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

Monday 17 July 2023

7.00 pm

Room 102, Hackney Town Hall, Mare Street, London E8 1EA

The press and public are welcome to join this meeting remotely via link

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

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**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1 **Apologies for Absence (19.00)**

2 **Urgent Items / Order of Business (19.00)**

3 **Declarations of Interest (19.01)**

4 **Health inequalities and medical barriers faced by trans and non binary community (19.02)** (Pages 9 - 48)

5 **Homerton Healthcare Quality Account 22-23 - HiH response (20.15)** (Pages 49 - 134)

6 **Met Police implementation of 'Right Care Right Person' model (20.30)** (Pages 135 - 148)

7 **Minutes of the Previous Meeting (20.56)** (Pages 149 - 162)

8 **Health in Hackney Scrutiny Commission Work Programme (20.57)** (Pages 163 - 176)

9 **Any Other Business (21.00)**

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

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

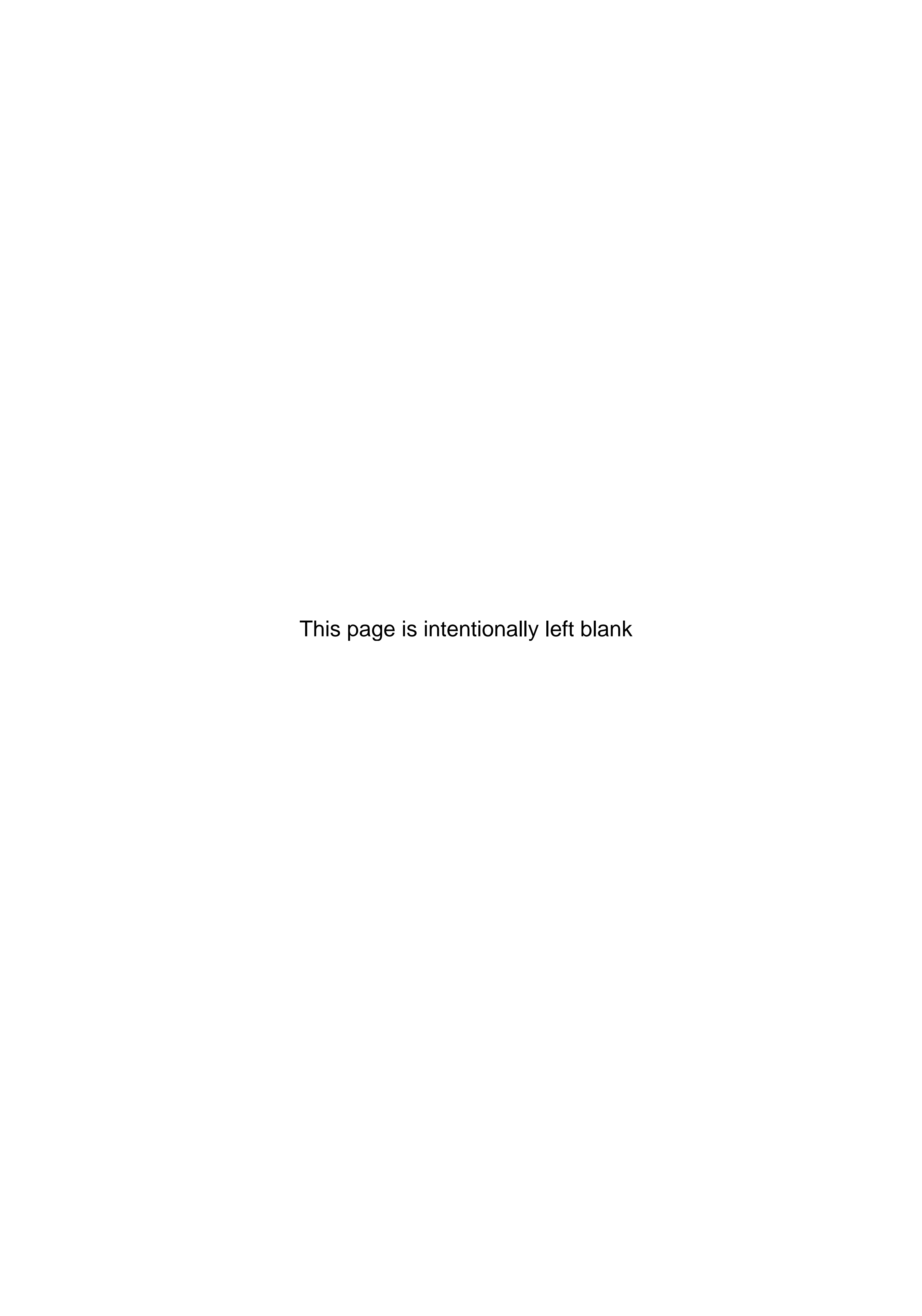
There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

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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Health in Hackney Scrutiny Commission 17th July 2023 **Health inequalities and medical barriers faced by trans and non binary community**	Item No **4**

PURPOSE OF ITEM
A context setting discussion to explore the health inequalities and specific medical barriers facing transgender and gender diverse residents in accessing primary and secondary health care.

OUTLINE
The barriers faced by trans and non-binary residents can include being asked (or fear of being asked) intrusive questions and being judged, and this relates to both 'front of house' and clinical encounters. Another key barrier is the lack of services having sufficient knowledge of or experience in providing the specific care needed for the trans community and the implications of delayed access to care for these patients.

It follows from motion agreed at Full Council on 1 March '23 which read:

"This Council believes in equity of opportunity and that human rights are the bedrock of our society. Trans women are women. Trans men are men. Non-binary people are non-binary. We believe in the dignity of all people, and their right to respect and equity of opportunity. We value the strength that comes with difference and the positive contribution diversity brings to our community. Our aspiration is for Hackney to be a safe, welcoming, and inclusive borough for everyone, no matter their gender identity or gender expression".

Approach:
- 3 elements: Contributions from Gendered Intelligence, from NHS and then Q&A with Members
- Focus on practical barriers and prejudice faced by trans and non binary people in accessing health services including delays in seeking care and how these can be overcome.
- In order to make it manageable, mental health, social care and CYP related issues are out of scope for this particular discussion however Members may be minded to pursue these in follow up sessions.

The participants will be:

Organisation	Role	Name
Gendered Intelligence	Head of Public Engagement	Cara English

Homerton Healthcare	Clinical Leads in Sexual Health and HIV, and Medical Examiners (*focus on wider secondary care for trans community not sexual health)*	Dr Katherine Coyne and Dr Sarah Creighton
	Chief Medical Officer Chief Nurse and Director of Governance	Dr Deblina Dasgupta Breeda McManus
NHS NEL	Chief Medical Officer	Dr Paul Giluley
GP Confederation	Practice Development Nurse Also ANP, IG Lead at Lower Clapton Group Practice	Heggy Wyatt

Key questions to be explored at the Session will include:

- How to develop current health services, beyond just sexual health services, to make them more inclusive?
- What specific improvements have been implemented already, if any, and what are the plans?
- What is the current NHS guidance? What problems does that create and what needs changing?
- How to empower GPs to make prescribing decisions themselves rather than automatically pass to secondary services (e.g. trans person requests hormone treatment, GP automatically refers to GIDS services, which has long and complex backlogs)
- How to make frontline staff (e.g. receptionists) more inclusive and sensitive to the the needs of trans and non binary patients
- How to raise awareness among primary and secondary care staff e.g. on basic actions such as changing one's name at the GP surgery

Attached please find:

a) Summary note from Gendered Intelligence. More details to follow.
b) Note from Homerton Healthcare on the key points they wish to raise and links to other key resources.

c) For background reading an update from April on Hackney Council's *LGBTQIA+ Strategic Framework*
d) For background reading a *Gender Diversity FAQ* from Hackney Council
e) Other useful background reading includes this link to NHSE's response (June 2022) to London Assembly Health Committee report on Improving-access-healthcare-trans-and-gender-diverse-londoners (Feb 22)

ACTION

The Commission is requested to note the reports and discussion and make any recommendations as necessary or agree further areas of work.

Health in Hackney Scrutiny Commission 17th July 2023

Whilst illegal to outright discriminate against a trans person based on their protected characteristic of gender reassignment, there remain many barriers to complete, holistic, effective and *human* care for trans people throughout the health service, both logistical and interpersonal. Sexual health services across the country — and particularly in London — are faring much better for trans people than in other healthcare settings e.g. primary care and specialised services[1]. However, NHS care overall is overwhelmingly more subpar for trans people than our cis peers.

Why we think this is important

As a leading trans-led organisation working towards improving the lives of trans and gender diverse people in the UK, Gendered Intelligence's staff and users are well placed in knowing first-hand the obstacles trans people face while accessing NHS care, and speaking to those. It's important than there is a universal and high level of care for all people accessing NHS services.

Why this is important for Hackney

In addition to basic legal and statutory duties, Hackney local authority has, across England and Wales, the fourth largest percentage of people who answered that they have a different gender than their sex as assigned at birth (10.72%) on the latest census[2]. Whilst this does not mean that over 10% of Hackney's population is trans or gender diverse, it does mean there is a heightened statutory and moral duty to an ostensibly outsized population. Gendered Intelligence can put some of our users in contact with Hackney to speak more on their experiences, if useful.

Overarching issues:

- Trans broken arm syndrome
- Multiply marginalised trans people fare worse than their peers: disabled trans people, for example, face multiple barriers to accessing care
- Active levers of discrimination/exclusion from healthcare services:

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[1] NB we won't go into details about issues with GICS/GIDS as these are widely known and outside of the scope of localised groupings).

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/genderidentity/bulletins/genderidentityenglandandwales/census2021

    - Poorly trained receptionists e.g. who refuse to change a name/title
    - GPs who bring personal biases to the consulting room, sometimes overtly. Refusing to refer to GICs or GIDS.
    - Gendered norms acting as barriers to care e.g. particular gendered expressions being read by gatekeepers such as GPs as meaning a non-seriousness about transition
    - Clinical Commissioning Groups (CCGs), now Integrated Care Systems (ICSs) – being used as cudgels, especially for people coming from private care (and being refused blood tests as too costly; GPs as above refusing shared care and using ICSs as the reason)
- Hormones not being prescribed in regular primary care
- Practice vs guidance

Remedies:

- Complete training of all staff at all levels who will come into contact with trans patients
- Shift to primary care - direct commissioning by healthboard for localised services, inclusive of voice work, therapy
- empowering GPs
- Trans leaders within services including primary care
- Disaggregation on records between sex and physical features - bottom up policy demand

Note from Homerton Healthcare
Dr Sarah Crighton (Consultant in Sexual Health/HIV, Homerton Sexual Health Services

There may be areas for discussion facing sexual health, Homerton Healthcare and the wider health economy in Hackney and North East London. I will be concentrating on sexual health and the wider health (and schools) economy.
I don't know whether Breeda and/or Deblina will talk from a Homerton perspective.

My points are:-

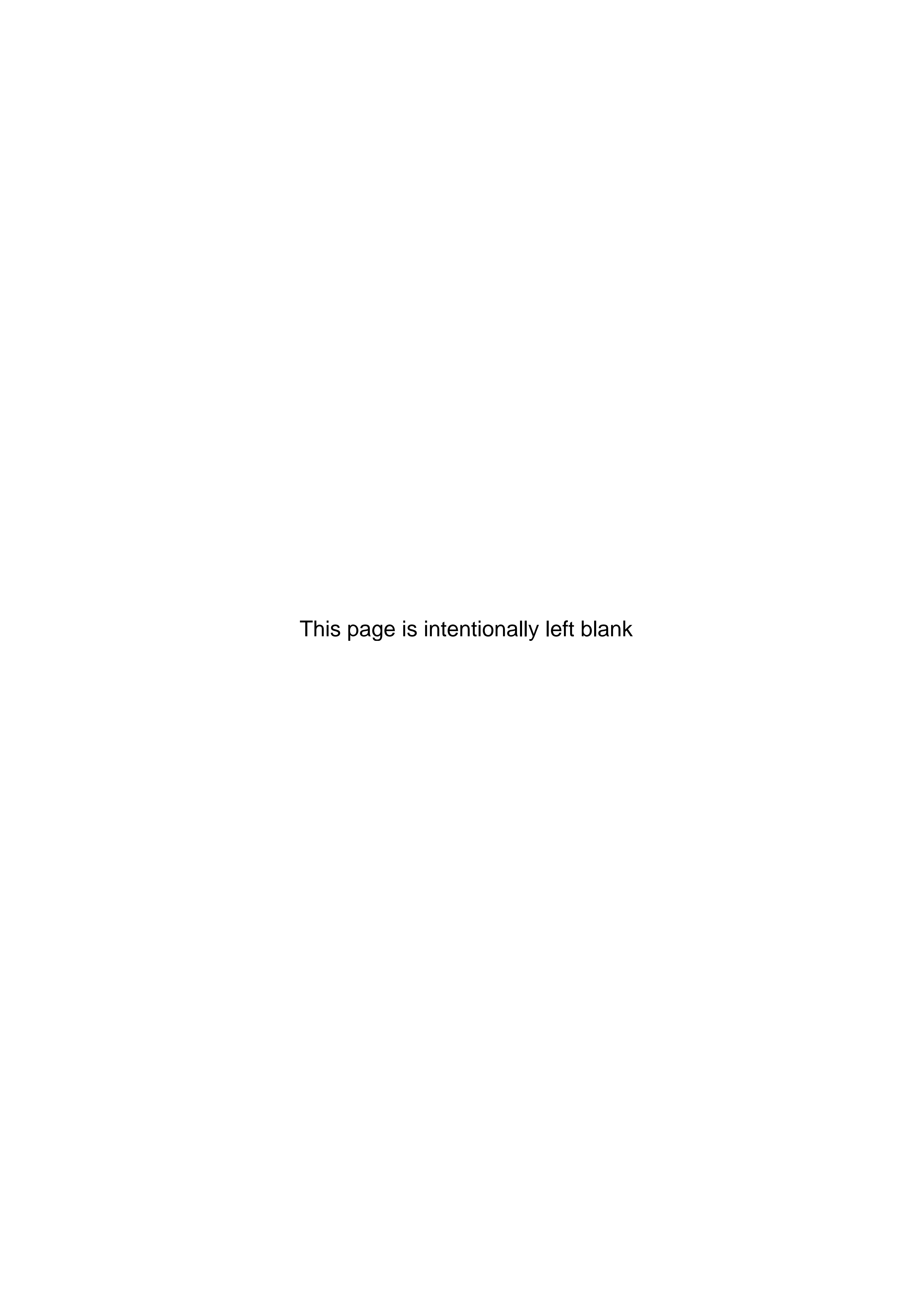
- I speak as a sexual health consultant, but also as the mother of an 18 year old trans woman
- Commissioning issues have exacerbated a long standing dearth of gender identity services, for both adults and adolescents. Waiting lists for NHS services are > 5 years
- Many people self medicate while waiting for specialist input. I will talk a little about what self medication means for the individual, and the dangers involved.
- Kings College Hospital and Chelsea and Westminster Hospitals run trans specialist sexual health clinics. These do not prescribe gender affirming hormones, but they do provide services which can make self medication less dangerous (needle exchanges, help with im injection, toxicity bloods) as well as trans sensitive sexual health services.
- There is no trans specialist sexual health clinic in North East London
- Guidelines include:-

General medicine (For clinicians providing general medical services to transgender and gender diverse people)

- **Trans healthcare - ethical topic - GMC (gmc-uk.org)**
- **Inclusive care of trans and non-binary patients (bma.org.uk)**

Endocrine prescribing recommendations

- Prescribing Recommendations for Gender Dysphoria, on behalf of NHS England Clinical Reference Group for Adult Gender Services' Prescribing Working Party . **PG12-GenderDysphoria.pdf (tgmeds.org.uk)** UK endocrine guidelines (currently draft awaiting ratification)
- World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People. **Standards of Care for Transgender and Gender Diverse People | Guidelines | JAMA | JAMA Network**
  comprehensive guidelines covering social psychological medical and surgical aspects of Trans health
- Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, **https://doi.org/10.1210/jc.2017-01658**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LGBTQIA+ Strategic Framework

Update April 2023

Contact me:

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020 8356 7596

@ECBats

Background

- Hackney's Single Equalities Scheme 2018-2022 identified the need for an LGBT+ Action Plan and a Trans, Nonbinary, Intersex and Gender Non-conforming (collectively known as "Gender Diversity") inclusion strategy.
- A Gender Diversity inclusion review of existing services was completed in early 2020 which made broad recommendations for service improvements. Unfortunately, further work was delayed due to the global pandemic.
- In 2021 the LGBT+ Action Plan and Gender Diversity Strategy were combined to form one piece of work which looks to set aspirations for Hackney to become a borough in which LGBTQIA+ people can thrive, and lay out a plan for how we may work towards those aspirations.
- The work began with a substantial research piece - a "Data and Insight Synthesis" - drawing on all the local information available and incorporating national data and insight, to identify gaps in insight and key features that underpin LGBTQIA+ wellbeing. Through this research work, six key themes were identified which form the basis of six "aspirations" which underpin the strategic framework.
- Small-scale testing of the aspirations and the approach was carried out which lead to the six aspirations being re-worded.
- The next stage is to incorporate the framework into our wider new Equalities Strategy, with a view to seeking public consultation in summer 2023.

The Aspirational Framework

A **Strategic Framework** is a document which will sets out what the council need to do over the next few years on a particular issue, outlining actions that need to be completed, changes we need to see, who is responsible for these and how we'll know we're doing well.

This framework needs to take into account what LGBTQIA+ people in the borough need, what are the communities priorities and challenges, what the council needs to do, how we'll know when the council are doing it well, and how the council will be held accountable for those actions.

To start, we've used all the research we've collected so far to identity six key areas that make the biggest impact on LGBTQIA+ lives when it comes to accessing services. We then turned those themes into six "aspirations" which would form the basis of an **Aspirational Strategic Framework** which is goal driven, looking at what we want to achieve, rather than action driven. This will support an approach of continuous improvement and encourage council services to be forward-thinking and creative in delivery

This approach has been chosen over an action-based plan in order to encourage long-lasting, transformative systems change and avoid a "tick-box" approach to delivery, an approach which does not always promote long term change.

Emerging themes from Insight Synthesis

The six key themes that emerges from the data and insight synthesis were

- Accessibility & Service Provision
- Intersectionality
- Demographics & Data
- Informed Allyship
- Participation & Engagement
- Community Resilience & Belonging

Detailed descriptions of each theme are available here

The Aspirational Statements

Theme	Hackney Council Aspires to…
• Accessibility & Service Provision	…ensure LGBTQIA+ people are able to access services that meet their needs where they are listened to, understood, and taken seriously without judgement
• Intersectionality	…recognise and celebrate the diversity of our LGBTQIA+ communities, paying attention to those who are often least heard and represented
• Demographics & Data	…improve our knowledge of our LGBTQIA+ communities through responsible data collection and use this information when planning services
• Informed Allyship	…be visible allies, open to learning and reflection, working in coalition with residents and organisations to promote LGBTQIA+ rights
• Participation & Engagement	…empower LGBTQIA+ people in Hackney to be able to influence the council on matters and policy that affect their communities
• Community Resilience & Belonging	…be a place where LGBTQIA+ people feel free and safe to express themselves with opportunities to connect with others

Full Council Motion

This framework is supported by a full council motion made on 1st March 2023:

This Council believes in equity of opportunity and that human rights are the bedrock of our society. Trans women are women. Trans men are men. Non-binary people are non-binary. We believe in the dignity of all people, and their right to respect and equity of opportunity. We value the strength that comes with difference and the positive contribution diversity brings to our community. **Our aspiration is for Hackney to be a safe, welcoming, and an inclusive borough for everyone, no matter their gender identity or gender expression.**

Read the full decision here

See how the motion aligns with the Aspirational Framework here

Approaches

There are two approaches to this work based on where the organisation has the most opportunity to effect change. While the two approaches may in some cases take place concurrently, there is some foundational work that needs to carry out before the influencing stage can be authentic and effective.

1. **Direct change**
   - Transformation within the organisation through training, onboarding, knowledge production and sharing
   - Policy review
   - incorporation of equalities actions unilaterally across different strategies and work plans
2. **Influence**
   - As we build our internal competency we use our experience and our relationships to influence and support partners to implement change within their own organisations.

Action Plan & Measurement

With the Aspirational approach, we approach the goals by considering "what is in our gift" - what can we deliver, provide or transform in order to work towards the aspirations - both in terms of delivery projects and long term systems change. This means that while there are some key issues we know residents want to see we can recommend, action plans need to be developed by the services and organisations who will be carrying out the work, and brought together under the framework.

Outcome measurement of individual projects which work towards the aspirations will need to be defined at the initiation with a clear link to the aspiration/s that the work seeks to address.

Measurements of the wider strategy are proposed to include:

- A LGBTQIA+ community reference panel is in place and actively engaged with this framework.
- Hackney develops robust data on our LGBTQIA+ population, and this data is actively used to understand the experiences of LGBTQIA+ people in hackney and their satisfaction with services.
- Data is routinely and responsibly collected and held by all council services, available via the Data Lake, and is used in service planning and wellbeing and satisfaction surveys alongside other demographic data
- Hackney achieves Silver or higher in the Stonewall Workforce Equality Index

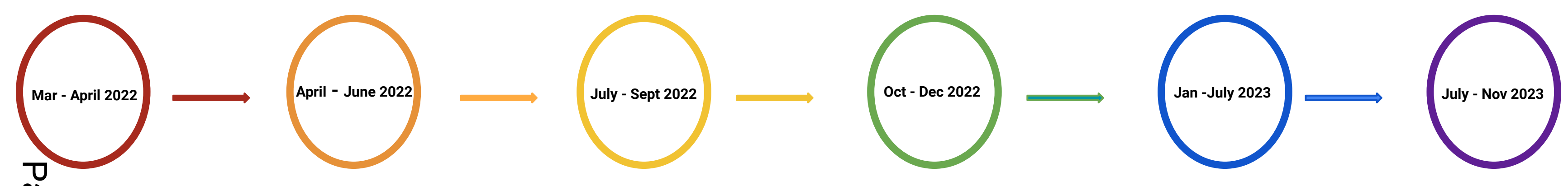
Opportunities

Opportunities identified for trialling the framework:

- Partners in CAMHS and organisations working with LGBTQIA+ youth are looking at the potential this approach has for partnership working and how both planned and new projects can be incorporated into this framework
- Working with Better Leisure on creating LGBTQIA+ friendly leisure centers - starting with Britannia Leisure Centre

Timeline 2022-23

This is the indicative timeline of the planned work - this has been revised since initial estimates



Data & Insight review

Completion of Data & Insight synthesis - drawing up themes and identifying particular cold spots and gaps. Understanding the needs & desires of the community, the conditions which are most likely to contribute to impact and the areas to challenge

Networking

Comms & collaboration plan including: networking with local organisations, groups & residents for opportunities to share learning. Creative comms to reach individual communities who are less often heard & represented, Utilising lived-experience expertise in Hackney. Identify potential peer researchers. Trust building with groups, organisations & individuals.

Small Scale Collaboration

Collaboration in the community - going to existing groups & working in locations to carry out hyper-local approach to collaborative knowledge generation taking a "what would it look like if..." and "what does good look like" approach. Identify champions & strategy panel who will proofread, sense check, and hold LHB to account during the implementation of the strategic framework

Draft Aspirations

Combine insights with result of collaboration to draft framework strategy. Define how it will be measured & by whom taking lead from champions/panel identified in collaboration phase. Use digital tools to ensure collaborators are able to check the development of the framework at regular intervals and are able to contribute.

Incorporation into Equality Strategy

Framework is incorporated into the wider council Equalities Strategy. This includes defining accountability, key actions and priorities and outlines how work will take place across intersections of marginalisation (e.g. links to the Aging Well & Anti-Racist strategies). To be presented at Cabinet prior to consultation.

Consultation

Equalities Strategy is taken to consultation with communities with a view to completion and approval by Cabinet in Winter 2023

The Aspirations: Small-scale testing

Small-scale testing of the approach was carried out in three ways:

- Focus groups styled as “Community Conversations” with two community-based groups, one with LGBTQIA+ Volunteers aged 25-50 and one with young people aged 15-21.
- An online portal using Google Sites for LGBTQIA+ individuals to provide detailed feedback anonymously
- A topic on “Hackney Matters” - this was open to all panel members, whether they were LGBTQIA+ or not. These questions were slightly different to those of the community conversations.
- Following the small scale testing, the original aspirations were re-written to try to remove “council-speak” and make them more meaningful to the communities.

The conversations

The conversations were split into three sections, with exploratory questions in each section

1. The Aspirations
   1.1. What do you think of the six aspirations?
   1.2. How would you write them, if you were to re-phrase them?

2. Achieving our aspirations
   2.1. What would it look like to live, work and/or study in Hackney if we were achieving all of the aspirations?
   2.2. What would be the biggest change to how things are now?
   2.3. What is the biggest challenge for Hackney to achieve this?

3. Holding us to account
   3.1. How can LGBTQIA+ communities in Hackney hold the Council to account for these aspirations?
   3.2. How can we make sure we're hearing from as many different voices as possible from LGBTQIA+ communities?

Re-written aspirations

Theme	Hackney Council Aspires to…	*Original text (prior to community conversations)*
Accessibility & Service Provision	ensure LGBTQIA+ people are able to access services that meet their needs where they are listened to, understood, and taken seriously without judgement	*ensure that all LGBTQIA+ people who come in contact with public services are listened to, understood, and taken seriously without judgement*
Intersectionality	recognise and celebrate the diversity of our LGBTQIA+ communities, paying attention to those who are often least heard and represented	*recognise and celebrate the diversity within the LGBTQIA+ community and understand the impact of multiple identities and experiences particularly those who are often least heard and represented*
Demographics & Data	improve our knowledge of our LGBTQIA+ communities through responsible data collection and use this information when planning services	*understand LGBTQIA+ communities and use information about our communities in making decisions*
Informed Allyship	be visible allies, open to learning and reflection, working in coalition with residents and organisations to promote LGBTQIA+ rights	*vocally and visibly support LGBTQIA+ communities and listen & learn from mistakes*
Participation & Engagement	empower LGBTQIA+ people in Hackney to be able to influence the council on matters and policy that affect their communities	*enable LGBTQIA+ people in Hackney to be able to make decisions and influence the council on matters that affect us*
Community Resilience & Belonging	be a place where LGBTQIA+ people feel free and safe to express themselves with opportunities to connect with others	*be a place where LGBTQIA+ people are safe to be our authentic selves and have opportunities to connect with each other*

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Gender Diversity FAQ

Gender Concepts

- What is “gender diversity”?
- What does “Gender Identity” mean?
  - Gender identity
  - Gender roles
  - Gender expression
  - Gender non-conformity
  - Gender reassignment

Gender Identities

- What do “transgender” and “cisgender” mean?
- What does “nonbinary” mean?
- What is the difference between “sex” and “gender”?
- What does “Intersex” mean?
- Collecting data on Sex & Gender
  - Recommended questions for collection of Sex & Gender identity:

Interacting with Gender Diverse People

- “my pronouns are…”
- What is misgendering?
- Use of Sir/Madam
- How do I ask someone what their pronouns are?
- What should I do if I accidentally misgender someone?
- What is “deadnaming”?
- Talking about people’s experience of transition
- Writing about trans people

Gender diversity & the law

- What does the law say about transgender people?
  - Gender Recognition Act 2004 (GRA)
  - Equality Act 2010 (EqA)
    - Public Sector Equality Duty
    - Codes of Practice
- Is Gender Identity a protected characteristic under the Equality Act 2010?
- What is “Self ID”?

Gender diversity in Hackney

- What are Hackney’s policies on gender diversity?
  - Policies & Guidance
  - Single Equalities Scheme
  - Single Sex Spaces
- How many trans people are there in Hackney?
  - Trans people in Hackney: Infographic
- What are the main needs and concerns identified by Gender Diverse people in Hackney?

Proud Hackney - the LGBTQIA+ Staff Network

Gender Concepts

What is “gender diversity”?

Gender diversity is a way of describing gender beyond a simplistic male/female binary, recognising that worldwide there are more than two genders, and that sex is more complicated than a simple male/female binary. “Gender diversity” covers a wide range of cultural practices and identities which can differ significantly from culture to culture. Some cultures have a similar binary view of gender that is common in Britain, but others may have three or more genders. “Gender Diverse” or “Gender Variant” are sometimes used as used as umbrella terms to encompass trans, nonbinary, gender non-conforming and intersex people.

Further reading:
"Visualizing Sex as a Spectrum" - Scientific American, 2017
Openly Twitter Thread, 2021

What does “Gender Identity” mean?

“Gender identity”, “gender roles” and “gender expression” are all different things.

Gender identity

Gender identity refers to your own sense of what your gender is. Everyone has a gender identity, and for most people it matches the gender they were assigned at birth. For others, their gender identity does not match the one assigned to them at birth. Some people may be transgender or nonbinary. Intersex is not a gender identity, however some intersex people may have been assigned male or female at birth, but later identify as a different gender. As described in a report presented at the United Nations Human Rights Council in 2021 put it:

> *“Gender identity refers to each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body and other gender expressions, including dress, speech and mannerisms. Human experience in relation to gender identity and expression is both complex and rich. A wide range of gender identities and expressions exist in all regions of the world, as a result of long-established cultures and traditions that transcend concepts of gender considered as the norm in a particular place and time.”*

Gender roles

Gender roles are the expectations that the societies or cultures in which we live impose on people of particular genders. Gender roles may vary from culture to culture, but generally include things like who does the child-rearing, the cooking, who is nurturing, who earns money, etc. Cultures which have more than two genders still tend to have gender roles, or certain expectations of the recognised genders. In the last few decades in Britain, in part due to feminist activism, there has

been significant movement towards viewing gender roles as socially constructed, rather than biologically determined, and gender roles are increasingly acknowledged as being harmful stereotypes.

Gender expression

Gender expression is how you present yourself to the world, for example your dress, hairstyle, makeup, mannerisms etc. The meaning of this will depend on the associations these expressions have with genders in a given culture, for example what is considered “masculine” or “feminine”? Many people will express their gender in line with their gender identity, but others may also choose to express their gender in an entirely different way to their gender identity. This is sometimes called “gender non-conformity”.

Gender non-conformity

Gender non-conformity means expressing yourself in a way which is different to your gender identity. People who are “gender nonconforming” sometimes abbreviated to “GNC”, may dress or act in a way which doesn’t conform to their culture or society’s expectations of gender roles and/or gender expression. Trans, nonbinary and cis people can all be gender non-conforming; being gender non-conforming does not mean someone is transgender.

Gender reassignment

Gender reassignment is the term used in the Equality Act 2010 to describe the protected characteristic of transgender people. It is generally accepted to be a synonym for “gender identity”.

Gender Identities

What do “transgender” and “cisgender” mean?

The word “transgender”, or “trans”, is used to describe people who are a different gender to the one they were assigned at birth. The person may or may not be undergoing medical treatment. “Transexual” is an older word for “transgender” and appears in legislation, however it tends to be seen as a more medicalised term. While some people do identify as transexual the word is generally not widely used by trans or nonbinary people. In UK law, “transgender” and “transexual” are synonyms.

“Cisgender” or “cis” describes a person whose gender identity corresponds with the one they were assgined at birth. So a cis man is someone who identifes as a man and was assigned male at birth. “Cis” is the antonym to “trans”, with cis meaning “on the same side as” and trans meaning “on the other side of”. Trans is not short for “transition”, although some trans people may undertake a transition process which may be social, medical or both.

Some trans people may also “detransition”, which means that they stop their social or medical transition and they may return to living as their birth-assigned gender. Research suggests that detransition is most often a response to transphobia and/or a lack of social, familial or medical support, and most trans people who detransition retransition later on in life.

This is covered in more detail in Hackney's Inclusive Language guide.

What does "nonbinary" mean?

Nonbinary (sometimes written with a hyphen: non-binary) is an umbrella term for a person who does not identify as only male or only female, or who may identify as both, or as neither. "Nonbinary" can be someone's gender identity, or they may be genderqueer, demigender, agender or another identity under the nonbinary umbrella.

Not all nonbinary people identify as transgender.

Many cultures and countries worldwide do not perceive gender as being binary as it is mainly seen in Britain.

This is covered in more detail in Hackney's Inclusive Language guide.

Further Reading:
A Short Guide to Non-Binary, Rainbow & Co July 2022
United Nations report on Gender inclusion, 2021
"Visualizing Sex as a Spectrum" - Scientific American, 2017
Openly Twitter Thread, 2021

What is the difference between "sex" and "gender"?

There is no straightforward answer to this question, and it has been the subject of academic and philosophical debate for a long time. Some languages and cultures don't have a separate word for sex & gender, some have many, and like with all language the meaning of words can change over time.

A United Nations report in 2021 makes the following distinction: "gender is a term used to describe a socio-cultural construct that ascribes certain roles, behaviours, forms of expression, activities and attributes associated with biological sex characteristics."

In the Equality Act 2010 "Sex" is defined as being a man or a woman, with the process of socially, legally or medically transitioning from one to the other as "gender reassignment". Other legislation, including the Gender Recognition Act 2004 (GRA), uses the words "sex" and "gender" interchangeably. If a trans person chooses to change their legal gender using the GRA, they will be able to have the "birth sex" section of their birth certificate amended to their new legal gender. This will enable them to be married as the correct gender and also to be recorded correctly on their death certificate. A Gender Recognition Certificate is not required in order to change a sex marker on medical records, driving licence, passport, or with a place of work. This means that while there may be different social meanings of sex and gender, in UK law and practice there is no distinction.

Nonbinary identities are not currently recognised in the Equality Act under the protected characteristic of “Sex”, but case law known as “Taylor vs Jaguar Land Rover Ltd” established in September 2020 that nonbinary people are protected under the characteristic of “Gender Reassignment”.

What does “Intersex” mean?

“Intersex” is not a gender identity. Intersex is used to describe people who were born with sex characteristics or physical traits that doesn't fit the typical biological definitions of female or male. These are also known as “Variations of Sex Characteristics” or or ”VSCs”. Some people prefer the term “VSC”, others prefer “Intersex”.

People who are Intersex may identify as male, female, nonbinary or in another way. It is difficult to know how many Intersex people there are, as this is not data that is routinely collected and there is still a great deal of stigma around and lack of knowledge of variations of sex characteristics which may make it hard for intersex people to disclose. The current estimate is that up to 2% of people could be born with variation of sex characteristics.

Under UK law it is legal and remains a practice to carry out surgery on babies born with born with sex characteristics that would identify a child with a VSC, such as differences in hormone levels and production, chromosomal variation, differences in reproductive organs and/or sexual anatomy. This is controversial and a key area for intersex activism, as many Intersex advocates view this surgery as non-consensual, violent and medically unnecessary. Following many years of campaigning, a few states in the USA have passed resolutions admonishing these practices and two hospitals have ceased the practice. Malta and Tamil Nadu in India are some of the few places in the world that have an outright ban on these surgeries.

