investigation perspective we do not differentiate between complaints or concerns. We always strive to fully engage with the complaint offering the opportunity to have a face-to-face meeting. We have responded to all complaints and concerns within our standards. None of our complaints have raised further issues after receiving our response.

#### Complaints

##### 1) Complaint for CNS about triage nurse First Contact Team – partially upheld

A Clinical Nurse specialist (CNS) from another borough complained they felt that we offered and then retracted the offer of a bed and also about the way they were engaged with. It appeared that there was miscommunication between the referring CNS and our triage CNS. The triage CNS confirmed we had beds but we would need more information and the admission would need to be discussed with the admitting consultant. The referring CNS heard that as “we will accept the patient and informed the family accordingly”. The additional information subsequently resulted in the admission being inappropriate based on the medical needs of the patient. When the triage CNS called the referring CNS to inform that admission was not appropriate the referring CNS became heated and our triage CNS ended the call. This could have been managed better, the Triage nurse agreed it may have felt abrupt but she had warned the CNS she would end the call. The triage CNS member engaged positively in reflecting on their contributions to this encounter

and reason for the complaint. The learning was shared amongst the appropriate colleagues to enhance the service in similar scenarios in the future.

2) Complaint around time to complete a 1<sup>st</sup> assessment for a community patient – Not upheld

A family complained that their loved one had not received an assessment visit from us over the weekend after a referral to provide palliative care was received on Thursday. Our investigation found that the decision to delay the 1<sup>st</sup> assessment was based on a telephone call we had with the family on the Friday which indicated that the patient who had capacity did not want to be seen by a palliative care team, the family reported that the patient was mobilising and stable on that call. The family agreed to discuss further with their loved one over the weekend. The family were given our 24/7 telephone number and the plan was they would call us back on Monday with the outcome of their conversation with the patient, however the patient was readmitted to hospital over the weekend.

3) Rudeness weekend receptionist – not upheld

The daughter of a patient complained that she felt she was communicated to in an abrupt and rude manner by a member of the reception team. The investigation could not resolve this issue satisfactorily as the receptionist could not recall the incident with any clarity and was confident that their manner is always friendly and approachable. Opportunity to revisit values and approach were nonetheless taken.

4) Concern about care of patient on the ward- partially upheld.

The wife of a patient complained about the use of particular continence-wear, which caused discomfort, she felt it was potentially not the correct size and may have led to a rash. The investigation revealed that a larger size of incontinence aid was used and the nurse also cut the elastic off the continence aid to increase comfort, however the choice of continence product did not fully take account of the patients changing needs and this aspect of their care should have been reassessed sooner. The medical team feel that the continence wear did not contribute to the rash. We have provided additional training to our ward staff around how to assess and select appropriate continence wear.

Concerns

1) Rudeness form reception – not upheld

A family member became distressed and heated when asked to repeat her loved ones name, the receptionist could not hear her as she was wearing a thick face covering. The receptionist asked if she could lower her mask and repeat the name, the person then became agitated and started to shout. The receptionist was able to deescalate the situation, however it transpired that the patient had not yet arrived.

2) Missed medication– not upheld

A patient's daughter complained that her mother had missed out on eye drop administration one morning was not upheld. The investigation established that the medication chart was signed and the relevant nurse assured it was carried out as per the medication chart.

### 3.8 Commissioning for Quality and Innovation

The target figures are Key performance indicators set by the Clinical Commissioning Group

Service users offered the opportunity to participate in advance care planning conversations by the 3rd contact	Achieved 95% (Target 100%)
Ethnicity recorded	Achieved 84.23% (Target 100%)

#### Referred patients' ethnicity

White	BME	Not stated
38.28%	54.92.56%	6.8%

#### Preferred place of death

	Achieved	Target
PPD achievement	78.79%	70 %

#### Diagnosis at time of referral

Cancer Diagnosis	Non Cancer Diagnosis	Non Cancer Target
51%	49%	35%

### 4.1 Care Quality Commission (CQC)

#### Periodic reviews by the CQC

St Joseph's Hospice was subject to an announced CQC inspection between July and August 2016. The inspection report was published in October 2016 and is available on the Hospice website. The CQC rated the quality of care provided by St Joseph's as "Good" overall. The table below is how the Hospice was rated in each of the five questions the CQC asks during an inspection.

CQC Question	Rating
Is the service safe	Good
Is the service effective	Good
Is the service caring	Good
Is the service responsive	Good
Is the service well led	Requires Improvement
<b>Overall</b>	<b>Good</b>

#### Reviews and investigations by CQC

St Joseph's Hospice did not participate in any special reviews or investigations by the CQC during 2022/23. We actively participate with our relationship manager and direct monitoring assessments.

## **Part 4: Improvements in Progress**

St Joseph's Hospice set out the following priorities or improvements in 2022/20223.

### **Our response to COVID-19 22/23**

The focus remained on the continued safety of all and to ensure everyone felt supported, informed and reassured. National and local guidance was followed and adapted and Matron, who is also our Director of Infection Prevention and Control (DIPC), has continued to provide all staff with guidance and support. Senior members of the clinical and management team maintained a presence via attendance at ward handovers and team meetings. The Director of Clinical Services continued to have fortnightly meetings with the two Trustees responsible for clinical governance. This enabled us to rapidly review SOPs, risk registers and other documents.

All services that were operating virtually have now resumed face-to-face contact and we were the first hospice to re-open its day hospice, initially with restricted numbers. We have been able to steadily increase capacity throughout the year and it is now operating as it did pre-pandemic.

We have continued to admit patients who are Covid positive. To minimise the spread, our hot and cold ward have remained in place. Lourdes Ward was designated as the hot ward for patients with a suspected or confirmed diagnosis. All staff on this ward had been fit tested for FFP3 masks to enable us to care for those patients with COVID and requiring an Aerosol Generating Procedure. We are delighted to report that we have had no patient outbreaks in 2022/23.

