Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2023/24
Date of Meeting Monday 17 July 2023

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

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Kam Adams, Cllr Sharon Patrick (Vice-Chair) and Cllr Claudia Turbet-Delof**
Apologies:	**Cllr Ifraax Samatar and Cllr Humaira Garasia**
Officers In Attendance	**Emmeline Bathurst, Georgina Diba (AD QA Safeguarding Workforce Development), Nina Griffith (Workstream Director Unplanned Care), Dr Sandra Husbands (Director of Public Health) and Chris Lovitt (Deputy Director of Public Health)**
Other People in Attendance	**Sally Beaven (Healthwatch Hackney), Councillor Alastair Binnie-Lubbock (Green), Dr Katherine Coyne (Homerton Healthcare), Dr Sarah Creighton (Homerton Healthcare), Jed Francique (ELFT), Dr Paul Gilluley (NHS NEL), Andreas Lambrianou (City and Hackney GP Confederation), Breeda McManus (Homerton Healthcare), Laura Pascal (Women's Rights Network), Councillor Clare Potter, Basirat Sadiq (Homerton Healthcare), Councillor Carole Williams (Cabinet Member for Employment, Human Resources and Equalities) and Heggy Wyatt (Lower Clapton GP Practice)**
Members of the Public	
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence (19.00)

1.1 Apologies for absence were received from Cllr Garasia and Cllr Samatar for lateness.

1.2 Apologies were received from Cllr Kennedy, Louise Ashley and Helen Woodland.

2 Urgent Items / Order of Business (19.00)

2.1 There was none.

3 Declarations of Interest (19.01)

3.1 Cllr Samatar stated that she was employed as a Wellbeing Network Co-ordinator for Mind - City, Hackney and Waltham Forest.

4 Health inequalities and medical barriers faced by trans and non binary community (19.02)

4.1 The Chair stated that the Commission had been asked to look at this by Full Council. He stated that Gendered Intelligence were due to participate in the item but had to give their apologies. He stated that the draft LGBTQIA+ Strategic Framework document in the papers had been added just to provide some background information but it was not agreed and was about to go to Cabinet the following week for approval. The public would be able to make observations on it once it goes out to consultation afterwards and he encouraged people to do so. He would discuss with Cllr Gordon whether it might come back to Scrutiny Panel. He stated that there were a wide variety of views on this issue and he had received questions from Cllr Troughton with whom he'd had a conversation and he'd accepted some public questions from Women's Rights Network/Hackney Labour Women's Declaration. The questions on the Framework document should be part of a consultation response and other issues would be dealt with at the meeting.

4.2 He welcomed the following invitees:

Dr Katherine Coyne (KC), Clinical Lead for Sexual Health and HIV and Medical Examiner, Homerton Healthcare
Dr Sarah Creighton (SC), Consultant Sexual Health/HIV, Homerton Healthcare
Dr Paul Giluley (PG), Chief Medical Officer, NHS NEL
Laura Pascal (LP), Women's Rights Network and Hackney Labour Women's Declaration
Helen 'Heggy' Wyatt (HW), Advanced Nurse Practitioner, GP Confederation/Lower Clapton Group Practice

Also in attendance were:
Emmeline Bathurst, Strategic Delivery Officer, Policy and Strategic Delivery
Sally Beaven, Executive Director, Healthwatch Hackney
Cllr Alistair Binnie-Lubbock
Dr Sandra Husbands (SH), Director of Public Health, City and Hackney
Andreas Lambrianou, Chief Executive, City and Hackney GP Confederation
Chris Lovitt (CL), Deputy Director of Public Health, City and Hackney
Breeda McManus (BM), Chief Nurse and Director of Governance, Homerton Healthcare
Cllr Claire Potter
Basirat Sadiq, Deputy Chief Executive, Homerton Healthcare
Cllr Carole Williams (CW), Cabinet Member for Employment, Human Resources and Equalities

4.3 Members gave consideration to:

Summary note from Gendered Intelligence
Note from Homerton Healthcare on the key points they wish to raise and links to other key resources.
For background reading an update from April on Hackney Council's LGBTQIA+ Strategic Framework
For background reading a Gender Diversity FAQ from Hackney Council
Other background reading included NHSE's response (June 2022) to London Assembly Health Committee's report on Improving-access-healthcare-trans-and-gender-diverse-londoners (Feb 22)