You may also come across the term “Disorder of Sex Difference” or “DSD”. This is less popular among intersex advocates, as it pathologises their bodies, rather than taking the approach of acceptance of diversity.

For further information, check out Interact’s Intersex Variations Glossary - a guide to people centered definitions of intersex traits & variations in sex characteristics.

This is covered further in the Inclusive Language guide.

Further Reading
Intersex Variations Glossary - a guide to people centered definitions of intersex traits & variations in sex characteristics (2022)
Supporting Intersex Inclusion in the Workplace - Out & Equal
The variations of sex characteristics and intersex project
How to be an Intersex Ally, ILGA, 2015
Intersex Human Rights issues, OIIE, 2021

Collecting data on Sex & Gender

Questions on Sexual Orientation and Gender Identity (often shortened to "SOGI" in data collection) can be particularly challenging to get right, however as a local authority with a duty under the Equality Act to promote equality, it is important we collect data on our communities and understand the local need.

Not all people will feel safe or confident in disclosing that they are trans or nonbinary, so getting the balance right in framing data collection questions is vital. When collecting data on sex & gender of staff or residents, the guiding questions should be "**what do we want to know**" and "**why do we want/need to know this**". This will help define the questions and the accompanying narrative.

The important aspect of any data collection is not the literal terms used, but that the terms used are easily understood, are collected with proportionate means to achieve a legitimate aim and that those completing data monitoring information understand the purpose of collection. We should also be mindful that the process of data collection, including the questions asked and the phrasing, does not create a hostile environment for marginalised staff or residents.

If we are collecting statutory data where we do not have control over the questions asked, for example for statutory HMRC returns, this should be explained in a narrative alongside the question.

When asking about gender identity, it is important to remember that "Transgender" is not a sexual orientation or gender identity, it is a way of describing the relationship of a person's gender idenity to that assigned at birth.

Recommended questions for collection of Sex & Gender identity:

What is your gender?

- ☐ Male
- ☐ Female
- ☐ Nonbinary
- ☐ Another term [free text]
- ☐ Prefer not to say

Is your gender identity the same as the sex you were assigned at birth?

- ☐ No
- ☐ Yes
- ☐ Prefer not to say

Further reading:
United Nations report on Gender inclusion, 2021
Stonewall Guide to LGBT+ data collection, 2016
Safety & personal data, ILO 2021
How to ask about gender and sexual orientation in a survey - Survey Monkey

Interacting with Gender Diverse People

“my pronouns are…”

Independent personal pronouns are the words we use to refer to a person. In English, these are gendered, and sometimes known as “gender pronouns”. Not all languages have gendered pronouns - only around half of languages worldwide. The ones we are most familiar with in English are “she/her/hers” and “he/him/his”. Many nonbinary people may use “they/them/theirs” which may feel odd at first as we tend to assume these are for groups of people, but the singular “they” pronoun has been in common usage in English for a long time and is commonly used to refer to someone whose gender you do not know; for example “someone has left their phone behind in the office”. There are also a number of other English gender pronouns which are less well known.

As gender expression and gender identity are different things, it might not always be obvious what gender identity someone has from the way they look, and it’s not always obvious from someone’s name. This means that it can be useful - and a really easy way of making trans, nonbinary and gender non conforming colleagues, residents and service users feel welcome and included - to routinely state what your personal pronouns are. Cisgender people sharing their pronouns can help normalise this, and mean that trans and nonbinary people are not singled out by being the only ones to share their pronouns.

Ways of doing this might be:

- Add your pronouns to your Google account at aboutme.google.com. N.b. If you are adding custom pronouns, you will need to use a backslash - i.e. she\they or they\he - rather than a forwardslash.
- Adding your pronouns to your email signature or letters
- Adding them to your Google, Slack or Linked-In profiles
- Sharing them at the start of meetings when you introduce yourself, along with your name & job title.

It is worth noting that not all transgender people are “out” at work, and for transgender people who are not out, it may be difficult or painful to have to use the wrong pronouns. In addition, some nonbinary people have no pronoun preference. Therefore asking people to state their pronouns should be optional rather than compulsory.

If you are adding your pronouns to your email signature, you can link to this page to explain why.

Alternative independent personal pronouns:

HE/SHE	HIM/HER	HIS/HER	HIS/HERS	HIMSELF/ HERSELF
zie	zim	zir	zis	zieself
sie	sie	hir	hirs	hirself
ey	em	eir	eirs	eirself
ve	ver	vis	vers	verself
tey	ter	tem	ters	terself

e	em	eir	eirs	emself

Further Reading:
History & usage of gender neutral pronouns - Devin-Norelle, 2020
MyPronouns.org - a guide
Map of Gender Distinctions in Independent Personal Pronouns
What social workers should consider when working with LGTBQ+ people
Pronoun Badges: Supporting Gender Identity in the Workplace, Chapter Z, 2021

What is misgendering?

Misgendering is when someone refers to someone else as the gender they're not. This might be due to using the wrong personal pronouns or by describing them as the wrong gender; for example if you say "she" about someone who is nonbinary, saying "the woman over there" when referring to a man, or using "Sir" when addressing a trans woman.

Misgendering is considered to be a microaggression / microincivility by many people, both cis and trans.

Misgendering can happen by accident if you don't know the gender of the person you're speaking to, or if you make a mistake. Misgendering can also be used to harass or bully trans people. If someone is persistently and/or deliberately misgendering a college or service user, this may lead to disciplinary procedures.

Some people may hold a philosophical belief that sex is binary and that people cannot change sex or gender. While people who hold philosophical beliefs may be protected from discrimination under the protected characteristic of "Religion or Belief", this does not mean that they can use that belief to misgender a colleague or service users. For example a registrar who holds a philosophical belief that homosexuality is wrong is not entitled to make comments about their colleagues who are gay and cannot refuse to conduct a same sex marriage or civil ceremony under those grounds.

Further reading:
Promoting equality for transgender staff and supporting transitioning at work, 2017.
What does it mean to misgender someone? Healthline, 2018
Pronoun etiquette, Robot Hugs Webcomic, 2014
MyPronouns.org - a guide
What social workers should consider when working with LGTBQ+ people, Community Care, 2022

Use of Sir/Madam

When using "Sir" or "Madam" based on someone's voice, gender expression or appearance, you may be inadvertently misgendering someone. This issue also arises when written correspondence uses "Dear Sir/Madam".

In written correspondence where the name of the recipient is unknown, it is recommended that letters are addressed "Dear Resident" or an appropriate substitute if the recipient is not a resident - e.g. "Dear Enquirer", "Dear Business Owner".

When greeting people verbally either face to face by telephone, it can be hard not to say "sir" or "madam" as many of us have been taught or trained that this is polite, however it is recommended that when greeting people whose names are unknown, you do not add "sir" or "madam" to your greeting. For example saying "Good morning, how may I help you" is sufficient, or if on the telephone and you know their name, using their name instead.

How do I ask someone what their pronouns are?

In an ideal world, this would feel as easy as asking someone's name. If you think about it in the same way, it makes it much easier.

The simplest way is to introduce yourself with your name and pronouns and allow the other person to share with you if they wish, or you could use more direct phrases such as "My name is ____ and my pronouns are ___ and ____. What are your pronouns?" or "I'm ____. I use __ and __ pronouns. If it's all right to ask, what should I use for you?".

Just as with people's names, sometimes we've been using the wrong name for someone for a long time and they've not been able to correct us, or perhaps we've forgotten their name and are too embarrassed to admit it. The same is true for pronouns, and ultimately it's about us becoming comfortable enough to ask, and to make it as safe and easy as possible for the person we're talking to to tell us their name or their pronouns.

What should I do if I accidentally misgender someone?

If you misgender someone by accident, the best thing to do is to correct yourself immediately, with a brief apology, then move on. Misgendering happens - and we all do it sometimes. Making a quick apology and swift correction amends the error without putting the person who has been misgendered on the spot.

If it is continual, it can be upsetting for the person being misgendered, and start to feel deliberate, even if it isn't. You can mitigate this by taking measures to ensure gender pronoun use is more normalised in your team, for example by always saying your pronouns when you introduce yourselves at meetings. Zoom and Teams both allow you to add your pronouns to video meetings, and you can also add them to your Google profile and your LinkedIn if you have one. Hackney ICT are currently looking at a way to allow gender pronouns to be visible in Google Meet.

Further reading:
What does it mean to misgender someone? Healthline, 2018
Pronoun etiquette, Robot Hugs Webcomic, 2014
MyPronouns.org - a guide
What social workers should consider when working with LGTBQ+ people, Community Care, 2022

What is "deadnaming"?

"Deadnaming" is a term that describes calling a trans person by the name they used pre-transition. While some trans people might not change their name, or might not mind a reference to their former name, many trans people find this difficult, and some may find it offensive or experience this as a microaggression. As with pronouns, the best thing to do is ask someone how they like to be called - just the same as you would if you weren't sure how to pronounce someone's name. Deliberately and/or repeatedly referring to a person by their former or an incorrect name is likely to be seen as disrespectful and could be considered workplace harassment.

Further reading:
Definition of "deadname", Merriam-Webster Dictionary
What to know about Deadnaming, Veronica Zambon, Medical News Today, 2021
What social workers should consider when working with LGTBQ+ people, Community Care, 2022

Talking about people's experience of transition

Not everyone will be comfortable talking about their experiences of being transgender or of transitioning, and the subject should be approached with sensitivity and cultural humility, just as you would approach discussing someone's experience of any aspect of their cultural background, e.g. race, disability or sexual orientation.

When talking about someone before their transition, It is considered respectful to use their current name and pronouns, and avoid referring to a trans person as their assigned gender at birth (AGAB) or by their former name (also known as a 'deadname'.) This will also ensure you are not revealing someone's trans status without their consent.

Further Reading:
"How to refer to trans people in the past" Jackson Bird, YouTube, 2018
Ted Talk: How to talk (and listen to) transgender people, Jackson Bird, YouTube, 2017
What social workers should consider when working with LGTBQ+ people, Community Care, 2022

Writing about trans people

Language changes quickly, and sometimes words that we may be familiar with fall out of use - for example while "Transexual" was in common use in the early 90s, "Transgender" is the usually preferred term today; although some people may still use the term "transexual". When writing about an individual, the best thing to do is to use the words they use about themselves. When writing about groups, there are three common errors:

"Transgenders" - Transgender is an adjective, so this should be written as "transgender people", or "transgender woman, transgender adults" etc. People should not be referred to as "transgenders". Similarly, "trans" is also an adjective, so when talking about individuals, "trans man" and "trans woman" would be two words, not one.

"Identify as" - When writing that someone is trans, writing that they "identify as a woman" or "identify as a trans woman" can be perceived as a microaggression. A better way of writing this would be "she is a trans woman".

"Preferred pronouns" - the word "preferred" is unnecessary. When writing what a person's personal gendered pronouns are, writing "their pronouns are they/them" would be accurate. Using "preferred" suggests that using a person's correct pronouns are optional, however using people's accurate pronouns is simply respectful, in the same way using their correct name would be.

If you would like a document proof read to ensure it is respectful of trans and nonbinary people, you can request that Proud Hackney conduct a sensitivity reading.

Gender diversity & the law

What does the law say about transgender people?

There are two key pieces of law in the UK. One is the Gender Recognition Act 2004, the other is the Equality Act 2010. The Gender Recognition Act sets out how trans people can change their gender on their birth certificate, if they wish to do so. The Equality Act sets out the law as it pertains to protecting people from discrimination.

Gender Recognition Act 2004 (GRA)

The Gender Recognition Act 2004 (GRA) enables trans people to change their legally recorded sex/gender from female to male or male to female. It sets out the process by which a trans person can obtain a Gender Recognition Certificate (GRC) which can then be used to permanently alter their birth certificate. This allows a trans person to be married in the correct gender and have their correct gender be recorded on their death certificate.

Such a law is necessary as the United Nations Human Rights Committee considers a failure to allow change of sex on official documents a form of discrimination. While groundbreaking at the time, the GRA has been critiqued by trans people and legislators for being unnecessarily bureaucratic and time consuming, and reliant on medical diagnoses that are now out of date.

Given the lack of figures about the number of trans people in the UK, it is hard to say with certainty, but it is estimated that only a small proportion of trans people go through the process of obtaining a GRC.

The GRA only applies for people transitioning to the opposite binary gender (male & female) and does not make provisions for nonbinary genders or for those who are under the age of 18.

It was hoped that the UK Government's consultation in 2018 would lead to changes to the Act, but only minor changes were made to make the process less expensive and to enable people to apply online.

Hackney Council's official stance is of support for Self Identification through a statutory declaration.

Further Reading:
Good Law Projects Legal Guidance - Trans Children In Schools (2022)
Letter to Equalities Minister from Mayor Glanville & Cllr Williams, February 2021
History of the Gender Recognition Act, Gendered Intelligence
Reform of the GRA 2004 - The Law Gazette
Response to Government status on GRA - Stonewall

Equality Act 2010 (EqA)

The Equality Act 2010 (EqA) drew together all the previously existing discrimination law to create a single piece of legislation. The Equality Act sets out to protect people in both workplaces and wider society from discrimination.

The act identifies nine protected characteristics: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. Under the EqA, it is illegal to discriminate against anyone because they have one or more of the protected characteristics. It is also illegal to discriminate against someone for associating with people with protected characteristics, or because you believe them to have one of these characteristics.

While the act makes no reference to people with a nonbinary gender, an employment tribunal held in September 2020 known as "Taylor vs Jaguar Land Rover Ltd" established that nonbinary and genderfluid people are protected under the characteristic of "Gender Reassignment".

Public Sector Equality Duty

The EqA also sets out the Public Sector Equality Duty, the three aims of which are:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Codes of Practice

The Equality Act Codes of Practice are published by the Equality & Human Rights Commission and consist of expanded guidance and detailed descriptions and examples of the act in practice. These Codes of Practice are statutory, and thus must be followed by the local authority along with the Public Sector Equality Duty.

Further Reading:
Citizen Advice: Guide to direct discrimination
Public Sector Equality Duty - Equality & Human Rights Commission
Codes of Practice - Equality & Human Rights Commission
United Nations report on Gender inclusion, 2021

Is Gender Identity a protected characteristic under the Equality Act 2010?

The term used in the Equality Act 2021 is "Gender Reassignment" (Part 3, Section 7). The definition of Gender Reassignment is broad, so while the specific term "Gender Identity" is not used, it is generally understood that it is covered by Gender Reassignment.

Gender Reassignment covers people who are:

- proposing to undergo,
- are undergoing or
- have undergone a process
- (or part of a process)

to reassign their sex by changing physiological or other attributes of sex have the protected characteristic of gender reassignment.

This can vary from person to person, and may include things like changing their name, their pronoun or how they express themselves. To have the protected characteristic of "Gender reassignment" one doesn't need to have undergone any surgical or medical procedure or have been through the process of obtaining a Gender Recognition Certificate under the Gender Recognition Act 2004.

It is worth noting that the protections of the Equality Act 2010 don't just apply to people who have the protected characteristic, but also those who are perceived to have it, i.e. "discrimination by perception" which is when someone is discriminated against because they are perceived to have a protected characteristic.

Further Reading:
Equality Act 2010 Guidance - UK Government
Citizens Advice: Guide to direct discrimination

What is "Self ID"?

"Self ID" or "Self Identification" generally means how we identify ourselves as having a particular characteristic or identity. For example, we might self identify as straight or gay, or as disabled. In terms of protection from discrimination under the Equality Act under the protected characteristics categories of disability, gender reassignment, race, religion or belief, and sexual orientation, there is no formal legal process to undergo in order to be recognised as having the protected characteristic beyond one's own identification of having - or being perceived as having - that characteristic.

In terms of gender identity/gender reassignment, "self ID" is sometimes used as a synonym for a Statutory Declaration of gender. In a number of countries, trans people can change their legally recorded sex via a Statutory Declaration, which is a formal legal process in which the individual declares something to be true in law, sometimes also known in British law as a "sworn oath". Making Statutory Declaration or sworn oath that you know to be false is a criminal offence, potentially resulting in a fine or even a prison sentence.

Hackney Council's formal stance is in support of the Gender Recognition Act to be reformed to allow trans people to make a Statutory Declaration of their gender.

Countries with self-identification based processes for changing legal gender include the following. In brackets is the year in which the process became law: Ireland (2015), Malta (2015), Norway (2016), Argentina (2012), Portugal (2018), Belgium (2017), Spain (2021). Scotland voted to update their Gender Recognition Act to allow Statutory Declaration in December 2022.

Further Reading:
What is a statutory declaration and how can they be used? - Boys & Maughan solicitors
Self Declaration - Equal Recognition Scotland
Letter to Equalities Minister from Mayor Glanville & Cllr Williams, February 2021

Gender diversity in Hackney

What are Hackney's policies on gender diversity?

Policies & Guidance

Hackney's implemented a policy on promoting equality for transgender staff and supporting transitioning at work in 2017.

As part of the LGBTQIA+ Action Plan, existing policies and guidance will be reviewed to ensure they are inclusive of gender diverse people, and sensitivity readings will be recommended as standard for all new policies and guidance.

Hackney's workplace guidance for Menopause & Menstruation explicitly includes all who menstruate, and new policies and guidance will undergo a sensitivity read by members of Proud Hackney.

Single Equalities Scheme

As part of Hackney's Single Equalities Scheme 2018-2022 a commitment was made to create an LGBTQIA+ Action Plan, part of which would include a review on Trans, nonbinary, Intersex & Gender non-conforming inclusion within the borough. The first stage of the review was completed in early 2020, however subsequent work was delayed due to the global pandemic.

This work is being led by Strategic Delivery Officer Emmie Bathurst, please contact them for further information.

Further Reading:
Transgender staff in Hackney - Leave & Absence polices
Report on Trans Inclusion, 2020
LGBTQIA+ Strategic Framework Update - November 2022

Single Sex Spaces

In focus groups, LGBTQIA+ residents have told us they prefer "gender inclusive" over the term "gender neutral" when discussing shared space facilities or services. Gender Inclusive spaces are those that can be used by anyone of any gender.

Where there is a need to do so, single sex spaces can be provided for under the Equality Act where necessary. Hackney's policy on Single Sex Spaces is as set out in the Equality Act 2010 statutory Code of Practice for Services, public functions and associations.

The relevant section is in Chapter 13 of the Code of Practice:

> *"If a service provider provides single- or separate sex services for women and men, or provides services differently to women and men, they should treat transsexual* people according to the gender role in which they present. However, the Act does permit the service provider to provide a different service or exclude a person from the service who is proposing to undergo, is undergoing or who has undergone gender reassignment. This will only be lawful where the exclusion is a proportionate means of achieving a legitimate aim."*

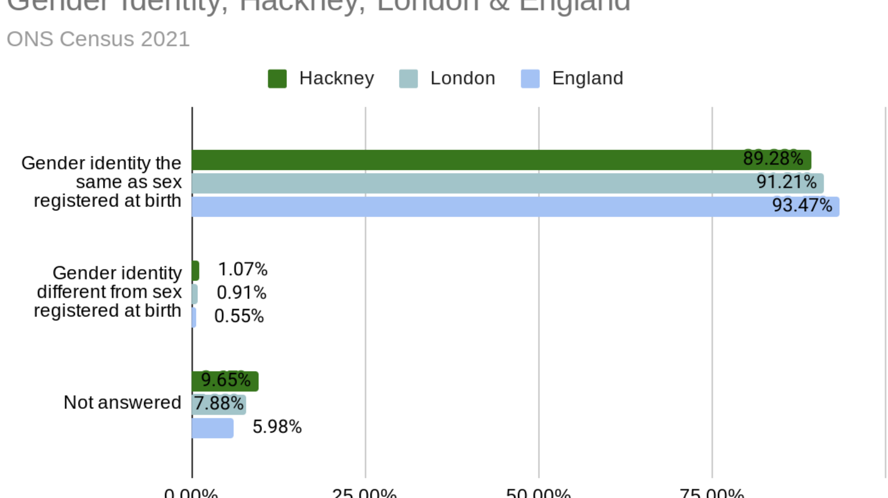
The code also provides examples of when it would be lawful to exclude trans people from services that align with their gender identity, and that this would be on a case by case basis.

There was an application in 2020 for Judicial Review to challenge this guidance, known as Authentic Equality Alliance vs Commission for Equality and Human Rights, with the applicant claiming that rather than inclusion as practice with exclusion on a case by case basis, the law should be read as exclusion as practice with inclusion on a case by case basis. This was not granted permission to proceed to Judicial Review so the Code of Practice is correct as stated.

* The act uses the term "transexual" rather than "transgender" although as described in the Inclusive Language guide these are synonyms, with "transgender" currently being the preferred term for most trans people.

Further Reading:
Code of Practice on Services, Public Functions and Associations

How many trans people are there in Hackney?



Questions on Sexual Orientation and Gender Identity were asked for the first time in the 2021 Census, allowing the first opportunity to understand the number of LGBTQIA+ people in the UK.

The data suggested that there are 2241 trans people in Hackney - just over 1% of the population. This is a relatively high number compared to the rest of London and England. In particular Hackney had a high proportion of people who identified as nonbinary or a gender identity other than male or female, as well as being home to a large number of bisexual, pansexual and queer residents.

Of those 2241 people, 670 are nonbinary or another gender identity other than male or female. It is likely that the 921 people who didn't write in a gender identity are the same gender as the one they wrote in response to the "sex" question. When we have multivariate data (more than one datapoint) we will have a clearer picture of how many trans men and trans women there are in Hackney.

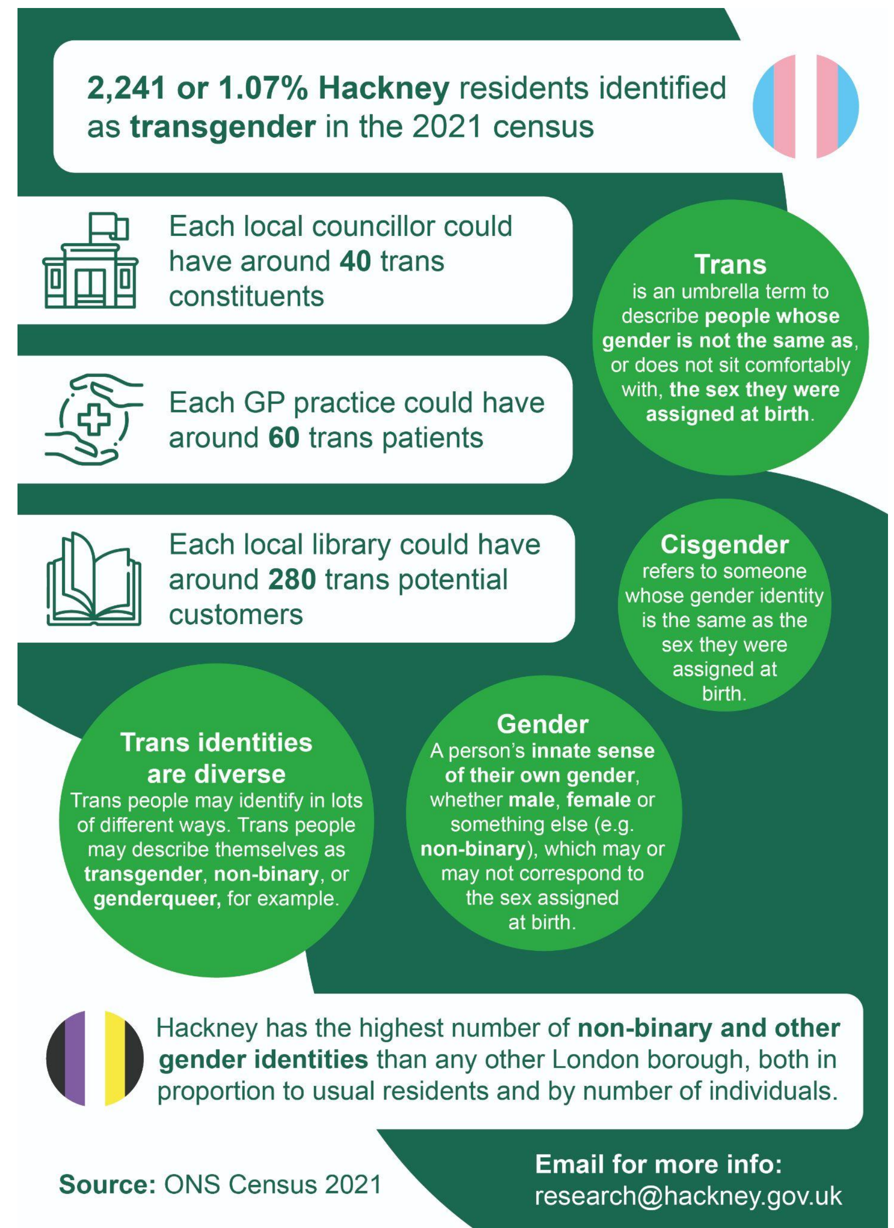
	Hackney	
	number	**%**
All those with a gender identity different from sex registered at birth	*2,241*	*100%*
Gender identity different from sex registered at birth but no specific identity given	921	41.1%
Trans woman	357	15.9%
Trans man	293	13.1%
Any other gender identity	670	29.9%

More information is available in Hackney's Sexual Orientation and Gender Identity Census Briefing

As part of the LGBTQIA+ Action Plan which is currently under development, it is hoped that services within Hackney will start to collect more information about gender diversity and sexual orientation so we can better understand the specific needs of the community.

Trans people in Hackney: Infographic

You can download this infographic here



What are the main needs and concerns identified by Gender Diverse people in Hackney?

Nationally, the picture is worrying. In the UK Homophobic & Transphobic hate crime has been increasing year on year at a rapid pace since 2016, with some news sources suggesting the rates have tripled for Homophobic and quadrupled for Transphobic hate crimes. While some of these figures may indicate greater confidence in reporting to the police & better recording of hate crimes

against those with the protected characteristic of gender reassignment or sexual orientation, this is unlikely to account for such a steep rise; Galop's 2021 report revealed that while 3 in 5 LGBTQIA+ people who experience a hate crime want or need help, only 1 in 5 is able to access it

Internationally, while some countries have taken steps forward in terms of providing better healthcare and more protections for trans people and the wider LGBTQIA+ community, some countries in both Europe and beyond have introduced laws which restrict the rights and freedoms of LGBTQIA+ people.

This broader picture of an increasingly hostile environment for Trans, nonbinary and gender diverse people as well as the LGBTQIA+ community as a whole is important context for considering local need, as witnessing and/or experiencing this level of hostility can have a significant impact on people's mental health and can reduce people's participation in community life, in focus groups and in using social spaces such as parks or gyms. The latter then has an impact on people's physical health and wellbeing. There may also be a lack of trust in public services or local government if gender diverse people have had poor experiences accessing services.

Locally, focus groups have been held with gender diverse people as part of both the consultation on the Single Equalities Scheme in 2017 and the Review of Trans Inclusion in 2019. The key themes and recommendations were very broad, covering all aspects of service provision including Education, Healthcare, Public Safety, sport and exercise as well as seeking more support politically as part of a wider equalities programme. Intersex voices are often particularly absent in diversity & inclusion work so attention will be paid to ensure this community is heard within this strategy.

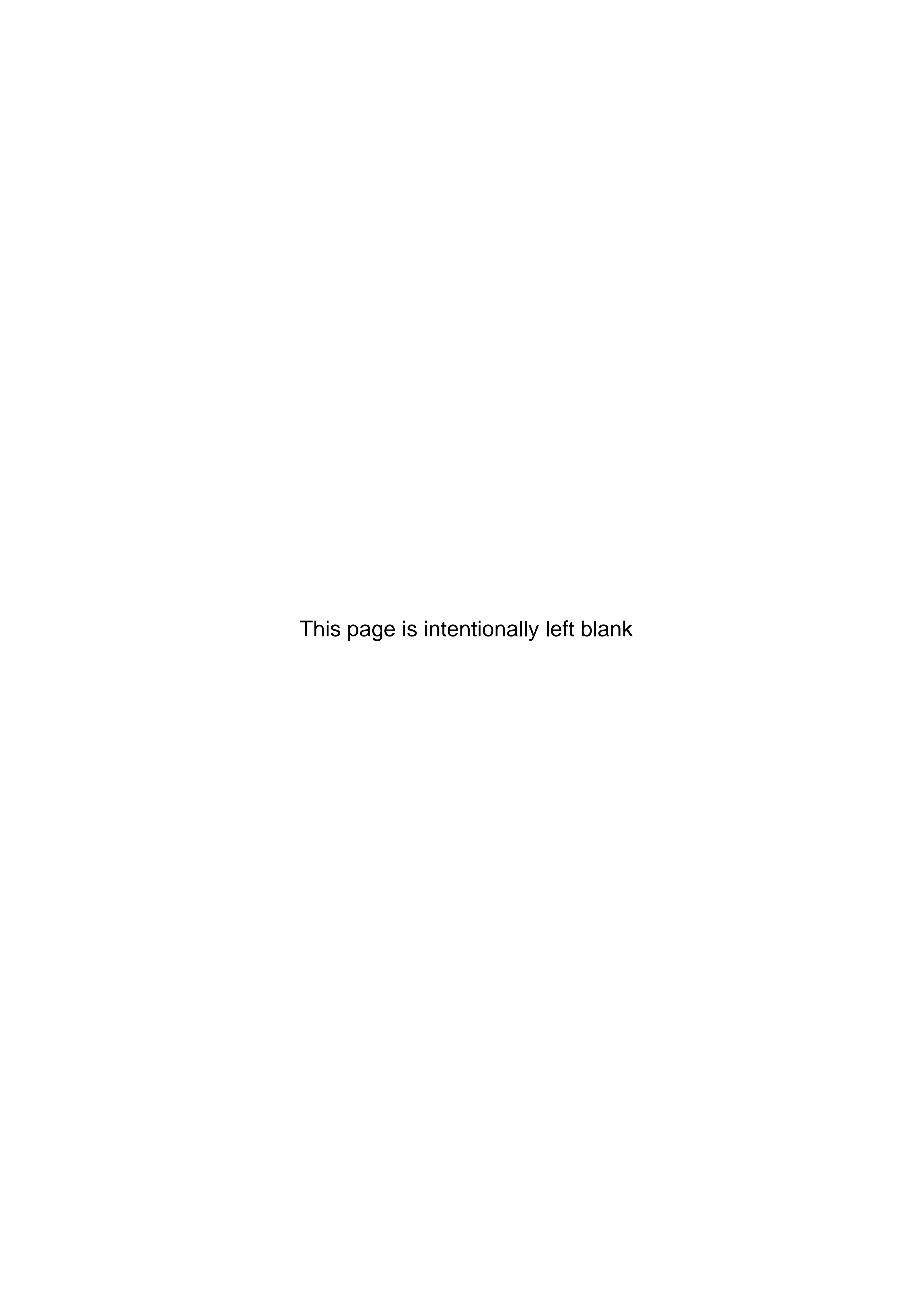
The new LGBTQIA+ strategy will pull all of these concerns together and collaborate with local residents and organisations to create an Action Plan and framework to address the issues.

Further Reading:
United Nations report on Gender inclusion, 2021
The struggle of trans and gender-diverse persons, United Nations
'Don't Punish Me For Who I Am': Huge Jump in Anti-LGBTQ Hate Crime Reports in UK - Vice, 2021
Transphobic hate crime reports have quadrupled over the past five years in the UK, BBC, 2020
Hate crime report 2021, Galop
Transphobic Hate Crime report 2020, Galop
Report on Trans Inclusion, 2020
Trans, nonbinary, Intersex & Gender Diverse Strategy slide presentation, 2021

Proud Hackney - the LGBTQIA+ Staff Network

Hackney's LGBTQIA+ staff network is open to anyone who identifies under the LGBTQIA+ umbrella, including gender diverse people. There is a Slack for LGBTQIA+ staff to meet, chat and share, and there is a Google community which is open to Allies.

Find out more about the staff network at their Google Site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Hackney

Health in Hackney Scrutiny Commission 17th July 2023 **Response to draft Quality Account for Homerton Healthcare for 22/23**	Item No **5**

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 NHS England/ NHS Improvement covering the previous financial year. The reports follows a nationally mandated template.

If there are outstanding issues we invite senior officers to discuss these at the Commission and they provide a response. We use the item for an annual check in on items at the Trust that we may not be covering elsewhere. Our response letter had to be done under Chair's Action because of the deadline Homerton Healthcare had to work to.

Please find attached

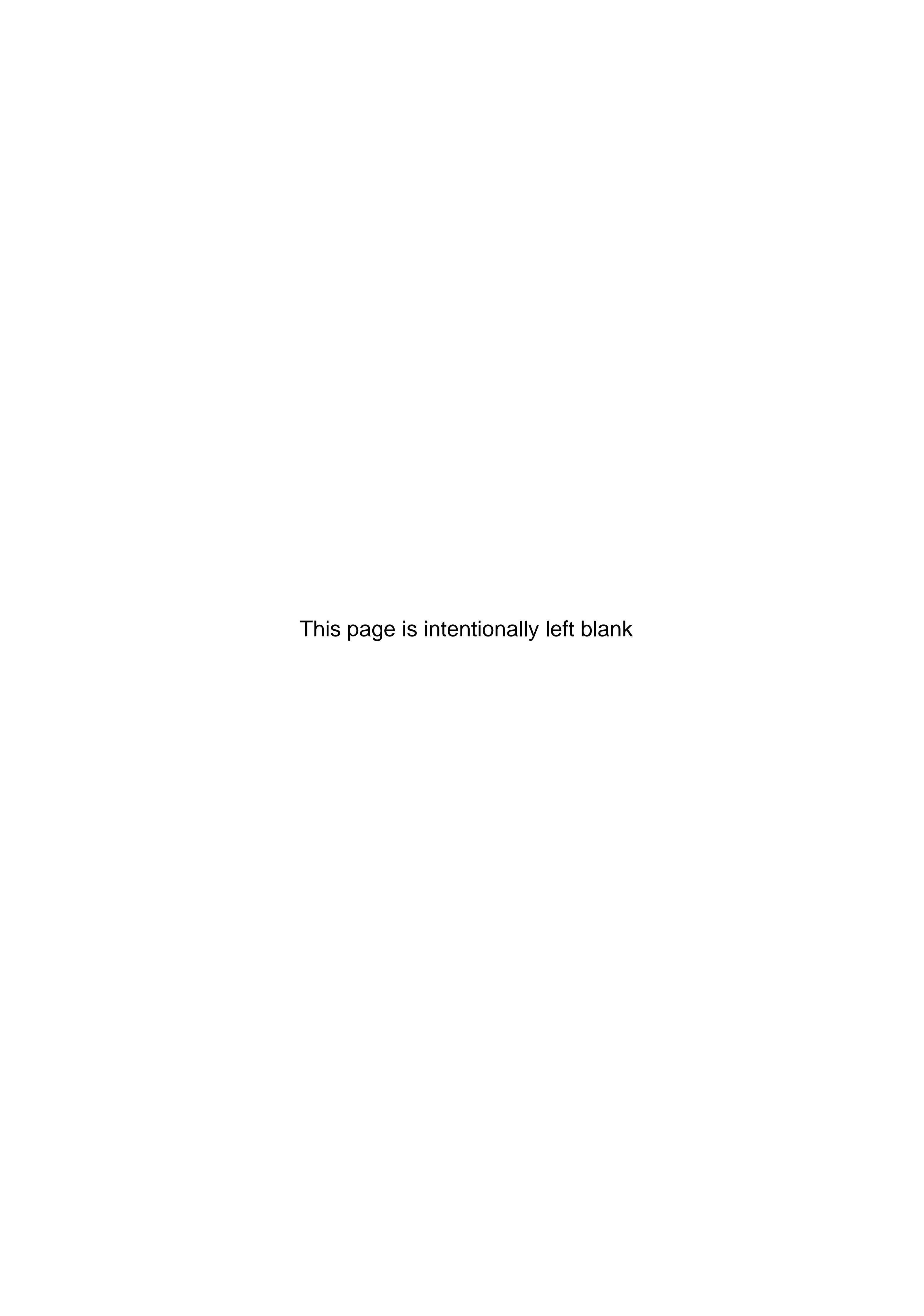
a) Quality Account for 22/23 of Homerton Healthcare NHS Foundation Trust
b) HiH's letter of response

Attending to answer questions on our response will be:

Louise Ashley, Chief Executive and/or
Breeda McManus, Chief Nurse and Director of Governance

ACTION

The Commission is requested to note the Quality Account letter.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Homerton Healthcare NHS Foundation Trust Quality Account Report 2022/23

INTRODUCTION

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

The reporting period covered within this quality account report is for the 2022/23 financial year (1st April 2022 to 31st March 2023).