### **Priority 1 Achieving FREDIE accreditation**

St Joseph's Hospice, is a modern, inclusive organisation. The Hospice has a strong Catholic heritage; the mission, and core values 'Quality, Justice, Compassion, Advocacy and Respect' that the founding Sisters gave us is still at the heart of all we do and as relevant today as it was 118 years ago when we were first established.

We respect human dignity, seeing every individual as unique, supporting our patients to reach their full potential until they die. To achieve this, it is essential to be responsive to the needs of the community we serve both as a provider of services and as an employer of choice, where everyone, be they service user, employee or volunteer, feels valued and respected for who they are. We are fortunate to operate in the most diverse city in England and in the most diverse boroughs of that city. This means that we can draw upon a wide range of talent and experience.

While we have a well-established Equality and Diversity Committee, an equality and diversity strategy and Freedom to Speak Up guardians who are supported by a network of 14 champions who represent most departments in the Hospice, we are all aware that strategies do not always create and realise a sustainable cultural change.

This year we have undertaken a great deal of work to develop our approach to Equality Diversity and Inclusion (EDI) as we seek to gain accreditation as a FREDIE (Fairness, Respect, Equality, Diversity, Inclusion and Engagement) organisation. We have re-badged everything we do for EDI as FREDIE and we have strengthened the FREDIE committee and the Networks that support it. We enjoyed Speak up Month during which individuals and teams made a number of Pledges to support a culture of speaking up together with our popular word search competition and combined these themes with those of Black History month a well-established and popular celebration in the Hospice.



This year also saw the marking for the first time of a complete programme for LGBTQIA+ History Month. We welcomed a number of speakers who spoke into the experience of being LGBTQIA+ and spoke into patient care and some of the challenges still faced by LGBTQIA+ persons.

We also updated our Trans Equity Policy and received training around the specific issues facing Trans People and patients in particular.

Also in terms of the FREDIE work, the Hospice held a series of Action Learning Enquiry sessions on the subject of the Menopause in preparation for developing a policy suite and advice to managers in supporting their staff.

Ever mindful of the debt of gratitude owed by the Hospice to the Jewish community this year we were able to mark Holocaust Memorial Day in person. Led by our Rabbi, it was an opportunity to give thanks for the generosity of the Jewish community towards the Hospice as well as to mark the Shoah (Holocaust) taking the themes of ordinary people and Light the Darkness identified by the Holocaust Memorial Trust. We hope to gain our FREDIE accreditation by the end of 2023.

## **Priority 2 Implementation of electronic prescribing and administration system**

As part of our continuous quality improvement journey we do not only review each incident, looking for learning to prevent recurrence, we also conduct systematic reviews of all incidents looking for themes as trends. We also submit our incident data to Hospice UK so we can be benchmarked against other hospices. Our incidents benchmark lower than the Hospice UK average. In 2021/22 we noted that all of our medication errors were attributed to human factors. We also noted that the majority relate to prescribing or administration of medicines. In an attempt to reduce our prescribing and administration incidents we made the implementation of an electronic prescribing and administration system (EPMA) system a priority for 2022/23.

Initially we looked at several different systems, However we decided to procure the system that was offered by our pharmacy providers, Ashtons. This had two main benefits; our pharmacy team are already familiar and trained on the system and could review and monitor each prescription without having to be on site. The fact the systems can be accessed remotely means that our on call doctors and consultants can see all the medication the patient has been taking before alerting or adding new prescriptions. This results in the patient receiving medication much quicker than if they had to wait for the on call doctor to attend site and then prescribe.

Since implementing the system in May 2022, 100% of all prescriptions have been reviewed by the pharmacy team. All prescriptions have been written correctly (start date, dose, times and duration). There has been a 96% reduction in administration errors and a 55% reduction in prescribing errors. Once familiar with the system, staff feel it saves time and supports handover as the system displays when the last dose of a PRN medication was given.

Our pharmacy provider has several years' experience working in mental health with hospices being a relatively new area for them. Their EPMA system was primarily developed for general and mental health settings and we have been able to work in partnership with them to develop additional functionality to suit specialist palliative care settings such as patch checks and oxygen prescribing.

## **Priority 3 Refurbishment of ward area**

We had intended to start the build in 2022/23, however the Ukrainian crisis appeared to cause a shortage of building material leading to costs to rise by 30 %. This coupled with the increase in fuel bills meant we had a funding gap off approximately four hundred thousand pounds. We are carrying this over to 23/24 as a priority.

However we have reviewed our care environment by undertaking the '15 Step Challenge' this is a suite of toolkits looking at Welcoming, Safe, Caring & Involving and Well Organised & Calm. The toolkits help to explore patient experience and are a way of involving patients, carers and families in quality assurance processes. The '15 Step Challenge' was developed in 2012 by the NHS Institute of Innovation and Improvement & refreshed in 2021 by NHS England. The purpose is to help staff, service users and others to work together to identify improvements that can be made to enhance the patient experience, it provides a way of understanding first impressions more clearly and how this impacts on initial experiences of care.

In late 2022 a group of non-clinicians including our User Group began with meetings to explore the process and on the allocated day spent an unannounced morning on both wards. There were areas highlighted where improvements could be made around signage, posters and gaining entry to the ward. There was also a focus on the environment on STM, areas were highlighted as looking in need of updating - this will be addressed in the refurbishment. The experience was very positive for all, with in particular excellent feedback around information provided, cleanliness, the welcome, communication and the care provided.

#### **Priority 4 - Care Closer to Home**

In collaboration with our partners East London Foundation Trust, NEL CCG's Tower Hamlets, Newham, City & Hackney and Waltham Forest areas we had hoped to progress a bid to the End of life integrator team (social finance) to extend the reach of our award-winning volunteer delivered services (Carer support, Benefits advice, Empowered Living Team, Namaste Care and Compassionate Neighbours). However due to the way our volunteer delivered services work in collaboration with service users and other care providers, it was impossible to attribute direct cost saving across the health economy to our services. As a result our partners at the ICB were unable to meet the finance agreement required by the end of life integrator team and therefore we were unable to progress our bid.