4.4 SC gave a verbal presentation. She stated she was a sexual health consultant and so not a particular expert in this area as her focus was medical prescribing but, she also had a child who is a transgender woman. Whilst most trans people are well adjusted the health outcomes overall for the cohort are not good. They are 18-20 times more likely to die prematurely, more likely to be victims of violent crime and be survivors of domestic violence and are less likely to engage with health and social care and are often not properly availing of antenatal care and contraception. Here is a very small population which is extremely vulnerable and the challenge is to make things fairer, she added. There is currently a 5 year waiting list to get an appointment for Gender Identity services in the NHS services and the Tavistock service has been closed pending recommissioning. A 5 yr wait at a time when someone is establishing their identity is damaging and inevitably many will attempt to go private or self medicate. Internet searches for hormones for example will throw up services that have been struck off by the GMC or are operating outside of Europe and to get a reputable service there is an 8 month waiting list for even going private. Afterwards trying to access the recommended medication is a challenge as most can't get the hormones prescribed by GPs or from the NHS. She described the challenges caused by the fact that the dosages can be unusual for many conditions and that even paying privately from a reputable source can be extraordinarily challenging. Accessing those medications via the internet horrified her but reminded her of what trans people go through. For sexual health services the NHS can make this less dangerous for patients e.g. with needle exchange or help with interpreting blood results. There is one specialist clinic in Chelsea and one in King's College and none in NE London. Patients come from all over the country just for the damage limitation aspect. They do offer bridging letters or letters of advice to GPs on what they recommend which are evidence based and there are guidelines which are referred to in the agenda papers.

4.5 Dr Gilluley gave a verbal presentation. He said he fully supported Dr Creighton on the inequalities for the trans community and one of the main aims of ICS was to address these in our populations regarding access, experience and outcomes. He explained the commissioning landscape. The GI Clinics are specialist mental health commissioned on a national basis and so not by the NHS NEL itself. The sexual health clinics are local authority commissioned via Public Health budgets although this whole area is being reviewed. He added that there is work that can be done on joint local authority-NEL commissioning.

4.6 HW gave a verbal presentation. They have a number of trans patients at Lower Clapton probably as they are seen as open and inclusive. She was happy to hear about the plans for the training session. She advised thinking beyond just hormone treatment. That of course is a problem if it is done unsafely. Other issues include pre-conception care for trans men who are not body dysphoric about their

uteruses and who might want to get pregnant. Another issue is trans people often won't remember appropriate contraception or remember bleeding. Unwanted bleeding when on HRT is an issue. Also the issue of gamete storage and fertility protection have to be considered before people start ordering things online. On gamete storage there are issues about peoples eligibility and timescales can get muddled and this can cause risks later in life. She added that the prescribing guidelines are a mess because medical practitioners prescribe within their competence and the guidelines state that currently we need an expert to have approved before they can prescribe properly. While this is correct and safe and appropriate, she added, we all need to be trained experts and of course we already prescribe for post menopausal women. She argued that we prescribe hormones for a lot of patients for a lot of reasons so we are experts in prescribing. On the issue of making GP Practices welcoming, staff need to be sensitive to what patients choose as their title and she works with Receptionists on this. There are issues around how to register people before they've got their Gender Recognition Certificate. Across primary care teams more needs to be done on making them more welcoming and sympathetic as there is a lot of politics and public debate at present and staff, unless properly trained, need to reflect on and to respect difference. She concluded that she would like some clarity from NHS NEL on gamete storage policies.

4.7 Members asked questions and the following was noted:

a) What is the scope for local GI related service commissioning?
SH replied that there was scope for local commissioning and there is in place a collaborative agreement on sexual health commissioning for NEL. They had just developed a new draft Sexual Health Strategy for City and Hackney which would inform this work. The key issues here are about very poor data about the numbers involved and their specific needs and the scope of services required to support them. Making sure you have appropriate, equitable and sensible services is the challenge. PG added that a key piece of work was needed on getting specialist training for GPs on prescribing hormones and the aim was to have a group of specialist GPs who, to begin with, could be one per borough and who would become the specialist GP others could refer to for advice or for prescribing advice in the cases where it's after a private assessment. The other issue was to support those sitting on waiting lists for long periods where GPs need to decide who would benefit from hormones more immediately. Another challenge for clinicians here is getting the balance of the doses right and also of course the ongoing monitoring. He stated he was in discussions with Dr Kamilla Kamaruddin, a Tower Hamlets GP, herself trans, who has worked in the area before and returned to give training to GP specialists. The other aspect here is about other staff within primary care being appropriately trained so there needs to be an assessment of what is available already and what could be provided within a hub for PCN staff. He described the LGBT Foundation Pride in Practice scheme, which provides accreditation to practices on inclusion. They grade Practices either bronze, silver and gold but they have yet to get a single practice accredited in NEL

b) What is the current status of the 5 yr wait for access to a Gender Identity Services?
PG stated that nationally there is a problem with accurate data on this and he undertook to provide the latest.