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

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

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

The annual Quality Account gives us an opportunity, each year, to reflect on our achievements and to openly share our performance and outcomes for public scrutiny. I've been reflecting on what an extraordinary year it has been. For the thousands of patients that have come both into our community services and into our hospitals we have continued to keep focused and make progress on all our key safety and quality priorities.

Within this report you will find the priorities set by the Trust Board for 2022 to 2024 together with the results and achievements for 2022/23. There are priorities set in Patient Safety, Safe and Effective and Patient Experience. As we are in the middle of our two-year cycle, we have reported partial achievement. We have identified ongoing actions going into 2023/24 to help us achieve our ambitions.

Our patient safety priorities are:

- To reduce the number of community and hospital attributed pressure ulcers,
- Reducing physical violence and aggression towards patients and staff and
- Improved management and reduction in the rate of falls.

We have a priority that cuts across both safe and effective priority:

- Just Culture and Safe Environment.

Our clinical effective priorities are:

- Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community-based services
- Improving our populations health.

Our patient experience priority is to:

- Improve the first impression and experience of the Trust for all patients and visitors.

In Part 3 of this report, a more detailed overview is provided of the progress of each quality priority achieved during 2022/23.

Quality & Patient Care

The impact of the Covid pandemic upon the Trust, our staff and our patients continued to be felt during 2022/23 despite the advancements in vaccination and management of the virus. It is encouraging that Trust continues to perform well against key national and local quality measures as we address the backlog of people awaiting elective care (non-urgent treatment) which developed during the initial Covid lockdowns.

The Trust continues to perform well against the 4-hour A&E treat/discharge target, remaining to be one of the best performing trusts nationally We continue to meet standard for monitoring the delivery of seven-day services, meaning that our patients are reviewed and assessed by senior staff whenever that are admitted.

There has been considerable effort to improve the cancer waiting targets with the Trust exceeding both the 2 week and 31-day targets. Performance against the 62-day target remains challenging and significant work to redesign several cancer pathways is underway across the North East London network to improve the patient journey.

The Trust continues to progress action plans developed in response to CQC recommendations and have delivered improved governance within maternity services. These improvements are supported and evidenced by regular audits to ensure the continued safe care of mothers and their babies. Work is also underway to implement a new IT solution that will enhance the accessibility and security of clinical information used within our maternity services.

The Trust continues to demonstrate a healthy incident reporting culture with a high incident reporting rate, ensuring that incidents are appropriately reported, investigated and actions taken where necessary to improve patient safety. Improvements have been made to how lessons learned from investigations are shared across the organisation.

There has been a significant amount of work undertaken towards the implementation of the new Patient Safety Incident Response Framework (PSIRF), which is due to be launched in September 2023. PSIRF replaces the existing Serious Incident Framework and represents a fundamental shift in how incidents are responded to, with a welcomed increased focus on learning and improvement, as well as ensuring that patients and their families are at the heart of our response.

The Trust has appointed the Head of Patient Safety as the Patient Safety Specialist who has attended the Trust Board to talk through their priorities for patient safety. Two Patient Safety Partners have been appointed from the local population they will provide a patient voice at the highest level, as well as speaking with staff and patients on wards.

We continue to report a high number of patient satisfactions despite the increasing demand on our services and the recovery following the pandemic. The Trust acknowledges that on occasions it may not be as responsive as we could be and are currently engaged in several quality improvement projects focusing on patient experience and patient engagement.

People

The Trust recognises that the most important resource and greatest asset within the Trust is our staff. As we emerged from Covid to face new challenges, the trust has implemented a number of initiatives supporting our staff with the cost-of-living crisis and staying safe both physically and psychologically at work. The Trust has continued to develop staff networks supporting Black, Asian or other Ethnic Groups and improving the experience of other groups such as disabled, differently abled or LGBTQ+ staff.

Progress will continue as we deliver the new strategy 'Our People Together' developed during 2022 and was launched in May 2023 aiming to build on our strengths, fully develop the scope of working with our partners, and set out how Homerton Healthcare can best contribute to improving health and care over the next five years, in a changing society and a new NHS structure.

Our role in the wider health and care system

The Trust continues to review our position within the local care system as the new Integrated Care Boards mature. The Trust will develop further partnerships with local stakeholders and health care providers to deliver a model of integrated care and health. This work is supported by the Trust's quality priority program that includes improving our populations health, looking to support the health our local community before urgent intervention is required.

Alongside the excellent reputation for the quality of care we deliver, we are also proud to be known for our wider contribution to the health and wellbeing of the populations we serve. We work in a place, City and Hackney (C&H), that has strong identities and vibrant communities. We work in partnership with many public and voluntary organisations. Our Chief Executive, as well as being the leader of Homerton Healthcare, is place-based leader for C&H. This means that she has responsibility for bringing together people to build an integrated partnership of all health and social care providers, to improve the health and wellbeing of local people.

I remain extremely grateful to every member of our staff for their compassion and professionalism in delivering care across all our services and teams wherever these are delivered.

I hope that this Quality Account provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Homerton Healthcare NHS Foundation Trust. I'd like to end by saying a huge thank you to all our staff and local partners who have come together in such an exceptional way to serve our communities. I hope you find this account informative and see that our patients remain at the heart of everything our staff do.

Louise Ashley
Chief Executive

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

2.1 PRIORITIES FOR IMPROVEMENT

Following the completion of the consultation and approval process during 2022, 7 quality priorities were agreed by the Trust to be undertaken with an extended the improvement cycle of 2 years (2022 to 2024) to enable successful delivery of these workstreams and embed long term improvements. Table 1 below provides a summary of the current priorities with detail included throughout the report.

Table 1 below provides a summary of progress of each of the Trust's quality priorities, see section 3.1 of this report for a detailed overview of the progress made during 2022/23.

Domain	Priority No.	Priority Title	Achieved during 2022/23	Going forward 2023/24	Progress assessment
Safe	1	To reduce the number of community and hospital attributed pressure ulcers	✓ 'Time to Turn' initiative. ✓ Skin Ambassadors in place ✓ Community improvement projects	➢ Training for carers ➢ Training non-nurse workforce ➢ Embedding actions following investigations	▲▲
	2	Reducing physical violence and aggression towards patients and staff	✓ Body cameras for staff ✓ Upgraded CCTV cameras ✓ Community staff awareness & training	➢ Continue Maybe training ➢ Reduce physical assaults on staff ➢ Support for lone workers	▲▲
	3	Improved management and reduction in the rate of falls	✓ Flagging high risk patients; ' think yellow' ✓ Simulation training for post falls ✓ Hot debrief & after-action reviews	➢ Maintain 'think yellow' across Trust ➢ Launch E-learning package ➢ Share learning from QI projects	▲▲
Safe & Effective	4	Just Culture and Safe Environment	✓ Our Future Together Strategy ✓ Psychological 1st aid for staff ✓ Developing new patient safety incident reporting framework (PSIRF)	➢ Implementing PSIRF methodology ➢ Embedding reporting metrics ➢ Develop 'Just culture' framework	►►
Effective	5	Appropriate identification and management of deteriorating patients, including maternity, paediatrics and	✓ Established Deteriorating Patient Oversight Group ✓ Flagging patients at risk of deterioration	➢ Improve frequency and accuracy of NEWS scoring ➢ New CQUIN ➢ Support paediatric, maternity and	▲▲

		community-based services	✓ New system for recording the prescription oxygen	community work streams	
	6	Improving our populations health	✓ Our Future Together Strategy ✓ Developing smoking cessation service ✓ Neighbourhood projects for early language pathways, improving mental health and long-term health needs	➢ Develop health and wellbeing of children and families ➢ Embedded new mental health, learning disabilities and autism strategy ➢ Link to community screening programmes for diabetes and obesity	
Patient Experience	7	Improving the first impression and experience of the Trust for all patients and visitors	✓ Our Future Together Strategy ✓ Patient engagement ✓ Our Estates plan	➢ Develop reporting metrics ➢ Collate other work streams	

Table 1; Homerton Healthcare NHS foundation Trust Hospital Quality priorities for 2022 to 2024

Key to progress:

Positive progress – expected to deliver	
Further development identified –	

Further information on the progress of the quality priority programme can be found in part 3 of this report.

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD

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

2.2.1 REVIEW OF SERVICES

During 2022/23 Homerton Healthcare NHS Foundation Trust provided and/or sub-contracted 68 relevant health services.

The trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2022/23.

2.2.2 NATIONAL AND LOCAL CLINICAL AUDIT

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

The Trust participates in relevant national audits and confidential enquiries programmes as listed through HQIP. HHFT confirmed participation in 64 national clinical audits of the 70 applicable to the Trust and 4 of the eligible national confidential enquiries covered relevant health services that Homerton provide.

National clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2022/2023 are listed in Appendix 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Implementation of actions implemented following the publication of the national audit 2022/2023

The Trust views clinical audit as an important tool to measure the effectiveness of our services . and to improve the outcomes of our patients. Examples of actions that the Trust intends to take or has taken following the review of relevant national audit reports published during the financial year 2022/2023 are detailed in appendix 2.

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

Learning from local audits 2022/2023

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe, evidence based and meets agreed standards. All staff are encouraged to complete clinical audits or other similar projects to monitor and improve services. There were 117 local audits registered during 2022/2023. The reports of 81 local clinical audits were reviewed during 2022/2023.

A selection of these audits is outlined in appendix 3 along with actions to improve the quality of health care provided.

2.2.3 PARTICIPATION IN CLINICAL RESEARCH

Clinical research remains high on the Government agenda with continued funding to Clinical Research Networks (CRN) ring-fenced for the promotion of research within the NHS. Research is written into the NHS Constitution, and this has recently been reinforced through the CQC inspection process. In September 2018 the Care Quality Commission (CQC) signed off the incorporation of clinical research into its Well Led Framework (NHS Trusts)[1]. The CQC formally recognises clinical research activity in the NHS as a key component of best patient care. Thus, clinical research is no longer perceived as just a 'nice to do' exercise in the NHS - it is now a key part of improving patient care. Furthermore, the government reflects this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England until September 2019, stated that 'Research is central to the NHS…. We need evidence from research to deliver better care. Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence. We can only correct that with research.' [2] This remains particularly pertinent in light of today's pandemic and the health crisis the population is encountering.

Homerton is committed to this path growing research capacity year on year. Innovation is a key focus in the coming years.

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 1026.

We aim to open studies that are particularly relevant to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that studies are in line with local clinical practice. During the lifecycle of each study the Research & Innovation (R&I) team ensure that all governance and regulatory processes are approved and adhered to; recruit patients who are eligible for the trial; collect and maintain necessary data and accurately record the data; and finally confirm secure archiving of all necessary trial related documentation at the end of the study. Additional approvals were sought during this pandemic from the Clinical Reference Group RG to ensure a balance between gathering vital information and ensuring our patients continued to receive optimal clinical care.

Participation in research remains important to patients with over 94% of a national consumer poll indicating that it is important for the NHS to carry out clinical research, with a similar number saying it was important so that new treatments could be offered by healthcare professionals. This figure was reflected in a small survey carried out locally by the research team.

The R&I team continue to be engaged in several high-profile studies that reflect our population. These include: *An Open Label Extension Study of GBT440 Administered Orally to Patients with Sickle Cell Disease Who Have Participated in GBT440 Clinical Trials,* sickle cell affecting disproportionately affects those of African and Caribbean heritage. We also contributed to *A Phase IIIb randomized open label study of nirsevimab (versus no intervention) in preventing hospitalizations due to respiratory syncytial virus in infants (HARMONIE)* a paediatric vaccine study.

The R&I team have been successful in supporting VERBO a Speech and Language Therapy (SaLT) innovation project which is now marketing to educational customers.

Financial challenges of 2021/22 have been overcome with an increase in commercial income and additional grant funding. It is expected this upturn will continue into the next financial years.

In 2022/23 R&I have encountered two major challenges this year. The first involved the research -80 freezers and centrifuges, which have not been housed in a suitable location since the downsizing of the in-house laboratory facility, it is anticipated this will be resolved in the coming months. The second challenge related to space for staff, but as 2022/3 concluded this saw a satisfactory resolution.

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1. Well Led Research in NHS Trusts: A Briefing for Clinical Research Network Staff about outputs from the work to establish research markers in CQC inspection
2. Excerpt from video Enhancing patient care through research

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2.2.4 GOALS AGREED WITH COMMISSIONERS

A proportion of Homerton Healthcare NHS Foundation Trust's income in the 2022/23 financial year was conditional on achieving quality improvement and innovation goals agreed between Homerton Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for the 2022/23 and 2023/24 financial year and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-23-24/

2.2.5 WHAT OTHERS SAY ABOUT THE HOMERTON

Care Quality Commission (CQC)

Homerton Healthcare NHS Foundation Trust is required to register with the Care Quality Commission. Its current registration status is 'registered with the CQC' with one condition attached to the registration. Homerton Healthcare NHS Foundation Trust has the following conditions on registration.

"The registered provider must only accommodate a maximum of 43 service users at Mary Seacole Nursing Home."

This is a reduction of 7 beds in comparison to the conditions on registration for the Mary Seacole Nursing Home in previous years. The reduction in bed numbers is administrative, and there is no actual bed loss to either the nursing home or the Homerton Transitional Neurological Rehabilitation Unit (HTNRU), where the 7 beds are located. The HTNRU is a wing within the Mary Seacole Nursing Home Building, however it operates independently of the home. For this reason, it is no longer considered within the Nursing Home registration.

There are no conditions of registration attached to the Homerton Hospital site or community services.

The Care Quality Commission has not taken any enforcement actions against Homerton Healthcare NHS Foundation Trust during the reporting period 2022/23.

We did not participate in any special reviews or investigation carried out by the CQC during 2022/23.

The Homerton Hospital site was last inspected by the CQC in January 2020, covering three core services: older people's services in medical care, maternity services and end of life care. The CQC considered the current ratings of the other services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the acute hospital site achieving an overall rating of 'Outstanding'.

The overall rating for the Trust remained 'Good', with the rating for both the Homerton Hospital and Mary Seacole sites unchanged in 2022/23. The following pages outline the current CQC hospital rating against the five domains of safe, effective, caring, responsive and well-led.

REPORT CONITUES ON NEXT PAGE

Homerton Healthcare NHS Foundation Trust:

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good
Combined quality and resource rating	Good

Homerton Hospital:

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

Mary Seacole Nursing Home:

Overall rating for this service	Good
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?	Good

Homerton Community Services

Community health services for adults	26 May 2017	Good	
Community health services for children, young people and families	26 May 2017	Good	

Action plans have been developed to address the CQC's recommendations, which are monitored and supported by Divisional and Trust-wide committees. Positive progress is being made against the plan, and a new IT solution to remedy the Maternity information software interface concerns is expected to go live in summer 2023. This will improve both safety and quality of care of Maternity services by ensuring that information is accessibly and securely held. Improvements made in response to the remaining actions are supported through the governance arrangements detailed elsewhere in this report, monthly audits using the 'Tendable' app and access to enhanced support from the Trust's dedicated quality improvement team.

2.2.6 NHS NUMBER AND GMC PRACTICE CODE VALIDITY

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

The Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data for **April 22 – Feb 23**:

- which included the patient's valid NHS number:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.30%	98.80%	99.60%		
Outpatients	99.70%	99.70%	99.70%		

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

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.80%	99.30%	99.80%		
Outpatients	99.60%	99.70%	99.50%		

- Emergency Care Data Set valid NHS number published in the Data Quality Maturity

Index for Reporting period November 22

SUS Dataset	Trust	National	Performance against National
NHS number	98.00%	81.90%	
General Medical Practice Code	93.80%	88.40%	

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

The Acute and Community Services Data Quality Committee's take place bimonthly. Locally agreed core DQ Acute and Community indicators continue to be monitored and discussed during committee meetings. This includes the Trust's NHS number and GP completeness as well as other data sets which are submitted to SUS.

Figures from the Data Quality Maturity Index (a monthly publication intended to raise the profile and significance of data quality in the NHS) are presented to the committees and the Trust's data quality performance is discussed. The DQMI mainly focuses on the completeness and validity of the data the Trust submits.

The Data Quality department complete quarterly audits to check the consistency of the key SUS data items for admitted patients and outpatients between SUS submitted data, Data warehouse tables and the front end of EPR (Cerner Patient Administration System).

The Data Quality Department distribute numerous DQ reports to services to improve the data completeness on clinical systems. There are on-going DQ checks, updates and staff training as and when new errors come to light.

Services contact the Data Quality team if they come across duplicate or confused records on the Trust clinical systems. This is investigated by the team who will then liaise with Healthcare records to merge. Where the query pertains to a duplicate or confused NHS number the query is reported to the National Back Office for investigation. Once there is a response and resolution the clinical system is updated. Duplicates and confusions are also picked up in the review queue of the MPI operator for HIE.

In addition, the DQ team work on several DQ clean up reports to improve the Trust's NHS number and GP completeness. This includes;

- the ***mini spine dashboard***, which flags records that have failed batch tracing due to NHS number, GP or address discrepancies. The team search for the correct demographics using the Summary Care Record and update the data on EPR.
- ***Keystone*** - which highlights correspondence that has No registered GP or unknown GP. The team search for the GP and send out the letter where the GP is found via hybrid mail.
- ***Current inpatients without NHS number or GP***
  Future outpatient appointments with no NHS number or GP
  Last week's AE Attendance with no NHS number and GP
  the team search for the NHS number and GP using the Summary Care Record and update EPR.
- ***GP association*** – the team clean EPR records where a GP has not been associated with a

practice
- ***GP clean up*** – the team update records where a GP has left the practice, or a GP practice has closed (data obtained from Organisation Data Service)
- ***RIO records without NHS numbers*** – the team investigate where there is a record with no NHS number. This is mainly the result of records being recorded locally and not linked to the spine. Where a national record is found the team will merge the local record.

2.2.7 INFORMATION GOVERNANCE ASSESSMENT REPORT

The Data Security and Protection Toolkit (DSPT) publish date has been deferred to June 30th 2023 by NHSE, due to Covid legacy impact. The status of the HHFT DSPT publication is designated as 'Approaching Standards' as assigned 1st July 2022 by NHSE.

2.2.8 CLINICAL CODING

Homerton Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the National Audit Office.
Homerton Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:

- On-going internal audit of clinical coding standards led by the Trust's Clinical Coding Auditor to identify areas where coding is not in line with national guidance
- Independent external audit of clinical coding standards to assess the overall quality of the Trust's clinical coding and to ensure any actions/recommendations are implemented appropriately (see attached the most recent report)

2.2.9 ACTIONS TO IMPROVE DATA QUALITY

The six dimensions of Data Quality (DQ); Completeness, consistency, accuracy, timeliness, uniqueness and validity are monitored on regular basis in order to provide intelligence for clinical and strategic decision making. The Trust strives to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

The Trust continues to have a monthly Data Quality Committee which reports to the Informatics Committee chaired by the Chief Executive. The committee alternates between Acute and Community services where both local and national indicators are reviewed and the steps the Trust needs to make to improve are discussed. Through the use of data quality indicators for both acute and community services, the committee is a vehicle for data quality improvement and awareness within the Trust. The committee promotes and maintains robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality. New data quality indicators will be monitored as and when identified and deemed necessary by the committees. This will continue to be the platform through which strategies, policies and standards are monitored to ensure they align with operational requirements.

A monthly Data Quality Bulletin is presented to the Informatics Committee by the Head of Information Services that highlights the Trusts position for both internal and national DQ indicators.

Regular daily, weekly and monthly processes are in place to monitor key areas such as;

- the accurate recording of patient demographics
- checking out and outcoming of appointments
- the timely production of discharge summaries and validation of notes
- accurate recording of length of stay (including A&E)
- the correct recording and coding of clinical events
- Caseload accuracy by monitoring the number of open referrals
- SUS data quality improvement
- DQMI data set improvement
- Death status on the Trusts clinical systems
- Mortality Data Flow Review

The Data Quality Team continue to work on updating the ethnicity of patients on the Trust's clinical systems using GP discovery data. The Trust has seen an improvement in outpatient ethnicity completeness from 94.2% in April 2022 to 95.8 % in Feb 2023. (Data from Commissioning Data Sets (CDS) Data Quality (DQ) dashboard 13/04/2023).

Similarly, there has been an improvement in the ethnicity and language completeness on the Community Services Data Set as seen below (Data from Data Quality Maturity Index (DQMI) as of 13/04/23).

Data Item	Nov-21	Nov-22
Ethnic Category	82%	90%
Language code	27%	51%

The DQ department has an internal SUS DQ dashboard that aims to capture admissions and attendances with data quality issues before the data is submitted to SUS. There has been a particular focus on the clean-up of main speciality, and there has been an improvement in completeness since this work was started in October 2022. The Trusts outpatient main speciality completeness has risen from 98.5 % in Sep 2022 to 99.3 % in Feb 2023 (Figures from CDS DQ dashboard 13/04/2023).

The team continue to monitor and manage the data quality on the master patient index of the Health Information Exchange. This is a critical piece of work ensuring that the Trust holds one record for every patient which can be viewed by other Trusts and organisations to ensure safe and effective clinical care.

There has been in improvement in the Trust's compliance with the Mortality Data Review Data Provision Notice. This mandates that all Acute trusts should update date of death on Spine services within 24 hours of the deaths which occurred in hospital (either in ward, theatre, A&E or outpatients) In September 2022 the Trust achieved 100% compliance after being at 30% in June. The Date Quality team continue to ensure the deaths are updated on the spine on a daily basis.

Quarterly audits are carried out in line with Data Security and Protection Toolkit guidance to ensure the validity and completeness of data submitted to Secondary Uses Service.

- Homerton Healthcare NHS Foundation Trust will be taking the following additional actions to improve data quality:

- The Data Quality Team will continue to maintain the Data Quality on the Health Information Exchange to ensure the information viewed by other Trusts is accurate and

complete.

- Continue to improve completeness in the Data Quality Maturity Index and Secondary Uses Service Dashboards by incorporating low performing completeness datasets into our Data Quality dashboards. By reviewing these data sets in the Date Quality committees we are developing a dialogue to push improvement forward.

- The Data Quality Team will be reviewing registration and check-in processes with services to ensure demographics are accurate. There will be a particular focus on ensuring GPs are associated with practices and that demographics are being checked at first point of contact at the hospital.

- Set up of a Data Quality intranet page.

2.2.10 LEARNING FROM DEATHS

During 2022/23 502 of the Homerton Healthcare NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Reporting quarter 2019/20	Number of deaths	Number of completed reviews
Quarter 1	107	106
Quarter 2	128	128
Quarter 3	133	133
Quarter 4	134	97

Table 2: mortality reviews completed per quarter – work for Quarter 4 is ongoing

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

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

Following the reviews 4 patients (<1%) of the patient deaths during the reporting period) were judged to be more likely than not to have been due to problems in the care provided to the patient (CESDI 2).

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

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

To provide assurance of the review process, a minimum of 50% of reviews scored as CESDI 0s

are reviewed either in a wider multidisciplinary format or independently by a second reviewer. However, many teams choose to review all of their cases by in a multidisciplinary forum. Additionally, the majority of cases in 2022/23 were also scrutinized at the point of death certification in the bereavement office by one of six Medical Examiners.

All reviews scored as CESDI 2s and above are investigated via the Trust's Serious Incident review process (note there were no cases scored a CESDI 3).

Summary of learning from case record reviews over the period 2022/23:
Areas of good practice:

These are often noted on multiple occasions in the mortality review tool and include:

- Bipartite / tripartite decision making with other specialties.
- Consultant led updates for the family which were appreciated.
- Good recognition of severity of illness and family enabled to spend time with patient.
- Patient involved in decision making at end of life.
- NIV benefits were continued to be assessed and ceilings adjusted when the trajectory changed.
- Consideration given to capacity assessment where this was in doubt.
- Several reviews out of hours took place to ensure comfort.
- Consideration given to the preferred place of death.
- Simultaneous planning for several discharge options for a patient with unclear disease trajectory.
- Referral for an Independent Mental Capacity advocate made where there was no known NOK.
- Daily Registrar review over a weekend.
- Whole MDT involved in liaison with family which picked up concerns about discharge plans which were then reviewed and amended.
- Terminal agitation well managed with palliative care team input.
- Arranged for religious leader to meet with family.
- New terminal diagnosis communicated sensitively.
- Staff dealt with NOK distress in a sensitive manner.
- Family questions addressed post death by the Consultant during a long conversation.
- Effective hand over between wards on patient move.
- Family abroad kept updated.

Areas for improvement and actions taken:

- These are often a single incident. Action taken listed in brackets.
- Known to Community palliative care but when more unwell transferred to hospital despite wish to remain at home (Action: Discussed in Multidisciplinary mortality meeting with Palliative care team, discussion around when it is realistic for patients to stay at home at end of life and difficulties when no family able to facilitate this).
- No side room capacity for a patient at end of life (Action: discussion regarding the different priorities for a side room and the lack of side rooms for good end of life care at times).
- Pressure on ward nurse to move a patient whilst they were actively dying – in this case the patient did not move (Action: discussion in MDT meeting to support team to do what is right for the patient in the face of ward move pressures).
- A patient with advanced malignancy had no previous realistic discussion about prognosis and dying (Action: feedback to Oncology team as appropriate prompted by MDT).
- Family requested Coroner referral about the timing of observations (Action: Medical Examiner had a long discussion with family and made onwards Coroner referral

although no concerns raised from Medical Examiner scrutiny).

- Prescription of PRN anticipatory medications and difficulty in prescribing (Action: MDT discussion involving Palliative care team, highlighted in mortality newsletter).
- ITU step down out of hours (Action: this cannot always be avoided but importance of planning and hand over reiterated in joint meeting between ward and ITU).
- Challenging situation with family not accepting treatment escalation plan (Action: Discussed in Multidisciplinary mortality meeting with Palliative care team, discussion around what strategies can be helpful if family struggle to accept death).
- Urgent care plan not up to date pre admission despite advanced nature of underlying illness (Action: feedback where feasible with main outpatient specialty managing the long term condition).
- Anticipatory medication not prescribed (Action: discussed anticipatory prescribing in the specialty mortality meeting).
- Distressed family member assaulted a staff member (Action: Datix completed, appropriate involvement of senior staff to support the staff member).
- Learning disabilities practitioner not involved from admission (Action: Learning disabilities practitioner role now more embedded, has attended all wards and established links with specialties, recent Medical Unit Meeting, active case finding by LD practitioner).
- Difficult advance care planning discussion with a patient who did not wish to engage (Action: palliative care team has discussed in specialty mortality meeting what support can be provided by inpatient and community based teams).
- Sensory impairment not appreciated by all staff (Action: discussed simple ways of highlighting additional patient needs including during hand over time in the Specialty review meeting).
- Transferred from other hospital close to death (Action: feedback given to the neighboring Trust).

Summary of the key achievements during 2022/23:

<u>1. Review of deaths in patients within 30 days of admission who had stayed in A&E for 6 or more hours</u>

In response to a publication in the Emergency Medicine Journal in 2022 "Association between delays to patient admission from the emergency department and all-cause30-day mortality" the Trust undertook several pieces of work to review consecutive deaths for the period from July to September 2022. These did find that the majority of delays in admission from A&E were due to clinical rather than operational reasons and did not identify any clear cases of avoidable deaths. Reasons for and mechanisms of admission as well as presentation to A&E overall is a complex situation that can be influenced by many factors including outside factors and no firm conclusions can be drawn other that there is no clear evidence of delays of admission leading to avoidable deaths for the period reviewed.

<u>2. Review of deaths with health inequalities – special arrangements</u>

In addition to the now established processes of reviewing Learning disabilities deaths in liaison with the Lead Practitioner for Learning Disability and Autism and linking with the national "learning from lives and deaths : People with a Learning disability and autistic people (LeDeR) programme, and death with a mental health flag in liaison with the East London NHS Foundation Trust as appropriate, the quarterly report to the Quality Committee now also contains information on ethnicity.

<u>3. Strengthening of mortality reviews with Community facing teams</u>

The Integrated Independence team (IIT) has been involved in mortality reviews both within their team led by a Consultant Physician and joining the hospital specialty teams by discussing patients whose care has been spanning both the inpatient and community setting. This process is now further embedded and in addition the Medical Examiner team (which is a separate process) is now starting to review some community death after the Medical Examiner team was joined by three GPs.

4. Ongoing roll out of Structured Judgement Reviews (SJRs) and linking in with the LeDeR process

The Royal College of Physicians' structured judgement review (SJR) methodology is part of a whole range of measures intended for review of deaths for specific adult inpatients. It is a validated research methodology which blends traditional clinical judgement based review methods with a standard format. The benefit is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care. The aim is to look at strengths and weaknesses of the caring process, to obtain information about what can be learnt about systems where care goes well and identify gaps or problems in the care process.
The AHSN (Academic Health Science Network) "Implementing Structured Judgement Reviews for Improvement" based on The National Quality Board Guidance 2017 suggests that each Trust should have mechanisms to review deaths of people;
With a Learning Disability
With a Serious Mental Health Illness
Those aged under 18 years

A Standard Operating Procedure has been developed which recommends for completed structured judgement reviews to be reviewed in the 2 monthly Mortality Leads meeting and at this point fed back to the parent team and it is suggested that this is then included in the local mortality review process and that the electronic mortality tool is updated as appropriate. If an overall care score of poor or very poor care is reached then this is referred to the Trust Incident reviewing process. These cases are also fed into the departmental governance structure. In 2022/23 this process has been used to mainly review cases that are triggered by 1). but also if triggered by the Medical Examiner system and where there is uncertainty a second independent SJR reviewer is involved in this process. Outcomes were shared as appropriate with the Adult Safeguarding team and LeDeR reviewers. The national Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) programme is commissioned by the Health Quality Improved Partnership (HQIP) on behalf of NHS England. The overall aim of the programme is to support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce health inequalities.

5.Publication of a mortality newsletter and dissemination of good practice and learnings

In 2022/23 work continued on the "Let's Talk about Death" mortality newsletter which is published on a 3 monthly basis on the Intranet and typically features learning cases and take home messages for a wide audience of Trust employees with the aim to provide ongoing examples for learning that span different specialties and enable better working for the benefit of patients with life limiting illness or those approaching the end of life. This is a joint enterprise by the Trust Mortality Lead and the End of Life Facilitator / Palliative care team and encourages others including trainees to get involved. In addition, work has been done highlighting some of the developments and achievements over the past years on the expanding mortality review process within the Trust.

2.2.11 SEVEN DAY SERVICES

Ten clinical standards for seven-day services in hospitals were developed in 2013. These standards define what seven-day services should achieve, no matter when or where patients are admitted. The focus was to ensure parity of care across the weekday and weekend.

Four of the 10 clinical standards were identified as priorities based on their potential to positively affect patient outcomes. These are:

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

The Trust continues to meet all these standards. This was last evaluated in July 2019 when the Trust repeated the case note review exercise reviewing 100 patients admitted to the hospital. The decision of whether a patient requires twice daily review or once daily was based on the clinical needs of the patient (using the standards set out in the national 7-day services guidance). Standard 2 (time to consultant review within 14 hours) was met in **87%** of patients. Considerable improvement was noted in those who received a review within that timeframe at the weekend (**96%**).

Clinical Standard 8 was met for patients admitted both during the week and weekend.

There has been no expectation from NHS England that further case reviews have been required since this time.

The on-call framework has not changed and consultant presence within the hospital continues to be prioritised both during the weekday and weekend. We continue to provide twice daily consultant reviews, when needed, as set out in standard 8. There is considerable flexibility built into the system so consultant cover can be increased to ensure these standards are met. An example of this was shown during winter 2021; consultant presence was increased with doubled up consultant rotas during covid surges. This was not required since this time but could be considered in the future If needed.

Future Plans – Seven Day Services

We will be guided by the national directives to determine what audits and notes reviews we undertake. We will continue to review incident reports and root cause analyses where there is any suggestion that there was a delay in consultant review. Winter planning will continue to be a priority to ensure these standards can still be met during periods of increased demand.

2.2.12 SPEAK UP SAFELY

Speaking up and ensuring a culture of staff speaking up is at the heart of the Trust's refreshed People Plan; 'Our Homerton People'.

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

The Trust has one Freedom to Speak up Guardian in the Trust who has dedicated time to promote speaking up and support staff who speak up. Some of the ways this is being done are attending open days, Team meetings, providing workshops as part of the Band 6 development program and the International Nurses Recruitment program.

In quarter 3 of 2022 the Trust also recruited 5 Freedom to Speak Up Champions who are from the staff networks and based across the Trust. Their role is to emulate and promote Speaking Up as well as sign posting staff on how to raise concerns. In line with national regulations, the Trust has an executive lead (Director of People) and a named Non-Executive Director with responsibility for speaking up (Dr Michael Gill).

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising concerns. Additionally, the Trust is in the process of adopting the National Guardians updated Raising Concerns at Work Policy which will be in place by 2024.