Despite this setback our volunteer delivered services have continued to grow. Our welfare benefits team supported people to claim £651,232 in benefits, they also supported individuals to make successful applications for white goods, bedding, school uniform etc. to other grant giving charities. Our Compassionate Neighbours service continues to focus on our harder to reach communities through engaging with faith leaders and community groups. This year they have been involved in a project working with women from Somalian communities in Tower Hamlets around death, dying, grief and loss. We have used our learning from this to tailor and adjust our training to hold informal sessions with groups of women in community settings in east London.

Supporting individuals to receive care and die in their place of choice is a key priority for all specialist palliative care providers. Over the past 3 years we have listened to the needs of our population, adapting our community services to provide all our care closer to home. We have increased the number of out-patient services we offer and our advanced nurse practitioners and therapists now offer joint clinics here at the Hospice and at our satellite clinic in Newham. This year we plan to expand our services at our Newham satellite clinic adding the provision of benefits advice.

We continue to support people in their own homes and have a dedicated palliative care consultant and specialist doctor who support our community teams offering domiciliary and outpatient consultation and advice and support to GP's and other health care professionals.

As you will see from this report, we have been able to support the majority of the people we care for to die in their preferred location. In conjunction with our partners in NHS north East

London we plan to work up a business case for a 'hospice at home service' which will support an equitable palliative care offer across East London.

## **Part 5: Statements of Assurance from the Board**

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

### **Referrals**

In 2022/23 we had 4504 referrals and 3130 were accepted. Acceptance rate of 71.7%. The reasons for service users not being accepted are: service user declined service, service user not eligible for service, service user offered services from another hospice, and service user too unwell to transfer.

#### **1.1 Review of services**

During 2022/23 St Joseph's Hospice provided six key service areas for the NHS. These were as follows:

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

We also provide the following services:

- Compassionate Neighbours
- Empowered Living
- Namaste Care (for people with advanced dementia)
- Education and training for health and social care professionals

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

#### **1.2 Income generated**

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

#### **1.3 Eligibility to participate in National Confidential Enquiries**

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

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

## **1.4 Research**

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

Due to the pandemic, we suspended our research activities, and hope to be able to resume them in 2023/24.

## **2.0 Quality Improvement and Innovation Goals agreed with our Commissioners**

In 2022/23 St Joseph's Hospice did not have set commissioning for Quality and Innovation and Quality (CQUIN) goals. However, the Commissioner requested that we improve on our recording of ethnicity to ensure we are caring for all ethnic groups in our community.

## **3.0 Data Quality**

We continually strive to improve data quality through:

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

## **4.0 Governance Toolkit Attainment Levels**

St Joseph's has highly robust information governance oversight and procedures. The Hospice has completed and submitted the NHS Data Security and Protection Toolkit for 2023/24 and all standards are fully met (43/43 mandatory evidence items met and 36/36 assertions affirmed). The Toolkit content was reviewed by St Joseph's external Data Protection Officer prior to submission to cross-check compliance. Copy of certificate attached.

Information Governance is overseen by the Information Governance Committee, which meets monthly and oversees all data security matters including Subject Access Requests, Freedom of Information, DPA and GDPR compliance and data and cyber security training. At the end Q4 2022/23, staff compliance with mandatory data security training was 97%. St Joseph's has been issued with its Tier 1 ICO certificate for 2023/24.

## **5.0 Clinical Coding Error Rate**

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

## **Part 6: GLOSSARY**

### **Care Quality Commission**

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

### **Clinical Audit**

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

### **Commissioners**

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

### **Overview and Scrutiny Committees**

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

### **Hospice UK**

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

### **Registration**

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

### **Regulations**

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

## Appendix 1 – MDS Data

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

### In Patient Unit

	22/23	21/22	20/21
% Bed Occupancy	52%	48%	53%
% Diagnosis – non cancer	26.8%	24%	25%
% Ethnicity – BAME	51%	45%	42%
% Patients returning home from an IP stay	29.3%	31%	33%
Average length of stay (days)	13.3	14	14.1

### Community Palliative Care Team – CPCT

	22/23	21/22	20/21
% Non-cancer patients	35%	31%	31%
% Ethnicity – BAME	64%	55%	67%
% Homecare patients who died at home/hospice	67%	73%	75%
Average length of care (days)	70.8	55.5	72

### Day Hospice

	22/23	21/22	20/21
% Diagnosis non cancer	37.5	31%	33%
% Ethnicity – BAME	49.3	48%	39%

## Appendix 2 – Audit Schedule for 2022/23

Title	Aims	Aspect of service delivery
<b>Regular audits</b>		
Infection Prevention and Control( IPC) - handwashing	To check compliance with infection prevention guidance and best practice	Are we safe?
IPC – Bare Below Elbows (BBE)		
IPC - catheters		
IPC - invasive devices		
Sharps	Ensure sharps are safely managed within the organisation	Are we safe?
Cleanliness audits	To check compliance with national standards for cleanliness in healthcare organisations	Are we safe?
Water testing	To check compliance with national water safety and hygiene standards	Are we safe?
Controlled Drugs audits	To check compliance with; <ul style="list-style-type: none"> <li>- Medicines Act 1968</li> <li>- Misuse of Drugs (Safe Custody) Regulations 1973</li> <li>- Department of Health Safer Management of Controlled Drugs; a guide to good practice in secondary care (England) October 2007</li> <li>- NMC standards for medicines management</li> </ul>	Are we safe?
Prescription & Administration of medication compliance audit.	To measure accuracy of medication prescriptions.  To measure administration of medication against the prescription with regard to timeliness, occurrence of omissions and rational for variance stated.	Are we safe?
Audit of STJH care against the NICE Quality Standard - End of Life Care for Adults (QS13 published 2011, updated 2021).	To measure practice against the 5 Quality Statements of QS13.  To devise an action plan to close the gap between the standard and actual practice.	Are we safe?
Blood transfusion - annual site inspection	To check compliance with blood transfusion guidelines and procedures.	Are we safe?