ACTION:
Dr Gilluley to provide latest available data on waiting lists for Gender Identity Services.

There is an additional issue around CYP transgender inequalities arising from the implementation of the Cass Report and this was a whole other area. The Chair commented that the focus of this meeting has to be adults but CYP SC would be interested in the latter information.

c) What training is there for reception staff and about how it is cascaded?
HW replied that it's currently and she would, for example, a Practice staff member an email if they'd noticed anything on equity of access that could be improved. She had become a point of contact for colleagues to talk to because of her experience with the subject. She added that medicine is too big for one person and has to be about teamwork and interests of staff being made known to the rest of the team can be a beneficial resource for everyone.

d) What support is there for those self medicating especially those on low incomes and are there controls on mail order drugs. A Member detailed case work of residents from migrant communities skipping meals in order to be able to afford medication?
SC replied that while there are a few reputable sources where one can source oestrogen the big concern is that people are having to turn to private healthcare. There are high instances of destitution as a result of this and people could lose their homes. There are very good guidelines in place from GMC and BMA and they are relatively easy to follow and there are things that could be adopted that are not currently mainstreamed, she added. The Chair asked about community languages. SC replied she was referring to guidelines for clinicians. She added that it's not all about hormones or sexual health. Attention to cervical, breast, CVD screenings can all get lost when Gender Identity can change. Conversely there is also the transgender "broken arm syndrome" where absolutely every condition gets related to the patient's transgender status when it may not be a relevant factor.

e) What is being done to address trans people not accessing general healthcare; what is the timescale for the roll out of specialist GPs and is there a case for a NEL lead?
PG reiterated it was in hand. They will be widening the training within PCNs e.g He reiterated that the Pride and Practice scheme would be expanded and he was meeting shortly with Dr Kamaruddin and they've identified a first cohort of GPs who could be trained. They were aiming for 1 per borough initially. A specialist within each PCN would be good but the general point was that they need to start with having GPs who can prescribe confidently but this needs to be operated on an NEL basis

f) Does the current guidance enable all GPs to prescribe hormones to this cohort?
PG replied it didn't but it is more complex. He stated that there is no reason why a GP cannot prescribe hormones already and many do so for other groups but the issue is that they have no training in prescribing hormones for trans patients and they don't have the confidence to do so, particularly in cases where the initial assessment has been done outside the NHS. He added that NHS NEL needs to consider how to give GPs the training to have that confidence so that there is a resource within the NEL area to address this community's needs. He added that, generally, clinicians need to think about how they work with mental health services and other parts of primary care and to ensure there is shared best practice in place to better respond to patient needs. HW added that there are guidelines which say we can't prescribe unless the person has been seen by a specialist but we can prescribe if we have the confidence. PG added that when patients are sitting o a waiting list for 5 yrs for access to a GI Clinic we have to train up our primary healthcare physicians to better handle these scenarios.

g) What further work is needed on these guidelines to further your objectives here?
PG replied that they have to keep pressure on upwards as well nationally so that patients will be seen at a more reasonable space of referral and that specialists are trained up. He reiterated that the main commissioning here is national.

h) Cllr Binnie-Lubbock (not a Commission Member) asked about the urgency of the training need; on using trans people more in outreach and publicity for general healthcare; and on gaps in data
CL replied that there is evidence that some trans people have worse sexual health outcomes and there are additional services for them but it is important too not to over sexualise people from this community as it is just one need and not the only one. He explained that the Sexual and Reproductive Health Strategy was about to go out for consultation and there will also be an overarching one for NEL. If there is a demand for a trans sexual health service the boroughs would be open to that and that the Homerton would be a natural place to provide that. He added that the Census has been revolutionary in terms of recognising LGBTQIA+ residents and more data would allow us to be more mindful of the sexual variation which is there. City and Hackney had added a section on vulnerable populations and trans people are one of those and this is not the case elsewhere. After the consultation they will come back to the Health and Wellbeing Board with the final draft and with an action plan and that could also come to Scrutiny if needed. They were also looking to work more closely with NHS NEL so the work can be better joined up among the various commissioners including work on sexual assault support and on fertility services.