In March 2023 the Trust created another route for staff to raise concerns this was by utilizing the incident reporting tool Datix. When reporting an incident staff can confidentially request further support from the Freedom to Speak Up Guardian. Datix was redesigned to allow staff to alert our FTSU Guardian, when they are concerned about an incident being reported. Only the Guardian will know this has done, and the Guardian can contact the member of staff to discuss the concern in complete confidence.

2.2.13 ROTA GAPS

Homerton has had a Guardian of Safe Working in place since the implementation of the new junior doctors' contract in 2016. Their role is to monitor the exception reports that come in and ensure any issues are addressed in a timely manner. Any vacancies in rotas are filled on a temporary basis by bank or agency doctors, whilst the post is advertised, and a substantive/fixed term doctor is appointed. The average fill rate for 2022/23 was 86% a decrease of 9% on the previous year.

Throughout the year there has been an upward variance in fill rate, with the quarters 1&2 having an average of 83% and quarters 3&4 average being 87%. There has been a continued attempt to use varied recruitment methods in some of the hard to fill specialties.

We still have some very hard to fill areas, with Radiology being a particularly difficult area with a national shortage of appropriately trained staff. The Trust Board of Directors receives reports from the Guardian of Safe Working on a quarterly and annual basis which includes details on fill rate and actions taken across the trust to support junior doctors.

2.3 REPORTING AGAINST CORE INDICATORS

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

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

1. Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care; NHSI Quality indicator ref 12

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

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

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

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

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The data in table 9 below describes the SHMI has been sourced from NHS Digital. The data period is from Dec'21 to Nov'22. Our Trust SHMI score is 0.86 which equates to NHS Digital Band 3 (lower than expected deaths when compared to the national baseline). No data is yet available for the period from December 2022 to present. This compares to the SHMI for November 2020 – October 2021 which was 0.87 with Banding 3 so very little change from the previous year.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Dec 2021 – Nov 2022	Value:0.86 Banding: 3	Value: 0.999	Value:1.2219 Banding: 1	Value: 0.7173 Banding: 3
	Jan 2021 – Dec 2021	Value:0.86 Banding: 3	Value: 0.999	Value:1.1897 Banding: 1	Value: 0.7127 Banding: 3
	Jan 2020 – Dec 2020	Value:0.85 Banding: 3	Value: 1.0016	Value:1.1845 Banding: 1	Value: 0.7030 Banding: 3
	Jan 2019 – Dec 2019	Value:0.77 Banding: 3	Value: 1.004	Value:1.1999 Banding: 1	Value: 0.6889 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
	Oct 2017 – Sep 2018	Value: 0.69	Value: 1.00	Value: 1.27	Value: 0.69

		Banding: 3		Banding: 1	Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Dec 2021 - Nov 2022	39%	40%	13%	66%
	Nov 2020 – Oct 2021	45%	39%	11%	64%
	Jan 2020– Dec 2020	47%	37%	8%	61%
	Mar 2019 – Feb 2020	51%	37%	10%	59%
	Jan 2019 – Dec 2019	48%	36%	10%	60%
	Jan 2018 – Dec 2018	46%	34%	15%	60%
	Oct 2017 – Sep 2018	43.60%	33.80%	14.30%	59.50%

Table 3: SHMI scores since 2017 to 2022 (NHS Digital)

Assurance Statements

The data for SHMI has been sourced from HED, Trust benchmarking tool. The latest data period is November 2020 – October 2021. Our Trust SHMI score is 0.87 and banding is an NHS Digital Band 3 (lower than expected deaths when compared to national baseline) which is a trend which has continued from previous years.

How is the Trust doing?

- Our SHMI score remains below 100 and has been for the previous years. Care is however needed when interpreting the SHMI score in isolation. It is best viewed alongside other metrics.

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

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

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)

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

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

It should be noted that The completion of the development and assurance work by NHS Digital

required operational processes to be updated, this meant the linkage methodology took longer than expected which has caused a subsequent delay in the timeliness of the PROMS publication series. This delay meant that complete PROMs data was not available to the Trust at the time of completing the Quality Account report.

Indicator	Reporting Period	Homerton Performance	National Average	Lower 95% Confidence	Upper 95% Confidence
Total Hip Replacement Surgery	Apr 2021-Mar 2022	**No data available at the time of compiling quality account report**			
	Apr 2020-Mar 2021	**No data***	Insufficient cases to be included		
	Apr 2019-Mar 2020	0.482	0.453	0.382	0.523
	Apr 2018-Mar 2019	**0.546**	0.457	0.386	0.528
	Apr 2017 – Mar 2018	**0.478**	0.458	0.394	0.522
	Apr 2016 – Mar 2017	**0.467**	0.437	0.370	0.504
Total Knee Replacement Surgery	Apr 2021-Mar 2022	**No data available at the time of compiling quality account report**			
	Apr 2020-Mar 2021	**No data***	Insufficient cases to be included		
	Apr 2019-Mar 2020	**0.256**	0.334	0.268	0.400
	Apr 2018-Mar 2019	**0.339**	0.337	0.271	0.402
	Apr 2017 – Mar 2018	**0.332**	0.337	0.270	0.403
	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.387

Table 4: PROMS data for hip, knee and hernia surgery.

Note: NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

Assurance statements

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

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre (Q1) and postoperative (Q2) questionnaires. Patients are asked to complete the Q1 form and post back to Homerton for submission rather than NHS Digital.

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

- Q1 data collection recently restarted in ‘joint school’ face to face since July 2022

- Trust to consider local collection / analysis of PROMS on Amplitude data analytics platform rather than using paper forms.
- Reviewing PROMs data when available and discussing these within relevant departments.
- Reviewing PROMS data on a regular basis through the Improving Clinical Effectiveness Committee.

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

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

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

Indicator	Reporting Period	Homerton Performance
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	2022/23	5.44% (London Average 7.54%)
	2021/22	5.51% (London Average 7.56%)
	2020/21	4.94% (London Average 6.86%)
	2019/20	4.97%
	2018/19	4.36%
	2017/18	4.66%
	2016/17	3.63%
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	2022/23	8.40% (London Average 7.02%)
	2021/22	8.05% (London Average 7.56%)
	2020/21	9.23% (London Average 8.00%)
	2019/20	9.12%
	2018/19	12.60%
	2017/18	11.95%
	2016/17	12.70%

Table 5: 28-day readmission rates for patients aged 0 – 15 and aged 16 and over. Source is HED benchmarking tool.

Assurance statements

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

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

The Trust has a robust clinical coding and data quality assurance process, and 30-day readmission data is monitored through the Trust Management Board on a monthly basis. The

Trust board readmission rates have agreed local exclusions applied over and above the PbR logic.

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

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

- It has been agreed by the Trust's Improving Clinical Effectiveness Committee that utilisation of the readmission report will be overseen the Divisional Leadership teams will support the specialties in the real time review of outliers and identify urgent interventions to reduce readmission.

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

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

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The Trusts responsiveness to the personal needs of its patients during the reporting period.	2021/22	Not available	Not available	Not available	Not available
	2020/21	73.0	74.5	67.3	85.4
	2019/20	64.7	67.1	59.5	84.2
	2018/19	63.4	67.2	58.9	85.0
	2017/18	68.1	68.6	60.5	85.0
	2016/17	66.3	68.1	60.0	85.2

Table 6: responsiveness to personal needs – source NHS Digital; NHS Outcomes framework

Note: Following the merger of NHS Digital and NHS England on 1st February 2023, NHS Digital are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed and is not available at the time of publication.

Assurance statements

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

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

With the increasing demands on our services and the recovery following the pandemic, we continue to report a high number of patient satisfactions. The Trust acknowledges that on occasions it may not be as responsive as it would like or expect to be, especially when the system is under extreme pressure.

Despite the challenges, the Trust's FFT data indicates high scores (April 2021-March 2022 = 90% [national benchmark = 85%]). The data shows a consistency in delivery and an upward curve over the past year in responding to the needs of our patients.

- The Trust is actively supporting staff with developing and completing quality improvement projects which will focus on patient experience and engagement to ensure that care provided

is tailored to individual needs.

- The Maternity department are currently developing new pathways for women to advocate for their wishes that include their cultural or religious needs in response to some patient feedback around discharge processes and patient wishes.

- In response to the Trust updating its values with the addition of “inclusive” we are now ensuring that patient stories are shared at every trust level board meeting, that patients can take part in service specific forums to give feedback and that they are able to co-chair our “Homerton Patient Voices” meetings to help steer the conversation to ensure it’s meaningful. This group also helps focus the Trust on patient feedback, their concerns and what really matters to them.

- The bereavement service is developing a new feedback tool to capture the experience of relatives and friends who have been impacted by the loss of a loved one at the Homerton. This is to ensure that throughout the whole patient journey we can ensure the patient and their loved ones are supported and included in the process.

- The introduction and development of the PIFU (Patient Initiated Follow Ups) pathway, patients can have a review period without an appointment and can initiate contact with the service to seek advice or bring forward an existing appointment, if their condition requires it. Patients are supported throughout the pathway with self-management tools, education and information on how to access the service as and when required

The National Staff Survey 2021 ran during October and November 2022 and was open to all staff employed substantively or under contract on 1 September 2022

The Trust’s 2022 results showed a reduction of 4% in recommendation as a place to receive care for their friends and family: down to 72%.

83% of our staff responding to the survey expressed the view that the care of patients/service users is the organisation's top priority.

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

- The survey was conducted on behalf of the Trust by Picker Institute, an approved provider by NHS England. All full- and part-time staff employed by the organisation on 1 September 2022 (with certain specific exclusions) had the opportunity to complete the survey electronically between October and November 2022. The Trust achieved a return rate of 47% over 50.5%, which represented a decrease of 3.5% from 2021.
- The Trust’s 2022 results showed a reduction of 4% in recommendation as a place to receive care for their friends and family: down to 72%.

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

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

- Continuing to implement ‘Our Homerton People’ plan - The plans and projects that will deliver the improvement in our people’s experience be made of the following key elements:

- People matter at Homerton Healthcare
- Achieving equality and inclusion for our people
- Creating a values-led organisation for all our people
- Supporting the health and wellbeing of our people
- Developing our people's potential
- Recruiting our People
- Developing our people's potential

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

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability, and chronic ill-health problems – many of which are avoidable. It is estimated that as many as half of all cases of VTE are associated with hospitalization for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognized as a clinical priority for the NHS in England.
Since the COVID 19 pandemic, the number of VTE risk assessments being performed within 24 hours has fallen below the target of 95%.

The reasons for this include:

1. Changes in the alert where a VTE risk assessment was not completed- previously these forced a decision before all the relevant information was available but in response to these concerns the alerts have been changed to regular reminder pop ups.
2. As activity has moved around the hospital there may be some issues with data quality- especially in surgical specialties where some patients not admitted to hospital may have been counted in totals –this continues to be an issue.
3. The effect of COVID 19 and then rises in urgent care demand – this is now less of an issue.

Our current figures for 2022/2023 are an improvement on the previous year.

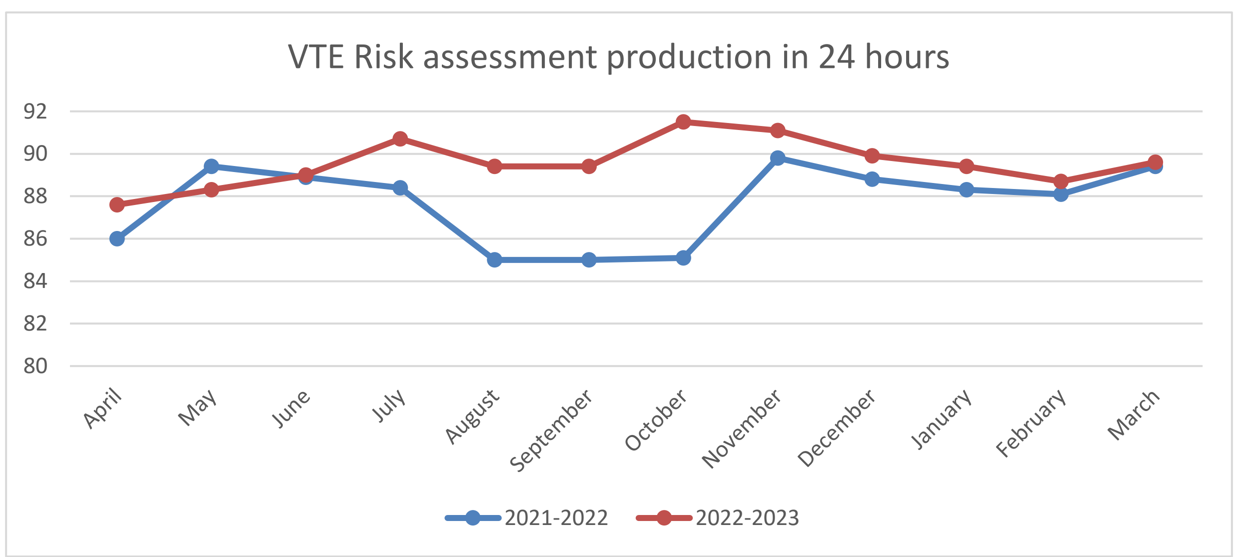

Figure 1: VTE risk assessment produced with 24 hours

Performance in 2022-2023 remained variable. The overall target of 95% completion was not reached. Overall performance was between 88 and 90% across the year.

Reporting Period		Homerton Performance
2022/23	Q1	**88.3**
	Q2	**90.3**
	Q3	**90.9**
	Q4	**89.2**

Table 7: Performance 2018-2022: ***(note national reporting was suspended since 19/20)***

Indicator	Reporting Period		Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2020/21	Q1	**88.9**	N/A	N/A	N/A
		Q2	**86.3**	N/A	N/A	N/A
		Q3	**85.7**	N/A	N/A	N/A
		Q4	**88.5**	N/A	N/A	N/A
	2019/20	Q1	**95.6**	95.6	69.8	100
		Q2	**95.9**	95.5	71.7	100
		Q3	**96.2**	95.3	71.6	100
		Q4	**93.6**	*	*	*
	2018/19	Q1	**95.5**	95.6	75.8	100
		Q2	**97**	95.5	68.7	100
		Q3	**96.9**	95.7	54.9	100
		Q4	**96.2**	95.7	74.3	100
	2017/18	Q1	**97**	95.2	51.8	100
		Q2	**96.7**	95.3	71.9	100
		Q3	**97.4**	95.4	76.1	100

Indicator	Reporting Period		Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
		Q4	**96.6**	95.2	67	100

*Table 8: VTE risk assessment data (NHS Digital); *publication suspended due to Covid*

Although there continues to be a significant difference in performance between the directorates there have also been many quality improvement innovations implemented to address the different aspects affecting performance in each division.

Assurance statements
There is clear plan to address the performance within the two clinical divisions.

Emergency Care, Medicine and rehabilitation services (EMRS)
For most of the year VTE performance across EMRS has been consistently greater than 90%. The 95% target was also met on several occasions.
There was an expected drop in performance in Quarter 4. This was related to high-volume winter activity, and significant increase in the number of medical admissions. During this period a significant number of patients were waiting in ED for greater than 4 hours. Patient records in ED are accessed via FirstNet. Firstnet does not have an automatic VTE pop up as most patients do not require VTE assessment as are not being admitted. This may explain a slight dip in completion of VTE forms.
VTE champions continue to help lead on VTE and check performance daily. This oversight has helped improve the EMRS completion rates over the last year.
It is also reassuring that when the small number of cases where the form has not been completed are reviewed the finding is that patients had appropriate VTE prophylaxis but that the form was not documented.

Surgical Women's and Neonatal Services (SWNS)

Most elective surgery patients arrive to the surgical admission areas on the day of surgery and are prepared for surgery by nurses and healthcare assistants. Completion of the VTE risk assessment form is the responsibility of the surgical team and is often completed by the most junior member of the team. Removal of the mandatory requirement in the electronic record for VTE risk assessment to be completed, has impacted completion rates in surgery more than medical patients.
Steps to improve VTE risk assessment compliance within SWNS has been to follow a Quality Improvement approach, initiating QI projects in several surgical specialties – the logic being that each of the specialties will be best placed to suggest improvements and engage with/implement solutions.

Quality improvement projects in T&O and general surgery have helped raise VTE assessment completion rates. The new surgical safety check has also been launched this financial year ensuring VTE risk assessment is discussed in the team brief prior to patients coming to theatre. Following this the maternity surgical safety checklist was also introduced in the latter part of 2022.

Where surgery is cancelled, cases continue to have incomplete VTE risk assessments – accounting for approximately 3% of VTE risk assessments reported. To address this a tick box has been added in EPR so that surgical patients admitted for a procedure that is then cancelled on the day, no longer require to have the full VTE risk assessment.

A nursing checklist on EPR has also been identified to which VTE risk assessment will soon be added as a point requiring to be checked off. This will be a final check before the patient leaves the department for discharge home or to the inpatient ward.

Reassuringly despite neither division achieving the 95% complication rate the overall VTE incidence in the hospital has not increased over the last few years

6. Clostridium difficile rate - NHSI Quality Indicator 24

Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection. CDI occurs mainly in elderly and other vulnerable patient groups especially, but not solely, in those who have been exposed to antibiotic treatment.

The laboratory for the Trust processes stool samples for *C.difficile* testing from both inpatients and community (GP) patients and all *C.difficile* toxin positive results are reported to the UK Health Security Agency (UKHSA) .

Since 19/20 the definition of Trust-attributable cases have been:

- HOHA=Hospital Onset Hospital Acquired = cases detected in the hospital two or more days after admission
- COHA = Community Onset Healthcare Associated = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 4 weeks
- COIA = Community Onset Indeterminate Association = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 12 weeks but > most recent 4 weeks.
- COCA = Community Onset Community Associated = cases occurring in community/within 2 days of admission when patient not an inpatient in reporting Trust in previous 12 weeks.

With this definition all HOHA and COHA cases are defined as ‘trust-attributable’.

The threshold for 22/23 was 19 Trust-attributable cases. There were 16 Trust-attributable cases (13 HOHA and 3 COHA) in 22/23.

The latest UKHSA ‘Fingertips’ data for *C.difficile* infection counts and 12 month rolling rates of hospital onset-healthcare associated cases, by reporting trust and month runs up to Jan-23. The Homerton rate is 15.0 per 100,000 against a national average of 20.1 per 100,000 i.e. lower than the national average.

The Trust hospital-onset rates for the past 7 years are reported in the graph below:

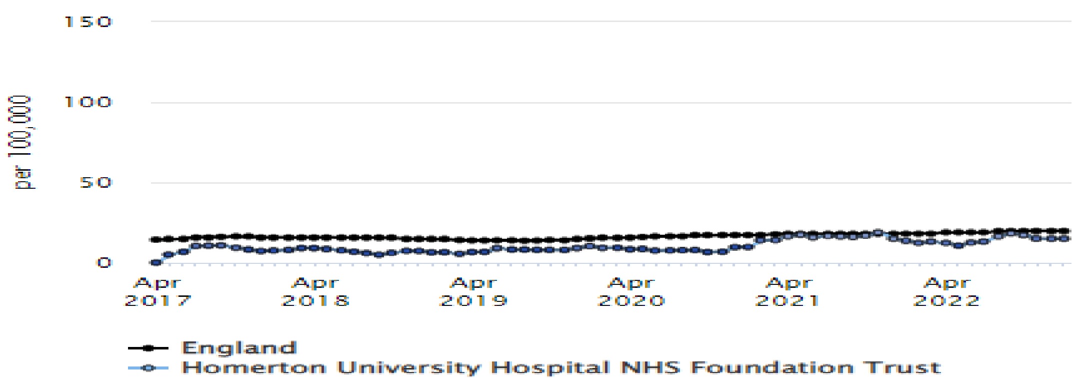

Figure 2: Homerton Healthcare c. diff rates

Assurance statements

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

The data for results up to Jan 23 has been taken from the UKHSA 'Fingertips' website (accessed on 02/05/23):

[Public health profiles - OHID (phe.org.uk)]

The unbenchmarked data for 22/23 is the data taken from the Trust's Winpath pathology IT system and submitted, after Chief Executive sign off, to the UKHSA surveillance website on a monthly basis. This data is cross-checked by the DIPC pre-sign off on a monthly basis by comparing a spreadsheet of the monthly Winpath laboratory data with the data submitted to the UKHSA website by the Infection Prevention & Control nurses.

All Trust-attributable *C.difficile* cases are reported as incidents and followed up by the ward team & Infection Prevention & Control team in partnership using a Post Infection Review (PIR) tool. The PIRs are then reviewed and signed off by the Trust's Assurance Panel.

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

The Trust intends to take the following actions to continue to decrease the rate of Trust-attributable *C-difficile* infection where there are lapses in care identified. However, it must be recognised that some cases of *C.difficile* infection are not preventable.

- *C.difficile* awareness teaching is included in the Infection Prevention & Control mandatory induction & annual update training.
- Focus on timely isolation of all ward patients with diarrhoea (where there is a possible infective cause) whilst awaiting *C.difficile* testing results.
- Focus on timely sending of diarrhoeal samples for testing for *C.difficile* enabling prompt identification of *C-difficile* toxin positive cases.

- Environmental decontamination by ‘terminal’ cleaning of the patient’s bed space on side room transfer (if applicable) and after discharge from side room
- Focus on clutter reduction in ward environments to enable high standards of cleaning.
- Regular audits to ensure compliance with national and local guidelines.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.
- Root Cause Analysis using a Post Infection Review (PIR) investigation tool of every case to identify lessons to be learnt and feedback to the multidisciplinary teams and into the governance structure to ensure learning across the Trust.

7. Patient Safety Indicators – NHSI Quality Indicator 25

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

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

During 2022/23, 13,689 incidents occurred across Homerton Healthcare, of which 11,151 were patient related. This is the highest number of incidents ever reported in a single financial year across the Trust, over 1,500 more than the previous year and represents an ongoing trend of increased incident reporting.

The table below shows the patient safety incidents that occurred in 2022/23 by harm caused. 72.8% of patient safety incidents caused no harm to patients.

Actual harm reported	Number	Percentage	National average (from 2021/22)
No harm	8116	72.8%	70.6%
Low harm	2631	23.5%	26%
Moderate harm	330	3%	2.9%
Severe harm	19	0.2%	0.3%
Death (safety incident related)	0	0%	
Death (not safety incident related)	55	0.5%	0.2%*
TOTAL	**11151**	**100%**	**100%**

Table 9: Number of patient safety incidents reported by harm caused.

**please note in national figures there is only one category for incidents resulting in death which does not distinguish between deaths related and not related to safety incidents.*

Assurance statements

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

The Trust submits all eligible incidents to the National Reporting and Learning System. Benchmarking data is no longer published by NHS England, but there is a year on year increase in incidents reported across the Trust, providing assurance that we remain a high reporting organisation. We report a higher than average number of incidents causing no harm and a lower than national average percentage of incidents causing harm.

During 2022/23 the Trust continued to work with staff to ensure incidents were appropriately reported, investigated and actions taken where necessary to improve patient safety. Improvements have been made to how lessons learned from investigations are shared across the organisation, and during the year, a new monthly Spotlight on Learning newsletter was launched. The Patient Safety Team provides a range of training across the organisation, via trust and junior doctor induction, ward development days, the nurse preceptorship scheme and many other forums to ensure staff feel supported in reporting incidents, and receive feedback on actions taken and lessons learned.

In August 2022, the new Patient Safety Incident Response Framework was published, and the Trust has undertaken a significant amount of work since then to ensure the organisation is ready to implement it in the autumn of 2023. This has included establishing an implementation group, chaired by the Chief Nurse; a detailed analysis of our incident profile in preparation for the development of the Patient Safety Incident Response Plan and Policy, and engagement with teams across the organisation to ensure they are aware and ready for the changes. The Trust welcomes the new Framework, and is excited by the potential for learning and improvement that it presents.

Further improvement work to the Datix Incident Reporting system has taken place throughout the year, and this will continue into 2023/24 as the system is updated ahead of the introduction of the Learning from Patient Safety Events (LFPSE) service, which will replace NRLS and STEIS for national incident reporting in the autumn of 2023.

3.0 Part 3: Other information

3.1 Overview of the progress with the Trust's 2022 to 2024 quality priorities

The following section describes the progress of each quality priority, the actions taken to drive the priorities, reporting metrics and the key risks identified going forward;

Priority Title **Domain**	**Target/Goal**	**Commentary**	**Reporting metrics** *(where available)*
1. To reduce the number of community and hospital attributed pressure ulcers **Domain:** **SAFE**	➢ To reduce number of hospital-acquired Category 3 and above PU with lapses in care by 60% ➢ To reduce number of community-acquired Category 3 and above PUs with lapses in care by 40%	**Progress made during 2022/23** ➢ Pressure Ulcer Strategy Group has encouraged a systemic approach to identify the challenges, find solutions, and drive change over the past months ➢ Trust strategy approach launched May 2022 supported by the Quality Improvement and Tissue Viability Team. ➢ Developed a Time to Turn Communications plan and commenced implementation ➢ Skin ambassadors programme started in May 2022 devised Community Pressure Ulcer Action Card that supports use of the ASSKING bundle ➢ Time to Turn Conference held in November during Stop the Pressure awareness week. ➢ Introduced Skin rounding trial on ECU north and patient turning added to documentation on RNRU ➢ Reviewing the nursing detail assessments and care plans on EPR ➢ Mini QI project launched in the community ➢ Training programmes for reviewed and now includes staff development days, preceptorship training for newly qualified nurses and overseas nurses joining the Trust and the Essential Skills Programme for healthcare assistants ➢ Pressure Ulcer Scrutiny Committee will continue to meet monthly to review incidents and lapses in care. The learning points and actions are summarised feedback to Leads and teams via email.	➢ Total number of pressure ulcers record as lapses in care. ➢ Reduction in the number of hospital acquired pressure ulcers reported during 2022/23

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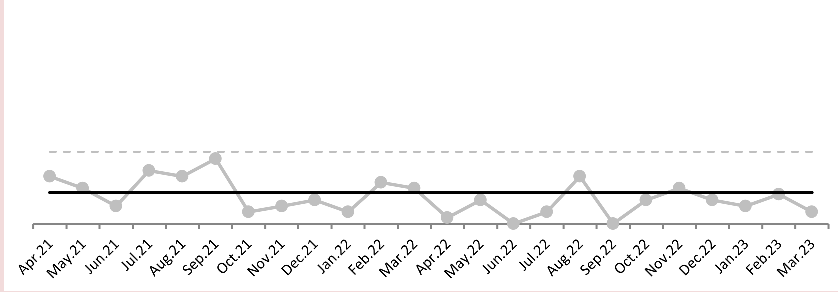
- Current hospital mattress pathway has been updated and capital funding has been approved for gradual replacement of the older dynamic mattresses
- Bed contract for the acute site and Mary Seacole Nursing Home (MSNH) has been reviewed to look at the available mattress options, and the ordering/ cancelling process to ensure there is enough equipment onsite
- Skin Ambassador Role was introduced with 11 community staff and 28 acute staff, either Health Care Assistant or Registered Nurse put forward for the role
- Achieved compliance with CQUIN 12 - Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
- The Datix form has been changed with the aim of making reporting easier and enable collection of more accurate date leading to simplified analysis to truly understand how we are doing regarding pressure ulcer prevention and management.

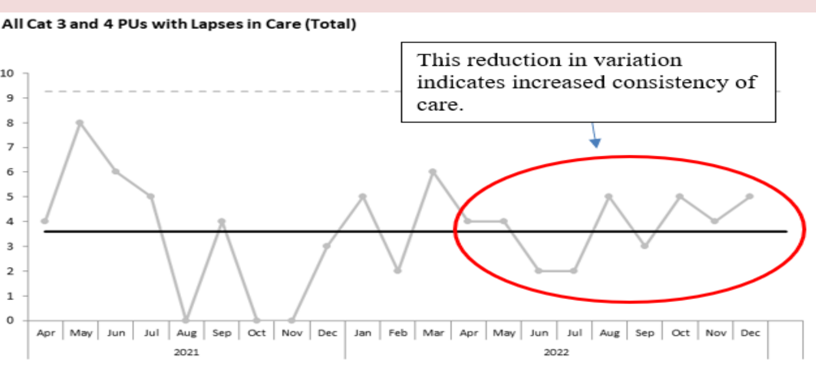
Key steps going forward into 2023/24

- Identify education and training needs of formal carers and ensure that the information provided meets their needs.
- Research digital options to support the programme to improve patient care and preventative approaches.
- Increase service user involvement in the programme.
- identify education and training needs of the non-nursing workforce (AHPs and others) within the Trust.

- Reduction in the average number (thick line) of Pressure ulcers with lapses in care across the acute and community



- The variation in numbers of pressure ulcers graded as category 3 or 4 with lapses in care has reduced, this indicates a greater consistency of care.



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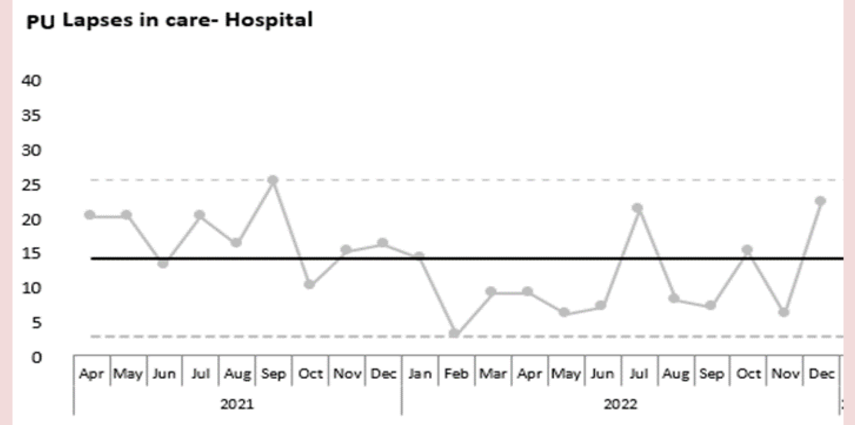
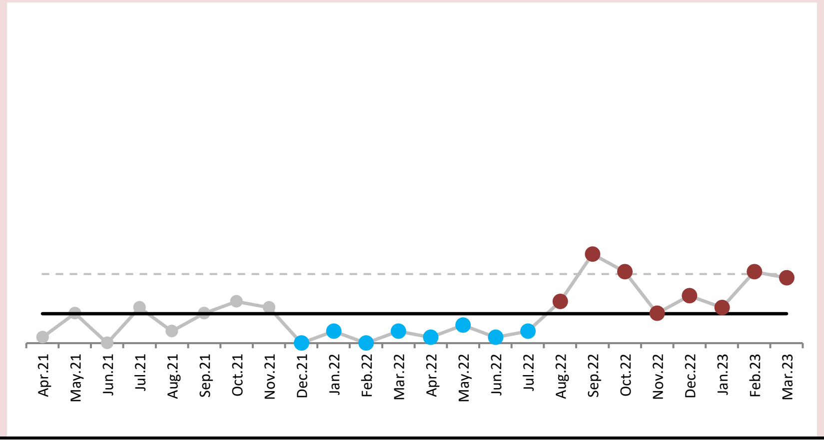
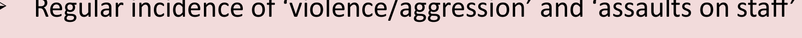
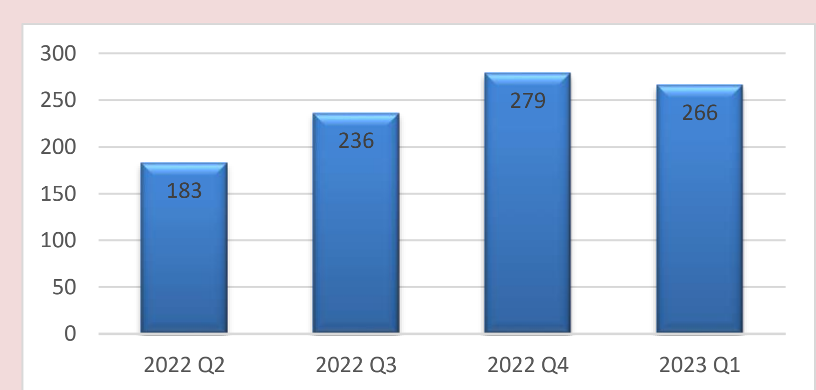
- Request a review of PU related community equipment with the Local Authority who are the commissioners for this service.
- Ensuring that actions identified in PUSC and mini–Root Cause Analysis are completed and embedded.
- Understand what needs to be done to address the human factors identified in incidents and SIs.
- Identify continuous areas for improvement through the PU Strategy Group, skin ambassadors, staff and patients.
- Continue engaging with TVS colleagues from other areas to share learning, ideas, and resources.
- Summer 'Time to Turn' Symposium to review progress made during 2022/23 including presentations of the Skin Ambassador change ideas and their findings.
- Design a designated pressure ulcer page on the intranet for staff and website for the general public.
- Utilising new incident reporting structure on Datix to enable Statistical Process Control Charts (SPC) and detailed data by ward and neighbourhood teams.
- Increased collaborative work between Children's Community Nursing team and Children's Therapies team to review the PU prevention pathway and wound care management has been reviewed and adapted.
- Online educational resources developed by the National Wound Strategy and industry partners available for staff wound care competencies through self-guided study.
- Scope local improvement projects identified by Skin Ambassadors introduced with 11 community staff

- The numbers of all categories pressure ulcers with lapses in care have remained consistent on the acute site



- The number of all categories of pressure ulcers with lapses in care have remained consistent within community settings



		and 28 acute staff on both community and acute settings.	
2. Reducing physical violence and aggression towards patients and staff. **Domain:** **SAFE**	➢ To make staff feel safe and secure giving them confidence and skills to deal with various forms of violence and aggression enabling them to deliver the best level of care to patients. ➢ Increase the use of lone worker devices ➢ Increase the number of staff receiving Maybo training	**Progress made during 2022/23** ➢ Body worn cameras for ED front line clinical & reception staff. ➢ Monthly V&A review meeting set up with Met Police and ED senior staff, review body cam footage and assist with ongoing investigation. ➢ Community Personal Safety Awareness Sessions with Met Police for all our community staff, 1st session was in January 2023 a further session booked for February; to inform and give advice to staff of potential risks while working in the community and how to keep themselves safe). ➢ Upgraded Trust wide CCTV cameras to IP HD cameras to support with prosecution ➢ Maybo enhanced CRT included on Trust induction, additional training sessions added from October 2022 to ensure 4 sessions a month. ➢ Updated intranet pages with information and videos staff safety initiatives. ➢ New V&A posters circulated and displayed in departments/wards. ➢ Community lone working staff receiving additional training on lone worker device usage to improve personal safety. ➢ Quarterly violence and aggression committee ongoing.	 ➢ Regular incidence of 'violence/aggression' and 'assaults on staff'  ➢ V&A incidents reported by category

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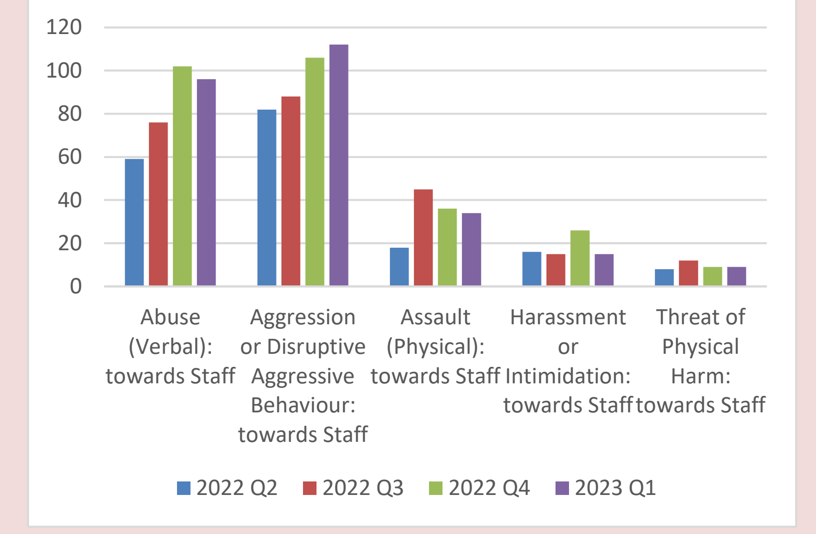
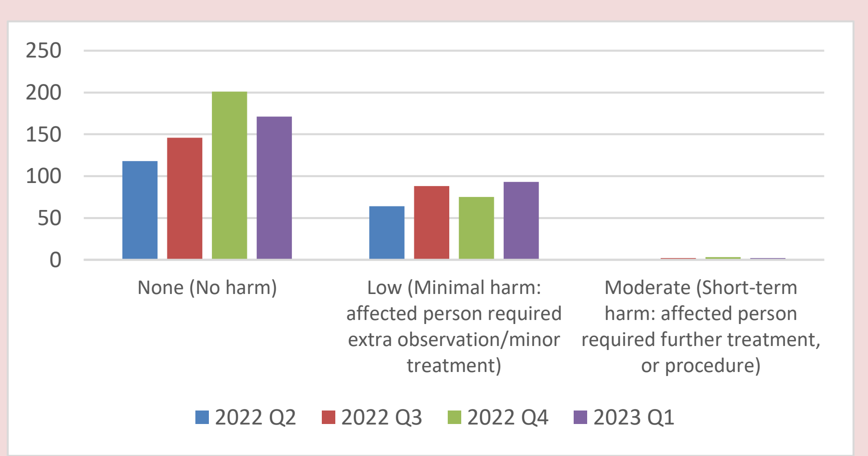
- Introduced a new sanction card in the V&A policy, Orange card for the community which is an injunction from specific community services.
- Since April 2022 22 yellow cards, 4 red cards, 1 orange card have been issued to clients.
- Continued partnership with Met Police on Operation Cavell, 4 police community protection notice issued (CPW).
- Increased number of reported crimes to police showing staff are more confident in escalating incidents with police. Increased number of convictions and fines resulting from offenders being arrested by the police for V&A incidents.