Blood transfusion – mock recall audit		
Medical gases audit	To check compliance with; - Medicines Act (1968) - H&S at Work Act (1974), - Misuse of Drugs Regulations (2001) - The Health Act (2006)	Are we safe?

**END**





<b>Health in Hackney Scrutiny Commission</b> 13th June 2023 <b>Minutes of the previous meeting</b>	Item No <b>9</b>
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## **OUTLINE**

Attached please find

- a) Draft minutes of the meeting of the Commission held on 26 April 2023
- b) Action Tracker

## **ACTION**

The Commission is requested to AGREE the minutes as a correct record and note any matters arising.

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London Borough of Hackney  
 Health in Hackney Scrutiny Commission  
 Municipal Year: 2022/23  
 Date of Meeting: Wed 26 April 2023 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 (Chair)
Cllrs in attendance	Cllr Sharon Patrick (Vice Chair), Cllr Ifraax Samatar
Cllrs joining remotely	Cllr Grace Adebayo, Cllr Kam Adams
Cllr apologies	Cllr Deniz Oguzkanli
Council officers in attendance	Georgina Diba, Director Adult Social Care and Operations Terry Ann Ewbanks-Thelwell, Head of Provided Services Stephen Haynes, Strategic Director, Economy, Regeneration and New Homes Dr Sandra Husbands, Director of Public Health, City and Hackney James Goddard, Strategic Head - Strategy, Assurance and Private Sector Housing Jennifer Millmore, Senior Public Health Strategist Chris Pritchard, Director of Strategic Property Andrew Trathen, Consultant in Public Health Helen Woodland, Group Director, Adults, Health and Integration
Other people in attendance	Sally Beaven, Interim Exec Director, Healthwatch Hackney Cllr Chris Kennedy, Cabinet Member Health, Adult Social Care, Voluntary Sector and Culture Vanessa Morris, CEO, Mind in City, Hackney and Waltham forest Cllr Claudia Turbet-Delof, Mental Health Champion, LBH
Members of the public	90 views
YouTube link	View the meeting at: <a href="https://www.youtube.com/watch?v=QjRbJgLmDNs">https://www.youtube.com/watch?v=QjRbJgLmDNs</a>
Officer Contact:	Jarlath O'Connell, Overview and Scrutiny Officer ☐ <a href="mailto:jarlath.oconnell@hackney.gov.uk">jarlath.oconnell@hackney.gov.uk</a> ; 020 8356 3309
<b><u>Councillor Ben Hayhurst in the Chair</u></b>	

- 1 Apologies for absence**
  - 1.1 An apology for absence was received from Cllr Oguzkanli.
- 2 Urgent items/order of business**
  - 2.1 There was none.
- 3 Declarations of interest**
  - 3.1 Cllr Samatar stated that she was employed as a Wellbeing Network Co-ordinator for Mind City, Hackney and Waltham Forest.

#### **4 Update on new Integrated Mental Health Network**

4.1 The Chair stated that in September the Commission had discussed the plans for a major redesign and re-tender of the Wellbeing Network and they looked at the draft specification for it. CHWF Mind had been given the contract as the co-ordinating provider and Members had agreed to have them and the commissioner back to discuss progress.

4.2 He welcomed for the item:

Jennifer Millmore (JM), Senior Public Health Specialist, LBH

Andrew Trathen (AT), Consultant in Public Health, LBH

Vanessa Morris (VM), CEO, Mind in the City, Hackney and Waltham Forest

4.3 Members gave consideration to the update report and JM and VM took Members through the report in detail. It covered: target population and support provided; the new service; strengths retained from the original service and key changes for the new service.

4.4 It was noted that the new service would prioritise a holistic and person centred approach also focusing on those with complex mental health needs. It would continue to be called the Wellbeing Network. Innovations would include that 7 of the partners will run an integrated team which will also support people with cost of living crisis, employment and vocational support and training as well as peer support on employment. She explained the Mind Forward model, for single session therapy which would support people to address issues as quickly as possible. There would be greater use of safe spaces and supporting VCS partners to provide mental health interventions and supporting people using open-access sessions.

4.5 Members asked questions and the following was noted:

(a) The Chair asked under what circumstances would a GP refer to Wellbeing Network rather than to IAPT and how has the contract been redesigned to support the higher level of need that was identified. VM explained that shared care was a critical element in working with GPs and social prescribers to understand where needs are best served. Some clients could come for an initial period of stabilisation before they accessed IAPT. She added that three of the providers are also IAPT providers themselves and they have very good relations with them all. Being able to navigate the correct support as quickly as possible was vital and their partnership manager for the Network would have regular engagement with other teams in the community and so should be able to resolve issues about pathway ambiguity quickly.

(b) The Chair asked if there was a hierarchy of provision. VM explained the three levels of referral criteria. One related to complexity of need, another on “moderate or severe clinical depression” which included some focus on personality disorder and there was a focus on those who might not be able to access primary care interventions because of life circumstances. The third category focused on health inequalities. JM added that they were working with NHS partners on a ‘no wrong door’ approach so that clients can be referred as smoothly as possible.

(c) The Chair asked how the service would support those with a much more complex need but not reaching the threshold for ELFT. VM explained that it would work right through the partnership and explained how some with complex needs often don't ask for help at all. The issue therefore was to recognise the complexity in people's circumstances and not just what they were presenting with. As regards identity based needs, she noted how City and Hackney had the highest level of severe and enduring mental health need in the country.