i) What funding is needed to underpin the Strategies?
CL reminded Members that because it is an open access services sexual health in one of the largest areas of spend from the Public Health grant so they need to look across the 5 years of the Sexual and Reproductive Health Strategy for example and at how investments which are badly needed can be made. There is no new money. The aspirations for Strategy will be coming to Cabinet. He added that HIV and HIV Care services will also be moving into NHS NEL's remit and this provides some further opportunities. They can't commit to more money but they can commit to doing more to meet the needs, and better data monitoring will help greatly. Re. having a specific service for trans people, he suspected there will be similar requests from across NEL as the data demonstrates there is a need. There are higher rates of HIV and syphilis for example among many in the trans community and they want to ensure services are as open and accessible as possible.

j) What can be done to improve data collection?
CL explained there is a national NHS data set which governs the codes used. Giving people confidence about the use of their data is key. The census data was important because for the first time we have reasonably granular data that does show places like Hackney and Tower Hamlets are good places for trans people to come and live, hence we have higher numbers. The next step is ensuring people are able to get the level of access they need into Primary Care and Mental Health services and at the moment the level of data at that deeper level is not available from the NHS. The fields are there but we need the people to collect the data. The data on sexual orientation is better but we rarely get data from the NHS because the numbers are too small and can't be disaggregated. In the Census data a very large number of people had refused to disclose and it is hard to get into the reasons here. It could be language but it's also about confidence. We need to be confident to ask and people need to be confident to disclose. SH added that it needs to be made clear that information collected in a

monitoring form is detached from clinical records. Also, if people don't fill it in, nobody is there to suggest to them that it might be in their best interests to do so. People always give addresses but wont give their sexuality or gender or even ethnicity and it's important to create an atmosphere of trust and give people the confidence that the information will not be shared with the Home Officer for example. Same issue exists on ethnicity and there are a lot of gaps in our data. We still have a population that is mostly inclined to mistrust how we might use the data. Work needs to be done to create this trust within the wider trans community.

k) What further work can be done to build trust so as to achieve a better data set?
SH replied that it's more complex than just doing a piece of comms work. We are working with local communities to build trust she added and in this, which is relational, we have to convince them why it's important that they disclose their data and we have to demonstrate that we are trustworthy.

l) What more can be done particularly in relation to migrant communities' fears about disclosure to the Home Office and what can be done to improve mental health data?
SH replied that there is the opportunity to collect information about individual characteristics everytime they have contact with services and we do analyse this. The problem is that the numbers here are small and that makes it difficult to draw useful inferences. It would be better to do that at NEL level where there would be strength in numbers. CL added that the census data gave us a baseline but not comprehensive set on LGBTQIA+. What we can do is to say to services, if there is no data recording taking place for this cohort you should really be getting it across all the protected characteristics. We could then look and if there are no trans people attending your IAPT service, for example, that should be your first question i.e is data being collected and why aren't certain cohorts presenting. SH added that we suspect that in the substance misuse service for example that there is under representation and it does not appear patients are disclosing gender identity. In all, the richer the data set the better the conclusions you can draw.

n) What can NHS NEL do on the data challenges at a sub-regional level?
PG replied that more needs to be done at NEL level. He added however that the trans community was facing an onslaught in the media which is traumatising for them and so getting data in that environment will never be easy. On the timescales he was meeting with Dr Kamaruddin and they hoped to have the specialist network up and running by the end of this year.

o) What can be done about the dangers of purchasing unregulated drugs online?
PG replied that it was incredibly difficult to regulate such access and there are a wider set of problems with self medication, again driven by the waiting lists for access to Gender Identity Services. The Chairs suggested we review progress in a year to see how the specialist GP training is working out. Another option would be to raise these issues at the INEL JHOSC level as the response here needs to be NEL wide.

ACTION:
Chair to suggest this subject is considered also at INEL JHOSC.

4.8 Cllr Williams (Cabinet Member for Employment, Human Resources and Equalities) commented she was pleased the Full Council had supported the motion and that the Commission had taken up the issue. She was pleased to hear from the

experts and expressed her gratitude to them. She wanted to echo Dr Gilluley on the vulnerability of this community and added that we have to be very careful about the toxic media environment here. She added that we need to ensure we are discharging our duties and we want to be careful about how we do that. This has been a good measured discussion, she added, and she wanted to echo CL's point about not over-sexualsing the trans community in these discussions as this is about gender identity. She concluded that she would welcome a review in a year or so and would be pleased to return and engage further with the issue.

4.9 Cllr Binnie-Lubbock added that he'd welcome a similar discussion focusing on trans young people perhaps at CYP Scrutiny Commission.