Key steps going forward into 2023/24

- Reduction of physical assaults on staff
- Continue raising awareness and improve reporting of incidents on Datix and to the police if appropriate.
- Impowering staff to not tolerate violence and aggression and seek sanctions through hospital process and police.
- Continue providing training in Maybo.
- Continue lone worker device to support staff in the community and acute site.
- Community Personal Safety Awareness Sessions with Met Police for all our community staff, 1st session was in January 2023 a further session booked for later in the year - to inform and give advice to staff of potential risks while working in the community and how to keep themselves safe.

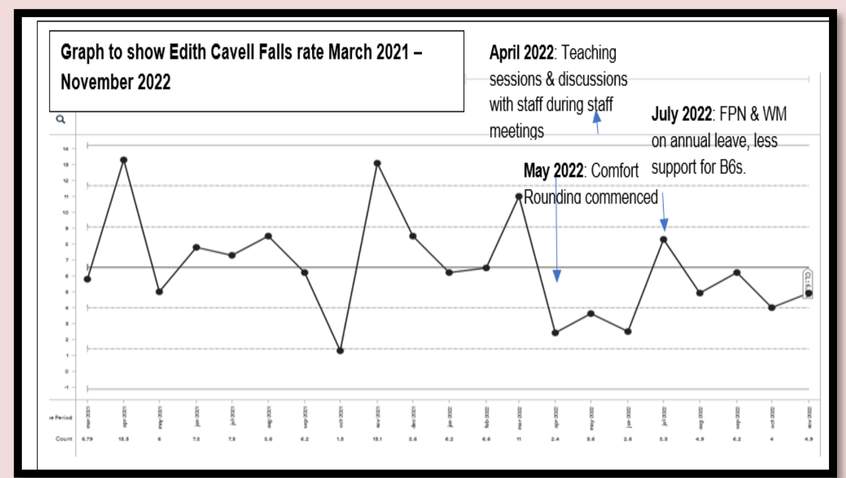
- Harm reported on Datix

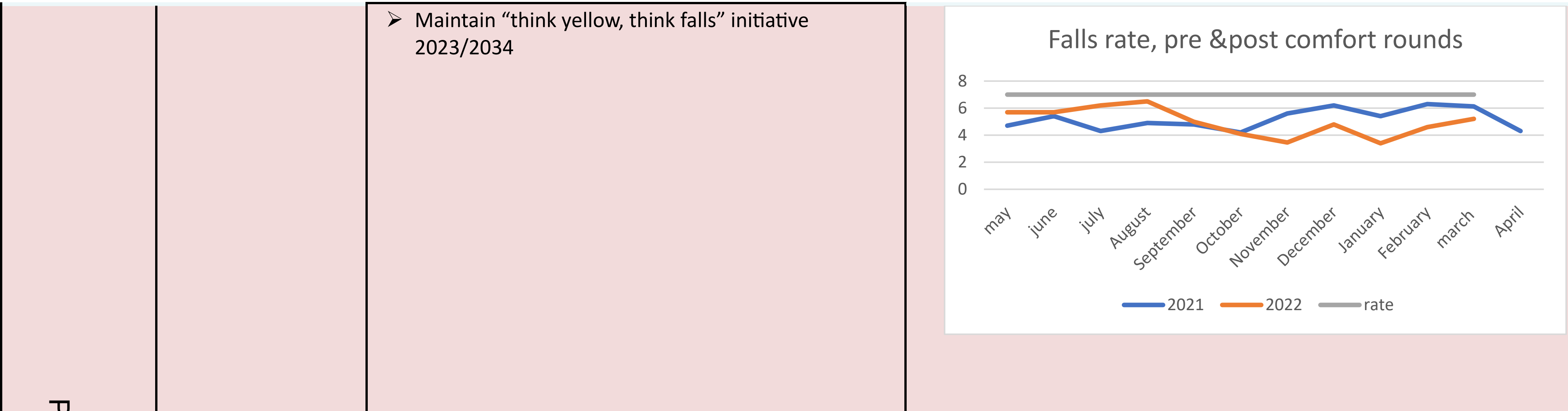


		➢ Work with our HPM team and ELFT colleagues to support training for staff on managing complex Mental Health patients	➢ Monthly usage of lone worker devices

	January 2023	February 2023	March 2023
Total Devices Issued	551	551	551
Total Used Devices	79	68	66
Total Usage Level of Staff With Devices	14.3%	12.3%	11.9%

3. Improved management and reduction in the rate of falls **Domain:** **SAFE**	➢ Reduction in the rate measured by the Inpatient Falls Prevention Nurse (FPN)	**Progress made during 2022/23** ➢ 'Think Yellow' campaign has been launched, led by Falls Nurse. Support from QI team to review and monitor effectiveness. ➢ Relaunch in August 2022 when yellow socks stocked on the wards, in process of sourcing yellow star wrist bands to identify patients at risk of falls ➢ Comfort rounding launched on Edith Cavell ward, next steps to explore aspects of 'enhanced observation hierarchy' including cohorting/bay watch bays.	➢ Falls prevention QI project on Edith Cavell ward

Page 91		➢ Post falls care – Algorithm developed and in situ simulation training rolled out for September and October. ➢ New post falls care algorithm developed and launched ➢ In situ simulation training being run over September and October introducing this algorithm ➢ Digital falls prevention training in development ➢ Pathway has been agreed which include MDT review and escalation to matrons ➢ Hot Debrief/after action reviews which are led by the falls nurse in falls with harm ➢ Falls team to offer training to ward managers about how to complete a hot debrief	
		Key steps going forward into 2023/24 ➢ Learning from QI project on Edith Cavell are now being transferred to other wards, with a plan to spread Comfort Rounding to Graham Ward. ➢ First level, E learning package agreed & developed which is suitable for all new clinical and non-clinical staff, band 2 and above. This will become part of the Trust's is mandatory package for all staff. (Compliance at 80% for all new staff trained within first year.) ➢ Investigate whether enhanced observation hierarchy, "Tag in, Tag out" and cohorting project has any benefit & whether MDT could participate. ➢ Hot debrief led by the fall's prevention nurse, completed with ward staff once a patient has fallen twice or more in Homerton wards within 2 days of the fall	➢ Reduction in falls rate noted following introduction of comfort rounds

		➤ Maintain "think yellow, think falls" initiative 2023/2034	

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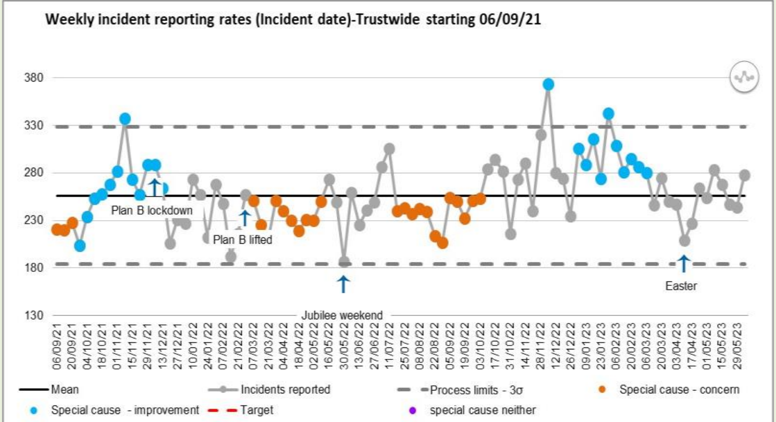
<tr>
<td>4. Just Culture and Safe Environment

Domain:

SAFE & EFFECTIVE</td>
<td>➢ New priority supporting, developing and promoting a just culture where staff feel safe to raise concerns.</td>
<td>**New priority for 2022-2024**
➢ Our Future Together - new strategy for the next five years launched. Six priorities that were developed close collaboration with our people, partners, patients, and local community; includes Develop happy, healthy & heard staff
➢ To be supported by the successful delivery of Our People Plan
➢ Psychological first Aid programme – support staff health and wellbeing
➢ Weekly warmer wellbeing programme including Trolley talk - highlighting (anonymously) what issues/ suggestions have been brought up with the Trolley owners and what we as a Trust are doing about it!
➢ Implementation of new Patient Safety Incident Response Framework
○ Task & finish group established
○ Draft policy and gap analysis to be submitted for approval during Summer 2023
○ New incident response methodologies to be implemented, e.g. Patient Safety Investigations After action reviews, multidisciplinary review, or facilitated debrief
➢ Business case to scope additional roles of dedicated investigation leads.
➢ Recruitment of patient Safety Partners to be completed during 2023/24
➢ Staff safety culture survey launched during Q1 2023/24. The survey will help us understand your thoughts on patient safety, incident reporting, and the culture Homerton has around this.</td>
<td>➢ Metrics will include:
○ The NHS Staff Survey People's reported experiences are an important measure of the plan's progress.
○ Employment resolution case numbers

➢ Freedom to Speak up interactions, trends and themes
○ 98 concerns recorded during Q1 2023/24;
○ Bullying/Harassment
○ Discrimination
○ Staff safety
○ Patient safety
○ Advice

➢ Incident reporting rates (weekly figures)
</td>
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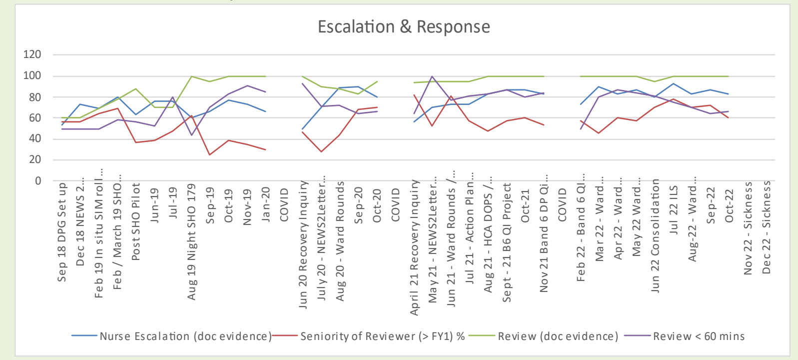
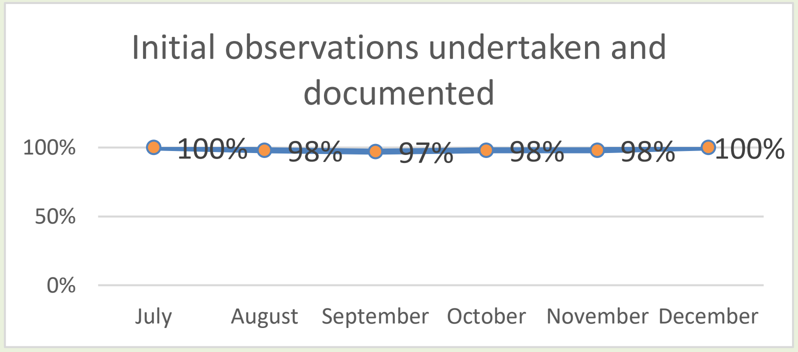
- Introduction of SEIPS framework for understanding outcomes within complex socio-technical systems.
- Implementation of new national incident reporting system (Learning From Patient Safety Events)
- Just Culture learning approach established with new resolution policies in draft to support a compassionate and learning based approach
- Freedom to Speak up process moved across to Datix to ease access and thematic analysis
- Ensuring safe environment for staff to raise patient safety concerns and Freedom to Speak up processes
- Carry forward activity from learning from incidents, patient experience and inquests

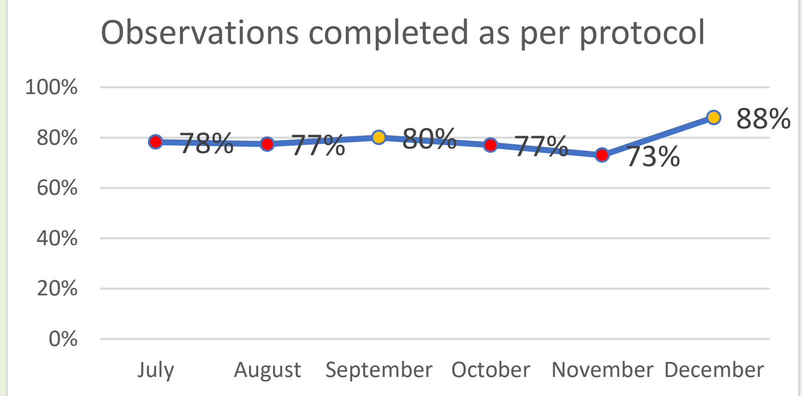
- Incidents reported by category Q4 2022/23 (top 5)

Category	Number
Patient – pressure ulcer or skin damage (Homerton acquired)	379
Patient - pressure ulcer or skin damage (non-Homerton acquired)	326
Patient – treatment or procedure	303
Staff – violence, abuse or aggression towards staff	267
Patient – admission	213

- Incident reporting 2022/23 (by harm)

Harm	Number
None (No harm)	10142
Low (Minimal harm: affected person required extra observation/minor treatment)	3277
Moderate (Short-term harm: affected person required further treatment, or procedure)	363
Severe (Permanent or long-term harm: e.g. fractured NOF)	20
Death (Not caused by a safety incident)	59

5. Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community based services **Domain:** **SAFE &** **EFFECTIVE**	➢ Expand the work completed for deteriorating adult inpatients to support maternity, paediatrics and community services.	**Progress made during 2022/23** ➢ Monthly audits completed in real time basis from EPR to review escalation enabling immediate remedial actions. ➢ Electronic Records are reviewed from previous 24 hours to identify point of deterioration, and identify if appropriate escalation has occurred ➢ Unplanned ITU admissions and patients with confirmed sepsis reviewed, KPI agreed with commissioners (antibiotics administered under 1 hour) ➢ Band 6 deteriorating patient QI project to raise awareness and MDT teaching across wards ➢ Simplified system for prescribing oxygen on EPR supported by weekly performance reviews shared with staff. ➢ Deteriorating Patient Oversight Group established during 2022/23 autumn to support community and maternity and paediatrics. **Key steps going forward into 2023/24** ➢ Adults - Improve frequency of recording of vital sign observations (with reference to NEWS score). This is a significant piece of work using multiple interventions to make improvements: o Updates to EPR process for inputting vital signs o Automatic update of vital signs onto EPR using vital links o Training of staff regarding NEWS score and frequency of observations ➢ Deteriorating Patient (adult) CQUIN launched for 2023/24 to provide oversight of activity across audit, maternity, paediatric and community services	➢ Escalation and response data (adults)  ➢ Paediatrics - Ongoing audit to collect data to look at CEWs escalation and unexpectedly deteriorating patients, with particular focus on time of response and documentation on electronic notes followed by thematic analysis (expected needs for further training for Doctors and Nurses on Optflow and CPAP initialization) ➢ Maternity (NEWTT observation audit) 

		➢ Acute Paediatric Deteriorating patient group has been formed with the plan to meet every 6-8 weeks and look into: o Ongoing measurement and results o monitor progress o Discussion and feedback of learning points of specific cases and identify positive case scenarios and "learning from excellence" ➢ CEWS- (paediatric) policy is currently being reviewed (policy and escalation thresholds being finalised. Currently having discussions regarding CEWS score on EPR and discrepancies with age. ➢ Maternity Escalation and Deteriorating Patient Group established during 2022/23 ➢ Maternity to continue NEWTT observations audit: o MOEWS - It has been planned and being implemented. We will study it prospectively in April 2023 o NEWTT: o Quality boards o Recommencement of case studies o Fresh Eyes from new inpatient matron starting 6 February 2023 o Rebranding of NEWTT trigger chart to ensure standardisation of escalation. o Recommence sharing of case studies to all staff ➢ Community Deteriorating Patient Group has been agreed for 2023/24 ➢ Community Workstreams to be developed during 2023/24	➢ Maternity (Completion of observations)  ➢ Community (to be established during 2023/24) ➢ CQUIN: Recording of and appropriate escalation and response to NEWS 2 scores for unplanned critical care admissions (to be included)

6. Improving our populations health **Domain:** **EFFECTIVE**	➢ Launch new Trust strategy "Our Future Together" ➢ Set up the Tobacco Dependence Treatment (TDT) Service at Homerton Healthcare ➢ Extend activity into other workstreams, e.g. diabetes, obesity etc.	**New quality priority supported by the launch of Our Future Together strategy.** https://www.homerton.nhs.uk/download/doc/docm93jijm4n13362.pdf?amp;ver=30420 **Progress made during 2022/23** ➢ New Quality Priority under development supporting improvements in population health by working with our patients and our partners ➢ Working in collaboration with our partners, develop a model integrated care and health partnership in City and Hackney which makes a real impact on its priorities of: o giving every child the best start in life o improving mental health and preventing mental ill health o improving outcomes for people with long term health needs. ➢ Hackney Early Language Pathways project that is running in the Hackney Downs Neighbourhood. The QI team have provided regular coaching to the project lead, as well as support to create surveys and analyse data into themes. ➢ Continue working on the Autistic Friendly Neighbourhoods project in the London Fields Neighbourhood through regular coaching sessions with the project lead. ➢ Vocational Rehabilitation Occupational Therapy (VROT) clinic that is currently being trialled in Hackney Marshes.	New metrics to be established for 2023/24 ➢ National metrics for health inequalities ➢ National metrics for health and wellbeing for children and families ➢ Reporting metrics identified for smoking cessation 9 to be reported form April 2023 onwards): ➢ Number of inpatients screened ➢ Number of inpatient smokers provided the TDT service ➢ Number of inpatient smokers provided NRT ➢ Number of inpatients referred to the local stop smoking service

Page 98		➢ Homerton Our Future Together - new strategy for the next five years launched. Six priorities that were developed close collaboration with our people, partners, patients, and local community; includes Develop happy, healthy & heard staff ➢ Provide health promotion advice at every point of contact, wherever possible; including smoking cessation	
		Key steps going forward into 2023/24 ➢ Measures of health and wellbeing for children and families will be within the top quartile nationally ➢ A Trust mental health, learning disabilities and autism strategy will be implemented, ensuring that patients are cared for appropriately in the best setting and with dignity and respect ➢ People with long-term conditions will have reduced admission rates and length of stay year-on-year ➢ Link to community screening programmes and health improvement initiatives (smoking cessation, diabetes and obesity) ➢ Start part delivery to the inpatients smoking cessation service from April 2023 ➢ Recruit new staff member to deliver the smoking cessation service – aim to complete the recruitment by end of August ➢ Maintain work on the Smokefree Homerton Steering Committee ➢ Approval process for the NRT Protocol and Smokefree Policy ➢ Agree on the pathway and protocol between the inhouse TDT service and the local community stop smoking service	

		➢ Explore the potential of part funding of the inhouse smoking cessation service by the public health service ➢ Develop comms package to promote the smoking cessation service	
7. Improving the first impression and experience of the Trust for all patients and visitors **Domain:** **PATIENT EXPEREINCE**	➢ Improve patient satisfaction scores	➢ Supported by the launch of the Trust's 'Our Future Together' strategy; ➢ Actively seek out the experiences and stories of our patients and carers to improve and develop our services ➢ AccessAble created detailed access guides to facilities, wards and departments across the hospital. The guides help patients, visitors and staff plan their journeys to and around the hospital. ➢ Relocation of phlebotomy to Lower Clapton Health Centre to provide a better patient experience. ➢ Homerton Patient Voice; meets every other month to discuss areas of patient and user involvement and engagement within the Trust. The membership includes Homerton staff, as well as patient and patient organisation representatives. ➢ Actively seek out the experiences and stories of our patients and carers to improve and develop our services ➢ 'Our Estates plan' to review the fabric and environment of the Trust premises.	➢ Metrics to be developed, including feedback from o Friends and Family Test, o Patient Advice & Liaison Service (PALS) enquiries, o NHS Choices, o Care Opinion and o Complaints Outpatient satisfaction survey for Emergency Dept survey, Maternity & theatres, o Regular environmental audits, Customer care skills training targets.

Table 10: quality priority updates for 2022/23 and 2023/24

3.3 Performance against national indicators

3.3 Performance against national indicators

During 2021/22, as a consequence of Covid, the Trust's actual performance against national operational standards suffered (along with the rest of the country). However, given the circumstances, the Trust delivered a comparably strong operation performance against the suite of core standards. It should be noted that due to the Covid pandemic.

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

Key Performance Indicators	Target	2020/21 Performance	2021/22 Performance	2022/23 Performance
A&E patients discharged <4hrs	95%	93.00%	86.93%	**80.59%**
Cancer				
2 Week Wait	93%	96.16%	94.43%	**93.56%**
31 Day Target	96%	98.43%	99.82%	**99.07%**
62 Day Target	85%	84.60%	82.88%	**79.76%**
Infection Control				
MRSA	0	5	1	**3**
Clostridium difficile (C.diff)	12	10	16	**24**
18 Week RTT Indicator				
Incomplete Pathways	92%	74.08%	80.17%	**80.49%**
IAPT Indicators				
6-week target	75%	98.02%	98.22%	**97.28%**
18-week target	95%	99.68%	99.76%	**99.32%**

Table 11: national indicators

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month.

Annex

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

1.1 Healthwatch Hackney

Healthwatch Hackney thanks Homerton Healthcare for the opportunity to comment on the Quality Account Report.

We commend Homerton Healthcare on the achievement of "outstanding" for the acute hospital and "good" for the trust against CQC ratings, and note that, in our recent trends analysis report, comments drawn from a wide variety of sources showed 77% of patients shared positive comments around quality. Following a suspension of comment collection during the pandemic, Healthwatch Hackney has now resumed monthly visits to Homerton Hospital for comment collection. As a result, the amount of patient experience data that we are collecting is increasing, leading to more meaningful reports. We look forward to continuing to use these reports to work in partnership to improve patient experience.

Healthwatch Hackney is particularly delighted to see the update on page 71 around priority 7 (Improving the first impression and experience of the Trust for all patients and visitors). We felt there were some excellent examples of collaborative working and patient involvement in this work, such as the storytelling event and wider engagement that fed into the Trust's 'Our Future Together', and the collaborative work with local residents to shape the Homerton Voice forum.

We recommend Homerton Healthcare works with Healthwatch Hackney to ensure effective use of patient feedback to improve patient experience by sharing all patient feedback received through Complaints, PALS and Compliments services and Friends and Family Test. Healthwatch Hackney patient/public groups can then review the feedback to propose meaningful recommendations or undertake additional engagement work where appropriate.

We note the extensive work around maternity, and would re-iterate the Healthwatch Hackney recommendations drawn from our report (The experience of maternity care in Hackney".

- A vision for co-production of antenatal care and support with service users especially for GP services

- Hospital and community maternity services should consider using different methods of engagement to review the levels of postnatal support to women in Hackney.
- External information – We recommend further engagement with women to ensure that health professionals including GPs can guide women to ‘approved’ trusted sources of information and advice which can include online apps as well as offline support for those who are digitally excluded. Starting in 2023 Healthwatch Hackney will be developing resources for women based on local experiences which we hope will fill this gap.
- Ensure that a patient information leaflet detailing contact information about available support (e.g. what is classified as an emergency, what to do in an emergency, language and advocacy support, what to expect during pregnancy, option to provide feedback etc,), is provided to all women during their pregnancy as a matter of routine at the time of the pregnancy announcement (at the GP or other services).

Healthwatch Hackney has been pleased to see the strong leadership Homerton Healthcare has shown in working with the local integrated place-based partnership, under the leadership of Louise Ashley. We look forward to continued partnership working in the future.

With many thanks,

Sally Beaven
Executive Director (acting)
Healthwatch Hackney

1.2 Overview and Scrutiny Committee

Overview & Scrutiny

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

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

23 June 2023

Ms Louise Ashley
Chief Executive
Homerton Healthcare NHS Foundation Trust
Trust Offices
Homerton Row
London E9 6SR

Email to: louise.ashley@nhs.net, breeda.mcmanus1@nhs.net and matthew.grantham1@nhs.net

Dear Louise

Response to Homerton Healthcare NHS Foundation Trust's draft Quality Account for 2022/23

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2022/23. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

We've been grateful for the continued support to the scrutiny function of yourself and your colleagues and for your continuing leadership role as Place Based Leader for City & Hackney.

Over the past year at our Commission we've had the following items which touched on your Trust:

- Development of new City and Hackney Place Based Partnership and the role of the Place Based Leader x 3
- Mental health emergency department pressures at Homerton
- Future options for Soft Facility Services at Homerton Healthcare
- Community Diagnostic Centres
- Impact of new hospital discharge funding scheme

We do appreciate the Quality Account exercise as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services. The Commission Members

take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We're pleased that the overall CQC rating for both the Homerton and Mary Seacole sites remain unchanged at 'Good' despite the pressure of having to rebuild elective care post the pandemic and increased winter pressures.

We support the 7 quality priorities you had identified in 2022:

1	To reduce the number of community and hospital attributed pressure ulcers
2	Reducing physical violence and aggression towards patients and staff
3	Improved management and reduction in the rate of falls
4	Just Culture and Safe Environment
5	Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community-based services
6	Improving our populations health
7	Improving the first impression and experience of the Trust for all patients and visitors

and that they are in place for a 2 year reporting cycle to ensure that sufficient and sustainable progress can be achieved with them. We commend the progress you are reporting thus far.

We noted with interest the following:

a) We note that the KPI for *A&E patients being discharged in less than 4 hrs* is at 80.59% and has fallen for the second year in a row and so remains below the target of 95%. The Trust historically performed really well on this and, while this is a challenging time for the NHS nationally, we look forward to hearing more about the context here and the mitigation plans.
b) Similarly, the KPI on the number of cases of *Clostridium difficile* has spiked from 16 to 24, as against the target of 12, and we'd be interested to know more about the reasons and the mitigation plans.
c) We commend the continued excellent performance of the IAPT service on the 6 and 18 week targets.
d) We commend too, the ongoing and very active role that the Trust plays in clinical research and your participation in national audits, as these will contribute to improving treatments and outcomes for our residents.

Over the coming year, and following our discussions, we will be revisiting a number of issues including: Emergency Dept mental health case management and in-patient capacity; the planned changes to Continuing Health Care, and health inequalities and medical barriers faced by the trans community. In January we hope to hear back on the future options for 'soft facility services' at Homerton Healthcare.

Members have also expressed concerns on such issues as: poor maternity health outcomes for Black women; poor prostate cancer health outcomes for Black men and the spike in rates of sexually transmitted infections. We are still refining our work programme for 23/24 and will get back to you on those which have direct relevance to yourselves.

We commend the report and are pleased that the Trust performs so strongly against a wide range of national quality assurance indicators.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Breeda McManus, Chief Nurse and Director of Governance, Homerton Healthcare
Matthew Grantham, Deputy Head of Quality and Patient Safety, Homerton Healthcare
Members of Health in Hackney Scrutiny Commission
Cllr Christopher Kennedy, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture
Dr Sandra Husbands, Director of Public Health, City and Hackney

1.3 Commissioners Statement for Homerton Healthcare NHS Foundation Trust 2022/23 Quality Account

Commissioners Statement for Homerton Healthcare NHS Foundation Trust 2022/3 Quality Account

NHS North East London Integrated Care Board is the lead commissioner responsible for commissioning health services from Homerton Healthcare NHS Foundation Trust on behalf of the population of east London.

Thank you for asking us to provide a statement on Homerton Healthcare NHS Foundation Trust's 2022/23 Quality Account and priorities for 2023/24.

We recognise that the impact of the pandemic is still being felt, with increased pressure on services and tackling the backlog of elective care. Despite this, we commend the measures and steps the trust have taken to ensure services are performing well against national and local quality measures. We note the trust continues to perform well against the 4-hour A&E treat/discharge target, being one of the best performing trusts nationally. We are aware of the continued effort the trust makes in improving the more challenging services, especially the 62-day cancer waiting times by redesigning several cancer pathways.

We applaud the continued progress of the seven priorities carried forward and welcome the new Our Future Together strategy which supports a Just Culture and Safe Environment and Improving Our Population Health priorities. We welcome the key steps going forward for each priority. We note that despite increasing demands the trust continues to report high patient satisfaction with the Friends and Family Test data showing an upward trend in patient satisfaction over the past year.

We are aware that the trust has undertaken important work to address health inequalities in the last year and we welcome the new metrics to be established for 2023/24: metrics on health inequalities and for health and wellbeing for children and families.

We are grateful to Homerton Healthcare NHS Foundation Trust and its staff for their commitment to collaboration and partnership working that will further support and develop our North East London Integrated Care System.

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

Overall, we welcome the 2022/23 quality account and look forward to working in partnership with the trust over the next year.

Zina Etheridge
Chief Executive Officer
North East London Integrated Care Board

2.0 Statement of directors' responsibilities for the quality report

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

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

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

• the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2020/21* and supporting guidance *Detailed requirements for quality reports 2019/20.* No specific guidance was issued for 22/23

• the content of the quality report is not inconsistent with internal and external sources of information including: – board minutes and papers for the period April 2022 to March 2023

– papers relating to quality reported to the board over the period April 2022 to March 2023

– feedback from commissioners dated June 2023

– feedback from governors dated June 2023

– feedback from local Healthwatch organisations dated June 2023

– feedback from overview and scrutiny committee dated June 2023

– the latest national patient survey completed September 2022

– the latest national staff survey published November 2022

– CQC inspection report dated January 2022

• the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the quality report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

• the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

Sir John Gieve
Chair of the Board of Directors
29/06/23

Louise Ashley
Chief Executive
29/06/23

Appendices

Appendix 1: National Audits reviewed 2022/2023

National programme name	Work stream / Topic name	Eligible	Participated	Status
Breast and Cosmetic Implant Registry	-	✓	TBC	Data Collection from Jan 2022 – December 22. Report Published 02/03/2023. PARTICIPATION DATA TO BE CONFIRMED
Case Mix Programme (CMP)	-	✓	✓	On-going Data Submission
Child Health Clinical Outcome Review Programme	Testicular torsion (NCEPOD)	✓	✓	Questionnaires to be Submitted by 30/06/2023
	Transition from child to adult health services (NCEPOD)	✓	✓	Data Submitted 100%
Elective Surgery (National PROMs Programme)	-	✓	✓	On-going Data Submission
Emergency Medicine QIPs	Assessing cognitive impairment in older People	✓	✓	On-going Data Submission
	Consultant Sign Off - 6 months only Apr-Oct 2022	✓	✓	2022 Audit Report Published April 2023 - Action Plan with lead
	Infection Prevention and Control	✓	✓	On-going Data Submission
	Mental Health self-harm	✓	✓	On-going Data Submission
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	✓	✓	On-going Data Submission
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	✓	On-going Data Submission
	National Hip Fracture Database	✓	✓	On-going Data Submission
National Gastro-intestinal Cancer Audit	National Bowel Cancer Audit	✓	✓	On-going Data Submission
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	✓	On-going Data Submission
Inflammatory Bowel Disease Audit	-	✓	✗	Did not Participate – data collection constraints.