(d) Members asked how the redesigned service will meet the needs of those who are currently under represented and what are the KPIs for the service. VM explained that the average length of support would be one year and a lot of the focus therefore was in embedding and expanding peer support and developing the pathways. She explained that there was no time limit in terms of people's ability to access peer support and that often many will feel the need for a little bit of top up support and this also will be provided. In relation to reach she stated that they had done well on access and outcomes for those from minoritised communities and this was because of the diversity of the service offer. They were achieving the best clinical and non-clinical support for those who experience the highest level of health inequalities. JM undertook to share the current KPIs for the service. They were a mixture of numbers in the service, outcomes, level of partnership working, ensuring the service is representative of the whole population. VM added that they take a strong intersectional approach and people of course are more than just different aspects of their identity. She also described the trauma informed approach and the work on anti-stigma (e.g Derman's work on suicide prevention with the Turkish-Kurdish community) which illustrate their inclusive approach.

<b>ACTION:</b>	<b>Public Health to provide the KPI's in place for monitoring the new Wellbeing Network</b>
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(e) Members asked whether Hackney's very high incidence of mental health need was because more were enabled to come forward than elsewhere. VM replied that, generally, incidence of poor mental health was higher: due to poverty; in urban areas, in areas of high pollution and due to racism and other forms of discrimination. Being able to talk about it was key as our GPs did very well compared to other areas. Prescription of antidepressants also was lower than in other areas which was to be commended. She noted that levels of access to services were lower in Black African communities and therefore they worked closely with the African Community School and IRIE Mind on this.

(f) Members asked about the trauma-informed approach by Mind and how to support those who don't have the capacity to seek help to come forward. VM explained that early identification was vital and communities must have high levels of mental health literacy. Peer support was also critical. JM added that making mental health

everyone's responsibility was key and it was not all about sending people to services.

(g) Members asked about service users' 'higher needs' in the current cost of living crisis e.g. higher rates of hunger, addiction and debt, and how this impacts on delivery and referral to other services who can help them. VM replied that the relationship between poor mental health and poverty was always complex and two way. Several of the partners are also in the Advice Network and they are able to refer onwards into their own services. They are also able to work directly with DWP for example. Accessing support when in poverty often causes some to feel shame and therefore providing open access to services was vital. She described their work with clients who might move onto IAPT but can be held by the Network to receive financial or vocational support. They have a good relationship with the DWP too which helps them understand supporting job seekers with mental health needs.

(h) Members asked about the provision of culturally appropriate services for those who have language barriers. VM described City and Hackney's Psychological Therapies Alliance which as well as Mind includes Bikur Cholim and Derman. There is also access to Language Line and to services which are designed and delivered by those with lived experience. There is also specific therapy support for those with racial trauma and which is targeted at relevant black communities.

(i) Members asked about the 'Mind Forward' model and what the typical next steps would be. VM replied that it was very flexible. Results could be achieved within the Model or there could be onward referral or it could lead them to access another part of the Model.

(j) The Chair asked whether unmet need was more serious than the service could provide and what monitoring and discussions with ELFT were taking place. VM explained that they have ongoing strategic and operational discussion with ELFT. They work with ELFT's 'community connectors' and they have a web of relationships and are linked into ELFT's 'crisis pathway'. They work together to design specific interventions where there is unmet need. JM added that when they do identify unmet need they can shift the budget around accordingly when necessary.

4.6 The Chair thanked the officers for their detailed update and welcomed the revised service under Mind's leadership. JM clarified that the contract was 2 yrs+1+1. The Chair added that in the future the Commission might wish to do a deep dive into a particular aspect such as 'crisis support'.

<b>RESOLVED:</b>	<b>That the report and discussion be noted.</b>
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## 5 Panel Discussion on 'Housing Regeneration and options for future proofing for adult social care needs'

5.1 The Chair stated that budget pressures in Adult Services were an ongoing challenge and in the Commission's previous discussions the issue of how we might better future proof our housing to meet future adult social care needs had been raised. He added that the intention was in no way to be critical as to why this hadn't been done before but rather focus on whether it might be achievable in the future and whether it stacked-up financially or on the context of current priorities. A key question would be, for example, how many of those currently in nursing and residential care who are out of borough could be dealt with in another setting or service context in the borough. There would be 3 presentations, one verbal.

5.2 He welcomed for the item:

Georgina Diba (**GD**) Director - Adult Social Care and Operations  
Terryann Ebanks Thelwell (**TE**), Head of Provided Services  
Helen Woodland (**HW**), Group Director, Adults, Health and Integration  
Stephen Haynes (**SH**), Strategic Director, Economy, Regeneration and New Homes  
James Goddard (**JG**), Strategic Head - Strategy, Assurance and Private Sector Housing  
Chris Pritchard (**CP**), Director of Strategic Property

5.3 Members gave consideration to 2 presentations:

- A. *Adult Social Care and Accommodation: Planning for future need*
- B. *Housing Regeneration and Delivery*

5.4 GD and HW took Members through their presentation which covered: *context; Hackney profile 2020-40; ASC reform white paper; the report 'A place we call home', local context and vision; what other types of options for ASC clients?; what are the other types of options for other clients with needs?; what do we offer currently?; Placement numbers; what are the benefits; Identifying future need.*

5.5 GD explained that it was important to do a thorough needs analysis of the current cohort and which might be in a position to come back into the community. Since the document was written the number receiving ASC support had risen to 3382 and it was rising by the week. ASC was the largest budget with the council but supported 2% of the population. HW cautioned that the aim here was not to build a two tiered system. Currently if they had alternative options they could keep so many more residents within their communities and this was the aim. The Chair commented on projections for bringing care home patients back in borough with extra care options instead, and did some rough calculations of potential savings with the new approach