4.10 The Chair invited a member of the public who had submitted questions to speak. Laura Pascal (Women's Rights Network and Hackney Labour Women's Declaration). She commented that in her view the discussion had been quite one sided and the meeting hadn't heard a valid gender-critical perspective. On GP diagnoses, there was an assumption that all GPs should do here is diagnose and prescribe and you wouldn't be recommending that for a mental health condition such as schizophrenia for example. Young people in the cohort being considered here can have a lot of comorbidities. There is a high cross over with autism. Gender reassignment was a serious decision to make and the consequences of taking cross sex hormones were serious, she added. They may be right for some people but absolutely not for others. Some people who transition really regret it and the effects of testosterone for example were irreversible. She added that there's a health crisis among young people and young adults are questioning their gender alongside a lot of other issues including their sexuality and there is a risk for young lesbians for example of being set on a path to transition that will affect the rest of their lives and damage their fertility. Life changing surgery removing healthy body parts may be right for some people but not for everyone, she added. It should not be for General Practice to decide and this needs to be considered and it should not just be an issue of how we can support GPs to do this. On the point by Cllr Binnie-Lubbock that if you're not counted you don't count, she would add that In all this discussion about data we must be careful to ensure that we're still collecting data about 'sex'. Services collect data about gender identity quite often and the question about sex is not even included e.g. in job applications to Hackney Council. There's language used about what gender you were "assigned at birth" which has led for example to the Census including terms that the public do not understand and the question of 'sex' is not being asked. She added that while she agreed that we have a vulnerable trans community who need to be protected, we also need to be careful that while we're doing so, that the impact on women and women's health inequalities are also taken into consideration. When thinking about data she felt very strongly that we need to be very careful to ensure that we are not erasing sex as a category, because sex matters.

4.11 The Chair thanked LP and repeated that concerns about what's in the draft Strategy document need to be raised in a response to the imminent consultation on that. He asked for comments on the points about GPs not being suitably qualified and on the need to record sex as well as gender.

4.12 SC agreed that GPs need to operate within their competence and should not be doing anything they are not fully trained on and therefore the NHS must ensure there is appropriate training in place. She took issue with the idea that GPs delivering harm minimisation here was going to increase demand for surgery. What clinicians were proposing in her view was that GPs have appropriate training to deliver harm

minimisation. Yes, absolutely, there is a higher prevalence of neuro diversity and mental health issues and we need practitioners to be able to deal with various outcomes. She added that the causality was difficult to pick apart here and what we need is care that is supportive of the individual and looks at the full picture and so we must have appropriate guidelines in place

4.13 In relation to the issue of recording sex as well as gender, SH replied that she agreed that in the context of a health data set it was important to record the underlying sex as well as gender, for the reasons discussed earlier including to make sure that people have access to relevant health screening and in diagnostic terms that doctors aren't overlooking certain possibilities because they assume they don't exist any longer because of the gender that someone presents with. For certain data recording however it may be less important. Re the Hackney job application she stated she was not really sure why it matters to your employer what your birth assigned sex was, it should only matter in the context of having a health issue that may impact the way you are able to work, in which case you can have a confidential discussion with occupational health about it, and in which case they would record your sex at birth as well as your gender. She added that while it is important improve data collection on gender it's equally important to improve data collection on all characteristics because that is how we get a good sense, in a personal sense, of what this person needs and we can also do useful analyses of the whole data set from which we can then draw reasonable inferences and conclusions that we can act on.

4.14 The Chair stated that he would suggest to the new INEL JHOSC Chair that this issue be taken up there. He stated that he had also received questions from Cllr Troughton, who could not be present, and some related to the wording of the Draft Strategy and he encouraged her to take those up in a consultation response. For this item he had wanted to keep a narrower focus to make it manageable. He added that officers may want to reply to some of the points Cllr Troughton had made. He concluded that they will keep the matter under review and it could come back in due course or be dealt with at INEL JHOSC

4.15 The Chair thanked all the participants for their contributions.

RESOLVED:
That the reports and discussion be noted.

5 Homerton Healthcare Quality Account 22-23 - HiH response (20.15)

5.1 The Chair stated that each year the Commission is required to provide comments on the draft Quality Account for the key local NHS trusts. He did this by letter because of the NHS deadlines involved and a copy of that and the draft report

were in the papers. The purpose of this item was to review the report and hear back about the comments raised in the Commission's letter.