				Additional resources identified for 2022-3/24
LeDeR - learning from lives and deaths of people with a learning disability and autistic people Previously known as Learning Disabilities Mortality Review Programme	-	✓	✓	Data Submitted. NEL 2022 -2023 Report to be published in August 2023. National Report to be published in July 2023.
Management of the Lower Ureter in Nephroureterectomy Work streams previously listed under Urology Audits.	Management of the Lower Ureter in Nephroureterectomy	✓	✓	On-going Data Submission
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	✓	✓	On-going Data Submission
	Perinatal confidential enquiries	✓	✓	On-going Data Submission
	Perinatal mortality surveillance	✓	✓	On-going Data Submission
Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia (NCEPOD)	✓	✓	Participated
	Crohn's disease (NCEPOD)	✓	✓	Participated
	End of Life Care (NCEPOD)	✓	✓	Audit to Start during 2023/2024
	Endometriosis (NCEPOD)	✓	✓	Data Requested and submitted, cases selected by NCEPOD. – Audit commencing in 2023/2024
	Epilepsy Study (NCEPOD)	✓	✓	2021-2022 NCEPOD Report Published in December 2022. Not a current NCEPOD Study for 2022/23

	Physical Health in Mental Health Hospitals (NCEPOD)	✓	✓	2021-2022 NCEPOD Report Published in May 2022. NCEPOD Study for 2022/23
Mental Health Clinical Outcome Review Programme	Suicide by people in contact with substance misuse services	✓	TBC	2021-2022 Report Published in March 2023
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit (NDFA)	✓	✓	On-going Data Submission
	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	✓	✓	On-going Data Submission
	National Core Diabetes Audit	✓	✓	Participated
	National Diabetes in Pregnancy Audit	✓	✓	On-going Data Submission
	National Diabetes Transition (linkage with NPDA)	✓	✓	On-going Data Submission
	NDA Integrated Specialist Survey	✓	✓	On-going Data Submission
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	✓	✓	On-going Data Submission
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	On-going Data Submission
	Paediatric Asthma Secondary Care	✓	✓	On-going Data Submission
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	✓	On-going Data Submission
National Audit of Cardiac Rehabilitation	-	✓	✓	On-going Data Submission
National Audit of Care at the End of Life (NACEL)	-	✓	✓	Participated in Round 4. Data Submission Closed. Report due July 2023
National Audit of Dementia	Care in General Hospitals	✓	✓	On-going Data Submission
	Spotlight Audit for Memory Assessment Services	N/A	N/A	Participation by NELFT, service run by NELFT not HHFT.
National Bariatric Surgery Register	-	✓	✓	On-going Data Submission

National Cardiac Arrest Audit (NCAA)	-	✓	✓	On-going Data Submission
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	On-going Data Submission
	National Heart Failure Audit	✓	✓	On-going Data Submission
National Child Mortality Database (NCMD)	-	✓	✓	On-going Data Submission – Data is submitted to CDOP. WELC submit data to NCMD for C&H
National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines	✓	✗	HHFT not participate in 2022/2023 as transferred to Pathology Partnership. Interest has been expressed for 2023/2024
National Early Inflammatory Arthritis Audit	-	✓	✓	On-going Data Submission
National Emergency Laparotomy Audit (NELA)	-	✓	✓	On-going Data Submission
National Head and Neck Cancer Audit (HANA)	-	✓	✓	On-going Data Submission
National Joint Registry	10 workstreams that all report within Annual report: • Primary hip replacement • Primary knee replacement • Primary shoulder replacement • Primary elbow replacement • Primary ankle replacement • Revision hip replacement • Revision knee replacement • Revision shoulder replacement • Revision elbow replacement	✓	✓	On-going Data Submission

	• Revision ankle replacement			
National Lung Cancer Audit	-	✓	✓	On-going Data Submission
National Maternity and Perinatal Audit (NMPA)	-	✓	✓	On-going Data Submission
National Neonatal Audit Programme (NNAP)	-	✓	✓	On-going Data Submission
National Perinatal Mortality Review Tool	-	✓	✓	On-going Data Submission
National Prostate Cancer Audit (NPCA)	-	✓	✓	On-going Data Submission
Out of hospital cardiac outcomes (OHCAO)	-	✓	✓	On-going Data Submission
Respiratory Audits	Adult Bronchiectasis Audit	✓	✓	On-going Data Submission
	Adult Respiratory Support Audit	✓	✓	On-going Data Submission
	Smoking Cessation Audit- Maternity and Mental Health Services	✓	✓	On-going Data Submission
	National Outpatient Management of Pulmonary Embolisms Audit	✓	✓	On-going Data Submission
Sentinel Stroke National Audit Programme (SSNAP)	-	✓	✓	Participated
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	-	✓	✓	On-going Data Submission
Society for Acute Medicine Benchmarking Audit (SAMBA)	-	✓	✗	Data collection constraints. Additional resources identified for 2022-3/24
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in	-	✓	✓	On-going Data Submission

bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.				
Trauma Audit & Research Network (TARN)	-	✓	✓	On-going Data Submission
UK Parkinson's Audit	-	✓	✓	Participated

Table 12: National clinical audits applicable to the Trust - source internal Trust records

Cancelled audits – 1 cancelled Nationally

- National Audit of Breast Cancer in Older Patients (NABCOP)

Audit Postponed

No relevant Audits were postponed during this audit period.

Audit Not Relevant to the Trust

There were 31 national clinical audits that were not applicable to the Trust, see table 3.

National programme name	Audit Name	Reason
British Spinal Registry	-	Not Relevant to Trust
Cleft Registry and Audit Network (CRANE)	-	Not Relevant to Trust
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Real-time surveillance of patient suicide	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide (and homicide) by people under mental health care	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide by middle-aged men (Topic closed 2021/22)	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide by people in contact with substance misuse services	Not Relevant to Trust
National Audit of Cardiovascular Disease Prevention Primary care	-	Not Relevant to Trust
National Audit of Dementia	Spotlight Audit for Memory Assessment Services	Not Relevant to Trust
National Audit of Pulmonary Hypertension	-	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary	Not Relevant to Trust

	Interventions (PCI) (Coronary Angioplasty)	
National Cardiac Audit Programme (NCAP)	National Congenital Heart Disease Audit (NCHDA)	Not Relevant to Trust
National Clinical Audit of Psychosis (NCAP)	EIP audit 2021/22	Not Relevant to Trust
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	Not Relevant to Trust
National Ophthalmology Audit (NOD)	Adult Cataract Surgery	Not Relevant to Trust
National Paediatric Diabetes Audit	-	Not Relevant to Trust
National Vascular Registry	-	Not Relevant to Trust
Neurosurgical National Audit Programme	-	Not Relevant to Trust
Paediatric Intensive Care Audit Network (PICANet)	-	Not Relevant to Trust
Perioperative Quality Improvement Programme (PQIP)	-	Not Relevant to Trust
Prescribing Observatory for Mental Health	Improving the quality of valproate prescribing in adult mental health services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing for depression in adult mental health services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing of antipsychotic medication in adult mental health services, including high dose, combined and PRN	Not Relevant to Trust
Prescribing Observatory for Mental Health	Use of clozapine	Not Relevant to Trust
Prescribing Observatory for Mental Health	Use of melatonin	Not Relevant to Trust
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	UK Renal Registry Chronic Kidney Disease Audit	Not Relevant to Trust
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	National Acute Kidney Injury Audit	Not Relevant to Trust
UK Cystic Fibrosis Registry	-	Not Relevant to Trust

Table 13; National audits not applicable to the Trust – source internal Trust records

Appendix 2: Implementation of actions implemented following the publication of the national audit and local audit 2022/2023

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
National Maternity and Perinatal Audit Clinical Report	Based on births in NHS maternity services between 1 April 2018 and 31 March 2019 in England and Wales The report captures 89% of eligible births, finding that one third of mothers with singleton pregnancies at term underwent an induction of labour. Other key findings include: • Of those experiencing an instrumental birth by forceps, as many as 1 in 20 did so without an episiotomy. • Of those opting for a vaginal birth after a previous caesarean birth, the proportion who went on to experience a vaginal birth was 61% • Of those experiencing their first birth, 23% had an instrumental birth, 23% had an emergency caesarean, and 44% who had a vaginal birth had an episiotomy.	(1) Improve the availability and quality of information about possible interventions during labour and birth, by offering individualised evidence-based information in a language and format which is accessible and tailored to each woman or birthing person's circumstances. Consider using the IDECIDE decision-making and consent tool (when available) (2) All women and birthing people should be routinely counselled and offered an episiotomy prior to experiencing a forceps-assisted birth, to reduce the chance of an OASI. (3) Conduct reviews of data completeness, data capture software and practices including mandatory field requirements. Utilise user feedback to identify patterns in missing data and opportunities to support healthcare professionals to provide complete data without	(1) IDECIDE tool not implemented but Maternity has a BAME Antenatal Group and the normal Antenatal Groups should be commencing soon. (2) Local guideline states to undertake episiotomies at forceps and there have been two cases in the last 6 months without episiotomy and these were reported on Datix and investigated. Prompt on K2 'Consider Abandoning Procedure if Delivery is NOT Imminent with 3 pulls.' (3) Contracts were awarded to Clevermed Ltd in March 2022 with a current go live date estimated around May/June 2023. However, the digital midwives run daily reports to ensure date is captured correctly and accurately for MSDS validation. This ensures that any issues with missing or incorrect data is actioned appropriately. Feedback is given to staff where necessary to support them to improve with accurate data capture and documentation. (4) Recorded on Maternity Dashboard. If not, Consultant Obstetric Anaesthetic can provide data.

		compromising clinical care. (4) Amend data fields to: ● collect the availability and timeliness of epidural anaesthesia ● separate the recording of intrapartum analgesia by type for both England and Wales ● collect analgesia and anaesthesia into two separate fields and enhance anaesthesia coding granularity to capture epidural, spinal or general anaesthesia separately in Wales.	
National Audit of Seizures and Epilepsies (Epilepsy12) and National Clinical Audit of Seizures and Epilepsies for Children and Young People	The report found that 70% (1379 out of 1974) of children and young people diagnosed with epilepsy had evidence of an updated and agreed comprehensive care plan. Other key findings include: • 65% (75 out of 115) Trusts and Health Boards had an adult epilepsy specialist nurse routinely involved in the transition of young people to adult services	(1) All females of child-bearing potential prescribed Sodium Valproate should have ongoing documentation regarding their status within the valproate Prevent Programme.	(1)The females of potential childbearing age are seen in epilepsy clinic 2-3 times a year and documentation completed with young person and parent/carer. Documentation kept on file and copy sent to GP.
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF) Based on 1,956 fragility fractures in 2020 and 2,033 fragility fractures in 2021, the number receiving FLS assessment within 12 weeks was	(1) Local health boards should ensure that they have appointed an Orthogeriatrician and that they actively support their leadership of multidisciplinary care in each trauma unit.	(1)Consultant Orthogeriatrician leads the MDT care of hip fracture patients. This is through clinical care on the wards, leading MDT meetings and leading the trusts hip fracture steering group.

	similar in 2020 and 2021 (64% and 65% respectively**)**	(2) Local health boards should ensure that falls teams in acute, community and mental health hospitals are included in quality improvement activities and are using the data from the National Audit of Inpatient Falls. (3) With falls teams reviewing health board level data and implementing focused quality improvement interventions should help improve the quality and safety of care in hospitals. (4) Health boards without an FLS should contact the Royal Osteoporosis Society and use their implementation toolkit to support them in preparing a business case. (5) Health boards that already have an FLS should ensure it is actively participating in the FLS-DB, and meeting its expected outcomes as defined by the FLS-DB's set of KPIs.	(2)The trust has a monthly strategic falls group where quality improvement projects are discussed to support inpatient falls prevention and management. Data from the National audit of inpatient falls, and data from our falls nurse and patient safety team guide the projects. (3)Progress on quality improvement projects are reviewed in the strategic falls group. Priorities for 2023/24 include enhanced observation, hot debriefs and recording of multifactorial falls risk assessment on EPR.
RCEM Fractured Neck of Femur (Care in Emergency Departments)	Over a period of 6 months, this RCEM QIP has accumulated 13949 individual cases from 159 emergency departments nationwide. This report represents a large scale national QIP delivered over a shared platform. • 49% of patients had their pain assessed	(1) Every ED should have a fractured neck of femur pathway and apply QI methodology to improve; a. time to pain assessment, b. time to analgesia, c. time to x-ray and, d. time to FIB.	(1)his is currently ongoing. Active QIP to concentrate particularly on speeding up time to XR and FIB. The aim is to prioritise these patients. NOF pathway already in situ. Due for an update (2)ED medical lead currently for hip fracture steering group. Regular

	on arrival at hospital within 15 minutes. • 56% of patients had received an X-ray within 90 minutes.	(2) Every ED should have nursing and medical leads for FNOF to champion the cause and steer improvement work. (3) Every ED should have nursing and medical leads for FNOF to champion the cause and steer improvement work. (4) Every ED should use a behavioural pain scoring tool for patients with cognitive impairment. (5) Triage nurses need to be supported and assisted in delivering timely and effective initial analgesia to any patient presenting with moderate or severe pain This would form the basis of an important QI project in itself. (6) Departments that have seen local improvements are encouraged to share good practices and submit case studies to RCEM.	meetings. No ED nursing lead for this at the moment. (3) This has now been implemented in our new AE fractured NOF ad hoc form (Abbey pain score). (4) Ongoing QIP. Awaiting first PDSA cycle. (5) This is ongoing for all patients with moderate or severe pain. Previous QIP.
National Child Mortality Database (NCMD)	Thematic report based on data collected from April 2019 to March 2021. (1) Changes in perinatal care, to reduce disease (e.g., reductions in preterm births, or brain injuries), or the impact of them (e.g., preterm brain injuries) are likely to have broad benefits to children, society and healthcare institutions	(1) Make prevention of preterm birth a priority. Social initiatives to reduce or mitigate the social determinants (e.g., smoking, obesity, and deprivation) require resources and support. Commissioners should seek to reduce deprivation and housing	(1)a) Maternity Consultant Lead for Preterm Birth runs a regular Preterm Birth Clinic. Preterm Care Bundle has been implemented including Fibronectin at Homerton. As part of the service an annual audit of preterm birth is conducted. (b) High BMI and Pregnancy Clinic is Consultant Led.

	across at least the first decade of life. Effective evidence-based perinatal interventions to reduce preterm mortality and brain injury exist (BAPM Toolkit; PERIPrem), however significant regional variation in clinical use has been noted. (2) The Perinatal Excellence to Reduce Injury in Premature Birth **(**PERIPrem) evidence-based perinatal care bundle has achieved a reduction in preterm mortality and brain injury in the South-West region after implementation.	insecurity, by integrating advice on employment, benefits and housing into maternity services, using health justice partnership and/or social prescribing models. Dedicated preterm birth clinics and implementation of evidence-based packages to predict and prevent preterm birth would ensure best-possible care to women according to their individual risk. (2) Ensure that the NICE Quality Standard QS116, which covers services for domestic violence and abuse in adults and young people, is used to improve the quality of care provided in this area. (3) Ensure broad and equitable implementation of evidence-based care bundles and single interventions (e.g., antenatal corticosteroids and magnesium sulphate) that reduce the impact of preterm birth. Delivery of all evidence-based therapies should be supported and benchmarked and compared between healthcare providers. (4) Ensure broad and equitable implementation of	(2) Maternity - Consultant Midwife/Public Health Lead Midwife oversees the Maternity Safeguarding Team which consists of Perinatal Mental Health Midwife, Safeguarding Midwife, Substance & Alcohol Misuse Midwife who case load women who fall under this category. Each area (zone) in the community is led by a Public Health Lead Midwife who oversee each area. Consultant Midwife/Public Health Lead Midwife works closely with different services across the Trust and different organisations ensuring the safest care can be provided for the vulnerable patients. (3) Magnesium Sulphate for Neuroprotection of the Fetus in Women at Risk of Preterm Birth already in place and local guideline in place. (4) NEWTT already in place. (5) *Maternity* - Local Learning Disabilities in Maternity Services guidance is already in place and implemented to local Practice. *Community Paediatrics* - Focussed and personalised care is provided to children with learning difficulties. Children in special needs schools as well as children in mainstream schools with LD are regularly reviewed by all the

		evidence-based bundles, care packages and single interventions that reduce the incidence and impact of brain injury around birth. Delivery of all evidence-based therapies should be supported and benchmarked between healthcare providers. In addition, the effective use of the Newborn Early Warning Trigger and Track (NEWTT) tool can reduce the severity of illness for babies who deteriorate after birth. (5) Improve parental and professional awareness of risk factors in children with learning disabilities (particularly the need for good nutrition, maintaining activity levels, avoidance of constipation, and appropriate responses to respiratory infections). (6) Ensure staff are aware of the importance of interpreting services being provided by professional interpreters at all stages of care, alongside provision of interpreting and translation services in NHS Trusts and all healthcare	relevant professionals including community paediatrics, dieticians, PT, OT and SALT. This helps to identify any complications early and get the specialist tertiary services input early. Most recently, the development of the PAC clinic proforma has helped to ensure compliance by prompting regular review of these factors more formally. (6) *Maternity* - Staff are encouraged to use Bigword. Maternity Unit is working towards acquiring Language Line that can enable better and immediate translation service when required via video consult. *Community Paediatrics* - In line with trust policy, we use advocacy service when indicated. For all appointments, admin staff ask whether interpreter services are needed. Ideally advocates are used face to face with telephone options when needed. Staff know and continue to be encouraged not to use family members for interpreting. (7) *Maternity* – Matron for Antenatal Clinic and Community is in the process of identifying the leads for the 5 different parts of the BCP. (8) *Maternity* - If the baby's death meets the Perinatal Mortality Review Tool (PMRT)

		services that provide care for women during pregnancy and beyond. (7) Implement provision of resources within the NHS [https://bills.parliament.uk/bills/3022] alongside programs such as the National Bereavement Care Pathway for Pregnancy & Baby Loss to support palliative care for the child, the family, and the clinical team. (8) Ensure that parents' views are sought and recorded as part of the child death review process. There was limited information from the CDOP process regarding parents' own views and concerns about their child's care during their child's life and death. The Child death review statutory and operational guidance requires parents' views to be sought and included in the process, however this is not yet happening in all cases. It will be important to find ways to improve this in future to help guide initiatives and support. (9) Ensure there is adequate multi-agency input into data collection and reviews so that	Criteria, parents ae routinely asked for their input. This is recorded on EPR within the progress notes section. Cases meeting the PMRT criteria are reviewed weekly for MDT review with Maternity and Neonatal Team. Learning drawn are shared with staff. *Community Paediatrics* - We have a substantive position for CDR nurse. Her role encompasses these aspects to include routinely submitting feedback from parents to meetings which is recorded on form C. (9) *Community Paediatrics* - Information is routinely collected across agencies at each child death review using standardised forms and incorporated into meeting papers for consideration and analysis. Relevant factors are recorded in Form C Analysis papers and in CDOP review forms.

		social environment factors, e.g., factors relating to safeguarding and deprivation, are appropriately collected and included for review.	
National Emergency Laparotomy Audit (NELA)	Homerton again outperformed in all recordable parameters with 100 % case ascertainment (86 cases) as compared to the national average of 84.5%(national standard 85%). All the Data for that period has been checked and cases has been locked. • Documentation of pre-operative risk assessment is 94.2% as compared to the national average of 84.0% (standard 85%). • 87.5% of the cases had access to theatres within the clinically appropriate time as compared to the national average of 82.8%. we can try and increase it to 100%. • The risk adjusted Mortality at Homerton Hospital is 8.7 % as compared to the national average of 9.3%. Most of the Mortality cases have been discussed in the appropriate Clinical governance/ MDT forum and mortality review tool has been updated. • 100% of the cases with predicted mortality > 5% were managed by the anaesthesia and general surgery consultant at Homerton	(1) The reporting of the CT scan by consultant is 67% which is still better than the national and AHSN 50% and 48% respectively. There is a room of improvement to increase it to around 80%. (2)	(1) The NELA pathway for management of emergency laparotomy will be included in the latest Emergency general Surgery policy which is in development

	Hospital. This is again much better than the 77.1% national average with minimum standard of 80%. • 82.6% of the patient aged above 80 and over 65 and frail were reviewed by the consultant geriatrician. This is far better than the national average of 28.4%. (Standard 80%). This is one area where we can improve and take it above 90%. • Outperforming at national and regional (UCLP) level on all published quality indicators. • For the year 8, all cases till NOV 2021 have been completed and locked.		
Neck of Femur Fracture (NOF) Jan- May 2022	Performance – Best Practice Tariff • 97.5% Assessed by Geriatrician in 72hours. • 100% Assessment for bone protection. • 97.5% had Specialist Falls Assessment. Length of stay Overall compared to other local Trusts we are still performing well (only Whittington was 15.5 days for their mean). Homerton also still performing well at discharging our patients back to their original residence; 80% compared to National average of 70%. Theatre delays 4 monthly deep dive to identify improvement.	(1) To update Hip fracture pathway (2) Inpatient falls resulting in Hip Fracture **Theatre Delays** • Documentation of why patient delayed/not suitable for surgery. • List prioritisation • Complex cases/staffing/resources • Perioperative assessment timing	(1) Pathway discussions ongoing. (2) in ED → QI work around highlighting risk of falls. 2-way dialogue between falls and hip fracture group now in place **Theatre Delays** - Early anaesthetic assessment - Education to staff around why hip fractures take priority. - Use of EPR by anaesthetics - Education to orthopaedics to use EPR to document.

JAG Accreditation Report	(1) There was evidence of very supportive general management input to the service. (2) There is strong clinical leadership and the service is congratulated on good governance and a robust audit programme which is published. (3) When interviewed, one patient specifically talked about a staff member 'going the extra mile' to support her in preparing for her colonoscopy and how this gave her the confidence to attend her scheduled appointment. This is an excellent example of compassionate care (4) When producing information leaflets the service sought specific feedback from patients to check that the information provided was clear and presented in a way that was easy to understand. This is excellent practice. (5) There are very good administration induction documents to support new staff appointments and ensure consistency in working practices. (6) The service currently has very short waiting times, with the maximum wait for routine patients of 2-3 weeks. This has been supported by	(1) We recommend that the recovery area could be further improved by replacing the curtains of the pods with doors. This would allow a reuse of some of the current endoscopy space by enabling patients to be confidentially admitted and discharged in their pods. (2) There is a map provided to help patients find their way to the endoscopy department, but signage around the entrance and access lift should be reviewed to make directions clearer, particularly for patients who would prefer to use the stairs rather than the lift. (3) We would recommend a review of the patient booking pathway, specifically for the patients that have not responded to either phone calls or texts. One option could be sending a ‘phone in letter’ rather than an appointment letter to ensure best use of the available capacity (4) The department may benefit from the employment of a Practice Educator to	

	insourcing which is now able to cease. due to backlog clearance and stability of the current demand vs capacity (7) It is exemplary that the service had made good recovery after COVID in terms of waiting. times and that the insourcing required to achieve this is now stopping. (8) The service has an excellent, well-resourced administration team who were happy in their working environment (9) There is an excellent induction programme in place for nurses and nursing assistants and evidence of signed competencies for all grades of nursing staff. (10) Nursing staff report having good access to both internal and external training. opportunities and are using the JETs workforce platform. (11) The team should be congratulated on the implementation of regular multidisciplinary virtual endoscopy human factors training to support team working and the development of skills. (12) The assessment team congratulate the service on its commitment to training the	support with training and education within the department.	

	trainees. This was demonstrated by the establishment of the endoscopy simulation. courses. It is noted that the trainees are happy and had provided good feedback on. their training opportunities		
National Audit of Care at End of Life	(1) 100% - case notes with an individualised Care Plan of care, recorded a discussion with patient regarding plan of care. (2) 100% Case note recorded discussions with families/carers regarding the possibility the patient may die.	(1) To promote staff confidence, support, and culture.	(1) Trust Education farmwork being devised to empower and promote staff confidence, support, and culture.

Table 14: actions identified from national audit reports

Appendix 3: Actions identified during local clinical audits

AUDIT TITLE	Directorate/ Service	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
What happens to safeguarding referrals by Homerton Healthcare Foundation Trust staff to children's social care	Corporate Nursing/ Safeguarding Children	(1) Audit the 'Quality of referrals sent to the Children Social Care Team (2) obtain outcome of the referrals if in the Paediatric Psychosocial Meeting Children Social Care (CSC) state, it is being screened. (3) Offering support Service	(1) Training for offering support services. • RedThread • Victim Support IDVA • Young Hackney Substance Misuse Team
Information sharing of vulnerable Antenatal women between Maternity and health visiting service	Corporate Nursing/ Safeguarding Children	Systems for effective information sharing should not depend on third party liaison and meeting attendance. For continuity of care and effective support of vulnerable antenatal women further improvements need to be made. (1) The process needs oversight by senior HV's and midwives to ensure referrals are being	(1) HV rapid response hub email set up so referrals are immediately managed on receipt. huh-tr.hvrapidresponse@nhs.net. Referral form updated with the new email address. Named midwife updated via email and verbally of the change in email address.

		completed, uploaded and noted on RIO. (2) The process of information sharing for vulnerable antenatal women needs improvements to ensure there is better recording of the direct liaison between midwives and health visiting service.	(2) HV representative at maternity psychosocial review the weekly list prior to the meeting and update at the meeting if referral not on RIO system.
High Risk Assessments and Risk Reduction Strategies in Sexual Health	CCS/ Homerton Sexual Health Service	Staff Teaching (1) Regular teaching would take place during Wednesday morning CPD sessions. The aim would be to book in these teaching sessions annually for existing staff. For new staff the aim would be for the findings of this audit to be included in the induction teaching sessions. The PowerPoint presentation would also be available on the S drive for new staff to access at any time. (2) Two groups of junior doctors start at the service in both August and February every year. Therefore, junior doctors joining the trust are expected to attend all required teaching as part of their induction. This can also include the results of this audit and the subsequent recommendations. Ad-hoc sessions or self-directed learning via the S drive can also be arranged. Proforma bundle (3) Creation and implementation of a high-risk bundle on proforma. (4) (3) Re-audit post implantation of high-risk bundle on proforma	(1) Outcomes presented and discussed in our team wide CPD meeting. (2) Recommendations for training to new rotating junior doctors joining the service bi-annually as well as signposting to staff to training section of our S-drive for updates. (3) Adaptations to our clinical software to support information gathering/documentation on risk and risk reduction.
Single Anastomosis Gastric Bypass (SAGB)/One Anastomosis	SWNS/ Bariatric Surgery	(1) Multidisciplinary (MDT) Oversight of OAGB Surgery (2) Provision of clear guidance on appropriate BPL (3) Review of Follow Up Process Post OAGB	(1) An independent review of the Bariatric governance structure has been commissioned. (2) patients potentially listed for OAGB must be agreed

Gastric Bypass (OAGB)		(4) Implementation of BOMSS Guidance for all OAGB Patients (5) MDT Oversight of Post Operative Complication in OAGB Patients (6) Bariatric Governance Review (7) Review of Bariatric AHP Structure (8) Further review of Homerton OAGB Patients	by the MDT and the limb length to be offered must be agreed too prior to surgery. (3) redesigned patient pathway built into Electronic Patient Record (EPR) System. (4) The current guidance regarding limb lengths have been incorporated into the pathways and structures as well as dietetic management and follow-up of such patients. (5) The Bariatric AHP structure is also under review. Therapies Lead involved in review to ensure there is robust support structure for HTTPS to escalate their concerns.
Compliance to BOAST guidelines on safe use of tourniquet in orthopaedic surgeries	SWNS/ Trauma & Orthopaedics	(1) To inflate tourniquet at safe pressures (a) Presenting in audit meetings. (b) Posters in theatres. (2) Improve operation note documentation. (a) Add pressure /duration /skin check /shut off / exsanguination to operation note template. (3) Increase awareness of guidelines (a) Presenting in audit meetings. (b) Posters in theatres. (4) To ensure improvement within service	(1) Presented in Audit Meeting Dec 2022 and Posters added to theatres. (2) Operation Note Updated (3) Guideline presented at Audit Meeting Dec 2022 and Posters added to theatres. (4) Reaudit in November 2023 to identify improvement.
3rd Degree Tears on the Birth Centre	SWNS/ Maternity	(1) Improved documentation of perineal support given during delivery. (2) Improve education about use of warm compresses for perineal support. (3) Improve recognition and prevention of PPH.	(1) Include teachings as part of MMT and on birth centre team meetings. (2) Use of support staff to weigh swabs (more support staff availability), escalate in a timely manner.
Transfer Audit for Birth Centre	SWNS/ Maternity	(1) Band 7 reviews in the room prior to transfer 95% of cases. Birth Centre Team leads to attend Band 7 meetings and Matron to support. (2) Present audit to Band 7s.	(1) Band 7 review in the room is ongoing work and continues to be audited. (2) Design course. Commence sessions online initially.

		(3) Design and implement Active Birth workshops aimed at reducing latent phase admissions/transfers.	(3) The Active Birth workshop is ready to roll out when the face-to-face antenatal class returns
Post appendicectomy prolonged hospital stay	SWNS/ General Surgery	(1) All laparoscopic appendectomies to be performed in under 24 hours of diagnosis. (2) To ensure improvement within service by decreasing the patients waiting time for surgery and in-hospital stay	(1) Two full day CEPOD lists (Tuesday & Thursday) introduced. (2) Emergency Appendicectomy Length of Stay is monitored as an ongoing Key Performance Indicator (KPI) for two full day CEPOD list intervention.

Table 15: Outcomes of local clinical audits

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

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

23 June 2023

Ms Louise Ashley
Chief Executive
Homerton Healthcare NHS Foundation Trust
Trust Offices
Homerton Row
London E9 6SR

Email to: louise.ashley@nhs.net, breeda.mcmanus1@nhs.net and matthew.grantham1@nhs.net

Dear Louise

Response to Homerton Healthcare NHS Foundation Trust's draft Quality Account for 2022/23

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2022/23. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

We've been grateful for the continued support to the scrutiny function of yourself and your colleagues and for your continuing leadership role as Place Based Leader for City & Hackney.

Over the past year at our Commission we've had the following items which touched on your Trust:

- Development of new City and Hackney Place Based Partnership and the role of the Place Based Leader x 3
- Mental health emergency department pressures at Homerton
- Future options for Soft Facility Services at Homerton Healthcare
- Community Diagnostic Centres
- Impact of new hospital discharge funding scheme

We do appreciate the Quality Account exercise as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services. The Commission Members

take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We're pleased that the overall CQC rating for both the Homerton and Mary Seacole sites remain unchanged at 'Good' despite the pressure of having to rebuild elective care post the pandemic and increased winter pressures.

We support the 7 quality priorities you had identified in 2022:

1	To reduce the number of community and hospital attributed pressure ulcers
2	Reducing physical violence and aggression towards patients and staff
3	Improved management and reduction in the rate of falls
4	Just Culture and Safe Environment
5	Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community-based services
6	Improving our populations health
7	Improving the first impression and experience of the Trust for all patients and visitors

and that they are in place for a 2 year reporting cycle to ensure that sufficient and sustainable progress can be achieved with them. We commend the progress you are reporting thus far.

We noted with interest the following:

a) We note that the KPI for *A&E patients being discharged in less than 4 hrs* is at 80.59% and has fallen for the second year in a row and so remains below the target of 95%. The Trust historically performed really well on this and, while this is a challenging time for the NHS nationally, we look forward to hearing more about the context here and the mitigation plans.
b) Similarly, the KPI on the number of cases of *Clostridium difficile* has spiked from 16 to 24, as against the target of 12, and we'd be interested to know more about the reasons and the mitigation plans.
c) We commend the continued excellent performance of the IAPT service on the 6 and 18 week targets.
d) We commend too, the ongoing and very active role that the Trust plays in clinical research and your participation in national audits, as these will contribute to improving treatments and outcomes for our residents.

Over the coming year, and following our discussions, we will be revisiting a number of issues including: Emergency Dept mental health case management and in-patient capacity; the planned changes to Continuing Health Care, and health inequalities and medical barriers faced by the trans community. In January we hope to hear back on the future options for 'soft facility services' at Homerton Healthcare.

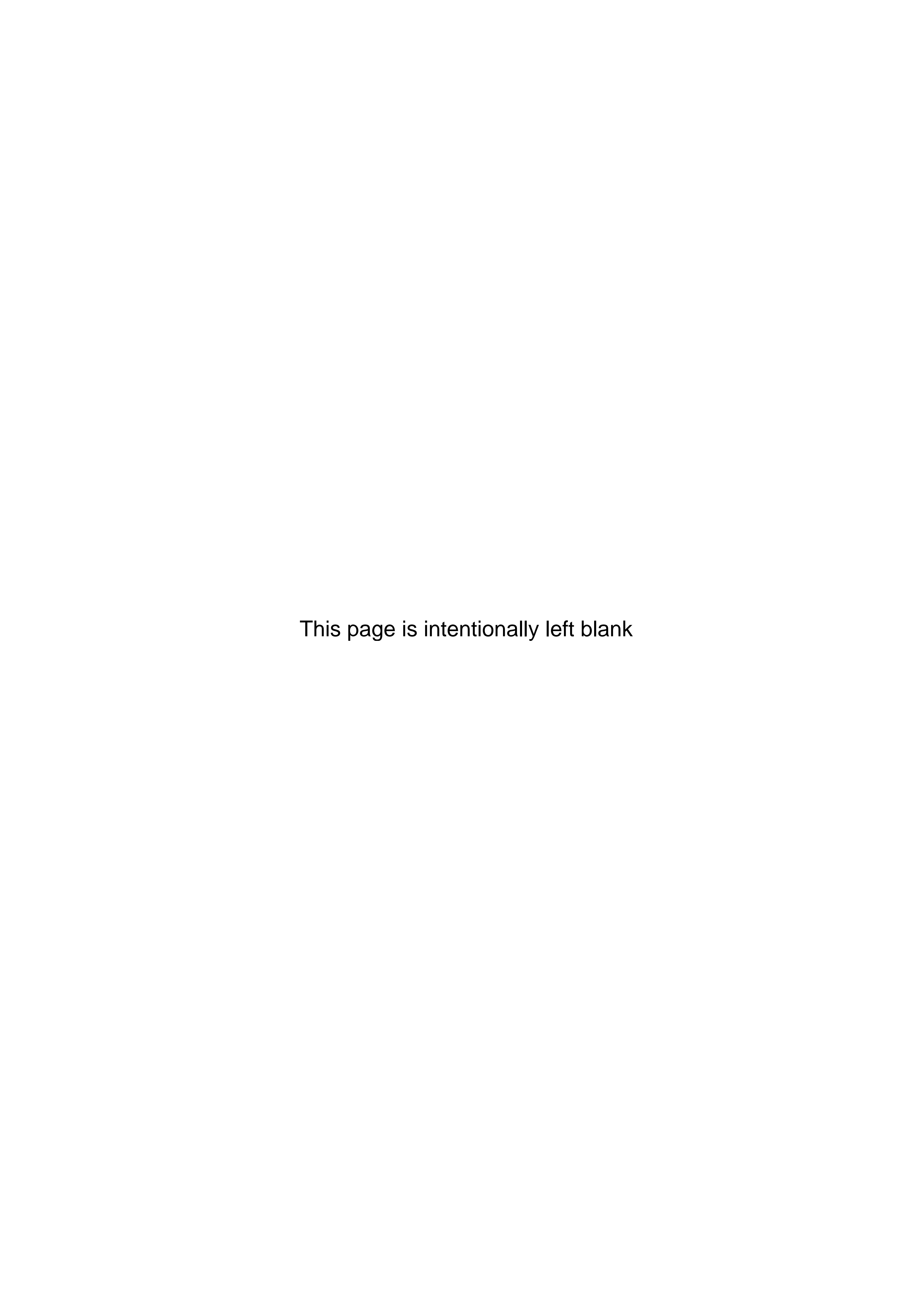
Members have also expressed concerns on such issues as: poor maternity health outcomes for Black women; poor prostate cancer health outcomes for Black men and the spike in rates of sexually transmitted infections. We are still refining our work programme for 23/24 and will get back to you on those which have direct relevance to yourselves.