5.6 SH and JG took Members through their presentation which covered: *Our building programme; our objectives; manifesto targets; new sites; adaptable homes; our commitments; Housing Strategy; key actions.*

5.7 SH explained that his department dealt with a lot more than housing regeneration and they also covered employment skills and adult learning as well as strategic housing and private sector housing but also town centre development and economic regeneration and in addition now with culture, libraries and heritage, so they take a holistic look at residents needs and are used to working across departmental boundaries. JG outlined the steps involved in the development of the new Housing Strategy which will have a larger focus on supporting housing, the current one which is being replaced has a stronger focus on private sector housing and in the various developments post-Grenfell. He added that the Ageing Well Strategy also has an important Housing Chapter which they use as a guide. They are currently engaged in completing the Housing Needs Survey and the Strategic Market Assessment, the latter being a more technical look at affordability. Stock Condition surveys for both council and private sector housing are also being done. The team have actions on them to support housing needs and develop an older people's housing strategy. It's a complex picture because this also has to encompass disabled residents of all ages. Anchor Hanover delivers supported housing for the council across 20 schemes and part of the challenge is that some of it is no longer best placed geographically for current need so all that has to be taken into account.

5.8 CP gave a presentation explaining the work of Strategic Property within Finance. They cover General Fund properties i.e. all the Council property that isn't schools, libraries or the town hall. His Corporate Asset Management team devise the strategy for the corporate estate and they have a good view right across the asset portfolios, which vary considerably by size and type of use. That team is working with Adult Services to establish what is needed here, to better understand demand and what different types of requirements there will be and to understand what sort of facilities Hackney will need to meet that demand. Once they've established this they can then look at suitable models to be able to deliver those plans and how these can be funded over time. They will work with Adult Services to help build the business case for suitable models and suitable products. They have experience of this from the work in that they developed new GP Practices on sites the Council owned and which had been underutilised. The finance model there had been straightforward in that the NHS had agreed to sign a lease at a certain level to pay back the debt incurred in developing those facilities. They looked forward to working with Adult Services teams on this. He added that the Audit Cttee was also doing a deep dive into Council borrowing so they need to develop this thinking so that all elements of the council can be properly informed. Once they know what products they need they will be able to go looking for sites externally or looking at sites they already have or which key partners might have within their estates and which could be part of a joint development.

5.9 Members asked questions and the following points were noted:



a) The Chair asked when there would be results from all the surveys and analyses that were currently being completed. JG replied that they all fed into the Housing Strategy which would be drafted in July and August and scheduled for Cabinet later in the year. There would then be a 12 week public consultation with the aim of formally adopting it in spring 2024.

(b) The Chair asked to what extent housing with care options will be included. JG replied that the Housing Strategy was multi tenure and they would also look at private ownership and there would be a significant chapter on supported housing. He added that they will work closely with Adult Services on a joint approach. They also employ specialists (e.g. statisticians) to do the modelling but wish to take time with this as it is important to get this vital aspect right. The Chair asked if they had all they needed from Adult Services officers to do the work and he replied that they had.

(c) The Chair asked about the timeline here and about the need for greater political impetus and also the average build cost of a 1 bedroom flat. SH replied it was c. £300k. HW explained that they have a Working Group across all those elements here and commented that in a sense whatever way they do it there is no choice because of the financial pressures on the ASC budget. However they configure it it will have to make financial sense in the long run and it is the right thing to do. They're working on the business case now and doing demand and financial modelling looking at the assets they've got and coming up with the forward plan.

(d) Members asked about the need for greater urgency and impetus here, noting that this is not new, that there are many comparators to look at and also asked about possible sites that Members themselves were aware of. They added that there would be a win-win here for housing if some residents could be released from the general fund housing category into a new extra care housing model. SH replied that officers fully agreed with this. In terms of sites they had identified 15 sites for general housing needs and others have been identified and could be put in the mix. The key was to ensure assets are used in the best way. They added that they were in discussions with Sanctuary about some sites for example and that shared ownership was another form of tenure that would be in the mix and there were also discussions on potential partnerships with Tower Hamlets. JG added that he'd also discussed options with pension funds.

(e) Members asked about what led to 25% increase in ASC demand since 2020. HW replied that it was complex but they were seeing pent up demand from covid era, at least in part. Many people managed during the pandemic but lockdowns had a dramatic impact on service demand. Older people for example not being able to get out had led to a decrease in their functional ability. Another driver was the cost of living crisis and she noted that we had heard from mental health colleagues about the impacts they were also seeing.

(f) Cllr Kenedy commented on the broader national political context and NHS drivers here adding that provision of care closer to home was intrinsic to the NHS's ICS model. Types of adapted accommodation that allow people to remain at home meet the needs of the ICS system which the government has put in place. In an ideal world a local system would not be a net exporter (Hackney) or importer (Havering) of care home places.

(g) The Chair asked about how the NHS 'Funded Nursing Care' system aligns with the funding models that would be under consideration here. HW explained that some individuals in nursing care may also be receiving some NHS funded care but the bulk of the cost comes out of Council budgets. The Chair asked if the NHS could provide more of the nursing element. HW replied that it was complex because some are in receipt of Continuing Healthcare, some is NHS, some is integrated budgets, but generally if they are included in the Council's figures then the Council is funding them.

(h) The Chair asked Cllr Kennedy about what more is required to help champion this at a political level. CK replied that Cabinet wanted reassurance that this work is going on across council departments, and it is clear that this is now happening. The biggest problem up to now had been that different departments were operating in silos. The finances don't stack up so a new approach is needed and what's under discussion here is the beginning of a way forward.