5.2 He welcomed for the item from Homerton Healthcare:
Breeda McManus (BM), Chief Nurse and Director of Governance
Basirat Sadiq (BS), Deputy Chief Executive

5.3 Members gave consideration to the Quality Account for 22/23 of Homerton Healthcare NHS Foundation Trust and to the Commission's own letter of response.

5.4 BM took Members through the report in detail commenting that the Trust was on a two year cycle with its 7 agreed quality priorities, as listed. She also added that, despite the pressures, the Trust still was one on of the best in the country on 4 hr A&E waits.

5.5 Members asked questions and the following was noted:

a) What was the initial feedback on the CQC inspection of the maternity service; how was the Trust performing on the target for number of staff appraisals completed and; whether the A&E wait performance was due to the need to deliver mutual aid to neighbouring trusts?
BM replied that completed appraisal rates continued to improve and they were now on 86% against an 85% target. On the CQC inspection of Maternity, they had received high level feedback on 3 areas to look at but there had been no indication that there would be any Regulatory Notices. As for the reasons for the 4 hr A&E wait performance, there were multiple factors here and it was not just down to a specific issue in relation to mutual aid. The acuity of the patients coming through was higher and delayed discharges of care continued to present a challenge as it has with all acute hospitals.

b) What is the future of the St Leonard's site; and on the elective backlog?
BS replied that she'd had recent meetings on the issue. There continued to be a strong commitment to running services at the site. A piece of work now has to be done with NHS Property Services and NHS NEL around how they can get the funding in place to improve the site. She was now part of a senior exec NEL wide working group on Estates and the key priority locally was to put a strong plan in place for the future of St Leonard's. On the elective backlog BM replied that she didn't have exact figures to hand. Unfortunately the recent industrial action had impacted on their elective activity. Their Priority 1 and Priority 2 cancer waits were of course attended to and generally they have been making real progress in driving down the elective waiting list across all the pathways.

c) GP Practices use of texts to patients seeking feedback is an excellent approach and asked how this feedback data is processed and used?
The Chair stated that this question was for Primary Care commissioning and it would be passed on to them.

ACTION:
O&S Officer to ascertain from commissioner for Primary Care for City and Hackney how the data from GP Practice text surveys to patients is handled.

d) How is CQC inspection regime changing?
BM replied that the systems and structures within the CQC are changing. There will be a lot more information requests and they will expect more specific requests and inspections rather than a large single Trust-wide inspection. The CQC will be able to come and review one service rather than a number of them and will be using information and intelligence to determine if they need one in the first place.

e) What further is being done to respond to the spike in mental health presentations at A&E at the Homerton
BM replied that they are very aware of the significant delays recently for mental health patients in ED and a lot of cross departmental and partnership meetings were taking place to tackle the problem. There were a number of projects in train across the system looking at crisis cafes, urgent responders and multi agency teams and the need for more community services to help reduce the numbers presenting to A&E. She gave reassurances that ELFT was very much onboard also to solve both the immediate and longer term challenges here.

f) What are the drop-out rates from the local IAPT service provided by the Homerton.
BM replied she did not have the figure at hand but would provide it.
ACTION:
Chief Nurse to provide the latest drop-out data for the Homerton's IAPT service.

g) How might Mary Seacole Home (operated by Homerton Healthcare) move from CQC rating of 'Good' to 'Outstanding'
BM replied that Mary Seacole was hoping to be inspected soon, as it had been some time. There wasn't anything they weren't doing, in her view, and if inspected tomorrow there should be no reason they wouldn't get Outstanding.

5.6 Sally Beaven (Healthwatch Hackney) informed the Commission about their imminent 'Enter and View' report on St Leonard's adding that they have a pool of resources to help with engagement around this important issue. BS thanked them for this and undertook to work with them.

5.7 The Chair thanked the senior executives for their report and their attendance. He stated that Members were very pleased at the continued high performance of the Homerton.

RESOLVED:
That the reports and discussion be noted.

5.1 The Chair stated that each year the Commission is required to provide comments on the draft Quality Account for the key local NHS trusts. He did this by letter because of the NHS deadlines involved and a copy of that and the draft report were in the papers. The purpose of this item was to review the report and hear back about the comments raised in the Commission's letter.

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BM replied that the systems and structures within the CQC are changing. There will be a lot more information requests and they will expect more specific requests and inspections rather than a large single Trust-wide inspection. The CQC will be able to come and review one service rather than a number of them and will be using information and intelligence to determine if they need one in the first place.

e) What further is being done to respond to the spike in mental health presentations at A&E at the Homerton
BM replied that they are very aware of the significant delays recently for mental health patients in ED and a lot of cross departmental and partnership meetings were taking place to tackle the problem. There were a number of projects in train across the system looking at crisis cafes, urgent responders and multi agency teams and the need for more community services to help reduce the numbers presenting to A&E. She gave reassurances that ELFT was very much onboard also to solve both the immediate and longer term challenges here.

f) What are the drop-out rates from the local IAPT service provided by the Homerton.
BM replied she did not have the figure at hand but would provide it.