We commend the report and are pleased that the Trust performs so strongly against a wide range of national quality assurance indicators.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Breeda McManus, Chief Nurse and Director of Governance, Homerton Healthcare
Matthew Grantham, Deputy Head of Quality and Patient Safety, Homerton Healthcare
Members of Health in Hackney Scrutiny Commission
Cllr Christopher Kennedy, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture
Dr Sandra Husbands, Director of Public Health, City and Hackney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Health in Hackney Scrutiny Commission 17th July 2023 **Implications of implementation of Right Care Right Person model by Met Police**	Item No **6**

PURPOSE OF ITEM

To explore the implications for health and care partners of the decision by the Metropolitan Police to implement 'Right Care Right Person (RCRP)' from 31 August.

OUTLINE

Metropolitan Police Service (MPS) Commissioner Sir Mark Rowley wrote to health and social care partners on 24 May to inform them that the MPS will be implementing the *Right Care, Right Person (RCRP) model,* withdrawing police officers from responding to most mental health related calls, by 31 August 2023. The MPS have taken this step following the pilot of the programme in the Humberside Police force area, which has significantly reduced the amount of frontline police officer time spent on a range of mental health related calls. The RCRP approach is based on medical and social care professionals dealing with the majority of people in mental health crises, rather than police officers, except when there is a risk of immediate harm. In London, the MPS estimates that over ten thousand hours of police officer time a month is currently spent on mental health related cases.

Ths policy represents a fundamental change to when Police will be deployed, particularly around welfare concerns, mental health incidents or missing persons or people absconded from hospital. The aim of the item is to discuss the implications for the health and social care system, including potential financial and reputational risks.

Attached please find:

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

d) Copy of letter which London Councils sent to the Commissioner of the Metropolitan Police expressing their concern.

Attending for this item will be:

Georgina Diba, Director of Adult Social Care Operations
Andrew Trathen, Public Health Consultant
Jed Francique, Borough Director, C&H Place, ELFT
Nina Griffith, Director of Delivery, City and Hackney Place Based Partnership

ACTION

The Commission is requested to note the reports and make any comments or recommendations as necessary.

REPORT TEMPLATE			
Title of Report	Police Approach - Right Care, Right Person - Implications for health and social care system		
Author(s)	Georgina Diba, Director Adult Social Care Operations		
Group Director Sponsor	Helen Woodland Group Director AH&I		
Meeting Title	Health in Hackney	**Meeting Date**	17.07.2023

Purpose of the Report	
For Discussion & Input	Health in Hackney are asked to note an approach being implemented by the Met Police from 31.08.2023 and the implications for the health and social care system, including potential financial and reputational risk. Hackney partners who are part of the health and care system welcome discussion and any input that facilitates a collaborative and collegiate response to improving the safety and outcomes to residents once Right Care, Right Person approach has been implemented.

Summary

- Police Force approach titled Right Care Right Person (RCRP) being implemented 31.08.2023
- Fundamental change to when Police will be deployed, particularly around welfare concerns, mental health incidents or missing persons / absconded from hospital
- There will be instances where members of the public and/ or professionals would have expected a Police responses due to risk posed, which will no longer be triaged as Police deployed
- Potential for increase in incidents leading to harm, serious injury or risk to life due to timescales for implementation
- At a Hackney placed based level, conversations with operational and senior Police colleague are positive; however, levers at local level are limited against the london wide and Central Met Police approach

Key Issues	
1	Notification by Police of plans to implement RCRP given on letter dated 24.05.2023 and shared at London DASS Branch Meeting 26.05.2023. There were 13 weeks given to health and social care partners to prepare for impact of Police approach, which in Humberside was implemented over a three year period
2	Mitigations by health and social care to respond to RCRP have potential financial implications. There will be increased reputational risk, due to the short period afforded to health and social care partners to put in place mitigating or alternative responses and capacity for instances when Police will no longer be deployed.

1. Background

1.1 On the 24th of May 2023 Sir Mark Rowley QPM, the Commissioner for New Scotland Yard, wrote to health and social care partners with respect to a model titled Right Care, Right Person (RCRP). The full letter can be found here. The model is being implemented by the Met Police in London from 31st of August 2023, giving a total of 13 weeks to implement a programme of change. It is of note that RCRP was a three year programme first developed and delivered in Humberside, in collaboration with partners such as ambulance, mental health, acute hospitals and social services.

2. Humberside Model RCRP

2.1 RCRP arose in Humberside following analysis by the force that they were being deployed to a high number of incidents that were concerned with welfare, mental health concerns or missing persons, including from hospital. The Forces view was that this detracted from their ability to focus on where a crime had occurred or where there was risk to life, in addition to their officers not being able to provide the most suitable intervention to the member of the public needing specialist support.

2.2 The legal advice received by the Humberside Police is set out on their website, but in brief, it notes that the Police do not have a duty of care under common law to protect individuals from harm, either harm caused by themselves or others. The police duty would arise from harm from criminal acts by a third party in most cases. Consideration is given to Human Rights Act Article 2 and Article 3; however, the duty under Article 2 is there must be threat of death and for both Article 2 and 3 the threat or risk must be real and immediate.

2.3 The RCRP works by the call taker in the force control room assessing the circumstances using the RCRP toolkit, alongside existing THIVE (threat, harm, risk, investigation, vulnerability, engagement) and the national decision model (NDM). The call handler will decide if a) police response required, b) police may be required to attend, possibly with a partner or c) not a police matter. Dependent on whether call from partner agency or member of the public, will determine how the person making the report is supported to undertake next actions. For example, if call from a member of the public and they are signposted to partner agency, who is unable to offer support, the Police may take on the responsibility of a concern for welfare check in this situation. It is understood the national RCRP Toolkit was being developed and was to be available from early July 2023. It is further stated that a national team, funded by the National Police Chief's Council, will be available to support police forces to implement the toolkit between July and Dec 2023.

3. Implications for Health and Social Care

3.1 The most immediate implication for health and social care arises from a 13 week window prior to implementation. There is limited detail at this stage as to concrete actions expected of health and social care partners to respond to changes in demand and risk from instances where members of the public or organisations would have called the Police previously, but would not now be deployed. It is believed this may relate to:

I. Concern for welfare i.e. person not seen for a period of time
II. Walkout of healthcare facility i.e. A&E
III. Person in mental health crisis who may be threatening self harm
IV. Person who may be deemed as missing, dependent on level of immediate risk i.e. resident with dementia
V. Call regarding welfare check on children and young people

3.2 The immediate risk around failure of deployment relate to the risk of harm or injury that may result for a resident, for example but not limited to: where a person takes they own life following call to Police; failure to

locate a person who has been flagged as missing; failure to provide care or immediate support to a person where there was concern with respect to welfare. These may pose additional risks in relation to the reputation of the Council, a partner or the Police, particularly in those cases that come to the attention of the Coroner or via a Safeguarding Adults Review / Serious Case Review or similar process.

3.3 There may be financial implications arising from the need to respond to the change in Police deployment; learning from Humberside suggests they may include but not be limited to:

I. Costs associated with additional dedicated staff in local crisis suites
II. Costs associated to local authorities, ICBs and health providers around funding of demand for resources to meet Mental Health Act s136 detentions.
III. Impact on the LAS, where in the Humberside model ambulances were required for all health-related movements, leading to increased provision of ambulances. It has not been set out the view of the London Ambulance Service as to how they would meet this increased demand.
IV. Increase in actions by local authority or provider staff to trace residents where there is concern with respect to welfare or location.

3.4 Emergency Departments or other wards may no longer call the Police if a patient leaves unexpectedly, hence additional policies and actions may need to be undertaken within the health trust to manage and respond to these.

3.5 Mental health patients who are sectioned and leave will not as routine be expected to be reported to the Police, unless there is an identified risk to self or others. The very nature of a person being sectioned suggests there would be risk to self and others, hence further clarification is needed on this point by the Police and in what instances they would deem their deployment necessary.

3.6 It is currently unclear the approach to be taken in relation to children and young people, though noted there could be an adoption of a different threshold of 'significant harm' as set out in the Children Act 2004 s31(9), that is stated as being arguably lower than that in Human Rights Act Article 2 and 3

4. Actions taken

4.1 In Hackney a Partnership group has been set up and running since early June 2023. This includes representation from place based health partners, mental health trust, colleagues in Children and Families Services, public health and wider colleagues who may be impacted (i.e. Emergency Planning and those supporting the night time economy). A collective view of the impact and risks from the local partnership has helped to inform the areas where the immediate response and focus needs to be given. This has been agreed as four key areas, with leads across the partnership as follows:

I. Mental Health and Crisis Pathways - Lead from East London NHS Foundation Trust but working across NEL partnership
II. Children and Young People - Lead in LBH Children and Families Service
III. Missing from Hospital - Lead from Homerton NHS Foundation Trust
IV. Welfare and Missing in Community - Lead from LBH Adult Social Care and ELFT

4.2 Conversations have been held at the local level between system partners and the Borough Commander. Within the NEL ICB a meeting was held of health leads and the borough commanders for the NEL area. For Hackney, these conversations were held between the borough commander and Group Directors for both adults and children. Conversations held were understood to be positive, with a focus on how we can work

together to implement this approach with a unified understanding of system pressures and a focus on achieving better outcomes for residents.

4.3 The City & Hackney Safeguarding Adults Board have also held conversations with respect to the RCRP, including at the Executive Meeting on 04.07.2023. Police colleagues here were able to set out the areas believed to be impacted, which included concerns for welfare, missing from or walking out of health care facilities, transportation purposes and handover of those in mental health crisis.

4.4 In these discussions local police leaders have also been realistic that implementation of changes will take some time to implement across the Met, therefore the 'go live' date of end August may shift. There are briefings planned in mid-July which will have further detail on this.

5. Next Steps

5.1 The MPS is setting up a partner delivery group, including health services and local government. A Chief Executive, DASS and DCS have been asked to sit on the group to ensure that the voice of London local government is represented, and representation has now been confirmed from three authorities to cover these roles.

5.2 The Hackney Partnership Group continues to meet on a weekly basis and to help unblock system challenges and make decisions arising through the four subgroups as set out in 4.1.

From Met Police Website

Introduction of Right Care, Right Person model

Right Care, Right Person (RCRP) is an operational model developed by Humberside Police that changes the way the emergency services respond to calls involving concerns about mental health. It is in the process of being rolled out across the UK as part of ongoing work between police forces, health providers and Government.
It is aimed at making sure the right agency deals with health related calls, instead of the police being the default first responder as is currently the case in most areas. It has been shown to improve outcomes, reduce demand on all services, and make sure the right care is being delivered by the right person.
It does not stop the police continuing to perform their key role of keeping people safe and where there is a real and immediate risk to life or serious harm – whether that be a person seeking to harm themselves or to harm others – officers will respond swiftly as they currently do.
In a letter sent to leaders of London health and social care providers on 24 May 2023, Commissioner Sir Mark Rowley confirmed that the Met will begin to introduce RCRP from September.
Sir Mark wrote: “It is important to stress the urgency of needing to implement RCRP in London.
“Every day that we permit the status quo to remain, we are collectively failing patients and are not setting officers up to succeed.
“In fact, we are failing Londoners twice. We are failing them first by sending police officers, not medical professionals, to those in mental health crisis, and expecting them to do their best in circumstances where they are not the right people to be dealing with a patient.
“We are failing Londoners a second time by taking large amounts of officer time away from preventing and solving crime as well as dealing properly with victims, in order to fill gaps for others.”

The current challenge

In March 2023, Met officers detained 573 people under Section 136 of the Mental Health Act and many more under Section 135, the two most commonly used powers of detention where there are concerns that someone poses a risk to themselves or others.
In London, it takes on average 14.2 hours in A&E and 8.5 hours at a health-based place of safety from the police arriving with a patient to medical staff taking over their care.
It is estimated that Met officers spend well over 10,000 hours each month responding to mental health concerns and dealing with what should principally be health matters.
Figures from the recent National Police Chiefs Council (NPCC) Productivity Review showed that nationally, police officers are spending just under one million hours a year sat with mental health patients in hospitals waiting for assessment. These are precious hours that are being taken away from tackling crime, addressing core policing priorities or using the powers that only the police have to target offenders and support victims.

While Met officers and staff are professional, compassionate and highly skilled in many areas, they are not trained to deliver the level of mental health care required by patients in crisis.

Implementation

As part of the roll out of RCRP, Met call handlers will receive training to use the model to triage incoming calls and decide on an appropriate course of action, including whether to deploy police officers or not.
The triage process is expected to result in officers attending far fewer calls, while identifying those where there is still a need for the police to be deployed, such as where health and social care partners need help, such as with patients who are violent or have assaulted healthcare staff or clinicians.
The Met continues to hold discussions with partners in ambulance, mental health, acute hospitals and social services to build, test and agree the approach so that there is a clear and shared understanding on when police will be deployed. The role out in London is also supported by the NPCC Mental Health Lead and the College of Policing, and is underpinned by new national policy being agreed between police forces and health services, with the support of Government.

Results at Humberside Police

Humberside Police identified that before the introduction of Right Care, Right Person, the force was deployed to an average of 1,566 incidents per month relating to issues such as concerns for welfare, mental health incidents or missing persons.
As a result of implementing Right Care, Right Person, Humberside saw average incidents per month reduce by 508 deployments – equating to 1,132 officer hours. This has allowed the force to reallocate saved resource to other specialist teams.

Right Care, Right Person implementation in London

Briefing – June 2023

Introduction

Metropolitan Police Service (MPS) Commissioner Sir Mark Rowley wrote to health and social care partners on 24 May to inform them that the MPS will be implementing the Right Care, Right Person (RCRP) model, withdrawing police officers from responding to most mental health related calls, by 31 August 2023.

The MPS have taken this step following the pilot of the programme in the Humberside Police force area, which has significantly reduced the amount of frontline police officer time spent on a range of mental health related calls. The RCRP approach is based on medical and social care professionals dealing with the majority of people in mental health crises, rather than police officers, except when there is a risk of immediate harm. In London, the MPS estimates that over ten thousand hours of police officer time a month is currently spent on mental health related cases.

National Roll out of Right Care, Right Person

In February 2023, the Home Secretary wrote to Chief Constables and Police and Crime Commissioners on the national approach to Right Care, Right Person[1]. The DHSC, the Home Office, NHSE, the National Police Chiefs' Council (NPCC) and the College of Policing have worked together to create a National Partnership Agreement on incorporating the principles of the Right Care, Right Person operating model that was piloted in Humberside, which is due to be signed off shortly.

The Home Secretary has encouraged local areas to work to identify how to implement the model once the National Agreement is finalised. We understand that the NPCC is due to publish a national RCRP toolkit, which will be available from early July 2023 and that a national team, funded by the National Police Chiefs' Council (NPCC), will also be available to support forces to implement the toolkit between July and December 2023. The DHSC has also committed to working with NHS England to develop guidance for Integrated Care Boards and Mental Health Trusts by July 2023.

Background to Humberside Police's model

The Humberside Police force area covers four local authorities, is approximately half the area of the Humber and North Yorkshire ICB and serves a population of around 920,000. Humber and North Yorkshire ICB has 3 Mental Health Trusts.

RCRP was piloted in Humberside over 3 years working with partners including the ambulance service, mental health, acute hospitals and social services. It was set up in response to the increase in calls to the police in relation to mental health, including many from other agencies who were unable to cope with demand.

They undertook a baseline exercise to assess the number of calls received under different mental health related call types:

- Concern for welfare
- Voluntary mental health patients

[1] Mental Health and Policing: Letter from the Home Secretary

- Walk out of health care facilities
- Mental Health Act s136
- AWOL after s17
- Transportation

RCRP in Humberside required an agreement between health and social care partners and police to ensure that those with the right skills, training and experience respond to the call for service. They developed a toolkit and training package for police staff, as well as various policies and memoranda of understanding for the police and partner agencies. The police then did not accept or attend calls that should be carried out by skilled health and social care professionals.

RCRP in Humberside uses a triage process for incoming calls to decide on the appropriate course of action. As part of the threshold tests for police intervention the following were included:

- Is there a real and immediate risk to life or serious harm to an identified person?
- Is it a medical emergency?
- Is a child at risk of significant harm?
- Is the person suspected to have a mental health problem?
- Has a crime been committed?

It is acknowledged in *College of Policing's report Right Care Right Person – Humberside Police*[2] that the Humberside model had two main barriers to implementation: internal culture and partnership relations, particularly with mental health providers due to a lack of capacity, and a perception that this would increase demand for services. The College of Policing's report focused on the need for a clear shared vision with staff and partners to help overcome these issues.

Implications for London

The MPS implementation of Right Care, Right Person would involve a significant reduction in the deployment of police officers to mental health related calls, on the grounds that these calls should be responded to by health and/or social care staff. The MPS has announced the rollout of a triage model to its call handlers to implement the changes.

There is widespread concern about how existing mental health and social services will be able to cope with an increase in demand, including from Mind, Royal College of Psychiatrists and the Centre for Mental Health.[3] This has not been addressed in the RCRP work in Humberside, and, as London has considerably higher levels of demand, as well as a more complex geography, it is not clear how health and social care services will be able to build capacity by the end of August to be able to manage this increased workload.

The Approved Mental Health Professional (AMHP) Leads network has raised concerns that when RCRP has been introduced by other police services it has sometimes been misinterpreted, with some people excluded from receiving the same level of support as others, and situations that meet the threshold for police attendance being declined by call agents. The MPS needs to provide assurances that call agents will receive appropriate training and guidance to ensure an appropriate response.

The majority of mental health cases that the MPS currently attend are for people over 18 years old. However, the introduction of RCRP will have implications for children and young people experiencing

[2] Right Care Right Person – Humberside Police | College of Policing

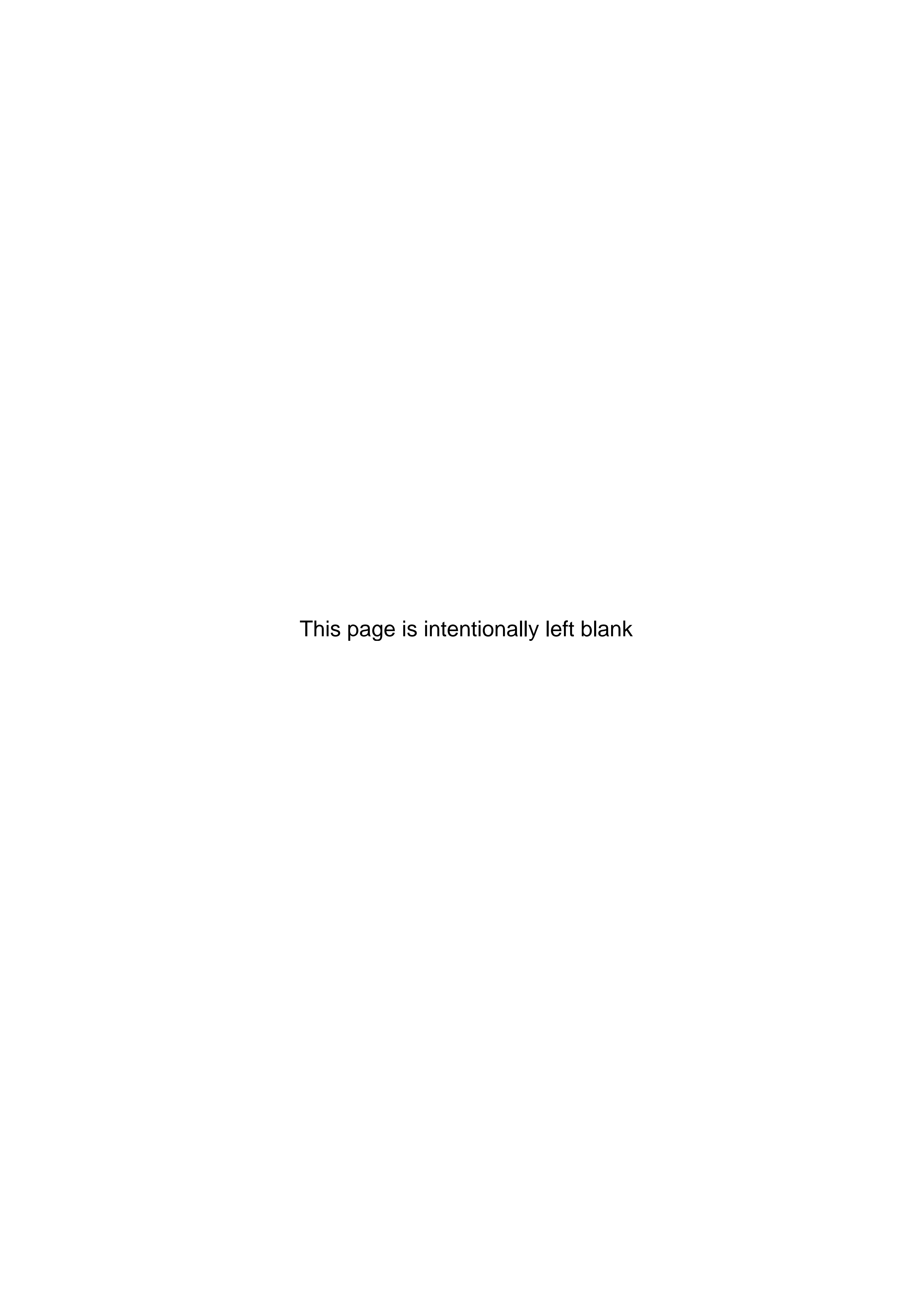
[3] Met plan to stop mental health response will leave thousands 'without support' | Metropolitan police | The Guardian

mental health crises. Therefore, it is important that children's services professionals are part of the discussions on how this approach progresses, and that the triage process developed addresses the specific needs for children and young people in mental health crisis.

Next Steps

The Chair and Vice Chair of London Councils wrote a private letter to Sir Mark Rowley on 9 June to raise concerns about the proposed implementation of Right Care, Right Person.

The MPS is setting up a partner delivery group, including health services and local government. A Chief Executive, DASS and DCS have been asked to sit on the group to ensure that the voice of London local government is represented.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To:
Sir Mark Rowley QPM
Commissioner of the Metropolitan Police

Contact: Clive Grimshaw, Strategic Lead for the Health, Wellbeing & Care
Email: Clive.Grimshaw@londoncouncils.gov.uk
Date: 8 June 2023

Dear Sir Mark,

We are writing following your letter of 24 May regarding the Right Care, Right Person (RCRP) model to express our disappointment at receiving such a letter with no prior engagement. The failure to engage is not consistent with our good track record of working together as partners serving Londoners and has caused significant and unnecessary concern and frustration across London, which could have been avoided.

The lack of engagement is especially disappointing given we are fortunate to have a range of robust and well-established mechanisms for working across agencies. Only a matter of weeks ago we held a positive, partnership discussion about the introduction of the mental health Concordat at the London Health Board.

We recognise the issues your letter highlights in terms of how vulnerable Londoners do not always receive the right response in their time of crisis. Although we recognise this to be the case, the solutions will only work in a sustainable way that improves the experience of those people if they are designed and implemented by partners working together. Partnership working will also be essential to ensure we have fully considered the implications for all people who might be impacted by this change and we note, as an example, the questions already raised about the way we respond to missing persons under the RCRP model.

As the College of Policing's own published report of the Humberside pilot states, partnership relationships and having a shared partnership vision are crucial to the success of implementing RCRP.

We truly believe this to be true and therefore see it as imperative that in order to proceed we need a dedicated forum for partnership working to be established. Although those partnership arrangements will inevitably be led by the Metropolitan Police Service and NHS England (London Region), we believe that it will be essential for local government partners to be fully involved and for arrangements to ensure good two-way communication and provide mechanisms for the wider local government sector to be updated on progress.

To assist with the work to move this discussion forward constructively, we would like work with you as local government to provide support and be part of to any partnership arrangements that are established to deliver reforms which ensure the right care is provided by the right person at the right time. We would like this to include a borough Chief Executive, a Director of Adult Social Services and a Director of Children's Services. Engagement of elected members will also be vital, ideally drawn from existing health governance.

We understand your desire to accelerate adoption of the Humberside model. However, in a City of the size and complexity of London, there will be very many difficult steps in the process which will require joined up working. Our ambition must be the implementation of a good model that delivers an improvement for Londoners, not a rushed one.

Yours sincerely,

Councillor Georgia Gould
Chair of London Councils and Leader of the London Borough of Camden

Councillor Elizabeth Campbell, Vice Chair of London Councils and Leader of the Royal Borough of Kensington and Chelsea

Councillor Gareth Roberts, Vice Chair of London Councils and Leader of the London Borough of Richmond

Hackney

Health in Hackney Scrutiny Commission 17th July 2023 Minutes of the previous meeting	Item No 7

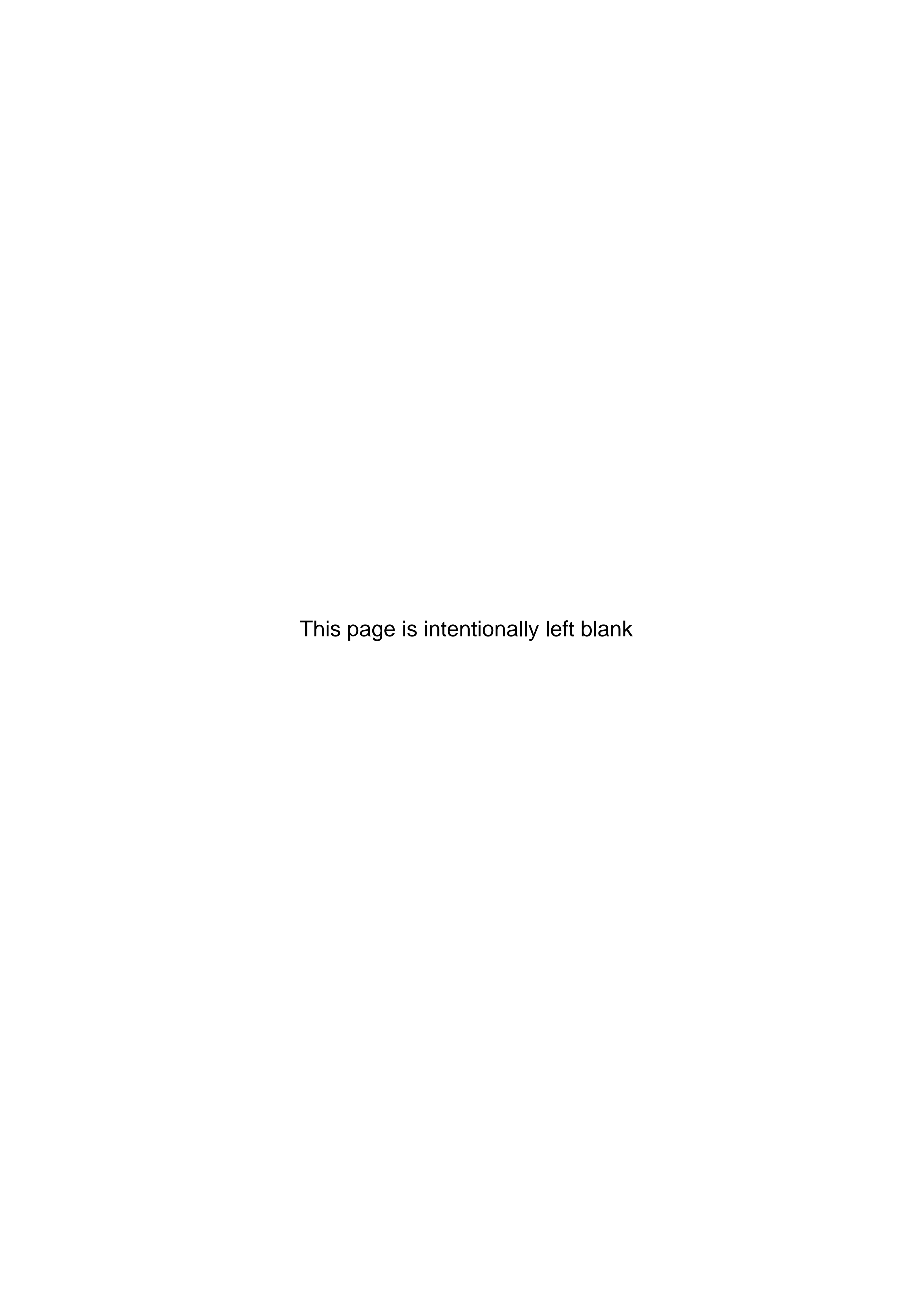
OUTLINE

Attached please find

a) Draft minutes of the meeting of the Commission held on 13 June 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: 2023/24
Date of Meeting: Tue 13 June 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 Kam Adams, Cllr Claudia Turbet-Delof**
Cllrs joining remotely	**Cllr Frank Baffour, Cllr Humaira Garasia**
Cllr apologies	**Cllr Grace Adebayo, Cllr Ifraax Samatar**
Council officers in attendance	**Suhana Begum, Senior Public Health Specialist, Adults Health and Integration** **Nina Griffith, Director of Delivery, City and Hackney Place Based Partnership** **Dr Sandra Husbands, Director of Public Health, City and Hackney** **Sam Kirk, Head of Sustainability & Environment, Climate Homes & Economy** **Tom Richardson, Environment Projects Officer - Sustainability, Climate Homes and Economy** **Jayne Taylor, Consultant in Public Health, Adults Health and Integration** **Dave Trew, Land Air Water Manager, Sustainability and Environmental Services, Climate Homes and Economy**
Other people in attendance	**Sally Beaven, Interim Executive Director, Healthwatch Hackney** **Cllr Alistair Binnie-Lubbock** **Richard Bull, Commissioner for Primary Care, NHS NEL** **Dr Kirsten Brown, GP Partner at Spring Hill Practice/Lawson Practice; Primary Care Clinical Lead for City and Hackney, NHS NEL** **Dr Tehseen Khan, GP Partner at Spring Hill Practice, PCN Clinical Director for Springfield Park PCN** **Andreas Lambrianou, Chief Executive, City and Hackney GP Confederation** **Dr Vinay Patel, GP Partner at Stamford Hill Group Practice and Chair of City and Hackney Local Medical Committee** **Jane Naismith, Director of Clinical Services and Joint CEO, St Joseph's Hospice** **Basirat Sadiq, Deputy Chief Executive, Homerton Healthcare**
Members of the public	88 views
YouTube link	View the meeting at: https://www.youtube.com/watch?v=RvEKFRmh0n8
Officer Contact:	**Jarlath O'Connell, Overview and Scrutiny Officer** jarlath.oconnell@hackney.gov.uk; 020 8356 3309

Councillor Ben Hayhurst in the Chair

1 To note the appointment of the Chair and Vice Chair for 2023-24

1.1 The Chair stated that at the recent Council AGM he had been appointed Chair and Cllr Patrick had been appointed Vice Chair for the year 2023/24. He welcomed to the Commission the two new members - Cllr Garasia and Cllr Turbet-Delof. He thanked Cllr Oguzakanil, who had left the Commission, for his contribution over the years.

2 Apologies for absence

2.1 Apologies for absence were received from Cllrs Adebayo and Samatar and from Helen Woodland. He welcomed Andreas Lambrianou (CE of GP Confederation) to his first meeting of the Commission.

3 Urgent items/order of business

3.1 There was none.

4 Declarations of interest

4.1 There were none.

5 Appointments to INEL JHOSC

5.1 Members gave consideration to the report from the Director of Legal, Democratic and Electoral Services.

RESOLVED:	**That Cllrs Hayhurst, Patrick and Turbet-Delof be appointed as the 3 Hackney Council members of INEL JHOSC for 2023-24.**

5.2 The Chair thanked Cllr Adams for his previous service on the committee.

6 Air Quality Action Plan 2021-25 - implementation update

6.1 The Chair stated that 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.

6.2 He welcomed for the item:

Dave Trew (DT), Land Air Water Manager, Sustainability and Environmental Services, Climate Homes and Economy
Tom Richardson (TR), Environment Projects Officer - Sustainability, Climate Homes and Economy
Suhana Begum (SB), Senior Public Health Specialist, Adults Health and Integration
Dr Sandra Husbands, Director of Public Health, City and Hackney
Jayne Taylor, Consultant in Public Health, Adults Health and Integration
Sam Kirk (SK), Head of Sustainability & Environment, Sustainability & Environmental Services and Public Realm, Climate Homes & Economy

6.3 Members gave consideration to a briefing *Health impacts of air pollution - progress update* from Public Health and Environmental Services.