(i) Cllr Turbet-Delof asked about the 10% figure of wheelchair adaptable homes while the Census showed that 14% are disabled; and about the need for community spaces in ASC accommodation. JG replied that the 10% figure was a 'planning guidance' figure. It referred to wheelchair need only, however the 14% disability refers to wider disability. He added that these units are bigger so they cost more and most will have to be ground floor and the 10% target is a tough one to meet however they have met it across the whole portfolio. In relation to community spaces, HW replied that they want to make schemes which will be part of the community and not institutions therefore cross council and community spaces are vital. Looking at the St Leonard's site for example there is huge scope for it to be a multi-use space with a mix of health and community facilities SH added that that it was important to think of community assets and community halls in the round and there is the potential for new thinking here. JG added that on the Older People's Housing Strategy they also need to think more widely and consider such aspects as under occupation and the potential for more downsizing plans.

(j) Members asked whether some of Anchor-Hanover's older people housing might be suitable for adaptation for Extra Care housing. JG replied they were and they were in discussions with them about this. He added that there is a need to up the pace of progress here. Anchor Hanover are developing a new strategy for all their

stock across the UK. This has led to greater movement on some issues. They also have a Compact in place and a good working relationship with them

(k) A Member asked about the increase in safeguarding cases around hoarding and self neglect. The Chair commented that this was out of scope for this discussion but was a very useful suggestion for a future work programme item.

<b>ACTION:</b>	<b>Safeguarding issues around hoarding and self neglect be added to the future work programme.</b>
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(l) Members asked about the need to benchmark this plan with other boroughs. HW replied that they were doing this and a lot of boroughs were further ahead than Hackney is on it. Their S151 officer had visited two boroughs who have set off on this path and they are looking at the financial models they are using as a benchmark. She suggested that benchmarking data can form part of the report when this comes back to the Commission.

5.10 The Chair asked HW whether she had the elements now in the place to begin this modelling work and what else needed to happen. HW replied that she was content on the officer side and pleased with the support from Cllr Kennedy. There was a need to raise the profile of this with Cabinet and the wider Member cohort because this was a long term project. The Chair stated that Commission Members were with HW and SH on the merits of this but that they acknowledge that there are competing needs across so many areas and unless and until the business case is built up it will be hard to champion this fully. Cllr Kennedy concurred stating that having the figures to back this was key but he was confident that this could be done.

5.11 The Chair asked that as soon as the surveys and business case were done if a briefing paper could come back to the Commission perhaps explaining what the different options are and what the models might look like.

<b>ACTION:</b>	<b>This issue to be added to the work programme with a report back in c. 6 months which should incorporate a draft business case and benchmarking data.</b>
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5.12 The Chair thanked all the officers for their detailed work and for their attendance.

<b>RESOLVED:</b>	<b>That the reports and discussion be noted.</b>
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**6 Minutes of the previous meeting**

6.1 Members gave consideration to the draft minutes of the meeting held on 15 March 2023.

<b>RESOLVED:</b>	<b>That the minutes of the meetings held on 15 March be agreed as a correct record and that the matters arising be noted.</b>
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**7. Work programme for the Commission**

7.1 Members noted the updated work programme. The Chair stated that at the next meeting on 13 June there would be items on the Air Quality Action Plan implementation, GP access and some of the local NHS org's draft Quality Accounts.

<b>RESOLVED:</b>	<b>That the updated work programme be noted.</b>
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**8. AOB**

8.1 There was none.

## Health in Hackney Scrutiny Commission - ACTION TRACKER 2023-24

*Note: Items returning are added to future work programme and not listed here.*

Meeting	Item	Action	Action by	Status
16/11/2023	Provision of NHS Dentistry in Hackney	The Chair to write to the CE of NHS NEL to progress the issues on changes to dentistry commissioning arising from this discussion.	Chair	
05/12/2022	Adult Social Care reforms - fair cost of care and sustainability	Group Director AHI to provide a brief update to the Chair on the funding position for next year (on Fair Cost of Care) once it is known.	Helen Woodland	
08/02/2023	Community Diagnostic Centres - update from Homerton Healthcare	CE of Homerton Healthcare to inform the Chair as soon as a decision was made on the siting of the proposed Community Diagnostic Centre.	Louse Ashley	
15/03/2023	Cost of living crisis and health equity	NG to provide further information on the timeline for the Free School Meals Task Group.	Nina Griffith	
26/04/2023	Update on new Integrated Mental Health Network	JM to provide the KPI's in place for monitoring the new Wellbeing Network	Jennifer Millmore	

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<p><b>Health in Hackney Scrutiny Commission</b></p> <p>13th June 2023</p> <p><b>Work programme for 2023-24</b></p>	<p>Item No</p> <p><b>10</b></p>
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### PURPOSE OF ITEM

To consider work programme items for the new municipal year.

### OUTLINE

Attached please find a first outline of the work programme for 2023-2024. This will be populated as Members agree the new items and it will be a rolling document, updated regularly. It already contains some existing commitments and regular annual items.

At the next meeting Members will consider a *Work Programme Suggestions* document which will combine suggestions from the Annual Scrutiny Survey which closes on **22 June** as well as other suggestions received.

Work programme suggestions are collated from:

- Members of the Commission
- Other Members
- Health and care partners
- Cabinet Members/Group Director/Directors
- Results from the Annual Scrutiny Survey of residents which is currently live and can be viewed here:

<https://consultation.hackney.gov.uk/policy-and-strategic-delivery/overview-and-scrutiny-public-consultation-2023/>

Partners and stakeholders are written to inviting suggestions and Cabinet also meet with the Scrutiny Panel (the Chairs and Vice Chairs of the Commissions) to discuss the work programmes for the commissions for the forthcoming year.

The Chair also holds slots in the work programme as it is very common to be asked to respond to urgent or topical issues.

### ACTION

The Commission is requested to give consideration to items for the work programme for the coming year.

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## Rolling Work Programme for Health in Hackney Scrutiny Commission 23/24

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	
<b>13 June 2023</b>	<b>Election of Chair and Vice Chair</b>					
	<b>Appointment of reps to INEL JHOSC</b>					
	<b>Air Quality Action Plan 21-25 implementation update</b>	Follow up from June 22	Climate, Homes, Economy	Land Water Air Team Manager	Dave Trew	
			Adults, Health and Integraton	Public Health Specialist	Suhana Begum	
			Climate, Homes, Economy	Environmental Projects Officer - Sustainability	Tom Richardson	
	<b>Local GP services - Access and Quality</b>	Briefing	NHS NEL Primary Care	Clinical Lead for Primary Care in City and Hackney and PCN Clinical Director	Dr Kirsten Brown	
			NHS NEL Primary Care	Primary Care Commissioner	Richard Bull	
			City and Hackney GP Confederation	Chief Executive	Andreas Lambrianou	
			Healthwatch Hackney	Executive Director	Sally Beaven	
		<b>St Joseph's Hospice Quality Account 22-23</b>	Annual item	St Joseph's Hospice	Director of Clinical Services	Jane Naismith
	<b>Work programme for 2023-24</b>	Discussion				
<b>17/07/2023</b>	<b>Health inequalities and medical barriers faced by trans and non binary community</b>		Homerton Healthcare	Chief Nurse	Breeda McManus	
				Clinical Lead for Sexual Health and HIV and Medical Examiner	TBC Dr Katherine Coyne	
			NHS NEL	Chief Medical Officer	Dr Paul Gilluley	
			NHS NEL	GP representative	TBC Dr Nick Brewer	
			Gendered Intelligence	Head of Public Engagement	Cara English	
			LBH - Chief Execs Directorate	Strategic Delivery Officer	Emmie Bathurst	
			Public Health - City and Hackney	Director of Public Health City and Hackney	Dr Sandra Husbands	
		<b>Healthwatch Hackney Annual Report 22/23</b>	Annual item	Healthwatch Hackney	Chair	Deborah Cohen
				Exec Director	Sally Beaven	
		<b>Homerton Healthcare Quality Account 22-23 - HiH response</b>	Annual item		Chief Nurse and Director of Governance	Breeda McManus
<b>11 Sept 2023</b>	<b>City &amp; Hackney Safeguarding Adults Board Annual Report</b>	Annual item	CHSAB	Independent Chair	Dr Adi Cooper OBE	
				Director Adult Social Care and Operations	Georgina Diba	
<b>10 Oct 2023</b>						

<b>15 Nov 2023</b>	<b>Adult Social Care and Accommodation - planning for future need (to include benchmarking)</b>	Follow up from 26 April	Adults Health and Integration	Director Adult Social Care and Operations	Georgina Diba
			Climate Homes and Economy	Strategic Director Economy Regeneration and New Homes	Stephen Haynes
<b>10 Jan 2024</b>	<b>Cabinet Member Question Time: Cllr Kennedy</b>	Annual CQT session	LBH	Cabinet Member for Health, ASC, Voluntary Sector and Culture	Cllr Chris Kennedy
	<b>Future options for Soft Facility Services at Homerton Healthcare</b>	Follow up 8 Feb	Homerton Healthcare	CE	Louise Ashley
			Homerton Healthcare	CFO	Rob Clarke
<b>12 Feb 2024</b>					
<b>14 March 2024</b>	<b>New commissioning arrangements for Dentistry one year on</b>		NHS NEL	Commissioner	Jeremy Wallman

## ITEMS AGREED BUT NOT YET SCHEDULED

<b>Pencilled dates</b>					
	<i>In future items the Commission to test the performance of primary care in NEL against the principles set out in the The Fuller Report.</i>				
	<b>New CQC inspection regime for Adult Social Care</b>		Adults, Health and Integration		
	<b>Estates crisis in Primary Care</b>		NHS NEL/ PCNs/GP Confed		
	<b>Outcomes Framework for City and Hackney Place Based System</b>	Follow up 5 Dec	Adults Health and Integration	Director of Delivery	Nina Griffith
	<b>Measuring the impact of anti racism actions in commissioning and service delivery in C&amp;H Place Based System</b>	Follow up 5 Dec	Adults, Health and Integraton	Director of Delivery	Nina Griffith
	<b>Liberty Protection Safeguards - progress on implementation of new system</b>	Follow up 5 Dec	Adults, Health and Integration	Principal Social Worker	Dr Godfred Boahen
	<b>Emergency Dept mental health in-patient capacity</b>	Follow up 5 Dec	Adults, Health and Integration/ ELFT/ NHS NEL	Director of Delivery	Nina Griffith

	<b>Consultation on Changes to Continuing Health Care - the Hackney perspective</b>		Adults, Health and Integration and NHS NEL		
	<b>Poor maternity health outcomes for Black women</b>	From Cllr Patrick	NHS NEL/ Homerton Healthcare		
	<b>Poor prostate cancer health outcomes for Black men</b>	From Cllr Patrick	NHS NEL/ Homerton Healthcare		
	<b>Safeguarding issues around hoarding and self neglect</b>	From Cllr Samatar	Adults, Health and Integration	Director Adult Social Care and Operations	Georgina Diba
	<b>Revisit progress of Wellbeing Network focus on crisis support</b>	Follow up from 24 April	Adults, Health and Integration	Senior Public Health Specialist	Jennifer Millmore
			Mind in CHWF	CEO	Vanessa Morris
	<b>Sexually transmitted infections (STI) and mental health</b>	From Cllr Turbet-Delof	Homerton Healthcare		
			Public Health		
	<b>Chagas disease - migrant health</b>	From Cllr Turbet-Delof	NHS NEL		
			UK Chagas Hub		
			Public Health		
	<b>NHS charging regulations on migrants</b>	From Cllr Turbet-Delof	NHS NEL		
			Homerton Healthcare		
	<b>Suicide and cost of living crisis and debt</b>	From Cllr Turbet-Delof	ELFT		
			Adult Services		
			Wellbeing Network		

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