ACTION:	Chief Nurse to provide the latest drop-out data for the Homerton's IAPT service.

g) How might Mary Seacole Home (operated by Homerton Healthcare) move from CQC rating of 'Good' to 'Outstanding'
BM replied that Mary Seacole was hoping to be inspected soon, as it had been some time. There wasn't anything they weren't doing, in her view, and if inspected tomorrow there should be no reason they wouldn't get Outstanding.

5.6 Sally Beaven (Healthwatch Hackney) informed the Commission about their imminent 'Enter and View' report on St Leonard's adding that they have a pool of resources to help with engagement around this important issue. BS thanked them for this and undertook to work with them.

5.7 The Chair thanked the senior executives for their report and their attendance. He stated that Members were very pleased at the continued high performance of the Homerton.

RESOLVED:	That the reports and discussion be noted.

6 Met Police implementation of 'Right Care Right Person' model (20.30)

6.1 The Chair stated that this was added to the agenda because of concerns bout the implication for the local health and care partners that some patients may fall between the safety nets here should Metropolitan Police proceed with implementing this new 'Right Care Right Person' model.

6.2 He welcomed

Jed Francique (JF), Borough Director City & Hackney, East London NHS Foundation Trust
Georgina Diba (GD), Director of Adult Social Care and Operations
Nina Griffith (NG), Director of Delivery, City and Hackney Place Based Partnership
Chris Lovitt (CL), Deputy Director of Public Health

6.3 Members gave consideration to the following:

Briefing from the Director of Adult Social Care Operations titled “Police Approach - Right Care, Right Person - Implications for health and social care system”
Note from Met Police website announcing the change
Briefing on the issue prepared by London Councils

6.4 GD took Members through her briefing paper in detail. She stated this was a fundamental change to the way police will be deployed in these instances. The model was first implemented in Humberside where it didn’t apply just to mental health cases but also to welfare concerns e.g. missing from health facilities. The Met Police informed stakeholders about this proposed change on 24 May with an implementation date set for 31 August, yet in Humberside they trailed this model for 3 years. The challenge will be to train up call handlers to make better decisions about who needs to be deployed. She added that they agree as a partnership that the most appropriate person be deployed whether they be health, social care or police. There are concerns about the financial implications in terms of implementing this in a short time period and the costs for additional dedicated staff. There are implications for councils and London Ambulance Service. Within Hackney the local partnership is looking at how it can alter its approach. There are 4 categories of cases here: mental health and crisis pathway; children and young people; those missing from hospital; welfare cases and those missing in the community. She added that conversations are ongoing between borough commanders and system managers at NHS NEL level as well as directors of adult and children’s services to examine the whole system pressures. The previous Friday a Police Partnership Board at New Scotland Yard had looked at the principles of RCRP, the current health demand on the Met and the legal obligations on them and on health services. There was general support for the principles of RCRP but the go live date of 31 Aug was very concerning for all partners. Health partners have been pushing for pan-London policies on the welfare category and on those missing from health establishments. London Ambulance Services was also procuring 14 new mental health ambulances over the next 2 years and this can be part of the mix. She expected progress across London on this by early August and she was happy to report back.

6.5 The Chair asked if we were still working towards a 31 August implementation date and if there was need to further or more urgent representations to Mayor of London and MOPAC. GD replied that that date is not changing but there is recognition that it took 3 yrs in Humberside and just 13 weeks was given to London. Partners across the entire system raised concerns to allow systems and partners to be able to respond to the risks and locally police are clear that they will continue to go out and support when they are triaged to do so. NG added that representations continue to be made to the Mayor of London and MOPAC, also through ADASS and through NHS NEL and through all political routes. In discussions with the police locally they are really keen to make this work and recognise that these timescales from the police side are challenging. She stated that for the Council the risk is all around timescales. She advised that they should wait for an update from the local police on realistic estimation of timescales before any push back or further escalation.

6.6 JF stated that the partnership which Adult Services had brought together on this and which the police is now engaging fully with is the best vehicle for responding to this. He added that ELFT is heavily involved in trying to find a local partnership solution.