6.4 DT, TR and SB took Members through their presentation in detail, which covered: r*ecap of key points from last year; new evidence, how 2022 compared for air quality in Hackey; changes to UK legislation and guidance, the achievements arising from Hackney's Air Quality Action pLan 2021-25; the PHE evidence review and the NICE guidance and what Hackney is doing as a result; the expansion of the air quality monitoring and assessment of traffic schemes; the web-based tool to reduce exposure to air pollution; the quality of the environment JSNA and the updated factsheet and conclusions.*

6.5 Members asked questions and the following points were noted:

a) The Chair asked why London was so slow in adopting the amended and tougher WHO standards and where was the 10 point plan to deal with the high NO2 hotspots. DT explained that the Action Plan details what they'd committed to but the WHO guidelines had changed. There was nothing to stop changes being made irrespective of the timeline of the action plan. WHO understands that a staged progression is needed and that is what they are doing and they are working towards those tighter guidelines.

b) The Chair asked where was the transparency of the datasets going to elected members regularly. DT explained the different parameters they are working to the annual report for the GLA for example, requiring them to report against the air quality objectives set out in their own strategy. Hackney has already said it needs to go further and be more ambitious and there is an ongoing need to be transparent about where the council is against the indicators.

c) The Chair asked whether we need a specific strategy with respect to the high NO2 areas. DT replied this is what the AQAP is designed to achieve and they will implement measures across the borough. There has been a significant improvement against the GLA baseline from 2013 for example. The AQAP is borough wide but they try to focus on hotspots and they work on such things as School Streets to protect the most vulnerable. The studies coming out since ULEZ show rapid reduction in pollutant levels and so the next set of data taking this into account will see significant improvements. It's about wrapping it all up into a whole package of measures, which is the AQAP.

d) The Chair asked about Dr Mudway's recommendations from last year on, for example, the need for such mitigation measures as use of HEPA filters in schools. DT described the green screen programme to put in new screens in schools. There are also monitors in schools and the recent modelling shows that more work has to be done on reducing the levels as against the WHO revised standard and that will be prioritised as part of a wider programme.

e) Members asked whether neighbouring boroughs were taking the same measures? DT described recently securing funding for a joint project with Tower Hamlets, Newham and City of London for a web tool that will provide advice to people and it will cover both indoor and outdoor pollution. There is a need to provide

advice in relation to indoor pollutants such as cleaning products or solvents for use on furniture and products relating to damp and mould. The monitoring plan is based on a template put together by the GLA but that is just a guide you can go above and beyond that and in Hackney we have 47 measures in our AQAP. He added that there are a range of cross borough initiatives and some single borough ones.

f) Members commended the more ambitious targets but asked how these interim targets align with what WHO is asking for and also what more was being done in terms of national lobbying. DT and TR explained that the WHO guidelines focus on health impacts alone and not feasibility. The interim targets are based on stepped reductions on health impacts but they are based on cities in Asia with much higher concentrations. The local objectives are based on feasibility and practicality and not just on health effects which is why they are lower. DT added that it was complex, some of the air pollution in London is caused by dust from the Sahara for example and there are other natural sources so it is important in a local plan to look at what they can actually deliver. There are no timescales for the 4 interim targets and we won't be able to get there overnight so a steady progression will be needed. The timescales depend on the particular pollutant. NO2 is probably going to be generated within the borough a lot more than the PMs as the latter will disperse more widely. With PMS there needs to be more joined up working and more pan London projects because of this. He explained how they were working on a pan London project to deal with pollution from Non Road Working Machinery eg on building sites which up to now did not have to meet the ULEZ targets. This was being changed. When the government consulted on the Air Quality Strategy targets for PM 2.5, Hackney responded that we needed to be more ambitious and the Mayor and Cabinet do actively lobby in various ways such as through London Councils. SK added that there have been huge improvements since 2013 and there are 47 actions in our AQAP which covers all departments of the council. The Mayor and Cllr Coban work closely with the Street Scene team on how to reduce poor air quality be it via LTNS or School Street and it's an ongoing and evolving process. The Council also responded recently to object to the plans to expand City Airport..

g) Members asked about boundary road hotspots and roll-out of the monitors. DT explained how they had secured funding to assess impact on air pollution on changes to road schemes e.g. as part of the LTNS and they've hired 4 new monitoring stations for 2 yrs which will be located at key hotspots: near Homerton Library, Amhurst Rd, Queensbridge Rd and Dalston Lane. They are not just monitoring but have also some very detailed dispersion modelling analysis also and this is reported on the website. The two permanent monitoring stations will be procured over the next 12 months and being permanent will ensure continuity. The webtool will aid in providing advice to those who live in those high concentration areas on how you can ventilate your home to reduce impact of outdoor and indoor pollution.

h) The Chair asked about the cost of the monitors and if they all monitored PM2.5, PM10 and NO2. DT explained that the permanent one in Old St will be NO2 and PM2.5. The one in Green Lanes is NO2 only and the 4 new ones will be NO2 and PM10 and of the two new permanent ones they are looking to have PM2.5 in at least

one of those. The monitoring stations will give ongoing real time data and not just monthly recording. In terms of cost it's about £10k per monitor and £8k for the enclosures..

6.6 The Chair asked if next year's update could present the average readings from all these new monitors with year by year comparisons and an indication of how these results measure against the 2005 and 2021 WHO guidelines and further detail on what the Council is doing to better educate, inform and mitigate against the worst effects. He stated that the priority for the future needs to be to focus down on those high concentration areas. He commended the officers for their excellent work and for making the time to present. TR offered to share more detailed reporting with Members who wished to receive it..

ACTION:	**TR to provide members who would like it with access to more detailed data monitoring on air pollution.**

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

7 Local GP services:- Access and Quality - update

7.1 The Chair stated that at the 12 January meeting Members had 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.

7.2 He welcomed for the item:

Dr Kirsten Brown (KB), GP Partner at Spring Hill Practice and The Lawson Practice and Primary Care Clinical Lead for City and Hackney, NHS NEL
Dr Tehseen Khan (TK), GP Partner at Spring Hill Practice, PCN Clinical Director for Springfield Park PCN
Dr Vinay Patel (VP), GP Partner at Stamford Hill Group Practice and Chair of City and Hackney Local Medical Committee (the local BMA branch)
Richard Bull (RB), Commissioner for Primary Care, NHS NEL
Andreas Lambrianou, Chief Executive, City and Hackney GP Confederation
Sally Beaven (SB), Interim Executive Director, Healthwatch Hackney

7.3 Members gave consideration to a briefing note entitled *GP Access* from NHS NEL Primary Care Commissioning and a tabled presentation *Springfield Park Primary Care Network* from Dr Khan.

7.4 KB and RB took Members through a detailed presentation which comprised two sections: *data update on GP workforce and access Oct 22-Mar 23; GP Contract 23/24 access requirements of GPs and PCNs for the coming year*.

7.5 TK took Members through his presentation which covered: *Population headlines; Insights - prevention barriers; Enablers; PCN additional roles; PCN Enhanced Access; Stamford Hill Health and Wellbeing Day; PCN agenda - focus on prevention; PCN Agenda (anticipatory care, personalised care, GP access); Take home messages.*

7.6 Members asked questions and the following points were noted:

a) The Chair asked about the need for a standard roll-out of the most up to date phone system to produce consistent data and added that he greatly welcomed the Healthwatch survey on GP access, the analysis of which is just being finalised. RB replied that he welcomed the Healthwatch data which they would study and combine with other patient experience data and discuss among the PCNs. TK gave a presentation on Springfield Park PCN and underlined their work on recruiting to the additional roles explaining that they had a PCN nurse that is shared among the 3 Practices and who focuses on childhood immunisation. He also detailed the particular challenges Springfield Park PSN faces because of its demographics.

b) The Chair asked if enough was being done re digital divide in areas with low smart phone usage. TK explained that the Charedi Community are less likely to use online as they don't use smartphones. Some Practices have a 'Patient Partner' system to complement digital access. He added that there are different ways to mitigate the effect of digital divide. They now run a triage system so those unable to access digitally are able to phone. With more patients accessing online eventually more capacity is freed up for those who must use the phone.

c) The Chair asked about the ability to collect robust data on call drop offs. KB explained that at Spring Hill in their Reception they can now see exactly how many calls are waiting, how many missed and how many dropped off in real time and this has been a great benefit. She described how they had cleared the 8.00 am rush by 8.30 using their new telephone triage approach and had dealt with 160 requests. RB explained that Practices now get support from GP Confed, who have expertise in quality improvement, and can help practices to understand their data and interrogate their digital system so that they can then flex staff accordingly. The Chair stated that it was good to hear of the progress here.

d) Members asked about language barriers and how Practices provide translation options. RB replied that all modern phone systems monitor the number of drop offs. A number of suppliers on the government framework are preselected because they meet the required competences. On language barriers he added that asylum seekers often use online as a good way to access Practices who can then do online translation and book an interpreter also if necessary. KB explained the options including using telephone interpreting by calling the patient back for a 3-way call with the interpreter on the call or in the room. She added that in her Practice they have staff who are fluent in many languages and they can also book face to face

interpreting through the Homerton's services. They also use Language Hub to interpret..

e) Members asked about residents having poor experiences with access at Lawson Practice and detailed some examples. KB apologised for this and stated that while she couldn't get into individual cases at committee she wanted to reassure Members that they were improving as evidenced in the latest results from the Patient Survey. Nobody is turned away and every contact is triaged, she added. She encouraged the Members concerned to contact the Patients Participation Group at Lawson and also to contact the Manager directly. RB encouraged the Members to leave feedback online via 'Care Opinion's and added he would raise it with Lawson. There had been an issue regarding continuity of patient care as Whiston Rd Practice had closed down after the partners had retired and patients had had to be dispersed to neighbouring Practices.

f) Sally Beaven (Healthwatch Hackney) summarised the better than expected results on their recent GP Access survey. They had phoned every Practice as part of the exercise and over 50% were answered in under 3 minutes. Compared with what they had been hearing they were pleasantly surprised. One issue that did emerge was that there was far too much variability on the recorded messages which callers receive and there was going to be some co-production work with Practices to try and standardise these and make them better. She added they would repeat their survey in 6 months.

g) Other Members asked about residents complaints re Lawson, re translation, re digital skills and need for face to face. KB agreed that the language barrier issue was a huge one and translation does take time. RB added that City and Hackney had invested more in GPs to reflect the huge proportion of the population whose first language isn't English and so the consultations will take longer. They had incentivised practices to do their own self assessment and they will look at this at the Primary Care Board.

h) Dr Vinay Pantel (LMC Chair) gave an overview on the GP access context and of funding and need for progress with the Council on on primary care estates and on the success of Duty Doctor scheme. Funding was now based on 3 formulae: the old Cahill formula and the more recent weighted payments and now adjusted payments. North East London suffers under these formulae as they are predominantly weighted towards elderly rather than other demographic factors or other acuity of need. The large younger population in Hackney for example has many pregnant women needing ongoing support and this is not acknowledged. On list sizes he explained that Stamford Hill Practice has jumped from 15500 to over 18000 off a baseline of 11500 and added to this recruitment and retention is difficult. GPs are not committing to Practices due to stress and many are opting to be locums. He asked the Commission if they could assist on a key issue which is the quality of primary care

estates, adding that they would like to take this forward together and there is a need for a more integrated approach with for example Public Health. There is a growing population and the very specific needs within that population require new thinking. Conversations have started on working with paediatricians at Homerton for example and more work needs to be done on health promotion and this needs to be built on. He commented that Hackney's Duty Doctor Scheme had been a great success and added that he, as a Waltham Forest resident, couldn't access such a service there. The Chair thanked him for this and added they would pick up the Estates issue.

ACTION:	**Estates in crisis in primary care item on future work programme to be brought forward.**

i) Members asked what's going to happen on disparities on telephone answering times as outlined in the Healthwatch survey results and on recruitment and retention of GPs. RB replied that the new phone systems will record all drop-offs. They will look closely at the Healthwatch survey results and share it with Practices and he offered to bring outcomes from the improvement plans on access back to the Commission.

ACTION:	**RB to share the outcome of the improvement plans for the Hackney PCNs on improving GP Access, once available.**

7.7 The Chair thanked the partners attending for their detailed work and for their attendance.He added that the current local research on access was the most in-depth he had seen in 10 years.

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

8 St Joseph's Hospice Quality Account 2022-23

8.1 The Chair stated that In June each year the Commission is asked to submit a response to the draft Quality Account which local health 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.

8.2 He welcomed **Jane Naismith (JN)**, Director of Clinical Services and Joint CEO.

8.3 Members gave consideration to the draft of *St Joseph's Hospice Quality Account 2022-23.*

8.4 JN took Members through the report which covered: *organisational context; priorities for improvement 23-24 (easy read project; increase access and community support for individuals with non cancer diagnosis; improvements to the hospice environment; implement new NHS Patient Safety Incident Response Framework); quality monitoring and review; improvement progress; statement of assurance from the board.*

She added that as they're not an NHS Trust, submission of Quality Accounts is not compulsory but they continue to do it as part of good clinical governance. Their 4 priorities as above are mainly focused on accessibility and inclusion. She stated they were very proud of their cancer vs non-cancer progress as both are now almost equal and she reminded members that rehabilitative palliative care can be preventative, illustrating how cases of breathlessness for example can lead to many more calls to NHS 111. She added that they benchmark against all hospices in the UK and on all measures they benchmark successfully and consistently and are higher performing.

8.5 Members asked questions and the following points were noted:

a) The Chair asked about the issue of cancer vs non cancer related patients using the hospice and on Council's own 'money hub' project. JN replied that 51% currently have cancer diagnosis. The government is re categorising Long Term Conditions as Major Conditions and this will have an impact. Those who are non cancer generally have more debilitating symptoms than the average cancer patient so outcomes can be worse for longer and this leads to a disease trajectory which is more challenging. With modern cancer treatments cancer patients generally manage and then deteriorate quickly. But if you have respiratory or heart or lung conditions you are more likely to have a very rocky journey. St Joseph's knows that there is a high unmet palliative care need locally, that there is a very mixed population with poor health outcomes. They do need to better meet his need and so that is why they have the emphasis on non cancer diagnoses also. On the Council's Money Hub, she stated that they were aware of it and do link in.

b) Members asked about the schedule for CQC inspections of St Joseph's and the special review. JM replied that CQC are very out of date in their visits which of course had stalled totally during the pandemic. They have been doing monitoring calls with them and an inspection is imminent. A recent visit had to be cancelled as the inspector was ill. They are also expecting monitoring visits from NEL ICS..

c) Members asked whether there were a greater number of admissions with dementia and how the service was adapting to that. JM described the local work their community nurses do with volunteers using the Namaste Care approach. These practitioners go into people's homes and focus on using the 5 senses to connect with people. It has proved very effective and reduces stress and anxiety and the reluctance to have care. Some of the patients are often non verbal and shut down and by the end of these sessions they are reacting. They do admit patients with dementia and they have a whole host of protocols to ensure they are monitored and

kept safe and they try to make the wards as dementia friendly as possible by focusing closeley on the built environment.

d) Members asked about the diversity accreditation award for the workforce. JM replied that the Institute of Diversity FREDIE accreditation was aimed at workforce rather than patients and it is not easy to achieve. She commented that in many of the local populations there is less of a tradition of nursing careers. She added that with the workforce there was a focus on ensuring that people bring their whole self to work and this improves productivity. They have an action plan in place and their assessor for FREDIE has been very pleased with progress so far.

8.6 The Chair commended the report and the evidence of above national average performance across all the metrics. He added that St Joseph's was a much appreciated and valuable institution in the borough. As many of the councillors are relatively new he suggested they would benefit from learning more and thanked JM for her kind officer of site visit which the Commission would take up.

ACTION:	**Site visit for Members to St Joseph's Hospice to be organised.**

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

9 Minutes of the previous meeting

9.1 Members gave consideration to the draft minutes of the meeting held on 26 April 2023.

RESOLVED:	**That the minutes of the meetings held on 26 April 2023 be agreed as a correct record and that the Action Tracker be noted.**

10. Work programme for the Commission

10.1 Members noted the updated work programme. The Chair stated that at the next meeting there would be the collated suggestions arising from the Scrutiny Public Survey as well as suggestions from stakeholders and he asked Members to submit their new suggestions by 22 June.

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

11. AOB

11.1 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	Issue will be revisited in future work programme.
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	Ongoing.
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	Ongoing.
15/03/2023	Cost of living crisis and heatlh equity	NG to provide further information on the timeline for the Free School Meals Task Group.	Nina Griffith	Update to follow.
~~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~~	~~Completed. Document sent to Members 7 June.~~
13/06/2023	Air Quality Action Plan implementation	TR to provide members who would like it with access to more detailed data monitoring on air pollution.	Dave Trew/Tom Richardson	Ongoing
13/06/2023	Local GP Services Access and Quality	RB to share the outcome of the improvement plans for the Hackney PCNs on improving GP Access, once available.	Richard Bull	Return to isuse before June '24
13/06/2023	St Joseph's Quality Account	Site visit for Members to St Joseph's Hospice to be organised.	Jane Naismith	To be arranged.

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Hackney

Health in Hackney Scrutiny Commission 17th July 2023 **Work programme for 2023-24**	Item No **8**

PURPOSE OF ITEM
To agree work programme items for 2023-24.

OUTLINE
Attached please find a copy of the

a) Work programme for 2023-2024 (please note this is updated regularly and is a working document)
b) Work programme for INEL JHOSC for 23/24, for noting
c) Themed list of suggestions received so far

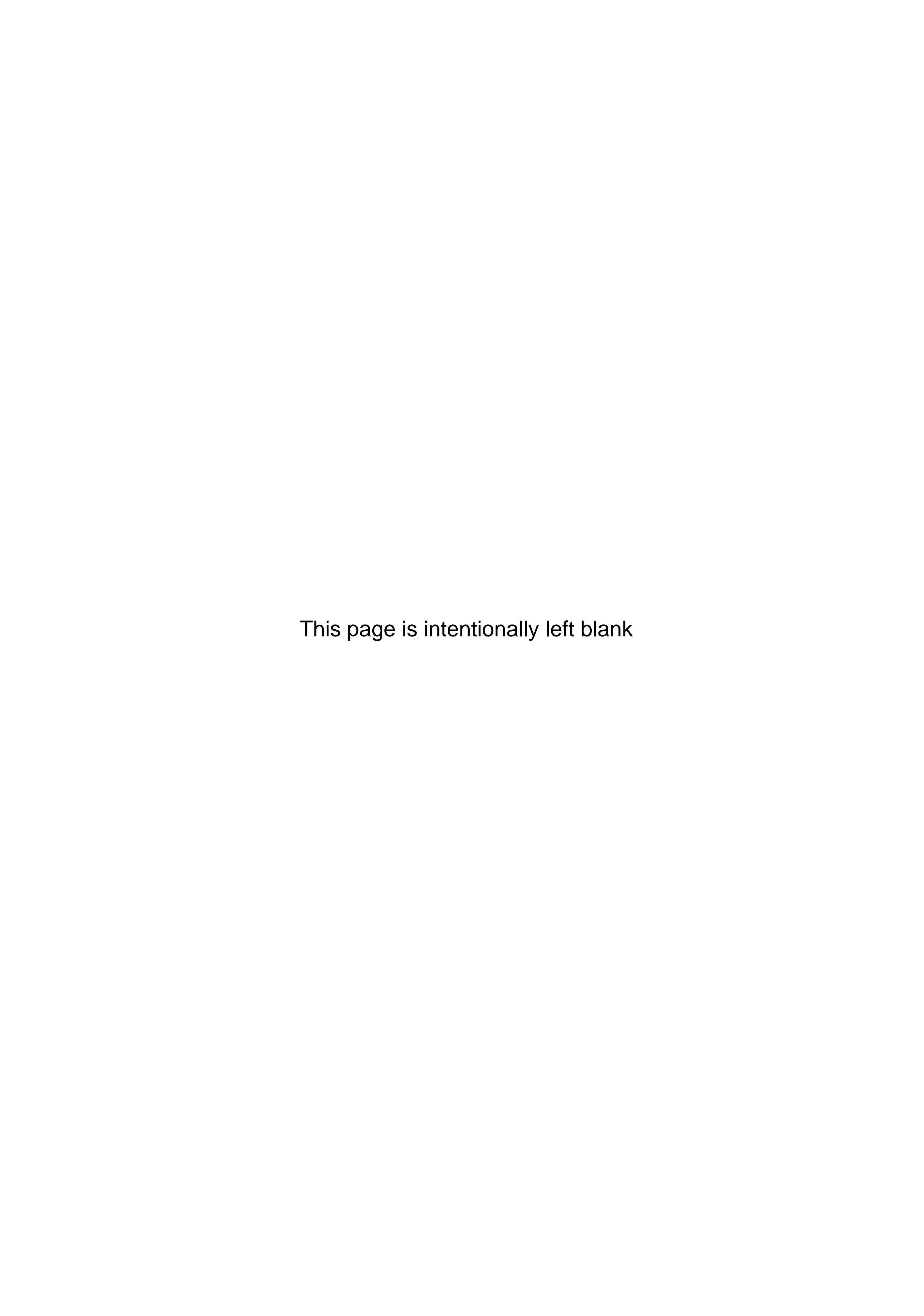
Members are asked to consider the *Work Programme Themed Suggestions* document which combines suggestions from the Annual Scrutiny Survey which are relevant to Health in Hackney as well as other suggestions received.

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

Partners and stakeholders were written to and invited to make suggestions. Cabinet also meets with the Scrutiny Panel to discuss the work programmes for the Commissions for the forthcoming year.

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

ACTION
The Commission is requested to agree 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**
13 June 2023	**Election of Chair and Vice Chair**				
	Appointment of reps to INEL JHOSC				
	Air Quality Action Plan 21-25 implementation update	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
	Local GP services - Access and Quality	Briefing	NHS NEL Primary Care	Clincial 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
	St Joseph's Hospice Quality Account 22-23	Annual item	St Joseph's Hospice	Director of Clinical Services	Jane Naismith
	Work programme for 2023-24	Discussion			
17/07/2023	**Health inequalities and medical barriers faced by trans and non binary community**		Gendered Intelligence	Head of Public Engagement	Cara English
			Homerton Healthcare	Clinical Lead for Sexual Health and HIV and Medical Examiner	Dr Katherine Coyne
				Consultant	Dr Sarah Creighton
			NHS NEL	Chief Medical Officer	Dr Paul Gilluley
			GP Confederation	Practice Development Nurse	Heggy Wyatt
			Public Health - City and Hackney	Director of Public Health City and Hackney	Dr Sandra Husbands
	Met Police implementation of Right Care Right Person model	Briefing	Adults Health and Integration	Director Adult Social Care and Operations	Georgina Diba
			ELFT	Borough Director C&H	Jed Francique
			C&H Place Based Partnership	Director of Delivery	Nina Griffith
	Homerton Healthcare Quality Account 22-23 - HiH response	Annual item	Homerton Healthcare	Chief Nurse and Director of Governance	Breeda McManus
11 Sept 2023	**City & Hackney Safeguarding Adults Board Annual Report**	Annual item	CHSAB	Independent Chair	Dr Adi Cooper OBE
				Director Adult Social Care and Operations	Georgina Diba
	Healthwatch Hackney Annual Report 22/23	Annual item	Healthwatch Hackney	Chair	Deborah Cohen
				Exec Director	Sally Beaven
	Pressure on Adult Mental Health services (TBC)				

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	TBC				
10 Oct 2023	**TBC**				
	TBC				
	TBC				
	TBC				
15 Nov 2023	**Adult Social Care and Accommodation - planning for future need** (to include benchmarking)	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
	TBC				
	TBC				
10 Jan 2024	**Cabinet Member Question Time: Cllr Kennedy**	Annual CQT session	LBH	Cabinet Member for Health, ASC, Voluntary Sector and Culture	Cllr Chris Kennedy
	TBC				
	Future options for Soft Facility Services at Homerton Healthcare	Follow up 8 Feb	Homerton Heatlhcare	CE	Louise Ashley
			Homerton Heatlhcare	CFO	Rob Clarke
	TBC				
12 Feb 2024					
	TBC				
	TBC				
	TBC				
14 March 2024	**New commissioning arrangements for Dentistry one year on**		NHS NEL	Commissioner	Jeremy Wallman
	TBC				
	TBC				

ITEMS AGREED BUT NOT YET SCHEDULED

Pencilled dates					
	In future items the Commission to test the performance of primary care in NEL against the principles set out in the The Fuller Report.				
	New CQC inspection regime for Adult Social Care		Adults, Health and Integration		
	Estates crisis in Primary Care		NHS NEL/ PCNs/GP Confed		
	Outcomes Framework for City and Hackney Place Based System	Follow up 5 Dec	Adults Health and Integration	Director of Delivery	Nina Griffith
	Measuring the impact of anti racism actions in commissioning and service delivery in C&H Place Based System	Follow up 5 Dec	Adults, Health and Integraton	Director of Delivery	Nina Griffith

	Liberty Protection Safeguards - progress on implementation of new system	Follow up 5 Dec	Adults, Health and Integration	Principal Social Worker	Dr Godfred Boahen
	Emergency Dept mental health in-patient capacity	Follow up 5 Dec	Adults, Health and Integration/ ELFT/ NHS NEL	Director of Delivery	Nina Griffith
	Consultation on Changes to Continuing Health Care - the Hackney perspective		Adults, Health and Integration and NHS NEL		
	Poor maternity health outcomes for Black women	From Cllr Patrick	NHS NEL/ Homerton Healthcare		
	Poor prostate cancer health outcomes for Black men	From Cllr Patrick	NHS NEL/ Homerton Healthcare		
	Services for those with learning disabilities	From Cllr Patrick	Adults, Health and Integration		
	Safeguarding issues around hoarding and self neglect	From Cllr Samatar	Adults, Health and Integration	Director Adult Social Care and Operations	Georgina Diba
	Revisit progress of Wellbeing Network focus on crisis support	Follow up from 24 April	Adults, Health and Integration	Senior Public Health Specialist	Jennifer Millmore
			Mind in CHWF	CEO	Vanessa Morris
	Sexually transmitted infections (STI) and mental health	From Cllr Turbet-Delof	Homerton Healthcare		
			Public Health		
	Chagas disease - migrant health	From Cllr Turbet-Delof	NHS NEL		
			UK Chagas Hub		
			Public Health		
	NHS charging regulations on migrants	From Cllr Turbet-Delof	NHS NEL		
	(note: the above has been done in detail at INEL and HiH)		Homerton Healthcare		
	Suicide and cost of living crisis and debt	From Cllr Turbet-Delof	ELFT		
			Adult Services		
			Wellbeing Network		

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INEL JHOSC Forward Plan

Potential date	#	Agenda item	Added to agenda on/by:	Author/Presenter
July 2023	1	Community voice: Paul Atkinson re North East London Talking Therapies	Chair	Guest: Paul Atkinson
	2	Collaboratives • Mental Health, Disabilities and Autism Collaborative • Community Health Collaborative	From Feb 2023 meet	Paul Calaminus/Selina Douglas Sally Adams
	3	Health update including slides on: • NEL Big conversation and staffing structure • Financial environment and operating plan • Strike action and Trust updates (BH/ELFT/NELFT/Homerton)	Standing item	Zina Etheridge Henry Black Shane Degaris, Paul Calaminus/Jacqui Van Rossum, and Louise Ashley
	4	ICS Five Year Forward Plan	May 23 internal and external discussions	Johanna Moss
	5	System recovery and resilience • Place partnership mutual accountability framework • System recovery and resilience in Urgent and Emergency Care	From Feb 2023 and Dec 2022 meets	Charlotte Pomery Clive Walsh
	6	Continuing Healthcare policies	Request from NHS	Diane Jones / Don Neame
Nov 2023	1	Health update including: ● Outcome of CHC consultation	Standing item	
	2	Improving the performance of NHS 111 across NEL.	From Feb 2023 meet	
	3	Primary Care Recovery Plan	Request from NHS	
Jan 24	1	Health update	Standing item	
	2	Update on outcomes of the NEL Research and Engagement Network	From Feb 2023 meet	
	3	Update on the work of the Barts Health-BHRUT Collaborative presented by the Chair in Common	From Feb 2023 meet	

	4	Financial Strategy	From Dec 2022 and Feb 2023 meets	
April 24				

ITEMS TO BE SCHEDULED

- Monitoring new Assurance Framework for GP Practices – follow up from July 2022
- NEL Estates Strategy from 21/22
- Acute Provider Collaborative – follow up from Oct 22 (is this covered by the BH/BHRUT collaborative?)

WORK PROGRAMME SUGGESTIONS BY THEME FOR HiH 23-24 (as at 7 July)

NB - O&S consultation responses from residents are often lengthy and are edited for brevity, the language used is repeated below to give flavour of the views

THEME	General topic/issue	Origin
Adult social care	New CQC inspection regime for ASC	Ongoing
Adult social care	Liberty Protection Safeguards - progress on implementation of new system	Follow up 5 Dec
Adult social care	Consultation on Changes to Continuing Health Care - impact on ASC	Imminent consultation
Ageism	Aware of attitudes that stereotype older people within the council	O&S consultation response
Air quality general	Greenwashing and removal of LTNs	O&S consultation response
Air quality general	Noise and air pollution. Licensed 4 nightclubs and 4 restaurants on our street without asking, leading to late night disruption and ASB	O&S consultation response
Air quality- cycling	Safe cycling needed in Downham Rd	O&S consultation response
Air quality - cycling	Not enough cycle storage, police not responsive on theft	O&S consultation response
Air quality - cycling	Cycling on pavements in Stoke Newington; greater provision of sheds and lockers in housing developments urgently needed.	O&S consultation response
Air quality - cycling	Further improvements needed to Cycleway 1 route	O&S consultation response
Air quality -LTNs	Improve air quality round schools, make school streets mandatory, penalties for abuse of blue badges and driving children to school	O&S consultation response
Air quality -LTNs	LTNs implemented with no proper consultation, needs rethink, traffic being funnelled into a few main roads, traffic delays making pollution worse	O&S consultation response

Air quality - LTNs	LTNs creating division between working and middle classes. They protect posh areas	O&S consultation response
Air quality - LTNs	Impact on Stoke Newington High St; concreting of Shoreditch park, closure of roads, public money wasted on vanity projects for the few.	O&S consultation response
Air quality- LTNs	Cameras and signs in Stamford Hill school streets constantly being vandalised	O&S consultation response
Air quality - LTNs	Please open our road the pollution is killing me. Council only care about the rich	O&S consultation response
Air quality - LTNs	LTNs driving up traffic on main roads and when there are roadworks the jams are horrendous and polluting	O&S consultation response
Air quality - LTNs	Issues of equity and robustness of data/research behind decisions on LTNs	O&S consultation response
Chagas disease	Chagas disease - an infections parasitic disease with prevalence in migrants from Latin America. https://www.gov.uk/guidance/chagas-disease-migrant-health-guide	Cllr Turbet-Delof
Community gardens	Lack of information on community gardens to support Hackney's LNRP	O&S consultation response
Community halls	Chronically under used could be better used for clubs, classes, health improvement	O&S consultation response
Disability	Freedoms and ability to get around for elderly and disabled has worsened	O&S consultation response
Drug misuse	Drug dealing and consumption on the streets increasingly opioid related	O&S consultation response
Drug misuse	Drug and alcohol abuse leading to anti social behaviour	O&S consultation response
Drug misuse	Open drug dealing and crack addicts on streets	O&S consultation response
Drug misuse	Drug using and dealing on residential streets. Streets unsafe	O&S consultation response
Drug misuse	Class A drugs, binge drinking and gangs - streets unsafe	O&S consultation response
Drug misuse	Huge rise in hard drug abuse on streets (Dalston) at all hours and near schools.	O&S consultation response

Exercise equipment in parks	No exercise equipment in some parks, other parks being favoured, equipment not being maintained.	O&S consultation response
Fast food	Fast food establishments around schools	O&S consultation response
Food growing and waste	More support for food waste and rainwater collection, better use of back gardens, community centred growing also need for community energy scheme	O&S consultation response
Foxes	Prevalence higher than ever (from resident of 40 yrs) - problems of littering, soiling, disturbed sleep	O&S consultation response
Gambling addiction	Growth of gambling establishments impact on low income groups, young people etc	O&S consultation response
GPs - Estates	**Estates crisis in Primary Care** (on long list for some time)	Dr Vinay Pantel, LMC Chair
GPs - Estates	**Primary Care and Neighbourhood Estates**	Dr Kirsten Brown, Primary Care Clinical Lead
GPs	Access to GP appointments	O&S consultation response
GPs	**Access improvement plans** - update after a year (June '24)	Dr Kirsten Brown Primary Care Clinical Lead
GPs	**The Fuller Repor**t and our local response. This is not just Primary Care of course.	Dr Kirsten Brown Primary Care Clinical Lead
GPs	**The Primary Care Provider Landscape** in City and Hackney and the potential of a single primary care provider organisation in the future.	Dr Kirsten Brown Primary Care Clinical Lead
Gym affordability	GLL pricing structures discriminates against working poor (also timing of cheaper classes)	O&S consultation response
Gym condition	King's Hall facilities are dirty, old and falling apart	O&S consultation response
Health inequalities	Poor prostate cancer health outcomes for Black men	Cllr Patrick

Health inequalities	Poor maternity health outcomes for Black women	Cllr Patrick
Health inequalities	NHS charging regulations on migrants	Cllr Turbet-Delof
Hoarding and self neglect	Safeguarding issues around hoarding and self neglect	Cllr Samatar
Housing	Intersectionality of mental health and housing issues	Cllr Kennedy
ICS/ Place Based Partnership	Update on City and Hackney **Place Based Partnership**	Dr Stephanie Couglin, Clinical Director
ICS/ Place Based Partnership	Overview of our **integrated delivery plan;** year-end delivery against the plan	Dr Stephanie Coughlin, Clinical Director
ICS impact	Outcomes Framework for City and Hackney Place Based System	Follow up 5 Dec
ICS impact	Measuring the impact of anti racism actions in commissioning and service delivery in C&H Place Based System	Follow up 5 Dec
Learning disabilities	Services for those with learning disabilities	Cllr Patrick
Long Covid	**Long Covid service and possible site visit**	Dr Stephanie Coughlin, Clinical Director
Mental health	Emergency Dept mental health in-patient capacity	Follow up 5 Dec
Mental health	Proposal by Met Police for expansion of '***Right Care Right Person'***[1] by Sept i.e. taking police officers out of interactions with those in mental health crisis. Major implications for ASC, NHS.	Cllr Kennedy
Mental health	**Adult mental health crisis** increased acuity, increased complexity. Spike in demand for mental health services (HUH has highest number of mental health referrals to ED	Cllr Kennedy

[1] Right Care, Right Person (RCRP) is an operational model developed by Humberside Police that changes the way the emergency services respond to calls involving concerns about mental health. It is in the process of being rolled out across the UK as part of ongoing work between police forces, health providers and Government.

	in North East London; increased demand across crisis pathway; significant increase in use of Homerton Psychological Medicine service etc	
Mental health	Mental health care for adults	O&S consultation response
Mental health	Mental health, queerness, neuro diversity, disability are intersecting exponentially greater need for better disability adaptation	O&S consultation response
Mental health	Suicide and cost of living crisis and debt	Cllr Turbet-Delof
Neighbourhoods	Have **Neighbourhood Forums** bedded in, how is learning shared, does VCS contribute/benefit	Cllr Kennedy
Neighbourhoods	**Neighbourhoods working – A review of leadership strategic direction could be helpful**	Dr Stephanie Coughlin, Clinical Director
Pharmacy	**Cost of Living** with respect to **medication a**nd the offer of Community Pharmacy as part of Primary care and how we can really help reduce health inequalities.	Shilpa Shah, NEL LPC
Sexual health	Sexually transmitted infections (STI) and mental health	Cllr Turbet-Delof
Sexual health	**Sexual and reproductive health strategy** - Access to contraception; Gynae menopause service	Dr Stephanie Coughlin, Clinical Director
Smoking	Improve stop smoking areas e.g. restaurant gardens	O&S consultation response

Already committed to and carried over:

- Health inequalities and medical barriers faced by trans and non binary community (17 July)
- Briefing on Right Care Right Person implementation (17 July)
- Homerton Healthcare Quality Account (17 July)
- Healthwatch Hackney Annual Report (11 Sept)

- City and Hackney Safeguarding Adults Board Annual Report (11 Sept)
- Adult Social Care and Accommodation - planning for future need (to include benchmarking)(15 Nov)
- Cabinet Question Time: Cllr Kennedy (10 Jan)
- Future options for Soft Facility Services at Homerton Healthcare (10 Jan)
- New commissioning arrangements for Dentistry one year on (14 Mar)

Yet to be added to this mix:

1) Overarching themes from the Complaints Service e.g ASC
2) Other responses from the 12 letters sent to our key health and care stakeholders including HCVS and Healthwatch