6.7 The Chair asked if a response meant that ELFT might provide a more immediate outreach response to situations. JF replied that the issues relating to presentations with mental health at ED (as discussed earlier) are multifactorial. One aspect is how do we provide more support in the community but there are a number of different elements being discussed from further developing the crisis pathways, to more diversionary activities, to bolstering the crisis line and the crisis hub activity. Clearly part of the upstream work is to shore up these elements so there will be less chance that people turn up at A&E.

6.7 CF explained the City's street triage service which provides one of the potential opportunities here. It is an expensive service because it does provide specific Mental Health outreach workers. Interest has been expressed in this model by the ICB (NHS NEL) with a view to adapting it across the whole of NEL as potentially there would be some economies of scale. Capacity was needed but the fact ELFT is there already provides a potentially interesting model.

6.8 The Chair asked if funding was the key factor therefore. CL replied that it had been trialled in the City for other reasons. He added that we have to be very careful about how we refer to people who come to take their own lives. Any areas which have a lot of large buildings provides more settings where people take their own lives and city has proportionally higher numbers of suicides therefore. The benefits of embedding more mental health workers with the police has been very successful in the City but there are of course issues around staffing and resources.

6.8 NG stated that what the police are arguing is that we all think about how we can respond better to key incidents of mental health crisis in the community and in the long run that we think quite differently about how we respond to those incidents more appropriately. The risk is in the timescales and our ability to find the workforce and resources to develop these pathways in the new model. Street triage was a model we could consider but it would be difficult in Hackney because the geography is very different. She added that London Ambulance Services runs mental health cars and they've been talking to Met Police at a pan London level about expanding those and this provided another part of the solution.

6.9 Members asked how this approach would be financed and about the potential demand. NG replied there are no specific financial resources for health and care services to respond to this which is why they're concerned. We need to think how we can support this change out of existing resources or how we could build a case for putting new resources to this if we can evidence potential outcomes or efficiencies in other areas by doing it, she added. We know that the LAS mental health cars are currently under utilised and there may be capacity to utilise these better. On demand, JF replied that people in mental health crisis are only one aspect and there is an upward trend in people presenting with mental health issues to EDs and with the police accompanying them. He added that in May there were 451 presentations to Homerton ED with mental health issues which was 50 more than the previous month and their highest rate yet. Staffing to meet this potential demand is a challenge.

6.10 Cllr Binnie-Lubbock (not a Commission Member) stated that reports on Humberside talk about a reduction in police hours but don't talk more broadly about the outcomes for the public over a longer timescale. GD replied that nothing had been shared yet from that trial on outcomes for the public but interest in it is high obviously. She reiterated that partnership colleagues are not disagreeing with the model itself

because having the right person attending to you, depending on whether you are lost, missing or scared is important. If the person is known to you be it a health worker, a social worker or police that would be even better. Outcomes for people from the Humberside trail have not yet been shared.

6.11 SH commented that in terms of outcomes she was not familiar with the Humberside model but was familiar with a slightly different model that had operated in south west Wales where there were trained mental health staff in Police call centres advising the police and helping the responders. The outcomes were better for patients, they were less likely to be held under S136 of the Mental Health Act and they were more likely to end up in the right place with the care that they needed. Significantly, people in mental health crises were increasingly not being taken to a police station but instead to a healthcare setting. From both models we've been able to determine that there's a benefit to the NHS. In the South Wales model they had managed to save the NHS money and the Police had paid for it. It may be something to throw into the pot in negotiations with the Met in terms of how to smooth the transition and by freeing up resources. Also, if the savings then accrue to the NHS then resources can be reconfigured to enable a longer term approach.

6.12 The Chair thanked Dr Husbands for her insights. He asked that once matters have progressed here the Commission would like to know the outcome and asked if the item could come back, but not too prematurely. Members will be curious as to whether the 31 Aug deadline happens. He thanked officers for their reports and their attendance.

ACTION:	Update on the 'Right Care Right Person' proposal be added to future work programme.

RESOLVED:	That the reports and discussion be noted.

7 Minutes of the Previous Meeting (20.56)

7.1 Members gave consideration to the draft minutes of the previous meeting.

RESOLVED:	That the minutes of the meetings held on 13 June 2023 be agreed as a correct record.

8 Health in Hackney Scrutiny Commission Work Programme (20.57)

8.1 Members noted the full list of suggestions received from stakeholders and the public and he thanked everyone for those. The Chair stated he would draw up an outline programme to share with Members for discussion and agreement.

RESOLVED:	That the updated work programme be noted.

9 Any Other Business (21.00)

9.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm